

Health equity for trans and gender-diverse Australians: addressing the inverse care law through the provision of gender-affirming health care in the primary healthcare setting

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Received: 18 July 2022
Accepted: 12 December 2022
Published: 24 January 2023

Cite this:

Clune S *et al.* (2023)
Australian Journal of Primary Health, **29**(2), 186–193.
doi:[10.1071/PY22149](https://doi.org/10.1071/PY22149)

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ABSTRACT

Background. Equitable access to gender-affirming hormone treatment (GAHT) for trans and gender-diverse people has been identified as a key factor in addressing rates of poor health outcomes in the trans and gender-diverse community. In Australia, GAHT is largely delivered via a medical model, and within acute care facilities. Medicalisation and pathologisation of gender-affirming care acts as a significant barrier to access for many trans and gender-diverse individuals. **Methods.** This project incorporated a case study approach using multiple methods to investigate a recent community sponsored, co-designed program providing GAHT that included a peer navigator (PN) model of care in a primary healthcare (community health) setting. **Results.** Service activity in Year 1 and Year 2 demonstrated acceptability of the model, with over 1000 appointments delivered. This was supported by client feedback survey data collected at their initial ($n = 110$) and then 6-months post visit ($n = 78$) with the PN, and 31 interviews with clients, staff and stakeholders. **Conclusion.** Findings highlight the integral nature of the PN to the sustainability of the program, with some key insights into potential barriers. Basing service design on an Informed Consent model recognises the agency of the individual and their right to equitable access to health care of their choosing.

Keywords: community health; services, equitable access, gender affirming care, organisation: culture, primary health care, trans health.

Introduction

Problem description

Demand for gender-affirming hormone treatment (GAHT) has consistently risen over the last decade, yet access to gender-affirming health care in Australia remains problematic (Bretherton *et al.* 2021). Medicalisation and pathologisation of gender-affirming health care acts as a significant barrier to timely access and poor engagement in health care by trans and gender-diverse people. Trans and gender-diverse community members frequently identify a lack of cultural safety, and trans-friendly environments as a disincentive to accessing health care. Accordingly, recorded health outcomes for trans and gender-diverse people are far worse than those for the cisgender population (LGBTIQ+ Health Australia 2021).

A recent survey of health and wellbeing of 928 trans and gender-diverse Australians showed only 34% of respondents described their health as very good or excellent (Bretherton *et al.* 2021). Self-reported diagnoses of depression and anxiety for survey respondents were 73% and 67% (Bretherton *et al.* 2021), compared with 10% and 13% of the overall Australian population respectively (Australian Bureau of Statistics 2018). Often, the lack of culturally safe health care acts as a direct disincentive to engagement (Ziegler *et al.* 2019), which can delay access to treatment due to a lack of trust in either their healthcare professional or the broader health system (Cruz 2014).

The state government of Victoria, Australia, established the Trans and Gender-Diverse System Project in 2018 to provide recommendations for future development of health

and social support services for trans and gender-diverse Victorians (AHA (Australian Healthcare Associates) 2018). From that project, the 'Proud and Strong: more support for LGBTI Victorians' suite of initiatives were introduced, part of which was the Trans and Gender-Diverse People in Community Health (TGDICH) program (AHA (Australian Healthcare Associates) 2018).

The TGDICH program was introduced to increase access to gender-affirming hormone treatment within a culturally safe space outside the acute care setting. Under an informed consent framework, the TGDICH program was the first in Australia to provide GAHT in the primary care setting using a peer navigator (PN) model (Clune *et al.* 2021). Informed consent is the term to describe an approach that acknowledges the rights of the individual to self-determination with regard to bodily treatments, based on current scientific, cultural and social knowledge. It recognises the person as the only one best placed to assess and judge potential benefits from access to treatment to their wellbeing (Cavanagh *et al.* 2016).

In keeping with Tudor-Hart's notion of the inverse care law, whereby services most needed by identified population groups are often difficult to access (Tudor-Hart 1971), the TGDICH program sought to locate culturally appropriate health care in primary care to increase access and optimise

utilisation for the trans and gender-diverse (TGD) community. Calls for a broader, more nuanced understanding of access argue that access is more than use of services by individuals and communities that is appropriate and proportionate to need (Levesque *et al.* 2013). Levesque *et al.* (2013) outline their conceptual framework of access to health care incorporating various more traditional dimensions of accessibility (approachability, acceptability, availability and accommodation, affordability and appropriateness) as they interact with abilities of individuals (ability to perceive healthcare need, ability to seek, ability to reach, ability to pay for, and ability engage with healthcare services) and how that interaction creates access proper. Aspects of the framework by Levesque *et al.* (2013) will be applied in this current discussion to understand how access is affected by changing availability of services (Fig. 1).

Available knowledge

The TGDICH program was developed by a consortium of health services providers and included two multidisciplinary clinics, one in regional Victoria and one in metropolitan Melbourne, with direct links to a gender clinic, and a state-wide training program for healthcare professionals and service provider organisations. Particular to the TGDICH program was a PN model that provided a culturally sensitive approach to health

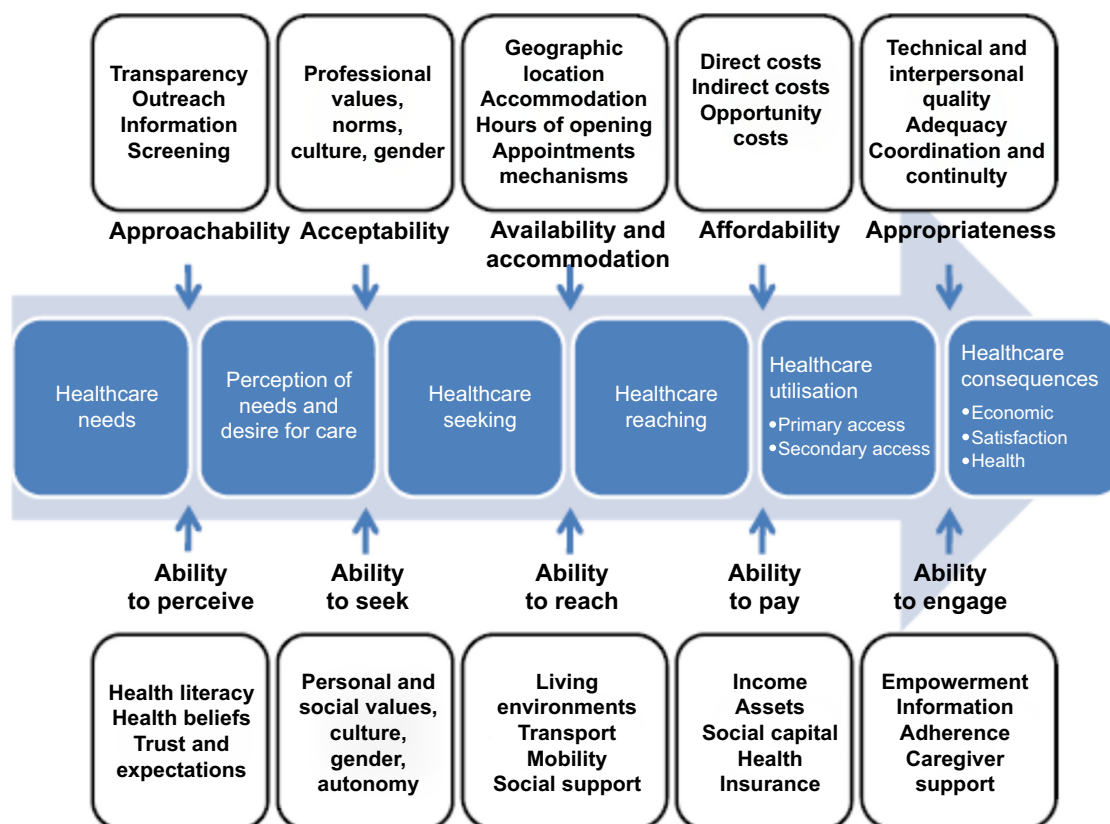


Fig. 1. A conceptual framework of access to health care proposed by Levesque *et al.* (2013).

service delivery, facilitating access in a mainstream, community-based setting. Like other PN models of care (Sheehan *et al.* 2018; Watts 2019), individuals with lived experience are employed to facilitate engagement with clients from a wellness model, focusing on client strengths (Repper and Carter 2011). PNs engaged with clients to understand their health priorities and provide current, relevant information to facilitate timely access to identified services. Co-design was the foundation of the TGDICH program, whereby the TGD community was actively involved in design, implementation, delivery and evaluation of the service.

The TGDICH program initially operated over 2 years across both locations. Clients were able to access GAHT via the in-house GP who either had an existing interest and practice in gender-affirming treatment or has received training provided as part of the TGDICH program.

Rationale and study aim

The objective of the study was to understand whether the introduction of gender-affirming health care using a PN model was desirable and sustainable in the community health setting.

Methods

Context

North Melbourne (NM) and Regional Victoria (RV) are like the rest of Australia in lacking mainstream gender-affirming health care. General population demographics were like other metropolitan and regional centres, with numbers of trans and gender-diverse individuals difficult to measure due to a lack of adequate reporting mechanisms or minimum data sets.

Intervention

The aim of the TGDICH program ('the program') was to embed GAHT into the primary care setting, thus optimising utilisation through increased access. Two multidisciplinary clinics were located within existing community health centres, neither of which provided GAHT prior to the inception of the program. Community health centres are independently managed Victorian services that focus on providing a wide range of health and social care to local communities with a focus on priority populations. Locations of the clinics were to optimise access to GAHT for local communities, with the regional location intended to minimise travel obligations. Importantly, the program model was built around having a PN as the initial contact point for TGD clients. The PN model was intended to optimise engagement with mainstream health through reduction of stigma and establishing a culturally safe environment. Clients were directed to the PN as the first point of contact at either location, whereupon they were

able to describe their health priorities and desired outcomes. Information was then provided by the PN and any appointments with internal healthcare practitioners, including endocrinology, were made.

Study design

We adopted a case study approach (Stake 2008) that incorporated mixed methods to best capture service activity and client experiences. All qualitative aspects of the study followed requirements of the Consolidated criteria for Reporting Qualitative research (COREQ) checklist (Tong *et al.* 2007).

Setting

Services were located at two separate locations: one in North Melbourne and one in regional Victoria.

Participants

There were three main participant groups: clients (existing and new); staff of both clinics, as well as partner organisations; and key stakeholders (members of the steering committee or the community advisory group, and advocates). The steering committee was selected from an existing network of expertise gained from the development of a similar, non-mainstream, program and included executive staff from each partner health service, state and national advocacy groups, and representatives from the TGD community. The community advisory group included representatives from the TGD community and was established prior to commencement of the program to ensure robust co-design.

Recruitment

Clients were informed about the evaluation project via word-of-mouth, newsletters and routine emails from the health services. Clients then contacted the research team individually to indicate interest, the research team followed up with clients to establish willingness to participate and set up times for interviews or focus groups. Clients were able to enter a draw upon completion of the online feedback surveys for a AUD100 gift voucher.

Staff and stakeholders were informed about the project via word-of-mouth, or direct email from TGDICH program staff, and approached the research team individually to indicate interest in participation. Times and locations were established for interviews or focus groups by the members of the research team. Staff members were not afforded the opportunity to win a gift voucher. All participants provided informed consent prior to the commencement of any focus groups or interviews, and they were free to withdraw from the study at any time.

Measures and data collection

Service utilisation data

Service data included contact between the PN and client (initial appointments and any follow-up contact), which were documents by the PN and referral rates, gathered from partner services for each financial quarter of program operation. Information was split according to clinic location and area of residence for clients. It was initially intended to create matched client data via the use of a linking key similar to a statistical linkage key (Karmel 2005). However, due to concerns with recruitment of already difficult-to-recruit population groups, this was not pursued. Instead, trends were observed over two time points.

Client feedback surveys

Client feedback surveys were developed specifically for this project, but drew from existing, validated measures (Victorian Agency for Health Information (VAHI) 2022), and were initially tested by steering committee members. Surveys were administered online to existing and new clients. Hardcopy surveys were available on request. Existing clients were surveyed once using a survey tool that included 21 single answer and text box questions assessing client satisfaction, impact of the PN on service utilisation, and likelihood of recommending the service to others. New clients were surveyed twice: immediately after their initial interaction with the PN and then 6 months after that initial interaction. Surveys consisted of 18 single answer and textbox questions for the immediate feedback survey, and nine single answer and textbox questions for the 6-month feedback survey. Respondents were asked about where they heard about the clinic, their self-rated health, and their perception of any impact of clinic engagement on their health. Respondents were asked to revisit these questions at the 6-month mark, whether they were likely to recommend the service and any other feedback.

Staff were invited to focus groups and/or individual interviews, and all interviews and focus groups were either via Zoom™ or telephone. Staff were asked to consider their experiences working in the program, as well as any barriers or enablers to the successful implementation or sustainability of the program.

Stakeholders were also invited to focus group or interview discussions that focused on their experiences in establishing and maintaining the program, and any barriers and enablers to successful implementation and sustainability of the program.

All interview and focus group discussions were transcribed verbatim by an independent, secure transcription service before being entered into NVivo 12 (QSR International). A selection of transcripts was reviewed independently by each author (SC, JC, and VL) to identify themes, which were later compared and revealed to be mostly concordant. Data were analysed using inductive thematic analysis (Braun and Clarke 2006) to identify themes related to client, staff and

stakeholder experiences. An inductive coding framework was developed that was refined iteratively by the research team to ensure themes best represented the data. These themes were then reviewed against the framework proposed by Levesque *et al.* (2013) to examine how they related to aspects of access and increasing utilisation.

Ethics approval

This project was approved by La Trobe University Human Research Ethics Committee (HEC20185).

Results

The co-designed program improved TGD sensitivity, reduced stigma and discrimination, and built the health sector capacity to meet the needs of TGD people. Training was designed for specific audiences, including GPs, medical specialists (endocrinologists), nurses, allied health practitioners, pathology staff and health services reception staff. Discussion about the training arm of the program is beyond the scope of this current article.

Service utilisation

Service activity was captured on a quarterly basis, using numbers of client appointments and referral rates, for both years of the program, and at both locations. Total numbers of appointments for the PN showed a consistent increase, with the regional location showing the largest quarterly increase of almost 100%. Clientele were similar across both locations in terms of age and gender declaration, generally aged between 18 and 35 years and male identified.

Referral data were gathered for each client registered with the PN at each location, with a combined referral rate of 884 for 2020 and 1401 for 2021 across both services. Referrals were made to 43 different services across both locations, with the four most common referrals including: GP services (35%); psychology/counselling (23%); GAHT initiation (17%); and social support (8%). Other referral destinations included services like hair removal, endocrinology, family/friend information, legal, and fertility. Referrals to endocrinology and nursing were higher in the metropolitan location. Clients were referred to endocrinology for GAHT in the initial stages of the program when internal capacity was insufficient and specialists from a partner organisation provided outreach services.

Client feedback

Clients were asked to reflect on the impact engagement with the clinics had on key concepts like changes to self-rated health, their ability to do the things that are important to them, and perceptions of changes to quality of life, social

and emotional wellbeing, and any changes in their sense of belonging. Clients were asked about their sense of satisfaction with their experiences with the PN. Information was collected from both survey and interview data.

Survey data

Response rates to feedback surveys were limited despite reminder emails, repeat mentions in health service newsletters, and gentle prodding from PNs to complete them. It is important to understand that feedback was sought during extended coronavirus disease 2019 (COVID-19) lockdown periods in Victoria, Australia, which may have affected people's willingness to engage in the survey. Also, data were not able to be matched to individual clients due to concerns in the steering and community advisory groups that there would be potential to identify individuals within a small, close-knit community, which may lead to hesitancy to participate. Given these data limitations, no tests of statistical significance were applied. Percentages are reported, despite small sample sizes, to enable easier comparisons.

Changes on self-rated health between initial PN appointment and 6-months post were noted, with the largest change in self-rated health described as very good (7–40%) (Tables 1, 2).

Clients were also asked if using the service affected their ability to do the things that were important to them as a proxy for empowerment and a possible increase in personal capacity to achieve their desired health outcomes. Most clients (75% and 87% respectively) across metro and regional locations felt they were more able to do 'important' things after engaging with the service. Clients from both services were asked about positive changes in their quality of life since using the service, answering 'yes' or 'somewhat' 82% and 65% of the time. Finally, clients were asked about changes in their social and emotional wellbeing and changes in their sense of belonging. Clients from both services answered 'yes' or 'somewhat' 81% and 50%, respectively, of the time when asked about impacts on their social and emotional wellbeing. Changes to sense of belonging, self-worth and trust were described as 'yes' or 'somewhat' 78% and 66%, respectively, of the time, across both clinic locations.

Table 2. Client feedback survey – impact of service engagement.

	Metro location n = 72(%)	Regional location n = 6 (%)
Quality-of-life changes since using service		
Yes	49	33
Somewhat	32	33
No	19	33
Changes in social and emotional health and wellbeing		
Yes	46	50
Somewhat	35	0
No	19	50
Changes in sense of belonging, self-worth and/or sense of trust		
Yes	39	50
Somewhat	39	16
No	22	32

Client interviews

Clients were asked to consider the most favourable aspects of the TGDICH program.

The most satisfying aspect of the TGDICH model for clients was the incorporation of informed consent.

I guess it's just been a very – a much more transparent process than I was expecting. Much less gate keeping than some horror stories I've heard from friends who went through the system with different providers or in previous years. So yeah, it was just very – I guess open lines of communication. (Client, metro location)

Clients voiced their complete support for the PN model, stating that having a person to contact within the broader health system helped smooth their pathway on what was often a complex journey.

When I first reached out to the peer navigator, I was feeling very unsupported and like I had no knowledge or access to

Table 1. Client feedback survey – self-rated health.

Self-rated health	Metro location		Regional location	
	Immediate feedback n = 80 (%)	Follow-up survey n = 72 (%)	Immediate feedback n = 30 (%)	Follow-up survey n = 6 (%)
Excellent	6	4	0	Not calculated (small n)
Very good	7	40	16	
Good	50	29	83	
Fair	30	20	0	
Poor	6	5	0	

the mental health networks which I needed. I felt like they were out there, and I didn't know about them, and I didn't know how to get in touch with them. They basically helped me figure out a pathway through all of that and I ended up with someone who I feel like is – I'm going to if not stay with for a very long time, at least get me through what I'm going through right now. So, I feel like I'm in a much better place. (Client, metro location)

I wanted a validating experience of something to be celebrated, not something to be pathologised [...] Seeing that there was a peer navigator was a positive thing. (Client, regional location)

Clients valued their experiences with the PN and how that facilitated their broader engagement with the health system. Some clients outlined the positive impact access to the PN, and associated cultural safety that entailed, had on their sense of validation and confidence in the system.

I have felt as though all the health practitioners I've met through this service has actually listened to me when I've been explaining health issues. I have not been made to feel as though I'm wasting time or overreacting. (Client, metro location)

I'm just going to not talk to my GP about it anymore, because he's not very helpful. I'm going to try and get this sort of information from the peer navigator, because they are more likely to be connected to a network of mental health practitioners who will actually be able to help me. So that's what I was expecting and that's what I was hoping for and I feel like that's actually exactly what happened. (Client, metro clinic)

Clients were also asked about possible barriers to engagement in the service, and particularly the impact of telehealth and wait times on their level of satisfaction. Most clients were aware of the challenges of accessing finite health services and during a global pandemic, with the potential for delays in access.

I think the clinic is great, and [PN] is doing [their] best. [They're] approachable and professional and always helpful. But I don't feel like there's enough resources for the clinic. It feels like resources are limited. Covid only amplified that feeling. (Client, regional location)

Client comments around favourable aspects and potential barriers to engagement are aligned with the approachability and acceptability dimensions of the model proposed by *Levesque et al. (2013)*. The implementation of a PN model provided a safe, welcoming space for clients.

Staff/stakeholder perspectives

Staff and stakeholders were asked about their experiences establishing and working in the program. Both staff and stakeholders described their involvement in the program either as a vehicle for their passion about TGD health or one part of a long history of advocacy for the TGD community.

I've been quite involved as an advocate for additional support for trans and gender diverse for many times, and I continue to do work with a number of different agencies to date. (Stakeholder)

Strengths of the program lie in the community buy-in and trust that was built as a function of access to the PN in addition to numerous trans-identified people employed across the program that helped to ensure the cultural safety of the health services as a result.

Seeing trans people employed at various levels of the program, including management, Peer Navigators, employing a trans nurse, so having trans people on the front lines, working with the clients, is the strongest asset for this program. (Staff member)

Key concerns raised included the financial sustainability and longevity of the program. Some staff members were mindful of the difficulty of funding the program solely from the federally funded reimbursement system, Medical Benefits Scheme (MBS).

We work off the smell of an oily rag sometimes based on how many clients – client access, and how much – because we're not charging gap fees, so we just go off Medicare. (Staff member, metro location)

In addition to financial vulnerability, staff and stakeholders were well aware of the personal vulnerability of the PNs as they draw from their lived experience while dealing with clients who may have complex trauma. There was a clear sense of the need to protect the PNs, understanding the complexity of working within, and representing, a system that can be traumatising to both PN and client alike.

I really do think that there should always be support for people with lived experience, because the pressures of representing an institution that might not always be doing a great job, it's really hard. (Staff member, metro location)

Comments by staff and stakeholders clearly demonstrate their commitment to the provision of much needed, equitable services to the TGD community, and in doing so, contribute to better health outcomes.

COVID-19 considerations

One clear recurrent theme from all conversations with clients, staff and stakeholders was the impact of the COVID-19 pandemic and its coincidental emergence with the initiation of the TGDICH program.

For clients, there were delays in access to both PNs and in-house healthcare professionals.

I mean, it's coronavirus and Christmas and a popular service, so I had no expectation of time. (Client, metro location)

Other clients were much more aware of the implications of minimal human contact caused by pandemic precautions.

COVID-19 is the second Pandemic I have lived through, and you would've thought with the trauma of losing a whole generation of men who treated me kindly and gave me a hug when I needed it; you would have learned lessons from the first Pandemic, in separating COVID-19 hysteria from COVID-19 scientific facts... (Client, regional location)

Staff were particularly mindful of the implications to service delivery associated with attempting to provide what was supposed to be a service that fostered a personal connection.

Well, the program has had an extreme amount of challenges, obviously, in light of establishing it during a pandemic. (Staff member, metro location)

Some people have had their appointments rescheduled three or four times, and in the end, they just end up going somewhere else [...]. (Staff member, metro location)

Not surprisingly, the impacts of COVID-19 on clients and staff were keenly felt, but were reflective of their various perspectives. Although clients were aware of impacts on their ability to take care of themselves in a way they valued, staff were predominantly concerned with their ability to provide an adequate service in a timely manner. Again, the commitment and motivation of the staff comes through.

Discussion

Gender-affirming health care for TGD people remains a priority, yet continues to be limited in Australia. The aim of this study was to investigate one attempt to increase access and hence address the inverse care phenomenon in Victoria, Australia. A conceptual framework for examining access in real terms has been applied to help analyse study

findings (Levesque *et al.* 2013). By examining access according to this framework, we are better able to understand the varying levers of access that ultimately lead to engagement and utilisation.

Locating GAHT in primary care

Raising numbers of health services via the primary health-care sector has been identified by the WHO as the most likely mechanism to increase potential access (World Health Organization (WHO) 2018). Gender-affirming health care has traditionally been located in the acute setting in Australia, with associated medicalisation and stigma acting as a direct disincentive to engagement. Levesque *et al.* (2013) argue that service availability does not translate directly to healthcare utilisation (Penchansky and Thomas 1981). Locating GAHT services in the community health sector enhances not only availability and accommodation, but addresses other dimensions included acceptability, affordability and appropriateness. In terms of access to gender-affirming health care, considering access in terms of the interaction between supply-and-demand helps to understand the complex interaction between the person, their community, and their experiences with the desired health service. Locating GAHT services in the primary healthcare setting reduces stigma by normalising TGD health care, hence enhancing engagement. Moreover, the pivot to telehealth during the COVID-19 pandemic facilitated initiation of, or ongoing access to, GAHT. The nature of GAHT makes demedicalisation unlikely; however, working from an informed consent model removes the assumption of pathology often associated with GAHT, and is associated with high levels of client satisfaction (Davy *et al.* 2018; Spanos *et al.* 2021). Ker *et al.* (2021) describe a recent program in New Zealand where GAHT was provided via a primary care-based pilot project, and noted the key success factor of that project was in the depathologising of trans health by providing it in a familiar place where clients had existing relationships.

Client feedback clearly identified the positive impact of the PN on service utilisation. Because of the presence (approachability) of the PN, services were perceived to be more 'appropriate' and clients developed an increased 'ability to engage' with a more appropriate model of care with the PN's support (Levesque *et al.* 2013). From discussions with all participant groups, the value of the PN and Informed Consent models within GAHT and the location of services in primary care, particularly community health services, were integral aspects of program success. Increasing the number of service locations has done little to affect Tudor-Hart's (Tudor-Hart 1971) inverse care law, but the addition of peer navigation has affected supply-and-demand aspects of access and utilisation to create an environment where TGD people are more likely to present for care.

Conclusion

The key elements for success of the TGDICH program are the PN model, Informed Consent and availability of appropriate community-based, gender-affirming care for TGD people. By moving GAHT into the community health setting, potential access is increased in real terms. However, the key to effective engagement and utilisation is the introduction of a PN into the model of care. By providing a culturally safe space that operates from a position of wellness and is strengths-based, TGD people are far more able to access the care they desire in a setting that is safe. Although Tudor-Hart speaks of locating services where they are most needed, what makes more impact is fostering engagement and utilisation by marginalised communities. The highly replicable nature of the TGDICH program indicates a promise of increased access to more culturally safe TGD services and a significant increase in engagement and utilisation of services by the TGD community.

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Data availability. The data that support this study cannot be publicly shared due to ethical or privacy reasons and may be shared upon reasonable request to the corresponding author, if appropriate.

Conflicts of interest. The authors declare no conflicts of interest.

Declaration of funding. This research was contracted research work and funded via project funds.

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