Australia: The Healthiest Country by 2020
Response to the ‘Discussion Paper’

The National LGBT Health Alliance supports the proposed approach to preventative health in Australia and welcomes the increased priority on keeping people healthy, rather than merely treating the sick. We call on the Taskforce to explicitly recognise the specific needs of lesbian, gay, bisexual and transgender Australians.

About the National LGBT Health Alliance

The National LGBT Health Alliance is an alliance of organisations across Australia that provide programs, services and research in the areas of lesbian, gay, bisexual and transgender (LGBT) health.

The Alliance advocates on LGBT health issues at the national level, seeks commitment from all sides of politics to support and develop LGBT health through research and service development, and builds capacity among LGBT health organisations across the country.

The Alliance is a newly formed organisation, which is governed by a Board of Directors with representation from each state and territory. Key areas of work for the Alliance include alcohol, tobacco and other drugs, mental health, ageing, LGBT research, sexual health (including HIV and other STIs), violence, health and wellbeing of people living with HIV, relationship recognition and the link between health and human rights.

Evidence on LGBT Health Status

The best source of evidence on LGBT health in Australia is the national ‘Private Lives’ survey, conducted by Gay and Lesbian Health Victoria and The Australian Research Centre in Sex, Healthy & Society at La Trobe University. The survey recruited 5,476 LGBT people to a national internet based survey in 2005.

Overweight and Obese – 29% of the LGBT sample were overweight and 16% obese. This is roughly equivalent to the Australian population in the National Health Survey (2001). However females in Private Lives were more likely to be overweight or obese (49%) than Australian women generally (38%).

Tobacco - 37% of LGBT people smoked tobacco on more than 5 occasions in the month prior to the survey. This compares to 24% of people who were ‘current’ smokers in the National Health Survey (2001).

In a study of drug use in the gay community, lesbians generally had the highest rates of tobacco use with the 30 – 39 age group smoking at a higher rate over a higher period of time. (Murnane 2000) The 2004 Sydney Women and Sexual Health Survey found rates of 34% for smoking compared to and ABS figure of 24% for Australian women generally. (Richters et al 2005)
Alcohol – Private Lives did not ask about alcohol consumption. However use of illicit drugs is significantly higher in LGBT populations than the general Australian population.

Data from a younger cohort in the Longitudinal Study of the Health of Australian Women (40,000 women) shows that non-heterosexual women were significantly more likely to report risky alcohol use (7% compared to 3.9%), marijuana use (58.2% compared to 21.5%), use of other illicit drugs (40.7% compared to 10.2) and injecting drug use (10.8% compared to 1.2%). (Hillier et al, 2003)

The National Drug Strategy Household Survey 2007 asked the sexual identity of respondents recruited through the telephone survey. An analysis by sexual orientation of alcohol and tobacco use has not been released to date.

Social Determinants of Health

Sexuality and gender identity should be recognised as social determinants of health, alongside other determinants including Indigenous and ethnic status. The stigma, discrimination and other forms of exclusion experienced by LGBT people influences health behaviours and access to health services. Tailored approaches and services will be required to reach LGBT communities.

The absence of LGBT people and communities from this discussion paper further excludes LGBT people and our needs from an effective health prevention response. An approach that only responds to the majority will fail, as it is minorities (including LGBT people) who tend to have higher risks and less access to health services.

Researchers, policy makers and the public health and primary care workforce will need training and development to enable them to include and understand the needs of LGBT Australians. Without this the social exclusion of LGBT people will continue.

The Department of Health in the UK has developed a series of briefing papers on LGBT health for health and social care staff. These papers cover health issues, population groups within the LGBT community (e.g. seniors) and access to services. See www.dh.gov.uk/equalityandhumanrights

Implementation

We welcome the approach of both universal and targeted actions to address health risks. We recommend that LGBT people and communities be explicitly acknowledged in this approach. This should involve supporting LGBT community organisations to undertake activities and interventions, as well as using LGBT community media for social marketing campaigns.

‘Communities of interest’, including the LGBT community, should be recognised as settings for action. Too often a settings based approach excludes LGBT people (and other communities of
LGBT people are usually minorities in their local neighbourhood, workplaces etc and may be fearful of being ‘out’ about their sexuality or gender identity in these settings. A settings based approach that works through communities of interest may need to be organised at a larger geographical area than local neighbourhoods.

**Research, Monitoring & Evaluation**

Most mainstream population level research has not included questions on the sexual and gender identity of respondents. So while LGBT people will have participated in this research there is no way of analysing their responses compared to non-LGBT people. While there is a growing body of evidence to show that LGBT people have higher risks and less access to health services, this is usually based on small community samples or international research.

We recommend that all major population based health research commissioned, funded or conducted by governments or related bodies (e.g. Australian Institute of Health and Welfare) should routinely collect and report data on sexual and gender identity. The recent National Drug Household Survey and the National Survey of Mental Health & Wellbeing show that this is feasible and acceptable.

We also recommend that monitoring and evaluation of program implementation (at the federal, state and local levels) also report on how it is accessible to and inclusive of LGBT people and communities.

**Funding**

Preventative health measures only receive around 2% of health funding. Often the day-to-day needs of the acute sector, enflamed by media reporting of ‘crises’, reduce this amount even further. A national preventative health strategy will need to have clear funding mechanisms and ways of ensuring that states spend sufficient resources on prevention.

The changes to the Australian Health Care Agreements (i.e. one ‘bucket’ of health money to the states) has a significant risk of reducing the already low funding to prevention. The new system of Special Purpose Payments and National Partnership Projects needs to find a way of ring-fencing prevention funds.

We recommend setting a target of increasing funding on preventative health over the years to 2020.

**Lessons from HIV**

The discussion paper acknowledges the general success of Australia’s response to HIV/AIDS. As organisations who have been working in the area of HIV prevention since HIV first appeared in
Australia, we would highlight the following factors involved in that success and recommend that they be utilised in addressing Australia’s response to obesity, tobacco and alcohol:

- national leadership, both at a government level and general population/media level. We support the establishment of the National Prevention Agency, with a role for its members to speak directly to the Australian people as well as advising government
- partnership between affected and infected communities, researchers, policy makers, service providers and government
- national strategies, agreed by the Commonwealth and states & territories, that clearly articulate the values, approach, goals, targets and actions required
- transparent and accountable funding mechanisms which ensure that prevention money can not be used for acute care
- accurate surveillance data and research (including social & cultural research), developed in partnership with communities and service providers
- recognition of the social determinants of health/enabling environment and actions outside of the health service sector (e.g. law reform).

References


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- Victorian AIDS Council/Gay Men’s Health Centre (VAC/GMHC),
- Western Australian AIDS Council (WAAC),
• Gay and Lesbian Health Victoria (GLHV)

• AIDS Council of New South Wales (ACON)

• South Australian AIDS Council (ACSA)

• AIDS Action Council of the ACT (AACACT)

• Northern Territory AIDS and Hepatitis Council (NTAHC)

*Submissions may be placed on the Preventative Health Taskforce website. Discussion papers and other material developed as part of the consultation process may also be placed on the website. The Preventative Health Taskforce will not accept submissions by organisations submitted wholly on a confidential basis. Where the nature of the material dictates however, submissions may append material marked Confidential and severable from the covering submission so that the submission can be placed on the website without the attachments. The Preventative Health Taskforce will accept confidential submissions from individuals where those individuals can argue that publication might compromise their ability to express forthright viewpoints or impact on a third party. Please note that any request under the Freedom of Information Act 1982 for access to a document (regardless of the document's assigned classification) in the possession of the Commonwealth will be determined in accordance with that Act.

I Accept