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SUBMISSION TO SENATE STANDING COMMITTEES ON COMMUNITY AFFAIRS INQUIRY INTO
Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health Report "Closing the gap in a generation"

Committee Secretary
Senate Standing Committees on Community Affairs
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By email via: community.affairs.sen@aph.gov.au

Dear Committee Secretary

Please find below a submission by Victorian Gay and Lesbian Rights Lobby (VGLRL) to the Senate Inquiry into Australia's domestic response to the world health organization's (who) commission on social determinants of health report "closing the gap within a generation".

We thank the Committee for the opportunity to make this submission, as the health and human rights of lesbian, gay, bisexual, transgender and intersex (LGBTI) Australian citizens are a matter of great concern to VGLRL.

About the Victorian Gay and Lesbian Rights Lobby (VGLRL)

The VGLRL aims to achieve equality and social justice for gay, lesbian, bisexual, transgender, intersex and queer (GLBTIQ) people living in Victoria. We work with the media, undertake and support research, conduct community education and directly lobby politicians across all levels of government. The VGLRL works cooperatively and constructively within the political framework, and the community at large, to achieve its aims. The VGLRL maintains a high level of community relevance through active collaboration with other organisations. Comprising a consultative membership base, the VGLRL is directly accountable to, and takes direction from, the GLBTIQ community.

Regards

Policy Working Group - Victorian Gay & Lesbian Rights Lobby

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Introduction

In the Preamble to its final report on the social determinants of health, the Commission on the Social Determinants of Health (CSDH) states that:

> Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death….(I)nequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces. (CSDH, 2008, online).

Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it - Final Report to the WHO Commission on Social Determinants of Health argues that 'The right to health is affirmed in the Universal Declaration of Human Rights and is part of the WHO's core principles. This report is grounded in the affirmation of equal and universal rights to health for all people, irrespective of economic class, gender, race, ethnicity, caste, *sexual orientation (our italics)*, disability, age or location' (Sen, Ostlin et al, 2007: xiii).

If this Committee can bear with us, for a moment, the long explication of gender, which follows, is absolutely crucial to this submission. We agree with Sen, Ostlin et al when they state that:

> Gender relations of power are complex, diverse, shaped by history and hence by the politics of both place and time. Like other social relations, gender relations as experienced in daily life, and in the everyday business of feeling well or ill, are based on core structures that govern how power is embedded in social hierarchy. However, as products of social structures, no matter how complex, diverse or deeply entrenched, gender systems are also malleable and subject to change (2007:1-2).

Within Australian and international instruments and policy documents the concept of 'gender' has been contested and changed over decades in line with social and political movements. Sen, Ostlin et al's study, carried out at the CSDH's behest, continues:

> ..principles, based on the distinctions between women and men, and the gender analysis on which they are based, have been challenged more recently by work deriving from social movements for sexual rights, in particular the lesbian / gay / bi-sexual / transgender (LGBT) movement…to be more inclusive and to recognise sexual and gender orientation as an important source of discrimination, bias, violence and challenges to health. The challenge is not only to policy but to the very concept of gender itself. Biological sex has never only consisted of the simple binaries – women and men. The presence of transgender people has been rendered socially invisible in some societies; in others their presence is socially recognised but they are relegated to the margins of society through discrimination and violence. But *the challenge to heterosexual norms by the LGBT movement goes beyond biology to the social and ideational realms where sexuality and gender are defined, negotiated and expressed….For the purposes of this report and the work of the Commission on Social Determinants of Health, the effects of sexuality-based discrimination on the health of people are vitally important* (Sen, Ostlin et al, 2007:8). (our italics)

If this is so, why is there no mention of sexual orientation or gender identity in CSDH's final report? It is puzzling that a paper funded partly by the Commission on the Social Determinants of Health - and published in 2007, fully one year before the Commission on the Social Determinants of Health's final report – frames sexual orientation and gender identity, specifically and explicitly, as social determinants of health (Sen, Ostlin et al, 2007; see also Pillay, 2012; Logie, 2011) while the final CSDH report makes no mention of gay, lesbian, bisexual, transgender, or intersex status as social determinants of health whatsoever (CSDH, 2008). In our view, this is a significant and serious omission.

RECOMMENDATION 1: THAT SEXUAL ORIENTATION AND GENDER IDENTITY BE REGARDED AS SOCIAL DETERMINANTS OF HEALTH IN ALL COMMONWEALTH GOVERNMENT LEGISLATION, POLICIES, STRATEGIES, ACTION PLANS, PROGRAMS AND SERVICE DELIVERY.

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Sen, Ostlin et al ask 'What determines the pace or pattern of change in gender systems and how they affect people's health? As with other stratifiers, this can depend on economic and social processes lying outside the health sector' (2007:10), and, as they have suggested above, in the political will for change.

The Victorian Gay and Lesbian Rights Lobby (VGLRL) contend that a 'social determinants of health approach', in isolation, is insufficient in understanding risk and causative factors in GLBTI people's health, or ill-health. We argue that 'social epidemiology', for instance that based on the work of Wilkinson and Pickett in their influential book, *The Spirit Level: Why More Equal Societies Almost Always do Better* (2009) and Sir Michael Marmot (2000) - which includes, but elaborates further on, a 'social determinants of health approach' - may be more productive. This suggests that social institutions that may, at first glance, appear to be unrelated to health do, in fact, affect health intimately. For instance, Burris, Kawachi et al assert that:

> Legal scholars in public health, including those in the health and human rights movement, have contended that human rights, laws, and legal practices are powerfully linked to health… Epidemiology has marshaled considerable evidence that social structures are broadly related to the level and distribution of health in a society, but bolstering claims of causation and intervening both require the elucidation of the mechanisms through which social structures actually influence health (2002:510).

Burris, Kawachi et al's proposition is that there is a need to 'move from thinking of the fundamental social determinants of health as the *starting point* of the analysis and ask instead how these social structures themselves arise' (2002: 510). Hence, it is necessary to explore how the social structures of the law, medicine and, we argue, religion, construct and significantly affect GLBTI people's health.

Please note that our responses to Terms of Reference a) and b) are embedded in our answers to Terms of Reference c) and d). In addressing specific Terms of Reference numbers c) (i) and (iii) and d) (i), (ii), and (iii) of this Inquiry, this submission will outline the ways in which 'political, social, and economic forces' - the real social determinants of health - literally affect gay, lesbian, bisexual, transgender and intersex (GLBTI) people's lives, deaths, illness and overall health inequity.

c) (i) Is a Social Determinants of Health Approach Being Adopted in Commonwealth Programs and Services?

Please note that this submission presents more of the legislative and policy aspects of the social determinants of health, as they affect GLBTI people. We commend to the Committee, also, the submission of the NSW Gay and Lesbian Rights Lobby, which concentrates, we have been informed, more on specific programmatic and service delivery responses.

We argue that, in order to have a complete understanding of the social determinants of health, it is necessary to understand how international covenants, policies and statements cascade - or do not cascade - down into Australian policies and laws and, in addition, national policy positions of non-governmental organizations and, further, into action plans, programs and service delivery.

The answer to the question that heads this section is both 'Yes' and 'No'. In some it is, but in some programs and services, it is not. We believe that, instead of partial and inconsistent adoption of a social determinants of health approach - or, more precisely, a 'social epidemiology' approach - in programs and service delivery, the Commonwealth should adopt a more universal, uniform and consistent approach to integrating factors which affect GLBTI people's health throughout all levels of activity.

RECOMMENDATION 2: THAT ALL COMMONWEALTH PROGRAMS AND SERVICE DELIVERY BE ALIGNED MORE CLOSELY WITH INTERNATIONAL BEST PRACTICE REGARDING SEXUAL ORIENTATION AND GENDER IDENTITY

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It is not possible to discuss gay, lesbian, bisexual, transgender and intersex (GLBTI) people's health without taking into consideration the 'political, social, and economic forces' which shape it.

These forces include both international and Australian health and human rights documents and actions that place it on the health agenda - and also those that render GLBTI health invisible, through omission and exclusion:

- International policies which are inclusive of GLBTI sexual orientation and gender diversity include Navi Pillay's, the UN High Commissioner for Human Rights' 2012 statement *Born Free and Equal: Sexual Orientation and Gender Identity in International Law*; the Pan American Health Organization/World Health Organization's media release dated 17 May, 2012, *World Health Organisation releases groundbreaking report condemning 'conversion' therapies*; the UN's 2008 *Statement on Human Rights, Sexual Orientation and Gender Identity* (Online at http://www.droitslgbt2008.fr/); the International Commission of Jurists' *The Yogyakarta Principles: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity.*

- Omission of explicit reference to GLBTI people's rights in the UN's *Universal Declaration of Human Rights; International Covenant on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights;* the *Madrid Statement: Mainstreaming Gender Equity in Health: The Need to Move Forward;* the *Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW)*

  and the World Health Organization's (WHO's) *Closing the gap in a generation: health equity through action on the social determinants of health - Final Report of the Commission on Social Determinants of Health*.

- National Australian and states' legislation which affects, and often excludes, GLBTI people's human rights and, therefore, their health outcomes. These include existing legislation such as the 2004 amendment to the *Marriage Act;* the *Same Sex Relationships (Equal Treatment in Commonwealth Laws - General Law Reform) Act 2009;* and individual states' *Equal Opportunity Acts.*

- Omission of legislation that has yet to be promulgated, such as the absence of protection for GLBTI people in Commonwealth anti-discrimination legislation on the basis of sexual orientation and gender identity; an Australian *National Human Rights Act;* and the fact that economic, social and cultural rights and remedies are not enshrined in the *Victorian Charter of Human Rights and Responsibilities 2006* may all have pronounced effects on GLBTI physical, social, and mental health. It is yet to be seen how well these effects will be addressed by the long-awaited *Consolidation of Commonwealth Anti-Discrimination Laws.*

- National and state policy documents that, to some extent, are inclusive of GLBTI people, such as the *National Women's Health Policy 2010; National Male Health Policy 2010; National Suicide Prevention Strategy 2009-10 to 2010-11 Action Framework 2009; Living is for Everyone Framework: A Framework for Prevention of Suicide in Australia; The Hidden Toll: Suicide in Australia 2010;* Australian Medical Association *Sexual Diversity and Gender Identity* 2002; Australian Psychological Society *Tip Sheet on Sexual Orientation and Homosexuality* 2008

- Omission of GLBTI issues from *Social Inclusion in Australia: How Australia is Faring;* and the *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014.*

In the remainder of this section we will show how international instruments and national policy statements are implicated in the construction of GLBTI health, ill-health, and even death.

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Although the World Health Organization's *Commission on the Social Determinants of Health* (2008) final report does consider issues of gender identity to be a social determinant of health - but only with regard to men versus women - several international instruments, to which Australia is a signatory, do indeed argue that discrimination on the basis of sexual orientation and gender identity are unacceptable, and that they affect GLBTI people's health. A division of the World Health Organization, itself, acknowledges that, in the efforts of some 'therapists' to 'cure' homosexuals, 'Repression of sexual orientation has been associated with feelings of guilt and shame, depression, anxiety, and even suicide' (Pan American Health Organization (PAHO), Online, 17 May 2012). We believe that shame, depression, anxiety, and suicide are health issues.

Therefore, sexual orientation and gender identity should be considered to be social determinants of health.

In another example, the *Yogyakarta Principles'* Principle 16 and Principle 17 deal with GLBTI people's right to health:

> Principle 16: Everyone has the right to the highest attainable standard of physical and mental health, *without discrimination on the basis of sexual orientation or gender identity (Our italics).* Sexual and reproductive health is a fundamental aspect of this right.
>
> Principle 17: States shall…Adopt the policies, and programmes of education and training, necessary to enable persons working in the healthcare sector to deliver the highest attainable standard of healthcare to all persons, *with full respect for each person's sexual orientation and gender identity (Our italics)*' (International Commission of Jurists, 2007, Online).

The Australian Medical Association (2002) *Sexual Diversity and Gender Identity*, Australian Psychological Society (2008) *Tip Sheet on Sexual Orientation and Homosexuality*, and American Psychiatric Association (1998) *Position Statement on Psychiatric Treatment and Sexual Orientation* and the *Guidelines* of the British Association of Counselling and Psychtherapy also have national position statements locating GLBTI sexual orientation and gender identity firmly as a social determinant of health.

For example, the Australian Medical Association's position statement on *Sexual Diversity and Gender Identity* states that:

> 6.2 The AMA reaffirms its belief in equity of access to health care for all Australians.
>
> 6.3 The AMA acknowledges that a doctor's use of language that assumes an individual to be heterosexual makes it harder for a person to disclose their sexuality.
>
> 6.4 The AMA is supportive of interventions that prevent the development of homophobia, as this will improve the health of all Australians.
>
> 6.7 The AMA believes that medical education curriculum should include subjects addressing issues of sexuality and gender identity. This should include information on the coming out process, education regarding discrimination, health needs of GLBTI subgroups and information about referral networks. This should start in medical school and be a part of continuing medical education at all levels.
>
> 6.10 The AMA opposes the use of "reparative" or "conversion" therapy that is based upon the assumption that homosexuality is a mental disorder and that the patient should change his or her sexual orientation' (Online, 2002).

In similar vein the Australian Psychological Society acknowledges the lack of scientific evidence for the usefulness of conversion therapy, and notes that it can in fact be harmful for the individual. Changing the sexual orientation of a person is not simply a matter of changing the person's sexual behaviour. It would require altering the emotional, romantic and sexual feelings of the person and restructuring self-concept and social identity (Australian Psychological Society, Online, 2008). The American Psychiatric Association holds a similar view:

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> Therefore, the American Psychiatric Association opposes any psychiatric treatment, such as reparative or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumpition that the patient should change his/her sexual homosexual orientation (American Psychiatric Association, 1998, cited by Australian Psychological Society, Online, 2008)

In a media release dated 17 May, 2012, the Pan American Health Organization (PAHO), a division of the World Health Organization, stated that:

> Services that purport to "cure" people with non-heterosexual sexual orientation lack medical justification and represent a *serious threat to the health and well-being of affected people (our italics)*….(and) constitute a violation of the ethical principles of health care and violate human rights that are protected by international and regional agreements…. there is a professional consensus that homosexuality is a natural variation of human sexuality and cannot be regarded as a pathological condition' (Pan American Health Organization, Online, 17 May 2012)

On 17 May, 1990, the World Health Assembly removed homosexuality from the list of mental disorders when it approved a new version of the World Health Organization's International Classification of Diseases (ICD-10). PAHO's Director Dr. Mirta Roses Periago stated that, 'Since homosexuality is not a disorder or a disease, it does not require a cure. There is no medical indication for changing sexual orientation' (Online, 17 May 2012). It, further, stated that practices known as 'reparative therapy' or 'conversion therapy represent 'a serious threat to the health and well-being—even the lives—of affected people'.

PAHO called on professional and educational organizations to disseminate national and international policy documents and to develop educational programs that de-psychopathologize sexual diversity and to prevent 'interventions aimed at changing sexual orientation' (Pan American Health Organization, Online, 17 May 2012). The media release continued: '"Conversion" or "reparative" therapies and the clinics offering them should be denounced and subject to adequate sanctions…In the media, homophobia in any of its manifestations and expressed by any person should be exposed as *a public health problem* and a threat to human dignity and human rights' (PAHO, Online, 17 May 2012).

According to an April, 2012, article in 'The Age', there are currently five organizations which practise so-called "conversion therapy" 'in Melbourne and at least 10 interstate. Modelled on America's "ex-gay" groups, all have fundamentalist Christian roots. Many view homosexuality as an illness that can be cured - an approach some describe as "pray away the gay"' (Lallo, Online, 8 April, 2012). They include EnCourage, Exodus Asia Pacific, Mosaic Ministries, Liberty Christian Ministries, Living Waters, and Roundabout Ministries. Currently, these organisations, and the treatments administered by them, are not regulated under Australian law, whether Commonwealth or State.

Nor does it appear that this practice is limited to the USA and Australia. The British Association for Counselling and Psychotherapy's new guidelines say the Association "opposes any psychological treatment such as 'reparative' or 'conversion' therapy which is based upon the assumption that homosexuality is a mental disorder, or based on the premise that the client/patient should change his/her sexuality...There is no scientific, rational or ethical reason to treat people who identify within a range of human sexualities any differently from those who identify solely as heterosexual." (Walker, Online, 2012).

The organisations listed above are mainly associated with various churches. But there may still be mental health professionals in Australia offering 'conversion therapy', if the British experience is anything to go by: 'It was long presumed most British counsellors and psychotherapists recognised that these (conversion therapies) were widely discredited. But a 2009 survey of 1300 industry professionals found more than 200 had tried to change a patient's sexual orientation, with 55 saying they still offered such a therapy'(Walker, Online, 2012).

GLBTI people's rights are not protected in Commonwealth anti-discrimination legislation. State anti-

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discrimination laws have exemptions which explicitly allow religious organisations to discriminate against GLBTI people in Australia. So GLBTI people may not have legal recourse against these organisations. These "therapies", however, may contravene State or national health legislation, and complaints to the relevant Health Service/Complaints Commissioner may be an avenue for redress. Alternatively, given the significant harm caused by such treatments, the VGLRL strongly encourages the Commonwealth Government to consider introducing policies or legislation to restrict the use of such treatments, particularly on minors, similar to that which has recently been passed in California.

RECOMMENDATION 3: THAT THE COMMONWEALTH GOVERNMENT CONSIDER INTRODUCING POLICIES OR LEGISLATION TO RESTRICT THE USE OF SO-CALLED 'CONVERSION THERAPY' TREATMENTS ON THE BASIS OF SEXUAL ORIENTATION AND GENDER IDENTITY

Therefore, with regard to the question of whether 'a Social Determinants of Health Approach Being Adopted in Commonwealth Programs and Services', our answer, in this respect, would be 'No'.

However, trying to turn GLBTI people into heterosexuals, which has been shown greatly to affect their mental health, is not the only way in which the social determinants of health are, or are not, incorporated into the Australian health sphere.

Gay, lesbian, bisexual, transgender and intersex individuals face some of the same, but also some different, types of health discrimination. For instance, the Australian Medical Association states that:

> 4.3.1 Recent studies have reported Bisexual people to have worse mental health than their homosexual or heterosexual counterparts due to more adverse life events and less positive support from family and friends (Jorm and Korten, 2002). Bisexual people may also be at greater risk of STIs due to a lack of targeted health promotion activities (Gonzalez, Washienko et al, 1999)
>
> 4.4.1 Transgender people are amongst the most marginalised and discriminated against groups in our society. Transgender people experience a high rate of depression and suicidal ideation (Clements-Nolle, Marx et al, 2001) Transgender people may be medically dependent due to the need for ongoing hormonal treatment or possible surgical intervention. These can lead to specific physical health problems'. (See also Couch, Pitts et al, 2007)
>
> 4.5.1 There is little published research on the Intersex population in Australia however anecdotal research indicates that experiences or expectations of discriminatory treatment may lead to decreased accessing of healthcare facilities. This has flow on effects for untreated mental and physical health problems (AMA 2002 Online).

Lesbian women's health needs are just as different from gay men's health needs as heterosexual women's are from heterosexual men's. In addition, as seen from the above, in a social determinants of health approach, the particular health needs of bisexual, transgender and intersex people must be integrated into all Commonwealth programs and service delivery.

One Commonwealth government department, at least, is making a concerted attempt to ensure that its strategies, programs and service delivery fully integrate a social determinants of health approach. Minister Mark Butler, the Minister for Mental Health and and Ageing, initially undertook a genuine and extensive national community consultation on ageing and aged care, seeking the opinions of people from many different socio-economic, racial, and ethnic backgrounds in different geographic locations. This is evident from the introductory paragraphs of his Department's recently released *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy Draft for Consultation.* It acknowledges that,

> Individually, LGBTI people are like any Australian. With Australia's diverse multi-cultural heritage, differing levels of education, varying levels of (dis)ability and other personal attributes, and differences based on geographic location (from metropolitan to rural and remote residence), sexual orientation, sex or gender identity diversity is

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> similarly widespread. However, collectively this cohort of older Australians has lived through a time where LGBTI people suffered stigma, discrimination, family rejection and social isolation' (Department of Health and Ageing, 2012:3).

Furthermore, it acknowledges that 'the GLBTI community' is not really *one* community,

> …although similarities may exist between constituent groups on sexual orientation (lesbian, gay, bisexual), sex (intersex) or gender (transgender). Each of these individual constituent groups may have specific social, cultural, psychological, medical and nursing care needs. For example transgender people may have different needs than gay men. There is, however, the shared experience of being part of a minority population likely to have been subjected to lack of inclusion or acceptance and discrimination and stigma throughout most of their lives' (Department of Health and Ageing, 2012:3).

One example that illustrates this is two residents in Victorian aged care facilities one, a gay man, whom workers would not touch, from fear of contracting HIV/AIDS and the other, a transgender woman, whom staff would not facilitate to dress in women's clothing (Matrix Guild, 2008). The consultation draft also takes into account the historical context of their identity formation; centrality of GLBTI identity to the individual; their embeddedness - or otherwise - in GLBTI society; their degree of 'outness' and relationship with their family-of-origin and family-of-choice. These statements recognize the complexity of individual GLBTI people's identities and the many intersecting social determinants which shape their healthcare needs.

We commend the Department of Health and Ageing since, to our knowledge, this is the government department which has taken the greatest number of social determinants of GLBTI health into account.

RECOMMENDATION 4: THAT THE COMMONWEALTH GOVERNMENT REGARD GAY MEN, LESBIANS, BISEXUAL, TRANSGENDER AND INTERSEX PEOPLE AS SPECIAL HEALTH POPULATIONS, WITH THEIR OWN PARTICULAR HEALTH NEEDS

In addition to the initial consultations, the Department has set up an ongoing advisory group of experts in GLBTI ageing and aged care, which acts as a bridge between the GLBTI community/ies and the Minister, giving feedback on such documents as the *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy Draft for Consultation* before it is finalised. For the first time, the Minister has agreed to include GLBTI people as a special needs group in the *Aged Care Act*.

Unlike the proposed *National LGBTI Ageing and Aged Care Strategy* above, there are a number of Australian government policies which, although they recognise GLBTI sexual orientation and gender identity as a social determinant of health, still propose limited, or no, interventions or programs. One example of this is the 2011 *National Drug Strategy* (Department of Health and Ageing, 2011) which proposes no actions to address this health problem. Other examples are the *Sixth National HIV Strategy 2010-2013* (Department of Health and Ageing, 2010) and the *Second National Sexually Transmissible Infections Strategy* (Department of Health and Ageing, 2010) which both acknowledge GLBTI people as at-risk population groups, but do not propose any strategies for addressing their attendant mental health issues.

The Commonwealth government makes no mention of GLBTI-specific, or -inclusive, programs or initiatives in its October 2012 *Fact sheet: Mental health, wellbeing and suicide prevention initiatives supporting children and young people* (Online, 2012).

The first of the 'five foundation principles' of the 2009 document titled *Men's Health Policy Information Paper Executive Summary* put out by the Commonwealth Government Department of Health (Online, 2009) is listed as 'gender equity'. In this document, gender is defined in binary terms as male and female and no reference is made to sexuality, gay, bisexual, transgender or intersex men.

Within the main body of the *National Male Health Policy* there are numerous references to gay, bisexual, transgender and intersex men's health, with specific mentions in 'Priority Areas' 2, 5 and 6. These refer to

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'health equity between population groups of males; building a strong evidence base on male health and using it to inform policies, programs and initiatives; and improved access to health care for males through initiatives and tailored healthcare services, particularly for male population groups at risk of poor health' (Online 2011).

Priority Area 2 states that 'Health information and policy documents targeting gay, bisexual and transgender males… should be in appropriate language and formats, and health information translated into community languages' (Commonwealth of Australia, 2010:16). It argues that health promotion messages targetted at specific groups of men should be couched in positive terms, with positive images. It further encourages everyone in the health sphere, from policy development personnel, to program managers and healthcare providers to work towards recognition of sexual orientation and gender diversity as important social determinants of health.

Priority Area 5 urges health researchers to 'Consider the interaction of the social determinants of health on sex, age and different population groups of males, including those from gay, bisexual and transgender groups' (Commonwealth of Australia, 2010: 26.

Specific barriers to gay, bisexual, transgender and intersex (GBTI) men accessing healthcare are acknowledged in **Priority Area 6.** Discrimination is stated to affect GBTI men's willingness to disclose their sexual minority status, which can negatively affect their health outcomes (Commonwealth of Australia, 2010: 26. See also Australian Medical Association *Position Statement on Sexual Diversity and Gender Identity,* Online, 2002). Health care initiatives and services should be specifically tailored for these population groups, which are at risk of poor health.

The *National Male Health Policy* suggests that measures to counter homophobic discrimination and failure of GBTI men to access healthcare could include routinely asking about sexual orientation and employing staff from diverse backgrounds, to provide positive role models (Online, 2010:28. See also Khan, Plummer et al, 2007).

GBTI men are not specifically mentioned in Priority Areas relating to 'Optimal health outcomes for males'; different life stages; or preventive health for males, particularly regarding chronic disease and injury (*National Male Health Policy,* Online 2010). This is somewhat surprising in the light of HIV/AIDS and higher rates of suicide among GBTI males (Leonard, Pitts et al, 2012; Australian Human Rights Commission, 2009; Corboz, Dowsett et al, 2008; Smith, Agius et al, 2008; Couch, Pitts et al, 2007; Hillier, Turner et al, 2005). Age and life stage should be considered social determinants of health, since the historical and socio-political context of their lives affects gay men's willingness to come out and, hence, to have their specific healthcare needs met (Department of Health and Ageing, 2012; GRAI, 2010; Matrix Guild and Vintage Men, 2009, 2008; Harrison, 2006).

There appears to be a disconnect between the main National Male Health Policy document and its 'supporting document' on *Social Determinants and Key Actions Supporting Male Health* (Online, May 2010), as there is no mention of gay, bisexual, transgender, or intersex men with regard to key actions. The only references to gender are to the binary definition of gender as only male versus female in the latter document.

Policies with no follow-up actions attached to them - and in which 'Key Actions' do not acknowledge sexual minority as a social determinant of health - are unlikely to positively affect the health outcomes of gay, bisexual, transgender, or intersex men.

RECOMMENDATION 5: THAT ALL GOVERNMENT POLICIES BE BROKEN DOWN INTO SPECIFIC ACTION PLANS WITH RESPONSIBILITIES, TARGET DATES AND BUDGETS ATTACHED TO THEM.

To our knowledge there are no research results, as yet, from the proposed Longitudinal Study on Male Health, however its planners seem to be headed in the right direction when they state that:

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'The Longitudinal Study will consider the social determinants of health with a focus on those males that are most disadvantaged. Males themselves will be actively involved in the design and implementation of the study' (*National Male Health Policy, 2010 p* 24). They demonstrate a knowledge of many of the determinants of men's health when they assert that the Longitudinal Study

- 'Examines the social, psychological, biological and environmental determinants of good health in males; including clarification of the cause and effect relationships between the health of males and these determinants….
- Includes a focus on life stages and key life transition points/events.
- Examines the social determinants of health such as socio-economic status, education, employment, income, location, cultural background and social support; and examine how these determinants may impact on males' physical and mental health.
- Considers the impact of sex, gender and age on males' attitudes towards their health, health behaviours, including help seeking and health outcomes' (2010:24).

It remains to be seen whether their definition of sex and gender, above, includes GBTI men and whether their research findings will flow through into government programs and services.

c) (iii) Is a Social Determinants of Health Approach Being Adopted in Commonwealth Data Gathering and Analysis?

There is an overwhelming need to collect much more data on GLBTI population groups if evidence-based healthcare, which takes all their social determinants of health, is to be adopted by the Commonwealth government. Some steps are being taken, in this regard, with the formation of a GLBTI advisory group on how the next Census might deal with issues of sexual orientation and gender identity.

By way of contrast, a possible overwhelming need to resist data collection may result from the 'unique health identifier' proposed for the national e-health scheme, whereby each person's complete health history will be recorded at a central location which can, supposedly, be accessed only by that person's own healthcare providers. This may have possibly unintended consequences for GLBTI people, some of whom, in the past, have been shown to consult different healthcare providers for their general, and for their sexual orientation- or gender identity-specific health issues (McNair and Dyson, 1999). This system could have very drastic negative effects on the lives of GLBTI people unless it is absolutely secure (and Wikileaks has demonstrated that even the most secure sites are not secure). For instance, if a GLBTI person (say one who was HIV+, or even one who wasn't) worked for a school, or hospital, or welfare agency that was run by a religious organisation. Say their employer got access to their health records from the e-health system. As the law stands, with the religious exceptions and exemptions to various states' *Equal Opportunity Acts* they could legally be fired from their job for no other reason than their sexual orientation (to say nothing of their HIV+ status). One possible unintended consequence of the e-health system might be that a GLBTI person might no longer access healthcare, in order to protect their livelihood.

GLBTI-specific issues have been covered in some national research. For instance, the 2008 Australian Bureau of Statistics *National Survey of Mental Health and Wellbeing* showed that GLB participants have higher levels of affective disorders (including major depression) than heterosexual participants.

Similarly, government-funded research such as the Commonwealth Department of Health and Ageing's 2004 paper on *Responding to the Mental Health Needs of Young People in Australia: Discussion Paper: Principles and Strategies* discusses how stigma and discrimination affect GLBTI people's mental health.

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The *Australian Longitudinal Study on Women's Health* has some shortcomings, when it comes to understanding intersectional aspects of discrimination, such as its failure to ask a question on sexual orientation of its older cohort.

RECOMMENDATION 6: THAT ALL COMMONWEALTH GOVERNMENT DATA COLLECTION INCLUDE SPACES WHERE GLBTI PEOPLE MAY SELF-IDENTIFY, ON A PURELY VOLUNTARY BASIS.

RECOMMENDATION 7: THAT THE COMMONWEALTH GOVERNMENT ADOPT A 'NOTHING ABOUT US WITHOUT US' POLICY, WHEREBY SPECIAL POPULATIONS ARE ALWAYS INVOLVED, AS RESEARCHERS, IN ANY RESEARCH ON THEIR SPECIFIC NEEDS.

d) (i) Is there scope for improving awareness of social determinants of health in the community?

We now draw the attention of the Committee to a model example of the integration of research, policy recommendations, partnership between the Victorian and several GLBTI community organizations and the media regarding one unique and successful way of improving awareness of social determinants of health in the community. This could act as a blueprint for the Commonwealth government, in the future.

Extensive research has been undertaken in Victoria, New South Wales and Queensland (Berman and Robinson, 2010; Leonard, Mitchell et al, 2008; Mc Nair and Thomacos, 2005) in relation to homophobic and transphobic abuse, harassment and violence against GLBTI people, including strategies to reduce harassment and discrimination.

With Respect: A Strategy for Reducing Homophobic Harassment in Victoria, a 2006 report prepared by the Attorney-General's Ministerial Advisory Committee on GLBTI Issues, recommended legislative changes together with a social marketing strategy to counter and reduce the unacceptably high levels of harassment and violence experienced by LGBTI individuals and communities.

Arising from this initial research, the *No to Homophobia* campaign (www.notohomophobia.com.au) was produced by a coalition of LGBTI community organisations, including the Victorian Gay and Lesbian Rights Lobby, and was launched on 28 August 2012. The campaign consists of two television advertisements portraying scenes of homophobic, transphobic and biphobic harassment. They portray various locations where harassment may occur, such as school, at work, and in a sporting context. They also include CALD actors. The TV advertisements are supported by a comprehensive on-line resource designed to equip individuals to 'get informed, 'take action' and 'find support', backed up by a social media presence on facebook and twitter.

The positive response to the campaign, evidenced through public support (50,000 plus views of the TV advertisements and 4,000 'likes' of the *No To Homophobia* facebook page) as well as extensive media coverage, demonstrates the appetite within both the LGBTI and mainstream communities for such initiatives. Given the extremely modest funding of the campaign (a $50,000 grant from the Victorian Department of Health), it is hoped that further funding will be made available to leverage the value of the TV commercials and standalone website.

The Victorian Equal Opportunity & Human Rights Commission has achieved success in promoting sexual and gender diversity in sport through its *Fair Go Sport* campaign and this model could be adopted in a variety of sporting or other settings.

There is scope for extension of these campaigns or similar national campaigns based to be deployed using a variety of methods to raise awareness of these issues and change community attitudes to promote the health and well being of GLBTI people.

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RECOMMENDATION 8: THAT THE COMMONWEALTH GOVERNMENT FUND SOCIAL MARKETING CAMPAIGNS TO INCREASE AWARENESS AND REDUCE THE INCIDENCE OF HOMOPHOBIA, TRANSPHOBIA AND BIPHOBIA

d) (ii) Scope for improving awareness of social determinants of health within government programs?

Our comments in the answer to c) (i) demonstrate that there is abundant scope for improving awareness of social determinants of health within government programs.

The Victorian Gay and Lesbian Rights Lobby assert that, unless there is full articulation between international health and human rights policy; its integration into domestic Australian and state legislation and policy; and programs and service delivery at the community level - complete with adequate budgetary resourcing for these initiatives - there will be a failure fully to address the social determinants of health which affect GLBTI people.

We strongly hold that Commonwealth policies and programs must be brought more into alignment with international health and human rights policy and UN covenants of human rights.

The changes to the Commonwealth Centrelink legislation, in July 2009 (the *Same Sex Relationships (Equal Treatment in Commonwealth Laws - General Law Reform) Act 2009*), reflected either a very poor understanding by the Commonwealth government of the cumulative financial disadvantage, during decades, of older GLBTI people, or a disregard of how this legislation further actively penalised a group which had already been greatly discriminated against by over 200 Commonwealth and State laws (HREOC, 2007; VGLRL and Law Institute of Victoria, 2007). This has caused immense ongoing stress to a number of GLBTI seniors, according to anecdotal evidence, which must affect their mental wellbeing and health. In this case, age was not viewed as a social determinant of health by the Commonwealth government.

The new Centrelink legislation was not equitable for GLBTI, but particularly lesbian, couples on at least six counts, i.e. it failed to take *outcomes* for a particular, disadvantaged minority group into account:

1) Usually, if there is to be a major change to Australian government payments, as with disability and aged pension arrangements, transitional arrangements are put in place, e.g. the 14-year phase-in of increased pension age, in order to allow people to adjust to the new arrangements. A grandfather clause, for example, might say that everyone who is on a particular benefit, as at 1 July, 2009, can remain on that benefit, whereas people newly receiving that benefit from 1July, 2009, will receive benefits according to the new arrangements. There were no transitional arrangements or grandfather clause put in place for lesbian and gay couples, who had only three months' notice from the time of the original press release issued by the Department of Human Services on 30 March, 2009 (DHS, 30-3-'09, Online), until they potentially lost 25%-100% of their benefit when the new law came into operation on 1 July, 2009. DHS remained intransigent about no grandfather clause in the face of a great deal of lobbying by many community organisations regarding the detrimental impact of the hurried legislative changes

2) There was a failure, on the part of the Australian government, to take into effect the historical context of the potentially traumatising (in the official, literal sense) effects of lesbian and gay people being forced, under threat of legal prosecution, to disclose their sexual identity and relationship to a large bureaucracy that had, hitherto, treated them with disdain and disrespect by refusing to recognise their relationships.

3) The Federal government failed (or refused) to understand that the people, e.g. older lesbian and gay people who have been discriminated against by a homophobic society for the longest time, were going to be those who were hurt the most by the new Centrelink legislation, because they would not be able to go out to work to recoup the benefits they lost with the legislative changes.

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4) There was a lack of understanding of lesbian culture, on the part of the Australian government, which thought that one member of a couple should be forced to sponge off their partner, in a reproduction of traditional, heteropatriarchal patterns of relationship. This is anathema to lesbians, and other GLBTI couples, who have striven hard to support themselves.

5) There was inherent gender inequity embedded within the requirement of a lesbian partner who is on a benefit to be supported by her female partner who was earning, since the supporting partner was likely to be earning less than a gay or heterosexual male supporting partner.

Article 23 of the *Universal Declaration of Human Rights,* declares that 'Everyone, without discrimination, has the right to equal pay for equal work' (United Nations, 1948, Online). It is generally, however, more difficult for two women to live on the pay of one woman than for a woman and a man to live on the pay of one man because of the persisting gap in gender pay rates.

The Centrelink legislation failed to recognise age, as well as sex, sexual orientation and gender identity, as a social determinant of health.

Beyondblue's *Maturity Blues* program, although it took age into consideration, did not integrate sexual orientation or gender identity issues into the program, thereby ignoring sexual minority as a social determinant of health.

'Quarantining' GLBTI health issues into GLBTI-specific international human rights statements; national and state health policies and human rights legislation; and programs/service delivery may, in some cases, not be a helpful strategy, since GLBTI individuals, like all other people, often experience multiple, intersecting forms of discrimination. Victorian Gay and Lesbian Rights Lobby contend that GLBTI issues should be included, as a matter of course, in all 'mainstream' policy documents, legislation, programs and service delivery, as special population groups, with its own particular needs. These could include documents concerning Aboriginal and Torres Strait Islander or culturally and linguistically diverse (CALD) status, (dis)ability, sex, age, and socio-economic grouping, amongst others.

Hence, there are at least two major aspects which need to be considered when embedding the social determinants of health in Government policies, strategies, and programs.

RECOMMENDATION 9: THAT IN ALL NON-SPECIFIC COMMONWEALTH POLICIES AND PROGRAMS GLBTI ISSUES SHOULD BE CONSIDERED AND INTEGRATED.

RECOMMENDATION 10: THAT IN ALL COMMONWEALTH GLBTI-SPECIFIC POLICIES AND PROGRAMS, OTHER FORMS OF DISCRIMINATION AND SOCIAL DETERMINANTS AFFECTING OTHER POPULATION SUB-GROUPINGS BE CONSIDERED AND INTEGRATED.

d) (iii) Scope for improving awareness of social determinants of health amongst health and community service providers?

In the past, the experiences of GLBTI people in the healthcare system - including community and residential aged care - have been found so wanting that three organisations have felt the need to publish their own best practice guidelines for service providers (Matrix Guild Vic Inc, 2011; GRAI - GLBTI Retirement Association Inc, Western Australia 2010a; Victorian Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing (2009).

Integrating GLBTI social determinants of health into the main policy and procedures documents of every health and community service provider, as a matter of course, might help to improve their awareness of

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widespread societal factors influencing GLBTI people's health and their knowledge of their responsibilities toward GLBTI clients in this regard.

Research on discrimination against GLBTI people in community and residential aged care demonstrates that homophobic, lesbophobic and transphobic discrimination is fairly endemic (GLBTI Retirement Association Inc (GRAI), Western Australia, 2010; Matrix Guild and Vintage Men, Vic, 2009, 2008; Harrison, South Australia, 2006. See also Guasp 2011, which gives UK parallels). Many aged care providers typically assert that they have no GLBTI clients (GRAI, 2010; Matrix Guild, 2009), but it has been demonstrated that they do, in fact exist, but feel reluctant to self-identify due to actual or feared victimisation (Walton, 2009). Further research is needed on the specific needs of GLBTI seniors who suffer intersecting social determinants of health, such as those from CALD or Aboriginal and Torres Strait Islander origin, in poverty, or having multiple morbidities and disabilities, to increase awareness of their specific issues and needs.

RECOMMENDATION 11: THAT SUFFICIENT GOVERNMENT FUNDING BE ALLOCATED FOR RIGOROUS RESEARCH INTO THE NEEDS OF GLBTI PEOPLE AT ALL STAGES OF THE LIFECYCLE.

Conclusion

Sexual orientation and gender identity are internationally-recognised social determinants of health yet are only partially and inconsistently recognized in Commonwealth government policy documents, such as the various parts of the *National Male Health Policy: Building on the Strengths of Australian Males.*

Commonwealth law and policies should be amended to protect and fulfill the human rights of LGBTIQ people to be free from the harmful effects of discrimination on the basis of their sexual orientation, gender identity and/or sex characteristics. The Commonwealth Government should, as a first step, ensure that the sex and gender diverse are recognized appropriately under Commonwealth laws and policies.[1]

While there are some positive Commonwealth government initiatives, such as the proposed Ageing and Aged Care Strategy, more can be done to achieve a consistent, whole-of-government approach to entrenching the social determinants of health in all government policies, programs and service delivery.

[1]Recent welcome reforms to passport policies should be adopted across all Commonwealth Government Departments.

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