the NETWORK for LGBT health equity

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Tobacco Control Network
Tobacco Technical Assistance Consortium
Whitman Walker Clinic

Comments submitted to the National Partnership for Action on the draft Achieving Health Equity Plan by Network for LGBT Tobacco Control

Dear National Partnership for Action:

It is with great excitement that we read the draft National Plan for Action on Achieving Health Equity presented on this site. We deeply respect the great amount of work put into this plan and laud the many excellent recommendations that have been put forth. Truly, were this plan to be fully implemented, the factors that have created a retinue of health disparities among many underserved communities would be dealt a great blow, and large strides towards health equity for all will have been made.

In no part detracting from our appreciation of the vision of this document, we would like to respectfully petition for one type of minor but systemic change throughout. That is the explicit and consistent inclusion of one still too-often overlooked population that experiences marked health disparities; sexual and gender minorities (SGM). Sexual and gender minorities, sometimes commonly referred to as LGBTs, have a long history of documented discrimination that has taken its toll on our health status. As but one example, it is not commonly known that it is legal to fire people for being SGM in over half the states in our country, and sadly, it is a circumstance that happens too often. Since we span every other disparity group, it is particularly difficult for SGM people who live with multiple stigmatized identities to achieve health equity. Of especial concern are the most vulnerable within our population, for whom overt discrimination is a daily if not hourly reality.

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The plan mentions SGM in the opening frame and we appreciate this. We would simply ask that effort is made to then continue this inclusion throughout the full document. SGM disparities are unfortunately too often overlooked, and thus unattended. So we hope you will agree, this is one opportunity where we should not let this omission be echoed forward.

We understand that specific suggestions for areas of inclusion will be most helpful. Thus we have reviewed the plan and compiled a list of strategic areas for inclusion below. Please feel free to contact us for further details on the science base in any of the areas. We look forward to being continued partners in the goal of achieving health equity for all.

Best,

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Strategic Suggestions:

Chapter 1

p.1, para 1: racism, [homophobia,] inadequate personal support systems

p.2, para 1: race, ethnicity, [sexual/gender minority status,] socioeconomic status, or other factors

p. 2 definitions: Health Disparity…physical disability, sexual orientation, [gender identity,] geographic location

p. 6 new para: **Increased awareness of health disparities in sexual and gender minority populations**

There are an estimated 8.8 million sexual and gender minority people in the United States, spread across every socio-economic, race, and ethnicity group. A consistent body of evidence has raised awareness of health disparities in this population, leading to acknowledgement in Healthy People 2010 as a disparity class. Evidence of the magnitude of these disparities is hampered by lack of data collection on many federal surveys but forthcoming efforts to enhance data collection as well as a forthcoming Institute of Medicine report will begin to redress these knowledge gaps.

p. 17: Kaiser family fnd reference note: they are actually very likely to have asked sexual orientation/gender identity on that same or similar surveys. If so, a stat from that about SGM would be illustrative here.

p. 19-20 Health Systems and Cultural Competency section note: both of these subjects are the site of dramatic disparities for SGMs, this is the most likely section to add a short para on experiences of SGM people in these subjects. i.e. ¼ of trans people on recent national survey have been denied healthcare. There are also examples of doctors and nurses demonstrating strong personal anti-SGM bias in surveys.

p. 22 Research and Evaluation note: suggest recommending SGM demographic questions for R&E, as they are often overlooked there as in surveillance, thus hampering knowledgebase.

Chapter 2: The Current Context

p. 31, Introduction: add verbage about SGM data collection challenges in discussion of data collection here.

p. 32 Demographics: there has been extensive analysis by the Williams Institute of same-sex household data from the Census as a proxy for LGBT population. See full report on this, would recommend adding this best-possible estimate here.

p. 36 Disparities overview: worth noting at least that AHRQ does not track for SGM, despite it being a measure in HP2010, alternate sources of info are available to create small para about SGM disparities here

p. 38-57 Disparities overview

There exists significant data to add SGM examples to the following sections: Cancer, HIV, behavioral health. [Note: there is also overwhelming likelihood that disparities exist for other sections, the almost total lack of SGM health outcome data impedes analysis].

p. 58-73 Social Determinants of Health: There exists evidence to reference SGM disparities in SES and housing.

p. 73-78 Behavioral Determinants of Health: There exists evidence to reference SGM disparities in all of these areas.

p. 85-96: Workforce: there exist notable challenges in offering no cult comp training to healthcare professionals, and discrimination against SGM students. We have a sincere pipeline problem with SGM researchers, including recent examples of them being targeted by political groups. Educational discrimination and lack of mentorship, as well as difficulty obtaining research funding for the subject have all conspired to depress the potential incoming research workforce.

p. 112 Obj. 1: Awareness: expand language to be inclusive of SGM, not just racial and ethnic minority populations. Actions: expand “office of minority health” to language that’s inclusive of LGBT health as well, such as “office of health disparities” or “office of health equity”

p. 113 Obj. 2, strategy 2: Expand language on Action 3 to be inclusive of all health disparities

p. 114 Strategy Media: in the box describing this, include SGM populations an example of health disparity populations alongside the others.

p. 118 Measures: expand language “minority and low-income populations” to be inclusive of SGM, for example, “minority, underserved, or low-income populations”

p. 120: Health Communication: Availability of materials for SGM populations and utilize

SGM inclusive language in intake forms. Clients (data is most clear for adolescents) often report fear of disclosing sexuality to providers, and inclusive communication can help build an environment of trust.

p. 124: Workforce training: SGM competencies are warranted in “Actions” and SGM communities in strategy. Recent surveys found few schools of public health, social work, or medicine are including substantial training on LGBT health.

p. 128: Strategy 17 – Data: The lack of quality data on SGM populations and subpopulations has been a major limitation to intervention development, policy development, and evaluation. SGM demographic questions in statewide and national public health surveillance systems and efforts to differentiate between SGM subgroups are indicated. This lack of data is well documented by Sell et al and by Mayer et al in a recent AJPH article.

p. 138: Intermediaries/partnerships: SGM organizations could be a valuable part of this work.

p. 139: Coordination: offices working with SGM health are part of some health departments.

p. 141: Health and Health System Experience: SGM experience difficulty with many healthcare settings, including challenges with recognition of partners and loved ones, trust in patient confidentiality, complicated insurance status, and treatment by staff.

p. 142: Inclusion of all under-represented parts of the community (e.g., SGM) can be a challenge and organizations need to specifically endeavor to promote inclusion.

p. 152: Measures of Change: Such indicators and data should be available for SGM populations (#1); however, due to limited public health surveillance they may not be. Waiting for improved data collection systems should not preclude efforts for inclusion.

END