As the population ages further, increasingly higher numbers of older adults will be at risk for multiple disabilities.

The development of the biopsychosocial model has led to physical health and mental health being inextricably linked, and the tenets of the model have proven to hold true for disabilities. In 2006, elderly individuals with motor disabilities were 2.11 times (95% confidence interval [CI] = 1.89, 2.35) more likely to have a comorbid mental disability than those without motor disabilities.[4] Unexpectedly, factors such as higher household incomes, residence in urban areas, and residence in the country's eastern region were also associated with a higher risk of comorbid mental disabilities.

In that same year, the risk of mental disability was 1.86 times (95% CI = 1.23, 2.81) higher when individuals with motor disabilities were diagnosed while they were members of the labor force than when they were diagnosed at the age of 65 years or older.[4] Generally, people are most active in terms of social production during the period in which they are participants in the labor force, and thus motor disabilities diagnosed during this period may have a greater impact on their mental health, resulting in comorbid mental disabilities.

As China is undergoing social reform, these findings highlight the need for implementing more comprehensive prevention and rehabilitation strategies. These strategies will support not only older adults themselves but also current labor force participants.

HEALTH FOR EVERYONE AT ALL AGES

Aging and disability are not only issues for the elderly population. Higher morbidity or disability rates among older people reflect an accumulation of health risks across the life span. Currently, the Chinese government is developing Healthy China 2030 as a national strategy.[7] The plan is a general guideline for promoting health in the coming 15 years. Health promotion for the entire population and throughout the life cycle is the primary theme, and older adults and individuals with disabilities are two of the key target populations. This strategy will provide great opportunities to engage in research and practice with respect to health and disability among older adults, as well as policymaking in terms of prevention and rehabilitation.

In conclusion, global aging, as an embodiment of the progress of human society and civilization, brings both challenges and opportunities. China is fully aware of its responsibilities and mission in population health and sustainable human development, as evidenced in Healthy China 2030. The next step is to implement specific proposals, comprehensive plans, and detailed measures to achieve the goal of active and healthy aging in China. Such activities will also contribute to population health across the Asia Pacific region and the world. AJPH

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Threats to United States Fully Reviewed and Strategic Plan for Integration of Transgender Military Members Into the Armed Forces

On July 26, 2017, President Donald Trump announced via Twitter his intention to ban transgender individuals from serving in the US military "in any capacity," citing "medical costs and disruption" as his rationale. He commented that he was doing the military a "great favor" by banning transgender personnel. This represented a sudden reversal of a fully reviewed and strategic plan for integration of transgender military members into the armed forces, originated and implemented by our military leaders to ensure cost-effectiveness and continued military readiness.

GENDER-AFFIRMING INTERVENTIONS

Transgender individuals have a gender identity that differs from their sex assigned at birth. Consequently, many transgender patients seek gender-affirming interventions to achieve concordance between physical appearance and function and their gender identity. Gender-affirming interventions include hormone therapy and gender-affirming surgical procedures such as breast or genital surgery and facial contouring.

At the Johns Hopkins Center for Transgender Health, we routinely take care of active duty and

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reserve military patients going through the transition process. This process does not occur instantaneously. A transgender service member, in coordination with his or her chain of command and military medical providers, develops a transition plan that incorporates the service member's health care needs and the unit's mission readiness; the mission always comes first. The service member cannot begin any transition-related medical treatment until the plan is reviewed and approved through the processes implemented by each service.

UNIT COHESION OR EFFECTIVENESS

Eighteen other countries allow transgender personnel to serve: Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom, all of which are Organization for Economic Cooperation and Development members, with the exception of Bolivia. A RAND study commissioned by the Pentagon during its policy review found that there was no effect on unit cohesion or effectiveness in those militaries.[1] Furthermore, the US military experience of having thousands of transgender personnel serving across the force without significant issues since transgender individuals serving openly became allowed indicates that the argument based on a disruption to the force is a pretext.

The claim that allowing transgender military personnel to serve reduces military effectiveness is not a novel one. The same false premise—that embracing a more diverse military force weakens our national defense and disrupts order—was disproven when it was applied to the integration of African American, female, and lesbian, gay, and bisexual service members.[2] At the heart of this argument is the belief that our service members lack the professionalism to work alongside those who are different when accomplishing the mission. This argument also questions the leadership ability of service members to direct a force that reflects the nation they serve and is disrespectful to all American military personnel.

OVERALL HEALTH CARE COSTS IN THE MILITARY

This transgender ban would have little to no effect on overall health care costs in the military. Even though transgender individuals are estimated to be overrepresented in the military compared with the general population,[3] one estimate in the *New England Journal of Medicine* suggested that medically necessary transgender-related health care would cost the military about $5 million a year,[4] less than a quarter of the $23 million the military spends on acne medications each year[5] and about 0.0001 of the $49.3 billion the Department of Defense spends on health care each year.[1] Furthermore, the provision of gender-affirming care, even in the general population, has been shown to be highly cost-effective.[6] The evidence is unambiguous: giving patients support and allowing them to embrace their identity consistently improve their quality of life.

SPEND $960 MILLION TO SAVE $10 MILLION

The cost argument is misguided because it fails to account for the cost to recruit and train replacements for thousands of productive service members with years of training and expertise who have been involuntarily discharged. A 2016 estimate suggests that the US military has between 2150 and 10 790 active and reserve transgender service members. In a recent article,[7] current and former professors from the Naval Postgraduate School calculated that it would cost $960 million to discharge the transgender personnel who are currently serving. As such, the Department of Defense would spend $960 million to save less than $10 million in annual health care costs.[1,7]

UNCONSTITUTIONAL AND IMMORAL

Furthermore, the threats to unit performance and morale by suddenly forcing out loyal personnel—who were serving their country without any issues—are likely more real than any imagined disruption from working alongside transgender individuals. Because the issue of transgender military service was fully vetted by our military leadership, and transgender personnel have served openly for the past year, the ostensible rationale for this ban put forth by the president is not rational. These service members were told just one year ago that they should be open about their gender identity and could trust their leadership not to punish them. To implement an order now to expel thousands of patriotic, mission-capable troops, using their honesty against them, is arguably asking our chain of command to do something both unconstitutional and immoral. Such an order could be far more damaging to military readiness than supporting our transgender troops.

Simply put, there is no moral, financial, medical, or military rationale to suddenly expel thousands of service members just for being transgender. Across the decades, our military has gradually but irreversibly arced in the direction of becoming more inclusive, by race, gender, sexual orientation, and now gender identity, while remaining unquestionably the most powerful and effective military fighting force in the world. AJPH

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Progress and Challenges in Sexual Orientation and Gender Identity Measurement in the First Year of the Trump Administration

A dossier of articles published in *AJPH* in August 2017 undertook a critical examination of a proposal by the federal Department of Health and Human Services' Administration for Community Living to remove a sexual orientation question from the National Survey of Older Americans Act Participants (NSOAAP).[1] These articles asserted the importance of having reliable, comprehensive data on lesbian, gay, bisexual, transgender, and queer (LGBTQ) people to advance health policy and programmatic goals and presented research showing the feasibility of collecting data on small populations such as LGBTQ older adults. The draft NSOAAP survey—with the sexual orientation question deleted—was subject to public review, and Administration for Community Living ultimately received nearly 14 000 comments from individuals and organizations, the majority arguing that the question should be retained.[2] As a result of this extensive feedback, the agency reversed its decision and included a revised measure in the final survey, one that no longer conflated sexual orientation with measurement of a person's gender identity. Researchers and advocates still rightly decried the lack of data to identify transgender older adults, but the agency's reversal was nonetheless an important victory during a year of challenges for LGBTQ equality.

PLAYING POLITICS WITH SCIENCE

In the same month that the sexual orientation measure had been deleted from the NSOAAP, the Census Bureau again failed to include further study of sexual orientation and gender identity measurement in its initial report to Congress on the 2020 Census and American Community Survey. Over years of engagement with experts in demography and measurement science, members of Congress, and federal agency staff, LGBTQ advocates have argued that without inclusion in major government surveys like the American Community Survey, we would never truly achieve full and equal protection of the law or develop a comprehensive public policy response to meet the community's needs. Sadly, it has since become clear that politics, not science, likely brought progress in this area to a halt. Inquiries from multiple members of Congress and investigative reporting revealed that drafts of the Bureau's Subjects Planned for the 2020 Census and American Community Survey report included sexual orientation and gender identity as potential subjects. One draft, obtained by National Public Radio, echoed the themes covered in the *AJPH* dossier, noting that these data could

> . . . aid in planning and funding government programs and in evaluating other government programs and policies to ensure they fairly and equitably serve the needs of all people. These statistics could also be used to enforce laws, regulations, and policies against discrimination in society.[3]

The Census Bureau reported in 2017 that Census data were used to allocate more than $675 billion across at least 132 federal programs, including health-related programs such as Preventive Health and Health Services, Maternal and Child Health, and Community Mental Health Services Block Grants.[4] Having data to evaluate and target these benefits takes on heightening importance given evidence of health disparities and economic instability among LGBTQ people.

In response to criticisms, Trump Administration officials have cited a lack of need for sexual orientation and gender identity data and the absence of a statutory mandate to collect it. Yet these arguments fall flat in the face of their own agencies' assessment of the value of these data for government programming and enforcement of LGBTQ people's civil rights. These assertions also stand in stark contrast to the recent decision to add a citizenship question to the 2020 Decennial Census under the stated rationale of enforcing the Voting Rights Act of 1965 (Pub L No. 89-110), a law passed 15 years after this question was last asked on a Decennial Census. This decision was made over the recommendations of former Census directors from both parties, scientific experts, and Bureau advisors, who predict that the inclusion of such a question at this late date

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