By Karen I. Fredriksen-Goldsen

Promoting **Health Equity** Among **LGBT** Mid-Life and **Older** Adults

Revealing how LGBT mid-life and older adults can attain their full health potential.

The older adult population is becoming increasingly diverse. Given the rapid demographic changes in the U.S. population, there is rising diversity in older adults by race and ethnicity, as well as by sexual and gender identity. It is estimated that more than 2.4 million adults ages 50 and older in the United States identify as lesbian, gay, bisexual, or transgender (LGBT) (Fredriksen-Goldsen and Kim, 2014), accounting for 2.4 percent of the population. Given the significant aging of the population overall, by 2030, LGBT adults ages 50 and older will number more than 5 million.

LGBT adults who are middle-age and older experience significant health disparities (Fredriksen-Goldsen, Kim, and Barkan, 2012; Wallace et al., 2011), defined as variations in health attributable to systemic environmental, economic, and social barriers that place individuals at a disadvantage in the larger society (Centers for Disease Control and Prevention, 2011). Disparities in physical and mental health among LGBT older adults reflect a number of complex risks factors, including experiences of discrimination and victimization, elevated levels of chronic stress, delayed and limited access to care, and, for some, the increased likelihood of economic and social deprivation and isolation. Yet, despite disparities and adversity they may experience, most LGBT older adults are healthy and aging well (Fredriksen-Goldsen et al., 2014a).

This article examines the health disparities of LGBT mid-life and older adults through a health-equity perspective. To address the range of health outcomes in these communities, we will look at strengths and resources, as well as challenges. The analysis will incorporate historical and changing social context. I also will consider steps for better addressing the unique health and aging needs of LGBT mid-life and older adults through innovations in services, policy, and research.

LGBT Health Disparities

Some common health problems are elevated for LGBT mid-life and older adults, even when taking into account differences in age distribution, income, and education. Compared to heterosexuals of similar age, lesbian, gay, and bisexual mid-life and older adults are at an elevated risk of poor general health, disability, and mental distress (Fredriksen-Goldsen, Kim, and Barkan, 2012; Fredriksen-Goldsen et al., 2013b; Wallace et al., 2011), and are more likely to engage in adverse health behaviors such as smoking and excessive drinking. Transgender midlife and older adults have significantly higher rates of poor general physical health, disability, depression, and perceived stress than do their

lesbian, gay, and bisexual counterparts (Fredriksen-Goldsen et al., 2013a).

Although LGBT older adults often are assumed to be a homogeneous group, there are important sub-group differences when it comes to health. Older lesbian and bisexual women have a higher risk of cardiovascular disease (Fredriksen-Goldsen et al., 2013b; Valanis et al., 2000), obesity, disability (Fredriksen-Goldsen et al., 2013b), and cancers of the reproductive system (Valanis et al., 2000) than heterosexual women of similar age, while gay and bisexual men have higher rates of poor general health (Fredriksen-Goldsen et al., 2013b), hypertension, and diabetes compared to their heterosexual peers (Wallace et al., 2011). Differences in health behaviors also are evident between sexual minority groups; older lesbians are significantly more likely to engage in heavy drinking compared to older bisexual women. Furthermore, diabetes is significantly more common among older bisexual men than among older gay men, and older bisexual men are less likely to have obtained an HIV test than older gay men (Fredriksen-Goldsen et al., 2013b).

Some LGBT older adults may also be at risk of social isolation because they are less likely to be partnered or married than heterosexuals of similar age, and older gay and bisexual men, compared to older heterosexual men, are more likely to live alone and have significantly fewer children (Fredriksen-Goldsen et al., 2013b). Because many LGBT older adults have peer-based social support systems, the oldest-old may be especially vulnerable to social isolation (Fredriksen-Goldsen et al., 2014a), which has been linked to poor mental and physical health, cognitive impairment, and excessive morbidity and premature mortality among older adults in the general population.

Caring and Aging with Pride, a study of 2,560 demographically diverse LGBT older adults across the nation, was developed to examine the health, aging, and well-being of LGBT older adults. One participant, an older gay man, explained his concerns about the future: "Isolation, finding friend support, caregiving and health are the biggest issues older gay persons face. Who will be there for us, who will help care for us without judgment?"

Promoting Health Equity

The primary focus in LGBT health and aging research has been on disparities and the negative experiences LGBT people may encounter. Glaringly absent in previous studies of LGBT health has been attention to health equity and the more positive aspects of LGBT health. A health-equity approach aims to reduce disparities and maximize efforts to reach full health capacity (Braveman, 2014). Through a health-equity perspective, our attention shifts to how LGBT older adults can achieve a sense of well-being, enhanced quality of life, and attain their full health potential (Fredriksen-Goldsen et al., in press).

Most LGBT older adults are healthy, satisfied with their lives, and aging well, with strong social ties.

As a multidimensional framework, a health-equity model attends to opportunities and constraints that might exist for LGBT individuals' health as they age. Promoting health equity requires an understanding of the intersecting nature of differential social positions, including age, sexuality, gender, socioeconomic status, and culture, and its relationship to strengths and risks across multiple levels—individual, community, environmental, and structural—as they influence the full range of health outcomes evident within these populations (Fredriksen-Goldsen et al., in press).

Historical and Changing Social Context

Understanding health equity within a life-course perspective considers the interplay of history, the timing and engagement of social roles and

life events, the interconnectedness of lives, and human agency (Elder, 1994, 1998). Social context, cultural meaning, and structural location affect the health and aging of LGBT older adults. The range of life experience of LGBT mid-life and older adults is vast, as they range from coming of age in the shadow of the Great Depression to being part of the Baby Boom Generation. LGBT older adults of the Silent and Greatest Generations (those born before 1946) came of age during an era when homosexuality and non-normative gender identities were invisible, and they were stigmatized and, at times, criminalized. The Baby Boom Generation (those born from 1946 to 1964) came of age at a time of dramatic social change reflective of the Stonewall riots and the civil and women's rights movements, as well as during the height of the AIDS pandemic in the United States.

In *Caring and Aging with Pride*, we find that LGBT older adults of the Silent and Greatest Generations are less likely to disclose their sexual orientation and gender identity, and have a higher degree of internalized stigma than those of the Baby Boom Generation. Interestingly, rates of lifetime victimization are lower for the older age groups (Fredriksen-Goldsen et al., 2014a; Fredriksen-Goldsen et al., 2011). Because those in the older age groups were less likely to disclose their sexual orientation or gender identity, such hiding may have been protective in that it decreased the risks of discrimination and victimization, yet it also may have reduced their opportunities to develop broad-based systems of support. The Baby Boom Generation shows higher community integration, larger social networks, and higher rates of discrimination and victimization.

While older age groups are less likely to participate in physical activities, they also are less likely to be engaged in substance use and more likely to receive regular health check-ups.

As we seek to understand age group differences from a health-equity approach, it is critical to attend to opportunities and risks and how they may operate differently by age in these communities. In *Caring and Aging with Pride*, a 72-year-old gay man shared, "In the course of many years since Stonewall, so much has occurred in our struggling attempt to gain respect, understanding and simple rights. Vigilance and determination are needed to bind our LGBT communities."

Opportunities and Strengths

Despite the focus on health problems, there are many positive signs of health, resilience, and strength among mid-life and older LGBT adults. Research demonstrates that most LGBT older adults are healthy, satisfied with their lives, and aging well, with strong personal and social ties (Fredriksen-Goldsen et al., 2014a). Ninety-one percent of LGBT older adult participants in our research engage in at least weekly leisure and wellness activities, and 82 percent engage in moderate physical activities. Eighty-nine percent feel good about beonging to their communities. More than a third (38 percent) attend spiritual or religious services or activities at least once a month.

Social support is one of the most important factors in physical and mental health. Most of our study participants have at least moderate levels of social support (Fredriksen-Goldsen et al., 2011). Friends, current and former partners, and others are integral members of LGBT older adults' families of choice, an emotionally close group that functions as family, although not related by blood or legal ties (Heaphy, 2009; MetLife Mature Market Institute and American Society on Aging [ASA], 2010; Muraco and Fredriksen-Goldsen, 2011; Nimmons, 2002). LGBT older adults are more likely than older heterosexuals to seek advice, assistance with personal matters, errands, emergencies, and emotional support from close friends (MetLife Mature Market Institute and ASA, 2010). In *Caring and Aging with Pride*, a 58-year-old gay man recounted, "When the AIDS crisis began, we took ahold of our own community to help

ourselves survive and showed the rest of the world how to do it. We need to keep doing it."

Social support, social network size, physical and leisure activities, and substance non-use are significantly positively associated with high physical and mental health quality of life among LGBT mid-life and older adults (Fredriksen-Goldsen et al., 2014a). And a positive sense of sexual identity is related to better mental health quality of life. Three-fourths of LGBT baby boomers who responded to an online survey believe that having lived as a sexual or gender minority has better prepared them to deal with the vicissitudes of aging (MetLife Mature Market Institute and ASA, 2010). Such "crisis competence," first defined by Kimmel (1978), suggests that navigating an LGBT stigmatized identity helps prepare adults for old age—another stigmatized identity. One 63-year-old lesbian in *Caring and Aging with Pride* said, "Our community needs to acknowledge our next stage . . . being old . . . embracing it gracefully."

The oldest-old in LGBT communities may be especially vulnerable to social isolation.

Challenges and Risks

It is important to recognize that health conditions that emerge in mid-life and later often have roots in earlier life experiences (Kelly-Irving et al., 2013; O'Rand and Hamil-Luker, 2005). Over their lifetime, most LGBT older adults have faced serious adversity, and contemporary and historical experiences of discrimination create elevated risk (Fredriksen-Goldsen et al., 2009). Because of being perceived as an LGBT person, 82 percent of LGBT older adult participants in our 2010 study had been discriminated against at least once in their lives, and nearly two-thirds (64 percent), three or more times (Fredriksen-Goldsen et al., 2011). A recent community survey of LGBT older adults in San Francisco found that nearly half (48 percent) had experienced discrimination or victimization based on their sexual orientation or gender identity within the past twelve months (Fredriksen-Goldsen et al., 2013c). Transgender older adults experience elevated rates of discrimination compared to non-transgender lesbian, gay, and bisexual older adults (Fredriksen-Goldsen et al. 2013a).

Lifetime experiences of victimization, discrimination, and internalized stigma have been independently associated with depression, disability, and poor general health in older lesbian, gay and bisexual (Fredriksen-Goldsen et al., 2013d), and transgender adults (Fredriksen-Goldsen et al., 2013a). Experiences of discrimination also can create obstacles to accessing and using necessary health and social support services. In our study, 13 percent of lesbian, gay, or bisexual older adult participants had been denied or provided inferior healthcare and almost a quarter (22 percent) of transgender older adults needed to see a doctor but could not because of cost. LGBT mid-life and older adults may be reluctant to disclose their sexual orientation or gender identity (Fredriksen-Goldsen et al., 2011), yet non-disclosure in healthcare settings can have detrimental consequences resulting in "failure to screen, diagnose, or treat important medical problems" (American Medical Association, 2013). As a 56-year-old transgender woman in *Caring and Aging with Pride* said, "In spite of the overwhelmingly positive experience I have had with my gender transition so far, I would say that my primary concern about the future is with access to health care and potential discrimination as a senior transgender person, especially if the need arises for emergency or long-term care."

Innovations in Services, Policies, and Research

As we move forward, it is critical to ensure a balance in our analyses of the range of health outcomes in these communities and assess fully the availability of supportive services. An important first step is to develop and implement screening mechanisms through which to identify

mid-life and older LGBT adults at risk of poor physical and mental health. Those without adequate services, supports, or resources, and those living alone are likely at elevated risk of social isolation and poor health outcomes. Innovative ways to effectively reach potentially hidden and isolated LGBT older adults need to be developed.

The unique histories of LGBT older adults must be gathered, so these are not lost to future generations.

Comprehensive health and aging services for such at-risk and vulnerable LGBT older adults are needed and will be best supported through fostering ongoing partnerships between healthcare and aging services. It is also essential that services and demonstration projects funded by the Older Americans Act target social and health services and programs that address the needs of vulnerable LGBT older adults and their caregivers. One 53-year-old lesbian in our study explained, "My primary concern is the lack of services for LGBT elders. It is imperative that the LGBT community and the government work together toward organizing services that provide members of the LGBT community, especially elder members, with such services." Given the effectiveness of anti-retroviral therapies, more adults also are living into old age with HIV disease, which in the United States has predominantly affected gay and bisexual men. The expansion of HIV prevention, education, and treatment programs for older adults, including LGBT older adults, will be an important step forward in battling the long-term impact of HIV.

There are recent advances in policies addressing the health and aging needs of LGBT mid-life and older adults. The Affordable Care Act (ACA) established nationwide non-discrimination protections in healthcare services based on sexual orientation or gender identity. And hate crimes based on perceived sexual orientation and gender identity can now be fully prosecuted (National Defense Authorization Act for Fiscal Year 2010, 2009). The Violence Against Women Reauthorization Act incorporates LGBT-inclusive language for domestic violence and access to abuse and trauma services. And, in states that legalized same-sex marriage, same-sex married partners have access to Social Security benefits, Medicaid spend-downs, bereavement leave, and inheritance of jointly owned real estate and personal property. We still need protection from discrimination based on sexual orientation and gender identity in employment, housing, and public accommodations at federal, state, and local levels to ensure the economic security and safety of LGBT mid-life and older adults.

The ACA mandates cultural competency training, but the curricula of medical schools only provide a median of five hours of specific training related to LGBT issues (Obedin-Maliver et al., 2011). Cultural competency training for health and human service professionals must address the diversity of LGBT mid-life and older adults and caregivers in terms of age, gender, ethnicity, race, education, income, geographic location, and ability. As a 58-year-old transgender woman in *Caring and Aging with Pride* asked, "Where do trans people that don't identify as LGB fit into the picture?" Competencies are necessary for effective practice across these diverse populations (Fredriksen-Goldsen et al., 2014b), and we need to develop processes by which to evaluate their implementation and effectiveness. Research also is needed that can differentiate age groups and assess the influence of time, period, and cohort. Longitudinal studies of health, aging, and sexuality of mid-life and LGBT older adults will aid in identifying potentially modifiable factors that account for health trajectories over time in these communities.

Services, policies, and research that seek to achieve health equity must also strengthen communities. Interventions should go beyond the individual level and target not only LGBT older

adults, but also their families of choice, informal caregivers, communities, and the larger society. Programs also should be designed to gather and cultivate the unique knowledge and experiences of LGBT older adults and the histories they have lived, so that these are not lost to future generations. LGBTQ Allyship is sponsoring an LGBTQ Intergenerational Project bringing together older adults and youth to build trust through sharing stories and creating space to talk about ageism and differences with the goal to cultivate a sense of shared history (The Seattle Foundation, 2014).

Such efforts undoubtedly will contribute to health equity by fostering community and a sense of belonging across generations, which, in turn, can benefit physical and mental health over the life span. Health, from a health-equity perspective, is a basic human right, best achieved through the accountability of health, aging, and other governmental systems and through the engagement and the full participation of all citizens, including LGBT mid-life and older adults, their families, and their communities. As a 63-year-old gay man in *Caring and Aging with Pride* noted, "The LGBT community has stepped up in the past to address coming out, AIDS, and civil rights. The next wave has to be aging."

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