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Social, Economic, and Health Disparities Among LGBT Older Adults

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Abstract

LGBT older adults are a heterogeneous population with collective and unique strengths and challenges. Health, personal, and economic disparities exist in this group when compared to the general population of older adults, yet subgroups such as transgender and bisexual older adults and individuals living with HIV are at greater risk for disparities and poorer health outcomes. As this population grows, further research is needed on factors that contribute to promoting health equity, while decreasing discrimination and improving competent service delivery.

Keywords

older adults; health disparities; LGBT; HIV; health service delivery

In *Healthy People 2020*, LGBT people are for the first time identified as a U.S. national health priority (U.S. Department of Health and Human Services [HHS], 2012), with the Institute of Medicine (2011) concluding that insufficient information exists on the health of LGBT people. One aspect of social justice is to better understand the social, structural, and institutional elements that create differential access to healthcare and health outcomes in this population.

There is accumulating evidence of health disparities among LGBT older adults, making LGBT older adults an at-risk population. The Centers for Disease Control and Prevention (CDC) (2014) defines health disparities as variations in health that negatively affect groups of people who have systematically experienced greater social or economic obstacles to health, historically linked to discrimination or exclusion. This article provides an overview of the social, economic, and health disparities, including higher rates of poor physical health and disability, HIV, and psychological distress in the aging LGBT population. It considers the interplay between risks and resources, and acknowledges differences between sub-groups within these communities.

Social Determinants of Health

Social determinants of health are defined as a range of personal, social, economic, and environmental factors that contribute to individual and population health, recognizing that poor health outcomes often are made worse by the interaction between individuals and their social and physical environment (HHS, 2016). LGBT older adults face health inequity and

disparities similar to other populations of older adults who are disadvantaged due to income, education level, and racial and ethnic background. Recent research has shown significant and important differences not only between LGBT older adults and their heterosexual peers, but also between sub-groups of the LGBT populace that often are classified together in research, service delivery, and policy analysis.

Several studies have examined the health and well-being of LGB older adults in comparison to their heterosexual peers and identified important differences, such as higher rates of poor mental health, smoking, and limitations of activities of daily living (Dilley et al., 2010; Conron, Mimiaga, and Landers, 2010). Those same studies have found higher rates of health risk behaviors, including excessive drinking among lesbian and bisexual women as compared to their heterosexual peers.

Research also has found important economic disparities between LGBT older adults and their heterosexual counterparts (Fredriksen-Goldsen et al., 2012). And sub-groups within the LGBT older adult population, including those who identify as bisexual, transgender, older than age 80, and living with HIV infections may be at greatest risk for economic insecurity and a subsequent impact on health and health-care access, which contributes further to health disparities.

Recently, Fredriksen-Goldsen and colleagues (2013a) analyzed data from the 2003–2010 Washington State Behavioral Risk Factor Surveillance System (BRFSS) on health outcomes and chronic conditions. They found that lesbian and bisexual women ages 50 and older had greater odds of disability and poor mental health compared to their heterosexual peers. They also found, however, that rates for poor physical health were similar between lesbian and heterosexual women. Differences may also depend on the intersection of gender and sexual orientation. In the BRFSS study, Fredriksen-Goldsen and colleagues (2013a) found that while lesbian and bisexual women had greater odds of obesity than their heterosexual counterparts, gay and bisexual men had lower obesity risk. Differences also were found in health behaviors, with gay and bisexual men, as well as lesbian and bisexual women, being more likely to smoke and drink excessively than their heterosexual peers. Wallace and colleagues (2011) also found that LGB older adults had poorer general health than their heterosexual peers.

While data suggest health disparities exist between sexual minority older adults and their heterosexual counterparts, studies also have noted important health-related differences between sub-groups of LGBT older adults. In the *Aging with Pride: National Health, Aging, Sexuality and Gender Study*, Fredriksen-Goldsen and colleagues (2013b) assessed direct and indirect effects of gender identity on physical health, disability, depressive symptomology, and perceived stress between transgender adults ages 50 and older and their non-transgender (LGB) peers. Significant differences were found in all outcome variables, with transgender older adults at higher risk for poorer physical health, disability, depressive symptoms, and stress than their non-transgender peers.

Important disparities have been noted between older and younger adults living with HIV infection as well. I found that older adults living with HIV are more likely to live alone and

be socially isolated than their younger peers (Emlet, 2006a). Fredriksen-Goldsen and Emlet (2012) have noted important disparities between older LGBT adults with and without HIV infection, including structural, interpersonal, and intrapersonal differences, such as heightened experiences of discrimination, poorer overall social support, a higher likelihood of living alone, and an increased likelihood of depression, anxiety, and suicidal thoughts.

While health disparities clearly are found among LGBT older adults in comparison to heterosexual peers and sub-groups (with some at greater risk), there are positive factors associated with positive adjustment, coping, and resilience. Positive sexual identity as a sexual minority, physical activity, and transgender identity were associated with increased mental health quality of life among 2,560 LGBT older adults across three age groups (Fredriksen-Goldsen et al., 2015).

Economic Disparities

People who live in poverty are less healthy than those who are financially better off, regardless of whether the benchmark is mortality, the prevalence of acute or chronic diseases, or mental health (Institute for Research on Poverty, 2014). There is growing evidence that overall, LGBT older adults are economically disadvantaged compared to their heterosexual peers and that sub-group differences exist, providing evidence of greater economic disparities among some sub-groups within this community. Approximately 26 percent of adults ages 65 and older in the United States live at or below 200 percent of the federal poverty level (O'Brien, Wu, and Baer, 2010). In contrast, in a national, non-representative sample of LGB older adults (ages 50 and older) Fredriksen-Goldsen and colleagues (2012) found nearly a third of the LGB older adults enrolled in the study lived at or below that economic threshold.

In addition, important sub-group differences were noted in that among both men and women, those who identified as bisexual experienced significantly greater rates of living at or below 200 percent of the federal poverty level (46.7 percent and 48.2 percent, respectively). Similarly in a study of transgender older adults, Fredriksen-Goldsen and colleagues (2013b) found that nearly half (47.5 percent) of those identified as transgender had household incomes at or below 200 percent of the federal poverty level compared to 29.4 percent of non-transgender (LGB) individuals in the study.

Additionally, nearly a quarter of transgender older adults experienced financial barriers to receiving health services compared to 6.4 percent of non-transgender older adults enrolled in the same study. And, older lesbians reported higher levels of financial barriers to care compared to their heterosexual peers. While the reasons for such disparities are not certain, our studies have shown that older lesbian and bisexual women are less likely to have health insurance than their heterosexual female peers and (Fredriksen-Goldsen et al., 2013a), while transgender individuals were more likely to have incomes below 200 percent of the federal poverty level compared to their cisgender peers.

In addition to sub-group differences, age and cohort affect economic security. Rates of poverty and low-income status increase with age, with increased rates of low income for

those ages 70 to 74, 75 to 79, and 80 and older (O'Brien, Wu, and Baer, 2010). Similarly, in examining differences among cohorts of LGBT older adults, the *Caring and Aging with Pride* study found significant differences between the young-old, middle-old, and old-old cohorts of LGBT older adults, with approximately 40 percent of those older than age 80 living at or below 200 percent of the federal poverty level. HIV was another risk factor; those who were living with HIV were nearly twice as likely to live at or below 200 percent of the federal poverty level than their HIV-negative peers (Fredriksen-Goldsen et al., 2015).

Social Risks and Effects of Social Support Resources

The interaction between LGBT older adults and their social environment has the capacity to be supportive as well as highly detrimental. Research has shown that social support (and in some cases, the size of social networks) can be tremendously beneficial. At the same time, the impact of social stigma, discrimination, and victimization can have dire and life-long negative consequences. In addition to experiences of homophobia, older adults may experience the potential of dual stigmas based on age, race-ethnicity, or other factors such as HIV status or gender identity (transphobia). I found that the majority of older adults living with HIV in my study experienced ageism and HIV stigma (Emlet, 2006b). Recently, Wight and colleagues (2015) identified a phenomenon they referred to as "internalized gay ageism," or the sense that one feels denigrated or depreciated in the context of gay male identify. Internalized ageism, in this study, was associated with an increase in depressive symptoms.

Results from the *Aging with Pride: National Health, Aging, Sexuality and Gender Study* have documented the deleterious effects of discrimination and victimization in this population. They found higher incidence of lifetime victimization was associated with poorer general health, more depressive symptoms, and greater disability among 2,439 LGB older adults (Fredriksen-Goldsen et al., 2012). Additionally, internalized stigma (internalized homophobia) was associated with greater disability and depression. In an analysis of individuals from the same study who were living with HIV infection, my colleagues and I (Emlet et al., 2015) found enacted stigma, or the extent to which an individual experiences prejudice and-or discrimination, to be associated with increased sexual risk behavior in older HIV-positive gay and bisexual men.

It also is important to recognize that experiences of social stigma, including enacted and internalized stigma, are not consistent across sub-groups of older LGBT adults. Fredriksen-Goldsen and colleagues (2013b) found transgender older adults had increased incidence of victimization and internalized stigma as compared to their non-transgender peers.

While expressed social stigma associated with sexual orientation can have significant effects on quality and length of life (Hatzenbuehler et al., 2014), there is consistent data regarding the protective influence of social support in these communities. The *Caring and Aging with Pride* study found that social support and increased social network size were associated with lower odds of depressive symptomatology, disability, and poorer general health (Fredriksen-Goldsen et al., 2012). The importance of social support as a protective factor is shown in a variety of studies with different samples of LGBT older adults. In a study of midlife and

older gay men from Australia, Lyons, Pitts, and Grierson (2013) found social support to be the most important factor associated with increased positive mental health, with support from friends being particularly critical. In a study of HIV-positive older gay and bisexual men from the *Aging with Pride: National Health, Aging, Sexuality and Gender Study*, Fredriksen-Goldsen, Kim, and I (2013) noted that social support was protective and associated with improved mental but not physical health and quality of life.

Additional At-Risk Populations

While LGBT older adults have been identified as an at-risk and underserved population by the Institute of Medicine (2011), we have come to recognize diversity among sub-groups and that some sub-groups within the umbrella of LGBT older persons are at greater risk for poorer health outcomes and disparities. We know that transgender older adults have increased risk for poverty, financial barriers to healthcare access, and greater internalized and enacted stigma than their LGB peers. They have higher rates of disability and lower overall social support (Fredriksen-Goldsen et al., 2013b). Bisexual older adults also have been found to have a higher likelihood of living close to the poverty level, compared to their gay and lesbian counterparts, and have increased internalized stigma and sexual identity concealment (Fredriksen-Goldsen et al., 2012). The same study found bisexual women had lower levels of social support than their lesbian peers, but the same did not hold true for differences between gay and bisexual men (Fredriksen-Goldsen et al., 2012). One potential reason for this difference was shown in the same study, where we found older bisexual women to have greater internalized stigma and higher levels of identity concealment, which may result in their identifying less with the LGBT community and lower levels of social support.

Beyond sexual orientation and gender identity, other factors may place LGBT older adults at increased risk for health disparities. One characteristic that has a serious impact on health outcomes and disparities is HIV status. Current estimates are that by the year 2020, nearly 70 percent of adults living with HIV in the United States will be ages 50 or older (Tietz, 2013). The dramatic increase in the number of older adults living with HIV is due to the confluence of new infections, combined with those who were infected earlier now aging with HIV (Heckman and Halkitis, 2014).

One recent study from the National Epidemiologic Survey of Alcohol and Related Conditions (NESARC) compared older adults with and without HIV on various health and mental health factors. Older adults living with HIV were significantly more likely to have an Axis I mental health diagnosis, substance abuse issues, hypertension, diabetic mellitus, arthritis, and lower physical functioning (Beatie, Mackenzie, and Chou, 2015) when compared to their non-HIV-infected counterparts. Unfortunately, this national survey only included forty-six older, HIV-positive adults. Recently, Wong et al. (2014) discussed the difficulty of finding an appropriate comparison group for those living with HIV. They suggested that uninfected older adults from the general population differ from those living with HIV infection with regard to demographic characteristics, prevalence of traditional risk factors for comorbid conditions, and socioeconomic profiles. Thus, older adults from the general population are not an appropriate comparison group; rather, a comparison group that

is identical to those with HIV infection, except for HIV status, would be an ideal comparison group (Wong, Althoff, and Gange, 2014).

The *Aging with Pride: National Health, Aging, Sexuality and Gender Study* examined 2,560 LGBT older adults with and without HIV infection. Of the 2,560 LGBT older adults enrolled in the study, 9 percent, or 233, had been diagnosed with HIV infection, including 14 percent of gay men and 21 percent of bisexual men. Important differences were found in domains of physical and mental health, resilience and risk factors, healthcare access, and health behaviors between those with and without HIV infection. Overall, those LGBT older adults living with HIV were significantly more likely (after controlling for income, education, and age) to have poorer overall physical and mental health, including higher rates of depression, anxiety, and suicidal ideation. They were more likely to live alone, experience the death of a same-sex partner, have lower levels of social support, and have greater experiences of victimization. They were also less likely to be married or partnered, and to experience more loneliness. They had greater emergency room use and somewhat higher rates of having a personal healthcare provider. With regard to health behaviors, those with HIV were significantly more likely to engage in sexual risk behavior and engage in the use of non-prescribed drugs than did their non-HIV peers (Fredriksen-Goldsen et al., 2011).

Conclusion

LGBT older adults increasingly are of interest to gerontologists, researchers, and policy makers as a vulnerable and underserved population. While the acronym LGBT may unintentionally signal a single population, these individuals are unique unto themselves, but also comprise a variety of sub-populations defined by sexual orientation, gender identity, and other factors.

Differences exist between LGBT older adults and their heterosexual older peers, but important differences in risk and protective factors exist between sub-populations of older LGBT adults. It is crucial for gerontological practitioners to be aware of and sensitive to the specific histories and needs of LGBT older adults, including issues of lifetime and current victimization and the effect those experiences have on access to care and quality of life.

While the needs of this population are receiving additional attention at local, state, and national levels, continued advocacy for improving access to care and working to remove disparities are critical. An emerging concern for many LGBT older adults is competent and compassionate long-term care. Stein, Beckerman, and Sherman (2010) found older LGBT adults living both in the community and in long-term-care facilities feared being mistreated or ostracized by peers, as well as by long-term-care staff in retirement facilities. In a study of 127 LGBT older adults, Johnson and colleagues (2005) found nearly 90 percent believe discrimination against LGBT individuals exists in long-term-care facilities. Thus, continued work on improving the competency and sensitivity of service providers, including those working in long-term care, will be critical for developing compassionate and sensitive care in the coming years.

Despite historical and extant discrimination and marginalization, many LGBT older adults have shown resilience and successful aging across cohorts. Nearly 90 percent of LGBT older adult participants in the *Aging with Pride: National Health, Aging, Sexuality and Gender Study* said they felt good about belonging to their communities (Fredriksen-Goldsen et al., 2015). The future of care and compassionate service delivery for these individuals will require us to learn to identify and build from their naturally emerging strengths (such as community identity, mastery, and social support), improve understanding and competence among providers as to the unique needs and historical consequences of this population, and continually work toward fairness and equity for all older adults.

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