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Older Lesbian and Gay Adults' Perceptions of Barriers and Facilitators to Accessing Health and Aged Care Services in Australia

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Abstract

Older lesbian and gay people can face considerable marginalisation, which may affect their perceptions and experiences of accessing health and aged care services. To inform strategies promoting accessibility, this study aimed to investigate perceived barriers and facilitators to health and aged care service access among older lesbian and gay adults. A sample of 752 cisgender lesbian women and gay men aged 60 years and older living in Australia responded to questions on a broad range of potential barriers and facilitators to service access. Several barriers and facilitators were commonly reported, with some differences between the women and the men. LGBTI-inclusiveness was among commonly reported concerns. A majority of participants reported a lack of LGBTI-inclusive service providers and professionals as a barrier. A majority also reported a perceived a lack of professionals adequately trained and competent to work with LGBTI individuals, with significantly more women than men indicating this as a barrier. Almost all participants indicated LGBTI-inclusive mainstream services as a facilitator for access. In all, inclusiveness appears to be a key issue for service access among older lesbian and gay people, which may need to be further addressed by service providers and policymakers for improving service accessibility.

Keywords: aged care; gay; healthcare; lesbian; LGBTI; older people

What is known about this topic:

- Older lesbian and gay people can face stigma and discrimination in health and aged care settings.
- Older lesbian and gay people express concerns about experiences of stigma and discrimination in these settings.

What this paper adds:

- We examined a range of potential barriers and facilitators to health and aged care service access among older lesbian and gay people in Australia.
- Inclusiveness was frequently reported as an issue relevant to perceptions of barriers and facilitators to service access.
- Health and social services may be made more accessible to older lesbian and gay people by ensuring their practices are inclusive towards these groups.

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Access to health care is vital to positive health outcomes when managing the health challenges that can arise during older age. However, older lesbian women and gay men face barriers in accessing care, often due to experiences of stigma and discrimination related to their sexual orientation. The health care needs of these groups are of additional concern due to having poorer health outcomes compared to older heterosexual people (Conron, Mimiaga, & Landers, 2010; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Gonzales & Henning-Smith, 2015). In addition, lesbian and gay people are less likely to have children, a partner, or biological family to take care of them as they age (Fredriksen-Goldsen, Kim, et al., 2013; Frost, Meyer, & Schwartz, 2016). Given these challenges, the following study investigated potential barriers and facilitators to accessing health and aged care services among older lesbian and gay people.

Previous research has found evidence of sexual orientation discrimination in health and aged care settings among older (typically at least 50 years and older) lesbian women and gay men (Barrett, 2008; Butler, 2017; Fredriksen-Goldsen et al., 2011; Gabrielson, 2011; Grigorovich, 2015; Hughes, 2007) and adults of all ages (Koh, Kang, & Usherwood, 2014). Evidence also suggests that some health and aged care professionals are biased against lesbian and gay people, or express discomfort in providing them with services (Caceres, Travers, Primiano, Luscombe, & Dorsen, 2019; Sabin, Riskind, & Nosek, 2015; Villar, Serrat, Fabà, & Celdrán, 2015). Even in the absence of overt forms of stigma and prejudice, services may be perceived as heteronormative and not inclusive, such as having assumptions of heterosexuality or neglecting to take same-sex relationships seriously (Hughes, 2007).

Research also suggests that many health and social service providers lack culturally competent practice skills for working with lesbian and gay communities (Caceres et al., 2019; Horner et al., 2012; Knochel, Croghan, Moone, & Quam, 2012; Kortes-Miller, Wilson, & Stinchcombe, 2019; Portz et al., 2014). Experiences of discrimination and exclusion in health and aged care settings can be a barrier to service access for older lesbian and gay people, with studies revealing the need for older lesbian and gay adults to feel included and understood by service providers (Hughes, 2007; Kortes-Miller, Boulé, Wilson, & Stinchcombe, 2018; Morales, King, Hiler, Coopwood, & Wayland, 2014).

Even older lesbian and gay people without personal experiences of discrimination and exclusion in health and aged care settings may anticipate or fear such experiences (Waling et al., 2019). The belief among health professionals that homosexuality is pathological was widespread in the 20th century (Brotman, Ferrer, Sussman, Ryan, & Richard, 2015), and homosexuality was formally classified as a mental illness by psychiatrists until 1973 (American Psychiatric Association, 1974). Living through a time when their sexuality was pathologised may mean that some older lesbian and gay people are distrustful or fearful of health professionals. Past experiences of stigma and discrimination in any context may also make them wary of health and aged care service providers. Older lesbian and gay people report a range of experiences of discrimination and victimisation throughout their lives, which may have been particularly widespread due to the prevailing social attitudes at the time, and the fact that homosexuality was illegal in many jurisdictions (Barrett, Whyte, Comfort, Lyons, & Crameri, 2015; Brotman et al., 2015; D'Augelli & Grossman, 2001; Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014; Fredriksen-Goldsen & Muraco, 2010; Lyons, Croy, Barrett, & Whyte, 2015; Lyons, Pitts, & Grierson, 2013).

Studies, primarily in the United States, show that some older lesbian and gay people are fearful of or reluctant to access services due to a perceived lack of inclusion and

understanding (Butler, 2017; Caceres et al., 2019; Fredriksen-Goldsen et al., 2011; Furlotte, Gladstone, Cosby, & Fitzgerald, 2016; Mahieu, Cavolo, & Gastmans, 2018; Metlife Mature Market Institute, 2010; Morales et al., 2014; Putney, Keary, Hebert, Krinsky, & Halmo, 2018; Sharek, McCann, Sheerin, Glacken, & Higgins, 2015). Studies in Australia have also found that some older lesbian and gay people expressed concern that their sexual orientation impacts the standard of care they receive (Hughes, 2009, 2017; Waling et al., 2019).

As well as potential barriers that are unique to lesbian and gay people, other barriers might also be experienced that may be common to older people in general. For instance, financial and other barriers such as lack of transport, distance, and geographical location have been found in previous research among older adults in general (van Gaans & Dent, 2018). Expectations of neglect and mistreatment in aged care can also be barriers to accessing services (De Bellis, 2010; McDonald et al., 2012). Research involving older lesbian women and gay men has found similar results (Fredriksen-Goldsen, Emlet, et al., 2013; Fredriksen-Goldsen et al., 2011; Hughes, 2007, 2009; King & Dabelko-Schoeny, 2009; Morales et al., 2014; Putney et al., 2018; Swank, Fahs, & Frost, 2013). While these studies have identified a range of concerns, more research is needed to comprehensively examine a broad range of potential barriers. This would help to identify the most common issues experienced in more recent times, as well as how sexuality-related concerns rank alongside general barriers that other older people may face. In addition to barriers, an assessment of potential facilitators is equally useful as a way of further informing initiatives for promoting accessibility.

In considering potential barriers and facilitators to health and aged care service access, it is helpful to highlight the service delivery context within Australia, and the factors that may be relevant in relation to potential barriers and facilitators to access. Earlier research (Barrett, 2008; Hughes, 2007) and a more recent study (Waling et al., 2019) have indicated that concerns exist about a lack of inclusiveness in health and aged care settings in Australia.

In the Australian context, most services emphasise LGBTI (lesbian, gay, bisexual, transgender, or intersex) inclusivity rather than just lesbian and gay inclusivity in order to improve cultural competence for this broader range of groups, with lesbian and gay adults generally expecting this to include them. Programs such as the Rainbow Tick LGBTI accreditation have sought to address this. The Australian Government has also funded Silver Rainbow to deliver LGBTI inclusivity training, developed the Aged Care Diversity Framework, and supported Actions to Support LGBTI Elders (a guide for aged care providers) to promote inclusivity in the aged care sector. Despite these recent changes, evidence suggests that older lesbian and gay people continue to experience discrimination due to their sexual orientation (Lyons et al., 2019). Furthermore, Australia only legally recognised same-sex marriage in December 2017. This, and recent government-initiated support for older LGBTI Australians, which recognises that issues of inclusiveness are ongoing, suggests that greater promotion of inclusivity is still needed. Distance and geographical location are also common barriers to service access in Australia, given its large proportion of rural and remote areas. In addition, a lack of transport can affect those in suburban areas who do not drive, and do not have access to or are unable to use public transport. In terms of cost, while Australia has a universal healthcare scheme, not all medical services are covered by the scheme, and those with private health insurance often pay additional fees for medical services.

The following study aimed to investigate perceived barriers and facilitators to health and aged care service access among older lesbian and gay people in Australia. We regarded a minimum age of 60 years as ‘older’ and sought to examine possible barriers and facilitators to care that were uniquely relevant to lesbian and gay older adults alongside a more comprehensive suite of potential barriers and facilitators that may be relevant to older adults of any sexual orientation. While most studies examine individual barriers or a small number

of barriers, we included a broad range of barriers and facilitators to help identify some of the most crucial to this age group. It also enabled us to consider how specific barriers and facilitators relevant to older lesbian and gay adults compared with others. As a secondary aim, we also considered possible gender differences in how older lesbian women and gay men perceived these barriers and facilitators, to explore whether perceptions may differ between the two groups.

Method

Participants

A sample of 895 participants aged 60 years and older living in Australia completed a nationwide survey. The survey covered diverse topics related to health and well-being with data collection between August 2017 and December 2017. A small number of participants indicated that they were transgender women (n = 35), transgender men (n = 4), or a gender identity other than male, female, or transgender (n = 16), and/or bisexual (n = 48) or had a sexual orientation other than lesbian, gay or bisexual (n = 56). Given the unique experiences and concerns of these groups in health and aged care settings, it is necessary for them to be examined separately. However, due to the small samples for each of these groups and the limitations of analysing quantitative data with small numbers, these participants were not included in this analysis. We also excluded participants who did not respond to any of the relevant study measures (n = 4). The final sample of 752 participants included 509 cisgender gay men and 243 cisgender lesbian women aged 60 to 85 years (M = 65.94, SD = 4.72).

Materials

The survey covered a range of topics such as mental and physical health, experiences of discrimination, and use of health and aged care services. This study included the below items:

Barriers and facilitators to health and aged care service access. Participants were asked "Which of the following are issues for you or would be issues for you when it comes to accessing health and/or aged care services?" and were presented with a list of 16 possible barriers to health and aged care service access, to which they could respond "Yes" or "No". Participants were then asked, "Which of the following would make it easier for you to access health and/or aged care services?" and were presented with a list of nine possible facilitators to health and aged care service access, to which they could respond "Yes" or "No". Several items referred to LGBTI, as the instrument was originally intended to cater for a diverse range of participants. Also, as mentioned earlier, it is common for government policy and services to refer to LGBTI populations as a broad group, with lesbian and gay adults generally expecting this to include them. These lists of potential barriers and facilitators were developed through discussions among the research team. The team includes researchers with extensive experience researching older people as well as LGBTI people specifically, and who regularly interact with service providers and community organisations that serve older LGBTI people in Australia, thus making them well-connected to potential issues that older lesbian women and gay men can face.

Socio-demographic variables. Participants gave information on a list of socio-demographic questions. They were asked to indicate their gender and sexual orientation with a range of common identity labels included for both questions, as well as a free response option to provide an answer not included on the list. We also asked participants their age, where they lived (capital city or inner suburban, outer suburban, regional, rural or remote area), their highest educational attainment (secondary or lower, non-university tertiary,

undergraduate university degree, postgraduate university degree), their annual pre-tax income, the status of their employment (full-time, part-time or casual, retired, other), their country of birth (Australia, overseas), and their relationship status (relationship, no relationship).

Procedure

Participants were recruited through a number of methods to obtain a diverse sample. The online survey was promoted in multiple ways. This included targeted paid advertising on Facebook. Relevant community organisations were also contacted, who sent information about the study to their members and contacts lists, such as through adverts in newsletters. A paper version of the survey was made available and promoted at a variety of community events that catered to LGBTI seniors in the state of Victoria, Australia, one of which was a conference that focused on LGBTI ageing and aged care. Paper surveys included reply paid envelopes to return the surveys. Where possible, both the web address for the online survey and details of how participants could request a paper copy of the survey were provided in study advertisements to allow participants to choose their preferred option. An information statement at the start of the survey informed participants that identifying information would not be collected and their responses were anonymous. Ethical approval for the study was awarded by the La Trobe University Human Ethics Committee (project number S17-088).

Data Analysis

A descriptive analysis of the socio-demographic variables was first conducted, with chi-square tests used to examine gender differences for each of the variables. We then computed descriptive statistics for each of the barriers and facilitators separately for the women and the men. Each of the barriers and facilitators were tested for gender differences

using multivariable logistic regressions, with the socio-demographic variables entered as control variables. Participants were excluded from the analysis when there were missing data on any of the variables. Data were analysed using Stata Version 14.1 (StataCorp, College Station, TX).

Results

Table 1 displays a comparison of the women and men for the socio-demographic variables. A majority of both groups were aged 60-69 years, with only a fifth aged 70 years or older. A majority of both were also retired, had an annual income of less than AU$50,000, and were born in Australia. There were no significant gender differences on these variables. However, there was a significantly greater proportion of the men living in a capital city or inner suburban area compared to the women, $\chi^2(3) = 17.31$, $p = .001$. The women were also significantly more likely to report having a university degree, $\chi^2(3) = 18.31$, $p < .001$. Significantly more women were in a relationship, $\chi^2(1) = 12.56$, $p < .001$, with approximately two-thirds in a relationship compared to approximately half of the men. Most participants (98.9%) completed the online version of the survey, and 82.2% of the total sample reported that they found out about the survey through Facebook.

Barriers to Accessing Health and Aged Care Services

Table 2 presents the list of potential barriers to accessing health and/or aged care services, including a comparison of numbers and percentages of the women and men who reported each barrier. For the women, the most commonly reported barrier was “Lack of professionals who are adequately trained and competent to work with LGBTI individuals”, with almost 70% agreeing to this item. This was followed by just over 60% agreeing to “Service providers/professionals are not LGBTI inclusive”, and just over 50% agreeing to

"Concern with being treated unkindly or unfairly" and "Lack of awareness of what services are available". Other common barriers were "Services cost too much" (approximately 44%), "Provider does not understand multiple needs e.g. being LGBTI and CALD* or LGBTI and Aboriginal" (approximately 37%), and "Somebody I know or heard about had a bad experience with an aged care service" (approximately 32%). Around a quarter of the women indicated that distance to services, lack of transport, knowing someone who had a bad experience with a health care service, and lack of time were barriers to access. Less than a fifth indicated a bad experience with a health care service as a barrier, while less than 10% indicated a bad experience with an aged care service, or having a partner, family, or friends not wanting them to seek treatment or support.

For the men, the most commonly reported barrier, at almost 70%, was "Lack of awareness of what services are available". This was followed by almost 60% agreeing to "Lack of professionals who are adequately trained and competent to work with LGBTI individuals", and over 50% agreeing to "Service providers/professionals are not LGBTI inclusive". Other common barriers were "Services cost too much" (about 41%) and "Concern with being treated unkindly or unfairly" (about 42%). Other barriers, including knowing someone who had a bad experience with an aged care service, distance to services, lack of transport, and providers not understanding multiple needs, were reported by about a quarter of the men. Lack of time and knowing someone who had a bad experience with a health care service were only reported by about a fifth of the men. Other barriers, including bad experiences with health or aged care services, or a partner, family, or friends not wanting them to seek treatment or support were the least common, reported by less than 10% of the men.

* Culturally and linguistically diverse

As further displayed in Table 2, the women were significantly less likely than the men to indicate "Lack of awareness of what services are available" as a barrier, AOR = 0.53, $p <$ .001. However, women were significantly more likely to report two other barriers, including "Lack of professionals who are adequately trained and competent to work with LGBTI individuals", AOR = 1.49, $p = .04$, and "Provider does not understand multiple needs e.g. being LGBTI and CALD or LGBTI and Aboriginal", AOR = 1.77, $p = .003$. There were no significant differences between the women and the men on the remaining barriers.

Facilitators to Accessing Health and Aged Care Services

Table 3 presents the list of potential facilitators to accessing health and/or aged care services, including a comparison of numbers and percentages of the women and men who reported each facilitator. All facilitators were endorsed by a majority of participants. For the women, the most common were "Affordable service", "Recommendation from a friend", "Having had a previous good experience at the service", "Mainstream services that are LGBTI inclusive", "Easy to travel to", and "Knowing that the service was LGBTI inclusive", to which over 90% agreed. The least commonly reported facilitators were "Culturally specific services that are LGBTI inclusive" and "Services that are tailored specifically to LGBTI people", to which around three-quarters agreed.

For the men, the most common facilitators were "Affordable service", "Recommendation from a friend", "Easy to travel to", "Mainstream services that are LGBTI inclusive", and "Having had a previous good experience at the service", to which over 90% agreed. Similar to the women, the least commonly reported facilitators were "Services that are tailored specifically to LGBTI people" and "Culturally specific services that are LGBTI inclusive". However, these were still reported by almost three-quarters of the men.

As further displayed in Table 3, significantly more women than men indicated that "Services that have LGBTI signage/inclusive language and representations", AOR = 1.76, p = .04, and "Services that are tailored specifically to LGBTI people", AOR = 1.54, p = .04, would make it easier for them to access health and aged care services. There were no significant differences between the women and the men on the remaining facilitators.

Discussion

This study investigated a broad range of potential perceived barriers and facilitators to health and aged care service access among older lesbian and gay adults in Australia. Some of the more commonly perceived barriers among both the women and the men were those that related to inclusiveness. Among the women, the top two barriers were those relating to health and aged care services or professionals either not being inclusive or not being adequately trained or competent to work with LGBTI individuals. Both of these were among the top ranked barriers for the men, however lack of awareness of available services was the most commonly indicated barrier in this group. These findings are consistent with previous research that has found that older lesbian and gay people often do not perceive health and aged care services to be inclusive (Fredriksen-Goldsen et al., 2011; Furlotte et al., 2016; Mahieu et al., 2018; Metlife Mature Market Institute, 2010; Morales et al., 2014; Putney et al., 2018; Sharek et al., 2015; Waling et al., 2019).

Some other common barriers included concerns about being treated unkindly or unfairly, which is a common concern among older people in general (De Bellis, 2010; Fredriksen-Goldsen et al., 2011; McDonald et al., 2012). A sizeable proportion of participants also reported cost of services as a barrier, in line with previous research that has found finances to be a common concern (Fredriksen-Goldsen, Emlet, et al., 2013; Morales et al., 2014; Putney et al., 2018). Approximately one quarter of participants indicated distance

and lack of transport as barriers, which previous research has also shown to be of concern for older lesbian and gay people (Hughes, 2007, 2009; King & Dabelko-Schoeny, 2009; Swank et al., 2013). Interestingly, only very small proportions of participants reported having a previous bad experience with a health or aged care service as a barrier to service access. This suggests that participants may not necessarily view previous experiences as a barrier to future help-seeking, perhaps assuming that services may be improved, or they have not had many negative experiences in the past, although additional research may be needed to more closely examine the relationship between past experiences and future decision-making.

A large number of participants agreed with all the facilitators of health and aged care service access. Several of these related specifically to the importance of inclusive services for LGBTI people. Overall, more participants gave preference to mainstream services that are inclusive rather than tailored specifically to them. This perhaps reflects previous research where many older gay and lesbian people express a desire for gay and lesbian-specific services, however some hold reservations about segregating services due to a fear that this might lead to further marginalisation of the community (Gabrielson, 2011; Hughes, 2007; Johnson et al., 2005; Mahieu et al., 2018; Neville & Henrickson, 2010; Putney et al., 2018; Sharek et al., 2015).

We found significant gender differences in several barriers and facilitators. Specifically, the men were more likely to report a lack of awareness of services as a barrier, while women were more likely to report issues related to adequate training and competence of professionals as barriers. With regard to facilitators, women were more likely to indicate inclusive signage, language and representations, and specifically tailored services as facilitators. These gender differences may be partly due to women having greater experiences of discrimination in health and aged care settings, or perhaps a greater awareness of or perception of discrimination. Research has found that women were more likely to suspect

discrimination from administrators and staff in retirement care facilities (Johnson et al., 2005). Previous research in Australia on concerns about accessing ageing and health care services has found that lesbian women were more concerned about services not recognising same-sex relationships than were gay men (Hughes, 2009). Studies have further found that women in general tend to access health services more often than men (Mukhtar et al. 2018) and research in Australia shows that older lesbian women are more likely to be caregivers than older gay men (Alba et al., 2019), all of which may result in additional contact with services. It is therefore possible that some gender differences were related to women having greater experience of services and therefore being more aware of challenges posed by issues related to inclusiveness, as well as greater awareness of what services are available. However, further research is needed into differences in how older lesbian women and gay men interact with services in relation to their specific needs.

Given that a lack of inclusiveness was viewed as a barrier to accessing health and aged care services by a large proportion of participants, it is important that service providers engage in inclusive practices. Such practices should account for the socio-historical context of the current generation of older lesbian and gay people. Some may have had histories of discrimination and victimisation from institutions in the past (Barrett, 2008; Butler, 2017; Fredriksen-Goldsen et al., 2011; Gabrielson, 2011; Grigorovich, 2015; Hughes, 2007), and may therefore be fearful of experiencing challenges when needing to engage with services. It is also important for service providers that adopt inclusive practices to effectively communicate this to alleviate concerns and to successfully remove this barrier to access.

Health and aged care service staff can foster a sense of inclusion towards lesbian and gay clients by not assuming heterosexuality, demonstrating cultural competence and respect towards their sexuality, acknowledging their same-sex partners, and providing culturally safe services for clients to disclose their sexual orientation on their own terms (Croghan, Moone,

& Olson, 2015; SAGE, 2012; Furlotte et al., 2016; Grigorovich, 2016; Hughes, 2009; Jihanian, 2013; Sharek et al., 2015). Services can also be made more inclusive through adjustments to websites, signage and brochures in waiting rooms (Croghan et al., 2015; SAGE, 2012; Hughes, 2009; Kimmel, 2014; Kortes-Miller et al., 2018). Staff can also be trained to be more inclusive towards lesbian and gay seniors (Concannon, 2009; Fredriksen-Goldsen, 2016; Fredriksen-Goldsen et al., 2014; Leyva, Breshears, & Ringstad, 2014; Portz et al., 2014; Waling et al., 2019). For health services that already have inclusivity embedded into their practices, it may still be important to raise awareness of the specific needs of older lesbian and gay adults, given their unique histories and potential concerns about institutional discrimination. Training and education programs on lesbian and gay cultural competence, such as the Rainbow Tick program, should also be supported financially and at the policy level by governments (Concannon, 2009; Meyer, 2011; Rosenstreich, Comfort, & Martin, 2011). Educational institutions and professional bodies responsible for service accreditation could also incorporate cultural competence training (Sharek et al., 2015). More broadly, health care policies should include strategies to reduce the health inequities experienced by lesbian and gay people through targeted inclusion of these groups (Fredriksen-Goldsen et al., 2014; Rosenstreich et al., 2011).

Limitations and Future Research

It is worth noting that the list of barriers and facilitators in our study was extensive, but not exhaustive. There may be additional barriers and facilitators not addressed, which could be more closely examined in future research. It may also be useful to utilise focus groups with older lesbian women and gay men to explore specific issues and lived experiences, and to examine how and why the barriers identified in our study pose particular challenges within the circumstances of their lives. While our study provides a broad

exploration of some potential common barriers, it serves as a starting point for future research that may investigate more specifically how these barriers are experienced and navigated by older lesbian and gay adults. Furthermore, we only asked participants about their perceptions of health and aged care services in general, rather than specifying the types of service. While we intentionally left the question broad, it is possible that participants may have had different services in mind when answering the questions. Future research could examine the specific services that older lesbian and gay people believe should be more inclusive, and whether there are specific types of services that they would prefer to be catered specifically towards the lesbian and gay communities.

Our study was also somewhat limited by our sample being potentially less representative of the broader lesbian and gay community, given that many participants were quite highly educated and born in Australia. While we had a relatively large sample and controlled for socio-demographic variables, including age, education, and country of birth, there is a possibility that a sample with a different profile may have additional or different concerns about accessing services. Particular groups, such as older lesbian and gay adults who identify as Aboriginal or Torres Strait Islander, may face unique challenges with regard to accessing health and aged care services. However, research that obtains large enough samples for analysis of these and other groups is needed in future. For now, our study provides a broad indication of potential barriers faced by older lesbian and gay adults in Australia and should be useful for guiding studies of more specific sub-populations. We also had fairly low numbers of participants in older age groups, such as those aged over 70 years. Future research that aims to recruit greater numbers in older age groups would be positioned to identify distinct age differences in barriers and facilitators. For example, those in the oldest age groups are likely to have spent a larger proportion of their lives when stigma and

discrimination was greatest (Fredriksen-Goldsen, & Muraco, 2010; Lyons et al., 2015), and might therefore have more specific concerns in accessing services.

Due to low numbers, we were also unable to examine the experiences of other groups from the LGBTI community, such as older people who are bisexual, transgender, or from other sexual and gender diverse communities, as well as people who are intersex. Future research should aim to recruit a larger and broader sample from the LGBTI community, and examine these groups separately, as many are likely to have different life experiences and needs with regard to health and aged care services. It is also worth noting that gender identity and sexual orientation can be diverse and complex, so it is important for future research to take account of the different ways in which people may identify, and the implications of these differences. Furthermore, our study was designed to allow different groups to complete the survey, such as those who identify as bisexual or trans, and some items therefore referred to LGBTI inclusiveness. Finally, our focus on examining the lesbian and gay population also meant that we were unable to make comparisons with heterosexual older adults.

Conclusions

Our study revealed that some of the more significant barriers to health and aged care service access among older lesbian and gay people were those relating to inclusiveness issues. However, other barriers that are more broadly applicable to older people in general were also relevant to many participants in our sample, such as the cost of services. Overall, our study suggests that there are barriers to health and aged care that heterosexual people do not face and would therefore need to be addressed for lesbian and gay people to experience fair and equitable access to care. There were also some gender differences, and these may also need to be accounted for when formulating initiatives to improve access to health and aged care services for older lesbian women and gay men.

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Table 1

Comparison of older lesbian women and gay men on a range of socio-demographic variables ($N = 752$)

	Women		Men		
	No.	%	No.	%	*p*
Age					.46
60-64 years	111	45.7	216	42.4	
65-69 years	88	36.2	181	35.6	
70+ years	44	18.1	112	22.0	
Residential location					.001
Capital city or inner suburban	65	26.9	187	36.8	
Suburban	62	25.6	132	26.0	
Regional	63	26.0	133	26.2	
Rural or remote	52	21.5	56	11.0	
Education					<.001
Secondary or lower	38	15.6	134	26.3	
Non-university tertiary	61	25.1	137	26.9	
Undergraduate university degree	73	30.0	147	28.9	
Postgraduate university degree	71	29.2	91	17.9	
Employment status					.11
Full-time	35	14.5	85	16.7	
Part-time or casual	49	20.2	81	15.9	

Retired	126	52.1	296	58.3	
Other	32	13.2	46	9.1	
Annual income (AUD)					.99
0-19,999	26	11.1	59	11.9	
20,000-49,999	98	41.7	205	41.5	
50,000-99,999	68	28.9	139	28.1	
100,000+	43	18.3	91	18.4	
Country of birth					.08
Australia	164	69.2	376	75.4	
Overseas	73	30.8	123	24.6	
Relationship status					<.001
No relationship	83	35.2	244	49.1	
Relationship	153	64.8	253	50.9	

Note. Gender differences were assessed using chi-square analyses conducted for each socio-demographic variable.

Table 2
Comparison of numbers and percentages of lesbian women and gay men who reported each barrier for accessing health and/or aged care services

	Women		Men			
	No.	%	No.	%	*AOR*	*p*
Lack of professionals who are adequately trained and competent to work with LGBTI individuals	155	*67.7*	278	*57.4*	1.49	.04
Lack of awareness of what services are available	118	*50.6*	346	*69.2*	0.53	<.001
Service providers/professionals are not LGBTI inclusive	141	*61.6*	259	*54.0*	1.33	.12
Concern with being treated unkindly or unfairly	121	*52.8*	201	*42.2*	1.32	.12
Services cost too much	99	*44.4*	197	*41.2*	1.13	.51
Provider does not understand multiple needs e.g. being LGBTI and CALD or LGBTI and Aboriginal	84	*37.3*	113	*24.4*	1.77	.003
Somebody I know or heard about had a bad experience with an aged care service	72	*32.3*	131	*27.5*	1.13	.53
Services are too far away from where I live	59	*25.9*	128	*26.6*	0.68	.10
Lack of transportation to the services I need	56	*24.7*	124	*26.0*	0.81	.31
Somebody I know or heard about had a bad experience with a health care service	53	*23.6*	89	*19.0*	1.29	.24
It is difficult to find the time for services due to other commitments (e.g., work, family, friends)	52	*22.9*	91	*19.2*	1.23	.36
I've had a bad experience with health care services before	37	*16.3*	46	*9.7*	1.64	.06
I've had a bad experience with an aged care service before	18	*8.0*	23	*4.9*	1.69	.14
My partner does not want to, or want me to, seek treatment or support	7	*3.2*	18	*4.0*	0.65	.39
My family does not want to, or want me to, seek treatment or support	3	*1.4*	11	*2.4*	0.52	.34
My friends do not want to, or want me to, seek treatment or support	4	*1.8*	10	*2.2*	0.83	.78

Note. Numbers (No.) and percentages (%) refer to participants who agreed to an item. These were calculated from the total number of participants who responded to the item (i.e., excluding missing data). Adjusted odds ratios are from multivariable regressions comparing men and women on each potential barrier, adjusted for all socio-demographic variables. AOR = adjusted odds ratio.

Table 3

Comparison of numbers and percentages of lesbian women and gay men who reported each facilitator for accessing health and/or aged care services

	Women		Men			
	No.	%	No.	%	AOR	*p*
Affordable service	226	*95.8*	466	*94.3*	1.42	.42
Recommendation from a friend	222	*94.5*	460	*93.5*	1.46	.38
Easy to travel to	217	*92.7*	449	*92.4*	1.12	.75
Mainstream services that are LGBTI inclusive	219	*93.2*	451	*91.1*	1.27	.50
Having had a previous good experience at the service	212	*93.4*	440	*90.5*	1.78	.13
Knowing that the service was LGBTI inclusive	217	*90.4*	442	*88.6*	1.28	.41
Services that have LGBTI signage/inclusive language and representations	204	*87.9*	406	*82.4*	1.76	.04
Culturally specific services that are LGBTI inclusive	165	*75.7*	337	*70.4*	1.38	.12
Services that are tailored specifically to LGBTI people	179	*76.8*	343	*69.3*	1.54	.04

Note. Numbers (No.) and percentages (%) refer to participants who agreed to an item. These were calculated from the total number of participants who responded to the item (i.e., excluding missing data). Adjusted odds ratios are from multivariable regressions comparing men and women on each potential facilitator, adjusted for all socio-demographic variables. AOR = adjusted odds ratio.