



Retirement Accommodation and Aged Care Issues for Non-Heterosexual Populations

Literature Review
2010



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INTRODUCTION

Australia's future population growth, distribution and age structure has significant implications for long-term policy, including service provision for health and aged care. It is estimated that by the year 2051 between 23% and 25% of Australians will be aged 65 years and over, compared to 13% in 2007 (Australian Bureau of Statistics 2008b). Using the generally accepted figure from the Kinsey Institute, it can be extrapolated that between 492,300 and 1.7 million people in Australia currently identify as gay, lesbian, bisexual, trans and intersex (GLBTI)¹. The number of older GLBTI Australians (up to 8% of older adults) aged 65 years and over is also expected to rise in line with national trends to approximately 500,000 people by the year 2051².

In addition to the usual issues facing older adults, such as loneliness, isolation, and loss of autonomy and independence, older GLBTI individuals may experience further stressors (Meyer and Northridge 2007). These are usually associated with sexual orientation, disclosure to health care providers, discrimination, lack of legal recognition, little if any protection of lifetime partnerships, and limited opportunities to meet other older GLBTI people (Equality South West 2006; Meyer and Northridge 2007).

In comparison to older heterosexuals, older GLBTI people are two and a half times more likely to live alone, twice as likely to be single and over four times as likely to not have children (Keogh, Reid, and Weatherburn 2006). As a consequence older GLBTI individuals may experience greater isolation, loneliness, lack of traditional family support and lack of recognition of partners (Keogh, Reid, and Weatherburn 2006). Many older GLBTI people have been exposed to ongoing discrimination and homophobia as a result of their sexual orientation, and may not access health care services as they fear disclosing their sexuality to health professionals (Gay and Lesbian Medical Association. 2001).

Older GLBTI people grew up during a time when homosexuality was illegal and those found to be engaging in homosexual activities were prosecuted. The attitudes of society in general, towards homosexuality were ones of persecution, condemnation, hatred and discrimination, with homosexuality commonly viewed as a "sickness, sin and disgrace" (Kimmel, Rose, and David 2006. 1). Consequently the GLBTI population was concealed from the general population with few people disclosing their sexual orientation for fear of reprisal and/or

1 These figures have been extrapolated based on the Australian population of 22 million with males accounting for 49.5% and females 50.5%. The lower prevalence has been calculated using the *Sex in Australia* study where 3% of males and 2.3% of females identified as non-heterosexual. Also included is the US prevalence of those males and females seeking gender reassignment. Those identifying as intersex have not been included.

The higher prevalence has been calculated using the Kinsey Institute's estimate of 10% of males and 5.5% of females identifying as gay and lesbian. The higher prevalence does not account for those identifying as trans and intersex as this data is difficult to ascertain.

2 This figure was derived from the average number of people identifying as GLBTI in Australia being 8%. The number of Australians aged 65 years and over by 2051 is estimated to average 24% of the total population. The average Australian population in 2051 is estimated to be 26 million people. Therefore 26 million x 24%=6,240,000 people aged over 65 years. Of these 8% are estimated to identify as GLBTI = 6,240,000 x 8% = 499 200 GLBTI people aged 65 years and over.

prosecution (Kimmel, Rose, and David 2006). As a result, getting older for many GLBTI people can mean increased fear of being "outed" after a lifetime of avoiding disclosure, or fear of lack of understanding and support as they age and seek supported care. Concealment of identity renders older GLBTI people invisible and may result in service providers failing to address or meet their needs.

The primary goal of this literature review is to identify previous research undertaken in this area, ascertain a better understanding of the general and GLBTI ageing issues and establish lessons learned from previous findings. Additionally this literature review aims to build on the findings of other researchers, identify any gaps in the current knowledge and highlight the significance of historical context when researching GLBTI issues.

Furthermore, this literature review was undertaken as part of a wider research project that investigated the attitudes and practices of retirement and residential aged care providers in Western Australia towards accommodating GLBTI residents. This resulted in the development of the best practice guidelines *Accommodating older GLBTI people*, and the report *We don't have any of those people here: Retirement accommodation and aged care issues for non-heterosexual populations*. A full copy of the report and the best practice guidelines can be found at www.grai.org.au and www.wachpr.curtin.edu.au.

This literature review is divided into three parts. Part A provides a background to GLBTI ageing issues and touches on general ageing issues in a global and local context. The social history of ageing and gay social history in Australia are also explored. Implications of an ageing GLBTI population are highlighted as well as some of the general health inequities experienced by some GLBTI people. Finally, Part A examines current aged care accommodation options available to older Australians and aged care policy and legal issues in terms of older GLBTI people.

Part B describes the methodology used in this literature review in addition to highlighting some of the limitations experienced in conducting such a review. Part C outlines the key studies, both internationally and within Australia, in terms of GLBTI gerontology. Current practices and attitudes of providers of retirement and residential aged care are also explored. Concerns of older GLBTI people are identified and implications for providers are outlined. Finally, recommendations are made for future research areas.

PART A BACKGROUND

1. Defining Ageing

The standard age used to define “older people”, set by the United Nations, is 60 years and older. The Australian Bureau of Statistics (ABS) in its many reports on population trends defines the term “older people” as 65 years and over. However Berry (2006) highlight that this definition may be inappropriate for the GLBTI population due to the impact of health inequities they may experience. Consequently, in the *GLBT Healthy Ageing Strategy*, Berry (2006) nominates 50 years and over to define older GLBTI people. Therefore it is important to be mindful of the possibility that some GLBTI people may require access to ageing facilities and support services earlier than the non-GLBTI population. This has significant implications for Government policy and service providers (Berry 2006). For the purpose of this literature review 65 years and over, in line with the ABS, will be used to define the term “older people”.

In this review, where relevant, age in years may be defined however where age is not specified it can be assumed that the age of 65 years and over is inferred. Additionally the terms old and older, in line with terminology used by gerontologists, will be used interchangeably to define the target population (Shankle et al. 2003).

2. General ageing issues

Australia’s future population growth, distribution and age structure has significant implications for long-term policy, including service provision for health and aged care (Australian Bureau of Statistics 2009a).

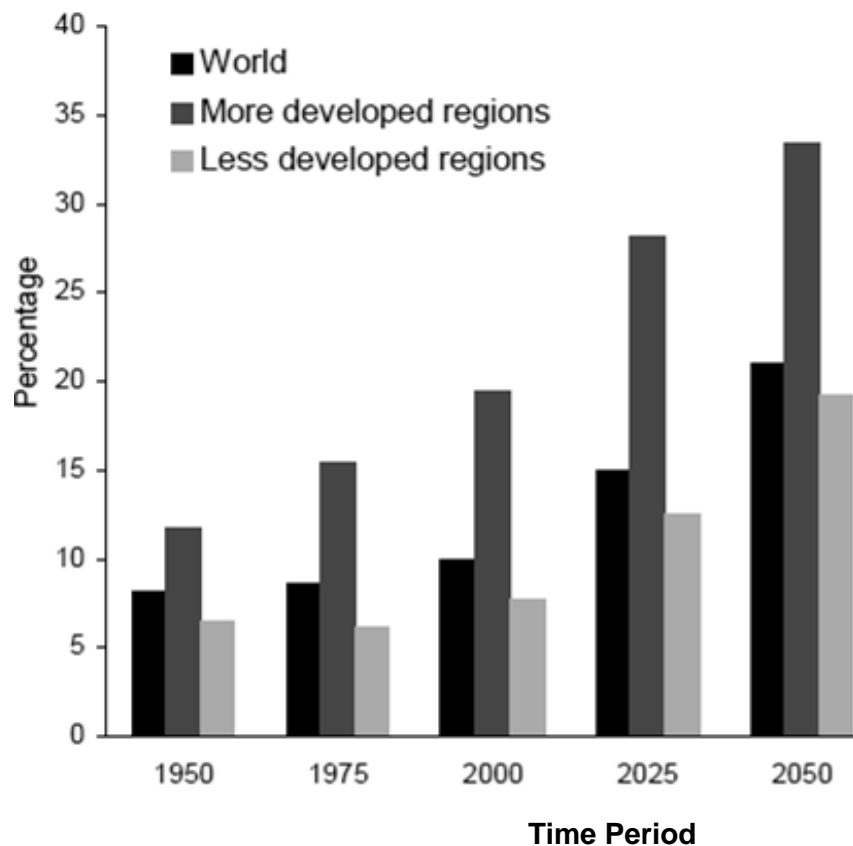
2.1. Global perspective

In 2007 11% of the world’s population was aged 60 years and older. This is estimated to grow to 22% by 2050. The United Nations (2001) estimate that by 2050 there will be more older people in the world than younger people, and that one fifth of older people will be aged 80 years or older. They also estimate the median age will rise from 15 years to 36 years. In comparison, by 2050 developed nations can expect 33% of their population (Figure 1) to be 60 years or older, compared with less developed nations where 20% of the population is expected to be 60 years an older (United Nations 2001).

2.2. Australia

Australia’s population is ageing in both size and proportion (Drabsch 2004). In 2007 Australia’s population was 21 million people, with 13% being 65 years or older. Australia’s population is expected to increase to between 25 and 27 million people by 2051 (Figure 2). Proportionally the ageing population is projected to increase to between 23% and 25% for the same period (Australian Bureau of Statistics 2008b). The median age of 36.8 years in 2007 is expected to rise to between 41.9 years and 45.2 years by 2056.

Figure 1. Proportion of population aged 60 or over: world and development regions 1950–2050

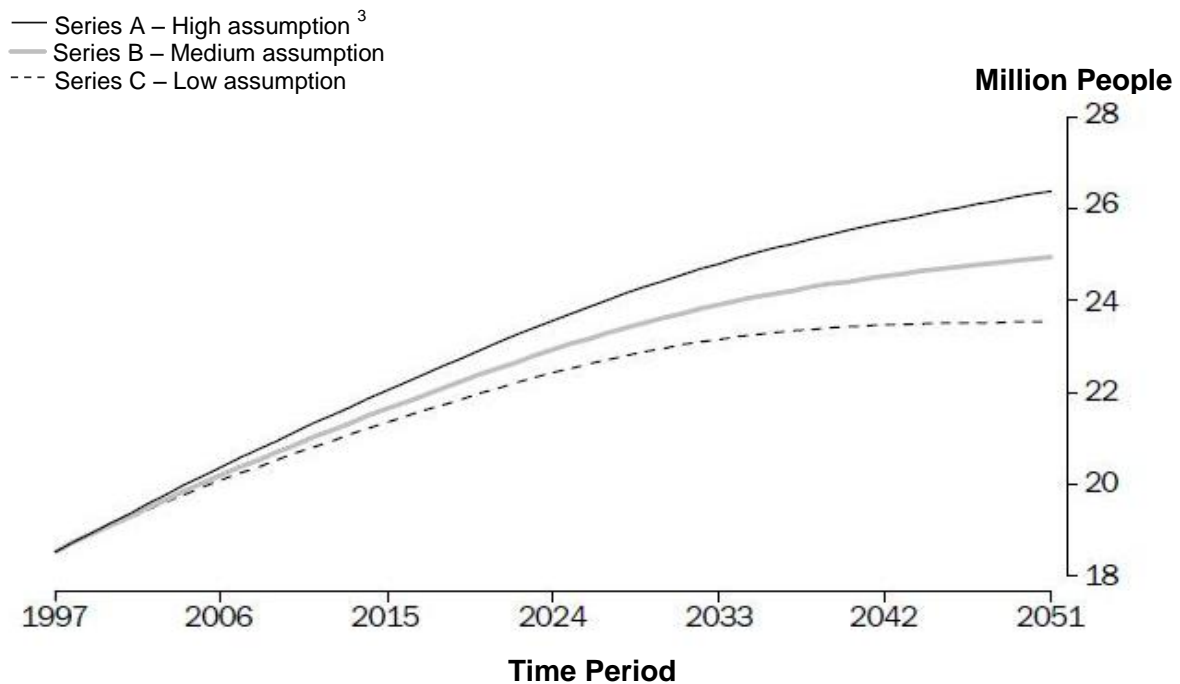


Source: United Nations (2001. 12)

Of the projected population, the age structure will change significantly with 23% - 25% of the population being aged 65 years and older, and between 4.9% - 7.3% aged 85 years and over (Australian Bureau of Statistics 2008b). The significant change in age structure as shown in Figure 3 can be attributed to sustained low fertility, increased life expectancy and net migration rates. As the world's population ages, net migration rates would need to increase significantly to overcome the global rise in the mean age. In terms of numbers, this would create a significant increase in Australia's population (Australian Bureau of Statistics 2009a; Drabsch 2004)

In June 2007, 11.9% of Western Australia's population was aged 65 years and the median age was 36.4 years. Western Australia's population is expected to increase from 2.125 million in 2007 to between 3 million and 3.3 million people by 2051. By 2051 it is estimated that 22.2% of WAs population will be aged over 65 years and the median age will be 42.6 years (Australian Bureau of Statistics 2007a).

Figure 2. Projected Population – Australia



Source: Australian Bureau of Statistics (2008b. 46)

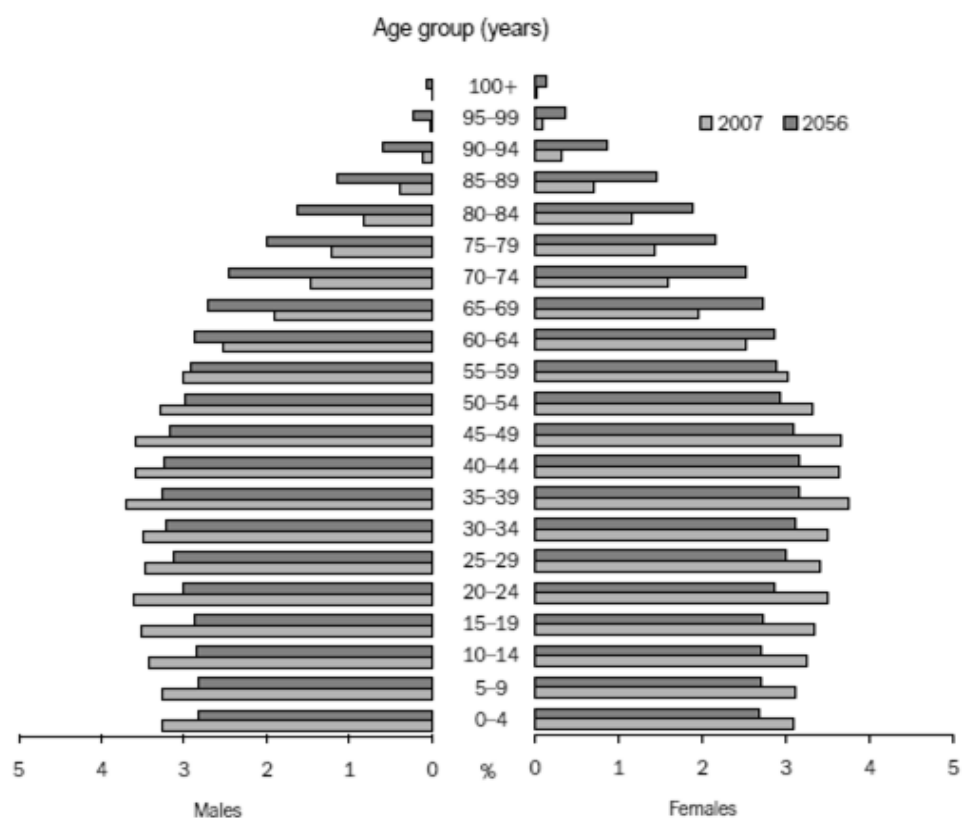
2.3. Implications of an ageing population

An ageing population will impact on the world’s economic and social sectors. This will influence family composition and living arrangements, healthcare services, and housing requirements (United Nations 2001). Such changing population trends and requirements are important for government policy and planning (United Nations 2001).

The economic impact of an ageing population in Australia is that projected spending in general is expected to exceed revenue by 3.5% of GDP by 2046-47, placing increased pressure on government expenditure in the areas of health, healthcare and aged care (The Parliament of the Commonwealth of Australia 2005). This is due to a greater number of people moving away from earning incomes and paying taxes to ‘retirement’, relying on self funded or tax payer funded pensions. It is estimated that by 2042 there will be half the people of working age supporting each person over the age of 65 than there currently is. The cost to government with regard to pensions and aged care expenditure (hospital and pharmaceuticals) is expected to double by 2051 placing a greater need on older Australians to supplement or fund their own retirement (The Parliament of the Commonwealth of Australia 2005).

3 Assumptions are made about future levels of fertility, mortality, internal migration and overseas migration over a projected period. Several assumptions are made for each of these components, leading to a total of 72 possible individual projections. For example, the three assumptions for fertility are: total fertility rate increasing to 1.9 babies per female, decreasing to 1.7 babies per female or decreasing to 1.5 babies per female by the year 2051.

Figure 3. Projected Australian population age and sex structure – Series B⁴



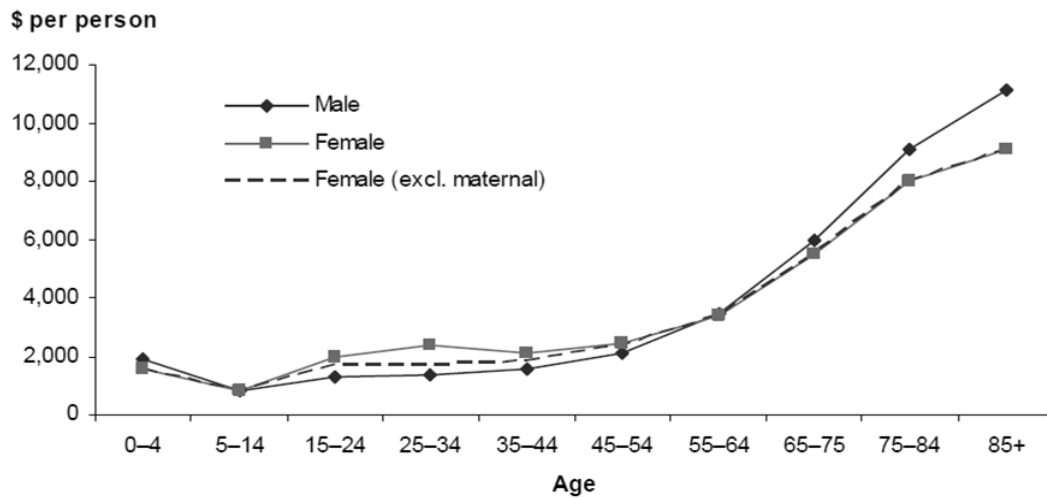
Source: Australian Bureau of Statistics (2009a. 3)

Increased funding of health care is another fiscal pressure the government is expected to incur as a result of an ageing population as indicated in Figure 4 and Figure 5. From the age of 60 years and over, per capita health expenditure increases dramatically (Australian Institute of Health and Welfare 2010). There will be a greater prevalence of chronic illness with the likelihood of people living with more than one chronic illness as they get older, putting further pressure on the cost of health care. Additionally health care costs, in the form of technological advances in treatment, techniques and equipment, will increase as the population ages (The Parliament of the Commonwealth of Australia 2005).

Living arrangements and housing requirements will also be impacted upon. Demand for affordable, accessible and suitable housing options will increase along with ‘age friendly communities’ which foster and support connectedness and social networks (The Parliament of the Commonwealth of Australia 2005). Furthermore, Drabsch (2004) postulates a greater number of elderly people will require accommodation with a variety of support mechanisms and there will be a greater number of people living independently in the community with family and community support. Consequently, the need and demand for both formal and informal care arrangements will increase.

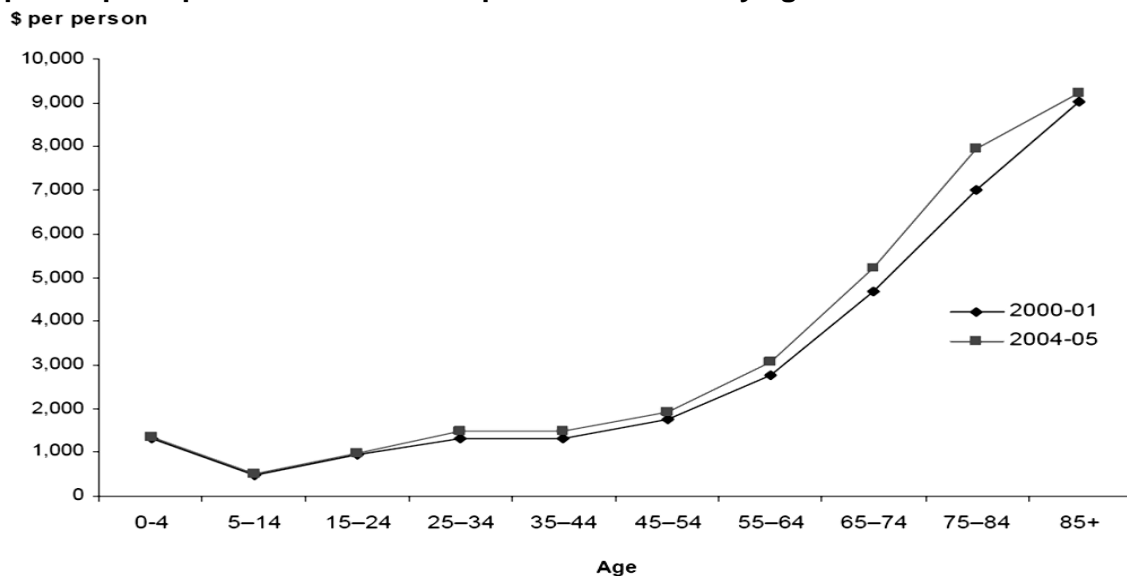
⁴ Series B closely reflects current trends and levels of fertility, mortality, internal migration and overseas migration

Figure 4. Allocated health expenditure per person by age and sex, Australia 2004-05 (\$)



Source: Australian Institute of Health and Welfare (2010. 16)

Figure 5. Cost of hospitals admitted patients, out-of-hospital medical services, and prescription pharmaceuticals and pharmaceuticals by age



Source: Australian Institute of Health and Welfare (2010. 19)

Currently family and friends constitute the majority of informal carers. As family structures change and people, particularly women, stay in the workforce longer an impact on the supply of informal carers is expected into the future. This may prove problematic as there is likely to be a gap in the availability of carers compared to the number of people requiring care (The Parliament of the Commonwealth of Australia 2005).

3. GLBTI population

3.1. Historical context

3.1.1. Ageing social history in Australia

Historically, the notion of older age and ageing has been an important cultural aspect for most societies, including Australia. Considering ageing in a historical context assists in providing a deeper understanding of how current values and attitudes towards older people have formed, and how the process of their evolution has influenced current attitudes and structures (Walker and Garton 1995). Of particular interest is how Australian's in general perceive older age, how they behave towards older people, their behaviour in their own older age and the value that older age has in Australian society (Thane 1995).

During the formation of colonial Australia the nuclear family emerged as colonists left grandparents and family relatives behind and built their new life in a foreign land (Walker and Garton 1995). As a result the next generation of children had few older role models and little contact with older people. Some argue that this notion of a 'young Australia' during colonial times was the beginning of ageism in Australia, which was clearly evident by the early 1900s (Thane 1995; Peel 2001).

The Commonwealth 'old aged pension' was introduced in 1909, due to the emerging demographic known as 'the aged poor'; as a result of the depression, high unemployment and declining marriage and birth rates (Davison 1995). The 'old aged pension' was a significant factor in defining *old age* in Australia, in addition to associating retirement with old age (Davison 1995).

The emergence of 'the aged poor' instigated Australia's first major crisis in aged care (Davison 1995). This was a result of lower socioeconomic groups, such as manual workers, being retired from paid work between 50 and 60 years of age, as they were perceived to be unproductive beyond that, in a highly competitive market. As such it was common for ageism to exist toward people from lower socioeconomic groups (Davison 1995; Peel 2001).

In addition to a person's socioeconomic status and physical ability, Australia's age profile was also significant in defining *old*. In the early 1900s Australia had a young age profile and the average life expectancy was around 50 years with four percent of the population being over 65 years. As a result of sustained low fertility and increased life expectancy this profile has changed over the years. In 2009 Australia's average life expectancy for males was 79 years and females 84 years, with 13.5% of the population aged over 65 years (Central Intelligence Agency 2009). McDonald and Kippen (1999) highlight that as Australia's age structure changes, so will society's notion of ageing, old and older people.

3.1.2. Gay social history in Australia

Rosenfeld (2006) states the importance of understanding the historical context of homosexuality, and how particular events influenced and shaped social relations, political reforms, sexuality and personal identity as we know it today. Additionally, knowledge of the impacts of past experiences of homophobia provides a better understanding of the issues and specific needs of GLBTI individuals, and sets the social context for GLBTI ageing (Barrett 2008; Fredriksen-Goldsen and Muraco 2010; Rosenfeld 2006).

Australia inherited its homosexual laws from the United Kingdom upon its colonisation in 1788, making homosexuality illegal in Australia, and those found to be engaging in homosexual activities were prosecuted (Freeman 2004). The attitudes of society in general, towards homosexuality were ones of persecution, condemnation, hatred and discrimination, and homosexuality was commonly viewed as a “sickness, sin and disgrace” (Kimmel, Rose, and David 2006, 1). Consequently the ‘gay scene’, although growing, was concealed from the general population with few people disclosing their sexual orientation for fear of reprisal and/or prosecution (Kimmel, Rose, and David 2006).

As a result of fear and invisibility, there was little motivation from the homosexual subculture for political activism or public debates until the late 1960s (Willett 2000). However in the early 1970s the first openly and politically active group formed. Campaign Against Moral Persecution (CAMP) was a significant player in advocating for gay law reform and rewriting gay history in Australia (Willett 2000). Consequently, the diversity of the ‘gay community’ became apparent through the numerous gay and lesbian groups beginning to emerge, along with specialised bars, cafes and restaurants (Willett 2000).

In 1972 South Australia was the first Australian state to decriminalise male homosexual acts (Bull, Pinto, and Wilson 1991). Other states followed over the next two decades, and finally in 1997 Tasmania became the last Australian state to decriminalise sex between consenting adult men in private. In 1973, both the American Psychiatric Association and the American Psychological Association removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (Kirby 2003; Lamberg 1998; Mendelson 2003). In late 1973, the Federal Council of the Australian and New Zealand College of Psychiatrists approved a clinical memorandum stating that homosexuality was not a psychological illness (Barr and Catts 1976).

This was a major breakthrough as homosexuality was no longer a psychiatric disorder that needed to be ‘cured’. However, a number of organisations still exist today, that promote reparative or conversion therapy. The majority of these tend to be religious groups such as “Homosexuals Anonymous, Metanoia Ministries, Love in Action, Exodus International and EXIT of Melodyland” (Kenji 2002. 800). The main secular organisation in the US advocating conversion therapy is the mental health organisation National Association for Research and Treatment of Homosexuality (Kenji 2002).

Of significance was the impact of HIV/AIDS in the 1980s on active homosexual males and gay communities worldwide. This redefined the notion of activism to include “the care and support of the ill, and the mourning, celebrating and commemorating of the impact of the disease upon the community” (Willett 2000. 192). Additionally activism took on lobbying for more research into HIV/AIDS. During this time activism in the form of protest changed to celebration and the rise of several large-scale annual gay festivals such as Mardi Gras (Sydney), Pride (Perth), Feast (Adelaide) and Midsummer (Melbourne).

The first such event, Mardi Gras was held in Sydney in 1978. It was a protest march and a show of solidarity, but was violently received by the police. The march was also a commemorative event to mark nine years after the Stonewall riots (a significant turning point in New York where the gay community fought against police harassment). However it evolved into a celebration of sexual diversity which encouraged visibility and community participation. Public interest escalated from year to year, with the television broadcast of the

event in 1994 (Willett 2000). Similar events are now firmly embedded in gay communities in most Australian capital cities. In Perth, this manifests in *Pride*, a month long celebration of cultural events each October.

Considerable progress has been made concerning law reform and broader gay and lesbian rights into the 21st century, as well as a shift in the general population's attitudes and acceptance of diverse sexual orientations. For trans and intersex individuals progress has been limited. In Australia, the Federal Government recently amended 85 laws to legally recognise same-sex de facto couples, however have not progressed further to allow same-sex marriage. Nor has the Federal Government provided comprehensive protection from discrimination based on sexual orientation, gender identity or relationship status (Department of Health and Ageing 2009).

Notwithstanding the advances made in the last 40 years, there is still a considerable amount of work to be done in building understanding, tolerance and acceptance of diversity by the general population.

This was illustrated globally when the United Nations, in December 2008, announced that 66 nations supported the inclusion of sexual orientation and gender identity in its Universal Declaration of Human Rights. However it is estimated that there are over 76 countries which still retain laws where consensual sex between same-sex adults is a criminal offence (Ottosson 2010). In Iran for example, punishment of a homosexual act is death. In 2005 two men were executed for acts of homosexuality and three men under the age of 18 years are awaiting execution for carrying out homosexual acts in 2009 (Human Rights Watch 2009). In Malawi in May 2010 a gay male couple were sentenced to 14 years imprisonment with hard labour after they undertook a symbolic wedding ceremony. They were charged with sodomy and indecency for committing unnatural acts but later received a presidential pardon (Geoghegan 2010).

A more comprehensive overview of gay social history in Australia is outlined in Appendix A.

There also remains to be considerable work in understanding the specific health difference between people of a diverse sexual orientation or gender identity, compared with the general population. These health differences are discussed further in section 2.4 of this literature review.

3.1.3. Ageism within the GLBTI population

There is a lack of research in Australia regarding the existence of ageism within the GLBTI population. However the limited research that does exist highlights contradictions to the assumptions and stereotypes of GLBTI people growing old alone and without social and support networks (Kean 2006). Harrison (2004) suggests that some research indicates the existence of ageism within the GLBTI population, however this also identifies other findings which challenge the notion. According to Harrison (1999) this highlights the fluidity and complexity of ageism within the context of the GLBTI population.

4. Defining the GLBTI population

For the purposes of this literature review, the GLBTI population refers to diverse sexuality groups whose “sexualities and/or gender identities fall outside the traditional heterosexual norm” (Zirngast 2002. 1). It is recognised that the GLBTI population is not homogeneous and that sub populations and diversity exist. Other terminology used include: queer, transsexual, gender queer, gender non-conforming and minority sexuality groups (Couch et al. 2007). For the purposes of this literature review the term GLBTI will be used as a representation of all sub groups within this target group.

It is difficult to accurately estimate the proportion of the population who identify as GLBTI for a number of reasons. There is very little data being collected on sexual identity within current research (Berry 2006). The Australian 2006-07 Census captured some information regarding same-sex couples and identified 27,000 same-sex couple families living in Australia during that period (Australian Bureau of Statistics 2009b). The Australian Government (2009) cautions that this figure may under report the number of same-sex couples living together and identifying the number of same-sex couples is not representative of the GLBTI population. Additionally, many GLBTI individuals may not feel comfortable identifying in a public arena due to fears of discrimination and homophobia. Consequently, the GLBTI population as a whole remains relatively invisible and un numerated.

In the United States of America (US), studies from the Kinsey Institute estimate that 10% of the male population identify as gay and 5% - 6% of the female population identify as lesbian (McNair and Harrison 2002). The study *Sex in Australia: Australian study of health and relationships* approximates that 97% of Australian males identify as heterosexual, 1.6% as homosexual and 0.9% as bisexual, and 97.7% of females identify as heterosexual, 0.8% as lesbian and 1.4% as bisexual (Smith et al. 2003).

These figures do not include those who are transgender, transsexual or intersex. Peerson (2009) estimates that in the US 1 per 30,000 adult men and 1 per 100,000 adult women seek gender reassignment surgery and that the rates are higher in other countries such as the Netherlands. These figures exclude those trans individuals who do not undergo or seek reassignment surgery. The number of intersex individuals is difficult to estimate due to the invisibility of this population in addition to the inconsistent criteria used to define intersex (Fausto-Sterling 1999). Fausto-Sterling (1999) estimates 1.7% of the population in the US are intersex individuals, however using a different criteria to evaluate intersex, Sax (2002) claims the truer figure is 0.018% of the US population. Furthermore, GLBTI populations have been categorised through self identifying, adding to the challenge of accurate data collection.

The fluidity of sexuality further complicates data collection as identity, attraction and behaviour are complex and changing; and there is not always consistency between the three (Hillier, Turner, and Mitchell 2005; McNair and Harrison 2002; Smith et al. 2003). Despite the difficulty in ascertaining accurate data on the size of the GLBTI population, it is feasible to suppose that the number of ageing GLBTI people will increase in line with global and national ageing trends. Additionally increasing community acceptance of diverse sexual orientations makes it easier for individuals to identify as such. Therefore, using the generally

accepted figure from the Kinsey Institute, it can be extrapolated that between 492,300 and 1.7 million people in Australia identify as GLBTI⁵.

4.1. Implications of an ageing GLBTI population

In addition to the usual issues facing older adults, such as loneliness, isolation, loss of autonomy and dependence, older GLBTI individuals may experience additional stressors (Meyer and Northridge 2007). These are usually associated with sexual orientation, disclosure to health care providers, discrimination, lack of legal recognition and protection of lifetime partnerships and limited opportunities to meet other older GLBTI people (Equality South West 2006; Meyer and Northridge 2007).

Having said this, it is important to note that diversity exists within the older GLBTI population. Consequently the stereotypical characteristics of older GLBTI people such as loneliness, isolation, mental health issues and exclusion, may exist in part for some, however they do not apply to the GLBTI population as a whole.

This is evident in the report *Private Lives: A report on the health and wellbeing of GLBTI Australians*, where Pitts et al. (2006) compare the general health of the wider population using the *ABS National Health Survey 2001* with the participants of the *Private Lives* study. The disparity between those who reported very good or excellent health is greater between the two groups particularly in the 15-24 year age group. In this study as participants became older the disparity between the two groups diminishes (Figure 6). The *Private Lives* study supposes that this is due to participants forging social support networks and developing confidence in their sexual orientation over time. This notion was supported by findings in the *Gay and Grey in Dorset* report (Equality South West 2006) where the majority of participants felt that as they became older their confidence increased when discussing their sexuality and they had developed good social networks and friends to support them.

However, the same participants did report that there are some negative aspects of becoming older and these were the continuing fear of homophobia and consequently the fear of being isolated (Pitts et al. 2006). Other research supports this, highlighting that in comparison to older heterosexuals, older GLBTI people are two and a half times more likely to live alone, twice as likely to be single and over four times as likely to not have children (Keogh, Reid, and Weatherburn 2006). As a consequence older GLBTI individuals may experience greater isolation, loneliness, lack of traditional family support and lack of recognition of partners (Keogh, Reid, and Weatherburn 2006). Many older GLBTI people have been exposed to ongoing discrimination and homophobia as a result of their sexual orientation, and consequently do not access health care services for fear of disclosing their sexuality to health professionals (Gay and Lesbian Medical Association 2001).

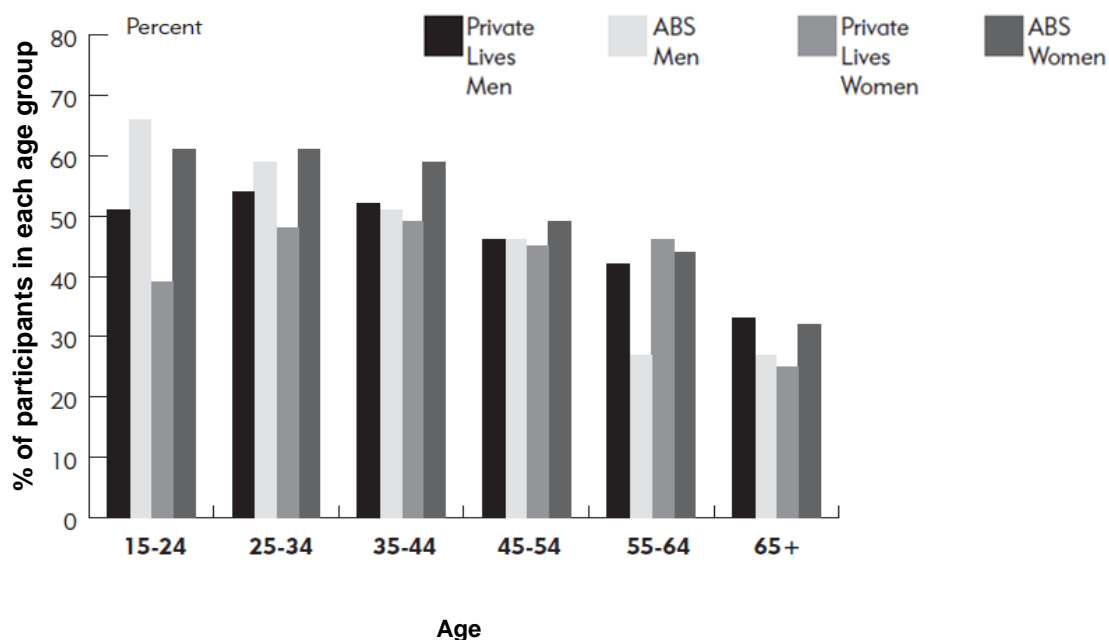
⁵ These figures have been extrapolated based on the Australian population of 22 million with males accounting for 49.5% and females 50.5%. The lower prevalence has been calculated using the *Sex in Australia* study where 3% of males and 2.3% of females identified as non-heterosexual. Also included is the US prevalence of those males and females seeking gender reassignment. Those identifying as intersex have not been included.

The higher prevalence has been calculated using the Kinsey Institute's estimate of 10% of males and 5.5% of females identifying as gay and lesbian. The higher prevalence does not account for those identifying as trans and intersex as this data is difficult to ascertain.

As in the Australian population, a greater number of older GLBTI people will require accommodation with a variety of support mechanisms and there will be a greater number of GLBTI people living independently in the community. Consequently, the need and demand for both formal and informal care arrangements for GLBTI people will also increase. While GLBTI people may have strong social networks, they may not have the same family support as their heterosexual counterparts and consequently may have a greater reliance on service providers for the provision of aged care (Keogh, Reid, and Weatherburn 2006).

Furthermore, some people living with HIV may require access to retirement and residential aged care services earlier than those who are not. Naturally occurring age-related illnesses such as cardiovascular disease, diabetes, osteoporosis, some cancers and dementia are presenting at an earlier age for some people living with HIV, causing early onset of ageing (Deeks and Phillips 2009). This has implications for service providers, as the need to accommodate much younger people with complex and unique care requirements increases.

Figure 6 GLBTI self-rated health status as good/very good compared to the Australian population



Source: Pitts et al. (2006. 29)

5. GLBTI general health

The GLBTI population is heterogeneous and exists in all sectors of society, encompassing a diverse range of individual health needs, issues and behaviours (Hyde et al. 2007). Individuals within the GLBTI population experience differing degrees of optimum health and health issues and it is imperative that generalisations are avoided. When discussing GLBTI health, it is important to recognise and consider that there are many healthy and happy GLBTI individuals. However as a population, overall disparities exist in contrast to the heterosexual population.

Such discrepancies tend to manifest in the form of poor mental and physical health and are likely to result from barriers related to sexual orientation and/or gender identity, which include heterosexism, homophobia, societal marginalisation and stigmatisation (Meyer and Northridge 2007). Furthermore, service providers' limited knowledge of GLBTI health issues can lead to the provision of inappropriate advice. This along with homophobic attitudes of some health care providers impacts on GLBTI individuals' health seeking behaviours, making them less likely to seek early intervention (Dunn, Wilson, and Tarko 2007; Gay and Lesbian Medical Association 2001; Hyde et al. 2007).

5.1. GLBTI Health related behaviours

The GLBTI population relative to the heterosexual population, experience elevated occurrences of obesity; tobacco, alcohol and substance use; poor sexual health practices; mental illness; injury and violence; and limited access to health care. These factors can lead to poorer health outcomes and potentially shorter life expectancies (Makadon et al. 2008).

People of a diverse sexual orientation or gender identity are: "four times more likely to have ever been homeless (12% 'homosexual/bisexual' v. 2.9% 'heterosexual'); twice as likely to have no contact with family or no family to rely on for serious problems (11.8% v. 5.9%); more likely to be a current smoker (35.7% v. 22%); twice as likely to have used illicit drugs (64.6% v. 33.2%); more likely to have had a chronic condition in the last 12 months (51.3% v. 46.9%); twice as likely to have a high/very high level of psychological distress (18.2% v. 9.2%); almost three times as likely to have had suicidal thoughts (34.7% v. 12.9%); five times as likely to have had suicidal plans (17.1% v. 3.7%); and four times as likely to have attempted suicide (12.6% v. 3.1%)" (Australian Bureau of Statistics 2007b). These disparities are explored further in the following sections.

5.1.1. Alcohol, tobacco and other drug use

The elevated level of alcohol, tobacco and other drug use in the GLBTI population, compared to their heterosexual counterparts, is well documented. For example in Australia, Pitts et al. (2006) in their report *Private Lives: A report on the health and wellbeing of GLBTI Australians*, found 37% of their survey population used tobacco on more than five occasions in the previous month compared to 24% of the Australian population. Hyde et al. (2007) further highlight the disparity by reporting that lesbian and bisexual women are nearly twice as likely to use tobacco than other Australian women.

In the report *Private Lives* (Pitts et al. 2006), survey participants reported elevated patterns of illicit drug use in line with international and national research findings. Hyde et al (2009) in their findings report that over 33% of lesbian and bisexual women had used illicit drugs within the previous six months, compared to 11.5% of Australian women surveyed in the

2007 National Drug Strategy Household Survey (Australian Institute of Health and Welfare 2008). Zablotska et al. (2008) in their report *Gay Men Periodic Survey, Perth*, found illicit drug use common among their sample of gay and homosexually active men, with 33% reporting the use of marijuana, 30% ecstasy, 29% amyl, 20% speed and 12% crystal within the previous six months. This compares to Australian heterosexual men where 11.6% reported using marijuana, 4.4% ecstasy, 0.6% inhalants (including amyl) and 3% meth/amphetamine (including speed and crystal) within the last 12 months (Australian Institute of Health and Welfare 2008). In a recent paper based on data from the *US National Epidemiologic Survey on Alcohol and Related Conditions*, McCabe et al. (2009) reported that 5.7% of lesbian and 3.0% of bisexual women had a drug dependency in the last year, compared to 0.4% of heterosexual women. Levels were also elevated for gay and bisexual males (3.2% and 5.1% respectively) compared to heterosexual males (0.5%).

Disparities in levels of alcohol consumption between GLBTI and heterosexual populations also exist, with some researchers suggesting that lesbian and bisexual females consume alcohol at similar, if not higher levels than males in general. This is validated by McCabe et al. (2009) who found that 20.1% of lesbian women and 25.% of bisexual women reported drinking heavily in the past year compared to their heterosexual counterparts (8.4%). Eighteen percent of gay males and 16.4% of bisexual males reported heavy drinking in the past year compared to 13.7% of heterosexual males.

5.1.2. Mental health

Individuals within the GLBTI population experience stigma, discrimination, marginalisation and violence (Meyer and Northridge 2007). These factors are referred to as minority stressors and can have adverse effects on mental health (Meyer and Northridge 2007). In addition to general stressors experienced by the population as a whole, the GLBTI population in general, experience greater levels of minority stressors and consequently are at greater risk of adverse mental health outcomes (Meyer and Northridge 2007).

Both national and international studies have highlighted elevated mental health problems amongst GLBTI people. In Western Australia (WA), Hyde et al. (2007) found that over a third of their participants (34.85%) had clinically diagnosed depression compared with 22.8% of women in the WA population. They also found elevated rates of anxiety (22.9%) of survey participants compared with 20.5% of WA women. Pitts et al. (2006) report elevated rates of depression in their study on the well being of GLBTI Australians (48.6% of male respondents and 44.4% of female respondents). Over 15% of their respondents also indicated they had suicidal ideation in the two weeks prior to participating in the study.

King et al. (2003) in their study of gay and lesbian people in the UK, found that gay men had 1.24 times greater risk of psychosocial distress than heterosexual men; and lesbian women had 1.30 times greater risk than heterosexual women. A study in New Zealand investigating the risk of psychiatric disorder and suicidal behaviours in young gay, lesbian and bisexual individuals, found that participants had 4 times greater risk of developing depression, 5.4 times greater risk of suicidal ideation and 6.2 times greater risk of suicide attempts, than their heterosexual counterparts (Fergusson, Horwood, and Beautrais 1999).

Transgender people also experience elevated levels of suicide attempts. This was reported in a study by Clements-Noelle et al. (2001) whose survey sample had much higher rates of

suicide attempts than the general US population. Other studies in the Netherlands also support such findings (Clements-Nolle et al. 2001).

5.1.3. Diet and physical activity

The GLBTI population are at greater risk of eating disorders, and being overweight and obese (McNair and Medland 2002). Pitts et al. (2006) found male participants were less likely to be overweight and obese (43%) compared to Australian males (54%), and cite body image as a possible reason. A greater number of homosexual males experience eating disorders than their heterosexual counterparts, with homosexuality possibly being a risk factor for eating disorders in men (Russell and Keel 2002). In their study of homosexuality and eating disorders, Russell and Keel (2002) found that gay male participants had greater dissatisfaction with their bodies and increased levels of bulimia and anorexia than heterosexual males. Twenty five percent of gay males in the study reported binge eating compared to 10% of heterosexual males and 11.7% reported purging in comparison to 4.4% of heterosexual males.

Eating disorders, overweight and obesity are more common among lesbian and bisexual women than heterosexual women (Valanis et al. 2000). Pitts et al. (2006) found that 49% of lesbian and bisexual women in their study were overweight or obese compared to 38% of Australian women. These disparities have also been found in a study on overweight and obesity in sexual minority women in the US by Boehmer, Bowen and Bauer (2007). They report that lesbian women were more than twice as likely to be obese and overweight as heterosexual women, and conclude that lesbian sexual orientation significantly increases the risk of obesity and overweight.

5.1.4. Sexual health

HIV/AIDS, hepatitis A and B, gonorrhoea, chlamydia, human papilloma virus, herpes, syphilis and pubic lice are the most common sexually transmitted infections (STIs) associated with men who have sex with men (McNair and Harrison 2002). Pitts et al. (2006) found that nearly 40% of males in their study had contracted pubic lice and 19% reported having gonorrhoea. This compares with 9.8% of the Australian population reporting ever having pubic lice and 2.2% having had gonorrhoea (Grulich et al. 2003).

Of the 995 newly acquired cases of HIV in Australia in 2008, 86.3% of the cases were in the Australian male population (National Centre in HIV Epidemiology and Clinical Research 2009). The predominant mode of transmission was through male-to-male sexual contact (66%), men who have sex with men and injecting drug use (3.2%), injecting drug use (3.1%) and heterosexual contact (27.1%) (National Centre in HIV Epidemiology and Clinical Research 2009). Persson et al. (2009) estimate that 1 in five Australians living with HIV identify as heterosexual. Globally, HIV predominantly affects heterosexual populations, however in Australia HIV is mainly transmitted through male-to-male sexual contact and therefore disproportionately affects the gay population (Persson et al. 2009).

Lesbians on the other hand have traditionally been perceived as a low risk group with regards to contracting STIs (Valanis et al. 2000). However Grulich et al. (2003) in their study found that STIs became more prevalent in lesbian and bisexual women the more sexual partners they had. Fethers et al. (2000) in their research on STIs and risk behaviours in women who have sex with women found that the prevalence of chlamydia, genital herpes,

gonorrhoea and HIV was low, with similar rates to that of heterosexual women reported. However lesbian and bisexual women had higher rates of genital warts (5%) and hepatitis C (5%) and hepatitis B (5%) than their heterosexual counterparts (8%, 1% and 3% respectively). Lesbian and bisexual women were also found to have increased prevalence of bacterial vaginosis (8%) compared to heterosexual women (5%).

Elevated levels of STIs can also be found in the 15-18 year old same-sex attracted youth. Hillier et al. (2005) in their second national report on the *Sexuality, Health and Well-Being of Same-sex Attracted Young People in Australia*, found that 10% of their participants reported having been diagnosed with a STI. This compared to 2% of participants within the same age group in a national secondary school study.

In a study by Clements-Nolle et al. (2001) examining the prevalence of HIV, risk behaviours, health care use and mental health status of transgender people, elevated rates of HIV were found. Of the male-to-female participants, 35% were living with HIV as well as 2% of female-to-male participants. Intersex people were excluded from this study as they did not meet the study participation criteria.

5.1.5. Access to healthcare

Research indicates that some GLBTI individuals have experienced discrimination from health care providers and generally access health care less than the heterosexual population. The Victorian Gay and Lesbian Rights Lobby reported in 2000 that 23% of GLBT Victorians accessing health care experienced discrimination. This was further validated in 2005 in their *Not Yet Equal* report which found 27.4% of lesbians, 11.8% gay men and 11.5% of bisexual people had experienced discrimination in a health care setting (McNair and Thomacos 2005). As a result, McNair and Thomacos (2005) claim that GLBTI individuals are more likely to conceal their sexual orientation from their health care provider, which can affect the quality of care they receive. Additionally GLBTI individuals are less likely to be screened for common health conditions and tend to present later for treatment (McNair and Harrison 2002).

5.2. GLBTI Health conditions

Some GLBTI people are faced with specific health issues as a consequence of their elevated levels of risky health behaviours, coupled with limited access to healthcare. Research has shown that GLBTI individuals may have an increased risk of certain cancers including breast and cervical cancer, AIDS related cancers and lung cancer (Gay and Lesbian Medical Association 2001).

Valanis et al. (2000) in their study found that 14% of lesbians and 17.6% of bisexual women had experienced some type of cancer compared to heterosexual women (11.9%). This can be attributed to higher rates of obesity and alcohol consumption, lower rates of pregnancy and births, and lower uptake of health screenings (Gay and Lesbian Medical Association 2001).

Disparities in the prevalence of breast and cervical cancer also exist. Valanis et al. (2000) reported fewer than 5% of heterosexual women having had breast cancer compared to 8.4% of bisexual women, 5.8% of lifetime lesbians and 7% of adult lesbians. A greater number of bisexual and lifetime lesbians reported having cervical cancer (2.1% and 2.2%) compared to 1.3% of heterosexual women. Another disparity of note reported by Valanis et al. (2000) was

elevated myocardial infarction by lifetime lesbians (3.1%) and adult lesbians (4.3%) compared with heterosexual women (2%).

5.3. Transgender health

Much of the research to date is focused on gay, lesbian and bisexual (GLB) individuals, however Meyer and Northridge (2007) indicate that some transgender health issues, particularly those associated with psychological, social and economic factors, will overlap with GLB health issues. Concerns specific to transgender individuals relate to “hormone therapy, masculinising and feminising surgery, and liquid silicone injection” which all aim to transition individuals across specific genders (Meyer and Northridge 2007. 493). Additionally, the experiences of GLB individuals outlined above may be amplified for transgender individuals as they are more likely to be marginalised from society, omitted from legislation and confronted with issues relating to gender reassignment such as the challenges of changing identity on legal documents (Levy, Crown, and Reid 2003).

5.4. Intersex health

As with transgender health, although much of the research has focused on GLB individuals, some intersex health issues will overlap with GLB health issues. Additionally issues specific to transgender individuals relating to gender reassignment also apply to intersex individuals. MacKenzie, Huntington and Gilmour (2009) suggest that health issues specific to intersex individuals are associated with psychological factors. Such factors manifest from the silence surrounding such a condition (that is, the child is unable to understand, but is aware that their condition is not spoken of) and a life time of managing differences (MacKenzie, Huntington, and Gilmour 2009).

Implications of the above findings, suggest that some GLBTI individuals may have poorer health outcomes than their heterosexual counterparts as they become older. Of note are those conditions arising from marginalisation (Meyer and Northridge 2007). It is difficult to ascertain the extent and enormity of such disparities due to the limited amount of research in this area and the invisibility of the GLBTI population.

6. Current aged care accommodation options

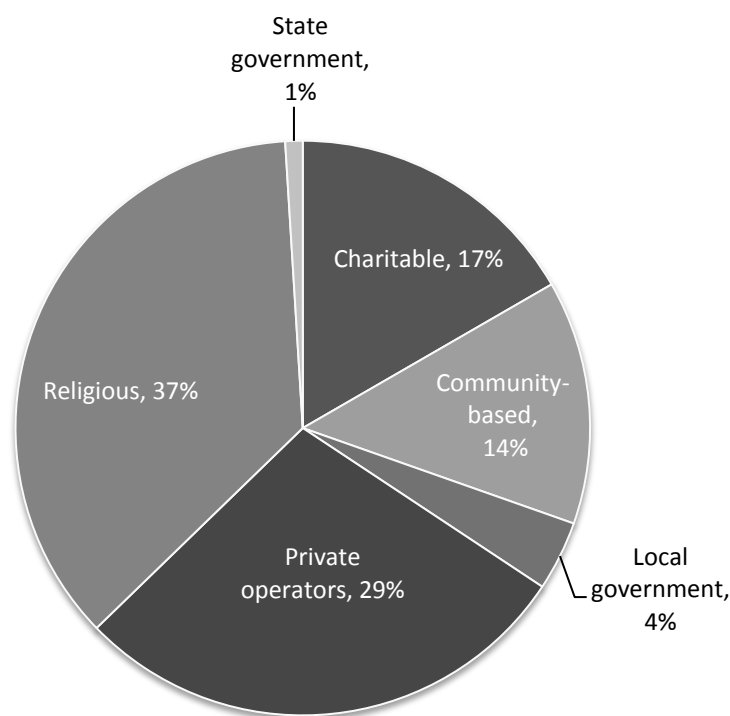
6.1. Service providers

The Australian Government, private enterprise and non-government agencies provide accommodation options for older Australians. Currently the Australian government funds over 17 different age related community care programmes, in addition to residential and respite accommodation (Australian Institute of Health and Welfare 2009a). Private enterprise providers also offer community care, residential care and respite services.

Nationally, the providers of residential care services are religious organisations (28.5%), private operators (27.9%), community-based providers (16.8%), charitable organisations (15.5%), local government (2.3%) and state government (9%) (Australian Institute of Health and Welfare 2009b). Comparatively, residential care services in Western Australia are provided by charitable organisations (16.7%), community-based providers (13.5%), local government (3.6%), private operators (28.7%), religious organisations (36.7%), and state

government (0.8%). Figure 7 demonstrates the providers of residential aged care in Western Australia and Figure 8 highlights the proportion of service providers for each state and territory

Figure 7. Type of organisation providing residential aged care services in Western Australia as at 30 June 2008



Australian Institute of Health and Welfare (2009b)

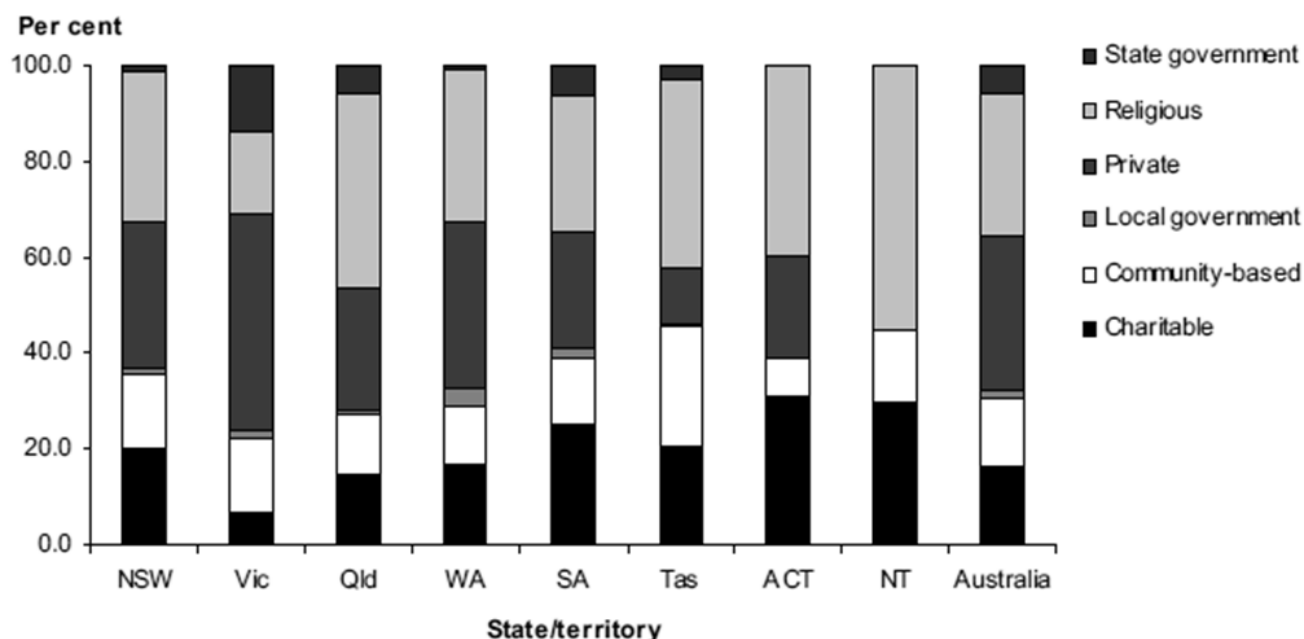
6.2. Possible pathways

Accessing of aged care services is fluid according to changing needs of the individual. This coupled with the diversity of available care programmes makes pathways to accessing aged related services complex. Figure 9 captures the complexity of the possible pathways to aged care services through the Australian aged care system.

The number of community care packages⁶ available to older people is designed to make it possible for individuals to reside in their own home for longer. The Federal Government's overall expenditure on aged care services reflects this. In the period from 2001-06, 85% of the total aged care budget was spent in four key community care areas: Veteran's Home Care, Community Aged Care Packages, Home and Community Care and Extended Aged Care at Home (Australian Institute of Health and Welfare 2009a).

⁶ Community Care Packages support people at home and aim to prevent premature or inappropriate admission to residential care

Figure 8. Providers of residential aged care services by State/Territory as at 30 June 2008



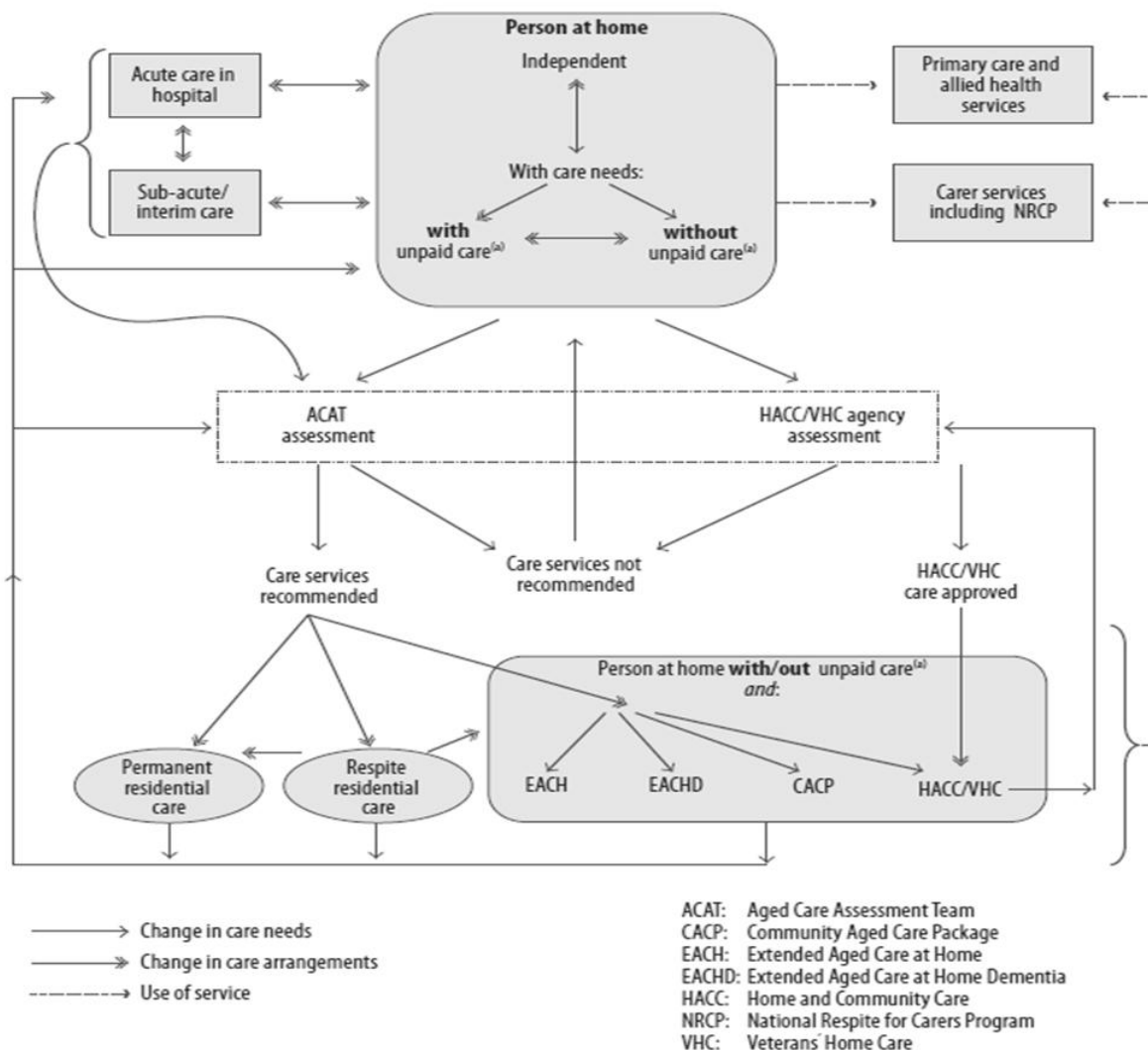
Source: Australian Institute of Health and Welfare (2009b. 11)

Further to community care options, other pathways available to older Australians are through independent living accommodation, such as retirement villages, and residential care. Residential care services include permanent accommodation (offering both high and low care) and temporary accommodation (respite). According to the Australian Institute of Health and Welfare (AIHW) (2009a) the most common pathway chosen by older people in their study was the 'no change' path, where accommodation status remained unchanged, that is to stay at home. They also found that other major pathways used by a large proportion of their cohort were that of permanent residential care only (23%) and access to community care services (14%). Eight percent of the cohort did not access any programme services prior to dying. It was also found that access to age care programmes increased as a person became older (Australian Institute of Health and Welfare 2009a).

6.3. Availability of services

Nationally in 2008, 112 places per 1,000 persons aged 70 years and over were available for both residential and community care. Of this allocation 20-25 places per 1,000 persons were to be directed to community care services with 16% of these for high care packages. The Australian Government allocated these ratios in line with the ageing population (Australian Institute of Health and Welfare 2009b, 2009c).

Figure 9. Possible movements through the Australian health and aged care system (2003–04)



(a) Excluding payments from government pensions and benefits.

Note: Figure includes selected government-funded programs only, for 2003–04.

Source: Australian Institute of Health and Welfare (2009a. 4)

Variation in the number of places available in aged care services occurs between states and territories. The Northern Territory has the highest ratio for combined aged care services available (226 places per 1,000 persons aged 70 years and over) compared with Western Australia (108 places per 1,000 persons aged 70 years and over) (Australian Institute of Health and Welfare 2009b). Variances also occur between urban and rural locations. Table 1 breaks down the availability of places for rural, regional and remote areas by services provided.

Table 1. Availability of residential and community aged care per 1,000 persons aged 70 years and over by state/territory and remoteness as at 30 June 2008

State/Territory	Major cities	Inner regional	Outer regional	Remote	Very remote	Total (70+)	Total (70+ population and indigenous population aged 50-69 years)
Residential places							
					Ratio		
NSW	89.6	87.6	74.3	70.0	30.0	87.8	85.7
Vic	88.3	91.7	78.9	75.7	--	88.4	87.9
Qld	88.2	82.8	81.8	82.5	85.0	85.9	83.2
WA	85.4	72.7	87.8	72.0	114.0	83.5	80.1
SA	98.0	83.7	84.5	77.2	162.2	94.5	92.7
Tas	--	95.9	67.9	94.3	76.7	86.8	83.8
ACT	77.0	0.0	--	--	--	76.6	75.6
NT	--	--	691.8	185.4	105.6	94.6	47.6
<i>Australia</i>	89.2	87.2	78.3	83.9	103.3	87.7	85.5
CACP							
NSW	20.0	21.0	14.2	16.8	50.0	19.8	19.3
Vic	20.6	19.4	14.1	20.0	--	19.9	19.8
Qld	18.8	16.9	21.3	34.9	84.6	19.4	18.8
WA	20.4	14.4	22.0	45.2	36.0	20.3	19.5
SA	19.2	26.4	15.5	16.4	66.7	19.8	19.5
Tas	--	23.3	13.0	45.7	50.0	20.4	19.7
ACT	22.7	0.0	--	--	--	22.6	22.3
NT	--	--	51.3	130.8	336.7	110.3	55.5
<i>Australia</i>	20.0	19.8	17.4	36.1	103.6	20.1	19.6
EACH & EACH Dementia							
NSW	3.1	3.1	3.0	--	--	3.0	3.0
Vic	3.2	3.1	2.8	2.9	--	3.1	3.1
Qld	2.8	3.0	2.3	0.7	1.8	2.8	2.7
WA	3.6	2.8	2.1	1.6	--	3.2	3.1
SA	3.0	2.8	3.2	--	--	2.9	2.8
Tas	--	4.2	1.5	2.9	--	3.3	3.2
ACT	6.7	0.0	--	--	--	6.6	6.5
NT	--	--	23.8	15.4	--	18.5	9.3
<i>Australia</i>	3.2	3.1	3.0	1.7	0.8	3.1	3.0
TCP							
NSW	1.1	0.9	0.4	0.0	0.0	1.0	1.0
Vic	1.2	0.5	0.0	0.0	--	1.0	1.0
Qld	0.9	0.9	1.1	0.0	0.0	0.9	0.9
WA	0.8	0.7	2.4	0.0	0.0	0.9	0.9
SA	1.4	0.0	0.0	0.0	0.0	1.0	1.0
Tas	--	1.7	0.0	0.0	0.0	1.1	1.0
ACT	1.5	0.0	--	--	--	1.5	1.5
NT	--	--	1.0	3.1	8.9	2.6	1.3
<i>Australia</i>	1.1	0.8	0.6	0.2	1.2	1.0	1.0
Combined places & Packages							
NSW	113.8	112.6	91.9	86.8	80.0	111.6	109.0
Vic	113.3	114.7	95.8	98.6	--	112.5	111.8
Qld	110.8	103.7	106.5	118.2	171.4	109.1	105.6
WA	110.1	90.7	14.3	118.9	150.0	108.0	103.6
SA	121.5	112.9	103.2	93.6	228.9	118.2	116.0
Tas	--	125.1	82.4	142.9	126.7	111.6	107.8
ACT	107.8	0.0	--	--	--	107.4	106.0
NT	--	--	137.9	334.6	451.1	226.1	113.8
<i>Australia</i>	113.4	111.0	99.4	121.9	208.9	111.9	109.2

Source: Australian Institute of Health and Welfare (2009b. 8)

Nationally in 2008 there were a total of 172,657 residential aged care places available (Australian Institute of Health and Welfare 2009b). The number of available places varied between states and territories. The Australian average is 61 beds per facility, compared to Western Australia, with 57 beds available per facility. Disparities also occur across level of remoteness with 68 beds per facility available in the metropolitan areas compared with 16 beds per facility in very remote areas (Australian Institute of Health and Welfare 2009b).

In comparison for the same period, nationally there were 40,280 community aged care providers, supplying packages to 20.1 per 1,000 persons aged 70 years and over (Australian Institute of Health and Welfare 2009c). The majority of these services were provided by mainstream service providers, however approximately 30% were provided by multi-purpose services⁷. Disparities in terms of provision of packages exist between states and territories with New South Wales and Victoria receiving the greatest number of community care packages as a result of their larger populations. As with residential care services, there are also differences in the distribution of care packages around the country with 67% of packages being distributed in major cities compared with very remote areas receiving 2% (Australian Institute of Health and Welfare 2009c).

6.4. Usage of services

Understandably, usage of residential aged care services increases as people become older and their health fails. The AIHW (2009b) state that in 2008, in the 85 years and older age group there were approximately 235 persons per 1,000 accessing permanent residential aged care. For the same period, usage rates were higher for females compared to males, which may be a result of females having a longer life expectancy than males. Over half of the people accessing residential aged care (55%) were 85 years and older and predominantly female (71%) (Australian Institute of Health and Welfare 2009b). Females in permanent residential care for the same period were twice as likely to be widowed and less likely to be married or in a de facto relationship compared with males.

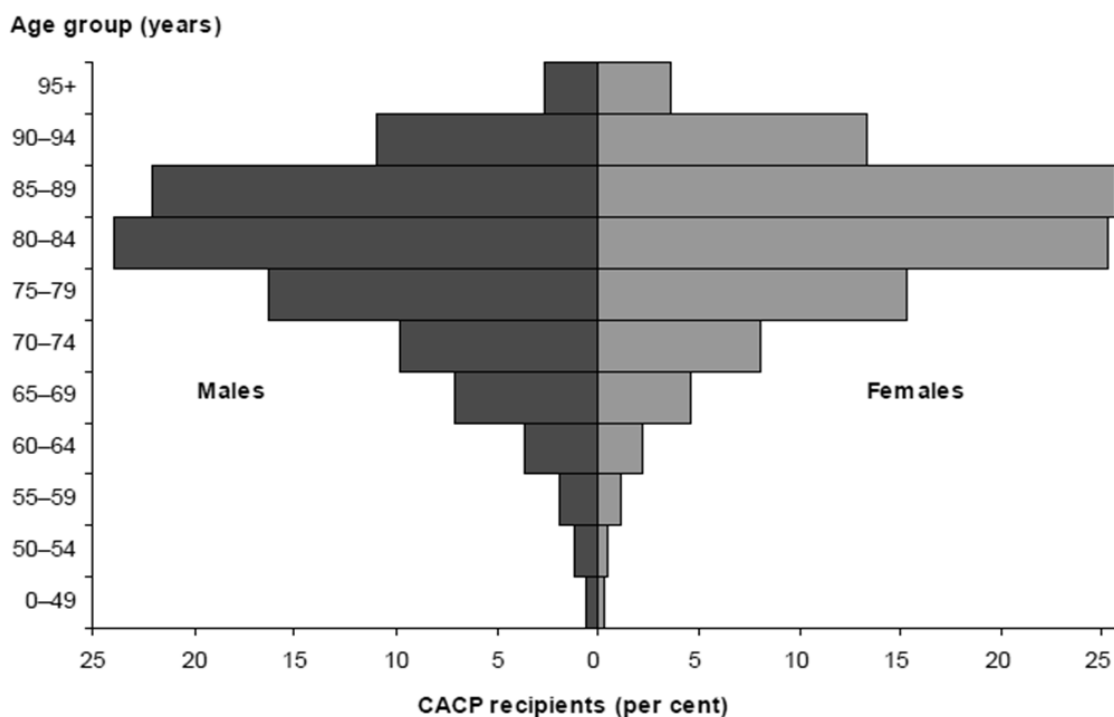
Generally, approximately 2% of places allocated to residential aged care services are for respite residents. This varies between states and territories with Western Australian providing the smallest proportion to respite (1.5%) compared with the Northern Territory who provide the greatest proportion to respite (5.9%) (Australian Institute of Health and Welfare 2009b).

Residents accessing respite services are generally younger than those accessing permanent residential care with 47% of respite residents being 85 years and over. Compared with those accessing permanent residential care (71%), there were less women accessing respite services (64%) (Australian Institute of Health and Welfare 2009b). Additionally a greater proportion of respite residents (34%) compared with permanent residents (26%) were married or in de facto relationships, with over half being widowed (54%).

⁷ Operating in rural and remote communities, multipurpose services (MPS) provide a mix of state and federally funded services of which aged care is one. MPS are usually located in rural and remote hospitals.

Nationally 65% of people using community aged care packages (CACP) in 2008 were aged 80 years and over and 16% were aged 90 years and over (Australian Institute of Health and Welfare 2009c). As with residential care, a greater proportion of CACPs were accessed by females aged 75 years and over (59%). They also tended to be older than their male counterparts with a median age of 84 years compared to 82 years. Figure 10 contrasts the differences in the aged profile of male and female CACP recipients.

Figure 10. Age and sex profile of Community Aged Care Package recipients, 30 June 2008



Source: Australian Institute of Health and Welfare (2009c. 23)

In Australia in 2008, the majority of CACP’s recipients lived in their own home (67%). Twelve percent lived in public rental accommodation and 7% lived in private rental properties. In WA during the same period, 64% of CACP’s recipients lived in their own home, 14% in public housing and 6% in private rental accommodation (Australian Institute of Health and Welfare 2009c).

Nationally for the same period, over half of CACP’s recipients lived alone (54%) and 42% percent lived with family. In comparison in WA, 56% lived alone and 41% lived with family (Australian Institute of Health and Welfare 2009c).

6.5. Usage trends

The number of services in both residential and community aged care is increasing in line with Australia's increasing ageing population. This is also reflected in the length of time services are used. The length of stay in residential aged care accommodation continues to increase from 131 weeks in 1998-1999 to 148 weeks in 2007-2008, with women spending more time in residential aged care (170 weeks) compared with males (110 weeks) (Australian Institute of Health and Welfare 2009b).

CACP began in 1992, with 235 packages available. As indicated in Table 2, in 2008 this number had grown to 40,280 packages (Australian Institute of Health and Welfare 2009b). Table 2 further outlines increases in the number of places in residential aged care facilities from 134,810 in 1995 to 175,472 in 2008.

Table 2. Number of total residential and Community Aged Care Packages places and provision ratio per 1,000 persons aged 70 years and over as of 30 June 2008

8

Year	Places and packages					Provision ratio ^(a)				
	Residential aged care	CACP ^(b)	EACH and EACH Dementia	TCP	Total	Residential places	CACP ratio	EACH and EACH Dementia	TCP	Total
1995	134,810	2,542	..	..	137,352	92.2	1.7	..	..	93.9
1996	136,851	4,431	..	..	141,282	90.6	2.9	..	..	93.5
1997	139,058	6,124	..	..	145,182	89.2	3.9	..	..	93.1
1998	139,917	10,046	..	..	149,963	87.1	6.3	..	..	93.3
1999	141,697	13,896	..	..	155,593	85.6	8.4	..	..	94.0
2000	142,342	18,308	..	..	160,650	83.6	10.8	..	..	94.4
2001	144,013	24,629	..	..	168,642	82.2	14.0	..	..	96.2
2002	146,268	26,425	..	..	172,693	81.9	14.8	..	..	96.7
2003	151,181	27,881	255	..	179,062	83.3	15.4	0.1	..	98.8
2004	156,580	29,063	860	..	186,503	85.0	15.8	0.5	..	101.2
2005	161,765	30,973	1,673	..	194,411	86.3	16.5	0.9	..	103.7
2006	166,291	35,383	3,181	595	205,450	87.0	18.5	1.7	0.3	107.5
2007	170,071	37,997	4,573	1,609	214,250	86.9	19.4	2.3	0.8	109.5
2008	175,472	40,280	6,240	1,963	223,955	87.7	20.1	3.1	1.0	111.9

(a) The ratios are based on ABS population estimates released in December 2008 (ABS 2008). Total provision may vary from the sum of the component parts because of rounding.

(b) From 1999, the data in this table include places and packages provided by Multi-purpose Services, and funding under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Non-residential flexible care packages are counted under CACP.

Source: Australian Institute of Health and Welfare (2009b. 2)

8 CACP Community Aged Care Package
 EACH Extended Aged Care at Home
 EACHD Extended Aged Care at Home Dementia
 TCP Transition Care Place(s)

7. Australian aged care policy and legal issues

7.1. Aged care policy

As a consequence of Australia's ageing population, good health and healthy ageing are key economic priorities for the Federal Government (Department of Health and Ageing 2008). This is reflected in Australia's ageing policy which aims to provide a range of support services for older people, as well as encourage individuals to be financially independent as they become older (Department of Health and Ageing 2008).

Supporting the Government's ageing policy and one of the top five research priorities is the national research goal '*ageing well ageing productively*' funded by the National Health and Medical Research Council and the Australian Research Council. Additionally the Ministerial Conference on Ageing reports directly to the Council of Australian Governments, having a direct influence on ageing policy. Furthermore the Australian Government is party to the Political Declaration (Madrid Plan), committing them to "promoting, providing and ensuring access to basic social service bearing in mind the specific needs of older people" (Department of Health and Ageing 2008).

Accordingly, Australia's aged care policy is developed in the context of "retirement income support, workforce, housing, social inclusion and medical, health and aged care services" (Department of Health and Ageing 2008). The two main pieces of federal legislation governing aged care services and programmes in Australia are the Aged Care Act (1997) and the Home and Community Care Act (1985).

These Acts govern the provision of residential aged care and home and community services. They also address issues such as planning, approval and responsibilities of service providers, subsidies, funding for service providers and financial assistance for recipients. Furthermore new places are allocated to service providers based on their ability to meet the care needs of the community, including those with special needs (Department of Health and Ageing 2008).

The legislation identifies community groups considered as having special needs as:

- people from Aboriginal and Torres Strait Islander communities;
- people from non-English speaking backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged; and
- a veteran of the Australian Defence Force or of an allied defence force; or their spouse, widow or widower (Department of Health and Ageing 2008).

Of note is the absence of GLBTI individuals in the legislation's definition of special needs groups. Consequently, older GLBTI individual's rights are protected under the general sections of the legislation. The Charter of Residents' Rights and Responsibilities protects a person's "personal privacy" and stipulates the right to "select and maintain social and personal relationships with any other person without fear, criticism, or restriction" (Department of Health and Ageing 2007a). The Guidelines for Compiling Assessment Data outlined in the Department of Health and Ageing's Documentation and Accountability Manual, assist nursing staff to identify residents' needs, wants and expectations. Items listed to be reviewed include sexuality, gender sensitivities, and the need for intimacy/privacy (Department of Health and Ageing 2007b). Ironically, as Bauer, Nay and McAuliffe (2009)

highlight, even though these issues are to be considered by nursing staff carrying out assessments, guidance is not provided to staff on how to respond to, or consider these specific needs in the daily provision of care.

Additionally, the National Programme Guidelines for Health and Community Care (HACC) 2007 identifies community groups deemed to have specific needs. Once again, GLBTI people are omitted. Issues of equity and access to HAAC services are addressed through principles that service providers should follow. Relevant to GLBTI individuals is the principle of 'without discrimination' – indicating that eligible people have access to services without discrimination on the grounds of sexual preference (Commonwealth Government 2007a).

Further adding to the invisibility of GLBTI individuals in aged care policy is the exclusion of discrimination based on sexuality in the Australian Government's Code of Ethics and Guide to Ethical Conduct for Residential Aged Care (Harrison 2002). The committee responsible decided individual providers could add a non-discriminatory clause based on sexuality, sexual preference and expression, at their own discretion (Harrison 2002).

7.2. Legal Issues

Ageing policy and legislation in Australia generally disregards the unique needs of GLBTI people. Where mentioned, GLBTI issues are addressed under general non-discriminatory and equal opportunity policies, rather than in the context of a specific needs group.

GLBTI legislative reform has occurred over the years with the first significant change being the decriminalisation of male homosexuality in South Australia in 1972 and the declassification of homosexuality as a psychiatric disorder by the American Psychiatric Association and Australian and New Zealand College of Psychiatrists in 1993. Female homosexuality was not formally recognised or outlawed, however lesbians did experience homophobic abuse and discrimination (Ministerial Advisory Committee on Gay and Lesbian Health 2003). Following the decriminalisation of male homosexuality, amendments to anti-discrimination laws began with the outlawing of discrimination based on sexual orientation and gender identity. Male homosexuality was removed from the International Classification of Diseases register in 1999, however transsexualism and gender identity disorders still remain (Ministerial Advisory Committee on Gay and Lesbian Health 2003).

In 2009 the Australian Government introduced the Same-sex Relationships Act, which removed discrimination against same-sex couples, ensuring the same rights as opposite-sex couples (Department of Health and Ageing 2009). Changes occurred in the following health and ageing legislation:

- Aged Care Act 1997;
- Health Insurance Act 1973;
- National Health Act 1953;
- Prohibition of Human Cloning for Reproduction Act 2002; and
- Research Involving Human Embryos Act 2002.

These changes impact on tax, superannuation, social security and family assistance, aged care, Medicare, child support, immigration, citizenship and veterans' affairs (Department of Health and Ageing 2009).

Despite the introduction of the Same-sex Relationships Act, it is still not possible for same-sex couples to legally marry under Australian law. A number of states however have made legislative changes to allow commitment ceremonies and the listing of same-sex relationships on the state's relationship register (Attorney-General's Department 2009).

7.3. Centrelink

Up until the introduction of the Australian Federal Government's Same-sex Relationships Act in 2009, same-sex couples were unrecognised and consequently ineligible to claim the same government benefits as opposite-sex couples.

Progress has been made with the introduction of the Same-sex Relationships Act. Advocates and GLBTI elders argue however that the implementation process of the Act has been unsympathetic to the needs of older GLBTI people who are already receiving or about to apply for the Aged Pension. Some argue that the Government's implementation process and lack of a grandfather clause⁹, ironically continues to discriminate against GLBTI individuals (Horin 2008). As Horin (2008) highlights other significant changes to social security legislation have included a grandfather clause which protects those people already in the system from negative consequences of legislative change. In the case of the Same-sex Relationships Act, this means that GLBTI couples already on an aged pension will be substantially financially disadvantaged as their income is reduced. Additionally, as the legislation is being implemented without an extended phase-in period, older GLBTI couples entering into retirement will not have had sufficient time to adjust their plans to ensure their financial security (Horin 2008). Also of concern is the stress and anxiety that older GLBTI people may now experience because of the new legislation. Having lived their lifetime concealing their sexual identity, they and are now required to disclose their sexual identity to government agencies (Birch 2009).

Some general legislative progress for GLBTI people has been achieved albeit it slowly. However future development of aged care policy and legislation in Australia must recognise GLBTI individuals as a group with specific needs. Only then can any real progress be made to meet the needs of an ever growing older GLBTI population (Harrison 2002).

⁹ A grandfather clause is an exception in new legislation that allows people already affected by the previous legislation to remain under the previous legislation.

PART B METHODOLOGY

1. Literature search

This literature search was undertaken using the following electronic databases: Australian Bureau of Statistics, ProQuest, CINAHL(EBSCO), PubMed, ISI Web of Knowledge, Psychinfo, Ageline, ScienceDirect, Curtin Library e-books and OVID. Other electronic searches were conducted using Google and Google scholar. The search terms used were: attitudes, sexual orientation, nursing home, retirement, housing options, health inequities, social context, aged care, ageing, aging, gay, lesbian, transgender, intersex, ageism and discrimination. The search was limited to the English language. The literature review research process is fully outlined in Appendix B.

The literature review aimed to ascertain a better understanding of general and GLBTI ageing issues and establish lessons learnt from previous findings. Additionally the literature review aimed to build on the findings of other researchers, identify any gaps in the current knowledge and highlight the significance of historical context when researching GLBTI issues. Furthermore, the literature review guided the development of an industry survey and best practice guidelines, through the identification of key themes which emerged from the literature.

2. Limitations of this review

This literature review is limited by the paucity of research, especially peer reviewed, in the area of GLBTI ageing within the Australian context. However, GLBTI gerontology is a growing research area and there are a number of studies being undertaken within the Australian context in addition to some Australian GLBTI websites addressing ageing issues. However, much of the progress made with regard to GLBTI ageing comes from the US. Consequently, this review draws on literature from the US and other countries, in addition to the available Australian data.

PART C KEY FINDINGS

1. Major studies – the GLBTI population and ageing

1.1. International studies

Historically, the US has led the way in GLBTI research. Consequently, it has been instrumental in undertaking research which explores the needs of ageing GLBTI individuals. Despite this, there is still limited research and data collected on the diversity within GLBTI communities, particularly older GLBTI people (Grant et al. 2010). It is important to note the diversity that exists within the GLBTI population and that findings across major studies will be specific to the context in which they have been carried out in. However, upon close examination of some of the major studies, emerging key themes can be identified. These key themes are presented in italics in Table 3.

Good social support is vitally important for older people. This is even more so for ageing GLBTI individuals as they are often estranged from their biological family and are more likely to live alone (Grant et al. 2010). Consequently social support often comes from close friends, frequently referred to as ‘families of choice’ (Equality South West 2006; Grant et al. 2010; Heaphy, Yip, and Thompson 2004).

Ageism in the general community is prevalent. Younger people are portrayed as being innovative, productive and contributors to society, whereas older people are perceived as being a drain on resources with their skills and contributions undervalued (Grant et al. 2010). The GLBTI population is no different, and according to Grant et al. (2010), ageism in the gay and bisexual male scene has significant impact on self esteem and self worth.

Another theme that strongly emerges from the literature is the impact of historical experiences of discrimination. GLBTI people who are currently accessing aged care services have lived in an era where there was a real threat of losing their job, family and friends, and risking imprisonment and medical cures if they disclosed their sexual identity (Barrett 2008). Consequently identity concealment and invisibility is a real issue and manifests as ongoing fear of discrimination and suspicion of government institutions (Brotman, Ryan, and Cormier 2003). This creates further marginalisation and stress on individuals as they may continually conceal their sexual identity (Barrett 2008).

Also emerging from the literature is the notion that GLBTI individuals are less likely to access health care services for fear of discrimination and homophobic attitudes by providers and carers. Consequently, some older GLBTI do not seek health care or disclose their sexual identity to health care providers, which can result in their medical needs remaining unmet.

Finally, the research highlights that older GLBTI people fear that homophobic attitudes by health care service providers will affect the quality of care they receive. Barrett (2008) concludes that inadequate quality of care can result from staff's personal value and belief systems impacting on their service delivery, lack of knowledge of anti-discrimination laws and legal responsibilities, and insufficient support/guidance from management.

Table 3. Key International GLBTI Ageing Studies

Author(s)/year	Title	Key Findings
Hays, T. V. Fortunato V. Minichiello (1997)	Insights Into The Lives of Gay Older Men: A Qualitative Study With Implications For Practitioners	<ul style="list-style-type: none"> • Few participants had positive relationships with their families and relied on friends and partners for support • Gay males are a growing visible minority group • Participants rarely disclosed their sexuality with health care providers as a result of their past experiences of discrimination by health care providers
Herdt, G. J. Beeler,& T. Rawls (1997)	Life Course Diversity Among Older Lesbians and Gay Men: A Study In Chicago	<ul style="list-style-type: none"> • <i>Historical experiences of homophobia</i> – a number of participants, particularly those over 51 years of age had some lingering impact of homophobia • <i>Current experiences of discrimination</i> – many participants experienced discrimination as a result of their sexual identity • <i>Invisibility</i> - 2/3 of participants hide their sexual identity at work • 2/3 of participants identified that they have a ‘family of choice’ rather than a biological family
Beeler, J. T. Rawls, G. Herdt & B. Cohler (1999)	The Needs of Older Lesbians and Gay Men in Chicago	<ul style="list-style-type: none"> • 68% of respondents had a ‘family of choice’ • 18% of respondents had experienced homophobic employment discrimination • 47% of respondents had experienced homophobic verbal abuse • 59% of respondents were either moderately or highly involved in the gay/lesbian community • Diversity within the older gay man and lesbian population needs to be recognised by service providers • The social context in which services are provided is an important consideration as the ‘gay/lesbian community’ is not always united and is heterogeneous
Brotman, S, B. Ryan & R. Cormier (2003)	The Health and Social Service Needs of Gay and Lesbian Elders and Their Families in Canada	<ul style="list-style-type: none"> • <i>Historical experiences of discrimination</i> – older gay men and lesbians often mistrust health care providers as a result of experiences throughout their life of marginalisation and oppression • <i>Current experiences of discrimination</i> – participants reported overt homophobia towards gay men and lesbians, consequently making them fearful of victimisation and discrimination within aged care ‘systems’ • <i>Invisibility</i> – past and current experiences of discrimination manifest in older gay men and lesbians concealing their identity, consequently further marginalising them and excluding them from social policy development • <i>Ageism</i> – participants reported that there was a perception that older people are asexual therefore making it more difficult to talk about older people’s sexual activity and sexuality
Heaphy, B. A. Yip & D. Thompson (2004)	Ageing in a Non-Heterosexual Context	<ul style="list-style-type: none"> • 52.9% of the women and 48.8% of the men agreed with the statement that ‘my friends are my family’ • 41% of female and 65% of male participants lived alone – this figure increased slightly with age • 50% of female and 30% of male participants indicated that their partners would be the primary care providers when the need arose – very few expected family members to take on this role

Author(s)/year	Title	Key Findings
MetLife Mature Market Institute (2006)	Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers	<ul style="list-style-type: none"> • 1/3 of participants said they were unaware of who would care for them as they aged • More than 3/4 of participants had important connections with 'families of choice' • 27% of respondents were concerned about discrimination as they aged • Participants were concerned about discriminatory and insensitive treatment by health care providers
Jackson, N. M. Johnson & R. Roberts (2008)	The Potential Impact of Discrimination: Fears of Older Gays, Lesbians, Bisexuals and Transgender Individuals Living in Small-To Moderate-Sized Cities on Long-Term Health Care	<ul style="list-style-type: none"> • <i>Current experiences of discrimination</i> – both heterosexual and non-heterosexual respondents acknowledged homophobic discrimination existed in long term care facilities • <i>Access to care</i> – 39% of GLBT respondents believed that there was equal access to care for GLBT and heterosexual individuals • The overall finding was that GLBT individuals fear discrimination and anticipate discrimination against them in health care settings
Meri-Esh, O. & I. Doron (2009)	Aging With Pride in Israel: An Israeli Perspective on The Meaning of Homosexuality in Old Age	<ul style="list-style-type: none"> • <i>Concealment of identity</i> – participants felt oppressed and isolated as a result of having to conceal their identity and pass as heterosexual • <i>Ageism within the general community</i> – there is a general negative attitude towards older people in Israel. Participants in the study felt that they were doubly discriminated against as a result of ageism in the general community as well as homophobia • <i>Ageism within the gay community</i> – participants felt rejected and alienated when they mixed with the gay community at large, for example when attending mixed age events and gay clubs
MetLife Mature Market Institute (2010)	Still out, still aging: MetLife study of lesbian, gay, bisexual and transgender baby boomers	<ul style="list-style-type: none"> • GLBT baby boomer's fears about ageing include: finances, end of life care, ageing in place and care giving. • Few feared discrimination based on sexual orientation and/or gender identity by care providers • Family acceptance of their sexual orientation and/or gender identity is high • Relationship recognition in terms of marriage are important to couples • 'families of choice' are important to GLBT people and often supplement 'biological families' • Over half of the participants indicated that they are confident that health care professionals will treat them with respect and dignity regardless of their sexual orientation and/or gender identity • Gay, bisexual and transgender men are nearly twice as likely to provide weekly care than their heterosexual counterparts • Experiences of bisexual men and women differ from those of lesbian, gay and transgender people

1.2. Australian studies

Historically in Australia, GLBTI ageing issues have received little attention in gerontology research, aged care policy, training, education, and interventions (Harrison and Riggs 2006). Recently however a growing body of research has emerged from Australia which is grounded in the perspectives and experiences of older GLBTI people (Harrison and Riggs 2006). Of significance is the ability for interventions (advocacy, policy, education and training) to address the real issues experienced by GLBTI people, and not the heterosexual assumptions made by researchers and policy makers (Harrison and Riggs 2006).

In line with international studies, a major theme identified in Australian studies is that past experiences of homophobia and discrimination play a significant role in a GLBTI person's health seeking behaviour and interactions with aged care service providers (Addis et al. 2009). Additionally some older GLBTI adults experience ageism from both within the GLBTI population and the general population, which further contributes to marginalisation and invisibility (Addis et al. 2009). Furthermore, heteronormativity has a strong presence within aged care policy making which promotes invisibility and marginalisation of GLBTI people (Phillips and Marks 2006).

Table 4 identifies some of the major studies in Australian GLBTI gerontology and highlights the key findings. Themes that strongly emerge from the key findings and issues can be summarised as heteronormativity, homophobia/discrimination, ageism, invisibility, quality of care and accessing of health services. Recurring themes in Table 4 are italicised.

Table 4 Key Australian GLBTI ageing studies

Author(s)	Title	Key Findings
Harrison, J. (1999)	A Lavender Pink Grey Power: Gay and Lesbian Gerontology in Australia	<ul style="list-style-type: none"> • <i>Heterosexism/homophobia</i> – gay and lesbian participants experienced heterosexist and homophobic attitudes within the aged care sector in addition to in the general population • <i>Ageism</i> – gay and lesbian participants indicated that to an extent there were negative attitudes toward ageing in gay and lesbian communities • <i>Invisibility</i> – participants made reference to current invisibility of older gay and lesbians in the aged care context
Chamberlain, C. & P. Robinson (2002)	The Needs of Older Gay, Lesbian and Transgender People	<ul style="list-style-type: none"> • <i>Heterosexism/homophobia</i> – most of the GLBTI population surveyed believe that GLBTI people have specific needs • <i>Ageism</i> – Respondents who were single, working class and male experienced isolation and loneliness, as well as ageism in the gay sub-culture
Harrison, J. (2002)	What Are You Really Afraid Of? Gay, Lesbian, Bisexual, Transgender and Intersex Ageing, Ageism, and Activism	<ul style="list-style-type: none"> • <i>Invisibility</i> – as a result of invisibility, GLBTI issues remain unacknowledged and hidden. Invisibility is also contributing to GLBTI elder abuse in supported aged care service • <i>Concealment of identity</i> – disclosure of sexual orientation and identity in unsympathetic environments is an underlying theme throughout Australian literature

Author(s)	Title	Key Findings
Ministerial Advisory Committee on Gay and Lesbian Health (2003)	Health and Sexual Diversity: A health and Wellbeing Action Plan for Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI)	<ul style="list-style-type: none"> • <i>Current experiences of discrimination</i> – the impact of heterosexism on GLBTI include: violence, discrimination and social marginalisation, isolation and invisibility • <i>Historical experiences of discrimination</i> – can lead to health problems and access to quality health care
Birch, H. (2004)	About time!: GLBT seniors ALSO matter	<ul style="list-style-type: none"> • <i>Historical experiences of discrimination</i> – affects GLBTI individuals accessing health, housing, community and aged care services. Experiences of homophobia displayed by health care providers negatively impacts on GLBTI individual's accessing health care • <i>Quality of care</i> – the assumption of heterosexuality and gender identity impacts on the service of care provider to GLBTI older people as their unmet needs remain unaddressed
Harrison, J. (2005)	Pink, Lavender and Grey: Gay, Lesbian, Bisexual, Transgender and Intersex Ageing in Australian Gerontology	<ul style="list-style-type: none"> • GLBTI issues include: <i>invisibility, isolation</i>, support networks, homophobic services, policy and law reform, training of staff, ageism and activism
Hughes, M. (2005)	Sexual Identity In Health and Aged Care	<ul style="list-style-type: none"> • <i>Historical experiences of discrimination</i> – impact on GLBTI older people's preparedness to access health and aged care services • As a population GLBTI people experience higher rates of chronic illness • Gay men experience higher rates of HIV and other STIs than the general population • GLBTI people have expressed concerns about <i>social isolation</i> as they become older
McNair, R. & N. Thomacos, (2005)	Not Yet Equal	<p><i>Current experiences of discrimination</i></p> <ul style="list-style-type: none"> • Almost 20% of the GLBTI respondents in this survey had received explicit threats • 20% of respondents experienced discrimination from health care providers as a result of their same-sex relationship

Author(s)	Title	Key Findings
GRAI (2007)	Older Gay and Lesbian People: Establishing the Needs	<ul style="list-style-type: none"> • <i>Heterosexism/homophobia</i> – there is a perception among GLBTI individuals that aged care facilities have homophobic attitudes • <i>Invisibility</i> – participants made reference to feeling like they would need to be constantly 'on guard' if they were living in aged care facilities • <i>Specific needs</i> – participants mentioned that accommodation facilities must be prepared to acknowledge differences and cater for needs of older GLBTI people • <i>Quality of care</i> – participants believed there was insufficient training of staff on specific needs of GLBTI residents
Barrett, C. (2008)	My People	<ul style="list-style-type: none"> • <i>Historical experiences of discrimination</i> affects on GLBTI elders. They have lived in an era where disclosing their sexuality could have resulted in imprisonment, loss of employment, ostracism by community family and/or friends, and the possibility of being subjected to curative medical treatment • <i>Current experiences of discrimination</i> can result in invisibility as GLBTI older people are likely to hide their sexuality/gender identity as a result of being fearful of discrimination, sub standard quality of care and misunderstanding by health care service providers • <i>Concealment of identity (invisibility)</i> can have negative impacts on GLBTI older people, manifesting as depression, anxiety, stress and the feeling of being undervalued • Inadvertent visibility impacts on older GLBTI people who cannot conceal their gender identity. Subsequently they need to be in a safe space free from discrimination by staff, other residents and visitors • <i>Dementia</i> – older GLBTI people need to be in a safe space where staff understand that they experience the same sense of loss and grief as heterosexual elders • Sexual and cultural expression is important for positive mental health, and older people need to be enabled to have privacy, sexual expression and physical touch • <i>Quality of care</i> – inadequate quality of care can result from staff being unaware of their legal obligations; their personal values and belief systems; lack of knowledge of anti-discrimination laws and lack of support/guidance from management • <i>Creating a safe space</i> – can result in GLBTI older people feeling valued, understood and safe

Author(s)	Title	Key Findings
Barrett, C., J. Harrison & J. Kent. (2009)	Permission to Speak	<ul style="list-style-type: none"> • <i>Ageism and homophobia</i> – perceived by the GLBTI community is reflected in the views of aged care service providers interviewed • <i>Sexuality</i> – aged care service providers view older people as asexual and they are not expected to be sexually diverse. It is not uncommon for libido suppressants to be used within residential care facilities to curb sexual expression • <i>Specific needs</i> – service providers did not expect older GLBTI people to have any specific needs • GLBTI older people in residential services – care providers were unsure of how to manage and support GLBTI residents in shared accommodation facilities • Transgender – service providers expressed their concerns about the industry's readiness to support older trans people to maintain their identity
Hughes, M. (2010)	Expectations of Later Life Support Among Lesbian and GAY Queenslanders	<ul style="list-style-type: none"> • <i>Emotional support</i> in later life for most respondents was expected to come from partners, LGBT friends and heterosexual friends; extended family (29.4%); 25.6% from siblings; 15.1% from children and 4.9% from neighbours • <i>Physical support</i> in later life for most respondents was to come from partners (53.6%); LGBT friends (36.4%); heterosexual friends (24.8); extended family (19.7%); siblings (15.9%); children (12.7%) and neighbours 3.5%. • Most respondents anticipated being self-reliant in terms of <i>financial support</i> in later life (62.3%); 46.6% anticipated relying on government support, 36.9% from partners; 6.2% from siblings; 7% from extended family; 4.9% from their children; and 2.4% from LGBT friends or heterosexual friends (1.9%) • <i>Socialisation</i> – 69.3% identified LGBT friends as those who they expected to socialise with in later life; 62% with heterosexual friends; 56.9% with their partner; 33.4% with extended family; 25.9% with siblings; 17.8% with their children; and 8.4% expected that they would have no one. • <i>Living arrangements</i> - 59.3% identified their partners as the most likely person they would be living with in older age; 25.1% identified LGBT friends; 10% with heterosexual friends; 4.6% with their children; 3.2% with their extended family and 0.5% with their neighbours

2. Current practices and attitudes - aged care industry

State and federal legislation guide the practices of residential aged care service providers. As such, practices across the industry work within similar governance frameworks. While there are good practices in some facilities, the providers of residential aged care are not a uniform group and consequently differences in practices and attitudes will exist.

In general, Australian gerontology and the aged care industry operate within a heteronormative framework, disregarding sexual diversity and sexual identity (Harrison 2005; Phillips and Marks 2006). Additionally the aged care industry generally employs the notion that older people are asexual and that matters of sexuality are private (Hamburger 1997; Hughes 2004).

2.1. Heteronormativity

Heteronormativity assumes that heterosexual orientation and heterosexual perspectives are the norm, and therefore disregards sexual diversity and gender identity (Tolley and Ranzijn 2006).

Current policy governing the aged care industry is framed in a heterosexual context and can unintentionally and indirectly marginalise and discriminate against GLBTI people (Irwin 2007). This results from specific needs not being consciously considered as well as the lack of awareness of relevant GLBTI issues (Tolley and Ranzijn 2006).

Older GLBTI people are not considered as a specific needs group in the Aged Care Act which reinforces their invisibility and further marginalises them (Phillips and Marks 2006). Additionally, admission and intake forms into residential aged care services often use heteronormative language such as husband, wife, married, divorced and family (Irwin 2007). Rarely do they provide an opportunity for individuals to declare same-sex partners, nor do they employ a broader definition of 'next of kin' to encompass 'families of choice' rather than biological families (Irwin 2007). This is significant as visiting rights, access to client information and involvement in client decision making is determined by such information (Irwin 2007). Furthermore, marketing material used by the aged care industry is also based on heteronormative assumptions with opposite-sex couples depicted on brochures, to the exclusion of same-sex couples (Phillips and Marks 2006; Tolley and Ranzijn 2006).

Tolley and Ranzijn (2006) theorise that the aged care industry is not immune from heteronormative assumptions as staff working within this industry will usually hold heteronormative assumptions in line with the general population. Consequently, staff and service providers do not usually perceive older GLBTI people as existing, let alone having specific needs.

2.2. Homophobia

Homophobia transpires from an irrational fear and/or dislike of people who are homosexual, and manifests as discrimination and/or violence (Barrett, Harrison, and Kent 2009). As with heteronormativity, homophobia exists within the broader community, and therefore is likely to exist within the aged care industry (Barrett, Harrison, and Kent 2009; Roach 2004). Homophobia when experienced in the broader community impacts negatively on GLBTI people, particularly those in rural communities (Barrett, Harrison, and Kent 2009).

However acts of homophobia within aged care services have greater consequences for older GLBTI people as they are dependent on such services and maybe constantly in contact with homophobic health care workers and other residents (Barrett, Harrison, and Kent 2009; Irwin 2007; Roach 2004). Resident's rights are protected by anti-discrimination laws, however Irwin (2007) suggests that this may only be useful in overt situations, and that covert institutionalised homophobia does exist and often goes unchallenged.

2.3. Sexual activity and sexual identity

Older people are generally viewed as being asexual and sexual expression within aged care facilities is perceived to be problematic (Barrett, Harrison, and Kent 2009). A study by Barrett, Harrison and Kent (2009) found that carers were surprised that older heterosexual couples were sexually active. They also found that a mono culture existed within the aged

care sector in relation to sexual diversity which perpetuated the mantra that “we need to treat everyone the same” (Barrett, Harrison, and Kent 2009. 55).

The aged care industry and perhaps much of the wider community, generally do not perceive older people as being sexually active. Consequently, issues relating to sexuality are often left unaddressed by aged care providers. In line with perceptions of the general older population, older GLBTI people are also considered to be asexual. They are therefore perceived by aged care providers as being no different than their counterparts when it comes to sexuality and sexual activity (Barrett, Harrison, and Kent 2009).

This is problematic as sexuality encompasses a much broader notion than sexual activity per se, and includes many dimensions of identity, which Harrison (2001) likens to that of culture. This narrow understanding of sexuality employed by aged care service providers renders GLBTI elders invisible, further marginalising them and creating unmet needs.

2.4. Privacy

Hughes (2004) posits that the notions of public and private spheres are not mutually exclusive and when applied in the context of aged care provision, can be conflicting. This is evident in aged care services in Australia, where at the policy level, client privacy is afforded utmost importance with providers being required to meet privacy standards to maintain their accreditation (Hughes 2004). A person’s privacy is protected under the Privacy Act and when applied to an aged care setting, such policy can facilitate the provision of a safe environment where older GLBTI may feel comfortable in disclosing their sexuality (Hughes 2004).

However, Bauer (1999) argues that even though the right to privacy is one of the fundamental responsibilities of aged care providers, in reality it is difficult to achieve. This is partly due to the fact the residential care facilities are constructed around the notion of ‘shared space’, making it difficult for residents to distance themselves from others (Bauer 1999). Privacy is also difficult to maintain when rooms are shared, regimented routines exist, there is limited available space, surveillance of residents is used as a risk reduction strategy and when client information is readily exchanged/discussed by staff in open spaces (Bauer 1999; Hughes 2004).

The Privacy Act while potentially facilitating a safe environment for residents may on the other hand be used by providers to disregard sensitive issues such as sexuality as a ‘private matter’ (Hughes 2004). Harrison (2001) likens privacy in aged care settings to the notion of taboo and that aged care providers and staff use privacy to avoid sensitive issues such as sexuality. This keeps GLBTI elders invisible and their specific needs unmet, as staff and providers are unable to gain an understanding of their GLBTI client’s experiences and issues (Harrison 2001).

3. Concerns of older GLBTI people

3.1. Institutionalised aged care

McNair and Harrison (2002) found that major concerns for older GLBTI people were not about their health per se, but rather about institutionalised discrimination pertaining to sexual and gender identity. In addition, concerns were raised about how homophobic attitudes of institutionalised aged care facilities would influence the quality of care delivered and the fear that this could result in elder abuse. Older GLBTI people in general do not feel that it is safe to disclose their sexual orientation and/or gender identity to aged care providers as a result of their past experiences of discrimination (Barrett 2008). This stems from a time when disclosure could have resulted in imprisonment, ostracism, job losses and medical interventions. Additionally concerns are raised as a large number of residential facilities are run by religious organisations (McNair and Harrison 2002).

3.2. Concealment of identity

As a result of fears of institutionalised homophobia, some older GLBTI people believe that they need to conceal their sexual orientation and/or gender identity from aged care service providers (Barrett, Harrison, and Kent 2009). Consequently, they may be forced 'back into the closet' and have to continuously maintain a facade of heterosexuality, placing them under immense stress and anxiety (Barrett, Harrison, and Kent 2009). Furthermore, concealment of identity renders older GLBTI people invisible and may result in failings to address or meet their needs.

The heteronormativity of aged care facilities is also of concern to many older GLBTI people. Heterosexual assumptions coupled with the notion of older people being asexual, can make GLBTI people feel that their same-sex relationships are not valued or understood and that partners will be excluded in care planning and decision making (Irwin 2007). Additionally Addis (2009) reports some older GLBTI people fear a lack of recognition and support of their 'families of choice' from service providers.

3.3. Social networks

Some older GLBTI people fear that going into residential aged care will render them socially and emotionally isolated from their communities. They will no longer be able to mix with other GLBTI people, access GLBTI services and activities or celebrate/attend special events and festivals (Birch 2004; Chamberlain and Robinson 2002; Chandler et al. 2005). Encouraging older GLBTI people in residential care facilities to participate in GLBTI community activities can be challenging due to their invisibility and identity concealment (Brotman, Ryan, and Cormier 2003). However encouraging GLBTI elders to access and remain connected to their GLBTI community and social support groups is important, as it can contribute to positive health outcomes (Birch 2009).

3.4. Financial security

As with older heterosexual people, older GLBTI people are concerned about their financial security as they age. In the report *Out and Aging* (2006) On the other hand lesbians were more concerned that their finances were insufficient to last their lifetime. This was partly due to older women generally having a lower earning capacity over their working years than men, and a generational factor where women were not expected or taught to be financially

self sufficient (MetLife Mature Market Institute 2006). Gay males on the other hand were more concerned about becoming dependent on others (MetLife Mature Market Institute 2006). Although this report is specific to the US population, it is likely to be applicable in the Australian context.

3.5. Cultural and sexual expression

Of concern to some older GLBTI people is the limited opportunity residential aged care facilities provide for cultural and sexual expression (Barrett 2008). They may be unable to display GLBTI related materials such as photos and community newspapers, nor are they able to watch gay TV without 'outing themselves' (Barrett 2008). Additionally the lack of opportunity for physical touch such as holding hands, kissing and hugging as well as physical intimacy is also a concern of some older GLBTI people (McNair and Harrison 2002).

4. Implications

A review of the literature reflects a clear divergence between services offered by aged care providers, and the unique needs and concerns of older GLBTI people. Consequently, the findings of this literature review have implications for providers of retirement and residential aged care service, as they appear to be ill prepared to meet the specific needs of older GLBTI people currently in supported accommodation. Unless change occurs and the sector recognise older GLBTI people as a minority group with specific needs, they will remain ill prepared to meet the needs of older GLBTI people seeking supported accommodation into the future.

Older GLBTI people currently accessing retirement and residential aged care services are a hidden population, as demonstrated by many Australian and international studies. Older GLBTI people may not feel comfortable or safe to disclose their sexual orientation and/or gender identity for fear of discrimination, abuse and reduced quality of care. This can have significant health implications and can manifest as stress, anxiety and depression from continually having to maintain a heterosexual persona. As providers may not be aware of the existence of older GLBTI residents within their facility, they are less likely to address adequately some of the underlying causes of such health issues. They are also less likely to support community connectedness and sexual expression, which can affect overall well being. Concealment of sexual orientation and/or identity can also have significant health consequences, as non-disclosure of important information may affect the provision of care.

Furthermore, heteronormativity and homophobia exist within the broad community and are therefore likely to exist in retirement and residential aged care facilities (Barrett, Harrison, and Kent 2009; Roach 2004). Specific to the aged care industry is its culturally diverse workforce. Some staff may come from cultural backgrounds where discriminatory attitudes and laws against homosexual activity are strong. Additionally perceptions, values and attitudes can impact on an individual's level of comfort around issues of sexuality and in particular diverse sexuality groups (Roach 2004). Therefore, standards of care may be compromised when staff hold negative personal attitudes towards GLBTI people. Additionally, acts of homophobia within aged care services have greater consequences for older GLBTI people as they are dependent on such services and are less likely to be able to choose their carers and social networks, potentially putting them in constant contact with

homophobic health care workers and other residents (Barrett, Harrison, and Kent 2009; Irwin 2007; Roach 2004).

Moreover, "terminology has implications for the way in which groups view themselves and live their lives" (Smith and Calvert 2001. 12). Of significance to staff and providers is the use of appropriate language that is respectful and aligned with how people identify themselves. Using gender-neutral and non-discriminatory terminology can make older GLBTI people feel comfortable and safe to disclose information that may affect their quality of care.

Furthermore, the provision of GLBTI-inclusive practices requires a fundamental understanding of diversity as well as knowledge of the impact of an individual's past experiences of homophobia and social exclusion (Smith and Calvert 2001). Providers need to have an understanding and appreciation of the impact of history and culture (sexual orientation, past experiences, race, gender, etc) on an individual's beliefs and behaviour, and their interactions with health professionals (Smith and Calvert 2001).

Finally, the findings from this literature review have implications for organisational policy. To assist in meeting the specific needs of older GLBTI people, organisational policy and procedures within the retirement and residential aged care sector should explicitly address GLBTI issues. Currently general equal opportunity and antidiscrimination policy encompass issues of sexuality, however by explicitly addressing GLBTI issues in organisational policy and procedures, organisations demonstrate their intent in having a GLBTI-inclusive environment and articulate what is expected of staff (Smith and Calvert 2001). It also limits unintentional and indirect marginalisation and discrimination of GLBTI people, which can occur when specific needs are not consciously considered and there is a general lack of awareness of relevant GLBTI issues (Irwin 2007; Tolley and Ranzijn 2006).

5. Future research areas

Further research is required to build on the current body of knowledge around older GLBTI people in an Australian context. A collaborate approach both across relevant disciplines and across different research populations will provide a national perspective and greater understanding of this underserved group. Areas of further research include:

- Developing a training and education strategy for the aged care sector around issues of sexuality and gender and sexual diversity in older people;
- Identify approaches to mobilise into organisational policy, inclusive-practices in the care of older GLBTI people;
- Examine the diversity within the older GLBTI population, identifying particular needs of sub-groups;
- Investigate the effectiveness of GLBTI-inclusive practices within the retirement and residential aged care sector;
- Explore the attitudes, perceptions and practices of the community care sector in relation to older GLBTI people;
- Identify approaches to facilitate the recognition of older GLBTI people as a specific needs group in the Aged Care Standards;

- Examine how retirement and residential aged care providers have integrated the Federal Government's same-sex legislation into organisational policy and procedures;
- Compare models of inclusive aged care practices applied to other minority groups and how these can be modified and applied to the older GLBTI population;
- Explore the implications of HIV and early ageing for providers of residential aged care; and
- The development of a GLBTI-inclusive assessment tool for providers of retirement and residential aged care which assists them to enquire and record information about sexual orientation at the point entry into a facility.

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Appendix A Gay Social History in Australia

Data sourced: (Australian Studies Centre Online n.d.; Sydney's Pride History Group 2009; Watson, French, and Blackman n.d.; Meyer 2002; Willett 2000; Darbyshire 2009)

1950s

- Homosexuality is illegal for males
- Those engaging in homosexual acts were prosecuted
- Discrimination was systemic in Government institutions
- Openly homosexual men were banned from being employed in Federal Government positions where they could access highly classified information - they were thought to possess a character defect which made them prone to pressure from foreign intelligence services. Therefore making them a national security risk
- Societal attitudes were ones of persecution, condemnation, hatred and discrimination
- Conversion therapy was practiced as a means to make people heterosexual
- Homosexuality was viewed as a "sickness, sin and disgrace" (Kimmel, Rose and David 2006. 1)
- Little motivation from the homosexual subculture for political activism or public debates as the 'gay scene' was concealed from the general population for fear of reprisal
- 'Gay scene' therefore invisible with little motivation (Willett 2000)
- The first attempt (unsuccessful) was made at establishing the first Australian homosexual law reform society
- Perth's earliest record of openly gay scene revolved around the Palace Hotel (1956)

1960s

- Stonewall Bar riots happened in New York - turning point in GLBTI activism - Gay Liberation Front formed in the US which motivated the formation of similar gay activist groups around the world (1969)
- Engaging in homosexual acts in all States in Australia is still a crime
- The ACT Homosexual law reform society successfully established in Canberra (1969)
- Support for homosexual law reform by The Humanist Society NSW (1969)
- Calls for decriminalisation of male homosexual acts are made by the NSW General Assembly of the Presbyterian Church (1967)
- NSW Council for Civil Liberties homosexual subcommittee agrees to support law reform similar to that of the UK, where the limited law reform of the Sexual Offences Act was granted (1967)

1970s

- The first branch of CAMP (Campaign Against Moral Persecution) is formed in Sydney. CAMP was Australia's first openly gay activist group. Branches around Australia soon followed.
- CAMP WA branch first meeting at St George's Cathedral in 1971
- CAMP Inc. - Australia's first homosexual magazine - was published and distributed
- Australia's first gay and lesbian demonstration takes place
- First public forum on gay liberation takes place
- The group Gay Liberation is formed in Sydney - first political activist association - other branches followed
- First National Homosexual conference is held in Melbourne

Appendix A Gay Social History in Australia (continued)

1970s

- NSW General Assembly of the Presbyterian Church votes for homosexual law reform
- Australia's first commercial gay magazine *William and John* is published
- First attempt in WA to decriminalise homosexuality – unsuccessful
- Canberra and Goulburn Anglican Synod votes for homosexual law reform
- South Australia becomes the first Australian State to decriminalise homosexuality
- Shaftesbury Hotel in Stirling Street, Perth was popular with members of the gay community
- The Spartans club opened – first safe space for WA gay community (1971) followed by the opening of Connections – Perth's first openly gay bar opened in Northbridge (1975)

1980s

- ALSO Foundation formed in Victoria
- The Gay Rights Lobby is launched in Sydney
- First reports of AIDS cases from the US
- The first case of AIDS reported in Australia
- The WA AIDS Council (WAAC) is established (1985)
- First National AIDS Conference is held
- Australian Federation of AIDS Organisations is formed
- World AIDS Day first celebrated
- NSW is the first state to prohibit discrimination against homosexuality
- WA passes homosexual law reform decriminalising homosexuality (1989)

1990s

- The Australian Medical Association removes homosexuality from its list of illness and disorders
- Tasmania decriminalises homosexual acts, the last Australian State, to do so
- The Rainbow Flag is adopted in Australia (1992) as a gay symbol
- Federal cabinet lifts the ban on gay men and lesbians in the defence forces
- First Australian lesbian couple adopt a child (Adelaide)
- The Australian Centre for Gay and Lesbian Research at University of Sydney is launched
- The first International Lesbian Day is held
- First gay and lesbian exhibition, *Pride and Prejudice*, is held at the Australian Museum
- First Aboriginal gay and lesbian visual arts exhibition, *Looking Good*, is held
- Federal Industrial Relations Commission extends family leave to same-sex couples under Federal Awards
- First sexual health booklet for lesbians is produced by ACON (Sydney)
- Federal Department of Immigration introduces reforms to the interdependency visa, providing same-sex couples same rights as heterosexual couples

Appendix A Gay Social History in Australia (continued)

1990s
continued

- WA Equal Opportunity Commissioner releases a report recommending the inclusion of sexuality in the Equal Opportunity Act 1984
- Niel van Zee first openly gay man in WA to run for public office – unsuccessful (1995)
- Brian Grieg & John Hyde first openly gay men in WA to be elected to public office
- Northbridge WA becomes home to the annual PRIDE celebrations (1991)
- PRIDE WA collective formed (1990)
- First PRIDE parade held in WA (1991)
- Giz Watson first open lesbian elected to an Australian parliament (1996)

2000s

- Victoria adopts transgender anti discrimination law
- Victorian Parliament passes statutory amendments, providing same sex-couples the same legal rights as heterosexual couples with regards to: inheritance, stamp duty exemption, property division, workers compensation, State superannuation, recognition as a parent of non biological child, recognition as 'next of kin'
- Single women and lesbians eligible for IVF treatment in Victoria, NSW and QLD
- Amendment of the ACT Government's parental Leave Legislation, allowing same-sex parents the same access to parental leave as heterosexual parents
- The Victorian Relationship Register commences
- Federal Government introduces Same-sex Relationships (Equal Treatment in Commonwealth Laws—Superannuation) Act 2008 and Same-sex Relationships (Equal Treatment in Commonwealth Laws – General Law Reform) Act 2008. The Act recognises both de facto and registered same-sex relationships, ensuring same-sex couples and their dependent children receive the same entitlements as married and heterosexual de facto couples and their dependent children.
- To support the Same-sex Relationships Act 2008, amendments were made to:
 - Aged Care Act 1997
 - National Health Act 1953
 - Health Insurance Act 1973

Appendix B Literature Review Research Process Flowchart

