Original Research Article

Health Disparities Among Lesbian, Gay, Bisexual, Transgender, and Queer Older Adults: A Structural Competency Approach

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Abstract

Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) older adults experience significant health disparities. Examining these disparities has become an international research priority, but gaps remain. In this review article, we summarize major contributions of and ongoing gaps in health disparities research among LGBTQ+ older adults, while focusing on four major content areas: (a) social determinants of health disparities, (b) mental, cognitive, and physical health disparities, (c) reproductive and sexual health disparities, and (d) seeking LGBTQ+-affirming and age-friendly care. Using a structural competency approach, we develop a four-part agenda for this research area that enhances our understanding of how macro-level systems, institutions, and structures drive health disparities among aging LGBTQ+ communities. We also outline future research on structural competency in LGBTQ+ older adult health, while providing recommendations for researchers and clinicians. These

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recommendations illuminate potential best practices for bettering the health and quality of life of LGBTQ+ older populations.

Keywords
aging, health, health disparities, LGBTQ+, older adults, structural competency

Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) older adults[1] face significant health disparities compared to their heterosexual and cisgender[2] counterparts (Fredriksen Goldsen & de Vries, 2019; Hash & Rogers, 2017). These disparities emerge and persist against a backdrop of historical and environmental contexts whereby LGBTQ+ people endure widespread discrimination and marginalization over the life course – problems that engender major psychosocial challenges for LGBTQ+ communities as they age (Fredriksen Goldsen & de Vries, 2019; Marshall & Cahill, 2021). For instance, LGBTQ + older adults struggle to access quality healthcare due to erasure and stigmatization in medical research (Flatt et al., 2022), lack of adequate resources and social support (Kum, 2017), medical mistreatment in aged care settings (Nowakowski et al., 2020), and limited access to LGBTQ+-affirming care (Donald et al., 2017; Obedin-Maliver et al., 2011). Emerging literature documenting these unique challenges allows stakeholders to better understand LGBTQ+ people's health needs in later life, while illuminating research gaps and opportunities for improvement in health disparities research.

At the same time, there is a global crisis in contemporary LGBTQ+ medicine with most medical providers and staff lacking knowledge on LGBTQ+ health and healthcare needs (Donald et al., 2017; Sumerau & Mathers, 2019), especially concerning LGBTQ+ older patients (Hash & Rogers, 2017). For example, most medical education and training in Western countries (e.g., US, Canada) still rely on essentialist understandings of sex, gender, and sexual binary systems (i.e., woman/man), which erases diverse patient populations (Donald et al., 2017; Obedin-Maliver et al., 2011). Additionally, clinicians who are unfamiliar with current LGBTQ+ terminology and community norms may struggle with offering respectful communication and counseling to LGBTQ+ patients (Nowakowski et al., 2020). Such clinical knowledge gaps reinforce LGBTQ+ health disparities by rendering invisible ways that macro-level systems, institutions, and structures disproportionately limit healthcare access and quality for historically marginalized populations (Hash & Rogers, 2013). Restructuring global healthcare systems by investing in more resources for LGBTQ + patient communities (e.g., community engagement) could ensure that LGBTQ+ older adults have better access to medical providers who are knowledgeable in both LGBTQ+ and older adult health needs (Fredriksen Goldsen & de Vries, 2019).

In this article, we review health disparities research among LGBTQ+ older adults, focusing on four major areas: (a) social determinants of LGBTQ+ health disparities in later life, (b) mental, cognitive, and physical health disparities, (c) reproductive and sexual health disparities, and (d) seeking LGBTQ+-affirming and age-friendly care.

Focusing on these content areas allows us to evaluate scholarship and better offer recommendations for advancing research and clinical practices for LGBTQ+ older populations. We also develop a four-part research agenda that applies a *structural competency approach* to reducing health disparities among LGBTQ+ older communities. A structural competency approach calls attention to how structural forces and social injustices (e.g., poverty, public policies, racism, and LGBTQ+-related discrimination) generate health disparities (Metzl & Hansen, 2014). Understanding structural competency enables researchers and clinicians to work with LGBTQ+ older adults in an informed, ethical, and culturally-competent manner, while comprehensively addressing patients' medical symptoms *and* their structural causes (Donald et al., 2017; Metzl & Hansen, 2014). We further synthesize emerging areas of LGBTQ+ health disparities research and highlight opportunities for stakeholders to advance structural competency in LGBTQ+ older adult health.

Social Determinants of LGBTQ+ Health Disparities in Later Life

Social determinants of health, or non-medical factors that influence health outcomes (World Health Organization, 2021), drive LGBTQ+ health disparities over the life course at multiple levels. Lifetime exposure to interpersonal stressors like stigma, discrimination, and violence as well as structural stressors like anti-LGBTQ+ public policies engender poor health outcomes among LGBTQ+ adults in later life (Fredriksen Goldsen & de Vries, 2019). LGBTQ+ older adults are exposed to higher rates of violent victimization, medical mistreatment, and social isolation compared to their heterosexual and cisgender peers (Cook-Daniels & munson, 2010; Marshall & Cahill, 2021), but have fewer legal protections due to anti-LGBTQ+ policies across the globe (Gridley & Kothary, 2016; Hua et al., 2019; Reygan & Henderson, 2019).

Older LGBTQ+ adults also face substantial economic insecurities, which drive health disparities. Using 2014–2017 Behavioral Risk Factor Surveillance System data from 35 US states, researchers have found that LGBTQ+ Americans have higher rates of poverty (21.6%) than their counterparts (15.9%), with especially high poverty rates among transgender people (29.4%) and bisexual cisgender women (29.4%) (Badgett et al., 2019). These disparities also vary across other sociodemographic subgroups of LGBTQ+ older populations, including race and ethnicity (Choi & Meyer, 2016; Crenshaw, 1989). Overall, experiencing these accumulating forms of stress over the life course increases risk of poor health for LGBTQ+ people in later life stages.

Mental, Cognitive, and Physical Health Disparities

Mental Health Disparities

Prior research illuminates several mental health disparities and potential mechanisms driving those health disparities among LGBTQ+ older populations. LGBTQ+ older adults have a higher likelihood of depression (Fredriksen-Goldsen et al., 2014;

Yarns et al., 2016), anxiety disorders (Yarns et al., 2016), and multiple health risk behaviors (e.g., suicide ideation, plans, and attempts compared to their heterosexual and cisgender peers (Capistrant & Nakash, 2019). LGBTQ+ older adults also face challenges in managing and protecting their mental health (Marshall & Cahill, 2021). For example, they report higher levels of social isolation and loneliness than their cisgender and heterosexual counterparts (Choi & Meyer, 2016). Emerging literature suggests pathways for improving mental health outcomes, such as receiving care from LGBTQ+-affirming clinicians (McKay et al., 2023), developing larger social networks (Fredriksen-Goldsen et al., 2015), and accessing long-term social support (Lampe, 2022a). Researchers note how LGBTQ+ older adults practice self-advocacy and empowerment in peer-support spaces (Lampe, 2022a; Nowakowski et al., 2019). Prior work also examines how LGBTQ+ older patient communities use resourceful strategies to protect their mental health (Marshall & Cahill, 2021), such as engaging with faith communities and receiving LGBTQ+-led peer support services (Lampe, 2022b; Nowakowski et al., 2020).

Lifetime exposures to stress exacerbate the need for mental health services among aging LGBTQ+ communities (Ducheny et al., 2019). For example, many transgender older adults face substantial obstacles in protecting their mental health due to repeated exposures to transphobia in public spaces and limited availability of mental healthcare professionals who are competent in transgender and LGBTQ+ community needs (shuster, 2021). Such adverse experiences can limit willingness to seek mental health services over the life course, as well as openness about sexual orientation and gender identity during clinical interactions (Fredriksen-Goldsen et al., 2013). Additionally, affirming medical providers engender more trust among LGBTQ+ patients, which increases openness about mental health challenges and action on clinical recommendations (McKay et al., 2023). Future research should continue to address how structural inequities (e.g., lack of LGBTQ+ inclusive public policies) exacerbate mental health disparities among LGBTQ+ older adults.

Cognitive Health Disparities

Cognitive health disparities, such as Alzheimer's disease and related dementias (ADRD), are also major health concerns among aging LGBTQ+ communities (Flatt et al., 2021). Chronic minority stress over the life course heightens risk of premature cognitive aging and decline among LGBTQ+ older adults (Correro & Nielson, 2020). Using 2015–2018 Behavioral Risk Factor Surveillance System data from 25 US states, Flatt et al. (2021) found that LGBTQ+ adults 45+ were more likely to report subjective cognitive decline than their counterparts. LGBTQ+ older adults also face compounding risk factors (e.g., diabetes) for developing ADRD (Correro & Nielson, 2020; Flatt et al., 2021). Dragon et al. (2017) also found that dementia-related diagnoses appeared more frequently among older transgender Medicare beneficiaries than cisgender Medicare beneficiaries.

Family caregivers confront multiple challenges (e.g., lack of tailored resources for LGBTQ+ ADRD patients and their family caregivers) when assisting their LGBTQ+

care partners with ADRD (Nowakowski et al., 2019). However, prior work also reports various examples of resilience (i.e., successful engagement of coping strategies) among this population, such as LGBTQ+ caregivers receiving support from families of choice and LGBTQ+ community networks (Anderson et al., 2021). Inclusive visitation and LGBTQ+ nondiscrimination policies in care settings promote partner engagement in care decisions in cancer care (Cloyes et al., 2018) and may offer the opportunity for greater caregiver engagement with ADRD care for LGBTQ+ patient communities. Prior research underscores the need for psychosocial interventions for LGBTQ+ older adults with ADRD and their family caregivers (Flatt et al., 2022).

Physical Health Disparities

LGBTQ+ older adults have a heightened risk of poor physical health outcomes including chronic health conditions, disabilities, and poor overall health than their heterosexual and cisgender peers (Fredriksen-Goldsen et al., 2017). Examples include disproportionately high levels of substance and alcohol misuse (Yarns et al., 2016), frailty and mobility issues (Marshall & Cahill, 2021), and cardiovascular disease (Caceres et al., 2017). Moreover, researchers suggest that LGBTQ+ individuals are at a higher risk of sleep health problems compared to their counterparts (Butler et al., 2020). LGBTQ+ older adults also experience substantial challenges in managing chronic pain (e.g., higher rates of arthritis) than their heterosexual and cisgender peers (Fredriksen-Goldsen et al., 2017). Chronic pain management over the life course may also lead to more frequent functional limitations in later life and an increased risk of inappropriate polypharmacy for LGBTQ+ people (Lim et al., 2014).

LGBTQ+ older adults face challenges in managing physical health problems and often require additional assistance or care (Hash & Rogers, 2017). However, many LGBTQ+ older adults struggle to receive assistance or care due to lack of familial support (Flatt et al., 2022) and earlier effects of policies/societal attitudes limiting access to marriage and family formation (Carpenter et al., 2021). LGBTQ+ people also have fears of experiencing medical neglect, mistreatment, and discrimination in adult day care, long-term care, residential aged care, palliative care, and end-of-life care facilities (Cloyes & Candrian, 2021; Elk et al., 2018). Greater engagement on LGBTQ+ older patient needs within these care settings is especially warranted. Yet, limited intervention research sufficiently aims to improve care for specifically LG BTQ+ older patients in these healthcare contexts.

Prior research notes higher rates of chronicity of health conditions for LGBTQ+ older adults compared to their heterosexual and cisgender peers (Dragon et al., 2017; Fredriksen-Goldsen et al., 2017). Utilizing US Medicare Fee-for-Service administrative claims data, Dragon et al. (2017) found that many aging related chronic conditions (e.g., chronic kidney disease) appeared more frequently among older transgender Medicare beneficiaries than older cisgender Medicare beneficiaries. Similarly, Fredriksen-Goldsen et al. (2017) assessed data from the 2013–2014 National Health Interview Survey and found that lesbian, gay, and bisexual older respondents had elevated rates of managing some chronic health conditions (e.g., lung disease) compared to heterosexual respondents. Few studies

comprehensively investigate how LGBTQ+ older adults' chronic health conditions may worsen over time and how social, psychological, and biological pathways of aging influence the chronicity of diseases among LGBTQ+ communities across the life course. Additional medical training with primary care physicians on both LGBTQ+ and older adult health needs may be a notable mechanism for improving preventative and chronic care for LGBTQ+ older patient populations.

Reproductive and Sexual Health Disparities

Cultural assumptions about the non-sexuality of older adults, along with LGBTQ+ erasure and stigma in healthcare, often drive reproductive and sexual health disparities among LGBTQ+ older populations (Lampe & Nowakowski, 2021). For instance, LGBTQ+ older adults have disparate access to reproductive and sexual health screenings due to limited cultural and clinical competencies on older adult and/or LGBTQ+ patient communities (Nowakowski & Sumerau, 2019). Many LGBTQ+ older adults struggle to maintain rights to sexuality, sexual health, and sexual well-being within aged care settings, due to the widespread normalization of heterosexual experiences and ageist assumptions of older adults' sexual practices (Hash & Rogers, 2017).

Except for health disparities research in sexually transmitted infection risk and management (including HIV), limited research addresses the specific reproductive and sexual health needs of LGBTQ+ older adults (Marshall & Cahill, 2021). Examples include (a) contraceptive method access and preferences (Lampe, 2022b; Lampe and Nowakowski, 2021); (b) breast/chest cancer risk among transgender patients receiving hormone therapy services (de Blok et al., 2019); (c) prostate cancer risk among some gay, bisexual, and queer (GBQ+) men, transgender women, and non-binary people (Rosser et al., 2016); (d) cervical, endometrial, and uterine cancer risk among some LBQ+ women, transgender men, and non-binary people (Patel et al., 2019); and (e) rectal and anal cancer risk among some GBTQ+ men and transgender women (Ceres et al., 2018). Further examination of these research areas can help inform clinical research and practice to improve the reproductive and sexual health of LGBTQ+ older populations.

About 38.4 million people globally were living with HIV in 2021, with the risk of HIV infection 28 times higher among GBQ+ men than heterosexual men and 14 times higher for transgender women than cisgender women (UNAIDS, 2022). The HIV/AIDS epidemic disproportionately impacts LGBTQ+ communities across the life course, with the number of LGBTQ+ older adults living with HIV increasing (Marshall & Cahill, 2021; UNAIDS, 2022). As more LGBTQ+ people with HIV age into later life, additional LGBTQ+-affirming HIV health education efforts may improve LGBTQ+ older adult health. For example, McKay and colleagues (2022) found that GBQ+ men over 50 who were HIV-negative and had an LGBTQ+ affirming provider were more likely to have ever tested for HIV, to be aware of and to believe in the U.S. Centers for Disease Control and Prevention's Undetectable = Untransmissible stigma reduction campaign, and to have more accurate HIV risk perception. However, LGBTQ+ older adults with HIV can experience notable barriers to

quality care due to compounding effects of LGBTQ+-, older age-, and HIV-related stigma in medical settings (McKay et al., 2022).

Seeking LGBTQ+ Affirming and Age-Friendly Care

LGBTQ+ older adults' lack of access to LGBTQ+ affirmation *and* age-friendliness in healthcare environments contributes to health disparities by discouraging utilization of health services (Nowakowski et al., 2019; Pereira et al., 2019). LGBTQ+-affirming healthcare systems, such as those with equitable visitation policies, pronoun documentation, and continuing education training for staff, are associated with higher patient satisfaction regardless of sexual orientation or gender identity (DiLeo et al., 2020), but these systems are less likely to exist in countries with more stigma towards LGBTQ+ people (Hash & Rogers, 2013). Age-friendly healthcare is crucial for LGBTQ+ individuals as they grow older and may require new screenings or treatments for the first time in midlife. For example, when LGBTQ+ older patients report having an LGBTQ+-affirming provider as their usual source of care, they are more likely to report that their chronic mental health conditions are managed, have visited their provider in the past year, as well as to have been screened for colorectal cancer, relative to patients with a non-affirming provider (McKay et al., 2023). These findings suggest that LGBTQ+ affirmation in medicine is core to optimal preventive care, especially screenings that become recommended in midlife or older age among a population who may likely have experienced or know someone who has experienced LGBTQ+ healthcare discrimination in earlier periods of their life.

In the case of transgender older adults, there are major gaps in medical knowledge concerning the short-term and long-term health effects of gender-affirming medical interventions, such as hormone therapy services (shuster, 2021). For instance, medical providers often have no or limited expertise on how gender-affirming surgeries (e.g., vaginoplasty procedures for transgender women) affect the reproductive health, sexual health, and chronicity management of transgender patients across the life course (Lampe and Nowakowski, 2021). Many medical providers also have misconceptions that older age is a strong risk factor to receiving gender-affirming medical interventions (e.g., hormone therapies) and may be used as a justification for denying or delaying gender-affirming care for older transgender patients (Lampe, 2022b). Given these findings, understanding the physiological impacts of gender-affirming care as well as how demand for such care changes with age are two key areas of interest for researchers and clinicians. By further investigating the intersections of LGBTQ+-affirming and age-friendly care, stakeholders can pinpoint the barriers, facilitators, and opportunities for improvement in healthcare for LGBTQ+ older patients.

A Structural Competency Framework for LGBTQ+ Older Adult Health

Four structural competency based approaches that emerged from our review of health disparities research on LGBTQ+ older adults: (a) examine upstream social and policy

factors that create opportunities for improving LGBTQ+ health, risk behaviors, and lack of social support; (b) identify research opportunities and infrastructure to examine LGBTQ+ individuals' accumulation of stress and poor health over the life course; (c) address structural causes of LGBTQ+ older adult inequities in medicine; and (d) emphasize intersectionality and community engagement among LGBTQ+ older communities. We address each of these future approaches and provide recommendations for researchers and clinicians to further improve structural competency in LGBTQ+ older adult health.

Approach 1: Examine Upstream Determinants and Create Opportunities for Improving LGBTQ+ Individual Poor Health

Structural competency highlights how identifying upstream social and policy factors can create opportunities for improving health, health risk behaviors, and lack of social support among LGBTQ+ older populations (Donald et al., 2017). Insufficient focus on the sociohistorical and environmental contexts and accumulated exposures to stress that LGBTQ+ older adults have experienced over their lifetime ignores the psychosocial drivers of health disparities among LGBTQ+ communities. For instance, LGBTQ+ older adults may have a heightened need to appoint a healthcare power of attorney to protect their healthcare wishes due to LGBTQ+-specific discrimination in medical and legal settings (Elk et al., 2018). However, many LGBTQ+ older adults legally do not have an appointed healthcare power of attorney due to financial and logistical barriers to advance care planning or the lack of supportive and reliable family members (Cloyes & Candrian, 2021).

Unsupportive and unreliable family members can also limit or deny the wishes of LGBTQ+ older adults (e.g., not allowing a legally unmarried partner to visit their LGBTQ+ family member in a hospice care setting), which exacerbate LGBTQ+ end-of-life disparities (Dickson et al., 2021). Thus, LGBTQ+ older adults may need tailored interventions for formalizing their advance care planning. By understanding how structural forces (e.g., LGBTQ-related neglect and discrimination in familial relationships) can play a vital role in advance care planning among LGBTQ+ older adults, for example, medical and legal professionals can better address the needs of LGBTQ+ older populations. Overall, a structural competency approach to LGBTQ+ older adult health disparities critically examines how upstream social and policy factors, such as LGBTQ+ stigma, impact LGBTQ+ individual health over the life course.

Approach 2: Identify LGBTQ+ Aging Research Opportunities and Infrastructure

Research opportunities and infrastructure to examine LGBTQ+ individuals' accumulation of stress and poor health over the life course are very scant, limiting researchers' and clinicians' ability to track progress towards eliminating known health inequalities. Structurally competent stakeholders recognize how lifetime exposures to stress resulting from stigma, discrimination, and violence against LGBTQ+ people over the life course

contribute to LGBTQ+ health disparities in later life, while prioritizing interventions combatting these drivers and risk factors (Donald et al., 2017). As the global LGBTQ+ older population is projected to grow exponentially (SAGE, 2021), there are valuable opportunities to expand data, methods, and designs when assessing the accumulated stressors of LGBTQ+ older adults and their impact on LGBTQ+ poor health over the life course. Such examples include (a) conducting large-scale or longitudinal quantitative studies, (b) collecting biomarker data, (c) incorporating LGBTQ+-inclusive survey measures and electronic health record fields, and (d) creating interventions for various LGBTQ+ older populations that specifically assess their stressors qualitatively over multiple time-points. A structural competency approach acknowledges the upstream structural vulnerability of LGBTQ+ older adults facing pervasive social inequity and how accumulated stressors from such social conditions are connected to downstream poor health outcomes. Expert and community stakeholderswill require higher quality data to document disparities and impacts of interventions to promote health equity among LGBTQ + older adults.

Approach 3: Address Structural Causes of LGBTQ+ Inequities in Medicine

A structural competency approach challenges researchers and clinicians to address the social and policy inequities in all spaces where LGBTQ+ older adults live, work, and seek healthcare, while focusing on structural causes of health disparities among aging LGBTQ+ communities. Some structural competency education has begun to focus on evaluating health disparities among underserved communities in healthcare, including LGBTQ+ populations (Donald et al., 2017). Maintaining structural competency in LGBTQ+ older adult health should involve comprehensively training medical providers and staff to understand how "upstream" problems (e.g., food and housing insecurity, social norms) lead to the downstream health symptoms and disparities among LGBTQ + older patients, thus encouraging more effective, ethical, and patient-centered care. For example, a clinician who incorporates a structural competency approach into their care practice might offer resources for free or affordable direct care services to a LGBTQ+ older patient who is recovering from a major surgery and lives alone. Medical providers and staff can understand the structural factors that catalyze chronic health conditions for their LGBTQ+ older patients if they first learn about their personal histories, biographies, and lived experiences with managing chronic conditions.

An enhanced understanding of structural competency that addresses social and policy inequities can also merit international comparisons of LGBTQ+ aging communities. Although criminalization status of same-sex sexual activity differs internationally, 11 countries to date have laws in which the death penalty is imposed or exists as a possibility for same-sex sexual activity (Human Dignity Trust, 2022). Thus, LGBTQ+ older adults in these countries may need more tailored mental health resources to protect their health and quality of life. Addressing such inequities in medical education, training, and practice can strengthen our understanding of LGBTQ+ health disparities in older adulthood.

Approach 4: Emphasize Intersectionality and Community Engagement

A structurally-competent approach to LGBTQ+ health disparities research emphasizes intersectionality and community engagement through all aspects of the research process, while meaningfully recruiting and engaging LGBTQ+ older communities from underrepresented backgrounds (Crenshaw, 1989; Kum, 2017). One example includes incorporating more racial, ethnic, and class-diverse research that addresses the health disparities of LGBTQ+ older populations globally. Prior research neglects to recruit and engage underrepresented LGBTQ+ communities, such as LGBTQ+ older survivors of sexual violence (Cook-Daniels & munson, 2010), LGBTQ+ older adults of color (Kum, 2017; Reygan & Henderson, 2019), older LGBTQ+ immigrants (Gridley & Kothary, 2016), and older bisexual people (Hash & Rogers, 2017). Interlocking systems of privilege and oppression influence the needs, outcomes, and experiences of LGBTQ+ aging populations (Crenshaw, 1989; Hua et al., 2019). Thus, assessing intersectionality and community engagement in research is crucial when examining LGBTQ+ health disparities in later life (Hua et al., 2019).

Although LGBTQ+ inclusive aging research is increasingly diversifying over time, most health disparities research on LGBTQ+ older adults examines white, able-bodied, American, and more financially advantaged respondents (Gridley & Kothary, 2016; Hua et al., 2019). Consequently, researchers lack knowledge of racial and ethnic minority, disabled, immigrant, and financially-disadvantaged LGBTQ+ older communities (Kum, 2017). Further, health disparities research on bisexual and transgender older adults is also scant (Lampe, 2022b; Nowakowski et al., 2020). Researchers and clinicians should strengthen their community engagement efforts with LGBTQ+ older populations while tailoring their research studies, skills training, and support interventions to the needs of LGBTQ+ older adults from underrepresented communities.

Researchers are continuing to advance community engagement efforts with LGBTQ+ older populations. Considering the importance that older LGBTQ+ adults from different cultural backgrounds often place on community engagement (Casado et al., 2022; Reygan & Henderson, 2019; Siverskog & Bromseth, 2019), this new focus has the potential to improve global health outcomes. As an illustration, to center LGBTQ+ communities in Alzheimer's research, researchers have developed the Research Inclusion Supports Equity (RISE) study, which includes a research registry for LGBTQ+ adults who (a) have memory concerns or a memory loss diagnosis or (b) are a care partner for someone with memory loss or a memory loss diagnosis (The Rise Registry, 2022). Novel initiatives like the RISE Registry continue to engage LGBTQ+ communities and reduce data gaps on LGBTQ+ health disparities. We call on researchers and clinicians to develop similar interventions that center structural competency in LGBTQ+ older adult health.

Discussion

In this review article, we summarize major contributions of and ongoing gaps in health disparities research among LGBTQ+ older adults, while focusing on four major

content areas: (a) social determinants of health disparities, (b) mental, cognitive, and physical health disparities, (c) reproductive and sexual health disparities, and (d) seeking LGBTQ+-affirming and age-friendly care. Each of the aforementioned contributions and research gaps offers valuable opportunities for improving the health and healthcare of LGBTQ+ populations.

Using a structural competency approach, we also develop a four-part agenda for this research area that enhances understanding of how macro-level systems, institutions, and structures drive health disparities among aging LGBTQ+ communities. Specifically, we call for new and expanded efforts to: (a) examine upstream social and policy factors that influence LGBTQ+ health, health risk behaviors, and lack of social support; (b) identify research opportunities and infrastructure to examine the LGBTQ+ accumulation of stress and poor health over the life course; (c) address structural causes of LGBTQ+ older adult inequities in medicine; and (d) emphasize intersectionality and community engagement among LGBTQ+ older communities. We also provide recommendations for stakeholders to further understand structural competency in LGBTQ+ older adult health to sufficiently improve LGBTQ+ health disparities in an equitable, effective, and ethical manner. Overall, adopting a structural competency approach allows researchers and clinicians to investigate and treat the structural factors of LGBTQ+ people's health needs in later life, while addressing the actual sources of their health disparities rather than receiving care that acts as a temporary bandage or ignores the structural forces that drive barriers to care.

This review is not exhaustive, nor does it represent all the social and clinical research priorities regarding LGBTQ+ older adult health disparities. In particular, many of the studies we reviewed reflect the tendency of LGBTQ+ aging researchers to spotlight US populations (Fredriksen Goldsen & de Vries, 2019). The disproportionate focus on wealthy Western countries renders invisible the unique cultures, institutions, and policy landscapes that differentially influence LGBTQ+ older adult health outcomes (Iacub et al., 2019; Reygan & Henderson, 2019; Siverskog & Bromseth, 2019; Suen, 2022). Prioritizing cross-cultural and international perspectives in the study of older LGBTQ+ adults could generate new empirical and theoretical contributions as well as insights regarding the development of more effective public policies and social interventions. Nevertheless, this review does aim to complement prior scholarship and notes an array of opportunities to fill research gaps, while centering the voices of LGBTQ+ older communities. Researchers and clinicians can meaningfully benefit from empirical insights into the structural competency of LGBTQ+ older adult health, while creating structural interventions within and beyond medical settings that could mitigate LGBTQ+ health disparities in later life. To this end, we conclude with a call for strengthening structural competency in LGBTQ+ older adult health to fully understand existing drivers of LGBTQ+ health disparities. Our review suggests potential pathways for ongoing social and clinical research and practice to integrate a structural competency approach in how macro-level systems, institutions, and structures impact LGBTQ+ health in older adulthood.

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Notes

1. The World Health Organization (2017) defines *older adults* as persons 60 years or over.
2. Sumerau and Mathers (2019) define *cisgender* as "an umbrella term that refers to people who conform to the sex and/or gender they are assigned at birth by political, medical, religious, and/or familial authorities" (pp. 5–6).

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