Second Time Overlooked in Crisis: Examining How HIV/AIDS Health Policies in the USA Connect with Policy Implications Today for Aging LGBTQ Adults During the COVID-19 Pandemic

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Abstract
U.S. policy has, once again, overlooked the health care needs of older adults who are lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ). This population is estimated to more than double in the USA (Fredriksen-Goldsen, in Generations 38(4), 86–92, 2015), with estimates of approximately 3 million LGBTQ adults over 50 currently and 7 million by 2030 (Services and Advocacy for GBLT Elders in SAGE, New York, 2018). The healthcare model for addressing the needs of LGBTQ persons has historically been that of a disease model of care, particularly during the HIV/AIDS crisis, and has recently moved to that of a health equity model in the past 20 years. The LGBTQ community, social work profession, and general medical community worked to create the health care equity model we have today and this paper will discuss how this evolved. The health care equity model addresses the health needs for older adult LGBTQ populations. Older LGBTQ adults are more likely to experience elevated rates of chronic conditions (such as HIV, cancer, diabetes), higher prevalence of anxiety/depression, greater substance abuse, higher economic insecurities, limited community resources, and limited access to health care services compared to heterosexual/cisgender counterparts. This paper discusses how health disparities among this minority population and heterosexual/cisgender individuals have been exacerbated during the COVID-19 pandemic. Further, this paper will address policy, research, and practice implications to understand how to assist this vulnerable subpopulation of LGBTQ persons.

Keywords Older adult LGBTQ populations · COVID-19 · Health disparities · Policy implications · HIV/AIDS

This paper explores the health care history literature, past and present, of the lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) populations in the USA, with a focus on LGBTQ older adult populations. The acronym LGBTQ will be used as an over-arching umbrella term aimed to encompass the broad identities of this unique and vulnerable minority population. I will explore how this history in the USA has affected and helped to create LGBTQ older adults’ health disparities today. The justification for examining this topic currently is because the COVID-19 pandemic continues to impact older adult populations (Brooke & Jackson, 2020), as well as exacerbate health disparities among minorities, such as the LGBTQ population (Kline, 2020), which calls for special attention to older LGBTQ adults. Drabble and Eliason (2021) discuss this intersection and note that LGBTQ older adults have been particularly vulnerable, with increased health risks during the pandemic. Marchia (2018) notes that there are gaps in the literature for this vulnerable sub population of older adults that need to be addressed regarding health disparities. This paper will make suggestions to address these gaps through policy, research, and practice implications during COVID-19.

Brief Overview of LGBTQ Population and Early Healthcare Policy History

The National Academy of Sciences’ Institute of Medicine (2011) discusses two historical ways of thinking about LGBTQ population’s healthcare needs. These two main contexts are as follows: (a) that the LGBTQ population’s “lifestyle” was seen as an illness itself and (b) that the HIV/AIDS pandemic shaped how the LGBTQ population was viewed
and treated for their health care needs (National Academy of Sciences, 2011). I will first discuss the emergence of the term homosexuality in medicine and how the medical community initially treated homosexuality and gender identity as a mental illness. I will then explore a brief history of the LGBTQ population’s health care policies and practices in the USA.

**The Medical Community’s Early Stance on the LGBTQ Community**

Societal norms during the late nineteenth century deemed homosexuals and gender non-conforming individuals as “inverts,” meaning having sexual inversions, placing these groups of people under the same category of “perverts” and social deviants (National Academy of Sciences, 2011; Reed, 2001). Even though human same-sex attractions have been seen across human history, the modern term of homosexual did not appear until the end of the nineteenth century (National Academy of Sciences, 2011). In fact, the term homosexuality was “invented” as a concept by Viennese-born human rights activist Karl Maria Kertbeny in 1868 as a progressive term to take away stigmatizing prior terms (Lang & Sutton, 2016). Theological doctrine and laws at the time were the main influencers of policies and social norms surrounding sexuality and gender, and anything outside the purview of procreative marriage was considered a sin (National Academy of Sciences, 2011). Homosexual acts, such as sodomy, were considered an illegal crime (National Academy of Sciences, 2011), and even today, religion is still the strongest social determinant to explain the rejection of homosexuality (Janssen & Scheepers, 2019). Theology, laws, and social norms influenced the domains of medicine and psychology during this period, affecting how the LGBTQ community was treated in terms of their health care needs.

Even though this initial doctrine spread into the medical community at the time, medicine was seen as progressive. Homosexuals and those with non-gender conforming identities were not seen as “sinful,” but rather as victims of a disease that needed curing (National Academy of Sciences, 2011). This view became the dominant thought process throughout the twentieth century in medicine and psychiatry (National Academy of Sciences, 2011). In opposition to this “standard of care,” the modern term of “sexual orientation” is credited to Sigmund Freud, who is the first person among the medical community that uses the word homosexuality in his work (Lang & Sutton, 2016; National Academy of Sciences, 2011). Freud asserted that someone who is homosexual (or bisexual) will move through psychotherapy, eventually settling on a heterosexual identity, and this shift would “cure” the depression and anxiety that resulted from the way society treats non-heterosexuals (Lang & Sutton, 2016). Freud stated that someone who was simply homosexual with no pathology did not need to be cured (Lang & Sutton, 2016).

This statement suggests that Freud may not have seen a non-heterosexual sexual orientation as a disease to be rectified, but rather the resulting neurosis and pathology that might occur from having this identity in our society (Lang & Sutton, 2016). This directly runs parallel with current work on minority stress theory (Meyer, 2003), suggesting that LGBTQ people experience minority stress due to stigma and discrimination in our society. Minority stress can cause negative mental health consequences and can affect the overall health of LGBTQ people (Meyer, 2003). Freud may have been ahead of his time in acknowledging that homosexuality was not a disease to be cured but was missing the crucial element of society needing to change its attitude towards sexuality that deviated from the “norm” of heterosexuality. Freud’s positionality may just reflect how in the field of psychology, discussions around how structure affects an individual’s health remains a missing element.

As noted above, the medical community in general disagreed with Freud (National Academy of Sciences, 2011), stating that homosexuality itself was a disease to be cured, not the pathology that resulted from having a homosexual identity (Reed, 2001). Lieberman (2005), in reviewing the book Recollecting Freud (Dundes & Sadger, 2005), discusses that Freud’s opponent in the psychological field, Isidor Sadger, believed that homosexuality itself was a curable disease using psychoanalysis, in line with dominant medical field views on homosexuality at the time (National Academy of Sciences, 2011). According to Dundes and Sadger (2005), despite Freud’s objection to defining homosexuality as a curable disease, Bayer (1987) homosexuality was considered a mental illness until its removal from the DSM in 1973 (Drescher, 2010). Drescher (2010) goes on to discuss how gender identity disorder was being debated at the time of his article, the main discussion being “What is normal sexuality or gender?” and should they be considered a disorder just because they are a deviation from the norm? Eventually siding with Freud, the medical community now embraces acceptance of diversity and difference in humans, rather than labeling people with deviations from the norm as a disease to be cured (Drescher, 2010). This progress of thought in the medical field helped lead to gender identity disorder also being removed from the DSM in 2013 (American Psychiatric Association, 2013). This lengthy history of LGBTQ people being seen as a disease to be cured by psychiatry set the stage for how the HIV/AIDS epidemic was handled and continues to affect LGBTQ older adults today during the current pandemic.

**History of Blaming LGBTQ Populations for HIV/AIDS: How Discrimination Leads to Scapegoating**

In 1981, the Centers for Disease Control (CDC, 1981) put out a statement in Los Angeles describing a pneumonia only being detected in gay men, showing that gay men were associated with
HIV/AIDS before it was known what it was. In fact, one of the early terms researchers started using for HIV/AIDS, published in The New York Times in 1982, was gay-related immune deficiency (GRID), which deepened the association with gay men and the disease (US Department of Health & Human Services, 2021). This history of the disease being associated with gay men in the USA from the start points to the fact that blaming of the LGBTQ community for HIV/AIDS was inevitable.

Martos et al. (2017) explains further that when the CDC discovered this disease, the Reagan administration ignored the illness soon to be known as HIV/AIDS altogether, causing deaths of thousands, remaining silent on the issue for all of the early 1980s (Zak, 2016). Reagan had stated publicly that being gay was “an abomination,” not even mentioning HIV/AIDS until after his reelection (Graham, 2020), demonstrating with his ignoring of the disease a political move on his administration’s part to win the election. The first time Reagan publicly mentioned HIV/AIDS was not until Reagan’s Hollywood friend Rock Hudson dies of the disease in 1985. Reagan finally had the surgeon general speak about HIV/AIDS to the public in 1986 (Richert, 2009). This silence from the president and his administration caused the lack of clear policy direction within multiple branches of the USA, including uncertainty within the Food and Drug Administration (FDA), the Surgeon General (Richert, 2009), and the Centers for Diseases Control (CDC) (Padamsee, 2017).

The US government, specifically the, even went as far as leaving out vital information on safe sex practices within HIV/AIDS education materials meant for the public, as they felt it promoted being gay (Shah, 2017). This was due to the flip-flopping policy recommendations about sex education by the CDC. At first, in 1984, the CDC was quietly funding community organizations that supported HIV/AIDS work, but the Reagan administration put a stop to this in 1985, citing that they did not believe that the government organization should be telling gay men how to participate in “sodomy” (Padamsee, 2017). The CDC was silenced by this retraction of funding and politics (Padamsee, 2017). This general censorship of the problem promoted by the US Government and the Reagan administration eventually led to the poor containment of the disease, discrimination of people with HIV/AIDS overall (not just people in the LGBTQ population), who lost their jobs, health insurance, and were subject to violence (Shah, 2017).

Goh (2008) argues that by the early 1980s, the media also has influence, portraying HIV/AIDS as being a result of the LGBTQ community’s choice of “lifestyle,” which led to the blaming, victimization, and stigmatization of the LGBTQ community. Singer et al. (1992) discusses in their book, Erotic Welfare: Sexual Theory and Politics in the Age of Epidemic, that HIV/AIDS affected the USA’s culture by prompting the need to blame others for disease in their panic, and that this blaming can be more harmful, even exceeding the damage done by the actual contagion. This blaming of disease ultimately leads only to the oppression of the group that is blamed, instead of leading to the unity of the public to contain the disease itself (Singer et al., 1992). Shah (2017) expands on this discussion in her book, Pandemic, by stating that the public was resistant to accept the contagious nature of HIV/AIDS and instead engaged in scapegoating the LGBTQ community, declaring the disease a gay cancer instead. This scapegoating of the LGBTQ population and those most at risk of catching the disease only impeded early containment efforts (Shah, 2017), backing up claims by Singer et al. (1992). Overall, blaming, combined with discrimination against LGBTQ people with HIV/AIDS, led to the collective trauma in the LGBTQ community (National Academy of Sciences, 2011), the hindering of treatment, and cure of HIV/AIDS.

This collective trauma brought on by a history of blaming LGBTQ people, from looking at LGBTQ people as a disease to be cured (Lang & Sutton, 2016), and causing a disease (Goh, 2008), has an intertwining affect with outward and inward stigma of the LGBTQ community (Scheer et al., 2020). When people are outwardly stigmatized in their communities, they end up turning that world view onto themselves, making that individual feel less than, weak, and exposed (Duncan & Cacciatore, 2015). This shame leads to feelings of being traumatized, while also contributing to physical and mental health problems (Casey et al., 2019; Harman & Lee, 2010; Mereish & Poteat, 2015; Scheer et al., 2020). This outward and inward stigma combined, along with trauma that this population faces, shows a need for further intervention. I will first discuss how (a) LGBTQ people intervened for their own people, (b) the social work profession’s response, and finally (c) the eventual general medical community’s response during the HIV/AIDS epidemic.

**Community Responses to the HIV/AIDS Epidemic**

**LGBTQ Population’s Response to Disease Model Treatment**

In 1969, as noted by Carter (2004) in their book entitled: Stonewall: The Riots that Sparked the Gay Revolution, members of the LGBTQ community banded together in what is now known as the Stonewall riots, where LGBTQ people rioted against the police at the Stonewall bar in New York City. These riots are the first time LGBTQ people protested the insufferable situation with police in New York City (Carter, 2004). The Stonewall riots are noted as the beginnings of the origins of LGBTQ health services (Martos et al., 2017). These services increased community mobilization and started the rejection of homophobia (Martos et al.,
ment teams that would care for individuals being diagnosed with HIV/AIDS. Social workers also created interdisciplinary care management models so that those diagnosed with HIV/AIDS could speak to each other about their commonalities, including feeling socially isolated and experiences of stigma (Rice & Willinger, 2003). Mayer et al. (2008) notes that national LGBT organizations, such as the Gay and Lesbian Medical Association, the National Gay and Lesbian Task Force, and the Human Rights Campaign, recognized the importance of advocacy for further research focused on sexual and gender minority health and service delivery. San Francisco social workers expanded on this research, establishing one of the first networks for social workers working during the HIV/AIDS crisis in 1985 (Rice & Willinger, 2003). This network, entitled the Social Work AIDS Network (SWAN), provided social workers with peer support, education, and advocacy platforms concerning sexual and gender minority populations (Rice & Willinger, 2003). SWAN advocated for policy measures and helped those social workers who worked with HIV/AIDS populations to make sure professional standards were being met (Rice & Willinger, 2003). By the 1990s, there were over 100 organizations that formed the National Coalition for LGBT Health, whose primary goal was to advocate for sexual minority health and reduce health disparities (Mayer et al., 2008). Social work networks and conferences on HIV/AIDS helped make change happen on a larger scale, bringing more recognition for the need to assist LGBTQ populations.

Social Work Response to Disease Model Treatment: Advocacy for Change

Rice and Willinger’s (2003) book about the social work profession’s response to the epidemic of HIV/AIDS, called *A History of AIDS Social Work in Hospitals: A Daring Response to an Epidemic*, discusses the early days of the disease. Social workers emerged as leaders from the first days (Rice & Willinger, 2003). Mayer et al. (2008) notes by the 1980s, because of the HIV/AIDS crisis, there were clinics, mental health groups, and providers that started to focus their attention on sexual minority health. Social workers established group interventions at these health facilities so that those diagnosed with HIV/AIDS could speak to each other about their commonalities, including feeling socially isolated and experiences of stigma (Rice & Willinger, 2003). Social workers also created interdisciplinary care management teams that would care for individuals being diagnosed and living with this disease (Rice & Willinger, 2003). This social work advocacy for those suffering from HIV/AIDS was helpful in establishing assistance for people living with the disease and helped to advocate for change at the local level.

Social work advocacy also established the infrastructure for administering grants from the National Institutes of Health and the Centers for Disease Control and Prevention (Mayer et al., 2008) for HIV/AIDS research. Mayer et al. (2008) notes that national LGBT organizations, such as the Gay and Lesbian Medical Association, the National Gay and Lesbian Task Force, and the Human Rights Campaign, recognized the importance of advocacy for further research focused on sexual and gender minority health and service delivery. San Francisco social workers expanded on this research, establishing one of the first networks for social workers working during the HIV/AIDS crisis in 1985 (Rice & Willinger, 2003). This network, entitled the Social Work AIDS Network (SWAN), provided social workers with peer support, education, and advocacy platforms concerning sexual and gender minority populations (Rice & Willinger, 2003). SWAN advocated for policy measures and helped those social workers who worked with HIV/AIDS populations to make sure professional standards were being met (Rice & Willinger, 2003). By the 1990s, there were over 100 organizations that formed the National Coalition for LGBT Health, whose primary goal was to advocate for sexual minority health and reduce health disparities (Mayer et al., 2008). Social work networks and conferences on HIV/AIDS helped make change happen on a larger scale, bringing more recognition for the need to assist LGBTQ populations.

Eventual Medical Community Response: Current Model of Health Care Equity

Previous advocacy from the LGBTQ community and the social work profession’s advocacy helped influence the medical profession’s move towards a health care equity model instead of looking at LGBTQ people as a disease to be cured. The LGBTQ population was eventually added to the federal government’s research agenda in the year 2000 by the (US Department of Health and Human Services, 2020) creating their decennial health disparities research report, *Healthy People 2010: Understanding and Improving Health*. This report showed that health care advocacy for LGBTQ people and recognizing their health disparities had become a federal health issue (Mayer et al., 2008), marking the move from a disease model to a health equity framework.

The health equity model relies on concepts from the minority stress model. The minority stress model discusses that sexual minorities experience greater health disparities due to discrimination against themselves as a minority.

2017). The Stonewall riots also sparked the first appeals for same-sex marriage (Marchia, 2018). From this literature, it can be concluded that the Stonewall riots lit a fire under the LGBTQ community to band together to fight for policy change. Even though the Stonewall riots began the fight for same-sex marriage, it was not until the HIV/AIDS epidemic that this became a priority of the LGBTQ rights movement.

The HIV/AIDS epidemic created a greater sense of community among LGBTQ people that had not previously existed, which forced the LGBTQ community to band together to fight HIV/AIDS for their own survival (National Academy of Sciences, 2011). HIV/AIDS was rapidly becoming responsible for the death of many gay and bisexual men in the USA (National Academy of Sciences, 2011), which led to the LGBTQ community launching their own social service agencies. Organizations such as the Gay Men’s Health Crisis in 1982 (Martos et al., 2017) and ACT UP were started by the artist and playwright Larry Kramer, who screamed until he was heard about how HIV/AIDS needed to be addressed (France, 2020). These organizations helped to address issues of sex education, food, transportation, physical assistance, and emotional support for those dealing with HIV/AIDS (Padamsee, 2017). LGBTQ people fought for same-sex marriage then not only as a basic human right, but for reasons during the HIV/AIDS crisis that were related to medical care. Examples of these medical care needs include the right to visit their romantic partner in the hospital, gain access to health insurance, or to be able to divide up family assets (Marchia, 2018). Since same-sex marriage is uniquely tied to these medical care rights, this was a motivator for LGBTQ activists to fight for this cause (Martos et al., 2017; National Academy of Sciences, 2011). Social workers ended up being one of the first professions to assist the LGBTQ community in advocating for those affected by HIV/AIDS.
population (Fredriksen-Goldsen, et al., 2014; Meyer, 2003). National Academy of Sciences (2011) adds that the “person in environment” framework backs the minority stress model, noting that intersectionality is important since the year that an LGBTQ person was born can often largely affect their health outcomes. Fredriksen-Goldsen et al. (2014) notes that both frameworks inform how health care practitioners and policy makers should currently address health care needs of the LGBTQ population and their sub populations, such as LGBTQ older adults, who have pertinent needs now in the COVID-19 pandemic.

Existing Health Disparities for LGBTQ Older Adults in the USA

SAGE et al. (2021) discuss that in 2017, the estimated population of LGBTQ people over age 50 was 2.7 million people in the USA, or about 2.7% of the population, and that the population for those 65-plus was 1.1 million people (SAGE et al., 2021). Fredriksen-Goldsen (2015) notes that this population is estimated to more than double, with estimates of approximately seven million LGBTQ adults over 50 by 2030 (Services & Advocacy for GLBT Elders, 2018). The growth of this population makes it even more imperative to do further research regarding this population’s health. Adams et al. (2013) argues that sexuality should be considered a health determinant and that practitioners need to consider the needs of sexual minorities while LGBTQ people live in a heterosexist world. This argument points out the need for the health care industry to adequately address pervasive stigma and discrimination related to LGBTQ individuals’ marginalized identities (Casey et al., 2019; Scheer et al., 2020). LGBTQ people in general experience unique health care disparities due to this stigma and discrimination (Emlet, 2016; Fredriksen-Goldsen, 2015; National Academy of Sciences, 2011).

Baptiste-Roberts et al. (2016), Colpitts and Gahagan (2016), and Mayer et al. (2008) establish that existing research in health disparities for sexual minorities has shown that LGBTQ populations, compared to heterosexual/cisgender counterparts, have a higher prevalence of many health ailments. These ailments can be attributed to non-equitable treatment and social inequities in society and not biomedical explanations of health (Marchia, 2018). Compared to their heterosexual/cisgender peers, LGBTQ older adults have higher rates of substance use, drinking, obesity, arthritis, diabetes, high blood pressure, chronic obstructive pulmonary disease (COPD), colon cancer, lung cancer, higher rates of mental health disorders, suicide attempts, greater disability rates, and overall lower rates of functional health when compared to heterosexual/cisgender peers (Baptiste-Roberts et al., 2016; Colpitts & Gahagan, 2016; Emlet, 2016; Mayer et al., 2008; Sage et al., 2021; U.S. Department of Health and Human Services, 2010). These populations also have disparities to tangible health care access and experience economic insecurity, employment discrimination, housing discrimination (especially in long term care settings), thin support networks, and fear discrimination when accessing aging services; all of which can be tied to health care needs (Baptiste-Roberts et al., 2016; SAGE et al., 2021). Transgender people and people with HIV positive status are at the most risk (Fredriksen-Goldsen, 2015). These disparities in health were present before the COVID-19 pandemic and have been exacerbated during this crisis.

Amplification of LGBTQ Older Adult Health Disparities During the COVID-19 Pandemic

The COVID-19 pandemic has been particularly difficult for older adult populations. In the USA, older adults are more likely to become seriously ill or pass away due to the disease (Brooke & Jackson, 2020; Kline, 2020). Older adults are also more likely to suffer long term physical effects of the virus due to the increased risk of having comorbidities, with 95% of deaths from COVID-19 being adults over 50 years of age (Stewart, 2021). Other serious conditions from having to socially distance are social isolation, loneliness, and the loss of caregiver support (Brooke & Jackson, 2020). There has also been “evidence of openly ageist discourses” (p.2044) which “complicates the experiences of living through Covid-19 for older people” and “contribute to feelings of worthlessness” (p.2044, Brooke & Jackson, 2020). Older LGBTQ people have seen similar discourses as their heterosexual peers, but with further complications due to the stigma and discrimination they face that is described above.

Certain health disparities have been exacerbated within different subgroups among the LGBTQ population (Daley & MacDonnell, 2011), such as older adults, and have been amplified during the COVID-19 pandemic (Kline, 2020). Drabble and Eliason (2021) and Jen et al. (2020) have found that during COVID-19, LGBTQ older adults have had elevated rates of chronic conditions (such as HIV, cancer, diabetes), higher prevalence of anxiety/depression, greater substance abuse, higher economic insecurities, limited community resources, and limited access to health care services. Other health determinants such as isolation and loneliness have also been intensified (Kline, 2020; Krause, 2021). Salerno et al. (2020) add that since LGBTQ older adults in general are four times less likely to have children, and twice as likely to live alone, and are more likely to be estranged from family compared to heterosexual/cisgender peers, concerns about solitude and mental health are even more troubling due to differences in social network size. This may make needing to socially distance a complex issue that may result in long-term mental health issues (Drabble & Eliason, 2021).
LGBTQ older adults also have a difficult time accessing the health services they need due to discrimination in medical settings, as well as lacking proper health insurance, which has been magnified by COVID-19 (Kline, 2020). Chatterjee et al. (2020) adds that along with this fear of discrimination, getting the COVID-19 virus has been a threat, leading to less screening of chronic diseases. Drabble and Eliason (2021) take into consideration also that due to lacking health statistics of LGBTQ people, especially during the COVID-19 pandemic, we will have limited information on long-term affects and outcomes of LGBTQ older adults who have suffered from the COVID-19 virus. More research needs to be done in this area for LGBTQ older adults with concern to long-term mental and physical affects from the COVID-19 pandemic.

Specific populations of LGBTQ older adults, such as those with HIV/AIDS, suffer even more from these concerns, with higher rates of posttraumatic stress disorder and isolation, lower physical health, and premature aging (Brown & Weissman, 2020). Despite this, some older cohorts of LGBTQ people who have HIV/AIDS have shown to be more resilient during the COVID-19 pandemic due to their experiences of living through the HIV/AIDS epidemic (Jen et al., 2020). Quinn et al. (2021) interviewed gay men who lived through the HIV/AIDS epidemic, asking them how they relate that epidemic to the current pandemic. Adults in their study made connections from having to wear condoms during the HIV/AIDS epidemic to having to wear masks now, needing to do so to save themselves and others. This research helps us understand that LGBTQ older adults have previously lived through a disease crisis, and the historical context noted above informs current research about the COVID-19 pandemic for this population. These connections back up the claim by Kline (2020) that the COVID-19 pandemic represents “a critical time to emphasize root causes of health inequality” (p. 241) for LGBTQ people, making it pertinent to address these above concerns through policy, practice, and research implications.

Addressing Needs of LGBTQ Older Adults Now During the COVID-19 Era: Equitable Health Policy, Practice, and Research Implications

Cahill et al. (2020) calls for a need for non-discriminatory health care for LGBTQ populations on all levels of policy, practice, and research implications and is pertinent in the COVID-19 pandemic. By discriminating against LGBTQ people in public health, we are causing further health disparities and compounding the issues noted above (Cahill et al., 2020). Advocacy for LGBTQ people and their sub-populations needs to be done to fully address public health. Directives suggest that policy makers should pay special attention to vulnerable sub populations, such as LGBTQ older adults, as well as those who have chronic conditions (i.e., HIV/AIDS, diabetes, heart disease), and look to these populations as partners in addressing health care issues within their communities.

Policy Implications

Discrimination should be prevented as it is seen to be one of the causes of the health disparities noted above (Cahill et al., 2020). One of the ways to lessen discrimination and address health disparities in public health is for a person’s identification as part of the LGBTQ community be recorded, thus ensuring the counting of this population through the generation of health statistics (Krause, 2021). COVID-19 has shown us how important legal protections are at the federal policy level and how this is connected to public health policies (Kline, 2020). If LGBTQ people are not counted in public health care records, how can policy makers have the information to serve this vulnerable population if this information is not known?

Kline (2020) discusses also how LGBTQ people in general have learned from the HIV/AIDS crisis and can bring this knowledge to the current COVID-19 pandemic. Blame in a pandemic only leads to poor health care, and Quinn et al. (2021) suggest calling for collective activism among LGBTQ people and their allies. Activism can provide help, not only for LGBTQ older adults, but for all minorities facing health disparities. This collective activism among LGBTQ communities and allies’ shines light on how this population has been through a pandemic before and advocated together to create real change (Quinn et al., 2021). Kline (2020) echoes these sentiments and speaks about how LGBTQ people were blamed during the HIV/AIDS crisis for the disease, just as Americans are blaming people of Asian descent for COVID-19, and how the broader community must put policies in place to fight against systematic discrimination as it leads to unfairly blaming whole communities for disease transmission. Advocacy needs to be done in this area since blaming does not lead to controlling the disease as shown above, but only harming the community it is targeting. LGBTQ people should be seen as the expert advocates, as this is now the second pandemic they are living through. Policy makers and service providers can be allies by reminding LGBTQ populations of their strength and community togetherness, giving this population power to make real change in their communities (Jen et al., 2020). The broader community will have to actively join the LGBTQ community’s lead in creating this change.

Practice Implications

Jen et al. (2020) discuss that all health professionals currently and after the pandemic should practice care that is
“person-centered, strength-based, and trauma-informed” (p. 608). Drabble and Eliason (2021) make suggestions for hospitals to become person centered: (a) ensure that health providers are trained to provide respectful and competent care and (b) increase access to LGBTQ health care community supports. de Los Reyes and Collict (2020) highlights the need to train practitioners to work with sexual minority patients as it increases positive attitudes towards LGBTQ populations and attitudes toward diversity in general. Rosa et al. (2020) adds that training can help professionals give care that is always inclusive of LGBTQ people’s needs, as it may be unknown who identifies as being part of this population, and to practice active listening skills to meet patients’ needs. Bristowe et al. (2018) states that to increase access to LGBTQ community care, providers should promote LGBTQ visibility, such as partnering with LGBTQ organizations. These suggestions combined would aim to provide care that is inclusive of LGBTQ people’s needs and would be person centered.

For a strength-based approach, Jen et al. (2020) note that LGBTQ older adults’ narratives should be guided as a resilient population. Older adults with HIV/AIDS are a particularly resilient group (Brown & Weissman, 2020). Despite the resiliency of this group, we are reminded that they still need the extra support during the COVID-19 pandemic (Brown & Weissman, 2020). This support can be provided safely during the current pandemic specifically, with practice delivery and remote program options (Drabble & Eliason, 2021). Gorenik et al. (2020) also found online programming for older adults helpful with mental and psychological distress during COVID-19. Healthcare providers must care and advocate for LGBTQ older adults in a way that limits transmission of illness, but also makes sure we are meeting the needs of a population that may be socially isolated during this time and need to maintain a sense of connection, as well as community (Jen et al., 2020). In this manner, we can support LGBTQ older adults to be able to play off their strengths, while providing support.

For a trauma informed practice, practitioners must understand barriers to health care access, as getting access to begin with can be filled with stigma and discrimination that can be traumatic for this population. Mayer et al. (2008) and Bristowe et al. (2018) discuss the barrier of tangible health care access further with three main causes: (a) reluctance of LGBTQ populations to disclose their sexual orientation or gender identity to their providers due to discrimination, (b) need for culturally competent medical care and services, and (c) health insurance access. All these barriers to tangible health care access make it difficult for older adults to receive the care they need, let alone deal with the health disparities they face. Chatterjee et al. (2020) discuss that fear of discrimination and stigma in health care settings, as well as COVID-19 as a threat, have led to people not seeking care. If people do not have access to health insurance due to discriminatory policies, they will not seek care. If a practitioner and the services they provide are not welcoming, a person who is LGBTQ will not visit their health care provider, leading to delayed diagnosis and more serious illness. If people do not feel comfortable disclosing their sexuality, it is difficult for practitioners to meet their specific needs. And finally, if a practitioner and the services they provide are not welcoming, a person who is LGBTQ will not visit their health care provider. These barriers need to be addressed further to meet the specialized healthcare needs of LGBTQ people.

Research Implications

Since we have limited research documenting this population, the main public health research directive for the LGBTQ older adult population should be to use a community approach. Community approaches aim to reduce discrimination/stigma while making new policies and directives, as LGBTQ people are experts on their own communities. Marchia (2018) describes that the making of LGBTQ history and activism comes from a grassroots activist lens, in line with policy implications indicated above. Marchia (2018) goes on to state that researchers should model the grassroots approach by being activists themselves, focusing on research that aims to increase access to equal treatment, resources, and combat stigma, since we know these contribute to better health outcomes. LGBTQ people had to band together to fight for their basic rights, such as getting access to treatment for HIV/AIDS, visiting their sick partners in the hospital, and obtaining health insurance for their partners (Marchia, 2018). LGBTQ people have been their own researchers and activists, so for this population, a ground up approach for research would be the most ethical method in obtaining information.

In line with an activist, ground up approach, Wallerstein and Duran (2006) discuss how to address health disparities using a collaborative approach called a community-based participatory action research (CBPR) approach. This approach has the community become a co-collaborator with the researcher, as they are the experts on their own community’s needs (Wallerstein & Duran, 2006). By conducting research in this manner, the researcher is gaining the proper knowledge needed to address health disparities directly from the community it aims to research. To conduct research specifically with LGBTQ older adults, the researcher should partner with an LGBTQ aging advocacy community organization, identify LGBTQ older adults who receive the services at the agency, find out LGBTQ older adults needs during and post the pandemic by interviewing both groups in focus groups, and work in tandem with them to meet their needs. To find out their needs, the researcher should run focus groups with the partner organizations and LGBTQ
older adults receiving the services, in line with a CBPR approach. This information should then be used to create a survey to ask LGBTQ older adults in the broader community about their needs and struggles during the pandemic. Questions that should be posed to agencies and LGBTQ older adults that they serve are the following:

1. What have been some of the major issues LGBTQ older adults have faced during the COVID-19 pandemic? This can be in relation to the general community, your agency, or yourself personally.

2. What have been some of the needs that LGBTQ older adults have had during the COVID-19 pandemic? This can be in relation to the general community, your agency, or yourself personally.

3. Have there been challenges meeting the discussed needs or addressing the discussed issues of LGBTQ older adults? And if so, what are the challenges? Are there needed services that should be offered?

4. Do you have any suggestions for questions we should ask in a survey discussing the issues and needs that LGBTQ older adults have had during the COVID-19 pandemic?

By asking questions in this manner, researchers can gain the knowledge needed to come up with research questions that can be asked to even begin to find the answers to assist this population. If a researcher does not know what this population is experiencing related to the COVID-19 pandemic, how can the actual research questions be developed? After obtaining important knowledge from the LGBTQ older adult community agencies about their needs, the researcher should work in tandem with this population to obtain the answers to problems related to their health care needs.

Conclusions

In summary, this paper discussed a brief healthcare history of the LGBTQ population in the USA and how in this history, blaming LGBTQ people for disease played a major role. Blaming fueled the discrimination and shame felt then and has affected the LGBTQ older adult population’s health outcomes to this day. The response of the LGBTQ population, the social work profession’s involvement, and eventual late response from the medical community during the HIV/AIDS crisis resulted in a general movement from a disease model of health care for LGBTQ persons, to that of a health equity model approach. This past knowledge helps to inform our current pandemic crisis of COVID-19 by assisting health care workers, including social workers, in how to specifically care for the healthcare needs for LGBTQ populations and their sub populations now. LGBTQ older adults have many health disparities due to poor past treatment by the medical community, before and during COVID-19, that have attributed to health inequalities discussed above.

Key suggestions for policy makers such as counting LGBTQ people in health care statistics, learning from the HIV/AIDS crisis, and using LGBTQ people as experts in developing their own policies are suggested. Practice with LGBTQ older adults should be person-centered, strengths based, and utilize trauma care approaches. Policy makers and practitioners should combine these suggestions when working with LGBTQ older adults. Researchers going forward should ask this community directly for help with their research on LGBTQ older adults as these older adults are the experts on outlining their needs. Further research efforts regarding LGBTQ older adult populations must be made to address these current and past health concerns. By combining policy, practice, and research approaches, the USA can make an impact to improve the overall health of LGBTQ older adults. Change must be made and implemented now by LGBTQ persons and their allies to make sure the health of LGBTQ older adults is a priority. There is no more pertinent time than during the current COVID-19 pandemic.

Author Contribution Breana Bietsch researched these ideas and findings independently and wrote the manuscript.

Availability of Data or Materials Availability of research is available upon request.

Code Availability No code was used for this manuscript.

Declarations

Conflict of Interest The authors declare no competing interests.

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Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.