**Older Lesbians’ experiences of ageing in place in rural Tasmania, Australia: A qualitative investigation**

**Abstract**

While there is increasing awareness of the specific health and aged care needs of older lesbian and gay people, little is known about their needs and experiences of ageing in rural communities. In Australia, older people are over-represented in regional and rural areas, however, rural communities face particular challenges to age-friendliness, including infrastructure and transport limitations, reduced health and social services. In this context, few studies explore older lesbians’ gendered experiences of ageing in place. To address this gap in the literature, this article draws on qualitative interviews with 13 rural Tasmanian lesbians over the age of 55, exploring their perceived barriers and enablers for ‘healthy ageing’ in their communities. Findings reveal that geographical isolation was a literal barrier to accessing specialist healthcare and lesbian-inclusive services, which may be absent in rural areas. The women perceived community health initiatives and social activities aimed at ‘healthy ageing’ in rural towns as heteronormative and unappealing for lesbians. In some cases women reported experiencing homophobic discrimination in these social groups. In contrast, rural communities were positively associated with a good quality of life derived from closeness to nature and feelings of reciprocity with rural neighbours and communities. These findings suggest that specific approaches to lesbian inclusive rural health and social care are required. Rural communities are well-placed to build on community strengths to ensure higher quality of place-based health and social care for isolated older people, including those of diverse genders and sexualities.

**Key words:** ageing, aged care, lesbian, rural, sexuality

**What is known about this topic:**
- Older lesbians face gendered and sexuality specific barriers to health and wellbeing as they age.
- Although ageing-in-place promotes older people’s wellbeing, rural communities face a range of challenges for age-friendliness.
- Older lesbians are more likely to live in regional and rural Australia than their gay male peers.

**What this paper adds:**

- A qualitative exploration of factors contributing and detracting from older lesbians’ health and wellbeing in rural Tasmania, Australia.
- An improved understanding of the specific gendered and sexualised experiences of rural ageing-in-place for lesbians.
- A consideration of the strategies rural communities and health and aged care services can employ to be inclusive of older lesbians.

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1. **Introduction**

As the population rapidly ages, the need for improved aged care is well-documented. In Australia, the population of people over the age of 65 is expected to increase to 23% by 2061, and with this comes a range of challenges for health and social care ([Australian Bureau of Statistics, 201](https://www.abs.gov.au/AUSSTATS/abs%40.nsf/mf/3222.0)7a). The World Health Organisation’s *Global Age-Friendly Cities and Communities Framework* (2007) states that respect and social inclusion are key aspects in establishing age-friendly communities into the future. Interdisciplinary scholarship has subsequently highlighted the health and aged care needs of lesbian, gay, bisexual, transgender and intersex (LGBTI) older people as a growing area of concern. As the baby boomer generation ages, the population of openly LGBTI seniors is likely to increase in the coming years (see Boggs et al., 2017). In Australia in 2012 the Aged Care Act 1997 was amended to recognise LGBTI people as a “special needs” group and the [National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Strategy](https://agedcare.health.gov.au/older-people-their-families-and-carers/people-from-diverse-backgrounds/national-lesbian-gay-bisexual-transgender-and-intersex-lgbti-ageing-and-aged-care-strategy) was subsequently launched. However as Waling et al. (2019, 1252) argue, there is a lack of understanding of what these initiatives have meant for LGBTI seniors in terms of their experiences of ageing and aged care in Australia. Following growing national concern around elder abuse, particularly in institutional settings, in 2018 the Australian Government ordered a [Royal Commission into aged care quality and safety](https://agedcare.royalcommission.gov.au/Pages/default.aspx). In this context, this article draws on qualitative interview data to explore the health and community care experiences and needs of lesbians over 55 living in rural Australia. In doing so, this research contributes to gaps in literature pertaining to older lesbians’ specific gendered experiences of health and ageing in rural communities.

LGBTI seniors share many of the similar health and social care needs as the broader elderly population, yet studies highlight the impacts of life-long discrimination and/or concealment of identity on LGBTI people, including poor mental and physical health, reduced access to healthcare and community services, and reluctance to utilise mainstream ageing services (for an overview, see Addis et al., 2009). LGBTI seniors express concerns about experiencing discrimination around their care needs and housing options as they age (Barrett et al., 2015; Crameri et al., 2015; Hughes, 2008; Orel, 2014; Ranahan, 2017), with some studies reporting that gay and lesbian seniors do not intend to disclose their sexuality if they have to live in residential care (see Bradford et al., 2016, 110). Gay and lesbian seniors also report apprehension regarding in-home social care service providers, with several studies finding concerns that care providers will have homophobic attitudes (Adelman, 2016; Brennan-Ing et al., 2014; Willis et al., 2018). As gay and lesbian seniors are less likely than heterosexual seniors to have close ties to biological family, they tend to rely more on informal care networks from friends and partners (Butler, 2018). However, friend informal caregivers typically provide less personal care and receive less support than more traditional family caregivers (Alba et al., 2019a), leaving many older lesbian and gay people with unmet needs.

Despite this increased scholarly focus on LGBTI ageing broadly, fewer studies examine lesbian experiences specifically. Given women’s higher life expectancy in developed nations, lesbians constitute a large portion of the ageing LGBTI population, yet are routinely overlooked in research, programs, and healthcare planning. Existing work suggests that compared with their heterosexual counterparts, older lesbians are more likely to experience disability, depression, obesity, and cardiovascular disease (Fredricksen-Goldsen et al., 2012). In addition to poorer health, studies in the US and Australia reveal that older lesbians are more likely to face financial hardship and housing insecurity in old age compared to gay men (Alba et al., 2019b; Cunningham et al., 2018; Ponce et al., 2010). Australian census data also suggests that coupled lesbians are more likely to live in regional and rural areas than gay men (Forrest et al., 2019), posing further challenges as they age.

In Australia, older people are overrepresented in rural and regional areas and this is projected to increase due to age-specific migration flows ([ABS, 201](https://www.abs.gov.au/AUSSTATS/abs%40.nsf/mf/3222.0)7a; Hancock et al., 2018). Ageing in place is a common policy initiative in countries such as the UK, US and Australia, promoting the continuation of older people residing in their home and avoiding institutional care. Phillipson ([2007](http://repository.keele.ac.uk:8080/intralibrary/open_virtual_file_path/i01n233005t/crp%20%27the%20elected%27%20and%20%27the%20excluded%27.pdf)) argues that place-based community attachment and belonging are two important dimensions to older people’s experiences of later life. However, rural communities face specific challenges to age-friendliness, including infrastructure and transport limitations, reduced health and social services, and difficulty retaining health care professionals (Hancock et al., 2018; [Winterton, 2016](https://www.tandfonline.com/doi/full/10.1080/08959420.2016.1145504)). Rural areas have historically offered a space for lesbians to reject traditional notions of heterosexual femininity, as illustrated by feminist separatism and lesbian land movements (Browne, 2011). However, Willis et al. (2018, 913) argue that rural life can constitute a “contradictory space” for lesbian seniors, with a simultaneous experience of community belonging and disruption or unwelcome. They suggest that “heterosexual normalcy” is reproduced in rural spaces through implict and explicit interactions in rural public spaces (2018, 914). Other studies reveal that heteronormativity also impacts healthcare access for lesbian seniors in rural areas, with rural services being less likely to be LGBTI-inclusive and geographical isolation posing a barrier to lesbian social supports (see Boggs et al., 2017; Bradford et al., 2016).

Heterosexual normalcy in rural spaces is also reproduced in Australian rural ageing research more broadly, with few previous studies exploring the healthcare needs of LGBTI older people in rural communities. The rural island state of Tasmania has a unique health profile and important LGBTI social history that makes it a compelling site to study older lesbians’ experiences. Tasmania has a rapidly ageing population, high rates of health risk indicators such as smoking, obesity, and chronic illness, lower average incomes, and reduced educational outcomes (Australian Bureau of Statistics, 2014; 2012). In addition, Tasmania was the last Australian state to decriminalise homosexuality in 1997 (Baird, 2006). Despite this history, over the last two decades Tasmania has led the way in Australian gay law reform, becoming the first state to officially recognise same-sex relationships, to legalise same-sex parent adoption, and to introduce marriage equality legislation to parliament (see Croome, 2013). Furthermore, contemporary polls consistently indicate support for LGBTI rights is now higher in Tasmania than nationally. For example, in the 2017 marriage equality postal survey 63 per cent of Tasmanian respondents voted in support of same-sex marriage (Australian Bureau of Statistics, 2017b). However, despite this increased support in Tasmania, the marriage equality debate arguably reignited homophobic sentiments reminiscent of decriminalisation debates of the 1980s-1990s, with tangible impacts on LGBTI community wellbeing. Recent incidents, such as anti-lesbian graffiti in the northern coastal township of Penguin ([Bennett, 2018](https://www.theadvocate.com.au/story/5714794/advocates-condemn-no-lesbians-graffiti-at-penguin-beach/?cs=12)), suggest that discrimination is still a significant issue facing rural lesbians, which may be pronounced for vulnerable older people. In light of these events, this research offers an important and timely analysis of rural lesbians’ health and aged care needs in Tasmania.

1. **Methods**

**2.1 Design**

This article reports on data that was collected as a part of an exploratory qualitative study that investigated older lesbians’ health and wellbeing in rural Tasmania, Australia. Participants were recruited using purposive self-selected sampling methods (Robinson, 2014) and snow-balling techniques. Between August and September 2019, we promoted the project through social media, newspapers, local radio, and word of mouth assisted by a range of Tasmanian LGBTI community organisations and social networks, local councils, and community houses. Given the focus of the study, inclusion criteria were: self-identify as a lesbian, aged >55 years, currently living outside major urban centres in Tasmania. The sample size (n=13) was based on consideration of the study design, nature of the topic and quality of the data. As in similar research, a limitation of self-selected and snowball sampling approaches in sexuality studies is the homogeneous sample it garners, with participants being predominantly white, middle-class, university-educated and ‘out’ in their communities (see Brown-Saracino, 2014).

Those who expressed interest in the study were provided with an information sheet explaining the aims of the research, as well as consent forms to consider. On obtaining the participants’ informed consent, semi-structured interviews were conducted by Author 2. The interviews lasted up to 2 hours and were conducted in person at mutually convenient public locations. All interviews were conducted using an interview guide focusing on a range of open-ended questions about participants’ experiences of living in their local area, accessing healthcare and other community services, their sense of community belonging and perceptions of growing older in their community. Interviews were audio-recorded and transcribed with consent. This project was approved by the University’s Human Research Ethics Committee. In line with the committee’s recommendations, participant protection strategies were prioritised at all stages of the design, conduct and reporting of the project. Data have been de-identified, and pseudonyms are used in all reporting of the data. Participants were reimbursed with gift vouchers as a token of appreciation for taking the time to participate in this study.

**2.2 Analysis**
Interviews were analysed using thematic analysis, with a focus on developing both inductive codes and themes that are identified during analysis, and deductive codes and themes that speak to the pre-existing areas of interest of the research team (Braun & Clarke, 2006). NVivo (v.11.2.2 Mac) was used as a software to assist with this approach. Following several rounds of immersion in the data and coding, Author 1 conferred twice with Author 2 to critically discuss preliminary codes and draft themes. In developing the analysis and linking to broader literature, Author 1 went back to the data to ensure that the patterns of meaning described in this article reflected data. This article presents a range of general findings across the analysis.

 **3. Findings**

Thirteen women between the ages of 57-70 participated in the study. All lived in a range of small towns around Tasmania with a population <6000. The majority (n=11) described themselves as white Australians, with two describing themselves as mixed race. Most participants were retired (n=7) or working part time (n=5), having worked in a range of areas such as retail, nursing, social work, farming, education, and management. Half described themselves in interview as working class (n=6), while others saw themselves as middle class (n=4), although most noted growing up poor. The majority of participants were married or partnered, with four couples participating in the study together. Five had been previously married or partnered with men and had children and grandchildren. All participants lived independently in homes they owned or rented and none received any aged care services at the time of interview. Five participants were born in Tasmania, three had moved to Tasmania with their families as children, and five had moved to Tasmania alone or with partners in the last ten years.

Considering what enables or prevents older lesbians’ healthy ageing in rural Tasmania, five key themes emerged from our analysis. In terms of enablers, participants emphasised the high quality of rural life and the importance of rural reciprocity. In contrast, barriers to wellbeing included geographical inaccessibility of healthcare, the heteronormativity of some community services, and fear of needing to access residential care services in the future.

**3.1 Barriers to healthy ageing in rural Tasmania**

**3.1.1 Geographical Barriers to Healthcare Access**

Rural areas experience well-documented healthcare access barriers precipitated by geographical isolation. LGBTI-inclusive practice research highlights that these geographical barriers are further exacerbated for rural LGBTI populations, as rural healthcare providers may not be trained or aware of LGBTI-inclusive principles (Barrett & Stephens, 2012). Reflecting previous research (e.g. Bradford et al., 2016), the women in our study expressed concern about the accessibility and quality of healthcare, particularly specialty care, in rural areas. Most women reported having to travel for up to two hours to access care:

I mean, there are doctors here, but I drive into town for everything. And they are only GPs, they don’t have any… Like if you need X-rays or anything… And at the moment there’s only one paramedic between here and [nearby town]. Yeah, it’s a rural area. (Wendy, 57).

No, you have to go up to [nearby town] if you... but I come into town to any doctors here. I Suppose that's an aspect, like when I had my accident, if it had been any worse than it was, you would be really stuck living out there and being you know, on a property where if you didn't have your phone with you or something... Nobody would see you if you couldn't get up and help yourself. And if you have a really life threatening injury, you might not get an ambulance in time. So, yes, sometimes it crosses your mind. (Bronwyn, 63)

The other thing is that I'm allergic to jack jumpers. I mean, really badly allergic. So [the ambulance] has got half an hour to get here after I get bitten. And I've got two epipens and I have to carry my phone with me everywhere. But last time the paramedics made it in 20-30 minutes from Hobart, and one of them said that’s the fastest she’d ever done it. (Anthea, 69)

Overwhelmingly, participants accepted inconvenience and risks associated with distance from healthcare as part of rural life (see also Bradford et al. 2016). While most described some local health services, few chose to access these and chose to travel instead citing better quality care and higher likelihood of lesbian-friendly providers in urban areas. Limited rural health services was also a concern in emergency situations. For example, Bronwyn shared a story of having a severe leg injury after an accident on a ride-on lawn mower. This accident made her aware of how living on an isolated rural property could be difficult as and older person. Some participants reported intentions to relocate from rural towns as they got older to be closer to more services for this reason.

When participants did find a local healthcare provider, they were often concerned about the longevity of the doctor-patient relationship, due to the high turnover rates of practitioners in rural areas ([Buykx et al., 2010](https://onlinelibrary.wiley.com/doi/full/10.1111/j.1440-1584.2010.01139.x)). This posed issues for older lesbians’ continuity of care, for example:

Well, there for a while, we only had one doctor’s surgery and I used to go over here to [nearby town]. And it did take, when I first came down, it did take a while to find a doctor with whom I felt comfortable. I had a really nice doctor, but then she retired. Then trying to get another doctor who was permanent there is really hard. I asked who would be replacing her and they said they don’t know. (Alice, 68)

I said to my GP, I told her, I am worried that I’ll have to go into a nursing home and whether I might, whether they’ll mistreat me there, And she said, ‘well, I’ll be your GP’ and I said, ‘no you won’t Helen, you’ll be retired by then.’ Yeah. So I have no control over that. (Trish, 70)

Here, participants expressed concerns about losing healthcare providers they trusted in contexts where that trust had been difficult to build over time. Importantly, Trish felt that her relationship with her GP was also connected to the quality of care she believed she might receive in residential aged care, with her GP’s retirement leaving a gap in her ongoing care. In rural areas LGBTI inclusion is often left to singular “change champions” in health services, making the delivery of holistic LGBTI-inclusive care fragile and conditional on individual clinicians (see Barrett & Stephens, 2012). As these participants demonstrate, this is an unsustainable model for rural communities, with more whole-clinic approaches to LGBTI inclusion needed, particularly in aged care.

**3.1.2 Heteronormative Community Healthy Ageing Programs**

A common concern about ageing in place for older rural lesbians was social isolation and the lack of appropriate community initiatives that were inclusive or appealing for lesbians. Many women felt that community-run activities, groups, or services that contribute to healthy ageing in place were heteronormative. For example:

I’ve looked up a couple of neighbourhood centres [in my local area]. But there’s nothing, you know, the stuff for all the women is like knitting and sewing. There’s not even a language course or anything like that. So… What’s there is stupid things like going for a walk along the river or something. (Lilac, 67)

I go to yoga. And sometimes I can’t go, I just suddenly feel this social anxiety, which is pathetic. Cause there’s a couple of old couples there. Everybody’s, you know, pretty… Well, they’re all pretty straight and conservative, I suppose. And so I sometimes feel difficulty going into the class. (Bronwyn, 63)

In these accounts the women describe heterogendered expectations and assumptions for sociability. For example, rural community organisations or local councils base their activities for older women around traditional feminine roles and activities (e.g. knitting, sewing). Here, rural community services were experienced as ambiently heterosexual spaces, with older heterosexual couples attending together or activities being highly gendered. Echoing Willis et al.’s (2018) findings, rural “heterosexual normalcy” was reinforced implicitly through these community healthy ageing initiatives. For some participants, this heteronormativity was also more explicitly evident through homophobia from community members:

I was going to the community garden, and I’m not not going because of what happened, but… There was a bloke there that one day said something like… “you’re the devil’s people” or something like that. And I got upset and probably responded angrily, which is not the best way to do it. I only just sort of said “you can’t say that” and I expected someone to stand behind me, but nobody did. (Trish, 70)

I go to the Women's Shed, And when I first started there were a couple of blokes from the Men's Shed, that had... And that was during the [marriage] survey. And they'd be quoting [conservative politician] Tony Abbott at me and that was... yeah... It does give you... not a fright, because you never totally expect everybody in a big group to accept you, but… (Sal, 58)

Here, Sal explained that she was participating in a local woodworking program during the 2017 same-sex marriage survey that saw Australians participate in a nation-wide poll on whether marriage equality should be legalised. Given the prominence of the debate in Australian media at the time, Sal noted that anti-gay views promoted by conservative politicians were used to make her feel unwelcome in the community group. Trish observed similar, more explicit sentiments at the time in her community garden. Such incidents have an impact on older lesbians’ health and wellbeing in rural areas where they may experience social isolation, compounded with the effects of life-long homophobia and heterosexism. Sal poignantly expressed never expecting to be accepted in social groups - a common sentiment among participants that shaped their interactions with their local communities.

**3.1.3 Avoiding Residential Aged Care**

Overarching participants’ experiences of rural ageing in place was a broader concern about their future care as older lesbians. As in previous research, all participants expressed dreading that they may need to enter a residential aged care facility in the future. For rural Tasmanian lesbians, this was particularly concerning given that many residential aged care facilities in their local or nearby areas were religious organisations that they believed would not be accepting of lesbians. Participants feared discrimination or sub-optimal healthcare and end-of-life care in residential facilities:

I used to think that if I had to move into town or go to a nursing home, I’d just kill myself. I just think well if I just try to, if I had to move into aged care, just trying to do it with as much grace as I could. Because I really dread it. Having to live amongst people who are socially excluding, who are not open to me. That’s what I dread. I dread being trapped in a place surrounded by people who are hostile. (Carrie, 61)

That's one thing that worries me a bit. Ending up in elder care with a bunch [of heterosexual people]. But you know, that's actually quite a heterosexual environment. And I know that I would feel not right. I'm hoping my memory will disappear quick enough so I don't care. But, but, yes there's certainly no place that I know of here were, as an old lesbian you might want to end up. (Silver, 67)

I am worried that when I do get into a nursing home in say 15 years… When I end up there, when she’s [her wife] put me away, (laughing) because she can’t bear it anymore. I am worried that there’ll be some religious person there that might decide they’re not going to notify [her wife] when I’m dying, or… will I be able to hold her hand when she comes to visit? And… Would they, not overtly, because I don’t think they could do it, because it wouldn’t be reasonable to overtly discriminate against me… But that covert stuff where… you always get your cup of tea at the end of the line and it’s cold or… (Sal, 58)

Given their life-long experiences of discrimination and the struggle many women of their generation had to live publically as lesbians, our participants were concerned that living in residential aged care may mean going back in the closet. As the accounts above demonstrate, residential care was seen as a “heterosexual environment” where, like their experiences of community services, participants feared both implicit and explicit discrimination, including a lack of recognition of their relationships. In the absence of inclusive aged care services, our participants did not outline alternative plans, hoping to live in their own homes as long as possible and some, like Carrie, preferring suicide over residential aged care (see also Waling et al., 2019). These findings highlight the need for improved lesbian-friendly aged care services and policy, particularly for regional and rural areas.

**3.2 Enablers for healthy ageing in rural Tasmania**

**3.2.1 High Quality of Rural Life**

While participants noted several barriers to healthy ageing in rural Tasmania, they also identified features of rural life that contributed to their health and wellbeing as lesbians. Many of our participants had intentionally relocated to Tasmania from major cities in mainland Australia. While this aligns with demographic trends in older people retiring to rural areas (Davis & Bartlett, 2008), lesbians emphasised the importance of rural spaces for their quality of life as they got older. The majority of participants believed that living in a rural area, surrounded by bushland or beaches, led to their sense of wellbeing:

We have a great place to live. It's a beautiful place to live. We get to look at chickens and Pademelons, and lovely blue wrens out our window and you know, Rosellas and watch the funny native hens, and see the pademelons. So having all that, we often talk about how grateful we feel that we are that we live in this lovely place. We own the house. So we have a level of financial security. I have some health conditions, but not anything that's, you know, too life threatening or too limiting, a little bit limiting. But You know, it's enough. So I really like that concept: enough. (Jan, 59)

[One of] the good things about getting older [is] that I can sit there for an hour in the morning and watch the birds in the gum tree. And you know, those things, which I love it's like, Whoa, this is so good! It is a whole new life. And I feel like I belong here, every time I drive over the hill from [town], and see the little cove it's like I'm home. (Trish, 70)

These accounts vividly position lesbians as part of the idyllic rural Australian landscape, characterised by native plants and animals. In contrast to the popular framing of LGBTI people as being “out of place” in rural areas (see Puar, Rushbrook, & Schein 2003), these women situate themselves as being closely connected to the natural environment around them, promoting a sense of feeling at home. This sense of being at home can also be seen as part of their process of ageing and self acceptance, with Jan expressing gratitude for what she has and Trish associating getting older with being able to stop and relax.

**3.2.2 Rural Reciprocity**

Although rural areas have been long associated with homophobia and conservatism for LGBTI people, our participants were drawn to the strong social ties and sense of community connection in rural towns. Feeling a sense of reciprocity and fostering neighbourly relationships within their communities was seen as a sustaining feature of ageing in rural areas:

I like being able to take eggs to people or people come to take some. But I like that aspect of that we get things and give them away sometimes to our neighbors, so it's kind of like a bit of community. Even our neighbor up the hill, He insisted on paying, that's okay, but it was, it's kind of, I felt good to offer our neighbors around us like up, the hill and over here, in the interest of good relationships, this is, it's kind of nice. (Jan, 59)

Our neighbor directly behind, he's been really good he'll come in sometimes and just do some work. If we need anything with a tractor or he splits our wood for us for a crate of beer or something. We say, Oh, we want to give him something, which we did anyway. But he said, oh no, just neighbors, just neighbors, for community. And it's really nice. (Bronwyn, 63)

[The local community have] had enough experience with us to at least understand that if we indicated that we do something or support something, we just do it like any ordinary people in the community, you know? You buy your raffle tickets from the CWA [Country Women’s Association]. And you... That sort of stuff in a local community, because that's what rural communities do with each other, all contributing. (Bev, 68)

These participants all describe different kinds of rural reciprocity, highlighting that part of living in a country town is being an active member of the community, contributing to community initiatives, assisting neighbours with agricultural labour, and sharing with others. As women who have experienced life-long homophobia, family rejection, and stigma, being part of a small community brought a sense of accomplishment. As Bev highlights, she and her partner worked to be seen “like any ordinary people in the community,” similarly Jan and her wife took pleasure in sharing their eggs with neighbours as a sign of reciprocity. Like Kazyak’s (2012) lesbian participants, gaining acceptance in rural communities was based on contributing, participating in ‘hard work,’ and being seen as ‘good people.’ Yet, it is important to recognise that this sense of belonging, inclusion and the ability to experience a “close-knit” rural community as positive is arguably mediated by participants’ white, middle-class status. As Fortier (2001) notes, queer narratives of place often falsely assume a homogenous queer subject who can feel “at home” in any location. It is worth considering how this idealised vision of community belonging factors into some representations of rural spaces as idyllic, while the challenges of rural life are disregarded.

**4. Discussion**

While LGBTI ageing is a growing area of scholarly and clinical concern, previous research has identified the need to recognise older lesbians’ specific gendered and sexualised experiences of health and ageing. Given lesbians’ high likelihood of living in regional and rural areas in developed nations like the US and Australia, further research is required to understand the health and social care needs of this ageing population. To address these gaps in literature, this article has explored the factors that enable and prevent older lesbians’ health and wellbeing in rural Tasmania, Australia. Drawing on qualitative interviews with 13 women over 55, we argue that inaccessible healthcare and heteronormative community services are key barriers to older rural lesbian’s wellbeing. The well-documented geographical barriers to quality health services faced by rural communities had a particular impact on older lesbians as limited local services reduced the likelihood that these would be lesbian-friendly. While community health services and social supports are often highly valued by rural seniors (Hancock et al., 2018), our participants experienced these as gendered and heteronormative, suggesting the need for more diverse and inclusive activities. As in previous research (Waling et al., 2019), participants dreaded residential aged care for similar reasons, fearing homophobic discrimination and reduced quality of care in the future.

The inaccessibility of quality local health and aged care posed a barrier to our participants’ wellbeing as the practical and financial difficulties of having to travel to access services made many less likely to access routine healthcare. However, our participants’ abilities to travel to access quality healthcare was arguably a product of their relative privilege as predominantly white, financially secure retirees in their 60s. Several participants noted that healthcare access would be more difficult for older, less mobile and poorer seniors in rural areas. As in previous work (Comerford et al., 2004), our participants valued the sense of freedom they gained by living in a rural area, yet some expressed underlying unease and concern for their safety due to geographical isolation, lack of health services, and heteronormativity of rural communities (see also Willis et al., 2018). In contrast, participants echoed the importance of ageing in place, associating rural living with peace, relaxation, and a strong sense of belonging. Troubling queer narratives of place that position rural communities as categorically hostile to LGBTI people, our participants reported close and sustaining relationships with their neighbours, often leading to reciprical social support that promoted health and wellbeing.

As the first empirical research to explore older lesbians’ health and social care needs in Tasmania, Australia, this article makes an important and timely contribution to LGBTI ageing and rural health research. Our findings suggest that healthcare, aged care, and community wellbeing initiatives are often heteronormative and gendered, with greater recognition of diverse genders and sexualities required in policy and practice. We have identified that specific approaches to LGBTI inclusive rural healthcare provision are required and that a whole-clinic response is often needed. Rural communities are well-placed to build on community strengths to ensure higher quality of place-based health and social care for isolated older people, including those of diverse genders and sexualities.

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