

LGBTIQ+-sensitive care for older people: recognising diversity in old age

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Lesbian, gay, bisexual, transgender, intersex and queer people face prejudice and exclusion not only when they are young. Even within elderly care it is a rarely discussed question if whether they can live their identities openly and on their own terms, and whether they can feel safe from discrimination in such settings. LGBTIQ+-sensitive elderly care is not an additional service, but an integral part of person-centred, anti-discriminatory and dignified support and care.

Invisibility in old age

Sexuality and gender diversity in old age are still largely invisible in society. Older people are often perceived as asexual, whilst at the same time it is taken for granted that they are heterosexual and cisgender. As a result, the lifestyles and needs of older LGBTIQ+ people are easily overlooked in care plans, counselling sessions and everyday routines (Gerlach & Schupp 2018: 198; Gerlach & Schupp 2020: 25). However, invisibility does not mean that gender and sexual identity lose their significance in old age. Rather, experiences throughout a person's entire life influence when people openly express their identity and what strategies they develop when dealing with, for example, care facilities. Particularly in the case of physical care, age, the body and gender identity can interact in a unique way; an intersectional and biography-oriented perspective is therefore indispensable for person-centred care (Lottmann 2020: 216–220).

When routines exclude

Discrimination does not arise solely from overtly derogatory behaviour. Even supposedly neutral forms, standardised interview procedures and organisational processes can systematically overlook certain ways of life. Institutional discrimination refers to disadvantages arising from established rules, habits and practices within organisations, even when individual staff members have no discriminatory intent (Gomolla 2016: 1–23). In elderly care, this is evident, for example, when a female resident is automatically asked about her husband, a chosen family is not recognised as a relevant support network, or a trans person's former gender identity is disclosed against their will. Furthermore, admission forms that recognise only two genders, a lack of support services for those who have experienced discrimination, a lack of safe spaces, or care planning that takes only biological kinship into account can make access difficult for. The German General Equal Treatment Act (AGG) lists, amongst other things, gender, age

and sexual identity as protected characteristics; its scope of application expressly covers social protection and health services (Sections 1–2 AGG). It also distinguishes between direct discrimination and indirect discrimination through seemingly neutral provisions, criteria or procedures (Section 3 AGG). The consequences of such structures can be far-reaching. Older LGBTIQ+ people may fear being discriminated against again in a care setting, having to conceal their identity or losing control over their personal information. Research indicates that dependence on third parties and the possibility of rejection are key concerns when using social and health services in old age (Lottmann 2020: 216–217).

Networks and dependencies

Many older LGBTIQ+ people have strong friendships and chosen families. These networks are often an important source of emotional and practical support. However, as the need for care increases, these networks may reach their limits, as intensive care tasks cannot always be undertaken. Furthermore, due to a tendency to have fewer children of their own, older LGBTIQ+ people are, on average, even more reliant on social services in old age than heterosexual older people (Acosta & Lottmann 2025: 383–389). At the same time, LGBTIQ+ older people are by no means a homogeneous population group. Their life circumstances vary according to factors such as income, gender, physical condition, place of residence, disability, experiences of racism and social networks. Current findings show, on average, health disadvantages and a heightened experience of loneliness compared with older cisgender and heterosexual people, with gender minorities being particularly disadvantaged (de Vries & Zindel 2025: 9–10).

What sensitivity means

LGBTIQ+-sensitive care for older people requires more than a one-off talk or a rainbow symbol at the entrance. It combines professional knowledge, a reflective attitude and binding organisational changes. The aim is not to encourage people to come out, but to create conditions under which they can decide for themselves what to share and with whom. This includes conducting conversations in an open manner. Instead of automatically asking about a wife or husband, staff can ask about significant others, partnerships or people who should be involved in decision-making. Practical recommendations also emphasise accessible information materials, designated contact persons, collaboration with queer communities and the permanent integration of these measures into quality assurance processes (AWO-Bundesverband e. V. 2021: 33, 249–250).

A sensitive organisation should:

- check admission forms and care records for heteronormative and binary gender assumptions;
- consistently respect self-chosen names, pronouns and forms of address;

- involve partners, friends and chosen families in accordance with the wishes of the person requiring care;
- take into account past experiences of discrimination and violence without reducing people to these experiences;
- establish complaints procedures and protection measures against discrimination and sexualised violence;
- Provide regular training for staff across all departments – from care and social services to administration, catering and management;
- Build partnerships with local LGBTIQ+ organisations and draw on their expertise appropriately;
- set out objectives, responsibilities and progress in the mission statement, staff development and quality management.

Reflect on prejudices

Training courses should not only explain concepts but also examine one's own professional practice. The anti-bias approach, for example, is well-suited to this, as it examines prejudice, power and discrimination at the interpersonal, structural and socio-cultural levels (Fleischer 2016: 2–4). Using specific situations as a starting point, staff can reflect on which ways of life they take for granted, whose relationships they recognise, and how institutional power influences their decisions. Furthermore, an educational approach that embraces diverse ways of life turns its attention to heteronormativity: heterosexuality and the binary gender system are not presented as a natural order with no alternatives, but as socially constructed norms. Such a perspective does not ask how queer people can be better adapted to existing processes. Rather, it examines how these processes must be changed so that diverse bodies, identities and relationships are taken into account as a matter of course (Hartmann 2022: 40–42).

Visibility without pigeonholing

The term LGBTIQ+ creates visibility and makes it possible to identify shared disadvantages. At the same time, it must not give the impression that all people described by it have the same life stories, identities and needs. Recognition of a group therefore remains linked to a dilemma: categories can open up political agency, but they can also define people and obscure differences within a group (Balzer 2019: 4). In practice, this means viewing terms as pointers but not drawing direct conclusions from them about other assumptions without getting to know the person. Not everyone wishes to speak openly about their sexual orientation or gender identity; not everyone requires specialised support; and not everyone uses the same self-identifiers. What is crucial is asking open questions, relying on voluntary disclosures and recognising individual self-definitions.

Responsibility requires structures

It is insufficient to expect care staff to demonstrate sensitivity, reflection and biographical knowledge without providing them with time, additional staff and structural support. The current framework conditions in elderly care often make it difficult to provide comprehensive, respectful and dignified care. Staff shortages, additional tasks and a lack of organisational ethical structures can cause moral stress when carers know what care is required but are unable to provide it (Wöhlke & Riedel 2023: 508–514). LGBTIQ+-sensitive care must therefore not be organised as an additional personal responsibility of individual committed staff members. Management must set aside time for further training and case reflection, define responsibilities and firmly embed anti-discrimination standards within the organisation. Funding bodies, policymakers and funding providers, for their part, bear responsibility for reliable funding, appropriate working conditions and an improvement in the generally precarious situation in many healthcare professions, such as elderly care. Raising awareness cannot replace structural solutions, but it can help to ensure that existing scope for action is utilised more consciously and equitably.

Diversity as a mark of quality

LGBTIQ+-sensitive elderly care is ultimately a litmus test for the quality of care as a whole. A care home that takes different life stories, bodies, relationships and support networks seriously does not merely improve the situation for queer older people. It strengthens a system of elderly care that does not judge people by supposed 'normal' life stories but instead places their self-determination and individuality at the centre. This requires three interlinked levels: reflective care staff, organisational structures that challenge discrimination, and a political framework that enables good care. Only when diversity is given equal consideration in the mission statement, during the intake interview, in care planning and in day-to-day interactions will sporadic openness become a reliable practice.

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