Addressing Healthcare Utilization Inequities in LGBT Cancer Survivorship: Translating Evidence into Policy and Practice

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Keywords: LGBTQ+, cancer survivorship, social support, discrimination, healthcare utilization barriers, Indiana state policy

Abstract

Cancer survivorship extends beyond treatment to encompass long-term physical, psychological, and social outcomes. For lesbian, gay, bisexual, and transgender (LGBT) survivors, this often means navigating systems that do not affirm their existence and survivorship needs and may expose them to toxic discrimination and stigma.

Using data from the All of Us research program, we identified healthcare utilization (HCU) barriers and psychosocial risk clusters, revealing stark disparities (Institute of Medicine, 2006). Bisexual and transgender survivors were disproportionately represented in the highest-barrier cluster, facing healthcare affordability and transportation challenges, delayed care, discrimination, high stress, and low social support—gaps that perpetuate avoidable suffering and inequity.

In this reflection, we consider how our results could inform actionable recommendations for both clinical practice and health policy. These reflections are grounded in three perspectives: (Institute of Medicine, 2006) the lived experiences and psychosocial vulnerabilities of LGBT cancer survivors, (AACR, 2024) structural healthcare access barriers, and (Ussher et al., 2022) opportunities to translate empirical findings into structural and practice-level change.

Introduction

Cancer survivorship extends beyond remission to encompass long-term physical, psychological, and social outcomes (Institute of Medicine, 2006). For lesbian, gay, bisexual, and transgender (LGBT) survivors, this often means navigating healthcare systems that do not affirm their existence and survivorship needs, and may perpetuate discrimination and stigma (AACR, 2024; Ussher et al., 2022; Cavallo, 2022). Using All of Us Research Program data, we identified clusters of high, medium, and low healthcare utilization (HCU) barriers (All of Us Research Program Investigators, 2025). Bisexual and transgender survivors reported the highest HCU barriers, including affordability, transportation challenges, and delayed care. These cancer survivors also reported the highest levels of discrimination and stress, and the lowest amounts of social support.

In this reflection, we consider how our results are actionable for clinical practice and health policy. These reflections are grounded in three perspectives: (Institute of Medicine, 2006) the lived experiences and psychosocial vulnerabilities of LGBT cancer survivors, (AACR, 2024) structural healthcare access barriers, and (Ussher et al., 2022) opportunities to translate empirical findings into structural and practice-level change.

Structural Barriers and the Cost of Care

Using data from the All of Us research program, we identified healthcare utilization barriers, especially among bisexual and transgender cancer survivors. Delays in care could result from the transportation barriers and the inability to take time off work. Cost-related barriers to medication use, such as skipping doses or asking for lower-cost alternatives, were also more prevalent among bisexual and transgender cancer survivors. Survivors with precarious employment or unstable insurance often lack the ability to pay out-of-pocket costs, and LGBT individuals are overrepresented in lower-wage jobs without healthcare benefits (Kinitz et al., 2023; Kinitz et al., 2025).These are not merely individual circumstances; they reflect systemic vulnerabilities.

From a policy standpoint, these findings point to a need for interventions that directly reduce financial toxicity and access barriers for LGBT cancer survivors. Examples include expanding transportation vouchers, covering telehealth mental health services to reduce transportation barriers, and eliminating high-deductible plans for long-term survivorship care. Without structural solutions, the burden of navigating survivorship will remain disproportionately heavy for those already facing discrimination.

Translating Findings into Clinical Practice

One of the most striking findings from our study is the gradient in psychosocial outcomes across HCU clusters. LGBT cancer survivors who experience more healthcare utilization barriers also reported the highest levels of daily discrimination and stress, coupled with the lowest reports of social support. This aligns with minority stress theory, where chronic stigma exposure drives poor health and barriers to healthcare utilization (Flentje et al., 2020; Meyer, 2003). In practical terms, these findings call for survivorship care to extend beyond disease and tumor-specific surveillance and treatment to include psychosocial screening.

Clinicians could conduct psychosocial screenings with LGBT cancer survivors to identify psychosocial stressors (e.g., discrimination), healthcare utilization barriers, and connect patients with the corresponding affirming resources such as peer navigators and mental health services. Psychosocial screening is an integral component of equitable survivorship care and should include discrimination, stress, and social support, which may uniquely predict care avoidance.

Translating Findings into Policy Change

Relevant policies at the federal, state, and community levels are summarized in Table 1. As the policy environment continues to evolve both federally and within Indiana, our recommendations are urgent and practical. At the federal level, Section 1557 of the Affordable Care Act (ACA) prohibited discrimination in federally funded healthcare programs on the basis of sex (including sexual orientation and gender identity) prior to rewrite (U.S. Department of Health and Human Services, 2024). However, its enforcement has been inconsistent across administrations, and it remains subject to ongoing legal challenges (Human Rights Campaign, 2024; Georgetown Law, n.d.). The original 2016 nondiscrimination rule issued by the Department of Health and Human Services (HHS) was partially vacated and later rolled back under the Trump administration, which removed gender identity and sex stereotyping from its interpretation of “sex discrimination” (U.S. Department of Health and Human Services, 2024). Portions of the original protections, including access to gender-affirming care, remain blocked by court injunctions and face persistent political threats.

These regulatory shifts have tangible effects on LGBTQ cancer survivors. For example, survivors continue to report being dismissed or stereotyped in clinical interactions, especially transgender cancer patients. A 2020 study found that nearly 25% of National Cancer Institute (NCI)-designated centers did not include gender identity or expression in their Patients’ Bill of Rights, and more than half excluded it from formal non-discrimination policies (JCO, 2020). This absence of public commitment can reduce engagement in survivorship care and perpetuates avoidable harm.

Meanwhile, recent Health Resources and Services Administration (HRSA) investments, such as the near $9 million Cancer Moonshot allocation to improve cancer screening and follow-up in underserved communities, such as LGBT cancer survivors, demonstrate a renewed but fragile stream of funding (HRSA, 2024). These advances are not guaranteed without durable policy safeguards. Within Indiana, the lack of statewide protections for LGBT individuals remains a significant barrier. There is no explicit state nondiscrimination statute covering LGBT individuals in healthcare or health insurance. Although Bostock v. Clayton County (2020) extended employment protections under Title VII to include sexual orientation and gender identity, Indiana has not codified those protections into healthcare contexts (Bostock v. Clayton County, 2020). Some local ordinances (e.g., Indianapolis, Bloomington, Tippecanoe County) offer limited coverage, but they only apply to roughly one-third of the state’s population (Mann, 2021). Transgender survivors in Indiana also live under increasingly restrictive and threatening policies: Senate Bill 480 (2023) bans gender-affirming care for minors, upheld by the 7th Circuit in 2024, and an executive order issued in 2025 prohibits gender-marker changes on birth certificates for adults – both of which signal a hostile policy environment for transgender Hoosiers throughout the life course and cancer survivorship (Indiana SB 480, 2023; ACLU of Indiana, 2024; Braun, 2025).

Table 1. *Policy Recommendations and Implementation Levers for Equitable LGBTQ+ Cancer Care Delivery*

Level of Action	Recommendation	Implementation Strategy
Federal Level		
	Fund culturally tailored survivorship programs	Urge HRSA and NCI to earmark grant funding specifically for LGBTQ-focused navigation and survivorship interventions.
	Mandate standardized sexual orientation and gender identity data collection	Require inclusion of sexual orientation and gender identity fields in EHRs, cancer registries, and survivorship plans coupled with provider training and privacy safeguards.
State and Local Levels	Mandate inclusive provider training	Propose statewide requirements for oncology teams to undergo LGBTQ affirming and bias-mitigation training.
	Require healthcare center transparency and inclusion statements	Mandate that Indiana hospitals and cancer centers publish inclusive Patients' Bills of Rights and non-discrimination policies explicitly referencing gender identity and expression.
Community and Clinical Engagement		
	Partner with LGBTQ advocacy organizations	Co-design culturally-informed survivorship plans and educational materials with local LGBTQ advocacy groups.

Our recommendations are actionable even in hostile policy climates, but durable change requires more than temporary fixes. Federal nondiscrimination protections must be codified, healthcare systems must make their inclusivity visible, and states like Indiana must close policy gaps that leave LGBTQIA+ survivors unprotected. By strengthening Section 1557 enforcement, passing the Equality Act, and mandating transparency in care, we can move beyond documenting disparities toward dismantling them. Equity in cancer survivorship is not optional, it is overdue.

Durable change requires more than temporary fixes. Policies, transparent healthcare systems, and enforceable protections are essential to equitable cancer survivorship.

Conclusion and Call to Action

Our work highlights both existence of barriers and the significance of barriers facing LGBT cancer survivors and the restrictions that limit capacity to fully address them. Even with one of the largest and most diverse national datasets available, the All of Us research program, small sample sizes for intersectional groups restricted our ability to examine nuanced differences, such as outcomes for transgender men versus nonbinary individuals or variation by specific cancer types, or examining the healthcare utilization barriers of people who hold both LGBT and racial/ethnic minoritized identities. These limitations underscore an urgent need for intentional oversampling of sexual and gender minorities in cancer research (Institute of Medicine (US) Committee on Lesbian Gay Bisexual and Transgender Health Issues and Research Gaps and Opportunities, 2011), as well as routine collection of accurate sexual orientation and gender identity data in both clinical and research settings. Without accurate data, inequities remain invisible, and opportunities for intervention are missed. Longitudinal research is also essential to understand how access barriers and psychosocial vulnerabilities evolve over time and influence survivorship outcomes, particularly for bisexual and transgender survivors who consistently experience the highest burden.

Despite these gaps, our findings are clear: LGBT cancer survivors face disproportionate barriers to survivorship care and heightened psychosocial vulnerability rooted in discrimination, financial strain, and social isolation. These are not individual hardships but structural failures of the healthcare system. Clinical practices must integrate routine screening for healthcare access barriers and psychosocial stressors, paired with patient navigation and peer support models tailored to LGBT survivors. Policy reforms must strengthen nondiscrimination protections, mandate data collection, and expand coverage for transportation, mental health care, and survivorship supports. Community partnerships must be empowered and funded to co-create responsive survivorship pathways that rebuild trust and address social isolation.

Delays in equity-driven reforms miss opportunities to reduce suffering and improve outcomes. Clinicians, health systems, policymakers, and community organizations each have a role to play in moving beyond documenting disparities toward dismantling them. This requires not incremental adjustments but structural transformation that centers equity as a core operational priority. Cancer survivorship cannot be considered complete while whole populations remain underserved and at risk of harm. The path forward requires us to affirm LGBT identities, remove access barriers, integrate psychosocial support as a standard of care, and invest in long-term research that holds systems accountable. Achieving equity in cancer survivorship for LGBT populations demands deliberate, evidence-based transformation, where policies affirm identity, clinical practices dismantle barriers, and research ensures no survivor is rendered invisible.

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