Barriers to Healthcare Utilization within the LGBTQ+ Community

A Literature Review

Christopher Floyd

University of Georgia

HPRB 5010

Dr. Proctor

April 22, 2025

Research Question

What barriers to care impact healthcare utilization in the LGBTQ+ community in the U.S?

INTRODUCTION

Despite social progress, LGBTQ+ individuals continue to face significant health disparities and barriers, including increased susceptibility to certain conditions, limited access to healthcare, and poorer health outcomes (Mirza et al., 2018). An estimated 11 to 12 million individuals within the United States identify as belonging to the sexual and gender minority (SGM) community (Zalabak et al., 2025). The LGBTQ+ is continuing to grow, as nearly one in 10 adults in the United States identifies as L.G.B.T.Q., according to an extensive analysis from Gallup; furthermore, the increases have been driven by young people and bisexual women (Miller & Paris, 2025). According to the analysis, one-quarter of adults in Generation Z, defined by Gallup as those 18 to 27, identify as L.G.B.T.Q., which included 14,000 adults across all of Gallup's telephone surveys (Miller & Paris, 2025).

LGBTQ+ is an abbreviation for lesbian, gay, bisexual, transgender, or queer. These terms are used to describe a person's sexual orientation or gender identity (Gay Center, 2025). Another term used is sexual and gender minorities (SGM), which refers to anyone who is not heterosexual or straight. Additionally, this term applies to individuals who are also not cisgender (ABCT, 2021). A cisgender individual is someone whose gender identity matches the sex they were assigned at birth. A cisgender man or cisgender woman is someone whose internal sense of gender aligns with societal expectations and norms associated with their biological sex (American Psychological Association, 2023). "Barriers to care" are defined as obstacles that prevent or limit the ability to obtain necessary healthcare services, which may lead to poorer health outcomes and greater health disparities (Healthy People 2030, 2020).

From survey responses among both LGBTQ+ and non-LGBTQ+ members, One-quarter (25%) of LGBT+ people reported being in fair or poor health compared to 18% of non-LGBT+ people. This was especially common among LGBT+ people with low incomes and those covered by Medicaid (Dawson et al., 2023). For example, a survey of LGBTQ+ individuals showed that black sexual minority participants were 2-2.7 times more likely to have postponed or avoided professional mental healthcare as compared to their white counterparts (Treatment Advocacy Center, 2024).

Several studies gathered data from the National Health Surveys reported sexual minority women were more likely to report poorer physical health compared to heterosexual women, as well as having less access to and utilization of healthcare services (Baptiste-Roberts et al., 2017). Additionally, a survey conducted among both LGBTQ+ and non-LGBTQ+ individuals revealed 50% of LGBTQ+ participants reported having an ongoing health condition that requires regular monitoring, medical care, or medication, which is a higher proportion than the 45% of non-LGBTQ+ individuals (Dawson et al., 2023). Delay of care and poor healthcare utilization within the LGBTQ+ population can further influence health conditions (McDowell et al., 2022). Further, in a survey conducted among both SGM and non-SGM individuals, sexual minorities were 2-3 times more likely than completely heterosexual men and women to delay care due to past negative healthcare experiences regarding healthcare access (Tabaac et al., 2020).

A study among SGM found lesbian, gay, and bisexual participants reported 1.06 higher odds of chronic illness compared to cisgender individuals (Jennings et al., 2019). Sexual minorities tend to delay seeking healthcare due to costs more than heterosexual individuals (Jackson et al., 2016). This group contains a wide range of sexual orientations and gender identities, reflecting a range of experiences and identities (Zalabak et al., 2025).

Research indicates older lesbian, gay, and bisexual adults were more likely than their heterosexual counterparts of the same age to experience poor overall health, mental distress, disabilities, sleep issues, and increased rates of nine out of twelve chronic conditions, such as low back pain and a compromised immune system (NIH-National Institute on Aging, 2023). Additionally, a study by Stonewall found that over the previous year, half of LGBTIQ+ people had experienced depression, three in five had experienced anxiety, and one in eight LGBTIQ+ people aged 18 to 24 had attempted to end their life (Mental Health Foundation, 2023). Moreover, LGBTQ+ people are at greater risk for certain conditions, diseases, and infections; for example, gay and bisexual men are more likely to have HIV/AIDS. Also, LGBTQ+ people have higher rates of HPV infection and related cervical or anal cancers (Cigna Healthcare, 2023). This data was collected from the National Health Interview Survey, where more than half of the sample reported facing these conditions (NIH-National Institute on Aging, 2023).

Sexual minorities' increased risk of foregoing annual routine physical exams, delaying care due to financial barriers, and being uninsured is consistent with extant research from both pre-and post-ACA samples of U.S. adults, which indicates healthcare access disparities are enduring and remain a critical area of public health attention (Tabaac et al., 2020). The challenges faced by sexual minorities in finding supportive and knowledgeable healthcare providers underscore the need for ongoing efforts to improve healthcare access and quality. From various literature reviews, sexual and gender minority (SGM) adults were found to experience higher rates of cardiovascular disease (CVD) and have poorer overall cardiovascular health compared to their cisgender heterosexual counterparts (Zalabak et al.,2025).

Gender minorities frequently encounter discrimination within healthcare settings, including verbal harassment and physical violence. These experiences contribute to a significant

proportion of gender minority individuals avoiding or delaying necessary medical care due to fear of mistreatment. For instance, a study amongst gender minorities found that 33% of gender minority participants reported experiencing healthcare mistreatment due to their gender identity or expression, and over 33% avoided healthcare because of anticipated mistreatment. Such avoidance can lead to poorer health outcomes for SGM (Clark et al., 2023). These negative experiences can lead to heightened anxiety or fear regarding healthcare environments.

This literature review aims to examine and identify the barriers that restrict access to healthcare for the LGBTQ+ community in the United States. The goal is to understand these challenges better and improve healthcare utilization among sexual and gender minorities (SGM). This review will explore how these factors contribute to healthcare avoidance, delayed treatment, insufficient provider knowledge, and limited access to inclusive insurance coverage. By analyzing these challenges, the review aims to highlight how structural inequities worsen adverse health outcomes and perpetuate cycles of marginalization. Addressing these obstacles is important for achieving a healthcare system that is fair, inclusive, and responsive to the needs of all individuals regardless of sexual orientation, gender identity, or expression. Furthermore, this review emphasizes the importance of applying an intersectional lens to health research, recognizing how overlapping identities, such as race, socioeconomic status, and geographic location, intersect with LGBTQ+ identities to influence healthcare experiences. These insights underline the urgent need for policy reforms, educational initiatives, and clinical practices that prioritize equity and affirm the dignity and health rights of LGBTQ+ populations.

METHODS

A series of searches were conducted through the UGA Libraries and ProQuest databases to explore the barriers that negatively impact access to sexual health resources within the

LGBTQ+ community in the United States. UGA Libraries serve as a fundamental component for academic research and scholarship within the university community. This system has also developed to include a diverse range of specialized collections and services that focus on identifying articles about the barriers that negatively impact access to sexual health resources for the LGBTQ+ community. ProQuest provides a wide array of products and services supporting research and learning across multiple disciplines, such as academic databases, e-books, dissertations, and historical archives. This database played an important role in supporting research and producing articles about the barriers that prevent LGBTQ+ individuals from accessing sexual health resources.

Inclusion and Exclusion Criteria

The inclusion and exclusion criteria were applied for all searches on UGA Libraries and ProQuest databases. Studies selected for review were published in peer-reviewed academic journals within the last eleven years (2014-2025). Though published during this period, some articles included data that had been collected as early as 2017 in their analyses. This study explicitly addresses barriers negatively impacting access to sexual health resources in the LGBTQ+ community. Further, only original research studies were included, and systematic reviews/literature reviews were excluded. This approach allowed us to gather insights directly from the primary research rather than relying on secondary sources such as systematic reviews or literature reviews, which can sometimes synthesize findings in ways that may overlook nuances present in individual studies.

The first step in selecting articles was reviewing the titles and abstracts of each search result to determine which articles were most relevant to the current research question. If an article's title or abstract was focused on a topic unrelated to the research question, it was not

considered further. After excluding articles based on titles and abstracts, the methods and results sections of the remaining articles were reviewed to assess their relevance. If the article was deemed relevant based on the content of these sections, it was selected for inclusion in this review. This systematic approach resulted in the selection of 23 articles that were not only relevant to the research question but also methodologically sound and representative of the target population.

Utilizing Boolean phrases, UGA Libs, was used to gather articles using the following search process included search terms #1: (sexual and gender minorities) AND (health disparities) AND (stigma). This search produced 277 articles prior to the addition of filters. Six articles were selected from this search. The second search included search terms #2: (sexual and gender minorities) AND (culturally competent care) AND (lack of training or development) AND (physician training culturally competent).This search produced 261 articles prior to the addition of filters. Six articles were selected from this search. The third search included search terms #3:(sexual and gender minorities or homosexuality or lgbtq) AND (health disparities AND lack of health insurance) Subject Term: insurance. This search produced 36 articles prior to adding filters.Three articles were selected from this search.

Utilizing Boolean phrases, The second database, ProQuest, was used to gather articles using the following search search terms #1: (sexual and gender minorities or homosexuality or lgbtq) AND (health disparities) AND (lack of health insurance). This search produced 24 articles prior to the addition of filters. Four articles were selected from this search. The second search included search terms #2: (sexual and gender minorities or homosexuality or lgbtq) AND (health disparities AND lack of health insurance) Subject Term: insurance. This search produced 515 articles prior to the addition of filters. Four articles were selected from this search.

RESULTS

The literature included in this review will focus on three interrelated themes impacting healthcare utilization and barriers to care for sexual and gender minorities (SGM): stigma and minority stress, the lack of competent care, and issues surrounding health insurance. By examining these three themes, the review aims to showcase the complex interplay between stigma, healthcare access, and health outcomes for sexual and gender minority populations.

Stigma & Minority Stress

Stigma has been identified as a clear and persistent driver of health inequities. Multiple forms of stigma can be seen both individually and interpersonally. This is thought to synergistically drive health disparities affecting Black and Latino gay, bisexual, and other men who have sex with men (GBM) (Jackson et al., 2022). Further, in a study among transgender Latinas in the South, perceived discrimination based on transgender identity resulted in 0.69 lower odds of receiving routine medical care in the U.S. within the past year. In the same study, it was found that perceived discrimination based on having sex with men resulted in 0.82 lower odds of receiving routine medical care in the U.S. within the past year (Goldenberg et al., 2024).

Gender identity stigma can limit access to social, educational, and insurance resources, which in turn undermines health literacy and healthcare utilization. This finding has been consistently reported across various transgender surveys and discussion papers focused on sexual and gender minority (SGM) health (Wiginton et al., 2023). A cross-sectional survey amongst SGM adults stated that one in six LGBTQ adults say they have avoided healthcare due to anticipated discrimination and experienced discrimination in healthcare encounters (Casey et al., 2019). From a survey of 301 HIV-positive Black and Latino gay men, stigma was found to be related to race and sexual orientation, predicting poorer sexual health among Black and Latino

GBM (gay and bisexual men); moreover, various forms of stigma can compound their effects on sexual health (Jackson et al., 2022). This compounded impact was assessed using a multivariate model of sexual risk, which highlighted experiences of homophobia, racism, and poverty as significant predictors (Jackson et al., 2022). A 2023 survey among LGBTQ adults found about two-thirds (65%) of LGBT adults experienced at least one form of discrimination/stigmatized experience in their daily lives in the past year, which can contribute to healthcare avoidance (Montero et al., 2024).

Stigma has also been found to be a barrier to sexual and health resources. Research shows both internalized and perceived stigma are strongly linked to lower rates of HIV testing among Black men who have sex with men (BMSM) (Burns et al.,2022). Although specific quantitative data are not easily accessible, several studies have documented the effects of stigma on HIV testing and utilization in this population. Further, a survey amongst both LGBTQ+ and non-LGBTQ+ adults reported that LGBT participants are also twice as likely as non-LGBT participants to report negative experiences when receiving health care in the last three years, including being mistreated or with disrespect (Montero et al., 2024). In addition, sexual minority groups from diverse racial and ethnic backgrounds experience higher stress levels due to LGBT stigma in their communities. This stigma can lead to increased isolation and decreased social support as individuals in the LGBT community will evade potential encounters with discrimination and rejection (McConnell et al., 2018).

Minority stress theory helps understand how stigma influences healthcare use among sexual and gender minorities. It is described as individuals from a stigmatized minority position who face adverse effects, or stress, of alienation from dominant social institutions (Goldenberg et al., 2024; Russell et al., 2022). Stigma can explain adverse health outcomes experienced by

sexual and gender minorities, as the minority stress theory describes how marginalized individuals experience chronic, cumulative stress (Lacombe-Duncan et al., 2022). Consistent with minority stress theory, stigma related to racial and ethnic identity in LGBT spaces, as well as LGBT stigma in one's neighborhood, was linked to increased stress for sexual minority men across all racial and ethnic groups (McConnell et al., 2018). Discrimination based on sexual orientation and negative attitudes toward transgender individuals can significantly impact healthcare utilization among SGM. These factors can discourage health-promoting behaviors, limit access to social support and community resources, and ultimately result in biological wear and tear on the body by elevating cortisol levels and increasing allostatic load (Lacombe-Duncan et al., 2022).

Lack of Culturally Competent Care

Research has shown that several LGBTQIA+ people have been mistreated by their doctor, denied care because of their gender identity, received care from an uncomfortable doctor, or even had to educate their doctor about their identity (Argyriadis et al., 2023). This lack of support in a healthcare context has been connected to the mismanagement and avoidance of healthcare services (Argyriadis et al., 2023). Cultural competency means understanding and respecting different cultures at both personal and organizational levels (Russell et al., 2022). Further, individuals from sexual minority groups may postpone or avoid seeking health care due to worries or fears about revealing their sexual identity, a deficiency of culturally appropriate preventive services, or a shortage of culturally competent medical professionals knowledgeable about LGB issues (Dahlhamer et al., 2016). These factors contribute to health disparities within sexual minority populations, as they may lead to delayed diagnoses, untreated health conditions, and a general decline in overall health outcomes; for example, within a study amongst LGBTQ+

and non-LGBTQ+ adults, gay men were 2.3 times more likely to report trouble finding providers than heterosexual men, which could exacerbate health outcomes among SGM (Dahlhamer et al., 2016).

A study conducted among GLMA healthcare providers found more than 50% of the providers reported not receiving any formal training into LGBTQ+ health, reducing their ability to provide culturally competent care to this population (Nowaskie et al., 2021). Healthcare workers need to develop skills to appreciate diversity, reflect on their own cultural values, and apply cultural knowledge in their practice (Russell et al., 2022). The findings of this study were corroborated by another qualitative study conducted among sex education workers that found a lack of LGBTQ+ curriculum contributed to discrimination against LGBTQ+ individuals in a healthcare context (Holt et al., 2025). Particularly, 18 % of medical providers reported a lack of medical provider experience or knowledge regarding health issues specific to the LGBTQ+ population (Nelson et al., 2023). This remains the reason for some LGBTQ+ community members to not see physicians or follow recommendations for routine health maintenance (Nelson et al., 2023).

For example, In a national telephone survey of US adults identified, 18% of LGBTQ+ adults in the sample reported avoiding going to a doctor or healthcare due to concerns of discrimination/poor treatment. Further, 16% of LGBTQ+ adults within the sample said they faced discrimination going to a doctor or health clinic (Casey et al., 2019). Additionally, a study among same-sex relationships found that 13% had difficulty locating a healthcare provider who is knowledgeable, supportive, and sensitive to the unique needs of sexual minority patients (Nguyen et al., 2024).

Lastly, 63% of sexual and gender minorities in a study amongst LGBTQ+ adults reported considering expanding their families, including the child welfare system, adoption, assisted reproductive technology, and conception from intercourse. However, an online survey amongst LGBTQ+ adults reported SGM do not express their reproductive health concerns to their healthcare provider due to lack of cultural competency care and perceived stigma (Griner et al., 2022). Moreover, these options for family building involve interaction with health professionals who may not have received training regarding the unique culture and needs of sexual and gender minority populations (Griner et al., 2022). This lack of training can result in inadequate support, discrimination, or misinformation, hindering equitable access to sexual health resources for this population.

Lack of Health Insurance

Historically, sexual minorities and same-sex couples have faced several barriers when it comes to accessing private health insurance. Unlike their heterosexual counterparts, they often encounter systemic challenges that can lead to lower coverage rates; further, same-sex couples may face difficulties in obtaining coverage or may be denied benefits due to outdated policies that do not recognize their relationships (Elton et al., 2022). A study involving both LGBTQ+ and non-LGBTQ+ individuals found that, compared to their heterosexual peers, there is a significantly higher percentage of both gay men (17.0% vs. 11.7%) and gay or lesbian women (22.5% vs. 14.1%) delayed or did not receive medical care due to cost in the past year (Dahlhamer et al., 2016). Additionally, a greater percentage of gay or lesbian women (24.4%) reported having no usual source of medical care compared to straight women (14.5%) (Dahlhamer et al., 2016).

A study explored factors' impact on Latina Transgender in the South; 20.77% of participants reported not having health insurance as the reason for not seeking routine medical care in the U.S. within the past year. Furthermore, 28.46% of participants thought their medical bills would be too high, being the reason for not seeking routine medical care in the U.S. within the past year (Goldenberg et al., 2024). This barrier impacts gender minorities, as transgender individuals often experience employment discrimination that leads to a lack of health insurance. Even transgender individuals with insurance frequently face policies with specific exclusions or barriers to coverage (Stroumsa et al.,2020). Moreover, Sexual minority adults have historically faced higher rates of lack of insurance and worse access to care because of structural inequities (Nguyen et al., 2024). This lack of insurance can hinder access to necessary medical services, preventive care, and overall health support.

In addition, a study amongst both LGBTQ+ and non-LGBTQ+ adults found that compared to heterosexual counterparts, 13.1% of sexual minority women were found to be uninsured. In comparison, 13.7% of sexual minority men reported being uninsured (Nguyen et al., 2024). However, only 8.6% of heterosexual women reported being uninsured, and 11.9% of heterosexual men reported being uninsured. Even with employer-based health insurance, both SGM women (42.3%) and men (46%) reported lower coverage compared to heterosexual women (54.1%) and men (55.9%) (Nguyen et al., 2024).

In a study of SGM, African-American men, and women were 2.01 more likely to have an interruption in their specialty alcohol treatment services and were 2.45 more likely to have an interruption in their specialty drug treatment services compared to heterosexual participants (Rice et al., 2024). However, bisexual African-American men and women were 2.35 more likely to have an interruption in their specialty alcohol treatment services. They were 2.17 more likely

in specialty drug treatment services compared to heterosexual participants (Rice et al., 2024). Similarly, sexual minoritized women, including White, Black, and Latina individuals, had significantly lower adjusted odds of health insurance coverage and a usual source of care compared to white heterosexual women. Additionally, a National Health Interview Survey among LGBTQ+ adults revealed that after controlling for demographic and socioeconomic factors, lesbian women reported higher odds of poor or fair health. One recent study of LGBTQ+ adults and non-LGBTQ+ adults found that minoritized women were 1.91 times more likely to face significant barriers to healthcare access, such as a lack of insurance and financial constraints (Madina Agénor, et al., 2023; Fredriksen-Goldsen et al., 2017). This is seen in a study indicating sexual minority women and men experience higher rates of unemployment and lack of health insurance compared to their heterosexual counterparts, with both groups being approximately twice as likely to face these barriers (Madina Agénor et al., 2023; Fredriksen-Goldsen et al., 2017).

Notably, In a secondary data analysis from the "National Growing Up Today Study" explored the influence of sexual minority status on health insurance and healthcare utilization, researchers found gay men were 2.21 times more likely than straight men to report being uninsured and 1.13 times more likely to report not having a routine physical exam. At the same time, lesbian women were 1.18 times more likely to be uninsured and 1.17 times more likely to report not having a routine physical exam than their heterosexual counterparts. This disparity was more pronounced for bisexual women, who were 3.76 times more likely to report not having a routine physical exam than heterosexual women (Charlton et al., 2018). Lastly, barriers to healthcare access, such as lack of health insurance, contribute to disparities, placing uninsured individuals at greater risk for poor health outcomes. Research amongst same-sex and

opposite-sex relationships indicated that partnered MSM were less than half as likely as men in heterosexual marriages to receive employer-sponsored dependent health insurance (Cooley et al., 2017).

DISCUSSION

Implications

Many of the chosen studies concentrated on in-depth qualitative interviews targeting a specific demographic or context; for this literature review, LGBTQ+. This approach allowed for rich, nuanced insights into participants' experiences, opinions, and motivations, thereby fostering a comprehensive understanding of the subject matter. This depth of knowledge is particularly valuable in capturing the lived experiences of LGBTQ+ individuals, who may navigate unique social, cultural, and personal hurdles. Additionally, the availability of resources and support systems, such as LGBTQ+ organizations and healthcare services, can vary greatly between urban and rural areas. Therefore, it is essential to conduct further research specifically focusing on the SGM population in rural contexts to understand their needs and lived experiences better. Such studies would illuminate the distinct challenges faced by these individuals, including issues like mental health, social isolation, and the need for tailored healthcare services.

There is also a need to improve healthcare providers’ capacity for culturally competent care. In a study that implemented an educational intervention aimed at improving the attitudes and knowledge of nurses regarding LGBTQ individuals, it was found that by participating in a 60-minute educational program, nurses enhanced their understanding of LGBTQ individuals, enabling them to deliver more culturally competent care in clinical environments (Traister et al., 2020).

However, strategies for assessing structural stigma faced by SGM individuals, as well as approaches that consider structural intersections (such as the interplay with structural racism), should be implemented and further developed in SGM communities. In recent years, legislation affecting LGBTQ rights has contributed to a greater polarization of the LGBTQ policy environment in the United States. It is understood that detrimental social policies can negatively impact the health and well-being of SGM communities; however, additional research will be necessary to explore how these policies influence the health burden experienced by SGM individuals (Weideman et al., 2024). A potential solution for stigma could be effectively implementing SOGI (Sexual Orientation and Gender Identity) data collection; a multilevel approach is necessary. This practice should extend beyond simply asking SOGI-related questions; for example, clinical settings must include practices throughout the organization that are inclusive and affirming to SGMs.

These include asking patients for their preferred names and pronouns, maintaining non-gendered bathrooms, updating electronic health records to include SGM identities, and ensuring that all providers and staff have completed SGM competency training (Tamı-Maury et al.,2024). This would help create environments where SGM feel seen, respected, and valued. When healthcare providers take the time to acknowledge and use the names and pronouns that patients identify with, it fosters a sense of recognition and belonging. This small but significant gesture can vastly enhance the patient experience and build trust between patients and providers. By prioritizing inclusivity and sensitivity, healthcare organizations can take meaningful steps toward ensuring that all patients receive the respectful and comprehensive care they deserve. It is essential to create safe, welcoming, and inclusive environments for sexual and gender minorities (SGMs). By fostering such environments, SGMs will feel more comfortable providing

information (Tamı-Maury et al.,2024). Addressing these barriers is important to ensure equitable healthcare for all individuals, regardless of sexual orientation or gender identity. These findings highlight the importance of intersectionality in health research and underscore the necessity for equitable healthcare for all sexual orientations.

In conclusion, a combination of educational interventions for practitioners and further research into the intersectional nature of barriers to care is required to improve healthcare utilization rates in the LGBTQ community. Implementing multilevel strategies, including comprehensive sexual orientation and gender identity (SOGI) data collection and the promotion of inclusive environments, is vital to ensure that SGM individuals feel comfortable sharing their identities, ultimately fostering equitable healthcare practices.

Limitations

One key limitation of this literature review is that only twenty articles were analyzed, which does not capture all barriers affecting access to sexual health resources in the LGBTQ+ community. Another limitation is most studies in the review were cross-sectional, collecting data at a single point in time, which limits their ability to show causation or changes over time. For example, while they may identify barriers faced by sexual and gender minorities in accessing family-building services, they cannot determine whether these barriers have improved or worsened over time or assess their impact on long-term outcomes like family stability or mental health. Therefore, the lack of longitudinal or experimental research limits the ability to develop evidence-based interventions or policies tailored to the specific needs of this population. The findings from these articles cannot be generalized to rural populations, as most of them did not discuss sexual and gender minority (SGM) experiences in rural areas. This is a significant limitation, as rural communities often have different social dynamics, access to healthcare, and

cultural attitudes compared to urban settings. For instance, stigma and discrimination might manifest differently in rural environments, potentially leading to unique challenges for SGM individuals that are not addressed in the existing literature.

Additionally, it is important to note that participant populations were not controlled for in our selection criteria. This means demographic variations or relevant characteristics among study participants across different original research articles may not have been systematically standardized. Such a lack of control can introduce variability in the outcomes and interpretations of the data, suggesting that the findings should be considered with this context in mind. By acknowledging these limitations, we aim to provide a clearer understanding of the strengths and weaknesses inherent in our research focus. The articles included in the results section had small sample sizes, which poses challenges in generalizing the results and findings to a broader population across the United States. Several articles included in the review utilized self-reported data, which raises concerns about the reliability of the information gathered. Self-reported data can be particularly susceptible to biases, such as self-reporting bias, where participants may provide inaccurate responses due to memory errors or personal interpretations of their experiences. Furthermore, social desirability bias may come into play, where individuals answer questions in a manner they believe will be viewed favorably by others rather than providing their true feelings or behaviors. This can compromise the validity of the findings and highlight the importance of using multiple data collection methods or triangulating results with objective measures to enhance the accuracy and reliability of the research outcomes.

CONCLUSION

This literature review emphasizes three interconnected barriers that hinder healthcare access and utilization for sexual and gender minorities (SGM): stigma and minority stress, a lack of culturally competent care, and disparities in health insurance coverage. Stigma and discrimination, as described by minority stress theory, create chronic stress that increases the risk of mental health issues and other adverse health outcomes and conditions. This stress can discourage SGM individuals from seeking necessary care. Compounding this issue is the absence of culturally competent healthcare providers who understand the unique health needs of LGBTQ+ individuals. This includes the need for inclusive communication and specific preventive care. As a result, SGM individuals often experience feelings of marginalization and mistreatment in medical settings. Lastly, structural barriers such as higher rates of uninsurance and underinsurance caused by employment discrimination and the exclusion of same-sex partners from benefits further limit access to healthcare.

REFERENCES

Mirza, S. A., & Rooney, C. (2018, January 18). *Discrimination prevents LGBTQ people from accessing health care*. Center for American Progress. https://www.americanprogress.org/article/discrimination-prevents-lgbtq-people-accessing-health-care/

Dawson, L., Long, M., & Frederiksen, B. (2023, June 30). *LGBT+ people's health status and access to care*. KFF. https://www.kff.org/report-section/lgbt-peoples-health-status-and-access-to-care-issue-brief/

TAC. (2024, February 7). RESEARCH WEEKLY: Black Sexual Minorities More Likely to Delay or Avoid Professional Mental Healthcare - Treatment Advocacy Center. Treatment Advocacy Center https://www.tac.org/research-weekly-black-sexual-minorities-more-likely-to-delay-or-avoid-professional-mental-healthcare/

Baptiste-Roberts, K., Oranuba, E., Werts, N., & Edwards, L. V. (2017). Addressing Health Care Disparities Among Sexual Minorities. *Obstetrics and Gynecology Clinics of North America*, *44*(1), 71–80. https://doi.org/10.1016/j.ogc.2016.11.003

McDowell, A., Myong, C., Tevis, D., & Fung, V. (2022). Sexual Orientation and Gender Identity Data Reporting Among U.S. Health Centers. *American Journal of Preventive Medicine*. https://doi.org/10.1016/j.amepre.2021.12.017

Tabaac, A. R., Solazzo, A. L., Gordon, A. R., Austin, S. B., Guss, C., & Charlton, B. M. (2020). Sexual orientation-related disparities in healthcare access in three cohorts of U.S. adults. *Preventive Medicine*, *132*, 105999. https://doi.org/10.1016/j.ypmed.2020.105999

Jennings, L., Barcelos, C., McWilliams, C., & Malecki, K. (2019). Inequalities in lesbian, gay, bisexual, and transgender (LGBT) health and health care access and utilization in Wisconsin. *Preventive Medicine Reports*, *14*(14), 100864. https://doi.org/10.1016/j.pmedr.2019.100864

Jackson, C. L., Agénor, M., Johnson, D. A., Austin, S. B., & Kawachi, I. (2016). Sexual orientation identity disparities in health behaviors, outcomes, and services use among men and women in the United States: a cross-sectional study. *BMC Public Health*, *16*(1). https://doi.org/10.1186/s12889-016-3467-1

Zalabak, A., & Raymund Gantioque. (2024). Cardiovascular Health Disparities Among Sexual and Gender Minority Adults. *The Journal for Nurse Practitioners*, *21*(2), 105295–105295. https://doi.org/10.1016/j.nurpra.2024.105295

Miller, C. C., & Paris, F. (2025, February 20). Nearly One in 10 U.S. Adults Identifies as L.G.B.T.Q., Survey Finds. *The New York Times*. https://www.nytimes.com/2025/02/20/upshot/lgbtq-survey-results.htm

The Center. (2023). *Defining LGBTQIA+*. The Lesbian, Gay, Bisexual & Transgender Community Center. https://gaycenter.org/community/lgbtq/

Sexual and Gender Minority Populations | Fact Sheet. (2021, March 11). ABCT - Association for Behavioral and Cognitive Therapies. https://www.abct.org/fact-sheets/sexual-and-gender-minority-populations/

APA Dictionary of Psychology. (2023, November 15). Dictionary.apa.org. https://dictionary.apa.org/cisgender

Healthy People 2030. (2020). *Access to Health Services - Healthy People 2030 | health.gov*. Health.gov. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services

Mental Health Foundation. (2023). *LGBTIQ+ People: Statistics*. Www.mentalhealth.org.uk; Mental Health Foundation. https://www.mentalhealth.org.uk/explore-mental-health/statistics/lgbtiq-people-statistics

CIGNA HEALTHCARE. (2023, October 1). *LGBTQ+ Health Disparities | Cigna*. Www.cigna.com. https://www.cigna.com/knowledge-center/lgbt-disparities

National Institute on Aging. (2023, June 5). *Improving the health and well-being of sexual and gender minority older adults*. National Institute on Aging. https://www.nia.nih.gov/news/improving-health-and-well-being-sexual-and-gender-minority-older-adults

Clark, K. D., Lunn, M. R., Bosse, J. D., Sevelius, J., Dawson-Rose, C., Weiss, S. J., Lubensky, M. E., Juno Obedin-Maliver, & Flentje, A. (2023). Societal stigma and mistreatment in healthcare among gender minority people: a cross-sectional study. International Journal for Equity in Health, 22(1). https://doi.org/10.1186/s12939-023-01975-7

LGBTQ Family Building Survey. (2019). https://familyequality.org/wp-content/uploads/2019/02/LGBTQ-Family-Building-Study_Jan2019-1.pdf

Jackson, S. D., Wagner, K. R., Yepes, M., Harvey, T. D., Higginbottom, J., & Pachankis, J. E. (2022). A pilot test of a treatment to address intersectional stigma, mental health, and HIV risk among gay and bisexual men of color. *Psychotherapy*, *59*(1), 96-112. https://doi.org/10.1037/pst0000417

Montero, A., Hamel, L., Artiga, S., & Published, L. D. (2024, April 2). *LGBT Adults' Experiences with Discrimination and Health Care Disparities: Findings from the KFF Survey of Racism, Discrimination, and Health*. KFF. LGBT Adults' Experiences with Discrimination and Health Care Disparities: Findings from the KFF Survey of Racism, Discrimination, and Health | KFF

Williams, S. L., & Mann, A. K. (2017). Sexual and gender minority health disparities as a social issue: How stigma and intergroup relations can explain and reduce health disparities. *Journal of Social Issues*, *73*(3), 450-461. https://doi.org/10.1111/josi.12225

Goldenberg, T., Tanner, A. E., McGuire, T., Alonzo, J., Mann-Jackson, L., Refugio Aviles, L., Galindo, C. A., Bessler, P. A., Courtenay-Quirk, C., Garcia, M., Reboussin, B. A., & Rhodes, S. D. (2024). The Role of Stigma and Resilience in Healthcare Engagement Among Transgender Latinas in the U.S. South: Baseline Findings from the ChiCAS Study. In *Journal of immigrant and minority health* (Vol. 26, pp. 850-858). United States: Springer.

Wiginton, J. M., Maksut, J. L., Scheim, A. I., Zlotorzynska, M., Sanchez, T. H., & Baral, S. D. (2023). Intersecting sexual behavior and gender identity stigmas among transgender women in the United States: Burden and associations with sexual health. *AIDS and Behavior*, *27*(9), 3064-3079. https://doi.org/10.1007/s10461-023-04028-w

Casey, L. S., Reisner, S. L., Findling, M. G., Blendon, R. J., Benson, J. M., Sayde, J. M., & Miller, C. (2019). Discrimination in the United States: Experiences of lesbian, gay, bisexual, transgender, and queer Americans. *Health Services Research*, *54*(S2), 1454–1466. https://doi.org/10.1111/1475-6773.13229

Nguyen, K. H., Levengood, T. W., Allen, H. L., & Gonzales, G. (2024). Health Insurance Coverage and Access to Care by Sexual Orientation During the COVID-19 Pandemic: United States, January 2021–February 2022. *American Journal of Public Health*, *114*(1), 118–128. https://doi.org/10.2105/AJPH.2023.307446

Burns, P., Omondi, A., Monger, M., Ward, L. M., Washington, R., Gomillia, C., Bamrick-Fernandez, D. R., Chizoba Anyimukwu, & Mena, L. (2021). Meet Me Where I Am: An Evaluation of an HIV Patient Navigation Intervention to Increase Uptake of PrEP Among Black Men Who Have Sex with Men in the Deep South. *Journal of Racial and Ethnic Health Disparities*, *9*(1), 103–116. https://doi.org/10.1007/s40615-020-00933-1

McConnell, E. A., Janulis, P., Phillips, G., Truong, R., & Birkett, M. (2018). Multiple minority stress and LGBT community resilience among sexual minority men. *Psychology of Sexual Orientation and Gender Diversity*, *5*(1), 1–12. https://doi.org/10.1037/sgd0000265

Lacombe-Duncan, A., Andalibi, N., Roosevelt, L., & Weinstein-Levey, E. (2022). Minority stress theory applied to conception, pregnancy, and pregnancy loss: A qualitative study examining LGBTQ+ people's experiences. *PLOS ONE*, *17*(7), e0271945. https://doi.org/10.1371/journal.pone.0271945

Argyriadis, A., Fradelos, E. C., Argyriadi, A., Ziegler, E., & Kaba, E. (2023). Advancing Access to Quality LGBTQIA+ Health Care: Gender Discrimination, Socio-Cultural, and Mental Health Issues: A Mixed-Method Study. *International Journal of Environmental Research and Public Health*, *20*(6), 4767. https://doi.org/10.3390/ijerph20064767

Russell, S., & Corbitt, N. (2022). Addressing Cultural Competency: Lesbian, Gay, Bisexual, Transgender, and Queer Cancer Care. *Clinical Journal of Oncology Nursing*, *26*(2), 183–189. https://doi.org/10.1188/22.cjon.183-189

Dahlhamer, J. M., Galinsky, A. M., Joestl, S. S., & Ward, B. W. (2016). Barriers to Health Care Among Adults Identifying as Sexual Minorities: A US National Study. *American journal of public health*, *106*(6), 1116–1122. https://doi.org/10.2105/AJPH.2016.303049

Nowaskie, D. Z., & Sewell, D. D. (2021). Assessing the LGBT cultural competency of dementia care providers. *Alzheimer's & Dementia: Translational Research & Clinical Interventions*, *7*(1). https://doi.org/10.1002/trc2.12137

Holt, L., Janek, S., & Yamey, G. (2025). Barriers and facilitators to implementing comprehensive sex education in Texas public schools: A qualitative study. *PLOS ONE*, *20*(1), e0316329. https://doi.org/10.1371/journal.pone.0316329

Nelson, N. G., Lombardo, J. F., Shimada, A., Ruggiero, M. L., Smith, A. P., Ko, K., Leader, A. E., Mitchell, E. P., & Simone, N. L. (2023). Physician Perceptions on Cancer Screening for LGBTQ+ Patients. *Cancers*, *15*(11), 3017–3017. https://doi.org/10.3390/cancers15113017

Griner, S. B., Spears, E. C., & Maskey, S. (2021). Advancing Cultural Competency Toward Sexual and Gender Minorities: Innovation in Maternal and Child Health Pedagogy. *Maternal and Child Health Journal*. https://doi.org/10.1007/s10995-021-03309-x

Elton, E., & Gonzales, G. (2021). Health Insurance Coverage and Access to Care by Sexual Orientation and Marital/Cohabitation Status: New Evidence from the 2015–2018 National Health Interview Survey. *Population Research and Policy Review*. https://doi.org/10.1007/s11113-021-09670-7

Stroumsa, D., Crissman, H. P., Dalton, V. K., Kolenic, G., & Richardson, C. R. (2020). Insurance Coverage and Use of Hormones Among Transgender Respondents to a National Survey. *The Annals of Family Medicine*, *18*(6), 528–534. https://doi.org/10.1370/afm.2586

Rice, J. K., Anderson-Carpenter, K. D., & Ellis, J. D. (2024). Risk factors of substance use treatment gaps among a nationally representative sample of black American adults in relation to sexual minority status and health insurance coverage. *BMC Psychology*, *12*(1). https://doi.org/10.1186/s40359-023-01352-7

Madina Agénor, J. Wyatt Koma, Pérez, A. E., McDowell, A., & Gonzales, G. (2023). *Differences in Health Insurance and Usual Source of Care Among Racial/Ethnic and Sexual Orientation Subgroups of U.S. Women and Men*. *42*(3). https://doi.org/10.1007/s11113-023-09774-2

Fredriksen-Goldsen, K. I., Kim, H.-J., Shui, C., & Bryan, A. E. B. (2017). Chronic Health Conditions and Key Health Indicators Among Lesbian, Gay, and Bisexual Older US Adults, 2013–2014. *American Journal of Public Health*, *107*(8), 1332–1338. https://doi.org/10.2105/ajph.2017.303922

Charlton, B. M., Gordon, A. R., Reisner, S. L., Sarda, V., Samnaliev, M., & Austin, S. B. (2018). Sexual orientation-related disparities in employment, health insurance, healthcare access and health-related quality of life: a cohort study of US male and female adolescents and young adults. *BMJ Open*, *8*(6), e020418. https://doi.org/10.1136/bmjopen-2017-020418

Cooley, L. A., Hoots, B., Cyprian Wejnert, Lewis, R., & Paz-Bailey, G. (2016). Policy Changes and Improvements in Health Insurance Coverage Among MSM: 20 U.S. Cities, 2008–2014. *AIDS and Behavior*, *21*(3), 615–618. https://doi.org/10.1007/s10461-016-1567-7

Traister, T. (2020). Improving LGBTQ Cultural Competence of RNs Through Education. *The Journal of Continuing Education in Nursing, 51*(8), 359-366. https://doi.org/10.3928/00220124-20200716-05

Weideman, B. C. D., & McAlpine, D. (2024). State LGBTQ policy environments and the cancer burden in sexual and gender minoritized communities in the United States. *Cancer Medicine, 13*(15)https://doi.org/10.1002/cam4.70097

Tamı-Maury, Irene, DMD,DrPH MSc, & Millett, T. J., M.P.H. (2024). Recommendations and Implementation Considerations for the Routine Collection of Sexual Orientation and Gender Identity Data in Research and Practice. *American Journal of Public Health, 114*(8), 777-781. https://www.proquest.com/scholarly-journals/recommendations-implementation-considerations/docview/3088684410/se-2