Heteronormativity in Healthcare: Neoliberalism, Bio-Politics, and Necropolitics

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HETERONORMATIVITY IN HEALTHCARE:
NEOLIBERALISM, BIO-POLITICS,
AND NECROPOLITICS

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ABSTRACT

This thesis analyzes how healthcare values heteronormativity. It takes a social science and theoretical approach to acknowledge LGBTQ+ health disparities, applies theoretical approaches as to why these disparities exist, and offers solutions to combat health disparities experienced by sexual and gender minorities. Neoliberalism, bio-politics, and necropolitics are the theoretical approaches utilized to understand the basis of disparities experienced by individuals in the LGBTQ+ community. Neoliberalism includes themes of capitalism and public health policies which influence discrimination in healthcare. Bio-politics was used to outline how the intersection of the biological body and politics can exacerbate health disparities through the power of controlling bodies. Necropolitics examines how the combination of homophobia, transphobia, and racism aid in the government control of life and death of certain populations.
CHAPTER ONE
INTRODUCTION

The lesbian, gay, bisexual, transgender, queer, and + (LGBTQ+) community experiences numerous health disparities in United States healthcare (Aleshire, 2018; Daniel & Butkus, 2015). Often, healthcare systems are heteronormative, or they are aimed at providing care for cisgender and heterosexual individuals. Heteronormativity means heterosexuality is the default within a binary gender system and anything out of this norm is abnormal. Further, the LGBTQ+ community has experienced heteronormative microaggressions and discrimination in healthcare settings (Dean, Victor, & Grimes, 2016). LGBTQ+ individuals experience healthcare differently from their cisgender and heterosexual counterparts (Aleshire, 2018). This issue is important as the LGBTQ+ community has been marginalized in the healthcare system. Heteronormativity in medical education, health insurance, and government regulations persist.

It is my thesis that this heteronormativity and discrimination can be connected to the overarching theoretical influences of neoliberalism, bio-politics, and necropolitics. These social and political theories influence institutions, such as healthcare, and the bioethics of what identities are allowed equality in healthcare. These theories serve as a basis to understand racism, homophobia, and transphobia that are enveloped in the United States heteronormative healthcare system. Systems of power can influence what is normative and what is abnormal in societies. Power and control of bodies can also create direct impacts on the health and lives of sexual and
gender minorities. Through utilizing the theoretical concepts of neoliberalism, bio-politics, and necropolitics, an understanding of how heteronormativity is upheld in the United States healthcare system will be analyzed. These three political theories complete the power structures that decide which lives are protected within the healthcare system due to the politicization of sexuality and gender.

Prior literature exists on topics such as neoliberalism and healthcare, however literature on specifically LGBTQ+ healthcare and bio-politics and necropolitics is sparse. These theories tend to encompass issues surrounding migration, violence, and social services, yet it is difficult to find content that meshes the three theories together to understand disparities in healthcare for particularly individuals marginalized because of their sexual and gender identities. This thesis will expand on existing literature, as well as create new perspectives on theoretical approaches to healthcare disparities.

**Two Worlds of Healthcare**

When compared to the cisgender and heterosexual population, LGBTQ individuals in the U.S. experience greater health disparities (Aleshire, 2018; Daniel & Butkus, 2015). Discrimination and stigma towards LGBTQ identities within medical settings contribute to disparities, which can affect the quality of care, access to care, and health outcomes of sexual and gender minorities (Aleshire, 2018, Young & Fischer-Borne, 2018). Moreover, stigma, marginalization, and discrimination are upheld at federal and state policies, furthering disparities in health care coverage and access to care (Daniel & Butkus, 2015). Meyer’s (2003) minority stress model establishes connections between discrimination and stigma that individuals of sexual minority experience to higher levels of stress. This can contribute to escalated rates of
mental health disorders. Despite the persistence of LGBTQ health disparities regardless of race or ethnicity, racial or ethnic minorities may experience a compounded discrimination (Aleshire, 2018; Daniel & Butkus, 2015).

Heteronormativity in society and healthcare contributes to low self-esteem, internalized transphobia, and internalized homophobia in sexual and gender minorities (Dejun, 2016; Dreyer, 2008). Sexual and gender minorities experience different forms of mental and physical health disparities; each community has unique experiences in the heteronormative healthcare system. This thesis will cover health disparities for the entire LGBTQ+ community, as there are overlapping disparities experienced by multiple sexual or gender minorities.

Health Disparities

Gay and Bisexual men are at higher risk for mental health problems such as major depression, bipolar disorder, and generalized anxiety disorder (Center for Disease Control and Prevention [CDC], *Gay and Bisexual Men’s Health*, 2016). Homophobia and stress from hiding sexual orientation can play a role in negatively affecting mental health; although being “out” can endanger MSM (men who have sex with men) in some settings, men who are “out” have better health outcomes (CDC, *Gay and Bisexual Men’s Health: Mental Health*, 2016). MSM are also at greater risks for suicide attempts as men are four times more likely to attempt suicide. In addition, gay and bisexual individuals have higher rates of suicidal ideation, attempts, and completion of suicide when compared to heterosexual individuals (CDC, *Gay and Bisexual Men’s Health: Suicide and Violence Prevention*, 2016; Paul, 2002).

Transgender individuals experience elevated rates of suicide attempt in comparison to their cisgender counterparts (Dejun, 2016). Discrimination in society contributes to an increase
in risk factors for depression and anxiety, in transgender and gender non-conforming individuals (Dejun, 2016). Furthermore, transgender individuals experience discrimination in health care access; 20% of transgender individuals have been refused services because of their gender identity (Aleshire, 2018; Agency for Healthcare Research and Quality, 2014).

Sexual minority women (SMW) experience numerous physical health disparities (Lewis et al., 2019). Lesbian and bisexual women are at increased risk of developing breast, ovarian, and endometrial cancers. These disparities were associated with fewer full-term pregnancies, fewer mammograms, and obesity (Hafeez, 2017). Similar to MSM, SMW are also at an increased risk for developing cardiovascular disease (Lewis et al., 2019; Wang et al., 2007).

In comparison to heterosexual men, gay men are at a higher risk of developing cardiovascular disease, chronic illness, cancer, and have lower rates of survival (Wang et al., 2007). Worsened health conditions in the gay community can be due to postponed doctor visits due to fear of experiencing discrimination (Winter, 2012). MSM are disproportionately affected by human immunodeficiency virus (HIV) in the United States. Black/African American and Hispanic/Latinx MSM are disproportionately affected by HIV across all age groups (CDC, HIV Among Youth, 2020). Pre-exposure prophylaxis (PrEP) is a preventative drug that individuals can take to diminish their chances of acquiring HIV (Siegler et al., 2018). However, barriers prevent many MSM from obtaining PrEP including cost, access, stigma, and healthcare provider willingness to prescribe (Hart-Cooper et al., 2018; CDC, HIV Among Youth, 2020; Petrill et al., 2017).

Transgender women of color are also at risk of acquiring HIV. Positive HIV diagnosis disproportionately affects Black/African American women. The prevalence of HIV diagnosis in
transgender women consisted of 44.2% Black/African women, 25.8% Hispanic/Latina women, and 6.7% white women. Transgender women of color are at an increased risk for acquiring HIV due to stigma, discrimination, and insensitivity in healthcare, racism, transphobia, and lack of gender affirming care (CDC, *HIV and Transgender Communities*, 2019).

**Heteronormativity in Medical Education**

Health disparities in the LGBTQ+ community can be connected to the heteronormative training that medical students receive (White et al., 2015). White et al. (2015) reported that one third of all medical schools in the United States requires no training on LGBTQ+ health. Within the entire timeline of medical education, the median of reported time spent on LGBTQ+ topics was five hours (White et al., 2015). This contributes to the lack of LGBTQ+ knowledge by physicians and care that LGBTQ+ individuals receive. The American Medical Association has failed to make LGBTQ+ healthcare education mandatory, and instead has only recommended medical schools teach LGBTQ+ health (White et al., 2015).

Petroll et al. (2017) conducted research to evaluate primary care physician knowledge and willingness to prescribe PrEP. This study examined how comfortable physicians were talking about the sexual orientation and sexual activity of their patients, their familiarity with PrEP, and if they had prescribed PrEP. While 76% of primary care physicians had heard of PrEP, only 28% were willing to prescribe it. Lastly, only 17% had prescribed it in the past year (Petroll et al., 2017). The unwillingness of a primary care physician to prescribe PrEP can create medical barriers for LGBTQ+ individuals seeking assistance for sexual health. Because mainstream healthcare is not capable of prescribing and treating LGBTQ+ individuals, LGBTQ+ specific clinics are necessary.
CHAPTER TWO

NEOLIBERALISM AND THE TIES OF INEQUALITY IN HEALTHCARE

Heteronormativity assumes all individuals are heterosexual, which in turn generates the marginalization of sexual minorities (Lind & Share, 2003; Drucker, 2018). Neoliberalism values market competition and utilizes privatization to reduce state influence on the economy. It also aims to minimize government interaction in social affairs. As neoliberalism places responsibility on the heterosexual family system, this has excluded and affected sexual and gender minorities in the LGBTQ+ community (Das, 2016). The system of neoliberalism aims to protect the mainstream normativity of society, leaving anyone outside of heteronormativity a minority and second class (Druggan, 2002; Das, 2016). The capitalist features of neoliberalism have created a healthcare system built for the privileged heterosexual community and a nuclear family. It prioritizes privatization that meets basic American family needs and cuts social programs for healthcare and education (Drucker, 2018). This is successively met with marginalization of the LGBTQ+ community from healthcare access.

Heteronormativity in Neoliberalism

Neoliberalism had a large influence on the Reagan Administration’s act to privatize the healthcare industry. Privatization allowed for a larger choice of doctors for patients, but it also furthered the inequality between the wealthy and poor by excluding access for certain groups of people (Grzanka & Miles, 2016; Wilkinson, 2002). Reaganomics aimed at promoting
competition within the market and transferring the local and state healthcare to privatized sectors in order to reduce government spending (Enright, 1892). Neoliberalism ideologies often prioritized and heterosexualized the family institution, which meant married heterosexual couples at the time benefitted from the privatization of healthcare. This left out LGBTQ+ individuals and couples since it was considered “deviant” for LGBTQ+ to be together in a heteronormative environment (Hindman, 2019). Privatized healthcare created more struggles for the LGBTQ+ community.

In the 1970’s transgender individuals were often excluded from private healthcare systems and insurance companies would refuse to pay for gender affirming surgery (Bell, 2020). In order to be covered, many individuals resorted to labeling themselves as “medically diseased” with the outdated diagnosis of “transsexualism” (Bell, 2020; Beek, Cohen-Kettenis, & Kreukels, 2016). In the 1980’s the medical term changed from “transsexualism” to “gender identity disorder,” and was listed as a psychosexual disorder (Meyer-Bahlburg, 2010; Beek, Cohen-Kettenis, & Kreukels, 2016). Although this allowed transgender individuals to have greater access to insurance coverage, the cisnormative and privatized insurance classification system labeled transgender individuals as having a disorder and discriminating against them for their identity (Meyer-Bahlburg, 2010).

While LGBTQ+ identities have battled the healthcare system for coverage and care throughout American history, the movement to begin large-scale activism for LGBTQ+ health can be attributed to the HIV/AIDS epidemic (Beyrer, 2020; Hindman, 2019). Due to the lack of government involvement in healthcare and sexual minority health, and in addition to homophobia, ACT UP (the AIDS Coalition to Unleash Power) began to advocate and spread
activism for MSM that were dying from AIDS (Beyrer, 2020). As the Reagan Administration was silent on this epidemic, the movement for LGBTQ+ health and human rights escalated (Beyrer, 2020; Hindman, 2019).

**Neoliberalism: Blatant Homophobia and Callousness Towards LGBTQ+ Health Disparities**

In Melinda Cooper’s book *Family Values: Between Neoliberalism and the New Social Conservatism* (2017), she dedicates a chapter to critique neoliberal perspectives on the AIDS epidemic. Richard Posner, a “Reagan-era appointee to the United States Court of Appeals for the Seventh Circuit,” economist, and neoliberal suggested that the AIDS epidemic could have saved the government money (Cooper, 2017, p. 168). The large number of deaths allowed the government to evade social security payments to the deceased individuals in the future (Cooper, 2017). Furthermore, neoliberals claimed that the irresponsibility of non-normative sex and voluntary risky behavior of consenting adults resulted in state and federal intervention because federal funding would need to provide testing and treatment for AIDS (Comaroff, 2017). Non-normative sex, or sex that rejected heteronormative standards, failed to uphold neoliberal standards of “proper” family values and principles that can uphold a heteronormative economy (Comaroff, 2017; Peterson, 2011). To illustrate the difference, Posner compared the transmission of tuberculosis as an involuntary infection, and HIV as voluntary, since heterosexuals were not engaging in “risky sexual behaviors,” due to their sexuality (Cooper, 2017).

The neoliberal defense to millions of individuals dying of AIDS, the majority MSM, was that “sexual risks” should not have equated to government funding for research, subsidized health care, or educational programs (Cooper, 2017). If AIDS had affected all individuals, such
as heterosexuals, instead of mainly MSM, perhaps the government and public health economists would have had a different response. The Reagan Administration's failure to respond adequately to the AIDS epidemic and the neoliberalist approach to support economics instead of the sexual minority’s lives exposed the contempt these systems of power have towards the LGBTQ+ community. Analyzing sexuality through market prices allowed the Reagan administration and fellow neoliberals to promulgate homophobic ideals. In addition, the neoliberal approach of underfunding social programs to maintain a high economy drives social control through the lack of government aid. Exacerbating deaths and health disparities in exchange for less required funding from the government connotes to the heteronormative production of power: choosing which lives are valuable and which lives are not.

Before 1986, many AIDS prevention and aid programs were turned down by the Reagan Administration (Francis, 2012). Because the Reagan Administration prioritized financial gain over MSM lives, homophobia was reinforced within the government. Patrick Buchanan, the White House director of communications at the time was quoted saying, “The poor homosexuals. The have declared war on nature and now nature is exacting an awful retribution” (Morris, 1999, p. 816). Because the AIDS epidemic affected mainly MSM in the U.S., the neoliberal heteronormative response was to ignore it. When financial support for the AIDS epidemic was finally addressed, the federal programs that were implemented by the government to provide treatment were heteronormatively named after a boy who got AIDS from a blood treatment: Ryan White (Reichard, 2016). Unfortunately, the hundreds of thousands of MSM deaths did not mean enough to the neoliberal government to pass funding for AIDS sooner, but gay icons, such as Elton John, were able to use Ryan White’s case to advance the agenda on AIDS funding
(Reichard, 2016). It is quite hypocritical for the government to avoid naming AIDS funding in memory of the many MSM who lost their lives because at the beginning of the AIDS epidemic it was labeled “gay cancer” by the media, and later Gay-Related Immune Deficiency (GRID) by health researchers (“A Timeline of AIDS”, 2020). It can be argued that the U.S. government had waited for the heterosexual population to be outraged by AIDS before they were willing to spend federal funding on the epidemic.

Furthermore, neoliberal tactics remain in the healthcare system in regard to medications used to prevent the transmission of HIV, such as PrEP. After PrEP was developed and funded by the drug company, Gilead, it was heavily advertised that MSM should take it to prevent acquiring HIV (Atuk, 2020). The wide use of PrEP was publicly funded through taxes to validate the efficacy of the drug (Atuk, 2020). However, after this government and tax funded research ended, Gilead raised the prices by 76% between 2010 to 2019; this allowed Gilead to charge a 35,000% markup of what the drug cost and what the consumer purchased (House Committee on Oversight and Reform, 2019). Furthermore, Gilead has blocked production of a cheaper generic version of PrEP (U. S. Food and Drug Administration, 2018). This control over the market price of disease blocking drugs not only benefits large pharmaceutical companies, but also privatized insurance companies, which individuals utilize to cover the price of the drug. Can this neoliberal system really claim that it benefits the systematically oppressed? Not a chance!

Further research on the availability of PrEP indicates that individuals that are insured are four times more likely to use the drug as opposed to those that are uninsured (Patel et al., 2017; Atuk, 2020). As reported by the CDC, MSM that are Black/ African American are disproportionately affected by HIV (HIV Among Youth, 2020). However, only 10% of those who
take PrEP are Black/ African American (Mera et al., 2017; Atuk, 2020). Data expresses that Black/ African American MSM have more barriers that prevent their access to PrEP when compared to White MSM that make up 75% of PrEP consumers (Hoots et al., 2016; Mera et al., 2017; Atuk, 2020). Not only does the heteronormativity of a neoliberal pharmaceutical system create barriers for MSM, but it further marginalizes people of color within the LGBTQ+ community. A double oppression of being a person of color and a sexual minority is upheld within neoliberal America, furthering health disparities for marginalized bodies. This compounded discrimination results in poorer health outcomes for intersectional LGBTQ+ identities (Aleshire, 2018; Daniel & Butkus, 2015).

The Ongoing Effects of Neoliberalism

Reaganomics in conjunction with neoliberalism has created lasting effects on the current privatization to health insurance and access to healthcare. The government has prioritized the capitalist system over marginalized bodies. Because the LGBTQ+ community experiences many healthcare disparities, this community has increased healthcare needs. Data shows that LGBT people are also vulnerable to low income and poverty (Badgett, Durso, & Schneebaum, 2013). Privatization of healthcare, which is a common theme in neoliberalism, makes it more difficult for low income and high-risk health patients to access healthcare. Healthcare as a commodity becomes restricted to only those who can afford it. Neoliberalism has affected the healthcare system of the U.S. and has caused privatization, as well as prescription costs to rise. This causes HIV preventative methods, such as PrEP, to become expensive for low-income individuals and people without insurance (Huey, Higham, & Watriss, 2020).
Neoliberal practices continue to influence mental health resources. The Diagnostic and Statistical Manual of Mental Disorders (DSM) has a history of homophobic and transphobic diagnoses in past editions. The American Psychiatric Association (APA) has since depathologized homosexuality, in 1973, and changed Gender Identity Disorder to gender dysphoria in the DSM-5, which was released in 2013 and is the latest edition (Beek, Cohen-Kettenis, & Kreukels, 2016; Drescher, 2015). As mentioned previously, the DSM-3 included “transsexualism” as a diagnosis, which many transgender individuals had to claim in order to make them “diseased” in order to gain insurance coverage for gender affirming procedures (Bell, 2020; Beek, Cohen-Kettenis, & Kreukels, 2016). The updated term gender dysphoria included changes in diagnostic criteria and was removed from sections about sexual dysfunctions and paraphilic disorders; research as well as social and political components contributed to this adaptation (Beek, Cohen-Kettenis, & Kreukels, 2016).

The importance of the DSM is not only for diagnostic purposes, but it also provides treatment plans, accessibility to disability benefits, and insurance coverage (Das, 2016; Cooper, 2004). The necessity of insurance coverage when a person needs prescriptions for their mental health challenges results in their needing an official diagnosis. This returns to the battle of pharmaceutical funding for the DSM and the economic power that the healthcare market has on treatment options. This neoliberal loop fuels the cycle of the privileged heteronormative subject to receive mental health treatment and coverage and leaves out an LGBTQ+ individual who may not have access to insurance or mental health care access. Individuals that are LGBT are more likely to be uninsured when compared to non-LGBT counterparts (Gates, 2014). It was only after Obergefell v. Hodges was passed in 2015 that same-sex partners had greater access to private

However, the system of labeling mental disorders and applying capitalistic features of whether the individual qualifies for insurance coverage not only has neoliberal and capitalistic tendencies, but the homophobic and transphobic history of the DSM is also problematic. Depathologizing homophobic and transphobic diagnosis from the DSM should not be met with the exclusion of individuals from receiving care. Instead of updating terms in each edition, the diagnostic process should be rethought entirely. The DSM does not create social justice, it needs reformation to do so. Creating a label of a diagnosis for health insurance purposes is not only capitalistic, but it can result in the exclusion of sexual and gender minorities from receiving care if they do not fall under a specific diagnosis in the DSM. Neoliberal approaches favor the norm while excluding those outside of them.

The structure of policies and programs in the United States fall back onto heteronormative frameworks (Mason, 2018, Bedford, 2009). The heteronormativity of policies and programs, like health care and diagnostic manuals, can be further traced back to neoliberal practices, but are also reinforced today by the politically conservative right. So, who exactly is being taken care of by the government? “Neoliberalism morphs into its audaciously murderous phase, overtly so now; global capitalism acquires a robust new energy in the privatization of the state’s machinery of death (Thobani, 2014, p. xvii). This passage emphasizes the role that the government plays in deciding whose life is worthy in a market driven environment. The privatization of key healthcare opportunities that affect social services such as mental health resources and prescriptions to prevent HIV, warp into this “machinery of death” that Thobani
A heterosexual, cisgender, White individual has the privilege of having access to healthcare and protection from the government, but anything out of the neoliberal norm is threatened with the destruction of their health due to privatization, which adds to LGBTQ+ health disparities. To answer the prior question, there are clear implications that the LGBTQ+ community is not being taken care of by the government.

**Advancing From Neoliberalism to Bio-Politics**

Neoliberal practices in relation to LGBTQ+ health show that economics were prioritized before the well-being of the LGBTQ+ population. “It is wise to remember that sovereignty is not abstract. It has a particular name, a face, an address, a geographical coordinate. Its face is White, it remains housed in White bodies, it is located in Westernity” (Thobani, 2014, xvii). The governing of citizens is expected to be equal, but it never has been. White bodies with heteronormative family values and capitalist economics benefitted from the sovereignty of neoliberal politics. Public health, health insurance, and social welfare funds are a handful of things impact the image of modern government (Pele & Riley, 2021). To have power over citizens health and instead generate rationalities on why it is important to not take action on health crisis’s, like epidemics or pandemics, creates a false security between citizens and government.

Heteronormativity in healthcare has resulted in the destruction of LBGTQ+ health. Cuts to programs and failure to implement healthcare education and discrimination legislation creates a violent space for the LGBTQ+ community. This forces sexuality and gender to become political to fight for equal rights because cisgender and heterosexual lives are optimized in U.S. healthcare. The heteronormativity in neoliberalism has resulted in entire generations of MSM
lost due to AIDS. Lasting effects of the Reagan Administration have induced Post Traumatic Stress Disorder (PTSD) in the LGBTQ+ generation that experienced the height of the AIDS epidemic in the 1980’s (Theuninck, 2010). Witnessing entire neighborhoods vanish due to heteronormative values of the government created long-term health effects on LGBTQ+ individuals.

In a capitalist driven country, norms can be the driving factor for who benefits from the government. As heteronormativity continues to threaten LGBTQ+ health, it must not be ignored that neoliberal politics damaged progress for this marginalized community. Privatization, discrimination, and economic prioritization have marginalized LGBTQ+ individuals. Damaging a population’s health threatens their survival and well-being. The dangers of neoliberal politics can be connected to the bio-politics of allowing one population to live and letting the other die. The exclusion the LGBTQ+ community has experience in healthcare because of heteronormativity in neoliberalism has demonstrated that the modern U.S. government is guilty of bio-politics. Fulfilling an agenda of socio-economic heteronormativity order has allowed privatized healthcare, pharmaceutical companies, and the government to profit off the health disparities of the LGBTQ+ community.

Overall, neoliberalism ideologies have infiltrated U.S. systems of healthcare to the point that transgender individuals have had to adopt the identity of being “diseased” in order to receive health insurance coverage, hundreds of thousands of MSM have died from AIDS due to capital prioritization, and individuals seeking preventative measures for HIV must be exploited by pharmaceutical companies in order to receive medication. While the privileged are reaping the benefits of the economy, the health of the LGBTQ+ population has suffered. Capital greed has
resulted in the decline and deaths of LGBTQ+ individuals. While the US. Government has neoliberal politics driving the economy, it also has bio-politics driving who gets health benefits and who is excluded.
CHAPTER THREE

BIO-POLITICS WITHIN HETERONORMATIVE SYSTEMS OF OPRESSION

Although the politicization of LGBTQ+ healthcare was uncovered through the failure of the Reagan administration’s response to the AIDS epidemic, which utilized neoliberal politics to privatize and therefor restrict access to healthcare for certain groups, the social and political control of normative health institutions can also be analyzed through the concept of bio-politics. Creating a bio-political body, or the intersection of the biological and the political, creates an opportunity for power to be exerted over certain bodies as well as excluding other bodies (Comaroff, 2017). As mentioned in the previous chapter about neoliberalism, the government excludes taking care of non-normative bodies, including gender and sexual minorities. It is apparent that political agendas have become shaped around who will benefit those in power, and whose health will be recognized as important. Neoliberal bio-politics has led to the formation of a “mere (health) management of populations for late capitalistic purpose” and this has turned “(human) lives into commodities that can be marketized or into worthless forms of existence that can be discarded, especially in situations of health and economic crisis” (Pele & Riley, 2021, p. 2). Not only have LGBTQ+ individuals been ignored during the AIDS health crisis, but the marketization of HIV preventative drugs utilizes at risk bodies for capitalistic purposes. Discarded bodies are excluded from healthcare prioritization and thus biopower is utilized.
Bio-politics and Marginalized Bodies

The interaction of heteronormativity in a bio-political health system can be attributed to the carelessness that those in power have over oppressed LGBTQ+ individuals. Michel Foucault explains the consequences of biopower in *History of Sexuality Volume I: An Introduction* (1978):

Another consequence of this development of biopower was the growing importance assumed by the action of the norm, at the expense of the juridical system of the law. [...] It is no longer a matter of bringing death into play in the field of sovereignty, but of distributing the living in the domain of value and utility. [...] The law operates more and more as a norm, and that the judicial institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory. A normalizing society is the historical outcome of a technology of power centered on life. (p.144)

This passage reflects the normativity that governmental systems pursue when creating laws and institutions (ie: healthcare). If power systems focus on life’s “value and utility” to “ensure, sustain, and multiply life” (Foucault, 1978), then these systems are protecting heterosexual family values that are normative in government systems, such as the United States government. Normative values of social and political structures allow regulation of which bodies are more important than others, which can then create disparities within certain populations, such as LGBTQ+ health disparities. Furthermore, the “value and utility” that certain citizens provide for a country is biased towards normative standards of who is fit for the capitalistic system (Pele & Riley, 2021, p. 2). The government viewed those dying rapidly of AIDS during the epidemic as young, unproductive, and poor, therefore, not worthy of having a strong “value and utility” towards their citizenship (Cooper, 2017).

This utilitarian neoliberal approach that only benefits the heteronormative majority not only excludes the LBGTQ+ community, but it chooses to let the “othered” die, which allows the government to utilize biopower. Bio-politics and the heteronormative approach of healthcare
allows for certain lives to live healthier lifestyles and have privileged access to care compared to others. Sexual and gender minorities have become “othered” from healthcare institutions and governments due to bio-political tendencies and heteronormativity. Politically marginalizing bodies normalizes the unprivileged. In this case, heteronormative politics have marginalized the LGBTQ+ body, creating inequalities. Health inequalities not only put LGBTQ+ individuals at a social disadvantage, but homophobia and transphobia upheld at government levels encourage bio-politics within the U.S.

**Neoliberal Bio-politics Disregard for LGBTQ+ Health**

Bio-politics meshes with neoliberalism as Foucault (1978) incorporates capitalism as the reason to control bodies. Regulating bodies, and I would argue excluding populations in regulations is considered regulating bodies, such as within social services, aids in perpetuating the normative values of the reproduction of life and capitalistic power. Below Foucault (1978) acknowledges the “administration of bodies,” which can also be interpreted as regulating bodies:

> The old power of death that symbolized sovereign power was now carefully supplanted by the administration of bodies and the calculated management of life. During the classical period, there was a rapid development of various disciplines - universities, secondary schools, barracks, workshops; there was also the emergence, in the field of political practices and economic observation, of the problems of birthrate, longevity, public health, housing, and migration. Hence there was an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations, marking the beginning of an era of "biopower." (p. 139-140)

Foucault expands on regulating bodies to a “calculated management of life” as well as public health as an economic and political issue. When governmental forms of power establish discriminatory legislation towards LGBTQ+ individuals in healthcare, essentially this system of power is “managing life.” As displayed in the previous chapter about neoliberalism, the perpetuation and continued dominance of capitalism come before LGBTQ+ lives. Neoliberalism
also prioritized heteronormative family values before LGBTQ+ lives, one could argue to “control the population.” Creating a heteronormative system of oppression subjugates the LGBTQ+ community and creates disparities. This displays biopower because the health of these populations becomes at risk, creating unhealthy populations as a result of “managing life.” This results in the “careless administration of the population” (Pele & Riley, 2021, p. 4).

The institutions that Foucault lists, including schools, uphold heteronormative standards and this reinforces the biopower over marginalized LGBTQ+ populations; this is especially apparent in medical schools. Healthcare is an institution that deploys biopower over which lives get proper healthcare and which do not. Physicians have the choice of either giving equal care to all or discriminating against individuals. Unfortunately, the latter is too common among LGBTQ+ experiences in healthcare due to a lack in LGBTQ+ education in medical schools (Nama et al., 2015). Medical education and the lack of LGBTQ+ curriculum will be further covered in the next chapter.

Exclusion and Neglect

Bio-politics can also be appertained to the exclusion of transgender and gender non-conforming bodies in healthcare settings as well as the lack of acknowledgement from medical institutions on transgender bodies’ rights. Medicalization of gender variance, such as transgender bodies, has become regulated by bio-politics (MacKinnon, 2018). Privatized insurance companies are inconsistent when it comes to covering the costs of medical gender affirming care, such as facial feminization surgeries (Gadkaree et al., 2020). Facial feminization surgery changes facial features from masculine features to a feminine features. Many individuals who are transitioning to be a woman get facial feminization surgery to enhance feminine features of
cheeks, lips, and face structure (Altman, 2012). Often, it is considered a cosmetic surgery and is rarely included in the most popular health coverage plans throughout the United States (Gadkaree et al., 2020). Facial feminization surgery aids in individuals with diminished mental health factors and quality of life associated with not having his surgery (Ainsworth & Spiegel, 2010). It also contributes to a reduced risk of depression and suicide as well as offers protection from gender-based violence (Grzanka et al., 2018). Facial feminization surgery benefits transgender individual’s mental health, yet it is merely considered cosmetic under cisnormative standards. In this example, biopower contributes to excluding the mental health benefits of transgender individuals.

Not only is excluding gender affirming medical care discriminatory, but it can be considered regulating of which bodies are important to receive medical care to improve the quality of life. Bio-ethically, it is not inclusive to ignore gender variances' needs. In addition, the cisnormative government and medical institutions continue to ignore medical necessities of the LGBTQ+ community. The transgender and gender non-conforming community continue to endure hostile advances from government institutions, mainly conservative members of Congress. Since the beginning of 2021, Human Rights Campaign reported that 240 anti-transgender bills had been introduced as of April 2021. Anti-transgender bills consisted of medical care, sports bans, and bathroom access (Ronan, 2021). This overt attack on transgender and gender non-conforming rights emphasizes the bio-politics involved in access to gender affirming care. The amount of exclusionary bills reinforces that discrimination towards transgender bodies is still prominent and it even goes as far to affect medical care. Bio-politics in the United States upholds the heteronormative and cisnormative prioritization of certain lives.
While these disparities exist, forms of power in healthcare and government can choose whether to fund research to diminish these disparities. Between 1989 and 2011, the National Institute of Health (NIH) funded 628 studies on LGBT health; this made up for .5% of all studies between this time (Coulter, Kenst, & Bowen, 2014; Boehmer, 2018). When topics of HIV/AIDS and sexual health were excluded, only .1% regarded other types of LGBT health. Furthermore, 86.1% of these studies researched sexual minority men (Coulter, Kenst, & Bowen, 2014). If only .1% of these studies addressed other types of health concerns, then LGBTQ+ health disparities are not being adequately funded. To only focus on sexual health within the LGBTQ+ is concerning, as data expresses that the LGBTQ+ community is affected by numerous other health disparities.

The connection of bio-politics and disease in LGBTQ+ health, such as cardiovascular disease and cancers, is important to observe because certain diseases are disproportionately high in LGBTQ+ communities (Wang et al., 2007). However, it seems as though these issues are not being funded as much as sexual health within LGBTQ+ health research. How is the issue of diseases, such as cancer and cardiovascular disease, meant to be addressed for the LGBTQ+ community if it is not even receiving adequate research funding? Neglecting research and ignoring that gender and sexual minorities have different health disparities than the cisgender and heterosexual population initiates biopower. The power of institutions to neglect health disparities remains unchecked in U.S. healthcare.

**Overpowered and Out of Control**

One of the largest issues with unharnessed executive power in the U.S. government is the threat of discriminating against an entire social group. This level of biopower marks the direct
power that institutions have on their citizens. This was observed in the Trump Administration’s attempt to repeal sex-based discrimination in the Affordable Care Act (ACA). The Obama Administration previously adapted the ACA to include regulations protecting transgender individuals from discrimination in healthcare (Clemens, 2021). In 2020, during the height of the COVID-19 pandemic, the Trump Administration ruled that only binary biological sex is protected from sex discrimination (Clemens, 2021). This not only threatened the health of the transgender and gender non-conforming community, but it also threatened to leave many individuals in a dangerous position during the COVID-19 pandemic. Bio-political motives of threatening the future of inclusive healthcare for transgender individuals was apparent within the Trump Administration.

Regulations protecting transgender and gender non-conforming individuals are important because this community experiences prevalent stigmatization within the healthcare system (Clemens, 2021). In addition to stigmatization, 20% of transgender individuals have been refused services because of their gender identity (Aleshire, 2018; Agency for Healthcare Research and Quality, 2014). Access to healthcare can be difficult for the transgender community due to fear of discrimination (Seelman et al., 2017).

This bio-political attack on the transgender and gender non-conforming community exposes the irresponsibility of the U.S. governmental system. Why should one administration be able to determine medical care for an entire social group? Power is not equally distributed in the U.S. government system; therefore, it lacks the ability to create unbiased systems to promote equality for its citizens. In this case equality within the healthcare system was almost infiltrated with transphobic legislation. Moreover, why must politicians have power over medical issues?
Biopower has the threshold to create detrimental health effects on marginalized populations. Medical practitioners and social scientists need to have authority when topics pertaining to healthcare need to be addressed. There must be proper checks in place to prevent a future administration from enacting such reckless actions in the future.

Because of the AIDS epidemic, the Food and Drug Association (FDA) banned MSM from donating blood in 1985 (Park et al., 2021). Recently, the deferral period to donate blood has changed. Due to COVID-19, the deferral period has changed to three months, meaning a man cannot donate blood unless he has abstained from sex for the past three months (Park et al., 2021). The decision to turn away MSM because of sexual identity stigmatizes their sexuality. By only excluding MSM from donating blood, it implies that HIV is a “gay disease” (Park et al., 2021). The CDC currently tests blood donations for HIV as well as performs nucleic and antibody tests. There is an estimated 1 in 1.5 million chance that HIV could currently be transmitted through blood transfusion. The biopower of withholding a population from donating blood by controlling when and which sexual identities can donate is discriminatory (Park et al., 2021). The blood donation process “governs life” through biopower by choosing who can and cannot participate in donations. (Kent & Farrell, 2015).

The emergence of data pertaining to infection due to blood transmission should be taken into consideration when updating guidelines. Since there are precautions in place and an extremely low chance of transmission, the continuation to defer and exclude the use of MSM blood donations is homophobic. The bio-political decisions of the FDA to allow MSM to donate if sex was abstained from for three months does not seem like an evidence-based decision, but a decision to uphold power over biological and personal, private decisions. Why hadn’t the
restrictions been looser before COVID-19? If the desperation for blood was dire, it would still be illogical to allow MSM to donate if there was such a risk, but that seems to be negated by the fact that the order to lift restrictions passed so effortlessly during the pandemic. To be able to control populations eligibility based on sexuality and on sexual practices exerts biopower over certain bodies and not others. Why is it necessary to continue tight control governmental control over MSM bodies?

Biopower Regarding Who Matters

Healthcare institutions in the U.S. control the health of sexual and gender minorities through power over who is included in quality care and who is not. Judith Butler writes in *The Force of Non-Violence*, “When we ask whose lives count as “selves” worth defending […] the question only makes sense if we recognize pervasive forms of inequality that establish some lives as disproportionately more livable and greivable than others” (2020, p. 21). Butler further analyzes the greivability of lives and what counts as violence and what does not. While examining LGBTQ+ healthcare in the U.S. it seems as though bio-politically run institutions do not count LGBTQ+ lives as greivable. Furthermore, it can be argued that these systems do not consider discrimination and phobias directed against gender and sexual minorities as examples of violence. If the definition of violence is to cause harm upon another individual, then the healthcare system is guilty of doing so. Therefore, greivable lives are lost due to the healthcare inequalities within the U.S. government and healthcare institutions, yet these institutions do not admit it.

Because the government fails to implement proper protections for the LGBTQ+ community, these lives are worth defending due to the “pervasive forms of inequality” that this community experiences. The power over which lives are greivable and deserving of equal
healthcare depend on capitalistic drives, racism, homophobia, and transphobia within institutions. This demonstrates that the government and healthcare institutions choose who is medically taken care of and included based on lives worth defending. The impact of racism, homophobia, and transphobia are deciding factors in determining whose life is greivable. The inequalities that stem from these discriminations continue to exist today.
CHAPTER FOUR

NECROPOLITICS AND THE CONTROL OF HEALTHCARE

Achille Mbembe, author of *Necropolitics* (2003), outlines his concept of necropolitics as the political sovereignty to decide as well as control life and death. Necropolitics aims to create a “world without,” or eliminate “undesirables” (Mbembe, 2003). Necropolitics is often presented in conjunction with topics of bio-politics and biopower. However, Mbembe addressed that “biopower is insufficient to account for contemporary forms of the subjugation of life to the power of death” (2003, p. 92). While certain social groups may be excluded from legislation or healthcare within bio-politics, necropolitics simply subjects citizens to death. This chapter will utilize necropolitics to examine the violent/brutal experiences in the healthcare setting and to demonstrate how the LGBTQ+ community is subjected to discrimination and stigma that ultimately leads to more health disparities as well as higher death rates.

“Small Doses” and “Spasmodic Surges”

Through necropolitical power, forms of government and institutions can increase death rates “by small doses (the cellular and molecular modes) or by spasmodic surges” (Mbembe, 2003, p. 38). This means necropower can contribute to mass eliminations of populations or small increments of death from lower scale operations. Often, marginalized bodies are affected by necropolitics. Unfortunately, this cycle is hard to stop, and as seen in LGBTQ+ health, disparities have always existed and continue to exist. The norms of healthcare and politics care only for the
privileged population, and the symbolic execution of disparities overtakes the unprivileged.

LGBTQ+ health disparities have caused significant deaths to the sexual and gender minority communities. An example of a “spasmodic surge” in LGBTQ+ deaths can be connected to the AIDS epidemic and the fact that the government knowingly turned its back on the deadly epidemic. In this circumstance, the necropower of condemning mostly MSM to death from AIDS caused over 300,000 deaths between 1987 and 1988 (Rosenfeld, 2018). To put that in perspective, about 600,000 people have died in the past year from COVID-19 (CDC, COVID Data Tracker, 2021). Because mostly MSM were affected by AIDS, states with large gay neighborhoods experienced more deaths. For example, 61% of all males between the ages of 25-44 years old died of AIDS in San Francisco (Rosenfeld, 2018). As large populations of citizens from gay neighborhoods were dying, the Reagan Administration necropolitically let them die. Silence equals death.

Currently, “small doses" of death rates can be ascribed to health disparities experienced by LGBTQ+ individuals such as higher rates of cardiovascular disease and cancers, along with lower survival rates that exist for sexual and gender minority individuals (Wang et al., 2007). As mentioned in the previous chapter, there is sparse research on these disparities and a lack of government funding in this field, thus, upholding “small doses” of LGBTQ+ deaths within a community that is unrecognized and discriminated against in healthcare. Heteronormativity within healthcare subjugates LGBTQ+ people to experience lower survival rates through discrimination as well (Wang et al., 2007). There is currently a lack of research on this topic, however, many LGBTQ+ individuals fear going to see a doctor due to the discrimination they will face. Transgender individuals who fear discrimination in the medical setting have poorer
health, and cisnormative healthcare can be transphobic (Seelman et al., 2017). The delayed medical care is a result of noninclusivity in healthcare.

These “small doses” can also be compared to a build up of stigma, discrimination, health disparities, and political threats. Lauren Berlant compares a “slow death” to “the physical wearing out of a population and the deterioration of people in that population that is very nearly a defining condition of their experience and historical existence” (2007, p. 754). The necropolitics behind subjugating a specific population, to a “slow death” is prominent in the U.S. when looking at LGBTQ+ health. The slowness of everyday discrimination and refusal to give care to patients in a clinic take a detrimental toll on the mental health of the LGBTQ+ community.

**Necropolitics and Healthcare Workers**

Not only is the United States government guilty of necropolitics, but homophobic and transphobic healthcare workers continue to wreck the health of the LGBTQ+ community. The United States fails to implement mandatory education in medical schools for sexual and gender minorities, leaving many healthcare workers uneducated on how to work with the specific needs of the LGBTQ+ community. As noted in Chapter 1, only one third of all medical schools in the United States require training for LGBTQ+ health (White et al., 2015). Furthermore, the average amount of time medical schools spends on LGBTQ+ health is five hours in the entire medical program (White et al., 2015). Failing to educate physicians on LGBTQ+ health allows for the lack of medical knowledge in healthcare workers to continue. This in turn supports necropolitical tendencies that condemn the LGBTQ+ community to experience health disparities, therefore, subjugating LGBTQ+ individuals to poor healthcare.
Data expresses that medical students find gender to be a societal debate and are not accepting towards transgender individuals (Nama et al., 2017). If a medical student is not accepting to transgender individuals, then how are they meant to treat transgender patients without bias? It is dangerous for a transgender patient to have a transphobic physician. Discrimination effects the quality of care that an individual receives (Aleshire, 2018). Furthermore, only 47.1% of adolescent healthcare providers felt confident in their medical ability with transgender youth patients (Nama et al., 2017). If not even half of healthcare providers for transgender youth are confident in their ability, then medical education needs to be restructured to ensure inclusive healthcare to gender minorities. The exclusion of teaching LGBTQ+ healthcare will lead to discrimination and further health disparities.

The American Medical Association and the American Association of Medical Colleges has not made LGBTQ+ curriculum mandatory in medical school (White et al., 2015). These institutions only “recommend” LGBTQ+ healthcare is covered in medical programs. This is problematic because the lack of LGBTQ+ healthcare knowledge produces unprepared healthcare providers (Nama et al., 2015). This issue relates to necropolitics because the American healthcare system is failing to produce students knowledgeable in LGBTQ+ healthcare and allowing unprepared healthcare providers to work in the field. As health disparities already exist, unprepared healthcare providers will only increase levels of inadequate care that LGBTQ+ patients receive.

Moreover, discrimination and stigma remain rampant throughout healthcare facilities. Discrimination within a healthcare setting can be detrimental to the health of the individual seeking medical care. It can be argued that blatant homophobia and transphobia by a healthcare
worker can submit a patient to experience health disparities as well as death in the long run. Due
to discrimination, an individual may postpone their doctors’ visits, which can impact their health
(Winter, 2012). Discrimination towards LGBTQ individuals in medical facilities can affect the
quality of care, access to care, and health outcomes (Aleshire, 2018, Young & Fischer-Borne,
2018). In addition, stigma, marginalization, and discrimination exist in federal and state policies,
upholding a normative attitude of discrimination towards the LGBTQ+ community in a
healthcare setting (Daniel & Butkus, 2015). Being refused treatment by a healthcare provider and
perceived victimization magnify suicidal ideation in LGBT youth (Compton & Whitehead, 2015;
Liu & Mustanski, 2012). It can be argued that intensifying suicidal feelings within an individual
can be attributed to necropolitics. The nature of refusing care and raising suicide risk is right
along the lines of encouraging death upon an individual.

**Racism within the Heteronormative Healthcare System**

Necropolitics also explores concepts of racism in political sovereignty. Mbembe writes
“racism is the driver of the necropolitical principle insofar as it stands for organized destruction,
for sacrificial economy, the functioning of which requires [...] a habituation of loss” (2003, p.
38). An anti-racist initiative within LGBTQ+ health disparities also needs to be utilized if the
United States is going to abolish health disparities. Homophobia and transphobia should also be
kept in mind when thinking of Mbembe’s concept of necropolitics and racism, as intersecting
identities of marginalized communities are greatly affected by power structures. The double
oppression of race and gender/sexuality influences health disparities (Aleshire, 2018; Daniel &
Butkus, 2015).
LGBTQ+ health disparities in the U.S. disproportionately affect the Black/African American and Latinx/Hispanic communities. Black/African American MSM experience the highest rates of HIV than any other group (CDC, Gay and Bisexual Men, 2020). This has been consistent since the AIDS epidemic began and even within the first five years of the AIDS epidemic, the CDC recognized Black and minority ethnicities were disproportionately affected (Francis, 2012). In addition, transgender women of color also experience high rates of HIV, which can be attributed to the higher rates of transphobia and racism these individuals experience in healthcare (CDC, *HIV and Transgender Communities*, 2019).

But if racism has become so insidious, it is also because it has now become a part of the constitutive drives and economic subjectivity of our times. [...] One allows oneself some racism not because it is something unusual but by way of reply to neoliberalism’s general call to lubricity. *Out* with the general strike. *In* with brutality and sex. In this era, which is so dominated by a passion for profit, this mix of lubricity, brutality, and sexuality fosters the “society of the spectacle’s” assimilating of racism and its molecularizing through structures of contemporary consumption. (Mbembe, 2003, p. 62)

This passage connects necropolitics to neoliberalism’s economic greed. It also enforces the idea that racism is overlooked in a capitalist society, even if it is causing higher death rates and health disparities. Due to economic disparities, the LGBTQ+ community already has lower access to health insurance. A study by Lambda Legal reported from a survey of rating healthcare fairness that 16% of respondents of color were uninsured compared to 9 percent of white respondents (2014). The neoliberal privatization of healthcare reinforces and increases health disparities for LGBTQ+ individuals of color. The fact that disparities are experienced through necropolitics and neoliberalism “molecularizing through structures” should be more of a concern for government action and much needed research.
Society is also responsible for continuing to conceal racist institutions instead of partaking in reforming entire structures and changing social attitudes. Mbembe writes, “we should fear a violent return to an era in which racism was not yet regulated to the “shameful parts” of our societies” (2003, p. 62). As demonstrated above, healthcare in the U.S. seems to be doing a poor job of regulating racism in the access and care that individuals receive. Although violence may be more concealed if it is seeping through systems of health to inflate diseases, such as cancers, in the LGBTQ+ community, it is “shameful” that racism in addition to homophobia and transphobia exists within a heteronormative modern structure.

The necropolitics of healthcare continue to emphasize the racism, homophobia, and transphobia that still exist in society today. Healthcare workers continue to have authority over which lives will be subjected to bias and discrimination, leading to a lack of quality care on the patient’s end. The uneducated and unprepared medical students will continue to uphold these attitudes of bias towards patients if they are not properly educated on the difference of medical care that the LGBTQ+ community needs. Attitudes and compulsive expectations of heteronormativity and cisnormativity are dangerous in the medical field. Because of necropolitics and homophobia, the AIDS epidemic was able to take the lives of many MSM. “Small doses” of lives are continuously taken due to the higher rates of cancers and cardiovascular diseases that remain under researched for the LGBTQ+ community.
CHAPTER FIVE
SOLUTIONS

The structure of policies and programs in the United States fall back onto heteronormative frameworks (Mason, 2018, Bedford, 2009). The heteronormativity of policies and programs, like health care and diagnostic manuals, can be further traced back to neoliberal practices, but are also reinforced today by the politically conservative right. Bio-politics and necropolitics dictate who gets the opportunity to receive quality medical care and who is condemned to an unequal death in the healthcare system. Heteronormativity along with racism play a role in which lives are greivable and worth caring for.

For an equal society, all citizens must have the ability to receive non-discriminatory healthcare. Inequalities due to governments, institutions, or insurance markets must be regulated to improve and equalize healthcare for gender and sexual minorities. Normative responses to health disparities will not address inequalities that minorities experience because often normative solutions benefit the heteronormative, White, middle to upper class citizens. It is important to examine the issue of LGBTQ+ health inequalities through political theories because sexuality and gender have become politicized. These factors determine who has the power over politicizing bodies to the point of excluding entire populations from receiving care.

The politicization of sexuality and gender has reinforced attitudes of homophobia and transphobia. Because these attitudes are currently held by the government and healthcare
institutions, it is critical to focus on the next generation that will be leading government and healthcare. In order to shape attitudes, proper inclusionary education is needed. The ignorance and unpreparedness of medical students to work with transgender patients is embarrassing for the United States. This can be changed if the American Medical Association acts to make LGBTQ+ education mandatory in medical programs. Furthermore, an adequate amount of time must be spent learning this material. This should be researched in order to provide an education worthy of medical student’s time and to best prepare them for working with all populations without bias.

LGBTQ+ education must be incorporated into all levels of education through the United States to prevent children from developing preconceived bias towards a population they have never learned about. Currently, many homophobic education laws exist in the United States. “No promo homo” legislation bans “homosexual” education in states such as Alabama, Louisiana, Oklahoma, Mississippi, and Texas” (GLSEN, n.d.; Lambda Legal, n.d; Lytle & Sprott, 2021). Texas and Alabama have legislation that only allows a heteronormative curriculum (Lambda Legal, n.d; Lytle & Sprott, 2021). This legislation prevents the education of anything related to gayness of LGBTQ+ topics to prevent the promotion of being LGBTQ+. Upholding heteronormativity in society, as demonstrated in this thesis, is not only marginalizing, but also dangerous for LGBTQ+ lives. Without education on these issues, youth will not only be uneducated, but the knowledge and reproduction of LGBTQ+ history will be absent and invisibilized.

Introducing a sex positive attitude earlier in youth’S lives can also shape their attitudes to create their own identity that is unphased by fear of discrimination. This affirming approach to sexuality can encourage less stigmatization within sexual minorities (Hyde, 2013; Ritter &
Terndrup, 2002). Creating an accepting environment can be achieved through utilizing a sex positive approach (Ritter & Terndrup, 2002). Although it may sound radical, sex positivity should be incorporated into education to encourage youth to feel safe from being discriminated against and enforce that all sexualities are welcomed. As I mentioned before, heteronormative approaches to issues tend to only benefit the heterosexual population. This approach incorporates queering youth’s education to teach positivity. Radical positivity may create radical change.

There needs to be more funding for LGBTQ+ health disparity research. The lack of federal funding in the past is disproportionately centered on sexual health within the LGBTQ+ community when there are plenty of other health disparities that must be addressed. The biopower of excluding funding for LGBTQ+ health disparities can be recognized in the lack of medical solutions for the LGBQ+ community. Research can help drive the need for treatment and financial aid that sexual and gender minority populations will benefit from. Identities with double oppressions, such as the intersection of racial and sexual/gender minorities, should be prioritized when conducting research, as this community experiences more discrimination and oppression.

Beyond what the government and institutions must implement, society can self-educate themselves on LGBTQ+ health disparities. Widespread recognition of social issues can motivate social movements and create change. Perhaps it can lead individuals to check their own implicit biases that they may have. Once individuals recognize how heteronormativity affects systems of oppression, society can become more aware of how heteronormative actions impact marginalized populations. Realistically not everyone can or wants to be researchers and physicians to make a
physical difference in LGBTQ+ health disparities, however, self-education is a great place to start to partake in social justice.

Although neoliberalism has lasting effects on the treatment of LGBTQ+ bodies and biopolitics and necropolitics are continued to be used today, there can be hope to train and create a more inclusive future. It can be preached repeatedly that each body matters, but that does not correlate to systems of power choosing which bodies matter. There is a lot of work that must be accomplished in order to create a just and equal future for LGBTQ+ health.
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VITA

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