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Monographic Section

Health beyond norms: Queer access, resistance, and the reimagining of care

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Abstract. The paper examines the ways in which healthcare systems, despite formal commitments to universality and equality, reproduce structural inequalities that marginalize people who escape heteronormativity, whether through non-normative gender identities, sexual orientations, or embodied expressions. The analysis situates these dynamics within a global perspective, highlighting how access to affirming care varies across geographical, political, and cultural contexts. Empirical evidence from international statistics and studies illustrates that disparities in healthcare access and outcomes are shaped by the intersection of structural stigma, socio-economic marginalization, and the persistence of pathologizing medical frameworks. The paper devotes particular attention to Italy, using data from the *Istituto Superiore di Sanità* (ISS) on the health status and healthcare experiences of transgender and non-binary people. These findings reveal marked inequalities in mental health, preventive care uptake, and exposure to discrimination, underscoring the gap between the formal promise of the national healthcare service and the lived realities of access. The discussion argues for a shift from rhetorical inclusion toward structural transformation, identifying key areas for change: destructuring medical epistemologies, reconfiguring the spatial organization of care, transforming professional education, and embedding institutional accountability. The conclusion reflects on the politics of resistance within healthcare systems, emphasizing that confronting normative structures is important for creating environments that are not only accessible, but queer-informed and just.

Keywords: queer, healthcare, Italy, health.

INTRODUCTION

Access to healthcare is widely recognized as a fundamental human right and a cornerstone of public welfare systems. Yet, as a rich body of scholarship in queer studies has shown (Epstein 1994; Heyes *et al.* 2016; Klein 2008; Wilton 2004), healthcare is far from being a neutral or universally accessible service. Instead, it acts as institutionalized field of power that shapes, disciplines, and regulates bodies according to dominant norms. Within this framework, health services have been conceptualized not merely as technical or humanitarian infrastructures but also as socio-spatial orders that participate in the reproduction of cis-heteronormativity by the assumption that sex, gender, and sexuality are stable, coherent, and naturally aligned (Enson 2015; Searle 2019). Drawing on Butler's (2004) theorization, gender and sexuality are not inherent ontologies but the effects of performativity – reiterated norms that are regulated and sanctioned through discourse, institutional practices, and spatial arrangements. What appears as "natural" sex is itself a cultural and political production, sustained by the cis-heteronormative matrix it seems to confirm.

As Johnston (2015: 808) observes, "sexual politics permeate all spaces – private and public, urban and rural, macro and micro," ia dynamic that also extends to healthcare systems (Lee, Kanji 2017; Röndahl *et al.* 2006). These dynamics are most acute for queer individuals – whether due to their non-normative gender identities, sexual orientations, or embodied expressions – whose access to care is frequently mediated by pathologizing frameworks and lack of knowledge.

From a broader critical perspective, queerness represents more than an identity category; it is a challenge to the very categories through which subjectivity is recognized and valued (Marella 2017). Queer identities destabilize the ontological and epistemological assumptions underpinning medical practice, exposing the contingency and partiality of its classificatory systems. This disruptive potential often triggers mechanisms of containment. Queer individuals are compelled to negotiate their visibility, to postpone or avoid seeking care, or to rely on informal and community-based health networks that operate in parallel to the institutional system (Alencar *et al.* 2016).

This study responds to the need for a critical examination of these entrenched dynamics. Specifically, it investigates how queer people encounter the healthcare system not as an inclusive space of care, but as a site of normalization, exclusion, and regulatory control. It situates the analysis within the broader theoretical frameworks of queer studies, while anchoring the empirical discussion in the Italian case. By engaging with both the structural dimensions of healthcare and the lived experiences of those navigating it, the work seeks to illuminate the ways in which inequality is produced and sustained within institutions that publicly claim to provide care for all.

TEORETICAL FRAMEWORK

From a sociological standpoint, institutions are built around cultural schemas that reflect the interests and experiences of majority populations (Durkheim 1951; Merton 1957). When marginalized groups enter these institutions, they can encounter a dissonance between their lived realities and the assumptions embedded in institutional design. This mismatch produces both symbolic and material effects: symbolic, in the form of misrecognition or invisibility; material, in the form of inadequate care, or confusion. In this sense, the healthcare system operates as a microcosm of broader social stratification, reproducing hierarchies through what Ahmed (2006) calls "institutional orientations": the ways in which spaces, procedures, and services are arranged around the needs of some bodies and not others.

One of the most powerful of these orientations is the sexual binarism that underlies biomedical classifications. As Iantaffi (2020) notes, the binary division of bodies into "male" and "female" is so deeply entrenched in contemporary somatic orders that it is perceived as a natural and self-evident truth. Yet, this perception is not a reflection of biological inevitability; it is, rather, an effect of historically sedimented power relations. Foucault's (1976) analysis of the medical gaze and biopower illustrates how medicine has never been limited to the neutral diagnosis and treatment of illness. Instead, it produces subjects, categories, and normative expectations, incorporating sexuality into the sphere of political management. The emergence of biopower marked a shift from simply prohibiting certain behaviors to actively shaping populations through regulation, surveillance, and normalization.

In this process, queer bodies have been persistently medicalized and regulated. The historical transition from juridical condemnation – such as the criminalization of sodomy – to medical pathologization, exemplified by the construction of "homosexuality" as a distinct medical category in the nineteenth century, shows how normative sexuality is inscribed and enforced within institutional practices (Gagnon *et al.* 1982; Brown, Knopp 2014). The clinic, as Philo (1996; 2000) has argued, became not only a site for diagnosing and treating illness but also a key institution for making bodies legible to the state, translating difference into pathology, and embedding these classifications into the apparatus of governance.

Alongside the discursive and classificatory dimensions of medical power, the absence of queer representations, the default use of binary gender markers, and the presumed heterosexuality of patients contribute to an atmosphere of exclusion that operates as much through affective cues as through explicit policy (Heyes *et al.* 2016; Martin, Miller 2013; Meer, Müller 2017).

Institutional legitimacy in healthcare is tightly linked to what can be termed institutional intelligibility: to be acknowledged as a patient, one must be classifiable within the system's existing parameters. For example, routine assumptions about patients' gender or sexual orientation can reinforce the perception that queer lives are illegible or undeserving of care. These microaggressions are not isolated events but part of a larger structure of normative violence that operates through everyday medical interactions (Ayhan *et al.* 2020; Keuroghlian *et al.* 2017).

Trans and gender non-conforming bodies often exceed or disrupt expected parameters, unsettling the frameworks through which care is typically delivered. As Wilton (2004) points out, even the dominant conceptualization of "sexual health" is framed through the lens of heterosexual reproduction, relegating queer experiences to a marginal or exceptional status. This framing has tangible consequences, including the systematic under-provision of relevant services and the production of environments where non-normative patients experience themselves as anomalous.

Such misalignment can generate friction in the clinical encounter, complicates diagnostic and therapeutic processes, and often places the burden of explanation, education, or self-justification on the patient rather than the provider (Logie 2012; Pega, Veale 2015).

QUEER ACCESS TO HEALTH SERVICES: A GLOBAL PERSPECTIVE

Empirical research conducted across diverse geographical contexts consistently points out a strong relationship between queerphobia and barriers to healthcare, while also revealing that such dynamics are unevenly distributed. The geography of queer healthcare access is shaped by intersecting social, political, and spatial factors, with significant variations linked to urban–rural divides, regional health policies, and local cultures of stigma or support (Duncan 1996; Moore 2015; Tanenbaum *et al.* 2025). Queer individuals living in conservative or underserved regions often face greater obstacles in securing affirming care and may be more susceptible to social isolation. Structural stigma in these settings is both spatially and politically contingent, rooted in specific histories of exclusion and resistance. The intensity of these dynamics is well-documented in the Global South. In South Africa, for instance, queer patients – particularly Black lesbians and transgender men – have reported widespread mistreatment in healthcare settings, ranging from verbal abuse to outright denial of care (Jewkes, Abrahams 2002; Nath, Mthathi 2011; Rispel *et al.* 2011; Smith 2015; Visser 2003). Importantly, such practices are not confined to countries lacking formal protection. Even in contexts with progressive legal frameworks, the legacy of medical pathologization continues to shape queer experiences of care. According to the literature and data on the subject, many individuals report persistent anxiety, stress, and fear in anticipation of medical encounters, suggesting that formal equality does not automatically translate into safe or affirming environments (Müller, Hughes 2016; Petroll, Mosack 2011). For example, in North America and Canada, the absence of standardized protocols and targeted training in queer health exacerbates mistrust and avoidance of medical services (Beagan *et al.* 2012; Podmore 2001; Griffin *et al.* 2023). In the United States, data from the Center for American Progress (CAP 2020) reveal that more than one in five LGBTQIA+ adults live in poverty, compared with 16% of their heterosexual and cisgender counterparts, while poverty rates among transgender adults approach 30%. These socioeconomic disparities intersect with ethnicity, disability, and immigration status, creating layered vulnerabilities that further limit access to care.

Within these contexts, health risks are frequently framed in ways that reflect and reinforce moralizing narratives about queer bodies. Lesbian women, for instance, are often excluded from reproductive health discourses under the assumption that they do not require gynecological screenings (Ayhan *et al.* 2020). Gay men continue to be disproportionately linked to sexually transmitted infections – particularly HIV – an association that fuels stigmatization and narrows the scope of attention to their broader health needs. A comparable logic operates in the medical management of transgender identities. In many healthcare systems, psychiatric diagnoses remain a prerequisite for accessing gender-affirming paths, thus reinforcing a medical model that frames gender diversity as pathological, despite sustained efforts toward depathologization (Castro Peraza *et al.* 2019). At the same time, the persistent absence of comprehensive training on queer health among providers fosters systemic barriers such as misgendering, intrusive questioning, and, in some cases, outright refusal of care (Carabez *et al.* 2015; Griffin *et al.* 2023).

Such situations exemplify what Fricker (2007) terms epistemic injustice: the systematic devaluation or dismissal of certain knowledge and experiences. This injustice contributes to "trauma-informed avoidance," (Searle *et al.* 2017) whereby queer patients delay or forgo necessary care because of prior negative encounters or the anticipation of harm. Avoidance in this sense is not a passive resignation, but it can be seen as an active survival strategy within systems that fail to affirm the legitimacy of queer lives (Alencar *et al.* 2016; Monaco 2024).

The consequences of exclusion from formal healthcare systems are profound and multidimensional. Mental health disparities are particularly stark: the prevalence of anxiety, depression, and suicidality among queer individuals far exceeds that observed in the general population (Ayhan *et al.* 2020; Griffin *et al.* 2023). Among transgender youth, suicide attempt rates are alarmingly high, often linked to experiences of rejection, discrimination, and restricted access to gender-affirming care. Physical health is similarly impacted. Reduced uptake of cancer screenings, delayed diagnoses, and higher rates of substance use – patterns documented among various queer subpopulations – underscore the ways in which structural exclusion reverberates through both preventive and acute care domains (Kaya, Calpbinici 2022). These outcomes reflect individual health choices and, at the same time, are embedded in systems that marginalize queer identities at the level of policy, practice, and space.

THE ITALIAN CASE: THE PARADOX OF UNIVERSALISM

Building on the theoretical and global perspectives developed in the previous sections, this part of the paper focuses on Italy as a strategic context for examining how structural inequalities exist also within a healthcare system that formally defines itself as universalistic. The Italian *Servizio Sanitario Nazionale* (SSN) publicly guarantees equal access to care for all residents, irrespective of socioeconomic status, nationality, gender, or identity. Yet, this universalistic promise coexists with institutional arrangements, professional cultures, and epistemic assumptions that remain deeply shaped by binary, heteronormative, and cis-centric norms (Corbisiero, Monaco 2024).

The empirical data discussed here is drawn primarily from national data produced by the *Istituto Superiore di Sanità* in collaboration with transgender community organizations and specialized clinics (ISS 2022). The ISS survey constitutes the most comprehensive dataset currently available on the health status, healthcare trajectories, and experiences of discrimination among transgender and non-binary people in Italy.

Mental health disparities emerge as one of the most acute indicators of inequality. According to the study, 40% of transgender AMAB (assigned male at birth) individuals and 34.5% of transgender AFAB (assigned female at birth) individuals report symptoms of depression, with rates exceeding 60% among non-binary respondents. In comparison, data indicate much lower prevalence in the general population – 4.7% for cisgender men and 7.7% for cisgender women (ISS 2024). Such differences point to structural trauma rooted in social stigma, compounded by repeated experiences of invalidation and violence, both outside and within healthcare contexts.

Access to preventive care also reflects these inequities. Only 20% of transgender AFAB individuals undergo Pap tests, compared to 79% of cisgender women. This gap emerges from a combination of material and symbolic barriers: on the one hand, insufficient provider knowledge and the absence of inclusive institutional protocols; on the other, patients' fear of discrimination, misgendering, or intrusive questioning. The ISS study further reports that 46% of AFAB and 34% of AMAB transgender individuals have experienced discrimination in healthcare encounters, often through inappropriate language, denial of services, or visible discomfort from medical staff. Such findings point to a climate of structural queerphobia in which healthcare environments – rather than being spaces of healing – act as arenas of marginalization and exclusion.

Lifestyle data reinforces the impact of exclusionary healthcare environments on broader health outcomes. Transgender individuals are more likely than their cisgender counterparts to engage in risky behaviors, such as smoking and binge drinking, and significantly less likely to participate in physical activity. For instance, 64% of AMAB and 58% of AFAB transgender respondents report being physically inactive, compared with 33% of cisgender men and 42% of cisgender women. These behavioral patterns are closely linked to social determinants of health: exposure to stigma, economic marginalization, and chronic stress often foster coping strategies that undermine long-term well-being. The disproportionate prevalence of HIV among AMAB transgender individuals – 6.45%, compared to 0.3% among cisgender men and 0.2% among cisgender women – further underscores the intersection of medical vulnerability and social exclusion.

Despite the urgency of these disparities, institutional responses remain fragmented and insufficient. Most healthcare providers lack specific training on gender identity and queer health. At the university level, medical curricula rarely incorporate modules on transgender and non-binary health or on delivering affirming care (Fonzo *et al.* 2021; Worthen *et al.* 2017). Even general practitioners – typically the first point of contact within the SSN – report feeling ill-prepared to meet the needs of transgender patients (Marconi *et al.* 2024; Vitelli *et al.* 2017). This knowledge gap contributes directly to healthcare avoidance: many Italian transgender and non-binary individuals delay or avoid medical visits entirely, turning instead to informal networks for support. Friends, community members, online platforms, and queer associations thus function as parallel systems of health information and care, compensating – albeit imperfectly – for the shortcomings of formal healthcare provision.

FROM INCLUSION TO TRANSFORMATION

Medicine has long relied on classificatory logics that presume a binary and biologically anchored view of sex and gender. The assumed coherence between sex, gender identity, and sexual orientation operates as an unspoken foundation of clinical protocols, diagnostic categories, and therapeutic pathways (Müller 2018). Within this framework, deviation from normative expectations is often viewed as pathological or exceptional – requiring special management, adjustment, or containment. In medical discourse, the queer body tends to appear not as a legitimate subject of health needs but as an anomaly to be explained or corrected. This framing shapes how care is organized, who it serves, and under what conditions access is granted (Berro, Zayhowski 2024).

The question, therefore, is not only that queer people are excluded from care, but that the core structure of care is built on assumptions that make queer existence marginal or illegible. The principle of neutrality – often equated with equality – further reinforces this order. Treating everyone "the same" in contexts marked by entrenched asymmetries and epistemic erasure does not produce equity; rather, it extends the reach of the norm. In such settings, queer individuals are compelled to self-regulate, translate their needs into acceptable terms, or suppress aspects of their identities to align with institutional expectations.

These dynamics are reinforced by the socio-spatial dimensions of healthcare. The symbolic authority of the medical profession and the institutional settings in which it operates confer legitimacy unequally. Being "seen" by a doctor, receiving a diagnosis, or being placed on a treatment pathway are processes mediated by normative categories. Those who fall outside them must often negotiate for recognition or accept misrecognition as the price of entry. In extreme cases, these encounters cross the threshold from discomfort to structural violence, reinforcing the notion that care is conditional and must be earned through conformity (Mkhize, Maharaj 2020).

The politics of knowledge production in healthcare further complicate this picture. Medical curricula in Italy and many other contexts tend to omit or marginalize queer health concerns, relegating them to elective modules or treating them as specialist knowledge (Murray *et al.* 2025). This results in a workforce that often lacks the conceptual, linguistic, and relational tools needed to engage with queer patients in affirming ways. Such epistemic gaps produce what can be conceptualized as "institutional ignorance": a systemic refusal to engage with certain forms of knowledge, rooted in the belief that they are unnecessary unless the patient conforms to dominant scripts. This ignorance reflects and perpetuates the priorities and blind spots of the institutions themselves.

Visibility within healthcare settings is also fraught with risk. Disclosure of gender identity, sexual orientation, or bodily difference is never a neutral act. It requires calculated assessment of potential consequences, weighing the possibility of improved care against the risk of judgment, avoidance, or abuse (Rosati *et al.* 2021). The fear of discrimination remains one of the most significant reasons queer people delay or avoid seeking medical help, even in cases of urgent need. Such avoidance is rooted in recurring mistrust, itself the product of repeated experiences of exclusion and harm.

The Italian case exemplifies these dynamics and lays bare the paradox of universalism. Although the SSN presents itself as a system for all, its structures, practices, and professional cultures continue to privilege normative bodies and identities. As a result, it reproduces the very inequalities it purports to eliminate, showing that universality, without structural transformation, risks becoming a rhetorical rather than substantive guarantee. National data indicate that transgender and non-binary individuals experience markedly worse health outcomes, higher levels of discrimination, and lower uptake of preventive services than the general population, despite formal assurances of equal access.

At a deeper level, these gaps point to a conceptual inertia that resists challenges to the epistemological and organizational order of healthcare. The persistence of cis-heteronormative frameworks, even in the face of evidence documenting their harmful effects, underscores the extent to which institutional change is constrained by the priorities and self-understanding of the system itself. Queer identities, by refusing to conform to established scripts, not only reveal the fragility of this order but also call into question the assumptions that underpin its authority. Addressing these issues requires more than the addition of diversity trainings or isolated acts of sensitivity; it calls for a redefinition of health as a situated, relational, and political process.

CONCLUSION: TOWARD A QUEER-INFORMED HEALTH JUSTICE

This article makes two main contributions to the study of queer health inequalities. First, drawing on global research and international statistical evidence, it shows how prevailing norms within healthcare systems operate across spatial, epistemic, and organizational dimensions, shaping the conditions under which queer bodies are recognized, misrecognized, or excluded. Second, by examining the Italian case through national ISS data in combination with recent domestic studies, the paper empirically points out how the promise of universalism is undermined by persistent structural inequalities that significantly affect mental health, preventive care, and everyday interactions with healthcare providers. Taken together, the analysis reveals that these inequalities are not isolated anomalies but structural features of healthcare institutions. The findings also highlight the central role of institutional intelligibility as a key mechanism through which inequality is reproduced.

For a queer-informed health just future, the challenge is not simply to repair a system that occasionally fails certain individuals but to interrogate the assumptions that define its sense of success and legitimacy. This entails shifting the analytical focus from the integration of marginalized individuals into existing frameworks to the critical examination of the very structures that produce marginality. Such an approach recognizes that equity cannot be achieved without addressing the institutional logics that normalize certain bodies while pathologizing others, anticipate the needs of some while considering others' needs excessive or irrelevant. Pursuing this transformation is neither straightforward nor without resistance. It requires confronting institutional discomfort, accepting the disruptions that come with reimagining entrenched systems, and sustaining critical engagement over time. Yet, it is precisely within this process that the possibility emerges for a healthcare system that is welcoming in its structure and practice.

A possible roadmap for this transformation calls for a sustained rethinking of the norms, expectations, and power relations that organize healthcare. This involves at least four interconnected areas of intervention, each of which engages directly with the forms of resistance likely to emerge from within institutional structures.

A core element to dismantle is the persistence of binary and essentialist visions of sex and gender within biomedical knowledge. These frameworks constrain clinical practice and also shape what is considered legitimate knowledge, marginalizing the lived realities of queer people (Daley 2011). One possible direction is the development of alternative knowledge paradigms that center patients' experiences as a critical source of expertise. This may include community-informed clinical protocols, interdisciplinary research that bridges medicine and social sciences, and critical revisions of diagnostic manuals to eliminate pathologizing or normative assumptions. Epistemological transformation also requires the creation of dialogical spaces where healthcare providers, activists, and scholars can engage on equal footing, enabling a redistribution of authority and a decentering of traditional medical expertise. Resistance here is likely to stem from entrenched professional hierarchies and the inertia of curricula and accreditation systems, underscoring the need for sustained advocacy and structural incentives for change.

The physical and symbolic organization of healthcare environments plays an equal decisive role in influencing who feels welcome and who experiences alienation. Waiting rooms, signage, intake forms, and procedural routines often reflect and reinforce normative assumptions about belonging, legitimacy, and visibility (Bell, Valentine 1995; Johnston 2015; Visser 2008). Rather than creating isolated "safe spaces" for queer patients – which risks reinforcing their exceptionality – a more just approach would involve embedding queer-informed principles into the design of all healthcare spaces. This could mean integrating gender-neutral facilities, adopting inclusive language and iconography across institutional communication, and revising administrative procedures to recognize diverse identities without marking them as deviations from a norm. These measures may have a profound symbolic and practical impact, signaling recognition and affirming the presence of marginalized identities.

Another persistent gap lies in the training and professional development of healthcare workers. Queer health concerns are often absent from curricula or treated as peripheral specializations rather than integral elements of patient-centered care. This results in a workforce that is technically qualified but ill-equipped to provide affirming and respectful care to non-normative patients (Hollenbach *et al.* 2014). Addressing this requires embedding comprehensive queer health modules into undergraduate and postgraduate medical education and developing continuing professional education programs that prioritize relational competencies. These competencies include the ability to engage respectfully with patients' self-identifications, respond affirmatively to disclosure, and recognize the impact of institutional structures on health outcomes. Active learning approaches – such as patient-led workshops, case-based discussions, and supervised practice – can help reframe queer patients as knowledge-holders rather than as passive subjects of clinical intervention.

Finally, the sense of distrust or alienation many queer individuals feel toward healthcare institutions must be addressed at the structural level through governance mechanisms that guarantee accountability (Lewis 2016). This includes adopting enforceable anti-discrimination policies, collecting data on sexual orientation and gender identity with appropriate safeguards, and establishing advisory boards that include representatives from queer communities.

The transformation outlined above is neither linear nor uncontested. It will necessarily provoke resistance from those invested in preserving the status quo, and it will require sustained effort from multiple actors across sectors. It is in the very act of confronting and negotiating this resistance that the possibility for a genuinely equitable healthcare system emerges. By dismantling entrenched norms, reimagining spaces of care, redistributing epistemic authority, and embedding accountability within governance structures, healthcare can move beyond superficial inclusion toward structural justice. Such a shift would not only improve access and outcomes for queer individuals but also strengthen the ethical and relational foundations of healthcare for all.

Future empirical research is essential to further advance the claims developed in this paper. While the present analysis integrates national-level data to illustrate the structural inequalities embedded within Italian healthcare, several areas require deeper investigation. Whitin this framework, qualitative research involving transgender, non-binary, and broader queer communities would provide a more nuanced account of how institutional intelligibility is negotiated in everyday encounters. Ethnographic studies within clinical settings could illuminate how binary norms are reproduced – or contested – in professional routines, organizational arrangements, and spatial practices. In addition, comparative analyses across regions or healthcare institutions would help identify how local organizational cultures and governance models contribute to divergent experiences of access. Finally, longitudinal studies would make it possible to trace how reforms in medical education, administrative procedures, or anti-discrimination policies reshape access over time. Such empirical expansions would refine the framework proposed here and also support the development of more context-sensitive strategies for structural transformation.

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