

The limits of the neoliberal paradigm? Health care politics and the sexual revolutions in the United States at a time of crisis (1970-1992)

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1. Introduction

'Any political movement that holds individual freedoms to be sacrosanct is vulnerable to incorporation into the neoliberal fold,' wrote David Harvey in his landmark work *A Brief History of Neoliberalism*. 'Neoliberal rhetoric, with its foundational emphasis upon individual freedoms, has the power to split off libertarianism, identity politics, multiculturalism, and eventually narcissistic consumerism from the social forces ranged in pursuit of social justice through the conquest of state power. It has long proved extremely difficult within the US left, for example, to forge the collective discipline required for political action to achieve social justice without offending the desire of political actors for individual freedom and for full recognition of particular identities. Neoliberalism did not create these distinctions, but it could easily exploit, if not foment, them.' (Harvey 2007, pp. 41-42). It is not hard to see why many would regard the explosion in civil rights movements of the post-1960s era as part of a larger narrative that viewed privatization and the decline of the social contract of the previous half century as the central economic and political story of the so-called 'Age of Reagan.' Many activists in these movements themselves adopted this perspective, with one gay rights campaigner arguing that LGBTQ rights during the 1970s had been 'a civil rights movement essentially looking to get government and society out of our lives,' and that the HIV-AIDS crisis of the 1980s had required the LGBTQ community to become 'the model of Reagan Republican voluntarism – we care for our own, we educated our own, we worked for others as well.' (Levi 1987, Cornell 9262). Breaking free of the shackles of state surveillance and repression and reshaping the norms of human relationships and notions of family were key demands of the multiple sexual revolutions of this period. As historians Brent Cebul, Gary Gerstle, and Melinda Cooper have noted, 'intimate roots of neoliberalism' centered upon contested politics of 'family values' were at the heart of the American social contract (Cebul 2021, Gerstle 2022, Cooper 2017).

Yet the relationship between sexual politics and political economy becomes rather more complicated when viewed through the lens of the American health care system. It is undeniable that sexual freedom required access to health services to have any meaning. From the availability of understanding and properly trained specialists to the development of dedicated LGBTQ or women's clinics, the history of the rights revolutions of the 1970s was as much about the economic reality of community formation as it was individual rights. The privatized nature of the US health care system was a constant and not a product of the late twentieth century, and the integration of sexual rights into mainstream politics required a consistent recognition of that reality, and not merely as a response to a neoliberal turn in US political economy. On the other hand, sexual minorities sought access after the 1970s to a welfare state designed from the start to exclude them, predicated on notions of a heteronormative family wage and gendered understandings of dependency (Cooper 2017, Canada, 2009). The HIV-AIDS crisis, in particular, placed enormous pressure on the nation's ramshackle social safety net during the 1980s, as large numbers of people living with HIV either lost their jobs and private health insurance or had never had insurance and had to navigate the state welfare bureaucracy for the first time. Viewing sexual revolutions in tandem with health care politics therefore disrupts the standard chronology of neoliberal transformation of the economy, as those campaigning for their rights as sexual beings found themselves increasingly excluded from the private health marketplace at the same time as they were fitfully integrated into the protective embrace of the state. In the realm of sexual politics, the boundaries between independence and dependency, private and public, capital and welfare, became ever more blurred, calling into question the utility of considering the 1980s as a turning point in political economy and the relationship between the state and capitalism.

This chapter begins with a consideration of a self-help movement that emerged in the 1970s to deliver specialist, non-judgemental health services to women and LGBTQ people. This development emphasized the need for individual empowerment and an understanding of the self that privatized the body in ways consistent with a neoliberal 'homo economicus' sketched out by philosopher Wendy Brown (2015). Yet the sexual health movement took shape prior to the era of frantic economic deregulation and state retrenchment gathering pace from the late 1970s. The focus then shifts to the efforts of those living with HIV in the

1980s to access Medicaid benefits, making themselves visible to the state in ways that reshaped the relationship between individual rights and state patronage at a supposedly critical time in the transition to neoliberal orthodoxy. This is not to deny the sustained attacks on the welfare state on the part of the Reagan administration, nor its failure to reach many of those living with the virus. Rather, a focus on the transition of debates over sexual politics from matters of individualism and the private sphere to dependency and a reliance on the state forces us to reconceptualize the economic model that preceded the neoliberal turn, one that presupposed heteronormativity as the principal organizing feature of health and welfare policy. The efforts of LGBTQ people to challenge what historian Margot Canaday has termed the 'straight state' (Canaday 2009) during the HIV-AIDS crisis demonstrate the limits of the social contract established during the so-called 'great exception' (Cowie 2017) of the New Deal and Great Society eras between the 1930s and 1970s. Furthermore, as Amy Offner has argued in her study of US international development policy, those efforts also make clear the consistent interrelationship of private and public in policy across the twentieth century (Offner 2019). This highlights the limited utility of neoliberalism as a tool for conceptualizing the political transformations of the 1970s and 1980s when thinking about health and bodily autonomy after the rights revolutions. This chapter joins the exhortation of urban scholars Andrew Diamond and Thomas Sugrue to avoid viewing neoliberalism 'as an insuperable force swooping in from beyond rather than a process that was shaped and sometimes constrained by local political actors, community organizations, and social movements' (Diamond and Sugrue 2020, p. 4).

2. 'Self-help' and the political economy of bodily autonomy in the 1970s

At their core, the sexual revolutions of second wave feminism and LGBTQ rights of the late 1960s and 1970s concerned self-knowledge: of one's own body, sexuality, emotions, and their capacity to reshape societal norms. The emergence of the women's self-help health care movement, symbolized by the publication of the Boston Women's Health Book Collective's *Our Bodies, Ourselves* in the early 1970s, demonstrated clearly the complex relationship between individual bodily autonomy, collective activism and empowerment, and the lived realities of a capitalist health care system. As Frances Hornstein, a lesbian feminist active in the early women's health movement, noted when recalling the emergence of self-help clinics, women who were in her words 'consumers' of health care were repelled

by the often ignorant and insensitive treatment they received by health providers, be they private or charity clinics. While attempting to learn how to provide their own basic care, including pap smears, pregnancy testing, and basic sexual health check-ups, women like Hornstein found efforts to establish formal self-help clinics required them to consider the relationship between health and money. When a group of women from California visited Boston to talk to local women's groups about their self-help clinic, they circulated flyers announcing their talk and asking for a five dollar donation to support their work. 'That was too much money,' recalled Hornstein, 'in my best "health care should be free" thinking. I didn't relate that \$5.00 to the \$25.00 I had paid the previous year for a Pap Smear, a painful pelvic examination and some suppositories for an infection.' She soon revised this initial wary approach and recognised the revolutionary potential of the knowledge and experience the Californians represented: 'They knew how to do Pap Smears. They knew how to do pelvic exams, recognize vaginal infections and how to detect pregnancy. All of the sudden, \$5.00 seemed like nothing. I think at that moment I would have scraped together as much money as was necessary and been glad to pay it.' (Hornstein 1973).

Sexual health was embedded in a health care system that was not only heteronormative and discriminatory but also dependent on payment for services, either on the part of individuals, health insurance providers, or the state. The latter was by far the smallest part of the system: even though the passage of Medicare and Medicaid in 1965 resulted in a rapid expansion of state investment in health care provision, most recipients of state funding were the elderly and women with dependent children on welfare, excluding the majority of those at the vanguard of sexual revolution at the turn of the 1970s. Much as liberationist groups wanted to build a communitarian and collective approach to bodily autonomy, they always had to contend with the act of monetary exchange and their relationship to a privatized health care system. The extent of their autonomy and empowerment was enmeshed within the system and subject to its constraints. It was not that an innate individualism rendered sexual revolutions subject to neoliberal historical processes, but rather that efforts to build collective identities around sex and gender were from their inception monetized. Early gendered health activism took shape with a clear understanding of that fact and a desire to combat it, however imperfectly. Many women involved in gendered activism had low incomes; they also used 'the health care system

during their active, healthy years, unlike men who go to doctors only when they are sick or old, [so] women are more likely to engage in an active struggle for change in health care.’ (Women’s Health Abortion Project 1969). But all those affected by the sexual health consequences of sexual freedoms experienced the challenges of finding accessible care.

The 1970s witnessed the exponential growth in dedicated sexual and gender health clinics in the United States, physical landmarks to the radically changed political landscape wrought by the rights revolutions of the long 1960s (Batz 2018, Bell 2020a). From the outset, they had to contend with the thorny question of financing their operations while ensuring as far as possible that all those who required their services could afford to do so. Many offered a means-tested sliding scale of fee payments, and some accepted Medicaid (though very few people qualified for Medicaid coverage, which required recipients to be severely disabled, elderly, or in receipt of Aid to Families with Dependent Children, as well as extremely impoverished). As demand for sexual health services grew, so did clinic capacity, but this only increased pressure on providers to balance the desire to empower sexual minorities to seek care and support while also paying the bills. The Homophile Community Health Service, a mental health non-profit organisation for gay people in Boston founded in 1971 and the only clinic of its kind in New England during that decade, increased its income more than five-fold in six years, allowing it to employ more paid staff as well as volunteers and widening its range of services. The clinic served over 400 people a year during the 1970s, ‘primarily funded through the moderate fees charged to clients of the agency. Fees are assessed based on income and assets. HCHS can accept all forms of medical insurance, and many clients pay for service through their insurance policies.’ (HCHS fact sheet 1978). The process of commodifying sexual identity through private health care provision happened to coincide with global changes in political economy, but occurred independently from them, in the context of a system developed far earlier in the twentieth century (Hoffman 2012, Gordon 2003, Derickson 2005, Quadagno 2006).

The construction of what might be termed a capitalist closet around sexuality during the 1970s comprised a complex amalgam of health care financing, homophobia, and class dynamics within emerging sexual liberation movements, whereby gatekeepers of care in LGBTQ-friendly clinics openly linked financial independence to successful integration into wider society. Two examples from the HCSC serve to highlight these complexities. The clinic

did not accept Medicaid, and so clients had to pay for treatment themselves or claim from their insurance. Yet a clinic administrator noted in 1979 that ‘despite the advantages of using insurance to pay for therapy quite a few of our clients are reluctant to do so. They may fear that their employers will find out they are in therapy, or that they are being seen by a therapist at a gay clinic, or they are being treated for “homosexuality.”’ The administrator, Susan Rosen, assured clients that employers could not determine the nature of insurance usage, nor would the name of the clinic nor the term ‘homosexuality’ appear on any financial statements from the insurance company (Rosen 1979). Her efforts to counter ingrained homophobia still rampant in US society came in the context of the need to raise clinic fees – often beyond what individuals could afford on their own – due to a combination of rampant inflation, expansion of services, and rent increases. Clearly the emerging crisis of political economy taking shape in the late 1970s provided a backdrop to the creation of this health care closet, but its roots lay in the privatized system of health unique to the United States.

The second example reveals equally longstanding processes of identity formation that belie an oversimplified correlation between individual rights and neoliberal capital in the late twentieth century. In 1979, another administrator at the Boston clinic admonished staff for regularly failing to collect payment from clients. Labelling the issue one of ‘client responsibility,’ Don Farwell explicitly associated non-payment with a failure to take treatment seriously, with the inevitable outcome that treatment would be futile, and the offering of therapy would have been wasted. Treating financial precarity with undue empathy would ‘feed right into the client’s own “oh, poor me” attitude and their lack of feeling responsible, low self-image,’ and suggest them to be ‘manipulative and controlling’. Adopting a well-established trope at the centre of the American Medical Association’s campaign to vilify comprehensive health insurance proposals back in the 1940s, Farwell asserted that not being compelled to pay in full would entice people to use services regardless of need, retarding their rehabilitation and integration into productive society. ‘Money is the motivator of the nations,’ he wrote. ‘For five bucks you get five bucks worth of the client’s motivation for self-improvement.’ He concluded that he hoped colleagues would ‘hopefully begin to understand the importance of money in the therapeutic relationship.’ (Farwell 1979). While Farwell’s exhortations were not universally or even

widely shared in the burgeoning non-profit care sector, and many clinics earnestly battled to provide services to anyone who struggled to pay, they do reveal an association between economic independence and full social citizenship common in US political discourse around health and welfare going back into the nineteenth century. But this paean to the merits of individual self-reliance did not come from those individuals seeking their rights as LGBTQ people by claiming and acknowledging their needs as sexual beings; it came from the community-forming clinics – in this instance with ‘community’ in the title – into which LGBTQ individuals entered to secure those needs. These sites of community building under the auspices of sexual health were capitalist in structure and created a ‘homo economicus’ in ways distinct from nations without a largely privatized health system. While other countries undoubtedly experienced the ever-encroaching reach of consumerism and neoliberal recalibration of capital that has led to what scholar Lisa Duggan has termed ‘the twilight of equality’ in modern rights politics, this process rarely extended to pathologizing poor queer communities in the way outlined here (Duggan 2003).

‘Self-help’ in health terms, then, represented both an empowering moment of community formation around individual self-realization and a process of the financialization of the body that involved stigma, class dynamics, and the recasting of the closet as an economic necessity to protect the actuarial realities of the insurance industry and employers. The rightward turn in the US and other western countries that characterized the turn of the 1980s influenced the trends identified here but did not cause them. Indeed, the HIV-AIDS crisis shifted the dynamics of health care politics dramatically and centered the state as a site of political engagement for LGBTQ movements for the first time, rendering queer bodies legible to state authorities just at the point the welfare state came under severe scrutiny as part of an apparent major realignment in American politics.

3. HIV-AIDS, the welfare state, and the shift from private to public in the 1980s

In a speech to the National Press Club in 1987, National Gay and Lesbian Task Force leader Jeffrey Levi argued that the HIV-AIDS crisis had ‘changed our relationship to government.’ From an understandable position of suspicion of state power, LGBTQ people ‘now look to the government to help save our lives...we have policy objectives and monetary objectives: we want our share of the budgetary pie.’ (Levi 1987). While those ‘monetary objectives’ included both private and public sources of funding for research and treatment to help

those living with HIV, it was clear that their ability to access care and treatment would depend heavily on a government response at all levels. Many with HIV were losing their jobs and therefore private health insurance, and research into the virus relied on state funding through the Centers for Disease Control and National Institutes of Health. Getting treatment in the absence of private insurance increasingly meant gaining entry to the Medicaid system of publicly funded services. The only route to a Medicaid card was via a welfare office's determination of disability, defined as a person unable 'to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death, or has lasted, or is expected to last, for not less than 12 months.' (Power 1983). Many people living with HIV were therefore forced to submit to a complex and discriminatory state regulatory regime to assess their eligibility, at the very point the Reagan administration was fighting to cut the welfare state and throw many recipients of disability benefits off the rolls (Katz 2008, pp. 209-215). The dynamics of efforts to expand the welfare state to encompass people with HIV at a time supposedly characterized by the acceleration of a neoliberal economic programme has been addressed in detail elsewhere (Bell, 2018). The focus here is on the significance of the interaction between HIV treatment activists and the Social Security Administration during the early years of the epidemic, a story of making queer bodies legible to the state at the point they were rendered closeted in the private sphere. This is not in any way to deny the reality of welfare state retrenchment and ingrained homophobia in the Reagan administration, nor the appallingly poor public health response. Yet the 1980s did witness a reorientation of sexual politics away from an individual rights focus towards one embedded more in state social policy, a process that questions the individual versus social justice binary sketched out by David Harvey (Harvey 2007).

On 26 April 1983, the Social Security Administration issued a directive authorizing AIDS as a 'disabling disease,' using the Centers for Disease Control's list of opportunistic infections associated at that point with HIV. Each State used its own Disability Determination Office to determine eligibility for benefits, resulting in chaotic and varied efforts on the part of welfare bureaucrats across the United States to come to terms with a new public health emergency. Those working in disability offices were used to seeing physical disability, often the product of workplace accidents or long-term degenerative conditions. Now they were exposed to the body as a site of contagion and rapid deterioration that was both unfamiliar and frightening. Initially, many state employees refused to process claims of people with HIV or to interview them for

fear of contracting HIV, such was the widespread ignorance of the aetiology of the virus. This prompted Reagan's Secretary of Health and Human Services, Margaret Heckler, to issue a directive to all SSA employees in July mandating them to process disability claims from people with HIV-AIDS: 'I want you to know,' she wrote, 'that I have personally met with AIDS victims and assured them that this Department would stand with them – that we will service their needs and rights' (Heckler 1983). This commitment around 'needs and rights' related to HIV came at a time when the epidemic was thought to affect principally gay men, making Heckler's comment the first time a federal cabinet member had included that group in the protective embrace of social policy in any form. And her directive sparked a dialogue between LGBTQ and sexual health activists and the Social Security Administration through the 1980s, part of a sustained effort to integrate people with HIV into the nation's ramshackle and complex social safety net, one that had up to that point been trapped within a set of assumptions about dependency crafted in the 1930s.

As the leading LGBTQ advocacy group at the time, the National Gay Task Force faced two key challenges in the struggle to access health care for people with HIV-AIDS: first, to push the SSA and state-level disability bureaucrats to recognise HIV-related illnesses as disabling and thereby award Medicaid access, and, second, to encourage and assist people with HIV to make an application. Soon after Heckler's order to local disability offices, Ben Schatz of the NGTF contacted Disability Determination Units in all states with the highest number of reported AIDS cases (HIV was still not identified at this point) – New York, California, Florida, New Jersey, Texas, Illinois, Pennsylvania, Massachusetts, and Georgia – and organised meetings with SSA and state officials. 'Most Social Security officials with whom I spoke were very helpful, interested, friendly – and uninformed,' Schatz wrote NGTF colleagues on 2 August 1983 in a report of his conversations. While all states claimed to have implemented the new Social Security rule on AIDS as a disability, there was significant variation in how guidelines were being interpreted and how many claims were being approved, and 'only in a few states – notably New York – was anyone able to speak knowledgeably about the order.' More concerning yet to Schatz was the very low number of claims submitted: 'the vast majority of people with AIDS appear to be either ignorant of potential benefits or unwilling or unable to file for them.' While illness made it extremely challenging to file applications in person, several states had made provision to allow phone or mailed applications, and in New York and San Francisco LGBTQ rights groups mobilized to help people make applications. Schatz pointed to several factors, including the complexity of the process and the long lead in times, but one point bears

particular scrutiny here: 'People do not want to come out of the closet, particularly to the US government. In light of the FBI's history of anti-gay surveillance and the numerous problems of confidentiality and AIDS, this fear is hardly ungrounded.' (Schatz 1983). While recognising this fear, Schatz and the NGTF were working hard to counter it, encouraging thousands of people with HIV-related conditions to file for disability benefits as a gateway to Medicaid: by the end of the decade, some 40% of people with AIDS received Medicaid, suggesting that HIV had reshaped the relationship between the health care system and the state in ways that had expanded, rather than contracted, its reach and relationship to sexual politics (Winkenwerder et al 1989, p. 1600).

By mid-1985, a NGTF survey of AIDS service organizations suggested that 'it is now easier for persons with AIDS and AIDS-related complex (ARC) to gain expeditious access to the benefits the Social Security Administration provides to disabled persons than was the case in the Spring of 1984.' NGTF Acting Director Jeff Levi claimed that the survey 'testifies to the success that can be achieved when the Social Security Administration and AIDS-related organizations engage in constructive joint efforts to make needed benefits available.' (NGTF press release 12 April 1985). Levi overstated the case: the battles to classify an ever-multiplying set of medical conditions linked to HIV as AIDS remained an uphill task, with the SSA determined to limit its AIDS definition to the narrowest set of diseases possible, excluding huge numbers, especially women and minorities (Bell, 2018). And the SSA continued its efforts to reclassify people on welfare, including people with HIV, as fit to work and throw them off the rolls during the 1980s. Yet the early 1980s was a period when some LGBTQ people became visible to the state as welfare claimants, changing their relationship with what had previously been, in Canaday's words, a 'straight state' at the same time as employers and private insurance companies were reinforcing the private sector closet by dismissing LGBTQ people from jobs and terminating their insurance coverage (Bell 2020b, Canaday 2009). This development placed the self-help movement of the proliferating number of service organisations into a mutually constitutive relationship with the state in a much more direct way than had been the case before the Reagan era. Despite efforts to slash the welfare state during the 1980s, the parameters of state engagement with those demanding health care access had been set when the US social safety net was constructed, not when it was being attacked. This point encourages us to rethink a neoliberal chronology when considering the politics of health and bodily autonomy.

4. Conclusion

In an article entitled 'The Complete Welfare Queen,' an HIV-AIDS treatment activist in the early 1990s reflected on the dramatic ways the epidemic had changed the relationship between people living with HIV and the US state. The author had encountered a fellow activist who had quit his high-paying job and gone on disability so he could concentrate on his health and on his activism. He sketched out the mechanics of this journey, placing the narrative of the welfare state into the context of a marginalised and enraged community struggling to secure the care they needed. 'Becoming a complete welfare queen may not be a good deal for you – right now,' he wrote. 'But you should always be aware of it as a possibility, as it's one of the best deals currently available for diseased pariahs in these United States.' Instead of toiling in stressful jobs while often suffering the impact of HIV-related illness, could not people abandon employment, potentially declare bankruptcy and shed oppressive debt, and enrol on Social Security benefits? 'Chances are there are a number of things that you wish you had done, or feel that you should have been doing all along. Go ahead and do them now, at government expense, if possible.' ('The Complete Welfare Queen,' c.1991). The anonymous author wrote for a radical magazine *Diseased Pariah News*, dedicated to providing irreverent and angry commentary for people living with the virus, many of them previously untouched by the indignities of trying to manage chronic health conditions in a political system almost wholly indifferent to questions of poverty and social exclusion. While the article barely acknowledged the grim reality confronting many trying to engage a punitive and parsimonious welfare system, it did reveal how the HIV-AIDS crisis had recalibrated the politics of sexuality since the emergence of a self-help health movement in the 1970s. Whereas once sexual liberation had entailed an escape from state repression, now activists advocated calling upon state patronage, one aspect of a multi-pronged effort to navigate a public health crisis and get the resources needed to stay alive and maintain their dignity in what remained at that point for most a terminal illness. Their efforts represented a challenge to the heteronormative assumptions of the US social safety net, integrating LGBTQ lives into a system designed when their existence was only acknowledged as a threat (Canaday 2009, Johnson 2004).

The agenda of an ACT UP New York strategy weekend on 'repairing the health care system' in 1992 demonstrated clearly how shockingly inadequate the whole health care and welfare infrastructure remained, and the extent to which their dreams of universal health care were further from reach than ever. The number of Americans without any health insurance was increasing year on year, and many of those were ineligible for state support. Even those with insurance faced ever increasing co-payments and deductibles for fewer covered services. While

those at the ACT UP strategy meeting worked out how to mount a campaign to secure health care as a right, positing the choice as one of ‘social good vs economic commodity,’ the political climate of the time – abortive Clinton reform efforts notwithstanding – suggested ever greater commodification of American lives commensurate with the neoliberal orthodoxy at the heart of the essays in this volume (ACT UP strategy planning weekend agenda 1992). Yet it is important to recognise that LGBTQ rights politics emerged in the 1970s into a bifurcated health care system and social safety net already securely in place, and into which they needed to integrate as best they could. In many respects the story told here has some historical parallels with the story of organised labour in the United States as periodised by labour historian Nelson Lichtenstein. By the time mass trade unionism became a reality in response to the Great Depression, the fundamentals of American corporate power and party politics were already in place, and neither the owners of capital nor the leaders of political parties historically disconnected from distinct class interests would ever be entirely reconciled to class struggle (Lichtenstein, 2002). Similarly, the rights revolutions of the 1970s revealed health care access as a vital corollary, a question of economic justice constrained within a social policy framework designed to privilege private provision and to restrict a public option to the smallest possible class of dependents, ranked by age and gender. Thus the dynamics of the ‘social good vs economic commodity’ dichotomy at the centre of struggles to provide health care to people with HIV after Reagan’s ascent to power were fully in place long before his name came to symbolise the dawn of a new age of neoliberal logic in political economy and politics.

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