MINISTRY OF HEALTH
MANATŪ HAUORA

23 OCT 2015

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A. D. Tait
fyi-request-3188-efea002d@requests.fyi.org.nz

Ref: H201504634

Dear A. D. Tait

Response to your request for official information

Thank you for your request of 30 September 2015 under the Official Information Act 1982 (the Act) for

> "a copy of the Ministry's 2003 review of Gender Dysphoria Services in New Zealand".

The information relating to this request is itemised below, with copies of documents attached.

I have decided under Section 9(2)(a) of the Act to withhold personal identifying information of individuals other than Ministry employees, in order to protect their privacy.

Request	Response
The Ministry's 2003 review of Gender Dysphoria Services in New Zealand	Attached are: 1. A position paper with the title "Gender Dysphoria and Surgical Reassignment Services", written by the Ministry of Health for a meeting with clinicians held on 30 April 2003. 2. Notes of the meeting with clinicians that was held on 30 April 2003, with the names and positions of the clinicians withheld. 3. A Health Report to the Minister of Health, dated 30 July 2003, with the title "Review of Gender Dysphoria Services including reassignment surgery". 4. A Health Report to the Minister of Health, dated 11 November 2003, with the title "Options for services

	for people with gender identity issues." 5. A Health Report to the Minister of Health, dated 6 May 2004, with the title "Future services for people with gender identity issues."

I trust this information fulfils your request. You have the right, under section 28 of the Act, to ask the Ombudsman to review my decision to withhold information under this request.

Yours sincerely

Dr Don Mackie
Chief Medical Officer
Clinical Leadership, Protection & Regulation

H201504634

From: "A. D. Tait" <fyi-request-3188-efea002d@requests.fyi.org.nz>
To: OIA requests at MOH <EmailMOH@moh.govt.nz>,
Date: 30/09/2015 08:48 p.m.
Subject: Official Information Act request - 2003 Review of Gender Dysphoria Services

Dear Ministry of Health,

I would like to request a copy of the Ministry's 2003 review of Gender Dysphoria Services in New Zealand.

Yours faithfully,

A. D. Tait

Gender Dysphoria and Surgical Reassignment Services

Position Paper

Meeting: 30 April 2003 Ministry of Health

Introduction

The Ministry of Health has initiated work on gender dysphoria services including gender reassignment surgery. The objectives of this work are:

- ⇒ To assess access to, and the availability of, gender dysphoria services throughout New Zealand within current resources.
- ⇒ Improve knowledge around gender dysphoria issues.
- ⇒ Improve consistency of advice and clinical care to consumers.
- ⇒ Facilitate referral of consumers to appropriate specialists.

5 Elements of Clinical Work for Gender Dysphoria Services

The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identify Disorders, Sixth Version, describe five elements of clinical work for the health service professional involvement with patients suffering from gender identity disorders (GID) viz.

- ⇒ Diagnostic assessment
- ⇒ Psychotherapy
- ⇒ Real-life experience
- ⇒ Hormone therapy
- ⇒ Surgical therapy

While the order of these services as listed above, is the logical desirable sequence in which the patient should receive them, this is not necessarily the current experience.

To date, much of the activity with which the Ministry of Health has been involved, has been surgical therapy, in particular gender reassignment surgery (GRS), which is at the end phase of step 5 of these recognised elements of clinical work. The reason that the Ministry's efforts have been concentrated in this area is because there have been applications for funding for GRS.

Funding for Gender Dysphoria Services

⇒ General Funding - Service Coverage by Service Area

There is provision for funding through Specialist Medical and Surgical services where these are available, and through Mental Health Services if the special criteria are met.

⇒ Special High Cost Treatment Pool

Currently there is no specific public funding allocated within New Zealand for GRS although applications can be made to the Special High Cost Treatment

(SHCT) pool under the category "treatment not currently available within the public health system".

The SHCT pool is a limited pool of approximately $5 million held by the MOH for distribution on a national basis. Established on 1 July 1999, this risk pool funds procedures that are outside the DHB funding envelope. Types of treatment funded from this pool includes; epilepsy surgery, laser treatment for malignant eye tumours, corrective genital/reproductive surgery for children and specific surgery for Parkinsons's disease.

Evidence for GRS – literature review

The New Zealand Health Technology Assessment review of GRS in February 2002 found that the quality of the evidence for the effectiveness of GRS is poor and based on a small number of poorly designed studies. While there was some evidence that some people had perceived benefit from GRS there were also people who were unhappy with the outcomes and later sought reversal. More research is required to improve the evidence base identifying the subgroups of transsexual people most likely to benefit from sex reassignment surgery.

Criteria for SHCT applications for treatments available only outside public hospitals

1. The treatment must not be currently available from any public hospital in New Zealand or under any existing contractual arrangement.
2. The treatment has proven efficacy throughout appropriate clinical trials, and preferably has also been established as effective when applied in regular practice.
3. The treatment is well established and not an experimental form of treatment.
4. Failure to receive the treatment could result in serious irreversible deterioration in the patient's condition or an inability to recover lost function, or significant impairment to normal development of a child; or
5. Failure to receive the treatment could deny an adult with a lifelong disability access to treatment, which could lead to a marked improvement in their quality of life.
6. The chosen treatment is cost-effective, that is:
   a. The expected long term savings to the health care system outweigh the initial costs of the treatment; and/or
   b. The dollar costs per unit of benefit are acceptable when evaluated against other MOH priorities.
7. Treatment would lead to reasonable prospects of survival and to an improved quality of life after treatment.

Specifically applications for GRS do not meet criteria 2 and 5. There is insufficient evidence to prove that this treatment is effective, and in the absence of sufficient effectiveness evidence, an economic analysis, which would consider cost effectiveness, cannot be undertaken. A lack of effectiveness evidence goes not mean that GRS is ineffective, it only means that there is a lack of good quality evidence to show that it is effective.

Failure to meet the funding criteria does not mean that all applications for funding will be declined. The policy enables applications to be considered for funding in exceptional circumstances, on an individual basis. To date while there are 10 applications under SHCT, none of these have yet made an additional application providing exceptional circumstances for their individual case.

Applications under SHCT for GRS

Currently there are 8 male to female and 2 female to male GRS applications to the pool. Should funding for GRS be made available, it is recognised that a selection process will be necessary. It is intended to take appropriate advice from consumers and clinicians.

Gender Dysphoria Services

Currently the Ministry has little evidence that comprehensive gender dysphoria services are available throughout the country. To update this information we have written to DHBs requesting the current services provided. The information received to date is tabulated below

DHB	Services
Auckland District Health Board	
Bay of Plenty District Health Board	1-2 patients per year referred to adult mental health services – no specialised service No comment re surgery or hormone therapy
Canterbury District Health Board	Approx 6 GP referrals annually for gender identity disorders. Referred to psychiatric services for assessment.. Following assessment maybe referred to endocrinologist.
Capital and Coast District Health Board	
Counties Manukau District Health Board	No gender dysphoria services provided. Would provide mental health services if person met the criteria for the 3% of population with most severe mental illness.
Hawke's Bay District Health Board	No services provided. No identified need. Mental health recall 2 cases for second opinion in 26 years
Hutt District Health Board	
Lakes District Health Board	
MidCentral District Health Board	GDS provided on an individual basis – no coordinated services.
Nelson Marlborough District Health Board	No mental health services provided
Northland District Health Board	Psychiatric assessment and treatment provided including counselling. Endocrinology and surgery referred.
Otago District Health Board	Diagnostic assessment & follow up ➢ endocrinology, No mental health/psychiatry/psychotherapy offered. No support services. Hormone therapy ➢

	prescribed from endocrinology. 2 patients currently having implant therapy (ex other DHBs)
South Canterbury District Health Board	No services provided
Southland District Health Board	
Tairawhiti District Health Board	Diagnostic assessment ➢ medical services Mental health/psychiatry/psychotherapy ➢ adult or child and adolescent mental health services Hormone therapy/endocrinology ➢ medical services Support for real-life experience ➢ not really offered or via adult or child and adolescent mental health services Surgical therapy ➢ General surgical services or via referral to Waikato plastic surgery services (Small visiting serive to TDH) TDH also provides some services through the Public Health Unit – part of the Square Pegs Programme. Youth Gay/lesbian support
Taranaki District Health Board	No specific gender dysphoria services. Mental Health Service has a range of specialists that could treat people with depression if the client met the threshold for eligibility to specialist mental health service.
Waikato District Health Board	No GDS services provided through Mental Health or general services at Health Waikato. Endocrinology does provide services
Wairarapa District Health Board	No specifically targeted services – few requests. Mainly referral to specialist services or information and support through social workers.
Waitemata District Health Board	We do not see a lot of people for this service - 1 or 2 per year. We do not perform any surgery of this type at North Shore Hospital. would be the contact person for North Shore Hospital.
West Coast District Health Board	
Whanganui District Health Board	No services for GDS. No requests for services for 5 years except for one referral for psych assessment.

Where to from here?

1. Meeting with clinicians on 30 April 2003
2. Meeting with consumers to follow clinician meeting
3. Agree on ideal service for New Zealand
4. Agree on what is a possible service for New Zealand with current resources/available funding
5. Agree on Treatment Guidelines to be used as the standard for care in New Zealand
6. Feedback to Minister

Notes of meeting held at Ministry of Health, Wellington on Wednesday 30 April 2003, from 1030 to 1530 hours to discuss **GENDER DYSPHORIA SERVICES**

Present

:, Waikato
, Waikato
, Wellington
Auckland
:, Wellington
Christchurch (from 1330 hours)
Dr Rob Buist, Principal Medical Advisor, MoH (until 1100 hours)
Christine Andrews, Clinical Advisor, MoH
Gabrielle Collison, Clinical Advisor, MoH

This meeting was held to canvass opinions and seek advice from clinicians who are recognised to have particular expertise in the field of gender dysphoria treatment.
Attendees were asked to come prepared with the following information to do a 10-minute presentation to the group

1. What services are currently being offered in your DHB/in adjacent/other DHBs for which you have knowledge?

    a. Psychological/psychiatric services
    b. Endocrine services
    c. Surgical services

2. What criteria are used in your/adjacent/other DHB to deliver these services?
3. What services have been available in the past if this differed from what is currently available?
4. What private services are you aware of?

A brief draft Position Paper summarising the Ministry of health involvement to date was circulated prior to the meeting and it was suggested that during the meeting, the following questions together with any other issues arising, could be answered.

- What services would be ideal for the New Zealand context?
- International treatment guidelines – should these be used as the standard of care in New Zealand?
- Should GRS be publicly funded and if so how many per year?
- Should there be a register of clinicians with expert knowledge/special interest and if so where? - MOH website?

In his brief opening comments, Rob Buist commented on the need for the Ministry to broaden its focus from Gender Reassignment Surgery to Gender Dysphoria Services in general, and the need for better co-ordination of such services. He further commented that when the appropriate policy has been developed, the Ministry could then remind DHBs to deliver these services or purchase them elsewhere.

had contacted the Clinical Leaders at ADHB and reported on the ADHB/Auckland services as follows

- , National Women's Hospital advised that they see a proportion of these people for HRT (either estrogen or testosterone

depending on the gender assignment wishes) and in the case of women wanting female to male reassignment, in some cases they have removed the uterus and ovaries to avoid the bleeding problems which otherwise arise.

- , Community/Ambulatory advised that there are not a lot of services provided other than at Endocrinology for hormone prescribing / monitoring and at Sexual Health for basic psychotherapy (2 psychotherapists employed), diagnostic assessment, hormone monitoring and prescribing and sexual health diagnosis and management. He added that Mental Health will pick up general mental health issues but he was not aware of any specific surgical or psychiatry services. He commented that he has a client base between 20 and 40 in number, male to female only, the clients he sees are not seeking GRS, many are in the professional entertainment/sex worker business, mainly wanting hormone treatment and most of them (90-95%) are already on hormones without monitoring before he sees them. A positive aspect is that seeing them in the Sexual Health Service is a convenient way of maintaining good sexual health for their professional activities and his clinic now has rules for these clients with compulsory baseline monitoring tests. There are transgender staff working in the clinic and referral is mainly by word of mouth/ad hoc. They use only cyproterone acetate.

- , Mental Health advised that their liaison service has done a few gender identity/ dysphoria assessments in the past as a psychiatrist had an interest but he has now left and they have not had recent referrals. He said that although they do see a few people whose gender problems lead to other problems such as depression, they would not consider this core business and feel that if a better service is needed in this area it should be planned and costed separately, including psychiatry/psychology input. He also advised that their psychotherapy service would not see this group as core business either and has no specific expertise in the area.

- : Surgical Services advised that no GRS is currently provided and there is no current expertise although ; did some in the past.

- Counties Manukau and Waitemata DHBs do not provide clinical services other than some mental health services.

- Other services available include GPs in who prescribe hormones, and 2 private psychiatrists .

reported on the Wellington Region Gender Dysphoria services as follows

- Clinical services are provided at Capital Coast Health and Hutt Valley Health and a pattern of partial service with variable facilities for management or psychological support, has occurred over about 15 years
- The criteria for assessment is a referral request from the primary sector, whether this is from a GP or a psychologist and almost all patients have a psychological assessment within the first year of hormone therapy
- Capital Coast Health largely provides services to patients within the region but also visiting service to Masterton. There is a wide mix of diagnoses with "some 'core' transgender, many possibly 'secondary', a few not transsexual, many on hormone maintenance not requiring surgery or further somatic change." There are 4 endocrinologists providing some service to around 48 patients, psychiatry/psychology has varied over the years with currently 2 psychiatrists giving an initial or surgical appraisal, surgery available is orchidectomy, hysterectomy, and mastectomy. ; at Sexual Health Service also provides some services to these clients.

- Hutt Valley Health has 2 endocrinologists providing some service and there are occasional psychiatric assessments both as part of transgender evaluation and management of other psychiatric issues for Hutt patients.
- Other services available include GPs for hormones and management, psychologists for management were available at CCH in the past and currently in private, private psychiatry opinions especially for surgery, and private plastic surgery

confirmed and added to comments

- stressed the need for consistency in availability and type of service provided around the country as otherwise clients travel to areas where services are available using false names and addresses or they seek blackmarket treatment which is totally non-monitored
- She advised that when the matter had been referred to the local Ethics Committee as to whether is was better to provide an incomplete/imperfect service to these clients or no service at all, the Ethics Committee had advised that an incomplete/imperfect service was better than none
- She commented that she has had patients who have had surgery in Thailand, Oregon and with team in Christchurch. Follow-up and treatment of complications is obviously more difficult and costly when the surgery is done overseas. Psychiatric services for these patients have been provided partly in public and partly in private. A female to male patient had her hysterectomy in public and mastectomy in private. A urologist in Wellington will do orchidectomy in public after psychiatric assessment.
- She liaises with a GP to provide cyproterone acetate for a sub-set of patients who are long term transgender patients requiring anti-testosterone treatment but not seeking surgery or psychiatric assessment/help.
- She questioned whether GPs should and advocated for GPs to be able to prescribe cyproterone acetate to a limit of one tablet per day
- She stressed the need for a network of endocrinologists, psychiatrists and sexual health workers

commented on services in Waikato, Bay of Plenty, Te Rawhiti and Rotorua

- History - 15 years ago they provided a public service where they tried to follow the Harry Benjamin Standards of care. They had 20-30 clients, 3 female to male and the rest male to female, clients came through word of mouth. They then lost their surgeon; Midland RHA decreed GRS to be cosmetic and thus provided no public funding for surgery, a regime that continued through the HFA. They struggled on with no surgeon and then the public service closed. They (tried to provide a private service and then this closed.
- Currently only services provided at Waikato are through Sexual Health where provides a similar service to that provided by F but there are no psychiatric services available
- He stressed the need for research/control groups where any gender dysphoria services are provided
- He reiterated the Ethics Committee's advice and commented that GPs don't know what services are available

confirmed comments and gave a presentation on the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version

- recommended that these standards should be followed
- She suggested following the prevalence rates adopted by the Netherlands of 1 in 11,900 males and 1 in 30,400 females

- She stressed the importance of the relationship between the mental health professional, the physician and the surgeon
- She recommended there be only one prescriber permitted to prescribe hormones for an individual patient to reduce the abuse of these drugs

commented on services available in Christchurch

- There is a team in Christchurch comprising 3 surgeons (plastic surgeon colo-rectal surgeon , and urologist), 2 Psychiatrists , 3 anaesthetists and a social worker. All services are private. There is no endocrinologist in he team and there were but are no longer 2 psychologists
- commented that little counselling is available
- GPs are the co-ordinators of care and prescribe hormones
- There is no public service other than GPs accessing the public system for endocrinology
- She stressed that cost is an enormous barrier
- She advised that whilst assessments should be done by psychiatrist, on-going counselling does not need to be done by a psychiatrist all the time and could be done by registered private counsellors if there was funding for this.

Gabrielle Collison gave a brief summary of SHCT applications made to the Ministry of Health to date for GRS and she commented on the visit she and Christine Andrews had made to discuss the issues with . Specific questions put to included:

Q. ***If we were to have a GRS service in NZ, how would we pick potential candidates?***

A. Patient selection would be by thorough screening to make diagnosis before surgical referral and then further screening by the surgical team – he advised that their criteria are very strict and from brief précis we provided of applications we have received, he anticipated that the surgeons would not be prepared to operate on some

Q. ***Do you do both male to female and female to male GRS?***

A. They only do male to female in Christchurch. Female to male GRS is very complicated, three stages of surgery, done at Monash by

Q. ***What is access/availability in NZ – how many do you do per annum***

A. They would be able to do up to 3 to 4 cases per year but thought 1 to 2 reasonable numbers. Have done 52 cases since 1992 – most from USA. He understands cases from NZ who can afford to pay also go to Thailand

Q. ***Can you comment on your outcomes – do you have follow-up records, peer review process, QA programme?***

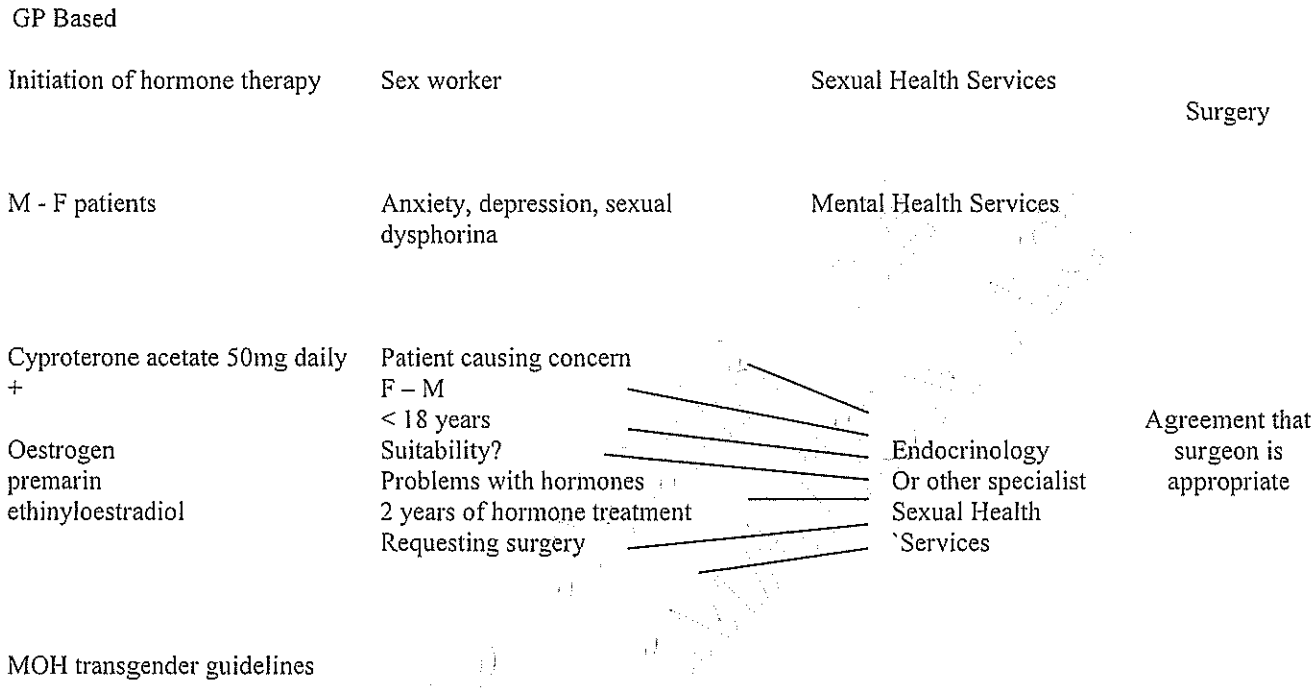
A. Presented to College of Surgeons when they had done 47 cases – do get complications – most common is constriction where penile skin meets bowel mucosa (hence importance of dilation post operatively

Q. ***Are you aware of any problems with current operative procedures – such as from hearsay rumour that excessive mucus production can be an unacceptable problem?***

A. re mucus – do get it during 3 months post op dilation. Now using much smaller section of bowel and thus less mucus production

There was comprehensive discussion and debate on the topic in general and on specific issues raised by participants. A suggested option/path forward is represented schematically below.

Referral Guidelines for Gender Dysphoria



Conclusions and answers to agenda questions

- ***What services would be ideal for the New Zealand context?***

Recognising the difficulty in making an absolute diagnosis, services need to contain all elements to adequately make an accurate diagnosis and should be consistent throughout the country. There needs to be better co-ordination with an emphasis on primary care and there are concerns about the availability of mental health services. It is noted that the young need to be supported through adolescence. The need for outcome research is recognised.

- ***International treatment guidelines – should these be used as the standard of care in New Zealand?***

It is recognised that these are optimum standards which should be followed as closely as possible whenever possible but conversely recognising the Ethics Committee decision, this should not be used as an excuse to provide no service.

- ***Should GRS be publicly funded and if so how many per year?***

A minority of participants at the meeting were in favour of having publicly funded GRS in New Zealand but restricting this to those for whom it is a personal imperative and a lifestyle choice.

The majority of participants at the meeting were not in favour of having publicly funded GRS in New Zealand on the grounds of prioritisation of other issues, which would be deemed to have a higher, ranking for the expenditure of public funds

- ***Should there be a register of clinicians with expert knowledge/special interest and if so where? - MOH website?***

The need to inform GPs about services available and how to access them is recognised. Whilst specialists with special interest and skills would be happy to have their names on a website available to GPs/Health Professionals, they would not wish to be named on a website generally available to the public. The reason for this is purely practical so that the limited resource can be use most effectively.

Ref. No.:20034162

- 4 AUG 2003
DISPATCHED

MINISTRY OF HEALTH
MANATU HAUORA

HEALTH REPORT

Subject: REVIEW OF GENDER DYSPHORIA SERVICES INCLUDING REASSIGNMENT SURGERY

HCO1/52/01 2

Date: 30 July 2003 **File Ref:** ~~HCO1/52/01~~

Attention: Hon Annette King (Minister of Health)

Priority:	Routine	Semi-Urgent	Urgent	24 Hour
	☑			

RECOMMENDATIONS

The recommendations are that you:

(a) note the information in this report. (Yes) / No

(b) note that the Ministry will be preparing an options paper for (Yes) / No ~~your~~ the Minister's consideration in October 2003

Received and forwarded to the Minister for her information 5th August 2003.

Dr Colin Feek
Deputy Director-General
Clinical Services Directorate

Advisor's
~~MINISTER'S~~ SIGNATURE:

DATE: 5th August 2003

REPORT

BACKGROUND INFORMATION

1. The purpose of this report is to update you on the progress of current work on Gender Dysphoria Services (GDS) including Gender Reassignment Surgery (GRS). This issue has already been the subject of previous briefings (see Briefing Request Ref. No.:20010873 and Health Report Ref.:20022985). On 26 February 2003 you replied to a letter from Tim Barnett MP, on behalf of the Rainbow Caucus Committee, about publicly funded GDS and GRS.

2. Comprehensive GDS comprise five elements: diagnostic assessment; psychotherapy; real-life experience; hormone therapy; and, surgical therapy that includes general surgical procedures as well as GRS.

3. Some GDS elements, like hormone therapy, mastectomy and orchidectomy, are funded via specialist medical and surgical services. Mental health services are also funded but only if people meet specific criteria. Currently there is no funding within New Zealand for GRS although applications are made to the Special High Cost Treatment (SHCT) pool under the category "treatment not currently available within the public health system".

4. Currently there are eight male to female and two female to male GRS applications to the SHCT pool. Male to female GRS is available in New Zealand at [redacted]. Hospital in Christchurch at an approximate cost of $30,000. Female to male GRS is not available in New Zealand.

5. The NZHTA review of GRS in February 2002 found that the quality of the evidence for the effectiveness of GRS is poor and based on a small number of poorly designed studies. While GRS is perceived to benefit many people, some people have been unhappy with the results and later sought reversal. No pre-surgical selection processes are available to determine which category people will fall into.

6. Historically the Ministry of Health involvement in this health service area has been restricted to applications for GRS through the SHCT pool. In January 2003, in response to consumer feedback, it was agreed that the Ministry should widen the GRS project scope to consider comprehensive GDS and not just GRS as it is inappropriate to provide a GRS service if other essential related services are not available.

COMMENT

7. On 21 February 2003 a letter was sent to all DHBs seeking information on the GDS they are currently providing for their patients with gender identity disorders. A small number of DHBs reported that they were not providing any of these services. Most DHBs reported that they were providing most or some service elements for a Gender Dysphoria Service. Generally these were not dedicated services with specific health professionals identified as having a responsibility for the service. In the very few instances where there was a more

comprehensive Gender Dysphoria service, this was delivered from the Sexual Health Service and catered for a particular subgroup of gender identity disorder people many of whom are in the entertainment/sexual health service worker industry.

8. On 8 April 2003 Ministry officials met with , plastic surgeon at Hospital, who together with a urologist and a colo-rectal surgeon offer a private male to female GRS service. Issues discussed included: criteria for people to be accepted as suitable for GRS; numbers of GRS cases to date; publication of results; and, 's ability to provide GRS should public funding become available.

9. On 30 April 2003 a meeting was held with health professionals currently providing Gender Dysphoria services in both the public and private sectors in New Zealand. These included endocrinologists, a psychiatrist, a psychologist/psychotherapist, and a sexual health physician. A summary of the outcomes of this meeting is contained in the answers to the following questions specifically addressed by the participants.

10. *What services would be ideal for the New Zealand context?*

Recognising the difficulty in making an absolute diagnosis, participants believed that GDS needs to include all five elements (diagnostic assessment; psychotherapy; real-life experience; hormone therapy; and, surgical therapy that includes general surgical procedures as well as GRS) to adequately make an accurate diagnosis and should be nationally consistent. They stressed that there needs to be better co-ordination with an emphasis on primary care and there are concerns about the availability of mental health services. The participants recommended that children and young people with gender identity disorders need to be supported through adolescence and they recognised the need for outcome research.

11. *International treatment guidelines (Harry Benjamin Guidelines) – should these be used as the standard of care in New Zealand?*

It is recognised that these are optimum standards which should be followed as closely as possible whenever possible but conversely, recognising the Ethics Committee decision (that it is better to provide **some** services for this patient group even if it is not the optimum service), this should not be used as an excuse to provide no service.

12. *Should GRS be publicly funded and if so how many per year?*

A minority of participants at the meeting were in favour of having publicly funded GRS in New Zealand but restricting it to people for whom it is a personal imperative and a lifestyle choice.

The majority of participants at the meeting were not in favour of having publicly funded GRS in New Zealand on the grounds of prioritisation of other services that would be deemed to have a higher ranking for the expenditure of public funds.

13. *Should there be a register of clinicians with expert knowledge/special interest and if so where? - MOH website?*

The participants recognised the need to inform GPs about services available and how to access them. While specialists with a special interest and skills in GDS would be happy to have their names on a website available to GPs/health professionals, they would not wish to be named on a website generally available to the public. The reason for this is purely practical so that the limited health professional time can be used most effectively.

14. We are currently in communication and correspondence with overseas specialists. In the few outcome studies available for GRS it is clear that one way of people avoiding regrets after GRS is to adhere to the 'Standards of Care' laid down by the Harry Benjamin International Gender Dysphoria Association. The literature showed that poor differential diagnosis, failure to carry out the two-year 'life test' and poor surgical results seem to be the main reasons behind the regrets. In the UK ten per cent of people do badly after GRS and are unemployable, socially isolated and chronically depressed. Another five per cent commit suicide.

15. A full day meeting with Gender Dysphoria service consumers has been scheduled for 6 August 2003. There will be six consumers including Maori and Pacific participants at the meeting and the agenda has been prepared in consultation with the consumers.

16. It is intended to then prepare an options paper for your consideration in October 2003.

IMPLICATIONS FOR REDUCING INEQUALITIES

17. Maori and Pacific Peoples are consumers of Gender Dysphoria services. Currently in some areas, some of these services are only available in the private sector.

Contact for telephone discussion (if required)

Name	Position	Telephone Direct Line	After Hours	Suggested First Contact
Christine Andrews	Clinical Advisor	4962563	025 2494569	1
Gabrielle Collison	Senior Advisor	4969034		2
Deborah Woodley	Manager	4962187		3

2003/4497

B4 I decide this I want an update on the SHCT Pool of money - (1) How much? (2) What has it been spent on since 2000? (3) Criteria for access to SHCT.

MINISTRY OF HEALTH
MANATU HAUORA

Subject: OPTIONS FOR SERVICES FOR PEOPLE WITH GENDER IDENTITY ISSUES

Date: 11 November 2003 **File Ref:** HCO1-52-0-2

Attention: Hon Annette King (Minister of Health)

Priority:	Routine	Semi-Urgent	Urgent	24 Hour
	☑			

RECOMMENDATIONS

The recommendations are that you:

(a) **Note** that gender reassignment surgery is part of the broader issue of delivery of gender dysphoria services — (Yes) / No

(b) **Note** the information in this report — Yes / No

(c) **Agree** to Option 1, or — Yes / No

(d) **Agree** to Option 2,or — Yes /No

(e) **Agree** to Option 3 — Yes / No

Dr Colin Feek
Deputy Director-General
Clinical Services Directorate

See Minister's comments above. Please include response in updated report.

~~MINISTER'S SIGNATURE:~~ Annette King

~~DATE:~~ 20.11.03

REPORT

BACKGROUND

1. You have asked for advice on funding gender reassignment surgery (GRS). This report addresses GRS as part of the broader issue of the delivery of gender dysphoria services (GDS) for transsexual people. This issue has been the subject of previous briefings; Health Report Ref. Nos.: 20034162, 20022985 and 20010873.

2. Only a very few people have been publicly funded for GRS. In 1995 the Core Health Services Committee and in 1996 the National Health Committee took the position, in their annual reports, that eligibility for publicly funded services should depend on individual patient circumstances, the degree of benefit expected from the services and the competing claims on resources. From this stance each of the four Regional Health Authorities (RHAs) took a different position.

3. Central RHA funded one case on exceptional individual circumstances; Northern made no comment (they may not have had a case); Midland sought ethics committee advice that concluded that the procedure was cosmetic and therefore should not be funded; and Southern also declined to fund GRS as it was seen as cosmetic surgery. In 1998/1999 the Transitional Health Funding Authority stated that GRS was not covered in current funding arrangements but a nationally consistent policy around GRS and other emerging treatments was required.

4. Historically, Ministry of Health involvement in this area has been restricted to receiving applications for GRS through the Special High Cost Treatment (SHCT) Pool under the category "treatment not currently available in the public health system". The New Zealand Health Technology Assessment of GRS in February 2002 found that the quality of evidence for the effectiveness of GRS is poor and based on a small number of poorly designed studies. Consequently the Ministry has declined these applications.

5. The wider group of people under consideration are transsexuals. These are people that are characterised by strong and persistent cross-gender identification accompanied by persistent discomfort with their sex. The Harry Benjamin International Gender Dysphoria Association[1] provides data from the Netherlands that indicates the prevalence for transsexualism is 1:11,000 in males and 1:30,400 in females. More recent observations, not yet confirmed by study, indicate that the prevalence may be higher. Accurate figures are not available for New Zealand.

6. During 2003 the Ministry has reviewed GDS provided by District Health Boards (DHBs), has met with clinicians currently providing GDS services (including endocrinologists, psychiatrists, clinical psychologists and sexual health

[1] The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version, February 2001

physicians), has consulted with clinicians providing GDS/GRS in the private sector and most recently met with consumers.

7. During the meeting with consumers as well as an in depth consideration of GDS/GRS in general, there was also discussion around the need for GDS for children and problems for transsexual people at the time of puberty. At this time the Ministry has only reviewed GDS available to adults. Services for children have not been considered.

8. The aetiology of transsexualism is complex and most recent authors[2] conclude that it "appears not to be a mental illness but rather a neuro-developmental condition that has not been shown to be overcome by contrary socialisation, nor by psychological or psychiatric treatments alone." It is most likely a host of factors will come to be identified as involved with causing transsexualism and consequently gender dysphoria. Accordingly they conclude that people, depending on their particular needs, can benefit from an approach that includes well-integrated and coordinated psychosocial intervention and support as well as hormonal and corrective surgery treatments. Assessment and management of GDS and GRS is spread over a number of years.

Survey of District Health Boards

9. A survey of GDS in DHBs indicates that diagnostic assessment services vary and where some areas may have well informed primary care practitioners, generally this is not the case and so diagnostic assessment is more likely to occur in secondary services.

10. The availability of the necessary mental health services required for both diagnosis and pre-surgical assessment for transsexual people is inconsistent throughout the country. In most DHBs transsexual people will only have access to psychiatric services if they fit the severity criteria for specialist mental health services (top 3%) and their only option is to self-fund for private services. A small number of DHB mental health services consider that people willing to undergo extreme interventions need a good mental health assessment and do provide a limited service.

11. The availability of psychotherapy in the public sector for transsexual people is limited and while some services are available through some DHB sexual health services, this is a low priority for DHBs. Consumers report having to use private services.

12. In the Harry Benjamin guidelines there is a strong emphasis on the need for appropriate assessment of people wanting to undergo both hormone therapy and perhaps later, gender reassignment surgery. It is essential that the diagnosis is made accurately and is not confused with other factors such as non-conformity to stereotypical sex role behaviour, transvestic fetishism (cross-dressing for the purpose of sexual excitement), or delusions that may be present in some psychotic disorders including schizophrenia. There are also

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[2] Dr Russell Reid, Dr Henk Asscherman, Professor Mickey Diamond, Professor Louis Gooren, Dr Frank Kruijver, Dr Joyce Martin, Dr Z-J Playdon, Mrs Terry Reed

intra-personal factors that need to be considered such as the belief that life will be perfect if only the person were a different gender.

13. Generally hormone therapy is available in the public sector mainly through DHB endocrinology and sexual health services and from some GPs. The hormone therapy of choice prescribed by many practitioners is currently a specialist only drug available only from secondary care specialists.

14. The availability of general surgical procedures (excluding GRS) varies throughout the country and may be dependent on surgeons sympathetic to providing a service. In one DHB it is considered cost efficient to provide bilateral orchidectomy rather than prescribe expensive anti-androgen hormone therapy.

15. GRS is not available in DHBs. Given other competing claims, DHBs do not see GRS fits in with other current priorities. A private GRS service is available for male to female surgery at [redacted] Hospital in Christchurch. Female to male GRS is not available in New Zealand.

COMMENT

16. In accordance with the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, a comprehensive GDS comprises five elements: diagnostic assessment; psychotherapy; real life experience (living as the opposite sex); hormone therapy, and surgical therapy that includes general surgical procedures as well as GRS. It is apparent that there is an inconsistent service across New Zealand where endocrinology services are generally available and mental health services are seldom available. During the consultation with clinicians and consumers, both stressed the need for consistency throughout the country.

17. To provide an improved more consistent service the following pathway would include:

    - referral from primary care to a local psychiatrist for assessment and diagnosis.
    - further referral to psychiatric specialists with special skills/knowledge in this area. All DHBs only accept referrals to mental health services that meet the 3% criteria. These people are very unlikely to meet these criteria or if they do, they may not be fit for surgery at this time and they will require ongoing mental health service care rather than just the assessment.
    - referral from primary care to secondary care endocrinology services
    - ongoing psychological/psychiatric support and hormone therapy.

18. In order to achieve this improved service, it would be necessary to increase DHB services in primary and secondary care which would include some DHBs needing to increase their volumes for outpatient endocrinology to cope with referrals and for most DHBs, the need for additional psychiatrists/psychologists

to be trained in GID/GRS. Whilst this would address the gaps identified by both consultant and consumers in the services currently available, it is a low priority for most DHBs.

Options for services

Option 1 – DHB public funding for medical treatment but no public funding for psychiatric assessment or GRS

What Option 1 involves

19. This option involves continuing with the status quo with regard to primary and secondary services provided in the public sector and excludes GRS on the grounds of poor evidence. The status quo would be enhanced by confirming with DHBs the secondary services to be provided by them viz. primary care referral to an endocrinologist and referral to mental health services where the patient is sufficiently stressed to fulfil the criteria (top 3% of patients with mental health illness).

Comment on Option 1

20. Currently under Population Based Funding Formula (PBFF), a DHB can fund the services deemed most appropriate for that population group. In fact if a DHB decides that a service such as GRS is a priority but does not have health professionals with the necessary skills to provide the service, the DHB can purchase the service privately, but given the DHBs current priorities and funding issues, it is extremely unlikely for this to happen with GRS. This option would raise the profile of GDS/GRS and the health issues of transsexual people with DHBs. It will also address to some extent the inconsistencies in current DHB service provision with relation to endocrinology services but it will not improve the major deficit areas, of access to mental health services for psychiatric assessment and diagnosis, and for ongoing psychological support.

Option 2 – DHB funded medical treatment services and public funding for a limited number of GRS procedures from SHCT Pool but patients self-fund any services necessary for pre-operative assessment and ongoing support which are not currently available through DHBs. This could be up to 3 male to female and one female to male (only available overseas) within every two-year period.

What Option 2 involves

21. This option would require a comprehensive service as outlined in the Harry Benjamin Standards and where these are currently available in primary and secondary services, these would continue to be provided. However, it would be the patient's responsibility to self-fund such mental health services that are currently not available in the public sector and to fund their own preoperative assessment (including travel and accommodation costs). Public funds from the SHCT pool would be available to fund a limited number of GRS procedures.

Comment on Option 2

22. This option would overcome the current impasse with the availability of publicly funded mental health services for this group of patients and would enable appropriate standards of care to be observed for major surgical procedures that are irreversible. The patient self funding would not be setting a precedent as with many other surgical procedures, while patients may receive their operations free of charge in DHB facilities, many of them have paid for their pre-operative care privately. It would, however, benefit only a small number of transsexual people and will do nothing to improve services for the wider transsexual population as a whole.

Option 3 – DHB public funding for medical treatment and pre-operative assessment and public funding for a limited number of GRS procedures from SHCT Pool. This could be up to 3 male to female and one female to male (only available overseas) within every two-year period.

What option 3 involves

23. As already stated, a comprehensive GDS comprises five elements: diagnostic assessment; psychotherapy; real life experience; hormone therapy, and surgical therapy that includes general surgical procedures as well as GRS. Apart from the primary and secondary services to provide diagnosis, hormone therapy and to support real life experience (as for option 1), this option would also require:

- private pre-surgical assessment in Christchurch for male to female GRS and in Australia/overseas for female to male GRS
- gender reassignment surgery plus any complications treated in either private sector or DHB facilities
- male to female procedure at [redacted] Private Hospital at a cost of $30,000 exc GST
- female to male procedure overseas at a cost of up to $80,000 (Australia)
- post surgical follow up and psychiatric support
- airfares and accommodation in New Zealand and Australia/overseas for pre-operative assessment, peri-operative treatment and post-operative follow-up and support.

24. Whilst the cost of the actual surgery in GRS is fixed and readily quantifiable, the costs of pre-operative assessment and care, peri-operative complications and ongoing life-long post-operative care can vary enormously. Consequently these costs are difficult to quantify but the Ministry's experience with the one patient for whom it has provided funding from the SHCT Pool is that post-operative costs alone can add a further $ 20,000 in addition to the $30,000 cost for the GRS surgery (male to female GRS). These post-operative costs cover

complications arising from the GRS and further corrective surgery to address patient dissatisfaction arising from the GRS.

Comment on Option 3

25. New Zealand clinicians agree that the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders should be followed as closely as possible for most elements of service and **must** be followed absolutely with regard to surgical therapy. It would be irresponsible and unethical to provide GRS without the essential underpinning and ongoing support services. Currently, with very few exceptions, the necessary mental health services for diagnosis, pre-operative assessment, and lifelong counselling are unavailable as publicly funded services.

Comment on all options

26. For any of the above options, cosmetic surgery and any other procedures such as laryngeal reshaping, rhinoplasty, hair removal, jaw reduction and waist liposuction should **not** be considered as core services to be publicly funded.

27. Should you choose Option 2, a selection process will be required. The simplest process would be to deal with referrals in date order of receipt following their acceptance for surgery by the nominated surgical team. (The private surgical team at Hospital have agreed they would carry out the assessment for male to female GRS but a similar arrangement would need to be made in Australia/overseas for the female to male GRS.) Patients wishing to have GRS, for whom the Ministry already holds applications to the SHCT Pool, would still need to be assessed by the appropriate surgical team to determine their suitability for surgery. They would need to be advised clearly as to the limit of the publicly funded services available and thus the extent of services they would need to self-fund. In the interests of fairness, this group should be given the earliest opportunity to have publicly funded GRS, provided of course they are assessed to be suitable for surgery (in accordance with the Harry Benjamin standards).

SUMMARY

28. In accordance with the arguments presented in the discussion above,

- Option 1 will enhance services currently available by improving the consistency of services across DHBs. This will be mainly in the primary care referral and secondary care endocrinology service areas. It is unlikely there will be significant or any improvement in the availability of mental health services required for GDS and GRS.

- Option 2 would provide a GRS service and would benefit a small number of transsexual patients. It would however require patients to self-fund some services and even if the actual GRS procedure is funded from the SHCT Pool, it is likely that it will fall back to DHBs to fund complications arising from GRS. This option would require the expenditure of significant public funds for a very small number of patients for a procedure for which

there is not a reliable evidence base of efficacy and for a condition group that DHBs have advised us is not a priority.

- Option 3 requires appropriate mental health services as an essential element of a GRS service, and currently such services are not provided by the public sector. These services may need to be purchased from the private sector.

Contact for telephone discussion (if required)

Name	Position	Telephone Direct Line	After Hours	Suggested First Contact
Colin Feek	Deputy Director-General	4962390	021 665100	1
Christine Andrews	Clinical Advisor	4962563	025 2494569	2
Gabrielle Collison	Clinical Advisor	4969034	021 807852	3

Ref. No.: 20045787

- 7 MAY 2004
DISPATCHED

MINISTRY OF HEALTH
MANATU HAUORA

HEALTH REPORT

Subject: FUTURE SERVICES FOR PEOPLE WITH GENDER IDENTITY ISSUES

Date: 6 May 2004 **File Ref:** HCO1-52-0-2

Attention: Hon Annette King (Minister of Health)

Priority:	Routine	Semi-Urgent	Urgent	24 Hour
	☑			

RECOMMENDATIONS

The recommendation is that you:

(a) Agree with the information in this report Yes / No

Dr Pat Tuohy
Deputy-Director General
Clinical Services Directorate

MINISTER'S SIGNATURE:

DATE: 18/5/04

REPORT

BACKGROUND INFORMATION

1. The purpose of this briefing is to confirm the decisions about services for people with gender identity issues (Health Report No: 20034437) that were discussed at your meeting with Ministry officials on 28 April 2004.

COMMENT

2. It was decided that general practitioners would be provided with further information about the management of hormone therapy for people with gender identity issues. General Practitioners would also be reminded that they could refer people to specialist endocrinologists in district health boards for advice on hormone therapy.

3. It was further decided that Option 2 (Health Report No: 20034437) was the preferred way to publicly fund gender reassignment procedures for a limited number of people. Option 2 is DHB funded medical treatment services and public funding of gender reassignment procedures from the High Cost Treatment Pool but patients self-fund any services necessary for pre-operative assessment and ongoing support, which are not currently available through DHBs. This could be up to 3 male to female and one female to male (only available overseas) within every two-year period.

IMPLICATIONS FOR REDUCING INEQUALITIES

4. There are no implications for reducing inequalities.

Contact for telephone discussion (if required)

Name	Position	Telephone		Suggested First Contact
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