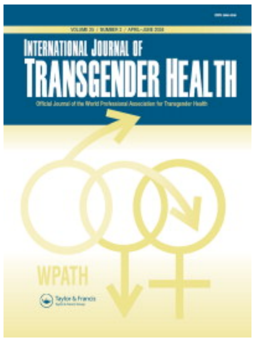

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Developing a gender affirming health response for trans and gender diverse Australians: a qualitative study

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ABSTRACT

Introduction: As trans and gender diverse populations experience disproportionately higher rates of discrimination, violence, mental health challenges, unemployment, and financial hardship, it is important to develop an evidence-based public health response for trans and gender diverse people seeking gender-affirming surgery (GAS). Resourcing and pathways for access vary across Australian states, with little research exploring the experiences of trans and gender-diverse people seeking GAS in Australia.

Methods: In-depth semi-structured interviews ($N = 9$) were conducted with three trans and gender diverse individuals, and six key representatives from community organizations (of which five identified as trans or gender diverse) in Queensland, Australia. Braun and Clarke's reflexive thematic analysis was employed to analyze interview data.

Results: Interviews explored experiences with and attitudes toward existing models of gender-affirming care, barriers to the provision of GAS, and opportunities for developing and implementing a publicly funded gender-affirming model in Australia. Findings indicate individual, societal, and structural barriers prohibit access to GAS, with opportunities identified to improve health and wellbeing outcomes for trans and gender diverse people in Australia.

Conclusions: Findings are relevant to both future research and informing clinical policy, to establish appropriate and accessible pathways to GAS in Australia. Further research is required to inform the development of a publicly-funded model within the Australian context. Exploration of health economics and health service optimization would facilitate better understanding of individual trajectories and health outcomes within Australia, and ensure that any reform applies a person-centered approach to care

KEYWORDS
Australia; gender-affirming surgery; gender-affirming care; health care; minority stress; Trans and gender diverse

Introduction

While social and structural recognition of trans and gender diverse identities continues to progress within Australia (Franks et al., 2022), no differentiated data exist regarding the proportion of the national population who identify as trans and gender diverse in Australia, with some sources proposing population-wide estimates of 4.5% who may identify as trans or gender diverse (Zhang et al., 2020).

Trans and gender diverse people experience disproportionately higher rates of verbal, physical, and sexual harassment, assault and discrimination relative to the general population (Bretherton et al., 2021; Cheung et al., 2018; LGBTIQA + Health Australia, 2021; Stewart et al., 2017; Swan et al., 2023) and report significantly poorer physical and mental health and quality of life (QoL) outcomes across societal and institutional settings (Day & Brömdal, 2024; Hughto et al., 2022; LGBTIQA + Health Australia, 2021; Manley et al., 2024; Phillips et al., 2024; Sanders et al., 2023; Swan et al., 2023; Watson et al., 2024). Perceived limited social integration, experiences of stigma, and social exclusion have been associated with poorer wellbeing (Stewart et al., 2017).

The incongruence experienced amongst trans and gender-diverse people between their gender identity and gender presumed at birth can commonly lead to a state of distress related to gender dysphoria (GD) (ACON, 2019). Gender-affirming

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surgery (GAS) has been associated with reduced GD and improved psychological wellbeing and QoL outcomes globally (Agarwal et al., 2017; Akhavan et al., 2021; Bailey et al., 2014; Defreyne, et al., 2017; Fallahtafti, et al., 2019; Javier et al., 2022: Papadopulos et al., 2017, 2021; Swan et al., 2023; Van de Grift et al., 2018), however, access in Australia remains complex, and largely limited to the private health sector (Piñón-O'Connor et al., 2023; Swan et al., 2023), with no national or consistent pathway across states established to access publicly-funded or affordable GAS.

GAS describes a single or multiple set of major and/or minor surgical procedures performed to affirm a person's experience of their gender identity. A wide variety of surgical interventions exist to rectify incongruent physical sex characteristics, such as genital or 'bottom' (i.e. hysterectomy, vaginoplasty, labiaplasty, metoidioplasty, orchidectomy, oophorectomy, phalloplasty), chest or 'top' (i.e. mastectomy, augmentation mammoplasty), facial (i.e. thyroid cartilage, hair transplant, facial feminizing), and vocal cord surgeries (Akhavan et al., 2021; TransHub, n.d.). GAS is uniquely placed in that it is currently not recognized within Australia's universal public health system (i.e. Medicare) yet is considered life-sustaining healthcare by many trans and gender diverse individuals (Bailey et al., 2014; Swan et al., 2023). Clear disparities exist within Australia between desired and accessed GAS, with a national survey of trans and gender diverse adults finding that amongst 403 participants presumed male at birth and 520 participants presumed female at birth, 2-31% had been able to access some form of GAS, while 44%–64% desired access to GAS (Bretherton et al., 2021).

International best practice for the provision of GAS is informed by the World Professional Association for Trans Health (WPATH) Standards of Care (version 8) (SOC-8) (Coleman et al., 2022). This is an evidence-based framework that provides clinical guidance for gender affirming care, criteria for access to GAS (e.g. referral(s) documenting: gender dysphoria, capacity to consent, age of majority, management of significant medical or mental health concerns, utilization of hormone therapy), post-surgical care, and optimal surgical training guidelines (Coleman et al., 2022). Criticized for creating barriers to access by over-pathologizing the trans and gender diverse experiences and gatekeeping access to GAS through the rigid application of homogenous eligibility criteria to evaluate a person's 'readiness' to access GAS (Ashley, 2019; Spanos et al., 2021; Verbeek et al., 2022), more recent efforts have been made to reduce gatekeeping measures (Coleman et al., 2022). Evaluations may still yield inaccurate assessments where trans and gender diverse patients feel pressured to convey "preconceived notions of normative trans experiences" to access GAS (Wu & Keuroghlian, 2023, p.231).

An alternative to the WPATH SOC-8 is the informed consent model of gender affirming care (Amengual et al., 2022; Verbeek et al., 2022), which emphasizes patient autonomy, knowledge, and experiences in making well-informed decisions supported by healthcare professionals (Cavanaugh et al., 2016; Schulz, 2018; Spanos et al., 2021). This approach involves the provision of accurate and relevant information provided by competent healthcare professionals to ensure thorough understanding of the potential risks and benefits of medical interventions (Australian Commission on Safety and Quality in Health Care, 2020). While the absence of a thorough psychological assessment process presents possible concerns about 'transition regret' (MacKinnon et al., 2020; Verbeek et al., 2022), these concerns are not supported by evidence (Bustos et al., 2021; Defreyne, et al., 2017; Sanders et.al., 2023; Swan et al., 2023).

Drawing on the experiences of trans and gender diverse individuals and key representatives from community organizations, the overarching aim of this study is to explore experiences and perceptions of access to GAS in Australia, and gain insight into opportunities for improving the provision of GAS for trans and gender diverse Australians.

Minority stress theory

Meyer's (2003) minority stress theory posits that minority groups experience disproportionately greater stressors within the context of stigma, resulting in poorer health and wellbeing outcomes (Frost & Meyer, 2023; Meyer, 2003). Objective elements external to the individual (e.g. structural discrimination, acute major life events, chronic stressors and microaggressions) act as distal stressors that contribute to the development of proximal stressors, which are internalized experiences of stigma (Meyer, 2003) such as learned rejection, expectant stigmatization, and identity concealment (Frost & Meyer, 2023).

Research within the trans and gender diverse population has associated minority stressors with negative health and wellbeing outcomes (Frost & Meyer, 2023; Testa et al., 2015; Timmins et al., 2017) but have identified that stress-ameliorating factors, such as a supportive social network and sense of belonging, may protect against the impacts of minority stressors (Hendricks & Testa, 2012; Meyer, 2003). Criticism of the application of the minority stress theory acknowledges the origin of its application to sexual orientation, and later, binary trans identities, but does not directly extend to consider the unique stressors experienced by the collective trans and gender diverse population (Frost & Meyer, 2023; Matsuno et al., 2022; Tan et al., 2020). Matsuno et al. (2022) further applied the model to non-binary populations, identifying minority stressors experienced by non-binary trans individuals to be consistent with the binary trans population, however acknowledged additional unique stressors, including binary normativity and interpersonal invalidation of identity.

GAS has been associated with greater life satisfaction and improved mental health among trans people who sought both genital and non-genital GAS in the United Kingdom (Bailey et al., 2014) due to decreased exposure to distal and proximal stressors through reduced gender incongruence and social discrimination, and the presence of community supports, which collectively reinforce the importance of establishing a clear and consistent access pathway to GAS in Australia. While not contending that access to GAS will resolve the negative impact of minority stress for all, particularly in the absence of social, political and legal transformation, it will contribute to its amelioration and as such the current study will be interpreted through the lens of minority stress theory.

Materials and methods

Research design

This exploratory qualitative study utilized in-depth semi-structured interviews to elicit nuanced participant perspectives. Data were analyzed using reflexive thematic analysis (RTA), a contextualist deductive method that prioritizes the context-contingent nature of an individual's experience within the conversation (Braun & Clarke, 2021; McKenna, 2015). This framework, which values participant experiences as knowledge within the context of navigating GAS access, is particularly relevant because lived-experience voices have been underrepresented in literature pertaining to trans and gender diverse people.

Furthermore, Braun and Clarke (2019, 2021) posit researcher subjectivity to be centralized to the RTA process; therefore, researcher reflexivity informed every stage of the research process. Positionality of the authors of this study include trans rights and health scholars and clinicians, who hold the belief that access to health care, inclusive of GAS, should be equitable to all. This position informed research design, analysis, and direction. Our scholarship spans disciplines of gender and trans studies, sociology, clinical and health psychology, and sexual health. The authors have been intimately engaged in trans rights, health research and practice, and advocacy within and beyond the Australian primary care environment for 4–25 years. Our authorship team includes researchers of non-binary and cisgender lived and embodied experiences spanning sexual orientations (pansexual, queer, heterosexual), and ethnic and cultural backgrounds (North African descent, White Australian, and White European descent).

Recruitment and participants

Participants were recruited *via* purposive and snowball sampling of the professional networks of the research team. This involved: (a) approaching prospective participants to take part in the study; and (b) distributing an electronic recruitment flyer to community organizations, and trans-specific websites and list-servs (i.e. Facebook groups). For breadth of insight, we sought perspectives from two types of participants: (a) people aged 18 years or older who identify as trans or gender diverse, and have accessed or attempted to access GAS in Queensland, Australia; and (b) representatives from community organizations aged 18 years or older who support trans and gender diverse individuals, including how to navigate GAS and other gender-affirming healthcare, in Queensland, Australia.

Interested people were provided with a participant information sheet *via* email detailing participation expectations, project aim, foreseen risks and benefits, and researcher contact details. Recruitment occurred from April-July, 2023. To mitigate risks to client confidentiality, candor, perceived power imbalance, and dual relationships, participants were interviewed by researchers whom they did not already know.

Sample size was guided by Malterud et al.'s (2016) model of information power, in which the more information of relevance held by the sample, the fewer participants are needed, which also informed participant selection. To maximize information relevance, participants were selected who had lived experience of seeking GAS, experience with supporting trans people in community organizations navigating GAS and other gender-affirming healthcare, and experience with both.

Sample specificity, research aim, theoretical underpinning, quality of dialogue, and type of analysis were considered alongside purposive sampling to analyze data. Whilst not exclusionary, participant demographic information (i.e. residential/work location, gender identity, experience with gender affirming care) was considered during the interview selection process to promote heterogeneity of the sample pool.

Data collection and analysis

Ethics Approval was granted by the University of Southern Queensland's Human Research Ethics Committee (Approval No: H20REA289), with research performed in accordance with the ethical standards consistent with the 1964 Declaration of Helsinki and its subsequent amendments.

In-depth semi-structured interviews were conducted by three experienced qualitative researchers (IW, AB and AM) from June–September, 2023. A majority of interviews were conducted by the first author, where three interviews were delegated to other members of the research team and deidentified so to manage prior relationships. Interviews were conducted either in-person or *via* video conferencing (Zoom/Teams), depending on participant preference.

Prior to the interview, participants were emailed a participant information sheet and were briefed verbally before the interview. Informed consent to participate and record interviews was obtained from all participants through a signed consent form (returned *via* email), and confirmed verbally prior to commencing the interview. Participants were advised that consent could be withdrawn, and that they could decline to answer any questions during the interview. Interviews were audio-recorded and transcribed verbatim through Teams and the external artificial intelligence software Otter (https://otter.ai).

The preliminary interview guide was adapted from (Piñón-O'Connor et al., 2023) work with health professionals providing gender-affirming care, and refined in consultation with trans rights and health scholars, clinicians, and sexual health practitioners. Interview questions explored participant demographic characteristics, lived-experiences and perceptions of access and barriers to GAS, and implications of maintaining existing models of care in Australia. Due to the sensitive information discussed during interviews, participants were provided with external referral resources for additional support and debriefing opportunities if needed. Participants were provided with deidentified transcripts and invited to make amendments to ensure accuracy and integrity of the data. No participants opted to amend their interview transcript.

Braun and Clarke's (2021) six-step approach to RTA was utilized to apply thematic analysis. These steps include 1) Familiarization with the dataset *via* immersion in interview recordings and transcripts, highlighting key points; 2) Assigning code labels to identify semantic points of interest and meaningful latent data; 3) Developing a thematic map to establish connections between codes; 4) Reviewing themes against the data and further refining them to reflect a set of distinctive and unified core concepts and subthemes; 5) Naming and defining the final themes and subthemes to ensure that they represented a clearly demarcated 'story' of the data, supported with illustrative quotes; 6) Analyzing themes within the context of existing literature to evidence an overarching analytical narrative.

Findings

Nine interviews were conducted. Interviews ranged from 40 to 92 min ($M = 63$ min). A brief summation of participant demographic data is seen in Table 1.

Three participants with lived experience were interviewed. One identified as trans woman; one as trans man; and one as non-binary, transgender, transmasculine, and genderqueer. One participant resided in metropolitan Australia, one in inner-regional Australia, and one resided in outer-regional Australia. Participant ages ranged from 20 to 55 years (mean = 35, SD = 18). Education ranged from high-school to post-graduate qualifications. All participants self-reported as White, and no participants identified as Aboriginal and/or Torres Strait Islander.

Within the community organization subgroup, six participants were interviewed across three interviews. Of these, five participants identified as trans or gender diverse (referred to as "dual participants"), and one participant was cisgender. All participants worked within metropolitan Australia. Participant age ranged from 34 to 67 years (mean = 49.7, SD = 11.5). All participants self-reported as White, and no participants identified as Aboriginal and/or Torres Strait Islander. Experience working (paid and/or voluntary capacity) with LGBTQIA + populations ranged from four to 30 years ($M = 11.3$, SD = 12.5).

Applying Braun and Clarke's (2021) six steps flexibly to generate and define themes from the dataset resulted in four themes and four sub-themes that collectively encapsulate participant experiences with and perceived barriers to accessing GAS, and reflections on reforming the current model of care: 1) Rumor has it; 2) Why are you policing our bodies? 2a) Individual and societal barriers; 2b) Structural barriers and gatekeeping; 3) Gambling with fate; 3a) It could be worse; 3b) It could be better; and 4) Affirming, affordable, and accessible.

Rumor has it

In the absence of a viable public pathway, participants relied on peer support and informal knowledge acquisition to navigate access to all forms of GAS. Josie (lived-experience, 30) mentioned limited publicly-available information pertaining to GAS, saying, "there's no understanding of complexities, no understanding of more advanced, experiential … I guess, journey level information." When discussing specific procedures and surgeons, participants alluded to an ever-present rumor mill. This experience was described by Spencer (lived-experience, 55):

> One of the big things that we talk about constantly is operations. How they've gone, what to expect, whether they've worked, whether they've helped with the dysphoria … who you can trust, who you cannot trust, that's a constant conversation within the transgender community.

This excerpt encapsulated the prominence of discussions surrounding GAS within the trans and gender diverse community, highlighting the importance 'word of mouth' has in informing an individuals' decisions to access GAS. Such informal knowledge acquisition was identified in the face of no apparent GAS access pathway and limited knowledge-base. Josie (lived experience, 30) commented on uncertainty about the availability of GAS in both the public and private sectors:

Table 1. Participant demographic characteristics.

Pseudonym	Age	Gender identity	Pronouns	Region
Trans and gender diverse lived experiences				
Spencer	55	Non-binary, transgender, transmasculine, gender queer	He/him	Outer-regional
Josie	30	Binary trans woman	She/her	Inner regional
James	20	Transgender male	He/him	Metropolitan
Community organization representatives				
Rory	44	Non-binary, gender flux	She/they/he	Metropolitan
Ned	49	Trans man	He/him	Metropolitan
Ollie	58	Trans male	He/him	Metropolitan
Will	34	Queer trans man	He/him	Metropolitan
Simone	46	Cisgender female	She/her	Metropolitan
Ines	67	Woman, trans woman	She/her	Metropolitan

> There's no information on how much it costs. I can't tell you now, it could be $13,000. It could be $150,000. I have no idea. Because at that level, information doesn't seem to be available easily. Especially not in … [an] Australia-centric market.

Overreliance on individual experience and opinions further convoluted understanding. As Will (dual participant, 34) observed, "…there's a mixed message about who is and who isn't doing a good job. I think it always comes down to your personal preference around what you're comfortable with and what you're not."

In addition to knowledge-sharing regarding availability and cost, peer support was described as essential in navigating current pathways to the range of GAS procedures, with some describing reliance on peer experiences to "coach you through" (Rory, dual participant, 44). Although noted to be less pertinent due to revised WPATH guidelines requirements, peer coaching remained a crucial response to the fear of being denied access to GAS and unclear existing access pathways:

> Trans groups online would … be like, 'go to this psychiatrist, they will ask you this question, you have to say this word for word'. That's how a lot of people were getting through, and still are … because of the gatekeepers and the fear that they're not going to get the care that they want or need. (Rory, dual participant, 44)

Distrust in the equitable provision of GAS also led participants to share and seek peer guidance regarding which healthcare professionals provide gender affirming care and which to avoid, 'loopholes' to maximize utilization of the publicly-funded Medicare Benefits Scheme and private health insurance benefits, how to navigate medical tourism, and strategies to fundraise for GAS.

Why are you policing our bodies?

Rory (dual participant, 44) articulated the frustration held by trans and gender diverse people in accessing GAS with the question, "Why are you policing our bodies?". This theme reflected individual, societal, and structural barriers to accessing GAS in Australia.

Individual and societal barriers

Participants emphasized wanting to feel 'ready' to pursue GAS, exploring their gender identity over a period of several months to several years before seeking access to GAS, particularly major or multi-step surgical procedures. Spencer (lived experience, 55) described a contemplation stage, where "I went back to, 'maybe this isn't a thing, maybe it is a thing, maybe it's not a thing. I'll just kind of keep sitting on it for a while because I don't want it to be a thing'", while Ned (dual participant, 49) described undertaking a "massive self-examination process" to "make sure I wasn't really making a mistake." Fear of external invalidation presented an additional internal barrier, with Josie (lived experience, 30) sharing that, "I wanted to make sure that whatever route I pursued was not going to be questioning my validity as a trans person."

Furthermore, cost was frequently described as the greatest barrier to accessing all forms of GAS. Participants perceived access as primarily through the private health sector within metropolitan areas, with negligible contributions from public and private health coverage to offset associated costs. Four participants had accessed 'top' surgery, with costs varying based on health insurance contributions, surgical revisions, additional travel expenses, and inflation. Feminizing 'bottom' GAS was perceived as inaccessible, although the accessibility of hysterectomy procedures within the public system was attributed to the relevance of the procedure to cis women. While no participants had accessed masculinizing 'bottom' surgery, access was perceived as limited.

Will (dual participant, 34) considered access to "really depend on who you are and what you've got, what sort of privilege you have." When contemplating GAS, financial burden was a major consideration for Josie (lived experience, 30):

> I could probably scrounge enough money to and figure it out. But it would definitely hinder things like buying cars, buying houses and just general life things … whether I can afford to have a child through IVF. So, I can choose to have a family or choose to go to surgery. So, the cost in of itself is such a negative prohibited point to be able to lead a normal life.

Similar experiences were shared by other participants, highlighting the impact of seeking GAS on an individual's daily life and future planning. Costs were greater for multi-stage surgeries (i.e. metoidioplasty, phalloplasty), and included 'invisible costs' such as travel expenses, surgical revisions, living expenses during recovery, medications, after-care, and allied health appointments. Ned (dual participant, 49) described the emotional and financial decision regarding access to 'bottom' surgery as "mortgage versus surgery". Participants admitted to finding 'loopholes' within Medicare, however out-of-pocket expenses remained substantial, and the benefit of private health insurance was perceived to be marginal, and associated with additional waiting periods and expenses.

The implications of recovery and aftercare, such as loss of income, unknown additional medical expenses, and fear of adverse surgical outcomes or medical complications, such as loss of desired level of sexual and reproductive function, were also described as barriers to accessing GAS. For some, this fear was underpinned by a lack of confidence in the quality of GAS currently accessible in Australia, with Ines (dual participant, 67) expressing concerns about pursuing 'bottom' GAS due to "unsatisfactory" quality, stating that "I don't want surgery for the sake of it."

Limited access to GAS was attributed by three participants to a lack of societal understanding of additional barriers faced by trans and gender diverse people. Simone (community organization, 46) referred to this as the "unearned privilege of people who don't have to deal with dysphoria," with James (lived experience, 20) observing that the media perpetuate the "misconception that gender affirming healthcare is optional."

Sensationalized and negative portrayals of GAS were perceived within the media and politics, with Ollie (dual participant, 58) expressing that "[trans and gender diverse people are] a good news story, as long as it's bad." Ines (dual participant, 67) described experiencing "cumulative aggressions" in day-to-day interactions across personal, workplace, public health, and private healthcare settings, with invalidation and discrimination experienced by participants seeking GAS. One participant (James, lived experience, 20) also described losing casual employment after accessing GAS in Queensland, Australia.

Structural barriers and gatekeeping

Structural barriers to accessing GAS were reported as existing within state and federal healthcare systems. Described as "subtextual gatekeeping" (Josie, lived experience, 30), an immediate barrier raised by seven participants was the lack of a pathway to access GAS within the public healthcare system.

Provision of gender affirming care in metropolitan and rural/regional areas was compared, with Spencer (lived experience, 55) noting that "the more rural or remote you might be, the less ability you have to have a doctor that's willing to kind of delve into this stuff with you and will walk the journey with you." Limited rural/regional access was also described as increasing costs and reliance on peer guidance to access GAS. Limited specialized training pertaining to the health care needs of trans and gender diverse individuals was mentioned by five participants, with Will (dual participant, 34) observing that "they [trans and gender diverse people] are just showing up to appointments and actually educating the practitioners."

Access to GAS was perceived as constantly fluctuating due to the limited number of surgeons and changes in individual surgeons' availability, with Ned (dual participant, 49) likening access to a "bottleneck" hindering progression from seeking to accessing GAS. Ollie (dual participant, 58) explained this as being driven by a sense of urgency, as "when you make the decision to transition, you want it all now. You don't want to wait another year, or another minute." Will (dual participant, 34) reflected on his experience seeking 'top' surgery, stating "I was very, very quick to be able to have surgery after my consult," but observed that "things have changed now, I think it's quite hard to get an appointment at that clinic." In discussing current waiting periods of six to 12 months to access GAS, Josie (lived experience, 30) reflected that "I personally didn't feel like I'd be able to survive."

Implementation of the WPATH SOC-8 to guide the provision of GAS within public and private sectors was contentious. Two participants perceived the standards to "provide consistency across the board" (Simone, community organization, 46) and offer "another layer of oversight" (Spencer, lived experience, 55); digressionary adherence to the WPATH SOC-8, however, was criticized for being inherently distrusting of the legitimacy of trans and gender diverse health care needs, and establishing a distrust between trans and gender diverse people and healthcare providers. Some participants also criticized the use of "forced psychometric testing … to prove that they [persons seeking GAS] are able to provide informed consent" (Simone, community organization, 46).

Ned described the requirements as "a waste of my money, a waste of my time, and insulting to boot." This sentiment was echoed amongst participants perceiving this gatekeeping as promoting additional barriers to access GAS. For example, Rory (dual participant, 44) described a "power imbalance to deny [or] not deny" access to GAS, establishing, "it is quite common for a surgeon to almost have that interpretation of the guidelines … I guess it's about their own risk, and how the gatekeepers … choose to manage risk." Participants also confided that they had given false report of their health and wellbeing status in order to obtain access to GAS. Parallel to this, Ned (dual participant, 49) shared his experience of navigating the cumulative barriers to access GAS:

> You happen to navigate [the] system, which can be difficult at the best of times. But you're doing it in a state of not knowing how people are going to treat you. Whether they're going to actually believe you or not. That's actually a big thing, and that can be very scary completely disempowering doing it where you're suffering from … immense gender dysphoria, which is an utterly horrible thing to go through, utterly horrid. And quite potentially doing it with the fear, very real fear of 'am I gonna lose my family? Am I gonna lose my friends? Am I gonna lose my job?' Basically, losing pretty much your whole foundation of life. And you're having all of these things and you're trying to navigate the system.

Gambling with fate

This theme explored perceptions of the current model of provision of GAS in which access was described as "a bit of a lottery" (Ines, dual participant, 67), referencing the variability of experiences, and acknowledging existing benefits and deficits within current structures.

It could be worse

In juxtaposition to the significant barriers to accessing all forms of GAS, participants perceived availability of gender affirming care, including GAS, to have improved. Gender affirming GPs were perceived as being more accessible in metropolitan areas, which Simone (community organization, 46) attributed to the introduction of LGBTQIA + specialized private practices. Access to hormone replacement therapy (HRT) through a specialized GP was also described as "an easy enough process" (Spencer, lived experience, 55).

Participants repeatedly expressed gratitude for a growing presence of healthcare providers who "just do it for a genuine love of the community" (Rory dual participant, 44). Clinicians currently supporting gender affirming care were perceived as deeply invested in the provision and development of equitable gender affirming care, including GAS. Furthermore, clinical utilization of an informed consent model in the provision of HRT was praised for promoting integrity, where individuals didn't feel compelled to "overperform their gender" (Josie, lived experience, 30) to access gender affirming care.

Access to GAS was perceived as limited through the private system, and inaccessible within the public system, with participants emphasizing the importance of reputation and bedside manner of surgeons, cost, wait time, and procedural techniques when considering any type of GAS. Several participants described clinicians to exceed expectations, with Will (dual participant, 34) sharing his "extremely stressful" experience of being supported by a GP to navigate gatekeeping:

> I was required to get a letter from my psychiatrist signing me off saying that I'm of sound mind … Trying to get that appointment was ridiculous … It took weeks and weeks of non-stop calling different people to try and see who had availability before I ended up getting my GP to write a personal letter or e-mail to the psychiatrist and say 'we've got this

> amount of time. Can you please just do a telehealth appointment with me [Will]?' And luckily, he agreed to doing that.

Participants tended to compare current access to GAS to none at all, rather than in relation to greater access. Ned (dual participant, 49) prefaced his perspective as:

> I'm very much a glass half full person. So, when I talk about how we really are lucky with what we have in Queensland, I'd like you to put that into perspective of … it being, 'oh my God, awful!', and we're not quite above the baseline yet. But compared to what it was, it's a lot better … But I would not say that we're anywhere near where it should be.

Participants able to navigate barriers to access GAS described improved wellbeing and alleviated GD:

> You've got people living with really, really serious dysphoria for a really longer period of time than what they need to. Even just being able to remove your breasts, if you're a female to male, actually just makes such a huge difference to your emotional and physical and mental wellbeing … You can't really describe it, just to be able to see your chest and just feel free for a moment. (Spencer, lived experience, 55)

It could be better

Described as "short-sighted" (Simone, community organization, 46), current access to GAS was criticized for failing to consider the longer-term implications of limited and privatized access. Will (dual participant, 34) spoke to the impact of individual, social, and structural barriers on an individual seeking access to all forms of GAS:

> I think there are lots of people that have had the same experience where, you know, you've been waiting years and years and years and saving all this money to do this thing that you know you're a very capable of making a decision around and have been thinking about for a long time and trying to have the financial backing to do that and to still have that one person at the end gatekeeping you and saying when you will do it or when you can do it … it's probably one of the biggest downfalls.

A lack of formal structural recognition within state and federal healthcare systems was attributed to inequitable distribution of public funding, and negative attitudes toward gender affirming care. These factors were perceived to lead to secondary structural implications, including extensive wait lists, privatized costs, inconsistent application of the WPATH SOC-8, and limited specialized clinicians. Will (dual participant, 34) summarized this disparity between supply and demand, stating that "there just needs to be more funding and everything. If you look at spaces like the gender service, you know they only have a couple of workers that are employed there to support hundreds and hundreds of people." This placed additional strain on existing gender services and allied health services to support the "implications of not having access [to GAS]" (James, lived experience, 20).

In response to limited access, participants described engaging in methods of fundraising to pursue any form of GAS within the private system. In addition to accessing personal savings and superannuation, participants reported fundraising methods to include selling and refinancing assets, loans, borrowing funds from family and friends, online campaigning, and sex work. Such methods were considered to be a risk to safety, health and wellbeing, and long-term security. The need to fundraise to access surgery was criticized as being a "horrible, disproportionate burden of being part of a minority that is not considered by society" (Simone, community organization, 46).

While no participants within the study had undertaken international travel to access GAS outside of Australia, some perceived GAS to be more accessible in Asian and South American countries, with reduced wait times, greater availability of surgical procedures, reduced costs, and less reliance on the WPATH SOC-8 guidelines when compared to Australia.

Others were hesitant to consider accessing GAS internationally. Ines (dual participant, 67) described it as "just too frightening", and Simone (community organization, 46) commented on "people not feeling safe to travel". Participants described concerns about costs, difficulty navigating an unknown medical system and standards, language barriers, additional travel expenses, limited social support, surgical and post-surgical health risks, and risk to safety due to hostile political climates. Spencer (lived experience, 55) confirmed, "if I have surgery, I feel like that's a fairly serious thing to undergo. And I would want to do that in my own country, in a medical system that I understood and that I trusted."

Participants expressed hopelessness regarding access to GAS. Spencer (lived experience, 55) admitted that "when I think about my future and my future mental health and wellbeing, I don't think about it in an optimistic way", with James stating that "even in the future, it [publicly-funded GAS] doesn't look like it's something that is really that achievable unless other surgeons and services kind of pop up."

Four participants described first- and second-hand detrimental health and wellbeing implications to being unable to access GAS. While Josie (lived experience, 30) described coping through "peer support and escapism," other participants described engaging in risky behaviors and coping strategies such as self-harm, self-mutilation, disordered eating, and substance misuse to manage growing desperation to access any form of GAS as "very common" (Will, dual participant, 34). Moreover, participants posited inaccessibility of GAS to negatively impact chronic health conditions, mental health, and limit individual potential to thrive. Rory (dual participant, 44) observed that:

> I can think of 20 people … friends and acquaintances that would be in jobs, helping community doing really good work, giving back, and they're not. They're on the disability support pension because their mental health is so poor because of their gender dysphoria, and other stuff. And so, they're just stuck in the mud on the bottom rung, unable to get themselves out of it.

Seven participants mentioned mental health implications for trans and gender diverse people unable to access GAS as desired, where Josie (lived experience, 30) described "intense levels of depression or suicidality" within the community when faced with compounding HRT shortages and inaccessible GAS. Similarly, when describing his future, Spencer (lived experience, 55) envisioned "I feel really unhopeful about it…I think it'll just get worse. I think for me…the only way out of it is death."

Affirming, affordable, and accessible

This theme reflected future hopes, considerations, and barriers to implementing a publicly-funded model of GAS in Australia. Participants emphasized an affirming, affordable, and accessible model to improve health and wellbeing, reduce suicidality and self-harm, and facilitate greater social engagement where "they're [trans and gender diverse people] comfortable to be out in public and be educated and to contribute to the broader community" (Will, dual participant, 34).

Affirming care was mentioned by six participants as critical in developing a safe and equitable model for the provision of all forms of GAS, with inclusivity and respect for trans and gender diverse identities at the forefront. Participants envisioned shifting away from a binary understanding of trans identities to ensure "that it's inclusive…that we bring everybody with us" (Spencer, lived experience, 55). Furthermore, participants emphasized a benevolent model of care where individuals are "comfortable and they're being treated how they would like to be treated" (Will, dual participant, 34).

Participants advocated for greater autonomy to explore surgical options to meet individual needs. To achieve this, Ines (dual participant, 67) proposed that:

> There needs to be a multidisciplinary assessment. There needs to be a team approach to the care that isn't, you know? 'Do you need your gonads out or not?' That's not the care. The care is: you're a person.

Participants proposed a person-centered approach to GAS, supported by a holistic multidisciplinary team (e.g. surgeons, GPs, endocrinologists, speech pathologists, social workers, psychiatrists, psychologists) to foster continuity of care prior to, throughout, and post access to the full range of GAS. Furthermore, in including "not just surgery, but also other gender affirming healthcare" (James, lived experience, 20), participants hoped that the model would allow individuals "the option to seek their own path" (Simone, community organization, 46). Further to this, Rory (dual participant, 44) advocated for national-level peak body funding so that, "wherever you are in Australia, you have the same access to information and support for being trans." In acknowledging resource limitations and the likelihood of wait lists to access GAS within a public model, interim mental health support was also considered essential. Furthermore, Ines (dual participant, 67) suggested that a center of excellence to meet the observed training and education deficit amongst healthcare professionals would "build more capacity so to help with feasibility and sustainability."

Participants described the importance of lived-experience involvement in developing a new model, to meet the nuanced needs of trans and gender diverse experiences, but also mitigate the risk of political subjugation:

> Once it hits like a policy level, once it hits like people who don't have that drive to use it as a method of career building, a method of building of the self even, it become not only unimportant, but frightening. (Josie, lived experience, 30).

Affordability was described as key by Simone (community organization, 46) as "it appears really unlikely for folk that that [GAS] will be accessible for them without some sort of miraculous windfall of money or even more miraculous, Medicare making that available under their system." Participants advocated for healthcare reform, describing the current distribution of federal and state funding as inequitable, because "it doesn't trickle down to the marginalized" (Ines, dual participant, 67). Spencer (lived experience, 55) delineated state and federal contribution as complimentary:

> They're not opposing, but they're just two different levels of government. One supplies the funding and the other supplies services. So, it needs to be both right? It needs to be funded by Medicare, and the services need to be available in the states.

Federal recognition within Medicare, Australia's universal health care system, was hoped to change GAS from being perceived as, "non- essential surgery or cosmetic based surgery, rather than something that's life saving or needed" (Josie, lived experience, 30). Participants proposed that all forms of GAS be "enshrined in Medicare" to ensure that "everybody might have some level of equal access to it" (Simone, community organization, 46). Concerns were expressed about limiting it to the publicly-funded system due to the risk of privatized fees with significant gap payments continuing to limit access. To address this, participants proposed that GAS be offered in private, publicly-subsidized, and bulk-billing settings, with continued privatized access to GAS to allow greater access autonomy (e.g. choice of surgeon, procedural technique, date) and ease financial and demand pressure from the proposed public model.

Finally, participants stressed improved access to all gender affirming services, particularly in rural and regional areas. Participants supported the value of a 'hub and spokes' approach to GAS, supporting a centralized trans and gender diverse health service built upon existing structures to act as a central 'hub' inclusive of GPs, surgeons, and allied health services. Participants were also adamant in advocating for the development of complimentary 'spokes' in rural and regional areas. Here, James (lived experience, 20) proposed "having a surgeon in all of those places might not be feasible … but having some sort of … connection point in all of the major population centers." A digital directory of services was also suggested to establish a convenient and transparent path to affirming services. Further development and access to resources, information guides, and policies was recommended to "demystify" GAS (Josie, lived experience, 30).

Participants perceived that the formal recognition of the various types of GAS within Medicare would inherently provide structural recognition and access clarity, with Simone (community organization, 46) describing the prospect as "life changing … even if they decided not to go down that path, to know that they had the option would enable them to set [out] with much greater clarity."

In reflecting on models of provision, despite criticism, the WPATH SOC-8 were not dismissed. Ollie (dual participant, 58) stated, "I think there needs to be some guidelines. Informed consent is not any good for people who lie and rush their way through the system." A reliance on psychopathology (e.g. diagnosis of GD) to access GAS was considered crucial by some participants and superfluous by others.

Experience with an informed consent model was limited to HRT, however, some perceived it as "the most optimal experience" (Josie, lived experience, 30). Integration of an informed consent model (partially or in totality) was anticipated to reduce "costing and waitlists on both psychology and psychiatry" (Josie) by removing additional access requirements. Participants demonstrated an overarching desire for a model that provides "access to any or all of the things they needed without any of it being prescriptive" (Simone, community organization, 46).

Three participants referred to economic benefits of a publicly-funded model of GAS in Australia. The "opportunity cost" (Ollie, dual participant, 58) of GAS was perceived as economically advantageous compared with the ongoing cost of services such as "mental health, GPs, going to emergency" (Ollie) currently required to support trans and gender diverse people to cope with inaccessible gender affirming care, "dysphoria, and resultant mental health issues" (Simone, community organization, 46). Moreover, participants anticipated that access to GAS would enable trans and gender diverse people to make greater social and economic contributions:

> We already know that we are over educated and under employed … society is actually missing out on all of the income and contributions that we can make to society because we are having so much stigma and discrimination, and we don't have fair access to the health care that we require. (Ollie, dual participant, 58).

Furthermore, while acknowledging that reliance on allied health services wouldn't "evaporate overnight", Simone (community organization, 46) anticipated that meeting trans and gender diverse health care needs would result in greater individual wellbeing and societal engagement, as people would not "be in survival mode constantly."

Participants hoped that an established public model of GAS would provide access to a wider variety of surgeons and surgical options, and that additional funding and formalized access to public GAS would attract more healthcare professionals to upskill in the provision of gender affirming care. Furthermore, Ned (dual participant, 49) predicted that a greater number of specialized clinicians would instill a "safety net" by establishing a model capable of responding to growing demand.

Several barriers were described in achieving affirming, affordable, and accessible GAS, including the "misconception that gender affirming healthcare is optional" (James, lived experience). Both lived- experience and community organization representatives described the burden of advocating for their health care needs, with Spencer (lived experience, 55) sharing that, "I feel like if people better understood what gender dysphoria was all about, then maybe the 'cures', so to speak, would be better understood." Advocacy leading to social and political recognition of trans and gender diverse people and their distinct health needs was perceived as essential in securing federal funding and state-based support.

Five participants expressed doubt about this prospect, however, as "politically, I don't think it will be very popular" (Spencer, lived experience, 55), with Will (dual participant, 34) attributing lack of political will to "…lack of education around our community and the investment in it. I don't think there's enough investment or want." Participants voiced a lack of confidence in the current socio-political landscape and state of healthcare and a lack of hope for structural change. Josie (lived experience, 30) asserted:

> There is not a feeling that our government, whether that's local, state, or federal, gives a crap about trans people, let alone queer people, we're not even… we're a rallying point for bigotry and nothing more, if we're viewed as people at all.

Rory further (dual participant, 44) observed the unstable political position on gender affirming care as "whenever there's a surge of left-wing politics, trans rights generally goes up." Will (dual participant, 34) attributed this instability to a lack of trans and gender diverse advocates at state and federal policy level, therefore advocating for "input from people that have the intention to provide care for trans people and non-binary people."

Discussion

This exploratory study sought to generate preliminary understanding of experiences and perceptions of access to all forms of GAS, barriers to access, and perspectives on models of GAS provision within Australia. Themes reflected perceptions of extremely limited access to GAS within existing public healthcare structures, which aligns with the lack of recognition within Australia's universal health insurance scheme (i.e. Medicare: Queensland Health, 2023; TransHub, n.d.). Private provision of GAS was described as limited and associated with significant access barriers, with findings supporting previous research noting a significant discrepancy between demand for GAS and accessibility (Bretherton et al., 2021; Piñón-O'Connor et al., 2023). Support within community was described as playing an important role in supporting those seeking GAS to navigate the healthcare system.

Themes also reflected barriers at individual, societal, and structural levels. Participants perceived a lack of recognition of trans and gender diverse healthcare needs, reflected by structural barriers such as prohibitive private costs, limited specialized clinicians and surgeons, and lengthy wait times to access private GAS. Furthermore, current pathways were criticized for gatekeeping access to GAS, where participants reported inconsistent application of evidence-based international guidelines (i.e. WPATH SOC-8).

Minority stress theory suggests that provision barriers can be attributed to implicit and explicit stigma and discrimination within state and federal healthcare structures (Hatzenbuehler, 2016; Livingston, 2021; Meyer, 2003). Although access to GAS would not absolve the population of social and systemic discrimination and stigmatization (i.e. cisgenderism and cisnormativity), interventions targeted to increase structural recognition of GAS, and reduce clinical stigma and discrimination, may assist to diminish the synergistic effect of minority stressors on the health and wellbeing of trans and gender diverse populations (Javier et al., 2022; Pellicane & Ciesla, 2022; Swan et al., 2023; Tebbe & Moradi, 2016; Testa, et al., 2015).

Minority stress theory also attributes physical, psychosocial, and financial implications to concomitant distal and proximal stressors experienced by trans and gender diverse people seeking GAS (Hendricks & Testa, 2012; Meyer, 2003; Testa et al., 2015). Participants described distal stressors related to negative social attitudes, as well as a lack of recognition, discrimination, and gate-keeping within healthcare settings. Participants also shared examples of internalized stigma (e.g. self-imposed 'readiness' hurdles) and anticipated rejection (e.g. social inclusion, meeting WPATH guidelines) that reflected proximal stressors (Quinn & Earnshaw, 2013; Wu & Keuroghlian, 2023).

Furthermore, themes reflected that while experiences of seeking access to GAS could be worse, they could also be better, with participants describing experiences of poor physical and mental health and suicidality consistent with previous research (LGBTIQA + Health Australia, 2021; Pellicane & Ciesla, 2022; Stewart et al., 2017; Swan et al., 2023). While perceptions of health and wellbeing may be partially attributable to the distal and proximal stressors associated with poor access to GAS (Frost & Meyer, 2023; Testa et al., 2015; Timmins et al., 2017), in the theme 'Rumor has it', participants also described a strong peer support network and clinical allyship within the trans and gender diverse community in Australia, which may help to ameliorate some of the implications of current distal and proximal stressors.

Participants also thematically expressed a desire to see 'Affirming, Affordable, and Accessible' healthcare for trans people seeking all forms of GAS, as well as greater recognition and allocation of funding for gender-affirming care, all forms of GAS, and allied health support at state and federal levels (such as Medicare) within existing public services *via* a publicly-funded model of care. Participants expressed a desire to see an evidence-based, holistic, and person-centered model of care encompassing both surgical and allied health services that reduced structural barriers, and increased acceptance of trans and gender diverse identities, within the healthcare system (Hatzenbuehler, 2016; Livingston, 2021). Participant beliefs that this would lead to improved health and wellbeing outcomes and quality of life are consistent with previous research (Agarwal et al., 2017; Akhavan et al., 2021; Bailey et al., 2014; Defreyne, et al., 2017; Fallahtafti, et al., 2019; Hendricks & Testa, 2012; Javier et al., 2022; Meyer, 2003; Papadopulos et al., 2017, 2021; Piñón-O'Connor et al., 2023; Swan et al., 2023; Testa et al., 2015; Van de Grift et al., 2018).

Publicly funded provision of GAS has been implemented in several countries to date. Sweden was the first country in the world to authorize legal GAS in 1972, and has since covered all GAS procedures through its high-cost protection (part of its universal healthcare system), including doctor's visits and medication (RFSL, 2022, 2023). Similarly, New Zealand has provided GAS through the public system since 2020, with high levels of demand reported across all forms GAS (Health New Zealand, 2023). Hong Kong provides heavily subsidized GAS through the public system, albeit with longer wait times compared with the more expensive private health system (Transgender Resource Center, 2022). Most Canadian provinces provide some forms of GAS through the public system, although some provinces do not cover surgery considered to be 'cosmetic' (such as facial feminization and breast augmentation) (GrS Montreal, 2024). While these examples demonstrate that publicly-funded access to GAS can be implemented within similar healthcare systems, further research is required to inform the development of a publicly-funded model within the Australian context. Exploration of health economics and health service optimization would facilitate better understanding of individual trajectories and health outcomes within Australia, and ensure that any reform applies a person-centered approach to care.

Discussion of publicly funded models of GAS provision in Australia is timely, however, with the recent submission by the Australian Society of Plastic Surgeons (ASPS) of Medical Services Advisory Committee (MSAC) Application 1754. The application proposes a number of amendments to existing Medicare patient consultation items, and proposes the creation of twenty-eight new major and minor surgical procedures for gender affirmation into the Medicare Benefits Scheme under a multidisciplinary model of care framework (Medicare Services Advisory Committee, 2024).

While the success of this application would make various GAS procedures accessible through the public health system, the structural barriers related to limited availability of existing clinicians as reflected in the theme 'It Could be Better' would continue to delay access for those who seek them. The theme 'Affirming, Affordable, and Accessible' reflects participant suggestions that these barriers could be addressed through the provision of clinician training designed to attract additional gender-affirming healthcare providers offering a greater breadth of services, which aligns with previous research (Franks et al., 2022; Piñón-O'Connor et al., 2023). Further research is needed to inform development of an optimal clinician training model.

Limitations

There are some limitations to this preliminary research. As an exploratory study, purposive sampling of participants within researcher professional networks limited the study sample, and resulted in overrepresentation of some demographic characteristics (e.g. metropolitan location, tertiary-educated, White, binary trans identities). This means that individuals who may have experienced more intersectional barriers to accessing GAS (e.g. First Nations people, Culturally and Linguistically Diverse people, people living with disability, people residing in regional/rural/remote settings) are underrepresented in this sample. It is also possible that participants with a stronger interest in advocacy for structural change agreed to participate in the study, meaning that other important perspectives may not have been captured here. Given that trans and gender intersecting 'categories of difference' (e.g. gender identity, race, sexuality, social-economic status, disability) often result in cumulative inequalities and exclusion (i.e. minority stressors) when navigating complex oppressive social systems (Lefevor et al., 2019; Wesp et al., 2019), further research is needed to understand the impact of intersectionality on experience and perceptions of access to GAS in Australia.

Although the issues raised in this paper are from a small recruitment pool from within Queensland, Australia and may not capture nuances of access and barriers to GAS experienced in other Australian jurisdictions, the concerns raised in the manuscript, in the main, stem from national-level issues that warrant further research and discussion.

Conclusion

The study positions trans and gender diverse voices as fundamental in informing future clinical policy and establishing appropriate and accessible provision of GAS in Australia. Access to various forms of GAS in Australia remain prohibitive, with the current model insufficient to meet the needs of trans and gender diverse people. A publicly-funded and holistic model of GAS utilizing an informed consent model should be explored, to ameliorate current access barriers and improve health and wellbeing outcomes for trans and gender diverse people in Australia. In any consideration of such a model, and the policies that underlay it, the voice of the trans and gender diverse communities, that is those with lived experience, should be central.

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Declaration of interest statement

The authors report there are no competing interests to declare.

Ethical statement

The research was granted ethical approval by the University of Southern Queensland's Human Research Ethics Committee (Approval No: H20REA289). All study activities were performed in accordance with the ethical standards of the University of Southern Queensland's Human Research Ethics Committee, and with the 1964 Declaration of Helsinki and its later amendments, including the Australian National Statement on Ethical Conduct in Human Research (2007)—Updated 2018.

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