MSAC Executive Teleconference

Date: Friday, 26 May 2023
Time: 12.00pm – 2.00pm
Toll Dial-in: s47F
Participant passcode: s47F

Agenda Item 5.6: New MSAC application 1754 - Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence

Consulted:
s22 Medical Officer, TAAD
Medical Officers, MBD

s22

Medical Specialist Services Section, MBD

s22

Presenter:
s22 HTA Adviser, MSAC Assessment Section

Purpose:
To seek MSAC Executive advice on the appropriate health technology assessment (HTA) assessment and pathway for MSAC application 1754.

Background:
The Australian Society of Plastic Surgeons Inc. (ASPS) has submitted an MSAC application proposing a suite of Medicare Benefits Schedule (MBS) consultation items (including health assessments, patient consultations and multidisciplinary care conference items) and surgical items (**Attachment A** and **Attachment B**). Also separately proposed are changes to PBS listed medicines used in the management of gender affirmation but are not encompassed by the MSAC application.

MSAC Executive advice has previously been sought regarding the appropriate pathway for the consideration of a suite of gender affirmation MBS items. At the July 2022 MSAC Executive meeting, the MSAC Executive were provided a s47C high-level overview of a suite of proposed MBS items for gender affirmation and were asked to advise whether:

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In summary, the MSAC Executive's advice at that time was (see **Attachment C**):

- Considered that the current MSAC process was suitable for appraisal of the application and did not consider that a specialist clinical committee was required.
- Accepted that the evidentiary basis to support the proposed items was likely to be limited.
- Requested the Department seek further clarification on what quality control measures will be implemented by the ASPS to regulate their members and ensure the safety of their patients in the event of surgery failures.
- Considered that a multi-disciplinary best model of care framework extending before and after any surgery was needed and that improving existing services and developing a framework of support could be a potential alternative to developing new MBS items.

Issue:

1. Ministerial correspondence

The Minister and the Department receive a number of enquiries from patients regarding the out-of-pocket costs of gender affirmation procedures. In these enquiries patients have reported facing high out of pocket costs for private gender affirmation surgery, up to $50,000.

A number of petitions have also been lodged with the House of Representatives to request Medicare funding for gender affirmation surgery, most notably in June 2021 Petition EN3307 - Gender affirming surgery should be covered by Medicare received 148,182 signatures. Previous Minister Greg Hunt's published responses to these petitions have been that an MSAC application would be required for consideration of an MBS item/s for gender affirmation surgery.

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2. Safety and quality control measures (previously raised by MSAC Executive)

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The application (pg 11 of **Attachment B**) does propose that the MBS items for gender affirming interventions are limited to medical practitioners that are registered specialists (would have met the training and qualification requirements set out by their professional board).

The application also references 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8'[1]. Chapter 13 – Surgery and postoperative care, describes a spectrum of gender-affirming surgical procedures for the diverse and heterogeneous community of individuals who identify as transgender. It makes 11 statements of recommendation and provides a discussion about the optimal surgical training in gender-affirmation surgery procedures, post-surgical aftercare and follow-up, access to surgery by adults and adolescents, and individually customised surgeries.

The application notes that the above referenced standards of care have been endorsed as a Standard of Care by the Australian Professional Association for Trans Health (AusPATH) but does not state whether (and how) the ASPS intend to implement any measures to regulate their members and ensure the safety of their patients in the event of surgery failure.

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3. *Proposed best model of care (previously raised by MSAC Executive)*

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Of note, there is a current MRFF Grant Opportunity assessing the optimal models of care for "Sexuality & Gender Diverse People & People with Innate Variations of Sex Characteristics", seen at:

https://www.grants.gov.au/Go/Show?GoUuid=e69dca85-1fcb-4e39-872d-b1ced05bb58b

The MSAC Executive may wish to advise, s47C

4. *Overlap of proposed and existing consultation items*

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The Department considers that the listed existing items provide for the services proposed by the applicant, and that new consultation items are not required for this specific patient group.

The Department notes that the applicant has requested specification of the patient group in the explanatory notes accompanying the health assessment (701, 703, 705, 707) and chronic disease management (CDM) items (721, 723, 729 and 732). This patient group can currently access the CDM items where the treating general practitioner (GP) assesses the person has a chronic condition and would benefit from a management plan and/or multidisciplinary team care. It is the Department's position not to specify eligible conditions due to the risk of excluding access to particular groups inappropriately. This patient group are not currently eligible for health assessments unless they also fall into an eligible category. s47C . The Department's perspective is that any such consideration of the consultation items can be undertaken separately to the consideration of the surgical items and this division would not impact the options put forward for the HTA and pathway for the surgical items.

5. *Overlap of proposed and existing surgical items*

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6. Utilisation of existing items for gender affirmation surgery
The Department understands that there is already some use of the existing MBS surgical items for gender affirmation surgery. However, due to the lack of reporting describing item use by indication, it is not feasible to determine the accurate extent of utilisation in the proposed population. Any assessment would require assumptions based on clinical expert opinion to estimate the potential current utilisation of existing MBS surgical items for gender affirmation surgery.

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7. Estimated utilisation
The application estimated that in 2023 there are approximately 128,145 transgender people (assumed 1.05%[2] of the population) that would be eligible for gender affirming surgery and that 47,087 primary gender affirming surgeries would be accessed from the range of available procedures (pg 7/14 of **Attachment A**).

The applicant determined the estimated number of surgeries by applying uptake percentages to the eligible population for each gender affirmation surgery type (i.e., gender affirming chest surgery, genital reconfiguration surgery, gender affirming facial surgery and gender affirming voice surgery). The estimated number of surgeries is not a 1:1 estimate of the number of eligible individuals who may undergo gender affirming surgery (i.e. one individual may have more than 1 of the gender affirming surgical procedures in each category). The uptake rates were based on the percentage of gender affirming surgeries reported in a retrospective audit of 540 Australian transgender individuals[3].

The applicant's utilisation estimates over 6 years have assumed a constant uptake rate s47C

A 2021 metanalysis of 7928 individuals who underwent gender affirmation surgery identified approximately 1% as having post-surgery regret (categorised as minor or major).[4]

8. Cost-effectiveness of the comparator has not been established
The existing MBS surgical items (comparator) were included on the MBS prior to the establishment of the MSAC and as such the none of the individual items comprising the comparator have undergone an HTA to establish cost-effectiveness. Any HTA comparing the

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9. HTA for revision items

The Department notes that for the comparator, there are no specific revision items rather revision is likely to be performed under the initial surgery item. s47C No revision surgery item descriptors, or fee, were proposed by the applicant s47C

Department Position

The Department notes the below three options for progressing the application.

Option 1 – s47C.

Option 2 – s47C.

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Table 1: High-level summary of Department proposed s47C

Component	**Description**	**Department comments**
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	The application states the diagnosis of gender incongruence would be made a person's managing clinician, usually a general practitioner, but sometimes by a sexual health practitioner, endocrinologist or psychiatrist. The diagnostic criteria are outlined in the International Classification of Diseases 11th Revision maintained by the World Health Organization (pg 1/35 of **Attachment B**). (2) Individuals requiring revision of primary surgical procedures for gender affirmation – s47C	s47C s47C
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Option 3 – s47C

Limitations and risks

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Table 2: Advantages, limitations and risks identified for each Option

	Option 1 – s47C	Option 2 – s47C	Option 3 – s47C
Advantages	s47C		
Limitations and risks			
s47C			
s47C			Same as Option 2

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		and effectiveness	
s47C			
s47C		Same as Option 1	Same as Option 1
s47C			Same as Option 2

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		s47C	

Action:

The MSAC Executive to:

- **Note** an updated MSAC application has been submitted and s47C
- s47C issue requires further information, development and/or consideration by clinical experts.
- **Note** the limitations and risks for each option.
- **Advise** the Department s47C

Author: s22 MSAC Assessment Section, OHTA Branch, TAAD
Medical Officer clearance: s22 Medical Officer, TAAD
Assistant Secretary clearance:

- Natasha Ploenges, Office of Health Technology Assessment Branch
- Nigel Murray, MBS Policy and Specialist Services Branch

Attachments:
A – MSAC 1754 Application Summary
B – MSAC 1754 Application PICO Set
C – Excerpt of July 2022 MSAC Executive Minutes for Item 5.5 Gender Affirmation
D – Department summary of gender affirmation surgery items and clinical algorithm
E – Department summary of patient and multidisciplinary consultation items

References:

1. Coleman et al. (2022). Standards of care for the health of transgender and gender diverse people, version 8. International Journal of Transgender Health 23(sup1): S1-S259.
2. Cheung et al. (2019). Position statement on the hormonal management of adult transgender and gender diverse individuals. Medical Journal of Australia 211(3): 127-133
3. Cheung et al. (2018). Sociodemographic and clinical characteristics of transgender adults in Australia. Transgender health 3(1): 229-238
4. Bustos et al. (2021). Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. Plastic and Reconstructive Surgery - Global Open 9(3): e3477.

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Attachment C - Excerpt from MEDICAL SERVICES ADVISORY COMMITTEE (MSAC)

EXECUTIVE Teleconference

Friday 1 July 2022, 12:00pm – 2:00pm

FINAL Minutes – Ratified 31 July 2022

5.5: Australian Society of Plastic Surgeons (ASPS) proposal for suite of gender affirmation MBS items and PBS medications

The MSAC Executive noted the Department sought advice on an appropriate pathway for the consideration of a suite of MBS items related to gender affirmation, submitted within a wider proposal to the Department by the Australian Society of Plastic Surgeons (ASPS) (the applicant). The intent of the proposed MBS items is for people experiencing gender incongruence[1] to have publicly funded access to medical gender-affirming care (for those who seek it). In addition to attendance items with specialists such as GPs, sexual health physicians, endocrinologists and psychiatrists, most of the proposals by the applicant aim to establish MBS items specifically for gender-affirming surgeries. The MSAC Executive noted that the applicant has established the Australian Collaborative on Access to Gender Affirming Medical Services (ACA-GAMS) to assist the development and progress of the proposal. s47C

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The MSAC Executive noted the Department's advice that while there are no specific MBS items for gender-affirming surgery there are items that provide for a range of surgical procedures and specialist attendances similar to what has been proposed, that may be utilised currently to assist people seeking gender-affirming medical care. However, the applicant advised that uncertainty exists in the sector regarding the appropriateness of billing these existing items and concerns had been raised that the implementation of certain changes to plastic and reconstructive surgery items from 1 November 2022 would limit access further. The Department advised that this change was in relation to amendment of item 45563. The MSAC Executive also noted that a disadvantage with the existing MBS items is the inability for the Department to measure utilisation for the purposes of gender-affirming medical care.

The MSAC Executive noted that the applicant proposed establishment of a dedicated clinical committee to consider and develop the MBS items, similar to those created by the MBS Review Taskforce, due to the complexity and variation in delivering gender-affirming medical care. The MSAC Executive considered that the current MSAC process was suitable for appraisal of the application and did not consider that a specialist clinical committee was required. The MSAC Executive accepted that the evidentiary basis to support the proposed items was likely to be limited.

1 ICD-11 https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f411470068

The MSAC Executive noted there is increasing consumer interest and demand for access to publicly funded gender affirming medical services in Australia. The MSAC Executive noted that gender reassignment surgeries are varied, involve different surgical specialities, are technically complex, and dependent on the individual desires of the person seeking it. The MSAC Executive also noted that people seeking these surgeries represent a very small proportion of the population and there are limited surgeons practicing in the field of gender-affirming medical care in Australia. The MSAC Executive acknowledged that people seeking gender reassignment surgeries may opt for medical tourism in other countries where surgery is less expensive, more readily available and less regulated than in Australia.

The MSAC Executive considered that strong quality control measures were required if this proposal for gender-affirming surgeries was publicly funded in Australia. s47C The MSAC Executive noted that assurance of safe and effective service for gender-affirming medical care was not just limited to gender-affirming surgeries but needed a multi-disciplinary best model of care framework extending before and after any surgery. The MSAC Executive considered that improving existing services and developing a framework of support could be a potential alternative to developing new MBS items.

The MSAC Executive advised that this proposal should undergo assessment through the standard HTA pathway to MSAC. The MSAC Executive considered the application should include the proposed best model of care for people experiencing gender incongruence seeking gender-affirming medical care. The MSAC Executive considered that any form of public funding for the provision of gender-affirming medical care should include an interdisciplinary care model to ensure the best quality care package is provided for the individual.

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Attachment D – Department summary of gender affirmation surgery items and clinical algorithm

Table 1 Primary feminising surgery MBS items

Primary Feminising surgery			Stage of surgery	Existing item	Existing item fee
Gender affirming chest surgery	Feminising chest surgery, by any method, including but not limited to, insertion of prostheses, autologous fat graft or local flaps			45528	$1,175.90
				45060	$1,343.95
				45535	$1,168.80
Genital reconfiguration surgery	Penectomy and bilateral orchiectomy			37405	$977.60
	Construction of neo-vagina	by any method using penoscrotal skin		35565	$723
		by skin grafting around a mould		45451	$500.85
		by any method using intestinal segment		35565	$723
Gender affirming facial procedures	Facial surgery	remodelling of forehead and orbits		40600	$1009.60
		one or more mandibular ostectomies and mandibular reshaping if undertaken			
		insertion of facial implants or bone grafts		45051	$500.85
		soft tissue surgery including skin advancement or local flaps to forehead or lips and including fat grafting			
	Chondrolaryngoplasty for gender affirmation (feminising)				
Laryngeal surgery	Gender affirming voice surgery			41876	$621.20
				41879	$1006.55

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Table 2 Revision feminising surgery MBS items

Revision Feminising surgery		Existing item	Existing item fee	s47C
Gender affirming chest surgery	Revision of feminising chest surgery			
Genital reconfiguration surgery	Revision of construction of neo-vagina surgery			
Gender affirming facial procedures	Revision of feminising facial surgery			

Table 3 Primary masculinising surgery MBS items

Primary Masculinising surgery			Stage of surgery	Existing item	Existing item fee	s47C
Gender affirming chest surgery	Masculinising chest surgery without surgical repositioning of the nipple areolar complex			31524	$1,099.70	
				45522	$667.85	
				31525	$549.70	
	Masculinising chest surgery with surgical repositioning of the nipple areolar complex			31524	$1099.70	
				31525	$549.70	
				45523	$1427.95	
				45520	$951.90	
Genital reconfiguration surgery	Hysterectomy with or without salpingo-oophorectomy			35750	$829.45	
				35751	$829.45	
				35753	$917.20	
	Construction of neo-phallus	by any method using local flaps		45006	$1097	
		by microvascular transfer of free autologous tissue (such as radial forearm flap or antero-lateral thigh flap)		45562	$1162.25	
				45565	$2019.00	
		by metoidioplasty (formation of penis from clitoral tissue)		37423	$977.60	
Gender affirming facial procedures	facial surgery	remodelling of forehead and orbits		40600	$1009.60	
		one or more mandibular ostectomies and mandibular reshaping if undertaken				
		insertion of facial implants or bone grafts		45051	$500.85	
		soft tissue surgery including skin advancement or local flaps to forehead or lips and including fat grafting				

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Table 4 Primary feminising surgery MBS items

Revision masculinising surgery		Existing item	Existing item fee
Gender affirming chest surgery	Revision of masculinising chest surgery		
Genital reconfiguration surgery	Revision of construction of neo-phallus surgery		
Gender affirming facial procedures	Revision of masculinising facial surgery		

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Attachment E – Department summary of patient and multidisciplinary consultation items

Table 1 Patient and multidisciplinary consultation items

Applicant proposed consultations during gender affirmation process	Existing items	Department comment
Initial patient consultation with health care provider (General Practitioner)	GP patient consultation items 23, 36, 44	Existing items considered appropriate for the proposed service
Patient access to the chronic disease management items	chronic disease management items (721, 723, 729 and 732)	This patient group would currently be eligible to access this group of items where considered clinically relevant by the GP It is the Department's position that specific patient groups should not be identified as eligible for these items, the policy intention is that these items are available for patients who meet the general criteria of the items and who would benefit from the services.
Patient access to the health assessment items	Health assessment items (701, 703, 705, 707)	This patient group would currently not be eligible to access this group of item on the basis of gender incongruence alone but a subgroup may be eligible under other criteria. The health assessment items are currently under review, the Department will note the applicant proposed specific inclusion of patients undergoing a gender affirmation process as a target group for these items as part of the review.
Patient appointments with specialists and consultant physicians following referrals from GP	Specialist Patient consultations (104, 105) Consultant Physician Patient consultations (110, 116) Sexual health practitioner patient consultations (6051, 6052, 6057, 6058) Psychiatric patient consultations (291, 293, 296, 300, 302, 304,306)	Existing items considered appropriate for the proposed service
GP led Multidisciplinary care conference - confirm diagnosis/develop treatment plan	GP led Multidisciplinary care conference (Organise (735, 739,743) Attend (747, 750, 758))	Existing items considered appropriate for the proposed service
Specialist led Multidisciplinary care conference - discuss surgical risks/benefits, timing of procedures	Consultant physician led Multidisciplinary care conference (Organise (820, 822, 823), Attend (825, 826, 828)) Sexual health practitioner led Multidisciplinary care conference (Organise (6064, 6065, 6067, 6068), Attend (6071, 6072, 6074, 6075)) Psychiatrist led Multidisciplinary care conference (Organise (855, 857, 858), Attend (825, 826, 828))	Existing items considered appropriate for the proposed service Currently there are no case conference items for specialists on the MBS, as opposed to consultant physicians for which there are existing items for this service. The Department will work further with the applicant to determine if their proposal is that specialists have access to case conference items for patients undergoing a gender affirmation process which would require a broader MBS consideration.

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Patient Discharge Multidisciplinary conferences	Consultant Physician led Discharge Multidisciplinary care conference (Organise (830, 832, 834), Attend (835, 837, 838)) Psychiatrist led discharge Multidisciplinary care conference (Organise 861, 864, 866), Attend 835, 837, 838))	Existing items considered appropriate for the proposed service Currently there are no discharge conference items for specialists on the MBS, as opposed to consultant physicians for which there are existing items for this service. The Department will work further with the applicant to determine if their proposal is that specialists have access to discharge items for patients undergoing a gender affirmation process which would require a broader MBS consideration.
Post treatment follow-up consultations provided to patients by a single medical practitioner (e.g., follow-up for surgery-related complications after gender affirmation surgery)	Specialist Patient consultations (104, 105) Consultant Physician Patient consultations (110, 116) Sexual health practitioner patient consultations (6051, 6052, 6057, 6058) Psychiatric patient consultations (291, 293, 296, 300, 302, 304,306)	Existing items considered appropriate for the proposed service

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FOI 4876 - Document 18

MSAC Executive
Medical Specialist Services Section
MBS Policy & Specialist Program Branch
Medicare Benefits and Digital Health Division
P: s47E(d)

15 Aug 2023

Dear MSAC Executive,

Thank you for your considered letter about our application for MBS items for gender affirming care. We note that the Department has been very generous with its time in considering the matters around this application. ASPS requests that this application now goes to the PASC meeting of the 7th/8th December and we will be available to attend to answer further questions and assist as needed.

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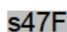
In relation to the summary points on the first page:

- ASPS accepts that the standard HTA / MSAC process will be employed and look forward to constructively working within that framework.
- Although evidence in this area is less than for some other areas of health, evidence is quickly building and members of our collaborative team are actively involved in research in this area. Should this application be successful, separate item numbers for procedures for people with gender incongruence will greatly facilitate high quality research, and our group are strongly considering applying for an MRFF grant to monitor the results of healthcare changes in this area.
- In regards to "regulation of our members", ASPS would like to clarify that we are a not-for-profit society of members, not a regulatory body. However, our organisation promotes education of members and does have a strong ethical framework with an associated ethics committee. In terms of "quality control", ensuring that providers performing this surgery are "specialists working in the field of their specialty" is likely to be desirable. The surgical Specialty Colleges have extensive non-technical and ethical training and ongoing governance and guidelines for their Fellows.
- ASPS agrees that a multidisciplinary team approach is appropriate as long as it is not constructed in a way that is cumbersome and a significant limit to timely and appropriate access to care. Involvement of the primary care physician is also crucial. Our proposal of expanding the "medical assessment" item xxxx to have gender incongruence as a defined group, we believe is a very good step for holistic care close to home. If it is then supplemented by an MDT that could be hybrid in model (videoconferencing and face to face) then we feel this would meet the needs of patients. The arguments against expansion of the "medical assessment item xxx" are understandable (slippery slope of more and more groups wanting this status) but are outweighed by the safety and holistic care benefits for this particularly vulnerable section of the population.
  In regards to developing best practice models of care *instead* of seeking item numbers, we regard this as inappropriately further delaying access to care for those who urgently need it. There are already multiple models of care co-existing in Australia for gender affirming surgery and several

being developed. In particular NSW Health and SA Health are in the very final stages of launching their public sector models of care. Australia's healthcare system is not a one size fits all model for any health issue. It is a complex system where states and territories reserve the right to have different models of care to that of the Commonwealth and that system has served the Australian public well. It would be problematic to demand a universally applied model of care for gender affirming surgery services for the same reason it is problematic for cardiac surgery. Services need to vary depending on geographic, cultural, and governance infrastructure reasons from place to place. Being over-proscriptive and at variance from other areas of surgery is not the answer. What is certainly needed in this area is to be evidence-based, holistic and to follow sound principles. ASPS believes that although item numbers are not ideal for embedding holistic assessment and multidisciplinary care, provisions can be made. It is also likely to be possible that once state and territory public services are underway, combined public / private patient MDTs will evolve.

Thank you for your time. We would be very happy to a further meeting prior to PASC if that would be helpful.

Kind regards,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MEDICAL SERVICES ADVISORY COMMITTEE (MSAC)
EXECUTIVE Teleconference
Friday 26 May 2023, 12:00pm – 2:00pm
FINAL Minutes – Ratified 26 July 2023

Excerpt Agenda item 5.6

5.6: New MSAC application 1754 – Patient Consultations and Surgical Procedures for Gender Affirmation in Adults with Gender Incongruence

The MSAC Executive noted the department sought advice on the appropriate HTA pathway for MSAC Application 1754 – *Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence* if the application received from the Australian Society of Plastic Surgeons Inc. (ASPS) meets the suitability requirements for the MSAC process.

The MSAC Executive recalled that its advice was sought by the department at the 1 July 2022 MSAC Executive meeting regarding the appropriate HTA pathway for the consideration of a suite of gender affirmation Medicare Benefits Schedule (MBS) items that had been proposed by the ASPS in a sample (partially completed) application. Following this initial engagement with the department last year, the ASPS has now submitted MSAC application 1754 proposing a suite of MBS consultation items (including health assessments, patient consultations and multidisciplinary care conference items) and primary and revision surgical items to support gender affirmation in adults with gender incongruence. The MSAC Executive noted the applicant has been advised by the department to submit a separate application to the Pharmaceutical Benefits Advisory Committee (PBAC) proposing changes to PBS listed medicines used in the gender affirmation of adults with gender incongruence and that access to medications will not be considered through the MSAC process.

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The MSAC Executive recalled the advice it provided at the 1 July 2022 meeting in summary as:

- The MSAC Executive considered that the current MSAC process was suitable for appraisal of the application and did not consider that a specialist clinical committee was required to be formed to perform a HTA of the proposed application.
- The MSAC Executive accepted that the evidentiary basis to support the proposed items was likely to be limited.
- The MSAC Executive requested the department seek further clarification on what quality control measures will be implemented by the ASPS to regulate their members under the surgical items and ensure the safety of their patients in the event of need for surgical revision.
- The MSAC Executive considered that a multi-disciplinary best practice model of care framework extending before and after any surgery was needed and that improving existing services and developing a framework of support could be a potential alternative to developing new MBS items.

The MSAC Executive recalled that this previous advice had been provided based on an incomplete sample application and noted other issues, in addition to those already raised above, have been identified by the department during the current suitability assessment of application 1754.

- The ASPS did not explicitly address in application 1754 what quality control measures will be implemented to regulate their members and ensure the appropriate management and safety of their patients where adverse events to occur following surgery. Although, the application did:

- propose that the MBS items for gender affirming interventions are limited to medical practitioners that are registered specialists; and
- reference the 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8'[1] which has been endorsed by the Australian Professional Association for Trans Health (AusPATH) and includes recommendations (Chapter 13) on surgical training, post-surgical aftercare, access to surgery and individually customised surgeries.

- The ASPS claim that the requested MBS consultation and surgical items would collectively facilitate a multidisciplinary best practice model of care framework for patients that extends before and after any surgery. There is also a current MRFF grant opportunity assessing the optimal models of care for "Sexuality & Gender Diverse People & People with Innate Variations of Sex Characteristics"[2].
- The department considered that the new consultation items proposed by the applicant are not required as they appear to overlap with existing consultation items. The applicant has proposed specification of the patient group in the explanatory notes accompanying the health assessment and chronic disease management items, however the department's position is to not specify eligible conditions due to the risk of excluding access to particular groups inappropriately. These patients would generally be eligible for the current chronic disease management items including GP management plan, team care arrangements and related allied health services. They are not specifically eligible for the existing Health Assessment items and they would only be eligible for these if they met the criteria for another specific condition. Note that the health assessment items are currently under review.
- The department considered that the proposed surgical MBS items would meet the MBS requirements for clinically relevant and necessary services and that the proposed surgical MBS items (for primary procedures) overlap with existing surgical items. However, the department considered that the policy intent of the existing items differed to the purpose sought in the application. The department also noted there are no specific revision items for the existing MBS surgical items, and that the primary surgical item is generally used for revision.
- The utilisation of existing MBS surgical items in the proposed population is unknown due to lack of reporting describing item use by indication and any assessment would require assumptions based on clinical expert opinion to estimate the potential current utilisation of existing MBS surgical items for gender affirmation surgery. The department considered the use of surgery performed overseas, or privately without use of MBS reimbursement in Australia, to be out of scope of an HTA for this application.
- The estimated utilisation for gender affirming surgeries in application 1754 is highly uncertain. The department highlighted that a robust estimate of utilisation will be challenging due to limited evidence to reliably inform the proportion of patients who will elect to undergo gender affirming surgery and that predicting future utilisation will be challenging as this is likely to be influenced (unknown magnitude) by perceptions and acceptance of gender affirming surgery. In addition, due to differences in individual preferences, there is likely to be wide variation in which gender affirming surgery(ies) (if any) a patient elects to undergo. Assuming patients would access the full suite of gender affirming surgeries may over-estimate the costs to the MBS and while sensitivity analyses could explore the assumptions used this may not reduce the uncertainty.

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1 World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, (2022) *International Journal of Transgender Health*, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9553112/pdf/WIJT_23_2100644.pdf
2 https://www.grants.gov.au/Go/Show?GoUuid=e69dca85-1fcb-4e39-872d-b1ced05bb58b

- The nominated comparator (existing MBS surgical items) encompasses a number of surgical procedures that are well-established in clinical practice which did not undergo an HTA assessment before MBS listing. As such, there are likely to be challenges with the level of contemporary evidence for the comparator. In addition, the cost-effectiveness of the comparator will need to be established before the comparative safety, effectiveness and cost-effectiveness of the intervention can be assessed. Consequently, the likely limitations and uncertainty in the clinical evidence may create high uncertainty in the comparative safety, effectiveness and cost-effectiveness assessments.
- There is a lack of information in the application as to what the proposed revision items would encompass and lack of information on the utilisation of these potential items. At this stage, an HTA for the revision procedure items is not considered feasible and can be considered subsequent to the assessment of the proposed primary procedure items, as a separate issue.

The MSAC Executive acknowledged all the issues, uncertainties, limitations and risks with the application and any HTA for the proposed MBS items. The MSAC Executive deliberated on whether the MBS items proposed in application 1754 would support a multidisciplinary best practice model of care framework for patients.

The MSAC Executive considered the advantages with having dedicated surgical item numbers for gender affirmation surgeries noting that data collecting would be unambiguous compared to using existing items where the indication for the service being claimed is not recorded. Specific item numbers would allow for the specification of pre-requisite services or consultations, including the involvement of other specialties or allied health professionals.

Furthermore, the MSAC Executive considered that this proposal should be considered via a holistic person-centred approach. The MSAC Executive noted that surgical intervention for this population was only one aspect of supporting gender affirmation in adults with gender incongruence. The MSAC Executive considered an approach which is person-centred and involves a multidisciplinary team may reduce the risk of harm to patients and assist in reducing the need for revision surgery. The MSAC Executive strongly reiterated their previous advice that these persons need to be managed in a multidisciplinary team noting the very individual experience of each person given the composite of multivariate interventions per individual.

The MSAC Executive considered that further consideration and consultation should be undertaken to ensure that gender affirming surgical services are provided within a patient-centred and multidisciplinary best practice model of care framework. The MSAC Executive considered the MBS item model alone may not meet the needs of patients and that a funding avenue that delivered a multidisciplinary framework could be explored by the department. The MSAC Executive considered that the department could undertake this policy work in parallel to the application.

The MSAC Executive also noted that of the people who undertake gender affirmation surgery, many choose to do so overseas, and did not want to disincentivise individuals seeking services that can be delivered appropriately and safely domestically. The MSAC Executive acknowledged there will be a high level of public interest in this application, highlighted by the ongoing enquiries to the Minister and department regarding the out-of-pocket costs of gender affirmation procedures and petitions lodged to the House of Representatives requesting Medicare funding for gender affirmation surgery. The MSAC Executive considered that MBS item numbers for the provision of surgical services alone do not represent best practice patient care and suggested the department could consider if supporting person-centred, or wrap-around, care approaches could be considered concurrently to the MSAC process. s47C

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s47C

The MSAC Executive agreed that it would not be feasible to undertake a HTA on each proposed surgical item individually and therefore supported the HTA assessing the proposed surgical MBS items as a suite. However, the MSAC Executive queried the department advice that the consideration of amendments to consultation items should be considered and progressed separately to the HTA on the surgical MBS items. The MSAC Executive reiterated their position for a person-centred multidisciplinary team approach to be the focus of this application, not just assessment of the surgical items.

The MSAC Executive considered that the appropriate HTA pathway to progress the application would be a focussed HTA via the full MSAC pathway (i.e., consideration by PASC, ESC and MSAC) that would collectively evaluate the suite of MBS items for gender affirming surgery. It is anticipated the application would progress as a DCAR and would need to establish cost-effectiveness of the comparator before progressing to assess comparative cost-effectiveness of the intervention. The MSAC Executive agreed that there are some elements of the development of the PICO that would benefit from PASC consideration before commencing a HTA such as s47C The MSAC Executive considered the assessment should be progressed as a two stage Assessment Report pathway where the first stage would assess the comparative clinical evidence and the second stage would look at the economic evaluation and financial analysis.

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A systematic review of PROMS measured health-related outcomes following treatment of gender incongruence

s47F and s47F

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FOI 4876 - Document 20

Gender affirming care

- Gender diverse people in Australia and New Zealand have overall poorer health outcomes when compared to cisgender people (1-4)

- They report significantly higher levels of psychological stress, suicidal ideation and suicide attempts and have poorer self-reported health than cisgender people (1-4)

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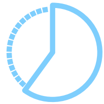
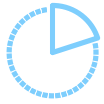
FOI 4876 - Document 20

Gender affirming care

- Currently in Australia and NZ gender diverse people report significant barriers to accessing gender affirming treatment (1,4)

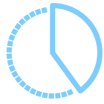


More than half of gender diverse people report that access to gender affirming surgery in Australia is a high priority (2)



19% of gender diverse people in NZ report wanting but being unable to access hormonal therapy (4)

67% of trans men in NZ report wanting, but being unable to access chest reconstruction surgery (4)



39-42% of gender diverse people in NZ reported wanting but being unable to access orchidectomy or hysterectomy (4)

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Do gender affirming medical and surgical treatments work?

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Methods

- We searched Pubmed, Web of Science, Embase and Psych Info in October 2022 using terms “transgender”, “gender affirming hormones”, “gender affirming surgery”, “quality of life”

- Two independent researchers individually conducted study selection and critical appraisal using PRISMA guidelines.

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Covidence

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Aldridge 2021

Edit

Select Full Text

1 / 9

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DOI: 10.1111/andr.12884

ORIGINAL ARTICLE

ANDROLOGY WILEY

Long-term effect of gender-affirming hormone treatment on depression and anxiety symptoms in transgender people: A prospective cohort study

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Funding information
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Abstract

Background: Cross-sectional studies show that transgender people are more likely than cisgender people to experience depression and anxiety before gender-affirming hormone treatment (GAHT). However, the effect of GAHT on mental health in transgender people, and the role of other factors that may have a predictive effect, is poorly explored.

Objectives: Using a longitudinal methodology, this study investigated the effect of 18-month GAHT on depression and anxiety symptomatology and the predictors on mental health outcomes in a large population of transgender people.

Materials and methods: Participants (n = 178) completed a socio-demographic questionnaire, the Hospital Anxiety and Depression Scale (HADS), the Multidimensional Scale of Perceived Social Support (MSPSS) and the Autism Spectrum Quotient–Short Version (AQ-Short) at pre-assessment (T0) and at 18 months after initiation of GAHT (T1).

Results: From T0 to T1, symptomatology was significantly decreased for depression (P < .001) and non-significantly reduced for anxiety (P = .37). Scores on the MSPSS predicted reduction in depression, while scores on the AQ-Short predicted reduction in anxiety.

Discussion: GAHT reduces symptoms of depression which are predicted by having higher levels of social support. Although anxiety symptoms also reduce, the changes are not significant and high levels of anxiety still remain post-GAHT.

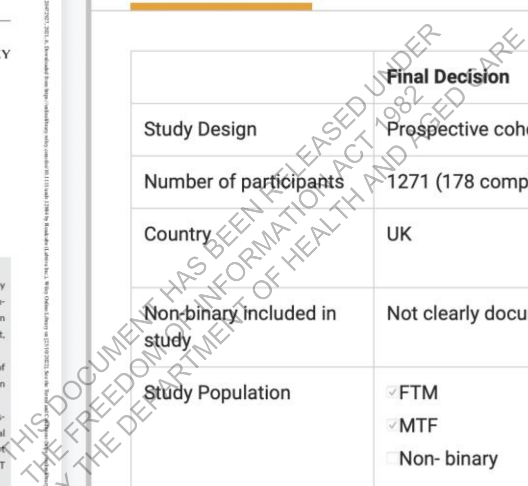
Conclusions: These results highlight the important mental health benefits of GAHT. Support services (professional, third sector or peer support) aiming at increasing social support for transgender individuals should be made available.

KEYWORDS
autism, hormone therapy, longitudinal, mental health, social support, transgender

Consensus

Completed

DATA EXTRACTION | QUALITY ASSESSMENT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	Final Decision	Kelsey Ireland *(reviewer 1)*	Nicola Dean *(reviewer 2)*
Study Design	Prospective cohort study	Prospective cohort study	Prospective cohort study
Number of participants	1271 (178 completed)	178	178
Country	UK	Nottingham Centre for Transgender Health UK	UK
Non-binary included in study	Not clearly documented	Not clearly documented	Not clearly documented
Study Population	☑ FTM ☑ MTF ☐ Non- binary	☑ FTM ☑ MTF ☐ Non- binary	☑ FTM ☐ MTF ☑ Non- binary
Treatment Included (specify hormones and or surgery)	Hormones	Hormone treatment	Hormones
Time of follow up	18 months	18 months	18 months
PROM Category			

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Inclusion criteria

- ✓ Studies in English
- ✓ Published 2010 and later
- ✓ Treatment with either surgery or hormones for >3 months
- ✓ Studies using validated patient reported outcomes measures of health-related quality of life or mental health

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Exclusion criteria

- x Non peer-reviewed studies
- x Reviews, editorials or case reports
- x Treatment with puberty blockers
- x Dedicated paediatric studies (<16 years)
- x Studies including <10 patients

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Study inclusion flow chart

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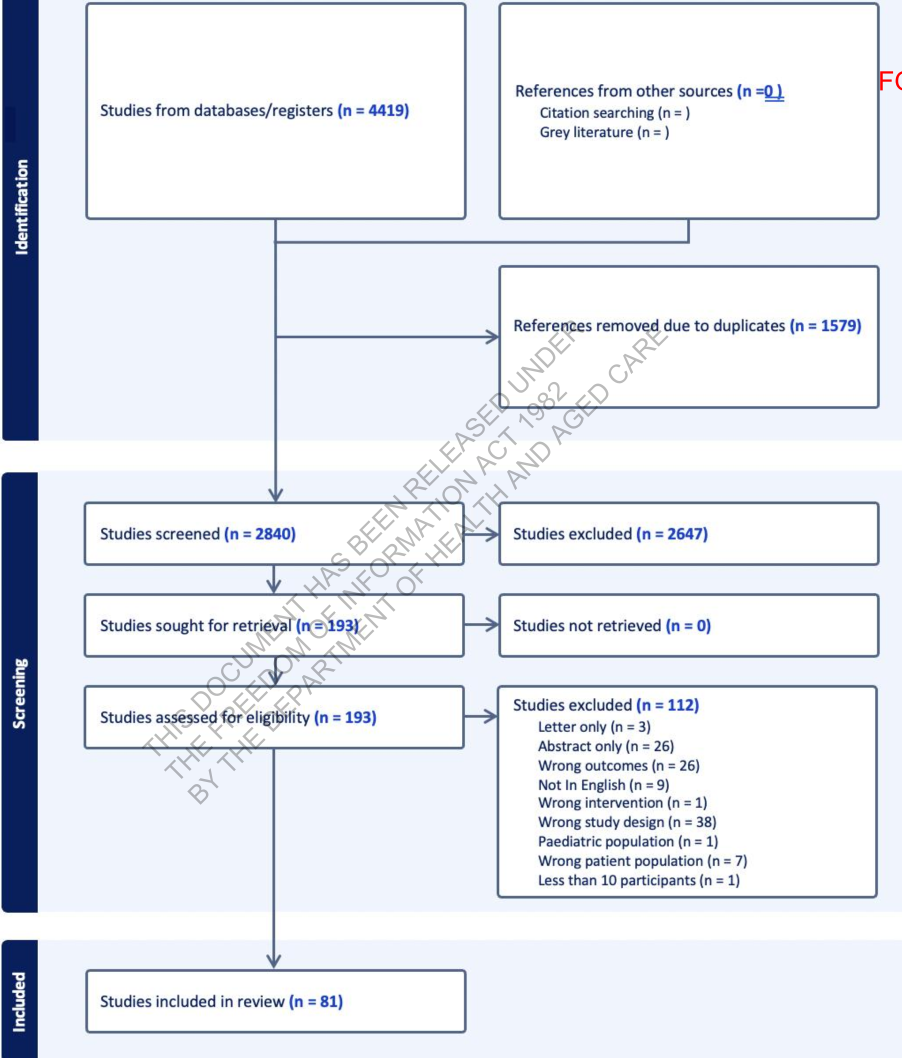

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Types of studies included

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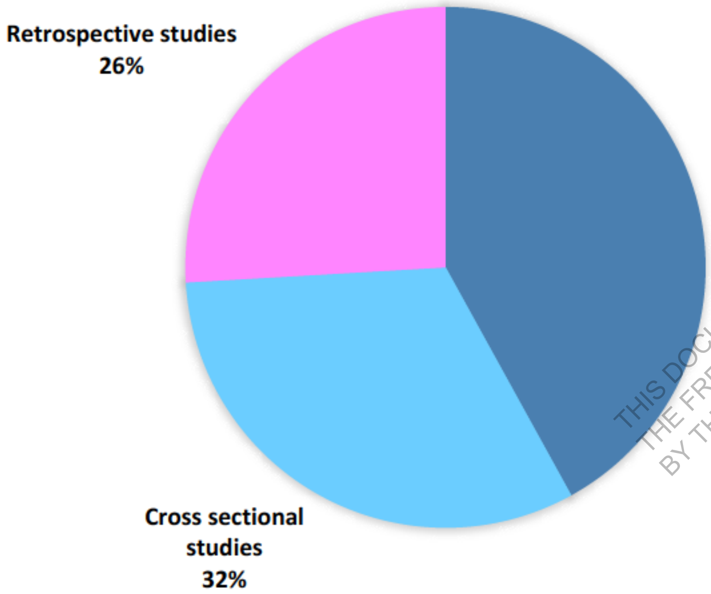

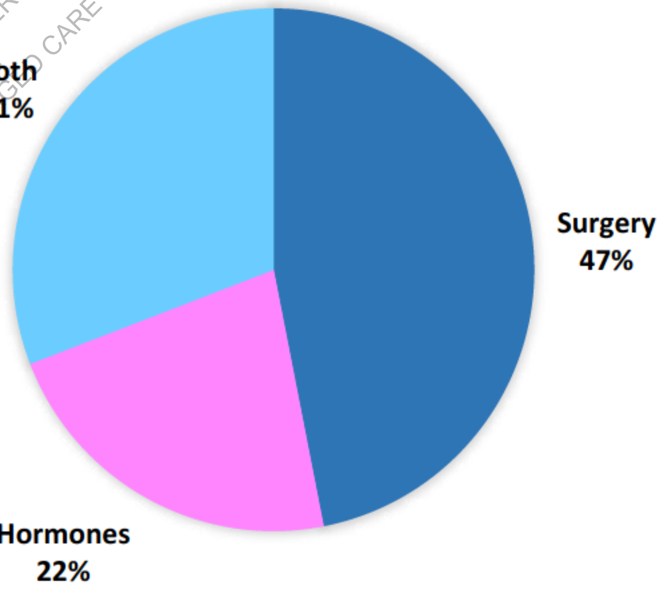

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Patient Reported Outcome Measures

- Over 80 different PROM variations
- Some very commonly used such as the SF36 and the WHO QOL questionnaire
- Others only used a single time

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Gender dysphoria	Body Image/ self- esteem	Mental illness	Health related QOL

Patient Reported Outcome Measures

The following questions ask about **how completely** you experience or were able to do certain things in the last two weeks.

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WHO QOL questionnaire	(Please circle the number)				
	Not at all	A little	Moderately	Mostly	Completely
10. Do you have enough energy for everyday life?	1	2	3	4	5
11. Are you able to accept your bodily appearance?	1	2	3	4	5
25. How satisfied are you with your mode of transportation?	1	2	3	4	5

Gender Dysphoria

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- 9 prospective cohort studies, 6 with data for analysis
- 1 retrospective and 2 cross sectional studies were not included in analysis

Utrecht gender dysphoria scale

	Disagree completely	Disagree	Neither agree or disagree	Agree	Agree completely
I prefer to behave like my affirmed gender.	1	2	3	4	5
Every time someone treats me like my assigned sex, I feel hurt.	1	2	3	4	5
It feels good to live as my affirmed gender.	1	2	3	4	5
I always want to be treated like my affirmed gender.	1	2	3	4	5
A life in my affirmed gender is more attractive for me than a life in my assigned sex.	1	2	3	4	5
I feel unhappy when I have to behave like my assigned sex.	1	2	3	4	5

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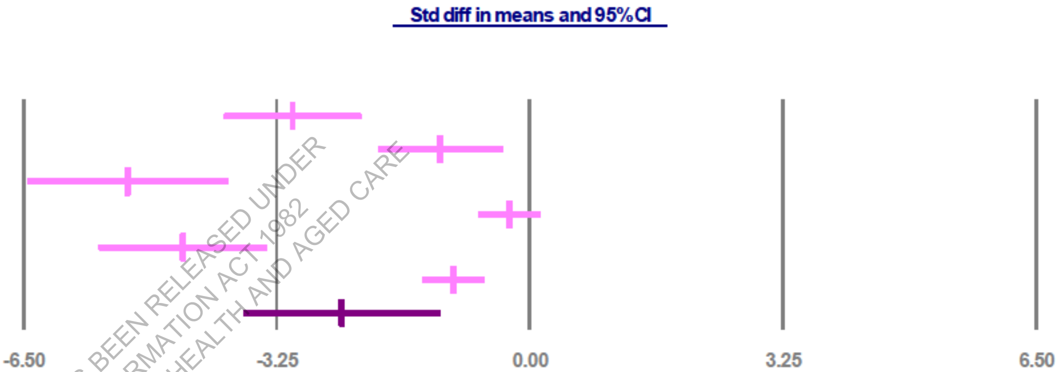
Gender dysphoria

Study name	Outcome	Statistics for each study					
		Std diff in means	Lower limit	Upper limit	Z-Value	p-Value	Total
Ascha 2022	Combined	-3.043	-3.918	-2.168	-6.815	0.000	35
Isung 2017	TCS	-1.147	-1.945	-0.349	-2.817	0.005	10
DeVries 2014	UGDS	-5.159	-6.449	-3.868	-7.835	0.000	33
VandeGrift 2016	SIBID	-0.265	-0.656	0.126	-1.326	0.185	26
PavanelloDecaro 2021	UGDS	-4.454	-5.533	-3.374	-8.087	0.000	36
FosterSkewis 2021	GPSQ	-0.983	-1.381	-0.585	-4.843	0.000	36
Pooled		-2.412	-3.672	-1.152	-3.752	0.000	



- 3 studies focused on surgery alone, 1 study on hormones alone and 2 on both surgery and hormones

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Body Image and self-esteem

- 11 prospective cohort studies, 7 with data for analysis
- 3 retrospective, 7 cross sectional studies not included in analysis

Self esteem scale: Rosenberg		Strongly Disagree	Disagree	Agree	Strongly Agree
1.	On the whole, I am satisfied with myself.	0	1	2	3
2.	* At times, I think I am no good at all.	0	1	2	3
3.	I feel that I have a number of good qualities.	0	1	2	3
4.	I am able to do things as well as most other people.	0	1	2	3
5.	* I feel I do not have much to be proud of.	0	1	2	3
6.	* I certainly feel useless at times.	0	1	2	3

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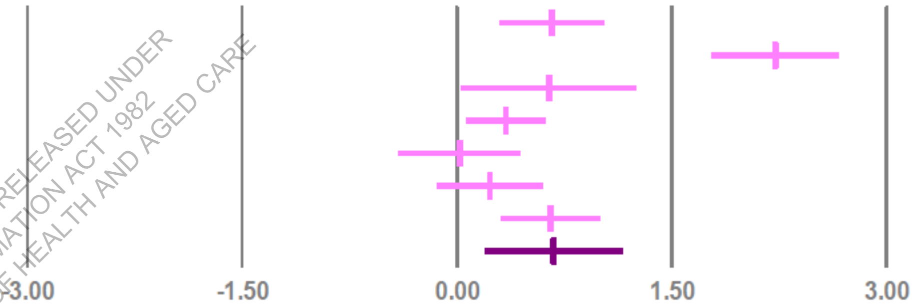
Meta analysis data

Body Image/self-esteem

Study name	Outcome	Std diff in means	Lower limit	Upper limit	Z-Value	p-Value	Total
Ascha 2022	BIS	0.663	0.297	1.029	3.553	0.000	35
Lane 2021	BIQOL	2.222	1.776	2.669	9.766	0.000	67
Isung 2017	BID	0.643	0.034	1.252	2.070	0.038	10
Gumussoy 2022	Combined	0.342	0.070	0.614	2.463	0.014	55
VandeGrift 2017	RSE	0.017	-0.411	0.444	0.077	0.939	21
VandeGrift 2016	Combined	0.230	-0.141	0.601	1.214	0.225	30
Chaovanalikit 2022	RSE	0.655	0.309	1.001	3.713	0.000	39
Pooled		0.675	0.195	1.154	2.757	0.006	



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- All 7 studies focused on surgery alone

Mental illness

- 17 prospective cohort studies, 10 with data for analysis
- 5 retrospective, 15 cross sectional studies not included in analysis

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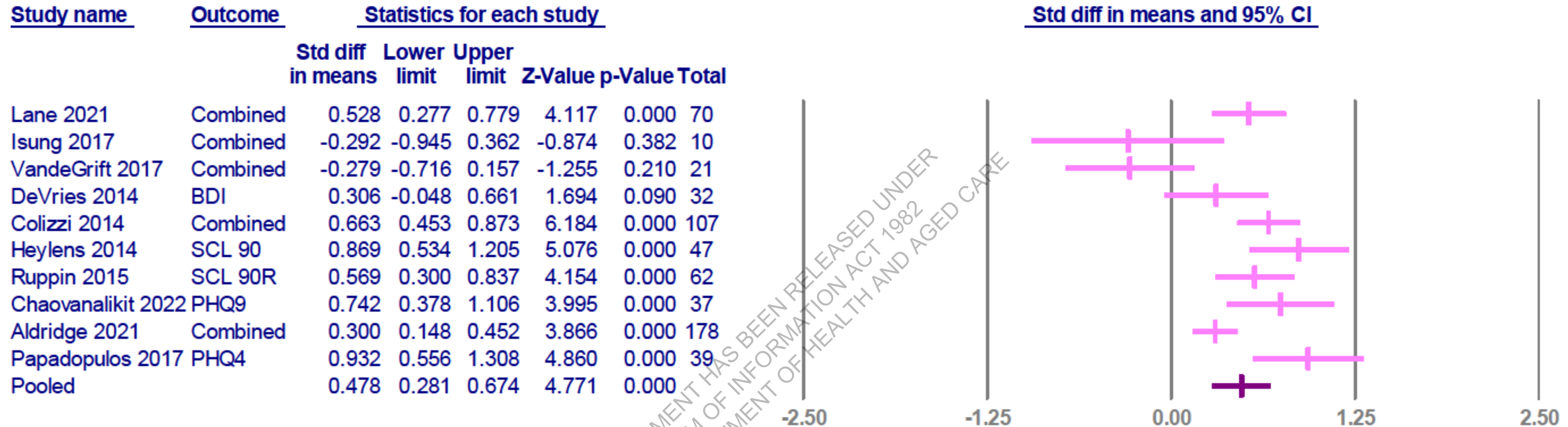
Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often

Mental Illness



Study name	Outcome	Statistics for each study					
		Std diff in means	Lower limit	Upper limit	Z-Value	p-Value	Total
Lane 2021	Combined	0.528	0.277	0.779	4.117	0.000	70
Isung 2017	Combined	-0.292	-0.945	0.362	-0.874	0.382	10
VandeGrift 2017	Combined	-0.279	-0.716	0.157	-1.255	0.210	21
DeVries 2014	BDI	0.306	-0.048	0.661	1.694	0.090	32
Colizzi 2014	Combined	0.663	0.453	0.873	6.184	0.000	107
Heylens 2014	SCL 90	0.869	0.534	1.205	5.076	0.000	47
Ruppin 2015	SCL 90R	0.569	0.300	0.837	4.154	0.000	62
Chaovanalikit 2022	PHQ9	0.742	0.378	1.106	3.995	0.000	37
Aldridge 2021	Combined	0.300	0.148	0.452	3.866	0.000	178
Papadopulos 2017	PHQ4	0.932	0.556	1.308	4.860	0.000	39
Pooled		0.478	0.281	0.674	4.771	0.000	

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- 5 studies focused on surgery alone, 2 studies on hormones alone and 3 studies on both hormones and surgery

Health Related quality of life

- 20 prospective cohort studies, 11 with data for analysis
- 11 retrospective, 17 cross sectional studies not included in analysis

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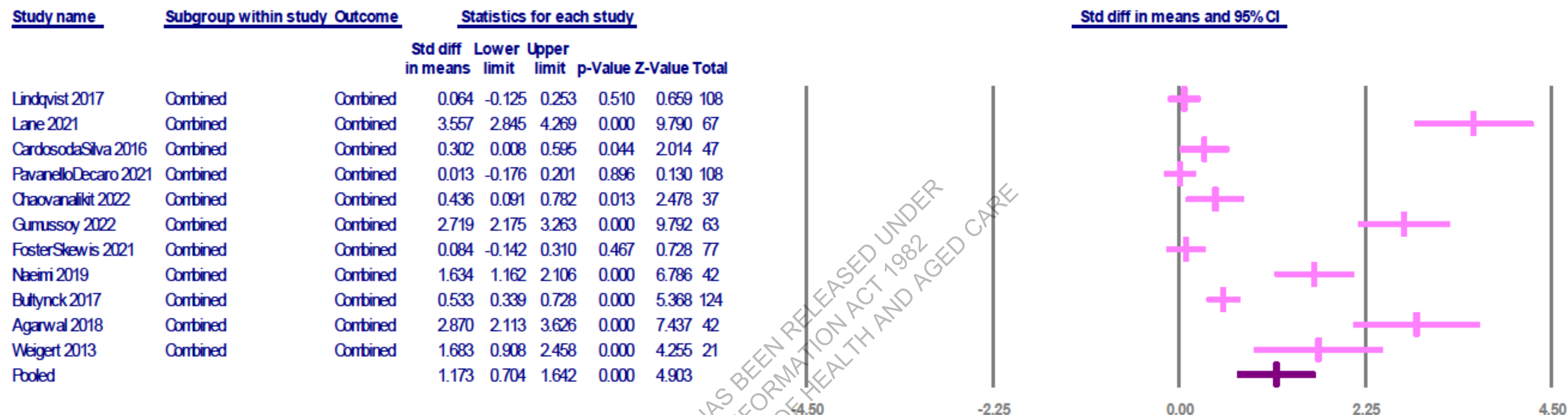
1. In general, would you say your health is:	SF-36 Questionnaire
Excellent	1
Very good	2
Good	3
Fair	4
Poor	5
2. Compared to one year ago,	
Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

Health-related QOL



Study name	Subgroup within study	Outcome	Std diff in means	Lower limit	Upper limit	p-Value	Z-Value	Total
Lindqvist 2017	Combined	Combined	0.064	-0.125	0.253	0.510	0.659	108
Lane 2021	Combined	Combined	3.557	2.845	4.269	0.000	9.790	67
CardosodaSilva 2016	Combined	Combined	0.302	0.008	0.595	0.044	2.014	47
PavanelloDecaro 2021	Combined	Combined	0.013	-0.176	0.201	0.896	0.130	108
Chaovanalikit 2022	Combined	Combined	0.436	0.091	0.782	0.013	2.478	37
Gumussoy 2022	Combined	Combined	2.719	2.175	3.263	0.000	9.792	63
FosterSkewis 2021	Combined	Combined	0.084	-0.142	0.310	0.467	0.728	77
Naeimi 2019	Combined	Combined	1.634	1.162	2.106	0.000	6.786	42
Bultynck 2017	Combined	Combined	0.533	0.339	0.728	0.000	5.368	124
Agarwal 2018	Combined	Combined	2.870	2.113	3.626	0.000	7.437	42
Weigert 2013	Combined	Combined	1.683	0.908	2.458	0.000	4.255	21
Pooled			1.173	0.704	1.642	0.000	4.903	

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- 8 studies focused on surgery alone, 3 studies focused on hormones alone

Conclusions

Gender affirming treatment in the form of hormone treatment and/or surgery results in significantly improved patient reported quality of life, gender dysphoria, body image, self esteem, anxiety, and depression in gender diverse people.

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Australian Government

Department of Health

Consultation Survey on MSAC Application 1754

Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence

MSAC welcomes input on MSAC applications for public funding from individuals, organisations representing health professionals or consumers and/or carers, and from other stakeholders. Please use this template to prepare your input. You may also attach additional information if you consider it may be useful in informing MSAC and its sub-committees.

Sharing consultation input

Submitted consultation input will be routinely shared with the applicant and with MSAC and its sub-committees.

- The applicant will receive a summary of comments from individuals, with the individual's name and other identifying information removed.
- MSAC and its sub-committees will receive both the summary and copies of the comments, with the name of the individual and other identifying information removed.
- Consultation input from groups or organisations will be provided in a complete form to both the applicant and to MSAC and its sub-committees.

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Thank you for taking the time to provide consultation input. Please return your completed survey to:

Email: commentsMSAC@health.gov.au

Mail: MSAC Secretariat,
MDP 960, GPO Box 9848,
ACT 2601.

PART 1 – PERSONAL AND ORGANISATIONAL INFORMATION

1. Respondent details

Name: Parents of Adolescents with Gender Distress - Victoria

Email: pagd.vic@gmail.com

Phone No:

2. Is the feedback being provided on an individual basis or by a collective group?

☐ Individual
☒ Collective Group

If an individual, specify the name of the organisation you work for

If a collective group, specify the name of the group

Parents of Adolescents with Gender Distress - Victoria

3. How would you best identify yourself?

☐ General Practitioner
☐ Specialist
☐ Researcher
☐ Consumer
☐ Care giver
☒ Other

If other, please specify

A collective of families with children and young people affected by gender distress

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PART 2 – CLINICAL NEED AND PUBLIC HEALTH SIGNIFICANCE

4. Describe your experience with the medical condition (disease) and/or proposed intervention and/or service relating to the application summary.

All of our children experience gender distress. Some have received 'gender affirming care' (GAC), generally without appropriate psychosocial diagnosis and support. In our lived experience, GAC is provided without a robust diagnostic process and co-occuring conditions of significance such as eating disorders, mental illness and neurodiversity are not properly explored prior to GAC being provided.

5. What do you see as the benefit(s) of the proposed medical service, in particular for the person involved and/or their family and carers?

None.

6. What do you see as the disadvantage(s) of the proposed medical service, in particular for the person involved and/or their family and carers?

Easier and cheaper access to GAC under Medicare will result in higher rates of surgery regret, suicide and litigation as the evidence to support it is of low quality. Refer to attached letter.

7. What other benefits can you see from having this intervention publically funded?

None.

8. What other services do you believe need to be delivered before or after this intervention, e.g. Dietician, Pathology etc?

Comprehensive psychological evaluation and exploratory therapy by independent practitioners MUST be delivered prior to GAC. This does NOT currently happen, so existing processes are inadequate and not suitable for purpose.

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PART 3 – INDICATION(S) FOR THE PROPOSED MEDICAL SERVICE AND CLINICAL CLAIM

9. Do you agree or disagree with the proposed population(s) for the proposed medical service?

☐ Strongly Agree
☐ Agree
☐ Disagree
☒ Strongly Disagree

Specify why or why not:

A significant number of gender distressed young people are neurodiverse, suffer from mental illness, body dysmorphia, eating disorders, chronic medical conditions. Any population with these conditions should not be eligible without comprehensive and robust psychological assessment and therapy, as recommended by RANZCP and NAPP

10. Have all the associated interventions been adequately captured in the application summary?

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☐ Yes
☒ No

Please explain:

Appropriate psychological interventions that should be explored prior to GAC have been ignored in the application.

11. Do you agree or disagree that the comparator(s) to the proposed medical service?

☐ Strongly Agree
☐ Agree
☐ Disagree
☒ Strongly Disagree

Please explain:

Appropriate psychological interventions that should be explored prior to GAC have been ignored in the application.
Comparing only to existing medical interventions ignores the increasing debate on appropriate treatment for gender distress.

12. Do you agree or disagree with the clinical claim made for the proposed medical service?

☐ Strongly Agree
☐ Agree
☐ Disagree
☒ Strongly Disagree

Specify why or why not:

Statements and benefits made in the application are not supported by high quality evidence, are contested within medical communities and are not supported by long term research.

PART 4 – COST INFORMATION FOR THE PROPOSED MEDICAL SERVICE

13. **Do you agree with the proposed service descriptor?**

- [ ] Strongly Agree
- [ ] Agree
- [ ] Disagree
- [x] Strongly Disagree

Specify why or why not:

14. **Do you agree with the proposed service fee?**

- [ ] Strongly Agree
- [ ] Agree
- [ ] Disagree
- [x] Strongly Disagree

Specify why or why not:

Surgical treatments provided according to 'patient choice' without a diagnostic test are clearly elective and not clinically necessary. The service should not be funded by Medicare.

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PART 5 – ADDITIONAL COMMENTS

15. Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed medical service?

Gender distress is a highly controversial condition. Research quality is low, surgical interventions are poorly evidenced and appropriate treatments are subject to controversy.

Until sufficient medical consensus and long term research evidence is available, the proposed medical service should not be funded by Medicare.

16. Do you have any comments on this feedback survey? Please provide comments or suggestions on how this process could be improved.

Thanks you for the opportunity to participate. Please see attached letter for further detail.

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Again, thank you for taking the time to provide valuable feedback.

Submission - 1754 - Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence

Our group PAGD VIC (Parents of Adolescents with Gender Distress, Victoria) are concerned by Submission 1754 to extend Medicare coverage in Australia to those seeking 'gender affirming' surgery. We are particularly concerned that statements made by Australian Society of Plastic Surgeons (ASPS) in support of the application are based on low quality data, are contested or simply incorrect. Specific statements of concern are below:

ASPS Submission Statements	PAGD Rebuttal
Conceptually it is important to understand that "gender incongruence" is the innate state. There are no prerequisite diagnostic tests required to establish the presence of gender incongruence. Some individuals who are "gender questioning" will not have gender incongruence, or it will not be persistent.	These statements are made with no reference and are not consistent. There is no distinguishable clinical difference made between gender questioning and gender incongruence and no viable explanation of why gender questioning may not be persistent but gender incongruence is innate. Surgery without an available test to establish a firm clinical diagnosis cannot be medically necessary.
The number and type of gender affirming surgical procedures accessed by people will depend on their medical suitability for particular procedures, their choices and whether they are pursuing masculinising or feminising procedures	Surgery determined by patient choice rather than medically diagnostic testing is clearly elective, not clinically necessary and therefore should not be eligible for Medicare funding.
Eligibility for Medicare benefits being payable for gender affirming medical interventions rendered to people with gender incongruence is established by The Health Insurance Act 1973, specifying that: A "clinically relevant service means a service rendered by a medical practitioner that is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient to whom it is rendered"	Eligibility is not established as without a diagnostic test, a GAC service cannot be determined to be clinically relevant. GAC is NOT generally accepted in the medical profession as being necessary as appropriate treatment for gender incongruence and is increasingly contested. Both psychiatry peak bodies, RANZCP and NAPP contest the statement that GAC is necessary or appropriate treatment.
Gender affirming medical interventions have been reported as reducing rates of psychological distress, suicide ideation and suicide attempt. (Almazan et al. 2021).	This statement is based on a low quality self reported survey. Higher quality longitudinal studies have found that psychological distress, suicide ideation and attempts increased significantly post sex reassignment surgery.[1]
Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 have been endorsed as a Standard of Care by the Australian Professional Association for Trans Health (AusPATH)	The WPATH 'Standards of Care', Version 8 have been self described as such and do not meet the requirements for clinical Standards of Care. Over 2000 medical professionals, public health scientists and other concerned individuals have signed a declaration challenging the validity of the Standards of Care.[2]

The Society estimates without justification 'that 128,145 transgender Australian adults would be candidates for gender-affirming medical interventions in 2023'. This represents enormous growth in a remarkably short space of time and with a recognised lack of long-term research on outcomes for these individuals[3], significant regret is a very real possibility.

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Potential regret is hard to estimate but previous research data would suggest that outcomes are not consistent with the benefits stated by the application. “The review of more than 100 international medical studies of post-operative transsexuals by the University of Birmingham's aggressive research intelligence facility (Arif) found no robust scientific evidence that gender reassignment surgery is clinically effective”[4] “eight former patients of the Gender Dysphoria Clinic at Melbourne's Monash Medical Centre believe they may have been misdiagnosed. Some have tried to commit suicide while struggling to live as the opposite sex after the irreversible operations”[5]

The Society suggests there is “broad public support” for its funding application. 148,000 signatures on a petition in a population of over 26,000,000 is disputed as “broad public support” and we would question the relevance of ‘public support’ in determining the medical recommendations for a specific treatment. We also challenge why a condition the Society is seeking to de-pathologise requires such serious and ‘personal choice’ medical interventions to be funded by tax payers.

PAGD would recommend that MSAC rejects this application based on the low quality of evidence and current scientific uncertainty regarding gender dysphoria and the medical interventions being undertaken. We are happy to answer any questions you have regarding this submission.

Regards,

Parents of Adolescents with Gender Distress – Victoria

pagd.vic@gmail.com

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[1] “Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden”. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885
[2] https://beyondwpath.org/
[3] “Psychiatry’s ethical involvement in gender-affirming care”. https://journals.sagepub.com/doi/10.1177/1039856218775216
[4] “Sex changes are not effective, say researchers” https://www.theguardian.com/society/2004/jul/30/health.mentalhealth
[5] “Sex change clinic ‘got it wrong’” https://www.smh.com.au/national/sexchange-clinic-got-it-wrong-20090530-br3u.html

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

26 October 2023

Professor Robyn Ward
Chair, Medical Services Advisory Committee (MSAC)

By email: commentsMSAC@health.gov.au

Dear Professor Ward,

Re: MSAC Application 1754

Thank you for inviting the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to provide input into the application 1754 - Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence.

The RANZCP is in the process of revising its Position Statement 103: Recognising and addressing the mental health needs of people experiencing Gender Dysphoria / Gender Incongruence. The RANZCP Board and Gender Dysphoria Steering Group have required that an extensive range of evidence is considered in this process. The RANZCP remains committed to supporting the Trans and Gender Diverse community and is mindful of the sensitivities around this topic, which necessitates a thoughtful and respectful approach. It is anticipated that a revised version of Position Statement 103 will be published by the end of 2023.

The RANZCP wishes to ensure that its input into matters relating to gender incongruence are informed by this process. The RANZCP has recently engaged with the Australian Society of Plastic Surgeons (ASPS) and will be attending their roundtable in December to further discuss gender affirming surgery.

We would be pleased to share a draft of the updated Position Statement once available. We look forward to working with MSAC to ensure that all services under the MBS are delivered in an effective and accessible manner that reflects contemporary practice.

If you would like to discuss this further, please contact s47F Executive Manager, Policy, Practice, and Research via s47F

Yours sincerely,

s47F

Ref 4172

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309 La Trobe Street, Melbourne VIC 3000 Australia
T +61 3 9640 0646 F +61 3 9642 5652
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

s22

From:
Sent: Monday, 30 October 2023 10:45 AM
To: CommentsMSAC;
Subject: RE: consultation survey - MCAS application 1754 [SEC=OFFICIAL]

Hello – currently the Gender Pathways Service consists of only one individual. However, please submit as a collective as there are additional people in attached services who support the submission, including myself as the clinician's line manager.
Kind Regards

Consultant Clinical Psychologist/Co-ordinator
YouthLink

Youth Mental Health
Mental Health, Public Health and Dental Services
223 James Street, Northbridge, WA, 6003
T: | M: I F: (08) 9328 5911
E: @health.wa.gov.au

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BY THE DEPARTMENT OF HEALTH AND AGED CARE

From: CommentsMSAC <CommentsMSAC@Health.gov.au>
Sent: Monday, 30 October 2023 7:00 AM
To: @health.wa.gov.au>; CommentsMSAC <CommentsMSAC@Health.gov.au>
Cc: @health.wa.gov.au>
Subject: RE: consultation survey - MCAS application 1754 [SEC=OFFICIAL]

CAUTION External Communication: This email originated from outside of the organisation. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good morning,

Thank you for your input into MSAC application 1754 - Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence and apologies for the delay in responding.

I note you have selected individual in the survey form but stated "*submitted on behalf of the Gender Pathways Service*" in the email. Could you please confirm if you wish to submit the survey as an individual or collective group.

Consultation input received from organisations is provided, in full, to the Applicant and to MSAC and its sub-committees for consideration. Input provided by organisations (and the name of the organisation) may also be cited in the Public Summary Document (PSD) which is published on the MSAC website.

Identifying personal and sensitive information is removed from consultation input received from individuals before the input is provided to MSAC and its sub-committees. In addition, the Secretariat incorporates input from individuals into a summary of consultation input. The summary does not include identifying details of individuals.

FOI 4876 - Document 23

The Applicant receives a copy of this summary, along with MSAC and the PICO Advisory Sub-Committee (PASC). The summary may also be included in the PSD.

For more information, please see this fact sheet on the MSAC website: MSAC Consultation FAQ – what happens to consultation feedback.

Kind Regards

Office of Health Technology Assessment Branch
Technology Assessment & Access Division | Health Resourcing Group
Australian Government Department of Health and Aged Care
| E: commentsMSAC@health.gov.au
Location: Sirius Building
PO Box 9848, Canberra ACT 2601, Australia

From: @health.wa.gov.au>
Sent: Friday, 27 October 2023 12:02 PM
To: CommentsMSAC <CommentsMSAC@Health.gov.au>
Cc: @health.wa.gov.au>
Subject: consultation survey - MCAS application 1754

Dear MSAC Secretariat,

Please accept this consultation survey for MCAS application 1754, submitted on behalf of the Gender Pathways Service.

Sincerely,

| Senior Clinical Psychologist | Gender Pathways Service
Pronouns:
North Metropolitan Health Service
Mental Health, Public Health and Dental Services
223 James Street, Northbridge WA 6003
T: | F: (08) 9328 5911
E @health.wa.gov.au W:nmahsmh.health.wa.gov.au
nmhs.health.wa.gov.au

One team, many dreams.
Care / Respect / Innovation / Teamwork / Integrity

We acknowledge the Noongar people as the traditional owners and custodians of the land on which we work, and pay respect to their elders both past and present. North Metropolitan Health Service recognises, respects and values Aboriginal cultures as we walk a new path together.

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Australian Government

Department of Health

Consultation Survey on MSAC Application 1754

Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence

MSAC welcomes input on MSAC applications for public funding from individuals, organisations representing health professionals or consumers and/or carers, and from other stakeholders. Please use this template to prepare your input. You may also attach additional information if you consider it may be useful in informing MSAC and its sub-committees.

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Mail: MSAC Secretariat,
MDP 960, GPO Box 9848,
ACT 2601.

PART 1 – PERSONAL AND ORGANISATIONAL INFORMATION

1. Respondent details

Name: [redacted]

Email: [redacted]@health.wa.gov.au

Phone No: [redacted]

2. Is the feedback being provided on an individual basis or by a collective group?

☒ Individual
☐ Collective Group

If an individual, specify the name of the organisation you work for

WA Department of Health - North Metropolitan Health Service – Gender Pathways Service

If a collective group, specify the name of the group

3. How would you best identify yourself?

☐ General Practitioner
☐ Specialist
☐ Researcher
☐ Consumer
☐ Care giver
☒ Other

If other, please specify

s47F

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PART 2 – CLINICAL NEED AND PUBLIC HEALTH SIGNIFICANCE

4. Describe your experience with the medical condition (disease) and/or proposed intervention and/or service relating to the application summary.

I am a s47F with experience in the assessment and support of people with *Gender Incongruence of Adolescence and Adulthood*. I currently work as the s47F in a WA Department of Health service providing assessment of readiness for people seeking to access gender affirming medical and/or surgical treatments, such as those proposed in the application.

5. What do you see as the benefit(s) of the proposed medical service, in particular for the person involved and/or their family and carers?

The available literature, as cited in the application, demonstrates the psychological, emotional, and social benefits of the proposed medical services. These medical services act to relieve or prevent the gender dysphoria, which is associated with decreased qualify of life, increased suicidality, and more severe mental health symptomatology.

6. What do you see as the disadvantage(s) of the proposed medical service, in particular for the person involved and/or their family and carers?

Nil

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7. What other benefits can you see from having this intervention publicly funded?

These interventions are already accessed by those experiencing *Gender Incongruence*, with payment typically comprising out of pocket fees or the use of other MBS items that are not specific to the treatment of *Gender Incongruence*. The out-of-pocket fees place an unreasonable burden on a client group who already face higher rates of socioeconomic disadvantage due to prejudicial and discriminatory public attitudes. Further, the use of other MBS items not specific to *Gender Incongruence* causes uncertainty or anxiety to health professionals providing a medically necessary treatment with established efficacy.

8. What other services do you believe need to be delivered before or after this intervention, e.g. Dietician, Pathology etc?

Some surgeons may request that the consumer consult with a Clinical Psychologist prior to the proposed intervention and that the Clinical Psychologist provide documentation to the Surgeon confirming the diagnosis of *Gender Incongruence*, and endorsing the consumers readiness for the proposed intervention, including the capacity to provide informed consent. Currently, this service is often funded using a GP Mental Health Care Plan and the associated MBS item numbers. Given that *Gender Incongruence* is not a mental health disorder, this could potentially be seen as incorrect use of such item numbers. The inclusion of Clinical Psychology or other mental health practitioner as required by the Surgeon or requested by the consumer, in preparation for the intervention, should

also be considered with relevant MBS items. Some Surgeons may request that a Psychiatrist provide this service, and I note such psychiatric input is already considered in the application

PART 3 – INDICATION(S) FOR THE PROPOSED MEDICAL SERVICE AND CLINICAL CLAIM

9. Do you agree or disagree with the proposed population(s) for the proposed medical service?

☐ Strongly Agree
☒ Agree
☐ Disagree
☐ Strongly Disagree

Specify why or why not:

The proposed diagnosis of *Gender Incongruence of Adolescence and Adulthood* accurately identifies the population for whom these services may be indicated. The diagnostic criteria for *Gender Incongruence of Adolescence and Adulthood,* necessarily and appropriately includes an element of self-determination, due to the inherently internal nature of identity. However, the criterion of "persistent incongruence" is not well specified and is interpreted differently across both professional background and between individual clinicians. It may therefore be appropriate to provide more specific guidance to this criterion as it relates to access to the proposed medical services. Developing guidance on this criterion must be strongly guided by the views of those with live experience of gender incongruence. Further specificity of this criterion would provide greater certainty and clarity for both clinicians forming this diagnosis, as well as for those individuals seeking to access gender affirming medical and surgical care.

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10. Have all the associated interventions been adequately captured in the application summary?

☒ Yes
☐ No

Please explain:

Whilst this field continues to evolve, the current range of gender affirming surgeries, to my knowledge, is well captured in the application.

11. Do you agree or disagree that the comparator(s) to the proposed medical service?

☒ Strongly Agree
☐ Agree
☐ Disagree
☐ Strongly Disagree

Please explain:

The comparators accurately capture the medical interventions currently accessed for the treatments of *Gender Incongruence* that are funded by out of pocket expenses or MBS items not identified for gender affirmation currently.

12. Do you agree or disagree with the clinical claim made for the proposed medical service?

☒ Strongly Agree

- [ ] Agree
- [ ] Disagree
- [ ] Strongly Disagree

Specify why or why not:

The evidence base for the proposed medical services is well established, as cited in the application.

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PART 4 – COST INFORMATION FOR THE PROPOSED MEDICAL SERVICE

13. **Do you agree with the proposed service descriptor?**

☐ Strongly Agree
☐ Agree
☐ Disagree
☐ Strongly Disagree

Specify why or why not:

I am unable to comment as this is outside my area of knowledge.

14. **Do you agree with the proposed service fee?**

☐ Strongly Agree
☐ Agree
☐ Disagree
☐ Strongly Disagree

Specify why or why not:

I am unable to comment as this is outside my area of knowledge.

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PART 5 – ADDITIONAL COMMENTS

15. Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed medical service?

No

16. Do you have any comments on this feedback survey? Please provide comments or suggestions on how this process could be improved.

No

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Again, thank you for taking the time to provide valuable feedback.

Australian Government

Department of Health

Consultation Survey on MSAC Application 1754

Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence

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MDP 960, GPO Box 9848,
ACT 2601.

PART 1 – PERSONAL AND ORGANISATIONAL INFORMATION

1. Respondent details

Name: [redacted]

Email: [redacted]@thorneharbour.org

Phone No: [redacted]

2. Is the feedback being provided on an individual basis or by a collective group?

☐ Individual
☒ Collective Group

If an individual, specify the name of the organisation you work for

If a collective group, specify the name of the group

Thorne Harbour Health (THH)

3. How would you best identify yourself?

☐ General Practitioner
☐ Specialist
☐ Researcher
☐ Consumer
☐ Care giver
☒ Other

If other, please specify

[redacted].
THH employs General Practitioners, Specialists and our Consumers are relevant to this submission.

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PART 2 – CLINICAL NEED AND PUBLIC HEALTH SIGNIFICANCE

4. Describe your experience with the medical condition (disease) and/or proposed intervention and/or service relating to the application summary.

In 2016, Thorne Harbour Health (THH) established Equinox, a peer-led Trans and Gender Diverse Health Service. We consult regularly with our patients to establish service needs and define priorities; and our practice reflects the outcomes of these consultations. Equinox services include General Practice healthcare, sexual health, mental health support, hormone initiation and management, pre-exposure prophylaxis (PrEP) and vaccinations.

5. What do you see as the benefit(s) of the proposed medical service, in particular for the person involved and/or their family and carers?

Medical interventions for gender affirmation is associated with improved health-related quality of life, reduced psychological disorders after receiving medical interventions, reduced suicidal ideation and suicide attempt, reduce gender dysphoria, and increased body satisfaction/image.

6. What do you see as the disadvantage(s) of the proposed medical service, in particular for the person involved and/or their family and carers?

N/A

7. What other benefits can you see from having this intervention publicly funded?

Beyond direct medical/wellbeing outcomes from gender affirmation surgery, there several social and financial benefits of the proposed medical service. At present, many trans people access superannuation to pay for surgery, which leaves them financially worse off in the long-term. Trans people often face social barriers to accessing high-income work (or any work at all). This results in significant negative long-term impacts on general health as trans people age with lower superannuation and saving, and would likely increase the burden on the public health system more broadly. Medical gender affirmation will also contribute to addressing health inequities between trans individuals and the general population.

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8. What other services do you believe need to be delivered before or after this intervention, e.g. Dietician, Pathology etc?

PART 3 – INDICATION(S) FOR THE PROPOSED MEDICAL SERVICE AND CLINICAL CLAIM

9. Do you agree or disagree with the proposed population(s) for the proposed medical service?

- ☒ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Specify why or why not:

10. Have all the associated interventions been adequately captured in the application summary?

- ☒ Yes
- ☐ No

Please explain:

11. Do you agree or disagree that the comparator(s) to the proposed medical service?

☒ Strongly Agree
☐ Agree
☐ Disagree
☐ Strongly Disagree

Please explain:

12. Do you agree or disagree with the clinical claim made for the proposed medical service?

☒ Strongly Agree
☐ Agree
☐ Disagree
☐ Strongly Disagree

Specify why or why not:

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PART 4 – COST INFORMATION FOR THE PROPOSED MEDICAL SERVICE

13. **Do you agree with the proposed service descriptor?**

- [ ] Strongly Agree
- [x] Agree
- [ ] Disagree
- [ ] Strongly Disagree

Specify why or why not:

14. **Do you agree with the proposed service fee?**

- [ ] Strongly Agree
- [x] Agree
- [ ] Disagree
- [ ] Strongly Disagree

Specify why or why not:

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PART 5 – ADDITIONAL COMMENTS

15. **Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed medical service?**

16. **Do you have any comments on this feedback survey? Please provide comments or suggestions on how this process could be improved.**

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Again, thank you for taking the time to provide valuable feedback.

Australian Government

Department of Health

Consultation Survey on MSAC Application 1754

Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence

MSAC welcomes input on MSAC applications for public funding from individuals, organisations representing health professionals or consumers and/or carers, and from other stakeholders. Please use this template to prepare your input. You may also attach additional information if you consider it may be useful in informing MSAC and its sub-committees.

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Sharing consultation input

Submitted consultation input will be routinely shared with the applicant and with MSAC and its sub-committees.

- The applicant will receive a summary of comments from individuals, with the individual's name and other identifying information removed.
- MSAC and its sub-committees will receive both the summary and copies of the comments, with the name of the individual and other identifying information removed.
- Consultation input from groups or organisations will be provided in a complete form to both the applicant and to MSAC and its sub-committees.

Consultation input may also be shared with HTA Assessment Groups from time to time to inform their reports to MSAC or with state and territory health representatives where the application is for a service to be delivered through public hospitals. Please do not include information in your input that you do not want shared as outlined above. In addition, to protect privacy, do not include identifying personal (e.g., name) or sensitive (e.g., medical history) information about third parties, such as medical professionals or friends/relatives.

How consultation input is used

MSAC and its sub-committees consider consultation input when appraising an application, including to better understand the potential impact of the proposed medical technology/service on consumers, carers, and health professionals. A summary of consultation input will be included in the Public Summary Document (PSD) published on the MSAC website once MSAC has completed its appraisal. The PSD may also cite input from groups/organisations, including the name of the organisation. As such, organisations should not include information or opinions in their consultation input that they would not wish to see in the public domain.

Consultation deadlines. Please ensure that your consultation input is submitted by the pre-PASC or pre-MSAC consultation deadline for this application. Consultation deadlines for each PASC and MSAC meeting are listed in the PASC, ESC, MSAC key dates available on the MSAC website. They are also published in the MSAC Bulletin. Consultation input received after the respective deadlines may not be considered.

For further information on the MSAC consultation process please refer to the MSAC Website or contact the Consumer Evidence and Engagement Unit on email: commentsMSAC@health.gov.au.
Thank you for taking the time to provide consultation input. Please return your completed survey to:

Email: commentsMSAC@health.gov.au

Mail: MSAC Secretariat,
MDP 960, GPO Box 9848,
ACT 2601.

PART 1 – PERSONAL AND ORGANISATIONAL INFORMATION

1. Respondent details

Name: [redacted]

Email: s47F

Phone No: [redacted]

2. Is the feedback being provided on an individual basis or by a collective group?

☐ Individual
☒ Collective Group

If an individual, specify the name of the organisation you work for

If a collective group, specify the name of the group

Genspect

3. How would you best identify yourself?

☐ General Practitioner
☐ Specialist
☐ Researcher
☐ Consumer
☐ Care giver
☒ Other

If other, please specify

Genspect is an international alliance of parent and professional groups whose aim is to advocate for a healthy approach to the care of gender non-conforming and questioning children and young people. We number in our thousands, and our members include numerous clinicians as well as medical researchers, teachers, parents and others concerned with the wellbeing of gender questioning youth. Genspect wholeheartedly supports the rights of sexual minorities in society and is proud to include gay, lesbian and transgender members in our team, as well as detransitioners. We have a zero-tolerance policy towards discrimination against sexual minorities.

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PART 2 – CLINICAL NEED AND PUBLIC HEALTH SIGNIFICANCE

4. Describe your experience with the medical condition (disease) and/or proposed intervention and/or service relating to the application summary.

Genspect was formed to advocate for a non-medicalised approach to gender diversity, in light of the large increase in children and young people presenting with gender dysphoria. Our members have broad expertise relevant to the issue of gender incongruence/gender dysphoria, and include many clinical professionals as well as transgender people, detransitioners, and parent groups. Through our sister organisation Beyond Trans, we provide support for detransitioners. In addition, we provide support and information for parents of children with gender dysphoria.

We are of the strong opinion that young adults and children are not equipped to make decisions about life-long changes associated with medical transition procedures. Adolescence and young adulthood are key developmental stages during which a sense of identity evolves. We believe that young people should be supported to accept and embrace their bodies in order to be healthy and content. We do, however, support the rights of mature adults, who possess capacity, to make informed healthcare choices regarding medical transition. Our experience is that young adults are currently making decisions on gender transition that many of them come to regret. In November 2023, Genspect will launch our Gender Framework document, which outlines a non-medicalised pathway for the management of gender dysphoria.

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5. What do you see as the benefit(s) of the proposed medical service, in particular for the person involved and/or their family and carers?

We do not see benefits for these services for the vast majority of those currently requesting them, who will instead suffer damage.

The bulk of those requesting these treatments are a new cohort of adolescents and young people, the majority female, as discussed in section 9 [1]. The rapid upswing in these people identifying as gender incongruent has characteristics of social contagion and parallels the rise of smart phone and social media use. Many of these young people present with a keen desire for hormones and surgery to alter their outward appearance. The strong ideological commitment of this new cohort to transgender issues and their intense desire for treatment means that there is certainly a "honeymoon" period when they get what they have been seeking. The studies that report decreased depression or suicidal ideation in patients who have received treatment are generally looking at relatively short-term outcomes. This may well be a placebo effect, rather than true therapeutic benefit [2]. However, the long-term outcomes of this treatment, particularly for this cohort, are completely unknown [3]; there are increasing numbers of detransitioners emerging who equally keenly regret their treatment. Please see section 9 for further discussion of this.

1. Kaltiala, R., Bergman, H., Carmichael, P., de Graaf, N. M., Egebjerg Rischel, K., Frisén, L., Schorkopf, M., Suomalainen, L., & Waehre, A. (2020). Time trends in referrals to child and adolescent gender identity services: A study in four Nordic countries and in the UK. Nordic Journal of Psychiatry, 74(1), 40–44. https://doi.org/10.1080/08039488.2019.1667429

2. Clayton, 2023. Gender-affirming treatment of gender dysphoria in youth: A perfect storm environment for the placebo effect – The implications for research and clinical practice. Archives Sex Behav. 52:483-494. Doi: 10.1007/s10508-022-02472-8

3. Levine, S. B., Abbruzzese, E., & Mason, J. M. (2022). Reconsidering informed consent for trans-identified children, adolescents, and young adults. Journal of Sex & Marital Therapy, 48(7), 706–727. https://doi.org/10.1080/0092623X.2022.204622)

6. **What do you see as the disadvantage(s) of the proposed medical service, in particular for the person involved and/or their family and carers?**

1. The possibility of future regret. The true rate of regret for transgender treatment and surgery is completely unknown, for several reasons [4]. Firstly, the poor quality of the published data and very high loss to follow-up in studies, as detailed in section 12. Secondly, the nature of the population seeking these services has now changed due to a massive increase in identification of adolescents and young people as gender incongruent, particularly girls and young women. (See below). The rate of regret or detransition in this population remains to be determined as it is a new phenomenon. However, one paper analysing data on hormone prescriptions in US military families found that the 4-year discontinuation rate for hormone prescriptions was 30% overall and 36% for transmasculine [5]. The existence of detransitioners who were formerly convinced that they were transgender contradicts the concept expressed in the application that gender incongruence is an "innate state". Thus, we can anticipate that surgery amongst this new cohort with cross-sex identification initiating in adolescence will result in large numbers of regretful patients.
2. High rate of complications and poor outcomes for some of these surgeries. As cited in the application, a review on phalloplasty found complications reported for 54% of patients although as it was noted that many articles did not comment on complications, this number can be assumed to be a minimum [6]. This should not be acceptable in elective surgery, and revision surgeries will significantly add cost burden. A review on surgeries generating a neo-vagina found that "studies reported on 1,684 patients with an overall complication rate of 32.5% and a reoperation rate of 21.7% for non-esthetic reasons" [7]. Another study found that "common patient-reported symptoms during clinical visit included pain (53.8%), dilation concerns (46.3%), and surgical site/vaginal bleeding (42.5%). Sexual function concerns were also common (33.8%) with anorgasmia (11.3%) and dyspareunia (11.3%) being the most frequent [8]. Construction of a neo-vagina using intestinal segment is a risky procedure used when there is insufficient penile tissue due to prior treatment with puberty blocking drugs. This operation led to the death of an 18 year old from an *E. coli* infection that was likely introduced with the colonic tissue [9]. Even double mastectomy has an unacceptable risk profile for an elective surgery where the aim is purely for an aesthetic outcome. One published case study details the outcome for a regretful Australian patient who had a double mastectomy at 20 years old: "The surgical outcome was not what was expected. There was extensive hypertrophic scarring, particularly around and under the nipple grafts, which were painful and itchy to the extent that wearing clothing was uncomfortable. s22

The subject also details that her transgender friends also discouraged her from speaking about this because "you are making trans surgery look bad." This emphasises the ideological hold which is preventing proper analysis of outcomes.
3. Long term loss of bodily function and health. Published work generally only details immediate surgical complications, and not the long-term health consequences for patients. We frequently only hear of these through online accounts of those who have undergone the procedures. Chronic urinary tract infections, incontinence, and other urinary problems appear to be common long-term consequences of genital surgery. One detransitioner who has undergone vaginoplasty has written about the outcome – s22

. It is beyond the scope of what we can cover here, but of course there are also multiple long term and poorly understood health consequences of cross-sex hormones, for example on cardiovascular health, vaginal and uterine atrophy, etc.
4. Loss of fertility. This is evident for those undergoing surgeries removing gonads, but potentially also a result of long-term hormonal treatment.
5. Loss of ability to breast feed. The regret of many detransitioners at loss of ability to breastfeed is frequently noted in their public statements, and has been published for the Australian detransitioner mentioned above - "It was really hard knowing that he wanted to breastfeed, and I couldn't give him that....And when they put him on my stomach, he crawled up, he was looking for my breasts....he spent so much time in his early life trying to fine my breasts." [10].

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6. Loss of sexual function. Internet chat rooms for transgender individuals reveal many concerns of former patients about sexual function. A well-known detransitioner several years post-vaginoplasty has written on Twitter: s22

]. The problem of narrow and shallow neo vagina is frequently commented on – this new orifice is permanently trying to heal, and has to be maintained by frequent, sometimes daily painful "dilation" sessions. Even with these efforts, depth and width are not always maintained. Outcomes for sensation are also unreliable. For females, vaginal atrophy from testosterone use is a substantial problem in maintaining sexual activity [12].

7. Difficulty forming relationships. A mature and thoughtful transsexual, , who recognises that her transition 30 years ago was a response to internalised homophobia, has written eloquently about the difficulty in finding a life partner: s22

8. Lack of mental health benefit. Although it is an oft-repeated mantra that these treatments are "life-saving", there is no good quality evidence for that, and the problems in the literature are detailed in section 12. A recent study on the Danish population of more than 6 million shows that suicide attempts and mortality remain high in adult transgender populations [14]. Preliminary data from Finland reported at a conference showed that gender reassignment treatment did not affect the need for ongoing psychiatric treatment [15]. There is no good quality research to indicate that surgical treatments improve mental health outcomes or lessen the risk of suicide. One study noted "the level of life satisfaction in transgender people was not increased in transgender who had undergone gender-affirming surgery as compared to those who were unoperated. A possible explanation may be that gender-affirming surgery – similar to other critical life events—only had a short-term effect on life satisfaction and bounces back to the initial set point of life satisfaction after some years." [16]

9. Impact on family. Our organisation fields daily enquiries from confused and grieving families. Many are torn apart by this issue. The majority are parents of children or young adults in the new adolescent-onset group. They can detail the multiple psychiatric co-morbidities or traumas that have led to this identification, and the majority say there was no early life gender non-conformity. This contradicts the idea presented in this application that this clinical diagnosis of gender incongruence is somehow "innate". Parents universally acknowledge the impact of online material and social media. They are frequently manipulated by clinicians who tell them that their child is likely to commit suicide if they do not medically transition gender. Families are highly distraught at seeing their children undertake medical treatment that they believe will cause long-term harm, with the mental health toll on parents continuing for many years.

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4. Cohn, 2023. The detransition rate is unknown. Arch Sex Behav. 52:1937-1952 https://doi.org/10.1007/s10508-023-02623-5

5. Roberts et al, 2022. Continuation of gender-affirming hormones among transgender adolescents and adults. J Clin Endocrinol Metab. 107:e3937-e3943. https://doi.org/10.1007/s10508-023-02623-5

6. Morrison 2016 Phalloplasty: A Review of Techniques and Outcomes. Plast Reconstr Surg. 2016 138(3):594-615. doi: 10.1097/PRS.0000000000002518.

7. Cutruzzula Dreher, 2017. Complications of the neovagina in male-to-female transgender surgery: A systematic review and meta-analysis with discussion of management. Clinical Anatomy 31:191-199. https://onlinelibrary.wiley.com/doi/abs/10.1002/ca.23001t.

8. Potter, 2023. Patient reported symptoms and adverse outcomes seen in Canada's first vaginoplasty postoperative care clinic. Neurourol Urodyn 42:523-529. doi: 10.1002/nau.25132.

9. Negenborn, 2017. Lethal necrotizing cellulitis caused by ESBL-producing E. coli after latharoscopic intestinal vaginoplasty. J Pediatr Adolesc Gynecol 30:e19-e21. https://doi.org/10.1016/j.jpag.2016.09.005

10. Gribble et al, 2023. Breastfeeding grief after chest masuculinisation mastectomy and detransition: A case report with lessons about unanticipated harm. Front Global Women's Health 4:1073053. Doi: 10.3389/fgwh.2023.1073053.

s22

14. Erlangsen, 2023 Transgender identity and suicide attempts and mortality in Denmark. JAMA 329:2145-2153. https://doi.org/10.1001/jama.2023.8627

15. https://benryan.substack.com/p/youth-gender-transition-treatment

16. Grupp, 2023 Are transgender people satisfied with their lives? BMC Public Health 23:1002. DOIhttps://doi.org/10.1186/s12889-023-15831-4

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7. What other benefits can you see from having this intervention publicly funded?

None. The funding of these interventions would amount to public funding for elective cosmetic surgery, given that the sole requirement is the very loose diagnosis of gender incongruence. These treatments are not medically necessary, and there is no requirement for a psychiatric assessment under this application. The surgeries are likely to lead to long term health consequences. Public funding for these procedures cannot be justified on medical or economic grounds.

8. What other services do you believe need to be delivered before or after this intervention, e.g. Dietician, Pathology etc?

People presenting with gender incongruence require appropriate long-term psychological therapy that takes a neutral rather than affirmative approach, before any medical intervention is contemplated. Common underlying co-morbidities and potential reasons for the feeling of gender incongruence should be explored, such as internalised homophobia, autism, ADHD, obsessive compulsive disorder, early-life bullying, sexual assault and other trauma, family relationship breakdowns. There should also be a requirement for an extensive period of social transition of several years duration, before any medical treatment.

PART 3 – INDICATION(S) FOR THE PROPOSED MEDICAL SERVICE AND CLINICAL CLAIM

9. Do you agree or disagree with the proposed population(s) for the proposed medical service?

☐ Strongly Agree
☐ Agree
☐ Disagree
☒ Strongly Disagree

Specify why or why not:

The proposed population is "individuals experiencing gender incongruence and electing to pursue medical interventions as part of their gender affirmation process" with the diagnosis being according to the WHO ICD-11 HA60 for Gender Incongruence of Adolescence and

Adulthood. There is very poor justification given for this population to be offered Medicare-listed treatments, as detailed below.

1. Lack of any meaningful diagnostic criteria. The diagnosis according to the WHO ICD-11 HA60 relies on just "marked and persistent incongruence between an individual´s experienced gender and the assigned sex". So, all that is relied upon is the patient's assertion of their feelings, and adherence to gender stereotypes that are to a great extent socially constructed. The application suggests that "the length of time of what constitutes 'persistent' gender incongruence is self-determined by the patient." (page 4), and thus the clinician seems to have little role in the diagnosis. Furthermore, the diagnosis of gender incongruence relies heavily on the patient's belief in rigid gender stereotypes. A patient will only sense a mind-body mismatch if they have restrictive ideas about the behaviour of each sex. A liberating broadening of outlook, rather than changing the body would seem to be a healthier option.

2. Unprecedented rise in numbers of adolescents and young people identifying as "gender incongruent". In the past decade there have been rapidly escalating numbers of children and young people with gender associated distress across the western world [17]. This is also documented in Australia; although there are no figures available for the increase in adult presentations, children's gender clinics have recorded a dramatic increase in some states [18] (Figure 1). Early figures from the Royal Children's Hospital in Melbourne showed that new cases referred for gender issues were 0-2 per year prior to 2009, followed by 8 in 2011 and relentlessly increasing since then to more than 1000 in 2022 [18,19]. Transgender support groups assert that this increase reflects increased acceptance of transgenderism, and hence people being more comfortable to now "come out". If, as suggested, this gender incongruence is "innate" we would expect to see similar proportions emerging in all age groups, but there is no evidence for a similar rate of increase for those over 30. Anecdotally, what we instead see is a lot of middle-aged women saying that they are glad this phenomenon did not exist when they were young, because as teenagers they would have readily opted out of womanhood and done permanent damage to their bodies and fertility. The increase is driven by teens and early twenties, predominantly female, who are the cohort historically most susceptible to social contagion. However, there are many factors that are likely contributing.

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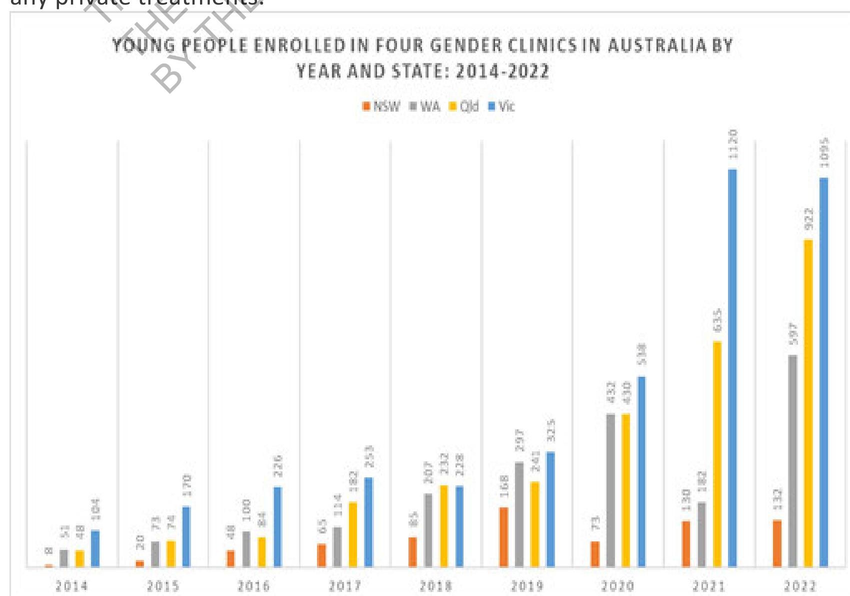
Figure 1. Australian figures for new enrolments each year at the major children's gender clinic in each state [18]. This is based on data provided by the gender clinics under GIPPA (formerly FOI). Note that the figures do not include Maple Leaf House in Newcastle (NSW) or any private treatments.



3. Comorbidities and alternative explanations for presentation. Those presenting with gender incongruence have a high rate of mental health co-morbidities or other features of their background that may explain the presentation, rather than it being "innate". High rates of autism, ADHD and other conditions such as obsessive compulsive disorder are seen in presenting individuals. As a result of neurodivergent features, the patients frequently feel like outsiders and seek an explanation for why they feel different. There are high rates of self-harm, eating disorders, experiences of trauma such as sexual assault, family breakdown, and disproportionate numbers of children in out-of-home care. The latter point alone indicates that gender incongruence can be trauma-related rather than innate. Many patients are same-sex attracted, and failing to accept that. Consequently, gender transition for these people can be viewed as regressive conversion therapy.

4. Increasing numbers of detransitioners and legal action against clinicians. As noted in section 6, the true rate of regret and detransition is not known. What is clear is that transgender activists viciously attack public detransitioners, and thus few are prepared to speak openly. However, there are more than 50,000 members of the online detransitioner support group on Reddit, r/detrans. These people document a myriad of health complaints that they attribute to hormones and/or surgery, apart from their distress at their altered appearance. Our experience shows that regret often takes 7-10 years, and numbers entering clinics are still increasing; hence, we can expect the needs of detransitioners to be an escalating concern. There is mounting anger amongst detransitioners about the medical treatment that was promoted to them as the best option to resolve their distress. There are increasing numbers of legal cases being mounted for medical malpractice. We have documented 16 ongoing court cases, with three new cases in the US emerging in the past week. There is at least one legal case mounted in Australia, by a young woman who was rushed through hormone treatment, mastectomy and hysterectomy. [20]

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5. Poor justification for treatment. WHO has redefined gender identity related health issues in the ICD-11, moving them from the "mental and behavioural disorders" chapter to the "conditions related to sexual health". There has been a concerted move to destigmatise and depathologise the condition, arising not from improved medical understanding, but as the result of intense lobbying by transgender activists. And this continues, as groups still consider the term "gender incongruence" to be pathologizing [21]. Distress associated with the condition is not a requirement for treatment under this proposal. It should then be asked, if this is not a pathology and there is no need for distress, what is the purpose of the radical surgical procedures, and how are they medically justified? The application notes that "The medical interventions accessed will depend on a person's personal choice as to which medical affirmation intervention(s) are right for them." This further emphasises that these are considered elective cosmetic surgeries, performed at the whim of the patient. Medical treatments should be recommended by clinicians following to a process of careful assessment and diagnosis and according to the medical evidence, not just selected by patients.

6. There are no restrictions sought. The application states that individuals diagnosed as above would be eligible for the medical interventions, with no restrictions requested. There is therefore no consideration of the person's mental health status at the time that they seek radical surgery. It is well acknowledged that the population with gender incongruence has a high burden of mental health co-morbidities, and it is inconceivable that this is not taken into account when considering suitability for surgery. Under these conditions, there will be a large burden of patients regretting surgery.

7. No good quality evidence for improvement in mental health
The application asserts that "gender affirming" medical interventions have been reported as reducing rates of psychological distress, suicide ideation and suicide attempts. The cited reference [22] is based on a low quality online survey. This survey was restricted to those over 18 who identified as transgender, but had an unusual number of people claiming to be

18, suggesting the participation of many children. The ideological nature of this issue makes online surveys the least reliable source of data. In addition, people who have detransitioned or desisted would not have taken the survey. Similar problems of low quality data beset most of the research literature claiming benefit for gender interventions. **No studies have examined whether mastectomies, vaginoplasties or phalloplasties are superior to psychological suicide prevention support.**

8. Current effects of loose diagnostic criteria. Most Australians would expect that since medical gender transition is a very serious, invasive, and potentially medically damaging procedure, it would only be undertaken by individuals who are truly tormented by a perceived mismatch between body and mind, and for whom all other approaches have failed. The truth of medical practice in this field currently in Australia is far from that. In practice, for both child and adult gender-related medicine, diagnosis is predominantly patient-led. As long as an "appropriate" practitioner is selected, treatment is solely dependent on what outcome the patient desires. For adults, hormones are freely available from particular GP clinics under "informed consent" with no requirement for psychological or psychiatric involvement. This generally involves two appointments; one where the patient is interviewed on their health status and desired treatment, and a blood test taken for baseline hormone levels, and a second appointment for prescription. Perusing online chat support groups shows that this is commonplace in Australia, with people seeking advice on where to get hormones or surgery with minimal "gatekeeping". Similarly, in this application, diagnosis of gender incongruence is proposed to be by a general practitioner with no requirement for distress. This is a very low bar for permanent, life-altering and radical surgery that is not medically necessary.

17. Kaltiala, R (2020). Time trends in referrals to child and adolescent gender identity services: A study in four Nordic countries and in the UK. Nordic Journal of Psychiatry, 74(1), 40–44. https://doi.org/10.1080/08039488.2019.1667429

18. Kenny, D.T. (2022) Number of children enrolled, receiving puberty blockade and cross sex hormones in five gender clinics in Australia, 2014-2021. https://diannakenny.com.au/number-of-children-enrolled-receiving-puberty-blockade-and-cross-sex-hormones-in-five-gender-clinics-in-australia-2014-2021/ Additional data for 2022 obtained by personal communication with D. Kenny.

19. Tomazin, 2020. Staying on her feet: how Michelle Telfer won the gender clinic battle. The Sydney Morning Herald. 2020-04-18 https://www.smh.com.au/lifestyle/health-and-wellness/staying-on-her-feet-how-michelle-telfer-won-gender-clinic-battle-20200416-p54kjf.html

20. Szego, 2022. 'Absolutely devastating': woman sues psychiatrist over gender transition. Sydney Morning Herald. 2022-08-24 https://www.smh.com.au/national/absolutely-devastating-woman-sues-psychiatrist-over-gender-transition-20220823-p5bbyr.html

21. https://tgeu.org/icd-11-depathologizes-trans-and-gender-diverse-identities/

22. Almazan, 2021. Association between gender-affirming surgery and mental health outcomes. JAMA Surgery 156:611-618.

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10. Have all the associated interventions been adequately captured in the application summary?

☐ Yes

☒ No

Please explain:

Need for reversal surgeries. If these surgeries are permitted then there will be an increasing burden of people with regret, who want the surgeries reversed. These people would not be able to receive any support under this plan, as they will not be then diagnosed with gender incongruence. There will be males wanting breast implants removed and females wanting breast reconstructive surgery. In the more challenging situation of regret of genital reassignment surgery by male patients, one paper reports performing reconstructive surgery for seven patients, using a three step procedure: "removal of female genitalia with

scrotoplasty and urethral lengthening, total phalloplasty with microvascular transfer of a musculocutaneous latissimus dorsi flap, and neophallus urethroplasty with penile prosthesis implantation." [23]. If the medical system is going to create problems, it should take responsibility for repairing the damage.

Patients who regret the surgeries proposed in this application will have suffered iatrogenic harm, and should be supported and compensated

23. Djordjevic et al. 2016 Reversal surgery in regretful male-to-female transsexuals after sex reassignment surgery. J Sex Med 13:1000-1007.

11. Do you agree or disagree that the comparator(s) to the proposed medical service?

☐ Strongly Agree
☐ Agree
☐ Disagree
☒ Strongly Disagree

Please explain:

This application does not consider the alternative approach of psychological therapy to explore the reasons behind gender incongruence and to help the person become comfortable in their own body. This is a much healthier and less damaging approach in the long term, and requires us to question the application's unsubstantiated claim that the gender incongruence as currently (but not previously) experienced in large numbers of adolescents is "innate".

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12. Do you agree or disagree with the clinical claim made for the proposed medical service?

☐ Strongly Agree
☐ Agree
☐ Disagree
☒ Strongly Disagree

Specify why or why not:

The claim is made that the health outcomes under this application will be non-inferior to doing the same procedures without specific Medicare item numbers. This is a trivial and meaningless comparison, due to use of the wrong comparator. It would be more appropriate to ask whether health outcomes would be better than (i) doing no treatment, or (ii) providing appropriate psychological therapy. There is no research, that makes these necessary comparisons.

There is a large discrepancy between published claims of benefits for these surgeries and the reality for those receiving them. The contact that our organisation has with those who regret their surgical treatments, as well as the online chat groups, tell a quite different story from the clinical literature. The medical literature in this field is failing to accurately report outcomes, or do the necessary comparisons, due to the following issues:
1. Bias and conflict of interest. The majority of clinicians publishing on these treatments are those providing the treatments. It is inappropriate that the only published records are from those making money from the treatments. This clear conflict of interest is generally unacknowledged. There is a heavy bias towards presenting the outcomes of their work in the best light. Researchers who are not connected with the treatment, and are therefore less likely to be biased, cannot readily access this patient group.
2. Inadequate length of follow-up. Many studies are only reporting short-term outcomes. Our experience is that regret often takes 7-10 years.

3. Loss to follow-up. Published studies frequently have 30-40% loss to follow-up. These may include cases of regret and detransition, those who wish to have no further contact with gender services, as well as suicide.

4. Limited studies on the new cohort of adolescent-onset gender dysphoria. Many of the studies are still reporting on an earlier cohort of people seeking gender transition – often those who were mature men at the time of transition. In addition, when this process was much less common, patients went through much more extensive psychiatric assessment. The rates of regret for these patients of previous years will not be relevant now to the large numbers of adolescents who seek gender treatments with minimal psychological or psychiatric assessment.

5. Asking the wrong questions. Patients may be asked if they regret the treatment. These treatments, that may include loss of genitals or breasts, are drastic interventions. Admitting regret for this may be very hard to do, and patients may find that they have to really convince themselves that everything is OK, in order to maintain stability. Asking more nuanced questions may elicit more revealing answers. In many published studies, patient interviews are not done, and the assessment purely relies on medical records, and whether regret or attempts to reverse the surgery were recorded in the patient's clinical file. These are not stringent assessments.

A number of recent papers have addressed the lack of good quality of evidence supporting both child and youth gender transition [24-28].

This is a highly politicised area of medical practice. It is essential that a truly independent review of evidence is done before any decision is taken to include the proposed treatments as part of the MBS. There are vested interests who stand to profit, including plastic surgeons, and also a strong ideological push for these treatments from activists, some of whom are clinicians. These interests should not be allowed to dominate, and a fair assessment of the clinical evidence must be completed.

24. Abbruzzese, 2023. The myth of "reliable research" in pediatric gender medicine: A critical evaluation of the Dutch studies and research that has followed. J Sex Marital Ther 49: 673-699. Doi: 10.1080/0092623X.2022.2150346

25. Clayton, 2022. The gender affirmative treatment model for youth with gender dysphoria: A medical advance or dangerous medicine? Arch Sex Behav 51: 691-698. Doi: 10.1080/0092623X.2022.2150346

26. Levine, 2023. Current concerns about gender-affirming therapy in adolescents. Curr Sex Health Rep 15: 113-123. Doi: 10.1080/0092623X.2022.2150346

27. Levine, 2022. Reconsidering informed consent for trans-identified children, adolescents and young adults. J Sex Marital Ther 48:706-727. Doi: 10.1080/0092623X.2022.2046221

28. Biggs, 2023 The Dutch protocol for juvenile transsexuals: origins and evidence. J Sex Marital Ther 49: 348-368. Doi: 10.1080/0092623X.2022.2150346

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PART 4 – COST INFORMATION FOR THE PROPOSED MEDICAL SERVICE

13. **Do you agree with the proposed service descriptor?**

☐ Strongly Agree
☐ Agree
☐ Disagree
☒ Strongly Disagree

Specify why or why not:

The suggested surgeries should not be listed on the MBS.
The application makes clear that the proposed surgical treatments are elective cosmetic surgeries as they seek to achieve a patient-defined aesthetic outcome, lack adequate evidence for improvement of patient health, and on the contrary will always worsen physical health by destroying healthy and functional breasts or genitals.

14. **Do you agree with the proposed service fee?**

☐ Strongly Agree
☐ Agree
☐ Disagree
☒ Strongly Disagree

Specify why or why not:

The procedures should be classified as cosmetic and not attract a medicare service fee.
The application makes clear that the proposed surgical treatments are elective cosmetic surgeries as they seek to achieve a patient-defined aesthetic outcome, lack adequate evidence for improvement of patient health, and on the contrary will always worsen physical health by destroying healthy and functional breasts or genitals.

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PART 5 – ADDITIONAL COMMENTS

15. Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed medical service?

The proposed interventions risk long-term health complications that affect not only the individual but also Australia's health budget.

16. Do you have any comments on this feedback survey? Please provide comments or suggestions on how this process could be improved.

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Again, thank you for taking the time to provide valuable feedback.

Australian Government

Department of Health

Consultation Survey on MSAC Application 1754

Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence

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MSAC welcomes input on MSAC applications for public funding from individuals, organisations representing health professionals or consumers and/or carers, and from other stakeholders. Please use this template to prepare your input. You may also attach additional information if you consider it may be useful in informing MSAC and its sub-committees.

Sharing consultation input

Submitted consultation input will be routinely shared with the applicant and with MSAC and its sub-committees.

- The applicant will receive a summary of comments from individuals, with the individual's name and other identifying information removed.
- MSAC and its sub-committees will receive both the summary and copies of the comments, with the name of the individual and other identifying information removed.
- Consultation input from groups or organisations will be provided in a complete form to both the applicant and to MSAC and its sub-committees.

Consultation input may also be shared with HTA Assessment Groups from time to time to inform their reports to MSAC or with state and territory health representatives where the application is for a service to be delivered through public hospitals. Please do not include information in your input that you do not want shared as outlined above. In addition, to protect privacy, do not include identifying personal (e.g., name) or sensitive (e.g., medical history) information about third parties, such as medical professionals or friends/relatives.

How consultation input is used

MSAC and its sub-committees consider consultation input when appraising an application, including to better understand the potential impact of the proposed medical technology/service on consumers, carers, and health professionals. A summary of consultation input will be included in the Public Summary Document (PSD) published on the MSAC website once MSAC has completed its appraisal. The PSD may also cite input from groups/organisations, including the name of the organisation. As such, organisations should not include information or opinions in their consultation input that they would not wish to see in the public domain.

For further information on the MSAC consultation process please refer to the MSAC Website or contact the Consumer Evidence and Engagement Unit on email: commentsMSAC@health.gov.au.
Thank you for taking the time to provide consultation input. Please return your completed survey to:

Email: commentsMSAC@health.gov.au

Mail: MSAC Secretariat,
MDP 960, GPO Box 9848,
ACT 2601.

PART 1 – PERSONAL AND ORGANISATIONAL INFORMATION

1. Respondent details

Name: Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Email: Advocacy@ranzcog.edu.au

Phone No: [redacted]

2. Is the feedback being provided on an individual basis or by a collective group?

☐ Individual
☒ Collective Group

If an individual, specify the name of the organisation you work for

If a collective group, specify the name of the group

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

3. How would you best identify yourself?

☐ General Practitioner
☒ Specialist
☐ Researcher
☐ Consumer
☐ Care giver
☐ Other

If other, please specify

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PART 2 – CLINICAL NEED AND PUBLIC HEALTH SIGNIFICANCE

4. Describe your experience with the medical condition (disease) and/or proposed intervention and/or service relating to the application summary.

RANZCOG members are involved in the care of people who are non-binary, gender diverse or transgendered in both public and private settings. This cohort of patients seek care from RANZCOG members for a range of concerns including abnormal uterine bleeding due to testosterone administration, abnormal uterine bleeding, complications that have arisen from previous surgery (often completed overseas) or persistent pelvic pain. Our members are also consulted for guidance or requests related to tubal ligation, tube removal, or hysterectomy.

For adults in the public system, our members report less interaction with a hospital multidisciplinary team, and a strong patient reliance on a supportive GP, mental health practitioner and endocrinologist. In many cases, this cohort has been living in their trans body for many years. In instances of chronic pelvic pain, abnormal bleeding, or for the transwomen, problems with dyspareunia, clinicians provide care similar to that provided to cis-women.
To comply with international SoC/guidelines and ensure appropriate care for patients requesting a hysterectomy, practitioners are required to ensure an adequate mental health assessment has been performed. Practitioners must seek two letters from clinicians who have known the patient and support their decisions regarding a hysterectomy. At present, a hysterectomy is funded under the Medicare system.

For younger patients in the public setting such as in a gynaecology outpatient clinic, our members consult as part of a multidisciplinary team in paediatric hospitals.
In the private setting, younger patients on occasion present to our members whilst waiting to be seen by a gender service. Many are distressed by their menses and require care and support.

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5. What do you see as the benefit(s) of the proposed medical service, in particular for the person involved and/or their family and carers?

The application outlines the importance of a multidisciplinary care team for those experiencing gender incongruence, but RANZCOG believes that this type of support is critical for all complex presentations, not just those with gender incongruence. In many cases the surgical requirement for this cohort is no more complex than those surrounding cis-women. Whilst RANZCOG do not support the creation of specialised MBS items, the College does support the extension of current MBS items to compensate for the 'complexities' and counselling involved in genealogical consultations and surgery. RANZCOG advocate for this code must be made available for use with all complex presentations not just those involving gender incongruence.

Complex patients presenting with multiple health problems, such as intellectual disabilities, epilepsy, abnormal uterine bleeding or chronic pelvic pain need to have equal access to MBS items, such as item 133. At present gynaecologists are severely underfunded, receiving effectively half of that a physician would when consulting with a patient with complex comorbidities.

RANZCOG believes that all people deserve equal access to publicly funded care. The College cautions against the creation of a specialised code to be made available only to those experiencing gender incongruence. The equivalent funding needs to be made available for intersex and cis-women living with complex gynaecological presentations.

It is important to acknowledge that in Melbourne the reported out of pocket cost for a patient electing to have top surgery is $10,000. Whilst the care provided is first-rate, the cost is out of reach for many.
It must be noted that for those seeking interventions such as a hysterectomy, public Medicare funding is available with no indication for surgery required, however waiting lists impede access for many.

6. **What do you see as the disadvantage(s) of the proposed medical service, in particular for the person involved and/or their family and carers?**

The College does not recommend establishing a specialised code for gender affirmation surgery given there is already a reluctance to provide this service in the public setting. If the public hospitals are unable or unwilling to provide publicly funded gender affirmation surgery, this code may only have the effect of slightly reducing the costs associated with private surgery.

Those experiencing gender incongruence should not be singled out. Many interventions for this cohort are straightforward and do not warrant a specialised code that attracts a higher rebate. Instead, a higher rebate would be far more impactful if made available to all complex, multifaceted patient presentations.

As stated above, RANZCOG advocate for equity of access for all. A patient requesting a hysterectomy who is experiencing abnormal bleeding and pain should be treated and funded equally regardless of their gender. The healthcare system would benefit far more from an equitable approach.

7. **What other benefits can you see from having this intervention publicly funded?**

RANZCOG see little benefit in isolating a specific cohort and restricting funding from those who need it. All complex patients deserve to be funded equally regardless of their gender.

Currently, most operations related to gender affirmation are carried out in the private health setting. Whilst it is possible for public hospitals to provide these types of gender affirmation services, there may not be a substantial interest in doing so.

RANZCOG caution that even if public funding is made available, whilst it may have a positive effect on availability of services, it would be at the discretion of each public hospital to determine their capacity to provide the service.

8. **What other services do you believe need to be delivered before or after this intervention, e.g. Dietician, Pathology etc?**

RANZCOG support the idea of continuity of care following gender affirming surgery in the public system. The College suggest the inclusion of funding for a single nurse to provide consistence care following surgery of this type if a specific MBS item is to be created.

Additionally, the College advocates for funding that allows a comprehensive model of care. Complex, multifaceted presentations may require funding for physiotherapy, psychologists, dieticians or exercise physiologists. However, these services should be funded for all patients not just those experiencing gender incongruence.

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PART 3 – INDICATION(S) FOR THE PROPOSED MEDICAL SERVICE AND CLINICAL CLAIM

9. **Do you agree or disagree with the proposed population(s) for the proposed medical service?**

☒Strongly Agree
☐Agree
☐Disagree
☒Strongly Disagree

Specify why or why not:

The College strongly advocate for equitable funding models for all people, not just those experience gender incongruence. RANZCOG acknowledge that there are many individuals who need access to comprehensive care and that the trans population represent only one such group. The MBS should support equitable access for all people, not just a select group.

However, RANZCOG recognise that the unaffordable costs associated with private gender affirming surgery leads many to seek care overseas. The risks of having surgery in countries with lower health care standards increases the risk of post operative complications for this cohort.

10. Have all the associated interventions been adequately captured in the application summary?

☒ Yes
☐ No

Please explain:

RANZCOG has no additional feedback.

11. Do you agree or disagree that the comparator(s) to the proposed medical service?

☐Strongly Agree
☒Agree
☐Disagree
☐Strongly Disagree

Please explain:

RANZCOG has no additional feedback.

12. Do you agree or disagree with the clinical claim made for the proposed medical service?

☐Strongly Agree
☒Agree
☐Disagree
☐Strongly Disagree

Specify why or why not:

The provision of a specific MBS item number may improve access to surgical treatment of a medical disorder, however this will only support one cohort, leaving many underserved.

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PART 4 – COST INFORMATION FOR THE PROPOSED MEDICAL SERVICE

13. **Do you agree with the proposed service descriptor?**

☐Strongly Agree
☐Agree
☐Disagree
☐Strongly Disagree

Specify why or why not:

14. **Do you agree with the proposed service fee?**

☐Strongly Agree
☐Agree
☐Disagree
☐Strongly Disagree

Specify why or why not:

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PART 5 – ADDITIONAL COMMENTS

15. Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed medical service?

16. Do you have any comments on this feedback survey? Please provide comments or suggestions on how this process could be improved.

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Again, thank you for taking the time to provide valuable feedback.