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14 March 2022

s 9(2)(a)

By email: s 9(2)(a)
Ref: H202117552

Tēnā koe s 9(2)(a)

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to the Ministry of Health (the Ministry) on 13 December 2021 for:

> *"All briefings, aide-memoires and Cabinet papers specifically on funding for transgender gender affirming surgery since 26 October 2017"*

Seven documents have been found within scope of your request. Information within scope of this request is itemised in Appendix 1 of this letter and copies of the documents are enclosed. The table in Appendix 1 also outlines the grounds under which I have decided to withhold information. Where information is withheld, this is noted in the document itself. I have considered the countervailing public interest in release in making this decision and consider that it does not outweigh the need to withhold at this time.

More information on gender affirming surgery and monthly updates is available on the Ministry's website: www.health.govt.nz/our-work/preventative-health-wellness/delivering-health-services-transgender-people.

I trust this information fulfils your request. Under section 28(3) of the Act you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Ministry website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

PP

Robyn Shearer
Deputy Chief Executive
Sector Support and Infrastructure

Appendix 1: Documents for release

#	Date	Title	Decision on release
1	13 November 2018	Health Report: Options to increase publicly funded gender affirmation surgery and improve gender affirming care	Released with some information withheld under section 9(2)(a) of the Act to protect the privacy of natural persons.
2	29 October 2019	Health Report: Establishing a Gender Affirming Surgery Service	
3	22 May 2019	Health Report: Implementing changes to improve access to gender affirming services	
4	1 October 2021	Aide-Memoire: Meeting with PATHA and Gender Minorities Aotearoa to discuss the transgender health work programme	Released with some information withheld under section 9(2)(a) of the Act to protect the privacy of natural persons and section 9(2)(f)(iv) of the Act to protect the confidentiality of advice tendered by Ministers of the Crown and officials.
5	30 November 2021	Information to support Hon Dr Verrall at the 'International Day Against Homophobia, Biophobia, Interphobia and Transphobia' meeting	Released with some information withheld under section 9(2)(f)(iv) of the Act to protect the confidentiality of advice tendered by Ministers of the Crown and officials.
6	4 March 2021	Briefing: Further advice on meeting the health needs of the transgender community	Released with some information withheld under section 9(2)(f)(iv) of the Act to protect the confidentiality of advice tendered by Ministers of the Crown and officials.
7	3 February 2021	Briefing: Improving the health system's responsiveness to transgender, non-binary and intersex people	Released with some information deemed out of scope and some information withheld under section 9(2)(a) of the Act to protect the privacy of natural persons and section 9(2)(f)(iv) of the Act to protect the confidentiality of advice tendered by Ministers of the Crown and officials.

MINISTRY OF HEALTH
MANATŪ HAUORA

Security classification: In-Confidence

Health Report: Options to increase publicly-funded gender affirmation surgery and improve gender affirming care

Date:	13 November 2018	Report No:	20182249
		File Number:	~~AD62-14-2018~~

Action Sought

	Action Sought	Deadline
Minister Clark	Note	
Minister Genter	Note	Routine

Contact for Telephone Discussion (if required)

Name	Position	Telephone	Contact Order
Caroline Flora	GM Population Outcomes	S9(2)(a)	**1st Contact**
Dr Andrew Simpson	Chief Medical Officer		**2nd Contact**

Actions for the Minister's Office Staff

This report contains recommendations.

Note any feedback on the quality of the report	

Health Report number: 20182309

Security classification: In-Confidence

File number: AD62-14-2018
Action required by: Routine

Options to increase publicly-funded gender affirmation surgery and improve gender affirming care

To: Hon Julie Anne Genter, Associate Minister of Health

Copy to: Hon Dr David Clark, Minister of Health

Purpose

This briefing describes options for the future coordination and delivery of publicly-funded gender affirming genital reconstruction surgery (gender affirmation surgery). It builds on initial advice provided in May 2018 [HR 20180924 refers], and proposes further work to improve gender affirming care pathways.

Key points

- Currently 114 New Zealanders (8 of whom have had an updated surgical assessment) are on the waiting list for gender affirmation surgery. At current rates, and not allowing for new additions, it could take over 50 years to clear the wait list.
- This briefing explores opportunities to improve the delivery of gender affirming care, including options to increase the numbers of publicly-funded gender affirming surgeries and initiatives to support the development of capability in the health sector.
- It is proposed that coordination of the service transfers to a DHB, to support a more efficient and integrated approach to gender affirmation surgery.
- It is recommended that enhancements to service delivery are phased, starting with a contracting arrangement with a private provider in the short term, before shifting to public coordination (and possibly provision), potentially from June 2020.
- In addition to changes to gender affirmation surgery, the Ministry will progress work with the sector and community on care guidelines and a package of care (i.e what other gender affirming surgeries could be provided), access criteria and care pathways. This will build on the good work that has already been done in the sector to progress work on transgender health care guidelines.
- As part of work to improve care pathways, we propose that navigator roles are established to support people as they access gender affirming care.
- To enable the implementation of this proposed approach, there is a budget bid on the long list for Budget 2019.

Contacts:	Caroline Flora, Group Manager Population Outcomes, System Strategy & Policy	S9(2)(a)
	Dr Andrew Simpson, Chief Medical Officer	

Recommendations

The Ministry recommends that you:

a) **Note** that minor improvements to gender affirming care can be done without new funding, however a different or larger service offering requires new investment.

b) **Note** the Ministry recommends a phased implementation of enhanced care, including the establishment of a DHB run service from July 2020, with increased service volumes from July 2019.

c) **Note** the Ministry has entered a budget item in the long list for Budget 2019 that includes increased surgery volumes, coordination, navigation and capability components.

d) **Note** that the Ministry can develop policy options for a broader package of care that encompasses other surgeries, including chest augmentation, mastectomies and hair removal.

e) **Agree** to meet with us to discuss your preferred approach. **Yes/~~No~~**

Caroline Flora
Group Manager-
Population Outcomes

Minister's signature:

Date: 13 Dec 2018

Health Report number: 20182309

Options to increase publicly-funded gender affirmation surgery and improve gender affirming care

1. The current provision of gender affirming surgery and care pathways is not keeping up with demand, or the needs of transgender and non-binary New Zealanders[1].

2. The experience of people in accessing gender affirming care varies considerably, depending on the capability of the health professionals and the region they live in. Transgender and non-binary New Zealanders regularly experience discrimination and barriers to care, as well as services that are not able to meet their needs. At worst, there are accounts of discriminatory practice, where people feel powerless to seek help.

3. A key concern is size of the current waiting list for gender affirmation surgery that is funded through the High Cost Treatment Pool (HCTP). Following the Health Report in May 2018 [HR 20180924 refers], the decision was made to change the 2004 commitment of three feminising surgeries (male to female), and one masculinising surgery (female to male) every two years to a minimum commitment. However, the number of surgeries offered over and above the three and one minimum is necessarily limited by available funding.

4. You have asked for advice on options to improve the delivery and coordination of gender affirmation surgery in New Zealand, including the development and implementation of care pathways.

Update on progress

5. Since May 2018, eight people have been referred to a private surgeon in Auckland for assessment for gender affirming surgery. Also since May 2018, eight additional people have been referred to the waiting list, meaning that the waiting list continues to grow.

6. The Ministry has had discussions with key sector stakeholders and members of the transgender and non-binary community to inform advice on changes to the provision of surgery. There was strong support for changes, noting that there is a considerable increase in demand for gender affirming care. See Appendix 2 for more information on the outcomes of the initial engagement with stakeholders.

7. From the discussions we have had, and work undertaken by the community and the health sector, it is clear that there is a strong interest in improving gender affirming care pathways and guidelines.

Current demand for surgery

8. We are expecting that there will be an increase in demand for surgery. Early indications from *Counting Ourselves* (the Aotearoa New Zealand transgender and non-binary health survey) indicate that at least a quarter of respondents (at least 300 people) are interested in gender affirming genital surgery. Interest in 'top' surgeries, such as chest reconstruction, facial feminisation and breast augmentation is higher still.[2] These estimates are supported by evidence from transgender people accessing endocrine services in Wellington, with 2 people accessing care in 1990, growing to 92 people in 2016. This demand is considerably higher than the level seen in the current gender affirming genital surgery waiting list.

9. There is also expected to be a change in the ratio between the demand for feminising and masculinising gender affirming care, with genital surgery currently publicly-funded at a rate of three feminising surgeries to one masculinising surgery. Early indications from *Counting Ourselves*, and

[1] Transgender and non-binary are being used as umbrella terms, recognising that transgender people may describe themselves in many ways including the use of indigenous terms such as; whakawāhine, tangata ira tāne, tāhine (Māori), māhū (Hawai'i and Tahiti), vakasalewalewa (Fiji), palo- pa (Papua New Guinea), fa'afafine (Samoa), akava'ine (Rarotonga), fakaleiti or leiti (Tonga), fakafifine (Niue). Non-binary refers to someone who doesn't identify exclusively as a man or a woman. There are many different ways that people may be non-binary male or female.

[2] This information is based on a discussion with Professor Jamie Veale and Jack Byrne, the researchers behind the *Counting Ourselves* survey. This information is an early cut of the data and not to be used beyond this paper. It is based on a sample size of over 1158 New Zealanders.

research into service demand for the Wellington Endocrinology Service highlights that in the future there will be a more even split between masculinising and feminising surgeries.

10. The experience of comparative countries highlights the likely level of demand where there is an established service. Scotland, with a population of approximately 5.5 million people, has provided an average of 44 gender affirming surgeries per year between 2013 and 2017. It is understood that demand grew when a national service was established in 2012, however previous levels of demand are unclear as only some regions funded the delivery of the service.

Opportunities to improve gender affirming surgeries

11. There are considerable opportunities to improve gender affirming surgeries and gender affirming care more broadly. This section focuses on changes to the coordination, funding and delivery of gender affirmation surgery, coordination and funding. It also considers whether a package of gender affirming surgeries could be offered.

12. Improvements to either gender affirming care or gender affirming surgery is likely to increase demand for both. A well-functioning care pathway may lead to an increased demand for surgeries. Conversely, without a functioning care pathway, it is difficult for people to progress to surgery.

13. In the development of this advice, we have considered a number of options across a range of criteria. The options include a combination of public and private delivery and/or coordination, including overseas delivery. We have also considered different funding mechanisms, including holding the funding within Ministry of Health appropriations or devolving funding to DHBs through the population-based funding formula or ring-fenced funding. The criteria used to assess these options included availability, effectiveness, efficiency, safety, accessibility and sustainability.

14. We have provided a summary of the viable options in Appendix 1.

15. Based on this analysis, the Ministry recommends the following:

    a. Preferred option: The Ministry would commence discussions with DHBs on transferring coordination of the service to a DHB, ideally by June 2020. This would be dependent on acquiring new funding of $1.275 million for increased surgery volumes through Budget 2019, and DHBs' willingness to take on the coordination of the service. As an interim solution, the Ministry would work with a provider to deliver 20 surgeries annually through the private sector if funded. A DHB coordination service would need to consider the best option for ongoing service delivery, but may continue with a private provider.

    b. Alternative option: The Ministry could establish a contract with a private provider if it is not possible to transfer coordination to DHBs. This would enable the delivery of more surgeries through the private sector, and a more efficient coordination mechanism. This option would also require the same level of new funding through Budget 2019 for higher surgery volumes.

    c. If no additional funding is available, the Ministry would continue to coordinate and fund surgeries through the High-Cost Treatment Pool. If we were to ring fence the $275,000 annual amount that has been spent on surgeries gender reassignment surgeries delivered overseas in the past, we would be able to provide up to eight surgeries at local rates every two years, with 30% of funding set aside for managing complications. If the cost of complications is higher, this may impact on the level of surgery provided.

Preferred solution

16. The preferred solution of developing a service within a DHB for the management and coordination of the waiting list would provide an efficient model of delivery that is sustainable, and more integrated with the provision of other gender affirming care. As DHBs maintain clinical and service expertise, they are also better placed to coordinate services.

17. The size of the current waiting list has been identified as a deterrent to DHBs who might be able to take over its coordination. We hope to address these concerns by showing a commitment to progress on the waiting list in the short term, and depending on Budget 2019 decisions, providing funding to support a higher level of surgeries through the DHB.

18. DHB coordination does not necessarily mean that the surgery would be provided publicly. There are a range of options, including establishing a private contract. However the DHB would ensure that there was an appropriate provider and could over time establish a sustainable publicly-provided service. A monitoring approach would be established that sits within standard accountability processes.

19. Based on communication with a private provider, we understand that the minimum number of surgeries needed for a single provider to maintain competency, and justify employing someone to manage the waiting list, would be 20 surgeries annually. However, if a private provider is used this is likely to be supplemented by privately-funded patients.

20. We estimate that 20 surgeries, including management of complications, would cost $1.55 million per annum, including additional funding for the management of complications. As more people wish to undertake masculinising surgery, this cost is likely to rise as these surgeries are more expensive. These costs do not take into account the cost of managing complications associated with the procedure.

21. To fund gender affirming surgery, we are seeking $1.275 million for up to 20 surgeries per annum. This is based on:

Make-up of costs	Cost per year
Cost of surgery	$1.1 million
Complications (additional 30%)	$330,000
Coordinator role	$120,000
Current funding from the HCTP	($275,000)
Total	$1.275 million

22. These cost estimates are based on a ratio of 3:1, which is the approximate ratio of people on the waiting list currently. The ratio of masculinising and feminising surgeries is likely to change to be closer to 1:1 over the next decade which would increase the costs by up to $100,000 at the current cost. The costs also factor in an additional 30% to cover potential complications, and $120,000 for a coordinator role.

23. The current costs vary each year, but to fund the three and one costs an estimated average of $551,618 every two years (or $275,809 annually). This is based on private surgery at the current ratios of feminising and masculinising surgery. It is proposed that this money is ring-fenced, and used to fund the new service.

24. While we would need to consider options at the time, shifting the coordination of this service is likely to involve shifting any funding acquired through the budget process to the new coordinator.

Alternative option: private coordination and delivery

25. If there is funding available, but DHBs are not able to coordinate the service we would look to develop an ongoing contract with a private provider for coordination and delivery of the service.

26. The main differences between this option and the status quo is that the current approach only enables a contract for surgery, and it draws from the HCTP which is a limited pool of money that may be prioritised for other surgeries. The proposed approach would provide ring-fenced funding for a set number of surgeries, including pre-assessments. This would also allow for the service to be devolved to a DHB in the future.

27. There are risks with this approach. While the private surgeon in Auckland is appropriately credentialed and certified, she is a new provider. They are also the sole surgeon in New Zealand offering this service, either publicly or privately. If there were issues with the provider or the provider stopped practising in New Zealand, we would need to revert back to using overseas providers that would cost more and therefore fewer surgeries would be provided.

28. To mitigate against these risks, it would be necessary to stipulate in any contract matters such as supporting training for other surgeons and minimum requirements for quality and safety, including clinical supervision, peer review and audit. A detailed service specification would need to be developed.

Enhanced status quo

29. If additional funding is not available through Budget 2019, we would need to maintain the current approach of funding surgeries through the HCTP. However, as the surgery is now available in New Zealand we would expect to be able to fund more surgeries, if gender affirmation was specifically ring-fenced in the HCTP.

30. We estimate that we could fund six feminising surgeries and two masculinising surgeries every two years within the current level of funding. While this would be an improvement, it will not be sufficient to address the current waiting list and meet current levels of demand for surgery.

Package of care

31. There is also a need to consider whether other gender affirming surgeries (including breast augmentation, mastectomies, orchidectomies, facial feminisation and others) are provided as part of an enhanced package of gender affirming care.

32. These other gender affirming surgeries are currently available through the public system. However, due to significant capacity constraints and the need for these procedures to be prioritised alongside other breast and body plastic surgical procedures, including cancer treatments, most gender affirming surgeries are assigned a lower clinical priority. As a result few people actually receive the surgeries.

33. Delivering a package of care that includes some of these broader gender affirming surgeries would be in line with some other countries. For example, British Columbia in Canada publicly funds the following surgeries specifically for gender affirming care: breast construction (in certain cases), chest construction, orchidectomy, hysterectomy. Scotland offers masculinising chest augmentation and feminising hair removal, and has committed to promoting transparency and equity in decision making around prioritisation acknowledging the difficulties transgender people face accessing surgeries.

34. In Australia, some people are eligible for a small number of surgeries where it is classified as 'medically necessary', including orchidectomies and hysterectomies. Some states provide subsidies/co-payments for other surgeries, for example Victoria provides between $3,000–$4,000 AUD (or $3,250-4,300 NZD) for chest surgery (bilateral mastectomy) and approximately $12,000 AUD ($13,000 NZD) for vaginoplasty.

35. New Zealand could consider providing a similar package so that people could access procedures as part of the gender affirming package of care.

36. There are also financial and staffing implications, as an additional package of care would not only add considerable cost but also add demand for plastic surgeons and other surgeons who are in high demand in the public sector. We would need to carefully manage any workforce and capacity risks that could lead to ensure it does not displace the treatment of people with symptomatic conditions.

37. Setting up separate pathways to access surgery would need to be considered carefully as it can cause inequities between different population groups. We recommend undertaking policy work on this with a view to future budget bids and service enhancements if you to pursue this option.

Improving gender affirming care generally

38. There has been some positive progress in improving health care in some regions, led by individual health professionals and highly committed and capable community members. Recently the Tāhine Hauora (the northern region transgender health service) has published their '*Guidelines for Gender Affirming Healthcare'* to promote quality and inclusive transgender healthcare across the northern

region. A copy has been provided with this briefing. Canterbury DHB is also working on their own pathways of care and we are aware of other regions that are actively pursuing improvements to gender affirming care as well.

39. In addition to the Tāhine Hauora guidelines, community members and health care professionals, led by Dr Jeannie Oliphant, Professor Jamie Veale and others have developed proposed national guidelines which have recently been published by the University of Waikato. The guidelines provide advice on good practice in transgender healthcare, as well as recommendations for the Ministry and DHBs on improvements. Their recommendations include providing flexible and responsive pathways, improvement of data collection, and improving capability and cultural inclusiveness among other recommendations.

40. These guidelines have been endorsed by a number of relevant professional bodies. We will work with DHBs and the authors to consider appropriate next steps and will provide you with a further briefing.

41. We also intend to meet with Auckland and Canterbury DHBs in November to understand their approaches and to discuss next steps in establishing a national approach to care pathways. After that meeting, we intend to engage other regions as well. It is important that any work on the latter involves members of the community. We will keep you updated on this work as it progresses.

Capability development

42. Alongside guidelines and care pathways, there are valuable opportunities to support capability development and empower community groups to provide appropriate support and advice to people accessing services. Community members have expressed the need for more information, and better support for health professionals to provide consistently good services. These initiatives would require a comparatively small amount of funding.

43. There are opportunities to:

    a. support the development of a professional group or association of transgender health specialists. This group would support capability development, advice on appropriate standards of care and would be a valuable source of independent advice to the Ministry. We have included $20,000 in the proposed Budget package.

    b. support the conference for transgender health care professionals that is likely to take place in Wellington in May 2019 as another opportunity to promote capability development for the sector[3]. We have included $40,000 in the proposed Budget 2019 package for this event.

    c. fund learning resources to improve capability of health practitioners, particularly in primary care. We have included $20,000 in the proposed Budget 2019 package for this group.

Supporting community navigators

44. In consultation, the opportunity to provide publicly-funded community 'navigators' was raised and strongly supported by those people we spoke to. Accessing gender affirming care services is complicated and stressful, and the ability to deliver transgender inclusive services is currently limited.

45. The intention of the community navigator role is to help people access appropriate services, particularly in the absence of consistent and easily accessible care pathways. The role would be designed to help people through the challenges of finding and accessing services, provide local information and appropriate support for this difficult process.

46. As an initial estimate, this initiative would cost $350,000 per annum for at least three full time equivalent roles in some main centres, including rural coverage. It is likely that these would be funded through contracts with NGOs. This has been included in the Budget 2019 package.

[3] If you wish to support this initiative then the Budget bid will need to seek funding in the 2018/19 financial year.

region. A copy has been provided with this briefing. Canterbury DHB is also working on their own pathways of care and we are aware of other regions that are actively pursuing improvements to gender affirming care as well.

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45. The intention of the community navigator role is to help people access appropriate services, particularly in the absence of consistent and easily accessible care pathways. The role would be designed to help people through the challenges of finding and accessing services, provide local information and appropriate support for this difficult process.

46. The Ministry believes that a consolidated national service would be sufficient to support people to access appropriate pathways. However, if Ministers wish to consider the navigator role, we estimate that this would cost $350,000 per annum for at least three full time equivalent roles in some main centres, including rural coverage. It is likely that these would be funded through

[3] If you wish to support this initiative then the Budget bid will need to seek funding in the 2018/19 financial year.

contracts with NGOs. The number of navigators and their distribution is scalable depending on available funding, which would need to be sought through the Budget process.

Budget implications

47. With additional funding, there is an opportunity to make substantial improvements on the status quo, and affirm the health care rights of the transgender population.

48. We proposed a total Budget 2019 budget package of $1.7 million. This includes:

    a. $1.275 million for a total of 20 surgeries annually, and coordination of the service.

    b. $350,000 for to fund a navigator in Auckland, Wellington and Christchurch.

    c. $40,000 would be used for supporting a Transgender health practitioner conference in May 2019, the establishment of a professional association of transgender health professionals, and capability development resources from primary health care

    d. $20,000 to support the establishment of a professional association of transgender health professionals, and

    e. $20,000 for capability development resources for primary health care.

49. We can continue work to support the development of nationally consistent guidelines and care pathways from within baselines.

Next steps:

50. Depending on decisions around gender affirmation surgeries and new funding through Budget 2019, we can commence work to establish either an appropriate contracting arrangement for the private coordination and delivery of surgeries starting 1 July 2019, or seek to transfer coordination by 1 June 2020.

51. We will continue to progress work on improving gender affirming care, and will keep you informed of progress.

52. We would welcome the opportunity to meet and discuss the content of this report, including the proposed budget bid for Budget 2019.

Proactive Release

53. The Ministry intends delaying this Health Report from publication under its proactive release policy because the information in this paper is Budget sensitive.

END.

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Appendix 1: Summary of relevant components of the package

	Currently	Provision of surgery		Coordination of surgery		
Option	**Status quo**	**Private, New Zealand Based Surgery**	**Public, New Zealand Based Surgery**	**MOH coordination**	**DHB coordination**	**Private coordination**
Pros	No additional funding is required It is already in place, so only minimal changes are required	There is currently capability and capacity to deliver the surgery It is cheaper than overseas options, and likely to be comparative to providing it publicly	A surgeon with the capability is employed in the public system, there is no capacity to provide the surgery currently Likely to be comparative to privately funded surgery costs	Easy for the Ministry to monitor. Does not require any changes. Maintains accountability around services. No additional funding.	They have the appropriate skills and expertise. They could integrate the service with the rest of the care pathway. Maintains separation between the coordination and provider, to enhance accountability.	Coordination and delivery together could improve the timeliness of surgery, as the referral is direct to the service provider.
Cons	Surgery is being provided at a rate significantly lower than demand The High Cost Treatment Pool limits contracting options	The one service provider is newly established No guarantees that the service will continue to operate As there is only service provider in New Zealand, it can function as a monopoly	Delivering surgery publicly is likely to either displace other surgeries, or require that they are contracted out to the private system Establishing public provision of the surgery would take time, as teams would need to be trained etc.	As the current coordination mechanism is not designed for surgeries that are (for administrative purposes) elective, it can create administrative inefficiencies. Coordination by the Ministry does not allow for clinical oversight. No additional costs.	Contractual and accountability arrangements for this function would need to be developed. We would need to fund this function.	A contract for this function would need to be developed. We would need to fund this function, either as part of surgeries or separately.
Cost	Can be funded within current appropriations	A small amount can be funded through the current appropriation, but new funding would be required for higher levels of surgery	To devolve funding to DHBs for this service, new funding would be required as DHBs have indicated they would be hesitant to take over a very long list	No new funding would be required.	New funding would be required.	New funding would be required.

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Appendix 2: Summary of initial engagement with stakeholders

Community engagement

As part of related work we met with a targeted group of people from the transgender community. These people were professionals with a depth of experience and strong ties to the community.

We met with the following people:

- Jack Byrne – Researcher, Counting Ourselves survey
- Jaimie Veale – Waikato University Transgender Health and Wellbeing specialist, Australia and New Zealand Professional Association for Transgender Health Executive Board Member
- Joey MacDonald – Kāhui Tū Kaha, LGBTTI Liaison & Training programme lead
- Ahi Wi-Hongi – Gender Minorities Aotearoa and New Zealand Prostitutes Collective
- Chase Knox – Gender Minorities Aotearoa.

The key points from the discussion were:

1. There is considerable growth in demand for services, and the current waiting list does not represent the actual demand for gender affirming surgery
2. The use of clinical prioritisation models for gender affirming surgeries is a barrier to accessing care, particularly when quality of life is not accounted for
3. Implementing informed consent models around hormones and other care would considerably improve accessibility to services
4. The most successful services are culturally appropriate and support holistic wellbeing
5. There is a large amount of regional variation experienced
6. A number of people experience significant discrimination in the health care system, but feel powerless to seek help as health professionals hold considerable power as they can provide the necessary care
7. There is an opportunity to improve accessibility by leveraging expertise in the community, through 'navigator' type roles, as well as information sharing and support.

Sector engagement

We also met with the following senior leaders and clinical experts from select DHBs:

- John Kenealy- Head of Plastic Surgery, Counties Manakau DHB
- Phillip Balmer- Director of Hospital Services, Counties Manakau DHB
- Jo Brown- Funding and Development Manager- Hospitals, Auckland DHB and Waitemata DHB
- Ralph LaSalle- Team Leader, Secondary Care, Canterbury DHB
- Debbie Holdsworth- Director of Funding, Auckland DHB and Waitemata DHB
- Bridget Farrant- Counties Manakau DHB

The key points from the discussion were:

1. The current commitments are well below the level of demand. It was estimated that up to 35 people annually may wish to access (genital) gender affirmation surgery, and higher for other surgeries.
2. There is collective interest in working on a pathway and package of care that improves accessibility, promotes fairness, and reduces vulnerability and variation in levels of service.
3. Important elements of a sustainable service would be:
    a. Integration between providers, and supporting a single provider until there is growth in both supply and demand of services
    b. Consideration of access to a broader package of care
    c. Input from consumers about priorities

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   d. To maintain competency, about 20 surgeries each year would be required to maintain competence.

4. Both Canterbury and Auckland DHBs have been working on gender affirming care pathways.
5. Understanding the issues and purpose is important for next steps in improving gender affirming care:
   a. DHBs are very unlikely to have any appetite to take over the waiting list in its current state
   b. There is variable access and support for (genital) gender affirming surgery between DHBs
   c. The High Cost Treatment Pool can be difficult for clinicians to access
   d. Competing with existing priorities is the biggest challenge in establishing a gender affirming care pathway.

We will continue to engage with the community and sector as we work to improve gender affirming care.

MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report

Establishing a Gender Affirming Surgery Service

Date due to MO:	29 October 2019	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20191933
To:	Hon Julie Anne Genter, Associate Minister of Health		
Copy to:	Hon Dr David Clark, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Jessica Smaling	Group Manager, DHB Funding, Accountability and Monitoring, DHB Performance, Support and Infrastructure	S9(2)(a)
Jane Potiki	Principal Advisor, System Flow, DHB Performance, Support and Infrastructure	S9(2)(a)

Action for Private Secretaries

Return the signed report to the Ministry of Health.

Date dispatched to MO:

Ministry of Health
30 OCT 2019
DISPATCHED

MINISTRY OF HEALTH
MANATŪ HAUORA

Establishing a Gender Affirming Surgery Service

Purpose of report

This report responds to your request for a briefing on activities to improve the coordination and provision of gender affirming surgery.

Key points

- As signalled in Health Report 20190873, the Ministry of Health (the Ministry) has recommended engaging an Auckland-based District Health Board (DHB) to provide coordination and management of the gender affirming surgery waiting list. Initial discussions are positive and further discussion is planned.
- Until a DHB can be appointed to provide coordination of the waiting list, the Ministry will continue to provide this function. Waiting list management rules and processes are being developed alongside a plan to check the readiness for surgery of those listed.
- The Ministry is and will continue to seek input from the transgender community to improve care pathways. Future engagement is expected to involve tailored engagement with relevant work programmes and will outline actions to improve the visibility of rainbow perspectives, particularly in mental health and addition services.

Recommendations

The Ministry recommends that you:

a) **Note** the Ministry has commenced discussion on waiting list coordination with two Auckland-based DHBs and will continue to progress this approach, with a view to transitioning to a DHB coordinated waiting list during 2020/21. **Yes/~~No~~**

b) **Note** that in the interim the Ministry is continuing to provide waiting list coordination and is implementing processes to increase the number of people referred for assessment and surgery during 2019/20. **Yes/~~No~~**

c) **Agree** to the Ministry proceeding to formal discussions with DHBs on provision of coordination of the gender affirming surgery waiting list, with a plan to shift this responsibility to a DHB during 2020/21. **Yes/~~No~~**

Michelle Arrowsmith
Deputy Director-General
DHB Performance, Support and Infrastructure

Hon Julie Anne Genter
Associate Minister of Health
Date: 15 Nov 2019

Background

1. This report responds to your request for a briefing on activities to improve the coordination and provision of gender affirming surgery, including:

   a. discussions with potential DHB providers of a coordination service

   b. potential impact/improvement in management of the waiting list for surgery (particularly how people are prioritised)

   c. how the Ministry will receive and incorporate advice from the transgender community on clinical pathways and options for further involvement (such as funding of community groups that support transgender New Zealanders).

DHB discussions on coordination

2. As advised in Health Report 20190873, the Ministry believes a DHB coordinating the waiting list provides the greatest surety of a well-managed and sustainable service for transgender patients. The desired short-term outcome is that a DHB can be appointed to provide coordination of the service and the waiting list, while Dr Rita Yang continues to provide publicly funded surgical services in her private practice. Over time, and with growth in funding, the Ministry would work with the DHB provider to establish a DHB-based service, and to recruit additional specialists with expertise in gender affirming surgery.

3. The Ministry has initiated discussion with two Auckland-based DHBs as a pre-cursor to establishing a national gender affirming surgery service. There was willingness from both DHBs to consider taking on coordination of the waiting list. Further discussions will be required to more clearly outline the requirements and funding arrangements. Both DHBs felt there is a need to undertake a piece of work to define the service model, multidisciplinary approach and referral pathways for gender affirming care. The outcome of this would be clarity about the scope of the service and how patients can access other components of the gender affirming care pathway.

4. The Ministry will continue to progress discussion with the DHBs with a view to establishing a DHB coordination service early in 2020/21. Funding for the level of coordination will need to be confirmed but is estimated at $100,000 per annum. Once the coordination service is in place, the timeline for introducing a DHB-provided surgical service can be considered. This is of key importance to ensure the provision of gender affirming surgery does not displace other burns and plastic surgical services which are often extremely high priority.

5. To progress the development of a nationally agreed service model the Ministry will facilitate workshops, with input from the transgender community and Professional Association for Transgender Health Aotearoa (PATHA). This model would be expected to gain consensus from a wide range of stakeholders on referral pathways and treatment decision-making for the national gender affirming surgery service. A key outcome will be clinical advice on how to best facilitate a service within the available funding, to optimise patient access while not raising unrealistic expectations.

MINISTRY OF HEALTH
MANATŪ HAUORA

Improved waiting list management and referring patients for surgery

6. To improve management of the waiting list in the short term the Ministry intends to separate gender affirming surgery from the High Cost Treatment Pool (HCTP) process. Health Report 20190873 noted that funding from the HCTP for gender affirming surgery was already effectively ring-fenced at a value of approximately $0.275 million per annum. The use of this funding for gender affirming surgery would have no additional impact on applications to the HCTP for other treatment.

7. The HCTP process was necessary in the past because of the lack of a DHB provider and the funding source. This process worked reasonably well when there was a New Zealand provider (Dr Peter Walker) who received referrals and completed the pre-surgical assessment and HCTP application. Under this arrangement an average of 2 – 3 people received treatment each year between 2005 and 2014.

8. Since the retirement of Dr Walker, DHB specialists continued to send applications for patients to receive gender affirming surgery to the HCTP. The arrangement was outside the normal process for managing HCTP referrals where the referring specialist retains clinical oversight of the patient and patients accepted by the HCTP are accepted for surgery which is usually arranged with some urgency.

9. The manager of the HCTP would list a referral when received and advise the referrer of the patient's position on the list. When arranging treatment he would liaise with the referring specialist and with an overseas provider (Thailand or the United States). Under this process two people received treatment, one each in 2016 and 2018.

10. The process to schedule surgery for patients was constrained by the need for a DHB specialist referral to access HCTP funding and the length of time the patients had been waiting. Patients required re-referral to the DHB for assessment, with inherent delays, were unable to be contacted, were found to be unfit for surgery, or were unable to travel overseas for treatment for personal or financial reasons.

Interim contracting approach

11. In establishing a gender affirming surgery service separate from the HCTP the Ministry will be able to contract directly with Dr Yang as provider in the short term, and with a DHB to provide the coordination service.

12. The intended contracting approach with Dr Yang is for an agreement for 2019/20 and 2020/21 that will:

    a. specify a minimum number of FSAs to be provided each financial year

    b. include pre-surgical work-up, such as hair removal, for people that are proceeding to treatment

    c. specify a minimum number of surgical procedures to be provided each year, indicatively at least 10 feminising procedures and 4 masculinising procedures

    d. include a pre and post-operative standard package of care (pre-admission assessment and two follow up assessments)

    e. agree how surgical complications will be managed

    f. include the ability to flex up the number of procedures if complications do not occur

g. provide payment based on actual FSAs and procedures provided

h. moving away from individual contracts for individual patients and activities will reduce the administrative burden, streamline and speed up the referral and assessment process

i. if a DHB coordination service can be established prior to the conclusion of the agreement, we will consider whether to transfer the contract to the DHB provider or contract separately with Dr Yang for surgery and with the DHB for the coordination services only.

Validation and readiness for surgery check

13. The agreement with Dr Yang will enable the Ministry to facilitate an increased rate of referral for surgical assessment. To increase the conversion rate from assessment to surgery it is important that delays in referral are minimised and that patients referred to Dr Yang are fit to proceed with surgery.

14. The following process has been developed to ensure sufficient patients are assessed to give the greatest possibility that at least 14 people can receive treatment by June 2020.

a. **Step 1:** confirmation of patient contact details for all patients on the waiting list to ensure the information is centralised, and up-to-date – where possible email contacts will be identified as back up to physical address.

b. **Step 2:** contact patients in batches of 50 and request that they return a questionnaire that:

i. confirms their contact details and preferred method of contact

ii. confirms that they still wish to proceed to surgery

iii. identifies risk factors for surgery such as body mass index or significant co-morbidities.

c. **Step 3:** have the questionnaire results reviewed by Dr Rita Yang or another appropriate clinician to determine whether an assessment should be arranged, if pre-surgical preparation is required or if the patient requires management of a medical condition prior to assessment.

d. **Step 4:** arrange a specialist assessment with Dr Yang for patients that are considered suitable to confirm whether treatment should proceed.

15. Waiting list rules and guidelines are being developed that ensures clear and consistent communication with patients and referrers and that there is a management plan for all patients that are not currently fit for surgery.

16. To facilitate the assessment and surgical process the Ministry intends to seek agreement from DHB funders for an alternative process to apply for travel and accommodation assistance for patients that meet the eligibility criteria of the National Travel and Accommodation (NTA) Scheme. If this agreement is reached, patients can be referred for an FSA without the requirement for a further referral from a DHB specialist, removing one delaying factor.

Incorporating advice from the trans-gender community

Current engagement with the transgender community

17. Research from, and engagement with, the transgender community shows their concerns have not been heard or adequately addressed in the past, and that they do not feel visible as a priority group in the Ministry's work. A range of work programmes underway offer an opportunity to improve this and provide the support and services needed. These include:

    a. expanding access to and choice of primary mental health and addiction supports

    b. increasing access to gender affirming surgery

    c. engagement on the Suicide Prevention Action Plan, especially with rainbow youth.

18. The Ministry has been actively working with sector groups and agencies on ways to improve outcomes in these areas. Several hui were held with members, sector groups and agencies from the rainbow community to ensure primary mental health services are collaboratively designed and tailored to meet the needs of rainbow communities. Following this, officials are writing a letter to those who attended, recognising the rainbow community as a priority population and committing to ongoing engagement with them.

19. Minister Robertson and Under-Secretary Logie met with representatives from rainbow organisations in September, to hear their concerns and advice on how to best administer the new $1 million Rainbow Legacy Fund to support the mental health of rainbow youth.

20. A targeted group of people with strong ties to the transgender community have also been consulted on the development of a gender affirming surgery package.

Opportunities to improve engagement with the transgender community

21. Given the amount of current and upcoming work to improve care pathways for transgender people, it is important these pathways are well informed and designed in partnership with the people they support.

22. The Ministry's approach to engagement in these areas is unlikely to include establishing a formal advisory group, but will involve tailored engagement with relevant work programmes and will outline actions to improve the visibility of rainbow perspectives in mental health and addiction. Non-governmental and community-based organisations are expected to be crucial in the delivery of wellbeing programmes for priority populations, including transgender people.

23. We will keep you updated on this work as it progresses and would welcome the chance to meet with you to discuss opportunities to further improve engagement with the transgender community.

Next steps

24. The Ministry will continue to report the status of the waiting list to you through the weekly report. Regular updates will be provided on the waiting list validation process and outcomes, as well as progress to deliver FSAs and gender affirming surgeries.

25. An update on the workshop and the progress to establish a DHB coordination service will be provided in March 2020.

ENDS.

Health Report

Implementing changes to improve access to gender-affirming surgeries

Date due to MO:	22 May 2019	**Action required by:**	Routine
Security level:	BUDGET SENSITIVE	**Health Report number:**	20190873
To:	Hon Julie Anne Genter, Associate Minister of Health		
Copy to:	Hon Dr David Clark, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Michelle Arrowsmith	Deputy Director-General, DHB Performance, Support and Infrastructure	S9(2)(a)
Dr Andrew Simpson	Chief Medical Officer	S9(2)(a)

Action for Private Secretaries

Return the signed report to the Ministry of Health.

Date dispatched to MO:

Implementing changes to improve access to gender-affirming surgeries

Purpose of report

This report seeks your agreement on the priorities for implementing changes to gender-affirming surgeries, given the funding available in Budget 2019.

Key points

- Budget 2019 includes an additional $2.992 million over four years for funding gender-affirming care, on top of the $0.275 million per annum already available.
- We propose to use this new funding to fund additional surgeries and to improve the coordination of surgeries in the medium term by shifting this responsibility from the Ministry to a district health board (DHB).
- This funding will also be used to cover the cost of managing any complications arising from surgery, where these must be managed by the private surgeon and cannot be addressed in a DHB-run service. Each person has their own clinical needs and post-surgery care requirements, so the cost of surgery and other care varies, we estimate the funding will allow up to an additional 12 surgeries per annum.
- We are seeking your agreement to the proposed approach, and we will then proceed to implement action.

Recommendations

The Ministry recommends that you:

a)	**Note** that Budget 2019 includes an additional $2.992 million over four years ($0.748 million per annum) for gender-affirming care on top of the $0.275 million already available	**Yes/No**
b)	**Agree** that the additional funding is used to fund additional surgeries and improve coordination of surgeries in the medium term by shifting this responsibility from the Ministry to a district health board.	**Yes/No**

Michelle Arrowsmith
Deputy Director-General
DHB Performance, Support and Infrastructure

Hon Julie Anne Genter
Associate Minister of Health
Date:

Background

1. We have previously provided you with advice on increasing publicly-funded gender-affirmation surgery and improving gender-affirming care [HR 20180841 refers].

2. Following advice in May 2018, a decision was made to change the 2004 commitment to fund a maximum of three feminising surgeries (male to female) and one masculinising surgery (female to male) every two years to a minimum commitment. However, the number of surgeries offered over and above the minimum is limited by available funding.

3. In advice in November 2018 [HR20182309 refers, see Appendix 2] we proposed four priority areas:

   - Funding an additional 15 gender-affirming genital reconstruction surgeries, including management of possible complications.
   - Transferring the coordination of surgeries, including management of the waiting list, to a private provider from July 2020.
   - Funding three community navigator roles to support people accessing services.
   - Capability initiatives, including supporting the establishment of a professional body, a transgender health care conference, and the development of learning resources for health care providers.

4. Our advice was that these proposals would require an additional $1.125 million, which would supplement funding already used for gender affirming surgery from the High Cost Treatment Pool (HCTP).

Proposed priorities for funding

5. Budget 2019 makes $0.748 million per annum of new funding available for gender-affirming care.

6. We are seeking your agreement to priorities for spending this Budget allocation, plus the additional $0.275 million per annum from the HCTP that is currently used to fund gender reassignment surgery (total $1.023 million).

What is achievable within the new Budget 2019 funding

7. We suggest the priorities for use of this funding should be increasing the number of surgeries, as well as improving the coordination of surgeries and management of the waiting list. We consider this the best use of this funding at this time.

8. Each person who undergoes surgery has their own clinical needs and post-surgery care requirements, so the price per surgery varies. However, we anticipate the funding will allow up to an additional 12 surgeries per annum (additional over the agreed minimum of 2 per annum from existing funding), depending on the type and occurrence of complications.

9. While this approach would mean that the other proposed initiatives including the navigator roles or capability initiatives would not proceed, there are other initiatives under way that will improve outcomes for Rainbow communities. These include actions in the Sexual and Reproductive Health Action Plan 2019-2025 to support improved care-pathways and improved capability in primary care to deliver inclusive health care

for transgender and non-binary people. There are also future funding opportunities for community groups with the establishment of the Rainbow Legacy Fund [CBC-19-MIN-0012 refers), and the inclusion of Rainbow communities as a priority population in new mental health initiatives.

Considering funding for other gender-affirming surgeries

10. You have asked officials about using the budget for funding 'top' surgery for people on the waiting list if that is their preference. 'Top' surgery refers to gender-affirming surgeries not including gender-affirming genital reassignment surgery (including chest augmentation, breast surgeries or facial feminisation among other).

11. At present, only gender-affirming genital reassignment surgery is funded directly through the High Cost Treatment Pool. 'Top' surgery is provided through DHBs, and is funded through their population-based funding. We understand that some DHBs are experiencing high levels of demand for plastic and reconstructive surgery, leading to variable access across the country and increasing unmet demand for 'top' surgery.

12. While we acknowledge the importance of 'top' surgery, on balance we believe that given the considerable waiting list for gender-affirming genital reassignment surgery this needs to take priority, at least in the short to medium term. At present, the waiting list for gender-affirming genital reassignment surgery is still growing and there is evidence to indicate that this is likely to grow further.

13. In the long term, with the proposed transfer of coordination for gender-affirming genital reassignment surgery to a DHB, there are opportunities to better integrate the complete package of gender-affirming surgeries. This is likely to require additional funding.

Funding for community groups

14. In the previous Health Report (see Appendix 2), we proposed that funding be provided for a transgender health professionals group that is now established as PATHA (Professional Association for Transgender Health Aotearoa). This group includes representation from interested health professionals and active members of the community.

15. When the Rainbow Legacy Fund (CBC-19-MIN-0012 refers) is established, this will support groups that promote wellbeing in the rainbow community, which may include PATHA.

Funding for management of complications arising from surgeries

16. When complications arise from private surgeries in New Zealand, they are typically dealt with either by the surgeon in private, or transferred to a DHB-run service if the private provider is unable to manage the complication.

17. To maximise the number of gender affirmation surgeries that can be provided each year we propose that people experiencing complications have these managed in the most clinically appropriate DHB, unless it is specifically related to the genital reconstruction.

18. When the complication is related to the genital reconstruction, can only be managed by the private surgeon, and it is not incorporated in the procedure fee, this will need to

be funded out of the gender-affirming surgery fund. As surgeries are being undertaken by a new provider and service, we cannot accurately predict the number or cost of complications that will occur in any given year. However, past experience tells us that three of seven people who had masculinising surgery and six of twelve who had feminising surgery experienced complications. Patients will no longer need to travel overseas, which historically increased the likelihood of complications. We expect the rate with the new provider to be lower as a combination of comprehensive pre-operative preparation and competent surgical skills means that fewer issues are likely to occur. Additionally, most complications are minor and can be readily fixed.

Shifting coordination of surgeries

19. The coordination of surgeries involves both coordinating assessment and surgical scheduling of patients already on the waiting list, and appropriate referral management of new patients referred for surgery. There are three possible options to coordinate surgeries: the Ministry (status quo), a DHB, or the private provider.

20. Ideally, the coordination of surgery (including management of the waiting list) would be transferred to a DHB. This is because management of waiting lists is core business for DHBs as they have the necessary clinical expertise. DHBs also have experience managing private provider contracts for clinical services. A DHB would need to employ a coordinator to take on this role and be willing to take on responsibility for the existing waiting list. This is likely to incur additional costs to, or reprioritisation within, Vote Health.

21. In the short term, while discussions with DHBs take place, the Ministry will continue to provide the coordination function.

22. The size of the current waiting list has previously been identified as a deterrent to DHBs taking over its coordination. We believe the new funding will help to address this concern by enabling progress on the waiting list in the short term, however, this remains a moderate risk.

23. With changes to the coordination of the waiting list, there is an opportunity to change the way people are prioritised for access to the list, taking greater account of clinical need and ability to benefit. This would not negatively impact on waiting times for people currently on the waiting list.

24. The diagram in Appendix 1 shows the proposed timing for shifting the coordination function. We will commence discussions with DHBs in the last half of 2019, with the intention that we negotiate coordination with a DHB for the next financial year. If this is not possible, we will provide advice on alternative options.

Budget communications

25. The Ministry has provided Budget communications on this initiative to the Minister of Health's office. We understand these have been shared with you.

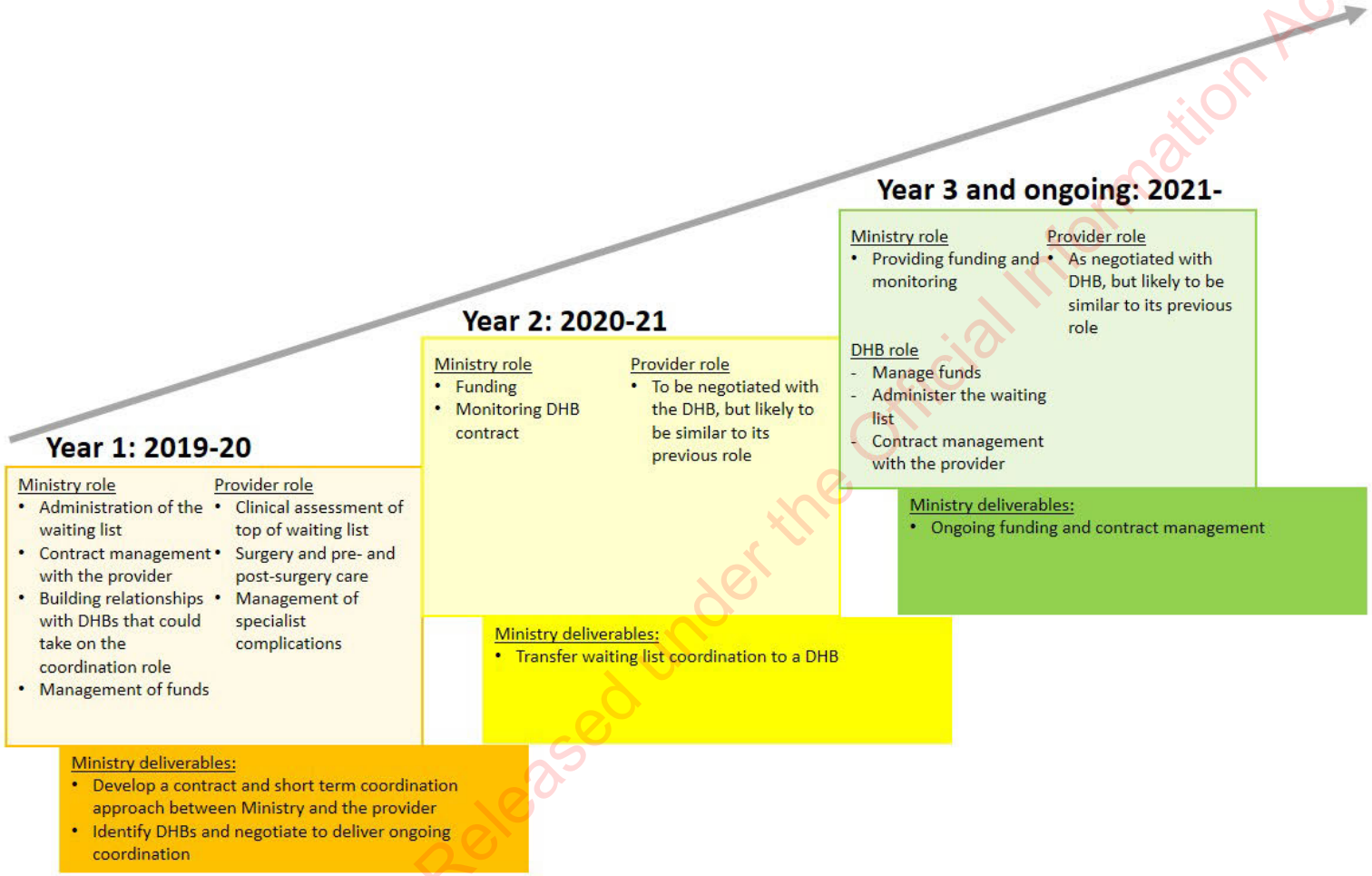
Next steps

26. We will continue to progress work on improving gender-affirming care and will keep you informed through the Weekly Report.

27. In the implementation of these changes we will meet with our community stakeholder group to share our proposal and seek input on communications.

ENDS.

Appendix 1: Diagram showing proposed timings for shifting the coordination function



Appendix 2: November 2018 advice

MINISTRY OF HEALTH
MANATŪ HAUORA

Security classification: In-Confidence

Health Report: Options to increase publicly-funded gender affirmation surgery and improve gender affirming care

Date:	13 November 2018	Report No:	20182249
		File Number:	~~AD62-14-2018~~

Action Sought

	Action Sought	Deadline
Minister Clark	Note	
Minister Genter	Note	Routine

Contact for Telephone Discussion (if required)

Name	Position	Telephone	Contact Order
Caroline Flora	GM Population Outcomes	S9(2)(a)	**1st Contact**
Dr Andrew Simpson	Chief Medical Officer		**2nd Contact**

Actions for the Minister's Office Staff

This report contains recommendations.

Note any feedback on the quality of the report	

MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report number: 20182309

Security classification: In-Confidence

File number: AD62-14-2018
Action required by: Routine

Options to increase publicly-funded gender affirmation surgery and improve gender affirming care

To: Hon Julie Anne Genter, Associate Minister of Health

Copy to: Hon Dr David Clark, Minister of Health

Purpose

This briefing describes options for the future coordination and delivery of publicly-funded gender affirming genital reconstruction surgery (gender affirmation surgery). It builds on initial advice provided in May 2018 [HR 20180924 refers], and proposes further work to improve gender affirming care pathways.

Key points

- Currently 114 New Zealanders (8 of whom have had an updated surgical assessment) are on the waiting list for gender affirmation surgery. At current rates, and not allowing for new additions, it could take over 50 years to clear the wait list.
- This briefing explores opportunities to improve the delivery of gender affirming care, including options to increase the numbers of publicly-funded gender affirming surgeries and initiatives to support the development of capability in the health sector.
- It is proposed that coordination of the service transfers to a DHB, to support a more efficient and integrated approach to gender affirmation surgery.
- It is recommended that enhancements to service delivery are phased, starting with a contracting arrangement with a private provider in the short term, before shifting to public coordination (and possibly provision), potentially from June 2020.
- In addition to changes to gender affirmation surgery, the Ministry will progress work with the sector and community on care guidelines and a package of care (i.e what other gender affirming surgeries could be provided), access criteria and care pathways. This will build on the good work that has already been done in the sector to progress work on transgender health care guidelines.
- As part of work to improve care pathways, we propose that navigator roles are established to support people as they access gender affirming care.
- To enable the implementation of this proposed approach, there is a budget bid on the long list for Budget 2019.

Contacts:	Caroline Flora, Group Manager Population Outcomes, System Strategy & Policy	S9(2)(a)
	Dr Andrew Simpson, Chief Medical Officer	

Recommendations

The Ministry recommends that you:

a) **Note** that minor improvements to gender affirming care can be done without new funding, however a different or larger service offering requires new investment.

b) **Note** the Ministry recommends a phased implementation of enhanced care, including the establishment of a DHB run service from July 2020, with increased service volumes from July 2019.

c) **Note** the Ministry has entered a budget item in the long list for Budget 2019 that includes increased surgery volumes, coordination, navigation and capability components.

d) **Note** that the Ministry can develop policy options for a broader package of care that encompasses other surgeries, including chest augmentation, mastectomies and hair removal.

e) **Agree** to meet with us to discuss your preferred approach. **Yes/No**

Caroline Flora
Group Manager-
Population Outcomes

Minister's signature:

Date: 13 Dec 2018

Health Report number: 20182309

Options to increase publicly-funded gender affirmation surgery and improve gender affirming care

1. The current provision of gender affirming surgery and care pathways is not keeping up with demand, or the needs of transgender and non-binary New Zealanders[1].

2. The experience of people in accessing gender affirming care varies considerably, depending on the capability of the health professionals and the region they live in. Transgender and non-binary New Zealanders regularly experience discrimination and barriers to care, as well as services that are not able to meet their needs. At worst, there are accounts of discriminatory practice, where people feel powerless to seek help.

3. A key concern is size of the current waiting list for gender affirmation surgery that is funded through the High Cost Treatment Pool (HCTP). Following the Health Report in May 2018 [HR 20180924 refers], the decision was made to change the 2004 commitment of three feminising surgeries (male to female), and one masculinising surgery (female to male) every two years to a minimum commitment. However, the number of surgeries offered over and above the three and one minimum is necessarily limited by available funding.

4. You have asked for advice on options to improve the delivery and coordination of gender affirmation surgery in New Zealand, including the development and implementation of care pathways.

Update on progress

5. Since May 2018, eight people have been referred to a private surgeon in Auckland for assessment for gender affirming surgery. Also since May 2018, eight additional people have been referred to the waiting list, meaning that the waiting list continues to grow.

6. The Ministry has had discussions with key sector stakeholders and members of the transgender and non-binary community to inform advice on changes to the provision of surgery. There was strong support for changes, noting that there is a considerable increase in demand for gender affirming care. See Appendix 2 for more information on the outcomes of the initial engagement with stakeholders.

7. From the discussions we have had, and work undertaken by the community and the health sector, it is clear that there is a strong interest in improving gender affirming care pathways and guidelines.

Current demand for surgery

8. We are expecting that there will be an increase in demand for surgery. Early indications from *Counting Ourselves* (the Aotearoa New Zealand transgender and non-binary health survey) indicate that at least a quarter of respondents (at least 300 people) are interested in gender affirming genital surgery. Interest in 'top' surgeries, such as chest reconstruction, facial feminisation and breast augmentation is higher still.[2] These estimates are supported by evidence from transgender people accessing endocrine services in Wellington, with 2 people accessing care in 1990, growing to 92 people in 2016. This demand is considerably higher than the level seen in the current gender affirming genital surgery waiting list.

9. There is also expected to be a change in the ratio between the demand for feminising and masculinising gender affirming care, with genital surgery currently publicly-funded at a rate of three feminising surgeries to one masculinising surgery. Early indications from *Counting Ourselves*, and

[1] Transgender and non-binary are being used as umbrella terms, recognising that transgender people may describe themselves in many ways including the use of indigenous terms such as; whakawāhine, tangata ira tāne, tāhine (Māori), māhū (Hawai'i and Tahiti), vakasalewalewa (Fiji), palo- pa (Papua New Guinea), fa'afafine (Samoa), akava'ine (Rarotonga), fakaleiti or leiti (Tonga), fakafifine (Niue). Non-binary refers to someone who doesn't identify exclusively as a man or a woman. There are many different ways that people may be non-binary male or female.

[2] This information is based on a discussion with Professor Jamie Veale and Jack Byrne, the researchers behind the *Counting Ourselves* survey. This information is an early cut of the data and not to be used beyond this paper. It is based on a sample size of over 1158 New Zealanders.

research into service demand for the Wellington Endocrinology Service highlights that in the future there will be a more even split between masculinising and feminising surgeries.

10. The experience of comparative countries highlights the likely level of demand where there is an established service. Scotland, with a population of approximately 5.5 million people, has provided an average of 44 gender affirming surgeries per year between 2013 and 2017. It is understood that demand grew when a national service was established in 2012, however previous levels of demand are unclear as only some regions funded the delivery of the service.

Opportunities to improve gender affirming surgeries

11. There are considerable opportunities to improve gender affirming surgeries and gender affirming care more broadly. This section focuses on changes to the coordination, funding and delivery of gender affirmation surgery, coordination and funding. It also considers whether a package of gender affirming surgeries could be offered.

12. Improvements to either gender affirming care or gender affirming surgery is likely to increase demand for both. A well-functioning care pathway may lead to an increased demand for surgeries. Conversely, without a functioning care pathway, it is difficult for people to progress to surgery.

13. In the development of this advice, we have considered a number of options across a range of criteria. The options include a combination of public and private delivery and/or coordination, including overseas delivery. We have also considered different funding mechanisms, including holding the funding within Ministry of Health appropriations or devolving funding to DHBs through the population-based funding formula or ring-fenced funding. The criteria used to assess these options included availability, effectiveness, efficiency, safety, accessibility and sustainability.

14. We have provided a summary of the viable options in Appendix 1.

15. Based on this analysis, the Ministry recommends the following:

    a. Preferred option: The Ministry would commence discussions with DHBs on transferring coordination of the service to a DHB, ideally by June 2020. This would be dependent on acquiring new funding of $1.275 million for increased surgery volumes through Budget 2019, and DHBs' willingness to take on the coordination of the service. As an interim solution, the Ministry would work with a provider to deliver 20 surgeries annually through the private sector if funded. A DHB coordination service would need to consider the best option for ongoing service delivery, but may continue with a private provider.

    b. Alternative option: The Ministry could establish a contract with a private provider if it is not possible to transfer coordination to DHBs. This would enable the delivery of more surgeries through the private sector, and a more efficient coordination mechanism. This option would also require the same level of new funding through Budget 2019 for higher surgery volumes.

    c. If no additional funding is available, the Ministry would continue to coordinate and fund surgeries through the High-Cost Treatment Pool. If we were to ring fence the $275,000 annual amount that has been spent on surgeries gender reassignment surgeries delivered overseas in the past, we would be able to provide up to eight surgeries at local rates every two years, with 30% of funding set aside for managing complications. If the cost of complications is higher, this may impact on the level of surgery provided.

Preferred solution

16. The preferred solution of developing a service within a DHB for the management and coordination of the waiting list would provide an efficient model of delivery that is sustainable, and more integrated with the provision of other gender affirming care. As DHBs maintain clinical and service expertise, they are also better placed to coordinate services.

17. The size of the current waiting list has been identified as a deterrent to DHBs who might be able to take over its coordination. We hope to address these concerns by showing a commitment to progress on the waiting list in the short term, and depending on Budget 2019 decisions, providing funding to support a higher level of surgeries through the DHB.

18. DHB coordination does not necessarily mean that the surgery would be provided publicly. There are a range of options, including establishing a private contract. However the DHB would ensure that there was an appropriate provider and could over time establish a sustainable publicly-provided service. A monitoring approach would be established that sits within standard accountability processes.

19. Based on communication with a private provider, we understand that the minimum number of surgeries needed for a single provider to maintain competency, and justify employing someone to manage the waiting list, would be 20 surgeries annually. However, if a private provider is used this is likely to be supplemented by privately-funded patients.

20. We estimate that 20 surgeries, including management of complications, would cost $1.55 million per annum, including additional funding for the management of complications. As more people wish to undertake masculinising surgery, this cost is likely to rise as these surgeries are more expensive. These costs do not take into account the cost of managing complications associated with the procedure.

21. To fund gender affirming surgery, we are seeking $1.275 million for up to 20 surgeries per annum. This is based on:

Make-up of costs	Cost per year
Cost of surgery	$1.1 million
Complications (additional 30%)	$330,000
Coordinator role	$120,000
Current funding from the HCTP	($275,000)
Total	$1.275 million

22. These cost estimates are based on a ratio of 3:1, which is the approximate ratio of people on the waiting list currently. The ratio of masculinising and feminising surgeries is likely to change to be closer to 1:1 over the next decade which would increase the costs by up to $100,000 at the current cost. The costs also factor in an additional 30% to cover potential complications, and $120,000 for a coordinator role.

23. The current costs vary each year, but to fund the three and one costs an estimated average of $551,618 every two years (or $275,809 annually). This is based on private surgery at the current ratios of feminising and masculinising surgery. It is proposed that this money is ring-fenced, and used to fund the new service.

24. While we would need to consider options at the time, shifting the coordination of this service is likely to involve shifting any funding acquired through the budget process to the new coordinator.

Alternative option: private coordination and delivery

25. If there is funding available, but DHBs are not able to coordinate the service we would look to develop an ongoing contract with a private provider for coordination and delivery of the service.

26. The main differences between this option and the status quo is that the current approach only enables a contract for surgery, and it draws from the HCTP which is a limited pool of money that may be prioritised for other surgeries. The proposed approach would provide ring-fenced funding for a set number of surgeries, including pre-assessments. This would also allow for the service to be devolved to a DHB in the future.

27. There are risks with this approach. While the private surgeon in Auckland is appropriately credentialed and certified, she is a new provider. They are also the sole surgeon in New Zealand offering this service, either publicly or privately. If there were issues with the provider or the provider stopped practising in New Zealand, we would need to revert back to using overseas providers that would cost more and therefore fewer surgeries would be provided.

28. To mitigate against these risks, it would be necessary to stipulate in any contract matters such as supporting training for other surgeons and minimum requirements for quality and safety, including clinical supervision, peer review and audit. A detailed service specification would need to be developed.

Enhanced status quo

29. If additional funding is not available through Budget 2019, we would need to maintain the current approach of funding surgeries through the HCTP. However, as the surgery is now available in New Zealand we would expect to be able to fund more surgeries, if gender affirmation was specifically ring-fenced in the HCTP.

30. We estimate that we could fund six feminising surgeries and two masculinising surgeries every two years within the current level of funding. While this would be an improvement, it will not be sufficient to address the current waiting list and meet current levels of demand for surgery.

Package of care

31. There is also a need to consider whether other gender affirming surgeries (including breast augmentation, mastectomies, orchidectomies, facial feminisation and others) are provided as part of an enhanced package of gender affirming care.

32. These other gender affirming surgeries are currently available through the public system. However, due to significant capacity constraints and the need for these procedures to be prioritised alongside other breast and body plastic surgical procedures, including cancer treatments, most gender affirming surgeries are assigned a lower clinical priority. As a result few people actually receive the surgeries.

33. Delivering a package of care that includes some of these broader gender affirming surgeries would be in line with some other countries. For example, British Columbia in Canada publicly funds the following surgeries specifically for gender affirming care: breast construction (in certain cases), chest construction, orchidectomy, hysterectomy. Scotland offers masculinising chest augmentation and feminising hair removal, and has committed to promoting transparency and equity in decision making around prioritisation acknowledging the difficulties transgender people face accessing surgeries.

34. In Australia, some people are eligible for a small number of surgeries where it is classified as 'medically necessary', including orchidectomies and hysterectomies. Some states provide subsidies/co-payments for other surgeries, for example Victoria provides between $3,000–$4,000 AUD (or $3,250-4,300 NZD) for chest surgery (bilateral mastectomy) and approximately $12,000 AUD ($13,000 NZD) for vaginoplasty.

35. New Zealand could consider providing a similar package so that people could access procedures as part of the gender affirming package of care.

36. There are also financial and staffing implications, as an additional package of care would not only add considerable cost but also add demand for plastic surgeons and other surgeons who are in high demand in the public sector. We would need to carefully manage any workforce and capacity risks that could lead to ensure it does not displace the treatment of people with symptomatic conditions.

37. Setting up separate pathways to access surgery would need to be considered carefully as it can cause inequities between different population groups. We recommend undertaking policy work on this with a view to future budget bids and service enhancements if you to pursue this option.

Improving gender affirming care generally

38. There has been some positive progress in improving health care in some regions, led by individual health professionals and highly committed and capable community members. Recently the Tāhine Hauora (the northern region transgender health service) has published their '*Guidelines for Gender Affirming Healthcare'* to promote quality and inclusive transgender healthcare across the northern

region. A copy has been provided with this briefing. Canterbury DHB is also working on their own pathways of care and we are aware of other regions that are actively pursuing improvements to gender affirming care as well.

39. In addition to the Tāhine Hauora guidelines, community members and health care professionals, led by Dr Jeannie Oliphant, Professor Jamie Veale and others have developed proposed national guidelines which have recently been published by the University of Waikato. The guidelines provide advice on good practice in transgender healthcare, as well as recommendations for the Ministry and DHBs on improvements. Their recommendations include providing flexible and responsive pathways, improvement of data collection, and improving capability and cultural inclusiveness among other recommendations.

40. These guidelines have been endorsed by a number of relevant professional bodies. We will work with DHBs and the authors to consider appropriate next steps and will provide you with a further briefing.

41. We also intend to meet with Auckland and Canterbury DHBs in November to understand their approaches and to discuss next steps in establishing a national approach to care pathways. After that meeting, we intend to engage other regions as well. It is important that any work on the latter involves members of the community. We will keep you updated on this work as it progresses.

Capability development

42. Alongside guidelines and care pathways, there are valuable opportunities to support capability development and empower community groups to provide appropriate support and advice to people accessing services. Community members have expressed the need for more information, and better support for health professionals to provide consistently good services. These initiatives would require a comparatively small amount of funding.

43. There are opportunities to:

    a. support the development of a professional group or association of transgender health specialists. This group would support capability development, advice on appropriate standards of care and would be a valuable source of independent advice to the Ministry. We have included $20,000 in the proposed Budget package.

    b. support the conference for transgender health care professionals that is likely to take place in Wellington in May 2019 as another opportunity to promote capability development for the sector[3]. We have included $40,000 in the proposed Budget 2019 package for this event.

    c. fund learning resources to improve capability of health practitioners, particularly in primary care. We have included $20,000 in the proposed Budget 2019 package for this group.

Supporting community navigators

44. In consultation, the opportunity to provide publicly-funded community 'navigators' was raised and strongly supported by those people we spoke to. Accessing gender affirming care services is complicated and stressful, and the ability to deliver transgender inclusive services is currently limited.

45. The intention of the community navigator role is to help people access appropriate services, particularly in the absence of consistent and easily accessible care pathways. The role would be designed to help people through the challenges of finding and accessing services, provide local information and appropriate support for this difficult process.

46. As an initial estimate, this initiative would cost $350,000 per annum for at least three full time equivalent roles in some main centres, including rural coverage. It is likely that these would be funded through contracts with NGOs. This has been included in the Budget 2019 package.

[3] If you wish to support this initiative then the Budget bid will need to seek funding in the 2018/19 financial year.

region. A copy has been provided with this briefing. Canterbury DHB is also working on their own pathways of care and we are aware of other regions that are actively pursuing improvements to gender affirming care as well.

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45. The intention of the community navigator role is to help people access appropriate services, particularly in the absence of consistent and easily accessible care pathways. The role would be designed to help people through the challenges of finding and accessing services, provide local information and appropriate support for this difficult process.

46. The Ministry believes that a consolidated national service would be sufficient to support people to access appropriate pathways. However, if Ministers wish to consider the navigator role, we estimate that this would cost $350,000 per annum for at least three full time equivalent roles in some main centres, including rural coverage. It is likely that these would be funded through

[3] If you wish to support this initiative then the Budget bid will need to seek funding in the 2018/19 financial year.

contracts with NGOs. The number of navigators and their distribution is scalable depending on available funding, which would need to be sought through the Budget process.

Budget implications

47. With additional funding, there is an opportunity to make substantial improvements on the status quo, and affirm the health care rights of the transgender population.

48. We proposed a total Budget 2019 budget package of $1.7 million. This includes:

    a. $1.275 million for a total of 20 surgeries annually, and coordination of the service.

    b. $350,000 for to fund a navigator in Auckland, Wellington and Christchurch.

    c. $40,000 would be used for supporting a Transgender health practitioner conference in May 2019, the establishment of a professional association of transgender health professionals, and capability development resources from primary health care

    d. $20,000 to support the establishment of a professional association of transgender health professionals, and

    e. $20,000 for capability development resources for primary health care.

49. We can continue work to support the development of nationally consistent guidelines and care pathways from within baselines.

Next steps:

50. Depending on decisions around gender affirmation surgeries and new funding through Budget 2019, we can commence work to establish either an appropriate contracting arrangement for the private coordination and delivery of surgeries starting 1 July 2019, or seek to transfer coordination by 1 June 2020.

51. We will continue to progress work on improving gender affirming care, and will keep you informed of progress.

52. We would welcome the opportunity to meet and discuss the content of this report, including the proposed budget bid for Budget 2019.

Proactive Release

53. The Ministry intends delaying this Health Report from publication under its proactive release policy because the information in this paper is Budget sensitive.

END.

Appendix 1: Summary of relevant components of the package

	Currently	Provision of surgery		Coordination of surgery		
Option	**Status quo**	**Private, New Zealand Based Surgery**	**Public, New Zealand Based Surgery**	**MOH coordination**	**DHB coordination**	**Private coordination**
Pros	No additional funding is required It is already in place, so only minimal changes are required	There is currently capability and capacity to deliver the surgery It is cheaper than overseas options, and likely to be comparative to providing it publicly	A surgeon with the capability is employed in the public system, there is no capacity to provide the surgery currently Likely to be comparative to privately funded surgery costs	Easy for the Ministry to monitor. Does not require any changes. Maintains accountability around services. No additional funding.	They have the appropriate skills and expertise. They could integrate the service with the rest of the care pathway. Maintains separation between the coordination and provider, to enhance accountability.	Coordination and delivery together could improve the timeliness of surgery, as the referral is direct to the service provider.
Cons	Surgery is being provided at a rate significantly lower than demand The High Cost Treatment Pool limits contracting options	The one service provider is newly established No guarantees that the service will continue to operate As there is only service provider in New Zealand, it can function as a monopoly	Delivering surgery publicly is likely to either displace other surgeries, or require that they are contracted out to the private system Establishing public provision of the surgery would take time, as teams would need to be trained etc.	As the current coordination mechanism is not designed for surgeries that are (for administrative purposes) elective, it can create administrative inefficiencies. Coordination by the Ministry does not allow for clinical oversight. No additional costs.	Contractual and accountability arrangements for this function would need to be developed. We would need to fund this function.	A contract for this function would need to be developed. We would need to fund this function, either as part of surgeries or separately.
Cost	Can be funded within current appropriations	A small amount can be funded through the current appropriation, but new funding would be required for higher levels of surgery	To devolve funding to DHBs for this service, new funding would be required as DHBs have indicated they would be hesitant to take over a very long list	No new funding would be required.	New funding would be required.	New funding would be required.

Appendix 2: Summary of initial engagement with stakeholders

Community engagement

As part of related work we met with a targeted group of people from the transgender community. These people were professionals with a depth of experience and strong ties to the community.

We met with the following people:

- Jack Byrne – Researcher, Counting Ourselves survey
- Jaimie Veale – Waikato University Transgender Health and Wellbeing specialist, Australia and New Zealand Professional Association for Transgender Health Executive Board Member
- Joey MacDonald – Kāhui Tū Kaha, LGBTTI Liaison & Training programme lead
- Ahi Wi-Hongi – Gender Minorities Aotearoa and New Zealand Prostitutes Collective
- Chase Knox – Gender Minorities Aotearoa.

The key points from the discussion were:

1. There is considerable growth in demand for services, and the current waiting list does not represent the actual demand for gender affirming surgery
2. The use of clinical prioritisation models for gender affirming surgeries is a barrier to accessing care, particularly when quality of life is not accounted for
3. Implementing informed consent models around hormones and other care would considerably improve accessibility to services
4. The most successful services are culturally appropriate and support holistic wellbeing
5. There is a large amount of regional variation experienced
6. A number of people experience significant discrimination in the health care system, but feel powerless to seek help as health professionals hold considerable power as they can provide the necessary care
7. There is an opportunity to improve accessibility by leveraging expertise in the community, through 'navigator' type roles, as well as information sharing and support.

Sector engagement

We also met with the following senior leaders and clinical experts from select DHBs:

- John Kenealy- Head of Plastic Surgery, Counties Manakau DHB
- Phillip Balmer- Director of Hospital Services, Counties Manakau DHB
- Jo Brown- Funding and Development Manager- Hospitals, Auckland DHB and Waitemata DHB
- Ralph LaSalle- Team Leader, Secondary Care, Canterbury DHB
- Debbie Holdsworth- Director of Funding, Auckland DHB and Waitemata DHB
- Bridget Farrant- Counties Manakau DHB

The key points from the discussion were:

1. The current commitments are well below the level of demand. It was estimated that up to 35 people annually may wish to access (genital) gender affirmation surgery, and higher for other surgeries.
2. There is collective interest in working on a pathway and package of care that improves accessibility, promotes fairness, and reduces vulnerability and variation in levels of service.
3. Important elements of a sustainable service would be:
    a. Integration between providers, and supporting a single provider until there is growth in both supply and demand of services
    b. Consideration of access to a broader package of care
    c. Input from consumers about priorities

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   d. To maintain competency, about 20 surgeries each year would be required to maintain competence.

4. Both Canterbury and Auckland DHBs have been working on gender affirming care pathways.
5. Understanding the issues and purpose is important for next steps in improving gender affirming care:
   a. DHBs are very unlikely to have any appetite to take over the waiting list in its current state
   b. There is variable access and support for (genital) gender affirming surgery between DHBs
   c. The High Cost Treatment Pool can be difficult for clinicians to access
   d. Competing with existing priorities is the biggest challenge in establishing a gender affirming care pathway.

We will continue to engage with the community and sector as we work to improve gender affirming care.

Health Report number: 20180841

Security classification: In-Confidence

File number: AD62-14-2018
Action required by: Routine

Genital reassignment surgery– initial advice on policy, funding and the engagement approach

To: Hon Julie Anne Genter, Associate Minister of Health

Copy to: Hon Dr David Clark, Minister of Health

Purpose

This report provides initial advice on genital reassignment surgery (GRS) policy, funding and engagement approach. Further analysis and consultation on the options will inform more detailed advice to be provided to you by September 2018.

Key points

- In the face of increasing community expectations, the provision of GRS has not been able to keep up with demand leading to a current waiting list of 105 people.
- The difficulties in accessing GRS impacts on the physical and mental wellbeing of trans and gender diverse New Zealanders. There are a range of options that could improve the coordination and delivery of GRS. This report provides initial advice on these options. We intend to undertake further analysis and report back to you by September with final advice and recommendations.
- More immediately, we propose a change to the current commitment to deliver a maximum of three male to female and one female to male surgery every two years, to make this a minimum commitment.
- We also propose to undertake a process to review those people currently on the waitlist, to ensure that they are ready and able to be operated on, and still wish to proceed.
- This report also provides advice on a targeted consultation process with members of the trans and gender diverse community and relevant medical professionals, and invites you to attend consultation meetings.
- It is important that GRS is seen as part of a pathway for gender affirming care. Advice will also be developed simultaneously on future settings and care pathways for gender affirming care.

Contacts:	Andrew Simpson, Chief Medical Officer	S9(2)(a) [redacted]
	Caroline Flora, Group Manager- Population Outcomes	

Health Report number: 20180841

Genital reassignment surgery – initial advice on policy, funding and the engagement approach

Recommendations

The Ministry recommends that you:

a) **Note** the development of advice on improvements to current funding and service arrangements

b) **Note** that the Ministry will commence work simultaneously on advice for future settings and care pathways for gender affirming care

c) **Agree** to a new commitment of a minimum of three male to female and one male to female surgeries every two years could be made **Yes/No**

d) **Recommend** that should you wish to finalise this change in surgery numbers, you discuss this with the Minister of Health **Yes/No**

e) **Agree** to the Ministry progressing work to review the waiting list **Yes/No**

f) **Agree** to a targeted consultation process with trans and gender diverse community stakeholders and medical practitioners **Yes/No**

g) **Confirm** whether you would like to attend consultation meetings with the trans and gender diverse community **Yes/No**

h) **Confirm** that you would like the Ministry to report back with the outcomes of consultation at the end of July 2018 and report back with detailed advice in September 2018 **Yes/No**

Dr Andrew Simpson
Chief Medical Officer

Minister's signature:

Date:

Genital reassignment surgery – initial advice on policy, funding and the engagement approach

1. This report provides initial advice on genital reassignment surgery (GRS) policy, funding and the engagement approach. Further analysis and consultation on the options that will inform more detailed advice to be provided to you by September 2018.

2. While GRS is the first area of focus, a broader piece of policy advice will be produced simultaneously on nationally consistent gender affirming health care pathways.

Background

3. In general, trans and gender diverse people's mental and physical wellbeing is markedly worse than that of the general population. Research shows that poorer physical and/or mental wellbeing and a higher risk of suicide is caused by the stigma, social exclusion, discrimination, bullying, rejection by family and friends that trans and gender diverse people face. It can also be caused by experiencing difficulties in being able to transition in a manner that is both timely and appropriate.

4. The evidence indicates that being able to express one's gender identity improves the health and wellbeing of trans and gender diverse people.

5. While health care options across the gender affirming care pathway are publicly funded, issues including variability in service provision and practice lead to a number of people not receiving services or transitioning in a timely or appropriate way.

6. A ministerial commitment in 2004 means that GRS is currently publicly funded at a rate of up to three male to female surgeries, and one female to male surgery every two years. Since 2004, 19 surgeries have been performed, equating to approximately 3 surgeries every two years.

7. The GRS waiting list is managed by the Ministry of Health. Management of the list involves liaison between the Ministry, medical professionals, and the people awaiting surgery to ensure people are re-assessed and still willing and able to undergo surgery. The process is time consuming and complicated, and this is made more difficult by changes in people's circumstances that occur while they are on the waiting list.

8. The waiting list for surgery currently stands at 105 people (79 male to female, and 26 female to male), and at the current rate would take over 50 years to complete. This number is likely to under-represent demand for treatment, due to barriers to care trans and gender diverse people face, including the possibility that the size of the current waiting list dissuades people from seeking surgery.

9. GRS is currently paid for from the High Cost Treatment Pool. This fund is available for one-off treatments not otherwise funded by the public health system and which are only available in the New Zealand private sector or provided overseas. The treatments must have proven efficacy.

10. New Zealand has not had the expertise to provide male to female surgery since the retirement of the previous specialist in 2014, who offered the surgeries privately. Since then, a small number of publicly funded male to female surgeries have been provided overseas. Female to male surgeries are more complex and have never been available in New Zealand.

11. Recently a qualified surgeon who has completed training in GRS, has been employed by Counties Manukau DHB as a general plastic and reconstructive surgeon. The DHB has not planned to provide GRS because of the wider quality, capacity and capability implications associated with providing a GRS service. There also has not been a formal national decision regarding this service change.

12. The surgeon's appointment may provide the opportunity to explore the option of providing GRS surgery in New Zealand. It is important to note that the presence of a qualified surgeon in New Zealand does not mean that the system is ready, in terms of capacity and capability of the surgical teams needed to support the lead surgeon. Furthermore, there are sustainability risks inherent in building a service around one person.

13. The appointment has also raised the expectations of the trans and gender diverse community. Access to GRS has been an increasing area of interest for the community, leading to media coverage in mainstream and rainbow community media.

14. GRS needs to be seen in the context of a broader pathway of care. The pathway of care includes primary care options including GP services, counselling and support services, and sexual health specialists. At a secondary care level, people can access publicly provided hormone therapy and secondary surgeries including mastectomies and orchidectomies (removal of the testes), and GRS through the HCTP. Additional feminisation or masculinisation procedures may also be required, eg breast reconstruction, facial or voice box surgery, to complete the process.

15. Not all trans and gender diverse New Zealanders are interested in GRS. Many people are comfortable without GRS, while others have medical reasons or experience barriers to accessing pre-requisite care that prevent them from undergoing surgery.

Current provision of GRS

16. Currently funding is provided through the High Cost Treatment Pool for people to access GRS overseas. The funding provided covers the cost of surgery, as well as funding travel for the patient and a support person. It also covers costs of any revisions or complications that may occur due to surgery.

17. The average actual cost of male to female surgery (including managing complications) over the last 13 years is $53,382, with a range from $25,587 and $81,975. Most of these surgeries were provided in New Zealand, with travel costs likely to be supported by the National Travel Assistance (NTA) policy.

18. The actual average cost of female to male surgery (including managing complications) over the last 13 years is $218,892, with a range from $45,169 to $535,034. Since 2005, two of the seven people receiving this surgery experienced significant complications with revisions accounting for an increase in costs - for both cases the surgery cost more than $500,000. Travel costs averaged $43,145 with a range from $10,765 to $148,946.

19. The need to travel overseas presents a barrier to care for a number of people. Nine people have been offered surgery since 2016, and only one has been in a position to travel. The barriers to surgery include medical issues, administrative issues or other life circumstances that prevent people from travelling overseas for up to one month.

20. There are also clinical risks in relying on overseas surgeons for GRS. There have been difficulties in getting DHB specialists to provide any necessary after care back in New Zealand, due to the lack of capability or understanding of the surgery. Revisions and complications generally have to be managed by the overseas surgeons.

Actions that can be taken now to improve acces to GRS

21. We have identified two actions that can be taken in the short-term to improve access and delivery of GRS, while further work is undertaken on developing a sustainable ongoing service (as per para 29).

    i) Changing the current commitment to deliver a maximum of three male to female and one female to male surgeries every two years, to a minimum commitment

22. This could increase the number of surgeries provided, although the amount of funds available within the High Cost Treatment Pool and priority against other surgeries would remain as constraints. The removal of a limit on the number of GRS delivered is likely to be viewed positively by the community. Should you wish to proceed with this change, it is recommended that you seek final approval from Hon Clark as minister responsible for health funding decisions.

    ii) Start a process to review the current waiting list.

23. Reviewing the waitlist is an important short-term priority so we can have a clear picture of the readiness of people on it, particularly those who are near the top of the list. Some people have

been waiting since 2006 and their circumstances may have changed. This has proven to be the case with several people offered surgery who were not able to take up the offer (and meant that the current commitment is not met). Care would need to be taken not to raise expectations of those on the waiting list.

24. Reviewing the readiness for surgery or people on the waiting list will enable more efficient processing of the waiting list and support more people to receive surgery. This is also expected to reduce the waiting list size, as some people will be lost to contact or be experiencing health issues that would make surgery inappropriate.

25. The waitlist would need to be reviewed by a team including a plastic surgeon, as an assessment of medical records would be necessary and a clinical assessment may be part of the process. Both Auckland DHB and Counties Manukau DHB have already indicated they may be able to undertake the validation process.

Actions being explored to reducing current waiting times for GRS

26. Alongside the actions above, we will explore the option of using the current funding mechanism (the High Cost Treatment Pool) to send patients to qualified surgeons for surgery through the private sector. This is dependent on qualified surgeons being willing and able to deliver services privately, including access to the appropriate surgery team and facilities.

27. In addition, we will develop advice on additional funding that could be sought in order to expedite assessment and treatment for patients on the current waiting list, however it does not account for new patients added. Funding could be applied through the current or amended High Cost Treatment Pool mechanism. This would be an interim solution to help reduce the current wait list while a decision on the ongoing sustainable solution was made and implemented.

28. As an initial indication, the table below sets out the estimated costs and timeframes to provide GRS to all those currently on the waiting list. These figures have been based on an estimated 80 percent of the waiting list, on the presumption that 20 percent of people would no longer proceed with surgery. These figures include the average total costs of surgery, including managing complications and travel.

Number of surgeries per year	Number of years to work through the current waiting list	Cost per year
2 per year (current)	40 years	$0.3 – 0.4 million per annum
8 per year	10 years	$1.2 –1.6 million per annum
16 per year	5 years	$2.3 – 3.2 million per annum
24 per year	3 years	$3.5 – 4.8 million per annum
40 per year	2 years	$5.9 – 8.0 million per annum

29. Alongside these surgeries we can also consider increasing access to other masculinisation and feminisation procedures. If GRS increases, it is likely that there would be increased demand for these surgeries. Early estimates of these costs include $8,000 to $16,000 per person for privately provided "top surgery" (breast reduction or remodelling), up to an estimated range of $61,000 to $124,000 for the full range of surgeries.

Options for the ongoing provision of Genital Reassignment Surgery

30. Alongside making short term changes, and considering medium term options, we will also provide advice on options for the ongoing, sustainable provision of gender reassignment surgery. This includes the following:

    a. Retain the status quo.

    b. Implement an enhanced version of the status quo that enables more efficient administration to ensure surgery is provided at the planned rate of four per two years.

c. Negotiate nationally to identify a DHB provider to manage the waiting list, coordinate and/or provide the service in New Zealand.

d. Negotiate a formalised private service agreement in New Zealand, similar to what was previously in place before the New Zealand surgeon retired.

e. Negotiate a formalised service agreement with an overseas provider.

f. Explore options for co-payment mechanisms for people undergoing GRS surgery.

31. Initial analysis of the benefits and implications of these options is provided in Appendix 1.

32. Based on the options analysis in Appendix 1, we propose that we do further work to explore options:

a. Negotiate nationally to identify a DHB provider to manage the waiting list, coordinate and/or provide the service in New Zealand.

b. Negotiate a formalised private service agreement in New Zealand, similar to what was previously in place before the New Zealand surgeon retired.

c. Negotiate a formalised service agreement with an overseas provider.

33. We will work with relevant DHBs and private providers to develop clearer price indications to enable a more detailed analysis of costs. Public surgery costs would need to factor in the costs of other surgeries that have been displaced due to limited operating theatre capacity, and would therefore be funded to be delivered in the private sector.

34. The development of options would include consideration of opportunities for developing an integrated service that includes other gender affirming surgeries as part of an integrated pathway of care. This would also factor in the good practice that is currently underway, including the services that are already provided as part of the Northern Region Transgender Health Service.

Consulting with relevant groups

35. Targeted consultation is important to test our initial options for the provision of GRS, and gender affirming care more broadly. Targeted consultation would enable the efficient development of advice, while incorporating the perspectives of those who are affected. Consultation would involve discussions with trans and gender diverse stakeholder groups with national representation, including those with experience of GRS. You may wish to front or attend meetings with trans and gender diverse stakeholders. We can work with your office to arrange this.

36. We will consult with DHBs to ensure a clinically and financially sustainable model is proposed. We will also consult with health care professionals and providers involved in gender affirming care, including GMs of plastics departments and the Northern Region Transgender Health Service.

Next steps

37. We will deliver more detailed advice on these options in September 2018, in time for the development of potential Budget 2019 initiatives.

38. Advice will be developed in parallel on future settings and care pathways for gender affirming care.

END.

MINISTRY OF HEALTH
MANATŪ HAUORA

Aide-Mémoire

Meeting with PATHA and Gender Minorities Aotearoa to discuss the transgender health work programme

Date due to MO:	1 October 2021	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	HR20212011
To:	Hon Dr Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Steve Barnes	Group Manager, Family and Community Health Policy	S9(2)(a)
Caroline Flora	Associate Deputy Director-General, System Strategy and Policy	S9(2)(a)

MINISTRY OF HEALTH
MANATŪ HAUORA

Aide-Mémoire

Meeting with PATHA and Gender Minorities Aotearoa to discuss the transgender health work programme

Date due:	1 October 2021
To:	Hon Dr Ayesha Verrall, Associate Minister of Health
Security level:	IN CONFIDENCE **Health Report number:** HR20212011
Details of meeting:	5 October 2021 2.00 – 2.30pm via Zoom

Purpose of meeting/ proposal:

You are meeting with Professional Association Transgender Health Aotearoa (PATHA) President, Dr Jaimie Veale to discuss the Ministry of Health's (the Ministry) transgender health work programme.

Dr Rona Carroll (PATHA Education Committee), Jack Byrne (Chair of PATHA Policy and Advocacy Committee), and Jove (Joe) Horton (Transgender Health Key Worker) will be in attendance.

Ahi Wi-Hongi, the National Coordinator of Gender Minorities Aotearoa (GMA), will also be in attendance.

Ministry of Health officials Steve Barnes, Group Manager Family and Community Health Policy, and Alex Burton, Principal Advisor National Services, will attend.

Talking points and attendee biographies are included in the appendices.

Comment:

PATHA and GMA background

- PATHA is an interdisciplinary professional organisation working to promote the health, wellbeing, and rights of transgender people.
- GMA are a nationwide transgender organisation working to support all transgender people and provide one-to-one peer support and information.
- You met with PATHA and GMA representatives in March 2021 to discuss work underway to improve Rainbow Health and you committed to meeting them again in six months.

We have engaged with PATHA and the transgender community about options for transgender health

- On 23 September 2021, we provided you with a briefing outlining 'Options to improve primary health care services for transgender people'

[HR20211570 refers]. This included options for supporting primary care clinicians to deliver gender-affirming care and culturally appropriate care more generally, standardising gender-affirming health care pathways, and adjusting primary health care funding settings.

- The Ministry and PATHA have a working relationship on ways to improve transgender health. We have been keeping in touch with PATHA on this work (as a group and as individual members). We have also engaged with GMA to ensure transgender lived experiences and expertise complement system and service knowledge in the development of preferred options.
- Additionally, the Ministry has engaged with a number of Responsible Authorities (including the Medical Council), as well as the Royal New Zealand College of General Practitioners (RNZCGP), Council of Medical Colleges, Health Media (New Zealand Doctor publishers), and Pegasus Health.

We are working with Responsible Authorities and Medical Colleges to understand developments in capability to support care for transgender patients

- PATHA has a strong focus on building the capability of the health workforce to meet the gender-affirming and general health needs of transgender people.
- The Colleges are responsible for providing training for the members in their health profession. We will continue to engage with the Colleges to understand more about the current training resources available and their uptake.
- We have also engaged with the Responsible Authorities to identify if they had clear guidance or knew of the training opportunities for the workforce to improve clinical and cultural competence when providing care to transgender people.
- Overall, we have found there is agreement that there is a need to build the capability of the health workforce to meet the needs of transgender people.
- There is a need across the health professions for both more specialised and general training to improve workforce awareness and responsiveness to the needs of transgender people. This may indicate that there is not enough training or guidance available to health professionals currently or they are not able to readily access materials that already exist. Additional funding could be used to develop training and education.
- The Ministry has been working with the RNZCGP to understand the continuum of workforce training options currently available to support general practitioners to deliver appropriate general health care and specific gender-affirming health care for transgender people. A range of workforce training and development resources already exist for primary health care practitioners, from introductory 'Trans 101' training that is appropriate for all staff within general practice, to specialised training for

those specialised in transgender care. Officials are also exploring other options with RNZCGPs, including practice audits and Cornerstone Continuous Quality Improvement modules.

- The Ministry has met with the Medical Council of New Zealand, who has a Statement on Cultural Safety that is elaborated further by each College to be specific to their profession. For instance, there may be further opportunities to build workforce capability into professional development via accreditation standards.

- S9(2)(f)(iv) [redacted]

Work is underway to expand community-based models of care and establish national guidance and lead clinical pathways for gender affirming care

- S9(2)(f)(iv) [redacted]
- [redacted]
- [redacted]

- There is a need to update national guidance and establish lead referral pathways in HealthPathways. PATHA has recently updated clinical guidelines on hormone therapy and plans to update the Guidelines for

Gender-Affirming Health Care after the World Professional Association for Transgender Health Standards of Care are released in December 2021. Upon completion, the RNZCGP intends to endorse the clinical guidelines to ensure CME credits are attached for general practitioners.

- S9(2)(f)(iv) [redacted]

We understand that PATHA and GMA are broadly supportive of the work to improve transgender people's access to primary care

- Officials met with representatives from PATHA and GMA on 22 September 2021 to give a high-level update on the work underway to improve access to primary care. There continues to be general agreement that the work is moving in the right direction and both organisations support the mahi.
- Specific comments from PATHA and GMA include:
    - The need to ensure that the primary care profession is not overloaded with new expectations for providing care to transgender patients, as the workforce is currently under pressure. S9(2)(f)(iv) [redacted]
    - The importance of ensuring that primary care services are well-connected to secondary services. This will be considered as part of the work to develop consistent HealthPathways.
- The Ministry has also received a request from GMA to endorse a resource they created by linking it on our website. The resource is called Supporting Transgender People and the Paramedic Council has made it a mandatory component of their certification. The Ministry is seeking internal agreement to endorse this resource in this way.

Progress is being made on updating the provision of gender affirming (genital) surgery

- In June 2021, we provided you with a briefing that included background on gender affirming surgery and provided an update on the plans to address the long waitlist for gender affirming genital surgeries in Aotearoa [HR20211116 refers].
- Patients who were historically accepted onto the waitlist under the High-Cost Treatment Pool (HCTP) are now being offered first specialist assessments (FSA) with the service provider. The Gender Affirming (Genital) Surgery Service (the Service), which specifically offers gender

reconstruction surgery, has reported that many of these patients who have been referred to the service provider for an FSA have been unsuitable candidates for surgery, due to complex physical or mental health co-morbidities. The Ministry is currently the coordinator of the waiting list for a FSA with the Service.

- We anticipate that improving the quality of referrals will ensure that suitable candidates progress through the waitlist for an FSA and surgery, hence improving the capacity and demand issues that the Service is currently facing. There are further opportunities to improve the utilisation of the Service capacity by ensuring all health needs are met in primary and community care.
- As of 31 August 2021, there were 295 patients on the waiting list for a FSA. This is a slight increase from 276 patients on the waitlist for a FSA as of 30 April 2021. Overall 74 percent of the referrals are for trans women and 26 percent are for trans men.
- Eight genital reconstruction surgeries have been performed this year, with one surgery booked for September 2021. An additional eight patients are progressing through the pre-operative pathway prior to surgery, and we anticipate we will reach 14 genital reconstruction surgeries this year (14 surgeries per year are publicly funded).
- The Ministry is meeting with the New Zealand Association of Plastic Surgeons to discuss the current training programme and whether there are any opportunities to increase positions or other options. The Health and Disability System Reform Programme also offer an opportunity to review what services are delivered in Aotearoa's public hospitals, including gender affirming surgery.
- District Health Boards can make decisions to prioritise gender affirming chest surgery. However, cancer treatments often take clinical priority in planned care, especially during changes to Covid Alert Levels. Therefore, cancer mastectomies would take precedence over a gender affirming case. Capacity issues would need to be addressed in order to improve service availability which could help separate gender affirming non genital surgeries from other surgical pools.

We anticipate that you may be asked about additional resourcing to support improved access to primary care for transgender people

- PATHA have asked whether additional funding will be included in the Ministry's plans to bring more gender affirming health care into primary care. However, due to Budget processes we are not at the stage where we can commit to additional funding in this area.
- **This aide-mémoire discloses all relevant information.**

Caroline Flora
Assistant Deputy-Director General
System Strategy and Policy

Appendix One: Talking points on transgender health

- Thank you for meeting with me to discuss transgender health, particularly our transgender health work programme.

Improving the health outcomes of transgender people and their access to health care

- I have recently received advice from the Ministry of Health on options to improve the health outcomes of transgender people and their access to primary health care and I am considering this advice.
- I understand both PATHA and Gender Minorities Aotearoa have worked with the Ministry to support the development of this advice and I want to thank you for engaging on this.
- What do you think would make the biggest different to improve the accessibility of health care for transgender people?
- I would like to ensure that the transgender community are involved in this work, as would the Ministry of Health. Are there any key transgender community groups you think the Ministry or I should meet with?
- How can the Ministry of Health and health and disability sector support you in your work to improve the wellbeing of transgender people?

Workforce cultural competency

- The Ministry of Health has been engaging with the health workforce to understand their training and development needs. I understand there is variation in guidance on how health professional deliver care for transgender people and there is an overall need for more general and specialised training across many health professions.
- What do you think would be useful for improving workforce cultural competency?
- Are there any workforces you think should be prioritised? Why?

System reform

- As we move towards the health and disability system reform, do you have thoughts on the key things that would improve care for transgender people?

Appendix Two: PATHA and GMA attendee biographies

Dr Jaimie Veale (she/her) is a senior lecturer in Psychology at the University of Waikato where she conducts research specialising in health inequities and social determinants of health for transgender people. Dr Veale is the President of PATHA, the Principal Investigator of Counting Ourselves: The Aotearoa New Zealand Trans and Non-Binary Health Survey, and a member of the Global Board of Directors of the World Professional Association for Transgender Health (WPATH).

Dr Rona Carroll (she/her) is a youth health general practitioner (GP) who holds a primary care based gender affirming hormone clinic, Mauri Ora, in Wellington. She is a senior lecturer at the University of Otago, Wellington in the Department of Primary Health Care and General Practice and has research and teaching interests in transgender health care. Dr Carroll educates GPs on providing gender affirming health care and has started a national GP transgender health peer support group, as well as a peer group for health professionals in Wellington who provide gender affirming care. Dr Carroll is a founding member of a new charitable trust called "Pride in Health" and is a member of PATHA's Education Committee.

Jack Byrne (he/him) is a senior human rights researcher and policy analyst, working as a contractor in Aotearoa and in the Asia Pacific on transgender health. He also works on legal gender recognition and legal and policy responses to end conversion practices. Mr Byrne previously worked for the Human Rights Commission for nine years, project managing the Transgender Inquiry; co-authored the Asia Pacific Trans Health Blueprint; and is the co-investigator for Counting Ourselves. Mr Byrne is a trans man and chairs PATHA's Policy and Advocacy Committee.

Jove (Joe) Horton (he/him) is a trans man, working within the public health system as the Transgender Health Key Worker in Tāmaki Makaurau. Mr Horton joined PATHA's Education Committee because he wanted to ensure more equitable health outcomes for trans and non-binary people throughout Aotearoa. Mr Horton advocates for proficient, empowering, and sustainable health care to be widely available and accessible nationwide in both primary and mental health care settings, enabling all people (including their whānau) to flourish and thrive.

Ahi Wi-Hongi (ia/they/them) is the National Coordinator of Gender Minorities Aotearoa. Ahi is a Diversity and Inclusion specialist, a Human Rights Advocate, and a Health promoter. Ahi is a member of the Wellington DHB's Sex and Gender Diverse Health Outcomes Working Group and previously spent six years with the New Zealand Prostitutes' Collective in a similar public health role. They have a particular focus on transgender people and sex workers in an Aotearoa context. Their passions include community-led action, human rights based models, population health, and kaupapa Māori frameworks for wellbeing.

Information to support Hon Dr Verrall at the 'International Day Against Homophobia, Biophobia, Interphobia & Transphobia' meeting, 30 November 2021

- The Government has committed to:
  - providing better access, support, and treatment for Rainbow communities, including our intersex and transgender whānau, through the health system
  - ensuring that New Zealand's health system is responsive to the unique needs of our Rainbow community
  - developing a rights-based protocol to prevent unnecessary medical interventions on intersex children.

Access to gender-affirming health care for transgender people is variable

- In general, transgender people experience poorer physical and mental health outcomes than the total population. These inequitable outcomes are often linked to the barriers that trans people experience in accessing health services, such as social exclusion, discrimination, cost, and limited clinical and cultural competency amongst the health workforce.

- There is variation across primary care providers and district health boards (DHBs) in the availability and delivery of gender-affirming care. Many services do not have a clearly identified pathway for people seeking gender-affirming care, with people required to privately pay for some services or access them through community organisations. This means that it can be difficult for transgender people to navigate the health system and access the services they need.

- There is a lack of sufficiently trained practitioners available for genital reconstruction (ie, there is only one surgeon in New Zealand who has the expertise and training to perform genital reconstruction surgery), and there is a lack of surgical access within public hospital facilities.

Significant progress has been made in improving Rainbow health…

Mental health and wellbeing support

- Budget 19 allocated $455 million over four years to roll out primary mental health and addiction responses nationally. Youth-focused services have an explicit requirement to be responsive to the unique needs of Rainbow communities.

- In 2019, a $1 million Rainbow Legacy Fund was established to improve the health and wellbeing of the Rainbow community through allocation of grants to organisations working with the Rainbow community.

- As part of Budget 2019, we also invested $77 million over four years to grow, upskill, and diversify our mental health and addiction workforce.

- In February 2021, the Government announced a $4 million targeted fund to support initiatives that provide mental health support to Rainbow young people nationwide. This is comprised of:
    - $3.2 million over four years for mental health services and
    - $800,000 over four years for the Rule Foundation to administer grants to improve mental health outcomes for future generations of Rainbow communities, with a focus on young people.

- DHBs have also received guidance for embedding a wellbeing and equity focus across their mental health and addiction services in their 2020/21 Annual Plans, including guidelines for engaging with Rainbow communities and ensuring equitable support options are available.

Gender-affirming genital surgery

- $2.99 million of additional funding over four years was provided through Budget 19 to establish a New Zealand-based service to lift gender-affirming genital surgeries to up to 14 surgeries per year. This is a significant improvement from the two surgeries per year previously funded through the High Cost Treatment Pool and performed overseas. However, the wait list remains long at 314 people (as of 19 November 2021).

- The service provider has performed ten gender affirming (genital) surgeries this year. The Covid-19 outbreak has affected the delivery of the service with two scheduled surgeries for December 2021 being postponed.

- An additional five patients are progressing through the pre-operative pathway prior to surgery.

… however, there is more work to do

There are opportunities to improve access to primary health care services for trans people

- There are significant opportunities to better respond to transgender people through the health system, particularly through primary care. This is because transgender people, like cis-gender people, receive most of their health care in primary care, through their general practice or a community provider.

- Appropriate and supportive gender-affirming care through primary health care will satisfy many people's needs and can reduce the need for more intensive health care across the life course. For instance, less stigmatising and more appropriate health services will improve mental health, and timely hormonal or 'minor' surgical interventions may reduce the need for more complex surgical interventions later in life.

- S9(2)(f)(iv) [redacted]

There are opportunities to improve the waitlist for Gender Affirming (Genital) surgeries

- In March 2021, the Ministry advised you that the most effective approach to improve the capacity and demand issues is to undertake a programme of work to simultaneously increase the capacity of the service while also ensuring that that the capacity is being used most efficiently [HR20211116 refers].
- The Ministry is engaging with plastic surgery clinical leadership to understand how access to gender-affirming surgery can be improved as part of the wider plastic surgery provision.
- We are also working with DHBs to standardise information related to pathways and DHB websites.

Taking a rights-based approach to health care for intersex children and young people

- Children and young people with intersex variations are at risk of undergoing medically unnecessary intervention because there is:
  - limited clinical guidance and training on intersex health care for health practitioners working in New Zealand. For example, the *Differences of sex development – Atawhai Taihemahema* guidelines only focus on the first 24 hours of a baby's life,

- a general lack of awareness and understanding about what it means to have variations of sex characteristics. This means that intersex children and young people and their whānau may not have all the neccessary information to make informed decisions about medical interventions.

- S9(2)(f)(iv) [redacted]

The health reforms provide an opportunity to ensure the health system is more responsive to the needs of trans people

- One of the central aims of the health reforms is to reduce variation in access to care. Because of this, the reforms are likely to improve access to gender affirming care, including gender affirming genital surgery for our transgender whānau.

- Significant changes to primary and community funding and service delivery are likely to be considered as part of the health and disability system transformation.

- In the longer term, a population health management framework and funding formula based around the needs of communities of interest ('localities') will be developed. This presents opportunities to better account for population groups with greater need, including transgender patients and those most likely to benefit from subsidised care. However, in the meantime, work is needed to increase availability of gender-affirming care and support the primary care workforce to become familiar with providing care for transgender people.

We have engaged with the Rainbow, human rights, and medical communities

Engagement on transgender mahi

- You have met with the Professional Association for Transgender Health Aotearoa (PATHA) and Gender Minorities Aotearoa (GMA). You are also scheduled to meet with the Council of Medical Colleges (CMC) Board of Trustees on 2 December 2021.

- Ministry officials have also engaged with the transgender community (Gender Minorities Aotearoa), the medical community (the Council of Medical Colleges, Royal New Zealand College of General Practitioners, the Medical Council, and PATHA), and some primary health organisations (Pegasus Health).

Engagement on intersex mahi

- You have met with Intersex Trust Aotearoa New Zealand (ITANZ), officials from the Human Rights Commission, the Children's Commissioner, and the medical community (Dr Neil Price, paediatric urologist), and you are scheduled to meet with the CMC Board on 2 December 2021.

- Ministry officials have also engaged with ITANZ, the Human Rights Commission, the Medical Council, and the CMC. The Ministry has also met with officials from the Australian Capital Territory (ACT), Victoria, and New South Wales (NSW). These states are currently progressing similar work to protect the rights of intersex people:

- ITANZ supports our proposed approach as it is the best way to build a conversation between the sector and the intersex community and improve health outcomes for intersex children.

Suggested talking points

Improving access to health care for transgender people

- Gender-diverse people experience poorer health outcomes, including mental health outcomes, compared to the general population. They also have difficulty accessing specific gender-affirming care.
- To improve the health outcomes of gender-diverse people and their access primary health care, we are looking at three things:
    - first, that existing primary and community healthcare meets the needs of gender-diverse people,
    - second, that best practice guidance on gender-affirming health care is in place, and
    - third, that the health workforce is supported to provide both general and gender-affirming care to transgender people.
- A strong and responsive primary health care system also has the potential to reduce the high rates of mental and physical health concerns experienced by transgender people and the need for more intensive care across the life-course, including gender-affirming genital surgery.
- The health reforms will also provide an opportunity to improve health outcomes for our Rainbow communities, as one of the central aims of the health reforms is to reduce variation in access to care.
- To address long-wait times for gender affirming genital surgery, we are committed to increasing the capacity of this service, while ensuring that transgender people on the waitlist are "surgery ready".

A rights-based approach to health care for intersex children and young people

- People with variations in sex characteristics have the right to live in a way they choose, free from discrimination and pressure to 'normalise' their bodies.
- I recognise that the unnecessary medicalisation of our intersex community has led to trauma and mental health concerns, and a lifetime of secrecy, shame, and isolation for many.
- This is why we must move away from a solely medicalised view of intersex health care, and why our government is committed to taking a rights-based approach to the care of intersex children and young people.
- Firstly, we are working to support health professionals deliver best practice health care for our intersex whānau.
- Secondly, we are committed to supporting intersex people to connect with others within the intersex community to understand what it means to live as an intersex person in Aotearoa, and to make informed decisions about their health care.
- I know that being diagnosed with an intersex variation can be an isolating, and confusing time for our intersex whānau and their families, given there is still a

general lack of awareness of what intersex means. It is important to me that our intersex community does not suffer further because of their experience with the health system.

Engagement

- It is important to me that the voices of our Rainbow communities are included in this work. Because of this, I have meet with members of Gender Minorities Aotearoa, and Intersex Trust Aotearoa New Zealand.
- However, I also know that it is important that we partner with the medical community. I have met with the Professional Association for Transgender Health Aotearoa on our trans mahi and will soon be meeting with members of the wider medical community to discuss intersex issues.
- This is the best way to build an ongoing dialogue between the Rainbow and medical communities and ensure the best health outcomes for our trans and intersex whānau.

Briefing

Further advice on meeting the health needs of the transgender community

Date due to MO:	4 March 2021	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	HR20210359
To:	Hon Dr Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, System Strategy and Policy	S9(2)(a)
Caroline Flora	Group Manager Family and Community Health Policy, System Strategy and Policy	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Further advice on meeting the health needs of the transgender community

Security level:	IN CONFIDENCE	**Date:**	4 March 2021
To:	Hon Dr Ayesha Verrall, Associate Minister of Health		

Purpose of report

1. This briefing responds to your request for further advice on transgender health, particularly around engagement with the transgender community and opportunities to collaborate on solutions that will meet their health care needs.

Summary

2. We recommend focusing on primary care as this is the most appropriate care setting for early and preventative health care and is where transgender people, like the rest of the population, receive the majority of their care.
3. Within primary care, we have identified three priority areas where we could improve the health care transgender people receive: supporting primary care clinicians to deliver gender-affirming care, standardising care pathways, and funding. There are opportunities to work with the transgender community on these areas.
4. We are proposing a programme of work for improvement in these areas, and in September 2021 we will provide you with a briefing seeking your further decisions on future work. S9(2)(f)(iv) [redacted]
5. Mental health and wellbeing are also critical and should be a part of any transgender work programme. An investment package to support Rainbow mental wellbeing has recently been announced, which may present an opportunity for engagement with Rainbow community organisations and subsequent collaborative design between these organisations and other primary health care providers. This investment may support transgender people.
6. We will engage with the transgender community as we develop the decision briefing that we will provide to you in September 2021. To date, Ministry engagement with the transgender community has been around specific time-limited projects. We could explore options to undertake consistent engagement with the intent of developing a work programme.
7. We will provide you with two further briefings on Rainbow health later in March 2021, focusing on intersex and gender-affirming (genital) surgeries. We recommend that these three papers be considered together to inform your priorities for Rainbow health and where the Ministry should focus work in this area.

Recommendations

We recommend you:

a) **Note** that the health needs of transgender people can be most appropriately addressed within primary care

b) **Agree** that officials progress a transgender health programme of work that focuses on primary care, including funding settings, supporting clinicians to be confident in delivering gender-affirming care, and standardising care pathways **Yes/No**

c) **Agree** that officials will provide you with initial options and an outline of proposed engagement in June 2021, with a focus on funding settings, supporting clinicians to be confident in delivering gender-affirming care, and standardising care pathways **Yes/No**

S9(2)(a)

e) **Note** that mental health and wellbeing are also critical to a transgender work programme, and investment in Rainbow mental wellbeing was recently announced

f) **Note** that we will engage with the transgender and wider Rainbow community to inform this work, and that we can explore options for more intentional engagement with the Rainbow community across different programmes of work in the Ministry

g) **Note** that we will provide you with two further briefings on Rainbow health in March 2021, and that these three papers should be considered together

Maree Roberts
Deputy Director-General
System Strategy and Policy
Date:

Hon Dr Ayesha Verrall
Associate Minister of Health
Date:

Further advice on meeting the health needs of transgender people

Context

1. We previously provided you with a briefing on improving the health system's responsiveness to transgender, non-binary and intersex people [HR20210124 refers].

2. Following a meeting with Ministry of Health (Ministry) officials on 11 February 2021, you requested three further pieces of advice on Rainbow health, including on transgender health care. This briefing provides you with an outline of a possible work programme, including engagement with the transgender community to identify their health needs and co-design ways to deliver this care.

Background

3. Our previous briefing [HR20210124 refers] described the importance of meeting the general health needs of transgender, non-binary and intersex peoples, as well as meeting those health needs that are specific to being transgender. While the Rainbow community is a priority health population with its own health needs, transgender people have additional specific health needs. Access to gender affirming care varies across Aotearoa.

4. While there have been some recent actions in this space (eg, funding to increase access to gender-affirming genital surgery) unmet demand and opportunities for improvement remain. The paper [HR20210124] described several areas for further work, some of which are already under way.

Primary care is the best place to focus efforts to improve health outcomes for transgender people

5. The majority of the health needs of transgender people can be appropriately addressed within primary care. This is also the appropriate place for coordination of care and referral to secondary and specialist services when required.

6. Ideally, the primary care sector would take the lead in providing health services, with clinicians supported and enabled to deliver gender-affirming care that transgender people feel comfortable engaging with.

7. While primary care provision is the responsibility of DHBs to manage, there are levers the Ministry can use to improve the care transgender people receive.

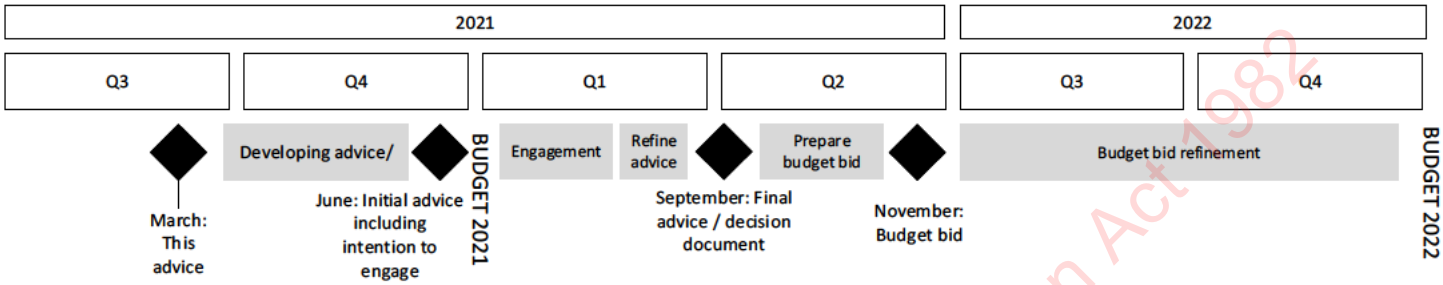
We have mapped out a programme of work for the next two years

8. We are proposing a programme that focuses on funding settings, supporting clinicians to be confident in delivering gender-affirming care, and standardising care pathways.

9. S9(2)(f)(iv) [redacted]

S9(2)(f)(iv) [redacted]

11. We will keep you informed throughout the process. The diagram below sets out our proposed timeframe.



12. Our June 2021 advice will present initial options and outline our proposed engagement. In September 2021 we will deliver a decision document, presenting final advice and seeking your decisions on further actions, including where you would like us to focus a Budget bid.

Funding

13. Ensuring appropriate funding is available to primary care providers to offer gender-affirming care is important. Despite often having higher health needs, capitation funding rates are the same for transgender people as the general population. Many transgender people seek out specific primary care clinicians or health services they know offer high quality care, so those clinicians are often offering care to many transgender people.

14. S9(2)(f)(iv) [redacted] There are a variety of ways to draw up a funding model, and they could include both reprioritisation of existing funding within DHBs, primary health organisation (PHO) flexible funding streams or using new funding.

15. We will consult with the PHO Agreement Amendment Protocol Group. This is a group which has consistently talked about the funding formula being unfit for purpose, and it is likely to be keen to be involved in developing ways to address this. We will also consult with the primary care sector and professional organisations. In the short to medium term, we will focus on ensuring that providers who are already providing effective and affirming care receive targeted funding so they can continue to do so.

16. We will need to be mindful that any changes in the short-term could be overtaken by the Government's response to the Health and Disability System Review. This will be reflected in the preferred option we present you with in September 2021.

Support primary care clinicians to become confident in the delivery of gender-affirming care

17. While many health practitioners are comfortable working with transgender patients and delivering Rainbow-inclusive services, others are less so. Different processes between DHBs (such as the necessity for psychological assessment prior to commencing gender-affirming hormone therapy) add to this uncertainty. This means that some transgender people still experience discriminatory practice by health practitioners – there is still a way to go before transgender people can be confident of being treated with dignity and understanding wherever they interact with health providers.

18. The *Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand*[1] were developed by an independent group of health professionals and community stakeholders and published in 2018. The Professional Association for Transgender Health Aotearoa (PATHA) has signalled their intention to update the guidelines, and we understand they intend to take a more in-depth focus on primary care than the 2018 guidelines.

19. When the updated guidelines are published, we will consider them for formal endorsement, and then support their dissemination and set the expectation that they are followed. PATHA intends to update these after the World Professional Association for Transgender Health has released updated Standards of Care, currently expected at the end of 2021.

20. PATHA has recently received funding and has developed an online training module for primary care on transgender health and wellbeing. There is now an opportunity for the Ministry to endorse them and support their implementation.

21. We will explore further training opportunities as part of the September 2021 advice. This will look at what professional development is required for different clinical and administrative groups in the primary care settings (eg, receptionists are an important part in creating a supportive environment for patients and are often the person a transgender person sees when, for example, someone wants to change their gender identifier), what can be done with different levels of funding, and the interplay of training with different models of funding.

Standardising gender-affirming care pathways

22. Our previous briefing described HealthPathways, a tool to give health practitioners guidance and referral pathways for a large range of clinical conditions [HR20210124 refers]. Canterbury DHB has developed a HealthPathway for gender-affirming care. These are available to all DHBs to localise to reflect services that are available in their area.

23. There are inconsistent ways of delivering care across the country, in relation to both gender-affirming care and general physical and mental health care for all Rainbow people. This is particularly pertinent for transgender people, as there is significant

[1] Oliphant J, Veale J, Macdonald J, Carroll R, Johnson R, Harte M, Stephenson C, Bullock J. Transgender Health Research Lab, University of Waikato, 2018. **https://researchcommons.waikato.ac.nz/handle/10289/12160**

variation across DHBs for transgender-related health matters including (but not limited to):

a. access to puberty blockers

b. access to hormone treatment

c. access to non-genital gender-affirming surgery – including surgery such as breast augmentation, hysterectomies, etc – which are the responsibility of individual DHBs, rather than genital reconstructive surgery which is overseen centrally by the Ministry

d. the extent to which a psychological assessment is needed before someone can access any of these services

e. access to psychological support for people who are transitioning, and for their whānau.

24. While provision of services is the responsibility of DHBs, the Ministry will explore adopting nationally consistent guidelines for eligibility for services where they are available. This could improve access to some services (eg, if there were national guidelines stating that a psychological assessment prior to commencing puberty blockers was not compulsory).

25. This work will look at what the eligibility requirements should be, taking into account up-to-date scientific evidence and views of the transgender community. It will also look at what mechanisms we can use to put these requirements in place. We will complete this by September 2021, and it will inform the advice we give you then.

Mental health and wellbeing are also critical

26. We have recently provided advice to the Minister of Health [HR20210208 and HR20210229 refer] on the implementation of an investment package to support Rainbow mental wellbeing, which was subsequently announced by the Prime Minister ahead of Big Gay Out 2021.

27. This package has two components:

a. increasing investment in Rainbow mental wellbeing through the Rainbow Wellbeing Legacy Fund

b. undertaking a procurement process to collaboratively design and expand youth mental wellbeing services provided by existing Rainbow community organisations.

These are supported by a total investment of $4 million.

28. There is potential for a new or expanded initiative/s under the Legacy Fund to contribute to health outcomes for transgender people. The inaugural funding round in 2020 provided funding to seven initiatives, including for PATHA to develop online training modules for primary care on transgender health and wellbeing.

29. The second component will require organisations seeking funding to explain how they would contribute to positive mental health and wellbeing outcomes for Rainbow young people. Rainbow community organisations are an important part of providing safe and inclusive support for Rainbow young people in their local communities, which includes being responsive to the needs of transgender young people.

Supporting community organisations and Youth One Stop Shops

30. Many Rainbow young people prefer to access health services through Youth One Stop Shops (YOSS). YOSS are designed to provide connected and holistic services that allow young people to access services that meet their needs in a safe, stigma-free environment. This model aims to decrease system complexity and increase access to services by providing a suite of co-located services.

31. YOSS are funded through a range of sources, including DHBs and primary health organisations. They may then partner with community and other organisations to provide services.

32. Community organisations themselves can be reluctant to seek government funding. This is because receiving it can mean they lose charitable funding, as they are less attractive (or seem less needy or deserving) to charitable funders. If funding from government is not sufficient, or ongoing, it poses sustainability risks for the organisations.

You also asked about the possibility of collaborating with the transgender community to design solutions to meet their health care needs as part of this work

Previous engagement has largely been on an informal basis

33. The Ministry engages with population groups in a variety of ways. For some priority population groups engagement is intentional and takes place on a regular basis. We establish advisory groups to consult with on relevant matters.

34. When we are developing particular policies or programmes, we may undertake public consultation. This could be in person (eg, public meetings or visits to relevant organisations) or virtually (eg, inviting written feedback or online surveys).

35. Previously, engagement with transgender (and wider Rainbow) communities has been on an informal basis. Although we do engage regularly with PATHA and other community groups and members, this tends to be on a topic-specific basis.

Alongside engagement, we also use material put out by Rainbow organisations to inform our work and understanding of what these populations' health needs are

36. While engagement has been done on an ad-hoc basis, we do appreciate the need for policies and services to be informed by lived experiences.

37. Material distributed by Rainbow organisations is a valuable resource for us. Recent examples include the Counting Ourselves survey of trans and non-binary people, and weekly communications put out by PATHA.

We have the ability to engage across a wide range of Rainbow organisations as we undertake this work

38. These include professional health care associations, community organisations, health providers, local networks, university groups, and takatāpui and MVPFAFF (Pacific) groups. We also expect that DHBs have local relationships with Rainbow organisations.

39. Stakeholders we have previously engaged with, and who you may like to meet with yourself, include:

    a. PATHA

    b. Kāhui Tū Kaha

    c. Gender Minorities Aotearoa

    d. New Zealand Prostitutes Collective

    e. F'ine

    f. Intersex Trust Aotearoa New Zealand.

40. We would welcome any suggestions you have of additional groups to engage with.

We could explore undertaking more regular and intentional engagement as this work progresses

41. We are proposing to engage with the transgender community and primary care sector as outlined in paragraph 9 so that their experiences and input inform the decision briefing that we will provide to you in September 2021.

42. Once you have made decisions on the programme of work, we could establish an advisory group included representation from the transgender and/or other parts of the Rainbow community. S9(2)(f)(iv) [redacted]

43. We would recommend that, if we establish an advisory group, it encompass the broader Rainbow community. There is a range of work under way in the Rainbow space across the Ministry. Intentional, aligned engagement would ensure we were not over-engaging with or fatiguing the community. It would also be useful for ensuring we are undertaking a coherent programme of work across the Ministry.

44. Once you have had an opportunity to consider this paper, and the two upcoming Rainbow health briefings, we would welcome direction from you on if and how you would like us to proceed with co-designing a programme of work with the Rainbow community.

Equity

45. Rainbow New Zealanders experience poorer physical and mental health than the general populations. Transgender people, in turn, can experience poorer health outcomes than other parts of the Rainbow community. This is driven by differences in levels of access, and negative perceptions and experiences of health care and the accompanying stigma. This leads to trans people having lower levels of engagement with health care providers, which leads to poorer health outcomes and further health inequities.

46. Improving health care for transgender people will allow this group to 'catch up' with their peers and will improve equity.

Next steps

47. We will provide you with two further Rainbow briefings on 17 March 2021. These will focus on intersex, and gender-affirming (genital) surgeries.

48. We will provide you with initial options and an outline of proposed engagement in June 2021, with a focus on funding settings, supporting clinicians to be confident in delivering gender-affirming care, and standardising care pathways.

ENDS.

Briefing

Improving the health system's responsiveness to transgender, non-binary and intersex people

Date due to MO:	3 Feb 2021	**Action required by:**	22 February 2021
Security level:	IN CONFIDENCE	**Health Report number:**	HR20210124
To:	Hon Dr Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, System Strategy and Policy	S9(2)(a)
Caroline Flora	Group Manager Family and Community Policy, System Strategy and Policy	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Improving the health system's responsiveness to transgender, non-binary and intersex people

Security level:	IN CONFIDENCE	**Date:**	3 February 2021
To:	Hon Dr Ayesha Verrall, Associate Minister of Health		

Purpose of report

1. This briefing responds to your request for advice on how the health system can provide better access, support and treatment for, and be more responsive to, transgender, gender diverse (non-binary) and intersex people.

Summary

2. Transgender, non-binary and intersex people have general health needs and may also seek a range of health supports to affirm their own gender identity. Often these populations face systemic barriers to access in both.
3. Recent improvements have focused on improving access to gender-affirming genital surgery and mental health and addiction supports. While progress in these areas was necessary and welcomed by the community, it does not address the entirety of the needs of transgender, non-binary and intersex people.
4. Improvements in primary care through addressing funding mechanisms, improving workforce capability and strengthening health care pathways across New Zealand is likely to make the biggest contribution to the health and wellbeing of transgender, non-binary and intersex people.
5. There are many examples of providers and non-governmental organisations (NGOs) offering effective and affirming care in New Zealand. These services are not fully funded and further investment may be required to ensure their sustainability and to empower the wider health sector to better support transgender, non-binary and intersex people.
6. There are initiatives that could be developed to provide better access to health care. These include offering an enhanced package of government funded gender-affirming care, developing a central hub of information, partnering with NGOs to provide peer support and delivering health promotion campaigns to address discrimination.
7. Opportunities identified require more thorough analysis, as well as engagement with the community and health sector if progressed. Officials are available to discuss your priorities for where the Ministry should focus efforts in these areas.

Recommendations

We recommend you:

a) **Note** that some transgender, non-binary and intersex people face barriers accessing both general and specific gender-affirming health care in New Zealand

b) **Note** that there have been recent improvements on gender-affirming genital surgeries, mental health and addiction supports and universal health services

c) **Note** there are other opportunities for improving the health and wellbeing of transgender, non-binary and intersex people, which if progressed would require consultation and potentially co-design with the communities they serve

d) **Note** that officials are available to meet with you to discuss your priorities for where the Ministry should focus work in the Rainbow health area

Maree Roberts
Deputy Director-General
System Strategy and Policy
Date:

Hon Dr Ayesha Verrall
Associate Minister of Health
Date:

Improving the health system's responsiveness to transgender, non-binary and intersex people

Background

1. This briefing responds to your request for advice on how the health system can provide better access, support and treatment for, and be more responsive to, transgender, gender diverse (non-binary) and intersex people. Although this briefing is specifically about these populations, the term Rainbow is used in places to describe people whose sexual orientation, gender identity, gender expression or sex characteristics differ from binary norms.

2. This is an initial briefing to outline barriers and initial opportunities to seek your priorities for further work in this area.

Health care needs of transgender, non-binary and intersex people

3. Members of the Rainbow community often face barriers to accessing universal health services, such as marginalisation and discrimination, and may be reluctant to engage with healthcare providers due to a lack of responsiveness to their needs[1].

4. In addition to general health needs, transgender, non-binary and intersex people may seek a range of health supports to affirm their own gender identity. This may include hormone therapy (puberty blocking and gender-affirming hormones), laser hair removal, voice therapy, counselling and social supports, and surgeries. Gender-affirming surgeries include both genital reconstruction and other surgeries, such as mastectomies. Not all transgender people will want these options, or may only want a few, but there is a significant lack of access and wide local variation to these services in New Zealand[2][3]. Many people must privately pay for some services or access them through community organisations.

5. Connection to supportive communities, healthy relationships, a positive sense of identity and acceptance from society all contribute to good health outcomes for Rainbow communities and protect against poor physical health, psychological distress and suicidality[4].

[1] Birkenhead, A. & Rands, D. (2012) *Let s talk about sex... (sexuality and gender): Improving mental health and addiction services for Rainbow Communities*. Auckland, New Zealand: Auckland District Health Board, OUTline and Affinity Services.

[2] Clark, T. C., Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., Fortune, S., Lucassen, M., Peiris-John, R., Robinson, E., Rossen, F., Sheridan, J., Teevale, T., Utter, J. (2013). Youth'12: *The health and wellbeing of New Zealand secondary school students in 2012*. Auckland, New Zealand: The University of Auckland

[3] Fraser, G., Shields, J., Brady, A., & Wilson, M. (2019). *The Postcode Lottery: Gender-affirming Healthcare Provision across New Zealand s District Health Boards*.

[4] Leonard, W., & Metcalf, A. (2014). Going upstream: *A framework for promoting the mental health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people*. Australia: National LGBTI Health Alliance

Access to adequate health care is variable

6. Research from and engagement with the transgender community shows they do not feel their concerns have been adequately addressed in the past[5] and they do not feel visible as a priority population. This is true for accessing both general health care as well as care related to their gender.

7. Transgender young people in the Youth '12 survey reported significant barriers to accessing appropriate primary and secondary health care, with 39 percent unable to see a healthcare professional when they needed to in the last 12 months, compared to 18 percent of their cisgender peers[2]. The 2019 Counting Ourselves survey also identified significant unmet need when treatment was sought by transgender people, ranging from 19 percent of people seeking hormone treatment, 67 percent of transgender men seeking chest reconstruction surgery, and 50 percent for transgender women seeking voice therapy[6].

8. Transgender and non-binary people need access to mental health and addiction services that are understanding and affirming of their gender identity and expression. Overseas research has shown that mental health professionals often view sexual orientation and gender identity as an underlying determinant of an individual's mental distress[7]. Additionally, the 2020 Working Group for reducing barriers to changing registered sex found that transgender and non-binary young people face barriers by not being able to access gender-affirming health care until after they have developed significant mental health needs[8]. Addressing these barriers requires both supporting the Rainbow responsiveness of mainstream mental health and addiction services as well as providing more options for people to access community organisations specialising in Rainbow health.

Recent improvements for Rainbow health

Gender-affirming genital surgery

9. $2.99 million of additional funding over four years was provided through Budget 19 to establish a New Zealand-based service to lift gender-affirming genital surgeries to up to 14 surgeries per year. This is a significant improvement from the two surgeries per year previously funded through the High Cost Treatment Pool and performed overseas, however the wait list remains long at 252 people. In December 2020 you received a briefing about the establishment of this service and an update on the surgeries performed in 2020 (HR20202156 refers). In March 2021 you will receive a further update on recent discussions with the service provider, the likely number of surgeries expected this year and opportunities for the Ministry to support the service provider.

Mental health and addiction support

10. Budget 19 allocated $455 million over four years to roll out primary mental health and addiction responses nationally. Youth-focused services have an explicit requirement to be responsive to the unique needs of Rainbow communities. District Health Boards

[5] Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T & Bentham R (2019), Counting Ourselves: *The health and wellbeing of trans and non-binary people in Aotearoa New Zealand.* Transgender Health Research Lab, University of Waikato: Hamilton NZ.

[6] Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T & Bentham R (2019), Counting Ourselves: *The health and wellbeing of trans and non-binary people in Aotearoa New Zealand.* Transgender Health Research Lab, University of Waikato: Hamilton NZ.

[7] McNeil, J., Bailey, L., Ellis, S., Morton, J., and Rehan, M. (2012) *Trans Mental Health Study 2012.* Scottish Transgender Alliance: Edinburgh

[8] https //www dia govt.nz/BDMReview-Working-Group-for-reducing-barriers-to-changing-registered-sex

(DHBs) have also received guidance for embedding a wellbeing and equity focus across their mental health and addiction services in their 2020/21 Annual Plans, including guidelines for engaging with Rainbow communities and ensuring equitable support options are available.

11. The Ministry provided additional funding to the LGBTIQ+ counselling service OUTline, as part of the COVID-19 psychosocial response. S9(2)(f)(iv) [redacted]

Rainbow Legacy Fund

12. A $1 million Rainbow Legacy Fund was established in 2019 to improve the health and wellbeing of the Rainbow community through allocation of grants to organisations working with the Rainbow community. The Ministry provided support for the establishment of the fund. The fund is administered by the Rule Foundation, which has been advancing the health, wellbeing and visibility of the Rainbow community since 1995. The inaugural round of the fund in 2020 granted a total of $100,000 across seven different initiatives, including an online transgender health training module for primary care, research on Rainbow ethnic youth in New Zealand, and initiatives to support and inform whānau of Rainbow people.

Universal services

13. Rainbow youth have been recognised as a priority population as part of the School Based Health Services enhancement programme funded through Budget 19. These services were also expanded and are now available in all Decile 1 to 5 public secondary schools, Teen Parent Units and Alternative Education sites. Universal youth health services, including Youth One Stop Shops, are anecdotally preferred by Rainbow youth and can offer health support at a timely life stage.

Relevant work underway

Gender identification in primary care

14. Currently the health system does not accurately or appropriately record all transgender and non-binary people's gender in health care settings. Inappropriate recording of gender identity can contribute to health inequities as people both avoid, and receive inadequate, primary health care as a result.

15. The PHO Agreement Amendment Protocol Group is beginning work to improve the recording and storage of gender identity in primary care. There are complex considerations for implementing these changes across the health system and correctly recording gender identity in a number of interrelated patient and IT systems. There are also implications for funding and capitation, and workforce guidance and training to support appropriate recording and use of gender information by staff is required.

16. Transgender people report poor experiences in primary care when they disclose their sex assigned at birth and their gender identifier[9], which can increase their reluctance to engage with primary care. However, there may be a clinical need for a person's sex

[9] Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T & Bentham R (2019), Counting Ourselves: *The health and wellbeing of trans and non-binary people in Aotearoa New Zealand*. Transgender Health Research Lab, University of Waikato: Hamilton NZ.

assigned at birth to be known, for instance for cervical screening for some transgender men. The consultation process so far has highlighted the need for consistent direction, standards, definitions and leadership from the Ministry in order to support the wider health sector to implement the changes. This work is in the early stages and the Ministry will keep you updated as the work programme develops.

Updating gender on Birth Certificates

17. The Government's response to the Working Group for reducing barriers to changing registered sex includes the Ministry of Health-led action to understand the retention and disposal of paediatric records. This is relevant to those seeking to change the registered gender on their birth certificate and requiring paediatric records to do so. With support from Archives NZ and Department of Internal Affairs, the Ministry will work with DHBs to understand how paediatric record systems operate and in what circumstances they may be destroyed. Following this, guidance for DHBs may be developed for the retention of and access to paediatric records. The Ministry will also explore other ways the health system can facilitate this process for people. You will receive an update on this by June 2021.

Health sector response to intersex people

18. A key issue for children and youth with differences in sex development is the opportunity for them to be supported to make their own decisions regarding their sex and gender identity. As part of the Ministry-funded Child and Youth Clinical Networks, the Paediatric Society established a national Intersex Clinical Network to investigate developing responses for people aged 0 to 18 with differences in sex development in 2017. Guidelines for healthcare workers caring for new-borns with differences in sex development were published in 2020. Further work to support intersex children and youth through referral pathways is being considered by the Ministry.

Further improving the health system's responsiveness to transgender, non-binary and intersex people

19. While these efforts have been welcomed by the communities they serve, they do not fully address the wide range of the population's needs. There are significant opportunities to better respond to transgender, non-binary and intersex people through the health system, particularly through primary care.

Primary care

20. The Rainbow community receives most of their health care in primary care, through their general practice or a community provider. Primary care is the most appropriate place for the multi-faceted needs of transgender and non-binary people to be met, with care delivered and coordinated in primary care and referring to secondary and specialist services when needed.

21. Research and community feedback indicate that supportive gender-affirming care through primary health care will satisfy many people's needs and can reduce the need for more intensive health care across the life course[10]. For instance, less stigmatising and more appropriate health services will improve mental health, and timely hormonal or

[10] Hyde, Z., Doherty, M., Tilley, P J.M., McCaul, K. A., Rooney, R. & Jancey, J. (2013). *The First Australian Trans Mental Health Survey: Summary of Results.* Perth: School of Public Health, Curtin University

'minor' surgical interventions may reduce the need for more complex surgical interventions later in life.

Primary care funding

22. The biggest barrier for access to adequate health care for Rainbow people is a lack of targeted or flexible funding to meet their health care needs. For example, coordinated care for a range of gender-affirming needs without additional funding to meet them can require a number of appointments, which, in general practice, have an out of pocket cost for the patient.

23. Despite these populations having higher health needs on average, current funding rates for transgender, non-binary and intersex people do not differ from the general population. This then relies on general practices and community organisations offering care beyond that contracted by government. There are many examples of providers and NGOs offering effective and affirming care and support, however their sustainability is uncertain. Sometimes people may go without adequate care in their region, or must travel long distances to access it.

24. As part of their work programme the PHO Agreement Amendment Protocol Group are considering the need and potential mechanisms for ensuring flexible funding to follow the patient through the health system to receive the care they need. The Ministry will update you as this work progresses.

Workforce capability

25. A key element of ensuring primary care is accessible, appropriate and can affirm one's gender identity is making sure health workforces have the capability and resources to deliver Rainbow-inclusive services. While the majority of practitioners are competent and informed, a common theme from the OutLoud report and the Counting Ourselves survey is a lack of understanding by some health practitioners[11] and mental health professionals[12] about transgender experiences and realities. For example, 13 percent of participants in the Counting Ourselves survey reported being asked unnecessary or invasive questions about their gender identity unrelated to their health visit in the last 12 months, and 17 percent reported a professional trying to stop them from being transgender or non-binary[13].

26. National guidelines for the provision of gender-affirming health care for children, youth and adults were published in 2018 and later endorsed by the Ministry. DHBs are implementing the guidelines to varying degrees, largely based on available funding and the capacity and capability of the workforce.

Health care pathways

27. HealthPathways is a tool to provide health practitioners with guidance and referral pathways for a large range of clinical conditions. Developing consistent HealthPathways for gender-affirming care, localised for each DHB region, is an important part of ensuring a consistent approach to health care for transgender, non-binary and intersex

[11] Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T & Bentham R (2019), Counting Ourselves: *The health and wellbeing of trans and non-binary people in Aotearoa New Zealand.* Transgender Health Research Lab, University of Waikato: Hamilton NZ.

[12] RainbowYOUTH & We Are Beneficiaries. (2018). *Out Loud Aotearoa.*

[13] Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T & Bentham R (2019), Counting Ourselves: *The health and wellbeing of trans and non-binary people in Aotearoa New Zealand.* Transgender Health Research Lab, University of Waikato: Hamilton NZ.

people. HealthPathways for gender-affirming care already exist and are available nationally, with many DHBs utilising them well. There is ongoing work from DHBs to strengthen the localisation of these pathways, with input from local communities, health providers and the Professional Association for Transgender Health Aotearoa. Strengthening these pathways will support more health professionals to offer timely health care and appropriate referrals to both peer and specialist support as required.

Potential further opportunities to explore

28. The following opportunities would require engagement and potential co-design with the community they serve, as well as further assessment on implementation, cost and timeframes for any work programme that results. Officials are available to discuss these options and their alignment with your priorities in this area.

Improving the consistency of assessment for gender-affirming care

29. Currently the Ministry of Health policy for accessing gender-affirming surgery requires a psychological readiness assessment. In practice this is often performed by the prescribing clinician, who generally knows the patient better than a mental health professional not familiar with the patient. However, some DHBs require a diagnosis of gender dysphoria to begin hormone treatment, and some require children to get a private assessment by a psychologist before starting puberty blockers or hormone treatment.

30. This approach can become problematic because requiring a diagnosis of gender dysphoria to transition creates barriers and can pathologise and stigmatise gender diversity. It is also important to consider potential misalignment with indigenous and cross-cultural understandings, for example takatāpui for Māori. Takatāpui embraces all Māori with diverse gender identities, sexualities and sex characteristics.[14]

31. A potential solution to explore is implementing consistent national guidelines for eligibility to access gender-affirming care. Informed consent means enabling transgender people to take the decision to transition themselves, without requiring the agreement of a mental health professional in all cases. Transgender people will have their own individual transition goals which may or may not include different aspects of social, mental health, medical or surgical care. This aligns with the Aotearoa New Zealand Guidelines for Gender-Affirming Healthcare and is practiced in some DHBs in relation to hormone therapy.

32. Nationally adopting a consistent approach could considerably improve access to some services and reduce the chance of stigmatising someone on their transition journey. The Ministry of Health keeps up to date with best international practice for providing gender-affirming surgery, and is considering other approaches for ensuring the health and wellbeing of transgender patients who are considering surgical interventions.

Partnering with NGOs to provide peer support and navigation

33. Communities have called for access to peer support services led by transgender and non-binary communities. Investing in peer support workforces leverages existing expertise and experiences from within the community and facilitates the sharing of information and experiences. Peer support may be particularly effective for the Rainbow

[14] Kerekere, E. (2017). *Part of The Whānau: The Emergence of Takatāpui Identity: He Whāriki Takatāpui* (*Doctoral thesis*, Victoria University of Welllington, Wellington, New Zealand

community, as Pegasus PHO informed the Ministry that 70 percent of Rainbow people who received peer support through their mental health pathway reported having no need to go onto trained counsellors.

34. The Budget 19 bid for gender-affirming genital surgeries also included but did not receive funding for three navigators through NGOs in the main centres. The intention was to help people access appropriate services and receive support along the way, particularly in the absence of consistent and accessible care pathways. Work to develop this proposal could be progressed further.

An enhanced package of care, including gender-affirming non-genital surgery

35. Unlike gender-affirming genital surgery (which has ringfenced resourcing as part of the service) and interventions for intersex people (which are accessed on a case by case assessment through the High Cost Treatment Pool), gender-affirming non-genital surgeries are provided by DHBs. This means access to them is subject to prioritisation and competition with other demands for planned care within DHBs.

36. While the volume of gender-affirming non-genital surgery in the year 2019/20 grew to 76 nationwide, there is considerable geographic variation in access to these surgeries, with some DHBs providing none locally. The overall number of surgeries is low and does not meet estimated demand, as most are assigned a lower clinical priority. The number and type of procedures performed in DHBs regions in the last three years is detailed in Appendix One.

37. New Zealand could consider funding a broader package of gender-affirming non-genital surgeries as British Columbia (Canada) and Scotland do, or providing subsidies for certain surgeries as some Australian states have. Further policy work would be required, as there may be risks to system capacity that could displace treatment of symptomatic conditions, and selection of specific types of surgeries could cause inequities between population groups. Additionally, feedback from the community indicates that while surgery is important to some, it is not sought by many and the focus must be beyond this.

Developing a centralised hub of information for transgender, non-binary and intersex people

38. Information on support options, health care pathways and general information and navigation relating to gender identity and health has been requested by communities. Many good resources exist, though they are fragmented and can be hard to find. The Ministry could support the development of a cross-agency hub of information at relatively low cost and in partnership with various Rainbow communities.

Public health promotion to address transphobia, discrimination and bullying

39. Rainbow people can face significant discrimination, exclusion, bullying, misunderstanding and violence from people they know as well as from wider society[15]. Discrimination is multifaceted and requires a variety of approaches to make society more accepting and enable Rainbow communities to feel safer, have better health and wellbeing and lead full lives. This includes health promotion and information campaigns to bring awareness of the experiences and realities of Rainbow populations, and equipping whānau with resources to understand and support the health of their

[15] Fraser, G. (2019). *Supporting Aotearoa s rainbow people: A practical guide for mental health professionals.* Wellington: Youth Wellbeing Study

Rainbow whānau. This could be done in partnership with community members and leaders, and could focus initially on health and wellbeing, with the health workforce a specific audience for attention.

Equity

40. Rainbow New Zealanders tend to experience worse physical and mental outcomes than their peers and often have more need to engage with the health system, yet face persistent barriers in doing so. Investment to ensure the health system is responsive to need and does not impose a cost barrier on people, as well as improving health supports relating to their gender, is crucial to achieve equitable health and wellbeing outcomes.

41. Rainbow people are also not a homogenous group. Intersectionality is a concept that recognises people who experience one form of marginalisation may also experience other forms of marginalisation, based on their ethnicity, socio-economic status, or gender identity. These may contribute to mental distress and when combined, have compounding effects on a person.

42. Progressing any of the opportunities underway and outlined in this briefing must consider the broad range of individual situations of Rainbow people, including culture, refugee status, disability status and proximity to health services.

Next steps

43. This is an initial briefing to outline barriers and potential opportunities, with the expectation of further work in this area aligned with your priorities. Most of the opportunities identified require engagement and potential co-design with the communities they serve. Further assessment is required on implementation feasibility, cost and timeframes for any work programme that results. Officials are available to discuss with you where the Ministry should focus our work in this area.

44. The Government's Response to the Health and Disability System Review also creates an opportunity to make the health system more responsive to the needs of transgender, non-binary and intersex people. Officials will engage with the Transition Unit as the Response progresses, to better understand the relevance to these opportunities and the Labour 2020 manifesto commitments.

ENDS.

Out of Scope