

Trans people are being let down by the Health Service

PERSPECTIVES

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There are a number of government-funded studies and reports that focus on, or refer to, healthcare services for trans people. There is knowledge in the Directorate and in the Ministry, as well as good intentions. Nevertheless, transforming this knowledge into policies and practical health care is a slow process.

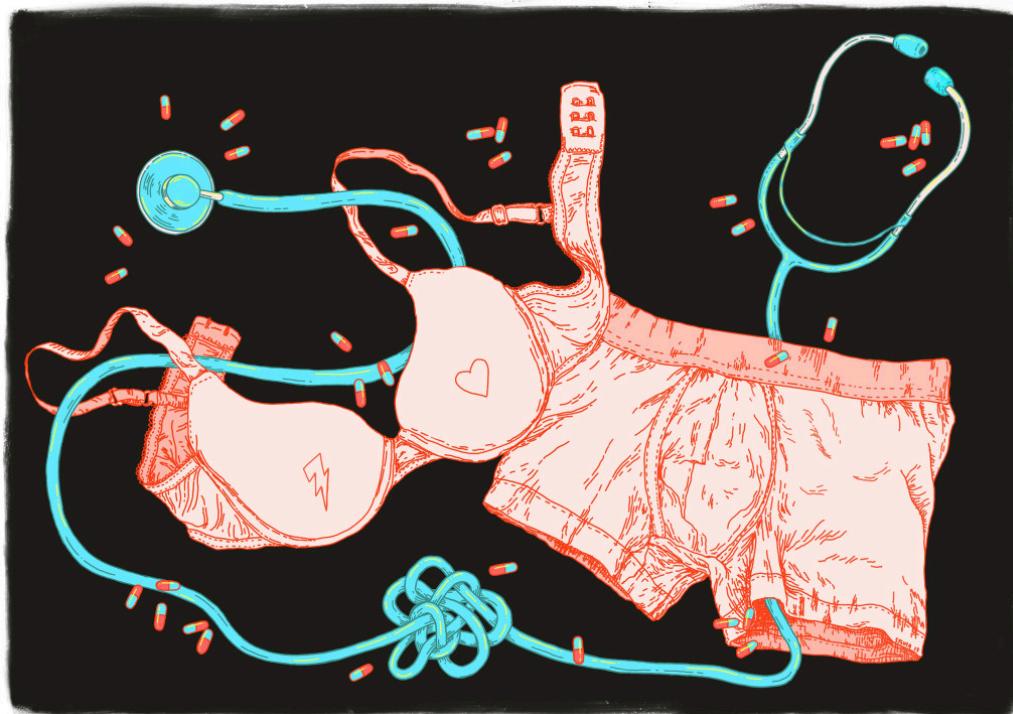


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Several studies confirm that the trans* segment of the population is larger than previously thought, i.e. greater than 1 % (1). This segment of the population – also referred to as the gender incongruent – has a poorer quality of health than the rest of the population (2). At the same time, we see that many have good lives and enjoy good health and a good quality of life. Unusual human propensities do not automatically give rise to poorer health and a

reduced quality of life. The reason for such outcomes must be found in external circumstances, for example in the availability of appropriate healthcare services and competence.

Tabell

Box 1 Defining the concepts

<ul style="list-style-type: none">• <i>Trans*</i> is an umbrella term used to refer to people who experience a mismatch between their gender identity or gender expression and the legal gender that was assigned to them at birth. This is not a homogenous group, and the concept includes people who identify as a trans person or transgender, people who have been diagnosed as transsexual, and people who have more than one gender expression and change between them. The asterisk in <i>trans*</i> is used to show the full trans spectrum and to accentuate the diversity among those who define themselves as trans people.
<ul style="list-style-type: none">• <i>Gender identity</i> is a person's inner experience of being female, male, both female and male, a trans person or none of the above.
<ul style="list-style-type: none">• <i>Gender incongruence</i> refers to the experience of a mismatch between a person's gender identity or gender expression and the gender assigned to them at birth.
<ul style="list-style-type: none">• <i>Gender dysphoria</i> refers to the discomfort caused by a mismatch between gender identity and the gender assigned at birth.
<ul style="list-style-type: none">• <i>Sexual health</i> may be defined as physical, mental and social well-being in relation to sexuality. Sexuality includes feelings, thoughts and actions, in addition to the physiological and physical aspects.
<ul style="list-style-type: none">• <i>The working groups</i> are key contributors to the activities of the Norwegian College of General Practitioners. A working group focuses on a particular field within general medicine. The home page for the working group on lesbian, gay, bi-sexual and trans health is found on this address: http://legeforeningen.no/Fagmed/Norsk-forening-for-allmennmedisin/Faggrupper/lesbisk-og-homofil-helse/.

The authors of this article are members of the working group on lesbian, gay, bisexual and trans (LGBT) health set up by the Norwegian College of General Practitioners (NFA). The working group (previously referred to as a reference group) is a key contributor to College activities. In this article, we focus on gender incongruence.

Gender incongruence replaces the 'trans' concept and refers to a mismatch between a person's own sense of gender identity or gender expression and the gender they were assigned at birth. The subjective experience of being a woman, man, both woman and man, a third option or none of the above, is referred to as our *gender identity*. If this identity is incongruous with the gender we were assigned at birth, this will result in pain which is often referred to as *gender dysphoria*. This dysphoria is a cause of poor health and should therefore be a priority target area for all health service providers. However, there is far too little evidence of such prioritisation. This is puzzling, since the Norwegian government has commissioned studies and reports, all of which make the same point.

The knowledge base

A report commissioned by the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) in 2012 on children with alternative gender expressions, stressed the need to raise the level of competence and change attitudes (3). The authors suggested that these children should receive support from local family counselling services. They did not, however, expect the required raising of competence levels to be rolled out nationwide, across all family counselling services. It was instead suggested that certain services should be selected, evenly distributed across the country.

In 2013, another Bufdir-funded study was published: *All sorts of people. Living conditions and quality of life for people with gender identity issues* (4). The report highlighted two findings. Firstly, that schools, employers, family members and public institutions in general have insufficient knowledge about, and little understanding of, gender identity issues. Secondly, that the Health Service is failing the gender incongruent.

In April 2015, a panel of experts appointed by the Norwegian Directorate of Health published a report entitled *Right to right gender – health for all genders* (5). Their mandate was to consider the stipulations relating to a change of legal gender, and the organisation of healthcare services for people with gender incongruence and gender dysphoria.

This work led to the introduction of new legislation concerning legal gender. Until June 2016 it had been a requirement that in order to be granted permission to change an individual's gender as recorded in the National Population Registry, the individual's reproductive organs would need to have been removed. Today, submission of a self-declaration to the Registry is sufficient. The requirement for body alterations has been abandoned. So far, more than 700 people have taken advantage of the opportunity to decide their own legal gender, irrespective of the gender they were assigned at birth and irrespective of body alterations. The report establishes that there are deficiencies and challenges associated with the current provision of healthcare services. Many who are entitled to health care associated with gender dysphoria do not receive the help they need and want. The report set out good and thorough recommendations on the best way to organise health services in order to meet the need for health care among the gender incongruent. This has yet to be implemented.

In January 2017, the Norwegian Ministry for Health and Social Affairs published an action plan entitled *Talk about it! Strategy for sexual health (2017–22)* (6). This replaced two separate action plans that focused on HIV and unwanted pregnancies respectively. It was a clear objective to highlight the importance of sexual health. The strategy document points out that all people of all ages must be given the necessary knowledge and skills to look after their own sexual health, and good sexual health must be assured for the entire population. The Health Service must ensure that the health and care sector promotes and disseminates knowledge about sexual health. Health

professionals must respect and understand the sexual needs of service users and patients. When and not least, how, do Norwegian health authorities intend to turn their knowledge into practice?

Restructure the provision of health services now!

We support the conclusion to the report entitled *Right to right gender, health for all genders*: All individuals who experience gender dysphoria must be offered competent health services on the care level they need. The clear majority of the panel of experts recommended provision of health services according to two main principles:

Available treatments should be structured so as to provide health care on the lowest efficient care level (the LEON principle), and the Health Service must strive to administer the smallest effective dose. This means that patients who only want transformative hormone therapy should have access to this without being required to undergo surgical adjustments. If major or minor surgical adjustments are wanted, then there must be no requirement to undergo hormone therapy.

Norwegian health services are indeed organised along the lines of the LEON principle, which means that general practitioners must make themselves available to all types of patients and problems, and assist patients by opening doors and coordinating initiatives. General practitioners are not required to know everything, but must be able to handle everything. Today, this is not the case with respect to the gender incongruent. In order to be able to handle problems relating to gender identity, gender incongruence and gender dysphoria, general practitioners need access to specialists. Currently, the only specialist service available is provided as a third-line service by Oslo University Hospital (7). The department's home page explains as follows: 'On suspicion of transsexualism, the general practitioner will refer you to your local outpatient child psychiatric service (BUP) or your regional outpatient psychiatric service (DPS). The BUP/DPS will then carry out a psychiatric assessment and refer you to the National Treatment Centre for Transsexualism (NBTS) at Oslo University Hospital.' This gives rise to three problems. Firstly, the national treatment centre expects patients to want to be either male or female, and to want to transition to the gender opposite to the one they were assigned at birth. Those who fail to fit into this pattern will not be offered treatment. Secondly, there is no regional second-line provider of hormonal or surgical treatment. Thirdly, the GP is sidelined.

Both the reports *All sorts of people* (4) and *Right to right gender, health for all genders* (5) point out that the service provision offered by Oslo University Hospital has been too restrictive, and that many have been excluded. This has in itself given rise to mental illness. Many do not wish to make the greatest possible change and convert to the opposite gender. If 'Peter' only needs a wig to become 'Petra', then the general practitioner ought to be able to authorise the required financial support. If 'Petra' perhaps also needs hormonal treatment or surgery, then the general practitioner should be familiar with this

type of treatment and have access to a functional second-line health care provider within the Regional Health Authority for consultation or referral, as is the case within most disciplines. These are clear recommendations of the report. They now need to be implemented!

We need sexology expertise

The need for sexology expertise in the Health Service is highlighted in the aforementioned reports, directly and indirectly. Doctors with sexology as a specialty will be a good supplement to hospital outpatient clinics in the treatment of the gender incongruent. Furthermore, it is difficult to envisage how the *Strategy for sexual health 2017–2022* (6) may be implemented without relying on existing expertise. There are already two specialist educational pathways in sexology: *specialist in sexology counselling*, and *specialist in clinical sexology*. Both pathways are structured according to the templates provided by specialties in medicine and psychology. They are currently approved by a Nordic authorisation committee under the auspices of the Nordic Association for Clinical Sexology. Norwegian health authorities should formalise these specialist courses.

To quote the *Strategy for sexual health 2017–2022*: ‘Good sexual health is a resource and a safeguard that boosts quality of life and stimulates coping skills. Sexuality involves feelings, thoughts and actions in addition to the physiological and physical aspects’. This concerns us all.

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