

Medical Services Advisory Committee (MSAC)

CONSULTATION MEETINGS WITH CONSUMERS

MEETING NOTES – DRAFT

Application 1754 – Surgical Procedures for Gender Affirmation in Adults with Gender Incongruence

8 May, 11 May and 12 May 2026

1. Introduction

Attendees

Meeting attendees included members of the Medical Services Advisory Committee (MSAC), staff from the Department of Health, Disability and Ageing (Medical Specialist Services Section), and one representative from a range of consumer organisations. These organisations were invited to participate as they had previously provided consultation feedback when the application was considered by MSAC in April 2025. The organisations represented were:

A Gender Agenda; ACON Health Ltd; Australian Feminists for Women's Rights; Australian Research Centre in Sex, Health and Society; Equality Tasmania Inc.; Family Planning Alliance Australia (FPAA); Feminist Legal Clinic Inc.; Genspect Australia; Inner City Legal Centre's Trans and Gender Diverse Legal Service; LGB Alliance Australia; MD Queer Health Collective; Monash Health Gender Clinic; Parents for Trans Youth Equity (P-TYE); Parents of Adolescents with Gender Distress – Victoria; Queensland Council for LGBTI Health; Sexual Health Quarters (SHQ); Thorne Harbour Health; Transfolk WA; Trans Health Research; Vital Collective; Women's Rights Network Australia; Working It Out.

Purpose

The key objective of the meetings was to gain input on current and future clinical service provision relevant to surgical procedures for gender affirmation in adults with gender incongruence.

Background

The Medical Services Advisory Committee (MSAC) is considering MSAC application 1754 – *Surgical Procedures for Gender Affirmation in Adults with Gender Incongruence*. This application is progressing via a two-stage process. The first-stage assessment of the clinical evidence was considered by MSAC in April 2025 (see the [Public Summary Document](#)). At that time, MSAC considered that there is a clinical need for gender-affirming surgeries for people with gender incongruence. While MSAC considered that the proposed surgeries are likely to be effective in the short-term for some people, this was highly uncertain due to limitations in the evidence presented in the application. MSAC advised that additional work

was required to ensure that MSAC has the necessary evidence and data to make its assessment and provide advice to inform the development of the second-stage assessment report (economic and financial analysis).

MSAC requested:

- a more comprehensive assessment of the clinical evidence for gender-affirming surgery for adults with gender incongruence;
- more work to be done to establish care pathways to meet the needs of people with gender incongruence; and
- further specific advice from a range of stakeholders to ensure that patients attain the best outcomes from these surgeries.

A series of stakeholder meetings occurred in view of that final request, with the option for participants to also provide written submissions. Additional consultation meetings occurred with representatives from clinical organisations and state and territory jurisdictions. The outcomes of these meetings are reported separately. All input provided will inform the MSAC recommendations to the Commonwealth Health Minister.

2. Summary of discussions and outcomes

Consumer attendees expressed many differing views at both the meetings and in written submissions. The material in this document reflects key themes and statements made by various consumer attendees at the three meetings and in later written submissions. The statements were about consumer attendees' experiences, perceptions and opinions, and were sometimes made on behalf of the organisations that they represented. **The document does not necessarily reflect points of agreement or shared terminology among the consumer attendees, and it does not reflect any statements made by the non-consumer attendees, i.e. by MSAC members or Department staff. Information in this document should be treated as opinion and experience of the attendees; statements have not been verified and therefore should not be assumed, relied upon, or cited as fact without appropriate verification.**

Consumer attendees described numerous barriers to accessing gender-affirming care. In particular, they described long wait times in the public system, high costs (especially in the private system), difficulty finding knowledgeable health care practitioners, and discriminatory treatment. On the other hand, they also described some facilitators of access to gender-affirming care. These included a knowledgeable General Practitioner (GP), the informed consent model (where a GP or other health care practitioner prescribes hormone therapy without needing the patient to be assessed by a psychologist or psychiatrist), and the private system generally.

By contrast, other attendees proposed that access to gender-affirming care is too rapid. They proposed that a lack of multidisciplinary assessment (especially on the informed consent model) equates to diagnosis by self-report and that health care practitioners generally do not adequately assess and treat comorbidities (especially mental health issues). It was expressed that this leads to some sub-populations being more harmed than benefited. Some attendees

expressed concerns that in particular young people, including young adults, are being fast-tracked along a clinical pathway where both consumers and practitioners are discouraged from exploring doubts about a person's transition and where limitations in the underlying evidence base are serious but not openly discussed.

It should be noted that gender affirming care for children and adolescents was discussed in the consumer meetings. It is recognised that this is of importance to the attendees, but as it is out of scope for the current MSAC application (which relates only to adults), the discussion has not been included here.

Barriers to accessing gender-affirming care that were experienced or noted by consumer attendees

Service design

- No or little surgery being provided in the public system, including because of state-based policy that prevents gender-affirming surgery.
- Gender-affirming surgery sometimes being viewed as cosmetic, e.g. breast augmentation or rhinoplasty for trans women.
- Some variation in state-based public policy which can affect access, including access to puberty blockers, the level of support in some jurisdictions across the public system and disparity in access to private practitioners able to provide components of gender affirming care.
- Long wait lists of 6 months to several years, especially for gender clinics in the public system, but also for private practitioners, who are in low supply and high demand.
- Some services required by the jurisdictions are not consistent with those recommended by the World Professional Association for Transgender Health (WPATH) guidelines.
- Private specialists (e.g. endocrinologists) stopping their practice of gender-affirming care because of insurance issues.
- Lack of clarity on the part of private health insurers concerning what surgical procedures they cover, leading to difficult decision-making for a patient about whether to get private health insurance.
- Lack of private surgery options in Australia, leading to travel overseas to access care.
- Lack of surgical training pathways and professional mentoring in gender-affirming surgery in Australia. It was proposed that lack of surgical specialisation could be leading to increased surgical complications.
- Coding systems relating to surgical access. An example was provided that hysterectomy coding can require 'female' on the birth certificate, rather than simply the presence of the relevant organ (a uterus). A man can have a uterus, including because of an innate variation of sex characteristics.
- Private hospitals, disallowing gender-affirming care. An example was provided that surgeries were cancelled after realising they are gender-affirming, despite the same surgeries being provided to cis-gendered people for cosmetic reasons. This experience was described by the attendee as discriminatory.

High financial costs, especially in the private system

Attendees reported high costs associated with:

- Consultations (both GP and specialists), attendees expressed that most consultations were not bulk-billed in the private system.
- Surgeries, where costs begin at \$10,000 and increase to \$30,000, especially if a person has a chronic health condition.
- Travel and accommodation costs relating to interstate care (subsidy of travel costs would help).
- Pre-surgical preparation (e.g. hair removal).
- Out-of-pocket costs of \$800 to \$2000 (plus appointment costs) for a WPATH pre-surgical assessment and letter of support (two letters may be required, doubling costs).
- Specialist consultations, when trying to source multidisciplinary wraparound care in the private system.
- Out-of-pocket costs where there are existing MBS items.

Surgeons' requirements

Attendees reported:

- Difficulty finding a mental health professional (e.g. a psychiatrist, clinical psychologist, psychologist, or mental health nurse) who is willing to provide the letter of support (or two) that is required by some surgeons in line with some WPATH clinical guidelines.
 - Attendees noted even psychologists who are comfortable working in trans care may not have specific training on gender-affirming care and the treatment of gender dysphoria. Some are trained around assessment for the WPATH letter of support for surgical access.
- Some practitioners (e.g. surgeons) require assessments that consumers expressed are probably unnecessary, but the practitioners rely on these assessments as a precaution against potential future litigation (i.e. being sued by a person who changes their mind post-surgery). Patients can experience these assessments as excessive and burdensome.
- Letters of support are sometimes required to be written within 3 months of surgery, which can be difficult given issues with access to appropriate clinicians.
- Inconsistent requirements, e.g. needing a WPATH letter of support in the private system but not the public system. Pre-surgical assessment is not standardised, with significant variation.
- Most surgeons requiring a diagnosis of gender dysphoria (as per DSM-5), beyond simply a record of gender incongruence, when some guidelines only require the latter. A diagnosis of gender dysphoria can have implications for a person's security clearances or access to life insurance.
- Surgeons or MDTs requiring improved mental health before hormone therapy or surgery (e.g. months or years of psychological treatment plus cessation of anti-

depressant medication), despite puberty blocker side-effects, life complications, and one of the intended effects of surgery being to improve mental health.

- A surgeon may specify an acceptable BMI. This can lead to people seeking care elsewhere.

GP-related factors

Attendees reported:

- Feeling that they had to educate both themselves and their GP about gender-affirming care. Attendees viewed some GPs as lacking relevant knowledge and proposed that this may originate in a lack of standardised education and training on gender-affirming care and on safe care for trans and gender diverse people, both for GPs and, earlier, medical students. It was expressed that some medical training curriculums do not include gender-affirming care and that this needs to be addressed by the relevant training colleges. It was also noted that informed GPs often train others informally in the absence of this formal education. One attendee proposed that GPs tend to lack comfort or confidence in providing gender-affirming care. It was noted that guidelines by the Australian Professional Association for Trans Health (AusPATH) exist and that some GPs practice within them to maintain insurance when providing hormone therapy, but that these guidelines are promoted by word of mouth, not the RACGP.
- Lack of financial incentive for GPs to provide gender-affirming care, because time-based MBS items provide too little reimbursement.
- GPs who do not provide gender-affirming care may instead refer people (e.g. to an endocrinologist or psychologist). It was stated that this may be safer than providing under-informed care but can delay the initiation of hormone therapy, sometimes by years.
- A consumer attendee expressed that some GPs appear to be unsupportive of trans people and are potentially transphobic.

Experiences of gatekeeping

Attendees reported:

- Having to prove their identity, which can be especially difficult for non-binary people.
- It can take strong advocacy from a person and their GP for specialists to accept that a procedure is appropriate and freely chosen. An attendee noted that this may occur more in the public system than the private system.
- People with disability often need approval (i.e. ‘sign off’) from their other health practitioners to access gender-affirming care. It was expressed that this often unreasonably includes those who don't have any impairment affecting their ability to give informed consent.

Experiences of discrimination

Attendees reported:

- Being unduly denied care, including care that is not gender-affirming. They described health care practitioner resistance or hesitation about providing gender-affirming care, and proposed that this is fuelled by the historical pathologisation of trans people and both misinformation and disinformation.
 - A consumer attendee reported that moving health care practitioners away from pathologisation toward gender-affirming care has been challenging, and that many practitioners who provide gender-affirming care find it the most rewarding aspect of their work.
 - It was proposed that a negative experience trying to access gender-affirming care can contribute to hesitation accessing health care more broadly.¹
 - Attention was drawn to a report on the health care experiences of trans people in Australia². It highlights widespread discrimination and a lack of knowledgeable health professionals, particularly in regional and remote areas.
- Diagnostic questions (e.g. WPATH assessment) being seemingly based on sexist understandings of binary gender, limiting treatment access for non-binary persons and persons with innate variations of sex characteristics.

Facilitators of access to gender-affirming care

Consumer attendees reported facilitators for gender-affirming care, that is, factors that helped with access to or provision of care. These facilitators were broadly categorised into service design factors, cost -related factors, GP related factors, community organisations and peer networks, and legal protections. These facilitators are described below.

Service design

- A specialised adult gender clinic or sexual health clinic (e.g. in the public system).
- Another indication for surgery, e.g. a breast cancer (BRCA) gene marker required for prophylactic mastectomy in the public system, or cysts potentially caused by hormone therapy requiring hysterectomy (though the person then goes through the public system under a gender they do not identify with).
- Withdrawal of superannuation to pay for surgery in the private system (albeit with a high tax rate and adverse impacts on financial security later in life).
- A years-long therapeutic relationship with a psychologist.
- The informed consent model (see the [Models of Care report](#)).
- The private system (although consumers expressed that the public system may feature closer clinical governance and oversight).
- Existing relevant MBS items that can be used by a private surgeon.
- Private surgeons and surgical training pathways overseas.

¹ <https://journals.sagepub.com/doi/abs/10.1089/lgbt.2020.0179>

² <https://www.transresearch.org.au/reports/healthcare-26>

- A public health system protective of people's rights.
- Victorian state-government funding of \$5m since 2019 for gender clinics and a GP training program on hormone therapy.

Cost-related factors

- Being able to afford the costs of care in the private system.
- Small dedicated funds held by gender clinics or advocacy organisations (it was expressed that modest amounts of funding may not support people for long enough to access the care they need).
- Funding initiatives like Project 491 (led by AusPATH) that welcome charitable donations and support people experiencing financial hardship to access gender-affirming care in the private system.

GP-related factors

- A GP who is well-versed, supportive and affirming.
- GP willingness to oversee hormone therapy, including after receiving resources from a specialised gender identity clinic. It was proposed that this helps to relieve the structural bottleneck that results in long wait times for specialised gender identity clinics. It was proposed that only ~1 in 10 GPs take up the offer for resources from the clinic.

Community organisations and peer networks

- A trusted community pathway, e.g. a community organisation providing a list of affirming practitioners, additional care navigation, and counselling.
- Care navigation and social support from a peer or someone with experience and understanding in online networks or community organisations.

Legal protections

- Advocacy and legal challenge (e.g. by the Human Rights Commission) supportive of people's rights of access to health care.

People with innate variations of sex characteristics

While the proposed population for MSAC application 1754 does not specifically include those with innate variations of sex characteristics, any patients who have gender incongruence will be able access the proposed items if they are implemented. Consumer attendees highlighted that people with innate variations of sex characteristics represent a subgroup of people who may seek gender-affirming care.

Attendees reported that at birth, people with innate variations of sex characteristics can undergo surgeries that cause significant damage (e.g. nerve damage, fissures and fistulas). As adults, they can struggle to find the right supports, which are forms of gender-affirming care, due to incomplete medical records (limiting interpretation of past interventions), a lack of relevant Medicare codes, gender clinics deciding that they cannot help, a lack of relevant knowledge of the part of GPs, specialist expertise being limited, and there being no dedicated intersex surgical care pathway. It was expressed that people are not offered psychological

support, either to get a diagnosis or post-diagnosis, since their gender incongruence is viewed as a biological phenomenon and on a binary model of sex and gender. It was proposed that this raises a risk of inequity, where trans people are offered psychological or psychiatric support but people with innate variations of sex characteristics are not. Attendees also noted that different hospital policies can also limit surgical access for people with innate variations of sex characteristics, where people lack a formal diagnosis or a diagnosis recognised by the hospital. This can be experienced as doctors undertaking a simple karyotype, stating that the person is male on that basis, then limiting available treatment. Some specialists struggle to read MRIs for people with innate variations of sex characteristics. It was proposed this can lead to doctors limiting treatment options, which can be experienced as gatekeeping. Information on treatment options and long-term outcomes can be limited.

MDT involvement

Some consumer attendees proposed that a strength of the public system is that its gender clinics provide care via multidisciplinary teams (MDTs). However, it was also proposed that requirements for a person to engage with providers such as psychologists and social workers risks infantilising a person and applying requirements that are not applied to people accessing other types of surgical procedures. Attendees noted a lot of multidisciplinary care involves referrals that are perceived as excessive and unnecessary and that, by contrast, potentially valuable MDT support after surgery is almost non-existent.

It was noted that access to MDTs for gender-affirming care in Tasmania was limited, and opportunities to seek care in Victoria had also changed, leaving Tasmanians with fewer opportunities to access to gender-affirming care, especially if surgery was sought.

It was noted that, before surgery, a person may need laser hair removal and access to a dietician to reach a body-mass index (BMI) acceptable to the surgeon. It was proposed that a Chronic Condition Management Plan can increase access to speech pathology and support for some of the physical health impacts of surgery. However, it was proposed that the existing MBS items for 5 allied health sessions per year may be insufficient for the extent of support that could be beneficial after genital surgery.

It was reported that the most common requests in peer-led drop-in spaces across QLD are for counselling and GP access. It was noted that, because of intersections of discrimination, disability and difference, people are needing longer consultations, but their provision is difficult to sustain without appropriate Medicare coding or billing, and thus it depends on state government funding.

The consumers proposed that MDTs should support people, not necessarily assess whether or not they are suited to care, and that therefore the role of a liaison psychiatrist should be made explicit in any MBS item to avoid interpretations of gatekeeping. If at least 3 clinicians are to form the MDT, costs to the patient should be considered and perhaps rebated via an MBS item. It was noted that assembling 3 clinicians with trans health experience would be unrealistic in WA. Consideration would need to be given to whether the workforce exists to support any mandated or recommended MDT involvement. It was proposed that peer workers should also be considered for MDT involvement, especially to support care navigation,

informed consent and recovery after surgery, as there is demand for them and that they provide significant benefits³.

It was reported that providers generally work in progression (i.e. referring a patient) rather than as a team (i.e. working closely together).

Some attendees suggested that MDTs were problematic. This was because MDT assessment and treatment are either not provided (under the informed consent model) or are not effectual because, on the broader gender affirmation model of care, they equate to different professionals affirming the person's self-report, rather than different professionals working collaboratively using independent clinical judgement. Consumers with this view felt that MDTs would be ineffective if they didn't safeguard against errors and what they perceived as 'unsafe groupthink', and raised concerns that MDTs offered affirmation rather than differential diagnosis, which they felt was detrimental to the consumer. The risk of blurring of legal and clinical responsibility and lack of accountability with MDTs was also raised, noting that this can be an issue with any MDT.

Identifying a safe practitioner

It was noted that people use community networks to identify a safe and understanding practitioner (such as a GP) and/or a surgeon who provides gender-affirming surgery of high quality (i.e. with desirable outcomes). It was proposed that identifying such a practitioner can be difficult and that, once identified, the practitioner or clinic (public or private) can be in high demand and thus have long wait lists, from 6 months to multiple years.

Attendees reported that people tend to undertake their own research to decide what they want and focus on finding a surgeon with whom they are comfortable. Costs are also relevant to choice of surgeon.

It was noted that people under guardianship orders must obtain guardianship approvals for any medical procedures deemed clinically necessary. It was proposed that this creates a sense of not being safe, even where the doctor is affirming or understanding, and that the same applies when an affirming or understanding doctor suggests that another health care practitioner be consulted before proceeding. It was suggested that the person may feel like their experience is being mediated or 'gate kept' by professionals or systems. It was acknowledged that the question then arises as to how multiple professionals or systems ought to be combined in a person's care, and with what requirements.

Attendees shared that a person with an innate variation of sex characteristics feels distressed and less safe when a specialist asks them to educate them on their needs. It was proposed that the provision of psychologically and culturally safe care is entirely the clinician's responsibility, the clinician should appropriately prepare for consultations, and that the patient can be helped by a support person (e.g. professional consumer advocate) who knows the keywords that clinicians are looking for.

³ <https://transfolkwa.org.au/wp-content/uploads/2026/03/Trans-Community-Clinic-Scoping-Project-2023.pdf>.

Consumer attendees noted that feelings of safety can be reduced by:

- Both health care and administrative staff misgendering the person (especially repeatedly and despite being corrected).
- Redundant invasive procedures (e.g. internal ultrasound).
- Inappropriate and unnecessary physical examinations.
- Constant questioning (e.g. about fertility).
- Intrusive questioning about a person's transition.
- Emphatic statements about irreversibility.
- Proceeding some way down the path of gender affirming care before being told it cannot be provided.
- Ruling out (including with laughter) particular procedures despite the person understanding and having a GP referral.

It was reported that all of this can feel traumatic, judgemental, like gatekeeping, and like it falls on the person to advocate for themselves.

Some attendees felt that parents are routinely excluded from the provision of gender-affirming care to their adult children. They proposed that parents' intimate knowledge of their adult child's conviction about the need to transition is excluded in favour of the informed consent model. They noted that there are cases of parents writing to inform the surgeon of their adult child's mental health history, with the surgeon then delaying surgery, suggesting that the surgeon was previously unaware.

Some attendees also reported that young people may feel distressed and unsafe because they have been told that if they do not transition, they are at high risk of suicide. They also reported that public discourse about the LGBTQI+ community being subject to hate, stigma and discrimination can influence how young people feel about themselves and the people who care for them.

Diagnosis

Some attendees suggested that diagnostic activities could function as burdensome obstacles to gaining access to care and may be unnecessary. By contrast, other attendees suggested that diagnostic activities overly rely on self-report, that more emphasis should be placed on comprehensive differential diagnosis, and that the care pathway can be difficult for consumers to remove themselves from.

Contrasting views on diagnosing gender incongruence in neurodivergent people were heard. Some attendees noted that people may mask their neurodivergence to avoid requiring extra sessions with a psychologist to get the pre-surgical assessment required. Other attendees felt an assessment for neurodivergent conditions should form part of the diagnostic process for gender incongruence but is rarely done.

Attendees noted that the informed consent model does not involve assessment beyond confirming the person's understanding of things such as side-effects. This model has been supported by AusPATH's Informed Consent Standards of Care. Some attendees reported:

- Access to hormone therapy or surgery has sometimes been conditional upon receiving a formal diagnosis or letter of readiness after 6+ sessions with a psychologist or psychiatrist. People have described this process as fairly intense.
- Pre-surgical assessment by a psychologist can include questions like 'Have you had women's thoughts?' This can strike the person as strange ('What is a woman's thought?') and they can feel like they have to come up with something on the spot to get a box ticked for surgical access.
- It can feel like an expensive box-ticking exercise for a person to be required by a surgeon to see a psychiatrist for a pre-surgical assessment where the person already has a years-long therapeutic relationship with a psychologist.
- An ongoing therapeutic relationship with a psychologist can reduce the discomfort or trauma of a WPATH assessment undertaken for the purpose of writing a letter of support for surgery.
- Assessment can be experienced as having to prove that you are trans.
- It can be humiliating and profoundly impactful for a trans person to first access hormone therapy via the informed consent model but then be denied therapy extension by a specialist after questioning. Such questioning can be experienced as questioning whether a person is 'trans enough' for ongoing care.
- There is a need for clarity on what is being assessed, because diagnostic labels can shift across gender dysphoria, gender nonconformity and gender incongruence.
- One consumer attendee proposed that a person should not need a diagnosis of gender dysphoria or gender incongruence to access an MBS-related subsidy for gender-affirming care. A person who no longer experiences gender dysphoria or gender incongruence after years of hormone therapy may still be indicated for surgery. Therefore, while a criterion for MBS-related subsidy is needed, it should be broad and not purely focussed on distress. Consideration should be given to who would be excluded by any criterion.
- Wording (such as in the proposed MBS items) is important. It can create the need for clinicians to use workarounds. For example, an endocrinologist, urologist or sexual health physician can prescribe PBS-subsidised testosterone for an established pituitary or testicular disorder. In the case of gender-affirming access, the disorder is that the patient does not have testicles.
- In contrast, some consumer attendees raised concerns about people being coached (including in online forums) on the answers required to gain access to surgery, and shared the view that people frequently reinvent their history (including personality, interests and hobbies) to enable gender transition. They also reported care being fast-tracked for young people which they perceived to be damaging.
- Some attendees raised issues about a perceived lack of consideration of comorbidities (especially mental health conditions related to past trauma), which they felt could be

contraindications for surgery. Some attendees also felt that the clinical pathway for gender affirming care begins in childhood and is characterised by too little emphasis on comprehensive differential diagnosis.

- These attendees noted differential diagnosis should consider, among other things, neurodivergence, borderline personality disorder and social contagion. They shared their view that rigorous diagnoses should include:
 - independent psychiatric or psychological assessment with documented differential diagnosis
 - mandatory consideration of psychological treatment alternatives and documentation of why they were not indicated
 - a minimum follow-up period sufficient to assess the stability of the diagnosis
 - clinical accountability for diagnostic reasoning that can be reviewed in the event of an adverse outcome.

Experiences of seeking gender-affirming care

Lack of support

Attendees emphasised that people face difficulties when seeking gender-affirming care, including a lack of support from GPs and others. Specifically, they, reported:

- A person can feel unsupported, like they are going it alone, including in seeking surgery overseas. Sometimes 30-40 consultations with various doctors, surgeons and specialists are required to achieve the desired outcome. The time that this takes can be difficult to endure for some people. The time that a person spends waiting for hormone therapy or surgery after deciding in favour of it may be a high-risk period for suicidality and depression. It has been described as a limbo phase when much of a person's life is on hold, with impacts on work, study and relationships.
- Most people navigate care themselves or through an individual provider such as a GP or psychologist, who is not necessarily working in a team. Most people rely on internet forums or word of mouth to learn about their care options, which is unregulated and risks misinformation. Educational resources are few. This may be due to the government largely relegating gender-affirming care to the private sector, which may lack oversight and thus leave trans people vulnerable.
- Expertise on the support and care options available is commonly held within the trans community rather than the medical community, which may function as a barrier to accessing gender-affirming care.
- Most GPs do not appear to be comfortable or confident providing hormone therapy, despite their prescribing authority and provision of hormone therapy for other indications (e.g. menopause). An example was provided where a consumer who was already prescribed hormone therapy, and had relocated, needed their prescription renewed. They shared that they had met with 7 GPs before finding one who was confident and willing to take on their ongoing care. It was noted that this costs the person time and money and has health impacts. It was proposed that trans health care is increasingly regarded as specialist care rather than a core competency of GPs, with

adverse impacts for trans people. Trans people are vulnerable when trans health care is not embedded in GP training.

- Trans people experience some GPs as unsupportive and uncaring. This may relate to the GP's religious background or mistaken beliefs owing to lack of education.
- It was proposed that trans health care is increasingly viewed as something that is political, or as treatment for a condition that is chosen. There is a feeling that trans health is vulnerable to political attack and defunding. It was felt there is a need to integrate gender-affirming care into mainstream medicine, including medical education, by extending existing frameworks rather than isolating gender-affirming care as an optional extra. This will make gender-affirming care more resilient against the possibility of being legislated out of existence.

The surgical process

Consumer attendees commented on aspects of the surgical process, sharing that:

- Private surgeons seem to provide greater surgical access to trans masculine people than to trans feminine people (though still with long wait lists and high costs).
- Long wait times for surgery can be the most difficult aspect.
- A surgeon may require prior hormone therapy for surgical access, but this is problematic because every person's gender-affirming journey is different, e.g. a non-binary person may want surgery but never want hormones.
- Before surgery, there can be two appointments with the surgeon (e.g. for planning and pre-operative photographs) and one with the surgeon's nurse, who provides orienting information (e.g. pictures of the operating room to ease anxiety). The patient does not tend to experience these as burdensome.
- Information provided by the surgeon before surgery varies. This includes variation in price transparency in the case of private surgery, such as whether the costs of surgery include the costs of post-operative compression wear. One attendee proposed that MBS items should consider the costs of these garments, since they are a critical part of post-operative care following some types of surgery. It was noted that the amount of information received from surgeons, including about possible side effects, varied, and that feeling sufficiently informed before surgery can depend on one's own research rather than on information provided by the surgeon.
- Attendees reported many surgeons feel that they lack specialisation in gender-affirming surgery, but some procedures (e.g. orchidectomy) seem surgically identical irrespective of indication.
- It can be difficult for health care practitioners who seek gender-affirming care for themselves from fellow practitioners. When a care-seeking encounter is traumatising, it can create a conflict for the person about whether to provide feedback.

With regard to provision of gender-affirming care across the country, it was noted that access varied across regions and across care providers, with long waiting times highlighted as a concern.

Some attendees raised other issues related to the surgical process, such as:

- Believing that information on suicide risk and surgical risks and outcomes, including evidence gaps, is not being adequately communicated to young people. These attendees felt that patients could be better informed and feel safer if health care practitioners acknowledged uncertainty and weak or lacking evidence.
- The need for access to independent, evidence-based information about all treatment options, including psychological treatment alternatives, and formal second opinion mechanisms that are genuinely independent of the treating team.
- Concerns about how surgical procedures are framed which downplay the seriousness of the procedures and the possibility of adverse events.

Care after surgery

Attendees commented on the need to provide better post-operative support, highlighting problems including:

- Limited access to post-operative support and care upon return to Australia when surgery has been undertaken overseas, or where surgery has taken place interstate, the need for more travel for follow up.
- Inadequate post-surgery care, including pain relief, and the experience of wraparound supports (such as post-operative care) being less thorough than those provided to cis-gendered people after the same surgery.
- It was proposed that demand for psychosocial support after surgery is sometimes unmet and often hospitals and medical teams outsource this to community organisations, which could indicate a need for additional resourcing.
- People have felt that they greatly benefited from the information and support provided in a community-based, peer-run post-surgical space for people recovering from masculinising chest surgery.

Other attendees commented that, after surgery, there is no follow-up to determine if the surgery relieved distress, and that some families report continued distress.

Detransition and regret

It was noted that it can be difficult for people who detransition to talk about their stories.

Some attendees expressed concerns that there is a lack of support for people who express doubts or who detransition. Some opinions included:

- People's regret at accessing gender-affirming care, or concerns about side-effects, can be minimised. Regret can be dismissed as internalised transphobia or as a rejection of one's identity.
- Rates of withdrawal from further care are high when underlying issues are treated.
- There are few dedicated supports for people who want to detransition. In the UK, the National Health Service (NHS) recognised the need for dedicated supports, commissioning a specialised service for people who detransition. Attendees reported that, in Australia, organisations like Lifeline have received training that embeds

gender ideology. The organisation Genspect operates ‘Beyond Trans’, a support service for parents and people who detransition.

- There are cases where regulatory and legal systems have not supported parental complaints, and time limits can be too short to allow personal injury claims for issues that have developed years after surgery.

Same-sex attraction

Some attendees expressed a view that gender incongruence is a consequence of same-sex-attracted people who are funnelled down a clinical pathway that does not support their same-sex-attracted characteristics and experiences. Their view was that transitioning is being suggested as an option for people dealing with internalised homophobia, who instead need their sexuality affirmed. They perceived gender affirming care to be a new form of homophobia.

Conversion therapy bans

Some attendees expressed concerns that health care practitioners who are critical of gender-affirming care stay quiet because of conversion therapy bans across Australia, which make it unlawful for a practitioner to discourage a person who is considering gender-affirming treatment. They also felt that evidence-based psychotherapy to explore gender incongruence has been reframed as conversion practice and effectively outlawed.

Evidence

MSAC identified an unmet clinical need for gender-affirming surgery, noting that there are people who would benefit from gender-affirming surgery who are not currently accessing it.

MSAC had acknowledged the need for more evidence, including on the magnitude of benefit and on additional issues raised by attendees such as regret, and had commissioned a more complete and rigorous evaluation of evidence on the safety and effectiveness of a range of gender-affirming surgeries. This evaluation had not yet been seen by MSAC.

Some attendees proposed that diagnosis overly relies on self-report and that this poses challenges for evidence development, making it difficult to identify who would benefit from gender-affirming surgery.

There were also some attendees that believed the WPATH Standards of Care (Versions 7 and 8) are not credible, cautious or evidence based, stating they reflect the views of advocacy and activist groups rather than evidence, and that any critical discussion of the evidence is routinely dismissed as discriminatory and harmful. Some attendees also felt that any new MBS item should be accompanied by a prospective data collection framework that enables ongoing review of outcomes, including regret, revision rates, and psychiatric outcomes post-surgery.

However, the views on self-reporting and WPATH Standards of Care as described above were contested by other attendees who were supportive of these approaches.