Transgendered People and Health Care

1. Introduction

This paper is designed to outline legal issues relating to health care for trans people. It is not meant to be a discussion of the medical aspects of health care, except as those medical aspects are relevant to the legal ones. It is written for trans people to know what services are available, and how to challenge laws or policies that restrict access to health care for trans people.

The concerns addressed in this paper were identified at the Trans/Action Justice and Equality Summit, Canada's first trans forum, in June 1999.

The paper first summarizes who trans people are; then sets out the issues raised at the Justice and Equality Summit. Then it sets out the legal framework for health care in B.C. The next section describes what health care services currently are, and are not, available to trans people. In that section trans people with different health needs are dealt with separately. Finally, the paper identifies legal strategies that are available to challenge deficiencies in health care for trans people.

2. Who are Trans People?

Transgendered people include:

▸▸ transsexual people – those among us who have a strong and persistent conviction that there is a mismatch between their true gender, and the gender their genitals suggest, and who may seek sex reassignment surgery

▸▸intersexed people – those among us who are born with gender markers which are ambiguous

▸▸cross dressers – those among us who, though we identify as members of one gender, may dress as, and pass as, members of the 'other' gender some or all of the time

▸▸drag kings or drag queens (from the Shakespearean stage direction, 'dressed like a girl' in an era when only men were on the stage): people who dress occasionally as members of the 'other' gender, usually for display

▸▸trans people – those among us who identify as neither gender, or as both genders

We have all been taught, wrongly, that there are two and only two human genders. The question to ask, always, is how an individual identifies: only that person can say what their gender identity is. No one can determine it for us/them

2. Issues about Trans People and Health Care from the Justice and

Equality Summit

Participants at the Justice and Equality Summit identified three main issues for trans people seeking health care:

- ▸▸ How to protect our access to services and our legal rights, without pathologizing us.
  For transsexuals:
  - ▸ Developing our own Canadian/B.C. standards to supplement the Harry Benjamin Standards
  - ▸ Concern about Vancouver Gender Clinics' role and control
  - ▸ Better Post-op care

  For other trans people
  - ▸ Health services which are inclusive of the needs of all trans people (eg youth)
  - ▸ Health services which are appropriate for trans people with gendered needs other than transsexuals; alternatives to the "True TS" model
- ▸▸ How to get improved access to services and funding/coverage
- ▸▸ The need for Sensitivity Training for health care providers and institutions

3. Background: The laws about how medical care is provided and regulated in British Columbia

In British Columbia, there is 'socialized medical care'. Medical insurance, which covers doctors' visits, hospital stays, and treatments by some other medical care providers including (for example) chiropractors, massage therapists, and physiotherapists, is available at a low cost. People on social assistance have medical insurance paid for them. The result is that most British Columbians have medical insurance. The cost of providing medical insurance is subsidized by the provincial government. The federal government contributes to the overall cost of social services in the province, which includes health care.

a. Legislation

The legislation governing medical services is called the *Medicare Protection Act*[1]. That law sets out the parameters of what kind of medical services are covered by medicare.

Another provincial law which is important for trans people looking at health issues is the *B.C. Benefits (Income Assistance) Act*, under which individuals receiving social assistance are able to have some health care services provided which are not covered under the general medicare

[1] RSBC 1996 C 286

scheme.

b. Regulations

The regulations under the Act have the force of law. The only difference between a regulation and a statute is that a statute can be changed only by the legislature; a regulation can be changed by Cabinet.

The regulations cover such topics as who can enrol, what the premiums are, and what services are covered and which ones are specifically excluded. And it deals with payment for medical services rendered outside the province.

c. The federal connection: the Canada Health Act

The federal government gets into the act with respect to health care by providing money to the provinces. Constitutionally speaking, health care is a provincial responsibility. But in order that Canadians have some consistency in the health care provided from one province to the other, the federal government has signed an agreement with the provinces under which it provides funding so long as the province complies with the terms of the agreement.

d. The Charter of Rights

The *Canadian Charter of Rights and Freedoms* is part of the constitution of Canada. It guarantees certain basic rights to every Canadian. If a law in Canada (federal or provincial) or a program of a government contravenes the *Charter*, the law will be held to be invalid.

> The Charter of Rights is part of the constitution of Canada, so it takes precedence over any other laws.
>
> The Charter guarantees equality to all Canadians, and it guarantees life, liberty, and security of the person.

There are two sections of the *Charter* which are especially important in the health care field. The first is section 7, which guarantees "the right to life, liberty and security of the person". The second is section 15, which guarantees

Notice that trans people are not listed; and 'gender identity' is not listed as a protected ground. However the courts have held that if a group of Canadians can show that they have experienced "historic disadvantage" in Canada, they will be protected by section 15. That is the way that gays lesbians and bisexual people got protection under the *Charter*. The Supreme Court of Canada said that gays, lesbians and bisexual people have suffered historic disadvantage, and they are therefore entitled to equality guarantees under section 15. There are no cases so far in which the situation of trans people has been considered in relation to the *Charter of Rights*, but the same thinking would apply: because trans people are a historically disadvantaged group, they are entitled to *Charter* equality guarantees.

e. Human Rights Legislation

There is a provincial human rights law, and a federal human rights law. Each of those laws guarantees that any 'service or facility customarily available to the public' (which would include health care) must be provided without discrimination on the basis of such factors as sex, race, ancestry, place of origin, or mental or physical disability. So far no human rights legislation in Canada protects against discrimination on the basis of 'gender identity' but trans people have been successful in arguing that they are protected against discrimination on by the ground of 'sex' or 'disability'. Those cases have held that a pre-op transsexual woman cannot be kicked out of a women's group because she is 'too mannish'; cannot be denied access to a women's washroom; and cannot be refused permission to 'transition' [change from one gender to the other] at work. The cases are discussed in detail in chapter _________. Basically, you must show first that you have been denied a 'service or facility customarily available to the public', and then show that you have been denied that service because you are trans.

f. Application of the Law: Later!

We will apply that very brief introduction to the legal framework surrounding the question of health care in British Columbia to the specific health care issues that trans people face in Part __

4. Health Care Issues for Trans People

All trans people have two kinds of health care issues: issues that relate to them specifically as a trans person, and general health care issues. An FtM transman still needs a Pap test...a cross dresser may need surgery on an arthritic knee...pre or post operative transsexuals may need allergy treatments...intersexed people may get pneumonia.

There are deficiencies in health services for trans people in both areas – both as to trans health issues, and as to general health issues for trans people.

We will look first at general issues of health care for trans people, and then at health care issues for trans people.

a. Trans People and Ordinary Health Care

Apart from getting medical attention and competent care for issues of gender identity, and issues of dealing with the transphobia of the culture, transpeople face the ordinary range of health care issues.

But accessing care is not straightforward for trans people. Trans people face ignorance and prejudice among health care providers. This has the result of discouraging them from seeking

medical care including regular checkups.[2]

Trans people can face difficulties getting ordinary social services. MtF's may be turned away from women's shelters if staff think that they don't 'pass'; if they seek shelter in a men's shelter they will be laughed at or worse. In Vancouver, however, hospitals routinely admit trans people to the ward of their target gender.

There is a case currently pending before the B.C. Human Rights tribunal called Nixon v Rape Relief[3]. Rape Relief, a women's crisis shelter, refused to accept Nixon, a postoperative MtF transsexual woman, as a volunteer. The case will determine whether Rape Relief had the right to turn away Ms Nixon, and, by extension, whether transwomen have a right to be admitted without discrimination to women's services.[4]

Trans youth are at risk in school for being bullied or bashed. And, along with lesbian gay and bisexual youth, trans youth are overrepresented among street kids.

Trans people are also at higher risk for some kinds of disease, including HIV/AIDS and alcoholism. Trans' sexual and injection risks for HIV arise from three main sources: social stigma and related negative self-image, economic vulnerability and related prostitution and substance abuse, and (for MtFs) the quest for a feminine body and the need for identity affirmation.[5] Their higher risk of substance abuse is a risk they share with all members of oppressed groups in society.

Apart from the Vancouver Gender Clinic, there are no social or health services targeted at trans people in British Columbia.[6] Materials and services designed for other target groups – gays and

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[2] One Vancouver FtM describes the difficulties he faces because he has had uterine cancer.

[3] Set to be heard in December 2000

[4] For a more extensive discussion of this case, see chapter 1

[5] Kammerer, N., et al "Transgender Health and Social Service needs in the Context of HIV Risk" IJT 3, 1+2, http://www.symposion.com/ijt/hiv_risk/kammerer.htm p 2. "One self-identified pre-operative transsexual told a horrifying story of being sent away from a well-known Boston emergency room after a car accident even though she was suffering from serious injuries, including fractured vertebrae and a concussion. When her male genitalia were discovered under her female clothing, she was dischared without treatment!:

[6] The High Risk Project, which focused on the day to day street needs of trans people particularly those in the sex trade, folded after four successful years.

lesbians, or sex trade workers, for example – are not necessarily useful to, or used by, trans people. Walter Bockting et al described a one year pilot project for HIV prevention education in Boston.[7] He identifies the components of a successful service:

> Community members designed and distributed recruitment materials. Trained peer educators facilitated a workshop. A video created by transgender artists personalized HIV/AIDS for participants, a panel of transgender persons living with HIV/AIDS enhanced perceived susceptibility to HIV infection, and sexually explicit materials depicting transgender role models eroticized safer sex. A transsexual community activist facilitated a special segment on empowerment and building community. Community involvement ensured cultural sensitivity of program intervention and evaluation Together, these strategies helped the community take ownership of the project and raised the credibility of the prevention message.

Other inequalities for trans people in the health care system

Trans people who require medical treatment for conditions unrelated to their trans status may or may not find a congenial environment. Though most hospitals in the Lower Mainland put trans people in the ward of their target gender, and if possible put them in single rooms, the attitudes of staff are unpredictable.

And rehabilitation or extended care facilities may or may not be welcoming to trans patients. They may not treat the patient's trans status as confidential; they may not intervene if other patients or staff use the wrong gender pronouns; they may not facilitate access to makeup or clothes of the target gender

b. Health Care Issues relating to Gender Status

i. Intersexed People

Intersexed people are people for whom the physical indicators of gender are ambiguous or contradictory. There are a number of such conditions, some of which are obvious on inspection of a baby's genitalia, others of which are hormonal and are not discovered sometimes till puberty. They include Klinefelter's syndrome (tubule dysgenesis, mostly, though not always correlating to karyotype 47,XXY), congenital adrenal hyperplasia (CAH), androgen insensitivity syndrome (AIS), and many others. Intersexed people were originally referred to as "hermaphrodites" or "pseudohermaphrodites", but since these terms tend to make people think of mythical figures, intersexed people prefer the term "intersexual".

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[7] Bockting, Walter O. et al "Transgender HIV prevention: Community involvement and empowerment" (1999) IJT 3, 1+2, http://www.symposion.com/ijt/hiv_risk/bockting.htm

There is a serious contest between the traditional medical paradigm and the reform paradigm with respect to intersexuality. Alice Dreger has compared the differences between the two paradigms.[8] The medical paradigm identifies intersexuality as an abnormality; the reform paradigm as a gender variation. The medical paradigm regards ambiguous genitalia as a problem in and of themselves, which left untreated may result in depression, suicide, etc; the reform paradigm says that unusual-looking gentialia are not a problem and points to treatment of intersexed genitalia as the cause of problems similar to those associated with childhood sexual abuse. The medical paradigm dictates treatment at the earliest possible opportunity – in infancy if possible – to eliminate any 'ambiguity' about a child's gender. The reform paradigm dictates that surgery should be done only if an intersexual person requests it.

The difficult question in this rigidly binary male/female world is 'what gender is a child whose genitalia are ambiguous'. The medical paradigm holds that a child's gender can be established by treatment as either a boy or a girl–that gender is entirely a matter of nurture, and that therefore the proper course of action is to eliminate ambiguity so as to create certainty in a child's gender identification at an early age. However the premise that a child can be genderized in whichever gender the neonatal surgeon chooses has come under severe criticism recently, with evidence that an identical twin whose intersexuality was 'treated' by making (him) a girl maintained his gender identity as male throughout his life.[9]

Recent studies point to the parallels between child sexual abuse and 'treatment' for intersexuality:

> In cases where the intersexed child is identifiable at birth, s/he is subjected to extensive testing physically, genetically, and surgically, to determine the sex most appropriate for rearing. Kessler (1990) notes that "physicians... imply that it is not the gender of the child that is ambiguous, but the genitals... the message in these examples is that the trouble lies in the doctor's ability to determine the gender, not in the gender per se. The real gender will presumably be determined/proven by testing and the "bad" genitals (which are confusing the situation for everyone) will be "repaired". Although the child is repeatedly examined through puberty, there is often no explanation given for these frequent medical visits. Because both parents and physicians view these treatments as necessary and beneficial to the child, the child's trauma in experiencing these procedures is often ignored. The underlying assumption is that children who do not remember their experiences are not

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8 Notes on the Treatment of Intersex http://www.isna.org/compare.html

9 Diamond, Milton/H. Keith Sigmundson (1997a): Commentary: Management of Intersexuality: Guidelines for dealing with persons with ambiguous genitalia. Archives of Pediatrics and Adolescent Medicine 151/10, Oct. 1997, 1046-1050; http://www.afn.org/~sfcommed/mdfnl.htm; and (1997b): Sex Reassignment at Birth: A Long Term Review and Clinical Implications — Reply. Archives of Pediatric and Adolescent Medicine 151/10, Oct. 1997, 1062-164; http://www.afn.org/~sfcommed/mdfnl.htm

> negatively affected. However, medical procedures "may be experienced by a child or adolescent as a trauma, with the medical personnel considered as perpetrators in collusion with the parents... the long-range effects of these events may have serious and adverse effects on future development and psychopathology".
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> ...Like victims of child sexual abuse, children with intersex conditions are subjected to repeated genital traumas which are kept secret both within the family and in the culture surrounding it. They are frightened, shamed, misinformed, and injured. These children experience their treatment as a form of sexual abuse, and view their parents as having betrayed them by colluding with the medical professionals who injured them. As in child sexual abuse, the psychological sequelae of these treatments include depression, suicidal attempts, failure to form intimate bonds, sexual dysfunction, body image disturbance and dissociative patterns. Although many physicians and researchers recommend counseling for their intersexed patients, patients rarely receive psychological intervention and are usually reported as being "lost to follow-up."... As a result, the intersexed child is often entirely alone in dealing with the trauma of extended medical treatment[10].

Some intersexuals have conditions which do not become evident until puberty. Those conditions may manifest as mixed sex indicators – for example, apparently feminine body with undescended testicles.

The existence of intersexual people is the most serious indictment of enforced gender categories. To modify the bodies of human beings to maintain the hegemony of the social gender system is one of the most egregious examples of discriminatory mistreatment one can imagine. The current evidence that intersexual people who are 'normalized' into one gender or another shortly after birth may nevertheless have an intractable gender identity in the 'other' gender offers a compelling rationale for accepting an individual's self-description as the basis of her gender. In other words: when the question is what a person's gender is, the authoritative answer can only be given by the person him/herself. And clearly that answer may be 'neither' or 'both' genders.

ii. Transsexuals

Transsexuals are people who experience themselves as having been "born in the wrong body". There is a very specific treatment regime for transsexual people, which can culminate in the transsexual having sex reassignment surgery to bring their bodies in line with their experience of themselves.

Transsexuals are listed in the Diagnostic and Statistical Manual IV – the bible of the American

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[10] Alexander, Tamara "The Medical Management of Intersexed Children: An Analogue for Childhood Sexual Abuse" (references omitted) http://www.qis.net/~triea/medical_abuse.html

Psychiatric Association – as suffering from "high intensity gender dysphoria". In plain language, that means "a person who is very unhappy with the gender of their body". The significance of having 'gender dysphoria' in the DSMIV is that it 'annoints' transsexuals with a psychiatric condition[11]. Surgeons who may perform sex reassignment surgery look to psychiatrists to provide a justification for surgical intervention. Being diagnosed by two psychiatrists (or one psychologist and one psychiatrist) as having high intensity gender dysphoria is an essential precondition for getting sex reassignment surgery.

Sex reassignment surgery has always been controversial. Though no one raises an eyebrow about other kinds of surgery which modify the body, including cosmetic surgeries of all descriptions, society does not permit sex reassignment surgery so easily. In fact, there is an international standard known as the Harry Benjamin International Gender Dysphoria Association standards of care.

The Harry Benjamin standards of care state their goal as follows:

> *The general goal of the specific psychotherapeutic, endocrine, or surgical therapies for people with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.*

According to the Standards of Care,

> *A clinical threshold is passed when concerns, uncertainties, and qeustions about gender identity persist in development, become so intense as to seem to be the most important aspect of a person's life, or prevent the establishment of a relatively unconflicted gender identity. The person's struggles are then vaioursly informally referred to as a gender identity problem, gender dysphoria, a gender problem, a gender concern, gender distress, or transsexualism. Such struggles are known to be manifested from the preschool years to old age and have many alternaqte forms. These forms come about by various degrees of personal dissatisfaction with sexual anatomy, gender demarcating body characteristics, gender roles, gender identity, and perceptions of others. When idssatisfied indviduals meet specified criteria in one of two official nomenclatures – the Interqantional Classifcation of Diseases -10 or the diagnostic and Statistical Manual of Mental Disorders – Fourth Ediction (DSM-IV) – they are formally designateds as suffering from a gender identity disorder (GID). Some person with GID exceed another threshhold – they persistently possess a wish for surgical transformation of their bodies.*

The Standards of Care provide that before a person is prescribed hormone, s/he must have been living in the 'real life test' for three months, or had at least three months of therapy. Before surgery can be undertaken, the patient must demonstrate:

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[11] For a more detailed discussion of the question of whether trans people have a disability, see the chapter called 'Ability/Disability and Trans People'.

- legal age of majority in her/his home nation
- 12 months of continuous hormonal therapy for those without a medical contraindication
- 12 months of successful continuous full time real-life experience
- psychotherapy is recommended though not required
- knowledge of cost, hospitalizqation consequences, complications, etc
- awareness of different surgeons

In addition, the person must demonstrate progress in consolidating the new gender identity, and progress in dealing with work, family, and interpersonal issues resulting ina signficantly bettter or at least a stable state of mental health.

So a person must be diagnosed as having a mental illness, then live in the target gender *before* they have had the assistance of reconstructive surgery – that is, at the time when they are least likely to 'pass' in their new gender – before surgery is medically indicated by the Harry Benjamin Standards of Care.

The Harry Benjamin Standards of Care exist to protect surgeons (in particular) from legal actions for carrying out sex reassignment surgery which the patient subsequently regrets. The price of the surgery from the patient's perspective is very high: they must jump through the hoops of the Harry Benjamin Standards, satisfy two mental health practitioners that their wishes for surgery are appropriate, then **live full time in the target gender.** The reality of this last part of the preconditions is that most transsexuals find themselves unable to keep their employment during the gender reassignment process.[12]

It is often the case that preoperative transsexuals have begun their life experience as a (part time or full time) cross dresser, only later finding their way to a gender clinic.

There is a movement to challenge the psychiatrization of gender. Trans activists point out that the DSM was amended to add gender disorders at the same time that homosexuality was removed from the DSM. They argue that the DSM operates as a mechanism of social control with respect to gender: if you're not clearly, and happily, male or female...you must be sick. The same structure of psychiatrization was in place with respect to gays and lesbians until 1973, when the American Psychiatric Association voted to have it removed.

Trans activists argue that gender is far more diverse than society has customarily assumed; that gender cannot adequately be described as an either/or phenomenon; and that it is transphobic to decide that because incidents of gender variance are statistically few, the gender variance itself must be pathological. Standards of care alternative to the Harry Benjamin standards of care have been developed by a group of experts and endorsed by the International Conference on

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12 See the chapter on Trans People and Employment for further information

Transgendered Law and Employment Policy[13]. The principles of those standards of care are:

> Transsexualism is an ancient and persistent part of human experience and is not in itself a medical illness or mental disorder. Transsexualism is a desire to change the expression of one's gender identity.
>
> Persons have the right to express their gender identity through changes to their physical appearance, including the use of hormones and reconstructive surgery.
>
> Persons denied the ability to exercise control over their own bodies in terms of gender expression, through informed access to medical services, may experience significant distress and suffer a diminished capacity to function socially, economically and sexually.
>
> Providers of health care (including surgical) services to transsexuals have a right to charge reasonable fees for their services, to be paid in advance, and to require a waiver of all tort liability except negligence.
>
> It is unethical to discriminate in the provision of sex reassignment services based on sexual orientation, marital status, or physical appearance of a patient.

The alternative standards of care deal with the risk of legal action to surgeons by providing for the simple expedient of having patients sign a waiver of all actions except an action for negligence.

Other trans people, especially other transsexuals, are wary of this approach, because they are afraid that if gender identity disorder were not classified as a mental illness, medical insurance schemes would no longer cover the surgery at all. It is a legitimate concern, because sex reassignment surgery is not universally paid for even in Canada.[14] There is a precedent, however, in the provision of abortions which, though they formerly required approval by a hospital committee, are now provided – and paid for – on the basis of a woman's decision made in consultation with her physician.[15]

Still other trans activists argue that it is not their bodies which are pathological, but the responses of the dominant culture to their bodies which is pathological. Transphobia is the problem, not gender identity disorder. On this view, if the culture were more accepting of the variance and fluidity of gender, there would be much less need – perhaps no need at all – for people to have dangerous surgical procedures to "change" genders. Instead they would be recognized as the gender they claim, whatever their 'matching' or 'unmatching' body parts. These activists support

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13 The full text can be found at http://www.altsex.org/transgender/healthlaw.html

14 Ontario, for example does not cover SRS under its medicare plan.

15 I am grateful to Christine Burnham for this insight.

the right of an individual to seek hormones and surgery if they want, but work for a day when there will be enough gender freedom to make those choices less necessary.

Being Regendered in British Columbia

In British Columbia there is only one facility which provides care to transsexual people. It is the Vancouver Gender Clinic, which is associated with Vancouver Hospital. The staff at the Vancouver Gender Clinic follow the Harry Benjamin Standards of Care. This means first of all that the Gender Clinic must be satisfied that the individual is a "true transsexual" and not (for example) a gay man so filled with internalized homophobia that all he can envision is to become a woman. For a trans person it can mean that the Clinic disagrees with the trans person's own assessment of her or his situation, and decides that the person is not a transsexual.

Without being enrolled in the Gender Clinic it can be difficult for a trans person to get the hormones he or she may need to begin the process of changing secondary sex characteristics, because most general physicians will not prescribe the hormones. Some trans people resort to acquiring the hormones on the street. And it is literally impossible to get MSP to pay for sex reassignment surgery unless you have been through the Vancouver Gender Clinic (or another gender clinic).

When the Gender Clinic is confident that an individual is ready for sex reassignment surgery, having successfully completed psychotherapy and the real life test, they make a recommendation to the Medical Services Plan that MSP pay for the surgery. MSP may or may not accept the recommendation. Common reasons for being turned down by MSP after being recommended by the clinic can include their requirement that an individual live in the real life test for two years rather than one;

MtF transsexuals can have a neovagina surgically created; MSP will pay for the procedure. However FtM transsexuals cannot have a neopenis constructed: MSP will not pay for the procedure. Their reason for refusing to fund bottom surgery for FtM's is that the procedure is much riskier and has much more uneven results than bottom surgery for MtF's.

There are no surgeons in British Columbia who perform sex reassignment surgery. So a person must go either to the only Canadian surgeon, who is in Montreal; or to a foreign clinic – in the U.S., or in Britain, or elsewhere. Unless a person is on social assistance, the individual must pay the costs of getting to the surgery and back again, and the costs of accommodation while they are there. People on social assistance will not have this expense paid for automatically, but if they take an appeal under the B.C. Benefits (Appeal) Act, they are likely to be successful in having this expense covered by the provincial government. [16]

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[16] Staff at the Gender Clinic can point you in the right direction to get help with the appeal process.

But of course bottom surgery is only one part of the transformation from one gender to another. For reasons which do not make logical sense, some parts of the treatment for transsexualism are paid for by MSP; other parts are not. The chart below outlines the procedures which may be involved for an MtF transsexual; and those which may be involved for an FtM transsexual, showing what each procedure is, and which procedures are covered by MSP, which additional ones may be covered by welfare for people on social assistance, and which procedures must be paid for privately.

The following chart relates to the medical procedures which are required for a complete transition from one gender to the other. It indicates the current average cost of the procedure, and specifies whether the service or procedure is covered by the Medical Services Plan of British Columbia on the prescription of any physician; covered by MSP on the prescription of a psychiatrist; or covered by MSP only on the recommendation of the Gender Dysphoria Clinic. Finally, it indicates whether a procedure is covered by the government for people living on social assistance, and whether, if it is covered for people on social assistance, it is necessary for the individual to invoke an appeal under the social assistance legislation, or whether it is available routinely to those on GAIN.

Male to Female Sex Reassignment

Procedure	Cost	varies	MSP/G.P.	MSP/Psych	MSP/GDC	MSP/GDC: discretion	GAIN: routine
Hormones	$24 - 125 per month	$1500 - 4000	X				X
Sex Reassignment Surgery-- Genitals	$10,000 - 23,000 +					X (but Pt funds shortfall)	
Electrolysis, facial hair	$4,000 - 8,000						X
Psychotherapy	($100-500 per month)		X	X	X		
Speech therapy							

GAIN:
tribunal

X?

X

sometimes

Issues of Discrimination in Delivery of Health Care Services to Transsexual People

Protections in the health care field: an introduction to the general law

There are two basic ways to challenge inequalities in the delivery of health care. You can file a human rights complaint, if you are being denied a "service or facility customarily available to the public", or you can challenge the law or the policy or practice of government or a governmental body which denies you equality as a trans person under the Canadian Charter of Rights and Freedoms – either under section 15, which is the section which guarantees equality rights, or under section 7, which guarantees the right to "life liberty and security of the person and the right not to be deprived thereof except in accordance with principles of fundamental justice".

In Canada, there is supposed to be consistency from one province to another in the delivery of health care. To ensure that is so, the federal government contracts with each province under the *Canada Health Act*. If the province agrees to the terms of that legislation, the federal government provides funds to the province.

There are five principles in the *Canada Health Act*: public administration of health care, comprehensivenes of health care, universality (available to everyone), portability between provinces, and accessibility. Failure by a province to observe these principles can result in a loss of federal health care dollars.

Section 9 says:

> In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or detntis, and where the law of the province so permits, similar or additional services rendered by other health care practititoners.

It would appear that an individual seeking sex reassignment surgery should be able to insist that it be available, since it is a "health serice provided by hospitals, [and] medical practitioners. But there is no definition in the legislation of what counts as an "insured health service"[17].

Attempts to rely on the *Canada Health Act* to force the provision of a particular service have been uniformly unsuccessful. The courts have held that the contract between the federal government and the province can only be enforced by one of them, not by a patient or by a doctor.[18]

Under the provincial *Medicare Protection Act*[19], the Medical Services Commission establishes what "determine the services rendered by an enrolled medical practitioner, or performed in an approved diagnostic facility, that are not benefits under this Act". But section 4(2) of the *Act* says "The commission must not act under subsection (1) in a manner that does not satisfy the

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17 Canadian Bar Association, "Health Care Reform: What's Law Got to Do with It?" Ottawa, Canadian Bar Association, 1994 notes that the choice of what is covered is essentially a policy choice. include quote from Cameron p 11

18 See for example *Lexogest Inc v Manitoba* [1993] MJ No 54 (CA)(leave to appeal to Supreme Court of Canada denied) which was a challenge of the rule that abortions would be paid for only if performed in a hospital, decided on the basis that the individual did not have standing to challenge the regime; Cameron v NS [1999] NSJ in which the court concluded that funding for in vitro fertization was not a 'medically necessary' procedure. Therefore the province was not obliged to fund it; However, in *Waldman v BC (MSC) [1997] BCJ No 1793 SC,* which was a challenge of billing restrictions imposed by the BC government on doctors by limiting the number of billing numbers issued in a geographic area, the BC Supreme Court held that because the *Medicare Protection Act* said that the Medical Services commission "must not act ...in a manner that does not satisfy the crieteria described in section 7 of the Canada Health Act", the province was not entitled to introduce the billing restrictions.

19 SBC 1992 c 76 s 4(1)(a)

criteria described in section 7 of the Canada Health Act (Canada)." That's the section that specifies the five principles. So...homefree, right? Should it not be possible to argue that sex reassisgnment surgery is a service performed by medical practitioners, and so the medical services commission is forbidden by section 4(2) from limiting access to those services? The courts have said 'no'.

The Charter of Rights

The two important sections of the Charter of

s. 7 Rodriguez v BC [1993] 3 SCR 519 Sue Rodriguez suffered from a progressively debilitating disease & wanted to be able to rely on a tech device to commit suicide when she could no longer enjoy life. The court held that the prohibition on assisted suicide violated Rodriguez' rights under s. 7. The court affirmed its decision in Morgentaler in holding that s. 7 encompasses notions of ... p 2 highlight — but went on to hold that the deprivation was saved by s. 1

b. Cross dressers
c. Drag kings/queens
d. Intersexed people

.[20]

5. Challenges of inequalities in the health care system
   a. The implications of human rights cases for health care for trans people
      1. Sex reassignment surgery
      2. Secondary procedures
         1. electrolysis
         2. shaving adam's apple
         3. breast augmentation: paid for if you fail the Tanner test (a breast size measure less than A cup)
         4. pay for breast reduction, hysterectomy, ooopherectomy: all done in B.C.
         5. penis construction: not paid for, also not medioplasty
         6. MtF

         7.
   b. Possible Charter Challenges

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[20] For issues in residential health care facilities, see findlay, barbara "Sexual Orientation and Gender Identity in Residential Health Care Facilities: A Draft Policy" which is an appendix to the chapter on employment.

1. The Petersen challenge
2. Electrolysis

Clinic has to approve
they recommend to Victoria
Victoria insitst on 2 year rlt

Clinic gives credit up to 1 year for pre-clinic cross living, requies 1 year under clinic care as well

Victoria may reject people but usually only for more information: they don't say "you are wrong" but ask for more information

- people do not necessarily get approved
- eg 'volunteering working or going to school'

3. Canada health act

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