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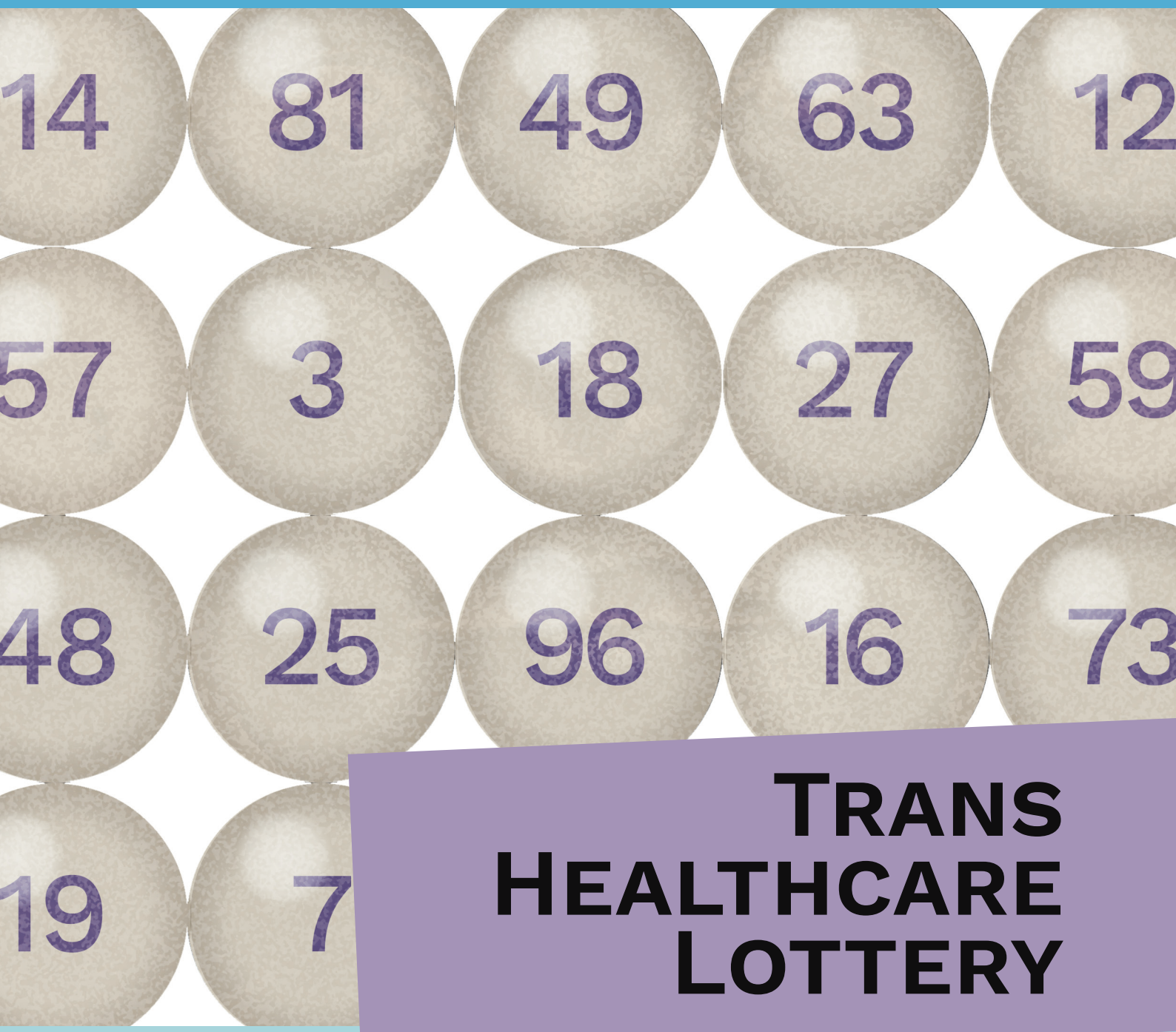

Trans Healthcare Lottery

Insurance coverage for trans specific healthcare

An overview on the basis of 17 countries in Europe

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The present document has been created with the greatest care, but it does not claim to be complete. Please send feedback and suggestions for amendments to **tgeu@tgeu.org**

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Find out more about Transgender Europe and its work on health: www.tgeu.org/issues/health_and_depathologisation/.

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1. Introduction

Overview

Trans people[1] are routinely discriminated against in healthcare settings and their health and well-being are underserviced.[2] Within the European Union, trans people are most likely among LGBT people to face discrimination in healthcare,[3] one in every five trans people has personally faced such discrimination[4] and 70% of trans people have undergone negative experiences in healthcare settings.[5] TGEU's latest healthcare report (2017) also reaffirmed that trans people face numerous barriers in enjoying their right to health, both in general and trans specific healthcare services.[6] It also highlighted trans people's difficulty in accessing affordable and comprehensive insurance that would cover their healthcare costs.

General healthcare refers to all types of services not related to being trans, for example going to see a general practitioner (GP) or dentist.

Trans specific healthcare (TSHC) includes getting a diagnosis, accessing hormones, various surgeries, tests or other medical procedures. Some trans people wish to access these services of their own free will and to better align their body to their gender identity. Others do so because it is legally required of them if they want to have their costs covered by insurance, access further healthcare, or legal gender recognition.

Forcing trans people to make a choice between their mental and physical integrity and accessing these services is a grave human rights violation.[7] Mandatory psychiatric diagnosis, medical examinations, hormone therapy and sterilisation are discriminatory on the basis of gender identity and expression and may constitute

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1 Trans is an umbrella term that refers to people whose gender identity does not match the sex that they were assigned at birth. Throughout this report, trans also includes non-binary people. Non-binary people do not identify with the sex that was assigned to them at birth and have a gender identity that does not correspond to being (exclusively) male or female. They might identify with being both, or neither of these two, their gender identity might be fluid, or they might not have a gender identity at all.

2 Commissioner for Human Rights of the Council of Europe. Issue Paper on Human Rights and Gender Identity. 2009. https://rm.coe.int/1680695d3c

3 European Union Agency for Fundamental Rights. *EU LGBT survey: European Union lesbian, gay, bisexual and transgender survey*. 2014. http://fra.europa.eu/en/publication/2014/eu-lgbt-survey-european-union-lesbian-gay-bisexual-and-transgender-survey-main

4 European Union Agency for Fundamental Rights. *Being trans in the European Union. Comparative analysis of EU LGBT survey data*. 2014. Pp. 41. http://fra.europa.eu/en/publication/2014/being-trans-eu-comparative-analysis-eu-lgbt-survey-data

5 Ibid, pp. 43.

6 Transgender Europe. Overdiagnosed but Underserved. Trans healthcare in Georgia, Poland, Serbia, Spain, and Sweden: *TGEU's Trans Health Survey*. October 2017. tgeu.org/healthcare

7 *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. p.11, 13. 2017. https://daccess-ods.un.org/TMP/3705690.80114365.html

torture and ill-treatment.[8] [9] [10] Several United Nations and Council of Europe mechanisms have called on governments to de-medicalise legal gender recognition procedures and instead base them on self-determination,[11] such as is available in Malta, Ireland and Norway.

The Council of Europe Committee of Ministers has called on states to ensure that trans people can enjoy the highest attainable standard of health without discrimination, that they have access to trans specific healthcare services without being subjected to unreasonable requirements, and that they use these services on the basis of their free, prior and informed consent, and that any limitations of insurance coverage are lawful, objective and proportionate.[12] The European Court of Human Rights has ruled that member states must not discriminate in their provision of insurance coverage for trans specific healthcare. These standards have been reaffirmed by the Council of Europe Commissioner for Human Rights.[13] The World Professional Association for Transgender Health (WPATH), the World Association for Sexual Health (WAS), and trans organisations across the world, have also repeatedly reiterated them.[14] [15]

Previous research has found that despite these state obligations, trans people are routinely refused cost coverage for hormones and surgeries.[16] More than half of trans people end up paying for services on their own.[17] This is particularly alarming, given the economic and

8 Human Rights Watch. *Torture and Cruel Treatment in Health Settings*. 2017. https://www.hrw.org/news/2010/01/20/torture-and-cruel-treatment-health-settings

9 *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, Juan E. Méndez. January 2013. https://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

10 See for instance https://tgeu.org/idahot_forum_map-launch/

11 See for instance The UN Committee on the Rights of the Child, a group of UN human rights experts, the Inter-American Commission on Human Rights, the African Commission on Human and Peoples' Rights and the Commissioner for Human Rights of the Council of Europe, "*Pathologization – Being lesbian, gay, bisexual and/or trans is not an illness*" *For International Day against Homophobia, Transphobia and Biphobia*, 17 May 2016. https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=19956&LangID=E

12 Committee of Ministers of the Council of Europe. *Recommendation CM/Rec(2010)5 of the Committee of Ministers to member states on measures to combat discrimination on grounds of sexual orientation or gender identity*. 2010. Recommendations 33-36. https://rm.coe.int/168047f2a6

13 European Court of Human Rights. *van Kück v. Germany* (*Application no. 35968/97*), judgment of 12 June 2003. Paras. 47, 73 and 82. L. v. *Lithuania* (*Application no. 27527/03*), judgement of 11 September 2007. Paras. 59 and 74. Commissioner for Human Rights of the Council of Europe, Discrimination on Grounds of Sexual Orientation and Gender Identity in Europe (2011), at 109–110; 126.

14 WPATH. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. 7th version*. 2011. http://www.wpath.org/site_page.cfm?pk_association_webpage=3926&pk_association_webpage_menu=1351

15 World Association for Sexual Health, *WAS statement about the WHO / ICD 11*, 06 July 2018. http://www.worldsexology.org/was-statement-about-the-who-icd-11/

16 TGEU and ILGA-Europe. *Transgender EuroStudy: Legal Survey and Focus on the Transgender Experience of Health Care*. 2008. http://tgeu.org/wp-content/uploads/2009/11/transgender_web.pdf

17 Ibid, pp. 11.

social marginalization of trans people all across Europe. It is well documented that trans people in general, and trans women[18], trans people of colour, trans migrants[19], and trans people with disabilities in particular, are disproportionately affected by unemployment and poverty.[20] Compared to the general population and LGB people, trans people are more likely to be low income and less likely to be high income.[21] They are also most likely to report long-term unemployment.[22] Trans people who have great difficulty in making ends meet are consequently more likely to engage in sex work, which exposes them to greater discrimination and violence.[23] Many take up sex work because the lack of insurance coverage means they have no other way to pay for hormones or surgeries.[24]

This report includes an analysis of the overarching themes in trans healthcare cost coverage in 17 countries: Austria, Belgium, Czech Republic, Finland, France, Georgia, Germany, Italy, Luxembourg, the Netherlands, Poland, San Marino, Slovakia, Slovenia, Spain, Russia and the UK (England and Scotland).[25] It reveals that sadly, it is only in a handful of European countries, such as the UK, the Netherlands, Germany, or Belgium that public health insurance covers most trans specific healthcare costs. In most other countries, public insurance only covers a limited number of procedures, and in some, such as Georgia, Russia, and Poland virtually nothing is covered. Further, even in countries where insurance coverage is available, trans people routinely face excruciatingly long waiting periods and humiliating treatment. Across the board, they are subjected to pathologisation and find themselves at the mercy of doctors, who routinely act as gatekeepers between them and the healthcare they want to access. Insurance coverage is subject to discriminatory limitations and often provided on an ad hoc basis. Trans people who are poor, who live outside big cities, non-binary people, and trans people with disabilities face additional barriers in accessing affordable care[26].

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18 Fundamental Rights Agency, *Being trans in the European Union*. Pp. 122.
19 Boglarka Fedorko and Lukas Berredo, TGEU. *The vicious circle of violence: Trans and gender-diverse people, migration, and sex work*. 2017. http://transrespect.org/wp-content/uploads/2015/08/TvT-PS-Vol16-2017.pdf
20 Fundamental Rights Agency, Being trans in the European Union. Pp. 122.
21 Ibid. Pp. 17
22 Ibid. Pp. 121.
23 Boglarka Fedorko and Lukas Berredo, TGEU. The vicious circle of violence: Trans and gender-diverse people, migration, and sex work. 2017. http://transrespect.org/wp-content/uploads/2015/08/TvT-PS-Vol16-2017.pdf
24 ibid.
25 Of the 17 countries, 11 are Western European countries and only 6 Eastern European. On the basis of the UN regional groups, Czech Republic, Georgia, Poland, Slovenia, Slovakia, Russia fall under Eastern Europe, while the rest under Western Europe.
26 Information on other marginalised groups could not be obtained through this report. It would be essential to do further research in this area, for instance with a particular focus on trans people of colour, young people, migrants, including asylum seekers and refugees.

While going private might mean better quality services, accessing private doctors is unaffordable for the vast majority of trans people. The same applies for private insurance, which is usually expensive and often excludes trans specific healthcare from coverage.

Given the social and economic marginalisation of trans people, it is particularly crucial that states live up to their obligations by providing accessible and quality care as well as comprehensive insurance coverage without discrimination on the basis of gender identity and gender expression. It is also essential that more targeted research and dedicated policy measures address insurance coverage by private companies, where the potential for discrimination is particularly high, preventing trans people from accessing medically necessary treatment.

METHODOLOGY

Between 2016-2017 TGEU conducted research to learn more about how the costs of trans specific healthcare are covered across Europe. The research consisted of three steps:

1. Local partners of the Global Network of Public Interest Law[27] (PILnet) filled in TGEU's survey[28] on the legal standards that are relevant for cost coverage. TGEU received responses from 18 countries.[29] (October - November 2016)
2. TGEU asked lawyers in 15 of these countries to answer some follow-up questions: 10 were available to do this. (October - November 2017)
3. TGEU asked its local trans activist contacts in 17 countries[30] to crosscheck the responses and complement the legalistic data with more personal accounts. This was important because the legal situation often did not reflect lived realities. Activists from 16 countries shared information about their country situation. Most of them added information in the survey document, but some responded via email or social media. Because of the availability of data, 17 countries were included in the end.[31] (October-December 2017)

27 http://www.pilnet.org/

28 The survey questions were the following: Which trans specific healthcare is covered in your country? To which percentage are the costs covered? Is a mental health diagnosis mandatory? What is the legal basis for trans specific healthcare cost coverage? What are main reasons trans specific healthcare is not or only partially covered?

29 PILNet also reached out to partners in Hungary, Monaco, Portugal, and Switzerland, but did not receive responses. TGEU received responses from Turkey after the deadline.

30 TGEU did not have contacts to local activists in San Marino.

31 Because of the availability of the data, Ireland was excluded. From within the UK TGEU received legal information about England and Scotland. Wales and Northern Ireland were excluded from the analysis.

Limitations

This report focuses on the overarching themes in trans healthcare cost coverage in the 17 participating countries, without aiming to describe each country situation in depth. It only includes information about countries that were covered by PILNet's local partners, even though there might be ample issues to highlight in others. In each of these countries TGEU reached out to one or two key activist contacts to learn more about the situation, but did not collect information from a larger sample of trans people. More comprehensive research on the lived experiences of trans people is required, especially with regards to trans people of colour, children and youth, and migrants, including asylum seekers and refugees. This publication does not include a comprehensive review of the relevant international or European policy framework, including EU regulations, judgments of the European Court of Human Rights, or policies within the realm of the European Social Charter.

2. The extent and guarantees of cost coverage across Europe

The extent of cost coverage across Europe

There is no country where all trans specific healthcare services are covered

Not one of the 17 participating countries have a public or private insurance scheme that would provide for fully comprehensive coverage of trans specific healthcare costs. Even in countries such as **Germany**, the **UK**, the **Netherlands**, or **Belgium**, where most healthcare costs are covered, there are numerous barriers that trans healthcare users are still face. For instance, in all four of these countries, there are discriminatory limitations in place that arbitrarily label some procedures, such as facial feminisation, as aesthetic and therefore exclude them from coverage or restrict funding to the least expensive procedures (Chapter 3C). Waiting times are another example of these barriers (Chapter 3D); it can take up to 2.5 years in the UK to get an appointment for an initial consultation and about two years in the Netherlands to start hormones.

> *"At first glance, insurance coverage for transgender health care looks fine in the Netherlands. But closer observation shows a different picture. Of course we are happy that basic psychology, hormone treatment and genital surgery is covered. But there's barriers or no coverage at all for some favourable hormone supplements, secondary surgery like for instance breast augmentation, genital surgery in foreign clinics or psychological support for partners or next of kin. Next to that, we regard the procedures to apply for coverage for treatments too paternalizing and strenuous and the outcome too arbitrary. In the end, coverage is strongly influenced by policies of the individual insurance company and the stamina of the applicant. Lots of room for improvement, I would say."* Lisa van Ginneken, Patient organisation Transvisie, the Netherlands.

Some countries provide virtually no coverage

In some countries, such as **Georgia**, **Russia**, **Poland**, or **Slovakia** there is very minimal or no insurance coverage that would facilitate trans people's access to healthcare. In **Georgia** no trans specific healthcare service is covered by either public or private insurance schemes. In **Russia**, the only TSCH that is covered by public insurance or the public health system is psychotherapy, while nothing is covered by private insurers. Some trans people have

been able to get a free consultation with an endocrinologist, but their hormones would not be covered.

> *"I'm not aware of a single case where a trans person could receive any sort of hormonal treatment for free. And it is basically safe to say that transgender persons in Russia always have to pay for any transition related surgeries themselves."*
> Diana Iashenkova, Transgender Legal Defense Project, Russia.

In **Poland** cost coverage has been provided in very rare cases on an ad hoc basis (Chapter 3E). In **Slovakia** there is no protocol setting out what would be covered, and the system is therefore unreliable (Chapter 3E).

Healthcare coverage in the law and catalogues of healthcare services

Across the participating countries, it greatly varies how cost coverage for general and trans specific healthcare is regulated. In some countries, there are legal provisions that establish the rules of cost coverage, including on trans specific healthcare. In others, conditions are set out in the catalogue of services of insurance providers and trans healthcare is also included. In a number of countries it is neither included nor explicitly excluded in catalogues, leaving ample space for inconsistencies in practice. There are also examples where trans specific healthcare services are listed as non-refundable. Although there is no golden rule for codifying cost coverage, the standards of the Council of Europe are crystal clear that any limitation on insurance provision must be lawful, objective and proportionate. In order for trans people to have genuine access to healthcare it is vital that the rules of cost coverage are transparent, clearly stated, and consistently applied.

Coverage set out in law

There are only a handful of countries where there are laws in place that provide for cost coverage, often because there is no law about general healthcare coverage either. In **Finland**, the Trans Act sets out that trans specific healthcare is specialised treatment and as such, it will be covered by the state.[32] With reference to the law on "sex change" in **Italy**, genital surgeries, the removal of the uterus and testes are covered by the public health system in any specialised medical centre that is able to perform them.[33]

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[32] *Act on the Confirmation of Gender of a Transsexual.* 28 June 2002/563. http://trasek.fi/wp-content/uploads/2011/03/TransAct2003.pdf

[33] Law 164/1982 on the rules concerning the adjustment and attribution of sex. http://www.portalenazionalelgbt.it/bancadeidati/schede/legge-14-aprile-1982-n-164

Hormones, mastectomy, and breast augmentation are covered on the basis agreements that are made between specialized centres and the regional health system. In **Spain**, some autonomous regions have trans specific laws in place that set out that surgeries are covered by the public system.[34] Many of them state that specific guidelines or catalogues of services should be in place, but these are often lacking or not publicly available. The region of Asturias does not have a law, but there is a protocol providing for cost coverage. Other regions may not have either a law or policy in place, but they have agreements with other regions about referring trans people there (Chapter 3F) and covering their costs.[35]

TRANS HEALTHCARE INCLUSION IN INSURANCE COMPANIES' CATALOGUE OF SERVICES

In **Germany**, the vast majority of trans specific healthcare services are covered by public and private insurance and included in catalogue of services. However, the principle of economic efficiency, bureaucratic hurdles, the necessity of diagnosis, long legal proceedings, and the exclusion of non-binary people from hormone therapy and surgery coverage still cause major issues for trans people (Chapter 3F).

In several countries, for instance **Austria**, **Georgia**, **Slovenia**, or **Russia** trans healthcare services are not included in the public insurance catalogue, but there is no explicit exclusion either. This can make it difficult to claim coverage:

> *"Transgender people are not mentioned specifically in any of the documents concerning compulsory health insurance, and from a legal standpoint that makes it impossible for them to receive any trans-specific medical help under the umbrella of public medicine."* Diana Iashenkova, Transgender Legal Defense Project, Russia.

In **Belgium** however, the public health system covers most trans healthcare procedures in practice, even though there are no codes that name them in the national catalogue of services that would specify the extent of coverage. This is helpful, because trans people are not automatically outed in the healthcare system. However, it also means that cost coverage is not always fully accessible. For instance, in the case of vaginoplasty, which has no

[34] These regions are Andalusia, Basque Country, Canary Islands, Madrid and Valencian Community. The other regions are Aragon, Asturias, Balearic Islands, Cantabria, Castilla-La Mancha, Castilla y Leon, Catalonia, Extremadura, Galicia, Murcia, Navarra, and La Rioja.
[35] Castile-La Mancha has such an agreement in place, but there is no confirmed information about others.

code in itself, different codes will be combined so as to cover as much of the costs as possible. It may happen that in the case of some surgical interventions, an additional cost for the aesthetic part of the procedure will be charged and this will not be covered by public insurance. In October 2017 a convention on transgender care was adopted by the government, providing coverage for 10-15 consultations per individual with a psychologist or a social worker and puberty blockers. The convention can be signed by any hospital in Belgium with some level of relevant expertise.

In **Georgia**, health professionals could register trans healthcare as a 'medical service standard', which could make it eligible for coverage. However, clinics that provide some services have so far refused to do this as they believe the committee making decisions in these cases will turn it down.

Case study: The impact of EU regulations on Luxembourg

In Luxembourg trans people have often relied on EU agreements to access surgeries or even hormones abroad, when not available in their home country. There have been two ways to gain coverage. Earlier EU regulations allowed people to get healthcare abroad, if their home insurance company gave them an authorisation[36] that they can use services and will be reimbursed.[37] The more recent EU directive on cross-border healthcare[38] provides the same, but also allows people to get services in private clinic and does not require an authorisation. A common issue in Luxembourg has been that this contradicts national rules that do require an authorisation, so people often find themselves in a Catch 22 situation. Further, the directive sets out that the home insurance company has to pay as much as the procedure would have cost in Luxembourg. However, if some procedures are not available in the country at all, there is no local cost to use as reference.

36 The S2 form is an authorisation to get planned health treatment in another EU country. Those applying should be treated the same as a resident of that country, but may have to pay a percentage of the costs up front.

37 *Regulations (EC) 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems* http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:166:0001:0123:en:PDF and *(EC) 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004* http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2009:284:0001:0042:en:PDF

38 *Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare* http://legilux.public.lu/eli/etat/leg/loi/2014/07/01/n1/jo.

EU DIRECTIVE ON CROSS-BORDER HEALTHCARE

The cross-border healthcare EU Directive (2011/24/EU) sets out that EU citizens can choose where they receive medical treatment across the EU. As long as the procedure is available in their home country and up to the amount that it would cost to get treatment at home, they will be reimbursed for the costs by their home insurance. The Directive also states that patients only need a prior authorisation in special circumstances - these become the exception rather than the rule. All Members States have to establish national contact points[39], where citizens can get information about available treatments abroad and reimbursement procedures.[40] As trans people often do not know how the Directive could be used to their benefit, it is important that contact points provide reliable information about the procedure, as well as about available trans healthcare.[41] Information should be provided about quality, access requirements, waiting times, and other key aspects that would truly help trans people get the care they need.

39 See a list of contact points here: https://ec.europa.eu/health//sites/health/files/cross_border_care/docs/cbhc_ncp_en.pdf

40 Commission report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare. The Commission To The European Parliament And The Council. September 2015. http://ec.europa.eu/health/cross_border_care/docs/2015_operation_report_dir201124eu_en.pdf

41 Joint submission by ILGA-Europe and TGEU as part of the public consultation on measures for improving the recognition of prescriptions issued in another Member State. January 2012. https://www.tgeu.org/sites/default/files/Consultation_on_EU_Cross-Border_Prescriptions_joint_submission_ILGA-Europe_TGEU_Jan_2012.pdf

3. Key issues

3.A Facing pathologisation and gatekeeping

Pathologisation and gatekeeping are human rights violations

All across the board in countries studied, insurance companies require trans people to get a mental health diagnosis in order to gain coverage for the healthcare services they need, and they do this for bureaucratic reasons. **Pathologising trans identities violates trans people's human rights and dignity and has been repeatedly criticised by TGEU and other human rights organisations.**[42] Diagnosis being a requirement for insurance coverage means that insurance companies and doctors are in a gatekeeper position: they have the power to decide whether a trans person will have access to affordable care or to any care at all. **Barring access to adequate insurance coverage is discriminatory against trans people and can have a detrimental impact on a person's mental or physical well-being.**[43]

Diagnosis is usually made on the basis of two diagnostic manuals, the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). Countries across Europe may use different versions of these manuals, both of which include a number of diagnoses commonly applied to trans people, so the exact label may vary.[44] However, diagnoses such as transsexualism or gender dysphoria as psychiatric disorders are used across Europe.[45] For example, in **Finland**, **Slovakia**, and **Poland** any cost coverage will require a diagnosis of transsexualism (F64.0 in the ICD-10), in **England**, **Belgium** and **the Netherlands** gender

42 Degner/ Nomanni analysed how mandatory psychiatric assessments of an individual's gender identity interfers with their human rights "Psychiatry in Legal Gender Recognition Procedures in Europe - A comparative human rights analysis" (2017): https://tgeu.org/pathologization-through-law-compulsory-assessments-in-procedures-for-changing-personal-status/ ; as well as a statement of TGEU and other trans organisations on the International Day of Action for Trans Depathologisation 2017. https://tgeu.org/statement-on-the-international-day-of-action-for-trans-depathologization-2017/

43 See for example https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31429-6/fulltext

44 Both manuals are periodically updated, but countries are not obliged to use the most recent version. ICD-10 for instance refers to the 10th edition of the ICD and DSM-5 to the fifth edition of the DSM. ICD-10 included the following diagnoses: Transsexualism (F64.0), Dual Role Transvestism (F64.1), Gender Identity Disorder of Childhood (F64.2), Other Gender Identity Disorders (F64.8), Gender Identity Disorder, unspecified (F64.9), Fetishism (F65.0), Fetishistic Transvestism (F65.1), Multiple Disorders of Sexual Preference (F65.6), Disorders of Sexual Preference, unspecified (F65.9) Sexual Maturation Disorder (F66.0), Egodystonic SexualOrientation (F66.1), Sexual Relationship Disorder (F66.2), Other Psychosexual Development Disorders (F66.8) and Psychosexual Development Disorder, Unspecified (F66.9). DSM V uses Gender Identity Disorder in Adolescents or Adults (302.85), Gender Identity Disorder in Children (302.6).

45 This may change with the adoption of ICD-11, expected in 2019. Read more here: https://transactivists.org/depathologization/

dysphoria or gender incongruence (DSM-5). Even in a country like **Georgia** where no trans healthcare costs are covered by insurance, trans people still need to have a certificate for being a "true transsexual" to access services, such as surgeries.[46] Similarly in **Russia**, trans people need a F64.0 diagnosis to access hormones, surgeries, or legal gender recognition, even though only their psychotherapy costs are covered by public insurance.

In **France**, trans healthcare costs were covered as related to a long-term psychiatric illness, under a special state insurance scheme called ALD that is reserved for those with a long-term health condition.[47] However, in 2010 trans healthcare was moved under the 'unclassified' label within ALD, practically depathologising being trans. Unfortunately, the public health system outside the ALD still handles being trans as a mental illness, and costs are only covered following a F64.0 diagnosis.

MOVING AWAY FROM DIAGNOSIS?[48]

As a positive example, the Luxembourg Minister of Justice and Minister of Social Security affirmed in May 2017 that trans healthcare should no longer be provided on a pathologising basis, and that TSCH cost coverage should be guaranteed.[49] The Advisory Commission on Human Rights (CCDH) published the same opinion on 13 October 2017.[50] Depathologisation has now to be transposed into the public insurance statutes.

In the Spanish regions of Andalusia, Aragon, Balearic Islands, Madrid, and Valencian Community, legislation prohibits the

46 Although the procedure is not established in law, the certificate is usually issued based on genetic, endocrinological, gynaecological or urological, two independent psychiatric and two independent sexological expert opinions, as well as psychological testing. *Situation of transgender people in Georgia*. WISG. 2015. http://women.ge/data/docs/publications/WISG_Transgender_survey_2015.pdf.

47 The ALD (affection longue durée) is a state insurance scheme set up for long-term illnesses. http://www.fondshs.fr/Media/Default/Images/Ressources-Allocations/Liste_des_ALD_30.pdf

48 Denmark, Malta and Sweden (not covered in this report) have depathologised trans identities, but TGEU does not have enough data on how this has impacted the provision of insurance coverage. See https://tgeu.org/malta-depathologises-trans-identities/; http://nordic.businessinsider.com/denmark-is-set-to-become-the-first-country-in-the-world-to-depathologise-being-transgender-2016-5/; http://www.socialstyrelsen.se/nyheter/2017/socialstyrelsenforberederandringavklassificeringavtranssexualism.

49 At a press conference on 17 May 2017, Félix Braz (Minister of Justice) presented the draft bill 7146 on modification of the sex and of the name or names in the Civil Register and modifying the Civil Code. He joined the opinion of Romain Schneider (Minister of Social Security). https://www.wort.lu/de/politik/justizminister-braz-stellt-gesetzenturf-vor-wenn-aus-paul-pauline-wird-591c6878a5e74263e13bfb4e

50 See more: https://ccdh.public.lu/fr/actualites/2017/10/avis-de-la-CCDH-sur-le-projet-de-loi-7146.html

diagnosis requirement. In practice however, endocrinologists often ask for assessment from another professional, such as a psychologist or a social worker.

"It is not a diagnosis in itself, but it is still something, some previous professional assessment. It feels like they want to "be safe" in legal terms, even though there is a law that protects them and even prohibits this requirement of a previous report of any kind. They still don't feel comfortable or safe going directly into the hormone treatment without someone else's back-up." Leo Mulió Álvarez, trans activist and psychologist, Spain

Pathologisation and gatekeeping in practice

Pathologisation and gatekeeping are strongly interlinked, as illustrated by the example of **Slovakia**:

> *"Getting the F64.0 diagnosis in Slovakia is like a casting for an acting role. If you act in the way that will make the doctor believe that you are a stereotypical woman or a man, they will grant you the role through the diagnosis of mental illness. You will also be partially paid by your insurance - sometimes. Do not hang on to your own health or medical needs. It is about knowing what your audience wants and giving it to them. It's literally a theatre."* Romina Kollárik, TransFúzia, Slovakia.

In the **Czech Republic**, access to trans healthcare and insurance coverage requires approval from a commission of medical staff. The commissions include a healthcare worker, a sexologist, psychiatrist, a clinical psychologist, a diabetologist, an endocrinologist, an expert in the field of urology or gynecology and a lawyer qualified in medical law.

In **Luxembourg** many forms of trans healthcare can be covered by the public health system, but not automatically. Trans people will need to apply for a prior authorisation from the public health institution, which is based on an opinion issued by the Social Security Medical Inspectorate (CMSS).[51] In the case of hormone therapy the Inspectorate decides on the basis of a psychiatric and endocrinologist opinion and a treatment plan by the endocrinologist.

[51] Annex C(15) of the CNS' statutes http://cns.public.lu/fr/legislations/ammd_dent/cns-ammd-med-tableau.html

In the case of surgeries, the CMSS requires a psychiatric opinion, the opinion and treatment plan of the surgeon, a "real life test" (see box below) for at least one year and under psychiatric follow-up, and a cost estimation. Furthermore, trans people's right to choose their doctor is also violated by the current rules. Insurance will only cover procedures by a surgeon who specialises in plastic surgery and practises in a center specialised on sex reassignment surgery. Even if someone is not satisfied with these doctors, their insurance claim will likely be rejected if they choose someone else.

> *"This is too strictly defined. The insurance statutes set arbitrary rules which are not tailored to the needs of the individuals, do not contribute to an improved quality of trans healthcare and restrict the free choice of a medical doctor."*
> Intersex & Transgender Luxembourg, Luxembourg.

In some cases, applications have been rejected despite all requirements being met. Intersex & Transgender Luxembourg has criticised these rules and called for their abolition.[52]

THE "REAL LIFE TEST" AS A HUMAN RIGHTS VIOLATION

In many European countries trans people have to pass a so called "real life test" (RLT) or "real life experience" (RLE) before being able to access trans specific healthcare or legal gender recognition. Passing the RLT/RLE means that the person has to prove they have lived expressing themselves in line with their gender identity for a certain period of time. The RLT/RLE heavily rely on gender stereotypes and are extremely limiting. They may put pressure on trans people to live up to such expectations for long periods of time. For instance, Finland and Luxembourg, require a period of one year, but in other countries possibly longer. The RLT/RLE always needs to be confirmed by one or more doctors, usually psychiatrists. The test is a prime example of gatekeeping by the medical establishment. It is discriminatory as it violates trans people's dignity and right to self-determination. It is dangerous because it forces people to publically out themselves for the duration of the RLT prior to beginning any medical interventions and often without having access to ID documents matching their gender identity. This exposes them to further discrimination and violence.

52 Enfants et adultes trans: Pour une application de l'approche affirmative dans le système de santé, to be published. www.itgl.lu

In **France**, the special state insurance scheme ALD can cover healthcare costs, if the person's doctor writes a referral for coverage under F64.0 and the public healthcare accepts this. They can however deny the claim and are not obliged to give any detailed explanation for the reasons.

In **the Netherlands** diagnosis is made by the so-called gender clinics: healthcare and coverage are only accessible via the diagnosis they issue. Insurance claims based on diagnosis issued by other doctors will not be automatically funded. Similarly in the **UK**, diagnosis is made at Gender Identity Clinics. In both countries, this de-facto monopoly results in considerable waiting times trans people have to endure (Chapter 3).

In **Germany** the bureaucratic maze is so confusing that it may discourage individuals from seeking healthcare and cost coverage even though they would be entitled to it. Trans related health issues are considered rare and complex in the German system and therefore all trans people need to first get an expert opinion from the Medical Service of the Public Health Insurance Companies (MDK), an independent public corporation, which provides binding opinions.[53] The application to the MDK is handed in by the person's psychotherapist: trans people routinely need to be in therapy for 12 months to access hormone therapy and 18 to access surgeries. The MDK often fails to make the right diagnosis and trans people cannot get the insurance coverage they rightfully should.[54] Fighting the MDK's opinion can take years, and no healthcare would be reimbursed in the meantime.

> *"I am a psychiatrist and psychotherapist, and work with a lot of trans people. Physicians working under these guidelines are forced to work against the modern knowledge about the treatment in relation to gender dysphoria or gender incongruence. For example, I have to do psychotherapy for over 18 months with people who have perfect mental health, because it is a requirement for them to access surgeries. This does not make any sense."* Annette Güldenring, Bundesverband Trans, Germany.

Other forms of gatekeeping include rules about economic efficiency, medical necessity (Chapter 3C) or the requirement for the person to be free from mental health issues or have mental health issues "adequately controlled". (Chapter 3F).

53 *Nebendahl*, Spickhoff, Medizinrecht, § 275 SGB V, Rn. 22

54 See also the Health Policy Paper of the German Trans Organisation BVT "Trans*-Gesundheitsversorgung Forderungen an die medizinischen Instanzen und an die Politik" (2016)

3.B PAYING TO BE VIOLATED

Across much of Europe, trans people are required to get a psychiatric diagnosis, undergo medical examinations, hormone therapy and sterilisation in order to change their gender marker in their documents. Currently 34 countries in Europe still require a mental health diagnosis and 14 require sterilisation.[55] Several United Nations and Council of Europe mechanisms have warned that these requirements constitute severe human rights violations and called on governments to put in place legal gender recognition procedures that are based on self-determination. It is striking that even when such requirements are in place, public insurance often does not cover the costs involved. Trans people are required to receive a psychiatric diagnosis to access care, which is a documented human rights violation.[56] The process for receiving this diagnosis is often not funded by insurance. As a result, to access trans specific healthcare, trans people must pay individually for an evaluation and diagnosis that violates their human rights. **Simply put, trans people have to finance their own human rights violations**. In **Poland** for instance, trans people need to receive a diagnosis before they apply to court to change their gender marker. This will only be covered by insurance if the doctor is registered with the National Health Fund. Because of the long waiting lists, many trans people end up paying for the diagnosis themselves.

In some countries, trans people can only access healthcare and insurance coverage if they have already changed their gender marker on their documents or have at least started the process. In **Finland** for a long time hormones were covered by insurance only if the person had changed their gender marker in their documents already. This regulation was recently changed by the public insurance company, but it is still required to have received a diagnosis and passed a real life test.

3.C SUBJECTED TO DISCRIMINATORY LIMITATIONS

TRANS HEALTHCARE EXCLUDED FROM CATALOGUES OF SERVICES

In some countries public insurance or the public health system explicitly exclude trans healthcare from services that are covered.

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55 For more information see Trans Rights Europe Map 2018, https://tgeu.org/trans-rights-map-2018/

56 See for instance instance The UN Committee on the Rights of the Child, a group of UN human rights experts, the Inter-American Commission on Human Rights, the African Commission on Human and Peoples' Rights and the Commissioner for Human Rights of the Council of Europe, *"Pathologization – Being lesbian, gay, bisexual and/or trans is not an illness" For International Day against Homophobia, Transphobia and Biphobia, 17 May 2016*. https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=19956&LangID=E

The **Czech** Public Insurance Act sets out a list of services that are excluded from coverage,[57] laser hair removal for instance. These will only be paid for if the doctor in charge confirms they are indispensable for the person's well-being.[58]

Exclusion is significantly more common among private insurance companies. The five major **Spanish** private medical insurers[59] expressly exclude all operations related to gender affirming treatment.[60] Even an insurer that is known for being LGBT-friendly[61] excludes TSCH from its services. **UK** surgical procedures in relation to gender affirmation are generally excluded under private medical insurance, with the exception of BUPA[62], which offers such procedures under certain insurance schemes. In **Italy**, private insurers do not list trans healthcare in their catalogue because it is linked to a psychiatric disorder and therefore not covered. In other cases private companies argued that it is cosmetic or aesthetic and as such, not refundable. In **Finland** private insurers either exclude trans healthcare from their services or they have not disclosed any relevant information. In **Belgium**, having hospitalisation insurance is not mandatory but recommended if surgical interventions are planned, and one needs to arrange this through private insurance companies or mutualities. The explicit exclusion of costs related to transsexuality, gender dysphoria, gender identity disorder or any formulation alike is forbidden. However, in many cases these insurance companies find other ways to exclude the coverage by mentioning the exclusion of aesthetic procedures, pre-existing conditions, psychiatric disorders, prostheses, implants, sterilisation, and the like. Insurance companies in Belgium also often engage in legal battles to avoid paying for trans healthcare. They have argued that the demand for trans depathologisation means that being trans is not a disorder anymore, trans healthcare is thus not necessary and does not need cost coverage.[63] **Russian** private insurance companies also explicitly exclude trans healthcare from their catalogues.

57 Annex 1 to the Public Health Insurance Act of March 7, 1997, last amended on January 31, 2017 (effective from April 1, 2017): https://portal.gov.cz/app/zakony/zakon.jsp?page=0&nr=48~2F1997&rpp=10#seznam

58 Ibid, Section 16(1)

59 Adeslas, Asisa, Mapfre, Sanitas, and Santalucía

60 See, for instance, Sanitas: https://www.sanitas.es/seguros/contratacion/?mboxSession=1476805515392-73204#/planes/986. Under "Nota previa informativa Sanitas Premium 500.000", pp. 2.

61 Seguros Positivos.

62 https://www.bupa.co.uk/

63 See the following press release: http://www.presscenter.org/en/pressrelease/20161026/insurers-are-not-allowed-to-discriminate-against-transgender-people?setlang=1

POSITIVE PRACTICE

The Belgian Gender Equality Body *Institute for Equality Between Women and Men* provides practical information on its website about how trans people can claim their rights vis-a-vis insurance companies.[64] If someone wants to challenge a negative decision by an insurance company, dedicated legal experts will help them write a formal letter or offer mediation. If the discriminatory treatment persists, the Institute also supports legal action.

ECONOMIC CONSIDERATIONS: LESS EXPENSIVE TREATMENTS COVERED MORE OFTEN

In many countries, insurance only covers trans healthcare that is less costly. As a general trend, psychotherapy and hormones are more likely to be covered than surgical procedures or other healthcare that are more expensive. In **Russia** for instance, only psychotherapy is covered. In **Germany**, public insurance applies the principle of economic efficiency. This means that they cover the least expensive intervention first and would only pay for additional services if the first one has not yielded 'results', i.e. has not considerably improved the health condition. In practice this means that they will first pay for someone's psychotherapy, then hormones, and would only fund other procedures if the person still experiences severe distress.[65] If someone wants to undergo top surgery but not take hormones, they will be unable to get their surgery costs covered by public insurance. This has been a problem especially for non-binary people and trans men who do not wish to take hormones.

MEDICAL NECESSITY VS. AESTHETIC PURPOSES

In multiple countries public insurance companies will draw an artificial divide between procedures that they label as medically necessary and those that they see as serving aesthetic purposes. Excluding certain services from coverage on such an arbitrary basis is discriminatory and can have harmful consequences on trans people's mental and physical well-being. In **France** for instance, breast augmentation is (under certain conditions) covered for cis women, and would only be covered for a trans woman if she had

64 See more information at: http://igvm-iefh.belgium.be/fr/publications/conclure_une_assurance_hospitalisation_conseils_pour_les_personnes_transgenres

65 Medical success refers here to alleviating the individual's distress, and does not aim to change the person's gender identity.

legally transitioned already. Having access to these procedures may be essential for the person's sense of self. They may also be instrumental in preventing further discrimination and violence, and therefore constitute a safety issue.

In **England** procedures are divided into two main categories: 'core' and 'non-core', the latter deemed 'cosmetic' or 'aesthetic' and therefore not automatically funded. Core procedures could include specialist assessments or hormones, whereas non-core procedures include hair removal or speech therapy, whose coverage will be context-dependent. For instance, hair removal of the genital region prior to vaginoplasty is covered. Hair removal on other parts of the body can be partially covered, but this depends on regional funding, and certainly not until (for example) all facial hair has been adequately removed. Hair removal coverage may be for a set number of sessions, or a set budget for a patient which can then be used in a 'mix and match' fashion between electrolysis and laser, for instance. With regards to speech therapy, National Health Service (NHS) funded Gender Identity Clinics (GIC) have voice specialists who do individual and group sessions which can be offered to people who have accessed GIC appointments. Strikingly, mastectomies are seen as core procedures, but breast augmentation as aesthetic. The position was similar in **Scotland** with certain surgeries, such as hysterectomies and vaginoplasty, covered by the NHS Gender Reassignment Protocol (GRP) and others, including breast augmentation and facial feminisation surgery, accessed via the Adult Exceptional Aesthetic Referral Protocol. The latter provides for so called "aesthetic" surgeries to be paid for in certain circumstances by the NHS and stringent assessments are carried out before approval is granted. In March 2017 however a decision was made to provide all trans people access to gender affirming care under the GRP[66], which in theory should enable easier access to surgeries previously deemed aesthetic.

In the **Czech Republic** public insurance pays 100% of costs for a mastectomy but 0% of costs for breast augmentation. In **Germany** breast augmentation is often rejected and public insurance companies will only pay for it if it was previously authorised and if hormone therapy has not led to the growth of breasts "which can objectively be considered as a female breast in size and shape".[67] The German High Courts have repeatedly stated that health insurance only covers treatments which are necessary to

66 Read more at: http://www.ngicns.scot.nhs.uk/wp-content/uploads/2015/07/Gender-Reassignment-Interim-Guidance-2.pdf
67 BSG, 11 September 2012 - B 1 KR 11/12 R

cure a disease or significantly reduce distress ("Leidensdruck"), but not such treatments that follow the patient's wish to achieve a specific and subjective ideal of beauty.[68] The Court's reasoning was that this would be discriminatory towards cisgender women.[69] In **Luxembourg** facial feminisation, depilation and other procedures have been excluded from the public health institution's statute since 2014, because they are seen as aesthetic.[70] As Intersex & Transgender Luxembourg highlighted:

> *"In Luxembourg some healthcare should be (re)integrated in cost coverage, as they can be essential to prevent discrimination and stigmatisation, for example beard depilation (for trans and also for cisgender women), facial feminisation and vocal cords surgery."*

In **Belgium**, coverage is available as long as there is a code in the national list of nomenclatures. For instance, epilation is not mentioned and is considered aesthetic. So even when a body part needs to be epilated before surgery, the epilation itself is not covered, whereas the surgery might be. As another example, mastectomy is covered but chest reconstruction is not.

In **Italy** facial feminisation and hair removal are considered cosmetic, not essential for gender affirmation treatment, and therefore not covered by the public health system. In sporadic cases private insurers have covered facial feminisation, even though it is seen as cosmetic and therefore usually excluded.

RESTRICTIONS BASED ON GENDER STEREOTYPES

Doctors often restrict trans people's access to healthcare and insurance coverage on the basis of stereotypical notions of what constitutes male and female behavior. In **Russia**, the only form of trans healthcare that is covered by public insurance is getting a diagnosis from a psychiatrist, which is a requirement for legal gender recognition, but even this may be difficult to get:

> *"In July 2017, Alexey, a transgender man from Yekaterinburg, was undergoing examination in the 'Sosnovy Bor' psychoneurological hospital to receive a diagnosis of 'transsexualism.' His doctor repeatedly expressed doubts about his gender identity and said that Alexey was trying*

68 *Nebendahl*, Spickhoff, Medizinrecht (Medical law), SGB V, § 27, Rn. 19
69 Ibid.
70 Annex C(15(1)) of the public health insurance (CNS) statute states that healthcare with an aesthetic purpose (depilation, facial and collar feminisation or masculinisation surgery, sculpture of the torso and the limbs) are excluded from cost coverage.

> *to deceive him, and that his behavior was 'not male.' Alexey was hospitalised, which he considers to be unreasonable for confirming the diagnosis of transsexualism. Eventually, he was told that he will not be diagnosed with transsexualism unless he gets a job."* Data provided by Transgender Legal Defense Project monitoring program.

In **Slovakia**, trans people have faced similar discrimination. The situation is severe because there are only two psychiatrists to turn to for a diagnosis:

> *"If the doctor decides that you are not 'trans enough', you are too old or too young, wearing wrong clothes, or did not use to play with the right toys, they can completely block your access to health care. It was denied to a few people just because the doctor did not like their haircut. And there are just two of them in the whole country. The insurance is completely useless if you can't use it."* Romina Kollárik, TransFúzia, Slovakia.

In **France**, the ALD insurance scheme only covers consultations with doctors who work in public healthcare. Trans people have been refused a diagnosis because they were not heterosexual, did not have or want to have a body that fit the stereotypical norms, or were deemed too old or too young. French NGOs have put pressure on doctors and the criteria are much less strict today, although treatment still depends on the region and the individual doctor. As a consequence, many trans people have chosen to go private or see doctors abroad.

> *"Today in France, trans people are still struggling to access trans specific medical care. Despite being less complicated than decades ago, trans people keep facing discrimination in the public and private health system. Trans NGO are still in conflict with the main physicians' association called SOFECT for many reasons, in particular because of discriminations and mistreatments. There is a lot to do to improve trans specific medical cares."* Sun Hee Yoon, Acthé, France.

The real life test, applied in numerous countries across Europe, is also routinely based on binary stereotypes. These restrictions can have a particularly negative impact on non-binary and gender nonconforming people's access to healthcare and cost coverage (Chapter 3F).

3.D INSURED BUT NOT CARED FOR

In many countries, public insurance might cover trans healthcare costs in theory, but trans people have limited or no access to services.[71] Key issues include that procedures are not performed in the country or that waiting times are extremely long. As a result, trans people are either left without services or have to seek avenues outside what is covered by public insurance and pay from their own pocket. Very few can do this and those who cannot are simply left behind.

PROCEDURES NOT AVAILABLE

In **Luxembourg**, most surgeries are covered by the public health system, but mastectomy with specific techniques, or phalloplasty, metoidioplasty and vaginoplasty, are not performed in the country. Many trans people try to access surgeries abroad, for example in Germany or Belgium. However, it is not automatic that their public insurance will cover these costs (Chapter 2). Similarly in **Italy**, the public health system would theoretically pay for a number of procedures, but in many parts of the country services are simply not available in medical centers. In the **Czech Republic**, even if someone can afford to pay for a mastectomy out of pocket, they will have difficulty finding a doctor who will perform the surgery. Local activists presume that the situation is worse for genital surgeries. In **Spain**, some autonomous regions have introduced laws focusing on trans rights and some explicitly include coverage. However, in certain regions, it is difficult to find doctors who perform surgeries and provide quality care.

> *"Some doctors say the surgeries are too risky or they do not know how to do them. Some strategically put endless barriers so people never get there. Others perform surgeries, but lack expertise, so people try to avoid them and go through a very difficult time until they have enough money to pay for a good private surgeon."* Leo Mulió Álvarez, trans activist and psychologist, Spain.

[71] Fundamental Rights Agency, *Being trans in the European Union*. Pp. 41, 2014

Positive practice

In some countries, trans people can seek healthcare in other regions or countries where it is more available and public insurance will pay for the costs. In Spain, there are interregional agreements in place, whereby people can be referred to Andalusia, Catalonia, or Madrid for surgeries. In Slovakia vaginoplasty is not available, but it is possible to access it in the Czech Republic and the Slovak public insurance would pay for it. The same would apply in the case of metoidioplasty and phalloplasty, but local activists do not know if anyone has used this option. San Marino has also introduced the same practice with Italy, but people might have to travel far to access certain procedures. Ireland has a similar agreement with the UK.

Extensive waiting times

In **England** the National Health Service (NHS), which is free at the point of delivery, covers almost all forms of trans healthcare, but waiting times even for an initial appointment at a Gender Identity Clinic span from 1 to 2.5 years.[72] In **Scotland** there are two main GIC's providing services, so many people have to travel considerable distances in order to access treatment. The situation with regards to waiting times is currently worse than in England due to the lead clinician at the Edinburgh Clinic being on maternity leave. As a result the waiting list, which had got down to a relatively short 4 months, was frozen in April 2017 with no new appointments being offered until her return in summer 2018. This has put considerable strain on the Glasgow clinic as they try to ensure continued care for those patients already being treated by the Edinburgh clinic. The Glasgow waiting list currently sits at around 12 months. If someone can pay for a private appointment, they will be able to access hormones faster and their hormones will still be covered by the NHS once they have been initially diagnosed and prescribed treatment. The situation is worse when it comes to surgeries however. Waiting times can last for years and if someone goes private, their surgeries will not be covered by the NHS.

72 The following are waiting times that each England GIC has reported on their websites (Nov 2017): Daventry: 30 months, Exeter: 18 months, Leeds: 16 months, London: 14 months, Newcastle: 13 months, Nottingham: 18 months, Sheffield: 12 months. These are average predictions, and indeed many people can wait considerably longer.

In **France**, getting a diagnosis can take between 3 months and 4 years in the public insurance scheme. In **the Netherlands**, extensive waiting periods are also a central issue. Public insurance will cover procedures on the basis of a referral from a multidisciplinary team of healthcare specialists at the two gender clinics. Regarding hormones there are no formal obstacles to obtain treatment outside the gender clinics, but the number of clinicians offering this treatment is limited and trans people need to wait for up to two years to access hormones. In **Slovakia**, public insurance covers getting a diagnosis, but there are only two psychiatrists who specialise in this. In **Austria** social insurance only covers trans healthcare in full if it is delivered by doctors who have a contract with a public insurance company. If someone seeks services from other doctors, only part of their costs will be covered.

3.E NEVER KNOWING WHAT TO EXPECT

As many countries lack clear policies about what trans healthcare costs are covered, funding decisions are often made on a case by case basis and are therefore completely unpredictable. Often there is little information on what the factors are that guide such decisions.

In **the Netherlands**, some forms of hormone therapy are fully refunded, but among hormones there are different conditions for coverage relating to how they need to be applied or used.[73] Transparent information about the conditions of coverage are difficult to access. Facial feminisation is funded on the basis of subjective criteria about the person's passability.

In **Finland**, public healthcare and insurance cover a number of procedures in principle, but in practice cost coverage decisions are often made on a case by case basis. These procedures include mastectomy, breast augmentation, genital surgeries, sterilisation, or facial feminisation. There is no publicly available information on the factors that are decisive in the assessment and which factors would more likely lead to a positive decision. Private health insurance companies either exclude trans healthcare from coverage or have refrained from making a statement about this.

In **Belgium**, the lack of trans specific codes in the national lists of nomenclatures leads to the situation that not all healthcare

[73] The conditions are related to the system of medicine coverage: one hormone treatment might be fully covered while another only up to 60%.

providers are fully aware of the possible use of existing codes for trans care, thus coverage depends on the experience of the provider.

In **Slovakia**, public insurance does not include trans healthcare in its catalogue of services, but in practice, doctor visits, hormonal treatment, hysterectomy, orchiectomy, and bilateral adnexectomy are covered.[74] With the lack of rules however, access to these services is not guaranteed.

> *"Healthcare and related insurance for transgender people in Slovakia happen just randomly. There are minimal official standards to adhere to and in practice, they are usually ignored. Almost everything completely depends on benevolence of individual doctors and their personal ideas on gender. They often do not follow human rights, law or medical standards, not even the diagnosis. And especially not the medical needs of transgender people."* Romina Kollárik, TransFúzia, Slovakia.

In **Russia**, no hormones or surgeries are covered by insurance. In very rare cases doctors have supported trans people in getting their surgeries covered by registering the procedure as cancer prevention. In **Poland** there have been some rare cases reported where hormones or mastectomies were covered for the same reason. Such cases of benevolence however are ad hoc and by no means reliable.

3.F Marginalized and further underserved

Although TGEU did not do targeted research on how restrictions on cost coverage affect trans people who experience multiple forms of oppression, unsurprisingly the responses suggest that those most marginalized face the greatest difficulty in accessing services. It is essential to conduct further research in this area, paying particular attention to the situation of trans people of colour, migrants, asylum seekers and refugees. The TSHC needs of children and young people also require specific investigation as their access to cost coverage is further complicated by specific protocols for minors and greater dependency on others to facilitate access to TSHC. Disabled trans people and those with complex diagnoses

[74] Slovak law (Act no. 576/2004, § 40 (1)) defines sterilisation for humans as "preclusion of fertility without removing or damaging of sexual glands of the person". Since surgery as part of trans healthcare removes the organs and prevents fertility, it is considered anti-conception. Interestingly, Slovak law however only recognises castration as anti-conception in animals, and not in humans.

face additional barriers.[75] The following can however be concluded from this research in terms of the additional barriers some trans people experience in having their healthcare costs met.

CLASS

In many countries, insurance either does not cover trans specific healthcare costs or trans people are unable to access quality services within a reasonable timeframe. Therefore, those who can afford it, try going private and cover all or most of their costs themselves. As unemployment and poverty disproportionately affect trans people by and large, it is only a small minority of trans people who will be able to do this. Those in a more unstable financial situation will be left without care, which will most likely affect their physical and mental well-being.

GENDER

In some countries trans women are negatively affected by arbitrary limitations on cost coverage, such as breast augmentation or facial feminisation being viewed as aesthetic interventions. Even though such procedures may be essential for the individual's sense of self or to reduce the likelihood of them experiencing discrimination and violence, they will not be covered. Mastectomies are more willingly funded by insurance schemes. With regards to hormones, there may also be gender based differences. In the **Czech Republic**, the public insurance has recently lowered its coverage on some testosterone hormones, so these hormones are much harder to access as they are more expensive.[76]

NON-BINARY AND GENDER NONCONFORMING PEOPLE

It is routine that insurance coverage is only provided when a trans person fits the gender binary and wants to align their body with stereotypically either male or female characteristics. In **Russia**, **Slovakia**, or **France** diagnosis, which is essential for insurance coverage, has been denied to trans people on that basis. In **Germany** the German High Court in Social Issues ruled that only interventions aiming at aligning a body clearly to the norms of a man or a woman need to be covered by insurance.[77] Further, the principle of economic efficiency in Germany also has an impact on people whose individual needs may not match the treatment plan: surgery costs will only be covered if the person has taken hormones already.

75 See Transgener Europe, Oppression Squared, 2017
76 Following a trans healthcare user's complaint, the Ministry of Health decided that Sustanon needs to be free. Nebido however continues to be too expensive for many.
77 BSG 29 September 2010, B 1 KR 5/10

In **Finland**, trans people need to have a diagnosis and have passed the real life test to gain coverage for hormones. Such regulations often force non-binary people to lie about their gender identity, sometimes for the whole duration of their mandatory therapy process, which may span a year or more.

> *"KELA [the Social Insurance Institution] pays for all medical costs in Finland so if they say they will not cover it, you cannot get coverage from anywhere else either. So non-binary people just end up paying a lot more. So what a lot of people do is that they get the binary diagnosis even if they are non-binary per identity. They just pretend they are binary in order to get the KELA coverage."* Panda Eriksson, Trasek, Finland.

In **the Netherlands**, although non-binary trans people are not excluded from healthcare coverage on paper, they often have to wait twice as long to access services.

> *"In the Netherlands non-binary and gender nonconforming people are not excluded from trans specific healthcare. Not by definition, but there is 'punishment' for being non-binary or gender nonconforming as the gatekeeping process often doubles in length."* Vreer Verkerke, Principle 17 - for tailored, human rights based health care, Netherlands.

POSITIVE PRACTICE

In Ghent, Belgium non-binary people can easily access insurance coverage for individualised treatment plans, which are based on the person's expressed wishes and not a fixed protocol. It is possible to only take hormones and not proceed with surgery, or only undergo surgeries and not take hormones beforehand.

DISABILITY

Several countries only allow trans people to access healthcare and insurance coverage if their mental health is reasonably good or they are coping well with any mental health problems. This is the case in the **UK**, the **Czech Republic**, **France**, **Poland** and **Slovenia**:

> *"I wish that trans people who need access to medical care in Slovenia wouldn't need to undergo invasive procedures and tests to prove they are who they are, while also needing to hide or silence parts of themselves which the medical practitioners see as unhealthy, i. e. mental health issues. No one should have such authority over other persons. Trans persons' needs and embodiments are autonomous entities, they should be respected and treated as such."* Anja Koletnik, Transakcija, Slovenia.

This means that trans people with psychosocial disabilities may not be able to access services at all. This is alarming as the rate of mental health issues is disproportionately high among trans people across Europe. Not being able to access trans healthcare may lead to further mental health issues, which traps trans people in a vicious cycle.

POSITIVE PRACTICE

In Italy, trans people with mental health issues, such as bipolar disorder or schizophrenia, are still able to proceed with their medical transition. Most specialised psychologists, who work with trans people, would recognize their mental health issues as not influencing their gender dysphoria, and would support them to be in therapy, but also start their hormone therapy.

PLACE OF RESIDENCE

In **Spain**, insurance is regulated not by the state, but by the 17 autonomous regions. Depending on the region, trans people may have entirely different levels of coverage. For instance, Andalusia, Aragon, Asturias, Balearic Islands, Basque Country, Canary Islands, Cantabria, Extremadura, La Rioja, Madrid, and the Valencian Community fully fund hormones, while Castile and León fund 70-100%[78], Catalonia and Galicia 60-100%[79] and Melilla does not fund hormones at all. In **Italy**, depending on the agreement that specialized centers have with the regional health system, some regions fully fund hormones and others do not fund hormones at all.

78 Depending on the individual's income.
79 Depending on the individual's income.

Even in countries where there are no such regional differences, the trans-friendliness of local healthcare providers can vary greatly. For instance in **England**, trans people are at the mercy of the local NHS structures called Clinical Commissioning Groups (CCG), who can decide which treatments are prioritised when it comes to funding. Some CCGs will fund treatments readily, but others give all the treatments a very low priority. Trans people therefore find themselves in a 'postcode lottery'.

In **Belgium**, regional differences in experiences in health care (both general and trans specific) are major. In the Flemish region, the overall attitude is much more positive and affirming, and trans-friendly than in Wallonia. This is strongly linked with a difference in political climate, equality policies, research and services dedicated to trans people.

In the **Czech Republic**, the commissions making recommendations on surgeries convene in Prague, which means that it is much harder for trans people outside the capital to access them. In **Russia**, in addition to state psychiatrists, commissions can also issue a diagnosis. The most progressive ones are in bigger cities, such as Moscow or St. Petersburg. Those who can afford to travel there will try to access these.

3.G Consequences

TGEU's survey was focused on legal aspects of insurance coverage and there was no targeted data collection on how the current systems impact trans people on the ground. However, based on the responses from local activists, it is evident that they have a severely negative impact on trans people's mental and physical well-being, or financial situation. For a more detailed picture further research would be essential in this area.

Mental health issues

It has been widely documented that trans people are disproportionately affected by mental health problems.[80] They are at high risk of suffering from depression, anxiety, self-harm, and suicidal ideation and attempts.[81] Not having access to affordable and quality healthcare services can have a lasting impact on trans people's mental health. Further, there are often no mental health services where trans people could seek support and even if there

[80] See for example Rebeka Thomas, Frank Pega, Rajat Khosla, Annete Verster, Tommy Hana & Lale Say, *Ensuring an inlcusive global health agenda for transgender people*. 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5327942/

[81] Fundamental Rights Agency, *Being trans in the European Union*. Pp. 77, 2014

are trans people are often reluctant to ask for help for fear of experiencing discrimination or abuse.[82]

> *"In the Netherlands it takes 22 months to access hormone replacement therapy. Of trans people seeking gender affirmative healthcare, 75% have reported that this had a harmful impact on their mental health. This negatively influences their social life, relationships and employment opportunities."* **Sophie Schers, Transgender Netwerk Nederland, The Netherlands.**

SELF-MEDICATING

Self-medicating with hormones can lead to severe health issues, such as blood clots, stroke, and liver problems. Sharing needles for hormone injections can increase the risk of HIV or hepatitis transmission.[83] In **the Netherlands**, extensive waiting periods are the major contributors to self-medication. In **Georgia**, many trans people self-medicate because the lack of insurance coverage makes it is too expensive to see a doctor and get the necessary tests done.[84]

CASE STUDY: MISTREATMENT IN RUSSIA

In 2011, Y. a transgender woman in Russia, consulted the region's head psychiatrist in her home city for a psychiatric evaluation. She wanted to get a diagnosis of "transsexualism" as a necessary step for legal gender recognition. Instead of granting her the diagnosis, the doctor referred her to the regional psycho-neurological clinic for an evaluation and treatment of depression. She spent nearly six months there. During the initial consultation and throughout the entire duration of her hospitalisation her doctor avoided the topic of gender dysphoria. At the end of six months, Y. was offered a choice: she must either admit an improvement in her condition of depression and be released, or she would be transferred to another department "where the violent ones were kept". Y. took the former option, and was released without getting the diagnosis she wanted. [...] Being disappointed in doctors, in December 2013 Y. began hormones on her own. Case study provided by the Transgender Legal Defense Project monitoring program, Russia

82 TGEU, *Overdiagnosed but Underserved* and FRA, *Being trans in the European Union*.
83 National Center for Transgender Equality, National Gay and Lesbian Task Force. *Injustice at Every Turn* - Executive Summary. A Report of the National Transgender Survey. https://www.glaad.org/healthcare
84 Natia Gvianishvili, Women's Initiatives Supporting Group (WISG). *Situation of transgender people in Georgia*. 2015. Pp. 66

Paying out of pocket

In 2008 the Transgender EuroStudy found that at least half of trans people accessing trans specific healthcare paid for their treatment themselves, after being refused by their insurance.[85]

In **England**, those who can afford it often use a private service, with typical costs being £200 for an hour-long consultation, of which two are required prior to receiving a diagnosis. A letter from a private practitioner, which explains that a diagnosis has been given, can sometimes be successful in convincing an NHS GP to give a prescription for hormones on the NHS, incurring only NHS prescription fees (£8.60 per prescription). The decision is entirely up to the GP - again, trans people are at the mercy of medical professionals. If rejected, they need to pay for hormones out of pocket.

> *"My fiancée has waited 3 years and 9 months for her first appointment at the Leeds GIC, following a letter 9 months ago telling us that she missed an appointment that she had never been told was scheduled. We went private over two years ago, which has caused problems when changing GP practices, who have then refused to refill repeat prescriptions that other GPs have previously provided."*
> Dr. Ben Vincent, University of York, England.

In **Italy**, getting a diagnosis from a doctor in the public health system is mostly covered by public insurance.[86] However, waiting lists for public doctors are sometimes extensive. Moreover, some doctors who feel they do not have the necessary expertise often redirect people to specialized centers. Other times, the local medical center does not have an agreement with the regional healthcare system to cover certain procedures. In the end, many go private or to specialised centres in other regions, and pay themselves.

> *"The costs for transitioning are still very high. A transition can cost roughly 5000 EUR, but could reach 20.000EUR when you pay for surgeries yourself, or when hormones are not covered by your regional agreements, and also depending on the number and type of surgeries chosen and needed. The gatekeeping role that the legal system plays in Italy*

85 *Transgender EuroStudy*. Pp. 10. In the current research project TGEU did not collect data on how much each healthcare service costs in the different countries.
86 Trans people still need to pay for the actual diagnosis report. The costs depend on the local health centre, but are around 300EUR.

makes the process even more difficult and expensive, with lawyers' costs, taxes and exhausting waiting times." Vick Virtù, Movimento Italiano Trans, Italy.

Fearing mistreatment by psychiatrists in the public health system, some trans people in **Russia** decide to turn to commissions for a diagnosis, but this is not covered by insurance. One commission was dismantled in 2015 because the chief doctor became the target of transphobic abuse.[87] He now operates a commission at a private clinic, but getting a diagnosis there is much more expensive and therefore inaccessible for many. As hormone therapy and other medical procedures are not covered at all, many find themselves in a difficult situation. According to a recent study about trans people's experiences in Russia, 62% had or were planning to take out a loan to cover healthcare costs.[88]

87 Dr. Dmitry Isaev was working at a college, supporting trans people, but transphobic activists wrote letters to the administration of the college and to the public prosecutor's office that he was "working with perverts". The administration made Isaev leave. Isaev now leads a new commission at a private clinic, and this is much more expensive. http://doctorpiter.ru/articles/12208/

88 Data provided by Transgender Legal Defense Project monitoring program.

4. Litigation and lobbying

In some countries trans rights activists have used strategic litigation to improve cost coverage conditions. Some of these efforts have successfully established progressive domestic case law. While the European Court of Human Rights (ECtHR) has not affirmed that trans healthcare costs always have to be covered, it has issued a number of important decisions establishing that limitations of coverage must not be discriminatory.[89] Some trans organisations engage in lobbying to improve access to healthcare.

Domestic case law

In **Germany** the Federal Social Court established in 1987 that public insurance companies must pay for surgeries and hormone therapy "in cases of transsexuality".[90] The Supreme Court came to a similar conclusion in 1995 for private insurance providers.[91]

In the **UK** case law established in 1999 that it is unlawful for the NHS to impose anything that amounts to a blanket ban on funding for trans healthcare, even for a limited period, because gender dysphoria is a medical condition and, as such, should be treated on the NHS.

The **Spanish** Supreme Court ordered in a 2013 case in Galicia that the public health system had to pay for a trans person's healthcare costs, including surgeries. As no services were provided in this region, the applicant was referred to Catalonia, where the procedures were available, and covered by Galicia.[92]

In **Belgium**, a trans woman, who changed her gender marker 1998 applied for general hospitalisation insurance in 2013. The company wanted to grant her insurance with the condition that all costs relating to gender dysphoria would be excluded from coverage. Supported by the Belgian national equality body, the woman went to court to challenge this discriminatory treatment. The insurance company argued that because of gender dysphoria, the woman was chronically ill, which can be grounds for excluding costs.

89 For more details on these cases see the jurisprudence section in "Toolkit – Legal Gender Recognition in Europe" 2nd revised version (November 2016): https://tgeu.org/toolkit_legal_gender_recognition_in_europe/

90 Annette Güldenring, *A critical view of transgender health care in Germany: Psychopathologizing gender identity – Symptom of 'disordered' psychiatric/psychological diagnostics?* International Review of Psychiatry, 16 Nov 2015. http://dx.doi.org/10.3109/09540261.2015.1083948

91 BGH, 8. 3.1995 – 4 ZR 153/94

92 See for instance http://www.20minutos.es/noticia/1907927/0/supremo-ratifica/condena-galicia-pagar/operacion-cambio-sexo/.

The court however established that since the end of her trans specific treatment the woman was no longer ill and the insurance company's treatment was discriminatory on the basis of gender reassignment. The company was fined and was ordered to grant insurance coverage, without the cost exclusion.

In **Finland**, a non-binary activist sued the public insurance company in 2016 because they would only cover hormones for binary trans people who have the F64.0 diagnosis:

> *"I had the so-called non-binary diagnosis, F64.8 and they wouldn't give me any hormone coverage. So I sued KELA [public health insurance] and then the court gave me a favorable decision."* Panda Eriksson, Trasek, Finland.

Unfortunately, KELA changed its policies at the same time, and it continues to be difficult for non-binary trans people to gain coverage (Chapter 3F).

EUROPEAN CASE LAW (ECTHR)

In *Van Kück v. Germany* the Court established that trans people do not need to prove they have not "caused" their own trans-identity, e.g. through self-medication.[93] The Court also ruled that where cost coverage for trans healthcare is available, any limitations must be lawful, objective and reasonable. It further stated that judges cannot replace medical expertise by making general assumptions "as to male or female behaviour".

In L *v. Lithuania* the Court said that nonexistent protocols for gender affirming care might leave trans people in "in a situation of distressing uncertainty." The Court suggested member states enable trans people to seek treatment abroad if not available in the country.[94] In *Schlumpf v. Switzerland* the Court ruled that an inflexible waiting period for diagnostic assessment (here two years) before undergoing health insurance-covered genital surgery cannot be enforced.[95]

LACKING POLITICAL WILL AND NGO CAPACITY TO LOBBY

Decisions on cost coverage are largely dependent on the political will of policy makers. Lobbying decision makers has been effective in some countries. In **Belgium** the Ghent gender team has been lobbying for years to have trans healthcare costs covered by

93 *Van Kück v. Germany*, Application no. 35968/97, 12 June 2003.
94 L. *v. Lithuania*, Application no. 27527/03, 11 September 2007.
95 Schlumpf v. Switzerland, Application no. 29002/06, 8 January 2009.

insurance. As a positive result, the transgender care convention now provides coverage for psycho-social consultations and puberty blockers, which is less than full coverage, but definitely an important step in the right direction.

> *"I do believe this would not have been possible if medical doctors had not argued for it, so I think that collaboration with the medical world can be really crucial. It has taken them countless hours of meetings, calculations, and proposals to get here, but it was effective."* Joz Motmans, Transgender Infopunt, Belgium.

Before 2017, trans people in **Italy** had to obtain a first court judgment allowing them to undergo surgeries and a then second one allowing them to change their gender marker. Thanks to the intervention of trans activists and legal professionals, it is now possible to apply for access to surgeries and documents at the same time and the court will issue one judgment for both.

Unfortunately few trans groups have capacity to lobby. In **Spain**, NGOs requested information from the autonomous regions about the number of surgeries that were provided in the past years, hoping that they can use this information to highlight concerns about waiting times. The public health system has not given any response. Even though further lobbying could potentially lead to positive changes, activists have little capacity to do so:

> *"We don't have the capacity, neither the resources to lobby. For pretty much everyone, activism in general is something they do in their free time, and they are overwhelmed by the day to day situations that come up. The very few associations that have staff, they give services to people, such as HIV testing or psychological assessment, but they aren't focused on lobbying."* Leo Mulió Álvarez, trans activist and psychologist, Spain.

5. Conclusions

Public insurance coverage for trans specific healthcare is still inadequate across most of Europe. There are only a handful of countries where insurance covers most trans specific healthcare services, including the Netherlands, the UK, Germany and Belgium. In some countries, such as Georgia, Russia and Poland hardly any coverage is available.

The conditions for insurance coverage are rarely set out in law or policy and trans specific services are often not included in the catalogue of services of insurance companies. At times, they are explicitly excluded. Cost coverage is often subject to discriminatory limitations. Some insurance companies are only willing to cover the least expensive procedures, which bars trans people from getting services on the basis of their individual needs. In other countries insurance companies draw an arbitrary distinction between medically necessary and aesthetic procedures. These limitations discriminate on the basis of gender identity and gender expression and should be removed. To ensure that trans people have access to quality care, it is vital that the rules of cost coverage are transparent, clearly stated, and consistently applied.

In numerous European countries, trans people are required to get a psychiatric diagnosis and undergo invasive medical procedures against their will to access legal gender recognition, healthcare, or insurance coverage. Regional and international human rights mechanisms have strongly criticised these requirements and have called for states to adopt legal gender recognition procedures that are separate from medical aspects and based on self-determination; healthcare should be provided on the basis of free and informed consent.

Despite the mandatory nature of invasive requirements, insurance often does not cover their costs. This means that trans people have to pay for human rights violations committed against them.

It is crucial that trans people's medical needs are decoupled from legal gender recognition procedures.

Further, depathologisation needs to lead to improved trans specific healthcare that is based on informed consent rather than leading to poorer cost coverage or more bureaucracy.

Trans people also routinely face gatekeeping by individual doctors, medical commissions, or insurance inspectorates who have the power to decide if they can access services and if those services will be covered. They are often forced to prove that they are “trans enough”, for instance by passing a real life test, or conforming to gender stereotypes. These requirements and procedures violate trans people’s dignity and human rights and must be abolished.

Even when services are available and covered on paper, trans people often have no access to procedures or have to wait for years for a single appointment. While going private might remedy this situation and grant trans people better access to quality care, most are unable to pay for services themselves.

The lack of affordable, accessible and quality care may have a detrimental impact on trans people’s physical and mental health. Some start to self-medicate, risking serious health issues. Others go out of their way to pay for services themselves. Some trans people engage in sex work to pay for hormones and surgeries, which may expose them to further discrimination and violence.

Some trans people face multiple barriers when trying to access insurance coverage. Non-binary and gender nonconforming people routinely face limitations: some countries exclude them from coverage either explicitly or in practice. Trans people with disabilities are also faced with heightened barriers. People living outside bigger cities have a harder time accessing affordable care. Overall, it is a minority of trans people, mostly those who are in a better financial situation, who have the means and options to access quality care. More research is needed to map how trans people experiencing further marginalisation are affected by poor insurance coverage, particularly trans people of colour, children and youth, and migrants, including asylum seekers and refugees.

If there is a lack of affordable and available services in their home countries, trans people in the European Union could also make use of progressive EU regulations. However, many are not aware that they could access hormones or surgeries abroad and have these covered by insurance. There is a strong need to better inform trans people about their rights when accessing healthcare in another EU country. Information should be gathered on the accessibility and quality of treatment choices and on cost coverage procedures. It

is essential to do further research on the barriers to cross-border healthcare access and to document cases where trans people have used EU regulations to their benefit.

In some countries litigation, lobbying, and working together with medical professionals have made a positive impact on increasing trans people's access to better insurance coverage. It is paramount for trans groups to have more financial and human resources to invest in such work.

Though not the focus of this report, findings suggesting that trans people might be discriminated against in taking out health insurances is alarming. The practice of insurance providers denying coverage or asking for higher premiums because of a person's gender identity-related health diagnosis or previous trans specific healthcare is discriminatory and should stop. Similarly, explicit exclusion of coverage for care that is specific and central to many trans people's health and well-being needs further assessment in regards to how much that affects trans people's ability to take out an insurance and their right to access healthcare.

It can be concluded that discrimination by insurance providers in policy and practice is widespread. All countries should have clear, transparent and uniformly applied rules in place on cost coverage for trans specific healthcare, the aim of which should be to foster trans people's physical and mental well-being. It is also essential that cost coverage is provided on the basis of individual needs, just as all healthcare should be provided. Lastly, any limitations on coverage must be lawful, objectively required, and proportionate in order to prevent discrimination against certain trans people on the basis of gender identity or expression. Not only the provision of trans specific healthcare but also cost coverage as a means of accessing it must comply with human rights principles.

6. Recommendations

TGEU recommends that state health systems and insurance providers ensure that:

1. Access to cost coverage for trans specific healthcare is provided to trans people without discrimination on the basis of gender identity or expression and that any limitations on cost coverage are lawful, objectively required, and proportionate.

2. Trans people have access to all insurance plans without discrimination because of their gender identity, or previous or future trans specific healthcare care needs.

3. Rules governing the provision, and cost coverage, of trans specific healthcare are transparent, clearly stated in law, policy, or catalogues of services, and consistently applied.

4. Cost coverage for trans specific healthcare is provided based on free and informed consent without requiring trans people to receive a psychiatric diagnosis, subjecting them to invasive requirements, such as the “real life test”, or expecting them to conform to binary gender stereotypes.

5. Legal gender recognition procedures are decoupled from trans people’s medical needs and so are based on self-determination rather than a psychiatric diagnosis or other medical criteria, and further:

    a. Cost coverage is provided without requiring trans people to have changed their gender marker or initiated the process of legal gender recognition.
    b. So long as a diagnosis or medical procedures are required for legal gender recognition, full cost coverage of such interventions is provided.

6. More resources are urgently invested into providing comprehensive trans specific healthcare that is respectful of human rights and freely available at delivery, irrespective of insurance coverage, nationality, migration status etc.

7. Trans specific healthcare is available and accessible and therefore:

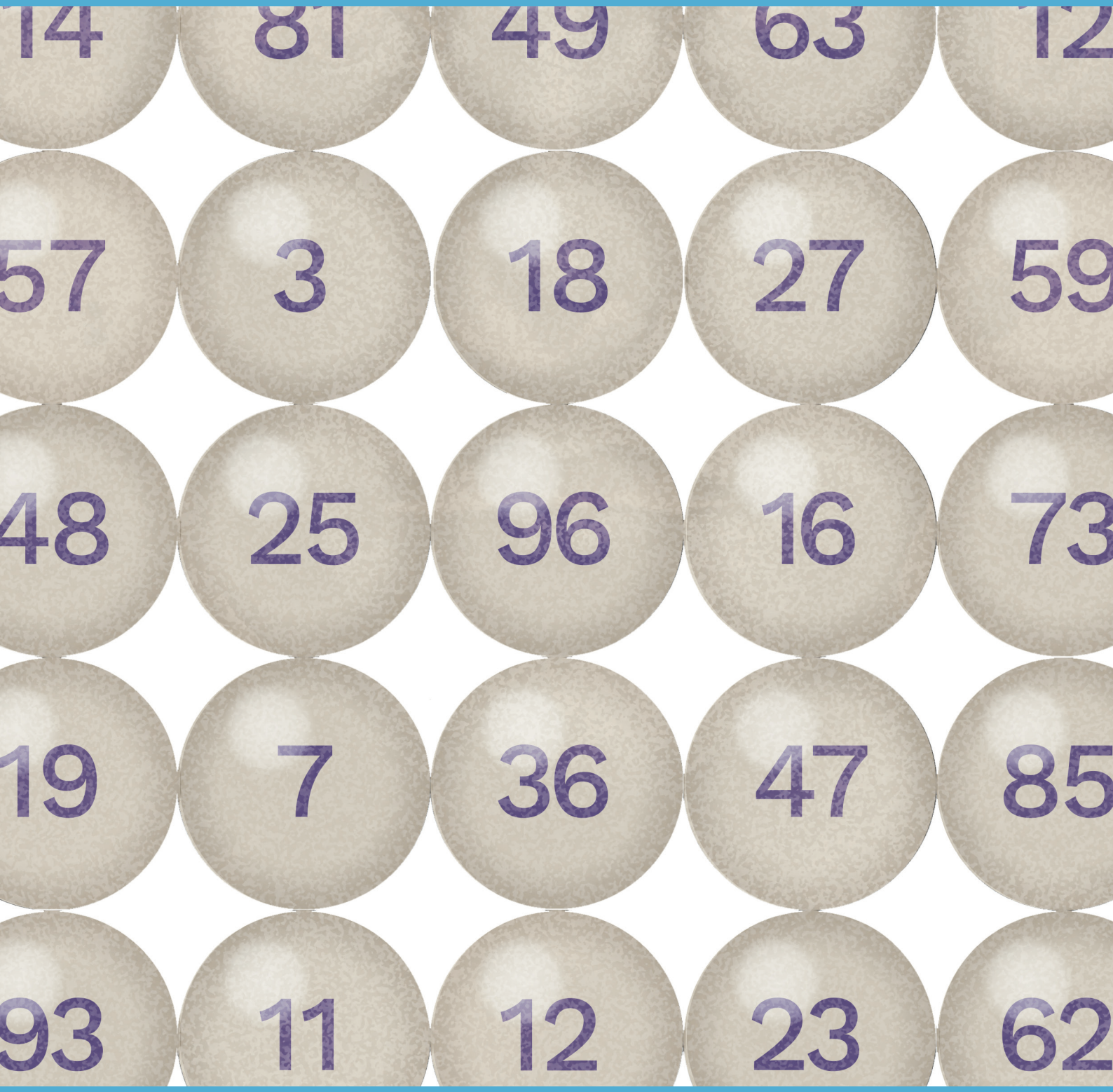
    a. Provide more resources to healthcare facilities in order to reduce extensive waiting times.
    b. Train a sufficient number of medical staff to be able to provide quality trans healthcare services.
    c. De-centralise services in order to provide the same quality of service throughout the country.

8. Disabled trans people, particularly those with psychosocial disabilities or people who have a mental illness, do not face barriers to obtaining trans specific healthcare or insurance coverage on an equal basis to non-disabled people.

9. National contact points set up under the EU cross-border healthcare directive inform trans people in the EU about their rights to access trans healthcare in other EU countries, including information about quality, access requirements, waiting times, and other key aspects.

10. Invest resources into further research and

    a. Map how trans people facing further marginalisation are affected by poor access to state healthcare and insurance coverage with a particular focus on trans people of colour, children and youth, migrants, asylum seekers, and refugees;
    b. Document barriers and drivers the EU cross-border healthcare system to improve the healthcare experience for trans people.



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