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THE RIGHT TO TRANS-SPECIFIC HEALTHCARE IN NORWAY: UNDERSTANDING THE HEALTH NEEDS OF TRANSGENDER PEOPLE

ABSTRACT

Human rights discourse on the rights of transgender people has to a large extent focused on access to correction of legal gender and medical preconditions for this change. Jurisdictions across the world are now beginning to free legal gender recognition from medical interventions and examinations. State bodies have, however, done little to realise the rights of transgender people to adequate healthcare. A key issue is whether international law obliges states to ensure access to trans-specific healthcare. This article examines the right to healthcare appropriate to transgender persons' needs. Drawing on in-depth interviews with transgender people living in Norway, it investigates how individuals explain their needs for trans-specific healthcare. It shows that Norwegian healthcare practice uses the diagnosis of 'transsexualism' to determine a person's needs for trans-specific healthcare and as such excludes many from receiving the healthcare they need. The article analyses whether trans-specific healthcare falls within the ambit of the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the right to necessary healthcare under the Norwegian Patients' Rights Act. It concludes that the Norwegian authorities are obliged to provide equal access to adequate trans-specific healthcare to those who need it.

Keywords: Health law; necessary healthcare; transgender; trans-specific healthcare.

I. INTRODUCTION

> *I spent all my money on surgery [facial feminisation surgery]. It made all the difference. I went fulltime [as a woman]. I don't like to use the word passing, but after the surgery I passed. It was incredible to be seen as the person I am.*[1]

As this quote suggests, facial feminisation surgery as a form of trans-specific healthcare may have a great bearing on the lives of transgender people. For example, it may facilitate 'passing', *i.e.*, being seen by others in accordance with one's gender identity, and help improve one's quality of life and mental health.[2] More transgender people suffer from poor mental health, and commit suicide, than other groups, including (non-transgender) lesbians, gays and bisexuals. An alarming number of transgender people suffer in this way.[3] A growing body of research shows that trans-specific healthcare, understood as hormone therapy and/or surgery, leads to self-reported improved quality of life[4]; however, transgender people face challenges in accessing trans-specific healthcare worldwide, including in Norway.[5] National

[1] Interviewee (anonymous) interviewed by the author 2015.

[2] J Cromwell, *Transmen and FTMs: Identities, Bodies, Genders, and Sexualities* (University of Illinois Press, 1999).

[3] N Roth, G Boström and K Nykvist, 'Hälsa på lika villkor? Hälsa och livsvillkor bland hbt-personer' (G Boström: Stockholm, 2006); RFSL, '"In society I don't exist, so it's impossible to be who I am." – Trans People's Health and Experiences of Healthcare in Sweden' (2017).

[4] J McNeil and others, 'Trans Mental Health Study 2012' (Scottish Transgender Alliance, 2012). See also section VI.B.2.

[5] S Whittle and others, 'Transgender EuroStudy: Legal Survey and Focus on the Transgender Experience of Health Care' (ILGA-Europe: Brussels, 2008); McNeil and others, 'Trans Mental Health Study 2012' (n 4); European Union Agency for Fundamental Rights (FRA), *EU LGBT Survey: European Union Lesbian, Gay, Bisexual and Transgender Survey - Results at a Glance* (Publications Office of the European Union, 2013);

authorities have so far failed to respond to transgender persons' healthcare needs. A related problem is the failure to recognise trans-specific healthcare as a human rights issue.

Drawing on in-depth interviews with transgender persons living in Norway, the article investigates how individuals explain their needs for trans-specific healthcare, as well as their experiences of seeking it. Against this background, by exploring how healthcare practice distinguishes between legitimate and illegitimate needs, the article provides a window into law in action. This concerns how the provision of trans-specific healthcare is organised, to whom it is made accessible and how administrative bodies[6] assess claims that trans-specific healthcare is lacking or inadequate. This raises the question whether, and to what extent, trans-specific healthcare falls within the scope of the right to the highest attainable standard of health under Article 12 of the ICESCR[7] and the European Convention on Human Rights (ECHR).[8] A related question is whether, and how far, trans-specific healthcare is included in the right to necessary specialist healthcare under the Norwegian Patients' Rights Act. The Act gives access to such care based on an individual medical assessment of needs, the

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Norwegian Directorate of Health, 'Rett til rett kjønn - helse til alle kjønn: utredning av vilkår for endring av juridisk kjønn og organisering av helsetjenester for personer som opplever kjønnsinkongurens og kjønnsdysfori' (Oslo, 2015); RFSL, "'In society I don't exist, so it's impossible to be who I am." – Trans People's Health and Experiences of Healthcare in Sweden' (n 3); Transgender Europe, 'Overdiagnosed but Underserved' (2017).

[6] The Norwegian County Governor, the Patients' Injury Compensation Board and the Equality and Anti-Discrimination Ombud. See section V.B.

[7] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR).

[8] Council of Europe, European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14, 4 November 1950, ETS 5 (ECHR).

expected benefit and its cost-effectiveness.[9] This leads on to the question of whether the way the Norwegian Patients' Rights Act is interpreted and put into practice by health authorities accords with Norway's human rights obligations, and the Norwegian Specialist Health Service Act.[10]

The article has six sections. The next section (II) describes trans-specific healthcare in Norway and the main arguments put forward against the current organisation of trans-specific healthcare. Section III presents the legal and empirical sources used to establish the prevailing law, the law in action and to identify individual needs. Section IV discusses needs for trans-specific healthcare described by transgender people living in Norway. Section V is concerned with the law in action, *i.e.* how needs are understood within the public healthcare service and administrative bodies. In section VI, the law is examined. In section A the right to health under international law is described and discussed, while section B examines trans-specific healthcare in light of the right to necessary healthcare under the Norwegian Patients' Rights Act. By way of conclusion, section VII, suggests that clarifying transgender people's right to trans-specific healthcare, and reorganising public trans-specific healthcare, will help ensure that more transgender people enjoy their right to such healthcare – and their right to gender identity.

[9] Lov om pasient- og brukerrettigheter [Patients' Rights Act] 2 July 1999 No. 63, s 2-1b; Forskrift om prioritering av helsetjenester, rett til nødvendig helsehjelp fra spesialisthelsetjenesten, rett til behandling i utlandet og om klagenemnd [Regulation on the prioritisation of healthcare] 1 December 2000 No. 1208, s 2.

[10] Lov om spesialisthelsetjenesten m.m. [Specialist Health Service Act] 2 July 1999 No. 61.

II. BACKGROUND

A. Trans-Specific Healthcare in Norway

Before describing the provision of trans-specific healthcare in Norway, it is necessary to explain the terminology involved. 'Transgender' is an umbrella term often used to refer to people who in some way are moving away from their birth-assigned gender, and thus refers to a diverse group of people.[11] Not all transgender people want—or need—trans-specific healthcare, or correction of legal gender ('legal transition') to live good lives. In this article, the term 'transgender' is used to refer to people who need trans-specific healthcare to improve their health. 'Transsexualism' is a psychiatric diagnosis and an identity category embraced by some people. As will be explained in II.B, it is a contested term, used in this article when relevant to describe medical practice related to trans-specific healthcare. 'Gender identity' refers to self-identified gender, whereas 'gender expression' refers to how gender identity is expressed.

The Norwegian public healthcare system seeks to provide good quality healthcare to everyone in need.[12] The provision of trans-specific healthcare is organised as a national treatment unit, known as the Norwegian National Unit for Gender Dysphoria and

[11] See for example S Stryker, 'My Words to Victor Frankenstein above the Village of Chamounix: Performing Transgender Rage' (1994) 1 GLQ: A Journal of Lesbian and Gay Studies 237, 251. Virginia Prince is often credited with coining the term 'transgender' but used it in a narrower way than its common use today. For more on trans-terminology, see S Stryker, *Transgender History* (Seal Press, 2008) 123-124; Cromwell (n 2) chapter 2; C Williams, 'Transgender' (2014) 1 Transgender Studies Quarterly 232-234.

[12] For more on the welfare state system, see A Kjønstad, A Syse and M Kjelland, *Velferdsrett I: Grunnleggende rettigheter, rettssikkerhet og tvang* (6th edn, Gyldendal Juridisk, 2017) 28–31.

Transsexualism (Trans Unit).[13] The Trans Unit provides trans-specific healthcare to patients who are diagnosed with F64.0 'transsexualism' under the International Statistical Classification of Diseases and Related Health Problems (ICD-10), published by the World Health Organisation.[14] The Norwegian version of the ICD-10 labels the following as mental disorders: *transsexualism* (F64.0), *gender identity disorder of childhood* (F64.2), *other gender identity disorder* (F64.8) and *gender identity disorder, unspecified* (F64.9). ICD-10 defines 'transsexualism' as: '[a] desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex'.[15]

To assess whether diagnostic requirements are met, the Trans Unit generally carries out psychiatric examinations consisting of questionnaires, clinical conversations and structured interviews.[16] There are no official Norwegian guidelines on the provision of trans-specific healthcare, and it is not included in the prioritisation guidelines.[17] Nonetheless, in the Trans

[13] For more on the organisation of healthcare services, see AK Befring, 'Helserett og Helsetjenesten' in A K Befring, M Kjelland and A Syse (eds), Sentrale helserettslige emner (Gyldendal Jurisdisk, 2016) 41–43.

[14] Ministry of Health and Care Services, Veileder: Nasjonale tjenester i spesialisthelsetjenesten (revised 31 January 2017) 40.

[15] World Health Organisation, 'International Statistical Classification of Diseases and Related Health Problems 10th Revision' <http://apps.who.int/classifications/icd10/browse/2016/en> accessed 24 November 2017. ICD-10 is currently under revision. The *Working Group on the Classification of Sexual Disorders and Sexual Health* has proposed removing 'transsexualism' from the mental disorders chapter, and including a trans-specific category ('gender incongruence') in the chapter *Conditions Related to Sexual Health*. World Health Organisation, 'ICD-11 Beta Draft' <https://icd.who.int/dev11/l-m/en> accessed 24 November 2017.

[16] Norwegian Directorate of Health, 'Rett til rett kjønn' (n 5) paras 5.3.2, 5.3.3.5.1.

[17] Ibid. para 1.4.

Unit, trans-specific healthcare is provided in a more or less fixed sequence. If diagnosed with 'transsexualism', the patient[18] undergoes a 'real-life experience' for a minimum of 12 months, during which the person lives in accordance with their gender identity. After the 'real-life experience' and endocrine and other metabolic examinations, hormones are prescribed.[19] If medically appropriate, transwomen[20] take oestrogen, possibly combined with anti-androgen, and transmen take testosterone. Eventually, the body begins to change. For transmen, the menses cease, the voice gets deeper and muscle mass and the growth of facial and body hair increase. For transwomen, body fat is redistributed to the hips and breasts, and hair growth and the size of the testes decrease.[21]

Patients are assessed for surgery after 1-3 years of hormone therapy. The Trans Unit performs breast or chest surgery, the surgical removal of the ovaries and ovum or testes and genital surgery. The Trans Unit does not provide corrections of the hips, cervix or nose as standard procedures. Patients are offered a speech therapist and hair removal, and transwomen can

[18] In this article 'patient' is used in accordance with the definition under the Patients' Rights Act (n 99) s 1-3 (a). Whether a person in a legal sense is a 'patient' is decisive for the rights of the person and the obligations of health professionals.

[19] In particular situations, when the patient does not wish to carry out the real-life test because, for example, they have a strong beard growth, treatment with anti-androgens can begin before the real-life test. Norwegian Directorate of Health, 'Rett til rett kjønn' (n 5) paras 5.3.3.5.3, 5.3.3.6.

[20] Here, the term 'transwomen' refers to people whose birth-assigned gender is male but who identify and live as women. The term 'transmen' refers to people whose birth-assigned gender is female, but who identify as men and live as men. See Stryker (n 11) 20.

[21] KA Tønseth and others, 'Kjønnskorrigerende kirurgi ved transseksualisme' (2010) 130 Tidsskrift for den norske legeforening 376; Norwegian Directorate of Health, 'Rett til rett kjønn' (n 5) para 5.3.3.6.

have sperm frozen.[22] Compression underwear, flaccid penile prostheses and vaginal dilators are included in the medical care equipment provided by regional health authorities to people diagnosed with 'transsexualism'.[23] Before 2016, hormone therapy and the surgical removal of the reproductive organs were preconditions for the correction of legal gender.[24] As of July 2016, the change of legal gender does not require medical interventions, and is based on self-declaration by people over the age of 16.[25]

B. Critique: The Lack of Trans-Specific Healthcare and the Pathologisation of Trans-Identities

Many transgender persons who seek trans-specific healthcare are denied such healthcare by gatekeepers. In 2015, an expert committee, appointed by the Norwegian Directorate of Health, concluded that many transgender people lack adequate trans-specific healthcare, especially those whom the Trans Unit has rejected.[26] For example, in 2016, 449 patients were

[22] Norwegian Directorate of Health, 'Rett til rett kjønn' (n 5) paras 5.3.3.6.2–5.3.3.6.5.

[23] Letter from the Ministry of Health and Care Services to the four regional health authorities, 10 May 2016.

[24] A Sørlie, 'Governing (Trans)Parenthood – The Tenacious Hold of Biological Connection and Heterosexuality' in D Otto (ed), Queering International Law: Possibilities, Alliances, Complicities, Risks (Routledge, 2017).

[25] Lov om endring av juridisk kjønn [Gender Recognition Act] 17 June 2016 No. 46, ss 2 and 4.

[26] The expert committee recommended reorganising and decentralising the current health services for people experiencing 'gender dysphoria'. Norwegian Directorate of Health, 'Rett til rett kjønn' (n 5). See also J van der Ros, 'Alskens folk: Levekår, livssituasjon og livskvalitet for personer med kjønnsidentitetstematikk' (Likestillingssenteret: Hamar, 2013). 'Gender incongruence' means experiencing a discrepancy between gender identity and birth-assigned gender, while 'gender dysphoria' means distress or discomfort that may follow from 'gender incongruence'. World Professional Association for Transgender Health (WPATH), 'Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People' (7th version, 2011) 5. The regional health authorities are currently (2017) working to reorganise the provision of trans-specific healthcare. Dokument nr. 15:1119 (2016-2017) Skriftlig spørsmål fra Ketil Kjenseth (V) til helse- og omsorgsministeren,

referred to the Trans Unit. Of these, 331 were accepted for medical examinations and 118 were rejected because the referrals were incorrect. According to the Trans Unit, half of the referred patients satisfied the criteria for receiving hormone or surgical treatment.[27]

Indeed, transgender people can access hormones through their general practitioner; however, this may be difficult. Often, GPs and other health professionals either know nothing whatsoever about trans-issues or, do not have sufficient knowledge. Because the Trans Unit is a national treatment unit mandated to provide trans-specific healthcare, many health professionals who are not affiliated with the Trans Unit are uncertain whether they have the authority to prescribe hormones. This may lead to transgender persons not receiving hormones according to the lowest effective care level principle.[28]

The political scientist Janneke van der Ros argues that the monopoly of the Trans Unit in providing trans-specific healthcare to people diagnosed with 'transsexualism' explains why many transgender people do not receive it. A key concern is that through its narrow application of the diagnosis of 'transsexualism' and its binary conception of gender, the

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[Written question to the Minister of Health and Care Services and Reply from the Norwegian Minister of Health, Bent Høie, on 29 May 2017].

[27] Nasjonal behandlingstjeneste for transseksualisme, 'Årsrapport 2016' <https://forskningsprosjekter.ihelse.net/senter/rapport/L-OUS-21/2016> accessed 24 November 2017; Norwegian Directorate of Health, 'Helhetlig gjennomgang av nasjonale og flerregionale behandlingstjenester i spesialisthelsetjenesten 2017: Nasjonal behandlingstjeneste for transseksualisme' (Oslo, 2017).

[28] Norwegian Directorate of Health, 'Rett til rett kjønn' (n 5); Norwegian Directorate of Health, 'Behandlingstilbudet til transseksuelle og transpersoner i Norge: Helsedirektoratets gjennomgang og vurderinger 2011' (draft 31 October 2011), 14.

Trans Unit has become the gatekeeper of trans-specific healthcare provision.[29] The diagnosis labels gender diversity as a mental illness, which is a related criticism that does not only apply to the Norwegian case. The philosopher Judith Butler states that '[t]o be diagnosed with gender identity disorder is to be found, in some way, to be ill, sick, wrong, out of order, abnormal, and to suffer a certain stigmatization as a consequence of the diagnosis being given at all'.[30] Within transgender studies, the power of medicine to (re)produce notions of 'normality' and 'abnormality', and thereby create hierarchies of human diversity, is strongly condemned.[31] The pathologisation of transgender people helps further stigmatise people who are already subjected to prejudice and stigma, and it may negatively affect transgender people's health.[32] The stigma involved with being labelled as having a mental illness[33] and its requirement for being provided with trans-specific healthcare may prevent people from seeking the healthcare they need or may delay people in seeking trans-specific healthcare. On the basis of the right to health (Article 12) and the right to non-discrimination (Article 2(2)) of the ICESCR, the legal scholar Jens Theilen argues that international human rights law lays down a right to depathologisation. It is argued that this is so due to the stigma involved in

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[29] J van der Ros, 'Den norske staten og transpersoner: velferdsstatens og rettsstatens unnlatelsessynder' (2016) 32 Norsk statsvitenskapelig tidsskrift 264.

[30] J Butler, 'Undiagnosing Gender' in P Currah, R M Juang and S P Minter (eds), Transgender Rights (University of Minnesota Press, 2006) 275.

[31] Stryker (n 20); Cromwell (n 2).

[32] Butler (n 30), 285; JT Theilen, 'Depathologisation of Transgenderism and International Human Rights Law' (2014) 14 Human Rights Law Review 327; Z Davy, A Sørlie and AS Schwend, 'Democratising Diagnoses?: The Role of the Depathologisation Perspective in Constructing Corporeal Trans Citizenship' (2017) Critical Social Policy first published online: 25 September 2017.

[33] For more on the stigma of mental illness and the hierarchy between mental and somatic healthcare needs, see F Callard and others, *Mental Illness, Discrimination and the Law: Fighting for Social Justice* (John Wiley & Sons, Ltd, 2012) 20-21, 125.

being labelled mentally ill and because only transgender people—and not cisgender people—are being pathologised.[34]

The UN Committee on Economic, Social and Cultural Rights (UN CESCR), which monitors the ICESCR, is concerned 'that transsexual and inter-sexed persons are often assimilated to persons with mental illness'.[35] *The Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity*,[36] which is a soft law document based on existing, legally binding human rights norms, states in Principle 18 that '[n]otwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed'[37]; however, in 2017, the European Court of Human Rights (ECtHR) found that requiring a gender identity disorder for legal gender recognition did not threaten transgender people's physical integrity. Moreover, even if it did so, it falls within the state's margin of appreciation to precondition legal gender recognition on a gender identity disorder. The Court thus concluded that the requirement was not in breach of states' positive obligations under Article 8 of the European Convention on Human Rights (ECHR).[38]

[34] Theilen (n 32), 330–31.

[35] UN CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Germany* (12 July 2011) UN Doc E/C.12/DEU/CO/5, [26].

[36] 'The Yogyakarta Principles (March 2007)' <http://www.yogyakartaprinciples.org/> accessed 24 November 2017.

[37] M O'Flaherty, 'The Yogyakarta Principles at Ten' (2015) 33 Nordic Journal of Human Rights 280, 283; 'The Yogyakarta Principles' (n 36) Preamble.

[38] *A.P., Garçon and Nicot v. France* nos. 79885/12, 52471/13 and 52596/13, ECtHR, 6 April 2017, ECHR 2017 (extracts), [139]–[140].

Nevertheless, the question is whether the diagnosis of 'transsexualism' is required—and should be required—for an individual to be viewed as in need of trans-specific healthcare and therefore to distribute rights to trans-specific healthcare.

III. METHODOLOGY

A. Legal Sources

The article focuses on trans-specific healthcare for people over the age of 18.[39] The term 'law in action' is used to refer to the professional non-legal application of law, *i.e.* healthcare practice and the organisational elements of trans-specific healthcare.[40] The term 'prevailing law', on the other hand, refers to the outcome of an analysis of the relevant legal sources.[41] When determining prevailing law, significant weight is placed on the argumentative strength and quality of the legal sources, *i.e.* whether the legal sources promote human rights values and whether they are based on a thorough and well-argued examination.[42] In this article, the ICESCR, the ECHR, and the Norwegian Patients' Rights Act are interpreted. Article 92 of the Norwegian Constitution obliges the authorities of the state to respect and to ensure human rights as they are expressed in the Constitution and in human rights treaties that are binding for Norway. The ICESCR and ECHR are also incorporated into the Human Rights Act,

[39] For an analysis of children's right to puberty suppression hormones and hormones in a Norwegian context, see AS Sondrup, 'Har barnet en rett til rett kjønn?: En vurdering av hvorvidt barnet har krav på pubertetsutsettende og femininiserende eller maskuliniserende hormonbehandling ved kjønnsinkongruens' (Master Thesis, University of Oslo, 2015).

[40] K Andenæs and LO Olsen (eds), *Sosialrett 2: sosialrettens oppgaver mot år 2000* (Tano Aschehoug, 1990) 49–50; T Mathiesen, *Retten i samfunnet: en innføring i rettssosiologi* (Pax Forlag, 2011) 229–35.

[41] P Augdahl, *Rettskilder* (3rd edn, Aschehoug, 1973).

[42] K Ketscher, 'Mod en argumentativ ret' (2000) Jussens Venner 272.

taking precedence over any Norwegian law in conflict with them.[43] Domestic legal sources that explicitly concern trans-specific healthcare are few and far between. For example, there is no case law from Norwegian courts. Preparatory works[44] for laws that regulate issues particularly concerning the lives of transgender people, and laws regulating the provision of healthcare rarely mention trans-specific healthcare[45]; however, there are a few cases from administrative bodies.

B. Qualitative Interviews

Qualitative interviews were conducted to identify individual needs for trans-specific healthcare and to determine how the institutionalisation of trans-specific healthcare influences individuals' experiences and the law in action. The interviews were also used to map and examine legal questions. This grounded approach to law allowed for an examination of how the law effects those who are governed by it.[46] Four transgender persons between the age of 20 and 40 were interviewed. Two of the interviewees identified as men and two as women. One did not have a Norwegian citizenship, and they were either unemployed or students. The interviews were conducted in 2015 in the context of the author's PhD project.[47]

[43] Lov om styrking av menneskerettighetenes stilling i norsk rett [Human Rights Act] 21 May 1999 No. 30 s 3.

[44] Under Norwegian law, preparatory works are viewed as a legal source.

[45] Briefly mentioned in Prop. 74 L (2015–2016) Lov om endring av juridisk kjønn, [Proposition to the Storting (bill)] para 8.5.3.

[46] For more on grounded theory, see AW Bentzon and others, *Pursuing Grounded Theory in Law: South-North Experiences in Developing Women's Law* (Mond Books: Harare and Tano Aschehoug, 1998).

[47] Approval to carry out the interviews was received from the Norwegian National Social Science Data Services 2 February 2015. Identifiable data was stored in the Services for Sensitive Data. See <http://www.uio.no/english/services/it/research/sensitive-data/index.html> accessed 24 November 2017.

The participants were interviewed face-to-face, and were recruited with the assistance of Norwegian lesbian, gay, bisexual and transgender (LGBT) organisations and personal contacts in the LGBT community.[48] Prior to the interviews, each participant provided written consent based on oral and written information about the project.[49] The interviews were semi-structured.[50] The interviewees were invited to speak freely regarding their experiences with health services and their desires for trans-specific healthcare. At the time of the interviews, medical interventions and examinations were required for legal gender recognition. While the 2016 enactment of the Gender Recognition Act ended this requirement, it did not lead to changes in the provision or the organisation of trans-specific healthcare. The participants' needs related to trans-specific healthcare that are analysed in this article are not ones they connected with the correction of legal gender.

While transcribing the interviews verbatim, the interviews were analysed to identify patterns of challenges related to healthcare settings. Then, having merged the patterns with the law and having decided to focus on the right to necessary healthcare and healthcare needs, the interviews were divided into thematic sequences of needs based on the patterns identified, and by the terms used by participants, such as 'passing'.

[48] The Norwegian Association for Lesbian, Gay, Bisexual and Transgender People (LLH, now Fri), Queer World, the Harry Benjamin Resource Centre, the Stensveen Resource Centre and the Association for Transgender People.

[49] S Kvale, *InterViews: An Introduction to Qualitative Research Interviewing* (Sage, 1996) 112–14.

[50] Ibid. 124.

IV. INDIVIDUAL NEEDS FOR TRANS-SPECIFIC HEALTHCARE

A. Introduction

The interviewees had received some form of trans-specific healthcare, such as breast/chest surgery, hormone therapy and/or facial feminisation surgery, either in the Trans Unit or in private clinics in Norway or abroad. Some had received hormones from their general practitioner or had ordered them from abroad.

When describing their needs for trans-specific healthcare, the interviewees spoke in terms of recognition, their bodies being judged, otherness, feminine and masculine appearances, and passing. Jason Cromwell writes that within transgender studies, 'passing means blending in and becoming unnoticeable and unremarkable as either a man or a woman. Blending in as normal means that one has succeeded and become a "real" man or woman'.[51] This implies that other people view transgender persons in accordance with their gender identity—and not as transgender, freeing them from the stigma.[52] Zowie Davy argues that passing is conditional on the bodily aesthetics of the transgender person and on the judging person and is not conditional on whether the judging person knows the transgender person from pre- or post-transition, as argued by Thomas Kando.[53] By 'bodily aesthetics', Davy means 'the appearance of the body that is subjected to judgments, whether that is personal and/or

[51] Cromwell (n 2) 39.

[52] Cromwell (n 2) 39.

[53] Z Davy, *Recognizing Transsexuals: Personal, Political and Medicolegal Embodiment* (Ashgate, 2011) 59; T Kando, 'Passing and Stigma Management: The Case of the Transsexual' (1972) 13 The Sociological Quarterly 475, 477.

public'.[54] Thus, passing is an ongoing process.[55] Not everyone desires passing or the normalisation embedded in passing. Instead some take pride in and demand recognition for their trans-identity.[56] Passing is closely related to gender norms and the way norms influence how bodies are judged. Bodies that conform to 'gendered norms of cultural intelligibility', as argued by Butler, are viewed as intelligible. Gender identities or bodies that do not conform to the cultural matrix are seen as 'developmental failures or logical impossibilities'—they are unintelligible—or do not pass.[57]

B. Surviving and Passing

Most significantly, the participants described trans-specific healthcare as a matter of life or death and as something for which they are willing to take great risks to obtain. Trans-specific healthcare enables them to live in accordance with their gender identity, and thus, to actually live. They narrate this in different ways, and used different strategies to ensure that they received the desired treatment, such as providing selective information and presenting themselves in conforming ways to fit the diagnostic norm, or purchasing hormones from abroad, which are strategies discussed in other studies as well.[58]

Aware of the risks involved in the unsupervised use of hormones, two interviewees began transitioning by purchasing hormones or contraceptive pills from abroad. They explained this

[54] Davy (n 53) 5.

[55] Ibid. 59; see also Kando (n 53) 477.

[56] Cromwell (n 2) 38–40.

[57] J Butler, *Gender Trouble: Feminism and the Subversion of Identity* (Routledge, 2006) 23–24.

[58] I Linander and others, 'Negotiating the (Bio)Medical Gaze: Experiences of Trans-Specific Healthcare in Sweden' (2017) 174 Social Science and Medicine 9; van der Ros, 'Alskens folk: Levekår, livssituasjon og livskvalitet for personer med kjønnsidentitetstematikk' (n 26); Davy (n 53).

choice in terms of having no other option. They were unsure whether and when they would fulfil the Trans Unit's diagnostic requirements. One participant explained that '[t]hose pills [hormones] are my identity. I don't exist without them'. According to the World Professional Association for Transgender Health, for many transgender people experiencing 'gender dysphoria', hormone therapy is medically necessary. As explained under section II.A, it causes physical changes that bring the body more into line with a person's gender identity.[59] By doing so, it facilitates the social recognition of their gender identity.

According to one interviewee, her suicide attempts and suicidal thoughts were rooted in loneliness and her bodily appearance. Because of her face, which she wishes was more feminine, she cannot always find the strength to leave her home. She explained that 'for most people in the street, I'm a man with boobs.' This indicates that her body challenges what society views as intelligible femininity. This has made her prey to physical, psychological and sexual violence. Her experiences with misrecognition are concrete examples of the violence of conventional gender norms.[60] For her, trans-specific healthcare may contribute to social safety and security in public spaces and may also enable her to take part in social and work activities. This shows that the lack of trans-specific healthcare may have many consequences and may put people's lives on hold.

The interviewees' poor health is consistent with findings in international studies on transgender people's health. In a Swedish study carried out in 2015, 36 per cent of the respondents reported that in the previous twelve months, they had been seriously considering

[59] World Professional Association for Transgender Health (WPATH), 'Standards of Care' (n 26) 33, 36.

[60] See also Butler (n 57) xxv.

committing suicide. The figure for the general population was 6 per cent.[61] The 2012 Trans Mental Health Study, which included respondents from the UK and Ireland, showed similar findings. This study also showed that transition reduces suicidal ideation and actual attempts. Of the respondents, 63 per cent reported that they thought about or attempted suicide more often before transitioning. Of the respondents, 78 per cent reported that transitioning improved their quality of life, and 74 per cent reported that it improved their mental health.[62]

The figures mentioned accord with the way other interviewees explained their needs for trans-specific healthcare. As mentioned in the introduction, one interviewee explained how, for her, facial feminisation surgery 'made all the difference', and that 'it was incredible to be seen as the person I am'. Imagining a life without the surgery was difficult for her. She stated: 'I think I would have killed myself after a while. I cannot see how things could have worked out okay without [the surgery]'. She implied that she had been struggling with suicidal thoughts and that facial feminisation surgery was lifesaving. Its lifesaving effect, and the root cause of her need for it, seem to do with the fact that surgery changed the way society judged her body. Before surgery, she did not 'pass'. Her body was judged unintelligible. Not being recognised as a woman caused stigma and poor health. In contrast, after surgery, society viewed her body as intelligible, and as that of a woman. This positively affected her health.

C. Bodily Visibility

The participants in this study largely related their needs for different types of trans-specific healthcare to what is visible to those judging them, and thus they placed the body and how

[61] Folkhälsomyndigheten, 'Hälsan och Hälsans Bestämningsfaktorer för Transpersoner: En Rapport om Hälsoläget Bland Transpersoner i Sverige' (Östersund, 2015) 40.

[62] McNeil and others, 'Trans Mental Health Study 2012' (n 4) 89, 82, 88.

the body may facilitate passing at the centre of their needs. They desired some surgery, although they did not desire genital surgery or they regarded it as less important than hormone therapy and/or breast/chest/facial feminisation surgery. One interviewee, for example, said that '[i]t's not very important for me to have a penis. That's not necessarily what makes you a man. It could have been different if everyone walked around with their penis out, but it's not like that'. Because genitals are less visible to judging persons, this form of trans-specific healthcare was less important to him. This contradicts dominant conceptions within medicine and the medical focus on genitalia rather than on, say, facial feminisation surgery.[63]

The way society judges bodies as intelligible or unintelligible seemed to be key to their needs for trans-specific healthcare. Their needs are therefore closely related to how conventional gender norms give meanings to bodies. The needs may therefore be explained as a need to pass or to be recognised. Indeed, these needs reproduce gender norms, but this does not make them less real or less legitimate for somatic treatment.[64] The needs demonstrate that bodies are crucial for people's lives and that needs for trans-specific healthcare must be understood in the light of the society in which transgender people live.

[63] T Folgerø and T Hellesund, 'Transseksualitet på norsk: Heteronormering av kjønn og hverdagsliv' in W Mühleisen and Å Røthing (eds), Norske seksualiteter (Cappelen Damm Akademisk, 2009) 99–120.

[64] See also Linander and others (n 58).

V. LAW IN ACTION

A. Needs Understood through the Provision and Organisation of Public Trans-Specific Healthcare

Trans-specific healthcare provided by the Trans Unit outlined under section II.A, consists of the forms of treatment, such as hormone therapy and breast/chest/facial surgery, that the interviewees stated they needed to improve their health and quality of life. For them, these are pressing and acute needs, which manifest themselves in suicidal thoughts. In theory, regarding the forms of trans-specific healthcare made available, the current healthcare scheme meets their needs and complies with the clinical guidance for health professionals outlined in 'Standards of Care' by WPATH.[65] On the other hand, current public trans-specific healthcare is conditional on the diagnosis of 'transsexualism'. Due to the way 'transsexualism' is applied by gatekeepers, many transgender people are prevented from receiving the somatic treatment they need. In the case of the interviewees, for example, when they needed trans-specific healthcare, the Trans Unit did not regard them as having any such need. Consequently, the interviewees sought trans-specific healthcare from private clinics or purchased hormones using the internet.

Under healthcare practice, not being diagnosed with 'transsexualism' means that one is viewed as having no need for trans-specific healthcare. This is contrary to the way the need for change of legal gender is understood under the Norwegian Gender Recognition Act, under which change of legal gender does not require the diagnosis of 'transsexualism', but is based on self-declaration.[66] This indicates that individuals are those best able to decide

[65] World Professional Association for Transgender Health (WPATH), 'Standards of Care' (n 26).

[66] Gender Recognition Act (n 25) s 2.

whether they need such a change. In contrast, healthcare practice makes it clear that transgender people are not viewed as those best able to decide which forms of trans-specific healthcare they need to achieve full legal and social recognition of their gender identity and thus to live full lives.

Like the determination of needs in the Trans Unit, the organisation of public trans-specific healthcare seems to indicate that the Norwegian authorities—although aware that many transgender people lack adequate trans-specific healthcare[67]—only view people diagnosed with 'transsexualism' as needing it. Until 2016, the provision of trans-specific healthcare was closely related to the correction of legal gender, which was the final step in gender confirmation treatment (hormone therapy, the real-life test, the removal of reproductive organs and genital surgery for transwomen) conditioned on the diagnosis of 'transsexualism'.[68] This practice was predicated on narrow gender binary norms that prevented many in need of legal and medical transition from receiving it.[69] This signalled that people who did not comply with these norms would not benefit from treatment, and thus it was taken for granted that complete gender confirmation treatment was necessary to change

[67] Norwegian Directorate of Health, 'Rett til rett kjønn' (n 5).

[68] A Sørlie, 'Tvungen identitet – en vurdering av norsk forvaltningspraksis' krav om irreversibel sterilisering ved endring av juridisk kjønn' (2014) 12 Tidsskrift for familierett, arverett og barnevernrettslige spørsmål 272; A Sørlie, 'Legal Gender Meets Reality: A Socio-Legal Children's Perspective' (2015) 33 Nordic Journal of Human Rights 353.

[69] This practice is still widespread across the world. For example, in 20 European countries legal gender recognition is preconditioned on sterilisation, and 36 countries require some form of trans-related diagnosis. Transgender Europe, 'Trans Rights Europe Map & Index 2017' <https://tgeu.org/trans-rights-map-2017/> accessed 24 November 2017.

legal gender. By continuing this medical practice, the current organisation and provision of trans-specific healthcare seem to (re)produce the gender binary norms underlying the former administrative practice for change of legal gender developed by the Trans Unit.

B. The Practice of Administrative Bodies

This raises the question of how administrative complaint bodies assess transgender people's claims that their right to necessary healthcare has not been met; however, it must be noted that few transgender persons lodge complaints with these bodies about trans-specific healthcare. The practices of administrative bodies, though there are few, support that the dominant understanding is that 'transsexualism' is required. In a case that examined the methods of depilation, which did not concern whether 'transsexualism' was required for this form of trans-specific healthcare, the county governor in Rogaland[70] wrote that the diagnosis of 'transsexualism' gives the right to hormone therapy and/or surgery provided by public healthcare services.[71] This indicates that the dominant conception of needs, and of the prevailing law, is that the diagnosis determines both needs for and rights to specialist healthcare.

[70] Rogaland is a county or administrative region in Norway. The County Governor is the chief representative of the King and Government in Norway. The County Governor serves as an administrative appeals body for several municipal decisions, including those on the provision of healthcare. For more on the County Governors, see <https://www.fylkesmannen.no/en/> accessed 24 November 2017.

[71] County Governor in Rogaland. Cases from the county governors are not publicly available. The author has received an anonymised version of the decision and has not had access to all the documents in the case. Case on file with author.

In a case heard by the county governor in Oslo and Akershus,[72] which concerned a minor who was refused puberty suppression hormones and chest surgery by the Trans Unit, the county governor concluded that the patient had received necessary healthcare (assessment) in compliance with the Norwegian Patients' Rights Act.[73] According to the county governor, the Trans Unit had carried out a sufficiently individual, concrete and reasonable assessment and had applied the relevant professional expertise. Significantly, the county governor placed weight on the fact that the patient was not diagnosed with 'transsexualism', and was offered continuous assessments. This line of reasoning assumes that, because the patient was not diagnosed with 'transsexualism', they had no legitimate need for trans-specific healthcare. The county governor did not assess the consequences of the refusal of puberty suppression hormones and chest surgery. Existing sources of binding international law were not considered. The precautionary principle, although not explicitly referred to in the decision, generally tends to prevent transgender people from receiving trans-specific healthcare when they need it. Therefore, it is reasonable to ask what would do the most harm: the refusal of trans-specific healthcare when needed or potential regrets.[74]

Cases from the Patients' Injury Compensation Board (PSN) are also decided on the basis of the diagnosis criterion.[75] In 2015, the PSN found that according to general good medical

[72] Oslo and Akershus are counties in Norway.

[73] The case concerned the Patients' Rights Act (n 9) s 2-1b (2) and the Norwegian Specialist Health Service Act (n 10), s 2-2. Case on file with author. The author has received an anonymised version of the decision and has not had access to all documents in the case.

[74] This question is addressed by Anders Skjellerudsveen Sondrup in his master's thesis (n 39).

[75] The Norwegian System of Patient Injury Compensation (NPE) and PSN are independent administrative agencies that consider compensation claims from patients alleging they have been injured by public health

practices, it took about six years from when the transgender patient was first examined before their being castrated. The patient argued that delayed treatment of 'transsexualism' resulted in anxiety, suicidal thoughts and the interruption of education and working life. According to the PSN, the observation time was important and necessary because the patient was considered not to be a 'typical transsexual'.[76]

These cases show that when patients are not diagnosed with 'transsexualism', not providing trans-specific healthcare is regarded as complying with the requirement for reasonable conduct. Furthermore, administrative bodies do not question the diagnosis as a means to determine needs or to determine what forms of healthcare comply with the requirement for reasonable conduct. This shows that administrative bodies uncritically apply the norms developed through the practices of the Trans Unit.

It appears that the practices of public administrative bodies and their conception of needs also affect the practices of private clinics in Norway. The Equality and Anti-Discrimination Ombud has dealt with two complaints against private clinics about alleged discrimination against transgender people, because they denied breast surgery to transwomen. In these cases, the clinics say they only provide breast surgery to transgender people whom the Trans Unit

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services. See Forskrift om Norsk Pasientskadeerstatning og Pasientskadenemnda [Regulation on the Norwegian System of Patient Injury Compensation and the Patients' Injury Compensation Board] 20 December 2002 No. 1625, s 2 and Lov om erstatning ved pasientskader m.v. [Patient Injury Act] 15 June 2001 No. 53, s 12. Patients can be granted compensation if they have suffered an injury caused, for instance, by an error or omission in their treatment. Patient Injury Act (n 75) ss 2 and 1. For more on the Patient Injury Act, see A Syse, M Kjelland and RG Jørstad (eds), *Pasientskaderett: Pasientskadeloven med kommentarer og utvalgte emner* (Gyldendal Akademisk, 2011).

[76] PSN-2013-1857, 24 April 2015.

has diagnosed with 'transsexualism'.[77] The Anti-Discrimination Ombud found that the refusal to provide breast surgery was a matter of medical professional discretion, which the Ombud cannot assess. Hence the private clinics were not breaching the Sexual Orientation Anti-Discrimination Act[78]. Similarly, in 2016, the Ombud held that conditioning trans-specific healthcare on the diagnosis of 'transsexualism' is a matter of medical professional discretion, which again the Ombud cannot interfere with.[79] According to the Ombud, in a legal sense, requiring the diagnosis did not result in a person being worse off, and thus did not result in discrimination.

Decisions made by administrative bodies also indicate that referring patients not diagnosed with 'transsexualism' for chest surgery is in breach of the requirement for reasonable conduct on the part of health professionals.[80] Transgender people are therefore unable to access trans-specific healthcare, other than hormone therapy, either from public or private healthcare institutions. Due to the uneven distribution of competence and a lack of knowledge about transgender issues, access to hormone therapy is also extremely limited.

[77] See Norwegian Equality and Anti-Discrimination Ombud, case 15/2243 of 14 September 2016 and 15/2259 of 14 September 2016.

[78] Lov om forbud mot diskriminering på grunn av seksuell orientering, kjønnsidentitet og kjønnsuttrykk [Act relating to a prohibition against discrimination on the basis of sexual orientation, gender identity and gender expression] 21 June 2013 No. 58. 1 January 2018 replaced by lov om likestilling og forbud mot diskriminering [Equality and Anti-Discrimination Act] 16 June 2017 No. 51, which also prohibits discrimination on the grounds of gender identity and gender expression.

[79] Norwegian Equality and Anti-Discrimination Ombud, case 14/1677 of 25 February 2016.

[80] Norwegian Health Personnel Board, case HPN-2008-157. Decision given 24 February 2009.

As shown in this section, transgender persons' access to trans-specific healthcare is limited by the diagnosis criterion, which excludes those not diagnosed with 'transsexualism' from receiving it and labels those who receive it as mentally ill.

VI. PREVAILING LAW: HUMAN RIGHTS AND THE NORWEGIAN PATIENTS' RIGHTS ACT

A. Right to Health under International Law

The Constitution of the World Health Organisation defines 'health' as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[81] This is a broad conception of health. Under the ICESCR, Article 12 guarantees a right for everyone, *i.e.* also transgender people, to enjoy the highest attainable standard of physical and mental health. Trans-specific healthcare is provided to alleviate distress caused by 'gender incongruence', thereby improving mental health.[82] The provision imposes corresponding obligations on the member states to protect, respect and fulfil this right.[83]

States have certain core obligations that must be carried out immediately. According to the UN CESCR, this includes guaranteeing 'that the right will be exercised without discrimination of any kind (art. 2.2)'.[84] Under Article 2 (2) in conjunction with Article 12 of the ICESCR, discrimination regarding the right to health on the basis of gender identity is

[81] Constitution of the World Health Organisation (signed 22 July 1946, brought into effect 7 April 1948).

[82] See section II.A.

[83] UN CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)* (11 August 2000) UN Doc E/C.12/2000/4, [33].

[84] Ibid. (n 83), [30].

prohibited, unless the differential treatment satisfies the justification test.[85] Thus a core and immediate obligation of the state is to ensure that the provision of healthcare does not discriminate against patients on the basis of their gender identity.[86]

Article 12 does not guarantee a right to health as such, but as the UN CESCR states, 'a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health'.[87] This includes timely and appropriate healthcare.[88] The right to health includes four interrelated and essential elements: availability, accessibility, acceptability and quality. 'Availability' means that sufficient functioning healthcare facilities, goods and services should be available. 'Accessibility' requires that healthcare facilities, goods and services are available to everyone, de jure and de facto. It has four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility. Furthermore, 'acceptability' means that health facilities, goods and services must be culturally appropriate, respectful of medical ethics, and designed to improve the health of those concerned. Finally, 'quality' means that

[85] UN CESCR, *General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)* (2 July 2009) UN Doc E/C.12/GC/20, [32]; UN CESCR, *General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* (2 May 2016) UN Doc E/C.12/GC/22, [9].

[86] Gender identity is also a protected ground of discrimination under formal Norwegian law. See Lov om forbud mot diskriminering på grunn av seksuell orientering, kjønnsidentitet og kjønnsuttrykk [Sexual Orientation Anti-Discrimination Act] 21 June 2013 No. 58, s 5.

[87] CESCR, *General Comment No. 14* (2000) (n 83), [9].

[88] Ibid. (n 83), [11], [17].

health facilities, goods and services must be scientifically and medically appropriate and of good quality.[89]

In Norway, trans-specific healthcare is available, but because of the medical and legal interpretation of needs, it is only accessible to a limited number of people, however, this treatment, as also expressed by the interview participants, is lifesaving for many who need it. Their right to health cannot be realised without trans-specific healthcare.[90] Norwegian authorities therefore have an obligation to ensure that trans-specific healthcare is accessible to more people in need of it, to enable them to enjoy the highest attainable standard of health under Article 12. This understanding is supported by Yogyakarta Principle 17 (g), which specifies that it is the obligation of states to '[f]acilitate access by those seeking body modifications related to gender reassignment to competent, non-discriminatory treatment, care and support'.[91]

The ECHR does not guarantee a right to health. However, Article 8 of the Convention gives everyone a right to respect for private life, and imposes corresponding obligations on the contracting states. Regarding the notion of personal autonomy, respect for human dignity and human freedom, the ECtHR has found that a right to personal development, physical and psychological integrity, and the establishment of details of one's identity, including gender

[89] Ibid. (n 83), [12].

[90] Concerning transgender children's rights to trans-specific healthcare, see K Sandberg, 'The Rights of LGBTI Children under the Convention on the Rights of the Child' (2015) 33 Nordic Journal of Human Rights 337, 345–46.

[91] Human rights bodies are increasingly applying the Yogyakarta Principles as a legal source of relevance and weight in establishing the scope of human rights norms. See O'Flaherty (n 37) 280.

identity, fall within the scope of the right to private life.[92] According to the Court, gender identity is 'one of the most intimate areas of a person's private life'.[93] Because bodies are judged as intelligible or unintelligible, trans-specific healthcare affects individuals' ability to be recognised in accordance with their gender identity. The recognition of gender identity, albeit social rather than legal, therefore concerns individuals' private life as it is understood under Article 8.

The ECtHR has heard several cases related to trans-specific healthcare in the light of Article 8. In 2003, in the case of *van Kück v. Germany*, which involved cost-reimbursement for gender confirmation treatment, the Court found that it was disproportionate to place the burden of proving 'transsexuality' and the medical necessity of trans-specific healthcare on the applicant.[94] According to the ECtHR, to be denied reimbursement 'had repercussions on a fundamental aspect of her right to respect for private life, namely her right to gender identity and personal development'.[95]

Schlumpf v. Switzerland, decided in 2009, concerned an applicant whose health insurance company refused to cover the costs of gender confirmation surgery because she had not met the requirement of a two-year waiting period prior to surgery. The Court held that the fact that the insurance company had mechanically applied the two-year waiting period, without

[92] *Christine Goodwin v. the United Kingdom*, [GC] no. 28957/95, ECtHR, 11 July 2002, ECHR 2002-VI; *van Kück v. Germany* no. 35968/97 ECtHR, 12 June 2003, ECHR 2003-VII; *Y.Y. v. Turkey* no. 14793/08, ECtHR, 10 March 2015, ECHR 2015 (extracts); *A.P., Garçon and Nicot v. France* (n 38).

[93] *van Kück v. Germany* (n 92), [56].

[94] Ibid. (n 92), [82].

[95] Ibid. (n 92), [75].

regard to the applicant's advanced age of 67, infringed on her freedom to determine her gender identity under Article 8.[96] According to the Court, it was likely that waiting for two years would influence the applicant's decision to go through with surgery. It therefore impaired her freedom to decide her gender identity. The case also demonstrates that access to healthcare is part of the right to respect for private life, because it concerns people's gender identity. Similarly, in 2009, the Council of Europe Commissioner for Human Rights at that time, Thomas Hammarberg, said that, for most transgender people, gender confirmation treatment is medically necessary to enable them to live meaningful lives.[97] The Council of Europe Committee of Ministers and the Parliamentary Assembly of the Council of Europe (PACE) recommend that states make trans-specific healthcare, 'such as hormone treatment, surgery and psychological support, accessible to transgender people, and ensure that they are reimbursed by public health insurance schemes'.[98] Being unable to access trans-specific healthcare impairs individuals' freedom to define their gender identity under Article 8 of the ECHR. Under Norwegian healthcare practice, the application of the 'transsexualism' criterion excludes transgender people from receiving necessary healthcare. This infringes on their right to respect for private life.

[96] *Schlumpf v. Switzerland* no. 29002/06, ECtHR, 8 January 2009.

[97] Council of Europe: Commissioner for Human Rights, *Human Rights and Gender Identity* (29 July 2009) CommDH/IssuePaper(2009)2, [3.3].

[98] Council of Europe: Parliamentary Assembly, *Discrimination against Transgender People in Europe* (22 April 2015) Resolution 2048 (2015), [6.3.1]; Council of Europe: Committee of Ministers, *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* (31 March 2010) CM/Rec(2010)5, [35]–[36].

The Convention on Human Rights and Biomedicine in Article 3 obliges states to provide equitable access to healthcare of appropriate quality.[99] The aim is to ensure healthcare in accordance with the person's medical needs. The Explanatory Report to the Convention specifies that the care must 'be of a fitting standard in the light of scientific progress and be subjected to a continuous quality assessment'.[100] In other words, the standard is evolving. 'Equitable access' means that states must effectively obtain 'a satisfactory degree of care'[101] for transgender people and that reasonable accommodation for different needs is required.[102] This means that needs for trans-specific healthcare must be individually assessed and adjusted and that healthcare must be provided.

Thus, international human rights law has much to contribute to the debate on trans-specific healthcare, which is covered by the right to health under Article 12 of the ICESCR and the right to respect for private life under Article 8 of the ECHR. National authorities are obligated to provide equal access to trans-specific healthcare to those who need it and to immediately correct discriminatory healthcare systems.

[99] Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, ETS 164 4.IV.1997. Ratified by Norway in 2006.

[100] Council of Europe, 'Explanatory Report to the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine' (1997), [24], [25].

[101] Ibid., [25].

[102] HS Aasen, 'The Right to Health Protection for the Elderly' in B Toebes and others (eds), Health and Human Rights in Europe (Intersentia, 2012), 285.

B. Trans-Specific Healthcare as Necessary Healthcare under Prevailing Norwegian Law

1. Access to specialist healthcare

The Norwegian Patients' Rights Act is based on general human rights principles. The Act aims to safeguard the life, integrity and human dignity of all patients. It seeks to ensure that all Norwegian citizens have equal access to good quality healthcare.[103] Public healthcare is organised into two levels: primary healthcare and specialist healthcare. Except in the case of emergency assistance, healthcare is accessed through primary healthcare services. Under Section 2-1a, patients have a right to necessary healthcare from this service. This includes the right to see a general practitioner and to be referred to specialist healthcare services when necessary.[104] Patients who require forms of trans-specific healthcare not provided by their general practitioner, such as surgery, will therefore be referred to specialist healthcare services.

In accordance with the state's obligation under Article 12 of the ICESCR,[105] the Specialist Health Service Act requires the state to provide the population with the necessary specialist healthcare services.[106] This means that the state must provide healthcare that satisfies the requirement for responsible conduct.[107] The standard that gives content to this duty is constantly modified to take scientific developments and changing norms and perceptions into

[103] Patients' Rights Act (n 9) s 1-1.

[104] Patients' Rights Act (n 9) s 2-1c.

[105] See section VI.A.

[106] Specialist Health Service Act (n 10), ss 2-1 and 2-1a.

[107] Specialist Health Service Act (n 10) s 2-2; Lov om helsepersonell m.v. [Health Personnel Act] 2 July 1999 No. 64, ss 4 and 16.

consideration. The right[108] of patients to receive necessary healthcare from specialist health services follows from the Patients' Rights Act Section 2-1b.[109] In principle, the right applies to everyone permanently residing in Norway.[110]

In a legal sense, people who are referred to the Trans Unit or who receive or are offered healthcare there or from other specialist healthcare services are patients.[111] Their rights concern healthcare as defined under Section 1-3 (c), *i.e.*, treatment which has a therapeutic effect (medical object) and are carried out by health personnel[112] for the purpose of nursing and care (the institutional element). 'Healthcare' includes examinations and assessments designed to prevent and remedy illness. 'Therapeutic' acts aim to cure a person partially or completely and thus to change their physical and/or psychological health.[113] Trans-specific

[108] For more on the concepts of rights under welfare law, see Kjønstad, Syse and Kjelland (n 12) 112–13. Healthcare shall be provided on the basis of informed consent, see Patients' Rights Act (n 9) ss 4-1 and 3-2. For more on patients' right to self-determination, see HS Aasen, *Pasientens Rett til Selvbestemmelse ved Medisinsk Behandling* (Fagbokforlaget, 2000).

[109] Patients' Rights Act (n 9), s 1-3(d) defines 'health service' as the municipal health service, specialist health service, dental health service and private providers of health services.

[110] Patients' Rights Act (n 9) s 1-2. For restrictions, see Forskrift om rett til helse- og omsorgstjenester til personer uten fast opphold i riket [Regulation] 16 December 2011 No. 1255, s 2. G Søvik, 'Utlendingsrett: Særlig om Oppholdsgrunnlag og Integrering' in A Kjønstad, A Syse and M Kjelland (eds), Velferdsrett II: Barneverns- og sosialrett (Gyldendal Juridisk, 5th edn, 2017) 399–445.

[111] Patients' Rights Act (n 9) s 1-3(a). On the legal term 'patient', see A Syse, *Pasient- og brukerrettighetsloven med kommentarer* (4th edn, Gyldendal Juridisk, 2015) 144, 161–62.

[112] 'Health personnel' means health personnel as defined in Section 3 of the Health Personnel Act (n 107), Patients' Rights Act (n 9) s 1-3(e).

[113] Patients' Rights Act (n 9) s 1-3(c); Syse (n 111) 166–68, 145–47.

healthcare aims to alleviate distress caused by a discrepancy between gender identity and the body,[114] and is therefore therapeutic, coming within the scope of healthcare under the Act, when health personnel provide it.[115]

When necessary, patients must be referred to specialist healthcare services. The right to necessary specialist healthcare is means-tested, and reserved for, those who need such care.[116] The type of healthcare that is needed must be based on a concrete exercise of medical discretion complying with the requirement for reasonable conduct[117]; however, the regulation on the prioritisation of healthcare in Section 2, which defines what is meant by 'necessary', places certain restrictions on this right.[118] For patients to have a right to specialist healthcare, the following two requirements must be met: 1) the patient must be expected to benefit from the healthcare, and 2) there must be reasonable proportionality between the costs of examination or treatment and the expected improvement of the patient's health (cost-effectiveness). The decision must be based on an overall assessment. Although the

[114] Tønseth and others (n 21); World Professional Association for Transgender Health (WPATH), 'Standards of Care' (n 26).

[115] See Patients' Rights Act (n 9) ss 1-3(c) and (e) and Health Personnel Act (n 107) s 3; See also LA Warberg, *Norsk helserett* (2nd edn, Universitetsforlaget, 2011) 319.

[116] The legal amendment to the Patients' Rights Act (n 9), which introduced two groups of patients—those with a need and those without a need—came into effect in 2015. For more, see Syse (n 111) 214–16.

[117] Specialist Health Service Act (n 10) s 2-2; Health Personnel Act (n 107) s 4; Prop. 118 L (2012–2013) Endringer i pasient- og brukerrettighetsloven mv. (rett til nødvendig helsehjelp og pasientrettighetsdirektivet m.m.), [Proposition to the Storting (bill)] paras 7.5.1, 7.5.2. See also Kjønstad, Syse and Kjelland (n 12) 230–31.

[118] Regulation on the prioritisation of healthcare (n 9).

requirements are cumulative, the conditions may influence each other regarding the extent of fulfilment.[119]

2. Expected benefit: clinical experience supporting trans-specific healthcare as beneficial

'Expected benefit' means that clinical experience suggests that active medical or interdisciplinary specialist treatment may improve the patient's length of life or quality of life for a certain duration. Alternatively, it means that a patient's condition may deteriorate without healthcare, or that treatment opportunities will be lost if healthcare is postponed.[120] The assessment must be based on scientific examinations and/or past medical experience, and it involves comparing the patient's situation with and without treatment.[121]

Trans-specific healthcare aims to improve the health, quality of life and functional level of transgender people.[122] Extensive international medical research supports the view that this aim is generally achieved. A study published in 1990 showed that 87 per cent of the transwomen and 97 per cent of the transmen who participated reported improved psychosocial outcomes.[123] In 2010, a Swedish follow-up study showed that almost all the

[119] Kjønstad, Syse and Kjelland (n 12) 229–33.

[120] Regulation on the prioritisation of healthcare (n 9) s 2(2).

[121] Kjønstad, Syse and Kjelland (n 12) 231–32.

[122] Tønseth and others (n 21) 377; Norwegian Directorate of Health, 'Helhetlig gjennomgang av nasjonale og flerregionale behandlingstjenester i spesialisthelsetjenesten 2017: Nasjonal behandlingstjeneste for transseksualisme' (n 27).

[123] R Green and DT Fleming, 'Transsexual Surgery Follow-Up: Status in the 1990s' (1990) 1 Annual Review of Sex Research 163.

respondents were satisfied with 'sex reassignment'.[124] A Dutch and American study with 55 participants showed that, after providing puberty blockers, hormone therapy and gender confirmation surgery, the wellbeing of the patients was similar to, or better than, that of people of the same age in the remainder of the population.[125]

This is consistent with the interviewees' description of the outcomes of the forms of trans-specific healthcare they received. Most importantly, trans-specific healthcare reduced suicidal ideation, and as indicated by one interviewee, it perhaps even prevented suicides. In their opinions, it has improved their lives significantly. Still, the Trans Unit did not consider them in need of trans-specific healthcare. The interviewees whose financial situations allowed them to receive treatment at private clinics paid for it themselves, while the interviewee who could not afford to do so was forced to wait until being diagnosed or having saved enough money for private treatment. The right of the interviewees to the highest attainable standard of health under Article 12 of the ICESCR is only realisable through trans-specific healthcare. Moreover, the ECtHR observes that trans-specific healthcare is medically necessary.[126] Trans-specific healthcare therefore generally fulfils the expected benefit requirement.

[124] A Johansson and others, 'A Five-Year Follow-Up Study of Swedish Adults with Gender Identity Disorder' (2010) 39 Archives of Sexual Behavior 1429.

[125] ALC de Vries and others, 'Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment' (2014) 134 Pediatrics 696.

[126] See *van Kück v. Germany* (n 92).

3. Evaluations of the cost-effectiveness of trans-specific healthcare

Few studies have examined the cost-effectiveness of trans-specific healthcare.[127] The costs of providing trans-specific healthcare must be considered in relation to the effects of the money spent, which for those who need trans-specific healthcare—such as the interviewees—are significant. Moreover, people with a better quality of life and better health cost the state less than people in poor health, who may not be able to work, or who need long-term mental healthcare. In 2015, a Swedish report on trans-specific healthcare for adults, suggested that, in the long-term, providing trans-specific healthcare to more people—that is, to those in need—may be socio-economically beneficial.[128] Thus, trans-specific healthcare generally meets the requirement of cost-effectiveness.

Trans-specific healthcare thus generally meets the requirements for expected benefit and cost effectiveness. It therefore also qualifies as necessary healthcare under the Patients' Rights Act: care which patients in need have a right to receive.[129]

[127] J Defreyne, J Motmans and G T'sjoen, 'Healthcare Costs and Quality of Life Outcomes Following Gender Affirming Surgery in Trans Men: A Review' (2017) 17 Expert Review of Pharmacoeconomics & Outcomes Research 543.

[128] Socialstyrelsen, *God vård av vuxna med könsdysfori: Nationellt kunskapsstöd* (Socialstyrelsen, 2015) 90. See also Socialstyrelsen, *God vård av vuxna med könsdysfori: Metodbeskrivning och kunskapsunderlag* (Socialstyrelsen, 2015). The annexes estimate costs of trans-specific healthcare in a Swedish context.

[129] The Patients' Rights Act (n 9) provides a right to an individual time limit within which necessary healthcare shall be provided, see s 2-1b (2); Regulation on the prioritisation of healthcare (n 9) s 4. The specialist healthcare services must prioritise between patients on the basis of the seriousness of their conditions and triage; Regulation on the prioritisation of healthcare (n 9) s 2a. See also A Sørlie, 'Retten til kjønnsidentitet som menneskerettighet: Kan norsk forvaltningspraksis' krav om irreversibel sterilisering ved endring av fødselsnummer forsvares?' (Master Thesis, University of Oslo, 2013) 56–61.

4. The right to trans-specific healthcare on the basis of individual needs

The interviewees described trans-specific healthcare as a matter of life or death. Their mental health and the ability to live in accordance with their gender identity are at stake. It is an acute need, which has driven them to take action to receive the necessary form of trans-specific healthcare to be seen as who they are.

The requirement of necessity determines the types and quality of specialist healthcare, which is informed by a professional medical assessment, strictly evaluated, and based on patients' needs. The healthcare must be of a certain standard[130] and meet the responsible conduct requirement, which, as mentioned under B.1, evolves over time in parallel with medical and ethical developments, and the needs of the population.[131] This means that the forms of trans-specific healthcare that met the responsible conduct requirement in the 1970s, when the medical practice was established at one hospital in Norway, may not necessarily satisfy medical assessments in 2017.[132]

The responsible conduct requirement imposes obligations on health personnel, which means they can be held liable if they provide healthcare that does not meet this requirement.[133] In 2009, for example the Norwegian Appeals Board for Health Personnel issued a warning to a

[130] Prop. 118 L (2012–2013) (n 117) para IV; Kjønstad, Syse and Kjelland (n 12) 233–34; Norwegian Supreme Court, Rt. 1990 s. 874.

[131] Health Personnel Act (n 107) s 4; Specialist Health Service Act (n 10) s 2-2; Kjønstad, Syse and Kjelland (n 12) 234, 45.

[132] In 1979, Oslo University Hospital was given national responsibility for providing trans-specific healthcare to people diagnosed with 'transsexualism'. In 2010, a unit was established as a Norwegian National Unit for Gender Dysphoria and Transsexualism (the Trans Unit).

[133] AK Befring and B Ohnstad, *Helsepersonelloven med kommentarer* (3rd edn, Fagbokforlaget, 2010) 56–80.

doctor for referring transgender patients for chest surgery without a sufficient medical assessment from the Appeals Board's perspective. According to the Appeals Board, gender confirmation treatment is a complex medical issue, which increases the requirement for thorough medical assessments. The Appeals Board also pointed out that the Trans Unit has national responsibility for providing trans-specific healthcare. However, as mentioned, scientific and ethical developments as well as changing guidelines in the field influence how the requirement is determined. In the light of the general poor health of transgender people and the good outcomes of treatment, it is reasonable to point out that not providing trans-specific healthcare may do more harm than potential regrets. In 2017, it should not be assumed that health personnel trained in transgender issues who are not part of the Trans Unit are acting contrary to the responsible conduct requirement if they refer transgender patients for chest/breast surgery, or prescribe hormone therapy.

The preparatory works of the Gender Recognition Act state that changing one's legal gender does not in itself bring a right to trans-specific healthcare. However, the fact that a person has changed their legal gender can be included in the medical assessment to determine what type of healthcare might be provided.[134] If a person has changed legal gender, this may influence the medical assessment of the patient's need for healthcare. Nonetheless, the granting of rights to trans-specific healthcare, as with other healthcare rights, is regulated under the Patients' Rights Act, and not the Gender Recognition Act.

Which particular forms of trans-specific healthcare are necessary thus depend on individual assessments with the responsible conduct requirement guiding provision, and should not be

[134] Prop. 74 L (2015–2016) (n 45).

preconditioned on the gender binary diagnosis of ‘transsexualism’. Healthcare must also be assessed in light of the right to gender identity under Article 8 of the ECHR and the right to health under Article 12 of the ICESCR.[135] For those in need of trans-specific healthcare, treatment thus helps them live a life in accordance with their gender identity, which includes being seen by society as such. Therefore, when determining patients’ rights, the fact that transgender people have a right to gender identity should be considered. This right is impaired when transgender people do not receive the trans-specific healthcare they need. Norwegian authorities are obliged under the ICESCR and the Specialist Healthcare Act to ensure equal access to adequate trans-specific healthcare to those who need it, which is a core and immediate obligation they have failed to carry out.

VII. CONCLUDING REMARKS

It seems to be an unwillingness to recognise the seriousness of transgender persons’ needs for trans-specific healthcare—both under medical practice and by administrative bodies. This may be related to the tendency to see physical healthcare needs as more profound and serious than needs concerning mental health issues. The diagnosis criterion under healthcare practices shapes the legal and medical assessments of patients’ right to healthcare and obstructs individual assessments. This leads to a misrecognition of needs. It promotes stereotypical and gender binary norms, which produce narratives legitimating access to trans-specific healthcare. What is important is to be a convincing ‘transsexual’ in the eyes of the healthcare services[136]; however, as demonstrated, ‘non-transsexual’ needs may be equally legitimate needs for trans-specific healthcare. Including a broader conception of needs under

[135] See section VI.A.

[136] See sections II.B and V: See also van der Ros, 'Alskens folk: Levekår, livssituasjon og livskvalitet for personer med kjønnsidentitetstematikk' (n 26) 56–71.

the law in action will not lead to risks of hasty decisions or regrets. Under the Patients' Rights Act, individual assessments of needs as well as the requirement for informed consent will help ensure that patients who need trans-specific healthcare will receive it, while those who do not abstain from it. If such care is not accessible to people who need it, the change of legal gender will lose much of its significance,[137] and the right to health and gender identity will become illusory.

The flaws in the provision of trans-specific healthcare also point to a more general weakness in the Patients' Rights Act. For example, legal scholar Anne Kjersti Befring criticises this Act for being too general and arbitrary.[138] Trans-specific healthcare provision is a good example of the way the vagueness of the Act and long assessments periods lead to a lack of adequate healthcare for a significant number of people. This raises the question whether changes can be made that would ensure trans-specific healthcare for those in need. One initiative, which was in progress in 2017, is the reorganisation of public trans-specific healthcare.[139] An alternative, or an additional change, would be to clarify transgender people's right to trans-specific healthcare by legal amendment and replacing 'transsexualism' with 'gender incongruence'. This will not represent a substantive change in Norwegian law because, as argued, the right to trans-specific healthcare falls within the scope of prevailing law, but it

[137] Recent gender recognition acts tend to overlook that bodies, and thus trans-specific healthcare, are crucial for transpeople's lives. Legal Scholar Chris Dietz, for example, criticises the Danish CPR law, which introduced self-declared change of legal gender, for ignoring this. C Dietz, 'Governing Legal Embodiment: On the Limits of Self-Declaration' (2018) .

[138] AK Befring, 'Retten til helsehjelp i helseforetakene' in R Førde, M Kjelland and U Stridbeck (eds), Candmag, candmed, candjur, candalt: festskrift til Aslak Syse 70 år (Gyldendal Juridisk, 2016).

[139] Dokument nr. 15:1119 (2016-2017) (n 26).

will help ensure clarity in the application of the law to trans-specific healthcare. Based on the model of the Argentine Gender Identity Act, which sets out a right to trans-specific healthcare, this could be clarified under the Norwegian Gender Recognition Act.[140] It is, however, important that clarifying or reorganising public trans-specific healthcare does not introduce another narrow conception of needs that is not sensitive to people's individual requirements.

[140] Identidad de Género [Gender Recognition Act] 8 May 2012 Ley 26.743, Art. 11.