The cost of gender re-assignment

A rebuttal of misleading and inaccurate information provided by the press

The cost of gender re-assignment

Management Summary

- *The issue of gender re-assignment costs has increasingly been in the press of late as part of the debate on NHS cutbacks. In many instances the information provided has been inaccurate or misleading: a few simple checks could have established better and more accurate figures than those quoted.*

- *This paper reviews the standard procedures available within the NHS: it sets out what a trans individual is likely to be offered within the NHS (and also what they are not). Cost information is provided, together with sources for that information.*

- *The broad conclusion is that treatment costs are highly influenced by whether an MtF trans service user undergoes surgery or not.*

- *For the vast majority of MtF trans people seeking treatment, who do not undergo surgery, the overall cost to the NHS is unlikely to exceed £1,000 over the person's lifetime. For those who do go on to seek surgery, the cost to the NHS is likely to be around £2,500 in respect of hormone and endocrine intervention and around a further £11,000 for the surgery (both figures aggregated over a twenty year period).*

- *Over the same period, a FtM patient, on average, may cost the NHS around £15,000 in respect of hormone and endocrine intervention and those FtM patients that undergo full surgical re-assignment are likely to cost a further £50,000 in respect of grs: since, however, the majority of FtM patients do NOT undergo full surgical re-assignment, it would be highly misleading to talk of this figure as "typical" or an "average". The typical or average figure for FtM intervention (excluding hormone treatment) is likely to be much closer to £20,000.*

- *The way in which figures are quoted is discussed: in particular, the use of terms such as "typical" and "average". In general, the press needs to be far more careful when it comes to estimating costs: they need to distinguish carefully between the actual cost of treatment applied to an individual; the typical cost of a particular procedure if it is provided; and the expected cost of treatment, which in most cases is unknowable.*

The cost of gender re-assignment

1. Background

Current debate over government cutbacks has led to questions being raised as to the validity of making certain procedures available to the public through the NHS.

A number of treatments are frequently put forward as examples of treatments that should not be provided "as priority" or which should only be provided when all needs in respect of more priority treatments have been met. Driven to its logical conclusion this argument would see the NHS withdrawing from a significant part of everyday low-level health care. Nonetheless, it has resonance with some sections of the public.

1.1 Lifestyle Choices

In particular, questions are asked about so-called lifestyle choice treatments – IVF or gastric banding – or treatments where an individual may be considered to have contributed significantly to their current condition.

Examples of the latter include treatment for motor and sports accidents or conditions arising from the use of alcohol or tobacco.

Argument is divided into two independent strands:

- the principle of whether a particular treatment should be made available
- the absolute cost of making a given treatment available

1.2 Gender re-assignment

One treatment - or more precisely, treatment area - which is frequently advanced as an area that should not be permitted under the NHS is gender re-assignment - or more broadly, the range of treatments available for a condition known as gender dysphoria.

Given the public interest in this topic and the fact that some argument is based on the second strand outlined above - the presumed absolute cost of such treatment - it is important that public debate remains informed and that where possible, accurate cost data are provided.

1.2 A history of misinformation

In respect of procedures such as gender re-assignment surgery, this was the case until approximately two years ago.

At that point, a single report in a national tabloid newspaper appears to have misunderstood the nature of figures being officially quoted, and gave out a significantly exaggerated figure in respect of gender re-assignment costs for Male to Female (MtF) transsexual patients[1]. This figure was then picked up by other newspapers and is now

[1] **The UK Press and factual accuracy**, *a submission to the Leveson Inquiry on Press Standards* by Jane Fae, December 2011

regularly quoted as true - even though there appears to be little effort made to validate it.

There is some evidence that the heightened figure is exacerbating opposition to gender re-assignment procedures, both in respect of individual cases and on the part of lobby groups such as the Taxpayers' Alliance.

2. Aim and Scope

2.1 Objectives

The aim of this report is to provide an outline of the most common procedures and processes employed in respect of gender re-assignment and the treatment of gender dysphoria. It further aims to provide both broad cost estimates for these procedures and to set out a basis on which it makes sense to talk of such costs.

Terminology is discussed: a range of averages are set out, together with an explanation of how these are most appropriately quoted.

3. Terminology

The following guidelines are derived in large part from work carried out with the media by Trans Media Watch[2]:

3.1 Definitions: medical

3.1.1 *Gender dysphoria* is an internationally recognized medical diagnosis describing the distress of an individual who experiences incongruence between their gender identity and their apparent physical sex. It is also used when an individual feels unable to present in the gender role which feels appropriate to them but is not the one commonly expected by their society.

It is occasionally referenced as *Gender Identity Disorder* - though this latter term is considered offensive by some in the transgender community.

3.1.2 *Gender affirmation (sometimes gender confirmation) surgery describes any surgeries* which may be part of transition. As with all medical therapy, these are a private matter between an individual and their doctor and should never be referred to without permission.

The term *gender re-assignment surgery* also appears in popular usage, although most commonly this appears to reference major surgical interventions in respect of an individual's genitalia: other interventions – *facial feminization surgery*, for instance – may or may not be included.

3.1.3 *Intersex* (adj) - describes an individual in whom genetic, hormonal and physical features that may be thought typical of as both male and female co-exist. Such individuals may be thought of as being male with female features, female with male features, or may have no clearly defined sexual features.

3.2 Definitions: individual

3.2.1 *Transsexual* (adj) describes a person who wishes to undergo, has undergone or is undergoing transition. Though not all those who identify as transsexual undergo medical therapy, 'transsexual' is considered most appropriate when used in relation to clinical practice. (TS)

3.2.2 *Transvestite* (adj, occ. noun) (sometimes crossdresser) describes a person who wears the clothing of the gender opposite to the one they were assigned at birth, but does not usually experience the requirement to live permanently in that role. (TV)

3.2.3 *Trans* (adj) is an umbrella term, describing people who experience the need to present themselves as, and/or who identify as other than the gender they were assigned at birth.

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[2] **Media style guide**, *by Trans Media Watch*, *July 2010* http://www.transmediawatch.org/ - accessed 5/12/11

This term is usually perfectly adequate (where such a term is relevant), and has tended to supersede the term *transgender* (adj) although this is still useful when readership or audience are unfamiliar with current terminology, e.g., "trans person/people".

3.3 Usage

3.3.1 The target gender should always be used:

- a trans (or transgender) man has transitioned or is transitioning from female to male (FtM)
- a trans woman has transitioned or is transitioning from male to female (MtF)

3.3.2 Transition describes the process of changing gender presentation. This may involve social, medical and surgical change – though not necessarily all three. Paying due regard to the privacy of medical detail, "transition" should prove an adequate descriptor in most pieces where these changes are relevant.

3.3.3 As above the target gender should always be used when describing transition i.e. John is transitioning from female to male.

4. Gender re-assignment: the process

4.1 International standards

The model outlined below is broadly in line with the model adopted by the NHS, and is consistent with the WPATH guidelines for treatment of gender dysphoria[3].

It should be noted that alternative approaches may be taken in other countries: and that those individuals seeking to pursue treatment through a private route may also follow a slightly different path.

Specifically the private route allows for a variety of approaches which are more flexible in their application and may better fit the individual patient's diagnoses and circumstances.

4.2 Identification and diagnosis

An individual with gender issues is likely to present initially to their GP, who should refer them onward to the local community psychiatric team for assessment.

4.2.1 This will result in one, or often two interviews, comprising an initial assessment (triage) and a follow-up in-depth interview with a qualified psychologist or psychiatrist. They will probe to establish whether there are other conditions affecting the patient's mental health (and possibly giving rise to a false sense of identification).

4.2.2 However, assuming that their initial assessment supports a diagnosis of gender dysphoria, they will then pass on a referral for the patient to one of the UK's Gender Identity Clinics.

Here the assessment is repeated, this time by clinicians who specialize in gender-related issues. Typically, there will be two assessments, by different clinicians, followed by a discussion to determine whether or not to admit an individual as a patient in need of treatment.

4.2.3 Waiting times for appointments at GIC's vary: however, it is not unusual for there to be a delay of 12 months or more between initial (community psych) assessment and first appointment at a GIC. Thereafter, there may be a further delay before a patient obtains their second appointment and a decision is taken as to whether or not to admit them.

4.3 Basic treatment

4.3.1 Patients requesting treatment for gender dysphoria (on the NHS or otherwise) are required to have undergone a minimum of three months "real-life experience", during which time they will begin the process of living in the role of their identified gender - or to undergo counselling.

There are two quite distinct clinical pathways, dependent on whether an individual

[3] WPATH Standards of Care, 7th Edition, *published by World Professional Association for Transgender Healthcare, September 2011* http://www.wpath.org/publications_standards.cfm accessed 5/12/11

presents as Male to Female (MtF) or Female to Male (FtM) - although the broad principles of both are the same. The full transition process is likely to involve, according to individual needs:

- endocrine intervention to change the hormone balance within the body (and bring about modification to "secondary sexual characteristics");
- social and behavioral, to assist the individual in coping with their new role (e.g., speech therapy);
- gender re-assignment surgery (grs), most commonly involving major reconstructive work on breasts and genitals;
- ancillary work (e.g., laser hair removal, facial feminization, etc.)

It should be noted that in most cases only the basic interventions (endocrine and grs) are provided on the NHS, and individuals are required to find funding for additional interventions privately.

4.4 MtF Intervention

4.4.1 Endocrine

This most commonly begins with prescription of a course of oestrogen (oestradiol valerate) in the form of patches, injection or pills.

The effect of this treatment is to increase the levels of oestrogen in the body and to begin the process of "feminization", or the acquisition of secondary female sexual characteristics that other women will have gained at puberty: there is likely to be a softening of facial characteristics, an increase in fatty tissue, particularly around the breast and thigh areas - and a corresponding loss of muscle. There will be some thickening of hair, as well as a reduction in beard and body hair.

In addition to oestrogen, the MtF patient may be prescribed Finasteride, usually in tablet form, where there has been some recent hair loss. Finasteride counteracts the effects of testosterone precursors, which are mostly responsible for hair loss in males, and over time will result in some degree of regrowth.

Finally, the MtF patient may be prescribed a testosterone blocker which, as the name suggests, acts to reduce or block altogether the production of testosterone within their body. These are administered to increase feminization thru allowing the body a greater chance of uptake of oestrogen.

Different drugs may act according to different mechanisms: thus, there are gonadotropin suppressants (using LHRH analogues such as triptorelin and leuprorelin), drugs that will interfere with the production of testosterone (spironolactone) and drugs that interfere with receptor binding of androgens (Cyproterone acetate, known more popularly by its brand designation of Androcur). These are all highly potent substances with both short and long-term side-effects. They are not prescribed lightly – and in general in the UK, not beyond two to three years.

4.4.2 Surgical

The principal gender re-assignment surgery sanctioned by the NHS involves three procedures:

- penectomy (removal of the penis)
- bilateral orchidectomy (removal of the testes)
- vulvoplasty and vaginoplasty (creation of a vaginal cavity and re-aligning of the urinary tract)

This work is usually preceded by a series of laser hair removal sessions, which are carried out for medical and not cosmetic reasons. The rationale is straightforward: the vaginoplasty process results in penile and sometimes scrotal skin tissue, which is in most cases quite hairy being inverted and brought inside the body. Failure to remove hair from this tissue can result in later infection, with an outside chance of serious medical complications for the patient.

4.4.3 Social and Behavioral

This is part a managerial function, part support and includes:

- therapeutic support and case management: individuals may require some degree of therapy and counseling, both to deal with their personal issues in respect of transition and to deal with issues arising socially
- speech therapy: hormone treatment does not bring about a shift in pitch and therefore the MtF transitioner needs to relearn the way in which she speaks

4.4.4 Ancillary

There are a wide range of additional procedures that may be requested or helpful in respect of the MtF transition. Surgical procedures include:

- cricoid shave: the removal of part of the Adam's Apple, where this is prominent.
- facial feminization surgery: a wide range of procedures that aim to modify bone or cartilage structures, typically in the jaw, brow, forehead, nose and cheek areas
- breast augmentation
- vocal cord surgery: will raise the pitch of the voice, but best carried out in combination with speech therapy
- laser hair removal

4.5 FtM Intervention

4.5.1 Endocrine

Endocrine treatments are used for two purposes in respect of trans men. Oestrogen derived female characteristics may be suppressed by the administration of progestagens (medroxyprogesterone acetate aka Provera or Farlutai, lynesterol aka Orgametrji or norethisterone aka Primolut N). In the UK, the commonest approach is to provide an

injection of depo-provera three-monthly until such time as testosterone levels are raised by other means.

Male characteristics which may result from the use of androgens include a suppression of menstrual bleeding, increased growth of body hair and beard, redistribution of body fat to accommodate a male pattern, enlargement of the clitoris and a deepening of the voice.

Typically, this is achieved through the use of testosterone esters (e.g. Sustanon), which may be applied by means of patches or gel (transdermal), injected intramuscularly.

4.5.2 Surgical

The principal gender re-assignment surgery sanctioned by the NHS involves a series of procedures:

- Bilateral mastectomy (breast removal)
- Chest contouring
- Hysterectomy (removal of the uterus)
- Salpingo-oophorectomy (removal of the fallopian tubes and ovaries)
- Genital reconstructive procedures (GRT): use either the clitoris, enlarged by androgenic hormones (Metoidioplasty), or free tissue grafts from the arm, the thigh or belly and an erectile prosthetic (Phalloplasty) to construct a penis. This may be accompanied by scrotoploasty, which uses tissue from the labia majora to create a scrotum, into which prosthetic testes may be inserted

The key point is that the range of treatments – and pathways – available for full FtM re-assignment are both more complex and subject to greater variation than those available for MtF treatment.

4.5.3 Social and Behavioral

This is part a managerial function, part support and includes:

- therapeutic support and case management: individuals may require some degree of therapy and counseling, both to deal with their personal issues in respect of transition and to deal with issues arising socially

5. Summary of Costs

5.1 MtF Costs

Category	Treatment	NHS status	Costs	20-year projection	Comment
Endocrine	Finasteride	Yes	c.£1.20 per month	£36-£60	Based on private costs of 1mg tablets, for three to five years preceding grs
	Oestrogen	Yes	£5-£18 per month	£2,400	Based on private costs of 1mg-2mg progynova tabs. Dose initially around 4-6mg per month falling off after two to three years.
Surgical	Laser hair removal	Yes	£300-£500	£300-£500	Based on an average of half a dozen sessions @£60-£100
	Gender re-assignment surgery	Yes	£10,600	£10,600	Based on UK private costs, autumn 2011
Social and Behavioral	Case management	As required	n/a	n/a	Not included in overall totals: any individual interacting with the NHS will require that their condition – for whatever reason – be managed.
	Therapy	As required	£200-£400 per hour	£800-£2,000+	Based on private figures and costs cited by GIC therapists.
	Speech Therapy	As required	£100-£120 per hour	£600 upward	Some degree of speech therapy may be granted, but with an upper limit
Ancillary	Cricoid shave	As required	£3,000	£3,000	Figure given by WLMHT: procedure only granted where it is considered essential
	Facial feminization surgery	Very Rarely	£2,000 to £20,000+	£2,000 to £20,000+	Lower price given is for entry level single procedure taken from UK private facility: upper levels cover multiple procedures
	Vocal cord surgery	Very rarely	£2,000	£2,000	Clinical view tends to favor speech therapy over surgery, as the latter has unpredictable outcomes: cost provided by clinical expert in grs.
	Breast augmentation	Very Rarely	£3,000-£8,000	£3,000-£8,000	Prices quoted are from UK private practice: exact cost would depend on nature of work carried out.
	Laser hair removal	Rarely	Average session cost: £60-£100	£10,000-£20,000	Based on figures obtained from trans women who have undergone hair removal and an average session cost of £60-£100

5.1.1 It is difficult to obtain an overall cost of treatment, as some elements will depend on the view of the individual clinician as to what is essential to the treatment for dysphoria: some procedures will not be needed – and some may be subject to a difference of view between clinician and patient.

Costs given above are in most cases referenced against private costs for a given treatment: in many instances, the NHS employs the same facilities (and surgical staff) as are accessed privately; and if the NHS is unable to purchase services for less than the individual private patient, that is a separate issue.

5.1.2 In general, the younger that treatment begins, the less the need for surgical intervention. Otherwise, based on the above, over a twenty year period, the typical MtF patient will cost the NHS:

- around £2,500 in respect of hormone and endocrine intervention
- around £11,000 in respect of grs

In some instances, depending on the patient, the policy of the clinic, and the view of the clinician, a MtF patient may be prescribed additional treatments, most commonly speech therapy and cricoid shave: these could add a further £3-£4,000 to the overall cost: but on average should be considered to add around £3-£400 per patient.

5.1.3 No figures are estimated for admin, or therapy, as this is largely either ongoing NHS cost, or in many instances substitutes for other treatments (see (6.) below). Thus, where calculating an average figure for the treatment of gender dysphoria, it would be valid to include therapy costs – but only a proportion of grs costs, since only a proportion of patients overall go on to have grs carried out under the NHS.

5.1.4 In addition, according to their ability to access funds and desire to carry out further work, the patient may spend a further £20,000 to £50,000 from their personal wealth on further (cosmetic) treatments.

A major debate persists as to what constitutes "cosmetic" treatment: technically, all treatments designed to improve outward appearance may be considered cosmetic. In practice, the clinical decision is based on the degree of distress caused the individual patient by failure to apply treatment.

On this basis, the author is aware of two instances where, in respect of individual circumstances, breast augmentation has been permitted,and it is now understood that where hormone treatment brings about zero breast growth, most GIC's will now offer surgical intervention: historically, it is understood, GIC's have offered some degree of laser hair removal and the cricoid shave process where an existing adam's apple is highly pronounced.

5.2 FtM Costs

Category	Treatment	NHS status	Costs	20-year projection	Comment

The cost of gender re-assignment

Endocrine	Progestagen	Yes	>£5	c.£40	Based on a single-shot depo-provera injection with three-month dose, and assumption of maximum of two years application
	Testosterone Esters	Yes	£10-£100	£14,500	There is wide variability in costing here, depending on which route is chosen for taking in testosterone and pre-existing levels of testosterone. Also, costs are likely to fall off after grt. c. 12 products were reviewed including Andropatch, Intrinsa, Testogel, Tostran, Nebido, Sustanon.
Social and Behavioral	Case management	As required	n/a	n/a	Not included in overall totals: any individual interacting with the NHS will require that their condition – for whatever reason – be managed.
	Therapy	As required	£200-£400 per hour	£800-£2,000+	Based on private figures and broadly understood costs of GIC therapists.
Surgical	Mastectomy (and chest contouring)	Yes	£5,000-£6,000	£5,000-£6,000	Private costs obtained by direct quote and from experience of trans men who have recently undergone surgery
	Hysterectomy / oophorectomy	Yes	£15,000-£50,000	£15,000-£50,000	The total cost is as quoted by a leading private clinic (which also does work for the NHS). However, as caveat they state: "The price would depend on exactly which pathway was appropriate and includes the cost of the hysterectomy (see above). Not all patients require all stages of a given pathway." Hysterectomy, carried out as a stand-alone procedure might account for c. £5,000 of these costs. A somewhat tighter cost range was obtained from a survey of leading clinicians at one of the UK's major GIC's, who estimated the
	Genital reconstruction (GRT)	Yes			

					figure for FtM surgical intervention as being in the range of £25,000-£40,000.

5.2.1 It is difficult to obtain an overall cost of treatment, as some elements will depend on the view of the individual clinician as to what is essential to the treatment for dysphoria: some procedures will not be needed – and some may be subject to a difference of view between clinician and patient.

Costs given above are in most cases referenced against private costs for a given treatment: in many instances, the NHS employs the same facilities (and surgical staff) as are accessed privately; and if the NHS is unable to purchase services for less than the individual private patient, that is a separate issue.

An example of this may be in respect of grt, also known as "lower surgery". The bulk of this tends to be done in London: however, it is claimed (and contested) that comparable surgery is available at (significantly) lower cost in Belgium – but many pct's refuse to fund this.

5.2.2 In general, the younger that treatment begins, the less the need for surgical intervention. Otherwise, based on the above, over a twenty year period, the typical FtM patient will cost the NHS:

- around £15,000 in respect of hormone and endocrine intervention
- around £50,000 in respect of grs

5.2.3 As for MtF, no figures are estimated for admin, or therapy, as this is largely either ongoing NHS cost, or in many instances substitutes for other treatments (see (6.) below).

6. Treatment of Costs

While the above tables set out as far as possible the known current costs of specific procedures, it is important to place these into context: to compare like with like and not – as some sections of the press appear to have done – to lump together all possible costs and claim them as the "cost of transition".

Various factors need to be taken into account, including:

- whether a cost is likely to be incurred
- whether a cost is technically a transition cost;
- whether a cost substitutes for other costs within the NHS

6.1 Cost incidence

Apart from core procedures (such as surgery), many of the above costs are conditional on two factors:

- whether there is an actual physical need for them
- whether the clinician treating the patient considers the need to be medically justified

Thus, some patients may require a cricoid shave in order to disguise the presence of a prominent adam's apple. However, it is not the case that women do not possess this feature (merely that theirs' tend to be less prominent): and nor is it the case that all those born in a male body will have a prominent adam's apple.

Therefore, the procedure would only be applicable in a limited number of cases.

In addition, clinicians need to decide whether applying a procedure is essential for a successful psychological outcome – or merely "helpful". Such considerations may apply to hair removal and breast augmentation, both of which are procedures available on the NHS to those born in a female body, and where extreme hirsutism (often the result of polycystic ovary syndrome) or breast anomalies (extreme lop-sidedness, or breast loss following a mastectomy) are causing acute psychological distress.

In other words, the request for a procedure may a) not be justified by a patient's physiognomy and b) needs to be demonstrably necessary in the view of the expert. There is no blanket approval for many such procedures.

6.2 Transition costs

There is some question as to what strictly constitutes a "transition cost".

For instance, the use of Finasteride to combat hair loss is associated with FtM transition: however, Finasteride is also an approved treatment for male hair loss and, at higher doses, as a treatment for prostate cancer. It is therefore not unknown for an individual to seek treatment with Finasteride even though they are not trans – or are not aware that they are at the time when they begin such treatment.

Similarly, and as already acknowledged, where hirsutism or breast anomalies cause extreme distress, comparable treatment is available on the NHS to women: the clinical decision is based on whether such treatment deals with a genuine need – or is merely cosmetic.

Where an individual is fully transitioned, they are, in law, to be treated for almost all purposes as the gender to which they have transitioned: therefore, there is a subtle but important distinction between and MtF patient requesting one of the above procedures as part of their transition process – and a post-transition patient requesting similar.

Again, there is a requirement, post-operatively, for continuing hormone treatment: and again, this is directly comparable with HRT, which is freely granted to women in order to treat a variety of symptoms (including menopause): whereas removal of hormones from a trans woman is likely to trigger a phase that is comparable to a menopause.

6.3 Cost substitution

This is considered at greater length below: the essential point, however, is that some costs negate the need for other costs.

Early intervention in gender dysphoria may reduce the degree of medical and/or surgical intervention required: most dramatically, where intervention occurs at or close to puberty, the amount of surgical intervention subsequently required, in total, may be significantly reduced, leading to less trauma for the patient and less likelihood of complications (for which costs are not factored into this report, but can be significant where they occur).

Early intervention is anecdotally reputed to be associated with a better outcome in born male patients – though there is no evidence that this is true in born female patients.

Further, a proportion of the therapeutic/psychiatric engagement is aimed at diagnosis and, in cases where there is some doubt as to the patient's transgender status is likely to result either in a patient receiving other (non-gender-related) treatment, or for therapy to be more extensive, possibly resulting in non-surgical outcomes.

Thus, although there is no quantified evidence for this, it is likely that higher therapeutic costs are likely, on average, to be associated with lower surgical and other costs.

6.4 Quoting costs publically

In the light of the above, there are a variety of ways in which it makes sense to quote the "costs" of treatment for gender dysphoria. These include:

6.4.1 Use of figures given by patients

"Ms Smith is undergoing treatment for gender dysphoria, which critics claim will cost £xxx on the NHS"

Various media (including the Daily Star) have claimed, as justification for costs quoted, either figures given by third parties (campaigners, politicians, etc.) or by the individual subject of those procedures.

This is a highly dubious route to take, since unless the third party is, themselves, a budgetholder or provider for one or more of the procedures outlined above, they are unlikely to have accurate up-to-date cost information to hand – let alone any idea of what the on-cost to the NHS is.

A survey of individuals who had recently undergone a range of surgical procedures on the NHS (from hip replacement, to removal of gall stones) revealed a very wide range of guesstimate, with no sense at all that individuals were in any way a good guide to the cost of their own operations. There is no evidence to suggest that trans individuals are any better qualified to estimate such costs – unless they have opted to pay for their own treatment privately.

From the convergence of figures quoted for procedures such as gender re-assignment surgery recently, it seems likely that these are the result of either ambush questions ("would you say that your treatment cost £x?") or simply a regurgitation of inaccurate information carried elsewhere in the press.

6.4.2 Use of figures for individual treatments

"Ms Smith is planning to undergo gender re-assignment surgery, which typically costs around £11,000"

This is possibly the easiest and most accurate approach – although it is not without its limitations.

Each stage of the transition process can be identified separately and teased out as above: typical private costs are available on application from private clinics. Similar figures may be obtainable from either funding bodies (primary care trusts) or GIC's, and there is little excuse for not doing such basic research. If in any doubt, the author of this document is happy to put journalists in direct touch with officials who are able to give out typical costs.

What this approach cannot do is give an exact figure for what will be spent on an individual patient: this would constitute a breach of patient confidentiality – and attempts to dig further, unless there is a clear issue of public interest in the individual case, is arguably a breach of privacy and unlawful.

An instance of the above is where a MtF individual chooses not to undergo full grs, opting instead for removal of testes and penis only: this costs significantly less than procedures including vaginoplasty; and without knowing whether this was the procedure opted for, any attempt to guesstimate individual grs costs is both intrusive and subject to a wide margin of error.

6.4.3 Use of broad figures for overall treatment

"Ms Smith is being treated for gender dysphoria: it is expected that the full cost of treatment will be around £xx"

There are circumstances in which such an approach to costs may be justified – particularly where the subject of a piece is the issue of costs and comparisons are being made to other procedures.

There are, however, clear dangers in this approach. First, given the caveats expressed above, a simplistic summation of all the possible costs that an individual may incur is likely to be misleading – possibly sufficiently misleading to trigger a referral under s1 of the Press Complaints Commission editorial code of conduct.

As already noted, it would be potentially misleading to pull together cases where there is significant psychotherapy and those where there is early surgical intervention, since there is a degree to which these are exclusive.

Use of the word "expectation" is also potentially misleading, since as well as a popular sense, it also has a technical statistical sense (in terms of "expected value") where it may be taken to reference either mean or median values of an event. This is of particular significance in respect of FtM grs, where it is reported that on average, only around one-third of patients undergo the full grs procedure.

The median "expected" cost of FtM grs is therefore closer to £20,000 than the upper limit often quoted of £60,000: the mean cost of FtM grs is closer to £33,000.

Finally, the Press need to be very careful to distinguish the cost per patient for treatment of gender dysphoria from the cost per patient that goes all the way through the process to grs and beyond. Obviously, the average cost per fully-transitioned patient is likely to be significantly higher than the average cost per patient, with the latter (depending on how patient is defined for these purposes) possibly as low as £1,000.

6.4.4 Use of comparatives: "up to", "between", "at least"

"Ms Smith is being treated for gender dysphoria: it is expected that the full cost of treatment will be between £xx and £yy"

In the light of comments above (6.4.3) this is not a bad approach to quoting costs: it acknowledges both range and uncertainty.

Far more questionable – and an approach used by some media – is to state that a procedure or process (will) cost "at least £xx": in respect of past treatments, it is, in the absence of close checking that may well have breached privacy, merely speculative.

In respect of future treatment, it is almost certainly inaccurate or misleading: since individuals do not know what treatments they will undergo (or be allowed to undergo) on the NHS at the start of their relationship with a GIC, it is quite inappropriate for the press to be stating such outcomes as fact.

In the context of FtM procedures, the statement that treatment or grs will cost "at least

£60,000" is openly mischievous, given that in most cases individuals do not opt for full surgical intervention.

6.4.5 Overall costs

In the course of a year, the UK's GIC's are responsible for dealing with several thousand patients, and carrying out around 150 grs procedures[4].

The overall cost is estimated at between £2 million and £5 million (depending on whether the focus is surgery alone or the entirety of treating all patients who may present with any condition that falls under the broad heading of gender dysphoria): this represents between 0.002% and 0.005% of the NHS budget, with the lower figure representing surgery only.[5]

As comparison, an official report into the cost of dealing with obesity, first published in 2007 and updated since, estimates the direct costs to the NHS of dealing with this condition as £4.2 billion annually – with a cost of £16 billion to the wider economy[6].

[4] Figure provided by senior clinicians within the NHS: it is estimated that at least as many again obtain surgery through private routes.

[5] Based on figures provided by the NHS estimating their budget for 2011/12 as c.£106bn: http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx accessed 15/12/11

[6] **Tackling Obesities: Future Choices**, Dr Bryony Butland, Dr Susan Jebb, Prof Peter Kopelman, Prof Klim McPherson et al, *published under the UK Government's Foresight Programme*, downloadable from http://www.bis.gov.uk/assets/bispartners/foresight/docs/obesity/17.pdf and cited by the NHS http://www.dh.gov.uk/en/Publichealth/Obesity/DH_078098 both links accessed 15/12/2011

7. The Lifetime Dimension

7.1 Use of Lifetime Costs

It has become increasingly fashionable, in some areas, to look at a "lifetime cost" for a particular treatment or procedure. This is particularly the case in business, where it is important to understand not simply the cost of a particular action now – but also the cost of any future commitments it brings in its wake.

The cost summary tables in (5.) provide some basis on which it might be possible to calculate a "lifetime cost" of transition. Such attempts should be treated with extreme caution: first, because the broader the net is drawn, the more any serious attempt to calculate such costs would require a judgment call to be made on whether a treatment was directly due to transition – or some other aspect of the patient's life.

Second, businesses that calculate lifetime costs for activities are also, usually, also interested in lifetime gains from the same activity. New plant is not viewed solely in terms of construction costs: it is also assessed in terms of the added production capacity it brings.

Similar considerations should arguably be applied to attempts to come up with lifetime figures for gender re-assignment processes, as there is growing evidence that NOT treating gender dysphoria accrues significant costs either in terms of additional costs to society – or in terms of benefits foregone.

7.2 Additional Costs

Society may incur additional costs in three ways:

7.2.1 Anti-social behavior

A common narrative, cited both in press reports on transition and in anecdote is how individuals who exhibited a range of disruptive, anti-social and criminal behavior prior to being diagnosed as gender dysphoric frequently undergo dramatic overnight changes once their condition is recognized and treatment begins. While formal evidence for this is patchy, studies that have been carried out support the view that social exclusion in general can lead to an increase in low-level criminal behavior. [7]

7.2.2 Mental illness

A second common narrative for individuals with gender dysphoria is that over years they will have frequent (and costly) exposure to the mental health system, presenting with a range of conditions, including depression and a tendency to self-harm. Again, these are costs that can be viewed as either/or: where individuals are being treated for gender

[7] **Economic Marginalisation, Social Exclusion and Crime**, by Hale, C., Hayward, K.J., Wahidin, A. & Wincup, E., Oxford University Press, 2005, *cited in* **"Transgender people and the Scottish criminal justice system: how do serving police officers understand and interact with transgender people?"**, by Jennie Kermode, University of Glasgow, September 2010

dysphoria, they are far less likely to be being treated for other conditions.

7.2.3 Suicide

In line with the above, the NHS have found that, in the UK, one of the highest incidences of suicide is to be found in the trans population. Again, this is not definitive: but there is a high presumption on the part of clinicians and others that this is the natural corollary to failure to receive treatment.

7.3 Social gains

Against the above, there are two positives that are frequently cited in respect of trans men and women. These are:

7.3.1 Social Conformity

If transition can be seen as providing a solution to a number of serious issues (as above) it is also frequently quoted as bringing to individuals a far greater sense of self-worth derived from the ability to "live inside one's own skin". In the sense that transition is often accompanied by a lessening in risks of anti-social behavior and mental illness, that suggests that long-term, individuals who transition will make a much more positive contribution to society.

Evidence on this front remains mixed, not least because current widespread prejudice means that many trans women lose jobs during transition and subsequently find it difficult to find employment. In theory, however, it seems likely that the post-transition individual will be that much closer to an "ideal" employee than pre-transition.

7.3.2 Tax Gains

A study carried out by James Barratt, head of Charing Cross GIC found that post-transition, FtM patients experienced significant increases in their earnings capacity – to the point that the additional tax revenue from these individuals more than covered the costs of transition.[8]

[8] Conclusion cited in direct interview with James Barratt, November 2011

8. Sources and attribution

8.1 Author

This paper was written by Jane Fae, an independent journalist and academic, who has published widely on issues of sex, gender and sexuality. For further information, or to raise questions in respect of particular issues raised here, please contact Jane on 01778 344271 or by e-mail at jane@ozimek.co.uk

8.2 Independent contribution

It was compiled in consultation with

- Dr James Barrett, Consultant Psychiatrist and Lead Clinician, National Gender Clinic
- Trans Media Watch
- St Peter's Andrology Centre, London

In addition, medical experts and members of the trans community with specific experience of medical matters were contacted for their input.

It does not represent their views and, unless specifically cited, should not be taken as doing so. They have however carried out a review and reference role in respect of the paper as a whole.

8.3 Citation

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