The Political Economy of Gender Politics in Trans-Related Healthcare: Between Medical Knowledge and the Global Market

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Abstract: This paper will examine access to healthcare related to “gender change” mobilizing a perspective that intends to reveal the political economy associated with (trans)gender politics. In the history of ‘transsexual healthcare’ the relationship between medical knowledge and financial profit was never linear. Since medical technologies, such as feminizing and masculinizing hormonal therapies and surgeries, became available and medical protocols were established (in some countries already in the 1950s), accessing gender transition has been facilitated, namely to those fitting the diagnostic criteria of “transsexualism” and “gender identity disorder” (substituted by “gender dysphoria” in DSM V). Simultaneous, however, treatments were made costlier for those not matching medical definitions and diagnoses of transsexuality. Two fundamental reasons underpin the inequalities in the access to trans healthcare. On the one hand, the rigid psychiatric categories for understanding gender variance, and the entailed protocols for “gender change”, contributed to exclude some individuals. On the other, the historical decline of the welfare state made medical procedures inaccessible for lack of coverage by national health systems or insurances. Consequently, and along class lines, opportunities for expanding a global market of privatized trans medical-care filled the gap, reproducing inequality at the expenses of a political economy for social and gender justice. Drawing on a comparative analysis (ERC funded project TRANSRIGHTS, http://transrightseurope.com/) between five European countries (Portugal, France, United Kingdom, the Netherlands, Sweden), we will explore how the connections between medical gatekeeping and the commodification of health at the global level impacted institutional protocols and standards of care. Following a genealogical method and aiming at analysing the political economy behind trans healthcare, we will resort to medical literature, policies adopted by medical teams, international and national reports and recommendations and claims from trans-activists. Surveys on trans-related health and in-depth interviews with trans-people and institutional actors will also be analysed.

Key Words: trans-related healthcare; health-care systems; gender politics; global market and inequality

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Introduction

This paper will examine access to healthcare related to bodily “gender change” (or transition, or confirmation, or recognition) mobilizing a perspective that intends to reveal the political economy associated with (trans)gender politics. We will provisionally, and still in a rough analysis, focus our reflection on the current effects of the developments of trans related healthcare by privileging a macrosocial angle. In this paper we do not intend to discuss the effective mobilization of a trans politics for the affirmation of gender identities or the processes entailed in such forms of resistance. Rather, we tackle the material side of redistribution, often neglected in favour of other political claims for the recognition of trans rights, for instance the right to self-determination of one’s gender outside the control of the medical apparatus. These apparatuses constrain still the forms through which a person can be transsexual, transgender or trans by controlling the procedures of diagnosis and, in general, the access to healthcare services.

When self-determination is slowly, but consistently, being recognized as a principle for legal change and the right to the choice of a gender becomes an individual responsibility (even if still, and most often, reduced to binary forms of gender), what occurs ‘after identity’ is key to evaluate how justice operates in practice. For that reason, a material analysis of the effects and processes of facilitation or gatekeeping of access to health provisions implies considering three aspects. Firstly, the ways in which maldistribution and unequal privileges or access cohabitate with the recognition of multiple trans identities and individual self-determination. Secondly, and at large, how biopower and control are today set beyond the state and its institutions as a consequence – not sufficiently envisaged by Foucault’s theorization in the 1970s and early 1980s – of neoliberal transnational capitalism, which brings along particular forms of (de)regulation beyond the geographical and cultural limits of the west. Neoliberal capitalism and its
Colonizing strategies bind the ‘west and the rest’ together in unprecedented ways that could not have been foreseen by Foucault (deceased in 1984). Transnational circulation of bodies and capitals under the ‘control’ of the global market are today beyond the power of the national state, and have to be considered when addressing the commodification of care and knowledge in a global market. Therefore, and thirdly, a transnational perspective is paramount to our analysis, whether we analyse the uneven forms of access to trans healthcare or the formation of a ‘class’ of experts (the specialists on transsexual care, namely surgeons, among others) that operates in the global market, beyond the borders of the nation and its legal apparatus. Considering biopower and the relation power-knowledge as market-driven rather than state-driven implies then a wider formulation of such control over bodies, which intends to expand Foucault’s original contribution on the basis of marketized strategies and the commodification of (trans)bodies.

These reflections result from a comparative analysis (still ongoing) between five European countries (Portugal, France, United Kingdom, the Netherlands, Sweden).1 The research already carried out in Portugal and the United Kingdom enabled us to explore the connections between medical gatekeeping and the commodification of health at the global level. In both countries trans people and medical doctors were interviewed in-depth. In addition, document analysis and ethnographic work were also carried out. Following a genealogical method and aiming at analysing the political economy behind trans healthcare, we resorted to medical literature, policies adopted by medical teams, international and national reports and recommendations, as well as claims from

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1 The research was carried out under the TRANSRIGHTS Project – Gender citizenship and sexual rights in Europe: Transgender lives from a transnational perspective (2014–2019) coord. Sofia Aboim (ICS-UL, ERC – Consolidator Grant n.º 615594; http://transrightseurope.com)
trans-activists. Surveys on trans-related health and in-depth interviews with trans-people and institutional actors were also analysed.

One conclusion triggered our reflection. While institutional protocols and standards of care reflect the tensions of national and transnational regulations and directives – whether political or medical –, the actual practice of a ‘transsexual medicine’, or even of a more openly transgender care still obeys national and local protocols. Nonetheless, the shortage of public ‘care’ is likely to pave the way for a transnational market of services and experts thereby consolidating a paradoxical, though predictable, political economy of privatized trans-related healthcare, which reproduces interlocked patterns of inequality for commodified trans-bodies.

**On trans rights and medical gatekeeping**

In the history of ‘transsexual healthcare’ the relationship between medical knowledge/practice and financial profit was never linear, and, as hinted by our comparative research, history seems to be repeating old patterns in new forms of unequal redistribution.

Since medical technologies, such as feminizing and masculinizing hormonal therapies and surgeries (namely genital surgeries), became available and medical protocols were institutionally established (in some countries already in the 1950s), accessing bodily gender transition has been facilitated, namely to those fitting the diagnostic criteria of “transsexualism” and “gender identity disorder” (substituted by “gender dysphoria” in DSM V).

The critique of such diagnosis and, overall, of medical views pathologizing trans identities, experiences and lives is well known, namely in what it reduces the ‘normality’
of gender to a binary heteronormative epistemology and how it excludes a great number of trans people from not only recognition but also medical care and support for bodily change.

The reactions, individually and collective, against bio-medical pathologization and for self-determination, aiming at the recognition of the plurality of gender identities (often beyond or outside the binary) and of the individual right to gender self-expression without previous certification or authorization from medical juntas or courts (often demanding sterilization procedures), is also at the core of trans activism.

This activism, at national, international and transnational levels, coupled with ripe political contexts, resulted quite recently in significant changes of the law in many countries: Malta, Denmark, Argentina, Ireland, Colombia… etc. Also, further legal changes in many others countries may be forthcoming (such as in the case of Portugal).

Trans movements have also been vocal in the defence of public coverage of trans healthcare, namely regarding hormonal treatments and surgeries, and for changes to standards of care making them more amenable to trans lives and realities.

However, even with de-pathologization in the countries previously mentioned, trans healthcare has always been of difficult access.

This in part was due to the scarce number of medical specialists willing to dedicate their careers to trans medicine (namely because of the marginal and devalued value of such medical fields within the bio-medical system itself). However, the immediate reason for such difficult access was and is, without a doubt, the heterosexist and binary views of most physicians and medical protocols.

There is in fact a closure of medical perspectives around stereotypical and traditional core-notions of ‘genders roles’, which has led the health system to build up the prototype
of the ‘good transsexual’ (that conforms or apparently conforms to strict diagnostic criteria) versus the ‘bad transsexual’ (that falls outside the realm of ‘scientifically legitimate’ gender expression and subjectivity).

Of course trans activism and movements (as well as the involvement of ‘sympathetic’ medical allies) have produced an impact upon diagnostic protocols and standards of care (as in the WPATH or even in the DSM). If these are, today, far from the stringent pathologization criteria of the past, they are still, notwithstanding, also far from full non-pathological acceptance of the whole range of trans experiences and lives.

Concurrent with the development of trans medicine in the Global North, mainly through gender identity clinics in the public health system (basically free of charge, but with the aforementioned strict criteria for inclusion and dispensation of care, which made treatments inaccessible for those not matching medical definitions and diagnoses of transsexuality), private and more de-regulated trans health provision emerged in the global capitalistic economy. This can be observed as early as in the 1960’s, with Morocco, for instance, appearing as a Mecca for surgeries directed at middle-class transsexual women from North America or Western Europe.

Of course private health provision came at a price, as only those able to afford the high rates practiced could access gender transitions (even if the offer in the Global South was and is often more moderately priced than private offer in the Global North, travels cost notwithstanding).

The development of a global trans health industry (deregulated and stratified – not only according to consumer markets and its different powers of purchase, but also by the political geographies of the global economy of health services) gained momentum in the 1980’s, with the rise of global neo-liberal politics and capitalism as well as the hegemonic
position of financial capital. Concomitantly, we have been observing the reduction of public welfare states and free healthcare (especially since 2000, and even more so after the 2008 crisis and the rise of austerity politics, namely in Europe).

A trans field of struggle

Consequently, and along class lines (and their intersection with other systems of oppression and inequality, such as race and ethnicity, etc.), opportunities for expanding a global market of privatized trans medical-care filled the gap left by the retraction of free public health services, reproducing inequality at the expenses of a political economy for social and gender justice.

We contend that such tendencies have increased in recent years, with the strange and paradoxical pairing of neo-liberal economics and de-pathologization (namely in legal/civil sex/gender identity and name change).

This seems to be the case most particularly in, at least, some of the aforementioned countries (Malta, Denmark, Argentina, Ireland, and Colombia), which removed diagnostic criteria from gender identity laws and introduced gender self-determination. If access to legal gender recognition was facilitated, it seems that access to trans medicine is increasingly difficult and restricted. Even when there are legal provisions in place which, in theory, would supposedly guarantee access to surgeries and treatments (genital, but not only), such as in Argentina, where diagnostic was replaced by a policy of informed consent.

Two fundamental reasons underpin the inequalities in the access to trans healthcare. On the one hand, the rigid psychiatric categories for understanding gender variance, and the entailed protocols for “gender change”, contribute to exclude many individuals. On the
other, the historical decline of the welfare state made medical procedures inaccessible for lack of coverage by national health systems or insurances. When this is coupled with the instrumental appropriation of trans self-determination and de-pathologization claims by political systems (despite the potential good-will of individual political agents), the result may well be one of overall degradation and suppression of public trans health services paired with a stratified market for trans health.

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This phenomenon is probably observable globally, but it is certainly occurring in countries such as Portugal (and the UK).

Portugal introduced a Gender identity Law in 2011, which greatly facilitated legal sex and name changes (overall procedural facilitation; changes, if ‘gender identity disorder’ is certified, can be made prior to any medical intervention; sterilization is no longer a requirement). From the point of view of health services, a diagnosis and psychiatric/psychological/medical monitoring were (and still are) necessary to access not only genital surgeries but hormonal therapy or other clinical interventions. Non-psy medical services were concentrated in two to three public hospitals, which had specialized teams led by well-known and competent physicians (namely surgeons). All this has changed in the past few years, with the dismantling of teams and the transference of major surgeons to private services. Presently, most of the dwindling public services function in an opaque manner and are the target for many grievous complaints by individual trans people, who do not feel able to access health services (or who are made to go through a Kafkian ordeal during an unpredictable time lapse, sometimes with poor surgical results that require correction in private services), and by trans organizations.
Of course some of these complaints could well be applicable to many other non-trans related public health services, namely due to the effects of the financial crisis coupled with right-wing austerity measures and privatization strategies. However, due to the historical subalternization of trans issues, these processes have been particularly effective and strong in this field.

As a result, the main option today for trans people in Portugal are a private practice (paradoxically, a Catholic hospital). This for-profit health organization, due to the international recognition of the main surgeon working there, and the prices practiced (although more expensive than in the Global South), also caters to trans people from richer European countries and even North America.

With the chaos and inefficiency of public services, only trans people with enough funds can access private health, even if some physicians working there are known to offer ‘discounts’ to more disadvantaged trans people. But this is done in a logic of charity and not of universal and free health provision.

Furthermore, the closure of medical views on trans (with some individual exceptions) is increasing and becoming more defensive, as trans activism gains wider political audiences. Medical agents are increasingly centred in the defence of ‘transsexuality’ and are openly hostile to narratives of ‘transgenderism’ (transgender is a word and category still not widespread in the Portuguese medical community, unlike other countries, namely those more following the United States model of identity politics).

This phenomenon produces not only a concomitant closure of health services (with the majority of medical practitioners functioning as gatekeepers, only allowing the passage of ‘good transsexuals’) but also a refusal of the medical establishment to accept, or even
just take seriously, all the demands by trans people whose gender identity does not conform with binary medical narratives.

Of course, due to this overall difficulty in accessing healthcare but also because of ideological and identitarian differences, we are now faced with increasingly strong divisions in the trans activism field. The latter oppose, basically, more conventional and organic LGBT+ and Trans organizations that tend to stress the demands of people identifying as transsexuals (and the main concern is access to medical care) versus more inorganic Trans* and Queer associations, movements and individual activists that are more centred in recognition claims (legal and formal). The clash between these two strands of trans activism is a complex one, mixing and entangling uneasy moments of cooperation with open and quite virulent hostility.

Discussion on these issues within the political system is ongoing, aiming at a revision of the 2011 Gender Identity Law. The openness to this discussion was made possible by the defeat of the Right-wing conservative government in the last parliamentary elections (October 2015) and the formation of a Left-wing government (of the Socialist Party, with an absolute majority support in Parliament due to the backing of the Communist Party and the Left Block). Public hearings are being held in Parliament (namely by the Left Block) and the Minister of Justice (Socialist Party) has been discreetly consulting with relevant stakeholders (including medical experts and trans activists).

Overall the initiatives promoted by the Left Block have been more amenable to de-pathologization and recognition concerns, without focusing so much on the question of trans healthcare (the latter is basically seen as following from the former). Paired with this, Trans* queer inspired movements have been more capable of media exposure, bringing the questions of recognition to the forefront. On the other hand, it is known
(namely through the interviews with medical doctors) that, regarding healthcare, closure and demands of transsexuality diagnostics are likely to become even more strict.

Paradoxically these two political strands may come to produce the same result (of course details may vary, and details are important): the Portuguese Republic is likely to abandon any criteria other than self-determination in what concerns legal sex and name changes, while at the same time, either through national legislation or through medical self-regulation, the scope of trans healthcare (private or public, if the latter can be made to function) will become increasingly narrow and focused in the ‘right sort of transsexuals’, abandoning all those who do not conform to the forms of medical reasoning and classification.

**The global market and the commodification of trans-bodies**

In a neo-liberal global capitalist system recognition comes cheap, and may even open up new market opportunities through the commodification of identities and life-styles. As such it is becoming apparent that trans de-pathologization and self-determination claims are being used and reduced to the sole scope of legal and civil identity (legal sex/gender and name) coupled with the mainstreaming of anti-discrimination laws fighting transphobia. These developments are, of course and by themselves, improvements in the overall situation of trans people (which may in fact produce relevant positive impacts on many individual lives).

However, this movement on the part of specific national and international political systems must not be disconnected from what seems to be happening in trans related healthcare. In the latter everything seems to be becoming more difficult and expensive, not only ignoring the needs and voices of a great number of trans people who do not fit
the medical stereotypical category of the transsexual, but also hampering free access to medical care even to those who do fit the diagnostic.

In trans healthcare two dynamics seem to be emerging.

On the one hand, we find a reduction and concentration of national public services (with very strict diagnostic criteria and protocols, excluding many trans people) or even the dismantling of those services. This is taking place in the global context of dwindling welfare states and the retrenchment of free public health systems.

On the other hand, we are faced with the proliferation of private health offer – on a national and global level, that is to say, as a transnational geography of trans health economics. This spread of private trans healthcare has several dimensions. It may pertain to the establishment of high quality, swift and highly priced medical solutions in the Global North (also adhering to strict protocols and diagnostic practices, either exogenously imposed or the product of self-regulation). It may also refer to the multiplication of trans health solutions in the Global South, much less expensive than those in the Northern hemisphere but also much less regulated and considerably less expensive (even if a stratified offer, with various degrees of quality, emerges, depending on the geography and purchasing power of customers).

These different dynamics may combine and entangle in complex manners. One important dimension must be stressed, however. In face of marketized medical de-regulation (as a potential by-product of de-pathologization and self-determination), namely regarding psychiatric protocols and diagnostics, processes of very defensive informal diagnostic by non-psy experts (chiefly surgeons) may emerge (and here we will be facing the realm of arbitrary gender beliefs), mainly as a strategy to avoid potential litigation and lawsuits.
All in all, we can say that the fight for trans recognition may be used to avoid redistribution. And this general dynamic may in fact contribute to produce classes of trans people: those that feel vindicated with the recognition of their gender identities and expressions (and of course recognition does produce general positive effects not only on the legitimate symbolic value of trans identities, but also on the practicalities of trans peoples’ lives) and have no concerns regarding gender bodily transformations; those that fit the medical criteria for transsexuality, and, having the opportunity or the money will always find health solutions; those that are excluded from medical care, either because they do not fit medical protocols and/or because they do not possess sufficient resources to fund private solutions (the most marginalized case would probably be that of trans female street prostitutes), and often, as an alternative, resort to self-medication (hormones and silicone injections, for instance). Of course these classes are analytical categories that actually combine and overlap in reality.

**Paradoxes: between knowledge and the global market**

Future analyses of the dynamics of trans related healthcare should consider a number of paradoxical developments, deriving from the clash between different views of the ‘good’ and ‘bad’ trans, the retrenchment of the welfare state and, most importantly, the growing opposition between a politics of recognition and the marketized dynamics of care. In these new forms of biopower, the erosion of the politic as a morals for recognition, can be easily overthrown by transnational capitalism. In this line of reasoning, biopolitics (and even necropolitics) is pervaded by the greedy dynamics of a market where profit is the leitmotiv. As the state withdraws, the market takes over and recognition is awarded a price, only achievable along class lines. In this line of reasoning, self-determination (though important in the law) is not exactly a free right, but a good (a commodity) that
has to be paid for. At least in many cases and whenever individuals wish to transform their bodies, whether a gender transition (genital or not) is desired or some modifications are deemed essential for affirming a person’s gender expression or identity. A main consequence of current transformations might be that traditional medical gatekeeping can well be transformed, at least to a certain extent, into a commodity, thereby exposing the tension between knowledge and market, medicine and profit.

As a result, the transnational arenas of circulation of services and bodies must be analysed at two levels and considering at least two main actors in this field: trans people themselves and their unequal access to care; transsexual medicine and trans healthcare provided by experts (namely surgeons), often in private clinics in the Global North and the Global South. As a consequence, a class analysis becomes timely so as to disentangle the margins of the trans as a discriminated collective that is nonetheless permeated by material hierarchies of capitals (e.g. financial and educational resources among others). In addition, the unequal layers structuring a quite unregulated private transnational market of experts must be considered. Expertise is for sail at a price, but as the price varies aiming to capture different ‘clients’ the space for much less qualified ‘experts’ widens. For this reason, the market becomes at the same time the central place for seeking care at the expense of the reproduction of inequality and the risk of death or severe health problems. Neoliberal capitalism is therefore at the centre of biopower, beyond the state, fostering the multiplication of more uncontrollable and varied mechanisms of control that escape the logics of traditional biopolitics, as put forward by Michel Foucault in his genealogical analysis of institutions.

In sum, recognition is important as a political aim, and legal changes are effectively, in spite of all shortcomings and obstacles, opening new spaces for gender identities and expressions that challenge the medical codification of transsexuality. However,
redistribution can be seen as the main problem inasmuch as a scheme of inequality is being reproduced beyond the nation-state, and the global market prevails, especially when the interests of neo-liberal capitalism overpass the already failing welfare-state. The truth is that a political hierarchy of redistribution (where is the money?) can be very different from the all-encompassing logics of recognition. The former does involve the allocation of resources, while moving beyond political recognition to a full notion of citizenship with the integration of civil, social and economic rights.

All in all, one key problem, when looking at the marketized dynamics of bodies and of expertise at the global and transnational levels, is the reproduction of inequality. Even if essential, the illusion of a political recognition at the legal level does not avoid maldistribution or misrecognition. Be who you want to be, the state puts forward in ‘progressive’ gender identity laws, but pay the price, the market adds with the compliance of the seemingly ‘progressive’ nation. As a consequence, we argue, the biopolitical analysis a la Foucault cannot elect the state as the only main agent of control. Rather, the market is overpowering and forms of control, even at the biomedical level, no longer work in expected forms as well. The market produces the possibility of ‘no control’, of fluidity and mobility, but then again only for those who pay. And among those who can pay, there are still divisions between types of markets: the quality ones for the rich or better-off, and those growing at the back alleys of medical expertise and centres. In either case, medical expertise as a commodity in the privatized healthcare market also produces a transnational business class set up upon the trade of medical knowledge, which is particularly relevant in the case of surgeons performing genital operations. The class effects and the harms of unequal access must therefore be analysed in tandem, in order to identify transnational patterns of maldistribution, when both knowledge and trans-bodies
are quite often commodities at odds with each other. The research already carried out proves well the provisional reflections shared in this paper.

References

To Be Completed