

WOMEN SPEAK AUSTRALIA

Medical Services Advisory Committee (MSAC) consultation survey on Medicare funding for gender-affirming surgery

Application 1754 — Surgical Procedures for Gender Affirmation in Adults with Gender Incongruence

BACKGROUND

Submitted by: Dr Elizabeth Caballero, President, Women Speak Australia

Professional background: Retired General Practitioner

Survey: <https://ohta-consultations.health.gov.au/ohta/1754-resubmission/>

Closes: Friday 9 October 2026, 11:59 pm AEDT

Application page: <https://www.msac.gov.au/applications/1754>

Providing input

I am providing input on behalf of a medical, health, or other (non-consumer) organisation.

Organisation and role

Women Speak Australia. Dr Elizabeth Caballero, President.

Overall position

Women Speak Australia supports the right of adults to make lawful decisions about their own medical care. This submission is concerned specifically with whether the proposed gender-affirming surgical procedures have sufficient evidence of safety, effectiveness and long-term benefit to justify Medicare funding.

WSA does not consider that the ability of an adult to access a procedure privately establishes that the procedure should receive public funding.

The procedures proposed under Application 1754 include substantially different operations with substantially different risks, outcomes and evidence bases. They should not be treated as one homogeneous intervention.

WSA is concerned that the evidence base remains limited by methodological weaknesses, heterogeneous patient populations and procedures, inconsistent outcome measurement and inadequate long-term follow-up. These limitations are particularly important when considering irreversible and sometimes complex reconstructive surgery.

MSAC's own April 2025 assessment identified the need for further assessment of long-term outcomes, regret and detransition, natural history, outcomes for non-binary people, best available care without surgery, and comparative safety and effectiveness. A further comprehensive assessment of comparative safety and effectiveness remains in progress ahead of the 26–27 November 2026 MSAC meeting.

WSA therefore does not support the proposed Medicare funding at this stage.

1. MULTIDISCIPLINARY CARE

1.1 What do you see the primary role(s) of multidisciplinary team care being for people with gender incongruence, including for those considering gender affirming surgery?

Please indicate all that apply.

WSA selection:

- support the wellbeing of the person (for example, psychosocial support)
- diagnostic purposes (informing diagnosis of gender incongruence or gender dysphoria)
- determining surgical readiness (including planning, timing and sequencing)
- determining post-surgical care pathways

Comment:

WSA considers that a multidisciplinary team should have a substantive clinical assessment role rather than functioning simply as a mechanism for facilitating access to surgery.

The assessment should include diagnosis, consideration of relevant physical and psychological health factors, assessment of the individual's understanding of the proposed intervention, assessment of alternatives, and consideration of whether surgery is likely to provide sufficient benefit to justify its risks.

Surgical readiness should include consideration of the specific procedure proposed, its irreversibility, foreseeable complications, possible need for revision procedures and the long-term consequences of the surgery.

Post-surgical care should also form part of the pathway because some procedures require continuing specialist management and may result in complications requiring further surgery or other interventions.

MSAC itself has identified the need for further advice concerning the role of the MDT in assessment, diagnosis, management and long-term care.

1.2 What level of requirement do you think should apply to multidisciplinary team (MDT) assessments for people considering gender affirming surgery?

WSA selection: MDT assessments should be recommended, but not compulsory, for everyone considering gender affirming surgery.

Comment:

WSA supports a robust multidisciplinary assessment process as a prerequisite for Medicare-funded surgery.

However, the composition and intensity of the MDT should be proportionate to the proposed procedure and the individual's circumstances. A person considering a complex genital reconstruction, for example, requires a different range of expertise from someone considering a less extensive procedure.

The important issue is that assessment should be independent, sufficiently comprehensive and capable of identifying relevant risks, comorbidities, uncertainty and alternatives.

A multidisciplinary label alone does not guarantee a sufficiently rigorous assessment. MSAC should therefore specify the functions that must be performed rather than relying solely on the number or professional titles of clinicians involved.

1.3 Which clinicians do you think should be involved/able to participate in a multidisciplinary team for each adult considering gender affirming surgery?

Please indicate all that apply.

WSA selection:

- Endocrinologist
- GP
- Gynaecologist

- Psychiatrist
- Psychologist
- Urologist
- Other: the relevant surgeon for the proposed procedure, and other surgical specialists according to the procedure

Comment:

The appropriate composition should depend on the surgery being considered.

For complex genital surgery, relevant surgical expertise is essential, as are appropriate assessment and management of physical and psychological health. GPs also have an important role because they may have knowledge of the patient's longitudinal medical history, including conditions and circumstances that may not be apparent during a single specialist consultation.

For some patients, additional expertise may be required, including sexual health medicine, physiotherapy, occupational therapy, speech pathology or other disciplines.

The MDT should therefore be sufficiently broad to address the actual risks of the proposed operation rather than being constructed around a predetermined affirmation pathway.

1.4 Noting the Medicare Benefits Schedule generally requires a minimum of three providers to form a multidisciplinary team, which of the below providers would you consider as mandatory to participate on each multidisciplinary team?

Please select a maximum of 3 options.

WSA selection: The MDT composition should be flexible according to the needs of the patient.

Comment:

WSA does not consider that one fixed combination of three clinicians can appropriately assess every proposed procedure.

The appropriate team for vaginoplasty, phalloplasty, hysterectomy, chest surgery or facial surgery will not necessarily be the same.

What should be mandatory is that the patient receives a comprehensive assessment appropriate to the particular surgery, including an appropriately qualified surgeon and independent assessment of medical and psychosocial factors.

2. SURGICAL PROCEDURES

2.1 In your experience, could one of the following combinations be representative of the combination of gender affirming surgery requested by most (>50%) people assigned male at birth identifying as women?

Options in the survey:

- Option 1 – Genital surgery, facial feminisation surgery and breast augmentation.
- Option 2 – Genital surgery, facial feminisation surgery, breast augmentation, tracheal shave and voice surgery.
- Other

WSA selection: Other.

Comment:

WSA does not consider that it is possible to identify a single combination of procedures as representative of more than 50% of patients without reliable Australian utilisation data demonstrating this.

The procedures listed are materially different operations with different risks, burdens, outcomes and evidence bases.

MSAC should not infer clinical appropriateness or establish Medicare funding on the basis of an assumed typical combination of procedures. Funding should instead be assessed separately according to the evidence for each procedure or clearly defined procedure group.

2.2 In your experience, could one of the following combinations be representative of the combination of gender affirming surgery requested by most (>50%) people assigned male at birth identifying as non-binary?

Options in the survey:

- Option 1 – Genital surgery
- Option 2 – Genital surgery, facial feminisation surgery, breast augmentation
- Option 3 – Genital surgery, facial feminisation surgery, breast augmentation, tracheal shave and voice surgery
- Other

WSA selection: Other.

Comment:

WSA does not consider that there is sufficient evidence presented in this consultation to establish which combination of procedures represents more than 50% of non-binary patients.

The heterogeneity of non-binary populations is particularly relevant when assessing a patient-centred surgical pathway. The evidence should demonstrate the population being treated, the interventions undertaken, their expected benefits and their short- and long-term outcomes.

The absence of sufficient evidence should not be resolved by assuming a standard surgical pathway.

2.3 In your experience, could one of the following combinations be representative of the combination of gender affirming surgery requested by most (>50%) people assigned female at birth identifying as men?

Options in the survey:

- Option 1 – Chest surgery and internal reproductive surgery
- Option 2 – Chest surgery, internal reproductive surgery and external genital reconstruction surgery
- Other

WSA selection: Other.

Comment:

WSA does not consider that one surgical combination can appropriately be assumed to represent more than 50% of patients without reliable Australian utilisation data.

Chest surgery, hysterectomy and genital reconstruction are different procedures and should be assessed according to their individual evidence, risks, benefits and long-term consequences.

This distinction is particularly important because the proposed procedures can involve irreversible removal or alteration of reproductive anatomy and, in the case of genital reconstruction, complex reconstructive surgery.

2.4 In your experience, could one of the following combinations be representative of the combination of gender affirming surgery requested by most (>50%) people assigned female at birth identifying as non-binary?

Options in the survey:

- Option 1 – Chest surgery
- Option 2 – Chest surgery and internal reproductive surgery
- Option 3 – Chest surgery, internal reproductive surgery and external genital reconstruction surgery
- Other

WSA selection: Other.

Comment:

WSA does not consider that the available information establishes a single combination of procedures representing more than 50% of non-binary patients.

MSAC should obtain reliable data regarding actual Australian practice before using an exemplar pathway as a basis for Medicare item development.

2.5 Are there other alternative exemplar(s) that may be more representative? Please describe below.

WSA response:

The proposed exemplars should distinguish procedures according to their nature, degree of irreversibility, complication profile, need for revision surgery, long-term care requirements and strength of evidence.

In particular, genital reconstruction should not be treated as equivalent to less extensive procedures.

The evidence should also distinguish between procedures that remove or alter reproductive organs, procedures that reconstruct external anatomy and procedures intended primarily to alter secondary sexual characteristics or facial appearance.

A single umbrella category of “gender affirming surgery” risks obscuring these important differences.

2.6 How are patients managed after undergoing gender affirming surgery?

WSA response:

Post-surgical management should be procedure-specific and should extend beyond the immediate postoperative period. It should cover monitoring for surgical complications, wound care, infection, urinary and other functional problems where relevant, sexual and reproductive health, pain and other postoperative problems, and timely specialist review and revision surgery when clinically required. Follow-up should match the procedure. That is especially important for complex genital reconstruction.

MSAC’s evidence assessment reported complication rates of approximately 31.5–43.8% for phalloplasty and 11.1–32.1% for vaginoplasty in the studies assessed. For phalloplasty, the most commonly reported complications included infection, urethral stricture or fistula, partial loss, dehiscence, and mechanical failure. MSAC also reported a 43.3% surgical revision rate in one

phalloplasty-with-prosthesis study (Falcone et al., 2018). Most of the safety evidence was short-term.

More recent evidence still shows substantial limits in the evidence base. A 2026 systematic review of phalloplasty (Tinajero et al.) found high complication rates and noted that urinary function, sensation, and cosmesis were poorly reported, which limits comparison between techniques.

Medicare funding should therefore not be considered only on the basis of the initial operation. The downstream clinical consequences and resource requirements of complications and revision procedures also need to be taken into account.

3. SUPPORT FOR THE APPLICATION

3.1 Do you support public funding for the health service or technology, as it is proposed to be delivered?

WSA selection: No.

Comment:

Women Speak Australia does not support Medicare funding for the proposed gender-affirming surgical procedures at this time.

This is not a view that adults should be prohibited from seeking surgery where it is lawful and clinically available. It is a separate question whether Australian taxpayers, through Medicare, should fund these procedures.

Public funding requires sufficient evidence that the benefits of an intervention justify its risks, costs and opportunity costs. At present, important uncertainties remain concerning long-term clinical outcomes, comparative effectiveness, rates and causes of complications, revision and reoperation requirements, long-term functional outcomes, outcomes across different procedures and patient populations (including non-binary patients), regret and detransition, the natural history of gender incongruence, the characteristics of patients most likely to benefit, and the outcomes of non-surgical or alternative approaches.

These are not merely theoretical concerns. MSAC itself requested further evidence on long-term outcomes, regret and detransition, natural history, non-binary populations, and best available care in the absence of surgery.

The surgical risk profile is also significant for some of the procedures under consideration. MSAC's April 2025 assessment reported complication rates of 31.5–43.8% for phalloplasty and 11.1–32.1% for vaginoplasty in the studies reviewed. For phalloplasty, the most commonly

reported complications included infection, urethral stricture or fistula, partial loss, dehiscence and mechanical failure. Most of that safety evidence was short-term, and those figures should not be read as Australian Medicare outcomes. MSAC also reported a 43.3% surgical revision rate in one phalloplasty-with-prosthesis study (Falcone et al., 2018).

A 2024 population-based study of phalloplasty in California (Zhang et al., Urology) found that, of 475 patients with record linkage, 55.3% subsequently re-presented to inpatient, emergency or ambulatory surgery settings for phalloplasty-related complications. Survival analysis indicated that 50% had re-presented by one year. Those encounters included urinary symptoms, catheter-related issues, urinary tract infection, fistula, stricture and wound problems, so the figure is a return-to-care rate rather than a rate of major surgical failure alone.

These figures should not be generalised to every gender-affirming procedure. They do show why the proposed services need careful procedure-specific assessment rather than being treated as one homogeneous category.

WSA therefore considers that the evidence threshold for Medicare funding has not yet been demonstrated. We recommend that MSAC not recommend public funding for the proposed surgical items on the current evidence base.

4. ADDITIONAL INFORMATION

4.1 Is there anything that has not been raised in previous consultation input and that you have not mentioned elsewhere that you would like to tell us about?

If you are submitting on behalf of an organisation, MSAC would be interested in understanding whether members had an opportunity to input their views and, if so, how, and if the views expressed were endorsed by the organisation and, if so, how.

Additional comments:

Women Speak Australia considers that the central issue for MSAC is not whether adults may choose to undergo gender-affirming surgery. The question is whether the evidence is sufficiently robust to justify Medicare funding.

The proposed procedures cover a wide range of operations. They should be assessed individually, or in clinically meaningful groups, rather than under a single umbrella description.

WSA is particularly concerned about the distinction between short-term patient-reported satisfaction and evidence of durable long-term health benefit. Satisfaction is important, but it does not by itself establish comparative clinical effectiveness or show that a procedure should receive public funding. The evidence also needs to address complications, revision surgery, long-term function, and outcomes over an appropriate period of follow-up.

MSAC has already identified these gaps. At its April 2025 meeting it requested further work so that the clinical assessment is robust, reflects Australian practice, and is tailored to the Australian population. The application page states that 1754 will next be considered at the 26–27 November 2026 meeting, and that a further comprehensive assessment of comparative safety and effectiveness remains in progress. Executive summaries on models of care and the natural history of gender incongruence have been published, but that further safety and effectiveness assessment has not yet been completed.

WSA therefore considers it premature to establish Medicare items for these procedures before that assessment is finished and the remaining uncertainties have been adequately addressed.

This submission is made on behalf of Women Speak Australia. The views expressed are the endorsed position of the organisation. Members had the opportunity to contribute their views, and this response was prepared and endorsed through the organisation's usual process for consultation submissions.

4.2 How did you hear about this survey?

Through stakeholder and advocacy networks and information circulated concerning MSAC Application 1754.

4.3 Do you have any suggestions on ways to improve this survey?

The survey would benefit from clearer separation between the different surgical procedures and from providing respondents with Australian utilisation data and procedure-specific evidence before asking them to identify representative surgical pathways.

The questions concerning representative procedures also appear difficult to answer reliably without Australian data demonstrating the frequency with which particular combinations of procedures are undertaken.

Future consultation would be strengthened by providing respondents with the evidence base, including the comparative safety and effectiveness assessment, natural history assessment and models-of-care assessment, before seeking stakeholder views on funding.

5. DECLARATION OF INTEREST

Selection: No interests.

Women Speak Australia has no financial, professional or personal interest in MSAC application 1754. The organisation does not provide the proposed services, is not the applicant, and does not receive funding from the applicant or from providers of these procedures. This submission sets

out the organisation's endorsed view on whether the procedures should receive Medicare funding.

REFERENCES

1. **Medical Services Advisory Committee (MSAC).** *Application 1754 – Surgical Procedures for Gender Affirmation in Adults with Gender Incongruence.* Australian Government Department of Health and Aged Care. MSAC application page, including the April 2025 Public Summary Document and current consultation information.
<https://www.msac.gov.au/applications/1754>
2. **Zhang TR, Harel D, Rivera A, Shahnawaz S, Qian Y, Berry C, Zhao LC, Radix A, Bluebond-Langner R, Mmonu NA.** Incidence, Complications, and Long-term Outcomes of Gender-affirming Phalloplasty: Analysis of a Large Statewide Population-based Dataset. *Urology*. 2024;185:27–33. <https://pubmed.ncbi.nlm.nih.gov/38340965/>
3. **Tinajero JD, Liang DGK, Wasay S, Djordjevic ML, Di Taranto G.** The Evolution of Phalloplasty for Masculinizing Gender Affirming Surgery: A Systematic Review of Surgical Techniques and Complications Over the Past 25 Years. *Microsurgery*. 2026;46(6):e70273. doi:10.1002/micr.70273. <https://pubmed.ncbi.nlm.nih.gov/42528020/>