LOCATING A MORAL JUSTIFICATION FOR STATE FUNDED GENDER AFFIRMATIVE HEALTH CARE

Diksha D Sanyal[*]

The judgment of the Supreme Court in National Legal Services Authority v. Union of India while a landmark development in recognition of transgender rights, threw open a Pandora's box full of questions having moral and legal dimensions. One such question pertains to the obligation of the state to fund gender affirmative healthcare services such as sex reassignment surgeries ('SRS'). Given how prohibitively expensive they are, this paper interrogates whether the state has a duty to provide for such healthcare services and attempts to provide a normative justification for the same. In the process, it rejects the two most popular reasons advanced for state funding – the identity thesis, and the autonomy framework. Drawing from Amartya Sen and Martha Nussbaum's capability approach, it instead argues for a shift towards an assessment based on the impact healthcare services have on the 'quality of life' of transgender persons.

I. INTRODUCTION

In 2014, the judgment in *National Legal Services Authority* v. *Union of India* ('NALSA')[1] recognised the right to self-determine one's gender identity. This gave rise to obligations on the part of the State to provide for the rights and welfare of transgender persons. Among them, affordable healthcare is one of the most important obligations of the State which needs to be examined. Since India lacks a systemic right to health,[2] debates regarding whether the State should fund gender affirmative healthcare services are controversial. Gender affirmative healthcare services in the context of health include processes and interventions, both surgical and non-surgical in nature that allows

[*] Research Fellow, Vidhi Centre for Legal Policy. I would like to thank Apoorva Sharma, Senior Research Associate, Jindal Global Law School for his inputs and comments. However, all mistakes remain mine.

[1] National Legal Services Authority v. Union of India, (2014) 5 SCC 438.

[2] Madhav Khosla, *Making Social Rights Conditional*: *Lessons from India*, 8 International Journal of Constitutional Law (2010). Here, Khosla argues that the model of socio-economic rights adjudication in India is based on a conditional social rights model where violation is contingent on state action. In other words, if the state has undertaken a definite obligation in the form of building a school or a hospital but does not fulfil it, the court can hold the state accountable. However, in India, there is no systemic right to health that allows the courts to pass orders requiring the executive to build hospitals wherever there is a shortage. An analysis of the Supreme Court's record in right to health cases leads Khosla to the conclusion that such cases bear a greater similarity to tort cases than social rights adjudication.

a person to assert their internally felt gender identity. This includes, but is not limited to sex reassignment surgery ('SRS'), hormonal therapy and counselling.[3] Given the integral importance of 'gender affirmative healthcare services'[4] for transgender persons, this paper tries to locate a moral justification for including such healthcare services within the broader understanding of a right to health that states have an obligation to protect, provide and facilitate.[5]

The question pertaining to such inclusion is far more complex than it initially appears to be. SRS is often projected as merely comprising of cosmetic procedures[6] which in no way can be understood as a 'basic service' or one that is 'medically necessary'. Therefore, States are often reluctant to provide for it. On the other hand, many transgender rights activists argue that viewing such procedures as merely cosmetic stems from a misunderstanding of their importance to a transgender person.[7]

At the very core of this disagreement lies the question of whether we see gender as being rooted in the form of an immutable identity or a freely made choice based on autonomy and self-determination.[8] If we accept the argument that it is a part of an immutable identity, then such healthcare services cannot be legitimately denied to transgender persons. Variations of similar arguments have been used earlier to demand equality of rights vis-a-vis other markers of disadvantage like race.[9] For the sake of simplicity, let us name this as the 'identity thesis'. However, the identity thesis is often constrained and limited by a strict regulation of who fits within that particular identity box or label. A narrowly defined category of who can avail of SRS results in exclusion of many individuals with legitimate demands. On the other hand, loosening the rigidity of access causes apprehension that such services would become 'free for all' leading to possibility of misuse. This apprehension is heightened in cases of limited availability of state resources especially in developing

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3 Harry Benjamin International Gender Dysphoria Association, *Standards of Care*: *Fifth Version,* February 2001, available at http://www.cpath.ca/wp-content/uploads/2009/12/WPATHsocv6.pdf (Last visited on September 7, 2017).

4 Dean Spade, *Resisting Medicine and Remodelling Gender*, 18 Berkeley Women's Law Journal (2003).

5 Office of the High Commissioner of Human Rights, *CESCR General Comment No 14*: *The Right to the Highest Attainable Standard of Health* (*Art 12*), 22nd Session of the Committee on Economic, Social and Cultural Rights, (11/08/2000), E/C.12/2000/4, available at http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC14.pdf (Last visited on June 8, 2017).

6 Spade *supra* note 4, 22; Eric B. Gordon, *Transsexual Healing*: *Medicaid Funding of Sex Reassignment Surgery*, 20 Archives of Sexual Behaviour (1991).

7 Spade, *supra* note 4, 29. Transgender persons argue that gender affirmative healthcare services are medically necessary, contrary to popular perception. They are integral for their bodily self-acceptance and identity as well as acceptance within society. Since such services are integral for their identity and social acceptance, labelling such procedures cannot be labelled as 'cosmetic'.

8 Paisley Currah, *Gender Pluralisms under the Transgender Umbrella* in Transgender Rights 3, 10 (1st ed., 2006).

9 Rogers Brubaker, Trans: Gender and Race In an Age of Unsettled Identities (2016).

countries. Therefore, policy decisions require a fair and objective basis. The identity thesis, in the context of transgender rights, relies on an exclusively medicalized model of gender dysphoria which has proved to be pathologising the transgender identity rather than changing in a fundamental way the very concept of gender.[10] This is a psychological condition wherein one experiences deep discomfort in the sex they are assigned at birth since it does not match their self-perceived gender identity.[11] Instead of furthering the idea of gender as a spectrum, it reduces gender to boxes—just a third one this time.

Then again law is a lot less sympathetic to autonomy claims. After all, if the argument is that all human beings should be free to choose their versions of a good life and there is no accepted standard to differentiate one conception of the good life from the other, then autonomy fails to provide a significant basis for state funding.[12] It can at most be an argument against state interference in an already existing service. It does not help distinguish claims of a person wanting a cosmetic surgery versus someone wanting a sex reassignment procedure. This dualism and tension between identity and choice, between what cannot be controlled and what can, has shaped the debate on whether the state should fund gender affirmative healthcare.

However, I argue that not only is this dichotomy between identity and choice a mischaracterisation of the debate but also that it is largely irrelevant. There are fundamental shortcomings in the identity thesis as well as the autonomy argument and neither of them solely helps us find a moral basis for state funding of gender affirmative health care services.

I argue that when we think of state funding gender affirmative healthcare services we must break out of this false identity-choice dualism. I suggest that it is not essential for us to arrive at a conclusion of whether gender is a core aspect of identity or if the trajectory of a person's life itself is an inseparable mixture of choices and traits. Instead, I propose that from the issues needs to be looked at from the perspective of the state's obligation to improve the quality of life of all individuals. In other words, we need to assess whether such gender affirmative healthcare services have the potential to *improve the capability of a person to live more meaningfully.*[13]

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[10] Spade, *supra* note 4.

[11] Harry Benjamin International Gender Dysphoria Association, *supra* note 3.

[12] Michael Sandel, *John Rawls*, *The Right and the Good Contrasted* in Liberalism and its Critics: Readings in Social and Political Theory 49, 53 (1984). Kantian Liberals like Rawls, believe in being neutral between the different conceptions of the good life that does not attach a value judgment between different ways of living. Rather, they support the creation of a fair framework within which individuals can choose their own values and ends. Within this general framework of course, there lies much disagreement about which scheme of individual rights best support this neutral framework.

[13] Amartya Sen, Development as Freedom, (2000).

There exist two lines of argumentation favouring state funding of gender affirmative healthcare services. The most widely recognised view, which derives itself from the identity thesis, is that such surgeries are often a 'medical necessity'.[14] This is because many transgender persons are said to suffer from a condition known as 'gender dysphoria' or gender identity disorder.[15] Long term suffering from gender dysphoria could lead to depression and even suicide[16] and thus it necessitates timely medical intervention. However, in order to fit in the category of 'medical necessity' transgender patients have to fit into a neat, linear trajectory of gender non-conformity leading to dysphoria.[17] Strict application of this diagnostic model has the tendency of pathologising and dominating the trans narrative rather than being open to the many ways of being trans itself.[18] This requirement puts an onerous burden on persons seeking such services and thereby leads to under-inclusion.[19]

The second line of thought argues that SRS are essential services because they are integral to the autonomy, personal development and the right to self-determination that every person enjoys.[20] Such an approach is used by the European Court of Human Rights and is discernible in decisions such as *Van Kück* v. *Germany*.[21] Some scholars have argued that the right to gender identity can be considered to be analogous to the right to reproductive freedom. Similar to pregnancy, it is a profound personal choice, gender transition or simply the ability to express one's gender in a manner that is intimately connected to their personal identity is a fundamental aspect of bodily integrity and privacy.[22] In the United States, such a right derives protection from the due process right to privacy.[23]

As pointed out earlier, this argument does nothing to further the moral differentiation between a woman seeking cosmetic surgery procedure such as breast augmentation and a transwoman seeking the same procedure. This question was discussed by the Queen's Bench in *R.* v. *Berkshire West Primary Care Trust,*[24] where the Court assumes that the same motivations lie at the core of each of their claims which is autonomy and self-determination. Such

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14 Megan Leslie, *Boys will be Girls*: *Sex Reassignment Surgery and the Ethics of State Funding*, 13 Dalhousie Journal of Legal Studies (2004).

15 Harry Benjamin International Gender Dysphoria Association, *supra* note 3.

16 Psychology Today, *Gender Dysphoria,* available at https://www.psychologytoday.com/conditions/gender-dysphoria (Last visited on July 19, 2017).

17 Spade, *supra* note 4.

18 Matthew P. Ponsford, *The Law*, *Psychiatry and Pathologization of Gender Conforming Surgeries for Transgender Ontarians*, 38 Winsor Review of Legal and Social Issues (2017).

19 *Id*.

20 Franklin H. Romeo, *Beyond a Medical Model*: *Advocating for a New Conception of Gender Identity In the Law*, 36 Columbia Human Rights Law Review (2005).

21 Van Kück v. Germany, (2003) 37 EHRR 51.

22 Romeo, *supra note* 20, 744.

23 Romeo, *supra note* 20, 745.

24 R. v. Berkshire West Primary Care Trust, 2011 EWCA Civ 247.

a narrative also fails to adequately capture the oppression, exclusion and marginalization that trans persons face due to their gender identity as compared to cis- persons.

I argue that both of these arguments are on two opposite ends of a spectrum and the solution lies somewhere in between—as a tentative middle ground. At the outset, it is important to dispel the notion that each argument operates in isolation. Each strand of argument has certain commonalities in as much as they are part of the same spectrum.

In Parts II and III of this paper, I describe the two common arguments that are made for the state funding of SRS and also explain the potential shortcomings of each. Part IV lays down a new framework for gender affirmative healthcare based on a moral foundation.

II. THE IDENTITY THESIS

NALSA gave legal recognition to the 'third gender' and spoke of gender in relation to self-expression[25], equality and dignity.[26] It located these rights within the golden trinity of Articles 14, 19, and 21 of the Constitution which provide for equality,[27] freedom of speech and expression[28] and the right to life respectively.[29] It recognised not only, that all persons have a right to determine their gender identity, but more importantly, that all persons would be able to access rights available to their chosen gender irrespective of whether they have undergone a 'SRS or not.[30] The Court also directed states to ensure adequate provision of healthcare services to transgender persons.[31]

Recent legislative attempts to pass a law crystallising the rights of transgender persons, show a shift in the stance of the government on the question of funding SRS. While The Rights of Transgender Persons Bill, 2015[32] provided that such treatment would be given free of cost. The Transgender Persons (Protection of Rights) Bill, 2016[33] outlined the responsibilities of the government with regard to SRS and hormone therapy but was silent on whether such treatment would be completely government funded or would follow a public-private partnership model that might entail significant costs for persons wanting to undergo the surgery.[34]

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25 National Legal Services Authority v. Union of India, (2014) 5 SCC 438, ¶ 63.
26 *Id*., ¶ 123.
27 *Id*., ¶ 61.
28 *Id*., ¶ 69.
29 *Id*., ¶ 73.
30 *Id*., ¶ 135.
31 *Id*., ¶ 135.
32 The Rights of Transgender Persons Bill, 2015 (draft bill).
33 The Transgender Persons (Protection of Rights) Bill, 2016 (pending).
34 Transgender Persons (Protection of Rights) Bill, 2016, §16.

Given this development, it is necessary to question what sort of healthcare the state is bound to provide for transgender persons. Since the right to gender expression has been recognized by the Supreme Court in *NALSA,* to take these recognised rights to their logical conclusion, it would follow that the state must not only, *respect* this right but also, *facilitate* and *protect* it.[35] Otherwise the rights recognized in *NALSA* would be rendered meaningless.

As pointed out earlier, one of the most common justifications given for getting access to gender affirmative healthcare services is that it is 'medically necessary'.[36] It was with the establishment of Harry Benjamin International Gender Dysphoria Association ('HBIGDA') in 1979[37] that the idea of the medical necessity to transition was first recognised.[38] HBIGDA established the transsexual Standards of Care ('SOC') which laid down the criteria for diagnosis, management and surgery of transgenders.[39] HBIGDA is now known as World Professional Association for Transgender Health ('WPATH'). WPATH Guidelines deals with the treatment of gender dysphoria, which refers to distress or discomfort caused by the discrepancy between an individual's gender identity and sex assigned at birth.[40] Many transgender individuals describe this phenomenon as feeling "trapped" in the wrong body.[41] They experience discomfort with their assigned gender and often adopt the dress and mannerisms of the gender they wish to belong to.[42] The incongruence in the gender they are assigned at birth and the one with which they identify can cause mental distress too.[43]

At extreme levels, the distress caused by gender dysphoria meets criteria of classified mental disorder.[44] Gender dysphoria has been recognised as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders.[45] Transsexualism has also been recognized in the ICD Classification of Mental and Behavioural Disorders as endorsed by the 43rd World Health

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35 Office of the High Commissioner of Human Rights, *supra* note 5.

36 Seth A. Jacob, *The Determination of Medical Necessity: Medicaid Funding for Sex-Reassignment Surgery*, 31 Case Western Law Review (1980).

37 Harry Benjamin International Gender Dysphoria Association, *supra* note 3.

38 R. Gupta & A. Murarka, *Treating Transsexuals in India*: *History*, *Prerequisites for Surgery and Legal Issue*, 42(2) Indian Journal of Plastic Surgery (2009), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845370/ (Last visited on June 10, 2017).

39 *Id*.

40 Harry Benjamin International Gender Dysphoria Association, *supra* note 3.

41 Gupta & Murarka, *supra* note 38*,* 228.

42 *Id*.

43 *Id*.

44 Harry Benjamin International Gender Dysphoria Association, *supra* note 3.

45 Wynne Parry, *Gender Dysphoria: DSM-5 Reflects Shift In Perspective On Gender Identity*, Huffington Post April 6, 2013, available at http://www.huffingtonpost.com/2013/06/04/gender-dysphoria-dsm-5_n_3385287.html (Last visited on June 10, 2017).

Assembly in 1990.[46] Transsexual individuals are not inherently disordered.[47] However, if they are suffering from clinical gender dysphoria, then there are several treatment options available for the same.[48] This includes hormone therapy, SRS and psychotherapy.[49]

As per the WPATH Guidelines, there are certain preconditions for undergoing irreversible SRS procedure.[50] These include-

> "persistent and well-documented gender dysphoria in the patient, patient's capacity to make a fully informed decision and to consent for treatment, age of majority in a given country and twelve continuous months of hormone therapy as appropriate to the patient's gender goals."[51]

The aim of hormone therapy prior to SRS is to introduce a period of reversible hormonal treatment before the patient undergoes irreversible surgical intervention.[52] Lastly, the patient needs to spend twelve continuous months of living in a gender role that is congruent with their gender identity.[53] The rationale for this condition is to provide ample opportunity for patients to socially adjust in their desired gender role prior to undergoing irreversible SRS.[54]

Although the WPATH Guidelines is used and recognized internationally as a useful starting point for understanding the kind of medical care that is required by transgender persons, relying exclusively on these guidelines to determine access to healthcare comes with its own set of risks. For instance, many transgender people do not wish their identity to be pathologized as a disorder or dysphoria.[55] Emphasizing their importance has exaggerated and privileged a medical approach which is reflected in the insistence on proving

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46 Jack Drescher, *Queer Diagnosis Revisited*: *The Past and Future of Homosexuality and Gender Diagnosis in DSM and ICD* 27(5) International Review of Psychiatry 1, 5 (2015).

47 Pam Belluck, *W.H.O. Weighs Dropping Transgender Identity from List of Mental Disorders*, New York Times July 26, 2016, available at https://www.nytimes.com/2016/07/27/health/who-transgender-medical-disorder.html?mcubz=3 (Last visited on September 17, 2017).

48 *Id*., 5.

49 *Id*.

50 Britt Colebunders, Griet De Cuypere & Stan Monstrey, *New Criteria for Sex Reassignment Surgery*: *WPATH Standards of Care*, *Version 7*, *Revisited*, 16 International Journal of Transgenderism, 222, 225, (2016).

51 *Id*.

52 *Id*.

53 *Id*.

54 *Id*., 226.

55 Annette Güldenring, *A critical view of transgender health care in Germany*: *Psychopathologizing gender identity– Symptom of 'disordered' psychiatric/ psychological diagnostics*?, 27(5) International Review of Psychiatry, 27:5, 427, 431, available at http://dx.doi.org/10.3109/09540261.2015.1083948 (Last visited on June 13, 2017).

'medical necessity' conclusively to be eligible for SRS.[56] For instance, in the United States, the prohibitive cost of SRS has led some transgender persons to seek coverage under insurance systems such as Medicaid.[57] While courts were initially hesitant, in the late 1970s and early 1980s, some began to find SRS medically necessary to treat for gender identity disorder and ruled in favour of transsexual plaintiffs seeking coverage of the procedure under state Medicaid statutes.[58] As of 2014, the exclusion of transition related healthcare was rectified and is currently covered under Medicaid. This is, however, subject to determination in each case of whether the procedure is medically necessary to the individual and is not merely experimental.[59] The quest for legitimacy in accessing healthcare has always been articulated in the uncomfortable language of 'medical necessity', a standard which is seldom a one size fit all.

Meeting this requirement for insurance claims has the unfortunate consequence of distorting the lens through which we see the legitimacy of a claim to access itself. For instance, in *Van Kück* v. *Germany*, the question before the court was whether a trans person who underwent SRS was entitled to get a fifty percent reimbursement from her insurance company.[60] Her insurance company would only provide the reimbursement if it could be proved that her SRS was a 'medical necessity'.[61] The Regional Court and the Court of Appeal had initially rejected her claim on the grounds that there was no conclusive proof based on the expert opinion that the operation would actually improve her social situation and that she should have tried 'less radical means'.[62] Although, this decision was later overturned by the European Court of Human Rights,[63] it does show that the medical practice requiring proof of 'medical necessity' often puts the treatment out of reach for many transgender persons because not every transgender person experiences their relationship with their body in a pre-defined manner.[64] The list of preconditions before accessing sex reassignment procedures has always been controversial and disputed.[65]

It is common in such cases for the dispute to revolve around the word of one expert against another. This leads to the privileging of the medical discourse over that of the informed choice and consent of the transgender person.

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[56] Gupta & Murarka, *supra* note 38.

[57] Jacob, *supra* note 36.

[58] *Id*.

[59] Ariana Eunjung Cha, *Ban Lifted on Medicaid Coverage for Sex Change Surgery*, Washington Post May 30, 2014, available at https://www.washingtonpost.com/national/health-science/ban-lifted-on-medicare-coverage-for-sex-change-surgery/2014/05/30/28bcd122-e818-11e3-a86b-362fd5443d19_story.html?utm_term=.f2071bb05021 (Last visited on June 13, 2017).

[60] Van Kück v. Germany, (2003) 37 EHRR 51, ¶12.

[61] *Id*., ¶ 22.

[62] *Id*.,¶ 16.

[63] *Id*.,¶ 79.

[64] Spade, *supra* note 4.

[65] Jacob, *supra* note 36.

Even doctors are divided over the validity of SRS as a treatment for gender identity disorder in different cases.[66] As a result, medical opinions in the same case can vary widely, and courts hearing insurance claims often are called upon to weigh conflicting medical testimonies.[67] Unfortunately, courts are not well-equipped to make such a determination.[68] Due to this, the courts rely heavily on the opinion of the medical expert and link the realisation of benefits directly to a litigant's neat fit into the diagnostic model.[69] This shows that there is sufficient danger in seeing SRS purely from a lens of 'medical necessity'. Courts attach excessive weightage to medical opinions which often puts onerous requirements of proving 'medical necessity' and fitting transgender persons into some pathologising discourse. Additionally, the courts are in no position to adjudicate between conflicting medical opinions. Finally, the dominance of medical discourse within the legal jurisprudence leads to exclusion of the views of transgender persons and accords lesser significance to their choice and informed consent.

III. THE AUTONOMY FRAMEWORK

The second common justification given for state funding of SRS is based on the principle of autonomy and self-determination that all individuals have a right to exercise in a civilised society.

In *Van Kück* v. *Germany* for instance, the European Court of Human Rights ('ECHR') held that Article 8 of the ECHR, which guarantees right to private life to every individual,[70] was violated when a transgender person was denied fifty percent reimbursement by her insurance company against the medical expenses incurred for gender reassignment services. It was held that Article 8 casts a positive obligation on the state to respect human dignity and recognise the right to self-determination.[71] Gender identity and expression is one of the most intimate aspects of private life and therefore the burden placed on a person to prove medical necessity of treatment including the need for irreversible surgery in one of the most intimate areas of personal life, seems disproportionate.[72] The court used the language of 'personal development' as being integral to the concept of 'private life'.[73] Such an argument, though

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66 The World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender and Gender Non-Conforming People*, 54, 58 (7th ed. 2011), available at https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf (Last visited on September 17, 2017).

67 Khan, *infra* note 153, 399.

68 *Id*., 407, 410.

69 *Id*.

70 European Convention on Human Rights, 1950 ('EHRR'), Art. 8.

71 Van Kück v. Germany, (2003) 37 EHRR 51, ¶ 69.

72 *Id*., ¶ 72.

73 *Id*., ¶75.

rhetorically appealing, fails to respond effectively to the legal and policy challenge that state funding of SRS raises. Mainly, there exist three problems if we are to rely on such an argument in other jurisdictions.

The *first* is that such a right can only be realised where healthcare is already universal and there are no pressing questions pertaining to allocation of scarce resources.[74] In *Van Kück,* though the court went into whether SRS is integral for transgender people to realise their right under Article 8, the case as such was not dealing with State's allocation of limited resources.[75] It was, pertaining to whether a private insurance company should reimburse the claimant for the money she spent on SRS.

Second, the jurisprudence on privacy in the EU is advanced and such a broad interpretation of what a private life entails is not available in suitable to all jurisdictions[76]. In India for instance, whether a right to privacy even exists has been challenged before the constitutional bench and is awaiting decision.[77]

Third, while the language of autonomy, self-determination and personal development sound appealing, this interpretation is open to challenge on the ground that it is made from a point of subjective satisfaction. Claims of SRS that are grounded on the concept of 'personal development' will often be placed at par with similar other claims that have lesser legitimacy, but which are also theoretically integral to autonomy and choice.[78] This explains why people often compare SRS to cosmetic procedures because ultimately if the argument for both is 'autonomy', there is very little to distinguish these two.

Further, if an SRS is integral to the full realization of an individual's personal development, it casts a negative obligation on the state to not interfere or restrict anyone's right to avail such services.[79] However, it does not easily explain why a positive obligation is cast on the State for providing the

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74 *Id*.

75 *Id*.,¶8, 28.

76 James Q. Whitman, *The Two Western Cultures of Privacy*: *Dignity Versus Liberty*, 113 Yale Law Journal (2004).

77 Supreme Court Observer, *The Aadhar Act and The Right To Privacy*, available at http://scobserver.clpr.org.in/cases/aadhar-card-case/ (Last visited on June 13, 2017).

78 *See*, *e.g.,* Clare Chambers, *Are Breast Implants Better Than Female Genital Mutilation*? *Autonomy, Gender Equality and Nussbaum's Political Liberalism*, 7 Critical Review of International, Social and Political Philosophy (2004). Here, Chambers, with particular reference to Nussbaum's work on female genital mutilation highlights the existing tension between political liberalism, or tolerance for multiculturalism and certain universal values such as gender equality which are not easily reconciled, especially when it comes to controversial, but autonomously chosen decisions such as female genital mutilation.

79 A negative obligation is commonly understood as those obligations where the state must only refrain itself from violating a right. A positive right on the other hand, obligates a state to actively realize those rights including making resource allocation wherever necessary.

same.[80] This distinction becomes particularly important when one considers that there are limited resources a State might have and difficult choices have to be made regarding allocation of these resources.

An interesting consequence of seeing SRS procedures as cosmetic in nature can be seen in *R.* v. *Berkshire West Primary Care Trust*.[81] Here the question for adjudication before the England and Wales Court of Appeal was whether the denial of the State to fund a breast augmentation procedure to a trans woman was justified under Article 8[82] and Article 14 of the ECHR. While Article 8 provides for the right to a private family life, the latter is a right against discrimination.[83]

In this case, the appellant-petitioner was a trans woman who had been diagnosed with gender dysphoria and had undergone intensive hormonal treatment for few years[84]. Despite this she had not developed adequate breasts as she had hoped for which caused significant distress for her.[85] In 2006, she sought State funding for breast augmentation procedures from the respondent Berkshire West Primary Care Trust.[86] However, she was denied this on the basis of the internal policies of the respondent. This policy was upheld not only in the lower court,[87] but subsequently by the England and Wales Court of Appeal as well. The respondent, Primary Care Trust, recognized gender dysphoria as a medical condition and even had a Gender Dysphoria Policy and a Cosmetic Breast Surgery Policy in place.[88] Under the former, certain procedures were classified into core and non-core, low priority procedures. While core procedures were routinely funded, non-core procedures were funded in only exceptional circumstances.[89] Under this policy, a breast augmentation procedure was classified as 'non-core' which meant that the client would have to show exceptional circumstances to avail funds.[90] Exceptional circumstances meant that one would have to show "significant health impairment" and strong evidence of medical intervention being necessary for "improving the health status".[91]

The decision reached by the executive authorities was challenged on several grounds. One of the main arguments raised on behalf of the petitioner was that insufficient importance was given to a breast augmentation surgery in the case of a trans person who has undergone long term hormonal

80 *Id*.
81 R. v. Berkshire West Primary Care Trust, 2011 EWCA Civ 247.
82 European Convention on Human Rights, 1950, Art. 8.
83 European Convention on Human Rights, 1950, Art. 14.
84 R. v. Berkshire West Primary Care Trust, 2011 EWCA Civ 247, ¶ 3, ¶13.
85 *Id*., ¶ 6.
86 *Id*., ¶ 4.
87 R. (AC) v. Berkshire West Primary Care Trust, 2010 EWHC 1162.
88 R. v. Berkshire West Primary Care Trust, 2011 EWCA Civ 247, ¶18.
89 *Id*., ¶ 19.
90 *Id*.
91 *Id*.,¶ 23.

treatment as not receiving such treatment had left her in a state of "full womanhood". As the appellant herself evocatively expressed it[92]

> *"I have exceptional circumstances in that I have not developed proper breasts. For a male to female transsexual to have breasts is a very natural and moral request. It is also necessary to establish feminisation in my journey from male to female. My life will be one of turmoil if this is denied. Not fully knowing what or who I am and neither will those around me in everyday life. Hormones also make one impotent, cause the penis to shrink and libido diminishes to nil. Hormones have not changed my form, my body is still recognisably male after 11 years of treatment…I have to carry on as I am, unable to be a woman and hopeless sexually as a man."*[93]

However, such a procedure was denied to her on the ground that there was no clear evidence of clinical benefit.[94] Hence she was denied treatment under the Gender Dysphoria Policy.[95] In addition, she was not found eligible under the Cosmetic Breast Surgery Policy either because she was not able to prove her case as an exceptional circumstance.[96] While it was argued that setting such a high threshold for a trans woman was not feasible given the in-exact nature of the scientific development in this field, however the court dismissed her argument on the ground that

> *"I understand why the appellant feels aggrieved that the respondent funds the core gender reassignment procedures outlined in the Policy, notwithstanding the absence of evidence of limited clinical effectiveness, but does not also fund breast augmentation surgery for persons like the appellant (given, in particular, that there is no professional consensus on the classification of core and non-core procedures for gender reassignment). But the answer in law to that feeling is that the respondent, in exercising its statutory responsibilities, has to make very difficult choices as to what procedures to fund and not to fund and the choice made in this case is not irrational"*[97]

While it is questionable why the underlying policy itself was not challenged in the case, another argument that reflects the controversial

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92 *Id*., ¶ 26.
93 *Id*.,¶ 6.
94 *Id*., ¶ 29.
95 *Id*., ¶ 35.
96 *Id*., ¶ 65.
97 *Id*.,¶ 35.

reasoning in this case was the argument of discrimination. The respondent in deciding whether to fund the appellant's breast augmentation surgery had excluded her from the Gender Dysphoria Policy because they felt that not to exclude someone like her who had received hormone therapy would be to discriminate against a cis- woman. They felt that a "trans female with no/minimal breast tissue" stood on an equal plane with a "congenital female with no/minimal breast tissue" and therefore should not have an "automatic advantage (or disadvantage) to congenital females when applying for a cosmetic procedure".[98]

Although this was not an integral issue for the resolution of the case, the court nonetheless went on to debate the relative importance of this argument and passed a few notable observations on this point.[99] While extensive arguments were made on behalf of the appellant to impress upon the court the significant difference between a trans woman wanting a breast augmentation procedure and a cis- woman opting for such a procedure in as much as the former sought it as a treatment as a part of a medical condition, and for the latter, it was adventitious.[100] The respondent countered this by saying that gender identity was an irrelevant criteria and ultimately it did not matter whether a clinical condition was inherent or adventitious.[101] What mattered more was that ultimately the two cases had to be comparable clinically.[102]

The court summarised these view points and did not make any conclusive assessment of either claim. Instead, it took a hands-off approach and held that these were ultimately differing "points of view".[103] Given that the respondent's decision was based on reasonable grounds and did not in any way violate the law, the Court could not supplant its own understanding over the decision reached by the Executive Authorities.[104]

However, what was curiously missing in the arguments of the appellant as well as the observations of the court was an analysis that connected the medical condition of gender dysphoria to the very real discrimination and societal stigma faced by trans persons which sets apart the experience of the cis woman from the trans woman. The appellant had articulated this when she said that her life would be left in a state of "turmoil if this is denied. Not fully knowing what or who I am and neither will those around me in everyday life."[105] (Emphasis added). In popular discourse this is known as 'passing'.[106] Trans

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98 *Id*., ¶ 38.
99 *Id*., ¶ 52.
100 *Id*., ¶55.
101 *Id*.
102 *Id*.
103 *Id*., ¶ 56.
104 *Id*.
105 *Id*., ¶ 6.
106 Chris Godfrey, *Transgender Men and Woman Discuss the Politics of Passing*, available at https://www.vice.com/en_us/article/wd7enm/passing-when-youre-transgender (Last visited

individuals have often spoken about how their appearance often becomes the first site of discrimination in as much as it is a ground for the denial of access to public places or services if they fail to "pass off" as "normal"- gender binary-individuals.[107] This also leaves them vulnerable to violence.[108]

This shows us the danger of relying on an autonomy- self-determination framework. Both cis women as well as trans women could want breast augmentation surgery for a variety of reasons and while not denying that in certain cases cis-women could be clinically in a similar position to a trans woman wanting breast augmentation surgery, this framework misses out on something very crucial to the understanding of this issue- that is social discrimination and stigma. A cis woman will never know the tribulations and anxiety of being constantly questioned about one's gender identity- about the difficulties of being seen and accepted as a 'woman' by society. This key point, the effect of social discrimination and perception on the lives of trans individuals was critically missing in the arguments as well as the reasoning of the judges. This is a relevant factor that executive authorities must take into account when making critical decisions on whether to provide for breast augmentation procedures or not. I will explore this argument with greater depth in the next segment of the paper.

IV. THE QUALITY OF LIFE ARGUMENT: LOCATING THE JUSTIFICATION WITHIN THE CAPABILITIES FRAMEWORK

If medical necessity and autonomy are not the strongest arguments which can be advanced for justifying State funded gender affirmative healthcare, the question remains as to what can form a justification for it.

One argument which, in my opinion, is a substantial improvement over both the identity thesis and the autonomy framework is the argument for improving the 'quality of life' (QOL) for individuals, especially transgender persons, by providing them with gender affirmative healthcare services at state's expense.

This norm developed by the World Health Organization ('WHO') is a universally acceptable tool of evaluating medical interventions. In fact, the WHO defines QOL as 'an individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation

on September 18, 2017).

[107] Meredith Talusan, *Bruce Jenner Doesn't Need to Pass to Deserve Respect. No Trans Person Does,* The Guardian April 26th, 2015.

[108] Human Rights Campaign, *Violence Against the Transgender Community,* available at http://www.hrc.org/resources/violence-against-the-transgender-community-in-2017 (Last visited on June 13, 2017).

to their goals, expectations, standards and concerns'.[109] Such a non-biological approach to medicine and healthcare emerged in the late 1970s at a time when advances in medical science had increased the life-span of many individuals but was accompanied by chronic illnesses at an advanced age.[110] It was argued that increasing life-span or mortality therefore could not be the only goal of medicine.[111] As per the WHO, there are six domains to adjudge a person's quality of life. These include the physical, psychological, level of independence, social relationships, environment, and spirituality.[112]

Such a holistic approach to medicine paves the way for redefining the very concept of 'medical necessity' and incorporating other vital dimensions of a person's life. For instance, the ability to form meaningful, independent, social relationships, psychological well-being, to develop a sense of stability in their social environment etc.[113] All these factors, contribute immensely to the quality of life of a patient. Most importantly, this approach to medicine itself makes room for patient autonomy in deciding the course of their treatment by placing their choices, cultural and personal values at the forefront of medical care and intervention.[114]

I argue that the quality of life argument has strong parallels with Amartya Sen's and Martha Nussbaum's Capabilities Framework in as much as it recognizes that every patient is different in their ability to convert a given set of resources into valuable functionings and accordingly, needs a greater or lesser degree of assistance in developing their capabilities to enjoy a meaningful life.[115] In other words, that the Capabilities Approach can demonstrate how gender affirmative healthcare services can improve the quality of life of a trans individual. This improvement in the QOL, or development of capabilities, occurs at two levels.

The *first*, is the improvement of self-perception and confidence which deeply affects the ability of trans persons to enter into meaningful social relationships in a manner that helps them realise and fulfil their emotional and sexual requirements.[116] Many trans persons experience depression, and

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[109] The WHOQOL Group, *The World Health Organization Quality of Life Assessment*: *Position Paper from the World Health Organization*, 41 Social Science and Medicine (1995).

[110] Dan Brock, *Quality of Life Measures in Health Care and Medical Ethics in* Quality of Life, 95, 103 (1st ed., 1993).

[111] A.J. Carr, P.W. Thompson & J.R. Kirwan, *Quality of Life Measures,* 35 British Journal of Rheumatology (1996).

[112] The WHOQOL Group, *supra* note 109.

[113] Carr, Thompson & Kirwan *supra* note 111, 275.

[114] *Id*.

[115] Amartya Sen, Development as Freedom, (4th ed., 2000); Martha C. Nussbaum, Creating Capabilities: The Human Development Approach, (1st ed., 2011).

[116] P.T. Cohen-Kettenis & L.J.G. Gooren, *Transsexualism*: ***A*** *Review of Etiology*, *Diagnosis and Treatment*, 46 Journal of Psychosomatic Research 315, 327 (1999).

anxiety.[117] Higher suicide rates among transgender have also been documented.[118] Having access to gender healthcare services improves the quality of life as it has a positive impact on their sexual satisfaction[119], as well as their family and social life.[120]

The *second*, slightly controversial aspect is that, given the current ordering of the social and legal matrix, such services become 'socially necessary'[121] if a trans person is to lead a life that is free from violence, stigma and discrimination. This will be explained in detail later.

Before getting into the two arguments, I will discuss the Capabilities Framework. Thereafter, I will elaborate on these two arguments and justify why such an approach is an improvement over the identity thesis and autonomy framework.

The Capabilities Theory appeared as a normative, theoretical framework for public policy in the context of international development.[122] It emerged not only as a critique to the existing theories of justice such as the Utilitarian Theory and the Rawlsian concept of Distributive Justice, but also became an illuminating, comparative tool to assess how well people were doing in their lives across cultures, communities and nations.[123] It provided a theoretical matrix within which to ask questions about well-being, development and socio-economic justice.[124]

To understand this theory, it is important to distinguish between functionings and capabilities. As per Sen, functionings are nothing but 'beings and doings',[125] that is the ability to be certain things such as educated and well-nourished as well as *do* certain things such as travel, work, or start a family life.[126] In other words, functionings are the things we are able to accomplish or achieve. Capabilities, on the other hand is the *freedom* to be able to make

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[117] American Foundation for Suicide Prevention, *Suicide Attempts Among Transgender and Gender Non-Conforming Adults*, available at https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf (Last visited on July 24, 2017).

[118] *Id*., 8.

[119] Constanza Bartolucci, Esther Gomez, Manel Salamero et al., *Sexual Quality of Life in Gender Dysphoric Adults Before Genital Sex Reassignment Surgery*, 12 Journal of Sexual Medicine 180 (2015).

[120] G. De Cuypere, E. Elaut, G. Heylens et al., *Long Term Follow Up*: *Psychological Outcome of Belgian Transsexuals after Sex Reassignment Surgery*, 15 European Journal of Sexual Health 127(2006).

[121] This term has been borrowed from Susan Etta Keller, *Crisis Of Authority*: *Medical Rhetoric and Transsexual Identity*, 11 Yale Journal of Law and Feminism (1999).

[122] Nussbaum, *supra* note 115*,* Preface, x.

[123] *Id*., xi.

[124] *Id*., 18.

[125] *Id*., 18.

[126] *Id*.,18.

these choices.[127] For instance, if I wish to go watch a play in a theatre, I have the capability to do so only if I have the means of transport, money to buy the ticket, and at the most basic level, the senses of sight and hearing to be able to enjoy the play. Whether I end up finally exercising this choice, is a measure of functioning. Therefore, capabilities are a person's real freedom or opportunity to be able to achieve a functioning which a person values.

Therefore, the ideal metric for evaluating a socio-economic developmental policy is to analyse what combination of capabilities a person has rather than assessing their level of resources or whether it promotes an overall utility.[128] Looking at the bundle of capabilities that a person has helps one to holistically determine the quality of life that a person has the means to attain.[129] For instance, if a trans woman wishing to achieve a degree of emotional and sexual satisfaction with people of the male gender might find it difficult to achieve that till she undergoes a SRS that helps her identify as a sexual being in the manner that is consistent with her internally perceived self-identity. However, if she finds herself constrained not so much by lack of resources but due to prevailing social attitudes and medical policies which are shaped by them, she is still experiencing deprivation. The capabilities approach is therefore able to capture a dimension of degradation in her quality of life that is missing in other tools of analysing socio-economic developmental policies which are resource oriented. The strength of this approach lies in its recognition of difference between different human beings in converting a given set of resources into a valuable functioning.[130] This capacity for individuation allows one to assess the quality of life with some degree of nuance that is not possible using other theories.[131]

The Capabilities Approach was instrumental in altering an income oriented approach towards well-being and formed the theoretical groundwork on the basis of which the Human Development Index came to be formulated.[132] However, Sen kept his theory open-ended in as much as he did not specify which aggregate of capabilities truly constituted the 'good life'.[133] This is where Martha Nussbaum, by supplying a list of capabilities that should be a part of every country's Constitution manages to strengthen Sen's approach. She is able to formulate such a list based on the amorphous but intrinsically important notion of human dignity such that denial of any of the capabilities on her list would be a denial of human dignity itself.[134] Nussbaum suggested ten important capabilities. These include life, bodily health, bodily integrity, senses, imagina-

[127] *Id*., 19.
[128] Sen, *supra* note 115, 19.
[129] *Id*., *20*.
[130] Nussbaum, *supra* note 115, 24.
[131] *Id*.
[132] *Id*., 17.
[133] *Id*., 19.
[134] *Id*., 29.

tion and thought, emotions, affiliation, practical reason, other species, play and control over one's environment.[135] These constitute a basic list of capabilities that every government must guarantee its citizens and as per Nussbaum, constitutes a thick, vague conception of the good.[136] However, she argues that since each of these capabilities is important in itself, they cannot be traded off against each other.[137]

The list proposed by Nussbaum contains both *internal* capabilities and *combined* capabilities. The former refers to a person's cultivated personality, knowledge, intellectual and emotional capacity.[138] The latter refers to the complex interaction of internal capabilities with the opportunities available in the social, political and economic environment an individual finds herself in.[139] This distinction is important since it helps one to distinguish, as Nussbaum puts it, "between two overlapping but distinct tasks of a society."[140] Therefore, while a society which might be able to develop the internal capabilities of its citizens, is not a just one until it also extends the opportunity or freedom to put these internal capabilities to use in the prevailing social-political environment.[141] At the same time, it is important to distinguish between internal and innate capabilities.[142] Innate or basic capabilities refers to the basic sensory, auditory, speech and thought equipment that human beings possess and which can be later cultivated to develop ability to speak, use language, thought and imagination constructively in a human way. Each person, in this theory, is an end in themselves.[143]

Drawing support from this foundational analysis of capabilities approach, I now proceed to further my argument using the idea of capabilities.

The primary argument is that gender affirmative healthcare services, including hormonal treatment, psychological counselling and SRS have notably caused a significant improvement in the QOL of individual. As mentioned earlier, such healthcare services have had a proven positive outcome pertaining to the sexual health, and family and social life of trans persons.[144]

In the language of the Capability Approach this would entail improving the capacity of bodily integrity, emotion, practical reason and affiliation. As per Nussbaum, bodily integrity refers to the freedom of mobility, to

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[135] *Id*., 33,34.
[136] *Id*., 34.
[137] *Id*., 35.
[138] *Id.,* 21.
[139] *Id*., 20.
[140] *Id*., 21.
[141] *Id*., 22.
[142] *Id*., 24.
[143] *Id*., 35.
[144] Bartolucci, *supra* note 119; G. De Cuypere *supra* note 120.

not be assaulted in any manner and have the opportunity for sexual satisfaction among others.[145] The capacity for emotion on the other hand is the ability to be able to love, grieve, experience justified anger etc.[146] Such a capability would be hindered when there are laws in place which prevent certain kinds of human association and interaction.[147] Amongst her list of capabilities, Nussbaum puts special emphasis on practical reason and affiliation.[148] Both these capabilities incorporate the notion of human dignity directly into the list itself. Practical reason refers to the ability to formulate one's own conception of the good and to be able to plan one's life accordingly.[149] By denying access to such healthcare services, the State is hindering their capability to shape their personal, intimate life decisions in accordance with their own conception of the good and within the existing social and legal realities that are central to their life. Thus, their capacity for practical reasoning is hindered.

Affiliation refers to having the capacity to engage in various forms of social interaction and being treated as a dignified human being worthy of respect. Anti-discrimination laws, for instance, are an example of what it means for a society to promote the capacity for affiliation.[150]

It is observed that not only do many who undergo such surgery report post-operative satisfaction with their altered bodies but also note greater psychological stability which is the pre-cursor to socially stable relationships.[151] Therefore, in terms of Nussbaum's list, those who receive such gender affirming surgery or other procedures are able to enhance their capability for bodily integrity, emotions and affiliation. In fact, Nussbaum categorically mentions that providing healthcare that neglects the need to maintain zones of personal privacy is a violation of the capability of both affiliation and practical reason.[152] At an intimate and personal level, the desire to undergo transition stems from the realization of the fact that the kind of life they envision for themselves in their internally chosen gender identity will always be out of reach if they do not attain a degree of psychological stability with their bodies, identity, and social environment first. Their capacity to bodily integrity in the form of being able freely enter into sexual relationships is hindered because of the psychological incongruence they experience with their own bodies.

This leads us to the second argument, which is that given the current social and legal ordering along gender binarian lines, it is essential for the

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145 *Id*., 33.
146 *Id*., 33.
147 *Id*., 33.
148 *Id*., 39.
149 *Id*., 34.
150 *Id*., 34.
151 Cuypere, *supra* note 120.
152 Nussbaum, *supra* note 115, 39.

state to provide such services as they are 'socially necessary'[153] for trans persons to lead a life free from stigma, discrimination, violence and harassment.[154] Here, Nussbaum's differentiation between internal and combined capabilities is particularly useful. Having access to gender affirmative healthcare services is useful for not only improving one's internal capabilities of emotion and bodily integrity but also provides them the means of planning their lives in accordance with their vision of the good in a society characterised by rigid gender binarian categories. Allowing them to do so enable them to navigate the complex terrain of socio-legal barriers and lead a life that they have reason to value. Of course, this does not obliterate any of the responsibilities that the state continues to have towards dismantling those very barriers itself.

It is a well-established fact that transgender persons are a socially and economically marginalized group.[155] In this context, NALSA judgment which recognises the rights of transgender persons is only an inchoate step. What will indeed determine how these rights are exercised is the extent of access to facilities to people as per their chosen gender identity which is made available to them regardless of whether they have undergone SRS. Furthermore, social acceptance and change in the underlying legal and social matrix will play a huge role in determining how these rights are exercised.

India Exclusion Report, 2013-14 notes that transgender people have to continuously deal with the fact that their gender identity is disputed, contested, disbelieved or fully denied by the society at large.[156] Furthermore, this community is faced with a limited range of options for living with an iden-

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[153] Susan Etta Keller, *Crisis of Authority*: *Medical Rhetoric and Transsexual Identity*, 11 Yale Journal of Law and Feminism (1999); Liza Khan, *Transgender Health at the Crossroads: Legal Norm, Insurance Markets and the Threat of Healthcare Reform*, 11 Yale Journal of Health, Policy, Law and Ethics (2013). In this paper, Khan makes an argument for recasting medical necessity to recognize the social and legal discrimination, violence and marginalization have to face. She also emphasizes on the importance of taking into account the legal implications of transition especially in cases of marriage, child custody etc. *See also* Gowri Ramachandran, *Against the Right to Bodily Integrity*: *Of Cyborgs and Human Rights,* 87 Denver University Law Review (2010) (arguing that there is an inherent social value in allowing transgender persons to undergo gender transition as this reinforces positive examples which can facilitate cultural and social change. She writes*, "For instance*, *transgender persons who choose to obtain body modifying surgery or engage in body disguising dress practices are changing their bodies, rather than the environment, both of which are probably contributors to gender identity disorder* ("*GD"*). *It is unclear why the insistence that we change the environment*, *rather than permitting transgender persons to change their bodies and clothing, is a superior response to GID. This is especially so when we realize that awareness of and respect for the bodies of transgender persons may contribute to positive changes in the cultural environment*.)

[154] CLPR Trust, *CLPR| TransForm National Conference – Transgender Rights and Law: Gee Semmalar*, January 16, 2017, available at https://www.youtube.com/watch?v=jc2p2ySX0gA&t=1348s (Last *visited on* July 24, 2017).

[155] Centre for Equity Studies—Shubha Chacko & Arvind Narrain, *Transgenders* in India Exclusion Report 2013-14 (1st ed., 2014).

[156] *Id*.

tity that is both felt within as problematic and continuously contested without by the society.[157] Using Iris Young's frame of analysis,[158] such a process of exclusion from participation in social life would constitute marginalisation.

Further, despite *NALSA,* the vast body of law, operates on a gender binary framework. Even now, it is easier to access rights within one recognized gender identity of male or female as compared to transgender or third gender.[159]

Transgender persons who experience discomfort in the sex assigned to them at birth seek to transition. For instance, a recent survey conducted by the Kerala government showed that most trans persons seek gender affirmative healthcare services to be able to identify in the gender of their choice.[160] However, such services are not just essential to alleviate a sense of personal discomfort experienced as a result of the incongruence between the physical and psychological identity of a trans person. It is a sad truth that to gain access to public spaces, jobs and opportunities in one's chosen gender identity, it is crucial for a trans person to obtain a psychiatric evaluation designating them to be suffering from the gender identity disorder and recommending a sex change operation.[161] Often without the requisite certificate they are unable to obtain other identity documents.[162] This, despite the fact that the Supreme Court in *NALSA* recognized the right to self-determine one's gender identity and held that in doing so the state could not insist on a SRS. Therefore, in the absence of any concrete law and administrative procedures, access to gender affirming health services, are therefore often the only way for transgender persons to participate effectively in society in their chosen gender identity.[163]

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[157] *Id*., 185.

[158] Iris Marion Young, *Five Faces of Oppression*, 1, 18 (2014), available at http://www.sunypress.edu/pdf/62970.pdf (Last visited on June 18, 2017). In this article, Young elucidates the meaning of oppression. She argues that oppression is not necessarily only a tyrannical, coercive power exercised by a ruling group over its subjects but can also exist in the form of 'systemic constraints' embedded in the "every-day practices of a well-intentioned, liberal society". These constraints are reinforced through norms, habits, symbols and institutional rules. Thus, she makes the point that oppression is structural rather than always being intentional. She identifies five distinct forms of this oppression. These include Exploitation, Marginalisation, Powerlessness, cultural imperialism and violence. Marginalisation according to Young is the most danger of oppression since it excludes certain groups of people from any useful participation in social and economic life. This leads to the material deprivation of that group. Though Young elaborates on this concept in the context of race, it is equally applicable to other non-racial forms of discrimination. Transgenders in India, especially *Hijras* have long been denied access to equal opportunities in the job market because of social stigma and societal prejudice. In the absence of educational opportunities and employment, most *Hijras*have to resort to sex-work and begging in order to sustain themselves.

[159] *See*, *e.g*., Nangai v. Supt. of Police, 2014 SCC OnLine Mad 988 : (2014) 4 MLJ 12.

[160] T.K. Devasia, *Why Kerala's Free Sex-Change Surgeries Will Offer a New Lifeline for the Transgender Community*, Scroll.in March 19, 2016.

[161] CLPR Trust, *supra* note 154.

[162] *Id*.

[163] International Commission Of Jurists, "*Unnatural Offences*": *Obstacles to Justice in India Based On Gender Identity and Sexual Orientation,* 19 (February 2017).

Moreover, non-binarian ways of self-presentation or having anatomical features that deviate from society's perception of normal can lead to harassment, violence and discrimination in all spheres of life.[164] Concealing their transgender identity with gender-conforming behaviour and presentation is the only available way to avoid the danger of being attacked.[165]

Further, without transitioning, a host of civil rights such as those relating to marriage, adoption, inheritance are out of reach for trans persons since there is no legislative framework that adequately clarifies the rights available to such persons under the framework of Indian laws which are gender binary in nature.[166]

The criticism faced by such an argument is that individuals should not be required to alter themselves to fit into society's perception of 'normality'.[167] However, such an argument ignores the fact that most, if not all individuals try to fit in within the societal settings they find themselves in one way or the other. The identification of certain characteristics as 'male' or 'female' is a social construct.[168] However, it is on the basis of this construct that the entire society, its laws, relationships and opportunities are structured. While this may be an undesirable state of affairs, it can by no means change overnight. To then deny people a reasonable opportunity to plan their lives in a manner that allows them to live their lives fully is an unjustifiable outcome. As pointed out earlier, in the absence of necessary laws and administrative procedures, those identifying outside the gender binary are often left with little means to exercise their rights meaningfully.[169] Their only recourse currently is to approach the judiciary for relief.[170] Given this, SRS and other gender affirmative healthcare services could significantly improve the QOL of transgender persons. It can enable them to participate in social, economic and political life in a more fulfilling manner. However, the lack of state funding for SRS and

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164 Centre for Equity Studies, *supra* note 155.

165 CLPR Trust, *supra* note 154.

166 43rd Standing Committee, Sixteenth Lok Sabha, *Report on the Transgender Persons (Protection of Rights) Bill, 2016* (July 2017).

167 Khan, *supra note* 153, 387.

168 Judith Butler, Gender Trouble (1st ed., 1990).

169 CLPR Trust, supra note 154.

170 *See e.g.*, the judgment of the Calcutta High Court in Atri Kar v. Union of India, 2017 SCC OnLine Cal 3196, order dated 16/03/2017. Here, a trans person who was the petitioner had to move to court because there was no 'third gender' in the examination form of a National Bank. She was thus denied the opportunity of appearing for the examination. This shows the difficulty faced by individuals who do not fall within the gender binary category or have been unable to obtain identity cards displaying their chosen gender. Till date, there are no set procedures in place for non-gender conforming or 'third' gender candidates. Nor is there any recognition or accommodation of those who might be undergoing gender transition at the time of appearing for the examination. Being non-binary therefore leads to the creation of legal uncertainty in status, rights and opportunities.

other gender transition services renders them inaccessible for many within the transgender community.[171]

One relatable example in this context is the state funding for schemes such as the 'Assistance to Disabled Persons for Purchase/Fitting of Aids/Appliances' provided by the Ministry of Social Justice and Empowerment.[172] It was conceived in 1981 to provide "durable, sophisticated, scientifically manufactured, modern, standard aids and appliances" to disabled persons.[173]

The main objective of this scheme is to assist the needy and disabled persons in procuring durable, sophisticated and scientifically manufactured, modern, standard aids and appliances to promote physical, social, psychological rehabilitation of Persons with Disabilities by not only reducing the effects of heir disabilities but at the same time, enhancing their economic potential.[174] Assistive devices are given to persons with disabilities with an aim to improve their independent functioning.[175] The scheme also includes essential medical/surgical correction and intervention, for the hearing and visually disabled as well as those who have orthopaedic disability.[176]

Therefore, reconstructive, corrective surgeries are already a part of state provided medical aid.[177] Although one can make the argument here that these schemes are provided because they directly affect the functionality of certain persons to contribute meaningfully to society, the same argument can nonetheless be made for transgender persons themselves. Such persons are often denied meaningful ways to participate in life because of their desire to transgress rigid gender norms and being denied the opportunity to express themselves in their chosen identity.

Therefore, it is important to recognize that certain surgical and medical interventions though not understood as being a 'medical necessity' in the manner of being life threatening are nonetheless funded and provided

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171 Yadavendra Singh, Abhina Aher, Simran Shaikh, et al., *Gender Transition Services for Hijras and Other Male-to-Female Transgender People in India: Availability and Barriers to Access and Use,* 15 International Journal of Transgenderism (2014).

172 Scheme of Assistance to Disabled Persons for Purchase/Fitting of Aids/Appliances, 2014.

173 *Id.,* 2.

174 *Id*.

175 *Id*.

176 *Id*., 3.

177 Scheme of Assistance to Disabled Persons for Purchase/Fitting of Aids/Appliances, 2014, 5. The government currently funds cochlear implants for the hearing disabled. A host of other plastic surgeries which are reconstructive in nature are performed in different state-run government hospitals as well. *See*, *e.g.*, Umesh Isalkai, *Sassoon Makes Plastic Surgeries Affordable*, Times of India January 11th, 2012, available at http://timesofindia.indiatimes.com/city/pune/Sassoon-makes-plastic-surgeries-affordable/articleshow/11442769.cms (Last visited on 23 September 2017).

by the state to improve the quality of life of certain individuals and classes of people.

It is important to note, that while Nussbaum's list gives us an idea of what capabilities are important for a government to pursue, it does not however, set any threshold or the extent to which it would be just for each capability to be realised.[178] Although the nuances and practicalities of the approach are workable through the competent legislative bodies, the purpose of this paper is to provide a normative justification for using the capabilities approach to argue for *why,* as a first step, the state should provide for such services in the first place.

What is distinctive about drawing a parallel with the Capabilities Framework is that unlike the identity thesis and the autonomy argument, this approach locates the normative justification for state funding in an analysis of marginalisation, stigmatisation and violence experienced by trans persons due to the interaction of their personal attributes with an oppressive socio-legal environment. Given the assumptions of gender binaries on which the entire foundation of our society is built, not being allowed to transition can lead to marginalisation and exclusion from a host of legal rights as well as more basic rights such as access to public spaces and acceptance in society. The option of surgery may prove to be a key way therefore for them to improve their quality of life by enhancing their capabilities for bodily integrity, emotions, affiliation and practical reasoning. Such an analysis of social conditions that contribute to creating disabling conditions is missing in the other approaches. Further, it maps in a concrete manner how such healthcare services can improve the capabilities of a trans individual themselves. By providing them the opportunity to experience better social relations, sexual relationships and a stable psychosocial atmosphere, it elevates their level of wellbeing. In doing so, it moves away from a restrictive physiological/biological approach to health.

By emphasising on the manner in which SRS is a 'medical necessity' due to gender dysphoria, the identity thesis is unable to break out of the rigid, pathologising discourse on trans identity that only serves to see it as a medical condition intrinsic to a transgender person. At an abstract level, this preserves the way of looking at trans lives as 'others'. It does not promote a deeper understanding of the normality of gender variance, transgression of gender norms and the potential for queerness that exists in all of us in the way we negotiate our relationship with gender in our everyday lives.

The QOL approach on the other hand puts a patient's own perception and values at the forefront. It relies less on pathologisation since the focus shifts from an understanding of strictly what is 'medically necessary' which is

[178] Nussbaum, *supra* note 115, 42.

onerous to prove, to one which focuses on improving the QOL. This does not completely do away with the requirement of medical interventions, but rather it seeks to reorient its goal.

Drawing from the Capabilities theory however avoids the pitfalls of both these approaches. In recognizing the stigma and marginalisation experienced specifically by trans persons it brings a certain depth and legitimacy to the demand put forth by trans persons for state funded gender affirmative healthcare services while also simultaneously re-orienting the goal of medicine towards trans patients.

V. CONCLUSION

Viewing the justification for gender affirmative healthcare through the lens of the 'Quality of Life' argument would shift focus from the value of medical procedures to one's physical health to its value in allowing the patient to function better and live in our society. It is unfortunate that gender non-conforming individuals are the subject of harassment and marginalisation. The value of gender affirmative healthcare lies in its ability to improve the experience and self-perception of those individuals who see their bodies and themselves differently as against labels society has assigned to them. This forms an integral aspect of their dignity itself. For them, these services are not just an attempt to become a better version of themselves; instead it is an attempt to finally be comfortable in their own skin. Those who undergo SRS for instance, often report a better experience vis-à-vis their social and personal relationships. Gender affirmative healthcare services have the potential of improving the quality of life.

Further, the danger in seeing SRS purely as a 'medical necessity' lies in its attaching disproportionate weightage to often conflicting medical opinions which puts onerous requirements on proving oneself to fit into a near diagnostic model. The dominance of medical discourse within the legal jurisprudence sometimes leads to the exclusion of the views and informed consent of the transgender person themselves.

This paper is not an argument to do away with the need for medical tests and psychological evaluations, which are required for better understanding of the distinctive circumstances of each individual. However, the proposed framework can serve to make these tests less onerous, focussing more on patient autonomy and informed consent and the role such services can have for a person's overall well-being. Therefore, rather than playing the role of a gatekeeper of identities, medical science would play the role of an enabler.

Existing justifications for state funded gender healthcare services also omits to highlight the socio-legal discrimination, violence and stigma

faced by trans persons as a reason for their wanting these healthcare services. The world outside the gender binary is a world of legal uncertainties. Therefore, denying trans individuals the opportunity to avail of transitioning services denies them the opportunity to plan their life with any certainty.

While some may argue that post NALSA, a transgender person can self-determine their gender identity and can access legal rights in their chosen gender identity but in reality, this is far from the truth. Rights will not be readily available to trans persons in the absence of a legislative framework. Law in our country are built on underlying notions of gender binary. This legal structure is complemented and contributed to by our societal beliefs and views which understand gender as binary and not as a spectrum. Thus, belonging and operating within the gender binary has important legal and social consequences. Therefore, being allowed to freely access gender affirmative healthcare serves an important moral function and allows transsexuals to choose the treatment they require as needed and validates their experiences as gender variant.

Lack of clarity in basic processes for, say, name and gender identity change has allowed bureaucrats to supplant it with their own procedures. Although unfortunate and in need of remedy, one cannot deny the hurdles this creates for trans persons and the subsequent impact it has on their health. In addition, apart from specific rights, more basic rights such as access to public spaces and acceptance without harassment become possible when one fits into the safety and comfort of the binary. Though not advocating for a binary world in any manner, few can disregard the value of acceptance and the impact this has on one's well-being.