



ORIGINAL ARTICLE

Demands for Health Care and Barriers to Health Care Access Among Transgender and Nonbinary People in Chile: A Nationwide Survey

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Abstract

Purpose: This article reports the results of the first national survey carried out in Chile on health care for transgender and nonbinary people. Knowledge of their main demands for interventions, and of the barriers to care that they face, is currently lacking. We seek to address this gap and provide data useful to policymakers in improving care for this population.

Methods: The survey was conducted between January 2021 and June 2022. The sample, consisting of 1116 participants, was recruited through social networks and transgender-rights organizations. Using chi-squared tests, statistically significant differences between items of interest and relevant sociodemographic information were identified. Data collected are reported based on frequencies (*f*) and percentages (%), and in contingency tables for the analysis of inter and intragroup variations.

Results: Individual psychological attention (54.5%) and endocrinological follow-up (41%) were the interventions most received by the full sample. Of all treatments desired but not yet received, speech therapy headed the list (50.8%). Costs (74.2%), long waiting lists (34.6%), and insufficiently trained professionals (30.8%) were significant barriers to access. These percentages varied according to both participants' gender identity and area of residence.

Conclusion: Provision for the care needs of the population surveyed was sparse. Differences in demands and access barriers were found between those declaring a female or male gender identity, and those whose identity was nonbinary or gender fluid, as well as between those enrolled in a public versus a private health system. These variations should be carefully weighed in developing effective trans and nonbinary health policies.

Keywords: barriers to health care access; demands for health care; nonbinary gender; transgender

Introduction

Multiple data point to the difficulties faced by the trans and nonbinary population in accessing appropriate medical care,^{1–6} both for general health problems and in providing for their specific care needs.^{7–10} Difficulties include the denial of care, professionals with little or no knowledge about trans health needs, and discriminatory treatment. Examples of the latter are inappropriate ver-

bal engagement, disbelief of their experiences and knowledge, questioning of their identity, exclusion of their identities in official forms, and mockery.^{11–14}

The Chilean health system is mixed, mainly consisting of a public insurance scheme known as the National Health Fund (FONASA), and a private one that consists of so-called Institutions of Health Insurance (ISAPRES). Seventy-eight percent of the country's

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population is enrolled in FONASA, a fund that includes two care modalities: institutional (public establishments) and free choice (private centers with copayment).¹⁵ In this context, the existing gender-specific health services are dissimilar in their characteristics, costs, and coverage, which adds to a significant territorial inequality. In the public network, although some gender identity units currently operate free of cost, they are self-managed services, with variable support and institutionalization, insufficient budget allocations, long waiting lists, and a heterogeneous portfolio of services. For its part, the private system charges high rates for required procedures, making them unaffordable for a large part of the population.

Relevant and quality health care for the demands of the trans and nonbinary population is an urgent need. The specialized literature consistently reports the negative mental health consequences for this population of the lack of timely psychological^{16–19} and medical support.^{20–23} It also describes general health vulnerabilities^{24–26} that include the negative effects of self-administered medications, bodily interventions performed outside health spaces such as industrial silicone injections, unattended reproductive health problems, a high prevalence of HIV, and an elevated suicidal risk.^{27–29}

To build socio-sanitary spaces able to attend to the care needs of trans and nonbinary people, a pertinent and representative diagnostic picture of this population at a national and local level is essential. In this article, we present the results of the first and only National Trans Health Survey conducted in Chile. The survey's objective was to explore the experiences of trans and nonbinary people in public and private health services.

Materials and Methods

The National Trans Health Survey (Chile)

An *ad hoc* questionnaire was prepared by the research team after collecting national and international evidence. The instrument was submitted for the judgment of experts, including researchers close to the topic and people from the trans and nonbinary community, to evaluate the relevance and appropriateness of the items, indicators, and response choices.

The final version of the National Trans Health Survey was a 53-item questionnaire focusing on three dimensions: health care and services demanded, access barriers to health care, and experiences of violence and discrimination in health centers. The questionnaire—in online format and self-applied through a web platform—was

shared through the project's social networks and disseminated by Lesbian, Gay, Bisexual, Trans, Intersex, and Queer (LGBTIQ+)* organizations and activists on various digital platforms.

To determine the respondents' gender, four possible gender identities were provided as answer choices: female, male, nonbinary, and gender fluid. Two other gender categories were included: gender not declared, and “other”—which included the option of writing a specific or more accurate answer.[†] The present analysis focuses on the four gender identities mentioned above, due to their greater presence in the sample.

The sample

The sample analyzed consisted of 1116 people who replied to the National Trans Health Survey between January 2021 and June 2022. To participate in the study, they satisfied three inclusion criteria: self-identification as a trans or nonbinary person, at least 18 years of age, and residence in Chile.

Statistical analysis

After coding, a univariate descriptive analysis was applied to the identification variables and the previously described topics of interest, using SPSS 28.0 software. Frequencies (*f*) and percentages (%) are used in the report. With the aim of exploring inter and intragroup variations, a bivariate analysis was carried out by cross-tabulating the information collected on experiences of access and care in the health system against the variables of gender identity, territory, and health service. A chi-squared test was used to detect statistically significant differences ($p < 0.01$ or $p < 0.05$), and the Pearson's correlation coefficient (*r*) was calculated to measure the strength of the associations. In this article, only statistically significant relationships with the highest coefficient of intensity values (*r*) are reported.

For the purposes of the bivariate analysis some variables had to be recoded. For example, in the case of the variable *gender identity and/or gender expression*, the six possible response choices were grouped into two: (1) binary gender identities (male and female) and (2) nonbinary gender identities. In the case of the variable *health provision* the multiple response choices were grouped into (1) private health insurance and (2) public health insurance.

*The plus (+) sign is used to represent diverse non-normative gender identities and sexual orientations that are not fully described by the letters and words contained in the acronym.

†Among the other categories given by the participants were non-gender, queer, trans, and non-conforming gender.

The items included as response choices the categories “Not Applicable,” “Does not Correspond,” or “No Answer,” which allowed participants a self-chosen passage through the questionnaire. This explains variations in the sample size (n) when certain distributions are presented. Moreover, most of the items allowed for multiple response options, so the percentages (%) presented are calculated based on the total number of respondents for each question, and not on the total responses to the item.

Ethics

The study was conducted in accordance with the Declaration of Helsinki of 1964 and approved by the Ethics Committee of Universidad de Las Américas (Protocol Code CEC_FE_2021011). After being informed about the objectives and methodology of the study, respondents signed a statement of informed consent, agreeing to their participation on a voluntary, anonymous, and confidential basis.

Results

Demographic data

Respondents' ages ranged between 18 and 74 years (Mode = 18 years; $X = 25.9$ years); more than two-thirds (68.2%) were between 18 and 32 years of age. 40.3% of the participants described their gender as male ($n = 450$), 34.2% as nonbinary ($n = 382$), 16.8% as female ($n = 187$), and 6.1% as fluid ($n = 68$). Around 1.4% did not declare a gender identity ($n = 16$), and 1.2% declared another identity ($n = 13$).

Participants without specialized health care

Of the total sample ($N = 1116$), 25.8% ($n = 288$) reported never having received medical and/or psychological attention for reasons related to their gender identity or gender expression (Fig. 1). The main reasons given were economic (37.5%) and having known about situations of discrimination in the place of care (33.8%), an answer that correlates significantly ($p < 0.01$; $r = -0.12$) with nonbinary or fluid gender self-identification. A third (33.1%) of these respondents said that they did not consider medical attention related to their gender identity necessary, an answer given almost six times more frequently by the nonbinary or gender-fluid respondents (15.4%) than by those identifying with a binary gender.

Turning to those participants who had received no attention in any of the national gender-identity programs ($n = 552$, Fig. 2), most stated a preference for

the private system (29.6%), and that such programs were not available in their region or municipality (25.1%). Economic reasons were least frequently given for nonattendance in these specialized services (1.5%)—they are provided without charge for those who have public health insurance (68.5% of the total population surveyed). Instead, a contributory factor may be the experience of discrimination in public health spaces: we found a significant correlation ($p < 0.05$; $r = -0.09$) between such experiences and nonattendance at these specialized public centers. Finally, it is important to highlight that 6.6% of the total population surveyed did not seek attention for *any* health reason.

Health interventions received

Table 1 shows the interventions or medical services received in connection with gender identity and/or expression, broken down by gender identity. Over half (54.5%) of the respondents had received individual psychological attention, and 41% hormonization or endocrinological follow-up (the first and second most commonly received interventions, respectively). These interventions were the most frequent for both males and females (59.9% and 58.9% for males, 54.8% and 61.1% for females, respectively). For nonbinary and gender-fluid participants, individual psychological attention was the *only* health service received by over 40% of them. Third in the frequency of health care received was psychiatric attention (34% of the sample), ranking first for male and female participants, and second for nonbinary and gender-fluid people. Percentages were far lower for genital surgeries. Only 1% of males had received metoidioplasty, 0.3% phalloplasty, and 0.3% testicular prosthesis implants. Of the female population, 9.6% had received vaginoplasty.

Health interventions desired but not yet received

Of all treatments desired but not yet received by the respondents, speech therapy headed the list, at 50.8% of the full sample. Dividing the participants by gender identity, 67.5% of those identifying as female, 51.1% of male, 46.2% of nonbinary, and 32.2% of gender fluid desired it. This intervention was most wanted by the female and nonbinary gender populations.

Analyzing the data by gender identity, the second intervention most wanted by females was vaginoplasty (63.7% wanted it), followed by facial intervention (61.1%), breast implants (59.9%), and chondrolaryngoplasty (49.7%). This demand for facial interventions

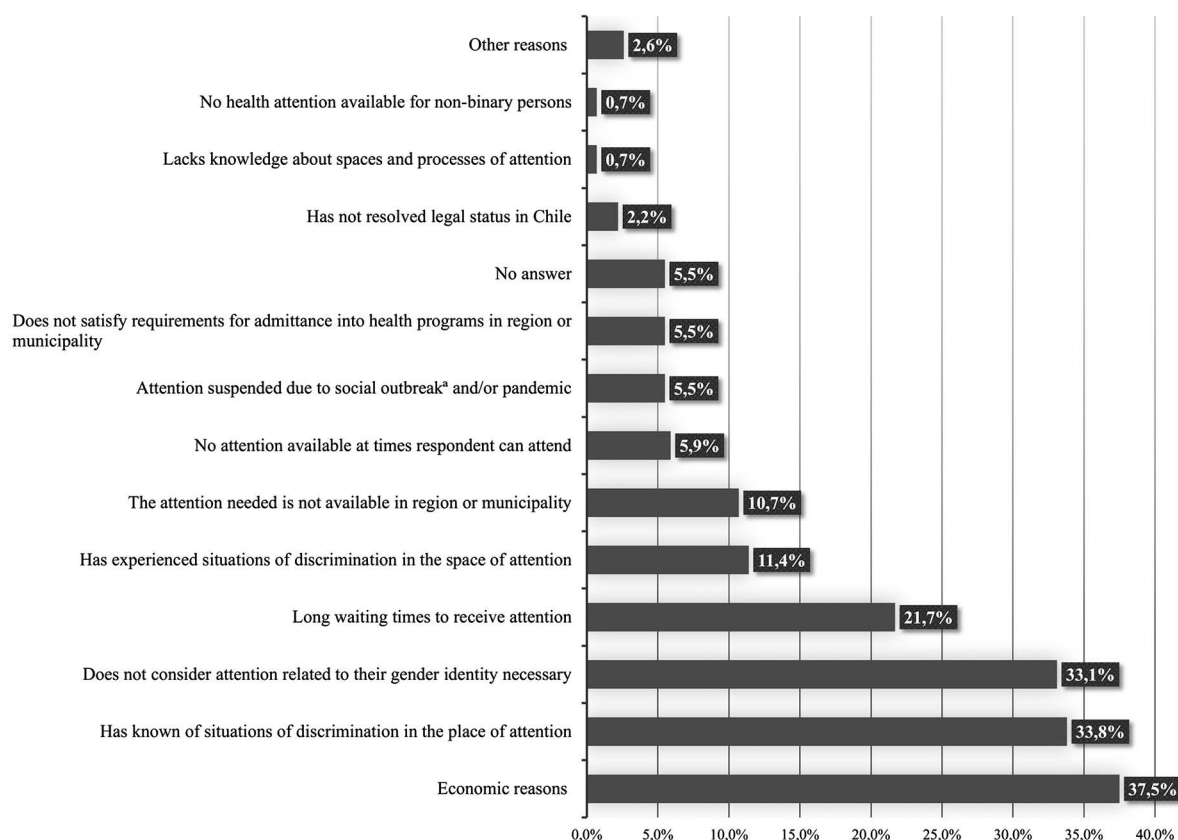


FIG. 1. Reasons why medical or psychological consultations were never carried out for issues related to gender identity and/or expression ($n=288$). ^aSocial outbreak is the name given to a series of massive demonstrations and riots, originating in Santiago and spreading to all regions of Chile that occurred mainly between October 2019 and March 2020.

was very high in comparison with the full sample, only 22.6% of which wanted it. It is noteworthy that 1 in 7 (14.6%) of females wanted surgery to mitigate the consequences of using industrial silicone, and that 4.5% wanted interventions to extract silicone, oil, or other liquids from their bodies.

Mastectomy was the intervention most sought after by the male population (73.6%), followed by hysterectomy (67.8%), oophorectomy (61.5%), and salpingectomy (59.4%). Only male gender identity participants wanted any of these interventions in a percentage greater than 40%. The only exception was mastectomy, desired by 55.9% of the nonbinary and 47.5% of the gender-fluid population.

The interventions most wanted by nonbinary participants after mastectomy and speech therapy treatments were for mental health care. The attention preferred was

psychological (44.7% individual, 43.8% in group), followed by psychiatric (33.9%). Similarly, in the case of gender-fluid participants, psychological attention came first (54.2% in group, 50.8% individual); mastectomy, third (47.5%); and psychiatric care, fourth (42.4%).

Whatever treatment options respondents preferred, their chances of obtaining it had been small, and in some cases minimal. For example, for those identifying as male, for every 147 people who wished for a testicular prosthesis only one had received it (Table 1). The odds against receiving other treatments were also high: phalloplasty (136:1); metoidioplasty (44.7:1), and facial interventions (44:1). For those identifying with the female gender, the largest gaps were for the insertion of buttock implants or prostheses (30.5:1); chondrolaryngoplasty (19.5:1); facial surgery (12:1); implant surgery or breast prostheses (10.4:1); and vaginoplasty (9:1).

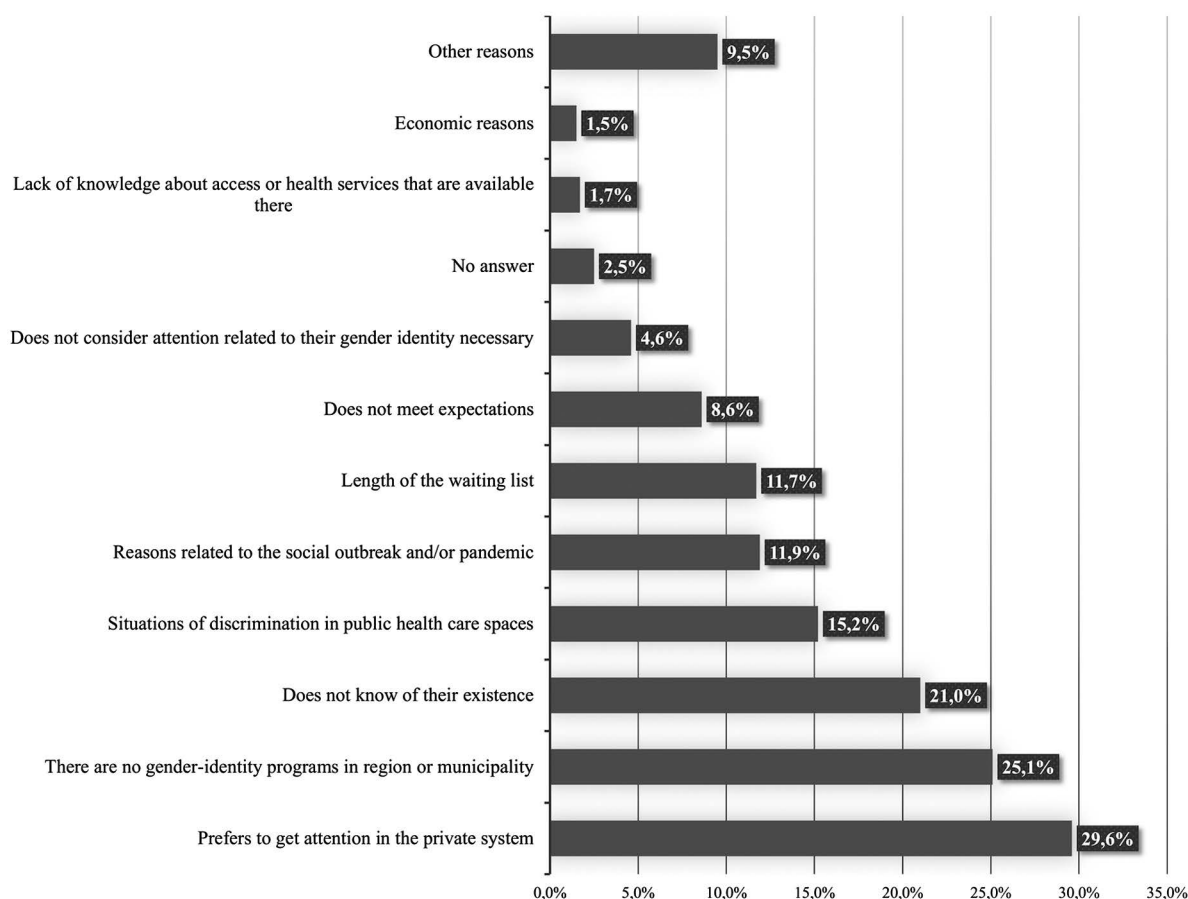


FIG. 2. Reasons why attention is not received in a gender identity program ($n=552$).

Access barriers

Difficulties indicated by the participants in accessing the specific services they wanted are displayed in Figure 3, according to gender identity. The reader should note that the data here, unlike in Figure 1, is about *specific and specialized care*, including several treatments of great complexity and for which there is little provision in Chile, as in the case of phalloplasty. Costs, long waiting lists, and a lack of professional training were the main reasons given across all gender identities.

Among those of nonbinary and fluid gender, the perception of professionals as lacking training was greater (at 36% and 39.3%, respectively) than among those declaring a binary gender identity. This perception may have a common source with two other access barriers more frequently identified by nonbinary and fluid gender participants: fear of suffering discrimination in health centers (36.3% and 41.1%, respectively) and

pressure from third parties not to access specific health care services (29.7% and 44.6%, respectively).

A bivariate analysis points in the same direction. It shows a statistically significant relationship between nonbinary or fluid gender identification and the mention of pressure from third parties as a barrier to accessing the interventions desired ($p<0.01$; $r=-0.23$), as well as fear of discrimination in the health service ($p<0.01$; $r=-0.23$), and health professionals' lack of training ($p<0.01$; $r=-0.12$).

Now, when we focused the analysis not on the interventions desired but on the *place of residence of participants*, various access barriers were identified (Table 2). At the national level, long waiting times (54.4%), lack of specialists in health centers (52.4%), lack of knowledge of the procedures performed in the region (40.3%), and high costs of health services (40.1%) predominated.

By crossing the information on barriers to access by place of residence with the participants' health

Table 1. Interventions or medical services received or still wanted (health interventions desired but not yet received) by gender identity

Intervention or medical service	N	Whole sample (N=972) ^a			Male GI (N=397)			Female GI (N=157)			Nonbinary GI (N=333)			Fluid GI (N=59)		
		Received, %	Still Wanted, %	Ratio	Received, %	Still wanted, %	Ratio	Received, %	Still wanted, %	Ratio	Received, %	Still wanted, %	Ratio	Received, %	Still wanted, %	Ratio
Hormonization/prescription or endocrinological follow-up	972	41.0	33.3	1.2:1	58.9	37.3	1.5:1	61.1	32.5	1.8:1	17.7	28.8	1:1.6	5.1	32.2	1:6
Individual psychological attention	972	54.5	37.8	1.4:1	59.9	32.0	1.8:1	54.8	34.4	1.5:1	49.8	44.7	1:1	44.1	50.8	1:1
Group psychological attention	972	5.4	41.6	1:7.6	5.3	38.8	1:7.3	7.0	41.4	1:5.9	5.1	43.8	1:8.5	3.4	54.2	1:16
Psychiatric attention	972	34.3	29.5	1:1	37.8	24.4	1.5:1	33.8	27.4	1:1	30.0	33.9	1:1	35.6	42.4	1:1
Extraction of silicones, oils, or other liquids	972	0.2	4.1	1:13.3	0.0	5.8	0	1.3	4.5	1:3.5	0.0	2.7	0	0.0	1.7	0
Body or facial reconstruction after use of liquid silicone	972	0.6	5.0	1:7	0.3	3.0	1:12	2.5	14.6	1:5.7	0.3	3.6	1:12	0.0	1.7	0
Facial intervention or surgery	972	1.6	22.6	1:12.8	0.3	11.1	1:44	5.1	61.1	1:12	2.1	19.2	1:9.1	0.0	20.3	0
Body or facial reconstruction after being a victim of aggression	972	0.4	3.0	1:5.8	0.0	1.8	0	1.9	6.4	1:3.3	0.3	3.6	1:12	0.0	0.0	0
Insertion of buttock implants or prosthesis	972	0.3	8.8	1:21.2	0.0	0.2	0	1.3	38.9	1:30.5	0.3	6.0	1:20	0.0	3.4	0
Mammary implants or prosthesis surgery ^b	573	1.7	20.4	1:1.2	NA	NA	NA	5.7	59.9	1:10.4	0.3	5.1	1:17	0.0	5.1	0
Phalloplasty ^c	813	0.2	19.3	1:52.3	0.3	34.3	1:136	NA	NA	NA	0.3	4.2	1:14	0.0	8.5	0
Implant of testicular prosthesis ^c	813	0.2	19.8	1:53.6	0.3	37.0	1:147	NA	NA	NA	0.3	2.7	1:9	0.0	5.1	0
Metoidioplasty ^c	813	0.7	26.4	1:30.7	1.0	45.1	1:44.7	NA	NA	NA	0.3	8.1	1:27	0.0	11.9	0
Vaginoplasty ^b	573	2.3	19.7	1:8	NA	NA	NA	9.6	63.7	1:9	0.6	3.0	1:5	0.0	3.4	0
Hysterectomy ^c	813	4.4	51.5	1:11.3	7.1	67.8	1:9.6	NA	NA	NA	1.5	36.6	1:24.4	1.7	35.6	1:21
Salpingectomy ^c	813	4.4	47.0	1:10.3	6.8	59.4	1:8.7	NA	NA	NA	1.8	35.1	1:19.5	1.7	39.0	1:23
Oophorectomy ^c	813	4.3	47.1	1:10.6	6.5	61.5	1:9.3	NA	NA	NA	1.8	32.7	1:18.1	1.7	37.3	1:22
Mastectomy ^c	573	13.3	63.1	1:4.7	22.2	73.6	1:2.9	NA	NA	NA	5.4	55.9	1:10.3	0.0	47.5	0
Speech therapy treatment	972	8.2	50.8	1:6	6.8	51.1	1:7.5	17.8	67.5	1:3.7	5.7	46.2	1:8.1	6.8	32.2	1:4.7
Chondrolaryngoplasty ^b	573	0.9	17.5	1:16.6	NA	NA	NA	2.5	49.7	1:19.5	0.3	4.8	1:16	0.0	6.8	0

^aThe sample (n=972 for this survey item) includes participants who declared "other" or "none" in reply to the question about their gender identity (26 replies).

^bTo avoid confusion, male gender identity respondents were omitted from the analysis.

^cTo avoid confusion, female gender identity respondents were omitted from the analysis.
GI, gender identity; NA, not applicable.

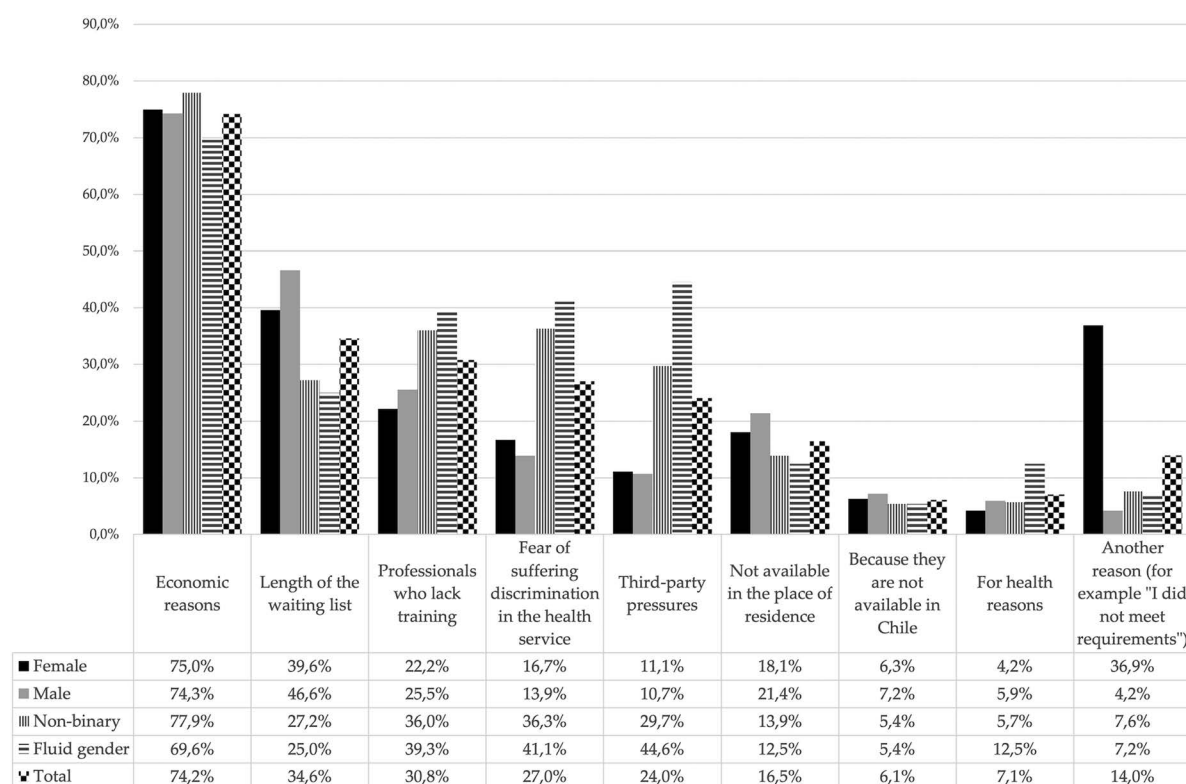


FIG. 3. Difficulties of access to interventions and services demanded by gender identity.

insurance provision, it was apparent that those enrolled in public health insurance were significantly more likely to consider the main barriers to access to be long waiting times ($p < 0.01$; $r = -0.33$), the lack of specialists in local health centers ($p < 0.01$; $r = -0.16$), and

Table 2. Barriers affecting access to health care by the trans and/or nonbinary population

Access barriers	Access barriers	
	National level (N=1113)	
	f	%
Long waiting times	606	54.4
Lack of health specialists in health centers	583	52.4
Lack of knowledge about the procedures performed in my region	449	40.3
High costs of health services	446	40.1
Lack of availability of health services	387	34.8
Long distance between my home and health centers	257	23.1
I do not think that there are any barriers	86	7.7
Access barriers related to trans-specific attention	61	5.5
Experiences of ill-treatment (own or of close others)	29	2.6
Difficulty in the distribution of medicines	4	0.4
Other access barriers	14	1.3

Considering each participant's place of residence.

the absence of care centers ($p < 0.01$; $r = 0.19$). In contrast, those attached to the private health system tended to consider the main access barrier to be the high cost of services ($p < 0.01$; $r = 0.19$).

Finally, enrollment in the private system correlates significantly with receipt of hormonization/prescription services or endocrinological follow-up ($p < 0.01$; $r = 0.12$); individual psychological care ($p < 0.01$; $r = 0.20$); group therapy ($p < 0.01$; $r = 0.14$); psychiatric care ($p < 0.01$; $r = 0.24$); phalloplasty ($p < 0.01$; $r = 0.24$); testicular prosthesis implant ($p < 0.01$; $r = 0.22$); mastectomy ($p < 0.05$; $r = 0.10$); and speech therapy treatments ($p < 0.01$; $r = 0.09$). By contrast, those enrolled in the public system were very likely to be waiting to receive these services.

Discussion

The survey data clearly reveal the sparsity of existing provision for the health services desired by the population studied. At the outset, it is important to note that 6.6% of the population interviewed stated that they preferred not to seek attention when faced by *any* health problem. Fears of suffering discrimination in health

services, and the lack of medical staff sufficiently trained in gender and sexual issues were among the main reasons given. The causes of this reluctance to attend need to be urgently addressed since they not only affect trans-specific health needs, but also the general health of the transgender and nonbinary population.

Demands for attention vary significantly depending on the gender identity analyzed. For instance, while mastectomy ranks first for male and nonbinary gender participants, female gender respondents give speech therapy treatments top priority, while for gender-fluid participants the demand for mental health care is paramount—interventions that, together with the demand for medical services, require special consideration in health programs aimed at this population. To distribute resources more equitably and avoid overlooking groups less represented in the population, the different needs of the trans and nonbinary population must be duly recognized.

Thus, while mental health care appeared to be a common demand of the whole sample, it was particularly strong in the nonbinary and gender-fluid categories. We should not forget the trans and nonbinary population's comparatively poor mental health indices, as noted in the literature—for example, mood, anxiety and somatization disorder, increased risk of suicide, nonsuicidal self-injury, and substance use disorders. There is much evidence attributing these conditions in part to a transphobic sociocultural context and this population's marginalization from health care spaces.^{16–21,28,30}

The inequality of access that appears to exist for those who do not identify with a binary gender deserves emphasis as a key finding of this study. It was precisely the nonbinary and gender-fluid population that referred to experiences of violence or discrimination in public health contexts as one of its main reasons for not receiving attention in the country's gender identity programs. This perception of discrimination, noted in many other studies, should draw attention to the importance of professional training on gender variations, and also to the urgency of designing public policies aimed at this population.^{31,32}

Attention should be paid also to the territorial distribution of health services received, considering that 10.7% of those who had never received gender-related medical or psychological care indicated that the attention they needed was not available in their region or municipality.³³ This gap in availability is even wider for those who reside outside the central zone of the

country. Such territorial inequity is of the utmost importance for Chile, given that the public health network does not provide health centers to which the country's entire population can be referred, but rather each hospital attends exclusively to a limited number of adjacent localities. The creation of specialized referral centers distributed by zone and with nation-wide coverage would allow this notable territorial inequality to be brought to an end.

Moreover, the fact that 39.1% of the population seek care from private medical services when they face any health problem—even though only 26.1% have private insurance—should be a warning sign for the Chilean public health system. This preference for the private sector may be due to poor evaluation of the National Health Service (SNS), mainly because of its long waiting lists and restricted access to specialists.³⁴ Yet the country's gender identity programs are located, precisely, in hospitals of the public health care network. The fact that those who have public health insurance (FONASA) are more likely to have to wait to receive medical attention; to experience situations of discrimination in health spaces, and to encounter a lack of specialists in zonal health centers (which often do not exist in their place of residence) is another important factor, especially considering that three-quarters of Chile's population, mostly those on lower incomes, is affiliated with public health insurance.

Limitations

Although this statistical review of the survey results provides valuable knowledge about the experience and needs of each of the gender identities considered, the relatively low participation of trans women in the survey is an important limitation. To gain a fuller understanding in future studies, we recommend that special attention be paid to the participation of this population.

Because this research was carried out during the COVID-19 pandemic, we were obliged to apply the questionnaire online. This made it difficult for people with little or no digital literacy to participate, especially the older population. Future studies should seek information specifically on older people in the trans and nonbinary community.

New, territorially specific, analyses aimed mainly at the health access barriers detected, as well as qualitative studies that allow a deeper reading of the results, are important as a follow-up to this study and for the public policies that derive from it.

Conclusion

This study shows that a quarter of the trans and non-binary gender population surveyed had never received care related to their gender identity or expression, and that half were not receiving care in a specialized gender health program. Endocrinological treatment, together with mental health interventions, were the forms of care most received by the population, although more than a third of the participants wanted them but had not yet received them. The nonbinary and gender-fluid population stressed the lack of specialized professional training, while expressing greater fear of discrimination, and suffering pressure from third parties to avoid gender-specific health care. The inter-group differences in demands for care and the access barriers faced described above must be considered in building relevant and effective public policies.

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Authors' Contributions

M.R.-P.: Conceptualization (lead), writing (lead), investigation (lead), methodology, project administration, funding acquisition, resources, and supervision. L.J.: conceptualization (supporting), writing (supporting), investigation (supporting), and visualization (equal). P.G.: Formal analysis and visualization (equal).

Author Disclosure Statement

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Abbreviations Used

GI = gender identity
NA = not applicable