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Body, rights and comprehensive health: Analysis of the parliamentary debates on the Gender Identity and Assisted Fertilization Laws (Argentina, 2011-2013)

Cuerpo, derechos y salud integral: Análisis de los debates parlamentarios de las leyes de Identidad de Género y Fertilización Asistida (Argentina, 2011-2013)

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ABSTRACT In this paper we present an analysis of the parliamentary debates of the Gender Identity Law (No. 26743) and the Assisted Fertilization Law (No. 26862) carried out in the Argentine National Congress between 2011 and 2013. Using a qualitative content analysis technique, the stenographic records of the debates were analyzed to explore the following questions: How was the public problem to which each law responds characterized? How was the mission of each law conceptualized? To what extent did those definitions call into question ideas of health and illness, in including in the public health system coverage for certain medical treatments of body optimization or modification? In the process of sanctioning both laws, the concepts of health and disease were put into dispute as moral categories. In this context, an expanded concept of comprehensive health arose, in which desires regarding reproduction and the body were included.

KEY WORDS Human Rights; Public Health; Personal Autonomy; Fertilization; Gender Identity; Argentina.

RESUMEN En este artículo se analizan los debates parlamentarios de la Ley 26743 de Identidad de Género y de la Ley 26862 de Fertilización Asistida, desarrollados en el Congreso Nacional argentino entre los años 2011 y 2013. A través de la técnica de análisis de contenido cualitativo se analizan las versiones taquigráficas de los debates parlamentarios con el fin de responder los siguientes interrogantes: ¿cómo fue caracterizado el problema público al cual ambas leyes darían respuesta?, ¿cómo fue conceptualizada la misión de ambas leyes?, ¿en qué medida dicha definición implicó poner en entredicho las nociones de salud y enfermedad con relación a la cobertura de tratamientos de optimización o modificación corporal por parte del sistema público de salud? El proceso de sanción de ambas leyes implicó tensionar los conceptos de salud y enfermedad como categorías morales. En dicho marco emergió una noción ampliada del concepto de salud integral que incluyó los deseos reproductivos y corporales de los ciudadanos y ciudadanas.

PALABRAS CLAVES Derechos Humanos; Salud Pública; Autonomía Personal; Fertilización; Identidad de Género; Argentina.

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INTRODUCTION

In Argentina, the demand and acquisition of rights related to people's free exercise of their sexuality and their autonomy of decision over their body in the medical field started to be interconnected after the last return to democracy. The end of the last Argentine civil-military dictatorship,[a] along with the reawakening of political, social, and cultural participation, and finally, the creation of international regulations in international conferences about population and development and the global conferences about women – carried out in El Cairo (1994) and Beijing (1995) – were favorable to this issue. However, these processes also faced some conflicts and tensions.

This paper will analyze the parliamentary debates regarding the Gender Identity Law (No. 26743)(1) and the Assisted Fertilization Law (No. 26862).(2) These debates took place in the Argentine National Congress between 2011 and 2013. Both laws constitute a part of several national regulations that broaden the legal use of the human body in relation to the medical field. In this sense, it is worth mentioning other laws that promote sexual and (non-)reproductive rights (Law No. 25673 on National Program of Sexual Health and Responsible Procreation and Law No. 26150 on Comprehensive Sex Education), the patients' rights in relation to health professionals and institutions (Law No. 26529), the decision on the type of intervention to be carried out during labor (Law No. 25929 on Humanized Labor and Birth) and the advanced healthcare directives (Law No. 26742 on Death with Dignity).

According to the Gender Identity Law (No. 26743) passed on May 9, 2012, an administrative proceeding is carried out to change someone's sex and name in the registry without previous authorization either by a group of experts or judicial decision. This law also establishes that the body adjustment to the self-perceived gender can be made – if required – through medical procedures, such as partial or total surgical procedures and/or hormonal comprehensive treatments. These treatments are included by law in the Argentine Compulsory Medical Program,[b] where it is also established that such treatments are free in public hospitals and are covered by social security programs or prepaid medical care.[c] On the other hand, the Assisted Fertilization Law (No. 26862) passed on June 5, 2013, guarantees comprehensive access to medical care procedures and techniques regarding medically assisted fertilization for any person of legal age without requesting any diagnosis or previous certification. This is the reason why same-sex couples as well as single people can have access to these techniques for free.

The development of body intervention technologies – in relation to altering the body diacritics that are culturally associated with either masculine or feminine genders or enhancing reproductive possibilities – defies the idea that nature and technology are opposed and antagonistic dimensions. These technologies open up a new field of possibilities to choose at the time they bring up again traditional bioethical debates. In this field, the definitions and boundaries of the concepts of life and gender differences are addressed in social discussions about the boundaries of scientific development and the reassignment of the duties and responsibilities of the medical professionals as well as the state.(4-6) The demand of the democratization of the access to these technological developments adds new questions to the already existing questions.

This paper intends to give these processes a sociological approach that states that the analysis of the changes in public regulations about the body makes it possible to visualize the ways in which the boundaries of legitimacy and illegitimacy regarding the uses of the body are displaced and reconfigured at certain moments and in certain fields of the public sphere.

The aim of this research study is to analyze the ideas regarding body desires that national male and female legislators supported while discussing the bills on the Gender Identity and Assisted Fertilization Laws, to describe the way in which the public concern that would be addressed in these laws was characterized, and to look into the way in which such characterization called into question the concepts of health and sickness as moral categories that were historically associated to the medical treatments of body adjustment to the self-perceived gender and to medically assisted reproduction technologies. The central concepts chosen for the analysis are those considered important when identifying the changes in the dynamics of body-related public regulations. These central concepts also make it possible to visualize the different positions that exist in current public debates on body and reproductive desires.

In this paper, it is intended to show that the discussions carried out in the Argentine National Congress were not just about the rational aspect of public policies design – in the sense of giving the best answer to the problems of the population – but also about the legitimate thoughts of male and female legislators that served as grounds for both legislations. This implied judgments of the traditional moral values related to the possibilities of body transformation and access to medically assisted reproduction technologies.

ABOUT THE RESEARCH

This research study is part of an ongoing doctoral research study that, based on the findings of a thesis to get a master's degree,(7) explores the changes in body-related public regulations in Argentina by analyzing the process of demand, enactment, and implementation of the Gender Identity Law. In previous research studies,(8) an analysis was made about the aspects of the parliamentary debate of this law that referred to the ways in which national male and female legislators understood the notions of gender and identity.

The study corpus includes the stenographic records of the parliamentary debates held to discuss and enact the laws on gender identity and assisted fertilization in 2011 and 2013. These documents were available at the website of the House of Representatives and the Senate. The stenographic records of the debates on the Gender Identity Law corresponded to the joint meeting of the General Law Committee and the Justice Board held on August 18, 2011 (House of Representatives), to the Regular Meetings held on November 30, 2011 (House of Representatives), and on May 9, 2012 (the Senate). On the other hand, the stenographic records of the debates on the Assisted Fertilization Law corresponded to the Regular Meetings held on June 27, 2012, June 5, 2013 (House of Representatives), and April 24, 2014 (the Senate). These documents were entered into a program that is used to analyze qualitative information and were analyzed by using a qualitative content analysis technique. According to Jaime Andréu Abela,(9) the analysis of the content is based on reading as a data-gathering instrument. Unlike regular reading, this type of reading must be systematic in order to find the indicators that allow "the inference of knowledge related to the conditions of production/reception (social context) of these messages."(9)

Below is a brief contextualization of the local development of the medical practices under study and their legal situation before both laws were enacted. Then, the analysis of the parliamentary debates is described on the basis of the analytical central concepts mentioned above.

MEDICAL TECHNOLOGIES AND SOCIAL DEBATES

As stated by Florencia Luna,(10) the first medically assisted reproduction techniques were aimed at middle- and upper-class women from industrialized countries.(d) In Latin America, these techniques were rapidly adopted from 1984 onward, and they were aimed at people with fewer resources.(11) Although the assisted reproduction techniques were not banned in Argentina before the law was enacted, they were carried out without a legal framework that would rule the practice. The decisions regarding their use and application were made by their private suppliers, and access to them was extremely expensive.(11) According to the author, the parliamentary debates of these techniques have been postponed because the ruling sectors had not previously conceptualized them as a public health problem and because the conservative sectors were against these techniques due to the ethical debates they still entail.(e) The first bill of national scope, which was aimed at regulating medically assisted reproduction techniques, was submitted in 1985. However, the relevant debate did not start in the Argentine National Congress until 2011. Before this law was enacted, two provinces had enacted their own laws: the province of Buenos Aires in 2010 passed Act No. 14208, and the province of Santa Cruz enacted Act No. 3225. Both laws legally recognized infertility as a disease and determined the coverage for its treatment by public hospitals, social security programs, or prepaid medical care in their pertinent territorial limits.

The bills on the Assisted Fertilization Law were first discussed in the Argentine National Congress on November 30, 2011. These bills included issues such as identity and filiation and the use of embryos for experimentation and trading of gametes. At the meeting held on said date, the majority opinion was voted in general, and the discussion in particular was postponed for a future meeting. Between this meeting and the following meeting, the situation changed: on March 27, 2012, the executive issued a draft to reform the Civil and Commercial Code, written by an amendment committee appointed by executive order No. 119/2011. This draft included a specific chapter that dealt with "filiation by assisted human reproduction techniques," where the concepts of "will to conceive" and "*post mortem* filiation" were defined. In subsequent meetings, it was agreed that the law under discussion would exclusively regulate health aspects and that the ethical and legal aspects should be stipulated in the Civil and Commercial Code. As a result, the bills finally debated in the Argentine National Congress were exclusively about the regulations of medical practices that have been used for over twenty years, their financing, and the people who may receive this treatment.

The so-called "sex reassignment surgery"(f) used to be banned in Argentina since the enactment of Law No. 17123 on Medical Practice in 1967, which established under section 19 subsection 4 that "surgical interventions that modify the sex of a sick person shall not be carried out unless authorized by court" [own translation].(13) The first legal intervention of this kind that was carried out in Argentina took place in 1994 after being authorized by court decision.(g) On that occasion, César Fidalgo, surgeon in the Ricardo Gutiérrez Hospital in La Plata, travelled to Chile to be trained on these techniques.(14)(h) Doctors Guillermo MacMillan and Antonio Salas Vieyra have been carrying out these interventions in Chile (that Trans-Andean country) since 1973,(16) which is the reason why that country was a pioneer in the region. In Argentina, until 2010, the judicial rectification of name and sex in the official identity records required that the applicant's genitalia coincide with the registered sex, which made that intervention compulsory, although it was illegal.(17) This was the reason why most of the people who applied for the change in the registry travelled to Chile first to undergo such intervention. Before the enactment of the Gender Identity Law, transvestites, transsexuals, and transgender people used to undergo hormonal treatments or surgeries without taking the proper health precautions, that is to say, by self-administration in a clandestine way, which was detrimental for their health.(18,19)

The issuance of several bills to regulate the processes to change people's legal name and sex started in 1995. However, none of them were discussed until 2011. The treatment and final enactment of the law must be placed in a broader scope of reconfigurations of the relations between the state and local sexopolitical groups. The legalization of same-sex civil marriages in 2010 was a turning point and gave political opportunities to demand more public policies for transvestites, transsexuals, and transgender people.

The absence of a national regulation for the use of and access to fertility treatments as well as medical practices of body transformation to adjust people's body to their own identity determined that only the medical field – or rather the medical field via the judiciary – had the last word on who could make use of these treatments and practices and under which requirements, which is the reason why both regulations were demanded by different civil society organizations.

Below are the opinions of male and female representatives and senators during the parliamentary debate of the laws under study. The focus will be on the definitions and tensions regarding the aim and the mission of the laws as well as the concerns voiced about the concepts of health and sickness when debating the public financing criteria of the medical practices under discussion.

AIM AND MISSION OF THE LAWS: RESTRICTED ACCESS, UNIVERSAL ACCESS, AND SOCIAL DEBT

A public response to a disease or to a universal right

The discussed bills on assisted fertilization(20) were aimed at regulating the use of and access to assisted human reproduction techniques. However, not all members of the Argentine National Congress conceived the public problem that the law would give answer to in the same way. The main tension or disagreement was that the aim of this law could be understood to be the promotion of legal conditions necessary for the public health system to give answer to a disease or the offering of a state guaranty so that male and female citizens could be able to fulfill their reproductive desires as if it were a "universal right." In terms of public policy design, the first conception involved that fewer people would be benefited from this right, which would exclusively benefit heterosexual couples who were involuntarily infertile. Sticking to this belief, a female representative stated the following:

> My bill is mainly based on the fact that infertility is a disease. So, for the applicants of the treatment to have coverage, they must have a medical diagnosis that states that they suffer from that disease. But nowhere, at any moment and on any of the times I have been interviewed did I say that I do not want this law to benefit everybody. I want it to be available for absolutely every person, male or female, who suffers from infertility. I do not care about their sexual orientation, their civil status or their age. The doctors will decide on that. I do care that everyone who is ill receives the proper treatment and has the same coverage. [Female Representative Majdalani, stenographic version from June 27, 2012(21)] [Own translation]

According to Diniz and Gomez Costa,(22) the medical category of infertility in medically assisted reproduction treatments is moralizing rather than medical. As these authors state, the function of the medical category of infertility has historically been that of offering moral support so that only heterosexual couples could have access to these technologies. The ideological precept behind this category states that body interventions are only acceptable if they are aimed at restoring a damaged natural order. It is worth mentioning that these treatments are not aimed at curing the causes of infertility, but at enabling human reproduction by means of controlled manipulation of the factors that are involved in such process. Focusing on the infertility category, the legislative bill that this representative stood for excluded same-sex couples and single people from having access to these techniques.

Supporting the opposite position, the female representative Iturraspe stated that:

> Legislating on sexual and reproductive rights involves several aspects: in terms of civil rights, it implies acknowledging rights equality and avoiding discrimination against any individual's sexual orientation or identity. Regarding social

> rights, it implies separating health from trading, in order to exercise the right to health, opposing the illness and body market to the right to decide and to choose according to the individual's personal needs and desires. [Female Representative Iturraspe, stenographic version from June 12, 2012(21)] [Own translation]

This representative showed a different way of understanding the public problem this law would give answer to: as an issue connected to sexual and reproductive rights and not exclusively as a problem related to the medical coverage of a disease. This definition complicates other dimensions involved in the policies under debate, such as the extension of social rights and equality of access as well as the decisions of people and their own desires, aspects that were not considered in the position that classified the problem as being exclusively related to the treatment of a disease. This position allows increasing the amount of people that would undergo these treatments.

A minority right, a message to society

The parliamentary debates on the bills on the Gender Identity Law had fewer discrepancies in connection with the public problem this law would give answer to. The topic of the debate was established from the beginning in terms of minority rights, non-discriminatory policies, and Human Rights.(23-27) It was strongly thought that although this law was aimed at stopping discriminatory acts against a specific *minority*, the consequences of such law in terms of social integration would positively affect society overall. About this, the female representative Alonso stated that:

> This is a debate of rights. This is an entirely constitutional debate that not only affects the life of a minority but of the Argentinian society that desires, wants and aspires to be an open, egalitarian society. It is a debate that is incumbent on all of us and it is a debate whose topics need to be taught and explained, that need to have more people involved, to be discussed and dealt with, people have to be convinced, persuaded. [Female representative Alonso, stenographic version from November 30, 2011(28)] [Own translation]

As the female representative said, this law would not only be a public policy aimed at a specific social group, but also a message or a pedagogical resource for the entire society. She also refers to the enactment of this law as a strategy to persuade society in order to create mechanisms of social inclusion that exceed the public policy under debate. In this sense, another female representative affirmed that:

> More progress has to be made regarding the rights of the transsexual community and the equality for the indigenous peoples, for women and children that are dying of hunger in our country for no reason. The challenge here is to keep fighting for these rights. Finally, as a society, we have to understand that if we are not capable of recognizing the others and respecting them as if they were us, no society will be able to overcome discrimination, prejudices, persecutions, mistreatment and violence. Therefore, the main step we all need to take is to recognize one another and begin to respect each other. [Female representative Reyes, stenographic version from December 30, 2011(28)] [Own translation]

Following this representative, the law under debate would be in line with other kinds of claims for rights and social compensation for groups who have suffered harm and discrimination, defined by the same female representative as "the others." In this sense, the issue is no longer understood exclusively in terms of rights for lesbians, gays, bisexuals, and transsexuals (LGBT), it also considers other social groups such as the indigenous peoples, women and children, seeking to bring complexity and to broaden the notion of inclusion, which is *per se* the background of this law. Moreover, this proposal expresses the intention not to enact a legislation that only affects one group in particular, but that its incidence may be extended in symbolical terms to a wider category of groups whose rights have been infringed.

Settling a social debt

A common aspect that marked the debate of both legislations was the idea of addressing a *social debt* that the state may have incurred throughout history with the groups covered in these laws and that are also characterized as victims. The female representative Bianchi, when referring to the Assisted Fertilization Law, stated the following:

> Mrs. President, today we have gathered again to discuss the Assisted Fertilization Law. Many words have been written and said about this issue. The bill we are dealing with is the result of the struggle of hundreds of male and female citizens that for the last twenty years have been demanding to stop considering medically assisted procedures as a market and to turn them into a health issue so that these proceedings can help them overcome the difficulties that prevent them from raising a family according to their own needs. [Female representative Bianchi, stenographic version from June 5, 2013(29)] [Own translation]

As the representative stated, the notion of debt was bonded to the necessities of a social class that is understood as the victim in a double sense: for its impossibility to procreate by natural means, and for the absence of a state that mediates between the necessities of the population and the medical-technological resources that are only available for private entities, which implies that having access to them is very expensive. According to this representative, the debt would be settled if the state used this law to narrow that gap.

Regarding the Gender Identity Law, the female representative Rodríguez expressed the idea of debt as follows:

> The state is in debt, because the right to identity – which, as it was said, is a human right that this country has been able to guarantee after a lot of sacrifice – does not really change with time and it is a prerequisite to exercise the rights to education, health, housing and even the right to life [...]. On the other hand, I think that it is essential to include in the drawing up of this bill something that has been said here: that the identity and the body cannot be separated. In the bill we have drawn, this definitely has to be included according to each person's own decision. [Female representative Rodríguez, stenographic version from August 18, 2011(30)] [Own translation]

The representative linked the idea of debt to the fact that the state has failed to historically recognize the identity of transvestites, transsexuals, and transgender people, which impeded the exercise of essential rights with severe consequences in their life conditions. She also bounded it to the possibilities of body intervention and modification, so that such debt would only be fully settled once the self-perceived identity is legally recognized, and access to the medical technologies of body transformation is guaranteed.

The aspects mentioned regarding the handling of both laws make people reflect on the current dynamics of claim for rights and on the public policies design in connection with the body. In this context, the social debt category has an economic and moral sense, which implies a specific characterization of those social groups the state and the society would be in debt with. These groups were considered vulnerable based on diagnostic categories or social stigmatization dynamics.

In *The Politics of Life Itself: Biomedicine, Power and Subjectivity in the Twenty-First Century*, Nikolas Rose(31) defined the concept of "biological citizens" within the framework of a more general analysis of the transformations in the medical field since the late twentieth century. Rose, assuming that every bill of the nation-state outlines citizenship in somatic terms, states that since the late twentieth century, the way in which biological aspects and citizenship are related is changing. His definition of "biological citizen" refers to beliefs, representations, attitudes, and daily practices that are created by the individuals when they interact with themselves, with other individuals, and in institutions under the terms of a *somatic* definition of the identity based on the notions of risk, suffering, and vulnerability. Based on Paul Rabinow's(32) concept of *biosociality*, the author describes the collective aspect of biosociality as a creation of groups and associations that aim at demanding the active policies of the state. These groups may be based on the medical categories to carry out their claims or deal with them and discuss them publicly. From these authors' perspectives, the biocitizenship experiences occur when the typically modern conceptions of citizenship that supported the idea of a united *national community* and of a fixed, unchanging nature are weakened. The dynamics of biocitizenship enable fragmented rights demands on the necessities of groups of individuals who share experiences related to their bodies. This is the framework of daily tensions where the analyzed debates gain importance.

The characteristics of the social groups that demanded both legislations may be understood in line with the ideas of Nikolas Rose.(31) The associations that demanded the Assisted Fertilization Law, such as *Concebir*, *Develar*, *Abrazo x dar vida*, *Sumate a dar vida*, and *Lesmadres*,(33-37) among others, are groups that revolve around the impossibility to conceive naturally, which is the reason why they demand attention from the state. These associations gather self-convened patients, people who cannot conceive naturally, or families made up of lesbian mothers. The associations of transvestites, transsexuals, and transgender people(i) claim for the recognition of their identity and body desires that defy the genetic binary system. According to these associations, the impossibility to fulfill their desires implies suffering and vulnerability that diminish the possibilities to fully exercise their citizenship.(18,22) These groups also demand rights by appealing to suffering and vulnerability. Unlike some of the associations that demanded the Assisted Fertilization Law, the latter groups expressly seek to take a distance from this issue and to discuss the diagnostic categories of the medical field.(j)

The configuration of these groups as victims was positive in terms of achieving parliamentary agreements on the necessity to pass laws that recognize and publicly improve these aspects. However, as it will be later stated, these discussions turned out to be insufficient when debating the financing of the demanded health benefits.

FINANCIAL AND MORAL ECONOMIES UNDER DISPUTE

What should the public health system finance?

In the framework of tensions and agreements over the mission of these laws, in both debates the health policy has been discussed in terms of the public financing criteria of the health benefits included in both laws. This situation implied calls into question certain notions of health and sickness.

The discussion about the boundaries of legitimate intervention of the body expresses the idea of rational allowance of the financial resources of the state. That is to say, the priorities for public financing and the criteria to either include or not certain health benefits in the health budget were discussed. During the debate on assisted fertilization, a female legislator stated the following:

> I consider it necessary to establish a priority system, not based on exclusion, but on equality, so that, since the resources are scarce and the population needs are many, effective coverage could be given to the necessity to procreate of those

> who have more economic difficulties to undergo treatment or those who have not had children yet. [Female representative Guzmán, stenographic version from June 5, 2013(29)] [Own translation]

This representative expressed the idea that the state does not have enough resources and that it is necessary to create rational public policies in the allowance of those resources based on concrete and specific criteria of access to public financing. She claimed that such criteria should be defined according to the economic situation of each individual or to the number of children they have. This idea, unlike the position that supports the idea of universal access, implied the definition of some particular (therefore unequal) access criteria. During the debate held on June 27, 2012, another female representative mentioned the following:

> My bill states that everyone who is sick can receive coverage for this treatment [...] The main difference is that for me, this is a disease, but for the governing authorities, it is not. For the governing authorities, it is a universal right. Now, I wonder, how can a universal right be included in the Compulsory Medical Program, which is a program that covers medical practices that are used to cure or to treat diseases? [Female Representative Majdalani, stenographic version from June 27, 2012(21)] [Own translation]

The female representative, Majdalani, outlined a main aspect in the debate of both laws, since these are laws that regulate the access, practice, and financing of medical interventions that take place in the ambiguity between health regulations and social inclusion policies. According to this representative, this would be contrary to the mission and objective of the Compulsory Medical Program that should exclusively include those practices that are aimed at curing or treating diseases. As previously stated, the infertility diagnosis as criteria of access to the treatments entails a moralizing notion that states that only heterosexual couples can legitimately have access to these techniques. Because of the previously mentioned characteristics, reproductive medicine is surrounded by permanent ambiguity between being defined as a medical treatment or as a service of technological production of babies.(22) Regarding the interventions undergone to adjust the body to gender identity, the globally used manuals of medical diagnosis have checked or are checking the categories that consider subjective experiences and body desires of transvestites, transsexuals, and transgender people as disorders.(39) In this sense, both medical practices are surrounded by disputes and ambiguities regarding their relation to the creation of diagnostic categories that have originally pursued moralizing purposes.

The idea of enacting legislations of universal access to these medical practices is expressed by certain members of the congress as a threat to the financial rationality of the state. During the debate on gender identity, a male representative expressed his ideas as follows:

> Regarding section 11, which guarantees hormonal and surgical treatments for free, I think the same, that is to say, that the allowance should not be denied, but it should be adjusted so that it does not apply to every single case. I am saying this because it is intended to include in the health system the possibility to ensure allowances, which scope, in my opinion, should be defined [...] We have to be cautious in those cases in which the state is obliged to cover those changes and adjustments. This is the reason why, by a draft we will propose to section 11, we will try not to give a lot of opportunities to esthetic treatments or of any other kind, but to accurately determine which are the treatments the state has to take responsibility for, because it is obvious that it cannot cover them all. [...] I will say in advance that I will be with the majority opinion, stating that I disagree with section 5 and 11,

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> proposing that previous medical, clinical and psychological assessment should be carried out before granting access to medical treatments in public services, prepaid medical care or social security programs. [Male representative Ferrari, stenographic version from November 30, 2011(28)] [Own translation]

In the previous paragraph, it is evidenced how the ability to decide in the medical or judicial field that ruled before the enactment of both laws was used, for some members of the Congress, to assess the interventions according to rational and moral criteria. For the representative, it was necessary *to be cautious* when dealing with hormonal treatments and surgical interventions so that these are not carried out every time they are required. This *caution* refers to two types of things: the kind of intervention (the modification of body aspects that are related to the people's sexuality, sometimes irreversible) and the use of financial resources of the state. This is why he asked to separate real needs from purely esthetic needs. This brings again the problem of who can decide whether an intervention in the case of body adjustment of transvestites, transsexuals, and transgender people is esthetic (superficial, dispensable) or really needed.

When the national rules that govern all over the country were debated, the medical and judicial fields were deprived of the authority to they used to have to decide before these laws came into force. The financing problem reintroduces the moral debates using economic language and categories. If it is either a moral or an economic problem, the arguments aim at watching over the interest of the majority, who may consider that they are being threatened by the desires of certain minority groups. It is no longer about the need of social defense before a moral problem, but about taking care of the state coffers in the face of an economic problem. In the framework of the debate on the Gender Identity Law, this warning covered an ideological debate about the acceptability limits in body interventions: for some representatives, those interventions that are carried out for real needs would be accepted, but interventions that are purely esthetical would not.

Comprehension and its shifts

The arguments that favor the idea of universal access were supported by the notion of comprehensive health, which acquired different meanings in each debate. The female senator Higonet defined the concept of comprehensive health as follows:

> Comprehensive health is not only the absence of a disease, but it also entails general wellbeing. When we learn about life-cycle, when we understand what is to raise a family, it is impossible not to know about or to deny the importance children have, they are our heritage, our seed. We have to deal with this situation of emotional, psychic and social stress of those couples who are not able to fulfill this dream, and the state has to be close to them. When we talk about building up a democratic spirit, when we talk about fair and equitable health, this has a lot to do with making use of science and technology so that those families are able to achieve that dream. [Female senator Higonet, stenographic version from April 24, 2013(40)] [Own translation]

This definition of comprehensive health mentions many of the hypotheses of the World Health Administration,[k] but it includes the achievement of people's reproductive "dreams" and, therefore, the access to technological resources that are needed to such end. During the debate on gender identity, the idea of comprehension was linked to the autonomy of decision, the election of people's life plans, which may include desires to change their bodies. According to the female representative Ibarra:

> We are strongly dealing here with everything that is related to autonomy of decision and to the possibility of designing

> our own life plan without interferences in what we decide to live regarding our body, our identity and our life. For these reasons, we argue that if third parties' rights are not affected or if there are no other rights involved other than the person's own identity and dignity, the state should recognize and respect that identity and mention it on laws, in the national ID and in the comprehensive access to the right of health. [Female representative Ibarra, stenographic from November 30, 2011(28)] [Own translation]

Later on, the same female representative added that:

> We are legislating on real situations, and in this case, on an issue that is elementary as the access to comprehensive health and as living our gender identity in the understanding that the body is attached to such identity, and it is part of that necessary adjustment to live our gender identity. [Female representative Ibarra, stenographic version from November 30, 2011(42)] [Own translation]

In this paragraph, comprehensive access to health is also linked to an idea that exceeds the mere absence of the disease. It refers to the idea of general wellbeing that is focused on building up an identity and a body that *goes with* the identity and cannot be separated from it. As this representative stated, the need to *legislate based on real situations* came up on both debates. Regarding the debate on assisted fertilization, it involved recognizing that the offer of certain medical technologies is available in Argentina and that the fact that there is no regulation about that results in an unequal distribution of such services and the impossibility to regulate their practices. The law was deemed necessary in two aspects: 1) regarding the medical practice itself (control of the use of technology: renderers' registry, amount of donations allowed by donors, etc.) and 2) regarding access democratization, because, since these practices occur in private health institutions, only people who have more economic resources could have access to them. Before the law came into force, it was the market mechanisms and the moralizing mechanisms in force in the medical field which determined the allowances of those technological-medical resources.

During the debate on the Gender Identity Law, the term *to legislate based on real situations* referred to the modification of public devices that define and assign people's identity and that, unknowing the reality of genders and sexuality, introduce and worsen stigmatization and discrimination. Regarding hormonal and surgical treatments in public health care, this implied undergoing interventions that were prohibited or carried out without medical supervision and in conditions that threatened patients' health.

In both debates, the body was explicitly considered in two spheres, the natural and the sociocultural spheres, as well as the way in which medical techniques of body adjustment connect both dimensions. In this context, the idea of comprehensive health triggers the moralizing debates based on financing. This idea of comprehensive health, present in both debates with their specifics, may be then understood as the link between biocitizenship-related demands of certain social groups and public policies of health financing.

CONCLUSIONS

The aim of this research study is to address the recent changes in the public regulations based on the body. To this end, it was dealt with the parliamentary debates carried out in the Argentine National Congress, in which the Gender Identity Law and the Assisted Fertilization Law were debated during 2011 and 2013. The aspects chosen when dealing with both laws make it possible to see the characteristics that the recent processes of claim for rights and public policies design have regarding the desires of body adjustment and/or optimization.

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First, the arguments and tensions regarding the objective and mission of these laws were addressed. During the debates on the Assisted Fertilization Law, the controversy between exercising a right based on a disease or considering it a universal right was thoroughly discussed. Regarding the Gender Identity Law, there was greater consent regarding the idea that it was a law aimed at a particular minority and that its effects would positively affect the entire social group. In both debates, male and female national legislators characterized the regulations under debate as laws that were enacted to settle a social debt owed by the state before certain specific social groups.

Later, the discussions about the public financing of the medical allowances under debate were analyzed. By the use of economic language and categories, the economic discussion covered up a moral discussion related to the boundaries of what is considered legitimate and illegitimate regarding the uses of the body. This discussion was carried out considering two opposed positions: that of rationality in the allowance of public resources and that of universal access. The first position required an evaluation of financing and access to treatments, whose role was assigned to the medical field. In the opposite position, it was stated that it was not about regulations related to pathologies but to people's desires – reproductive desires or identity constructions. Since these desires cannot be assessed, access to these practices should be universal.

The idea of enacting universal access legislations for certain medical practices was considered by certain congress members as a threat to the financing rationality of the state. This discussion came to an end with the introduction of the term "comprehensive health" in reference to a notion of general wellbeing that includes people's reproductive dreams and desires and that also respects people's life plans, thus including the building of a body identity that corresponds to their own identity.

Regarding the analyses of both debates, there is still a lot to be considered about the dynamics of claim for rights in the light of the processes of current identities adjustments. Considering the cases selected, it is possible to discern the process of demand of specific public policies by groups of people who experienced body vulnerability. In both cases under study, the state considered both laws as a way to settle a social debt owed to those groups and, to this end, it was based on the notion of "comprehensive health."

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ENDNOTES

a. The Argentine civil-military dictatorship took place between 1976 and 1983.

b. The Compulsive Medical Program was created in 1995 by executive order No. 492/95. This program was based on Act No. 23661 (1989), which created the National Health Insurance System and which, according to Susana Belmartino,(3) took place during a crisis of hyperinflation and deregulation of the system of services. In this context, the hospitals were transferred to the provinces and there was decentralization towards the municipalities.

c. The Argentine Gender identity Law was regulated in its civil aspects (name and sex change in the official national ID) by executive order No. 1007/2012 and in its health aspects by executive order No. 903/2015. The Assisted Fertilization Law was ruled by executive order No. 956/2013 a month after being enacted.

d. The first successful pregnancy accomplished by in vitro fertilization occurred in 1978 in England by doctor Robert Edwards.

e. According to the author, the central concepts of the ethical debates are based on the possibility or impossibility to discard supernumerary embryos. In the case of choosing not to discard them, it would be compulsory to donate them under the term of "prenatal adoption." These debates were also based on the possibility to make genetic diagnosis before implanting the embryos.(11)

f. The first "sex reassignment surgery" was undergone in Germany in 1931 by Lili Elbe, who died after the intervention. It implied creating a neovagina in a male body. Later, the first successful intervention was carried out in Denmark in 1952.(12)

g. Decision of the First Court of Appeals in Civil and Commercial Matters in San Nicolás in 1994 made by judges Juan C. Maggi and Carlos A. Vallilengua.

h. It is worth mentioning that similar techniques are used without requiring any judicial authorization in the cases of babies who were born with incomprehensible genitalia in accordance with the hegemonic regulations on gender. Under the criteria of "medical urgency," their genitalia is surgically intervened in order to be adapted to the normal criteria regarding genitalia.(15)

i. Two of the bills under debate were submitted by coalitions of sexopolitical organizations. The bills 7643-D-2010 and 7644-D-2010 were issued by the Argentine Federation of Lesbians, Gays, Bisexuals and Trans (FALGBT) [*Federación Argentina de Lesbianas, Gays, Bisexuales y Trans*], which gathers, among other organizations, the Argentine Association of Transvestites, Transsexuals and Transgender People (ATTTA) [*Asociación de Travestis, Transexuales y Transgéneros de Argentina*]. The bill No. 8126-D-2010 was the initiative of the National Front for the Gender Identity Law, gathering Agrupación Nacional Putos Peronistas; Asociación de Lucha por la Identidad Travesti y Transexual (ALITT); Cooperativa Nadia Echazú; Hombres Trans Argentinos; Movimiento Antidiscriminatorio de Liberación (MAL); Futuro Trans; Encuentro por la Diversidad–Córdoba; Movimiento de Integración Sexual, Étnica y Religiosa (MISER); Antroposex; Organización Viudas de Perlonher; Jóvenes por la Diversidad; Escénika Arte y Diversidad; Cero en Conducta (Santiago del Estero); ADISTAR-Salta, Comunidad Homosexual Argentina, Asociación por la Igualdad de Derechos (APID); Crisálida (Tucumán); Ave Fénix; Asociación de Mujeres Meretrices Argentinas (AMMAR) Córdoba; and independent activists.

j. The critics to the diagnostic categories of the medical field are the central concept of the campaign "Stop Trans Pathologization 2012"(38) created in Spain in 2007. Local organizations join this campaign, which aims at removing the diagnostic categories that appear in the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association and the International Classification of Diseases (ICD) of the World Health Organization.

k. The Constitution of the World Health Organization signed in 1946 by the representatives of 61 states that took part in the International Health Conference defines health as "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."(41)

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