# Who's Paying for IVF?

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This week, two stories on the front page of the National Post are relevant to the ongoing discussion about public funding of IVF. The first story is about a Halifax woman who has been waiting 11 years to be seen by a foot surgeon. The surgeon currently has a waiting list of 3,500 patients. The second story is about the Quebec government's plan to index tuition fees for university students which would result in an approximate annual increase of 3%. Five thousand students took to the streets in protest. Meanwhile, at least one University rector in Quebec has pointed out that limited funding is having an impact on the ability of the province's four medical schools to maintain accreditation.

These two stories – one about funding problems for the health care system, the other about funding problems for the educational system – are relevant to the debate about public funding of IVF. If we can't adequately fund current health and educational programs, which arguably benefit all Canadians, how can we justify additional expenditures aimed at responding to the desire of the few infertile Canadians who seek medical assistance to have children.

IVF costs between $7,000 and $10,000 a cycle. Often more than one cycle is required to achieve a live birth. Currently, Quebec is the only province to publicly fund IVF and it has done so since August of 2010. Originally it was estimated that in the first year the program would cost about 32 million. Since then, the total cost is believed to have more than doubled. Official information to confirm this, however, is not easily available.

The proponents of public funding for IVF are quick to put the program costs into a broader social context. They insist that this expense to the health care system is offset by savings resulting from reduced admissions to the neonatal intensive care unit (usually referred to as the NICU).

With IVF it is not uncommon for fertility doctors to transfer more than one embryo per cycle. This practice is known to result in twin, triplet and higher order pregnancies. The infants are often born pre-term (less than 37 completed weeks of gestation) with low birth weights (less than 2,500 grams). These infants are at risk of learning disabilities, developmental delays, visual and respiratory problems, and they typically require admission to the NICU. In the NICU they can receive special care during the first days, weeks, months of life.

Not only do multiple pregnancies and pre-term births represent a significant potential harm to newborns, they also represent a significant cost to the health care system. In Canada, the average hospital cost for full-term babies is $1,050. The average hospital cost for babies born less than 28 weeks gestation is $84,235.

An obvious way to reduce costly admissions to the NICU is to reduce the number of premature, low birth weight newborns. One way to achieve this is to reduce the number of embryos transferred in an IVF cycle. The problem with this seemingly straightforward strategy, however, is that IVF is privately paid for and the paying customers insist on transferring multiple embryos per cycle and taking a chance on having multiple births. Physicians, who are sympathetic to their patients' financial considerations, do as their patients direct. The only way to change physician practice is for the government to pay for IVF. If IVF were publicly-funded, then physicians would limit the number of embryos transferred – or so the argument goes.

The problem with this argument is that it presupposes that the only way to have physicians reduce the number of embryos transferred in an IVF cycle is for the government to pay for IVF. This is a false supposition. There is a more obvious

(and cheaper) way of achieving the laudable goal of reduced embryo transfer. This alternative would have physicians practice in accordance with the standard of care, as outlined in clinical practice guidelines.

There is the 2010 joint Society of Obstetricians and Gynaecologists of Canada and Canadian Fertility and Andrology Society *Clinical Practice Guideline on Single Embryo Transfer*, and the 2013 *Clinical Practice Guideline on the Number of Embryos Transferred* published by the Canadian Fertility and Andrology Society. Physicians should follow these guidelines. They should practice good medicine and reduce the number of embryos transferred per cycle, regardless of who is paying for the IVF.

The bottom line is that the health care system and the educational system are short on funding. There are priorities in both of these systems that need to be addressed, for the benefit of all Canadians, long before we debate the merits of having tax payers support the reproductive goals of infertile Canadians who seek medical assistance. Moreover, when it is time to debate this issue, we will want to look carefully at funding in support of family-making, not just funding for IVF. There are many legitimate ways of making families (including international adoption which can be as costly (and in some instances more costly) than IVF). There is no principled reason for the government to preferentially support (through financing policies) one way of making families over another.

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