

À: Robert Salois, Commissaire à la santé et au bien-être, Québec

De: Françoise Baylis et Ryan Tonkens, Novel Tech Ethics, faculté de médecine, Université Dalhousie

Sujet: Consultation sur les activités de procréation assistée au Québec

On August 5, 2010, Québec became the first Canadian province to publicly fund open access to *in vitro* fertilization (IVF).¹ Québec residents (women or couples) who experience infertility or have a heritable genetic condition can have up to three stimulated, or six un-stimulated (i.e., modified natural) IVF cycles paid for by the public health care system.²

This public policy aims to: (1) increase access to fertility treatment; and (2) reduce costs to the provincial health care system by reducing the multiple birth rate (by 25%) which, in turn, would reduce the number of admissions to the neonatal intensive care unit for the treatment of premature twins, triplets or higher-order multiples. Hospital costs for the treatment of preterm babies is considerably higher than the cost of care for full-term babies. According to data from the Canadian Institute for Health Information, the average in-hospital cost for full-term singleton babies is \$1,050. The average in-hospital cost for singleton babies born premature (less than 28 weeks gestation) is \$84,235.³ And, obviously, this dollar figure increases significantly with the premature birth of twins, triplets or higher-order multiples.

Publicly available information (which is limited) suggests that the first of the two public policy objectives – to increase access to fertility treatment – has been met. A press release by the Société Québécoise de Fertilité et d'Andrologie (dated May 27, 2011) reported an increase in the number of completed IVF cycles in the first six months of Québec IVF funding. There were 2,403 completed IVF cycles between August 5, 2010 and February 5, 2011, compared with 1,831 in 2009.⁴

As regards the second objective – to reduce costs to the provincial health care system – publicly available information is incomplete. In 2011, François Bissonnette, using data from the CARTR database, reported that in the first six months of Québec IVF funding, elective single embryo transfer occurred 49% of the time (compared with 1.6% before), and the occurrence of twinning and higher-order multiples dropped to 5.2% (compared with 27.2% before).⁵ Bissonnette also reported a noticeable reduction in the clinical pregnancy rate to 31% overall (compared with 42.7% before). A more recent

¹ Gouvernement du Québec. Loi sur les activités cliniques et de recherche en matière de procréation assistée. http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/A_5_01/A5_01.html

² Gouvernement du Québec. Programme québécois de procréation assistée. Available from: <http://sante.gouv.qc.ca/programmes-et-mesures-daide/programme-quebecois-de-procreation-assistee/>

³ Canadian Institute for Health Information. 2009. Too early, too small: A profile of small babies across Canada. https://secure.cih.ca/free_products/too_early_too_small_en.pdf

⁴ Société Québécoise de Fertilité et d'Andrologie (May 27, 2011). Press release. http://www.cfas.ca/index.php?option=com_content&view=article&id=1121%3Afirst-sqfa-conference&catid=1014%3Aquebec&Itemid=691

⁵ Bissonnette, F. First 6 months of the Quebec ART program. http://www.cfas.ca/index.php?option=com_content&view=article&id=1123%3Afirst6-qc-en&catid=1014%3Aquebec&Itemid=691

review of data from Bissonnette's IVF clinic (OVO) confirms these provincial trends. Comparing data from 2009 with data for the year following public funding (August 5, 2010 – August 4, 2011), elective single embryo transfer occurred 85% of the time (compared with 17.3% before), and the multiple pregnancy rate dropped to 1.6% (compared with 25.8% before). The ongoing clinical pregnancy rate dropped from 31.9% to 23.3%, with a cumulative clinical pregnancy rate of 29.7% (this rate includes a second cycle involving a vitrified-warmed embryo transfer).⁶

Overall, these data are promising and seem to indicate at least partial achievement of the two goals motivating the decision to publicly fund IVF.

This brief submission identifies ethical concerns with each of these public policy goals.

1. Increase access to fertility treatment

- 1.1. *By selectively funding IVF, the Québec government evidences a preference for a high-tech response to infertility. This is unjustified and discriminates against those who prefer a no-tech option and those who pursue a no-tech option having failed to meet their reproductive goals through IVF.*
- 1.2. The Québec government should maintain a neutral stance regarding the means by which medically or socially infertile individuals and couples become parents – whether through assisted human reproduction or adoption. Both of these family-making strategies are legitimate and characteristically expensive. It is estimated that the cost of IVF in Canada is approximately \$15,000 per cycle. The cost of domestic adoption through a licensed private agency ranges from \$10,000 to \$20,000 and for international adoption the cost can be as high as \$30,000.⁷
- 1.3. Adoption can satisfy the goals of people who desire to found or expand a family of their own. On average, there are 2500 domestic adoptions in Canada every year (with an additional 2000 international adoptions to Canada).⁸ In 2011, there were 6800 clinical pregnancies in Canada that resulted from the use of assisted reproductive technologies.⁹ It is unclear why the government publicly funds IVF instead of funding family-making projects which individuals or couples could choose to pursue through IVF or adoption depending upon their preference for high-tech or no-tech solutions to unwanted infertility.

2. Reduced costs to the provincial health care system

- 2.1. *Where possible and appropriate, the Québec government should look for ways in which to administer the publicly-funded health care system in a cost-effective manner.*

⁶ Velez, M., I. Kadoch, S. Phillips, & F. Bissonnette (2012). Rapid policy change to single-embryo transfer while maintaining pregnancy rates per initiated cycle. *Reproductive Biomedicine Online*, 26(5): 506-511.

⁷ Adoption Council of Canada, <http://adoption.ca/faqs>.

⁸ Adoption Council of Canada, <http://www.adoption.ca/family-bonds>.

⁹ 2011 CARTR Results. Canadian Assisted Reproductive Technologies Register. 2001 Pregnancy Outcomes. http://www.cfas.ca/index.php?option=com_content&view=article&id=1207:2011-cartr-results&catid=1012:cartr&Itemid=670

- 2.2. *The laudable goal of promoting single embryo transfer, and thereby reducing the multiple birth rate and promoting the health of pregnant women and newborns, does not depend on assisted reproduction services being publicly funded.* As an alternative, the government could simply mandate physicians to practice in accordance with the standard of care in Canada. In 2010, the Joint Society of Obstetricians and Gynaecologists of Canada and Canadian Fertility and Andrology Society Clinical Practice Guidelines were published encouraging elective single embryo transfer.¹⁰ Since then, in 2013, the Canadian Fertility and Andrology Society published *Clinical Practice Guidelines on the Number of Embryos Transferred* which states unequivocally that the goal of IVF should be the birth of a healthy singleton.¹¹ Physicians should practice good medicine and reduce the number of embryos transferred per cycle (predominantly to single embryo transfer), regardless of who is paying for IVF.
- 2.3. Interventions other than IVF contribute significantly to the multiple pregnancy rate (e.g., ovarian stimulation). Public funding of IVF does not impact this source of multiple births.

CONCLUSION: Using provincial tax dollars to fund IVF is neither a wise nor a fair investment.^{12,13}

There is no doubt that infertility can be very distressing for those that are affected by it, given their desire to found or expand a family. Yet, infertility affects only a minority of Quebecers. It is estimated that 11.5-15.7% of couples in Canada experience infertility¹⁴ and that only about half of these couples will seek medical treatment for it.¹⁵ Added to this total are those who want access to IVF for social infertility (e.g., gay couples who want to create a family using IVF). This means that there may be 6-8% of Quebecers who might benefit from public funding of IVF.

In sharp contrast, 100% of Quebecers would benefit from ready access to the services of a qualified general practitioner, increased subsidization of pharmaceutical care, reduced wait times and increased support for dental care. Increased public funding for these health services would benefit many more citizens than does the public funding of IVF. Indeed, in the face of these needs, it is hard to ethically justify spending millions on the interests of a discrete minority – those who want free access to IVF.

¹⁰ Min, JK, Hughes, E., and Young, D. Joint Society of Obstetricians and Gynaecologists of Canada – Canadian Fertility and Andrology Society Clinical Practice Guidelines Committee. (2010). Elective single embryo transfer following in vitro fertilization. *Journal of Obstetrics and Gynaecology Canada*. 32(4): 363-377. http://www.jogc.com/abstracts/201004_SOGCClinicalPracticeGuidelines_3.pdf

¹¹ Min, JK, and Sylvestre C. Canadian Fertility and Andrology Society Clinical Practice Guidelines Committee. (2013) *Guidelines on the number of embryos transferred*.

http://www.cfas.ca/images/stories/pdf/cfas_cpg_embryo_transfer_2013.pdf

¹² Baylis, F. (July 13, 2012). Say no to public IVF funding. <http://o.canada.com/2012/07/13/say-no-to-public-ivf-funding/>

¹³ Baylis, F. (February 27, 2013). Who's paying for IVF? <http://www.themarknews.com/articles/whos-paying-for-ivf/#.UadOPqPNipo>

¹⁴ Busnik, T., Cook, J., Yuzpe, A., Tough, S., and Collins, J. (2012). Estimating the prevalence of infertility in Canada. *Human Reproduction* 27(3): 738-746.

¹⁵ Boivin, J., Bunting, L., Collins, J.A., and Nygren K.G. (2007). International estimates of infertility prevalence and treatment-seeking: potential need and demand for infertility medical care. *Human Reproduction*. 22(6): 1506-1512.