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Voluntary sterilisation and access to IVF in Québec

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ABSTRACT

Bill 20, An Act to Enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation, was introduced to reduce costs associated with Québec's healthcare in general and in vitro fertilisation (IVF) in particular. Passed in November 2015, the new law introduces a number of exclusion criteria for access to and funding for IVF treatment. Remarkably, one exclusion criterion—prior voluntary sterilisation—has prompted little critical commentary. The two justifications offered for restricting funding for IVF on the basis of voluntary sterilisation are that (1) there are cheaper options than IVF for sterilised individuals who want children, and (2) society should not have to pay for IVF for persons who are infertile by choice. I argue that both of these justifications are unsatisfactory, insofar as they contravene the chief value underlying, and current practices of, Canadian healthcare, and rely on problematic ascriptions of personal responsibility for health.

INTRODUCTION

In an effort to curb rising costs associated with Québec's healthcare system in general and in vitro fertilisation (IVF) programme in particular, Health Minister Gaétan Barrette introduced Bill 20, *An Act to Enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation*.[1] The Bill passed in November 2015.[2] The new law introduces a number of constraints on access to IVF in Québec, including (1) moving IVF coverage out of the realm of public health insurance (Régie de l'assurance maladie du Québec (RAMQ)) and into the realm of tax credits; (2) requiring individuals (both male and female) who use third-party donated eggs or sperm to receive a positive psychosocial assessment; (3) limiting the number of embryos transferred during IVF to one embryo for women under 37 years and two embryos for women 37 years and over; (4) restricting coverage for IVF to individuals who do not already have children; and (5) excluding from coverage individuals who have undergone voluntary sterilisation.[1]

Many of these constraints have been subject to much public debate. For example, the move of IVF coverage to tax credits has been criticised as unfair to lower income families, rendering IVF a feasible option for only a select few.[3] The requirement of a positive psychosocial assessment of those using donated reproductive materials has been criticised as discriminatory, since it disproportionately affects same-sex couples who must rely on donated reproductive materials.[4] However, surprisingly little attention has been paid to the exclusion of individuals who have previously undergone voluntary sterilisation. The focus of this paper is on the legitimacy of this exclusion criterion.

The two justifications offered for restricting funding for IVF on the basis of voluntary sterilisation are that (1) there are cheaper options than IVF for sterilised individuals who want children, and (2) society should not have to pay for IVF for persons who are infertile by choice.[5] In what follows I argue that both justifications are unsatisfactory. I argue, first, that appealing to cost in this case is at odds with current practices in Canadian healthcare, and assumes, falsely, that IVF and its cheaper alternative are equally desirable. Second, I argue that denying IVF on the basis of a prior choice is problematic because (1) it contravenes the chief underlying value of Canadian healthcare that need alone should determine access to healthcare resources, and (2) it does not follow that individuals ought to be held responsible for their decisions to become sterilised in a way that would justify excluding them from funding for IVF.

While the focus of this paper is IVF access in the Canadian context, much of the discussion here—particularly pertaining to the extent to which individuals can properly be held responsible for their health-related decisions—is generalisable to other jurisdictions that impose similar restrictions to IVF access on the basis of prior sterilisation. This includes the UK, where the National Health Service (NHS) does not provide funding for either sterilisation reversals or fertility treatment, including IVF, to individuals who have undergone voluntary sterilisation.[5 6] It also includes parts of the USA, where some states mandate IVF insurance coverage, but limit that coverage to individuals who have not undergone voluntary sterilisation.[7 8]

VOLUNTARY STERILISATION AND OPTIONS TO REGAIN FERTILITY

According to a 2002 Canadian contraceptive study, voluntary sterilisation was the most common method of contraception among married Canadian couples between the age of 35 and 44 years.[9] Québec has the highest proportion of sterilised couples (53%) among all Canadian provinces.[10] For women, sterilisation is typically carried out by tubal ligation, a process where a woman's fallopian tubes are cut or blocked in order to prevent pregnancy. Female sterilisation by tubal ligation is intended to be a permanent method of contraception and appropriate only for women who do not wish to have any future children. However, there is a chance that a woman will later come to regret her sterilisation and seek ways of re-establishing her fertility. Contemporary Canadian data on the rate of sterilisation-regret are limited. A 1981 study of the rate of regret among 495 sterilised women in

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Montreal revealed that 5% of women between the ages of 25 and 44 years experienced regret after sterilisation, as measured by a retrospective questionnaire about their attitudes towards their sterilisations.[11]

A number of factors have been identified as increasing the likelihood that a woman will experience regret after sterilisation. These include (1) young age at the time of sterilisation,[11–13] (2) change in marital status after sterilisation[9] and (3) loss of a child.[14] Prior to the introduction of Bill 20, voluntarily sterilised women who wished to have children had two options, tubal sterilisation reversal and IVF, both of which were covered under the provincial healthcare plan.[15 16] Bill 20 changed this and now excludes women who have undergone voluntary sterilisation from coverage for IVF.

JUSTIFICATION FOR EXCLUSION ON THE BASIS OF VOLUNTARY STERILISATION

The availability of cheaper alternatives

The first justification for excluding individuals who have been voluntarily sterilised from IVF coverage appeals to the cost of IVF relative to the alternative, namely tubal sterilisation reversal.[5] The cost for tubal sterilisation reversal is between $C600 and $C800.[15] The cost of one cycle of IVF will depend on the fertility clinic where it is offered and is approximately $C5500.[17] This price excludes the additional costs of adjunct services, including consultation, intracytoplasmic sperm injection (ICSI), ultrasound and medications.[17] At three cycles (which is the number of cycles the provincial plan currently covers) the amount expended on IVF per couple would exceed $C16 000.

Thus, it is clear that sterilisation reversals are cheaper than IVF treatment. However, what is not clear is exactly how much money will be saved by excluding voluntarily sterilised individuals from IVF coverage. To determine costs saved, one would need to know the number of people who are currently voluntarily sterilised; of those, how many experience regret of sterilisation; of those, how many would prefer IVF to reversal if given the option between the two; and finally, how many would not already be excluded from IVF by other considerations. Most individuals who undergo voluntary sterilisation have already had at least one child,[11] and this would already preclude them from accessing IVF under the exclusion criteria.

But even if the saving from excluding the voluntarily sterile from IVF funding were tremendous, in the Canadian context, where healthcare resources are allocated on the basis of medical need and need alone,[18] patients are not confined to the cheapest available option. In fact, in some cases, only the more expensive option is provided to patients by the healthcare system. For example, coverage for reconstructive breast surgery is offered to a woman following a mastectomy, even though a prosthesis would be a cheaper option. This invites the question why IVF should be treated any differently.

If IVF and tubal sterilisation reversals were both equally desirable, then appeal to cost might have some bite. But this is not so. To be sure, tubal sterilisation reversals carry with them certain benefits that IVF does not. These include the permanent restoration of fertility (if the reversal is successful), freedom from further intervention after the procedure (as would be needed for IVF), reduced risk of ovarian hyperstimulation syndrome[19] and lower risk of multiple pregnancies.[14] However, tubal sterilisation reversals also carry with them significant drawbacks. First, they require surgical intervention, which carries added risk. Second, sterilisation reversal procedures require the use of subsequent contraception or possibly another sterilisation procedure if no further children are desired (and if that is the preferred method of contraception).[20] Third, for women 37 years and older, pregnancy rates are significantly lower following tubal sterilisation reversal than they are following IVF.[21] Fourth, the length of time to pregnancy after tubal sterilisation reversal is longer than in the case of IVF.[19] Fifth, there is an added risk of ectopic pregnancy following tubal sterilisation reversals. Sixth, with the popularity of IVF the number of tubal sterilisation reversals has declined, and with this so too has the surgical expertise required to perform them.[14] Seventh, depending on the way that the tubal sterilisation was performed, tubal sterilisation reversal may not be possible.[21] Finally, tubal sterilisation reversal will not be a feasible option for same-sex couples and couples where the male partner has fertility issues. Thus, sterilisation reversals and IVF will not clearly be equally desirable for everyone. The appeal to cost—and specifically the fact that sterilisation reversal procedures are cheaper than IVF—to limit coverage for IVF fails to recognise this fact.

The significance of choice

The second justification for exclusion on the basis of voluntary sterilisation appeals to the significance of an individual's choice to become sterilised.[5] But how individual choice justifies restrictions on access to medical services is not obvious. Indeed, in the context of the Canadian healthcare system, individuals are not normally held responsible for their choices in this way. That is, scarce medical resources are not allocated on the basis of whether an individual's illness or condition that requires expenditure of those resources was a result of that individual's choice. For example, individuals who chose to smoke do not receive lower priority for treatment of lung disease than those who did not. Nor is an individual who chose to go rock climbing given lower priority for treatment for a broken leg than an individual who slipped on an icy sidewalk.

Canada may be unique in this regard, especially in the light of a growing trend towards holding persons responsible for their health-related choices. In the UK, where restrictions similar to those in Canada on IVF access are in place, resources are often allocated on the basis of whether an individual has made 'responsible' choices concerning their health. For example, the NHS has recently implemented rationing criteria that preclude the obese and smokers from undergoing non-life-threatening operations such as hip replacements.[22] A similar trend is evident in the USA, where, in an effort to encourage individuals to lead healthier lifestyles, some organisations have adopted policies that will refuse employment to smokers.[23]

There are arguments that can be advanced in defence of holding persons responsible for their health-related choices in this way.[24 25] The most prominent such defence is found in luck egalitarianism.[26] For the luck egalitarian, inequalities are tolerable if those inequalities arise from choices for which individuals can reasonably be held responsible. According to this view, unequal distributions of goods (which may include healthcare resources) are just if those goods are distributed according to factors for which agents are responsible; unjust if those conditions are brought about by 'brute bad luck'.[27] In the case of the distribution of IVF funding, one may argue that the unequal distribution of funding for IVF is just insofar as the group that receives funding is infertile by bad brute luck (eg, a blocked fallopian tube), whereas the group that is excluded from funding is responsible for their infertility by virtue of having chosen to undergo sterilisation.

To evaluate this line of argument, it will be useful to look more closely at the concept of responsibility. Gerald Dworkin

distinguishes three senses of responsibility: role responsibility, causal responsibility and liability responsibility.[25] Role responsibility speaks to the activities that fall under the purview of a particular role. For example, as an employee, I am role-responsible for carrying out the tasks that fall under my job description; as a parent I am role-responsible for ensuring the well-being of my children. Role responsibility is not relevant to our discussion, and so I will not further consider it here. Causal responsibility refers to the causal role an action or event plays in bringing about a particular outcome. If I push Jones, I am causally responsible for him falling down. Similarly, I may be causally responsible for my atherosclerosis, insofar as I eat a lot of fatty foods. Finally, liability responsibility involves two things: (1) culpability and (2) liability. To deem an individual culpable for an action or outcome is to say that the action or outcome was that individual's fault. To deem an individual liable for an action or outcome is to say that certain consequences (eg, punishment) follow from that judgement. To deem me liability-responsible for Jones' fall involves blaming me and assigning consequences to my action. Likewise, to deem me liability-responsible for my atherosclerosis involves blaming me for my condition and requiring me to either live with it or bear the cost to have it remedied.

The above distinctions reveal that ascribing responsibility to someone for a particular act or outcome can mean a number of things. Furthermore, it is important to note that not all ascriptions of causal responsibility legitimise an ascription of liability responsibility. There is a difference between my tripping and consequently pushing Jones and my deliberately pushing him. In both cases, I am causally responsible for Jones falling. But only in the latter case should I be held at fault and penalised for his falling down. In short, establishing causal responsibility does not necessarily entail liability responsibility, and there is a danger in conflating the two and drawing normative conclusions from non-normative causal facts.

To return to our case of IVF funding, it is clear that the Québec government is holding persons liability-responsible for their infertility. What is not clear is why such an ascription of responsibility should follow from the fact that an individual previously chose to become sterilised. Take, for example, a woman who has undergone a voluntary sterilisation many years ago, but now wants to use IVF to have a child. In this case, the woman is causally responsible for her infertility, insofar as it was her decision to undergo sterilisation. But it does not necessarily follow that she ought to be held liability-responsible for her infertility. There may be extenuating circumstances that reduce or eliminate the level of liability responsibility she may have. Unless it can be shown that the woman's choice to become sterilised entails liability responsibility, limiting the funding she receives for IVF on the basis of voluntary sterilisation is unjustified.

There are a number of ways in which liability responsibility can be reduced or eliminated. The first would be if an individual's choice was not fully voluntary. The voluntariness of an individual's choice can be affected by a number of factors, including coercion from others. A woman's decision to become sterilised may have been influenced by pressure from her family or social group not to use contraception. Or her husband may have threatened to leave her if she did not consent to sterilisation.[12] The voluntariness of one's choice can also be affected by one's circumstances. A woman may have had limited access to alternative reliable contraceptive methods, or felt that sterilisation was the best option to alleviate the financial burden that a child would bring. She may also have been in an unstable or abusive relationship when she sought sterilisation, as evidence suggests is sometimes the case.[11] In all these cases it would seem inappropriate to claim that the woman's sterilisation was her fault, and to require that she bear the consequences of that sterilisation.

The second way of reducing or eliminating liability responsibility would be to say that the now-voluntarily sterilised woman lacked sufficient information about the consequences of her actions. Such a condition would obtain if, for example, she was not told before sterilisation that in undergoing sterilisation she would be ineligible for IVF. Indeed, since limiting funding for IVF for those who have been voluntarily sterilised is a new restriction introduced by Québec's new law, it is doubtful that this condition could be satisfied for the women who will most immediately be affected. Thus, at minimum, a new law that restricts funding for IVF on the basis of prior sterilisation would need to accommodate those who were sterilised prior to that restriction.

The foregoing discussion reveals that there are numerous factors surrounding voluntary sterilisation that reduce or eliminate the extent to which individuals can be properly held liability-responsible for their infertility. This should cast doubt on the appropriateness of using individual choice as a criterion for allocating scarce health resources generally and funding for IVF particularly. Furthermore, there may be unintended undesirable consequences of implementing a policy that limits funding for IVF for those who are voluntarily sterilised. As was previously mentioned, women who underwent sterilisation before the age of 30 or began building their families early are often the ones who later come to regret their decision to become sterilised.[13] Early family-building is correlated with lower income and education levels.[28] In fact, there is further evidence that sterilisation by tubal ligation tends to be more common in women with lower education levels.[29] All these considerations suggest that to restrict access to IVF in the way Québec has done is to do so on the basis of characteristics that are correlated with membership to an already disadvantaged class of individuals. Women who are under the dominance of others, in unhappy relationships, or poor and uneducated bear the brunt of the law, and thus the law runs the risk of further burdening those individuals. Fairness requires that any burdens that a policy designed to save money place on others be distributed equally in all socioeconomic groups, unless there is a morally relevant reason why an unequal distribution of burdens is permissible. Québec's new law violates this requirement.

Finally, the luck egalitarian framework that the justification for exclusion on the basis of voluntary sterilisation rests can be challenged as too unforgiving. Luck egalitarians maintain that inequalities that are not the result of individual choices should be redressed; those that are the result of individual choices should not be redressed. Thus, by a luck egalitarian standard, a just society will tolerate inequalities if they are brought about by the voluntary choices that individuals make. The problem is that many people's voluntary choices can sometimes have very bad outcomes that it would seem improper for any standard of justice to not redress. As Elizabeth Anderson argues, to allow individuals to suffer—from poverty or illness, for example—and claim that such a state of affairs is just, simply because those individuals made voluntary choices that led to those outcomes, reveals a serious defect in the theory.[30]

The basic complaint is this. People make choices they later regret. Sometimes these choices are hastily made; other times, they are made after careful deliberation. To hold people liability-responsible for those choices is harsh—too harsh—especially when, as in the case of healthcare, the penalties attached are severe. Thus, even if it could be well established that an

individual's choice was fully voluntary, informed and made in the absence of any responsibility-mitigating factors, it does not follow (without considerable further argument) that an individual should be held liability-responsible for the consequences of her choices. In our IVF example, even if it was the case that a woman's sterilisation was voluntary, it does not follow that she should then be excluded from receiving funding for IVF treatment because that consequence is excessively severe.

CONCLUSION

I have argued that the justifications offered for exclusion from IVF coverage on the basis of prior voluntary sterilisation are weak. The arguments on the basis of cost are at odds with current practices of allocating healthcare and leave those who want a child with the option of surgical reversal, which may not be their first choice or one with the greatest chance of success. The arguments on the basis of a prior choice to be sterilised contravene a fundamental value of the Canadian healthcare system by making access to treatment determined by something other than need. There will also often be mitigating factors that reduce or eliminate the degree to which individuals can be held liability-responsible for having chosen to be sterilised, and limiting funding on the basis of voluntary sterilisation risks disadvantaging an already disadvantaged group of individuals. Finally, allocating medical resources on the basis of a prior choice relies on a problematic framework for justice that places harsh and undue burdens on individuals. Thus, those who wish to defend the legitimacy of exclusion on the basis of voluntary sterilisation will need to offer some other justification for this exclusion criterion.

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Notes