

RESEARCH ARTICLE/ÉTUDE ORIGINALE

Medical Necessity and the Public Funding of In Vitro Fertilization in Ontario

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Abstract

The recognition of a health care service as medically necessary under the Canada Health Act is contingent on a variety of practical and political factors. This article examines how in vitro fertilization (IVF) came to be understood as a medically necessary service in Ontario, focusing on the establishment of public funding for one cycle of treatment. The article argues that the legitimacy of medical necessity in the contemporary period is tied to three interrelated factors: the recognition of a service as sufficiently “medical,” as efficient and as urgent—that is, something to be funded now and not later. By applying this framework to the case of IVF in Ontario, the article demonstrates not only the ongoing malleability of medical necessity but also how the government of Ontario has mobilized the three aspects of medical necessity to make a case for the public funding of a highly contested health care service.

Résumé

La reconnaissance d'un service de soins de santé jugé médicalement nécessaire en vertu de la Loi canadienne sur la santé dépend de divers facteurs pratiques et politiques. Cet article examine comment la fécondation in vitro en est venue à être considérée en Ontario comme un service médicalement nécessaire, axé sur l'octroi d'un financement public d'un cycle de traitement. Il soutient que la légitimité de la nécessité médicale à l'époque contemporaine est liée à trois facteurs interdépendants, à savoir la reconnaissance d'un acte « médicalement nécessaire », efficace et urgent dont le financement ne saurait être différé. En appliquant un tel cadre au cas de la fécondation in vitro en Ontario, cet article démontre non seulement la malléabilité continue de la « nécessité médicale », mais également comment le gouvernement de l'Ontario a mobilisé les trois aspects pour justifier le financement public d'un service de santé très contesté.

Keywords: Canada; Ontario; in vitro fertilization; medical necessity; public funding; reproductive technologies; infertility

Introduction

The services provided under provincial public health insurance programs vary from province to province. While many services are uniformly covered, there are significant differences in coverage for home care, ambulatory care and eye exams, to name just a few examples. These differences suggest variance not only in the capacity of provinces to provide comprehensive health care coverage but also in their priorities regarding what services are considered essential.

Variations in public funding are particularly evident in services related to women's reproductive health. Access to abortion is one highly politicized example, and there are also significant differences in terms of whether and how provinces fund midwifery care, cervical cancer screening and assisted reproductive technologies such as in vitro fertilization (IVF).¹ In the case of IVF, most provinces have no funding at all, but both Manitoba and Quebec offer tax credits for a range of infertility services and New Brunswick offers a one-time reimbursement of up to \$5000. In 2015, the government of Ontario announced that it would be changing its funding model by funding one cycle of IVF and subsequent embryo transfers for eligible women in the province, for up to 5,000 women per year (this number was raised to 9,000 eligible women per year in 2017) (Snow, 2018: 120).

IVF is an intervention that aids in the conception of a child through the creation of embryos outside the body, with subsequent implantation in a woman's uterus. Direct funding for IVF, unlike initiatives to subsidize reproductive technologies through tax credits or reimbursement programs, requires an explicit articulation of the treatment of infertility as a matter of medical necessity. Funding through provincial health care programs for IVF had previously existed—in the 1980s and early 1990s in Ontario, and more recently, as part of an expansive public funding program for infertility care in Quebec (2009–2015)—but in both cases, funding was rolled back, deemed both unnecessary and too expensive to provide through the public system. Ontario's relatively new program, however, provides a particularly important example, as it takes a different approach, using public health care dollars to provide IVF that is justified in the name of medical necessity but using a program that is delivered outside its publicly funded health insurance program. Ontario is also a useful example, as it is the only jurisdiction in Canada where IVF has been continuously funded—for different populations, in different ways—since the technology's emergence. The variance in the provision of IVF in Ontario over time reveals the complex processes through which medical necessity is recognized and an intervention considered important enough to merit public funding. If policy making may be understood as a matter of discourse construction in which government actors and key stakeholders strategically deploy certain arguments and narratives in order to inform policy change (Bhatia and Orsini, 2016), then policy making in the case of IVF in Ontario provides a critical example of how discourses of medical necessity have been constructed, operationalized and deployed to reorganize the priorities of a publicly funded health care system.

This article interrogates how IVF has been understood and articulated as a site of medical necessity within provincial health care systems, focusing particularly on the province of Ontario. Drawing on analysis of policy documents from 1989 to 2015 and on interviews with key actors that were conducted on the governance

of reproduction in Canada,² the article argues that the recognition of medical necessity in the contemporary period is dependent on three interrelated discourses, which were constructed and mobilized in the case of funding for IVF in Ontario. First, the health service must be recognized as legitimately “medical,” which often occurs through processes of medicalization. Second, the health service must be seen as efficient—as delivering good value for money expended, in terms of health outcomes. Third, the health service must be seen as involving an issue of immediate concern in order to merit consideration as part of the public health insurance program, either as urgent in terms of funding treatment for patients—that is, in cases where health may be rapidly declining—or urgent for government, as in cases where the courts have deemed coverage is necessary. By applying this threefold framework to IVF policy in Ontario, the article traces decision making about a highly contested health care service, demonstrating both the politicization of medical necessity and the malleability of the definitions of *medical*, *efficiency* and *immediacy*, as advocacy groups and their supporters in the then-Liberal government of Ontario used these three concepts as they made a case for public funding, albeit outside the regular provincial health insurance program.

The Bounds of Medical Necessity: Medicalization, Efficiency, Immediacy

The Canada Health Act requires that provinces fund all “medically necessary” hospital services and “medically required” physician services as a condition of federal health transfers to meet the criteria of “comprehensiveness” under the act. The Canada Health Act is absent a definition, however, and physicians have been left to make decisions about what necessity means and to work together with provincial governments to decide what services can and should be funded (Flood and Erdman, 2004). Although there is relatively limited literature addressing how decisions are made about what is “in and out of Medicare” (Flood et al., 2006), scholarship on medical necessity has worked to identify what the term has come to mean in practice. In the early days of provincial health insurance programs, individual physicians simply applied their clinical judgment and provided those services that they felt patients needed, funded in turn because they were provided in hospital or by a physician. However, meanings of medical necessity have changed over time, evolving to “the maximum we can afford” with the rolling back of the welfare state and, more recently, to “what is scientifically justified” and “what is publicly funded across all provinces” (Charles et al., 1997: 365–94). Other research on medical necessity draws on cases where health care services have been removed, or “delisted,” from provincial health insurance programs (Giacomini et al., 2000).

In addition to scholarship on the definition of medical necessity, researchers have provided useful insights about how this language comes to be applied to a particular medical intervention.³ For example, research on Canadian drug policy has suggested that access to health care services is increasingly mediated by marketing campaigns that work to expand the range of illnesses, disorders and conditions addressed by the medical profession (Moynihan and Cassels, 2005). As more conditions and disorders emerge, so too may the range of legitimately funded interventions. Further, Dan Irving (2012) describes how advocates for funded access to gender-confirming surgeries mobilized arguments related to cost savings,

identifying how funding these surgeries would save taxpayers money by preventing alcohol and substance abuse, psychological trauma and exceptionally high rates of suicide. Finally, research on litigation related to health care in Canada suggests that provincial health policy may be influenced by cases calling for the public provision of certain health care services—even when the litigation is unsuccessful (Flood, 2014: 99). If media coverage, support and recognition of a health care service make a convincing case that the service is medically necessary, the service may become a politically charged issue seen to necessitate immediate funding.

Taken together, this scholarship points to three potential influences on the operationalization of medical necessity when provinces consider adding health care services to schedules of benefits, namely medicalization, efficiency and immediacy.⁴ These three factors need not be equally weighted—urgency in the case of a pandemic might be the most important, with the medical nature of the disease or disorder already established and the efficiency of the intervention assumed. Yet as a group, these factors provide some theoretical parameters about what medical necessity is taken to mean, providing an inductive framework for the sorts of health care services that might be considered for public funding.

Medicalization

At the risk of oversimplification, the recognition of a problem as a medical issue is integral to its potential to be funded within provincial health insurance programs. While there are a great deal of problems and interventions recognized easily as medical issues—acute and chronic illnesses, infectious diseases and life-threatening conditions, to name a few—there are others that are not recognized as sufficiently medical.

When new services are included in health insurance programs, their inclusion may be a matter of medicalization: “the process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses and disorders” (Conrad, 2007: 4). The term comes with a critical past, and relevant scholarship has often focused on the implications of over-medicalization and the ways that pharmaceutical companies and other for-profit groups have benefited by framing relatively normal aspects of life as sites for medical interventions, including new drugs or new diagnostic tests or ongoing medical monitoring (Purdy, 2001: 249). At the same time, medicalization may include the ways in which the discovery of new viruses come into the purview of medicine. For example, medicalization can be used to describe the emergence of AIDS or Legionnaire’s disease, and the ways that their treatment has been shaped by social, political and economic factors.

In the case of provincial health insurance programs, medicalization can help explain how some services and interventions come to be included. The widespread use of bone mineral density scans to screen women for osteoporosis and for osteopenia (pre-osteoporosis) is an instructive example. Little was known about osteoporosis until the 1980s, in part because its defining characteristic, a loss of bone mineral density, is a relatively normal part of aging. Marketing to inform women about osteoporosis increased significantly in the 1990s with the development of a new osteoporosis drug. In 1995, Merck, the pharmaceutical company responsible

for the increased marketing, provided subsidies for “bone density testing machines needed to ensure that women would get the diagnosis for which Merck’s drug would be prescribed” (Moynihan and Cassels, 2005: 142–43). Despite a lack of supporting evidence for the intervention, there was a marked increase in bone mineral density testing across Canada in the 1990s (Kazanjian et al., 1999). Bone mineral density testing and treatment for osteopenia is now a routine part of women’s menopausal health care, funded across Canada.

The provision of funded, routine screening for risk of potential future osteoporosis is a matter of medicalization, as osteopenia itself has come to be recognized as a disorder. To this end, medicalization is one important factor in the decision to add new services to provincial health benefits schedules. Health care services need to be either historically conceptualized as serving an important medical purpose or be part of a process of contemporary medicalization in which they are articulated, and rearticulated, as an important medical intervention.

Efficiency

The concept of medical necessity has increasingly included an expectation that funded health services will be effective, insofar as they will be proven to work and to do so in ways that do not put undue financial burdens on provincial budgets (Charles et al., 1997: 378). First, efficiency assumes effectiveness, insofar as the health service improves the health of the patient with regard to the illness, disease or disorder with which they have been diagnosed. This effectiveness is generally determined by identifying the most desirable outcomes for patients and the frequency with which they are achieved. In some cases, assessing effectiveness is straightforward. For example, in the case of patients who have a treatable form of cancer, the most desirable outcome is understood to be treatment that removes the cancer from the body and puts the body into remission. Treatments like surgeries, chemotherapy and radiation that are relatively successful in achieving these outcomes are understood to be effective. The effectiveness of a health care service might also be measured in terms of risks relative to outcome. When a treatment is known to lead to the desired outcome only in a small number of individuals (rather than at a population level) or if it involves significant risks or side effects relative to the desired outcome, it may be viewed as ineffective. There are cases, however, in which effectiveness is difficult to measure. In cases of chronic illness, for example, effectiveness may be measured in terms of quality of life and the absence of adverse events. In terms of IVF, the desired outcome of achieving pregnancy has been the presumed measure of success, although what counts as efficient may change over time.

Second, the evidence demonstrating the utility of a treatment is measured against relative costs to the health care system. A treatment can be viewed as effective if it is viewed as achieving its desired outcome—or, at least, the best possible outcome—for as low a cost as possible; that is, it achieves the best outputs with the fewest economic inputs. Determining the efficiency of a particular treatment is challenging, however, because the efficiency of the costs of a particular treatment is largely speculative, with the costs of a treatment weighed against potential alternative approaches for which actual costs are not necessarily available (Fierlbeck, 2011: 4).

While it may be a fool's game to try to measure efficiency in the provision of health care services, efficiency is a useful concept to use in assessing health care expenditures and speculating about how to best distribute scarce health care resources, and it is a concept that seemingly guides a great deal of discussion about what services should be listed in provincial health insurance programs. And in the scholarship on medical necessity and the provision of particular health care services, efficiency—and more specifically, cost efficiency—is central to the listing of health care services (Charles et al., 1997).

Immediacy

Even when a service is viewed as legitimately medical and considered effective in terms of cost and outcomes, its inclusion in public funding programs is not guaranteed. The illness, disorder or condition must also be seen as a relatively urgent matter, requiring funding now and not later.

There are two ways in which immediacy is generally established, both of which are tied to growing support for public funding. The first occurs when there is a growing incidence of the illness, condition or disorder. Where there is a rising occurrence of a particular illness, for example, there may be pressure to act to ensure that the illness does not become widespread among the population; in these cases, funding is provided as a matter of population health.

There is an important relationship between the notion of immediacy of health care provision and medicalization, as the expansion of the target population for a particular illness, disorder or condition can be shaped by medicalization. The understanding of osteopenia, for example, as a disorder in need of screening and treatment came in part as a result of changes to the diagnostic criteria for osteoporosis that redefined normal bone mineral density in terms of the bone mineral density of a thirty-year-old woman, effectively ensuring that all older women would either have osteoporosis or have osteopenia (Moynihan and Cassels, 2005: 142–43). And while there are good reasons to engage in preventive care, the idea that the mere risk of disease constitutes a site for intervention is expanding patient populations outward (Fosket, 2010). When this idea is coupled with increasingly mobilized health advocacy groups campaigning for access to new treatments and pharmaceutical firms marketing the same, there is often a sense of urgency surrounding the “discovery” of new illnesses, disorder or conditions.

The sense that the provision of a health service is a pressing matter can also come from the language of human rights and discrimination, including through claims made to human rights tribunals or through other types of litigation. There have been a number of cases in which people have contested the absence of certain health services from provincial benefits schedules and sought their inclusion, asserting that a lack of access constitutes discrimination under section 15(1) of the Canadian Charter of Rights and Freedoms or other human rights legislation. For example, in *Auton v. British Columbia (Attorney General)*, the parents of four preschoolers with autism challenged the government of British Columbia because the behavioural interventions they requested and/or provided for their children were not funded under the provincial health insurance program (*Auton v. British Columbia [Attorney General]*, 1997). Although the lower courts agreed

that the failure to fund discriminated unfairly against children with autism on the basis of disability under section 15(1), the Supreme Court disagreed because the behavioural interventions were not seen to be services requiring coverage—that is, they were “non-core” medical services provided by other than medical professionals (Flood, 2014). Following the decision, however, public support for the behavioural intervention was extremely high, with one poll finding that 89 per cent of Canadians supported funding treatment under provincial health insurance programs. Despite the Supreme Court ruling, applied behaviour analysis (ABA) was seen to be medically necessary in the court of public opinion; funding continued in provinces where it already existed, additional new funding was announced in Ontario, and Nova Scotia funded ABA for the first time.

Litigation and human rights claims related to the provision of a health care service are, however, not always successful in mobilizing support or leading to funded services. In *Cameron v. Nova Scotia (Attorney General)* (1999), a heterosexual couple (Cameron and Smith) sought reimbursement for infertility services (including IVF) under the Nova Scotia health care insurance plan but were informed that the costs were not eligible. Cameron and Smith turned to the courts, claiming that the denial of reimbursement discriminated against them on the basis of disability, again, under section 15(1) of the Canadian Charter of Rights and Freedoms. Their argument was that as infertility is a disability, and IVF and the other services they received are medically necessary treatments for that disability, they should be covered under Nova Scotia’s provincial health insurance program. Since IVF may help people conceive a child but does not address an underlying (and ongoing) physiological medical condition, the view of IVF as a medically necessary treatment for infertility—rather than a social intervention to address undesired or unintended childlessness—has been hotly contested.

At trial, the court found that the provision of IVF was not “medically necessary” in the terms of the Nova Scotia Health Services and Insurance Act. Cameron and Smith appealed, and the Nova Scotia Court of Appeal ruled that while the couple was right in their claim that infertility is a disability that cannot be discriminated against under the Charter of Rights and Freedoms, the denial of funding is a reasonable limit within a health care system within which scarce resources must be carefully allocated. This finding, affirmed in *Auton*, did not lead to the kind of public support that later occurred for the behavioural interventions for children with autism, and no new funding for IVF in Nova Scotia was forthcoming.

The recognition of a health care service as necessitating publicly funded provision is, then, a matter of constructing medical necessity. Though the concept of medical necessity is itself malleable—contingent on the health care service in question and the seeming importance of its use—the potential for a health care service to be funded by a province can be understood as requiring recognition of it both as a legitimate site of medical practice and as a service that provides a desirable health outcome at a proportionate economic cost; it also requires a widespread recognition that the time has come to fund the service, either because there is a growing population of people experiencing the illness, disorder or condition or because there is mounting public pressure (often associated with litigation).

Funding IVF in Ontario

The evolution of public funding for IVF in Ontario provides a useful case study to demonstrate the malleability of medical necessity and the factors that may influence the discursive construction of a health care service as medically necessary (or not) at a given point in time. Ontario is the only province to have provided dramatically different models of public funding for IVF over a period of more than 30 years, with significant shifts in its approach and justification for how IVF should be covered.

Until 1994, the government of Ontario was the only province in Canada to broadly fund infertility treatments. That year, in a move to reduce costs to Ontario's health insurance program, IVF was removed from the provincial schedule of benefits, with an anticipated cost savings of \$4.4 million per year (Giacomini et al., 2000: 1487; Boyajian et al., 2014: 336). While cost savings were identified as the impetus for the change, other reasons were later given, including "the application of 'medical necessity' as a criterion for coverage" (Giacomini et al., 2000: 1487) and alignment with the recommendations of the Royal Commission on New Reproductive Technologies. The commission, which reported in December of 1993, had found that there was insufficient evidence to use IVF for nearly all indications and that providing IVF for most diagnoses was not cost-effective (1993: 523–24). This recommendation gave sufficient support to the Ontario Ministry of Health to delist IVF for all diagnoses but bilateral fallopian tube blockage (Ikonomidis and Dickens, 1995).

From 1994 to 2006, there was some lobbying related to the public funding of IVF, but clinicians and patients' groups were largely preoccupied with federal politics and the parameters on infertility service provision that would be established by the federal Assisted Human Reproduction Act. By 2006, the federal legislation had passed and the Infertility Awareness Association of Canada (IAAC)⁵—an industry-funded patient advocacy group—turned its attention once again to lobbying for provincial funding for IVF. IAAC was focused on a relatively new argument, namely that IVF is cost-effective when funding requires patients to undergo single embryo transfer, a practice which reduces the occurrence of costly, high-risk multiple births, which can result in a range of complications related to both infant and maternal health. Rather than simply demand that clinicians engage in single embryo transfer as a matter of good medicine, IAAC articulated the need for single embryo transfer as something contingent on funding from the province, as clinicians would not and could not transfer single embryos without public funding. This argument was also being used in Quebec, the United Kingdom and elsewhere and was quickly becoming central to the discourse about the cost-effectiveness of funding IVF (L'Espérance, 2013).

In 2006, IAAC requested that the government of Ontario examine the possibility of expanding coverage for IVF. The province's Medical Advisory Secretariat conducted an assessment, and although it identified advances in the effectiveness of IVF for a range of medical indications, it ultimately found that "IVF has a less favourable cost-effectiveness profile compared with alternative treatment options" and recommended that IVF not serve "as the first line of treatment in the majority of cases" (Medical Advisory Secretariat, 2006: 9). The Medical Advisory Secretariat

did, however, recommend the continuation of funding for IVF in cases of bilateral fallopian tube blockage, and it recommended the expansion of funding to cases of severe male factor infertility. Lobbying continued, and despite the findings of the Medical Advisory Secretariat, then-Ontario Premier Dalton McGuinty announced that if re-elected, he would create an expert panel on infertility that would likely lead to increased funding for IVF.⁶ His government was re-elected, and Ontario's Expert Panel on Infertility and Adoption was established in July 2008.

The Expert Panel—composed of adoptive parents, representatives of infertile people, clinicians and academics—issued its report on August 26, 2009. Entitled *Raising Expectations*, the report is divided into two parts: infertility and adoption. In the section on infertility, the report focuses on recommendations to fund three cycles of IVF, justified largely in terms of the need to reduce multiple births. *Raising Expectations* makes clear that it is both efficient and medically necessary to limit the number of embryos transferred, as doing so would reduce risks to the children conceived, limit health risks to women and reduce costs to the health care system. The report states that “Ontario cannot afford to NOT fund assisted reproduction services” (Expert Panel, 2009: 9). It later reiterates that the recommendation to reduce multiple births should only occur “in conjunction with our recommendations on funding,” namely that there be publicly funded IVF (105).

On August 18, 2009, days before the Expert Panel on Infertility and Adoption released its report, law professor Amir Attaran and his partner, Ana Ilha, filed a complaint with the Ontario Human Rights Tribunal to contest that the province covered IVF only in certain circumstances, thereby discriminating against those with other medical conditions. Ilha had a low ovarian reserve, a condition in which a woman has fewer eggs than one might expect for a woman of the same age (Flood, 2014: 104). The case (which was consolidated to be heard with similar cases in 2010) was deferred while documents were procured in 2011 (*Ilha v. Ontario*, 2011) and then adjourned in 2014 to allow for the potential resolution of the complaint through the government of Ontario's new policy (*Ilha v. Ontario*, 2014). At the time that the complaint was launched, Ilha commented that “if the government decides that it is going to change its policy, I'm happy to drop it” (Krashinsky, 2009).⁷

In April 2014, the government of Ontario announced that it would be acting on the recommendations of the Expert Panel, funding IVF in the province in order to help the estimated “one in six Ontario couples ... affected by infertility at some point in their lives” (Government of Ontario, 2014). The Ontario Fertility Program would begin in 2015 and cover one cycle of IVF (rather than the three cycles recommended by the Expert Panel) for all eligible women, to a total of 5,000 cycles a year, with funding tied to the transfer of a single embryo.⁸ Further, the Ministry of Health and Long-Term Care also indicated that “access will be expanded to include both medical and nonmedical infertility (single people, LGBTQ people, people with disabilities) under this new funding policy” (Advisory Process for Infertility Services, 2015: 1). An advisory committee made up of “medical experts and patient representatives” (one of whom was Amir Attaran) was appointed to develop a plan for implementation and advise the government on the provision of services (Advisory Process for Infertility Services, 2015: 3).⁹ In October 2015, the government of Ontario removed IVF and intrauterine

insemination from the funded services provided under the Ontario Health Insurance Plan, to be provided instead by the new funding program, reducing access to IVF for women with bilateral fallopian tube blockage from three funded cycles to one. The Ontario Fertility Program rolled out across the province in December 2015.

IVF in Ontario: Efficiency, Immediacy ... and Medicalization?

Comparative scholarship addressing the public funding of IVF in different jurisdictions has revealed a number of different policy rationales for funding. While cost-effectiveness (that is, efficiency) is perhaps the most significant, other rationales have emerged, including the argument that leaving IVF to the public sector exacerbates inequality by limiting access to costly fertility treatments to those with financial means (Mladovsky and Sorenson, 2010: 122). This argument has been used in the Canadian case, and especially in relation to expansive coverage for fertility treatments provided by the government of Quebec between 2009 and 2014 (Scala, 2014: 67–68; Carsley, 2012: 21). The public funding of IVF and other fertility treatments in some jurisdictions has also been justified as a means to improve the total fertility rate of a population, with pro-natalism often an underlying rationale. The decision to broadly fund one cycle of IVF in Ontario, however, is reflective of the political operationalization of the discourse of medical necessity—that is, the ways in which medical necessity was reconstructed in order to make broadly funding IVF thinkable. The construction of medical necessity, then, occurred through the explicit mobilization of efficiency and immediacy as reasons that the province needed to fund at least one cycle of care. Medicalization, as described below, occurred in a different way, and rather than working to reinforce the view of IVF as a medical intervention, the government of Ontario actively contested that this was the case, deciding instead to provide funding through the Ministry of Health and Long-Term Care rather than through the Ontario Provincial Health Insurance Program.

Efficiency

Although IVF has improved over time, its effectiveness in achieving a pregnancy hovers around 30 per cent per cycle, depending on the age and physiological circumstances of the woman in question. To achieve a high rate of pregnancy, which has long been the presumed desired outcome of IVF, those being treated should generally have access to three cycles of treatment. The idea that three cycles would be necessary to ensure the effectiveness of the treatment was built into Ontario's previous approach to funding IVF for women with bilaterally blocked fallopian tubes. This was also apparent in the Medical Advisory Secretariat's assessment of both the clinical effectiveness and cost-effectiveness of IVF and the finding of its report indicating that IVF should not be the "first line of treatment" for infertility in most cases, excluding bilateral fallopian tube blockage and severe male factor infertility (Medical Advisory Secretariat, 2006: 9).

When the Expert Panel on Infertility and Adoption issued its report, the effectiveness of IVF was rearticulated in terms of a different desired outcome—pregnancy achieved through single embryo transfer, avoiding the complications

associated with multiple births. Although this outcome would be possible simply by mandating single embryo transfer, the view of the Expert Panel that single embryo transfer, and the related reduction in multiple births, should be tied to provincial funding bound the possibility of improving fetal and maternal health outcomes to funded care. The Expert Panel's estimate that \$400–550 million could be saved through the reduction of multiple births, which was the basis for its claims of cost savings, was supported only through reference to data provided by IAAC. As noted above, IACC is an industry-funded patient advocacy group, and while it provides many important services to patients, including support groups, the organization is also deeply invested in the proliferation of funded infertility services. IAAC had taken up the argument that funding could reduce multiple births and commissioned a relevant research report, which it then used to support its lobbying strategy for the public funding of IVF.¹⁰

Reference to this number—a cost savings of \$550 million—was also central to the lobbying campaign of *Conceivable Dreams*, an Ontario-based interest group focused specifically on the public funding of IVF in Ontario; the group has pressured government and staged virtual and real-life rallies to call for funding. During Ontario's 2010 pre-budget deliberations, *Conceivable Dreams* created giant building blocks that were placed on the steps of the provincial legislature spelling “out ‘\$550 million’ (i.e. the amount the Ontario Expert Panel on Infertility and Adoption estimated the province would save in long term health care and social services costs by funding IVF)” (*Conceivable Dreams*, 2015). The extent to which the Expert Panel's report, relevant press releases and media interviews repeated and emphasized the cost savings associated with the potential reduction in multiple births shifted the focus away from the effectiveness of IVF in achieving pregnancy. These interventions refocused attention instead on the need for single embryo transfer, suggesting that funding would lead to the reduction of multiple births which, it was suggested, would save taxpayers millions of dollars over time. Efficiency, as articulated in the policy process leading to the public funding of IVF in Ontario, was then about reducing the incidence of adverse health outcomes that could be avoided with or without funding.

Immediacy

In terms of immediacy, calls for the public funding of IVF in Ontario relied on the claim that the incidence of infertility is rapidly increasing, affecting too many Ontarians to ignore. When the Medical Advisory Secretariat issued its report in 2006, it noted that the best Canadian data at the time came from survey data conducted for the Royal Commission on New Reproductive Technologies, which indicated that 8.5 per cent of married or common-law women between the ages of 18 and 44 experienced infertility in Canada in 1992 (approximately 1 in 12 heterosexual married or common-law couples); this number decreased significantly if the definition of infertility was expanded to include a second year of potential conception. The Medical Advisory Secretariat recognized the limitations of this outdated data and also pointed to higher rates in other developed countries, including a reported rate of 16 per cent in the United States (for women between 15 and 44 years old in 1995), 14 to 16 per cent in the United Kingdom and approximately 10 per cent in the Netherlands.

Advocates of public funding for IVF had long referenced estimates that 1 in 6 Canadian couples experienced infertility, a statistic evident in popular media as far back as 1990. This estimate, however, relied on an extrapolation and misinterpretation of outdated American data that incorporated information about people who had undergone surgical sterilization, which artificially inflated the incidence of infertility in the general population (Royal Commission on New Reproductive Technologies, 1993). Nevertheless, discussion of a rate of 1 in 6 couples persisted, and the Expert Panel on Infertility and Adoption wrote both that “right now in Ontario, one in eight couples is struggling with infertility” and that “one in six couples” has experienced the same (Expert Panel, 2009: 85).

The same claim was taken up and repeated in both press releases and media reports during this time, most commonly articulated in terms of a disembodied approximation that stated “it is estimated” without citation. And although some sources did reference the survey research of the Royal Commission on New Reproductive Technologies, by 2009 the claim that 1 in 6 couples experiences infertility was the one widely touted. Advocates of public funding had long used this number, but its reappearance in the Expert Panel’s report gave it new weight, and it was subsequently taken up by *Conceivable Dreams* and in the popular media. Over time, further slippage about the incidence of infertility has occurred, with *Conceivable Dreams* suggesting that 1 in 6 Canadians—rather than 1 in 6 Canadian couples—are “affected by” infertility (*Conceivable Dreams*, 2016).¹¹

The rising incidence of infertility and its assumed prevalence have been articulated as important reasons why IVF should be funded in Ontario, insofar as the pressing demand necessitates supply: more and more people need care. However, the emphasis on the need to fund IVF because of a high incidence of infertility has focused on the seeming inevitability of infertility (given its frequent occurrence), rather than focusing on prevention. The focus on “1 in 6” is nearly always articulated in terms of access to IVF and an increased need for funding, so that infertility can be addressed through medical interventions, and rarely in terms of preventive care, such as sexual health education to prevent sexually transmitted infections or addressing exposures to environmental toxicants. Infertility patient groups have continued to focus on the need to improve access to services, including public funding for IVF, with little attention to broader social interventions that might work to prevent infertility. While the experience of infertility may be unavoidable for some—those born with bilaterally blocked fallopian tubes, for example—the call for addressing rising infertility by providing IVF without any focus on prevention is notable. Combined with the extensive lobbying and advocacy campaigns mounted by *Conceivable Dreams* and IAAC and a desire to avoid litigation in the human rights complaint brought by Amir Attaran, the increasing number of Ontarians experiencing infertility was used to argue in favour of the pressing need to fund IVF.

And Medicalization ... ?

As mentioned above, advocates’ calls to fund IVF focused on the rising incidence of medically experienced infertility, including descriptions of the widely felt heartbreak of not being able to conceive. Medical organizations and advocacy groups

alike have been invested in having infertility recognized by the provincial government as an important medical condition, with IVF and other fertility services as the relevant treatment, and in garnering public support for this perspective (L'Espérance, 2013). The delisting of IVF in Ontario in 1994 was justified on the grounds of only providing evidence-based medicine, which demonstrated the commitment of the government of Ontario to the legitimacy of IVF as a medical service, albeit only in very specific cases. Among the most vocal critics of the 1994 delisting were medical experts who saw limiting IVF only to women with double-blocked fallopian tubes as too restrictive, preventing those for whom the treatment was “clinically appropriate ... including those with oocyte depletion, scarred fallopian tubes, endometriosis, and inadequate sperm” from accessing care (Nisker, 2009: 764). In Ontario, IVF has long been viewed as a medical intervention, albeit one with desired outcomes that the government of Ontario remained unwilling to fund and that lacked broad public support.

This changed in part with the mobilization of the arguments related to multiple births and also when the report of the Expert Panel on Infertility and Adoption rearticulated infertility as a matter of social justice. The section of the report addressing infertility begins by articulating that the “medical condition” of infertility requires “medical treatment” and asserting that infertility is on the rise. However, the report also includes the statement that “many other Ontarians—same-sex and single people and people with illnesses like cancer or HIV—need help to start a family” (85), operating from the understanding that any publicly funded IVF treatment should be extended to single people and same-sex couples looking to build their families. In just a few words, the Expert Panel made clear that social experiences of infertility would be included in any funding program in Ontario; there was no explanation of this change in its longstanding approach to IVF solely on evidence-based medical grounds, other than this mention of a commitment to family-building in a way more broadly conceived than ever before. Rather than engage in an extensive articulation of the need for IVF for notions of “social infertility” and engage in the discursive construction of LGBTQ reproduction as falling within the parameters of what is medical, the government of Ontario simply stated that care would be extended.

In this case, while IVF was increasingly recognized as medically necessary, the expansion of IVF to single women and LGBTQ people provides an important example of the complexity of medicalization and the outward expansion of what comes to be understood as legitimately and appropriately medical. The use of IVF to help same-sex male couples get pregnant using an egg donor and a surrogate, for example, in cases in which everyone involved is ostensibly healthy and has a functioning reproductive system, challenges the idea that the procedure is medically necessary in more conventional terms. This approach implicitly medicalizes healthy people—framing them as impaired in some way—in order to facilitate access to services that would help them create children in the ways that they desire.¹² Historical legacies of the medicalization of LGBTQ people hover in the background of these debates, as many healthy people negotiate diagnoses of infertility and endure testing in fertility clinics in order to get access to care.¹³

In advocacy efforts leading to the announcement of the new funding, the emphasis remained on the medical experience of infertility as necessitating

treatment and on the potential health effects and cost savings of reducing multiple births. In his announcement of the Ontario Fertility Program, then-Minister of Health and Long-Term Care, Dr. Eric Hoskins, reinforced the commitment to a medical understanding of infertility, stating that “it is a serious medical issue” but also that “by creating a more equitable and accessible fertility program, the government is supporting family-building for those who couldn’t otherwise have the opportunity to have children” (Ferguson, 2015).

Historically, the language of medical necessity and evidence-based medicine has been invoked in ways that implicitly or explicitly limit access to fertility treatments on the basis of sexual orientation and marital status (Scala, 2014). However, the government of Ontario’s approach, which reasserted the importance of infertility as a disease to be treated through fertility treatments and also included a simultaneous commitment to expand care to populations that might not experience medically indicated infertility, worked to legitimate the use of public health funding for infertility treatments while contesting solely medical conceptions of infertility. Although problems remain,¹⁴ by stating and restating that infertility is a disease that affects a significant proportion of Ontarians, the Expert Panel on Infertility and Adoption, relevant advocates, popular media and the Ministry of Health and Long-Term Care demonstrated the importance of health funding to address infertility. At the same time, by recognizing the social nature of infertility experienced by many single and LGBTQ people, the Ontario Fertility Program takes for granted that fertility treatments are at once a matter of medicine, but not always a matter of medical infertility, and therefore treatment is funded outside the Ontario Health Insurance Plan—not quite relisted, but almost.

Conclusion

Medical necessity, a touchstone for the provision of publicly funded health care, remains central to the legitimacy of a funded health care service. In Ontario, the 2018 election of a Conservative government led by Doug Ford has raised new concerns about the political nature of medical necessity. In April 2019—following the new government’s first budget speech—the government announced that it was working with the Ontario Medical Association to find cost savings through the delisting of certain procedures, which included a highly controversial proposal to cut sedation during colonoscopies. This proposal was framed as eliminating inappropriate and unnecessary interventions as well as streamlining the provision of publicly funded health care services, indicating that the discourses of medicalization, efficiency and immediacy are being deployed once again in response to a seemingly urgent need to reduce health care spending in the province.

The funding of infertility care continues in Ontario, and many women and families have been able to use publicly funded IVF to have biologically related children and to have the families they want. It is clear, however, that this was made possible through the strategic and political mobilization of medical necessity through the discourses of medicalization, efficiency and immediacy. The focus on cost savings and fetal and maternal health through arguments about multiple births, as well as the problematic articulation and rearticulation of the rising incidence of infertility, served to validate new debates in the mid-2000s in Ontario about whether IVF

should be a funded health care service in terms of the efficiency and immediacy of IVF as a public health service. Moreover, while IVF could have been constructed solely as a medical issue through appeals to long-present understandings of infertility as a serious medical issue and as a disease, the Expert Panel on Infertility and Adoption and, subsequently, the Ministry of Health and Long-Term Care, defined infertility as at once medical and nonmedical, making it part of provincial health funding but outside the purview of medically necessary services funded under the Ontario Health Insurance Plan.

The simultaneous engagement with the tropes of medical necessity to legitimate the funding of IVF, while contesting the need to provide health services for medical purposes, raises new questions about what a health care system can and should provide. Although medical necessity, however it has been defined, has long been a way for provincial governments to legitimate health care spending, the government of Ontario's articulation of health care spending as at once medically and socially necessary offers potential for governments to rethink how they define health care spending and the boundaries of what is medically justified.

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Notes

1 In vitro fertilization is a medical intervention that involves an egg being fertilized by sperm in a Petri dish, after which a resulting embryo (or embryos) is implanted into a uterus to create a pregnancy. The term often refers to the group of interventions leading up to the implantation of the embryo, including but not limited to the extraction of eggs from a woman's body, the fertilization of the eggs and any freezing and thawing of eggs, embryos or sperm.

2 The interview data for this article come from a research project on the regulation of assisted reproductive technologies in Canada (Cattapan, 2015a). This research included 18 semistructured interviews with key policy actors who engaged in the development of federal legislation on assisted human reproduction.

3 On IVF in Ontario and a philosophical approach to medical necessity, see McLeod (2017a, 2017b). See also Hughes and Giacomini (2001).

4 On the utility of defining medical necessity, see Hurley et al. (1997).

5 In September 2015, IAAC changed its name to Fertility Matters Canada. Because the campaign for IVF in Ontario largely occurred prior to this name change, this article refers to the organization using its name at the time.

6 For a discussion of how election promises and related lobbying influenced Quebec's funding of IVF in 2009, see L'Espérance (2013).

7 While Amir Attaran did not incite the advocacy related to the public funding of IVF, pressure put on the provincial government as a result of his case may have contributed significantly to the government decision to fund IVF. Given the timing of the case, it is possible that his contributions were significant in ways beyond the scope of the present article.

8 The Ontario Fertility Program also covers artificial insemination, intrauterine insemination and medically indicated fertility preservation.

9 The advisory committee issued its report in October 2015, recommending that nonmedical infertility be included in funded care; no age and body mass index cutoffs for eligibility; and single embryo implantation for women under the age of 35, unless they had three or more failed cycles of IVF.

10 Interview with Bev Hanck, then-executive director of the IAAC, December 7, 2011.

11 More recent estimates suggest that although there has been an increase in the rate of infertility in Canada, the rate decreased from 1 in 6 to 1 in 9 (of married and common-law couples with a female partner aged 18–44) when having had sexual intercourse in the last year was added as a criterion, and the rate decreased further when couples were asked about “trying for pregnancy.” See Bushnik et al. (2013).

12 This point was raised through the thoughtful contributions of one of the anonymous reviewers of this article. Thank you for this very helpful insight.

13 See, for example, Mamo (2007).

14 These problems include, for example, a focus on treatment rather than prevention and a tacit endorsement of certain models of family-building. See, for example, Cattapan (2015b).

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