The many meanings of deinsuring a health service: the case of in vitro fertilization in Ontario

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Abstract

There is currently much international interest in principles and processes for determining which services should qualify for health insurance packages. However, there has yet been little analysis of the implications of actual deinsurance decisions made by such priority-setting exercises. This paper reports experience from the case of in vitro fertilization (IVF) deinsurance in Ontario, Canada. The analysis addresses some of the more social aspects of financial incentives by characterizing funding structures as means of communicating complex policy objectives, rather than mechanistic reward-penalty systems. Deinsuring IVF was intended to support several policy goals, including: controlling public expenditures, restricting public coverage to ‘medically necessary’ services, applying evidence of effectiveness as a criterion for medical necessity and implementing part of a policy program to control new reproductive technologies. It may seem a modest step to remove one dubious service from public insurance coverage. Nevertheless, as interpreted by stakeholders, deinsurance of IVF may inadvertently promote the opposite of what policy makers intended. This case suggests that priority-setting decisions based on incomplete information, inconsistently applied principles and too little attention to health system dynamics (perhaps the norm in ‘real-world’ priority-setting) can have the perverse effect of undermining progress toward health reform goals of improved health, reduced expenditures and more rigorously evaluated services. The case of IVF in Ontario offers several lessons for other jurisdictions engaged in priority-setting and service deinsurance: (1) individual services interact with the rest of the system and cannot be removed without systemic effects, (2) inconsistent use of coverage principles can undermine legitimacy of both priority-setting principles and processes and (3) ‘evidence-based’ decisions can founder on differing stakeholder ideas about appropriate evidence and on the inconsistent message given by commercializing ineffective or unproven care. © 2000 Elsevier Science Ltd. All rights reserved.

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Introduction

Background

‘Priority-setting’ and ‘resource allocation’ have become bywords for health system reform. Health
insurance programs around the world — public and private — are reviewing both their processes for making coverage decisions and covered services themselves, to fashion more affordable and acceptable packages of basic service. Policy analysts have described a number of principles to guide systematic decisions about the priority and coverage eligibility of individual services (Crawshaw et al., 1990; Eddy, 1991; GCCHC, 1992; OTA, 1992; Ham, 1993; Deber et al., 1994; Klein, 1994; CMA, 1995; Wilson et al., 1995; DCE, 1997). Most approaches emphasize traditional technology assessment criteria of effectiveness and efficiency, mediated by community values (e.g., ethical principles, participatory structures, population and individual preferences, etc.) (Klein, 1993; Tymstra and Andela, 1993; Goold, 1996; Lenaghan et al., 1996; Richardson and Waddington, 1996; Lomas, 1997; Stronks et al., 1997). Health policy makers often expect (or at least hope) that explicit and principle-based deinsurance exercises will achieve multiple health system goals: lower spending and improved health by eliminating payment for — and practice of — dubiously effective or unnecessary medical care. Stricter coverage criteria also potentially create stronger incentives for new technologies to ‘prove themselves’ via rigorous scientific evaluation.

Alongside these policy initiatives, critiques and case studies of actual priority setting processes are also beginning to appear. In practice, political or organizational imperatives have compromised technocratic, principle-based approaches — sometimes to the demise of the priority-setting process altogether (e.g. Redmayne and Klein, 1993; Campbell, 1995; Cooper, 1995; Ham, 1995; Blumstein, 1997; Chinitz and Israeli, 1997). Early reports suggest that decisions can be strongly influenced by stakeholders’ varying interpretations of ‘what is at stake’ in the coverage of a given technology (e.g. Redmayne and Klein, 1993; Giacomini, 1999). To date there has been little research documenting stakeholder responses to actual deinsurance decisions made through explicit priority-setting processes.

This paper reports experience from the case of deinsuring in vitro fertilization (IVF) in the Canadian province of Ontario. It extends the current literature by analyzing not only the reasoning that went into the deinsurance decision, but also the impact of the decision in terms of stakeholders’ understanding of the essential ‘meaning’ of the policy and the part these meanings play in their initial responses to the policy.

The findings illustrate the complexity of implementing deinsurance and tracing its effects. This case suggests that priority-setting decisions based on incomplete information, inconsistently applied principles and too little attention to health system dynamics (perhaps the current norm in ‘real world’ priority-setting) can have the perverse effect of undermining progress toward improving health, reducing expenditures and evaluating services rigorously. Although some of the findings are specific to IVF or Ontario, we believe many of the same types of effects can be expected for other procedures in other jurisdictions. This analysis offers several lessons for improving the process, the credibility and the health effects of other priority-setting exercises. First, individual services are embedded within systems of service. Removing even ‘inefficient’ or ‘ineffective’ service can affect remaining services and costs in the system, potentially in ways that offset anticipated gains. Second, criteria-based priority-setting can lose its legitimacy through the failure to articulate key criteria (e.g. ‘medical necessity’) or through selective, rather than systematic, application of criteria across services. Finally, even scientific ‘evidence-based’ decisions can lead to confusion and dissent among stakeholders affected by a deinsurance policy. Different stakeholders hold often incompatible views on what evidence is relevant and what types or ‘levels’ of evidence are credible. Relegating a still-experimental service to the commercial sector (rather than to research settings) through deinsurance can send especially confusing messages about both effectiveness as a coverage criterion and the value of evaluation evidence.

Methods

Our case study of deinsuring IVF focused on two research questions: (1) what was the nature of the IVF deinsurance policy and the scope of stakeholders’ interests in the policy? and, (2) what meanings have various stakeholders attributed to deinsurance and what have been their initial responses based on these interpretations? The approach was guided by a conceptual framework (Giacomini et al., 1996a; Giacomini et al., 1996b) derived from the growing body of literature addressing the social dimensions of financial incentives (e.g. Whyte et al., 1955; Kerr, 1975; Backoff and Mitnick, 1981; Kohn, 1993a, 1993b; Stone, 1997). This ‘communication model’ of financial incentives characterizes funding structures as means of communicating complex policy objectives, rather than as mechanistic reward-penalty systems. This view supports a qualitative, interpretive approach to the empirical investigation of financial incentives. The case study methods implied by the communication model of financial incentives (Giacomini and Goldsmith, 1996) have been applied to other recent cases of health care funding changes (see, e.g., Hurley et al., 1997a, 1997b; Lomas and Rachlis, 1997; Giacomini and Peters, 1998). In the analysis, we characterize stakeholders’ interpretations of the deinsurance policy and identify common themes regarding what deinsurance can mean to those expected to respond to the policy.
Several sources of data were used. We conducted a qualitative content analysis of documents concerning IVF in Ontario, the deinsurance decision and reactions to it (e.g., policy documents and bulletins, unpublished research reports, news media; academic editorials, letters to the editor and published scholarly analyses; stakeholders’ press releases, position statements, briefs submitted to policy makers and orientation materials; clinic patient education materials). We conducted 21 semi-structured interviews with individuals representing public and private clinic providers, members of the provincial Joint Review Panel that recommended deinsurance IVF, an Ontario consumer advocacy organization for the infertile, the federal Royal Commission on New Reproductive Technologies, IVF evaluation researchers, the Ontario Ministry of Health and the Ontario Medical Association. Interviews explored the perceived meaning of the deinsurance policy, its early consequences and its likely implications. Follow-up interviews were conducted as necessary to clarify and triangulate key findings. We also conducted a telephone survey of the 12 Ontario IVF clinics (five public, seven private) in 1996 regarding utilization patterns, fees and research involvement before and since deinsurance. Eight clinics responded (four public, four private), three did not respond after several attempts and one refused to participate in the survey. Of the responding clinics, most were only able to give partial information on utilization trends before and since deinsurance (which, although disappointing, was not surprising as there are currently no provincial or federal standards for maintaining utilization and outcome data or for making them publicly available). Analysis involved identifying key themes of policy interpretation and elucidating both sub-themes and conceptual relationships between these categories.

The policy and the policy making process

In February of 1994, the Ontario Ministry of Health announced that, on the recommendation of an ad hoc review committee, physician payment for IVF for indications other than completely blocked fallopian tubes would be removed from the Ontario Health Insurance Plan (OHIP) Schedule of Benefits. The Ministry of Health described the policy in a press release on 17 Feb 1994 (MoH, 1994a):

The services that will be removed from OHIP coverage [include, among 7 others]… in vitro fertilization, except for complete fallopian tube blockage, for a maximum of three cycles… Doctors may continue to provide these treatments, but will charge patients for them, using the Ontario Medical Association’s fee schedule as a guide.

The deinsurance initiative began in the summer of 1993 when a ‘Joint Review Panel’ of the Ontario Ministry of Health and the Ontario Medical Association (hereafter, ‘the Panel’) convened to review a set of services proposed for deinsuring to meet a $20 million total physician expenditure reduction by “removing services [from the physician fee schedule] that were not medically necessary…” (MoH, 1994a). The impetus was cost control in the physician sector; deinsuring IVF was expected to save $4.4 million per year in physician billings (Pringle, 1995). However, the Ministry’s later explanations (and rationalizations) of the decision noted several other policy objectives including the application of ‘medical necessity’ as a criterion for coverage, the implementation of recommendations of a Royal Commission concerned with the appropriate use of new reproductive technologies and the consideration of scientific evidence and professional opinion in coverage decision-making. The Ministry argued that, “IVF is expensive, it is not medically necessary and the medical community is split on its effectiveness” (Brooks, 1994, p. 970) and that the policy “agreed[d] with a recently released federal government report [i.e., the Royal Commission on New Reproductive Technologies] that recommended IVF should not be publicly funded except for fallopian tube blockage” (MoH, 1994a, p. 1).

The decision-making process unfolded as follows. The Panel was chaired by the Dean of Nursing at the University of Toronto; members included two representatives from the Ontario Medical Association, two representatives of the Ministry of Health and two public representatives. The Panel deliberated for three months, soliciting limited public input through one day of hearings in Toronto and through voluntary written submissions and letters. The Panel began with a list of nineteen services for possible deinsurance — eight services proposed by the Ontario Medical Association and eleven proposed by the Ministry of Health (see Table 1). These services were selected by “[taking] into account the earlier public reaction and the experience in other provinces” (Pringle, 1995, p. 3). Notwithstanding its mandate to save $20 million, the first principle of the Panel’s process was: “do not take costing into account in decision-making” (neither did the Panel address the related issue of cost-effectiveness). The other two principles were, “seek gender and age equity” and, “do not consider whether Ontario Medical Association or Ministry of Health is source of item” (Pringle, 1995). Despite the brief opportunity for public consultation, the Chair maintains that, “public input [was] enormously influential in persuading the panel what not to delist” (Pringle, 1995). The volume
<table>
<thead>
<tr>
<th>Services</th>
<th>Who Suggested</th>
<th>Estimated Annual Physician Billings ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Deinsuring:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In vitro fertilization for conditions other than complete fallopian tube blockage</td>
<td>MoH</td>
<td>4.4</td>
</tr>
<tr>
<td>Reversal of sterilization</td>
<td>MoH</td>
<td>1.5</td>
</tr>
<tr>
<td>Routine newborn, ritual, or cosmetic circumcision</td>
<td>MoH</td>
<td>1.0</td>
</tr>
<tr>
<td>Removal of tattoos (except resulting from abuse)</td>
<td>MoH</td>
<td>0.2</td>
</tr>
<tr>
<td>Repair of torn earlobes (except from acute trauma)</td>
<td>MoH</td>
<td>0.1</td>
</tr>
<tr>
<td>Removal of acne pimples</td>
<td>MoH</td>
<td>2.0</td>
</tr>
<tr>
<td>Injection of simple varicose veins</td>
<td>MoH</td>
<td>2.5</td>
</tr>
<tr>
<td>Removal of certain benign skin lesions</td>
<td>MoH</td>
<td>5.9</td>
</tr>
<tr>
<td><strong>Recommended NOT Deinsuring:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual health examinations (but do plan to phase out, replace with age/risk periodic health examinations)</td>
<td>OMA</td>
<td>40</td>
</tr>
<tr>
<td>General anesthesia for uninsured dental procedures</td>
<td>MoH</td>
<td>1.8</td>
</tr>
<tr>
<td>Otoplasty to correct outstanding ears</td>
<td>MoH</td>
<td>0.5</td>
</tr>
<tr>
<td>Removal of port wine stains on the face and neck</td>
<td>MoH</td>
<td>0.3</td>
</tr>
<tr>
<td>Travel assessments/immunization clinics</td>
<td>OMA</td>
<td>0.25</td>
</tr>
<tr>
<td>Insertion of testicular prosthesis</td>
<td>OMA</td>
<td>0.05</td>
</tr>
<tr>
<td>Insertion of penile prosthesis for impotence</td>
<td>OMA</td>
<td>0.22</td>
</tr>
<tr>
<td>Intracorporeal injection for impotence</td>
<td>OMA</td>
<td>0.22</td>
</tr>
<tr>
<td>Uvulopalatopharyngoplasty (for snoring or sleep apnea)</td>
<td>OMA</td>
<td>0.22</td>
</tr>
<tr>
<td>Excision of calcaneal spurs (heel spurs)</td>
<td>OMA</td>
<td>0.057</td>
</tr>
<tr>
<td><strong>No Recommendation:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss clinics</td>
<td>OMA</td>
<td>1.6</td>
</tr>
</tbody>
</table>
of testimony in support of not deinsuring IVF was second only to that supporting the annual health exam.

The Panel relied on information formulated concurrently by the federal Royal Commission on New Reproductive Technologies (hereafter, ‘the Royal Commission’), which issued its final report on November 15, 1993. The Royal Commission reviewed the social, ethical and medical implications of many new reproductive technologies, including IVF and eventually published the following recommendations regarding IVF specifically:

128. IVF for bilateral fallopian tube blockage be an insured service under provincial medical programs within the regulatory framework recommended by the Royal Commission on New Reproductive Technologies.

129. The province of Ontario discontinue coverage of IVF for indications other than bilateral fallopian tube blockage and that the resources be reallocated to fund clinical trials of unproven but promising techniques (RCNRT, 1993b, p. 564).

The regulatory framework referenced in the first recommendation includes elements such as the funding and oversight of basic and clinical research, compulsory licensing and reporting requirements for all providers, practice guidelines regarding appropriate assessment and referral for IVF and confining unproven drugs and procedures to practice under research protocols with human subject protections (as opposed to allowing unproven services to be available in the private market) (RCNRT, 1993b). The Royal Commission’s two recommendations, together with its regulatory framework, comprised a policy package designed to be adopted in whole to stem privatization and increasingly inappropriate use of IVF. However, the only portion of these recommendations implemented in Ontario was the deinsurance of IVF for non-blocked tubes. Ontario deinsurance policy deviated from the Royal Commission’s recommendations insofar as it did not reallocate resources to fund clinical trials.

Neither federal nor provincial agencies implemented the Royal Commission’s broader regulatory framework to contain the effects of IVF deinsurance or otherwise control the use of new reproductive technologies. In July of 1995, the federal Health Minister called a voluntary moratorium on a selected set of nine particularly controversial reproductive technologies, some associated with IVF (e.g. egg-selling, sperm-selling, surrogacy contracting and embryo selection by sex). Some IVF providers publicly defied the moratorium (see, e.g., Canadian Press, 1995). In 1996, the federal parliament failed to pass legislation criminalizing the nine practices and proposing a ‘management regime’ for regulating reproductive technology (e.g. Dickens, 1996; McTeer, 1996).

Members of the Panel have mixed opinions about the value of their work. The Chair has described the list of candidate services as a ‘haphazard’ and ‘bizarre’, commenting that, “…this exercise in delisting was a failure as a process for rationally determining what medical procedures should and should not be publicly insured… working from a haphazard collection of procedures is no place to start this kind of process” (Pringle, 1995, p. 8). She also felt the hurried schedule allowed neither systematic analysis nor thorough public consultation. The Chair and the two consumer representatives issued a public statement cautioning that the Panel had not been able to consider the systemic implications of its deinsurance policy (MoH, 1994a):

The [Panel] process… was regarded as a piecemeal approach to a systemic problem. Questions about the meaning of delisting, the ultimate results in terms of costs to individuals, effects on the health status of the population, practice changes by physicians, risks of a two-tiered system, etc. have still not been answered and are likely to recur. The relationship of this process to any reform of the health care system was a cause of much concern.

Panel members objected to the ultimate policy goal of saving $20 million in physician billings and favored instead non-budgetary principles such as medical necessity and equity for screening the services. They characterized the cost-saving goal as, “arbitrary, unrelated to ‘medical necessity’, [and] a cause for doubt as to the sincerity of the review process” (McInnes, 1994).

At first glance, Ontario’s act of deinsuring IVF — i.e., removing the service from insured benefits

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Services covered by OHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVF</td>
<td>Non-IVF treatments</td>
</tr>
<tr>
<td>Totally blocked fallopian tubes</td>
<td>Before deinsurance: yes; after deinsurance: yes</td>
</tr>
<tr>
<td>Other infertility diagnoses</td>
<td>Before deinsurance: yes; after deinsurance: NO</td>
</tr>
</tbody>
</table>

Table 2: Diagnosis and procedure contingencies for public insurance, before and after IVF deinsurance
— seems relatively straightforward. However, the deinsurance policy is neither simple nor clear to those involved with IVF services. First, deinsurance applies only to particular uses of the service. Public payment for IVF now depends upon diagnosis (Table 2): Ontario women with blocked tubes have coverage for all infertility treatments; Ontario women without blocked tubes have coverage for infertility treatments other than IVF (such as intrauterine insemination, donor insemination and tubal surgery). Second, deinsurance added one more barrier to a number of existent barriers to IVF access. Patient selection criteria varied between clinics (Ikonomidis and Lowy, 1994; Ikonomidis and Dickens, 1995). Those undergoing publicly-insured IVF faced considerable out-of-pocket costs; privately-paid drugs and ancillary services typically totaled several thousand dollars. The Joint Panel, noting these extra costs to public IVF, deemed IVF an “inequitable technology” geared to wealthier OHIP beneficiaries and so less appropriate for public subsidy (Panel member interview). Importantly, IVF was already available on a private pay basis in the province. Individuals able to pay a higher premium, unwilling to wait several months for treatment, failing public clinic selection criteria, or wishing to attempt a fourth or fifth try have always had the option of seeking care at a private clinic for an additional cost of about $3250–7200 per cycle.

Third, “IVF” per se was not listed in the OHIP Schedule of Benefits as a discrete service with a discrete billing code and fee attached to it. Rather, IVF involves a complex set of procedures including diagnostics, surgery, laboratory interventions and drugs. Many have distinct billing codes that may be used in contexts other than an IVF regimen. A list of the typical elements in the IVF process appears in Table 3 (RCNRT, 1993b). The deinsurance policy withdrew public payment for two procedures crucial to the treatment regime (oocyte retrieval and embryo transfer) and implicitly deinsured the remaining elements by reemphasizing standing policy that, “…any service provided by a physician, laboratory or hospital that supports an uninsured service is not an insured benefit” (Ministry of Health, Bulletin 4265, “Changes to Ministry of Health Schedule of Benefits of October 1st, 1992”. 8 March 1994 [distributed to physicians, hospitals, clinics and laboratories] p.4).

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Table 3 Services comprising the ‘IVF service’

<table>
<thead>
<tr>
<th>Description</th>
<th>Generic type of service</th>
</tr>
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<tbody>
<tr>
<td>Diagnosis (f)</td>
<td>Exam</td>
</tr>
<tr>
<td>Diagnosis (m)</td>
<td>Diagnostic lab procedure</td>
</tr>
<tr>
<td>Ovulation induction (f)</td>
<td>Fertility drugs</td>
</tr>
<tr>
<td>Semen analysis (m)</td>
<td>Diagnostic procedures (bloodwork, ultrasound?)</td>
</tr>
<tr>
<td>Egg retrieval (f)</td>
<td>Diagnostic lab procedure</td>
</tr>
<tr>
<td>Sperm wash</td>
<td>Diagnostic lab</td>
</tr>
<tr>
<td>Egg fertilization</td>
<td>Operative procedure Z718: “laparoscopy for oocyte retrieval”b</td>
</tr>
<tr>
<td>Embryo transfer (f)</td>
<td>Lab procedure</td>
</tr>
<tr>
<td>Implantation determination (f)</td>
<td>Lab procedure</td>
</tr>
<tr>
<td>Emergency proceduresd</td>
<td>Operative procedure Z585b: “hysteroscopy with embryo transfer”c</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>Diagnostic lab procedure</td>
</tr>
<tr>
<td>Hospital stay</td>
<td></td>
</tr>
</tbody>
</table>

a Key: m = male partner of couple; f = female partner of couple. Sources: patient services adapted from description of IVF process described by the RCNRT (1993); delisting policy from Ministry of Health Bulletin 4265.
b These are the two explicitly “delisted” procedures.
c Hysteroscopy may now be replaced by catheter implantation (provider interview); the MoH bulletin refers only to hysteroscopy.
d All other procedures are delisted implicitly according to the following policy: “…any service provided by a physician, laboratory or hospital that supports an uninsured service is not an insured benefit. Therefore, no claims to the Ministry should be made for any initial consultations, follow-up assessments, counselling, diagnostic investigations (e.g., ultrasound, laboratory tests), preoperative laboratory work/assessments which are in support of an uninsured service such as… uninsured IVF…” (Ministry of Health, Bulletin 4265, “Changes to Ministry of Health Schedule of Benefits of October 1st, 1992”. 8 March 1994 [distributed to physicians, hospitals, clinics and laboratories] p.4).
infertility treatment regimens. Ambiguity remains about both the services covered (or not) and valid diagnostic indications; Some providers may capitalize on this ambiguity to ‘game’ the system on the behalf of some patients (interviews with providers, consumer advocate). Compliance is not directly monitored or enforced. The deinsurance policy applies only to physician billings and IVF remains substantially publicly subsidized through global operating budgets to university and hospital-based clinics. Some independent clinics also receive public research grants which subsidize salaries for laboratory and clinical personnel (Table 4).

What messages did IVF deinsurance send?

IVF deinsurance sent a variety of policy messages to stakeholders interested in IVF. Interpretations of the policy message focus around three broad themes: (1) imperatives for demonstrating health service effectiveness, (2) the meaning of medical necessity (and related concepts) as principles guiding health service coverage and, (3) intentional or unintentional effects on health service market dynamics, including supply and demand side responses, delineation between public and private health service sectors and effects on health expenditures.

The effectiveness imperative

To some, the deinsurance policy exemplifies ‘evidence-based decision making’ guided by the principle of clinical effectiveness. To others, it represents the capricious use of evidence to rationalize deinsuring an expensive service. The Panel justified its decision to deinsure IVF on the grounds that there was no decisive evidence of the service’s effectiveness for conditions other than blocked tubes.

IVF has been difficult to evaluate using rigorous randomized controlled trials (Goeree et al., 1993; Solimon et al., 1993). The two only two such reports published by 1993 (and indeed, up to present time) both came from a trial conducted in Ontario public IVF clinics prior to deinsurance (Jarrell et al., 1993; Solimon et al., 1993). The trial, apparently the only one of its kind, aimed to assess the effectiveness of IVF to normal care while waiting for IVF (during which time other infertility treatment may or may not be pursued1). Results showed a statistically significant benefit for individuals with blocked tubes. Effectiveness for other conditions was inconclusive due to too few study subjects; a positive but statistically insignificant effect was found for endometriosis (Solimon et al., 1993).

Clinical trials notwithstanding, IVF advocates and skeptics disagree over what constitutes good evidence. These disagreements hinge on issues such as what specific function of IVF should be evaluated (e.g., producing pregnancies or babies, diagnosis or treatment, mental health or physical health) and what evaluation designs (e.g., controlled trials, descriptive statistics, individual case reports, anecdote) are credible. Altogether, the policy sends unclear messages regarding the importance of evidence-based coverage, evidence-based clinical practice and evaluation research to generate evidence.

Different stakeholders apply different standards of scientific evidence to the question, “does IVF work?” Policy makers questioning the value of IVF (i.e., the Panel, the Royal Commission, consulting clinical epidemiologists) applied the most stringent standard of clinical evaluation (randomized, controlled clinical trial findings) and found evidence of IVF’s effectiveness lacking except in the case of blocked tubes. IVF for other diagnoses, such as endometriosis, was not demonstrated to be ineffective, rather, the study was

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1 In the absence of a waiting list for IVF, it is difficult to convince individuals to participate in a controlled trial. Control group members are likely to seek IVF elsewhere or drop out of the study. With a queue, individuals can be randomized to ‘early’ versus ‘late’ treatment with IVF (by randomizing their position in the queue). Pregnancy rates in those still waiting can then be compared to rates in those who have received treatment.
inconclusive due to limitations of the research design. This lack of evidence translated into the Ontario Health Minister’s statement to the press (explaining IVF deinsurance) that “test tube babies” remain “experimental” (Papp 1994).

In contrast to the dearth of controlled trials of IVF’s essential effectiveness, the scientific literature abounds with case series as well as controlled trials comparing different techniques of IVF to each other. Many IVF advocates find credible ‘evidence’ of effectiveness in stories of personal success and the reports of uncontrolled clinical trials and cases. Cases (rather than populations) have always provided the primary data for developing and practicing IVF. The procedure involves a great deal of direct observation of — and participation in — the conception process. Because of this direct experience by both providers and patients, IVF participants are often unwilling to allow that anyone in the experimental group of an IVF trial could get pregnant by any means other than IVF.

Even more contentious than the question of legitimate study design is the question, “if it works well, how well is ‘well enough’ to justify public payment?” While policy makers and clinical epidemiologists seek a substantially increased probability of live births from IVF, many consumers and providers seek mere “possibilities”. They speak in terms of being given “chances”, “miracles” and so forth, not in terms of statistical likelihoods and rational optimization. For example, a newsletter for allied professionals in Ontario infertility clinics describes the gratification of achieving “a miracle” against the odds calculated by evaluative science: “…somehow we made it work when ‘statistics and research’ said it would not be possible” (OFSN, 1992).

Policy makers and evaluation researchers also differ from providers and consumers with regard to what they believe to be the salient benefit of IVF. Clinical research has evaluated IVF as a treatment technology to produce pregnancies or live births. But some providers argue that IVF produces important benefits even when it fails to produce a baby. For example, IVF also functions in some cases as a diagnostic technology. It offers clients and providers unique insight into the couple’s reproductive function and when it fails, unique demonstration that “nothing can be done” for the couple’s infertility (provider interviews). This additional diagnostic information and emotional closure can potentially benefit the woman’s physical health by obviating further infertility interventions; it benefits couples’ and individuals’ emotional health by allowing them to “get on with their lives”.

These differing views on what constitutes “evidence” create serious tensions for priority-setting exercises committed to principles of both “values” and “effectiveness”. If coverage decisions are to reflect both scientific evidence and social values, policy makers will have to come to terms with the fact that the public, the profession and policy analysts can value fundamentally different types of scientific evidence. The ethos of “chances”, “hope”, or “miracles” for individuals (which consumers tend to value) is inconsistent with the ethos of “clinically important effect sizes” or “statistically significant differences” for populations (which technology assessors value). It would be antithetical to the trend toward involving public values in coverage decisions to dismiss one basis as irrational or irrelevant.

Ironically, the ‘evidence based’ coverage deinsurance decision may have weakened both incentives and means for investigators to test IVF’s effectiveness through randomized trials. First, after deinsurance, providers face less, not more, pressure from payers to demonstrate the value of their service through randomized trials. The new ‘payer’ (the private consumer) is in a weaker position to insist upon rigorous evaluation than the province and typically does not ‘believe in’ the results of clinical evaluation to the degree that provincial policy makers or other health care administrators do.

Second, public clinic queues have provided the only ethical and practical source of control cases for controlled trials for assessing IVF’s effectiveness. The new user fees have virtually eliminated these queues and consequently controlled trials. Although the Royal Commission had recommended that the province offset deinsurance with IVF research subsidies, this recommendation was not followed. Consequently, deinsurance halted Ontario’s randomized trial, the first and, thus far, the last “in which IVF treatment is compared with no IVF treatment with respect to clinical pregnancy rates” (Jarrell et al., 1993 para 24; provider interview).

Medical necessity

The Ministry portrayed ‘medical necessity’ as a key criterion in its review of selected services and deinsurance of IVF (Gerard, 1993; Brooks, 1994; MoH, 1994a). Because ‘medical necessity’ is the basis for coverage mandated by the 1984 Canada Health Act, this term has high currency in debates over which services belong in provincial health insurance plans. However, it remains a largely undefined and slippery concept for policy making purposes (e.g. Bergthold, 1995; Rachlis, 1995; Charles et al., 1997; Hurley et al., 1997a, 1997b).

The concept of medical necessity played an influential but highly ambivalent role in shaping both Ontario’s deinsurance decision and stakeholders’ interpretations of its meaning. The Panel’s and Ministry’s use of ‘medical necessity’ to justify deinsuring
IVF has been interpreted to mean several things: (1) that if a service is deemed not medically necessary, it means that the condition it treats is not a legitimate medical problem; (2) that the lack of a principled definition and ambiguity of the concept of ‘medical necessity’ can be used capriciously to justify cutting health benefits for other reasons; or, (3) that ‘medical necessity’ can be determined inductively by evidence of its coverage in other jurisdictions or its similarity with other provincially insured services (rather than deductively by the application of principles).

Because policy makers invoked the rationale of ‘medical necessity’, some interpret IVF’s deinsurance as a judgment about the legitimacy of need for IVF (apart from the merits of IVF itself). Consumers argue vehemently that infertility is a legitimate medical condition and IVF a legitimate treatment: “Infertility is a serious medical condition resulting in the abnormal function of the reproductive system and deserves treatment as does any other medical condition” (IAAC, 1994). Indeed, the Panel’s consensus was that infertility is a medical need and infertility treatment legitimate medical care. The Panel declared in its submitted recommendation that, “In Ontario treatment of infertility is considered medically necessary and is, therefore, covered by OHIP” (MoH, 1994a). Annulling the final decision to deinsure IVF, the Ministry stated that the deinsured services generally were not ‘medically necessary’, but in the same announcement affirmed that infertility treatments are considered ‘medically necessary’. Nevertheless, the infertile felt that deinsuring IVF along with several cosmetic services reinforced a message that the service is frivolous — elective but not medically needed.

Consumer advocates protest that the idea of ‘medical necessity’ is nowhere legislatively defined and implies no specific criteria or processes for deinsurance (IAAC, 1994; Tennant, 1994). They advocate an individualized determination of medical necessity: rather than applying the concept at a system-wide level to determine covered benefits, they argue that it should be applied at a clinical level in treatment decision making: “What is medically necessary for one person may not be medically necessary for another one” (Kennedy, 1995, p. A10). Similar conclusions have been reached by critics of deinsurance more generally (Klein, 1994; Rachlis, 1995; Charles et al., 1997; Hurley et al., 1997a,b). Although deinsurance made IVF coverage diagnosis-contingent, providers and consumers complain that coverage on the basis of tubal blockage still offers too little discretion for matching treatment regimens to specific individual needs (provider, consumer advocate interviews).

Deductive reasoning based on definitions, principles and algorithms is one way to apply the concept of ‘medical necessity’. However, Ontario stakeholders also used two types of inductive analysis to argue for or against the medical necessity of IVF. First, they referred to IVF coverage policies in other jurisdictions. This strategy was used to legitimate both opposing claims: that IVF should be publicly funded and that it should not. The Panel noted the lack of IVF coverage in other Canadian provinces, who are all obligated by federal law to cover ‘medically necessary’ services and considered this evidence that IVF is not medically necessary (Panel member interviews). Canada’s federal Health Minister did not view the coverage of IVF in Ontario as evidence of its status as a ‘core’ service to be covered by all provinces (Pole, 1995). Consumers advocates, on the other hand, argued that IVF’s medical necessity is evident in its public coverage in countries outside Canada (e.g., some UK jurisdictions, Australia, The Netherlands, France) and its legislated inclusion in private insurance packages for several U.S. states (Redmayne and Klein, 1993; IAAC, 1995).

A second inductive critique considered whether services ‘like’ IVF remained covered. Those who feel that deinsuring IVF was capricious compare IVF to other services to illustrate that IVF has been unfairly ‘singled out’ for deinsurance, while many covered services share similar characteristics of medical necessity (IAAC, 1994; Tennant, 1994). A submission to the Panel, for example, questioned: “…I wonder why IVF has been singled out and lumped together with such ‘lifestyle’ issues as tattoo removal and vasectomy reversal… if [not life-threatening] is the definition of medical necessity, then many, many procedures could be delisted… cataract surgery, for example, or hip replacement” (Tennant, 1994). Rhetoric arguing for public coverage compares IVF variably to joint replacement, optometry, psychoanalysis, or abortion with regard to its qualifying features for public coverage (e.g. its use to restore function rather than prolong life, its instrumental use in family planning) (Panel member interview; IAAC, 1994). This practice of inducing medical necessity criteria from examples, rather deducing it from abstract principles, has been found in policy arguments for service coverage since the inception of medicare in Canada (Charles et al., 1997).

Further complicating the issue of medical necessity is IVF’s role as a reproductive health service. Deinsuring reproductive care is not new in Canada. An entire spectrum of reproductive services — low and high cost, low and high technology, for birth achievement as well as birth control — have been proposed for deinsurance in some province over the past decade. Nevertheless, the relationship of IVF to reproductive capacity and behaviour is indeed an important feature of the deinsurance ‘message’ as understood by stakeholders.

The idea of ‘rights’ coloured reactions to the IVF deinsurance policy. Some advocates of IVF argue
that people have a right to reproduce. Symbolically, public funding affirms this privilege; withdrawing public support violates it. Infertility Awareness cited in its brief to the Panel the United Nations 1948 Universal Declaration of Human Rights, which "recognizes the right of everyone to have children" (IAAC, 1994). IVF advocates introduce the theme of rights to reproductive 'choices' rather delicately with the suggestion that provinces who offer the choice of abortion should offer the symmetric choice of a full range of infertility interventions, e.g.: "The tax dollars of the infertile pay for reproductive health care for the fertile — they pay for maternity and sterilization and abortions" (Papp, 1994). The intention is not to question the coverage of abortion, but to invoke similar principles to cover IVF (IAAC, 1994). The Women's Health Bureau supported publicly insuring IVF under the rubric of women's reproductive services (Panel member interviews). Some providers agree that deinsuring IVF impinges reproductive rights and choices, or constitutes government interference in private family life (provider interviews; Gerard, 1993). Other providers clearly see access as less of a 'right', for example when they refuse IVF to candidates they consider psychosocially unfit for treatment or parenthood (Ikononidou and Lowy, 1994).

IVF coverage has been cast not only as a 'right to reproduce' issue, but also a 'right to health care' issue. Many involved in the IVF debate question whether it is essentially medical care, or foremost some other type of nonmedical social or personal service. Some insist that infertility care is essentially a medical service for a physical or even mental health problem (provider interview). Some see it as medical intervention for a non-health problem because IVF simply circumvents but does not remedy the underlying pathology that causes infertility (provider interview). Others have characterized IVF (along with other deinsured services) as more of a lifestyle choice or a luxury; in support of the deinsurance policy, the Ontario Medical Association president declared, "We've allowed the frills to creep in. Because we've not been willing to say no — until now" (Kennedy, 1993, p. A10). The Royal Commission, according to a well-articulated ethical framework based on an 'ethic of care', argued that infertility treatment is not a medically unnecessary luxury (RCNRT, 1993c).

Deinsurance and market dynamics

In Ontario, deinsuring IVF did not mean that it became unavailable. Rather, it became available only privately at market-determined fees. This introduced a new market dynamic to IVF provision in the province. Stakeholders express particular concerns about issues such as the fairness of a 100% user charge for a service popular among the infertile, the appropriateness of private enterprise by infertility care providers and whether this instance of deinsurance portends more health care privatization in general.

Deinsuring IVF blurred further an already a fuzzy boundary between the public and private IVF sectors. ‘Public’ IVF clinics in Ontario are those whose overhead costs are funded by the provincial health system through hospital operating budgets. ‘Private’ IVF clinics (mostly for-profit and physician- or investor-owned) are those whose overhead costs are covered through private fees. Physicians in both public and private clinics have always been able to bill the public health insurance plan for covered services and to bill patients privately for services not covered by the public plan (e.g. cryopreservation and sperm assessment) as well as other costs (e.g. ‘program development’). In addition, providers often work in both public and private clinics, so that clients assessed in the public clinics are sometimes offered the option of seeing (for a fee) the same physicians at a private clinic with a shorter wait and access to services not available in the public system (consumer advocate, provider interviews).

The intertwining of the public and private IVF sectors generates financial cross-subsidies in both directions. Public funds continue to subsidize many aspects of private IVF (e.g. Baird, 1995). These subsidies include public insurance for pregnancies and complications of private IVF, increased incidence of multiple births and low-birthweight babies with long-term disabilities and the associated costs of social support. Public funds also support the medical centres that house IVF programs, provide access to patients and train physicians who practice private IVF. In the other direction, private IVF fees generate extra revenue for publicly-funded hospitals, which is sometimes used to subsidize other non-IVF hospital services (provider interview).

Demand for IVF persists despite high out-of-pocket prices. Many view this demand as rooted in the unique psychology of the desire for children. Some view IVF-seekers’ powerful yearning with compassion (RCNRT, 1993c), while others view it with more derision or skepticism (Panel member, providers interviews; Tennant, 1994). Many infertile individuals endure financial hardship and unknown medical risks — if not through IVF, then through any accessible treatment — for the slightest possibility of having a child. Anecdotes abound of people selling their houses or cars, depleting their savings, using credit cards, borrowing relatives’ money, or moonlighting to fund the out-of-pocket costs of IVF (consumer advocate, provider interviews). As a consequence of the increasing personal expense of IVF, patients increasingly sell some of their eggs to
finance each IVF cycle (Nisker, 1995; Nisker, 1996). In doing so, women decrease their own chances of conceiving through IVF and incur undetermined health risks. For these reasons, the Royal Commission declared egg-selling unethical.

Deinsuring IVF also encourages substitution among infertility treatments and clinics. Individuals unable to finance private IVF have turned to services still publicly insured, such as surgery or repeated cycles of intrauterine insemination (provider interview; IAAC, 1995). Because deinsurance has reduced the disparity in financial costs between the public and private sectors, it appears to have led to substitution of private clinic use for public clinic use. Although standard measures of utilization are not available, in the Toronto area (with several public as well as private clinics), after deinsurance the average wait in public clinics dropped from 36 months to 3 months in two and from 12 months to 0 in the third, while two private clinics report a 140% increase and a 4% decrease in demand.

Consumers, then, seem to have reacted largely as one would expect. Given inelastic demand, many go to great lengths to obtain IVF despite increased personal costs. Where this is not possible, they substitute lower-cost alternatives. Given the equalizing of public and private financial costs, they are preferentially using private clinics where the ‘time costs’ in waiting have traditionally been lower (and the quality of care or amenities are perceived by some to be higher).

Deinsurance also potentially affects the supply of IVF providers and services. While the number of public IVF clinics in Ontario remains unchanged at five, IVF capacity in the private sector did increase coincident with deinsurance. Private IVF clinics have attracted venture capital in recent years, especially for more technologically ‘advanced’ services. The number of private clinics increased from 6 to 7 in 1994. Urban clinics have also added private ‘satellite’ clinics in outlying areas to perform all services up to the stage of egg retrieval (after which the central IVF clinic takes over).

Competition among clinics appears to be increasing, although more in terms of quality than of price. The Ministry’s deinsurance policy advised that clinics “use the OHIP fee schedule as a guide” for determining private IVF fees. But prices vary considerably. Public clinics’ physician fees range threefold, from $1000 to $3200 (provider survey). Some clinics set prices to pursue objectives such as attracting patients for clinic-based research, matching local competitors, or increasing service volumes (provider interviews). Quality competition is based on ‘state-of-the-art’ technology, staffing with impressive clinical credentials or compassionate manner, or ‘beautiful facilities’ (provider, consumer advocate interviews). Providers market their services with claims based on varying definitions of a ‘success rate’, varying methods of calculating rates and little comparability across clinics (RCNRT, 1993a).

Although consumer advocates try to educate consumers about these variations in outcome reporting and to pressure clinics to express rates in consistent terms, advertised IVF outcomes remain unstandardized. This is a major concern of those who have examined the IVF markets in Canada and the U.S. (e.g. RCNRT, 1993a; Neumann, 1997).

Making IVF coverage conditional on diagnosis has introduced an incentive for strategic diagnostic and treatment behaviour. Some providers have contested the Ministry’s anatomically-based definition of “totally blocked fallopian tubes”, arguing for a broader, function-based definition (provider interview). In addition to the incentive for ‘diagnostic creep’ (Simborg, 1981), providers and patients are sometimes choosing less sensitive tests that do not as readily rule out totally blocked fallopian tubes, thereby preserving their entitlement to public funding for IVF (provider interview). Diagnosis-based strategic marketing in the IVF field is not new. While standardized infertility rates show little change over the past few decades, public awareness of infertility and its new ‘high tech’ treatments has generated the perception of a growing infertility epidemic in North America (Scritchfield, 1989; RCNRT, 1993d).

Some IVF clinics start IVF earlier in the infertility experience, before less invasive measures have been exhausted (provider interviews). More generally, the IVF industry is cultivating new markets of ‘infertile’ people, e.g., postmenopausal women, fertile women postponing childbearing (the potentially infertile) (Medical Post, 1995) and even those seeking posthumous conception (e.g. Toronto Star, 1995).

Deinsurance was intended above all to control public spending for physician services. In the most immediate sense, the policy did save public money: it supported a contractual decrease of the provincial physician budget by $20 million. However, it remains unknown whether IVF- and infertility-related spending within Ontario’s physician budget have changed, or by

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2 There is tremendous variation in claims of effectiveness in marketing and information materials offered by North American IVF providers. ‘Success rates’ may be calculated based on any number of populations and endpoints, the choice of which can dramatically alter ‘success rates’ and confuse anyone trying to make unbiased comparisons of effectiveness.

3 An anatomically blocked tube has a physical obstruction that is evident even in the absence of an egg’s passage through it. Functionally blocked tubes may not be anatomically obstructed but nevertheless be impassable by an egg. Anatomical blockage is a subset of functional blockage.
how much. Data necessary for evaluation (e.g. reliable utilization statistics on IVF and substitute and complementary services) remain uncollected and unavailable. The effect on costs cannot be calculated by simply subtracting the IVF physician fees from the provincial health care budget. Deinsuring physician payment associated with IVF affects the delivery and use of other health care services (e.g. rates of surgery and intratuberine insemination, commitments of specialists between public and private clinics, hospital investment in capital for IVF clinics and cross-subsidization of other hospital programs with private IVF revenues). The ripple of utilization adjustments in turn affects health care needs (e.g. due to complications from alternative procedures, multiple births).

Importantly, deinsurance was not the only policy tool available to control provincial expenditures for IVF and IVF-related needs. Infertility consumer advocates argued against IVF deinsurance on the grounds that larger cost savings might come from regulatory reforms to cut down on poor treatment practices, such as standard clinical guidelines for IVF and the accreditation of IVF providers (IAAC, 1994). Such regulation was also recommended by the Royal Commission but has not been implemented provincially or federally.

Discussion

Deinsuring IVF was intended to support several policy goals: (1) To save the Ontario Health Insurance Plan $4.4 million through reduced physician billings for IVF; (2) To affirm that public payment be restricted to ‘medically necessary’ care; (3) To apply scientific evidence of effectiveness as a criterion for the medical necessity of a service; and, (4) To take a first step toward applying the painstakingly formulated recommendations of the federal Royal Commission on New Reproductive Technologies.

To those who advocate evaluation-based coverage of health care technologies, it may seem that Ontario policy makers took a modest and constructive step by removing one service of dubious effectiveness and high cost from public insurance coverage. As it plays out, however, Ontario’s deinsurance of IVF could inadvertently accomplish the opposite of what policy makers had hoped. It remains unclear whether public infertility- and IVF-related spending has gone up or down. ‘Medical necessity’ was inconsistently defined and understood by stakeholders to refer to various service characteristics: experimental status, effectiveness, legitimacy of infertility as a medical indication, coverage status in other jurisdictions and as a Trojan horse for obscuring ‘real’ decision criteria such as cost control.

Rigorous evaluation of IVF’s effectiveness has stalled and uses for unproven purposes have moved further into the private sector. Utilization of other underevaluated infertility interventions in the public sector may have increased as a result of deinsurance.

As a financial incentive tool, deinsurance does not necessarily create an incentive discouraging inappropriate services. Ontario’s deinsurance of IVF conveyed ambiguous signals about ‘the right thing to do’, as well as ‘how to do the right thing’. This case suggests some generic lessons for other jurisdictions engaged in priority-setting and service deinsurance: (1) individual services interact with the rest of the system, (2) inconsistent use of coverage principles can undermine popular legitimacy of priority-setting principles and processes, (3) ‘evidence-based’ decisions can founder on differing stakeholder perceptions of valuable types and topics of evidence, as well as the inconsistent message given by commercializing unacceptably ineffective (or unproven) care.

First, many services are inextricably connected to other parts of the health care system. For service priority-setting, it is seldom easy to define either ‘the’ service in question, or ‘the’ alternative to which it might be compared (Ham, 1993; Giacomini, 1999). IVF’s purposes have been variously conceived (so to speak) by different stakeholders as: to produce a baby (any baby, a genetically related baby, or a healthy baby), or, barring a baby, to produce pregnancy, hope, diagnostic answers, or psychological relief. Alternatives to publicly-paid IVF, then, could be anything from other clinical interventions for achieving conception (e.g., tuboplasty, waiting, private IVF), other means of producing psychological relief (e.g., counseling), or other means of achieving parenthood (e.g., adoption, surrogacy). The purpose of and alternatives to IVF depend upon the goals of its users, its payers and the economic and organizational context in which it is delivered.

As an item on a list of potentially deinsurable services, IVF appears deceptively discrete. In practice however it is better thought of as a component integrated into a system of services. Its removal has systemic effects on other services and on the care that particular populations receive. If IVF is less available, demand for its variously understood ‘alternatives’ increases. Thus, a policy about the role of a given service is by implication also a policy about the role of its alternatives. The health effects and social costs of turning to alternatives such as tubal surgery, private IVF, surrogacy, adoption, or ‘giving up’ remain poorly understood. The ad hoc deinsurance of a discrete service — according to a limited characterization of that service and a non-comparative understanding of its expense and effectiveness — guarantees neither lower spending nor improved outcomes in populations or individuals.
Second, the selective or incomplete application of assessment principles can undermine the popular legitimacy of health service priority-setting. Despite the Panel’s public explanations of its process and its rationale for deinsuring IVF, stakeholders remain confused (and skeptical) about the true criteria and agenda driving the decision. Perceived criteria for the decision include clinical effectiveness (a criterion the Panel did use), the legitimacy of the need for infertility services (a criterion the Panel explicitly rejected) and coverage in other jurisdictions (an impetus for examining IVF, but not a criterion officially used by the Panel to judge it). The concept of medical necessity was used repeatedly to justify the decision, but left vaguely defined. Medical necessity and its various connotations (need, effectiveness, etc.) appear to have functioned more as post hoc rationalizations rather than as a priori rationales for withdrawing coverage. The highly selective application of the review process to only a few services appeared very unfair to consumers and providers who believe in the value of IVF, as well as to the Panel members doing the review. The net effect has been unclear understanding of how health services are valued, a general consensus that the service restrictions were primarily cost-reducing and residual skepticism about priority-setting exercises.

This case suggests that the legitimacy of structured decision-making processes will rest not only on the integrity of the criteria and reasoning used in the algorithms (e.g., GCCHC, 1992; Deber et al., 1994). Legitimacy will also depend on how effectively the criteria are communicated to and agreed to be valid by stakeholders and on how consistently the criteria are applied across services. A seminal Dutch proposal for determining service coverage has suggested the four ‘screens’ of: necessity, effectiveness, efficiency and whether the service should be left to individual responsibility or provided out of a community commitment to solidarity (GCCHC, 1992). When applying this decision-making algorithm hypothetically to IVF, the authors conclude that, “…from the medical-professional viewpoint, in vitro fertilization would be necessary care, reasonably effective and, compared to alternatives, reasonably efficient”, but that it fails on the basis of solidarity: “…a broad, not to mention compulsory, solidarity would not seem to be justified, so that in vitro fertilization will not be included in the basic package” (GCCHC, 1992, p. 88).

The Ontario case suggests that this type of rational priority-setting would not be so straightforward. Canadian stakeholders in 1994 did not agree readily on IVF’s effectiveness status, or even on acceptable effectiveness parameters. Efficiency was all but disregarded: although cost was a central concern, cost-effectiveness principles and data played little role in the policy debate. Many remain unconvinced that infertility treatment is established as valid necessity, despite both the Royal Commission’s and the Panel’s explicit attempts to validate the needs of the infertile and to separate these from the issue of IVF payment. Finally, opinions diverge on a solidarity basis for IVF coverage and ideas about solidarity can be difficult to distinguish from ideas about rights as well as necessity.

IVF clearly represents many things to many people. These qualitative dimensions and stakeholders’ strong opinions about which ones count, can confound standardized approaches to priority-setting. In jurisdictions outside of Canada, health system administrators have also diverged in their understanding of the essential, defining qualities of IVF for the purpose of coverage decision-making. Redmayne and Klein (1993) investigated the widely varying reasoning behind the in vitro fertilization (IVF) coverage decisions of six UK purchasing authorities. Reasons for declining to cover IVF included: a belief that those in need of IVF are not ‘really ill’; local affluence and the ability to pay privately; high cost; reluctance to ration by volume to control costs; the argument that money could be spent on more reliably effective services (specifically, hip replacements); and a local opinion-leader’s conviction that IVF is not effective. Reasons for deciding to cover IVF included: its inclusion in larger a larger package of infertility services; strong lobbying by a local provider or local pressure groups; concern about psychological and marital stress due to infertility; a commitment to ‘the family’; a sense of moral obligation given the coverage of other reproductive services such as contraception and abortion; a belief that the epidemiological need for IVF is limited (creating a natural limit to IVF spending); explicit limitation of the service to women/couples under 40 with no more than one child (again to limit spending); and a belief that the procedure is effective. The UK experience illustrates the multitude of criteria that decision makers have applied to deinsurance in general and to IVF in particular.

Beneath technologies, their purposes and their alternatives, lie constituent interests. In the policy world, selective divestment from certain health services readily translates into selective divestment from certain populations’ needs. Because IVF deinsurance selectively deinsures only some infertile people for only some treatments, consumers have interpreted the policy to be divisive to the ‘community’ in need. More generally, IVF privatization through deinsurance signals a movement away from the solidarity principles underlying social insurance (Stone, 1993).

Finally, even ‘evidence-based’ coverage decisions can send mixed messages about the proper role of evidence as well as the proper role of yet-unproven or ineffective technologies. The Panel’s reference to scientific evi-
dence as justification for deinsuring IVF was, outwardly, a step toward rationalizing benefits through technology assessment. However, as stakeholders interpret the policy, the deinsurance of IVF does not herald more stringent evidentiary standards for health service coverage. Stakeholders disagree over key issues such as whether relevant evidence was used, whether services should be disqualified for a lack of evidence of effectiveness or only for proven ineffectiveness, whether clinical evidence applies at the level of provincial coverage decision-making vs. service-level clinical decision-making and whether it is appropriate to apply evidence standards to discrete services (e.g., IVF) rather than to programs of care (e.g., infertility treatment) for defined conditions. Deinsurance also seemsunlikely to create incentives for more rigorous evaluation in the future. Individual infertile consumers seem less insistent on rigorous evaluation evidence than are collective payers such as insurance plans. Despite official announcements to the contrary, deinsurance did not send a clear message that IVF remains ‘experimental’. Its dispatch to the private sector (rather than to research protocols and stringent ethical oversight) served to characterize it rather as an ‘elective’.

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