Introduction: Access to fertility care

Owen K. Davis, M.D.[a] and Rebecca Z. Sokol, M.D., M.P.H.[b]

[a] Ronald O. Perelman and Claudia Cohen Center for Reproductive Medicine and Department of Obstetrics and Gynecology, Weill Medical College of Cornell University, New York, New York; and [b] Department of Medicine and Department of Obstetrics and Gynecology, Keck School of Medicine, University of Southern California, Los Angeles, California

Given that only an estimated 24% of infertile couples in the United States can fully engage in the medical care required to successfully conceive, the American Society for Reproductive Medicine (ASRM) has incorporated improved access to the full gamut of fertility therapies as an integral component of the Society's strategic plan that was launched in 2014. Toward this end, the ASRM hosted a two-day summit held in Washington D.C. in September 2015 that attracted thought leaders, both speakers and attendees, from around the world. This issue's Views and Reviews focuses on several key areas integral to this effort: an appreciation of the economic challenges to access, as well as the impact and interplay of racial, ethnic, emotional and gender-specific issues in the treatment of infertility. The potential to broaden access to care through modification of existing assisted reproductive techniques is also explored. (Fertil Steril® 2016;105:1111–2. ©2016 by American Society for Reproductive Medicine.)

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This month's Views and Reviews section addresses a pressing issue in the field of reproductive medicine; specifically, the need for improved access by those in need of fertility care from the basic to the advanced treatment modalities that are available. The goal of expanding access to fertility treatment is an important prong of the American Society for Reproductive Medicine's (ASRM) strategic plan, which was kicked-off in 2014. Toward this end, the Society convened an intensive two day summit in the fall of 2015, in Washington D.C. that attracted thought leaders from around the United States and the world; this meeting included presentations from a distinguished panel of invited speakers as well as break-out sessions designed to strategize how best to move this mission forward. An understanding of the manifold and complex issues that limit access to fertility care is a crucial first step toward developing and promulgating actionable items, in addition to considering how current therapies could potentially be modified to expand utilization by those in need. We have asked experts who participated in the summit to author articles in this month's Views and Reviews section that focus on the numerous barriers to care and novel therapeutic strategies.

To start, Adashi focuses on the disassociation between the concepts of procreative liberty, specifically the right to procreate, from the underwriting of fertility services in the United States. Infertility is still not widely viewed as a disease, and treatments are seen as costly; under-insurance rates are high and lead to significant out-of-pocket expenditures. Although fifteen states have infertility-care mandates, only six include meaningful access to assisted reproductive technology (ART). Further, access is complicated by factors such as age discrimination and the exclusion of same-sex couples. Indeed, "ever-use" of infertility services, according to the National Survey of Family Growth, actually declined between 1995 and 2010. Dr. Adashi proposes targeted advocacy efforts involving the engagement of self-insured employers and private national and government insurers (e.g., Tricare) through the reduction of multiple births and an emphasis on attracting and maintaining employees through family-friendly policies. This is a compelling cause.

Quinn and Fujimoto evaluate racial and ethnic disparities in ART access and outcomes. In the United States, those utilizing fertility services are disproportionately non-Hispanic white women. Where they exist, insurance mandates do not apply to Medicaid, the uninsured, or many covered by self-insured employers. In addition to economic barriers, sociological, cultural and/or religious beliefs may impact both the stigma surrounding

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Reprint requests: Owen K. Davis, M.D., Department of Obstetrics and Gynecology, Weill Medical College of Cornell University, 1305 York Avenue, New York, New York 10021 (E-mail: okdavis@med.cornell.edu).

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infertility and the acceptability of specific treatment options, leading to a delay in seeking care. Physical access may also be a significant issue given the in-homogeneous geographic distribution of obstetrician-gynecologists and ART clinics. Finally, there is evidence that black, Asian and Hispanic patients have worse ART outcomes, according to the Society for Assisted Reproductive Technology Clinic Outcome Reporting System database. Such outcome disparities likely stem from a panoply of factors including biological variations in body mass index, the prevalence of fibroids, and tubal factor infertility, but may further result from nutritional and environmental factors. The authors suggest that an important first step is consistent reporting of race and ethnicity in the data that we collect and analyze.

Rich and Domar describe the complex emotional barriers to reproductive care. As a result of the psychological burden of infertility, even couples with a good prognosis frequently do not enter into care and/or have high rates of drop-out, in part, due to fear of failure and a lack of awareness; 50% of infertile couples never seek care and 20% of those who do, wait over 2 years before seeing a specialist. The authors note that once engaged in treatment, drop-out rates of up to 50% are seen even in insured patients. Approximately 40% of first time infertility patients manifest psychological disorders, principally anxiety and depression. The authors suggest access may be improved through education of referring physicians and nurses, thus leading to timely referral, and additionally, through implementation of effective screening and referral procedures for psychiatric issues, promotion of educational materials, enhancing the involvement and support of the patients' partners, and education of clinic staff regarding the psychological components of infertility and fertility treatments.

Mehta and colleagues focus on the barriers to access for the male partner. The male partner is often overlooked in the evaluation and treatment of a couple's infertility. The scope of male factor is not completely understood; current estimates of the prevalence are largely limited to ART data. Accurate identification of and referral for male factor infertility may have important public health implications as semen quality can reflect overall male health. Even when treated through ART, evaluation of the male may reveal underlying conditions including tumors, genetic disease, endocrine disorders, and toxic exposures. The authors point out that a number of barriers exist. Men are generally less apt to access medical care than women. Men may perceive male fertility disorders as connoting a lack of "virility." There exists a significant geographic disparity in the distribution of reproductive urologists. In addition, treatment of the male with non-obstructive azoospermia entails a significant increase in ART-related costs.

Finally, Paulson and colleagues describe ways in which the practice of ART can be potentially modified to reduce cost and improve the ease and tolerability of treatment, while maintaining a level of efficacy exceeding that of "low-tech" alternatives such as ovulation induction with intrauterine insemination. A variety of clinical protocols are explored. In vitro maturation of oocytes, particularly in selected patients (e.g., women with polycystic ovary syndrome), could permit successful in vitro fertilization without the need for and risks of controlled ovarian hyperstimulation, thus mitigating the medication-associated costs of ART. Mild stimulation protocols may be useful, some incorporating oral agents such as clomiphene with low doses of gonadotropins; improvements in the ART laboratory have markedly enhanced the efficiency of in vitro fertilization, thus calling into question the need for traditional "aggressive" ovarian stimulation. Such an approach could reduce both cost and patient drop-outs. Another alternative to conventional ovarian stimulation is the "modified natural cycle" in which a low dose gonadotropin add-back, concurrent with administration of a gonadotropin-releasing hormone-antagonist, is administered once the dominant follicle has been recruited by endogenous mechanisms. The modified natural cycle would likely be most applicable to good prognosis, young patients or conversely low responders who fare poorly on high dose protocols. The authors close with an exploration of the option of novel incubation systems, specifically intravaginal culture (IVC), in which insemination and embryo culture take place in a small, gas permeable plastic device that is placed and maintained in the vaginal cavity. Such an approach would reduce the costs associated with laboratory space, equipment and personnel and could be deemed more "natural" by some patients. IVC could play a meaningful role in global access to fertility care, e.g. in under-resourced areas.

All in all, these superb articles serve to frame the challenges to the access and utilization of infertility services in the United States and globally and serve as a thoughtful and provocative basis for further consideration, exploration and research.