Highlighting disparities in access to care for infertile men: a call to action

Historically, there has been a gap between reality and the published literature about which demographic subgroups are most affected by infertility. Most epidemiologic studies on infertility have focused on the populations of patients who are either presenting for evaluation or who have received care. Therefore, the myth that infertility is a disease of the more fortunate has been inadvertently perpetuated by disparities in access to care and misguided health policy (1). Decade after decade, the roots of such inaccurate perceptions grow deeper. These observations are most exemplified by the marginalized populations, a prime example being infertile men. Receiving significantly less funding and less attention by reproductive medicine researchers, the general population of infertile men has been incompletely characterized in the past (2). Moreover, the subgroup of infertile men that we know the least about are those who have never presented for evaluation. To address this gap in the medical literature and provide fuel for better-informed health policy, Persily et al. (3) from New York University sought to characterize the community-dwelling population of men with male-factor infertility, regardless of whether or not they have been previously evaluated for infertility or have pursued treatment.

To achieve this objective, the authors used the National Survey for Family Growth (NSFG), a longitudinal study of in-person structured interviews designed to provide nationally representative data of trends related to fertility and family structure in the United States. Although the NSFG has been conducted in continuous multiyear cycles since 1973, somewhat unsurprisingly it has included men only since 2002. In this cross-sectional population-based study of NSFG data from 2011 to 2017, men aged 16–45 years who were married or cohabitating with a woman and had not had a vasectomy were included. In addition to characterizing the population of self-identified subfertile and infertile men in the United States who had not previously sought infertility services, another goal of the study was to compare them to the subgroup who had received fertility testing.

There was a total of 7,519 men who met inclusion criteria, with 384 (5.1%) who self-identified as infertile and 577 (7.7%) who had previously had fertility testing. After the authors applied sample weights, they reported that 4.8% (95% confidence interval [CI] 4.1%–5.6%) of the population of men aged 16–45 years who are married or cohabitating have unevaluated infertility, and 8.7% (95% CI 7.7%–9.7%) of the same population had previously undergone fertility testing. These figures correspond to approximately 1.7 and 3.1 million American men, respectively. In a multivariable logistic regression analysis, unevaluated infertile men have lower incomes, are less educated, are less likely to be married, and are less likely to have private health insurance than men who have had a fertility evaluation. The authors uncovered some important details regarding the health insurance disparities in this population. Self-reported infertile men with Medicaid (multivariate odds ratio [OR] 5.75, 95% CI 1.35–24.99), Medicare, government, or military managed health care insurance plans (multivariate odds ratio 2.29, 95% CI 1.01–5.23), and men who were uninsured (multivariate OR 2.60, 95% CI 0.97–7.02) are more likely to be unevaluated than those with private insurance (see Supplemental Table 1 in Persily et al. [3]).

The greatest strengths of the study are the quality of the data set and the importance of the question being studied. The most significant limitation of the study is the self-reported nature of infertility among the study's subjects, which lacks granularity as to the reason why one may feel this way and certainly leaves open the distinct possibility that some of these patients were incorrect in their assumptions about their fertility status. Importantly, men who previously underwent vasectomy were excluded. However, the self-reported nature of the male factor coupled with a lack of exclusion of female-factor infertility may have skewed the results and should be considered when interpreting the data.

For policymakers, it is critical to understand the scope of any given problem, and the onus is on those of us in academia to publish such data to provide them with the most accurate information. Persily et al. (3) should be commended for this contribution to the medical literature, which helps to define the population of men with male-factor infertility, highlight access to care disparities, and quantify the scale of the problem among community-dwelling men outside of the infertility clinic. Population-based studies that shine a spotlight on health care utilization and disparities in access to care among infertile patients provide valuable insights toward improving infertility coverage for all (1, 2), and it is imperative that we use this type of data to continue to fight for our patients, especially the underserved male partners. Expanding insurance coverage for male infertility services would be the most effective way for health policy advocates to address this disparity in access to care.

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https://doi.org/10.1016/j.fertnstert.2020.04.020

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