In the UK, there is great variation in the standardized level of service provision for IVF (Ledger and Skull, 2000). Waiting times for treatment vary considerably, which means that even where National Health Service (NHS) funding for IVF treatment is available, some couples may not be able to access it if the woman reaches the designated upper age limit for treatment while waiting. Considering that the NHS was created to offer equal access to health care across the UK, regardless of income or area of residence, the existing ‘postcode lottery’ of unequal access to fertility treatment is problematic.

This is not simply another resource allocation issue affecting a publicly funded health service. With respect to both the need for treatment and the resulting benefit, it is qualitatively different from better-known paradigms such as the allocation of organs for transplantation. While the benefit for all patients is a child, we will argue that the need for treatment is not the same for all and that the patients in greatest need of help are the ones who do not already have a child of their own. In an effort to remedy the situation in the UK, the National Institute for Clinical Excellence (NICE) published a guideline on fertility treatment in February 2004 (National Institute for Clinical Excellence, 2004). One of its key recommendations was that the NHS should offer up to three stimulated cycles of IVF treatment to couples, provided that the woman is aged 23–39 years at the time of treatment and there is an identified cause of their fertility problems or they have been infertile for at least 3 years (NICE, 2004). Shortly afterwards, the then Secretary of State for Health, John Reid, released a press statement in which he recommended that all primary care trusts (PCTs) should begin implementing the NICE guideline by offering ‘at least one full cycle of treatment to all those eligible’ from April 2005. Dr Reid added that he would expect ‘the NHS to make progress towards full implementation of the NICE guidance’ in the longer term (Department of Health, 2004).

The PCTs are facing the task of setting concrete criteria for prioritizing patients and establishing waiting lists. Although the Department of Health has offered little guidance on eligibility criteria for fertility services, Dr Reid advocated a principle of prioritization according to need: ‘In providing this NHS service, as with all others, our priority must be to help those in greatest need’ (Department of Health, 2004). Unfortunately, it is not immediately clear what the criterion for greatest need should be and how this will help the PCTs in making prioritization decisions in the light of conflicting demands of equity and cost efficiency. We therefore propose a modification to the current guideline concerning the prioritization of IVF treatment in practice. While we remain in general agreement with the fundamental principle that preference should be given to those who need treatment most, careful consideration of this principle leads us to different conclusions about its practical application.

Much like other medical disabilities, infertility lowers people’s quality of life by diminishing their chance to live in...
accordance with their own conception of what constitutes a good life (Daniels, 1998; McMillan, 2003). Childlessness falls short of many people’s conception of a fulfilled life. For those who want children, it is frustrating and painful to have their life plans thwarted in this way. While every infertile person or couple is similarly deprived, it is intuitively plausible to argue that those who have never had the opportunity to become parents have a greater need for fertility treatment than those who already have children and subsequently become infertile. Indeed, Dr Reid said that for this reason, he ‘will be asking the NHS to give local priority to couples who do not have any children living with them’ (Department of Health, 2004). There are, however, several problems with this formulation.

First, by emphasizing couples, Dr Reid’s criterion discriminated against the small number of single women who need IVF to become parents. As the definition of the family is changing and expanding in our society, non-medical factors such as marital status should be irrelevant for decisions about eligibility for treatment. If there is a right to receive medical treatment for infertility, that right surely resides in an individual, not in a couple (Robinson, 1997).

Second, the criterion penalizes those who exhibit good parenting skills by helping parent their stepchildren. Situations where one partner in a relationship already has a child but the other does not are increasingly common. According to the above criterion, a man or a woman with no child of his or her own who is unwilling to provide a home for any stepchildren will be at higher priority than someone who is willing. This seems to us unfair.

Third, as it stands, the criterion is worryingly imprecise and thus creates an incentive for parents to act dishonestly or against the interest of their children. There is considerable variation in how ‘living with’ could be defined. The arrangements made to care for children after a couple separates should be made in the children’s interest and not distorted by the desire to meet a criterion for higher priority for IVF treatment. However, such distortion could theoretically take place when one parent is tempted to shift care of a child over to the other parent, as may occur when, after a separation, one of the parents of a child subsequently desires a child with a new partner. Generally, allocation schemes should not create an incentive for patients to benefit from acting dishonestly or irresponsibly.

To remove this last difficulty, we recommend that parental responsibility rather than residence be used in determining eligibility. This criterion has the advantage of being precise and readily verifiable, eliminating the temptation to equivocate about existing family conditions, and the danger that hitherto stable family relationships may be disrupted in the process.

In the light of the other difficulties, we believe it is fairest to adopt a differentiated approach towards prioritizing IVF patients, taking into account the variety of family arrangements that exist in our society. At the same time, such an approach should do justice to the intuition that the childless should have the greatest opportunity to become parents when resources for treatment are limited.

In Table I, we show how prioritization of fertility patients according to such an objective criterion of need might work in practice. The approach is based on a method of resource allocation known as reason-based maximizing consequentialism, which was developed to compare competing claims for health care resources (Savulescu, 1998). A just distribution of resources is taken to be one that is supported by the greatest number of individual rational claims. In our approach, we assume that every childless person who is medically prevented from having a child that he or she wants has a need for fertility treatment. We count every person who has never had the opportunity to become a parent as having a rational claim on the available resources. Note that this requires that the claims of patients requesting IVF treatment be treated individually, rather than taking the couple as a unit as in Dr Reid’s criterion. To be able to sum up the claims of all affected and to weigh them against each other, we have grouped together those kinds of patients who have an equivalent need for fertility treatment. We have then ranked the resulting distinct categories from highest to lowest.

A couple without children is given the highest priority (category I), because in such a situation, two people are affected by infertility and deprived of the opportunity to become parents. This couple’s plight in effect amounts to two rational claims, and they should receive priority over a couple where one partner already has a child from a previous relationship, because the latter couple only has one rational claim on the resource (category II). However, both couples should have priority over couples where both partners already have children.

Similarly, a single infertile woman should have a right to access fertility treatment, but at a lower priority than a childless couple—for the simple reason that the needs of two people should count for more than the need of one. In fact, from a rational claims perspective, her situation is no different from the one of a couple where one partner already has children and the other does not (category II).

Lastly, we have included an additional category (category III), which is based on the consideration that a charitable prioritization scheme should take into account the natural desire for a biological child of one’s own. A situation may arise where a couple will seek fertility treatment even though both partners have parental responsibility for children from previous relationships, because they wish to have a child together. Intuitively, such a couple’s plight is greater than that of a couple who already have children from their present relationship, although they should nevertheless be at a lower priority than any arrangement where at least one of the interested parties has never had the opportunity to be a parent. Accordingly, a couple who already have children of their own is given the lowest priority (category IV).

Table I. Prioritizing fertility patients according to need, from highest to lowest

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Couples with no children to date</td>
</tr>
<tr>
<td>II</td>
<td>One partner with child from a previous relationship + one childless partner; or a single woman</td>
</tr>
<tr>
<td>III</td>
<td>Couples where both partners have parental responsibility for children from previous relationship (but no children together)</td>
</tr>
<tr>
<td>IV</td>
<td>One or more children in present relationship</td>
</tr>
</tbody>
</table>
To sum up, we propose two recommendations concerning the prioritization of patients for IVF treatment. First, we suggest that parental responsibility rather than shared residence be used as a criterion for eligibility. Second, we present a need-based approach that we believe can be used coherently to distribute publicly funded treatment. In an attempt to achieve a fair way of prioritizing patients, we make distinctions between different family arrangements, based on the number of existing children. We believe that our approach treats like cases alike and ranks different cases relative to each other in a manner that is both equitable and charitable. It should be noted, however, that a more sophisticated method of prioritizing many IVF patients will most likely take into account many factors that we have not considered here such as the length of infertility, the woman’s age and the probability that the treatment will be a success. However, if prioritization is to remain truly needs-based, then the first question to ask should always be: who has been most affected by their infertility? To provide treatment for those who need it most should be the overriding consideration that supersedes all other factors. Although the secondary factors may prove to be useful in enabling patients to be ranked within the broad categories we have established here, we acknowledge that this might be unacceptably complex in practice. Moreover, we think that prioritizing solely on the basis of the number of existing children should be sufficient for all practical purposes.

References

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