THE CONVERSATION

Financial motives drive some doctors' decisions to offer IVF

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Around one in 25 Australian babies are conceived using assisted reproductive technologies (ART), including in-vitro fertilisation (IVF). These interventions are almost all offered in private fertility clinics, backed by a thriving fertility industry.

Women who are deemed eligible for IVF can have an unlimited number of cycles subsidised by Medicare, but out-of–pocket costs can range from several hundred to several thousand dollars per cycle.

Our research, published today in the journal Human Fertility, suggests the money being made from IVF could be subtly changing the advice doctors give.

Informed consent

Although IVF is a well-established procedure, it is not without its risks. These include ovarian hyperstimulation syndrome, where hormone levels rise too much (causing abdominal swelling, nausea, vomiting and diarrhoea); obstetric complications such as premature delivery; and psychological distress, especially if the process fails.

Although long-term outcomes for children conceived using IVF appear to be similar to non-IVF children, questions remain about possible harmful impacts, including developmental abnormalities and cancer.

Given the financial, physical and psychological burdens of IVF, patients must be able to make informed decisions about whether to pursue these treatments in the first place, and when to stop. So it's concerning that couples are often oversold the likelihood of success.

This "overselling" may be a result of the way information about "success rates" is conveyed. A 30 year-old woman has a 40% chance of a live birth after a single complete IVF cycle (so, after all viable embryos have been transferred). A 40 year-old woman, in contrast, may have a 10% chance of a live birth following a complete IVF cycle.

The same 30 year-old might have a 70% chance after six complete cycles, while the 40 year-old might only have a 25% chance.

Success rates of IVF may appear deceptively higher if success is defined as clinical pregnancy (of just six to eight weeks), or live birth at a stage that is generally incompatible with sustained life (as early as 20 weeks or 400 grams).

Alternatively, rates may appear lower if they are reported per embryo transfer rather than per complete cycle.

Commercialising IVF

In 2014, two major players in the ART industry were floated on the stock exchange for more than A$300 million each. This reportedly boosted some fertility specialsits' annual salaries to more than A$1 million. But what about the effect of commercialisation on patients and taxpayers?

To investigate this question, we conducted in-depth interviews with a range of professionals involved with ART in Australia, including obstetricians, policy advisors, researchers and counsellors.

Interviewees said financial motives were influencing ART practices in Australia, with some women offered IVF who don't actually need it. Others are offered repeated cycles of treatment, even when they aren't likely to succeed.

This dynamic was seen to be facilitated by the current Medicare system. The safety net protects patients by limiting the amount they have to pay out-of-pocket once they reach a certain threshold.

But it can also potentially encourage over-servicing and over-charging. There is no cap on the number of procedures that can be offered or the fees that can be charged. Doctors can therefore offer additional services for higher fees without patients incurring significant additional costs. This has serious implications for the health system.

As one of the people interviewed in the study observed:

I just think the business model and the fact that it takes advantage of Medicare, and the fact that the Medicare safety net helps spread the risk of out-of-pockets from the patient to the taxpayer is just basically being used to make some people a lot of money.

Importantly, nobody who was interviewed suggested that ART clinicians were deliberately misleading patients for their own financial benefit. The problem identified was subtler and reflects a deep ambivalence at the heart of medicine.

On the one hand, doctors are expected to be committed to their patients, research participants or the general public, and not concerned primarily with their own enrichment. On the other hand, doctors need to earn a living and, in Australia at least, do so in a health system that supports – and even depends upon – publicly subsidised private practice.

There is no reason these interests are incompatible but their co-existence raises questions about how commercial interests may influence practice.

The commercialisation of ART raises questions not only about the motives and behaviour of clinicians, but also about how those seeking ART services should be viewed. They could be

seen as patients who are potentially highly vulnerable and to whom clinicians have a duty of care requiring them to play an active role in guiding patients in their health care choices even if this means that some interventions are strongly discouraged.

Or they could be viewed as consumers free to choose whatever interventions they want in a health care marketplace, no matter how much they cost or how unlikely they are to succeed. This idea is, of course, predicated on the assumption that consumers will be provided with accurate information about risks, costs and benefits which, as many others have noted, cannot be assumed.

Although the Human Fertility study was small and does not represent the views of all professionals involved with ART in Australia, it reveals that concerns about the impact of commercial interests in ART have not simply been drummed up by the media for dramatic effect. It is time for an honest discussion about the Australian fertility industry, and about the role of money in medicine more generally.