



ASSISTED REPRODUCTION AND DISTRIBUTIVE JUSTICE

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ABSTRACT

The Canadian province of Quebec recently amended its Health Insurance Act to cover the costs of In Vitro Fertilization (IVF). The province of Ontario recently de-insured IVF. Both provinces cited cost-effectiveness as their grounds, but the question as to whether a public health insurance system ought to cover IVF raises the deeper question of how we should understand reproduction at the social level, and whether its costs should be a matter of individual or collective responsibility. In this article I examine three strategies for justifying collective provisions in a liberal society and assess whether public reproductive assistance can be defended on any of these accounts. I begin by considering, and rejecting, rights-based and needs-based approaches. I go on to argue that instead we ought to address assisted reproduction from the perspective of the contractarian insurance-based model for public health coverage, according to which we select items for inclusion based on their unpredictability in nature and cost. I argue that infertility qualifies as an unpredictable incident against which rational agents would choose to insure under ideal conditions and that assisted reproduction is thereby a matter of collective responsibility, but only in cases of medical necessity or inability to pay. The policy I endorse by appeal to this approach is a means-tested system of coverage resembling neither Ontario nor Quebec's, and I conclude that it constitutes a promising alternative worthy of serious consideration by bioethicists, political philosophers, and policy-makers alike.

INTRODUCTION

The Canadian province of Quebec recently passed legislation amending its Health Insurance Act to cover the costs associated with assisted reproduction, including In Vitro Fertilization (IVF).¹ The province of Ontario, meanwhile, recently de-insured IVF treatments.² How should we determine which of these two policies is the right one? Both provinces cited cost-effectiveness as their grounds, but the question as to whether a public health

insurance system ought to cover IVF raises the deeper question of how we should understand reproduction at the social level. To assess the justifiability of Quebec's new policy we must ask whether the individual or the collective ought to bear the costs of reproduction in general, and assisted procreation more specifically. In this article I examine three strategies for justifying collective provisions in a liberal society and assess whether public reproductive assistance can be defended on any of these accounts.

We could conceive of reproduction as a matter of right to which the collective bears a corresponding duty. This approach has considerable intuitive appeal and support from human rights doctrine. But in order to generate a duty incumbent on the collective to provide us with the

¹ Quebec Health Insurance Act (QHIA). 2009. RSQ, c. A-29, s. 3, 1st par., subpar. e and s. 69, 1st par., subpar. c.2.; c. 30, ss. 46 and 48.

² Ontario Health Insurance Act (OHIA) 1990. RRO. REGULATION 552 s.24.

means to reproduce, the right in question would have to be of a positive sort and arguments to this effect, I show, lack adequate normative weight and carry spurious implications. We might instead think that public reproductive assistance could be grounded in the argument for welfare according to which our collective responsibility is one of sustaining a threshold of basic need satisfaction for our fellow citizens. While this type of argument looks promising, I argue that reproduction fails to qualify as a basic need on a theory thereof that is properly sensitive to justificatory neutrality.

In the second half of the article I argue that we should instead consider assisted reproduction from the perspective of the contractarian insurance-based model for health coverage. I consider two leading versions of this model, one which has us consider items for inclusion in a public health insurance package on the basis of medical necessity alone, and one which has us also consider for inclusion items unpredictable in nature and cost. I endorse the second of these approaches and argue that infertility shares an important affinity with other kinds of unpredictable incidents against which rational agents would choose to insure under ideal conditions. The policy I recommend by appeal to this approach is a means-tested system of coverage resembling neither Ontario nor Quebec's. I argue that it constitutes a promising alternative worthy of serious consideration by bioethicists, political philosophers, and policy-makers alike.

THE POLICY QUESTION

IVF is a form of assisted reproductive technology (ART) wherein an embryo is created outside the womb and transferred to a woman's uterus for implantation. The technique is now a routine part of infertility treatment in developed countries. The current costs in Canada, per cycle, are approximately: \$3,500–7,000 for hormone therapy and other medication, and \$3,500–5,000 for IVF proper, including egg removal, embryo creation, and embryonic transfer.³ Infertility affects between 12–16% of Canadians, yet only a small fraction of these individuals can afford repeated IVF treatments.⁴ Canada's Assisted Human Reproduction Act (AHRA) specifies that IVF cannot be criminalized at the provincial level, but says nothing as to whether it must be subsidized.⁵ Until recently the province of Ontario covered the cost of IVF

proper, although not the cost of hormone treatment. In 1994 the province de-insured the service altogether, except in medically necessary cases of dual fallopian blockage.⁶ The procedure remained uninsured across Canada until 2009 when Quebec passed legislation amending its Health Insurance Act to include coverage for IVF services and mandating that private insurers guarantee coverage for all associated medications and hormone treatments.

Ontario cited an annual savings of \$4.4 million in physician billings.⁷ Quebec estimated spending \$36 million each year, but expects to save considerably more than this by minimizing the burden imposed on the public health insurance system by maternal-foetal complications that can arise when the costs of IVF are borne by individuals who, in the hopes of increasing their chances of success the first time, elect to have multiple embryos implanted at once. Multiple transfers lead to increases in the rates of multiple births, which have been associated with significant maternal and fetal health complications, as well as physical and cognitive disabilities. IVF with a single embryo transfer has been shown to almost entirely eliminate multiple births.⁸ But policy-makers in Quebec could presumably have just criminalized multiple transfers as a means of limiting medical expenses, thereby saving the associated medical costs and the millions it now anticipates spending on IVF. And what if it turns out that Quebec was wrong about its projected savings, as incoming evidence is beginning to suggest?⁹ Would it, on these grounds, overturn its policy? Or more importantly, *should* it? To answer this we must address the more foundational question of how reproduction is to be understood at the social level, and whether it is the type of good whose costs must be borne collectively.

One might quarrel from the start with the idea that reproduction should be addressed as a matter of public responsibility, as distinct from parenting. Some opponents of public funding for IVF argue that it is not child bearing that should be valued as a public good, but child rearing, and that the infertile should not be provided with reproductive assistance when they could instead adopt.

³ For a typical fee schedule see www.ivfcanada.com/services/fees/ [accessed 11 Jun 2013].

⁴ T. Bushnik, J.L. Cook, A.A. Yuzpe, S. Tough & J. Collins. Estimating the Prevalence of Infertility in Canada. *Hum Reprod* 2012; 27: 738–746. Averaging the cost of IVF at \$10,000 per cycle including medications, a single treatment equates to 14% of the median family income in Ontario.

⁵ Assisted Human Reproduction Act (AHRA) (S.C. 2004, c.2).

⁶ OHIA, *op. cit.* note 2. Medical necessity will be discussed in the final section of this article.

⁷ M. Giacomini, J. Hurley & G. Stoddart. The Many Meanings of Deinsuring A Health Service: The Case of In Vitro Fertilization in Ontario. *Soc Sci Med* 2000; 50: 1485–1500.

⁸ These include an increased risk of fetal or neonatal mortality, preterm birth, and mental and physical defects. Maternal complications, such as preeclampsia, gestational diabetes, placenta previa, placental abruption, and caesarian delivery also arise more often in multiple births. In Vitro Fertilization and Multiple Pregnancies: An Evidence Based Analysis. *Ontario Health Technology Assessment Series* 2006; 6(18).

⁹ The total cost per year in Quebec is in fact believed to be more than double the original estimate. F. Baylis. 2013. Who's Paying for IVF? *The Mark* 27 February. <http://www.themarknews.com/articles/whos-paying-for-ivf#> [accessed 12 Jun 2013].

There are good reasons to claim that persons have a duty to adopt.¹⁰ But why should this duty fall more heavily on the infertile? And we must acknowledge how difficult, expensive, lengthy, and discriminatory the adoption process can be. Certainly this process should, for reasons of justice, be made easier.¹¹ But this would not address what I take to be the larger issue, which is that many (indeed most) people actually value child bearing specifically, as evidenced by the number of persons currently seeking IVF as opposed to adoption.¹² So it is certainly worth discussing whether this particular value is one for which the collective is properly responsible.

According to the former president of the Ontario Medical Association, this value is decidedly not a matter of public responsibility. In support of the province's move to de-insure IVF, he stated: 'we've allowed the frills to creep in. Because we've not been willing to say no – until now.'¹³ Along with IVF, the other services he recommended for de-insurance were the removal of tattoos, acne pimples, and benign skin lesions. The suggestion being made was that IVF constitutes a frill, which, like tattoo removal, represents an expensive lifestyle choice the costs of which should be borne by the individual alone. Comparing assisted reproduction to tattoo removal is perhaps a belittling way to have made the point, but it raises the very reasonable challenge as to why the collective may be called upon to pay for the former costly choice but not the latter. Can we offer a response to this 'expensive taste' challenge? That is precisely what I aim to explore here.

THE RIGHT TO REPRODUCE

One way of making the case for public reproductive provisions could be to regard reproduction as a matter of right. The United Nations (UN) and the World Health Organization (WHO) recognize 'the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so . . . [and] to make decisions concerning reproduction free of discrimination, coercion and violence.'¹⁴ This statement strikes a

powerful chord in the wake of historical violations, such as the coercive sterilization measures carried out in Hitler's Germany and Indira Ghandi's India, and in light of apparent present violations such as China's One Child Policy. We may well think that such policies are wrong because they violate reproductive rights, and that conceiving of reproduction as a matter of right – invoking an irrefutable entitlement with respect to the actions of others and the state – provides a defence against future violations of this sort.

There are, however, some important distinctions to be drawn before proceeding with an analysis of reproductive rights as the foundation of public reproductive assistance. In the descriptive or legalistic sense, we have a right only insofar as it is affirmed by the legal doctrines of our nation. In the normative or moral sense, we have a right in virtue of our humanity; moral rights, if not affirmed by legal doctrine, ought to be. Rights also have both a negative and a positive component; one component of a right may, or should, enjoy legal protection and the other not. The negative component of a right carves out a sphere of justified non-interference; the positive component imposes a duty on others to provide us with the substance of our right. In deciphering whether the argument for collective reproductive assistance can be grounded by appeal to a right to reproduce we must evaluate both the negative and positive component of the right from both a descriptive and a normative perspective.

Let's begin with the negative component of a reproductive right. The UN and WHO statement articulates this aspect of the right in avowing that persons should be free to make the reproductive decisions and to take the reproductive actions they choose. This claim is intuitively powerful but is in the descriptive sense false, as no signatory states have actually recognized reproductive rights at the legislative level. Certainly the Canadian state does not force us to procreate, and it might make sense to say that we enjoy a legal right *not to* reproduce.¹⁵ Abortion is legal, birth control is widely available and subsidized, and no woman is legally obligated to bear a child even if she has contracted to do so (commercial surrogacy contracts of this sort have been criminalized).¹⁶ Yet this entitlement not to reproduce clearly rests on legislated rights to privacy, equality, and bodily integrity. The pre-1986 Canadian law banning (non-medically necessary) abortions was struck down by appeal to the equality and

¹⁰ T. Rulli. The Value of Adoption. In *Family Making: Contemporary Ethical Challenges*. F. Baylis & C. McLeod. Oxford: Oxford University Press (forthcoming 2013).

¹¹ D. Weinstock & J. de Wispelaere. Licensing Parents to Protect our Children. *Ethics and Social Welfare* 2012; 6: 195–205.

¹² Raising Expectations, Recommendations of the Expert Panel on Infertility and Adoption. 2009. Ontario Ministry of Children and Youth Services. <http://www.children.gov.on.ca/htdocs/english/documents/infertility/RaisingExpectationsEnglish.pdf> [accessed 11 Jun 2013].

¹³ Giacomini et al., *op. cit.* note 7, p. 1488.

¹⁴ World Health Organization. 2010. *Progress Report: Reproductive Health Strategy*. http://whqlibdoc.who.int/hq/2010/WHO_RHR_10.14_eng.pdf [accessed 11 Jun 2013]; United Nations. 1994. *International*

Conference on Population and Development (Cairo) <http://www.unfpa.org/public/cache/offonce/home/sitemap/icpd/International-Conference-on-Population-and-Development/ICPD> [accessed 11 Jun 2013].

¹⁵ C. Overall. 2012. *Why Have Children?: The Ethical Debate*. Cambridge, MA: MIT Press: 30–32.

¹⁶ AHRA, *op. cit.* note 5, s. 6.

privacy clauses in the Charter of Rights and Freedoms, not to negative reproductive rights.¹⁷

According to defenders of the human rights model, however, while we may not currently have negative reproductive rights in a descriptive sense, we do in a moral sense, and our nations would be moving in a morally commendable direction to indoctrinate them.¹⁸ This need not imply that people's reproductive freedom must always go unchecked. It may be perfectly legitimate for the state to indoctrinate negative reproductive rights and at the same time limit the age at which someone can turn to IVF, or impose restrictions on the number of embryos they can have transferred in any one cycle. (Indeed public outcry in the case of Rajo Devi Lohan, a 70 year old woman who gave birth to twins using IVF, and of Nadya Suleman – otherwise known as Octomom – who had octuplets due to a multiple-transfer IVF treatment, suggests that regulations would enjoy widespread support.) Such regulations would not undermine negative reproductive rights but simply make them of the *prima facie* variety, and hence defeasible in cases where they come into conflict with weightier moral considerations.¹⁹

But the problem is that even if we legislated a *prima facie* negative right to reproduce, this still couldn't provide us with grounds for the public coverage of IVF, because as the basis of an argument for the allocation of finite resources, the right to reproduce would have to be of the positive kind. That is, it would need to legitimately impose obligations on others to provide us with the means we require to have children.²⁰ A positive right to reproduce does not exist in Canada in a legalistic sense. The existence of a great number of other funded services might seem to point in that direction, including gynaecological and obstetric services, maternity facilities, baby health centres, maternity and paternity leave, family allowances, preschools and the public education system. Yet many of these provisions are justified by a concern to promote the well-being of children, and others to offsetting the costs incurred by parents in lost income. So while I will discuss these services later, suffice it to say here that they may signal any number of public commitments rather than a legal recognition of positive reproductive rights.

But *should* we recognize positive reproductive rights? The case might look like this:

A positive right to reproduce [may be] justified by our shared humanity. Because fertile people have a right to add children to the family, infertile persons must have

this right as well; a legal distinction based on bad luck in the genetic lottery of physical equipment is not justifiable. If anyone is entitled, then everyone is entitled, to have offspring that are the product of one's own gametes. This seems to imply as social policy the provision, at public expense, of all necessary means to reproduce.²¹

Christine Overall cautions in her 1987 book *Ethics and Human Reproduction* that, when articulated in these terms, positive reproductive rights would entail an entitlement of access to women's bodies as the very means of reproduction. The upshot of legislating such rights could thus be a form of indentured reproductive servitude of the sort imagined by Margaret Atwood in *The Handmaid's Tale*.²²

But more recently, in *Why Have Children* (2012), Overall concedes that this worry is exaggerated, as positive rights end where the negative rights of others begin. And she goes on to argue in favour of positive reproductive rights on the grounds of ensuring that procreational services will be distributed in a non-discriminatory way, so that no one will be denied access on the basis of social identity characteristics such as marital status or sexual orientation, or on the basis of age, health status or impairment unless medically necessary. On her account, positive reproductive rights must be of the *prima facie* variety, extensive enough to ground the public provision of reproductive services like IVF where a society can afford it, yet defeasible enough that a patient may not unilaterally determine how the procedure will be carried out, to have as many embryos transferred in one cycle as she may wish, to access the procedure at any age, or to have as many cycles as she'd like at public expense.²³

For Overall, these limitations are justified by the need to prevent harms to mothers and children and to not over-burden the taxpayer. But what isn't clear is why a concern for discrimination generates grounds for public coverage at all when regulations to this effect could be enacted. Public coverage is geared to addressing a lack of access based not on age or sexual orientation, but on ability to pay, which is not a social identity characteristic, nor explicitly linked to health concerns. Unless denying access on the basis of ability to pay is discriminatory, Overall's argument does not necessitate public coverage, but anti-discrimination legislation and the freedom of all to purchase the services they desire.

Aside from whether the positive right even justifies public coverage, it's unclear how the positive right itself is justified, *prima facie* or otherwise. Identifying the importance of some value by calling it a right only pushes the

¹⁷ R. v. Morgentaler, [1993] 3 S.C.R. 463.

¹⁸ C. Beitz. 2009. *The Idea of Human Rights*. New York, NY: Oxford University Press.

¹⁹ Overall, *op. cit.* note 15, p. 22.

²⁰ S. Uniacke. In *Vitro Fertilization and the Right to Reproduce*. *Bioethics* 1987; 1: 241–254.

²¹ C. Overall. *Ethics and Human Reproduction: A Feminist Analysis*. Boston, MA: Allen & Unwin: 176.

²² *Ibid.*: 182.

²³ Overall, *op. cit.* note 15, p. 26.

question back on itself: if we proceed from asking 'why is X of value' to saying 'X is of value because it's a right' then our next step must be to ask 'why is X a right' and to answer 'because X is of value'. Introducing the idea of a right does not save us the task of sorting out why X is a matter of collective duty. We still need to know why we should collectively satisfy positive reproductive rights but not positive rights to pursue other goals that are of interest. Declaring something to be a right may well have a signalling effect – in terms of showing others how much we happen to value it – but it cannot replace the conceptual work of providing a legitimating criterion for a rights claim. One explanation might be that a right responds to a vital human need; but if so, we should turn to a basic needs framework for grounding public reproductive assistance.

THE NEED TO REPRODUCE

A more promising strategy, therefore, might be to regard reproduction as a basic need, such that in arguing for the satisfaction of needs themselves we thereby argue for public reproductive assistance. This is consistent with the claim that the welfare state takes as its central aim the provision of a social safety net, or guaranteed baseline, composed of those needed goods and services without which citizens can be said to suffer harmful deprivation.²⁴ In order to assess whether reproduction qualifies as a basic need, and hence whether IVF might form part of the relevant social baseline, we require some criterion by which to identify items that properly belong in this category.²⁵ According to David Braybrooke's influential discussion, the basic needs that form the relevant social baseline are the 'course-of-life' needs that enable us to live or function normally, and that are 'indispensable to mind or body in performing the tasks assigned a given person under a combination of basic social roles, namely the roles of parent, householder, worker and citizen.'²⁶

The kinds of needs pertinent to fulfilling the relevant roles would be both biological and social, and would presumably include such things as adequate food, clean water, exercise, rest, and some baseline level of preventative and restorative health care, as well as education, political participation, basic income protection and meaningful employment opportunities.²⁷ Reproduction (and reproductive assistance where necessary) could also

easily qualify, with respect to fulfilling the social role of parent (assuming not everyone's need could be satisfied through adoption). Braybrooke's version of the basic needs argument thereby seems to offer grounds for the universal coverage of IVF on the basis of its relevance to our being able to fulfil the social role of parent, a deprivation with respect to which amounts to a grave harm.

Braybrooke doesn't give much content to this notion of harm except to say that we need no more justification for 'wanting to participate without derangement' in the four roles than we do 'for aiming at health or living.'²⁸ The implication is that a person is leading a harmed life if she doesn't participate in the four social roles, where the harm in question is equivalent to hunger or thirst. But for a great many people childlessness is a blessing and a choice, not something we can say about thirst, or illness or even poverty. As David Copp argues:

We do not want to be committed to the claim that a person who has freely chosen the life of an ascetic, and who is living alone on a mountain in the desert, must necessarily be living a harmed or blighted life. It would only be harmed or blighted if she did not choose this life, or was unable to because she lacked the necessities that would have allowed her to choose a more standard life.²⁹

Copp's point is one to be taken seriously if the basic needs strategy is meant to yield grounds for welfare provisions in a liberal society. The liberal state understands the very principle of equality as mandating neutrality amongst competing conceptions of the good. The satisfaction of this commitment requires that the state exhibit an equal concern and respect for all citizens by devoting identical shares of what society has to offer to promoting the ambitions of each.³⁰ We must therefore ensure that our distributive policies do not arbitrarily privilege conceptions of the good that value certain roles over others. *Pace* Braybrooke, it is not at all obvious that no more justification is required for wanting to participate without derangement in the roles he enumerates than for aiming at health or living. And whatever justification is provided will probably be consonant with a particular conception of the good espoused by some but not all. The state therefore cannot promote their satisfaction over others without violating neutrality. If the basic needs strategy is going to provide grounds for the core programs of the liberal welfare state, and IVF services along with them, it will have to do so consistent with this commitment.

²⁴ R.E. Goodin. 1988. *Reasons for Welfare*. Princeton, NJ: Princeton University Press: 8.

²⁵ H. Frankfurt. Necessity and Desire. *Philos Phenomenol Res* 1984; 45: 1–13.

²⁶ D. Braybrooke 1989. *Meeting Needs*. Princeton, NJ: Princeton University Press: 48.

²⁷ K. Nielsen. Autonomy, Equality and a Just Health Care System. *Int J Appl Philos* 1989; 4: 41.

²⁸ Braybrooke, *op. cit.* note 26, p. 49.

²⁹ D. Copp. 1998. Equality, Justice and the Basic Needs. In *Necessary Goods: Our Responsibilities to Meet Others Needs*. G. Brock, ed. Lanham, MD: Rowman & Littlefield: 124.

³⁰ R. Dworkin. 1985. *A Matter of Principle*. Cambridge, MA: Harvard University Press: 127.

Let me briefly sketch an account of basic needs that satisfies this criterion and examine whether reproduction can be counted among them. As Harry Frankfurt has forcefully argued, claims of need carry a greater sense of urgency than claims based instead upon what a person happens to want. Yet not all need-claims carry the same urgency. Needs that derive from some existing desire, such as the pen one requires to do a crossword puzzle, have decidedly less urgency than needs one cannot help having.³¹ Following Frankfurt, we can think about the needs of citizens as falling into two categories, one decidedly more urgent than the other. Some things are needed as a means of realizing our particular goals and projects, while other things are needed by way of being able to formulate, revise, and make rational decisions in accordance with a system of value. We can refer to the former needs as *doctrinal*, insofar as they arise only in accordance with our specific comprehensive doctrines, and the latter needs as *preconditional*, insofar as they constitute the necessary preconditions of selecting amongst such doctrines.

Preconditional needs are those things that are, as the name suggests, preconditions to being able to rationally reflect on, evaluate, and endorse certain ends as worth pursuing. They are the kinds of needs to which the liberal state (or rather, our fellow citizens who will be footing the bill for their satisfaction) can and should be expected to attend. On the one hand, they are non-volitional in the sense that Frankfurt had in mind, and urgent insofar as we cannot help but have them. The satisfaction of preconditional needs also demands a kind of necessary temporal priority over the satisfaction of doctrinal needs insofar as we cannot know what we need by way of achieving our goals until the preconditions of goal selection have been secured. Such needs also enjoy a kind of political priority insofar as the state cannot exhibit its commitment to remaining neutral amongst competing conceptions of the good unless persons have been enabled to select and pursue such conceptions in the first place.

On this account the state has a duty to meet preconditional needs not because their satisfaction will enable the pursuit and achievement of any specific goals it seeks to promote, but because citizens are thereby enabled to decide for themselves which goals and projects to pursue. This account finds pedigree in John Rawls' *Political Liberalism*, wherein he argues that the 'basic needs of all citizens must be met so that they can take part in political and social life . . . The [idea here is] that below a certain level of material and social well-being, and of training and education, people simply cannot take part in society as citizens, much less as equal citizens.'³² He

defines the primary goods as items citizens *need* by way of realizing the two moral powers of reasonability and rationality, the latter being the capacity 'to form, to revise, and rationally to pursue . . . a conception of what we regard for us as a worthwhile human life.'³³

The preconditional needs for which the collective bears responsibility may include nutritious food, clean water, safe housing, income protection against old age, disability, and unemployment at no lower a level than the lowest liveable wage for a given society, elementary and secondary education, and near comprehensive health care or health insurance. Although there is much to say about each item, there isn't space. The pertinent question is if reproduction also qualifies and hence whether we can derive grounds for public IVF coverage on the view sketched here. The answer is no. Most of the needs that arise with respect to how we will parent (whether we will send our kids to soccer camp or piano lessons, or bring them up in a certain religious faith) arise in conjunction with the particular conception of the good to which we subscribe. The costs of satisfying these doctrinal needs are rightfully borne by individuals. What of the need to bear children? The inability to procreate cannot be said to impair our agency, or to impede the exercise of Rawls' second moral power. Infertility does make some conceptions of the good unavailable, but it doesn't eclipse our ability to reflect rationally on questions of value, or to commit ourselves to goals as such, the way hunger, thirst or fever do.

On a purely biological conception of need, reproduction might qualify – although this is, for good reason, both debatable and controversial.³⁴ It would also qualify by appeal to some perfectionist claim about the value of parenting. But on the neutral account I have offered here reproduction fails to qualify as a precondition to the rational selection of goals. Does this mean that the other reproductive services and family-oriented programs Canadians enjoy constitute an unjustified burden on the taxpayer? Not insofar as these programs respond to important preconditional needs. Public schools respond to the educational needs of children, and paediatric health services to their health needs. Gynaecological and obstetrics services respond to the health needs of expectant mothers. Parental leave and family allowances respond to the income needs of parents, which might otherwise be insufficiently met due to the demands of early parenthood. IVF does not seem to respond to any of these other important preconditional needs, and since we have been unable to ground reproduction as a preconditional need unto itself, Quebec's policy remains unwarranted on a liberal basic needs account.

³¹ Frankfurt, *op. cit.* note 25.

³² J. Rawls. 1996. *Political Liberalism*. New York, NY: Columbia University Press: 302.

³³ *Ibid*: 179.

³⁴ Uniacke, *op. cit.* note 20, p. 241.

INFERTILITY INSURANCE

Insofar as the previous strategies have been unable to provide grounds for Quebec's IVF policy, does this mean that we must endorse Ontario's? It doesn't follow that the best alternative to universal coverage is complete de-insurance. Above the baseline of preconditional needs to which the welfare state attends, there remain considerable income inequalities among Canadian citizens. Against the backdrop of these inequalities, IVF is a privilege of the wealthy. So is yachting; but something about inequality of access to IVF seems to smack of unfairness in a way that inequality of access to yachts does not. In the interests of ironing out this particular doctrinal unfairness might we perhaps make a case against the universalism of the two extant IVF policies and in favour of a system of differential subsidies, wherein only those citizens whose median income falls below the national average, say, or who cannot afford three cycles of IVF annually, would be entitled to public coverage? And can we make a case for this type of policy whilst leaving other doctrinal inequalities intact, and whilst avoiding rights rhetoric and perfectionism?

I have been proceeding on the basis that IVF aims to promote the good of reproduction, and thus asking whether reproduction qualifies as a proper subject of collective responsibility. This has been the correct approach, but it may have eclipsed something important, namely that although IVF serves the good of reproduction, it is nonetheless a health service and covered (in Quebec) as part of the health insurance system. Certainly the public nature of the goods of reproduction and health warrant distinct discussions, and we should not assume that because one good is addressed via the other's institutional channels that they thereby enjoy the same normative foundation. (Consider that much health promotion happens in the classroom, but we clearly regard health and education to constitute two distinct public goods.) And yet, what makes assisted reproduction distinct from unassisted reproduction and other ways of building families is that the former is delivered as a health service. We should thus investigate our grounds for selecting items for health coverage and indeed our very grounds for public health insurance itself.

By popular accounts, Canadian Medicare is grounded in the notion that health shouldn't be commercialized, and hence that health care must be provided via non-market mechanisms so as to avoid undermining its inherent value with the assignment of a dollar value.³⁵ But as a description of public health provision in Canada this

account is false. The provinces provide health insurance, not health care, and thus engage as much in the assignment of price values to health goods and services as private providers do. (Just because the individual doesn't get the bill, doesn't mean there is no bill.) And as a justificatory defence of the public system in Canada this account is question-begging, as there are competing arguments that take better account of the fact that what needs justifying is a public health *insurance* system specifically.³⁶

The economic argument for public health insurance speaks in its favour not because health is too important to be valued in market terms, but because of the market failure endemic in a private scheme, where profit-seeking leads to costly claims investigations, coverage denials, and higher per capita health spending.³⁷ The contractarian argument, meanwhile, grounds public health insurance in the prudent decision-making of rational agents under hypothetically ideal conditions. While both arguments provide a sound rationale for public insurance specifically, the economic argument implies that the basic package should only cover what is most cost-effective, while the contractarian argument says that our basic package should include whatever would best promote the goals endorsed by rational agents under ideally favourable conditions. Since the jury is still very much out as to whether Quebec's policy will be more cost-effective in the long run than Ontario's, I propose we explore further the contractarian argument.

For the contractarian, welfare provisions are thought to mirror – and to be justified by – the hypothetical choices of rational agents. Contractarian theorists concerned to adduce grounds for public health coverage thus proceed by asking two related questions: 1) would a group of hypothetical citizens denied knowledge of their conceptions of the good and information about their likelihood of acquiring a disease or disability, but given equal and ample funds to spend on a variety of public goods, elect to spend a portion of those funds on health coverage? And, if the answer to the first question is yes, then: 2) what goods and services would they elect to cover with the portion of funds they would be willing to devote to health coverage?

According to contractarian theorists Norman Daniels and Ronald Dworkin, respectively, it would indeed be prudent for hypothetical choosers to devote some portion of their funds to health coverage. For Daniels this is because the choosers, reasoning from behind the Rawlsian veil of ignorance, would seek to protect fair equality of opportunity, and would identify health as

³⁵ R. Romanow. 2003. *Building on Values: The Future of Health Care in Canada*, Commission on the Future of Health Care in Canada: pp. xv–xvii <http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf> [accessed 11 Jun 2013].

³⁶ Note that what I make is a case for IVF funding consistent with a public health insurance system, as opposed to a system of public health care. As my interest in this article is to determine whether Quebec or Ontario has made the correct funding decision, that my argument pertains to the Canadian public health model is thereby appropriate.

³⁷ J. Heath. Health Care as a Commodity. *Policy Options* 2003: 68.

indispensable to the protection of their fair opportunity shares.³⁸ For Dworkin this is because disease and injury bear an unpredictable quality in terms of their opportunity costs, and it would be prudent for the hypothetical choosers to risk pool against contingencies that each alone could never adequately budget for.³⁹ On both accounts, health is a good to which the hypothetical choosers would agree to devote some share of their resources, and thus a matter of very non-hypothetical collective responsibility. But because they would want to devote a share of their funds to other public goods as well, the choosers would need to set a health budget and make tough allocation decisions about what to cover.

For Daniels, health protects fair equality of opportunity, our fair share of which is constituted by the normal range of functioning made available to us by our native skills and talents and our society's level of material well-being. Our fair opportunity share is unjustly diminished whenever our otherwise normal range of functioning is impeded by disease or disability. In other words, since disease and injury impede our normal species functioning they impede our fair share of opportunity. In the interests of protecting fair opportunity shares, our health package must cover all services necessary for restoring or preventing departures from normal functioning.⁴⁰ If resource constraints demand further limit setting on treatment coverage, policy-makers must reason as the hypothetical choosers would and supply grounds for the proposed restrictions that would be acceptable to those denied coverage.⁴¹

Policy-makers in Ontario appealed in their 1994 decision – as provincial health policy-makers are mandated to do by the Canada Health Act – to the concept of medical necessity, and concluded that, except in cases of dual fallopian blockage, IVF does not qualify.⁴² The idea of medical necessity has been understood in countless different ways, but a popular way of cashing this out is the one supplied by Daniels: a medically necessary service is one that treats or prevents a departure from a patient's normal range of species functioning, while a non-medically necessary service is one that enhances her otherwise normal (and thus fair) range.⁴³ According to policy-makers in Ontario, a woman suffering from dual fallopian blockages has an identifiable medical condition that interferes with her normal functioning, or the oppor-

tunities that would otherwise be available to her in the absence of her condition. In other cases, infertility is not a departure from a patient's normal functioning range, but a natural part of the ageing process; its treatment is thereby not a medical necessity. It is hard to dispute this if we accept the idea that medical necessity is tied to normal species functioning.

We could of course try to disrupt this connection, but we need not do so. We can accept it and still make a contractarian case for IVF coverage. That is, we do not have to show that IVF is indispensable to normal species functioning in every case in order to undermine Ontario's de-insurance move. We can instead dispute the idea that coverage should depend exclusively on medical necessity as opposed to some other criterion that hypothetical choosers would find it rational to employ. On Dworkin's account, prudent hypothetical choosers would deem it necessary to risk pool against the unpredictability of ill-health. The choosers would focus their resources on insuring services the need for which cannot be predicted, nor budgeted for on an individual basis, so as to best protect their personal resources in the face of vast and unforeseeable costs.⁴⁴ Emergency care is one example among many: we can't predict when or if we'll need it, or how much of it we'll need. And if we cannot predict or budget for something individually, it makes good sense to risk pool against it.

If we take the relevant micro-allocation question to be about unpredictability, and ask whether infertility is unpredictable, then in an important sense our answer must be yes. It's true that the longer we wait the higher the risk we run, so in this sense it might well be predictable. But the more steak we eat the higher the risk of heart disease we run, and it would be profoundly irrational not to insure against heart disease. This is relevant because the unpredictability of heart disease is not just about whether we'll get it (which genetic information coupled with environmental and lifestyle information can often predict) but what the costs of treating it will be. And while we might have a pretty good idea that our biological clocks will start winding down at 34 and shut down at 54, we have no idea if we'll need 1 round of IVF or 10 in between, and so no idea how much we should save for it.

If we thus apply the 'unpredictability' test, rather than the 'medical necessity' test, it looks as though we may have reasonable grounds for IVF coverage. And we have, I think, a very good reason for employing the unpredictability test provided by the fact that what the Canadian state provides is health *insurance*, the very point of which is to enable risk pooling against individual bad luck. Still, it doesn't follow that the hypothetical choosers would find it prudent to insure against infertility unconditionally, in light of the expense relative to the

³⁸ N. Daniels. 1985. *Just Health Care*. Cambridge, UK: Cambridge University Press: 27–50.

³⁹ R. Dworkin. 2002. *Sovereign Virtue: The Theory and Practice of Equality*. Cambridge, MA: Harvard University Press: 73–83, 311–318, & 331–338.

⁴⁰ Daniels, *op. cit.* note 38.

⁴¹ N. Daniels. 2009. *Just Health: Meeting Health Needs Fairly*. Cambridge UK: Cambridge University Press: 117–132. Daniels calls this procedure 'accountability for reasonableness.'

⁴² Giacomini et al., *op. cit.* note 7, pp. 1492–1494.

⁴³ Daniels, *op. cit.* note 38.

⁴⁴ Dworkin, *op. cit.* note 39, pp. 314–317.

success rate, and also the moral hazard it could generate (once covered, the insured might wait even longer to start a family).⁴⁵ The rational choosers would thus have good reason to condition entitlements.

One option would be to limit the number of cycles covered annually. But since fertility continues to decline with age, making people wait a year for their next round seems inefficient. A better option would be to condition entitlements on the inability to pay. Although the hypothetical choosers wouldn't know their own conceptions of the good, they would know that many such conceptions include not only child bearing, but demanding careers that may necessitate the delaying of child bearing. The real unknown, then, is not only whether they might need IVF or how much of it, but also whether the careers for which they choose to put child bearing on hold will turn out to be lucrative enough to support the costs of treating infertility, should it arise. The true unpredictability is thus about having a desire for both biological children and a career that creates a need for IVF without generating the income to cover it. So that is precisely what it would be most prudent to insure against.

It is essential that the hypothetical choosers would be asking not only whether something is unforeseen, but whether its *costs* cannot be predicted or budgeted for individually. They would also have to regard something as a significant impediment to goals whose realization they might want to protect. Reasoning in this way the choosers would elect to cover infertility treatment but not, say, rhinoplasty. While a misshapen nose may be unpredictable, the costs of treating it are not, and the impediment it presents would not strike hypothetical choosers as great enough to devote limited resources to insuring against, unlike infertility.⁴⁶ Now, because the choices of rational agents under ideal conditions yield, on the contractarian model, the normative grounds of real world institutions and their distributive mandates, the hypothetical choosers have provided us with solid grounds for a policy of income-conditioned IVF coverage, where entitlements are justified by unpredictability but limited by ability to pay.

⁴⁵ The success rate is approximately 25–30%, which decreases further in women over 40. This might seem to call into question the prudence of IVF funding. But while success rates should certainly play a role in selecting services for health coverage, the good to which a service responds is what is in question here. If it turned out that some other service addressed the same good to a higher degree for a lower cost, then that is what ought to be covered. But what is not an option, on this account, is the provision of no service whatsoever. Insofar as we have identified the relevant good as one to which the collective should attend, some service is therefore required, even if the best available service is still not as effective as we might like a covered service to be.

⁴⁶ Dworkin's strategy is in essence to have us ask ourselves: 'would you insure against X?' This is a surprisingly effective test. It can, I think, largely help us determine which doctrinal needs can be met neutrally and which can't (IVF, yes; nose job, no; yachting, no).

There are three interrelated challenges to consider with respect to this policy. The first holds that while means-tests are typical of welfare programs geared to the provision of cash transfers (like employment and disability insurance) they are not typical of, nor appropriate to, programs geared to meeting needs in-kind (like education). But health insurance falls somewhere in the middle. Health services are provided in-kind by health practitioners, but insurance is provided by the state as a cash transfer to the practitioners. Thus, a health *insurance* system leaves a conceptual door open to discussions of this kind. And a number of Canadian health programs are already income-conditioned, such as those that provide greater drug coverage for lower income citizens, or dental care for children from low-income families.⁴⁷

The second objection asks whether means-testing undermines the very ideal of universal health coverage, whereby everyone should have equal access depending solely on need. It does not. If we keep in mind the distinction between preconditional and doctrinal needs we can consistently hold that the former needs should be attended to in a universal way as part of the guaranteed social baseline, and at the same time that, insofar as a society has the resources to attend to a portion of people's doctrinal needs as well, it ought to do so but not necessarily in a universal way. The hypothetical choosers would want to guarantee unconditional protection of their most basic needs so they should never find themselves without the very preconditions of choice-making, but over and above the baseline, they would choose to attend to those doctrinal needs whose lack of satisfaction it would be most prudent to risk pool against. And at the level of doctrinal need there is no reason that coverage must be universal, as the very purpose of this coverage is to even out inequalities of access generated by severe income differentials.

The third objection asks whether I am advocating replacing the 'medical necessity' test in health policy decision-making with the 'unpredictability' test. My answer is no. The former test should be used to identify the preconditional health needs that must be met universally. The latter test should be used at a secondary level, once something has been deemed non-medically necessary but before it can be deemed unworthy of coverage.⁴⁸ The medical necessity test should have us ask whether some condition impedes normal functioning while the

⁴⁷ For example, British Columbia's *Fair PharmaCare* and Ontario's *Drug Benefit Program* and *Children in Need of Treatment Program*.

⁴⁸ Although I have made this case by appeal to the Dworkinian model, Daniels could also support this account. He argues that the realization of important social goals other than opportunity may justify the provision of certain non-medically necessary health services (including reproductive ones) provided they enjoy alternative normative support, which is precisely what I have supplied here. Daniels, *op. cit.* note 38, pp. 149–150.

unpredictability test should only then have us ask whether some condition would strike hypothetical choosers as prudent to risk pool against. While means-testing may not be appropriate for medically necessary services, it may be perfectly legitimate in the realm of unpredictability. On the account I have offered here, therefore, IVF ought to be covered unconditionally in cases of medical need, while in non-medically necessary cases it ought to be covered for those who can't afford it.

CONCLUSION

The project of this article has been to investigate assisted reproduction as a question of distributive justice and thereby to evaluate the justifiability of Quebec's IVF policy. I showed that the rights-based and needs-based

arguments for treating reproductive costs as a matter of public responsibility face serious practical and normative challenges. The policy I put forth as an alternative by appeal to the contractarian insurance-based model for health coverage avoids these challenges in addressing unjustified inequalities of access to IVF without appeal to rights rhetoric or perfectionism. On the view I offered here, reproductive assistance is a matter of collective duty, but only in cases of medical necessity or inability to pay. While the policy I have defended resembles neither of the two extant policies in Canada, it has ample normative support to warrant serious consideration by political philosophers, bioethicists, and policy-makers alike.

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