FERTILITY associates | a better understanding
TE RAUHANGA O TE WHARETANGATA

Background to the fertility CPAC

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Leaders in Fertility

First, acknowledgements to Wayne Gillett

UNIVERSITY of OTAGO

SAPERE AUDE

Te Whare Wānanga o Otāgo

How the NZ health system works for fertility

Clinic decides services to offer

Patient choice of clinic

Patient choice of treatment

Clinic set prices

Patients pay everything

Waikato District Health Board

MINISTRY OF HEALTH
MANATŪ HAUORA

Eligibility criteria for treatment (CPAC)

Contract specifies what is funded

Contract specifies prices

Cap on annual spend

DHB pays for everything

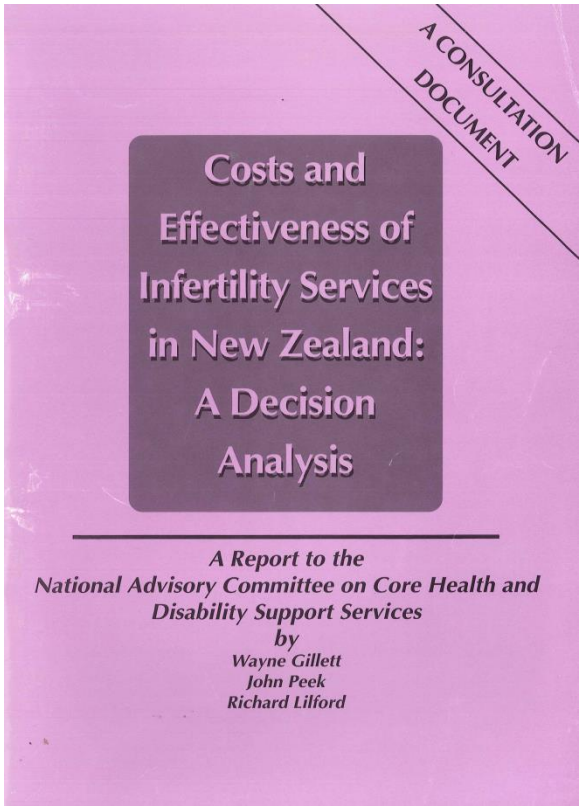
Patient goes to clinic with contract

Leaders in Fertility

Before CPAC

- 1st IVF service public, National Women's Hospital, 1983
- 1st private fertility clinic, Fertility Associates, 1987
- By mid 1995
  - Auckland – 3 clinics (2 private, 1 'DHB')
  - Hamilton (private)
  - Wellington (private)
  - Christchurch ('DHB'-University partnership)
  - Dunedin ('DHB')
- Very different levels of funding geographically
- Different eligibility criteria geographically

‘Costs and effectiveness of infertility services in New Zealand: a decision analysis’ (1995)

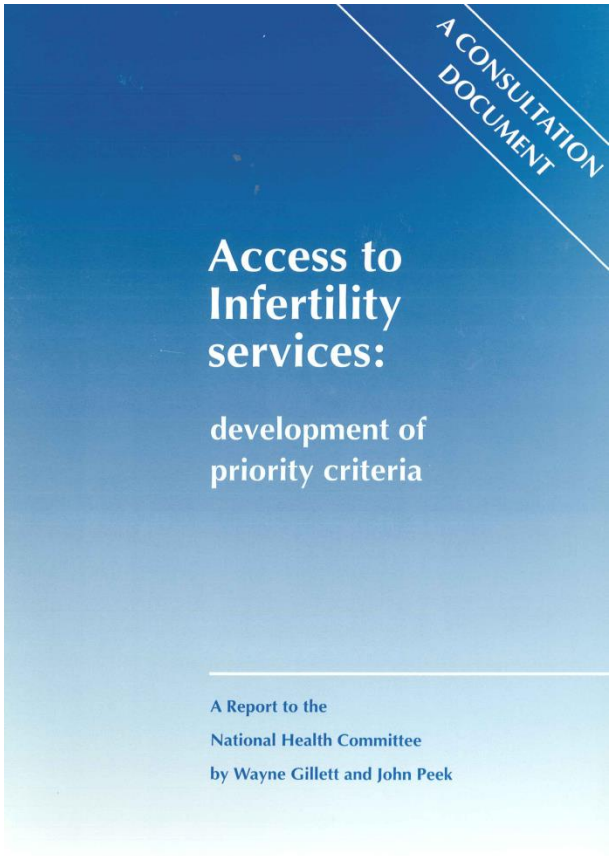


- Commissioned by **National Advisory Committee on Core Health and Disability Support Services**
- ‘*This paper is a start in formulating advice on the types and priorities of fertility services.’*
- *‘Before making recommendations to the Minister of Health about the circumstances when fertility services should be publicly funded, the committee will consider the views of purchasers, consumers, providers and members of the public.’*

Key findings

- Only 2 of 4 Regional Health Authorities (RHAs) provided significant public funding for ART services
- About $9.3 M was being spent on fertility services in NZ
  - Half privately
  - Half publicly
    - Only $1.5 M explicitly on infertility
    - Rest via gynaecology
- IVF beneficial for most types of infertility
- Too much money (~ 32%) being spent on diagnosis

Access to infertility services: development of priority criteria



- Asked for:
  - Draft priority criteria
  - Advice on optional configuration of publicly funded infertility services
- Base guidelines on existing funding ($4.5 M), but adaptable to different levels of funding

CPAC in general

- Wait < 6 months for service
- Booked at time of assessment
  = given certainty of treatment and timeframe of treatment
- Transparency of decision-making to offer or decline a service
- Consistency between doctors
- Eligibility based on:
  - Need for treatment
  - Ability to benefit
  - Social values included in prioritisation

Key recommendations

- Free access to investigation for all couples
- Standardise diagnosis to save money for treatment
- 4 step scoring system for treatment
- *'Priority criteria model gives weight to couples least likely to conceived without treatment'*
- '*However little can change the impact of on the final score of declining fertility with age'*
- Ministry of Health press release: *'The authors make it clear that applying the priority criteria to the current level of funding ($4.5M) could not reasonably meet the demand for services – the access threshold would have to be set too high (65 points).*

4 steps

- Exclusion factors
  - Eg. unable to safely parent
- Modifying factors
  - Removing hydrosalpinges
  - Weight improvement if BMI outside defined range
- Objective criteria, max 1.0
- Social criteria (now called ‘subjective’ criteria), max 100
- Final score = objective x social

- **Body weight**
  Women with very low body weight for height (BMI, body mass index) may become anovular, and are often over responsive to ovarian stimulation with drugs. Women with very high body weight for height often have irregular ovulation, and respond poorly to ovarian stimulation. Relatively small changes towards 'ideal' body weight often lead to significant improvement in ovulatory patterns in response to ovarian stimulation. However, there are few quantitative data linking the degree of under/over weight with the degree of ovarian response, so this factor has not been incorporated into the priority model. We advise weight improvement programmes before beginning treatment in women who are outside the BMI range of 18-32. We accept that there are factors that limit the success of weight improvement, and in this circumstance it is reasonable to proceed with treatment providing the ovarian response is closely monitored. Treatment should only continue if the response is satisfactory.

Women with a BMI outside the range 18-32 should undergo weight improvement programmes before beginning a infertility treatment

What changed?

	Aspect		Original points	What changed?
O2	Woman's age	=< 35	10	Ministry changed so =< 39 all got 10 points
		36-37	7	
		38-39	4	
		40-41	2	
		>= 42	1	
O3	Basal FSH	Always within	10	Used to decide own or donor eggs
		Sometimes above	8	
		Mostly/always above	2	
04	Woman's smoking	Non-smoker	10	Became exclusion
		Smoker	6	
	BMI			Became exclusion
	Free access to investigation			Aligned with access to treatment

What happened next?

- 2000 Extra funding for IVF treatment to enable the CPAC system
  - $5.9 M for tertiary fertility treatment contracts
  - CPAC threshold set at 65
  - One ‘package’ per couple in a relationship
    - IVF + any frozen embryos, 4 x IUI, 4 x DI, 4 x OI
- 2004 Extra funding to enable a second package
  - Extra ~ $4.5 M, but
  - $2 M of the extra funding to come from reduction in multiple deliveries from SET policy

Controversies

- Some exclusions - health or ideology?
  - Eg. BMI > 32
- Some exclusions – ethicity blind
  - Eg. Is an Indian's BMI > 28 comparable to a Pasifika's BMI > 32?
- Exclusion for social factors
  - Eg. Having >= 2 children living at home
- Social endpoint for a medical service
  - Endpoint of 'opportunity to benefit' = opportunity to parent