Infertility, Social Exclusion and Social Policy

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Abstract

For married or cohabiting couples, the inability to conceive can lead to guilt, marital tensions and feelings of social exclusion. When their siblings and friends are raising children, many low-fertility couples feel left out of ‘normal’ adult life in which maturity is often associated with parenthood. In addition to these personal and relationship struggles, medically assisted conception and the use of reproductive technologies raises broader social policy questions about who is given access to treatment, which medical interventions are necessary, who pays, and how the courts will deal with the inevitable disputes.

This paper uses the discourse of 48 qualitative interviews with men and women undergoing fertility treatment in Auckland, New Zealand to introduce several policy concerns. I examine how these men and women talk about infertility and social exclusion, and their experiences and views about medically assisted conception. Their comments are compared with findings from international research on infertility as well as social policy discussions from Australia and New Zealand about who has the right to reproduce, how much assistance the medical profession should provide, and how the state regulates these treatments.

Background Context

Sociological research from a number of countries has shown that most adults assume that love, marriage, and parenthood go together in the “normal” adult lifestyle (May 1995, Baker 2001: 124). Even though a childfree lifestyle is increasingly possible through more reliable contraception and more liberal social attitudes, most married couples – about 85% - still produce children (McDaniel & Tepperman 2000). When sociologists asked people why they want children, they usually say they will enrich their lives, cement their love with their partner, provide them with unquestioning love, enable them to pass on their name and culture, bring them status, and normalize their lives (Callan 1982, Cameron 1990). Research has also concluded, however, that there is considerable social pressure to reproduce, although this pressure varies by culture, age and gender (Morell 1994).
Social pressure starts from childhood when girls are given dolls to play with and asked questions like: ‘How many children do you want to have when you grow up?’ The subtle pressure continues into adulthood and comes from family members, friends, and even strangers in the form of polite personal questions (“How many children do you have?”) as well as widespread assumptions – even by sociologists - that all adults are parents and all women are mothers. Considerable research concludes that parenthood is still used as a rough indicator of maturity, femininity and masculinity, heterosexuality, sexual prowess, mental health and even moral worth (Callan 1987, Cameron 1997, Bergert 2000). At the same time, fertility problems seem to be on the rise and low fertility is often correlated with environmental pollution, cigarette smoking, high stress levels, alcohol abuse, prolonged use of birth control pills, and of course, increases with women’s age (Adair & Rogan 1998, Coney & Else 1999). As the age of marriage rises and more people repartner and try to produce children later in life, conception problems become more apparent. However, the apparent rise in infertility is also compounded by the increase in voluntary childlessness, making the childfree lifestyle more prevalent and visible.

Previous studies have suggested that when people become settled with a suitable partner and establish some financial stability, they usually expect to reproduce and are often terribly upset if they find they cannot (May 1995, Adair & Rogan 1998, Ulrich & Weatherall 2000, Exley & Letherby 2001). Increasingly, more people are seeking the assistance of fertility clinics, which have been established in many countries around the world. In this paper, I will consider some social policy issues arising from medically accepted conception, using some of the stories from qualitative interviews with people undergoing fertility treatment in Auckland, New Zealand to illustrate the ambiguities and complexities involved. Although this research was done in New Zealand, I believe that the implications pertain to many different jurisdictions. The legal and
social concerns are widespread in OECD countries but policy issues from both Australia and New Zealand will form the focus of this paper.

**Study Design**

This research project, funded by the University of Auckland, was originally designed as a pilot project to understand how low fertility and fertility treatments affect feelings of wellbeing and personal relationships of men and women in couple relationships. The participants were located with the co-operation of two hospital-based fertility clinics and an infertility association in Auckland. Clinic staff gave new patients my information sheet about the study, and the infertility association provided this information in their newsletter. Interested participants were encouraged to contact me for two personal and confidential interviews. We planned to interview each participant on two occasions: towards the beginning of treatment at the clinic and about six months later. This would allow us to monitor changes in treatment outcomes as well as attitudes towards the treatments, relationships and life plans.

I completed the first twelve interviews myself but employed a (female) graduate student to do the remaining first interviews and all the second interviews. These took place in the participants’ homes, lasted about one hour, and were audio-taped and later transcribed. As participation in the study is voluntary rather than a random sample and the number of participants is small, no generalisations came be made from the findings. However, the stories of the participants offer some insights into a number of policy issues for low-fertile people, for fertility clinics and for governments.
The Participants

When the Human Subject Ethics Review Committee of my university insisted on the method of finding participants, I was immediately concerned that my sample would be too small. As soon as people contacted me, I began to interview them but after one year of advertising through the clinics and infertility association, only 24 people came forward to be interviewed\(^1\). Other researchers of infertility have also reported difficulty in finding participants, especially males (Lloyd 1996).

Both partners in ten couples were interviewed separately, as well as two individuals. One man's much younger partner could not speak English well enough to participate and the other individual was an educated lesbian woman who lived alone. We interviewed each person on two separate occasions, representing about 50 hours of qualitative interviews. Most (17 of 24) were legally married, the rest were in *de facto* relationships (except the lesbian woman). Most participants had combined household incomes of over $60,000 a year, well above the New Zealand average. The women were between the ages of 29 and 46 years, and the men ranged in age from 34 to 68 years. Most participants were *Pakeha* (New Zealanders of 'European' origin), three were European immigrants, and three had Maori ancestry.

After beginning the study, I found that several participants had been undergoing treatments for years but only recently approached these particular clinics. Because the sample was small, I included all the people who volunteered. Most had no children but three couples were attempting to have another child together and several individuals had children with another partner. The participants or their spouses have undergone a wide range of fertility treatment, with

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\(^1\) One additional person said she was interested but then called back the next day and withdrew, saying she was too upset to talk.
various interventions such as hormone stimulation, assisted insemination with husband’s sperm, egg or sperm donation, and in vitro fertilisation (IVF).

Some General Findings

Before I discuss any social policy implications of my research, I want to mention several general findings to illustrate some of the relationship issues and the social context of the policy concerns.

1. Infertility and Social Exclusion

The issue of social exclusion can be addressed from the point of view of the participants of the study or from a broader social policy perspective. First, many people we interviewed told us that their inability to reproduce made them feel frustrated, worried about marital stability, and excluded from ‘normal’ adult life, especially when their siblings and friends were having children. For example, a 34-year old wife in my study said:

“I have a lot a guilt because I perceive it is my fault that we don't have any children. (My husband) doesn't and he gets quite upset when I say it so I have a lot of anxiety about him leaving me for somebody who can have children.”

A 38-year-old husband commented:

“You definitely miss out on something [if you don’t have children] because a lot of my friends have got kids and … you gradually get further and further away . . . When we’ve gone out with couples who have got kids and we haven’t and the couples with kids talk kids. It's all kid talk and we, you know, we can’t contribute…”

One 38-year-old woman in a cohabiting relationship said:

“We’ve had nine friends in the last two months who told us that they’re pregnant and only four of those I think it was planned as such. So we’ve very quietly and privately struggled with that … Deep down, we’re saying ‘What about us? What about us?’”
At the same time, most participants felt that they could not be entirely open with their friends and family about the nature of their treatments because they were so personal to their couple relationship but also socially controversial. When they did talk about their treatments to relatives and friends, some openly disapproved, saying that treatments were too invasive or expensive, that they were too old to continue trying to conceive, or they made jokes about men’s sexual prowess (or lack of it). One woman was unusually open and mentioned that she discussed their fertility problems with her sister, mother and several female friends but said her partner was unable to talk to his male friends and relatives, and consequently had little social support to help deal with his experiences:

“He was afraid that he would be mocked, ridiculed, made to feel he wasn’t a ‘real man’… a guy’s reaction to another guy would be that he hadn’t got the goods … [but] he communicates very well with women so he’s quite happy for my sister to be his confidante …”

Men’s reluctance to confide in other men about their experiences with infertility or with the treatment was widespread in my study.

Women said they usually talked to their female friends and relatives about both their inability to conceive and some of the details of their fertility treatments. However, several women mentioned that their friends and relatives did not always understand the extent of their frustration over their fertility problems or their grief over miscarriages or stillbirths. One woman who had a stillborn baby girl, said: "… I lost a lot of friends when she died because they didn't know how to handle it, which was sad…I have had one daughter and I am always a mother and I know that deep down.” So some participants felt socially excluded because their friends and siblings were getting pregnant or continually talking about their children. However, they also felt excluded because they were having treatments that were difficult to discuss with others, and
included work absences for frequent clinic visits, regular injections, debilitating side effects from drugs, miscarriages, and emotional ups and downs.

At the same time, one participant suggested that the opportunity to have fertility treatments in a medical clinic made her feel socially included. Processes like assisted insemination with a donor's sperm or in vitro fertilisation can be used to challenge the dominance of heterosexist discourse by separating reproduction from heterosexual intercourse (Michaels 1996). The one lesbian woman I interviewed illustrated this point well when telling her story about deciding to become a mother and to seek assistance from a fertility clinic:

"You know, it'd probably be a lot easier if I just went out and I had a fuck with some bloke. I mean that would be quite easy. I don't want to do that because it would feel like a violation of who I am and this, in a way, odd as it is, is more normal".

This woman said she felt socially excluded with her inability to reproduce. However, the opportunity to conceive in a medically safe environment, without heterosexual intercourse, made her feel that she too had a right to become a mother.

2. Interference With Social Functioning

Fertility treatments involve hormonal drugs that alter women's moods, sometimes make them feel queasy, and interfere with social functioning. Some of the women in the study talked at length about their health problems leading to diagnosis, including details of menstrual cramps, problems with painful sexual intercourse, and discussions of endometriosis. They also discussed treatment difficulties, such as injecting themselves with hormones, problems with drug-induced queasiness, bouts of crying, and alternating feelings of depression and elation. A 40-year-old woman talked about the drug reactions:
“I could feel my oestrogen level was really low. I get bad headaches. I can’t … I can hardly keep my eyes open. I’m so tired, lethargic. I just feel dreadful, like walking in treacle…”

A 38-year-old woman said:

“… my body's saying: hey, you're getting ready to have a baby! And when it's told you're not having a baby, it goes wonky…”

Some of the males talked about the difficulties of comforting their wife when she was experiencing drug side effects, failed to become pregnant, or had a miscarriage. Both men and women agreed that the emotional ups and downs of fertility treatment were difficult to deal with. Men also commented on the problems with having sex ‘on command’ (at a particular hour of the day) or providing sperm donations at the clinic, especially before going to work in the morning. Yet most of the men said that they did not tell their friends, family or co-workers about these experiences or treatments.

For more women than men in the study, the drugs and the trips to the clinic interfered with their paid work. Eleven of twelve men worked full-time (one was retired), but I was interested to note that less than half of the women were in satisfying jobs or careers. Some were marginally employed or outside the labour force at the time of treatment, and had their work and life plans ‘on hold’ until they found out if they were pregnant. This waiting, however, sometimes lasted years. Also, an unusual number of women were in the process of changing jobs from something they did to earn a living to developing a ‘career’, but this usually involved self-employment from home and lower remuneration (and often related to alternative health practices).

A 34 year old woman said that she had been “sitting in a job I didn't like, waiting to get pregnant”, although she was now working toward a more enjoyable (but less lucrative) career.
Another woman mentioned that she had not been employed for the past four years because she was saying to herself: “I can't get a job because I might get pregnant. We can’t go on a holiday ‘cause I might be pregnant”. One man I interviewed, nearing the end of his tether with fertility treatment, talked about receiving the news that the treatment did not work:

“The expectancy arose, then everything dropped. It rose then dropped and it was so totally exhausting. Your life just stops and then with the end result that I think that I felt inclusive - you are looking around all the time and not worrying about what's happening and don't end up having enough fun. That sort of feels brain dead and you don't feel like talking to people - things like that ... I don't really want to go through what I did before. It's just too destructive.”

Several women said that if they were successful at procreating with medical assistance, they would feel compelled to stay home and devote their full attention to this much-cherished child. If this occurred, they would help perpetuate the cultural discourse that conflates femininity and motherhood and suggests that the ‘normal’ family is a gendered one with two heterosexual parents, a father earning money and a mother at home caring for the children.

3. Focus on Genetic Connection

Researchers note the hierarchy of treatments in the minds of patients undergoing medically assisted reproduction. Letherby (1999) found that donor insemination is usually favoured over egg donation, which is favoured over surrogacy. The preference for sperm over egg donation is related to an ‘ideal of motherhood’ in which the relationship between motherhood, children and family is primary. Similarly, many couples turning to fertility clinics oppose adoption in favour of having ‘their own’ children.

Most people in my study said they wanted a child that was their ‘own’. In many cases, however, they glossed over the fact that they were using someone else’s sperm and occasionally
someone else’s eggs, but reproducing in this way was considered more desirable than adopting or living without children. Several participants thought that local adoption included potential intervention by birth mothers and other family members, and that overseas adoption was preferable but more expensive and complicated. Several men who expressed discomfort about adoption were concerned about their inability to bond with ‘someone else’s child’. The few participants who were open to adoption said that they wanted a child ‘no matter what’, whether through additional fertility treatments, fostering or adoption.

Several participants talked about choosing a sperm donor. In New Zealand, the fertility clinics offer a computerized listing of donors, including their physical and social characteristics but no names or contact details. The participants of my study all said that they wanted a donor with similar physical characteristics (such as hair colour, height and weight) to the male partner in the couple or to themselves (in the case of the lesbian woman). Some even tried to match their education and religion with the sperm donor’s. The emphasis on similar physical characteristics is an effort to appear as a genetically connected family, should the assisted insemination lead to the birth of a child.

4. The Cost of Treatment

Fertility treatments can be very expensive. In New Zealand, assisted insemination with husband's sperm can cost less than $1,000 NZ but in vitro fertilisation costs over $8,000 for one attempt (and only one attempt can be made per month). Therefore, it is not surprising that most people in my study had above-average household incomes. Five of the twelve couples were eligible for one publicly funded treatment. Of these, only one woman became pregnant after one treatment; the rest paid for additional treatments with their own money. Two couples paid under $5,000 and
the other five couples paid from $10,000 to about $34,000, excluding expenses for complementary or alternative treatments or nutritional supplements to improve their general health and fertility. Although some couples went into debt to finance their treatments, men were more likely than their female partners to calculate the cost of various treatments and to find unacceptable the growing cost on their household budgets.

Several comments from my interviews illustrate the costs and implications of continued treatment. A 38-year old professional male, whose wife’s IVF treatments were unsuccessful, said:

“I’m not adverse to trying IVF again but I think it would just cripple you financially and devastate your relationship. It’s more invasive than AIH [assisted insemination with husband’s sperm] and I found that quite invasive… We don’t want to, ad infinitum, carry on with that and end up an emotionally drained couple. We have to get on with our lives.”

One woman, who was seven months pregnant from her third fertility treatment (and 2nd IVF), provided information about cost when she talked about how she would have felt if the treatment hadn’t worked:

"I would have been really disappointed if it hadn't worked, especially for the second time round, but I don't think I would have tried IVF for 5 years unsuccessfully. Realistically, I wouldn't have been able to try again for quite a few years because I would have had to pay off an $8,000 loan that it cost for the 2nd treatment. ...I think I would like to try again in another year’s time [to have a second child]. Financially, we couldn't afford it but I would still like to use the [frozen] embryo and hope that it works. It costs $350 a year to keep it frozen and we will pay for the first year and when it comes around to the next payment, I think we will then reconsider because of the cost..."

This comment suggests that it is not only the cost of one treatment that is the issue but the price of continuing treatments as well as the storage of sperm, eggs or embryos. Most participants also paid for expensive drugs and nutritional supplements.
Social Policy Issues

Several policy issues arise from these interview comments. Who is excluded from treatment? Who determines when the treatments are ineffective and should stop? And who pays?

1. Who is Excluded from Treatment?

The New Zealand health system pays for only one cycle of treatment if there is a medically diagnosed fertility problem. In Australia, state legislation governs fertility treatments but the focus is also on clinical diagnosis or a risk of passing on a genetic condition to be eligible for Medicare rebates (Walker 2000). Several couples in my study had to pay out their own money because doctors could find no medical reason for their inability to conceive.

In New Zealand, both married and de facto couples in stable relationships are now given access to treatment but de facto couples have been excluded in some Australian states. In Victoria, for example, de facto couples were excluded until 1997 when three cohabiting couples successfully argued before the Human Rights and Equal Opportunities Commission that clinics could not discriminate on the basis of marital status (Walker 2000: 293). Most other Australian states seem to accept de facto couples but they sometimes have to prove a stronger commitment to each other than do married couples (Walker 2000:300).

Lesbian or single women have been excluded from fertility treatments in both Australia and New Zealand (Adair & Rogan 1998, Haines & Weiner 2000). In Australia, several successful court cases have recently challenged this practice (Bennett 2000, Dower 2001, Skene 2002: 118, Zinn 2002). The exclusion of lesbians from fertility treatment has been controversial in Australia and has focused on the need to preserve ‘the family’ as a (heterosexual) institution, and suggestions that the welfare of children would be undermined without two heterosexual
parents (Dower 2001). My study included only one lesbian woman who was ineligible for publicly funded treatment but was accepted by a private clinic. She told me she had no medical reason for approaching the fertility clinic but rejected self-insemination and sought medical assistance to ensure that the sperm was screened and procedures were ‘done right’.

Publicly funded clinics often give priority to couples who have produced no children together (Adair & Rogan 1998). In my study, several individuals had repartnered and wanted to produce children together. Women patients are also expected to be below a certain age (which varies from 35 to 38 years old), as the probability of a live birth declines substantially with a woman’s age. In my study, there were several women over 38: one 44-year-old mother and another 46-year-old mother were having private treatment to have additional children. Heavy smokers and very obese women also can be excluded. In fact, the clinical decision of a doctor legally can exclude some potential patients in both Australia and New Zealand (Adair & Rogan 1998, Skene 2002:118).

Fertility clinics want to avoid giving false hope to patients with poor chances of success and also want to prevent wasted clinical resources. However, they also need to keep their ‘success rates’ high because they use these to attract new patients, encourage others to proceed with treatment, and to attract private or government operating or research funding. As these technologies become more widespread, especially in places like the United States, they create a competitive medical marketplace, competing for patients with package deals, instalment payments, non-medical support services and other enticements (Becker 2000: 15).

In New Zealand, fertility clinics operate in both private and public hospitals – couples might have one treatment from the public system and then decide to continue with a private clinic that accepts a broader range of patients. Private clinics tend to be less stringent about who
they accept for treatment as long as the patient can pay. However, they often relate to patients the probability that the treatment will lead to a successful pregnancy, allowing them to make their own decisions about continuation.

2. When Should Treatment Stop?

Private clinics sometimes permit older women to continue taking treatment even when the probability of pregnancy is very low. There were at least three women in my study who probably should have had their treatments terminated by the clinics. One was a 36-year old working class Pakeha woman, married for 14 years, who produced a stillborn baby seven years ago after donor insemination. Since then she has had eight sperm donations, one IVF cycle and two egg donation cycles (with her sister’s eggs). She mentioned that she felt very socially isolated, didn’t know any childless adult women, and couldn’t imagine life without children. At the time of the second interview, she was beginning to realise that she should stop trying to conceive.

The second woman who had trouble stopping treatments was a 44-year-old middle class Pakeha woman who for two years had been trying to have a second child with medical assistance even though she was told by clinic staff that the probably of pregnancy was less than 5%. Her husband said he wanted to stop treatments but was going along with her wishes to continue because it seemed so important to her. In the first interview, he talked about the treatment being stressful and negatively affecting their relationship:

“At times we got rather niggly with each other. I did my best to try and support (my wife) but perhaps there were times when I felt like yelling: ‘Enough is enough. I’m sick to death of hearing about another injection. I’m sick to death of it not happening. I’ve had a gutsful!’ … I knew it was important to her and it is quite hard”.
In the second interview, his wife was still not pregnant. He spoke of the “sense of sadness” at having only one child, but he rejected the idea of egg donation:

"Egg donors I wouldn’t take - I think not, because it is akin to adultery to me. Like adoption - you wouldn’t know what you are going to get and I guess it would be a part of me but never a part of (my wife)... there’s always the risk - with someone else’s egg it is a bit of a lottery ... if push comes to shove, I would consider adopting but that would mean looking overseas and it is really expensive."

The couple already have a two-year-old daughter, who we saw before and after the interviews.

The father showed more affection for the child than the mother did, and she seemed quite depressed during both interviews. In fact, the couple’s attempts to have another child seemed to be pulling them apart. Although the clinic offered counselling services to them, they had not taken full advantage of them.

The third woman who had difficulty stopping treatments was a 46-year-old Maori mother with four children from a previous marriage (all through caesarean births). In the past four years, she has experienced an operation to reverse a tubal ligation, six cycles of assisted insemination with her husband’s sperm, one cycle of IVF, and seven miscarriages. She said that she and her husband are now considering egg donation because she wanted “to give” a baby to him. She described the process of trying to conceive as:

“Very frustrating and very disappointing. Even if you do get pregnant, the chances of miscarrying are really high. You keep thinking that you just get on with your busy life, you have your study and you have your existing children, grandchildren and lots of things happening in your life. I’m not prepared to let that go yet because I still feel quite young and I still have some options that I can explore before I chuck it in... I think at the age of 50 that would be a determining point for me ... I know of a woman who is 50 something and she has just conceived through an egg donor, in New Zealand, in fact she has conceived to the lady who has offered me an egg as well. That’s amazing because it’s her 3rd time round with egg donors. I was just blown away.”
When discussing their decision about whether to accept the offer of the egg donor, she explained that she would be doing this more for her partner than for herself because she already had children of her own but he did not. Later, she explained:

“For me, going on this journey of trying desperately to have a baby has got a lot to do with my relationship with [my partner]... A lot of people when they meet their soul mate, the most important gift they can give that person is to reproduce a life and this is one of the reasons why we have children - we want to reflect something of ourselves into that child... I feel it would be the best gift I could give him and I feel he deserves it. He has not only raised my four children but he has raised seven children from his previous relationship. He is the most caring, loving person that I want him to experience that joy. To me, that is my primary goal in wanting to get pregnant. Secondly, I am very maternal and love babies... I know there are huge risks at my age getting pregnant, with my history... High chance of miscarriage, etc. Those are the two reasons for me.”

Clearly, some people are willing to undergo difficult and expensive treatments to produce a child, despite advice from doctors, friends and family to stop trying. Should clinics be permitted to take money from this couple for services that have proven to be ineffective for several years?

3. Who Pays?

Many of the participants in my study felt that they had a right to reproduce. Some felt that the public health care system should offer them more assistance in their attempts to conceive because it was so important to them and their families, as well as to the wider society. Many went into debt to pay for their treatments but others simply used up their savings. The lesbian woman, who worked as a social worker, used about $25,000 of her inheritance money and said that she would keep trying to conceive until it was all gone. Another couple had spent $34,000 with unsuccessful fertility treatments. Several participants asked why the public health system was not helping them more when there was considerable public concern about declining birth rates.
A couple of participants also expressed the belief that patients who were paying for their treatments with their own money received better service than those relying on the public health system. They were referring to the fertility diagnosis and actual treatments, as well as counselling and follow-up sessions. One woman, who was using the public system, also said: "When you go for your IVF, they are all over you like a rash and if it doesn't work, you don't see them again ... they don't want to know you if it doesn't work". Certainly the facilities in the private hospital looked more prosperous than the public facilities, but I had no way of verifying if staff is more attentive in the private system. However, it appears as though there is a two-tiered system of fertility treatment in New Zealand: one for the rich and one for the poor.

Discussion

This qualitative study has highlighted some policy issues surrounding medically assisted conception that merit further consideration. More childless couples are turning to fertility clinics but even after four cycles of treatments, only about 50% to 60% of couples are able to conceive (Pearn 1997, Bergert 2000). Most New Zealand couples, however, do not continue that long, as the average treatment duration is only 1.6 cycles (Gillett & Peek 1997).

Low fertility couples whose treatment is unsuccessful can accept their childlessness and get on with their lives, yet living in a childless marriage remains socially undesirable in certain segments of society (especially among Pacific and Maori people in New Zealand). Couples can keep trying with various methods of medically assisted conception but this can be emotionally draining and financially costly. They can apply to adopt a child but there is a shortage of able-bodied infants in both New Zealand and Australia, and waiting lists are long (Adair & Rogan 1998, Baker 2001: 20). In addition, the adopted child is not genetically connected, which is so
important to many people. Couples can become a foster parent but this is not a permanent arrangement. They can look to overseas adoption – but many find this expensive and complicated. They can find a surrogate mother but the legality of this pursuit is dubious and the process can be expensive. Clearly, there is no easy solution for these would-be parents.

The high cost of medical services mean that governments need to distinguish between medically necessary interventions and interventions requested for social reasons. Consequently, people with no apparent medical reason for infertility cannot depend on publicly funded services in either Australia or New Zealand. Yet in pronatalist societies, such as these two countries, we place a high value on the ability to reproduce and those who cannot often feel excluded from normal adult life. At the same time, treatment recipients sometimes say that the very treatment that is supposed to solve their problem is either unaffordable or further isolates them from family and friends, as well as interfering with their usual social activities and paid work. Especially women’s paid work is affected by fertility treatments because women take the drugs regulating their ovulation and women are implanted with sperm, eggs or embryos.

One issue raised by this study is the state’s role in the affordability of medically assisted conception. With so much public concern about declining fertility rates in countries such as Australia and New Zealand, we might expect the state to pay for more than one month of fertility treatment and for a broader category of family types than stable heterosexual couples. In my NZ study, most participants desperately wanted to become parents but many were prevented from continuing their treatments by cost, their family type, or lack of medical diagnosis for their infertility. Presumably, many would-be parents cannot access fertility treatment in the first place, so would never appear in a study sample such as mine. Rather than trying to encourage all women to become mothers or to have more children, efforts to raise fertility might focus on
those who really want to become parents. People seeking fertility treatment certainly fit into this
category.

The other side of the coin is to see these treatments in the same light as cosmetic surgery
and to argue that people have no ‘right’ to reproduce, especially if their attempts are costly for
the general public and/or have a low probability of effectiveness. Yet it is inaccurate to say that if
people want to pay for their own treatment, that is their business. First, this means that higher
income couples have more opportunity to become parents, which surely is unfair. Second, we
should be aware that even privately funded treatments sometimes have public costs, especially
when things go wrong, such as ectopic pregnancies and miscarriages (Baird 1997). Using one of
the examples from my study, should the New Zealand public be expected to pay if a 46-year-old
mother of four has six miscarriages after four years of private treatment and needs to be rushed
to a public hospital? The New Zealand health care system will pay for accidents and hospital-
based emergencies but makes patients pay for preventive health care and routine visits to the
general practitioner\(^2\). It is not surprising, then, that most patients pay for fertility treatments.

Finally, the last policy question I have is should private clinics permit people to continue
their treatment when the probability of success is so low? Should governments insist that clinics
cease treatment when treatments fail or should this be left to the woman or couple to decide?

Conclusion

When I began this qualitative study, I thought that the sample would be too small to yield any
useful findings. However, supplemented with overseas research, the project has generated

\(^2\) The state subsidizes the private services of general practitioners but patients are still asked to pay about $50 a visit
in Auckland. Beneficiaries receive a discount but pay around $25.
several useful sociological findings relating to the relationship between fertility and identity, the
social pressure to reproduce, and gender differences in the response to infertility and fertility
treatments. In addition, it was provided human stories to illuminate the dilemmas, ethical
problems, and social policy issues that accompany reproductive technologies, especially
medically assisted conception.

The remaining question is: In times of declining fertility, should fertility clinics be permitted to assist more would-be parents? Should clinical guidelines and legislation expand their ideas about ‘suitable parents’ and broaden their definitions of ‘family’? Should more public health money assist couples or individuals to become parents, especially in New Zealand?

These questions, of course, are not as simple as they sound because judgements must always be made about who should receive medical treatment when scarce public resources are involved. However, we are excluding people who want to become parents but are not in heterosexual or legally married couples. Especially in New Zealand, we are certainly excluding many people from parenthood simply because they cannot afford the cost of treatment.
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Social exclusion is influencing how social policy issues are conceived, debated, researched and addressed, particularly in Europe. It has also been given prominence as a focus of the Rudd Government's social policy agenda. This paper reviews the debate over the definition and measurement of social exclusion, focusing on its relationship with poverty, defined in terms of low-income. The analysis social exclusion, marginalization or social marginalisation is the social disadvantage and relegation to the fringe of society. It is a term used widely in Europe and was first used in France. It is used across disciplines including education, sociology, psychology, politics and economics. Social exclusion is the process in which individuals are blocked from (or denied full access to) various rights, opportunities and resources that are normally available to members of a different group, and which are