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Racial differences in men seeking fertility treatment in North America: a timely report by the Andrology Research Consortium

The coronavirus disease 2019 pandemic has amplified existing racial disparities in healthcare outcomes that reflect racial inequalities present throughout the structure of our society. There is no clearer demonstration of these disparities than the greater reduction in the already shorter life expectancy of black and Latino Americans compared with that of white Americans during 2020 (1). Although clinicians who treat infertility focus on birth rather than on death, the care we provide is not immune to unjust racial disparities. If anything, the myriad barriers in access to infertility care, such as variable insurance coverage and high out-of-pocket costs, mean that infertile men may be at even greater risk of disparate health care.

Characterizing racial differences in fertility care for men in North America is challenging. Studies employing private insurance databases have access to impressive numbers of patients but are limited by their dependance on billing codes and incomplete fertility-related insurance coverage. Reports based on national surveys are more representative of the entire population; however, they lack clinical details and rely entirely on patient self-reporting. To better characterize male infertility care, the Society for the Study of Male Reproduction established the Andrology Research Consortium (ARC), a collaboration between 22 male fertility centers throughout North America. The ARC previously reported that before being seen by a male fertility specialist, 12% of couples had undergone intrauterine insemination (IUI) and 5% had undergone in vitro fertilization. Given that 73% of the entire cohort reported abnormal semen analysis results, some of these couples may have benefited from an earlier evaluation of the man; hence, the American Society of Reproductive Medicine recommended that both partners be evaluated during a fertility workup.

The ARC's most recent report on 6,462 men focused on racial differences in male fertility history and treatment (2). Compared with other races, white men sought evaluation sooner, whereas black and Indian/native men waited longer before seeking evaluation. White men were more likely to self-refer, whereas Asian/Indo-Canadian/Indo-American men were less likely to self-refer. The data recorded by the ARC are somewhat limited, and so, one can only speculate why these differences might occur. Perhaps these findings reflect that white men have greater access to care or higher levels of trust in the health care system.

The ARC also reported racial differences in prior fertility treatment. Black men were less likely than men of other races to have undergone IUI before a male evaluation, whereas Asian/Indo-Canadian/Indo-American men were more likely to have undergone IUI. Most male fertility specialists would consider it optimal that the man be evaluated before a couple undergoes infertility treatment with IUI or in vitro fertilization in case there is an opportunity to optimize semen quality. The racial differences in prior fertility treatment might reflect different access to IUI or differing relationships between minority groups and reproductive endocrinologists, providers who are usually responsible for IUI. Clearly, further investigation is required to explain the racial differences reported by the ARC.

The ARC's investigation of racial differences in male fertility care highlights some challenges in studying this topic. The ARC is composed of 18 centers in the United States and 4 centers in Canada, and of the total population of the 2 countries, approximately 10% is Canadian. However, 90% of patients in the ARC dataset are from the 4 Canadian centers, undermining the assertion that this dataset is representative of North America. The United States and Canada have very different health care models, which might have led to divergent access to records between the 2 countries. Additionally, there are challenges in characterizing race across these very different nations (3). The United States Census Bureau asks questions regarding ethnicity (of Hispanic, Latino, or Spanish origin) and race, categorizing people into 1 or more race(s) of white, black or African American, Asian or Pacific Islander, American Indian or Alaska Native, or other. The situation is very different in Canada, where the census asks for more granular detail on the country of ethnic origin rather than categorizing people into specific races. However, the Canadian census does make use of the concept of "visible minority," in which individuals can identify as being a minority based on their physical appearance. Although there is value in research collaboration among Canadian and American centers, these differences, as well the exclusion of any centers from Mexico, limit our current understanding of racial differences in male fertility care across North America.

Others have attempted to explore racial differences in male fertility care, more commonly in the United States. Using the National Survey for Family Growth, our group characterized differences in men who used infertility services vs. men who identified as subfertile but did not seek infertility care (4). Although non-Hispanic white infertile men were more likely than other infertile men to use infertility services, race ceased to be a significant factor when income, education, and health insurance status were taken into account. Another informative study evaluated the impact of racial minority status on infertility care in a veteran affairs setting, where access to health care evaluation is free and universal to veterans, regardless of their socioeconomic status (5). Racial minority veterans were equally likely to undergo an infertility evaluation as white veterans. However, fertility treatment, which is not covered by insurance unless

it is directly a result of military service, was reported by only half as many racial minority veterans. These studies suggest that enhancing access to infertility care by mandating insurance coverage will partially address certain racial differences in fertility care.

Despite the challenges in characterizing racial differences in infertility care, the members of the ARC should be congratulated for their significant contribution to our understanding of this important topic. The largely unfunded collection of data of over 6,000 men from over 20 centers speaks volumes about the dedication that the ARC members have toward the advancement of our field. Armed with the findings of these studies, we can advocate for public policy reforms with the goal of racially equitable fertility care.

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