Some trusts have adopted a system of a "ring-fenced" allocation per head of consultant and if any of this funding remains unused it can be carried over to the next financial year.

The time is right for the Government adequately to fund the CME/CDP activities of career-grade hospital staff. (This should include part-time staff. A doctor who works half time must not be half trained). In view of the travel distance involved, the costs of courses, and the rising cost of hotel accommodation, I suggest that more realistic funding might be achieved by the provision of funding of £100 per CME point obtained for courses outside Northern Ireland and a lesser sum for local courses depending on the distance of the Trust from Belfast.

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Why the NHS should fund infertility services

One in six couples is infertile (Lower, 1993). Of these, in Northern Ireland, approximately 1400 make use of assisted reproductive technologies annually. Currently in Northern Ireland, no public funding is available for in vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI), (College of Health Report, 1997/8). Treatment, therefore, depends solely on the couple's ability to contribute financially towards the costs incurred.

Pressure to ration and prioritise treatments within the NHS is significant. The 1995 House of Commons Health Committee report on priority setting in the NHS stated that the NHS must remain responsive to shifting public concerns and debate. Bowling (1996) randomly sampled the views of the British population. Out of twelve possible health priorities interviewees ranked 'treatments for children with life threatening illnesses' first and 'treatment for infertility' eleventh, just above 'treatment for people aged 75 and over with life threatening illnesses'. However, when the public is asked, in isolation, if infertility treatments should be funded by the NHS their answer is different. For example, 84% of medical students at Queen's University felt that infertile couples should not fund their own infertility treatment. (Moore *et al*, 1998) Caldwell *et al* (1998) in another study reported similar findings.

In dealing with the issue of infertility, there is, amongst the community at large, a lack of understanding of the associated stresses. Diana, Princess of Wales famously remarked when she was patron of 'Birthright', a research charity of the Royal College of Obstetricians and Gynaecologists, that "infertility was not a disease and people should get on with their lives". In Northern Ireland particularly, the situation is further confounded by an active fundamentalist religious lobby which sees assisted reproduction as immoral.

In other areas of health service provision there are nationally set minimum numbers of treatments purchased: no such requirements exist for infertility. In a publication entitled "Effective Health Care – the Management of Subfertility" (University of Leeds, 1992) it was proposed that 40 IVF treatment cycles should be purchased per 100,000 population. Taking the Northern Health and Social Services Board as an example within Northern Ireland, they should fund 160 treatment cycles per year for a population of 400,000 Bull and Lyons, (1994). *They fund no cycles.*

Currently, in Northern Ireland all assisted reproduction treatments are provided at the Regional Fertility Centre, Belfast. The cost, to a couple, of a single cycle of IVF is £945.00 and ICSI £1500.00. These are amongst the cheapest prices in the United Kingdom. However, this does not include the cost of drugs as, over the years there has been a considerable amount of good-will from general practitioners who have written the necessary prescriptions. Where they will not, the couple can expect to pay up to £1,000 extra.

In many other health service regions financial provision is made for assisted reproduction, resulting in a 'baby-by-postcode' scenario. However, in these areas funding is often severely limited. For example, couples over 35 years old are often excluded as are those where one or other partner already has a child. This system of funding is not equitable either. If there must be funding restrictions, and this seems inevitable as there is no area of medicine with unlimited funding, perhaps it would be better if authorities decided to spend an annual sum on the provision of

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assisted reproduction services, for example to cover the drugs budget. Then, all patients would be expected to provide top-up sums to pay for the remainder of treatment costs. However, this should be standardised across not only Northern Ireland but the whole of the UK, to remove the baby-by-postcode phenomenon.

Whilst there is no funding for assisted reproduction in Northern Ireland, the government does fund the initial assessment of the infertile couple by the general practitioner and subsequent referrals to both local and regional centres for further investigation. In the hospital setting everything from semen analysis to laparoscopy is funded as are all surgical interventions. Even reanastomosis of the fallopian tubes following a change of mind after tubal sterilisation is funded in most of Northern Ireland. The inconsistency is particularly obvious in severe tubal disease where although *evidence based criteria* show surgery is not a sensible option it is fully funded whilst IVF is not.

There are also hidden costs with assisted reproduction. Couples who are personally investing heavily in assisted reproduction are keen to maximise their chances of pregnancy and, therefore, often ask for three embryos (the maximum number legally allowed) to be transferred. In Belfast, and increasingly in the rest of the United Kingdom this is not policy and three embryos are only transferred in exceptional circumstances (Levene M I *et al*, 1992). But, where couples have to bear the costs of treatment one can understand their wish to maximise success even at the risk of a higher order multiple pregnancy. All over the world assisted reproduction is responsible for a large increase in multiple births. These are associated with high rates of neonatal complications and higher costs after discharge due to chronic health problems and developmental disabilities (Neumann *et al*, 1994; Callahan T L *et al*, 1994).

As Davey and Popay stated in 1993: "Health care should be delivered according to each person's need for it without discrimination on the grounds of the means to pay, age, sex, social class, place of residence, ethnic status or any other socio-demographic characteristic of the recipient." In line with this, we feel that NHS funding of infertility services in Northern Ireland, especially assisted reproductive technologies, should be reviewed. The inconsistencies in funding should be addressed in an aim to provide the best *evidence-based* medicine in this highly charged and emotive area of medical care. For many unfortunate couples IVF or ICSI is the only effective treatment option.

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