Editorials

Addressing Disparities in Infertility Care

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See related article on page 623.

People of all races, ethnicities, nationalities, gender identities, sexualities, and socioeconomic statuses experience infertility. Epidemiologically, infertility is experienced by 15% of couples and becomes more prevalent with age.[1] Studies have found that infertility disproportionately affects more women of racial and ethnic minorities, especially Black women.[2] Improvements in assisted reproductive technologies have allowed some people with infertility to have the family of their dreams. However, in the United States, many couples with infertility have been unable to benefit from these scientific advancements because of significant racial and socioeconomic disparities.

Compared with White women in the United States, Black women experience higher rates of infertility, a longer time to evaluation, lower treatment utilization, and poorer therapeutic outcomes.[3-7] Black women with infertility are much less likely to seek care and commonly wait twice as long before seeking care.[3] A study using a national electronic in vitro fertilization database of approximately 70,000 patient cycles found that Black women had a considerably higher rate of miscarriage and a lower rate of clinical pregnancy than White women. The study also found that Black women have lower live birth rates than White women after adjusting for age, body mass index, infertility etiology, hypertension, diabetes mellitus, cycle type, intracytoplasmic sperm injection, preimplantation genetic testing, and the number of transfer cycles.[5] Additionally, poor prognostic factors are more common in Black women, including age older than 35 years, obesity, tubal disease, and uterine factors.[5,8] Undoubtedly, these disparities are sustained by a myriad of social determinants of health, including economic stability and inequities in the health care system. We would be remiss not to acknowledge the impact of ancestral slavery, racism, stress, implicit bias, medical mistrust, and the racial wealth gap. Addressing the root causes and improving these disparate outcomes require multiple interventions and the development of evidence-based strategies.

The ability or "freedom" to have a child when desired is a reproductive rights issue; however, for many couples, especially minorities, this right is difficult to exercise financially. The cost of an in vitro fertilization cycle, including medications, ranges from $12,000 to $30,000.[9] Cost is a significant barrier when considering the persistent racial wealth gap in the United States. The net wealth of the average Black household in the United States is only one-tenth of the average White household.[10] In 2021, the median household income in the United States was $69,717 per year, while the average annual income for a Black family in the United States was $46,774.[11] In addition, the past decade has seen a reversal of progress for reproductive rights. These changes have left many women without access to comprehensive reproductive health care nationwide. Although a select subset of women may be able to navigate these barriers successfully, the brunt of these changes is often compounded for women of minority groups. The disproportionate ratio of infertility specialists to patients and the geographic differences in clinician saturation also contribute to this problem.[12] In the United States, approximately 12 million people experience infertility, with only about 1,500 fellowship-trained reproductive endocrinologists available, mostly concentrated in urban areas.[12] Widening the breadth and scope of practice of family physicians to incorporate basic fertility care, especially in suburban and rural areas, provides a potential path to increasing access.

To improve these disparities, clinicians and health policy makers should join forces to advocate for insurance coverage that incorporates the full spectrum of fertility care. We can work toward improving access with early and skillful diagnosis and treatment, both of which have been excellently addressed by Dr. Phillips and colleagues in this issue of *American Family Physician*.[13] The article provides an informative overview of common causes of infertility, a detailed description of the main etiologic categories, and

appropriate methods for a comprehensive workup and treatment. More research is needed to understand the complex racial, social, cultural, and economic factors that prevent patients from accessing fertility care and to provide better access and care across all groups experiencing infertility. For family physicians, who provide much of women's health care in the United States, minimizing implicit bias is essential to increasing access. Family physicians are in an ideal position to offer an initial evaluation, counseling, and management of common causes of infertility, including referrals to infertility specialists when needed. Couples trying to conceive can be encouraged to track ovulation with calendar-based phone applications and urine-based ovulation predictor tests. Some serum tests are likely to be covered by insurance as part of an annual wellness visit, such as a day 21 serum progesterone level to confirm ovulation and laboratory testing for polycystic ovary syndrome. These interventions and referrals should be offered to *everyone*, regardless of race, ethnicity, sexuality, gender identity, socioeconomic status, or language barriers.

Incorporating basic fertility awareness and education into wellness visits can empower patients who may experience future difficulties with conceiving. Physicians should counsel their reproductive-age patients about conception and fertility goals in the same way we counsel about contraception. Oocyte cryopreservation is no longer experimental and can help female patients feel empowered if they elect to postpone childbearing. Patients who wish to cryopreserve their oocytes should be referred to a reproductive endocrinologist. It is important to avoid making assumptions about who can afford fertility preservation.

Although great strides must continue in the fight for insurance coverage expansion and sociocultural change, we contend that widespread use by primary care clinicians of this infertility article by Dr. Phillips and colleagues is also imperative for meeting the needs of patients seeking fertility care and improving reproductive health equity. Additional resources that can assist family physicians in fertility care and patient advocacy are listed in *Table 1*.

TABLE 1

Resources to Assist Family Physicians in Fertility Care and Patient Advocacy

Resource	Website
American College of Obstetricians and Gynecologists: Infertility Workup for the Women's Health Specialist	https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/06/infertility-workup-for-the-womens-health-specialist
American Society for Reproductive Medicine: Fertility Evaluation of Infertile Women	https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/practice-guidelines/for-non-members/diagnostic_evaluation_of_the_infertile_female.pdf
Resolve: The National Infertility Association	https://resolve.org

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