ARTICLE

Should fertility treatment be state funded?[1]

Abstract:
Many states offer generous provision of fertility treatment, but this article asks whether and how such state funding can be justified. I argue that, at most, there is limited justification for state funding of fertility treatment as one good among many that could enable citizens to pursue valuable life projects, but not one that should have the privileged access to funding it is currently given. I then consider and reject reasons one might think that fertility treatment has a special claim to funding, over the other goods that might enable life projects. First, I deny that fertility treatment has a special claim to funding on the grounds that infertility is a disease or disability. Second, I argue that individuals do not have a right to assistance with the project of having a child of their own. Third, I deny that providing fertility treatment is a special case on the grounds that having children is good for society. However, there may be one exception: states have a reason to fund fertility treatment for same-sex couples that does not apply to heterosexual couples.

Introduction

At present, the NHS offers up to three cycles of IVF to women under 40 and one cycle to women aged 40-42. Many countries offer far more generous provision, including France, Belgium and Slovenia; in Israel, for example, IVF cycles are funded up until the birth of two children for women under 45. However, IVF cycles often fail to result in live births. In the UK, for women aged 38-39, the failure rate per cycle is nearly 80% and even for the group that does best, of women under 35, the failure rate is 67.2%.[2] This article asks whether and how such state funding of IVF and other assisted reproductive technologies can be justified.

Many of the ethical issues surrounding such fertility treatment are much debated, such as whether assisted reproductive technologies should be used to select for children with particular characteristics.[3] So too, there are debates over the details of the provision of fertility treatment; for instance, regarding whether age or having existing children should affect eligibility for treatment, or over the unequal provision of treatment across local authorities in the UK.[4] Yet, as John McMillan has observed, less attention has been paid to the more general question of whether fertility treatment should be state funded at all.[5] Further, that attention which has been paid has largely defended such provision, with the notable exception of some feminist critiques.[6]

However, despite many states' generous funding for fertility treatment, I argue that such provision cannot be justified as simply one component of a more general state funded healthcare system. Instead, there is, at best, a far more limited justification of funding on the grounds that fertility treatment is just one good among many that enables citizens to pursue valuable life projects, but not one that should have the privileged access to funding it is

currently given over and above these other goods. Clarifying the justification of fertility treatment has implications both for what goods it must compete with for funding and for its resulting pattern of distribution.

To begin, I outline the limited justification for fertility treatment that I propose. I then consider and reject reasons that fertility treatment might have special or privileged claim to funding over the other goods that enable valuable life projects. First, in section 2, I deny that fertility treatment has a special claim to funding on the grounds that infertility is a disease or disability. Second, in section 3, I argue that individuals do not have a right or otherwise special claim to assistance with the project of having a child of their own. Third, in section 4, I deny that providing fertility treatment is a special case on the grounds that having children is good for society. There is, however, one exception: there is a reason for states to fund treatment for same-sex couples that does not apply to heterosexual couples.

1. One good among many

To start, I suggest that having a child of one's own is best characterised as one project that can make for a valuable or meaningful life among many including, say, careers, intimate relationships, or religious practices. So too, there are a diversity of conceptions of the good among citizens and, hence, ideas about what forms part of a good life. So, while for one individual what makes life goes well might be having a rewarding job, for another it may be raising a family or travelling to new places and for someone else, trips to the gym and meals with friends. In addition, not all lives with meaning or that go well must include raising children, let alone having children of one's own in the sense that fertility treatment permits. To deny this is to deny that those who choose to remain childless or who adopt instead of going though fertility treatment can lead good and meaningful lives.

As such, I propose that fertility treatment is one among many goods that states could provide to enable citizens to pursue their diverse valuable life projects or have access to activities that make their life go well or seem meaningful. States may sometimes provide funding for the activities that we value, for instance, helping citizens to own their own home or providing access to green places for leisure activities. However, since resources are limited, states cannot provide any and every good that might enable each particular life project.[7] Choices have to be made.

Thus, this article's argument is that if – and only in so far as – states should directly fund citizens' life projects, then fertility treatment has to compete for limited resources with the funding of other valuable life projects. As this article will defend, it is unjustifiable for a state to provide fertility treatment more generously than it funds other valuable life projects, in both the quantity of funding and the lack of means testing.

Yet, at present, many countries are disproportionately generous in their funding of fertility treatment, as compared to the other goods that might make one's life go well or enable valuable life projects. To illustrate, consider the following UK-based examples. IVF is not means tested in its distribution as are other similar goods, like grants for higher education. So too, is it justifiable that a 40-year-old woman is funded to have a chance at having a child, but housing benefit is limited such that those under 35 cannot live in a flat of their own and unemployment benefit restricted so those on it are not permitted to holiday abroad? Alternatively, why is fertility treatment funded but not undergraduate or master's degrees that might provide a better choice of careers? Indeed, the cost of a master's degree is fairly similar to the cost of a couple of IVF cycles.[8] Or, why fund a chance at having a child of one's own, but not the goods that might enable the formation of other kinds of valuable intimate relationships, such as dating websites?

So, *if* one holds that states should fund valuable life projects, then I suggest that the conclusion of this article is that funding for fertility treatment should be reduced.[9] The

alternative would be to fund each and every good that would enable citizens to pursue their myriad particular life projects more generously, so that their funding is akin to that for fertility treatment. However, given resource constraints, a far more likely outcome is a reduction in the generosity of fertility treatment funding, at least from the levels of many European countries.

In contrast, however, *if* one holds that states should not directly fund life projects, then fertility treatment should not be state funded. It is beyond this article's scope to defend the claim that a state should so fund life projects; indeed, later I suggest reasons for scepticism about state funding of intimate relationships in particular. Instead, my argument is that the appeal to valuable life projects is the best available justification for funding fertility treatment, but even it does not justify the current comparative generosity of state funding, of providing generous non-means tested funding of fertility treatment and not other goods that would also promote valuable lives. To make this argument, the rest of the article considers and rejects three sets of reasons to give fertility treatment privileged or special status in comparison to other goods that promote valuable life projects or activities: reasons that would justify funding for many seeking fertility treatment that would not apply to funding for the pursuit of a myriad of other life goals.[10]

2. But it's a disease

First, I consider perhaps the most obvious grounds for privileged access to funding: that infertility is a disease and, hence, in so far as states should pay for citizens' healthcare, fertility treatment should be funded as just one dimension of that care. Indeed, healthcare is often regarded as a good states should provide.[11] Something like this justification is prevalent among those defending funding fertility treatment; for instance, McMillan claims that fertility treatment meets a medical need and, within debates over its precise allocation, fertility treatment is often treated as one more element of healthcare.[12] However, I now argue that an appeal to disease forms a poor justification for funding fertility treatment: infertility fails to count as a disease in the relevant sense needed to justify funding and the resulting pattern of distribution from this justification is anyway undesirable.

When allocating fertility treatment, infertility is commonly defined as not conceiving a child after one, or sometimes two, years of regular unprotected heterosexual intercourse.[13] To examine whether infertility is a disease so defined, I begin with the biostatistical model where disease is defined as an adverse departure from normal species functioning, and so a deviation from what is statistically normal given one's age and sex.[14] On this view, infertility is a disease where an individual falls short of the statistical norm in time to conception, given their age and sex. Daniels uses this model of disease when justifying healthcare funding where, and on the grounds that, it helps secure to equality of opportunity, which McMillan applies to fertility treatment in particular.[15]

However, for many seeking fertility treatment, being unable to conceive for a year may not be a clear failure of normal functioning. Fertility declines with age, yet the average age of a woman seeking IVF on the NHS is 35 and one third of those who receive treatment are over 37.[16] Treating the common effects of ageing is not to restore normal functioning: it is normal, statistically-speaking, for ageing to lead to a loss of certain capabilities. Nor do single women refraining from having unprotected sex or same-sex couples suffer a failure of normal functioning in failing to conceive in a twelve month period. As such, it is doubtful that some claim of statistical normality will succeed in showing that fertility treatment always, or even tends to, treat a disease understood as a failure in normal species functioning.

One might object that some seeking fertility treatment clearly do suffer a failure of normal functioning; for instance, a couple in their twenties or a woman with blocked fallopian tubes. However, that does not show that 'it is a disease' succeeds as a justification for most cases;

instead, those suffering a genuine failure in normal species functioning may be the outliers. Justifying the current provision of fertility treatment requires a more wide-reaching defence.

Yet, it might be further objected that the common definition of infertility is merely a rule of thumb, indicating when it is medically sensible to intervene in the normal processes of reproduction, rather than an account of disease. But, one might continue, infertility remains a disease. The majority of those seeking fertility treatment would probably conceive after some, perhaps longer, period of time.

However, regardless of whether infertility could be seen as, in general, a failure of normal functioning, a second and more serious problem arises in taking that failure to justify the funding of fertility treatment. It matters that infertility can be defined as an *adverse* departure from normal functioning in a relevant sense to justify funding treatment. Not just any statistical abnormality can count, otherwise we end up with morally reprehensible conclusions where we should fund treatment for things like homosexuality, as it is not the statistical norm.[17] Furthermore, lack of reproductive success cannot itself suffice to make for an adverse departure: we would not want to conclude that those preferring same-sex partners have a disease, given the reproductive failure resulting from their statistically unusual sexual preference, let alone that it should be treated. So, there must be some role for value somewhere on the way from labelling something a disease to holding that diseases should be treated, especially where the state provides that treatment. Further, it would not suffice to claim, inspired by Daniels, that we would only treat those diseases that undermine equal opportunity: there is reason to be troubled by calling homosexuality a disease, even if not one to be treated.

Some draw the strong conclusion that one cannot rely on a biological model of disease, instead proposing a value-laden model, where our values alone define disease. Others hold that one can have a biostatistical model but add a notion of adverse functioning that discriminates in the right way.[18] Either way, however, there are particular problems with regarding infertility as a disease to be treated by state-funded healthcare: if infertility is a form of adverse functioning, it is not one that is adverse in the right way to justify funding.[19]

Many physical diseases clearly count as adverse states of affairs given they cause, or increase the risk of, physical pain, limited mobility, or decreased life span. Infertility, itself, does not have any such consequences.[20] However, infertility does share with many diseases the feature of causing suffering. For some, the desire to have children is deep-rooted, and those unable to conceive may suffer psychological turmoil. At first glance, that it causes suffering might seem to show infertility is an adverse state of affairs in the salient respect to count as a disease to treat. Yet, in response, first, fertility treatment is not always a good cure for the turmoil or psychological distress facing those who wish to conceive but cannot. It is often ineffective, and so fails to alleviate distress. Indeed, since repeated failures may heighten distress it may be that the more generous the state provision of fertility treatment, the greater the suffering caused, given the psychological stress of undergoing treatment, even aside from its physical risks.

Second, one should ask whether the way in which failing to conceive causes psychological distress grounds a claim to funded medical intervention. Note here that the distress from lacking a child is not akin to that caused by some mental illnesses. Instead, the frustration of any valuable life project may cause distress. Yet that frustration and distress is not generally reason to treat medically, even where we can: a person too short to join the police is not, by virtue of their deep rooted commitment to having that job, entitled to funding for leg-lengthening operations. The worry is that we are beginning to lose touch with what made health seemingly a special category, with privileged claim to funding. Too many other life projects may cause distress if thwarted and could be alleviated by medical intervention.

The same argument applies if one broadens the notion of adverse functioning to include those physical features limiting choices or opportunities, or that lead to disadvantage or perceived disadvantage. An array of medical treatments could be offered to those failing to achieve what they desire: boob jobs for those wanting to be glamour models, Modafinil or Ritalin for those without ADHD but who want to do better in their education, and so on. The argument here is not merely that there might be some slippery slope to funding too many medical interventions; rather, the claimed 'specialness' of health, which grounds its privileged access to funding, is undermined through incorporating all such thwarted desires. Further, again, the desire to have a child does not seem special, in terms of entitlement to funding, as compared to other goods. The normal functioning part of McMillan's or Daniels' argument, then, turns out to be central after all, if we want to say healthcare has special claim to funding.

However, there is one exception to the arguments above. Compassion and a desire to alleviate distress may motivate us to provide fertility treatment to those suffer a terrible illness rendering them infertile, whether directly or through treatment; this might, for instance, include some cancer sufferers. There are two possible motivations here: that this is all we can do to alleviate the special awfulness of their situation, or that we should correct for damage caused by medical intervention and so provide funding where infertility is a side-effect of treatment.[21] Funding fertility treatment in these cases may have an equivalent justification to breast reconstruction after a preventative mastectomy or to funding wigs for those suffering hair loss from chemotherapy. However, the standard case of the infertile couple does not create a demand for compassion of the same kind and this article seeks a general justification of fertility treatment. Frustration in having one's own child is not the kind of thing that grounds a claim to special treatment on the grounds of the rare awfulness of one's situation: it is just like any other frustration of a life goal.

At the least, the arguments thus far show that fertility treatment is not easily seen as one straightforward instance of a more general justification of state funded healthcare: on a biostatistical model, infertility may not count as a disease for the majority seeking fertility treatment and, regardless, infertility is unlike other physical diseases in causing psychological distress rather than having consequences such as physical pain, likelihood of limited life or diminished mobility. Further, as one final problem, justifying fertility treatment on the grounds of an appeal to disease might result in an unattractive pattern of distribution.

With adverse functioning as part of our definition of disease, those with clear underlying causes for infertility, such as blocked fallopian tubes, may have greater entitlement to treatment than those for whom the causes of infertility is unclear. This issue is especially likely at an age where conception is less probable, although still possible: on the adverse functioning account, the woman with a clear deviation from normal functioning with blocked tubes would have a claim to immediate treatment, whereas perhaps we would make the woman who is infertile for unknown reasons wait an amount of time deemed statistically normal for her age. Yet, there is reason not to discriminate between the two groups: the distress caused may be much the same, given both are frustrated in their pursuit of a valuable life project. So too, for those who focus on suffering rather than functioning to determine whether to treat or what is a disease, the differing degree of distress among individuals might lead one to conclude that the more emotionally perturbed the individual, the more 'diseased' they are, and so the more deserving of treatment.

The rest of the article turns to consider two further justifications of funding fertility treatment over other goods that might enable people to pursue valuable life projects. Before doing so, however, I briefly consider whether an argument from appeal to disability succeeds to any greater extent than a disease-based one. Following the WHO, one might hold that infertility is a disability, understood as an impairment with social consequences. States might then fund fertility treatment to alleviate the social consequences of the disability, just as they might fund

wheelchairs for those unable to walk. However, on this medical model of disability as an impairment in normal functioning, parallel arguments apply to those above regarding disease.[22] Again, then, does infertility constitute a lack of normal functioning for most seeking treatment? If so, is it a failure in the relevant respect to ground a demand a claim for medical treatment or akin to other frustrations in our various different life projects?

However, a social model of disability raises some interesting questions. On this model, a disability is best understood as a product of how society is structured. Indeed, at least some infertility is a direct result of society's structure: for instance, for those women who delay having children owing to the career structure that they face, then struggle to conceive. Likewise, it may be because we structure society around raising children in a nuclear family that lacking a child of one's own is an important form of disadvantage that deprives people of a crucial kind of relationship. But we have a choice: change society or the individual. Hence, on a social model an appeal to disability does not show that we should intervene medically rather than by tackling social structures. Further, section 4 argues that, for most instances of infertility, there is reason to change society instead. First, however, I address whether there is something special for individuals about having a child of one's own.

3. The uniqueness of parenting?

Some might hold that having one's own child is somehow different from other activities that could give our lives meaning or contribute to our wellbeing. On the grounds of this uniqueness, one might argue that fertility treatment deserves privileged access to funding. However, in the arguments to follow, I defend the comparison of having one's own child to other projects that might make life go well by rejecting two arguments that parenting is different: an appeal to a right to parent and to what the majority want.

I begin by asking whether individuals have a right to become parents, and a right of a kind that creates a claim for assistance from society. Here, one cannot just appeal to the human right to marry and found a family found in the UN declaration. As Warnock has observed, this is a right not to be debarred from forming a family, not a right to assistance.[23] To support this, consider that – barring a handful of political philosophers – few think a state must fund people's attempts to find a marital partner, let alone that this is a human right. At any rate, appealing to human rights does nothing to address the more basic question of what grounds the right. Here, I turn to address that more basic question. Note, however, that my argument is limited to the right to assistance with having one's own child: there are a whole cluster of reasons unaffected by my arguments that could ground both a right to parent one's existing children and to reproductive autonomy in choosing whether to try to concieve or whether to terminate a pregnancy.

So, first, one might offer a very strong grounds of the right by claiming that having a child of one's own is a basic need: either as a biological imperative or an essential component of human flourishing. Yet, according to the ONS, in 2011, one in five women aged 45 had never given birth, and there are good reasons to refrain from claiming that these women, some of whom will be childless out of choice, fail to have their basic needs met or are unable to flourish.[24] First, such a claim looks implausible: there is limited and inconclusive evidence on whether whether children increase overall life satisfaction or happiness.[25] For some, at least, a life devoted to rearing children is unrewarding: consider the description of valium as 'mother's little helper'. Second, to make such a claim would be disrespectful of the life choices of others. That sort of disrespect is particularly inappropriate from states: a state should not disrespect the choice to remain childless or adopt. In addition, against a background of gender inequality and a long history of reducing women to their biological functions, we should be especially wary of the claims of a biological imperative or basic need to have children, or of its unique importance for a valuable life.[26]

It might be objected that nonetheless a variant of the above defence succeeds: for those who want a child, it is essential for their flourishing or even a basic need that they are able to have a child.[27] However, again this claim is untrue. While it may be a serious setback in one's life plans to be unable to conceive and yet wish to, some succeed in flourishing regardless. So too, this line of defence would not succeed in showing that having a child is special among life projects: the frustration of any life plan to which we are deeply committed may be a setback to our flourishing. Again, my goal is to deny that fertility treatment should have special funding status, over and above other life projects.

As an alternative grounds, however, one might argue that while having a child of one's own is not a basic need it still has special importance. To do so, one might appeal to existing defences of the right to parent one's own child and consider if they extend to a right to become a parent. Some such accounts are irrelevant for my purposes here. 'Child-centred' accounts, grounding the right to parent on the interests of the child in being raised by their biological parents, cannot apply to possible future children like those who are the desired result of fertility treatment.[28] Attempting to extend such accounts to not yet existing children is liable to create serious issues with the non-identity problem, and perhaps some variant of the repugnant conclusion.[29] To talk of benefits to not yet existing children, if even coherent given there is no existing entity who benefits, might imply that all have a duty to have as many children as possible to bring about these benefits.

A 'parent-centred' approach appears, at first glance, more promising.[30] Indeed, Jurgen DeWispelaere and Daniel Weinstock appeal to Harry Brighouse and Adam Swift's defence of the specialness of the parent-child relationship to claim that states have an obligation to promote the 'fundamental right' to parent, and so to facilitate it through either fertility treatment or adoption.[31] On this view, having a child makes a distinctive contribution to wellbeing and flourishing owing to the unique moral quality of the parent-child relationship. Children are vulnerable and dependent, lack the ability to exit, are initially trusting and unconditionally loving. As a result, parents have special responsibility for the child's immediate wellbeing and future development. Parenting, Brighouse and Swift claim, thus enables people to develop and exercise capacities that contribute, for many, to living 'fully flourishing lives'.[32]

Having children, then, is taken to be unique: it is not interchangeable with, nor substitutable by, other forms of intimate relationship.[33] Brighouse and Swift do allow, however, that people can flourish without children. So, is this sense of the uniqueness of the relationship enough to ground a right to assistance to become a parent? While DeWispelaere and Weinstock argue that the availability of adoptive children may limit provision of fertility treatment, here I question the uniqueness of having a child of one's own, whether through adoption or fertility treatment.

For each feature claimed to make the parent-child relationship unique, other intimate or caring relationships exist which share that feature. One could also find these features in a collection of separate relationships. So, one might care for an elderly relative with dementia, where there might be limited reciprocity in the relationship and one was responsible for the vulnerable relative's wellbeing. Alternatively, one might care for a pet dog with no ability to exit, and where the trust of that pet was spontaneous. So too, friendships and other adult intimate relationships may share features of the parental relationship, albeit more fleetingly: we can help those close to us with future plans, care for them when they are vulnerable and so on.

Furthermore, one can have important and valuable relationships with children who are not one's own. Responsibilities for a child's future development and current wellbeing might be shared with godparents, child minders, teachers or relatives. One might develop and exercise very similar capacities in these roles to those involved in parenting. As such, it is

doubtful that parent-child relationships are non-substitutable: some combination of the various other important caring relationships that form part of a life may suffice. To argue for uniqueness of parent-child relations is to undervalue or overlook the diversity and depth of people's connections to one another outside of that particular relationship.

Yet it might be objected that something remains unique in the extensiveness of a parent's control and responsibility over a child, as compared to other intimate relationships with adults or with children not one's own. Alternatively, one might claim that the specialness of the parent-child relationship cannot be broken down into separate components, but is somehow an emergent property of relationships bearing all the salient features. However, that does not show that states should fund the chance of having this particular kind of relationship over and above other forms of intimate relationship, even supposing that states should be funding relationships. One could argue that all intimate relationships are, in their own way, unique. In addition, to insist that the degree of control that parents in a nuclear family have over children is special, and to deny the importance of relationships with other adults for a child, is to privilege a very historically and socially particular form of intimate relationship.

Further, even if there is some unique quality to the parent-child relationship, that does not show that it is special as compared to other valuable life projects, such that it should have privileged access to funding as at present. All manner of intimate relationships aside from having a child of one's own through fertility treatment may make distinctive contributions to wellbeing and flourishing. As might all manner of other life projects. Furthermore, a problem with treating having children as akin to other life projects may even be highlighted through considering providing fertility treatment as an extension to parental rights. One possible defence of parental rights is that states should not interfere in valuable intimate relationships, unless the relationships involve abuse and neglect. As such, the state's main duty may be a negative one of leaving space for such relationships, rather than interfering in them or privileging one form over another as in funding fertility treatment. Fertility treatment, then, may be unlike the other goods that enable valuable life projects.

Here, however, one might object that there is still a plausible ground to think parenting special: that the majority desire to become parents. Burley offers something like this argument, claiming that behind a veil of ignorance, 'the average individual would deem having genetically related offspring a constitutive element of leading a good life'.[34] Appealing to Dworkin's hypothetical insurance market, she argues that we would choose to insure against being infertile, and as such there is reason to fund fertility treatment.[35] That the majority have children and think it constitutes part of a good life to the extent they would insure against its absence, suffices to make infertility different to other barriers to life projects. One might further argue that having children makes a larger contribution to the welfare of most people than other goods or life projects.

Yet, first, having one's own child is not made unique among life projects merely by being widespread: a desire for intimate romantic relationships or a rewarding career are also widespread and, in the UK, so is owning one's own house. Second, the empirical basis for the claim that having children contributes more to welfare than other projects or goods is dubious at best. Some evidence suggests that having children leads to a drop in overall life satisfaction, recovered only when the child leaves home.[36]

Regardless, however, one might insist that if the majority desire a particular good then it would be undemocratic for a state not to provide it. In reply, this would disadvantage those who have less popular life projects: if – and only if – a state should fund valuable life projects, it should do so evenly in giving individuals equivalent levels of funding for their life projects. In addition, in the context of feminist concerns about the construction of female identity around motherhood and fertility treatment as reinforcing that, mentioned earlier, we may be especially concerned if states disproportionately fund this one good.

So, at best, fertility treatment should only be funded if and in so far as we also fund other valuable life projects. Desiring to have one's own child is but one particular conception of a component of a good life among others and not one which has special claim to assistance grounded on an appeal to health, rights, or the majority. However, I now consider one final set of objections to my argument against the privileged funding status of fertility treatment: that a society has reason to provide such treatment aside from its value to the individual or couple.

4. Children are good for society

One might argue that having children is a social good, given that having future citizens ensures state stability and the continued funding of goods like pensions.[37] However, the good of having children is met by a society producing a sufficient number of future citizens through reproduction or admitting migrants to make up for any shortfall. It is not necessary that all have children and not is having one extra child obviously a social good. Indeed, given the cost to society and the environment of having a child one may think there are good reasons not to have too many children born to a population, such that refraining itself may be a social good. So, funding fertility treatment is not good for society on the grounds that it ensures state stability – unless a population is in severe decline without it.

However, one might object that any child is an overall benefit to society, given the child's likely future contributions, such that funding fertility treatment pays for itself. Yet, while making this calculation is tricky, two factors make its success improbable.[38] First, to raise a child is costly, even without IVF. Second, it tends to be cheaper for societies to allow adult migrants in rather than raise a child from scratch.

A different line of defence argues that fertility treatment has a claim to funding as it promotes equality: surely all should be able to have children and not only the rich or those with the brute luck to be fertile. Yet that does not show that fertility treatment is different to the other goods that enable the pursuit of valuable life projects. Indeed, it may be desirable to decrease inequality or the effects of bad brute luck and ensure that all can lead valuable and meaningful lives, but that is no argument that children are unique and fertility treatment should receive its current, uneven level of funding. Furthermore, in a more equal society we may have even less reason to fund fertility treatment: citizens would be able to afford to pay for it themselves, if they desire it.

Another variant of the inequality argument, however, holds that fertility treatment is special as it corrects for a particular inequality. In many professions, women's most fertile period coincides with the crucial period for becoming established in a career. As a result, many women delay childbearing then suffer consequences in struggling to conceive. So, one might argue that women face a structural injustice that could be mitigated through provision of fertility treatment in their middle-age.

Yet we have two options when faced with a structural injustice: we can change the individual or the structure. To provide fertility treatment in this case is to make a structural problem into a problem with the individual, who is deemed infertile and so poorly functioning. Providing a not very good chance at conceiving through medical intervention does nothing to undermine structural injustice. It might be objected that we should still provide fertility treatment to women currently adversely affected by structural injustice as an interim solution, although in the long term we should change the structure. However, funding fertility treatment may even support the injustice, since it is liable to reduce pressure for change: that women cannot have children easily at a stage convenient for employers becomes a medical issue. Further, against fears that refusing funding for fertility treatment sacrifices current women for the sake of future gains, giving women a poor chance at having a child later on is an inadequate form of compensation.

Nonetheless, there is an exception here, of funding assisted reproduction for same-sex couples. State support for heterosexual couples and for the traditional nuclear family, such as limits on access to marriage and tax breaks for families, may be forms of structural injustice that have made it harder for same-sex couples to form their desired kinds of family unit. So too, life choices are made harder by the prevalent notion that the heterosexual nuclear family is the ideal place to raise children, which restricts access to caring relations with children. However, in contrast to the case of women in general, here fertility treatment might act to undermine the structural injustice.[39] Fertility treatment might challenge the normal construction of the family through creating new forms of family. Further, fertility treatment in this case may well be a social good, in supporting a diversity in ways of life with these varied forms of the family.[40] In contrast, fertility treatment for heterosexual couples further reinforces the very same ideal of the traditional, heterosexual, nuclear family.

All the same, the above gives but one consideration in favour of funding fertility treatment for same-sex couples. It may be that the possibility of adoption is enough to create diverse forms of family life and to challenge injustice. But it may also be that more is required of a state to respond to injustice – and fertility treatment is one plausible part of that response.[41] Indeed, fertility treatment may present a greater challenge to traditional constructions of the traditional nuclear family than adoption does, in challenging ideas about who can have children and not only who can rear them.[42]

However, one might object that such funding would still act to support the nuclear family ideal, of two parents plus children, even if it would encourage greater flexibility in who can be parents.[43] One might even take such an idea further, and make the case for funding fertility treatment for single persons who desire children, to alleviate the structural injustices associated with the nuclear family. In response, however, one would have to weigh the respective injustices of supporting the notion of a nuclear, if not traditional, family against that of excluding those who desire same-sex partners from such a notion of the family. I suspect that the injustice of the latter would be greater than the former. So too, I suggest that the argument for funding fertility treatment for single persons is weaker than that for same-sex couples, owing to the great number of existing single parent households. Partly as a result, the injustices facing such single parent households, while considerable, are most likely better solved through means other than that of creating more such households; for instance, by undermining social stigma and alleviating poverty.

5. Conclusion: The distribution of fertility treatment

To conclude, states have greater reason to provide fertility treatment for same-sex couples than for heterosexual couples who, I have argued, have no special claim to this good over and above other goods that promote valuable life goals. This article does not suggest that individuals do anything wrong in using IVF if a state offers it, but instead presents a challenge to current funding priorities. Further, it suggests a limit to the extensiveness of the right to parent one's children: it is not a right to assistance to have a child. To close, I reflect on the scope of these conclusions.

While this article focuses on current, non-ideal societies, one might claim that in an ideal society everyone would have access to fertility treatment and every other good that makes life go well. Yet even in ideal societies, resources will be limited, and so it still matters that we get clear on whether fertility treatment is a good that should be provided as part of healthcare, or something to which we have a right, or one good that can make a life go well. Answering that question will have implications for a range of much debated issues. So, to illustrate, on a valuable projects approach – assuming we fund life projects – then there is no reason internal to the justification of funding that factor such as age and existing children should matter when distributing fertility treatment. As such, settling the question of what justifies fertility treatment promises to shape how the good should be distributed.

Notes

[1] I would like to thank Liam Shields, Stephen John, Chris Nathan, and two anonymous referees for this journal for their detailed comments on versions of this article. I am also grateful for the helpful comments of audiences at the Politics Department, University of Essex; MANCEPT seminar series, University of Manchester; Society for Applied Philosophy Annual Conference; V Meetings in Ethics and Political Philosophy, University of Minho, Portugal.

[2] Statistics from the Human Fertilisation and Embryology Authority, 2010, available at http://www.hfea.gov.uk/ivf-figures-2006.html#1276.

[3] E.g. Julian Savulescu, 'Procreative beneficence: Why we should select the best children', *Bioethics,* 15, 5- 6 (2001): 413-426; Kyle W. Anstey, 'Are attempts to have impaired children justifiable?', *Journal of Medical Ethics*, 28,5 (2002): 286-288.

[4] E.g. Drew Carter, Amber Watt, Annette Braunack Mayer, Adam Elshaug, John Moss, Janet Hiller, 'Should there be a female age limit on public funding for assisted reproductive technology?', *Journal of Bioethical Inquiry*, 10, 1 (2013): 79–91; Bart Chwalisz, Enda McVeigh, Tony Hope, and Stephen Kennedy,'Prioritizing IVF patients according to the number of existing children—a proposed refinement to the current guideline', *Human Reproduction* 21, 5 (2006): 1110-1112; Richard E. Ashcroft, 'Fair rationing is essentially local: An argument for postcode prescribing', *Health Care Analysis,* 14 (2006): 135-144.

[5] J. R. McMillan, 'NICE, the draft fertility guideline and dodging the big question', *Journal of Medical Ethics*, 29, 6 (2003): 313-314.

[6] For examples of defenders see: Justine Burley, 'The price of eggs: Who should bear the costs of fertility treatment?', in John Harris and Søren Holm (eds.) *The Future of Human Reproductions: Ethics, Choice, and Regulation* (Oxford University Press, 1998), pp.127-149; Jurgen DeWispeleare and Daniel Weinstock 'State regulation and assisted reproduction: Balancing the interests of parents and children' in *Family Making: Contemporary Ethical Challenges* eds. Françoise Baylis and Carolyn McLeod, (Oxford University Press, forthcoming); Josephine Johnston and Michael K. Gusmano, 'Why we should all pay for fertility treatment: An argument from ethics and policy', *Hastings Center Report*, 43, 2 (2013): 18-21; John McMillan, 'Allocating fertility services by medical need', *Human Fertility*, 4, 1 (2001): 11-13; Mary Warnock, *Making Babies: Is there a right to have children?* (Oxford University Press, 2002). However, some express doubts, e.g. Philipa Mladovsky and Corinna Sorenson, 'Public financing of IVF: A review of policy rationales', *Health Care*

Analysis, 18, 2 (2010): 113-128. For feminist concerns see, for instance, Margret Brazier 'Reproductive rights: Feminism or patriarchy?' from the *The Future of Human Reproductions: Ethics, Choice, and Regulation*, pp.66-76.

[7] Here, the claim is not that promoting access to valuable life projects is the only or actual reason to provide goods like access to parks but, instead, that this is one possible justification of funding and one which could apply to fertility treatment.

[8] The estimated costs of IVF vary significantly, for two discussions see Mladovsky and Sorenson, 'Public financing of IVF: A review of policy rationales'; Anna Smajdor, 'State-funded IVF will make us rich… or will it?' *Journal of Medical Ethics*, 33, 8 (2007): 468-469.

[9] Some welfare egalitarians, for instance, might propose that states fund life projects directly.

[10] Henceforth, by 'privileged' or 'special' claim to funding, I mean reasons to think that a state has particular reason to fund fertility treatment more generously (in terms of amount or lack of means testing) than the various other goods that might enable citizens' various life projects.

[11] For justifications of this, see, for instance, Norman Daniels, *Just Health Care* (Cambridge University Press, 1985); Allen E. Buchanan, 'The right to a decent minimum of health care', *Philosophy & Public Affairs*, 13, 1 (1984): 55-78. On these accounts, fertility treatment could be justified if it treats a disease, and so improves functioning, or meets a medical need.

[12] McMillan, 'Allocating fertility services by medical need'; for examples of the latter, see debates over the 'postcode lottery', e.g. Richard E. Ashcroft, 'In vitro fertilisation for all?: The question is for local purchasers to answer, not for NICE', *BMJ: British Medical Journal* 327, 7414 (2003): 511.

[13] For instance, the WHO and HFEA use this definition: to illustrate, see http://www.who.int/reproductivehealth/topics/infertility/definitions/en/.

[14] Christopher Boorse, 'Health as a theoretical concept', *Philosophy of Science* (1977): 542-573. Note that while this account has many problems, these are not problems for this article: my arguments do not depend on this being a successful account of disease in general or not – regardless, it fails for fertility treatment.

[15] Daniels, *Just Health Care*; McMillan, 'Allocating fertility services by medical need'.

[16] Statistics from the Human Fertilisation and Embryology Authority, 2010, available at http://www.hfea.gov.uk/ivf-figures-2006.html#1276. Note, it is disputed at what age fertility declines.

[17] For a discussion of homosexuality see, Elselijn Kingma, 'What is it to be healthy?', *Analysis*, 67, 2 (2007): 128-133, at pp. 132-133.

[18] For a discussion of value-laden versus value-free accounts, see Lennart Nordenfelt, 'The concepts of health and illness revisited', *Medicine, Health Care and Philosophy*, 10, 1 (2007): 5-10.

[19] It may be that some of the arguments to follow could apply to other cases such as minor injuries that cause no pain, limited life or diminished mobility, although this is beyond the scope of the article.

[20] Here, I avoid discussing mental illnesses which may well be differently defined, on the grounds that infertility most likely counts as a physical condition.

[21] With thanks to Bob Goodin for the latter suggestion.

[22] For an examination of social and biological models, see Lorella Terzi, 'The social model of disability: A philosophical critique', *Journal of Applied Philosophy*, 21, 2 (2004): 141-157.

[23] Warnock *Making Babies*, pp. 28-29.

[24] Office for National Statistics, UK, 'Cohort fertility, England and Wales 2011' (2011). Available at http://www.ons.gov.uk/ons/rel/fertility-analysis/cohort-fertility--england-and-wales/2011/cohort-fertility-2011.html.

[25] For limited and somewhat weak evidence in favour of improved satisfaction, see, for example, Angus Deaton and Arthur A. Stone, 'Evaluative and hedonic wellbeing among those with and without children at home', *Proceedings of the National Academy of Sciences* 111, 4 (2014): 1328–33; Katherine S. Nelson, Kostadin Kushlev, Tammy English, Elizabeth W. Dunn, and Sonja Lyubomirsky. "In defense of parenthood: Children are associated with more joy than misery." *Psychological Science*, 24, 1 (2013): 3–10, but see also their 'Parents are slightly happier than nonparents, but causality still cannot be inferred: A reply to Bhargava, Kassam, and Loewenstein' *Psychological Science* 25, 1 (2014). For evidence against, see Luca Stanca, 'Suffer the little children: Measuring the effects of parenthood on well-being worldwide' *Journal of Economic Behavior & Organization* 81, 3 (2012): 742–50. For this article's purposes, I need not define wellbeing precisely: for those with some subjective or self-report element in their definition, the studies listed here should be of interest. For those without such a subjective element to their account of wellbeing, the second objection above suggests that children should not be included on a state's objective list.

[26] For more detailed analysis, see for instance Margret Brazier 'Reproductive rights: Feminism or patriarchy?'; Mary Anne Warren, 'IVF and women's interests: An analysis of feminist concerns.' *Bioethics* 2, 1 (1988): 37–

57. For another critical discussion of the basic needs approach, see Vida Panitch, 'Assisted reproduction and distributive justice.' *Bioethics* (2013), doi: 10.1111/bioe.12067, at pp.5-6.

[27] With thanks to Paul Bou-Habib for suggesting this criticism.

[28] For the contrast of child centred and parent centred, see Harry Brighouse and Adam Swift, 'Parents' rights and the value of the family', *Ethics*, 117, 1 (2006): 80-108.

[29] For these problems, see Derek Parfit, *Reasons and Persons* (Oxford University Press, 1984).

[30] Although not all are relevant here: for instance, Anca Gheras' account based on the experience of pregnany does not apply to not-yet-parents, in 'The right to parent one's biological baby', *Journal of Political Philosophy*, 20, 4 (2012): 432-455.

[31] De Wispelaere and Weinstock 'State regulation and assisted reproduction'; Brighouse and Swift, 'Parents' rights and the value of the family'.

[32] 'Parents' rights and the value of the family', at p. 95.

[33] *Ibid*., at p. 92.

[34] Burley, 'The price of eggs', p. 142.

[35] For another insurance argument, see Panitch, 'Assisted reproduction and distributive justice', pp. 7-10. Again, however, I suggest that on her justification fertility treatment is akin to other goods that promote valuable life projects.

[36] See footnote 25.

[37] This good has one feature of a public good: state stability bears the feature of non-excludability.

[38] For one attempt at the calculation see for instance Smajdor 'State-funded IVF will make us rich… or will it?'.

[39] Here, one might worry that singling out this group for treatment would disadvantage its members. If so, there would be reason against doing so, given the aim is to reduce disadvantage.

[40] A parallel argument might also be made in racist societies that have forbidden marriage between different races or ethnic groups, or where those in such marriages face discrimination of a structural kind that might be overcome by fertility treatment.

[41] As one further caveat, beyond the scope of this article to explore, some forms of fertility treatment may well be otherwise problematic, such as surrogacy.

[42] With thanks to an anonymous referee for suggesting this last point.

[43] With thanks to another anonymous referee for suggesting this objection.