Who Gets Access to Fertility Treatment? Reimbursement and Equity in Europe

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Abstract

Access to assisted reproductive technologies (ART), including IVF and intracytoplasmic sperm injection, depends partly on national funding rules. In Switzerland, mandatory health insurance reimburses intrauterine insemination under specified conditions but does not cover ART. Belgium and Denmark fund ART within defined age and eligibility limits. These differences leave patients with similar clinical needs facing different financial barriers.

The authors examine these policies alongside findings from the Swiss mixed-methods HoPE study on psychosocial and spiritual needs and wellbeing in fertility care. The survey identified emotional quality of life as an area of concern. Interviewees described uncertainty, emotionally difficult decisions, and the strain of fitting treatment into everyday life. Financial pressures added to these difficulties for some participants. The study was not designed to evaluate reimbursement or compare treatment sequences, so its findings provide context for the policy discussion rather than evidence of a funding effect.

The authors' discussion considers treatment effectiveness, age-related fertility decline, and the implications of oocyte donation. They argue for funding that gives patients access to clinically appropriate treatment within clear eligibility limits. Decisions about coverage need to account for prognosis and treatment burden, alongside the financial and other barriers patients face.

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Key Points

1. National funding rules create different financial barriers for patients with similar fertility treatment needs.

2. Funding should support clinically appropriate care, taking prognosis, treatment burden, and barriers to access into account.

3. Reimbursement reforms should be evaluated for their effects on equitable access, patient wellbeing, and long-term psychological outcomes.

INTRODUCTION

Around one in six people experience infertility worldwide. Recognised by the WHO as a disease of the reproductive system, it affects people across geographical regions and socioeconomic groups.[1] Yet receiving a diagnosis does not necessarily mean being able to afford treatment.

European countries differ in who can receive assisted reproductive technologies (ART) and how much treatment is publicly funded. Age limits and the number of covered cycles vary, and some systems also restrict eligibility according to relationship status, sexual orientation, or family constellation.[2] A clinical indication alone therefore does not determine access. Patients who are ineligible for funding must meet the costs themselves.

Access to state-of-the-art fertility treatment has been discussed as a possible indicator of healthcare and societal development.[3] In a survey across six European countries, the USA, and Australia, around 70% of respondents thought that IVF should be covered by health insurance.[3] Limited access to fertility care may contribute to socioeconomic inequalities.[4] Public funding can reduce financial barriers, although limited health literacy, stigma, discrimination, and difficulties accessing services may still prevent people from receiving care.[2,4]

In Switzerland, the difference between intrauterine insemination (IUI) and ART reimbursement is particularly relevant. Mandatory basic health insurance covers some diagnostic procedures and treatments, including IUI under specified conditions. Patients generally pay for ART themselves and may face substantial cumulative costs over several cycles.[5,6] The question is whether this distinction leaves some patients unable to pursue the treatment recommended for them.

The Swiss mixed-methods HoPE study investigated psychosocial and spiritual needs and wellbeing during infertility and fertility treatment.[7,8] Participants described emotional and practical difficulties, with financial strain adding to the burden for some. The authors consider these experiences alongside clinical evidence and European policy examples to discuss what reimbursement should cover and where its limits might lie. The study itself did not evaluate reimbursement policies.

CLINICAL EVIDENCE AND COST CONSIDERATIONS

For unexplained infertility, the European Society of Human Reproduction and Embryology (ESHRE) recommends IUI with ovarian stimulation as first-line treatment. Age, duration of infertility, and previous treatment should inform the decision to move to ART.[9] An individual participant data meta-analysis found no statistically significant difference in cumulative live birth rates between IVF and stimulated IUI in this population.[10] There is therefore no basis for assuming that IVF is always the preferable starting point.

The FASTT trial examined the next treatment step after unsuccessful clomiphene-IUI in couples with unexplained infertility. Skipping gonadotropin-IUI and proceeding to IVF shortened the time

to pregnancy and reduced the cost per pregnancy.[11] This finding applies to that particular sequence; it does not resolve the broader question of which initial treatment offers the best value.

Coverage may also affect decisions within ART treatment. A large USA study found an association between mandated IVF coverage, fewer embryos transferred, and lower multiple-pregnancy rates.[12] By reducing financial pressure, coverage may make elective single-embryo transfer more feasible. Reducing multiple pregnancies could in turn prevent perinatal complications and associated healthcare costs.[13]

REPRODUCTIVE AGE AND OOCYTE DONATION

Age-related fertility decline needs to be distinguished from infertility associated with endometriosis, tubal disease, or male factors, even when more than one cause is present. IVF cannot remove the effect of oocyte ageing. Counselling should therefore address the prognosis with a patient's own oocytes separately from the prospects offered by donated oocytes.[14,15]

Evidence in older patients also calls for attention to treatment sequence. In the FORT-T randomised trial, women aged 38–42 years with unexplained infertility had higher pregnancy rates with fewer cycles when they started with IVF rather than stimulated IUI.[16] This finding supports an age-sensitive choice of treatment. It does not establish that IUI is generally inappropriate or overused in Switzerland.

Whether public funding should extend to patients in their mid-forties is harder to resolve. Expected benefit must be weighed against treatment burden and the allocation of limited resources. Preliminary UK registry data for 2024 put the live birth rate at 8% per embryo transferred for patients aged 43–44 years using their own oocytes, across fresh and frozen transfers.[17] This figure excludes cycles that never reach transfer. Funding limits should reflect prognosis, and patients need clear information about how outcome figures apply to their own situation.

Oocyte donation offers a different prognosis when oocyte ageing or ovarian insufficiency limits the chance of pregnancy with a patient's own oocytes. Pregnancy risks associated with advancing maternal age remain.[15] Funding decisions must also account for donor protection and the interests of donor-conceived people. In Switzerland, the Federal Council has announced plans to permit oocyte donation through a revision of reproductive medicine legislation.[18] This is a proposed change, not a description of current legal access.

HOW REIMBURSEMENT SHAPES FERTILITY TREATMENT IN SWITZERLAND

Swiss mandatory basic health insurance reimburses up to three IUI cycles per pregnancy and excludes ART.[19] Hospital patient information also describes age-related restrictions on reimbursement.[20,21] These reflect reimbursement practice rather than a fixed age threshold in the national benefits schedule. For patients considering ART, the cost remains a separate constraint on what they can pursue.

Reimbursing IUI is consistent with its role as a first-line option for unexplained infertility.[9] A difficulty may arise when ART is clinically preferable but unaffordable, leaving IUI as the only funded option.

The consequences of delay deserve particular attention in advanced reproductive age, when treatment prospects are declining.[14] Prolonged unsuccessful treatment may also add to distress. Funding rules should leave room to move to ART when the clinical circumstances warrant it.

Belgium and Denmark offer useful comparisons. Belgium reimburses ART-related laboratory activities and medication for up to six cycles in eligible patients younger than 43 years old.[22] In Denmark, regional criteria require referral before the woman turns 40 years old and treatment to end before she turns 41 years old.[23] From 2026, publicly funded provision has expanded to up to six ART treatments for a second child, subject to

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clinical assessment.[24] Both countries fund treatment within defined limits, although neither provides a model that can simply be transferred to Switzerland.

In the European Atlas of Fertility Treatment Policies 2024, which rates legislation, funding, and patient perspectives, Switzerland appears in the low-rated dark-red category, at the opposite end of the scale from Belgium and Denmark.[2] The rating describes the policy environment, rather than the proportion of costs reimbursed or clinical success. The Atlas and European registry survey reflect policy at the time of their assessments;[2,25] the national sources above describe more recent arrangements. These comparisons do not isolate the contribution of funding to equitable access.

INSIGHTS FROM A MIXED-METHODS STUDY

HoPE began with a survey and then used its findings to develop the interview guide, following an explanatory sequential mixed-methods design.[7,8,26] For this paper, the survey provides measures of quality of life and wellbeing. The interviews add accounts of living through treatment, including difficulties that these measures alone cannot explain. The authors selected both components for this reason, while recognising that reimbursement was outside the study's original focus.

The quantitative component was an anonymous online survey conducted from October 2022–January 2023. The convenience sample comprised 326 women who were receiving fertility treatment or had received it within the previous 5 years. Recruitment used partner institutions, medical practices, associations, and social media. Validated instruments included Fertility Quality of Life (FertiQoL), WHO-5, and the Spiritual Needs Questionnaire (SpNQ). Analyses included descriptive statistics and exploratory subgroup comparisons using independent-samples t-tests or Mann–Whitney U tests, as appropriate.[8] Participants scored a mean of 46.35 out of 100 on the emotional FertiQoL subscale and 13.89 out of 25 on the WHO-5. Higher scores represent better emotional quality of life and psychological wellbeing, respectively.[8]

The published quantitative analysis found lower wellbeing among women without children than among those with children.[8] It does not establish whether an IUI-first sequence differs from direct ART in its psychosocial effects. The authors therefore use the survey findings to describe patients' wellbeing, without attributing differences to treatment sequence or reimbursement.

The qualitative component comprised 23 semi-structured interviews with 26 affected individuals, conducted between April–September 2023.[7] Survey respondents could volunteer by contacting the researcher, and recruitment also included word-of-mouth referrals. Quantitative findings informed the interview guide. Interviews were recorded, transcribed, and analysed thematically using deductive and inductive coding. Findings were discussed within the research team and advisory group. Although the published study also included professional focus groups, the accounts discussed here come from affected individuals.[7]

Interviewees described recurring hope and disappointment, uncertainty about treatment outcomes, and the demands of appointments and procedures.[7] These experiences concerned fertility care as a whole. They do not establish that IUI was more burdensome than ART, that particular treatments were inappropriate, or that ART should have started earlier.

Deciding whether to continue treatment was itself emotionally demanding. As one participant described: "It was such intense ups and downs; deciding whether to keep going or stop, weighing the pros and cons."[7]

Financial pressures were also reported. Some participants described severe financial strain that restricted spending on travel, leisure, and activities that might otherwise have provided relief from treatment-related stress.[7] These accounts show how treatment costs can affect daily life, but they do not establish whether

reimbursement influenced the choice or timing of a particular treatment.

The authors bring these findings into the reimbursement discussion at the stage of interpretation. The survey describes emotional quality of life and wellbeing, while the interviews give context through participants' accounts of treatment and financial strain. Together with external evidence, they inform questions about access without estimating a funding effect. Both samples were self-selected, and the experiences of people unable to access treatment may be underrepresented.

THE AUTHORS' PERSPECTIVE: REIMBURSEMENT, EQUITY, AND REPRODUCTIVE JUSTICE

The authors' concern is that clinical recommendations may be difficult to act on when patients cannot afford the proposed treatment. The HoPE findings document emotional and financial strain; the argument about how funding might affect treatment choices draws on the wider clinical and policy evidence. The authors support access to assessment and clinically appropriate care within defined limits. Such access gives patients a chance to pursue treatment; it cannot guarantee a child.

Reproductive justice asks whether people can make meaningful decisions about having children when social and economic inequalities restrict their options.[27] Treatment costs are one restriction among several. Language barriers, limited health literacy, stigma, discrimination, and mistrust of healthcare institutions can remain even in funded systems.[4] Improving access therefore also means examining how services reach and support people who may struggle to use them.

The authors favour reimbursement rules that allow clinicians and patients to choose appropriate care without avoidable financial obstacles.[2,4,28] The number of funded cycles and any age limits should be published, justified by evidence, and reviewed as evidence changes. Expected benefit and safety must remain part of individual decisions. Oocyte donation needs its own criteria because its prognosis differs from treatment using a patient's own oocytes, and donors and donor-conceived people have interests that require protection.[15]

CONCLUSION

The comparison with Belgium and Denmark shows that public funding can have clear boundaries. Switzerland could consider coverage for ART within defined limits based on age, prognosis, and clinical indication. The current exclusion leaves patients to bear substantial costs, including when ART is considered appropriate for them. One option would be to assess coverage for a defined number of clinically indicated ART cycles, with publicly available eligibility and review criteria. This could include direct access to ART when clinically justified, rather than routinely undergoing unsuccessful IUI attempts first. Discussions about expected outcomes, treatment burden, personal costs, and alternatives could help patients make informed decisions, particularly if these conversations are revisited as circumstances change.

Although Swiss law already requires that psychosocial support be offered, its clinical implementation should be further expanded to cover the entire fertility journey, from diagnosis through treatment to its conclusion, regardless of outcome. Any reform would offer an opportunity to evaluate its effects. National monitoring should be extended, including assessment of waiting times and differences in access across socioeconomic groups.

Patient-reported wellbeing and treatment burden could provide information beyond clinical outcomes. Patients and professional groups could also contribute to reviewing the criteria over time. Funding arrangements could leave room for individual clinical circumstances while maintaining clear limits. Where a clinically reasonable treatment remains unaffordable, it would be worth considering how this financial barrier affects the options available to patients.

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References

1. World Health Organization (WHO). Infertility prevalence estimates, 1990-2021. 2023. Available at: https://www.who.int/publications/i/item/978920068315. Last accessed: 15 August 2026.
2. Fertility Europe, European Parliamentary Forum for Sexual and Reproductive Rights (EPF). European atlas of fertility treatment policies 2024. 2024. Available at: https://fertilityeurope.eu/wp-content/uploads/2025/06/FERTIL-Atlas_EN-2024-no-month.pdf. Last accessed: 17 December 2025.
3. Quaas AM et al. The role of state-of-the-art IVF care as a marker of societal development. Hum Reprod. 2025;40(1):9-11.
4. Quaas AM, Manoj M. Infertility: still a largely uncovered and undertreated disease. J Assist Reprod Genet. 2021;38(5):1069-70.
5. Theile C, Klaiber A. Künstliche Befruchtun-diese Methoden sind erlaubt. Beobachter. 2025. Available at: https://www.beobachter.ch/gesellschaft/kunstliche-befruchtung-diese-methoden-sind-erlaubt-818132. Last accessed: 16 October 2026.
6. Brzykcy A et al. If only I knew: fertility policy and family planning in Switzerland. 2025. Available at: https://www.diversity-inclusion-platform.ch/if-only-i-knew-fertility-policy-and-family-planning-in-switzerland/. Last accessed: 25 September 2026.
7. Bernet M et al. "It's like having a second job": qualitative insights into the emotional burden of infertility and the need for coordinated care. J Psychosom Obstet Gynecol. 2025;46(1):2505589.
8. Bernet M et al. Quality of life, spiritual needs, and well-being of people affected by infertility and its treatment: quantitative results of a mixed-methods study. J Assist Reprod Genet. 2025;42(6):1853-62.
9. Romualdi D et al.; The Guideline Group on Unexplained Infertility. Evidence-based guideline: unexplained infertility. Hum Reprod. 2023;38(10):1881-90.
10. Lai S et al. IVF versus IUI with ovarian stimulation for unexplained infertility: a collaborative individual participant data meta-analysis. Hum Reprod Update. 2024;30(2):174-85.
11. Reindollar RH et al. A randomized clinical trial to evaluate optimal treatment for unexplained infertility: the fast track and standard treatment (FASTT) trial. Fertil Steril. 2010;94(3):888-99.
12. Martin JR et al. Insurance coverage and in vitro fertilization outcomes: a U.S. perspective. Fertil Steril. 2011;95(3):964-9.
13. Alteri A et al.; ESHRE Guideline Group on the Number of Embryos to Transfer. ESHRE guideline: number of embryos to transfer during IVF/ICSI. Hum Reprod. 2024;39(4):647-57.
14. Leridon H. Can assisted reproduction technology compensate for the natural decline in fertility with age? A model assessment. Hum Reprod. 2004;19(7):1548-53.
15. Ethics Committee of the American Society for Reproductive Medicine (ASRM). Assisted reproduction with advancing paternal and maternal age: an Ethics Committee opinion. 2025. Available at: https://www.asrm.org/practice-guidance/ethics-opinions/assisted-reproduction-with-advancing-paternal-and-maternal-age-an-ethics-committee-opinion-2025/. Last accessed: 13 October 2026.
16. Goldman MB et al. A randomized clinical trial to determine optimal infertility treatment in older couples: the Forty and Over Treatment Trial (FORT-T). Fertil Steril. 2014;101(6):1574-81.e1-2.
17. Human Fertilisation and Embryology Authority (HFEA). Fertility treatment 2024: trends and figures. 2026. Available at: https://www.hfea.gov.uk/about-us/publications/research-and-data/fertility-treatment-2024-trends-and-figures. Last accessed: 13 October 2026.
18. Federal Office of Public Health (FOPH). Bundesrat beschliesst Eckwerte für die Zulassung der Eizellenspende. 2025. Available at: https://www.bag.admin.ch/de/nsb?id=103995. Last accessed: 13 October 2026.
19. Federal Office of Public Health (FOPH). Annex 1 to the Health Care Benefits Ordinance, section 3 Gynaecology, obstetrics and reproductive medicine. 2026. Available at: https://www.bag.admin.ch/dam/de/sd-web/lmdyprmtRKyP/KLV_Anhang%201_per%201.7.2026.pdf. Last accessed: 13 October 2026.
20. Inselspital Bern, Universitätsklinik für Frauenheilkunde. Übersicht der angebotenen Kinderwunschtherapien. Available at: https://frauenheilkunde.insel.ch/de/unser-angebot/kinderwunsch-und-hormone/kinderwunschzentrum/behandlungen. Last accessed: 16 October 2026.
21. Universitätsspital Zürich (USZ). Intrauterine insemination (IUI). Available at: https://www.usz.ch/fachbereich/reproduktions-endokrinologie/angebot/intrauterine-insemination-iui/. Last accessed: 19 August 2026.
22. Institut national d'assurance maladie-invalidité (INAMI). Médicaments utilisés dans les troubles de la fertilité. Available at: https://www.inami.fgov.be/SiteCollectionDocuments/troubles_fertilite_feminine.pdf. Last accessed: 13 October 2026.
23. Region Hovedstaden. Fertilitetsbehandling. Available at: https://www.regionh.dk/sundhed/fertilitet-graviditet-og-foedsel/fertilitet/sider/fertilitetsbehandling.aspx. Last accessed: 13 October 2026.
24. Danish Ministry of the Interior and Health and Danish Regions. Udmøntningsaftale om flere forsøg til fertilitetsbehandling til andet barn. 2025. Available at: https://www.ism.dk/Media/639019912347569634/Udm%C3%B8ntningsaftale%20om%20flere%20fors%C3%B8g%20til%20fertilitetsbehandling%20til%20andet%20barn.pdf. Last accessed: 13 October 2026.
25. Calhaz-Jorge C et al. Survey on ART and IUI: legislation, regulation, funding, and registries in European countries-an update. Hum Reprod. 2024;39(9):1909-24.
26. Poth CN (ed.), The Sage Handbook of Mixed Methods Research Design (2023), London: SAGE Publications Ltd.
27. Tam MW. Queering reproductive access: reproductive justice in assisted reproductive technologies. Reprod Health. 2021;18(1):164.
28. Mitter V, Widmer R. Ungleicher zugang zur fortpflanzungsmedizin in der Schweiz. Schweizerische Ärztezeitung. 2021;DOI:10.4414/saez.2021.19491.