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Defining Necessity: The Politics of Knowledge in Ontario's and Quebec's In Vitro  
Fertilization Funding Debates

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## ABSTRACT

### Defining Necessity: The Politics of Knowledge in Ontario's and Quebec's In Vitro Fertilization Funding Debates

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Rapid advances in reproductive technologies have led to unprecedented shifts in debates about regulation of, and access to, these services. In a world where a single cycle of in vitro fertilization (IVF) costs upwards of \$10,000, questions arise about whether and, if so, why public money should fund IVF. To examine the politics at the core of this complex ethical and practical dilemma, this thesis explores the political decision-making processes underlying two notable pieces of IVF funding legislation: Ontario's 1993 decision to remove IVF from its government-provided health insurance and Quebec's 2008 decision to fund three rounds of IVF for all citizens. Through these case studies, this thesis examines the patterns of interaction between non-governmental stakeholders in IVF funding decision-making forums and seeks to determine which mechanisms these stakeholders employ to shape medical funding decisions more broadly. Further, it explores the relationship between professional and lay expertise in political forums. Testing the assertions of past research, this study seeks to ascertain whether lay experts have gained substantial political credibility in these Canadian provinces. To answer these questions, I completed a textual analysis of 37 parliamentary debate records and 65 newspaper articles spanning two provinces and twelve years. I coded the records for each stakeholder's framing of their stance on

IVF issues and for the relative standing of different categories of stakeholders in both the media and political arenas. These results revealed medical professionals' and professional organizations' continued dominance in IVF funding decisions, particularly in Ontario. In Quebec, key lay experts, such as infertility advocacy organizations and public figures, moderated this dominance. Comparison of stakeholder standing and framing in these two cases further suggests that the greater heterogeneity of stakeholders represented in decision-making forums in Quebec was an important factor in promoting Quebec's decision to fund the service. Indeed, while many of the same frames were deployed in the two provinces, lay experts in Quebec reinforced frames presented by professional witnesses and likely played a role in Quebec's pro-funding decision. Ultimately, professionals still firmly control medical funding decision-making processes in Canada, though lay experts of various kinds are becoming more prominent as advocates for the public.

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# 1

## Introduction

“The first step in de-insuring services should be to define ‘medically necessary’...Initially, the process should be a joint one with the [Ontario Medical Association] and [Ministry of Health]. Input should then be sought from expert groups, for example, [the Infertility Awareness Association of Canada], as the representative of the infertile population. Then the public should be allowed to participate in this very important discussion.”

– Infertility Awareness Association of Canada (November 1, 1993, Standing Committee on Social Development, Ontario)

Improvements in infertility treatments and reproductive technologies have created numerous means by which individuals struggling with infertility may become pregnant. From intrauterine insemination to in vitro fertilization (IVF), reproductive technologies help to improve the chances that individuals can have the child they want—if they can afford it. These new technologies come at a massive cost (\$10,000 or more per cycle) that may be prohibitive to a large proportion of the population (Bouzayen & Eggertson 2009:243). In Canada, where health insurance is publicly funded, the expense raises the question of whether—and, if so, why—government health insurance should pay for procedures such as IVF. At its heart, the issue of IVF funding calls into question who has a right to have children and at what cost. This analysis addresses the only two Canadian provinces—indeed, the only states or provinces in North America—with publicly-funded IVF. Through comparison of the



decision-making process underlying Ontario's 1993 resolution restricting IVF funding to individuals with bilateral blocked fallopian tubes and the process that determined Quebec's 2008 decision to fund IVF for all, I locate social and political factors motivating a province's decision to publicly fund in vitro fertilization.

In 1993, the Ontarian Parliament introduced the highly disputed *Expenditure Control Plan Statute Law Amendment Act* (Bill 50, December 14, 1993). This act amended the existing *Health Insurance Act* and *Hospital Labour Disputes Arbitration Act* and, in doing so, restructured government-health provider relations, revised health system administration, and delisted a number of health services—including in vitro fertilization except for women with bilateral blocked fallopian tubes—from funding under Ontario's state-provided Ontario Health Insurance Plan (OHIP). Fifteen years later, in 2008, amidst conversations about regulating new reproductive technologies, Quebec's Parliament made the lauded and controversial decision to include in vitro fertilization in Quebec's government-provided health insurance plan. Having previously offered a tax credit reimbursing 30% of an IVF cycle's cost, the government opted to expand coverage to fund three full rounds of in vitro fertilization for all individuals. While it is important to acknowledge that fifteen years and a number of national legislations—including Canada's *Assisted Human Reproduction Act* (2006)<sup>1</sup>—passed between Ontario's decision to defund IVF and Quebec's decision to expand its coverage, comparison of these two cases presents fascinating insight into the political processes underlying medical funding decisions and the interplay between

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<sup>1</sup> In 2006, the Canadian government issued Assisted Human Reproduction to regulate the use and research of reproductive technologies. This act outlaws human cloning, enacts measures to protect the safety of individuals undergoing treatments, and requires that research related to infertility treatments take place in regulated environments (Health Canada 2008).

stakeholders in Canadian legislative forums. This thesis specifically examines the roles of the public and of professional and lay experts in parliamentary hearings and in the mass media in both provinces. The rest of this chapter will introduce expert research on these topics, describe the study design, and outline the plan of thesis.

## **PUBLIC VOICES IN THE POLITICAL SPHERE**

Political science theory and research traditionally suggests that public opinion is an essential component of legislative processes and that politicians act primarily in hopes of gaining public favor to secure votes for reelection (Brettschneider 1996; Burstein 2003, 2006; Pettinicchio 2010; Stimson, MacKuen, and Erikson 1995). Numerous researchers have noted, however, that many cases contradict the assumed tight correlation between the public's desires and politicians' actions (Petry and Mendelsohn 2004). As political scientists Francois Petry and Matthew Mendelsohn (2004:505) contend, "there is a firmly embedded assumption in the popular folklore of politics that politicians are highly attentive to public opinion." This myth is particularly false in the case of medical funding debates, where politicians and professionals often reign heavily dominant (Contandriopoulos 2004; Freidson 1986; Jasanoff 1990). Meanwhile, variation in government structure—federalism versus parliamentary systems, for example—may alter the correlation between public opinion and policy outcomes (Brettschneider 1996). In Canada's parliamentary system, in particular, the party system isolates policymakers from public opinion and creates an environment antagonistic to active citizen involvement (Mendelsohn 1996; Petry and Mendelsohn 2004; Pettinicchio 2010). Further, as L. Graham Smith (1982, 1984) contends, public participation in Canada has primarily been restricted to operational

planning—such as intervention design and implementation—and has not extended to normative debates about the ideals underlying policy decisions. Following from this, it is likely that public opinion may have little influence on problem definition in Canada’s medical funding debates.

## **PROFESSIONAL AND LAY EXPERTISE**

An alternative approach to understanding the public’s importance in political decision-making emphasizes the roles of social movements and organized advocates. Social movement analysts agree that non-experts face challenges in gaining access to political forums, but recent developments in the field suggest a rising tension between professional and lay experts in the political realm and an increasing relevance of non-professional opinion, particularly in medical and environmental debates (Epstein 1996; Eyal and Buchholz 2010; Newman et al. 2004). As Newman et al. (2004:220) articulate, “service users” may be “conceptualized very differently from the ‘clamorous public’ or ‘demanding consumers’” that past research suggests. Indeed, these patients or consumers may be “‘experts’ whose knowledge and experience can contribute to the development of new policies and practices” (Newman et al. 2004:221). This thesis examines lay experts’ emergence and assesses the relative influence of the public, professionals, and lay experts in shaping IVF funding decisions. In doing so, it seeks to uncover the factors impacting non-governmental stakeholders’ establishment of credibility and the development of standing in political arenas.

## *Traditions of Professionalism*

Andrew Abbott (1988:1) begins *The System of Professions* with the simple, yet powerful, statement that “the professions dominate our world.” And, indeed, medical professionals and professional organizations have traditionally heavily dominated the medical policy field. Advice from scientific experts regulates outcomes and often serves as the authoritative voice on topics ranging from pharmaceutical regulations to environmental reforms (Davis and Abraham 2010; Jasanoff 1990). As Sheila Jasanoff (1990:250) argues, in legislative processes, scientific advice is “part of a necessary process of political accommodation among science, society, and the state.” Further, “a state of knowledge that satisfies tests of scientific acceptability and supports reasoned decision-making” is essential in constructing an effective political process (Jasanoff 1990:250). While professionals are far from the only players in legislative forums and, arguably, are not necessarily “the prime movers of those processes,” they hold a uniquely defined position among non-governmental stakeholders (Freidson 1986:205). Legislative processes rely heavily on the positioning of actors within a hierarchical system and the system therefore expects these actors to complete unique duties and present different perspectives (Freidson 1986:230). In essence, as Abbott (1988) aptly contends, professionalism exists because “our market-based occupational structure favors employment based on personally held resources, whether of knowledge or of wealth” (Abbott 1988:234). In the case of medical funding decisions, medical professionals maintain their dominance because they have unique control over healthcare provision and a unique understanding of medical conditions and treatments.

Despite this traditional dominance, recent work in the sociology of expertise suggests a decline in reliance on professional expertise. Eliot Freidson (1986:230) contends that words like “*technique, social control, hegemony, domination or monopoly of discourse*” are too strong to describe the role of professionals in political economy. Similarly, Abbott (1988:325) maintains that the other forces that play alongside professionalism “may have finally become stronger” while Gil Eyal and Larissa Buchholz (2010) argue that a variety of actors—ranging from consumer unions to patient groups—have gained traction and the capacity to effect change in politics. In sum, though professionals maintain a strong legacy of dominance and ownership of scientific and medical knowledge, more recent research suggests that trends are shifting and other stakeholders are gaining respect and influence.

### *The Rise of Lay Expertise*

While professionals and intellectuals have traditionally controlled medical decisions and health-related legislation, lay expertise appears to be rising in predominance and there is a growing belief among sociologists in the value of non-professional stakeholder involvement in scientific fields (Epstein 1996; Eyal and Buchholz 2010; Wynne 1996; Zola 1972). While sociologists do not advocate for the complete exclusion of medical professionals from decision-making, many argue along the lines of Irving Kenneth Zola’s (1972:503) point that “patients have so much to teach their doctors as do students their professors and children their parents.” In fact, lay people may be better equipped to represent the social dimensions of scientific knowledge and to identify the cultural and social implications of a given set of reforms (Wynne 1996). For example, in Brian Wynne’s (1996:40) examination of English

sheep farmers' reactions to radioactive consequences of the 1986 Chernobyl accident, he notes that "lay people...showed themselves to be more ready than the scientific experts to reflect upon the status of their own knowledge" and to "relate it to that of others and their own social identities." Indeed, literature makes clear that lay experts' involvement in political decision-making complements and reinforces professional experts' advice.

Further research highlights the great strides that have resulted from the actions of patient groups and of other non-professional actors. Steven Epstein (1996) provides a particularly strong analysis of lay experts' role in the HIV/AIDS movement in the United States as he argues that the success of the AIDS movement demonstrates that social movements' engagement with science can expand and fortify the movements and their aims. Importantly, Epstein (1996:419) contends that activists in the AIDS movement constructed themselves as an "obligatory passage point" and, in so doing, established their roles as representatives of the people. Ultimately, Epstein and others suggest that, by learning the language of medical experts, activists—ranging from health educators, to journalists, to HIV positive individuals—can establish credibility within the professional domain and therefore gain access to political forums and influence in legislative decisions.

Though these examples hint at the increasing presence of laypeople in political forums, there is certainly no consensus about the relevance of lay expertise in defining medical policy decisions. Some argue that "unmediated anecdotal evidence" may corrupt medical decisions and have negative implications for safety and public health (Davis and Abraham 2010). Meanwhile, Lindsay Prior (2003:53) goes so far as to

argue that laymen are not experts by citing the dictionary definitions of “layman” and “expert”:

- ‘Layman’: 1. One of the laity. 2. An outsider or non-expert (esp. in relation to law or medicine)  
‘Expert’: 2. Experienced (in), having experience (of). 2. Trained by practice, skilled.

Lay knowledge, Prior maintains, is not as valuable as professional knowledge and cannot be considered as such. While she acknowledges the value in assessing how affected individuals think and feel about their circumstances, Prior (2003:41) argues that there exists “a line of boundary around the domain of expertise.” As she concludes: “to paraphrase the sentiments of Max Weber (1948), scientific and medical experts might not be able to instruct us about what we ought to do, but they can instruct us about what is and is not possible to do—and how, exactly, to do it” (Prior 2003:54). Science and medicine, these pro-expertise advocates contend, are very much still relevant, critical, and dominant in the political realm.

Overall, though some academics question laypeople’s relevance in policy debates, the predominant view is that lay expertise is increasingly pertinent in today’s government. Indeed, as Epstein (1995:408) concludes, “the arena of fact making encompasses not just immunologists, virologists, molecular biologists, epidemiologists, physicians, and federal health authorities—but various credentialed experts plus the mass media and the pharmaceutical and biotechnology companies.” Further, activists have been increasingly involved in movements ranging from AIDS activism to drug regulation and have fought to protect values “*other than* the pursuit of science” as they “[transform] the practices by which science constitutes knowledge” (Epstein 1995:427). While social movements of course continue to struggle against

traditions of professionalism, advocates have seen a “new wave of democratization” arise in health care debates and past research suggests optimistic outcomes for this trend (Epstein 1996:349).

*Interest Groups, SMOs, and Advocacy Organizations.* Lay experts gain traction and credibility through mobilization and the formation of social movement organizations. Previous sociological works suggest that interest groups can be broadly defined as “voluntary associations independent of the political system that attempt to influence the government” (Andrews and Edwards 2004:481; Burstein 1998). Kenneth Andrews and Bob Edwards (2004:481) specifically cite Jeffrey Berry who defines a *public* interest group specifically as one “that seeks a collective good, the achievement of which will not selectively and materially benefit the membership or activists of the organization.” On the other hand, a social movement organization is conceptualized as a group that engages with a social movement outside of institutions of political decision-making (Andrews and Edwards 2004:482).

While analyses frequently distinguish between social movements and interest groups, current research argues that the line between these types of groups is not as clear as previously indicated (Andrews and Edwards 2004; Best 2012; Burstein 1998). As Andrews and Edwards (2004:485) highlight, “many of the influential definitions of public interest groups, social movement organizations, and nonprofit advocacy organizations share a common focus on the pursuit of good framed in the public interest.”<sup>2</sup>

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<sup>2</sup>For the purposes of this thesis, I define “interest groups” as voluntary associations pursuing specific benefits in their constituents’ interests (Andrews and Edwards 2004; Best 2012). I use the more specific term “advocacy organization” to represent non-professional interest groups.



In the realm of medical funding legislation, interest groups present joint challenges “to medical policy, public health policy and politics, belief systems, research and practice” and incorporate supporters ranging from informal organizations to media networks (Brown and Zavestoski 2004:679). These organizations have far-reaching aims and effects including the resolution of health access issues, reduction of the traumas of disease experiences, and reduction of racial, gender-based, or other health inequalities (Brown and Zavestoski 2004:679). These health social organizations build upon related movements, target increased public awareness of health access issues, and mobilize around social issues in healthcare to improve the experiences of “ill” populations (Brown et al. 2004).

Interest groups stand at the intersection of the state and the public. In claiming to represent the good of the people, these organizations work hand-in-hand with policymakers to secure their beneficiaries’ best interests and, in doing so, can alter the landscape of medical research, service provision, and the social and political structures of society more broadly.

## **METHODS OF INTERVENTION**

Lay experts employ a number of mechanisms to intervene in political processes. First, stakeholders influence mass media and public opinion to alter the agenda-setting process and move issues up or down policymakers’ task lists (Andrews and Edwards 2004). Further, organizations seek access to decision-making forums, push to achieve policies that are favorable for their constituents, “monitor and shap[e] implementation,” and influence the long-term priorities and resource allocation of governments and other political machines (Andrews and Edwards 2004:479; Evans

1996). Specifically, advocacy organizations participate in decision-making forums to “broaden the focus” of issues or “[divert attention] to aspects of the issue over which [they] have greater control” (Pettinicchio 2010:132). Through direct participation in the political process, actors also assert their legitimacy and directly target undecided policymakers and those who previously opposed their initiatives (Andrews and Edwards 2004; R. A. Smith 1984). By providing fresh insight relating directly to their policy issue of interest, advocacy organizations may push for reforms of related policies and reinforce existing messages relating to their cause (Burstein and Linton 2002). David Pettinicchio (2010:132) cites a Bauer, Pool, and Dexter (1963), which demonstrates through interviews that “members of Congress will hear anyone who brings fresh information on an issue.” Specifically, research suggests that advocates are most effective when they provide elected officials with the resources and information needed to successfully win reelection (Burstein and Linton 2002). Additionally, interest groups monitor subsequent endeavors of policymakers to enforce sustained support and ensure that the benefits of their efforts continue past the initial mandates set by policymakers (Andrews and Edwards 2004). Finally, as the Mississippi Civil Rights Movement of the 1950s and 1960s demonstrates, advocates interrupt program functions, negotiate with officials, and stage protests (Andrews 2001:89; King, Bentele, and Soule 2007).

A successful advocacy initiative is predicated on a combination of the previously discussed actions, favorable group characteristics, and a constructive political context. In his assessment of the factors fostering the American Medical Association’s (AMA) rise to power, Mark Peterson (2001) highlights key

characteristics of powerful interest groups in politics. The rise of the AMA indicates that traits such as information control and recognition as a “knowledge-based, high-status” group lend themselves to political power (Peterson 2001:1150). Further, frequent contact with policymakers and possession of a specific political “niche” increases an organization’s credibility and prominence in a given area (Peterson 2001:1150). Meanwhile, a “large and dispersed membership” ensures that the organization has a large reach and expansive potential influence (Amenta et al. 2010; Peterson 2001:1150). Finally, organizational resources, knowledge of the target population, and funding availability ease the challenges of disseminating specialized information to the population and to policymakers (Amenta et al. 2010; Peterson 2001:1150).

These organizational characteristics must be coupled with a productive political context to ensure advocacy organizations’ success. Amenta, et al. (2010) contend that the most successful movements deal with issues that are already on the legislative agenda. Successful social movements are also fought based on “credible” and “plausible” claims directed both at the elite and at society as a whole (Amenta et al. 2010:299; Epstein 1996). As these authors aptly state “SMOs [social movement organizations] almost invariably claim to represent a group extending beyond the organization’s adherents and make demands that would provide collective benefits to that larger group” (Amenta et al. 2010:290). In short, the keys to a successful advocacy effort are the mobilization of a diverse set of leaders and access to a range of resources from members and the general public alike (Amenta et al. 2010).

Policy change occurs through the processes of “problem recognition and agenda setting; the specification of policy options; and the politics of selecting among proposals and enacting legislation” (Burstein 1991:346). Throughout these processes, policy, culture and social movements interact and shape relationships, providing a framework for the activities of both advocates and political actors (Best 2012; Burstein 1991; Cress and D. A. Snow 2000).

### *Shaping Discourse in the Media*

This thesis focuses both on the direct participation of stakeholders in decision-making forums and on the impact of agenda-setting through the mass media. While public discourse is presented in forums ranging from parliament to scientific congresses to conversations between civilians on the street, mass media is the forum in which discourse from all of these different arenas interacts and ideas combine (Ferree et al. 2002:10–11). Media is also the forum in which expert knowledge is disseminated and, through investigative journalism, on occasion produces knowledge of its own (Blocher 2012). Media therefore becomes a primary site of political contest, develops a significant influence over the other forums of conversation, and provides stakeholders a measure for assessing the success of their initiatives (Ferree et al. 2002:10). In turn, the spread of a stakeholder’s frame through mass media may lead to a “ripple effect” throughout the various political decision-making arenas (Ferree et al. 2002:11). Therefore, those who are most successful in commandeering mass media are therefore likely to experience the greatest victories in shaping policies and reforms.

In general, stakeholders shape cultural definitions and frame issues according to their interests to influence both the media and political arenas. Framing is the process by which actors organize “a diverse array of symbols, images, and arguments” to construct a coherent picture and argument and shape the meaning and interpretation of problems to best suit their beneficiaries’ interests (Ferree et al. 2002:14). By tying these symbols and arguments to an underlying concept which highlights the causes, consequences, and potential repercussions of the issue, stakeholders confer specific meanings and interpretations to events which may benefit their causes (Ferree et al. 2002:14). To achieve direct benefits for their constituents, these stakeholders, in turn, construct the variety of political positions that surround contentious issues such as IVF funding or access to abortion and may inject their frames into policy debates through forums such as the mass media to alter policymakers’ goals and priorities (Benford and D. Snow 2000; Cress and D. Snow 2000).

To shape policy, public and media discourse constrain policymakers and pushes them to conform with “dominant tendencies” to ensure their future reelection (Ferree et al. 2002:15). Indeed, the media is essential to democracy because it enables problem solving and deliberation in the interest of the common good (E. Baker 1998; Rosen 1996). As McCombs and Shaw (1972; cited in Pettinicchio 2010) argue, media is one of the only ways in which the public—which is not involved in daily political exercises—is informed of political events. While public discourse is only one factor amidst many shaping decision-making priorities, “doing badly in mass media discourse creates vulnerability in pursuing policy interests” and the ability of stakeholders to construct their meanings and interpretations as the most important ones

is often central to policy success (Ferree et al. 2002:16). In short, as Rachel Best (2012:796) asserts, it is critical to understand that “culture is not an isolated realm of social life that can be separated from politics” and that one of the most fundamental tools of health advocates and politicians is the act of cultural redefinition through manipulation of the public forum.

## **OUTCOMES OF STAKEHOLDER INVOLVEMENT IN POLITICS**

There are three categories of policy outcomes that result from political challengers’ interventions and framing efforts. First, advocacy efforts may impart direct benefits—gains for an organization’s specific constituents (Best 2012). These include such impacts as moving items up the policy agenda and altering the content of policies to secure benefits for individuals suffering from a particular disease (Best 2012). Further, interest group activity may lead to resource redistribution to benefit constituents who are more likely to mobilize and advocate on their own behalves (Berry 1999; Best 2012; Radcliff and Saiz 1998). For example, if infertile couples organize themselves in support of their cause, the reallocation of resources may advance their efforts and reduce the social and political power of the majority or elite classes (Best 2012). Finally, advocacy may lead to systemic effects altering the overall structures of policy procedures and government activities (Best 2012). As Best (2012:782; see also Armstrong and M. Bernstein 2008) asserts, systematic changes alter “the rules of the game for all participants.” In medical research funding in the United States, “disease advocacy reshaped funding distributions, changed the perceived beneficiaries of policies, promoted metrics for commensuration, and made cultural categories of worth increasingly relevant to policymaking” (Best 2012:780).

Of particular note, Best (2012:784) argues that disease advocacy led Congress to view disease patients, rather than the general public, as the main medical research funding beneficiaries. When patients are viewed as beneficiaries, moral and ethical considerations of worthiness contribute to funding decisions and those patients' interests may be weighed against the general public's interests (Best 2012; Steensland 2006).

These discussions of beneficiaries and of adjustments to overall health funding priorities are central to the debates explored in this analysis. As Maureen Baker (2008:78) suggests, "not all governments see access to reproductive services or declining fertility as problematic." The marks of a successful advocacy initiative are changed political agendas, altered legislative proposal content, an increase in relevant representatives' votes, and faster passage of legislation (Amenta et al. 2010:301). This thesis therefore considers whether lay experts' involvement and reframing of funding issues led to a significant shift in one of these factors, which subsequently led the Ontarian and Quebecois governments to readjust their views on the importance of IVF as a state funding priority (M. Baker 2008:78).

## **INFERTILITY AND LAY EXPERTISE: AN INTERSECTION**

Steven Epstein (1996:331) asserts that "without the sustained, interactive participation of scientists, the mass media, and voices within the AIDS movement, the controversy simply would not have achieved significance, either socially or scientifically, and the 'black box' ('HIV causes AIDS') would never have been reopened for consideration." This thesis tests Epstein's ideas in a new realm of science within a distinctly different national context. By assessing different

stakeholders' roles in framing IVF funding discourse in the mass media and in political spheres in Ontario and in Quebec, this study examines the patterns of interaction between professional and lay experts in infertility debates and attempts to determine whether this interplay between stakeholders played a role in problem definition and in establishing the two provinces' divergent funding decisions.

Ultimately, I pursue Epstein's (1995:430) suggestion that an "extended study of the relation between biomedicine and social movements could provide for a deeper and more comprehensive analysis of the construction of medical knowledge and the transformation of medical practice." By examining various stakeholders' standing in policy debates and analyzing their framing of the issue, I apply Epstein's ideas to a different medical issue in order to unravel the social dimensions of IVF debates, examine how interactions between non-governmental stakeholders shape policy and framing in IVF funding debates, and explain the impact of lay expertise on this specific case of medical funding decision-making processes.

## **METHODOLOGY: SOURCES, CODING, AND STUDY DESIGN**

To examine the interaction between professional and lay expertise in IVF funding debates, 37 parliamentary records and 65 newspaper articles spanning two provinces and twelve years were analyzed. The data I collected allows me to answer the question "how does the relative presence of different stakeholders in media and parliamentary discussions influence problem definition and policy outcomes in IVF funding debates?" This data allows me to demonstrate a correlation between the level of involvement of different categories of stakeholders and the framing of IVF debates.



It also enables analysis of lay experts' impacts in shaping Canadian medical funding decisions.

The central concepts in this research are stakeholder credibility, in vitro fertilization funding debate framing, and problem definition and agenda setting by policymakers. Credibility was assessed based upon standing—"having a voice" in a forum of legislative discussion (Ferree et al. 2002:86). As Mark Ferree et al. (2002:86) articulate, standing is a critical measure of power and influence because parliamentary witnesses and media sources are selected "because they speak as or for serious players in any given policy domain: individuals or groups who have enough political power to make a potential difference in what happens" (Ferree et al. 2002:86). Consequently, credibility and the legitimacy of expertise are measured in this study based on the frequency of appearances by different categories of stakeholders in provincial and national news media and parliamentary sessions in both provinces. Framing and problem definition were coded into a number of categories based on previous research on IVF funding, as described in the attached Appendix.

### *Methods of Data Collection*

All data was collected through textual analysis of parliamentary debate records and newspaper articles. Documents published beginning five years before and ending two years after each policy decision were examined. For Ontario, I examined documents and media beginning in 1989 and extending until 1995. For Quebec, I studied documents ranging from 2005 to 2011. I selected the beginning of this range based on the date of the very first reference to the discussed policy in legislative records. I elected to code data from after the passage of the bills to ensure that I

garnered information about implementation and public and editorial reactions to the policies. I specifically selected the two year timeframe based on initial readings of Quebec's parliamentary testimony which suggested that the major political discussions about implementation occurred in the first two years following ratification.

*Parliamentary Debates and Committee Hearings.* To assess standing and framing in the political arena, I coded transcripts from meetings of Ontario's Legislative Assembly, Quebec's National Assembly, and a number of parliamentary committees in both provinces. For Ontario, I specifically coded 8 transcripts from Ontario's Legislative Assembly and 8 transcripts from the Standing Committee on Social Development. For Quebec, I analyzed 11 records from the National Assembly, 7 from the Committee on Social Affairs, 1 from the Committee on Health and Social Services, 1 from the Committee on Citizen Relations, and 1 from the Committee on Public Finance. All of Quebec's parliamentary transcripts were initially recorded in French. The Columbia Tutoring and Translating Agency translated them to English for my purposes. For both provinces, I coded every document an archive search returned. I used the search terms "in vitro" and "IVF," as well as the French terms "FIV and "fécondation artificielle." I also used "Bill 50" and "Expenditure Control Plan Statute Law Amendment Act" as search terms for Ontario and "Bill 26," "Bill 23," and "Bill 89" as search terms for Quebec.

*Mass Media.* To ascertain stakeholder presence and impact in the public arena, I analyzed articles from three major Canadian newspapers. To garner a consistent national perspective, I coded 7 articles discussing Ontario's IVF funding debate and 15 articles regarding Quebec's from the Toronto-based *Globe and Mail*—Canada's

centrist “newspaper of record” with a 2011 weekly circulation of 1,906,336 newspapers (Newspapers Canada 2012). I also coded articles from one provincial newspaper in each province to achieve a more local perspective. For Ontario, I coded 18 articles from the liberal, Toronto-based *Toronto Star*, which had a weekly readership of 1,932,385 in 2011 (Newspapers Canada 2012). Similarly, I coded 25 articles from the centrist *Montreal Gazette*—Montreal’s premier English newspaper with a 2011 weekly circulation of 806,122 (Newspapers Canada 2012). In all cases, I coded every document my archive search uncovered. I used the search terms “in vitro” and “IVF” to search for relevant articles. I also searched for “Bill 50” and “Expenditure Control Plan Statute Law Amendment Act” in searches relating to Ontario and “Bill 26,” “Bill 23,” and “Bill 89” in searches for articles discussing Quebec.

### *Methods of Data Analysis*

I first performed a quantitative analysis enumerating the different types of media and parliamentary witnesses who appear in hearings and newspaper records related to IVF funding. I then assessed the difference in ratios between Ontario and Quebec to establish a baseline understanding of each type of stakeholders’ overall presence in the two decision-making processes. I also enumerated the prevalence of a variety of frames and cross-tabulated their use by different types of stakeholders. The low number of available parliamentary and media records relevant to this thesis topic limited further quantitative measures. To reinforce my findings, I complemented this quantitative analysis with a comprehensive qualitative analysis of all records.

## *Strengths and Limitations*

Through a combination of qualitative and systematic quantitative analysis, this study provides robust and multi-faceted insights into the Canadian political decision-making process. Specifically, consideration of the objective numerical presence of categories of witnesses coupled with qualitative deconstruction of witnesses' testimony and decision-makers' discourse provides detailed insight into the factors underlying Ontario's and Quebec's policy outcomes. Further, the comparison between Ontario and Quebec strengthens the study's conclusions because the provinces demonstrate vastly different outcomes despite existing under the same national context.

While this study is strong overall, it has a number of limitations. First, as previously mentioned, Quebec's parliamentary transcripts are recorded primarily in French. As I am unable to read French, I made initial readings of French documents using online translation tools and then had the Columbia University Tutoring and Translating Agency translate critical sections. While this service employs experienced translators, the involvement of a third party translator must be considered when assessing coding accuracy.

This thesis faces additional barriers in the representativeness of the research design. Much political decision-making occurs behind closed doors and many influences cannot easily be understood via public records analyses (Ferree et al. 2002). Public discourse and the information that the government releases are certainly important components of the decision-making process, but it is important to be aware that there are other factors and conversations that are virtually impossible to gain

access to. Similarly, it is important to consider that the results of this study only really apply directly to their specific provincial contexts and that the limited number of records available for analysis constrained the statistical significance and generalizability of the study's findings.

In addition, the potential for media bias should be considered when assessing media analysis results. While mass media presents essential insight into the manner in which debates are presented in the public sphere, it is prone to bias. The character of the event, the political slant of the newspaper, and the character of the issue itself may shape decisions to cover events in public media (Earl et al. 2004; Oliver and Maney 2000). Further, individual writers may select quotations and references based on their own intentions and political views. That said, designing a study—such as this one—which draws from consistent and comparable media sources reduces the effect of bias (Barranco and Wisler 1999:320). Further, consideration of what the news media covers provides important insight into what is considered important based on “news-value factors and cultural imperatives” (Barranco and Wisler 1999:320). In sum, while I took measures to control for bias and while media is perhaps the most important component of this analysis, the potential for bias in the media outlets' representations of stakeholder perspectives may temper the results.

Finally, it is important to consider the impact of time elapsed between Ontario's defunding verdict and Quebec's funding decision. National reforms—such as Canada's *Assisted Human Reproduction Act* (2006)—were enacted in this time period and may reflect a change in Canadian society's general views toward IVF between 1993 and 2008. While the Quebec and Ontario examples provide a valuable

comparison of different takes on public funding within the same national context, the reader must be aware that the Canadian national context and perspective may have evolved in the fifteen years between the two pieces of legislation.

## **PLAN OF THESIS**

Chapter 2 examines global trends in IVF funding policies and outlines the evolution of Canada's policies regulating new reproductive technologies. The chapter further discusses how Ontario's and Quebec's funding decisions were born of Canada's national policies and explains the legislative processes in both provinces.

Chapter 3 outlines the role of various stakeholders in shaping problem definition and agenda setting in Ontarian and Quebecois parliaments. Through analysis of transcripts from parliamentary assembly and committee hearings, this chapter argues that medical professionals and interest groups maintain dominant roles in both provinces' political arenas. Further, this chapter assesses dominant frames in IVF funding debates and contends that conflict over medical necessity definition is central to IVF funding decision-making process. The chapter suggests that the diversity of stakeholders represented in Quebec's political arena enabled its positive funding outcome.

Chapter 4 establishes the media's role in shaping decision-making processes and assesses trends in stakeholder standing and framing in news media coverage of IVF funding debates. The chapter highlights the greater diversity of stakeholders represented in the news media and examines the contexts in which statements by members of the public are deployed in the public forum. Analysis of media coverage

reinforces the ideas presented in Chapter 3 and the assertion that diverse stakeholders reinforce the same frames and ideas from multiple perspectives to gain traction.

Chapter 5 draws conclusions from both the parliamentary records discussed in Chapter 3 and the media sources outlined in Chapter 4. This chapter argues that professionals maintain their unique position of power in defining and shaping their areas of expertise, but that lay expertise may present a similarly influential perspective when a diversity of stakeholders come together in support of shared goals. Indeed, Chapter 5 concludes that the difference in outcome for Ontario versus Quebec may be explained, at least in part, by the relatively homogenous set of witnesses who presented in Ontario, as compared to the range of perspectives represented in Quebec's debates.

## 2

### **In Vitro Fertilization Funding Debates in Context**

The two Canadian cases discussed in this thesis inform and are informed by parallel debates occurring across the Western World. From Austria to the United States, countries are challenged to define the limits of and access to emerging new reproductive technologies. Philosophies about whether IVF should be publicly funded vary, with countries such as Belgium and France providing full public coverage of IVF for women under the age of forty, while others, such as the United States, have taken a more hands off approach that leaves the decision to private insurance companies (Berg Brigham, Cadier, and Chevreul 2013; Neumann 1997). While public funding of IVF is certainly contingent on the existence of public healthcare and generally exists in democratic systems, research suggests a series of additional social and political factors that impact funding decisions.

The value of reproduction and of access to IVF may be understood by examining the variety of political, social, and economic rationales that a variety of stakeholders have historically utilized to perpetuate their positions on IVF funding legislation. State-funded IVF is most frequently presented in newspaper articles and academic literature as a financial decision—intended to decrease the financial burden of multiple pregnancies and premature births caused by the overuse of cheaper and



riskier forms of fertility treatments (Bouzayen and Eggertson 2009:243). As Renda Bouzayen and Laura Eggerston (2009:243) assert: “For infertile couples, the cost of becoming pregnant is largely a private matter in most of Canada...However, the cost of treating complications from multiple births that often occur following advanced fertility treatments is a public one.” However, some literature questions the cost-effectiveness of publicly funding IVF and contends that funding the service may undermine the improvement of preventative services and therefore lead to negative health impacts and economic loss (Smajdor 2007:468). In a similar vein, some opponents argue that maximizing the public good does not mean covering everything, as “unlimited needs cannot be covered by a finite budget” (Witt et al. 2002:29).

Relevant studies also suggest a number of non-financial rationales presented in support of publicly-funded in vitro fertilization. First, some stakeholders argue that IVF should be publicly funded because infertility is a medical condition and IVF is a clinically appropriate treatment (Mladovsky and Sorenson 2010). Along these lines, Elizabeth Sternke (2010:xi, 223) asserts that “infertility is a socially constructed disability” because inability to fulfill “gender expectations” and their “social responsibilities as mothers” compromises women’s psychological well-being. Anne Fidler and Judith Bernstein (1999:495) further argue that “issues related to infertility have a significant impact not only on the health and well-being of the individual or couple affected but on society as a whole.” The authors agree that the “psychological effects are similar to those of cancer and heart disease...social isolation, clinical depression, and reduced job performance and life satisfaction” (Fidler and Bernstein 1999:497). Ultimately, it is clear that issues of medical necessity and the desire to

prevent the causes and consequences of infertility are central to in vitro fertilization funding debates worldwide.

Another set of arguments constructs IVF funding as a social imperative. First, some stakeholders contend that access to funded IVF is a human right (Mladovsky and Sorenson 2010). Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) defines the right to health as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and implores that:

...health facilities, goods and services must be affordable for all. Payment...has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households. (Committee on Economic, Social and Cultural Rights 2000)

Meanwhile, the *UN Declaration of Human Rights* states in Article 16 that “Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and found a family” (Mladovsky and Sorenson 2010:121–122). Though some would argue “that in a world of many competing needs, not all needs can become rights,” others contend that infertile couples “are required to pay into the insurance pool that provides pregnancy coverage for others while receiving little or no support for their own family-building needs” (Fidler and J. Bernstein 1999:505). Similarly, many stakeholders assert that publicly-funded IVF is justified because health inequalities are unjust (Mladovsky and Sorenson 2010:121). In Canada specifically, Edward Hughes and Mita Giacomini (2001:438) express concerns that “the private funding of IVF creates a potential mal-distribution of resources along two

population dimensions: between the sub-fertile and those without fertility concerns and between the wealthy and the poor.” While mandated coverage may not eliminate all access issues—due to discrepancies in geographical distribution of fertility centers and quality of services—public funding of IVF theoretically gives all individuals access to some degree of IVF services (Mladovsky and Sorenson 2010:122). Finally, some stakeholders support public funding of IVF to stimulate the country’s total fertility rate, reducing the social burdens of an aging society with a waning birth rate (Mladovsky and Sorenson 2010:123). Together these rationales indicate a social obligation and moral imperative for publicly-funded IVF.

## **IN VITRO FERTILIZATION POLICY IN CANADA**

Before assessing the application of these debates to Ontarian and Quebecois contexts, it is important to consider the legislative processes defining a bill’s trajectory in each province. In Ontario, the first step after a sponsor introduces a bill is its first reading, where the purpose of the bill is explained to the Legislative Assembly (Legislative Research Service 2011). A second reading follows, including initial debates between Members of Parliament about the principle of the bill (Legislative Research Service 2011). Generally, after the second reading, a legislative committee reviews the bill. At this time, public hearings are conducted, amendments are considered, and witness testimony is gathered (Legislative Research Service 2011). Finally, the committee reports recommendations to the House and, during a third reading, the bill is voted on for final approval (Legislative Research Service 2011). If the bill passes, the Lieutenant Governor signs the bill into law (Legislative Research Service 2011).

The legislative process in Quebec is much like the process in Ontario. After the bill sponsors' introduction, Members of National Assembly (MNAs) assess the needs and opinions of people that the bill would affect and the Government House Leader refers the bill to a committee for further assessment (Assemblée Nationale Quebec 2013). The MNAs then debate the principle of the bill before a parliamentary committee studies it (Assemblée Nationale Quebec 2013). The committee stage is generally the point at which external witnesses are seen. Finally, the committee reports to the Assembly, a vote takes place, and, if the bill is passed, it is moved forward for assent by the Lieutenant-Governor (Assemblée Nationale Quebec 2013).

Through these multistep processes, regulation and funding of reproductive technologies were thoroughly examined and debated at both the national and provincial levels. Via these mechanisms, the progression of policies and debates in Canada and its provinces emerged consistent with global discourse and events. In 1993, amidst rising concerns about the ethical, social, and legal ramifications of new reproductive technologies, the Canadian government initiated the Royal Commission on New Reproductive Technologies (Chenier 1994). The Commission published a report detailing safety and ethical guidelines for the use of reproductive technologies based on eight principles: "individual autonomy, equality, respect for human life and dignity, protection of the vulnerable, non-commercialization of reproduction, appropriate use of resources, accountability, and achieving balance between individual and collective interests" (Chenier 1994). The report recommended the restriction of some practices—such as the sale of human eggs and sperm—and suggested the establishment the National Reproductive Technologies Commission (NRTC) to

oversee research and implementation of other services, including sperm collection, human zygote research, and assisted conception services (Chenier 1994). Further, the report stated that in vitro fertilization has only proven effective in cases with bilateral blocked fallopian tubes (Chenier 1994). The 1993 Royal Commission on New Reproductive Technologies served as an essential building block for the 2006 *Assisted Human Reproduction Act*. This act of the Canadian federal government regulates research on and use of new reproductive technologies (Health Canada 2008). The act outlaws practices such as human cloning, enacts safety measures to protect those undergoing infertility treatments, and requires that research related to reproductive technologies take place in a regulated environment (Health Canada 2008). Together, these national initiatives serve as a clear basis for provincial and national decisions regarding the funding of infertility services.

The provincial legislations discussed in this thesis—namely Ontario’s *Expenditure Control Plan Statute Law Amendment Act* (Bill 50) and Quebec’s ratification of IVF funding—have clear roots in these national policies. Indeed, it was the recommendations of the Commission on New Reproductive Technologies that spurred Ontario’s 1993 decision to reexamine its previous policies that included public funding of IVF. Ultimately, Bill 50—which amended the *Health Insurance Act* and *Hospital Labour Disputes Arbitration Act*—restructured the relationship between the government and health providers and delisted a number of services from Ontario’s Ontario Health Insurance Plan (OHIP). In keeping with the recommendations of the Royal Commission on New Reproductive Technologies, among these delisted services was in vitro fertilization except for women with bilateral blocked fallopian tubes.

Past research suggests four major goals for the defunding of IVF in Ontario: (1) to reduce public costs associated with IVF usage, (2) to assert that public funding should only be used for “medically necessary” services, (3) to promote evidence-of-effectiveness-based decisions, and (4) to work toward applying the Royal Commission on New Reproductive Technologies recommendations (Giacomini, Hurley, and Stoddart 2000). However, additional research suggests a series of tensions underlying these apparently straightforward claims. First, authors confirm the importance of medical necessity as they argue that “‘medical necessity’ was inconsistently defined and was used to refer to a number of factors ranging from ‘experimental status’ to ‘effectiveness’ to ‘legitimacy of fertility as a medical indication’” (Giacomini et al. 2000:1496). Meanwhile, Ikonomidis and Dickens (1995:379) assert that Ontario’s approach may violate the *Canada Health Act*’s intention to “facilitate reasonable access to health services without financial or other barriers.” Further, Brooks (1994:970) comments that “For an estimated 5% to 15% with blocked fallopian tubes, male infertility, endometriosis and unexplained infertility, IVF may be the only appropriate treatment,” but that Ontario only accounted for blocked fallopian tubes. Further, Giacomini, Hurley, and Stoddart (2000:1496) express unease that “medical necessity” was used as a sort of “Trojan horse for obscuring real decision criteria such as cost control” and, together with Brooks (1994), highlight the fact that the “health effects and social costs of alternatives such as tubal surgery, private IVF, surrogacy, adoption, or ‘giving up’” are not well understood (Giacomini et al. 2000:1496). Meanwhile, addressing the social justice debates, Brooks (1994:972) asserts that social currents must be acknowledged to avoid the emergence of “a two-tiered system” in

which “infertile patients who can afford to pay will have a chance to conceive a child” and “those who cannot pay will be forced to remain childless.” Jeff Nisker (2008:426) further argues that Canada is “alone” amongst countries that have similar regulations for the ethical use of assisted reproductive technologies in its lack of public funding for “clinically appropriate” treatment. Ultimately, historical events and past policy studies of Ontario’s debates suggests origins in the Royal Commission on New Reproductive Technologies, in tension with social imperatives.

Quebec’s decision to explore IVF funding also had roots in Canada’s national policies. Indeed, discussions of funding decisions arose from conversations about Quebec’s Bill 89 (2004), Bill 23 (2007), and Bill 26 (2009). Each of these bills mandate that assisted procreation activities take place in licensed centers, that research be approved and overseen by an ethics committee, and—in the case of Bill 26—that “the assisted procreation services determined by regulation are insured services within the meaning of the act” (Assemblée Nationale Quebec 2009). In fact, as later results outline in detail, the insurance clause was born of concerns by Members of the National Assembly that the province could not enforce strict regulations of reproductive technologies without financially supporting the procedures.

While existing research has not yet examined the tensions underlying Quebec’s policy, I will use primary research to assess these debates in comparison to Ontario’s. This brief review of the historical factors underlying the passage of both Quebec’s and Ontario’s IVF funding decisions provides important context for later discussions and makes clear that, in both cases, conversations about the public funding of in vitro fertilization were initiated amidst discussions of safety and regulation. This thesis

operationalizes the rationales introduced by past research into a series of concrete frames to track the progression of the debate and seeks to determine why the final decisions ultimately diverged, despite their similar roots.

Ultimately, it is clear that Ontario's and Quebec's in vitro fertilization funding policies have similar origins in Canada's national context. Further, past research suggests that the paths to these legislative decisions were far from straightforward and involved reconciling deep tensions between cost-effectiveness, medical prioritization, and social imperatives. These past studies and the global debates about in vitro fertilization inform my research design and motivate my study about the role of the interactions between various stakeholders in defining IVF funding policies. Indeed, existing discourse about IVF debates encourages my systematic evaluation of the various frames presented and stakeholders' means for using these frames to shape policy outcomes.



# 3

## Valuing Voice: Establishing Credibility in Parliamentary Forums

As past research suggests, parliamentary debates and committee hearings are non-governmental stakeholders' opportunities to intervene in political decision-making processes. By participating in these decision-making forums, stakeholders draw attention to aspects of issues that are relevant to their causes, present new information to politicians, and, often, insert public voice into debates (Andrews and Edwards 2004; Epstein 1996; Pettinicchio 2010). While it is impossible to garner a complete image of behind-the-scenes conversations, examination of parliamentary records provides important insight into the standing of different categories of stakeholders in the political sphere and the influence of their framing of the issues in shaping problem definition and agenda-setting.

### STANDING

#### *Witnesses with Spoken Voice*

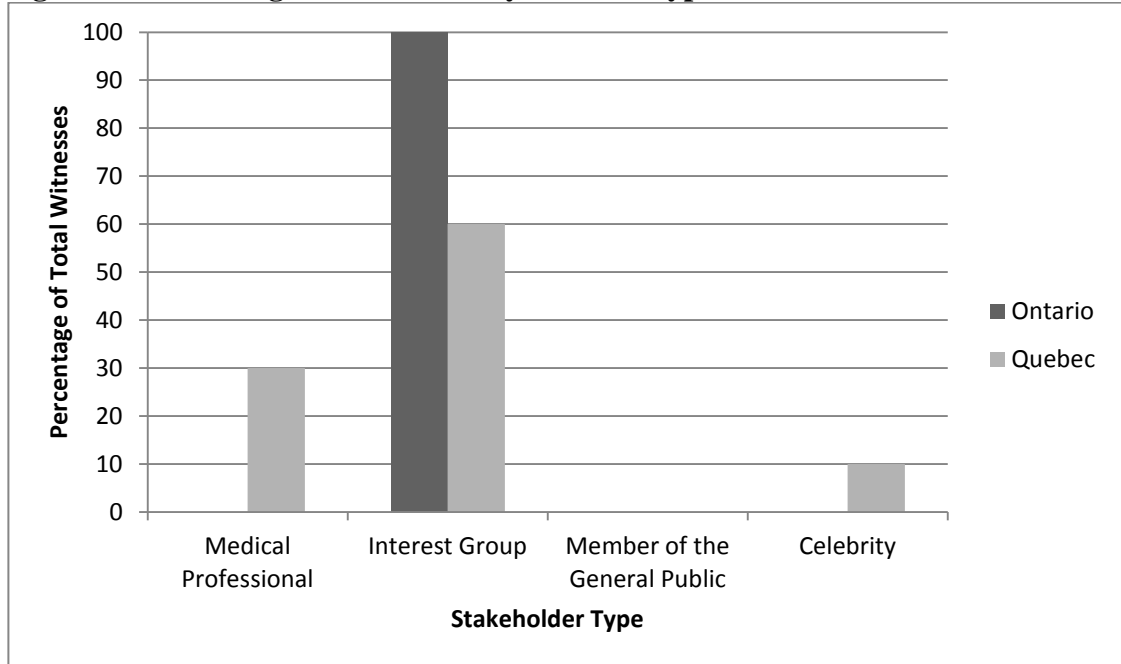
As shown in **Table 3.1** and **Figures 3.1** and **3.2**, analysis of the debates leading up to the passage of IVF funding legislation in both provinces reveals distinct patterns in which stakeholders possess standing in political forums. In Ontario, medical

professionals and professional associations of physicians heavily dominate debates surrounding Bill 50. The Ontario Medical Association (OMA)—Ontario’s major professional organization for physicians—either presents spoken testimony or is cited by witnesses in every hearing about Bill 50. Indeed, professional organizations—including the OMA, Ontario Hospital Association, Sudbury and District Medical Society, and the College of Physicians and Surgeons of Ontario—represent 67% of all parliamentary witnesses appearing in Ontario’s IVF-related debates. Meanwhile, non-professional interest groups have a much smaller presence, comprising only 34% of witnesses. Despite advocacy groups’ efforts to incorporate public voice, members of the general public never present testimony in Ontario’s hearings about Bill 50.

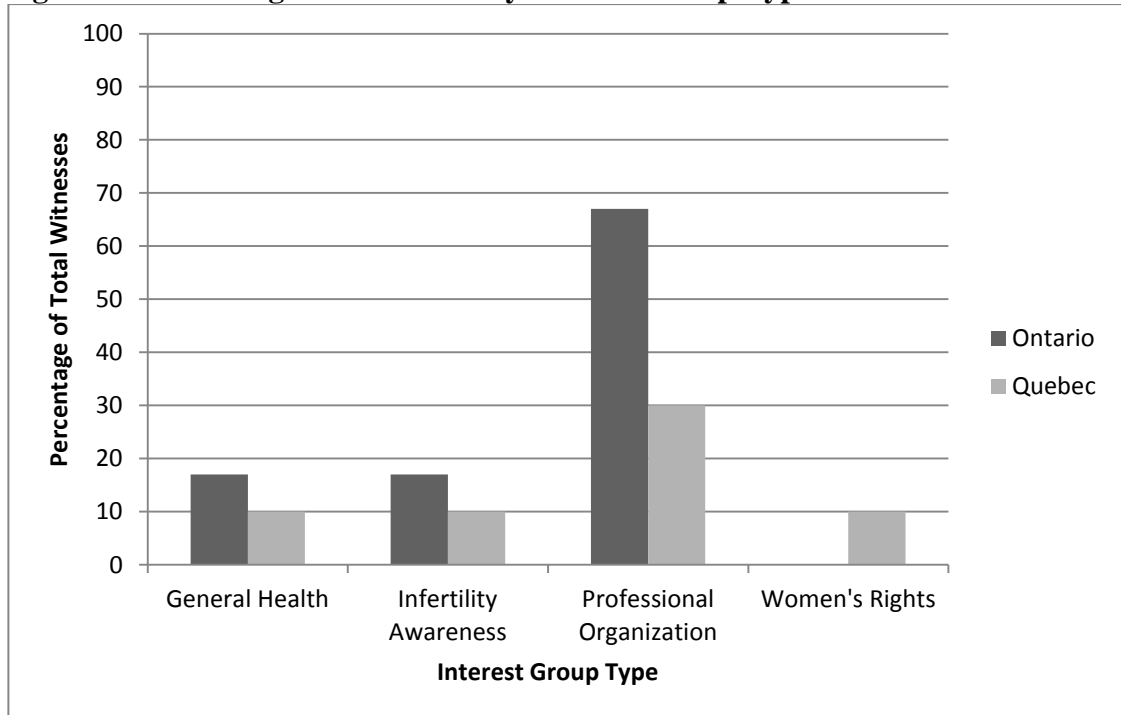
**Table 3.1: Relative Presence of Witnesses with Spoken Voice in Parliament**

<b>Stakeholder Type</b>	<b>Ontario</b>		<b>Quebec</b>	
	<b>Number</b>	<b>Percentage</b>	<b>Number</b>	<b>Percentage</b>
Medical Professional	0	0%	3	30%
Interest Group	6	100%	6	60%
General Health	1	17%	1	10%
Infertility Awareness	1	17%	1	10%
Professional Organization	4	67%	3	30%
Women's Rights	0	0%	1	10%
Member of the General Public	0	0%	0	0%
Celebrity	0	0%	1	10%
<b>Total</b>	<b>6</b>	<b>100%</b>	<b>10</b>	<b>100%</b>

**Figure 3.1: Standing in Parliament by Witness Type**



**Figure 3.2: Standing in Parliament by Interest Group Type**



While medical professionals maintain a strong presence in Quebec's IVF funding debates, they share the stage with a wider range of stakeholders than in Ontario. Medical professionals and medical professional organization each comprise 30% of total parliamentary witnesses in Quebec. Meanwhile, non-professional interest groups—including infertility awareness groups, women's health organizations, and general health organizations—represent 30% of witnesses. Celebrities also appear in Quebec's hearings. Specifically, Julie Snyder—a television star—appears as a witness in a meeting of the Committee of Social Affairs and represents 10% of the ten total witnesses appearing in Quebec's IVF funding debates.

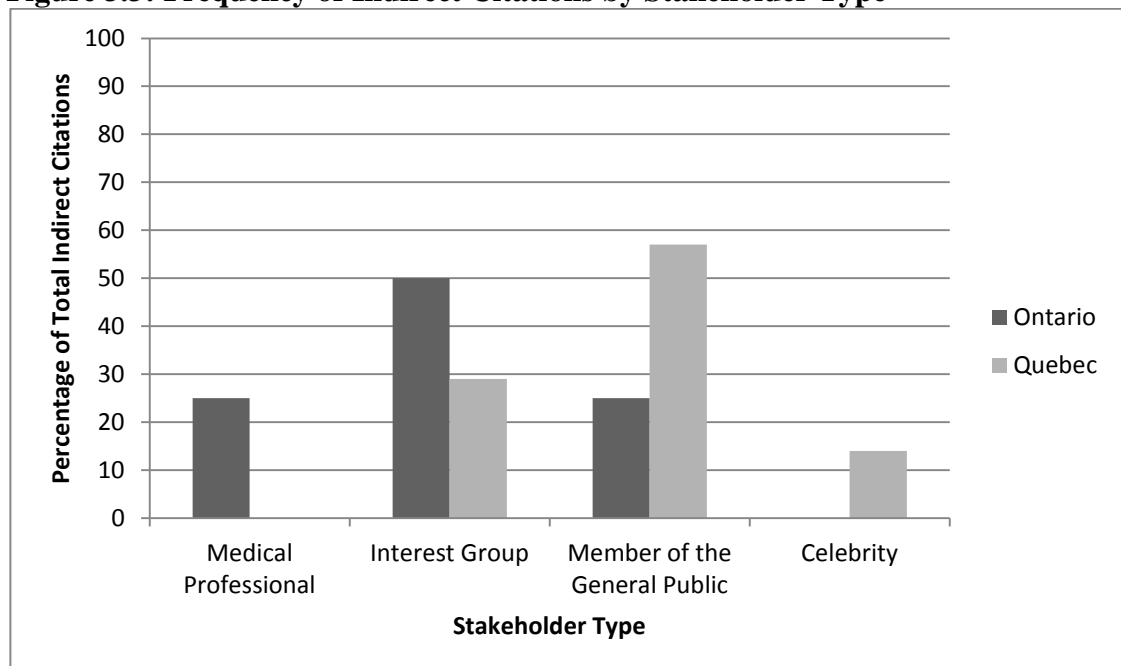
### *Stakeholders Cited Indirectly*

While not provided the same degree of standing as those who appear as witnesses with spoken voice, a variety of stakeholders are represented in Parliament via indirect citation. In both Ontario medical professionals comprise 25% of indirect citations and medical professional organizations make up 50% (see **Table 3.2 and Figure 3.3**). Meanwhile, in Quebec, professional organizations represent 29% of indirect testimony. Most notably, however, members of the public, while not given the opportunity to present their views directly, are quoted in politicians' testimony. Indeed, members of the general public comprise 25% of indirect quotations (10% of overall testimony) in Ontario and 57% of citations (24% of overall testimony) in Quebec. In Quebec, politicians cite stories of a number of individuals suffering from infertility. In Ontario, however, members of the public only appear as signatories on a petition made alongside medical professionals. Indeed, in Ontario, members of the public are only represented when coupled with a more prominent actor.

**Table 3.2: Frequency of Indirect Citations in Parliament by Stakeholder Type**

Stakeholder Type	Ontario		Quebec	
	Number	Percentage	Number	Percentage
Medical Professional	1	25%	0	0%
Interest Group	2	50%	2	29%
General Health	0	0%	0	0%
Infertility Awareness	0	0%	0	0%
Professional Organization	2	50%	2	29%
Women's Rights	0	0%	0	0%
Member of the General Public	1	25%	4	57%
Celebrity	0	0%	1	14%
<b>Total</b>	<b>4</b>	<b>100%</b>	<b>7</b>	<b>100%</b>

**Figure 3.3: Frequency of Indirect Citations by Stakeholder Type**



## FRAMING IVF FUNDING DEBATES

**Table 3.3** consolidates the ideas presented in Ontario's and Quebec's parliamentary debates into six frames. These frames describe the dominant themes in discourse about public funding of IVF and serve as a crucial cornerstone for later discussions. It is important to note that the pro and anti camps often deploy the same general frames with different spins.

**Table 3.3: Dominant Frames in IVF Funding Debates in Ontario and Quebec**

Frame	Pro	Anti
Cost-Effectiveness	Funding IVF discourages the use of cheaper infertility treatments, such as ovarian hyper stimulation drugs and discourages multiple embryo transfers. This, in turn, decreases the risk of multiple births and the accompanying financial burdens associated with complicated pregnancies and prematurity.	Funding IVF is extremely expensive and places an additional burden on the already-strained public health system. The province does not have sufficient resources to fund all services that may be seen as medically necessary and must prioritize.
Medical Necessity	Infertility is a disease and in vitro fertilization is a medically necessary treatment required to treat this disease in a safe and appropriate manner. Further, IVF reduces the prevalence of multiple births and the medical complications associated with complicated pregnancies and prematurity. IVF also reduces the mental health consequences of prolonged infertility.	Infertility is not a disease and/or it should not be prioritized for funding over other legitimate conditions such as cancer.
Social Justice	It is unjust that some individuals are able to access IVF while others are not. Private funding of IVF creates a two-tiered society in which the rich can take advantage of fertility treatments while the poor cannot. Infertile couples have a right to have access to appropriate treatments (IVF).	It is unjust to use taxpayer dollars on a service that benefits only a small subset of the population.

Population Control	IVF reinvigorates flagging birth rates by enabling those who previously could not have children to reproduce.	IVF produces too many children, placing a major burden on a country which already has too few resources and employment opportunities for its current citizenry.
IVF is Experimental	In vitro fertilization has been proven effective and safe. Further, publicly funding the procedure enables government regulation and oversight of IVF because the government controls the money going into the fertility clinics.	In vitro fertilization is still a relatively new treatment and is still experimental. Regulations and testing are necessary to ensure that the treatments are safe and effective.
Women's Rights	Funding of IVF gives women the right to control whether or not they have children and reduces inherent social inequalities between women.	Treating infertility with IVF reduces the focus on preventative measures and the causes of infertility. Funding should instead be directed toward regulation and ensuring that these procedures are safe.

### *Framing Funding Support*

In both provinces, the pro-funding camps rely heavily on frames of social justice and medical necessity to justify their positions. While these frames are frequently interspersed with threads of cost-effectiveness and discussions of regulation, politicians, medical professionals, and advocacy organizations alike focus heavily on the social justice and health benefits of IVF funding. The following sections break down how specific types of actors use these frames in Ontario's and Quebec's funding debates.<sup>3</sup>

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<sup>3</sup> Ontario's decision to defund in vitro fertilization was part of a broader piece of legislation which defunded a variety of medical services. Parliamentary discussions about changes to Ontario's Health Insurance Plan sought to define procedures for prioritization of medical services funding. Therefore, many of the debates about Bill 50 did not relate solely to IVF. Consequently, a chart delineating stakeholders' use of various IVF funding frames (like Figures 4.3 & 4.4) cannot be constructed because Ontario's debates do not solely relate to IVF and do not directly parallel their Quebecois counterparts. The text of this chapter provides a comprehensive review of stakeholder testimony.

*Politicians.* In both Ontario and Quebec, politicians in support of IVF funding primarily deploy medical necessity and social justice frameworks to support their viewpoints. In the Ontario case, where external witnesses are few and far between, Bill 50 opponents focus primarily on the injustice of public opinion's absence from determinations of medical necessity in delisting health services. Jim Wilson, an MPP from Simcoe-Grey, is the most prominent member of the opposition and asserts:

After extensive public consultation, the state of Oregon, as honourable members know, has come up with a list of health care services it will pay for and a list of those it won't pay for.<sup>4</sup> But unlike Oregon, the [Minister of Health] is not even consulting with the public when she makes her service cuts. The minister and a group of senior civil servants are rationing health care behind closed doors. It is time for the minister to come out of the back room and present this House with a list of services she has already cut and a list of services she will fund in the future. (Legislative Assembly of Ontario April 9, 1992)

Indeed, Mr. Wilson makes clear that there is great injustice in the government's delisting of services without consideration of non-governmental perspectives. In a subsequent testimony, he contends:

...all provincial governments are...delisting services, hoping that somebody like an in vitro fertilization interest group won't take them to court and say, "We believe it's medically necessary; here is the scientific data," and take them all the way to the Supreme Court of Canada to try and prove the point that it's a violation of the Canada Health Act. (Legislative Assembly of Ontario December 8, 1993)

In short, proponents of in vitro fertilization funding in Ontario really manifest as proponents of public participation. Rather than deploying IVF-specific frames, the politicians advocate on behalf of public presence in political decision-making.

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<sup>4</sup> To determine which services qualify for inclusion in the state-provided Oregon Health Plan, the Oregon Health Evidence Review Commission (HERC)—which includes legislators, community leaders, and health professionals—prioritizes medical conditions and treatments based on “clinical effectiveness and cost-effectiveness.” This Prioritized List emphasizes prevention and health education and therefore preferences treatments that prevent illness over those that treat existing illnesses (Goar 1993; Oregon Health Plan n.d.).



In Quebec, in contrast, a fierce cohort favors IVF funding, arguing directly against the Minister of Health and his supporters. While numerous arguments are presented supporting the proposed legislation, they are primarily arguments about medical necessity and social justice. As Eric Caire (MNA, La Peltre) asserts, “if one is to speak of infertility as an illness...one must necessarily ask oneself whether or not this illness requires treatment and whether or not this kind of treatment, like others which are medical procedures, should be covered by the Quebec Medical Insurance Board” (Quebec Committee on Social Affairs June 10, 2008). Indeed, Mr. Caire draws upon a framework heavily utilized in Quebec as he argues:

...we fail to grasp that aspect of our mission that represents those individuals, that represents those persons, and we abandon a huge part of the population, in a context where one must be consistent, no? When we say that the government reimburses abortion, when we say that the government reimburses vasectomies and vasovasectomies and tubal ligations and that, when one suffers from infertility and I want to emphasize this word “suffers,” one is given an insignificant tax credit...I believe we've gone down the wrong road and have betrayed our fundamental mission as parliamentarians which is, first and foremost, to represent and speak on behalf of individuals. (Quebec Committee on Social Affairs June 10, 2008).

Much in line with many non-government lobbyists, Caire and his supporters contend that the government must fund IVF because it is unjust to deem similar services medically necessary but exclude IVF from similar recognition and funding. Importantly, Caire also acknowledges his role as a representative of his constituents and their individual interests. Meanwhile, Bernard Drainville (MNA, Marie-Victorin) presents the other dominant frame in Quebec's debates as he contends that failing to fund IVF will create a two-tiered society in which the rich can afford infertility treatments and the poor cannot. “The average revenue available for a family, after

taxes, was \$55,837,” Drainville states, “Do you know many couples, Ms. President, who earn an average of \$55,000 and who have, moreover, \$10, 000 hidden in the bottom of a drawer so that they can pay for in vitro fertilization? I don’t think so” (Quebec National Assembly June 4, 2008). Indeed, Mr. Drainville’s testimony is very much in line with the social justice frame that reoccurs frequently in IVF funding debates. Together, these examples make clear that the political support in Quebec is very much built upon medical necessity and social justice frames.

*Medical Professionals.* In both Ontario and Quebec, physicians and their professional organizations appear only as proponents of public funding and as advocates of characterizing in vitro fertilization as a medical necessity. In Ontario, these doctors and professional organizations clearly assert before Parliament that Bill 50 is unacceptable because it provides the government too much power to prioritize health services and to decide what publicly-funded medicare should cover. Dr. Tom Dickson, President of the Ontario Medical Association, contends that “Bill 50 in its original form was draconian and ill conceived...The proper delivery of health care is too vital to this province to be sacrificed to a short-term agenda that ignored the input of providers in the interests of patients” (Ontario Standing Committee on Social Development October 19, 1993). Similarly, the College of Physicians and Surgeons of Ontario opposes the bill on the grounds that it permits the government too much latitude in determining which services a patient may receive. “Decisions regarding what medically necessary services are provided to a patient,” the College contests, “are the responsibility of that patient’s physician...He or she is trained to make judgments based on the patient’s clinical condition and needs; ministry officials are

not” (Ontario Standing Committee on Social Development October 19, 1993). In short, medical professionals in Ontario advocate strongly for IVF funding on the basis of medical necessity. Importantly, these physicians are chiefly focused on who has the authority to define medical necessity and on the governments’ role in the matter.

As in Ontario, physicians and medical professional organizations in Quebec primarily frame IVF funding as an issue of medical necessity, with a secondary focus on social justice and cost-effectiveness. This trend first appears when MNA Louise Harel of Hochelaga-Maisonneuve argues that it is unjust that only those with sufficient funds can access IVF and then cites an Association of Obstetricians and Gynecologists of Quebec statement that “infertility is a medical problem and can easily be compared to an unwanted pregnancy, and I quote, he said: ‘We have the money for contraception and abortion, but not for fertility. This is unjust’” (Quebec National Assembly April 14, 2005). Physicians Dr. Seang Lin Tan and Ms. Camille Sylvestre of the McGill University Reproductive Center echo similar sentiments and use numerical evidence to reinforce the message that infertility is a medical condition:

It is important to note that infertility is an important question for it affects 15 percent of couples and this number is only going to increase because people are procreating at later and later stages of life. Unfortunately, it's often regarded as an insignificant medical problem, even though we know, according to certain studies, that infertility causes absenteeism in the nation, diminishes production and the spending of resources--it's not just depression, but moral depression. (Quebec Committee on Social Affairs March 28, 2006)

While the doctors also draw upon cost-effectiveness and population control as justifications for their support of IVF funding, they ultimately conclude that the health benefits of increasing chances of reproductive success and reducing multiple pregnancies are critical factors (Quebec Committee on Social Affairs March 28,

2006). The Quebec Association of Pediatricians takes a similar approach and advocates for IVF funding on the grounds that it will discourage the use of ovarian stimulation and other cheaper infertility treatments, thereby reducing multiple pregnancies and premature births (Quebec Committee on Social Affairs March 29, 2006). Moreover, the Association contends that infertility is “a health problem which increases in our society, under the influence of a number of factors including the increasing age of the women who decide to procreate” (Quebec Committee on Social Affairs March 29, 2006). Further, drawing on examples of countries such as Belgium, Sweden, France, and England which subsidize IVF, the organization asserts that the aforementioned reduction of multiple pregnancies will greatly reduce both medical consequences and financial costs. MM. Francois Bissonnette and Robert Hemmings, obstetricians specializing in reproduction, expand on the discussion of this intervention’s cost-effectiveness as they contend that reducing multiple pregnancies and utilizing reproductive technologies will fuel the global economy by diminishing unnecessary costs and health consequences (Quebec Committee on Social Affairs March 28, 2006). Finally, the Canadian Fertility and Andrology Society (CFAS) argues that “the numbers prove that infertility remains a major health problem in Canada” and maintains that it is unjust that “couples affected by infertility are saddled with a significant financial burden, if their condition obliges them to seek assisted procreation treatments” (Quebec Committee on Social Affairs March 28, 2006). Overall, it is clear that the dominant frame among medical professionals is the medical necessity of combating infertility to reduce preventable health consequences and associated or indirect financial burdens.

*Advocacy Organizations.* In both Canadian provinces, non-professional advocacy organizations support IVF funding through similar medical necessity and social justice frames. In Ontario, the only two non-professional organizations to appear as witnesses are the federally-funded Infertility Awareness Association of Canada (IAAC) and the Patients' Rights Association. Each of these organizations appears in one meeting of the Standing Committee on Social Development and both unsuccessfully attempt to assert the need for public participation in defining the medical necessity of various services. The IAAC, in particular, notes that "Infertility is a medical condition affecting one in six couples of childbearing age in Canada" and comments that the World Health Organization recognizes infertility as a disease and classifies in vitro fertilization as an important treatment for this condition (Ontario Standing Committee on Social Development November 1, 1993).<sup>5</sup> The IAAC further contends that:

The first step in de-insuring services should be to define "medically necessary"...establish procedures to finalize definitions and criteria. Initially, the process should be a joint one with the OMA and MOH [Ministry of Health]. Input should then be sought from expert groups, for example, IAAC, as the representative of the infertile population. Then the public should be allowed to participate in this very important discussion. (Ontario Standing Committee on Social Development November 1, 1993)

Indeed, these advocacy organizations spend much of their testimony advocating for the public's right to participate in the governments' process defining which conditions and medical services are medically necessary.

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<sup>5</sup> The International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) define infertility as "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse" in their 2009 Glossary of ART Terminology (Zegers-Hochschild et al. 2009).

Similarly, in Quebec, interest groups reinforce the frames of medical necessity, social justice, and cost-effectiveness. Specifically, the Association of Infertile Couples in Quebec (ACIQ) strongly advocates for funding on the bases of medical necessity and cost-effectiveness. Drawing upon personal experience with infertility, the ACIQ representative shares:

There are people who say that receiving an infertility treatment does not cure the illness, and that one should not assume such costs. To tell you, from a personal viewpoint, it is an illness. There are people who fall into depression because of infertility; there are couples who separate because of it. Significant percentages of couples who need to separate will not do so. Such social costs are not negligible in a society. So, I think that infertility is an illness and that infertility treatment, when it allows couples to have children, helps enormously. Then, if you don't have children following the treatment, well at least you will have tried. You will have tried and then have the personal satisfaction of saying: I tried everything I could to have children. (Quebec Committee on Social Affairs June 10, 2008)

Through this testimony, the ACIQ turns the cost-benefit discourse on its head and implores politicians to consider the human cost of failure to fund in vitro fertilization and reinforces the message that IVF is a medically necessary service. The ACIQ representative further supports this claim as she argues that Quebec's health insurance covers other forms of assisted reproduction—such as artificial insemination and ovarian stimulation—and draws upon Belgium's success in reducing the costs and health consequences associated with multiple pregnancies (Quebec Committee on Social Affairs June 10, 2008).<sup>6</sup> Overall, the ACIQ representative's testimony complements physicians' arguments and draws together issues of medical necessity and cost-effectiveness to encourage the government to recognize the challenges that infertile members of Quebec's population face.

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<sup>6</sup> Belgium fully funds six cycles of in vitro fertilization for women under the age of 40 (Berg Brigham et al. 2013).

*Public Figures.* The presence of public figures distinguishes Quebec's decision-making process from Ontario's. While only medical professionals, professional organizations, and two advocacy organizations appear in Ontario's debates, celebrity Julie Snyder reinforces calls for IVF funding in Quebec through the story of her own battle with infertility and claims of medical necessity and social justice. Snyder specifically contends that "the current policy of tax breaks in Quebec is no longer acceptable, for two main reasons: it obliges infertile couples whose financial means are limited to borrow money, which is often impossible, and thereby creates a huge social injustice" and it encourages "private clinics [which] have quickly realized that they can profit from these tax credits" to increase their fees (Quebec Committee on Social Affairs June 10, 2008). Indeed, she argues that "the Quebec state refuses to consider infertility as an illness" and that IVF should be covered because similar services—such as vasectomies and tubal ligations—are included in Quebec's health insurance plan (Quebec Committee on Social Affairs June 10, 2008). Finally, Snyder contends that IVF will save money by reducing multiple pregnancies. Having been invited to speak in IVF debates because of her celebrity status, Snyder reinforces the social justice and medical necessity frames that other stakeholders present.

*Members of the General Public.* Finally, while members of the general public never appear before Parliament, parliamentarians represent the ideas of these constituents through quotations and references to popular petitions. In Ontario, near the beginning of the Bill 50 debates, MPP Bill Murdoch (Bruce-Grey-Owen Sound) presents a petition to the Legislative Assembly with approximately 1,000 signatories

which contends that “proposals made under the government’s expenditure control plan...will have a devastating impact on access to and the delivery of health care” and implores that the government “withdraw these proposed measures and reaffirm its commitment to rational reform of Ontario’s health care system” (Legislative Assembly of Ontario July 15, 1993). Similarly, in the midst of Quebec’s IVF debates, Members of National Assembly (MNAs) present a petition signed by 196 citizens of Quebec imploring the government to fund in vitro fertilization (Quebec National Assembly February 20, 2007). The petitioners specifically assert that reproductive technology funding will combat a declining birth rate and, along the same vein as Julie Snyder’s testimony, argue that IVF should be covered because the expansive state health insurance already includes abortion, tubal ligation, and vasectomy (Quebec National Assembly February 20, 2007). In short, through petitions, members of the general public echo more prominent stakeholders in emphasizing the social justice and medical necessity frames.

In Quebec, in addition to supplementing the decision-making process through petitions, pro-funding parliamentarians detail their constituents’ emotional and economic hardships to appeal to their opposition’s emotions. For example, MNA Bernard Drainville, a strong proponent of government-funded IVF, cites constituent Annie Perreault’s financial burdens and the emotional rollercoaster that her infertility spawned:

We are an infertile couple. We have been trying, by all imaginable means, to have a child for eight year. We’ve tried several treatments, including medication, laparoscopic surgery, uterine operations, artificial insemination—without success. For five years we have been in the long and costly process of in vitro fertilization, doctors have told us that this is likely the only possibility...We have undergone five treatments



until now, and in total this has cost us nearly \$50,000 if one includes the cost of accompanying medications, and the RAMQ doesn't even cover the medication for in vitro fertilization, in vitro costs between \$3,000 and \$7,000 and, on top of that, you need to take into account the price of medicine... We mortgaged our house, exhausted our credit line. Just last month, we tried a sixth in vitro fertilization—our last chance because we no longer have the resources to do so...it's a challenge to make economies and go into debt for this ultimate dream. (Quebec National Assembly June 4, 2008)

As evidenced above, Drainville tugs on his opponents heartstrings by highlighting the unjust fact that these infertility sufferers have drained their savings in a number unsuccessful attempts to have children. In another instance, Drainville cites constituent Valerie Cote who corroborates the moral imperative and social justice approach put forth in Ms. Pereault's statement:

You will surely tell me that the State gives a tax break of 50% for fertility treatments. I consider myself lucky to have been able to borrow the necessary money for my treatments. If I had not been able to borrow, I wouldn't have my son to cuddle every day. Many infertile couples don't have this chance. In effect, the tax break doesn't help infertile couples who don't have the means to shoulder the costs. (Quebec National Assembly June 4, 2008)

Indeed, as these statements demonstrate, though members of the public do not speak in parliamentary debates, parliament members recount individuals' personal struggles to advance the social justice discourse supporting IVF funding.

Ultimately, IVF proponents in both Ontario and Quebec primarily center their arguments around medical necessity and social justice, with a secondary focus on cost-effectiveness. Yet, advocates in the two provinces apply the same frames quite differently. In Ontario, both the social justice and medical necessity discussions are geared toward discussion of public involvement in decision-making. In Quebec, in

contrast, stakeholders present a more multifaceted perspective and reinforce IVF-specific messages of social justice, medical necessity, and cost-effectiveness.

### *Framing the Opposition*

Unlike the more multifaceted approach of IVF funding proponents, the opposition in both provinces heavily focuses on three specific frames: cost-effectiveness, experimental risk, and the protection of women's rights. In both cases, parliamentarians comprise the majority of the opposition and emphasize the financial burdens that IVF funding places on the healthcare system. Meanwhile, in Quebec, women's rights organizations raise concerns about insufficient focus on preventing the causes of infertility and about protecting the rights of women as guardians of their own bodies. The following section details the specific arguments that politicians and witnesses present in opposition to public funding of in vitro fertilization.

*Politicians.* In Ontario, Minister of Health Ruth Grier and her supporters are the primary representatives of parliamentary opposition to IVF funding. This cohort advocates for Bill 50 on the grounds that cost cutting is necessary to maintain Ontario's successful medicare program, as seen in Ms. Grier's statement to the Legislative Assembly:

The current fiscal situation forces us to face an inescapable truth: Our system is the most expensive publicly funded system in the world... If we keep spending as though the sky were the limit, we will not have a universal health care system to pass on to our children and our children's children, because the system would become unsustainable. (Legislative Assembly of Ontario July 26, 1993)

The bill, Ms. Grier continues, "is not for the purpose of allowing government to practise medicine...nor does it allow the government to stop paying for medically

necessary services...” (Legislative Assembly of Ontario July 26, 1993). Indeed, Ms. Grier represents the dominant opposition view that cutting funding of in vitro fertilization is necessary in the interest of funding other necessary services. Ms. Grier’s predecessor, the Honorable Frances Lankin, presents the other dominant view in Ontario’s opposition: concern about the experimental nature of IVF. Mr. Lankin specifically contends that “...we have to have a health system that is based on good analysis of what the health outcomes of procedures are” and argues that there is a lot of uncertainty about “whether it is an effective procedure, whether there are good health outcomes of the babies that are produced with that kind of technological intervention” (Legislative Assembly of Ontario April 9, 1992). In sum, Ontario’s parliamentary opposition embodies the negative frames of cost-effectiveness, prioritization, and the need for regulation of experimental techniques.

Meanwhile, in Quebec, Minister of Health and Social Services Phillippe Couillard and his backers champion the necessity of prioritization in deciding which health services to fund. The opposition’s overall frame is embodied by Couillard’s assertion that:

...to govern is to choose. If we could, ladies and gentlemen, we would like to help all seniors, all children in difficulty, all patients in Quebec tomorrow, give them everything they need. However, once again, we must make choices according to one’s priorities, which are, in general, the collective priorities of society—priorities on which we will never agree. Each of us has a definition of what a society’s priorities are. And I would say that, for this reason, I have chosen to abandon a medical practice that is very fruitful and very lucrative, several years ago, so that I could consecrate myself to public service and thus the bettering of the health system. (Quebec Committee on Social Affairs June 10, 2008)

In essence, in the opposition's view, strategic allocation and focus on benefiting the general population, rather than only IVF patients, should be the driving factor behind IVF legislation. This belief in assessing broader priorities defines the political opposition in both Ontario and Quebec.

*Interest Groups.* Very few non-governmental witnesses testify against IVF funding in either province. Indeed, there is not a single Ontarian witness who formally testifies against public funding of IVF. Every non-governmental witness—whether interest group, medical professional, or member of the public—testifies in support of IVF funding. While the balance is not quite as skewed in Quebec, the only non-political stakeholders to present testimony against IVF funding are the Council on the Status of Women (CSW) and the Planned Parenthood Federation of Quebec (FQPN). The Council on the Status of Women does not directly address the issue of IVF funding, but contends that “having recourse to medically assisted procreation techniques should not, in any case, substitute the necessity of protecting the reproductive capabilities of men and women” (Quebec Committee on Social Affairs March 29, 2006). The council further combats the dominance of physicians in defining medical necessity and argues that:

...we believe that doctors are experts in that which concerns medical acts, in practices, but for a question as vast as medically assisted procreation, in which there are important ethical issues, we think it necessary to widen the scope of people responsible, to consider in this sector how to propose guiding frameworks, or at least to suggest such frameworks and perspectives which could be approached by an ethics committee, where there will be duly accredited centers. (Quebec Committee on Social Affairs March 29, 2006)

The government, the CSW asserts, should protect the right of women to have a say in their own health services and should divert funding for infertility treatments to

preventing sexually transmitted infections and other causes of infertility. Similarly, the Planned Parenthood Federation of Quebec advocates strongly against funding of IVF, arguing that funding these “burdensome, costly, inefficient and risky for the health of women and children” technologies detract from preventing factors leading to infertility, such as sexually transmitted infections and environmental risks (Quebec Committee on Social Affairs March 30, 2006). In sum, women’s and patients’ rights organizations in Quebec—the only non-governmental witnesses to testify against IVF funding—rely heavily on the negative frames of women’s rights and public health.

Overall, government figures advocating against IVF funding due to experimental risks and financial concerns heavily dominate the opposition in both provinces. That said, the non-government actors who do appear before Parliament add some diversity to Quebec’s opposition argument as they rely primarily on frames of women’s rights and public health concerns.

## **CONCLUSION**

Ultimately, the predominance of medical professionals as witnesses in Ontario’s debates about Bill 50 constructs the discussion of medical funding—and of IVF funding specifically—as a debate about medical necessity. When considering this conclusion, it is important to note the relatively low number of parliamentary records analyzed (16 from Ontario, 21 from Quebec) and the fact that the IAAC was the only witness to testify explicitly about in vitro fertilization. All other stakeholders discussed in this analysis testified more broadly about all of the medical funding cuts associated with Bill 50. Nonetheless, consideration of all testimony makes clear that

the Ontarian Parliament's hearings about the 1993 *Expenditure Control Plan Statute Law Amendment Act* are essentially debates about who has the authority to define medical necessity. Supporters of the bill—namely Minister of Health Ruth Grier—argue on the basis of cost-effectiveness and the need to cut expenses given limited health funding. Meanwhile, the overwhelming dominance of medical professionals and medical professional organizations as witnesses ensures that the government-physician power struggle, rather than issues of social justice or women's rights, is central to medical funding decisions. Meanwhile, patient advocacy organizations such as the IAAC attempt to introduce public opinion in defining medical necessity, but are at the mercy of more prominent players. In the case of Ontario's 1993 *Expenditure Control Plan Statute Law Amendment Act*, the relative absence of non-professional interest groups appears to have enabled massive cuts and physician-dominated debates about medical necessity.

In Quebec, in contrast, IVF funding debates involve a greater balance between politicians, medical professionals, and other stakeholders. Though the government opposition relies on similar frames of prioritization and cost-effectiveness, the proponents of IVF funding present a more multifaceted argument. Indeed, discussion topics ranging from the cost-effectiveness and medical necessity of treating infertility to the social justice issues related to unequal access overwhelm the opposition's argument that funding IVF would place an undue burden on Quebec's health system. Ultimately, it seems that the diversity of stakeholders and the bill proponents' multifaceted approach is an important factor distinguishing Quebec's decision-making process and funding outcome from Ontario's.

# 4

## **Painting Perceptions: Stakeholder Influence in the News Media**

While examination of parliamentary records provides important insight into stakeholder standing in government forums, media coverage analyses lend insight into the image presented to members of the general public. Indeed, newspaper coverage plays a critical role in shaping public perspectives of political processes and is the only forum through which members of the general public are able to voice their views (E. Baker 1998; McCombs and Shaw 1972; Rosen 1996). As such, consideration of stakeholders' relative standing in news media coverage and framing of the funding issue in this arena plays a critical role in assessing whose perspectives are considered important in shaping problem definition and which stakeholders have the political and financial resources to gain traction in the public sphere.

### **STANDING**

Examination of media coverage of Ontario's 1993 *Expenditure Control Plan and Statute Law Amendment Act* and Quebec's 2008 decision to incorporate in vitro fertilization into its health care plan suggests notable patterns in which stakeholders have a voice in debate media coverage. Interestingly, the relative standing of different

stakeholders varies significantly from standing in the previously discussed parliamentary hearings and debates.

As in the aforementioned case of parliamentary hearings, politicians and interest groups comprise a large majority of stakeholders quoted in media sources. As **Table 4.1** and **Figures 4.1** and **4.2** show, politicians in Ontario represent 39% of overall stakeholder quotations and tie interest groups for the largest proportion of utterances. In Quebec, politicians are the most quoted group of stakeholders and represent 22% of stakeholders cited in media testimony.

Interestingly, medical professionals and professional organizations maintain a less dominant role in media coverage than in parliamentary debates. In Ontario's coverage, medical professionals and medical professional organizations each comprise 11% of citations. In Quebec, medical professionals put forth 17% of utterances, while medical professional organizations expressed 7%. In short, while medical professionals and their professional organizations maintain a strong presence, they are not as overwhelmingly dominant as in parliamentary debates and committee hearings.

Potentially the most interesting discrepancies between news media and parliamentary standing are the relative presences of non-professional interest groups, academics, celebrities, and members of the general public. While the celebrity presence remains approximately the same—Quebec's Julie Snyder represents 12% of citations and remains the only celebrity to speak on the issue—there are notably more quotations by academics and members of the public and fewer by advocacy organizations. In Ontario's media coverage, academics—who did not have standing in parliamentary debates—comprise 4% of quotations. Meanwhile, members of the

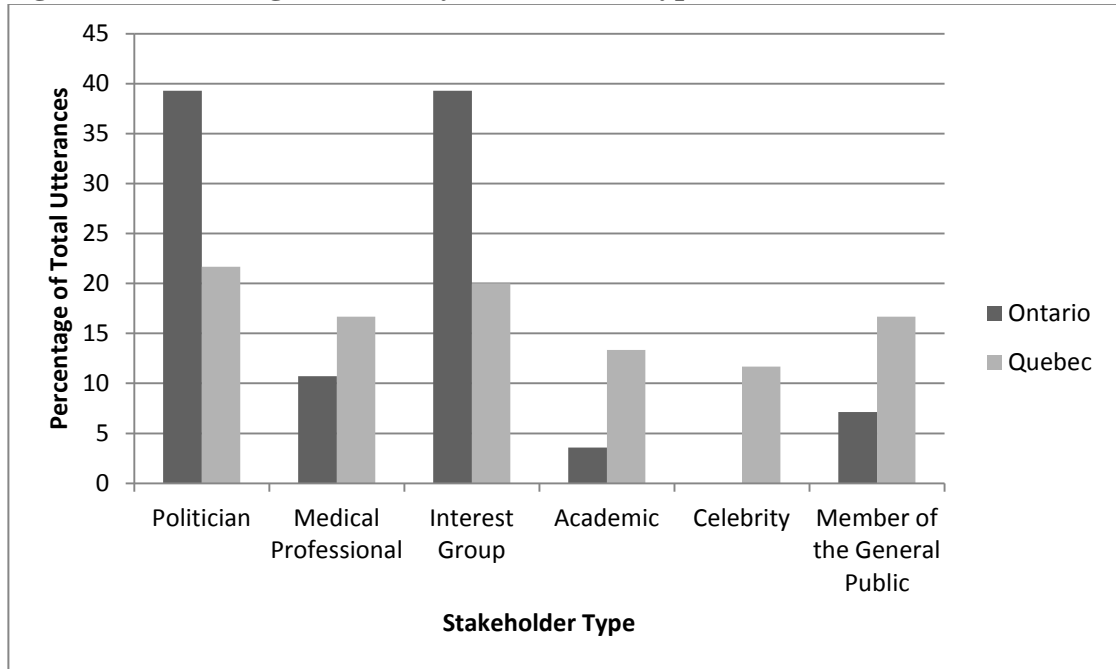


public—who appeared in parliament only via indirect citations—represent 7%. Similarly, in Quebec’s coverage, academics represent a significant 13% of media quotations and members of the general public are cited nearly as many times as interest groups at 17%. Finally, non-professional interest groups—namely infertility awareness organizations, patient advocacy groups, and women’s rights organizations—represent 29% of overall citations in Ontario and 13% of utterances in Quebec, a smaller presence than they had in parliamentary debates. Indeed, while it is important to note that the comparison is not perfect because politicians were not included in calculations of parliamentary debate standing and because fewer debate records than media records were available for analysis, the considerable differences in the relative presence of stakeholders in these two cases presents important insight into the influence of various actors in different political decision-making forums.

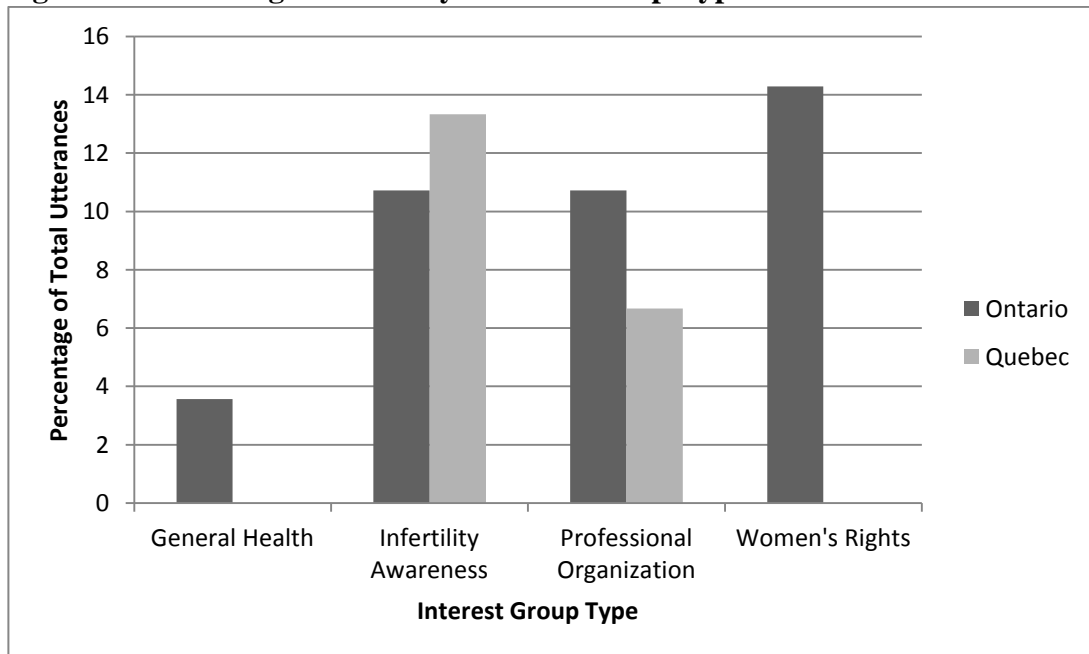
**Table 4.1: Relative Presence of Stakeholders in Media**

<b>Stakeholder Appearances in News Media</b>				
<b>Stakeholder Type</b>	<b>Ontario</b>		<b>Quebec</b>	
	<b>Number</b>	<b>Percentage</b>	<b>Number</b>	<b>Percentage</b>
Politician	11	39%	13	22%
Medical Professional	3	11%	10	17%
Interest Group	11	39%	12	20%
General Health	1	4%	0	0%
Infertility Awareness	3	11%	8	13%
Professional Organization	3	11%	4	7%
Women's Rights	4	14%	0	0%
Academic	1	4%	8	13%
Celebrity	0	0%	7	12%
Member of the General Public	2	7%	10	17%
<b>Total</b>	<b>28</b>	<b>100%</b>	<b>60</b>	<b>100%</b>

**Figure 4.1: Standing in Media by Stakeholder Type**



**Figure 4.2: Standing in Media by Interest Group Type**



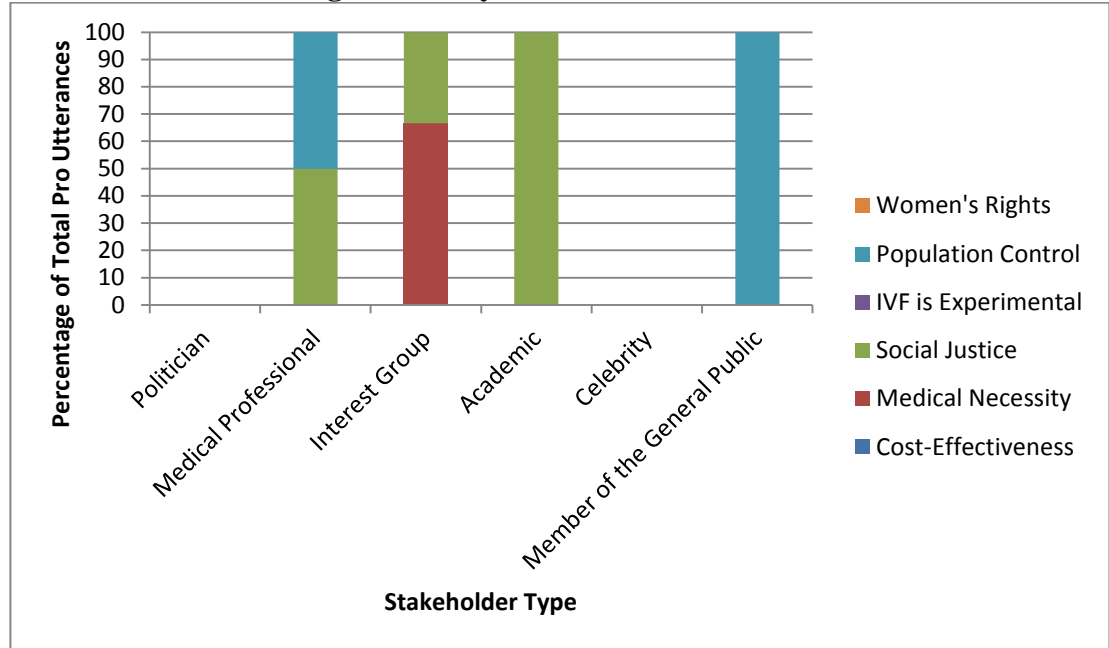
## FRAMING

### *Framing Funding Support*

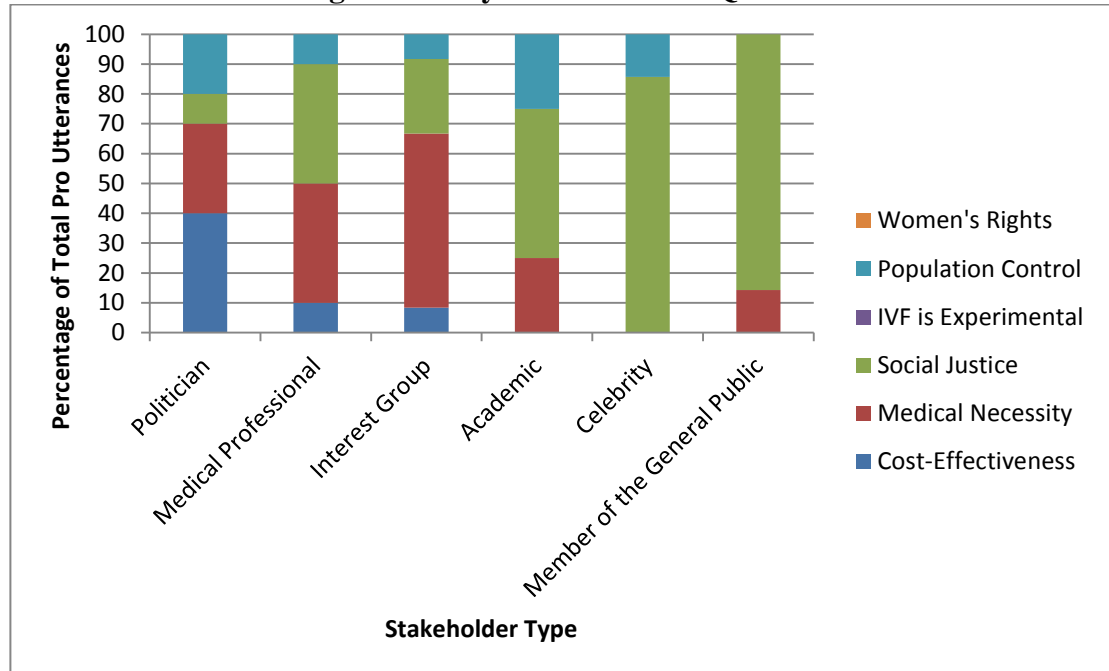
Analysis of media coverage of IVF funding debates in both Ontario and Quebec suggest that the social justice and medical necessity frames which dominated the parliamentary hearings are also the predominant factors in media coverage (see **Tables 3.3 & 4.2 and Figure 4.3**). While these frames are interspersed with discussions of cost-effectiveness, women's rights, and population control, there is a heavy emphasis on infertility as a disease and on the unjust nature of unequal access to IVF services. The following section dissects how specific actors utilize each of these frames in both Ontario and Quebec.

*Politicians.* Politicians play vastly different roles in the media coverage of Ontario's and Quebec's decision-making processes. In Ontario, virtually every politician cited in newspaper coverage represents the opposition. Indeed, the only mention of a politician who is even remotely in support of IVF funding is a mention that liberal leader Lyn McLeod "slammed [Health Minister] Grier for holding only one day of public hearings on a proposal to cut 19 medical services from OHIP" (Anon 1993b). In Quebec, in contrast, political figures represent a larger diversity of opinions and present a greater variety of frames. Political IVF funding proponents particularly focus on issues of population control, with secondary focuses on medical necessity, cost-effectiveness, and social justice issues. In multiple instances, figures such as Premier Jean Charest express optimism that funding in vitro fertilization would increase births by approximately 1,500 per year (Marsden 2008). Meanwhile,

**Table 4.3a: Pro-Funding Frames by Stakeholder in Ontario Media**



**Table 4.3b: Pro-Funding Frames by Stakeholder in Quebec Media**



Charest supplements his assertions with acknowledgment that IVF is a medically necessary treatment and Minister of Health Yves Bolduc (the successor of previously mentioned Health Minister Philippe Couillard) expresses optimism that the policy will cut costs associated with multiple pregnancies.

*Medical Professionals.* As in the parliamentary hearings and debates, medical professionals and their professional organizations are cited primarily as IVF funding proponents. In Ontario, the majority of these medical professionals and professional organizations deploy frames of medical necessity and assertions that there must be checks and balances in defining this term. While the Medical Director of Ottawa Civic Hospital's IVF center cites population control as a benefit of IVF funding, the majority of medical professionals' or organizations' quotations express concerns, similar to those expressed in Parliament, that the proposed Bill 50 "could give bureaucrats the power to dictate when, why, how and where patients get treated" (Anon 1993c). In the Quebec case, medical professionals and representatives of professional organizations advocate for IVF funding primarily based on medical necessity, with an additional emphasis on population control. Seang Lin Tan of the McGill Reproductive Centre states that one in eight Canadian couples struggles with infertility (Krashinsky 2009), while others, such as the Canadian Fertility and Andrology Society, assert that funding IVF will reduce major public health concerns such as multiple pregnancies and premature birth. In sum, as in parliamentary testimony, medical professionals and medical professional organizations primarily support IVF because they consider infertility a disease and IVF a medically necessary treatment to treat the condition and reduce its public health consequences.

*Interest Groups.* Interest groups also retain their strong presence as funding proponents. As in the parliamentary debates, the vast majority of interest groups are cited as IVF funding supporters. In Ontario's case, interest groups' quotations primarily represent the Infertility Awareness Association of Canada (IAAC) or the Ontario Medical Association (OMA). As indicated in Chapter 3, the OMA argues against Bill 50 in support of public and medical professional involvement in defunding decisions. The IAAC focuses primarily on social justice and medical necessity frameworks and advocates for IVF funding on the grounds that infertility is a medical condition for which IVF is a proven treatment. Indeed, one quote contends that "the tax dollars of the infertile pay for reproductive health care for the fertile" (Papp 1994), while another asserts that the IAAC is disturbed that the "government considers IVF to be some sort of esthetic frill; that one can somehow choose infertility as one would choose to get a tattoo" (Anon 1993a). In Quebec, non-professional interest groups support IVF funding with a range of frames. Organizations such as the IAAC primarily emphasize the medical necessity of IVF—as seen in executive director Beverly Hanck's statement that infertility is a "serious medical condition with economic, social and personal consequences" (Fidelman 2010). However, these organizations also pinpoint factors such as the potential for a reduced burden of multiple pregnancies and the social justice benefits of universal IVF access. Overall, interest groups supplement the perspective of medical professionals as they reinforce messages of medical necessity and emphasize the public health benefits associated with public funding of in vitro fertilization.

*Public Figures.* Like in parliamentary debates, the only public figure to appear in media-based IVF funding debates in either province is Julie Snyder, who plays a prominent role in the discourse and draws on social justice frames to assert her support for IVF funding. In a number of instances, Snyder draws on the public's empathy and sense of justice as she questions why others should not be able to access the services that enabled her to have a family. "There are some people who can only afford one treatment," Snyder remarks, "so you cry with them...It's deeply unfair. I promised God that if I had my baby I'd do my best to help others" (Wente 2010). It is unjust, Snyder reasons, that only Quebecois citizens who have financial resources can access this important tool in combating infertility. Indeed, this celebrity provides a level of high-profile reinforcement for pro-funding frames that was notably absent in Ontario.

*Academics.* Academics represent a more significant percentage of utterances in media coverage of IVF funding debates than they do in parliamentary hearings. Yet, academics still make a limited number of appearances overall and generally appear as IVF funding opponents. In fact, in Ontario, only one pseudo-academic appears in debate media coverage. In this instance, Kirsten Kozolanka, who wrote a university thesis about infertility, comments that women "have mutilated bodies...through their pursuit of infertility" and that in vitro should be funded to reduce this phenomenon (Pigg 1990). In Quebec, however, academics are more frequently quoted in support of IVF. Specifically, *New Scientist* magazine cites "flagging birth rates" as an incentive for IVF funding (Rinehart 2007) while Jeff Nisker calls upon a social justice frame and rhetoric of inequality to justify his claims.

In sum, though they do not comprise a large proportion of stakeholders, academics are often cited by writers to validate frames presented by other stakeholders.

*Members of the General Public.* Members of the general public have a stronger voice in media coverage than they do in parliamentary debates in either province. In Ontario, an article quoting results from a telephone poll represents members of the general public. While 71% of callers state their opposition to including IVF in the Ontario Health Insurance Plan (OHIP), the 29% in support of inclusion cite frames of social justice—commenting that “OHIP should cover those who are unlucky and can’t have children for any reason”—and arguments that IVF will spur the province’s birth rate (Turner 1993). Meanwhile, in Quebec, members of the general public appear primarily in personal testimonies used as introductions and “hooks” for both news and editorial pieces. As they describe the emotional and financial strains wrought by their hard-fought battles against infertility, these members of the general public draw upon frames of social justice and medical necessity to justify their cause. For example, Michel Kriaa and Josee Goupil state that they have spent \$23,000 on fertility treatments and comment that they know many others who have had to borrow the money for IVF (Fidelman 2010). Overall, in both provinces, members of the general public represent a minority of cited stakeholders, but echo familiar frames in their personal opinions and emotional testimonies.



## *Framing the Opposition*

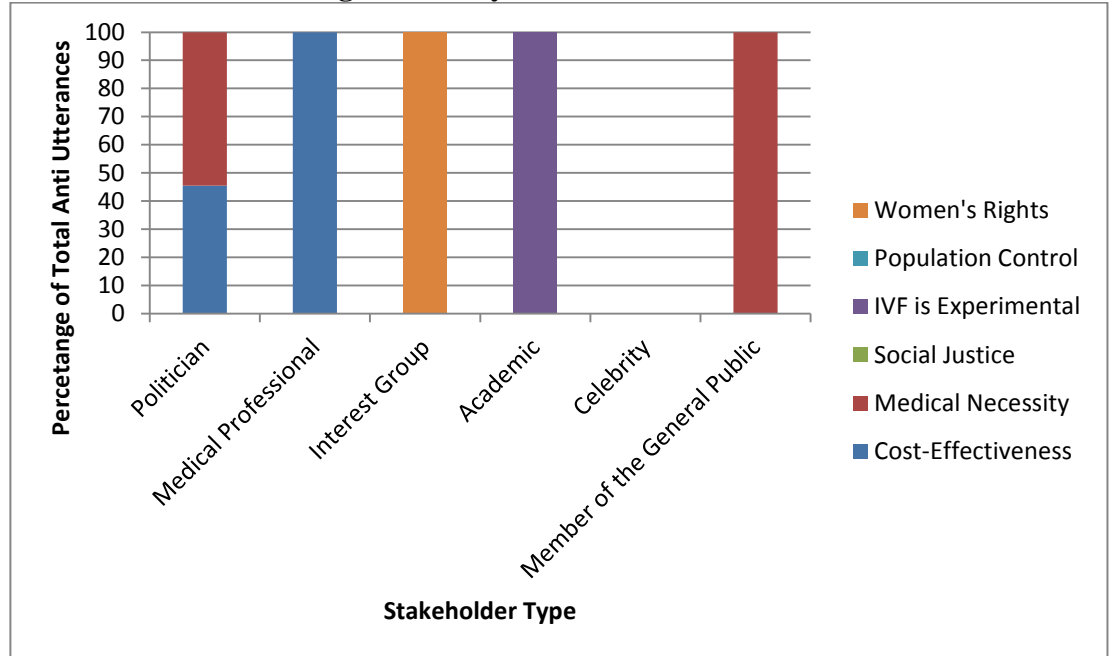
As in parliamentary hearings, IVF funding opponents primarily deploy frames of cost-effectiveness and the need to prioritize medical necessities in media quotations. Indeed, while a variety of stakeholders present these frames and supplement them with concerns about women's rights and about the experimental nature of IVF, the overwhelming negative view is a fear that funding IVF will detract from sufficiently funding other medically necessary services. The following section outlines the specific arguments various stakeholders present to challenge IVF funding.

*Politicians.* Politicians cited in media coverage of both provinces' debates argue against IVF funding almost exclusively on the grounds of cost-effectiveness and prioritization (see **Table 3.3, Table 4.2, and Figure 4.4**). In Ontario, a number of politicians state that defunding IVF is necessary for the OHIP's long-term sustainability. Individuals ranging from Minister of Health Ruth Grier to Treasurer Floyd Laughren assert that IVF is an experimental procedure that should not be prioritized over other medically necessary conditions and argue that financial necessity—rather than a desire to diminish the authority or rights of physicians, members of the public, or other stakeholders—requires that they take the proposed cost-cutting measures (Anon 1993c). Interestingly, though these politicians acknowledge funding proponents' concerns that they are excluding other stakeholders' opinions in defining medical necessity, they contort these concerns to legitimate their own arguments and assert that representation in defining medical necessity is not the issue at hand. While Quebec's media coverage includes only two instances in which a politician speaks out against IVF funding, both embody an argument similar to that

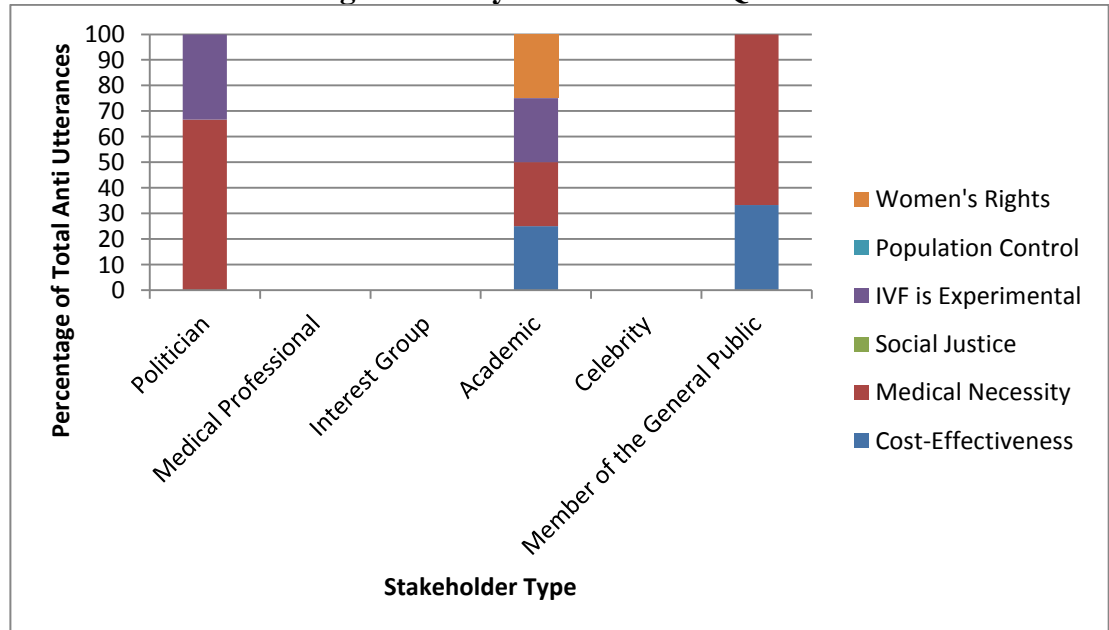
presented in Ontario. Specifically, politicians contend that the procedure is expensive, has a high failure rate, and should not be prioritized over more serious health concerns (Aubin 2008; Marsden 2008). Further, Health Minister Philippe Couillard argues that “infertility is not an illness and that illness is the only thing for which the agency that handles medical bills ought to pay—the agency’s name, after all, is *Regie de l’assurance maladie*” (Aubin 2008). In sum, in both cases, government opponents of IVF funding directly refute claims of medical necessity and primarily base their public opinions on frames of cost-effectiveness and the experimental risk.

*Medical Professionals.* Notably, medical professionals make virtually no comments to the media in opposition to IVF funding in either Ontario or Quebec. While a number of medical professionals cited in Ontario’s coverage address their desires to have input in the funding prioritization process, the only mention of a medical professional who may oppose IVF is a comment by Dr. Michael Wyman, vice-president of the OMA, who argues that “the concept of everything to everybody, anytime will have to change because the system just can’t afford all of that” (Priest 1993). The “system will go bankrupt” if health care applies to “everyone, everywhere,” Wyman argues, so services must be prioritized based on necessity (Priest 1993). In Quebec, no medical professionals speak out in the news media against funding IVF.

**Table 4.4a: Anti-Funding Frames by Stakeholder in Ontario**



**Table 4.4b: Anti-Funding Frames by Stakeholder in Quebec**



*Interest Groups.* The only interest groups to testify in opposition of IVF funding in media coverage of either province's debates are Planned Parenthood of Canada and the National Action Committee on the Status of Women. Both organizations appear in media coverage of Ontario's debates about Bill 50 to argue on the basis of women's rights and preventative health services. Specifically, Planned Parenthood of Canada advocates for prevention and health education, while the National Action Committee on the Status of Women calls IVF a "failed technology [that] has serious dangers for both women and the children that they bear" (Anon 1993b). In sum, as in the case of parliamentary testimony, the only interest groups to testify against IVF funding argue in favor of protecting women's rights and focusing on preventative services.

*Academics.* Academics in both provinces reinforce the messages politicians present as they advocate for cost-effectiveness and prioritization in funding medical services. In Ontario, the only anti-IVF funding utterance by an academic is a refutation by Will Kymlicka of the University of Ottawa Department of Philosophy who argues against the attitude that "any new medical procedure should be immediately included in the health-care system, even before its safety and efficacy have been established" (Kymlicka 1993). Similarly, only one academic—Abby Lippman, an epidemiologist and women's health advocate—speaks on behalf of the opposition in Quebec's media coverage. Across multiple articles, Lippmann consistently questions why IVF should "take precedence for scarce government dollars over items like Quebec's over-burdened daycare system or lack of midwives and family physicians" (Blackwell 2010). In short, in both cases, academic opponents

of IVF funding—though few in numbers—reinforce the ideas that the government presents and represent a unique perspective that was absent from parliamentary sessions.

*Members of the General Public.* Finally, in media coverage, members of the general public present important support for the opposition cause. While the only members of the general public represented in parliamentary testimony were IVF funding proponents, media coverage highlights both sides of public opinion. As previously mentioned, a poll in Ontario cites members of the general public and notes that 2,319 callers (71%) oppose OHIP coverage of in vitro fertilization (Turner 1993). The article further delineates their rationales, which focus primarily on frames of cost-effectiveness and prioritization of medical necessities. Respondents' statements range from an assertion that IVF should not be covered "because it's not life threatening" to a comment that "if couples want children badly enough they should be able to find their own money to pay for it" (Turner 1993). Indeed, the public voice represents a spectrum of frames in media coverage of Ontario's debates. Meanwhile, members of the general public in Quebec appear a number of times in opposition to IVF funding. Notably, a summary of readers' online opinions highlights concerns ranging from "Seriously? This is the priority? Are you kidding me?" to "trying so long to conceive without success must be very difficult mentally and emotionally, as are a lot other things..." (Anon 2010). In both cases, media presents the only opportunity for direct public input. However, in both cases readers speak out only through indirect forums such as surveys or online forms. Overall, though their relative presence is low compared to other stakeholders', comments by members of the general public confirm

that they are generally in agreement with the interest groups, politicians, and medical professionals who claim to represent their interests.

## CONCLUSION

By and large, trends in standing and framing are fairly consistent in news media and parliamentary debates. In Ontario, although a greater diversity of stakeholders is represented than in parliamentary hearings, medical professionals, professional organizations, and politicians maintain their dominant positions and advocate primarily for comprehensive reviews of medical necessity and analyses of cost-effectiveness, respectively. Interestingly, however, women's rights organizations—who were notably absent in parliamentary testimony—appear in news media coverage and advocate *against* IVF funding in defense of women's freedom and preventative services. Meanwhile, public opinion—which was absent from parliamentary hearings—is cited directly and is used quite explicitly to draw upon readers' emotions. Overall, Ontario's media coverage highlights a more heterogeneous sample of both stakeholders and frames than the province's parliamentary discussions.

In Quebec, the previously observed balance between politicians, medical professionals, and other stakeholders remains fairly consistent. While interest groups' and politicians' statements are the majority of utterances, an array of actors—ranging from academics to members of the public—appear in media coverage. Though its various stakeholders present a number of rationales, Quebec's media coverage is much more skewed in support of IVF funding than is Ontario's. Indeed, despite its more heterogeneous pool of actors, Quebec's coverage represents a much less balanced

perspective on the issue of IVF funding. Overall, though the evidence is fairly one-sided, Quebec's media coverage reaffirms the conclusion that the Quebec's diverse stakeholders reinforce each other's claims.

# 5

## Conclusion

This thesis began with a puzzle: given their similar national contexts, why did Quebec choose to fund IVF for all of its citizens while Ontario did not? In light of this dilemma, I set out to examine the factors and processes underlying Ontario's and Quebec's divergent funding decisions. I specifically sought to determine how relevant stakeholders shaped policy outcomes and whether the interaction between advocates and professional witnesses played a role in defining these two distinct results. Prior research has suggested a decline in professional dominance in political decision-making, particularly with respect to science and medicine, and a rise in the credibility and standing of lay experts (Davis and Abraham 2010; Epstein 1995, 1996; Eyal and Buchholz 2010). Indeed, previous works suggested that advocates gain traction by asserting their roles as representatives for the general public and by deepening their understandings of technical terminology and concepts to gain access to government circles and advisory sessions (Epstein 1995, 1996). The findings of the current study tend to support these claims.

Analysis of parliamentary and media records from Ontario suggests that medical professionals are still very much the dominant players in IVF funding decisions. In parliament, the overwhelming predominance of medical professionals as



witnesses turned debates about IVF funding cuts into arguments between professionals and government officials about professional expertise and the legitimacy of government intervention. The near-absence of non-professional stakeholders—only two non-professional organizations testified in Ontario’s parliamentary hearings about Bill 50—exaggerated this dynamic. Ultimately, though the Infertility Awareness Association of Canada and a few Members of Parliament hint at the need for public participation in the prioritization of medical services, Ontario’s parliamentary transcripts suggest that medical funding decision-making is still very much an issue of professional opinion versus government constraints.

Media coverage of Ontario’s IVF debates represents a larger array of stakeholders, though medical professionals and professional organizations remain among the most-cited non-governmental stakeholders. Meanwhile, the frames of medical necessity and cost-effectiveness remain dominant across a variety of stakeholder appearances, though social justice also comes into play. Importantly, public opinion appears for the first time in media utterances, with writers frequently directly citing personal stories of infertility-suffers, often to draw upon their readers’ emotions. This finding is much in line with previous research suggesting that encouraging narrative and personal stories breaks the boundaries between the public and the personal and, in so doing, encourages citizens to engage politically (Ferree et al. 2002:284–285). In short, the current findings agree with past assertions that individuals without previous allegiances are engaged through emotional or moral shocks. Overall, media coverage from Ontario suggests that the media is the forum in

which different forms of expertise truly mix and where the opinions of the public have their one chance to be directly represented.

Meanwhile, in agreement with recent literature in the sociology of expertise, Quebec's IVF funding debates represent a more balanced perspective. Though government officials in Quebec still frame IVF as an issue of prioritization and cost-effectiveness and medical professionals maintain a prominent role as experts in the debates, a number of lay experts appear as both advocates and opponents of the initiative. Just as Epstein's (Epstein 1995, 1996, 2007) works suggest, advocacy organizations such as the Infertility Awareness Association of Canada deploy medical terminology and technical expertise to reinforce the ideas that other stakeholders present. These laypeople reinforce ideas of medical necessity and prioritization, while also introducing frames such as social justice and women's rights. Ultimately, it is this diversity of stakeholders that distinguishes Ontario's legislative processes from Quebec's.

The balance between professional and non-professional advocates remains fairly constant in media coverage of Quebec's debates. Interest groups and politicians represent the majority of citations, but academics, members of the general public, public figures, and medical professionals join in on testimony. These actors present frames ranging from the importance of social justice issues to issues of cost-effectiveness to the need for population control. As in Ontario, writers primarily deploy members of the general public to enhance social justice discourses and draw on readers' emotions. On the whole, Quebec's media coverage is quite one-sided, as nearly all of the cited stakeholders argue in favor of IVF funding, but it reinforces the

idea that a combination of professional expertise *and* lay expertise enhances the diversity of a debate and tempers the dominance of medical professionals and discussions of medical necessity.

Overall, my findings reinforce the view that advocates earn credibility and standing in policy debates by studying and deploying the language of experts and by presenting themselves as the conduits for the general public. In addition, my findings support the suggestion that a diversity of stakeholders may lead to more liberal policies (Epstein 1996), as seen in the contrast between Ontario and Quebec. However, the continued struggle between professionals and politicians in both provinces certainly confirms that the transition to lay expertise is not simple and that doctors and government officials are not entirely receptive to this change. While Ontario's and Quebec's IVF funding debates clearly represent what Epstein (1996:349) terms "democratization struggles in the biomedical sciences and health care," they also confirm that this struggle is far from over. In both cases, the public continues to fight for a voice while medical professionals and formal organizations maintain their stronghold over medical expertise and representation in parliamentary discussions.

In addition to corroborating claims about the interaction between professional and lay expertise, this thesis confirms past studies' findings about the methods and impact of interest groups and of lay experts in political processes. First, my findings corroborate past claims about the relationality of arguments used in political forums (Ferree et al. 2002). In essence, frames do not exist in a vacuum but are instead often crafted using opposition arguments as their foundations (Best 2012; Ferree et al.

2002). As a result, as was clearly evident in this study, concepts—such as the need for prioritization in funding medical services—are often used on both sides of an argument. In short, stakeholders shape not only policies that are directly of interest to their beneficiaries, but political discourse more broadly, as they present arguments in support of their intended outcomes. Further this study reinforces Best's (2012) finding that advocacy organization may have impacts beyond direct benefits for their constituents. Though the small number of records available for examination and the relatively short timeframe studied limit the explanatory power of my findings, my research highlights the constant tension between the interests of taxpayers at large and the interests of infertility disease patients—a finding that agrees with Best's (2012) assertion that shifts in the perceived beneficiaries of policies may alter policy outcomes. Indeed, one of the distinguishing features between Ontario and Quebec seems to be that disease patients were prioritized in Quebec while a broader constituency was favored in Ontario's prioritization-based decision. In addition, my findings suggest a relative lack of public presence in parliamentary forums as compared to public standing in the media. This finding confirms the essential role of the media in enhancing public presence in political debates and reinforces the view that the media is essential to democracy (Ferree et al. 2002; McCombs and Shaw 1972; Pettinicchio 2010). Overall, this study reinforces past assertions about the far-reaching impacts of advocacy initiatives and the importance of non-governmental forums in providing space for public input in political debates.

Having analyzed the courses of IVF funding debates in Ontario and Quebec, it is important to turn to broader applications of the concepts uncovered in this thesis.

Continuing this study beyond the boundaries of Quebec and Ontario would create an important context for future debates across North America and the Western World. Further, while my results suggest that one of the key factors distinguishing Quebec's funding decision from Ontario's is the heterogeneity of stakeholders represented in Quebec's debates, it would be interesting to perform a more quantitative analysis of stakeholder standing and framing encompassing a broader time period and larger group of issues to further examine this inclination in a causal and systematic way. In addition, while my results provide an in-depth examination of standing and framing by a variety of institutional stakeholders, to better understand the standing and influence of members of the general public, it would be informative to examine the mechanisms available for members of the general public to interact with and convey ideas to their advocates. Finally, these results provide a strong groundwork for an examination of the factors underlying state funding of other controversial procedures—such as abortion, stem cell research, and adoption. Policies on these procedures define a state's stance on whether its citizens have a right to reproduction, at what cost, and at the expense of what other services. It would be fascinating to further examine the dueling role of advocates and professionals in shaping funding decisions about these similarly high stakes procedures which lie at the crossroads of ethical issues, human rights discourse, and practical constraints.

While moral and ethical lines continue to be drawn and the credibility of lay experts in medical funding decision-making is continuously evolving, it is clear that advocates play a critical role as channels for public opinion and maintain a system of checks against government officials and medical professionals. Ultimately, though the

applicability of these results to other contexts must be further explored, it is clear that lay experts present a real and growing challenge to professional expertise and institutional control.

## APPENDIX

### Coding Instrument: Parliamentary Records

#### 1) Debate Identification:

- a. Which province does this parliamentary record reference?
  1. Ontario
  2. Quebec
- b. Date of debate or committee hearing
  1. Day
  2. Month
  3. Year
- c. In which committee or assembly did this conversation occur?
  1. Quebec National Assembly
  2. Quebec Committee on Social Affairs
  3. Quebec Committee on Health and Social Services
  4. Quebec Committee on Public Finance
  5. Ontario Legislative Assembly
  6. Ontario Standing Committee on Social Development
  7. Ontario Standing Committee on the Legislative Assembly

#### 2) Stated purpose of debate or committee hearing:

#### 3) Actor #\_

- a. Actor type
  1. Politician
  2. Medical professional
  3. Interest group
  4. Member of the general public
  5. Academic
  6. Celebrity
- b. If the actor is an interest group, which type of interest group?
  1. Infertility
  2. General health
  3. Professional organization (ex. Society of Obstetrics and Gynecologists of Canada)
  4. Women's Rights
- c. Name of actor/organization: \_\_\_\_\_

- d. Is the actor quoted with spoken voice?
  1. Yes
  2. No
  
- e. If the actor is NOT quoted with spoken voice, who references the actor?
  1. Politician
  2. Medical professional
  3. Interest group
  4. Members of the general public
  5. Academic
  6. Celebrity
  
- f. Does actor #\_ support public funding of in vitro fertilization?
  1. Yes
  2. No
  3. Unclear/Neutral
  4. Cannot determine
  
- g. If YES to #3b, how does the actor frame their support for IVF funding? (primary)
  1. Cost-Effectiveness
  2. Infertility is a disease
  3. IVF is a medical need
  4. Infertility is a public health concern
  5. IVF is a human right
  6. Health inequalities are inequitable
  7. IVF will increase the country's total fertility rate
  
- h. If YES to #3b, how does the actor frame their support for IVF funding? (secondary)
  1. Cost-Effectiveness
  2. Infertility is a disease
  3. IVF is a medical need
  4. Infertility is a public health concern
  5. IVF is a human right
  6. Health inequalities are inequitable
  7. IVF will increase the country's total fertility rate

LEAVE BLANK IF NONE STATED
  
- a. If the debate does not focus directly on IVF, how does the actor frame their support for the legislation?
  1. Cost-Effectiveness
  2. Will not cut medically necessary services

LEAVE BLANK IF NONE STATED



- i. In general, who does the speaker cite as the primary “winners” or “losers” from public funding of IVF? (primary)
  1. General public
  2. Disease patients
  3. Medical professionals
  4. Government
  5. Interest groups
  
- j. In general, who does the speaker cite as the secondary “winners or losers” from public funding of IVF? (secondary)
  1. General public
  2. Disease patients
  3. Medical professionals
  4. Government
  5. Interest groups

LEAVE BLANK IF NONE STATED
  
- k. If NO to #3b, how does the actor frame their opposition to IVF funding? (primary)
  1. Cost-Effectiveness
  2. Infertility is not a disease
  3. IVF is not a medical need
  4. Infertility is not a public health concern
  5. Publicly-funded IVF may lead to other public health concerns
  6. IVF is not a human right
  7. Health inequalities are not inequitable
  8. IVF is experimental
  9. Public funding of IVF threatens the rights of women
  
- l. If NO to #3b, how does the actor frame their opposition to IVF funding? (secondary)
  1. Cost-Effectiveness
  2. Infertility is not a disease
  3. IVF is not a medical need
  4. Infertility is not a public health concern
  5. Publicly-funded IVF may lead to other public health concerns
  6. IVF is not a human right
  7. Health inequalities are not inequitable
  8. IVF is experimental
  9. Public funding of IVF threatens the rights of women

LEAVE BLANK IF NONE STATED

- m. If the debate does not focus directly on IVF, how does the actor frame their opposition to the legislation?
  - 1. Cost-Effectiveness
  - 2. Too much government power to define medical necessity
  - 3. Physicians will cut services if government does not payLEAVE BLANK IF NONE STATED
  
- n. In general, who does the speaker cite as the primary “winners” or “losers” from the prevention of IVF funding? (primary)
  - 1. General public
  - 2. Disease patients
  - 3. Medical professionals
  - 4. Government
  - 5. Interest groups
  
- o. In general, who does the speaker cite as the primary “winners or losers” from the prevention of IVF funding? (secondary)
  - 1. General public
  - 2. Disease patients
  - 3. Medical professionals
  - 4. Government
  - 5. Interest groupsLEAVE BLANK IF NONE STATED

**4) Additional notes and important quotes:**

## Coding Instrument: Newspaper Articles

### 1) Article Identification:

- b. Which province does this article reference?
  - 1. Ontario
  - 2. Quebec
- c. Date Published
  - 1. Day
  - 2. Month
  - 3. Year
- d. The article was published in which newspaper?
  - 1. *Globe and Mail*
  - 2. *Montreal Gazette*
  - 3. *Toronto Star*
- e. Section and page number:
  - i. The article was published in which section?
    - 1. News
    - 2. Editorial/Opinion
    - 3. Globe Life
    - 4. Focus
    - 5. Letter to the Editor
    - 6. Insight
    - 7. Life
    - 8. Unknown
  - ii. The article was published on which page?

### 2) Writer Bias:

- a. Does the writer of the article support public funding of in vitro fertilization?
  - 1. Yes
  - 2. No
  - 3. Unclear/Neutral
  - 4. Cannot determine
- b. If YES to #2a, how does the author frame their support for IVF funding? (primary)
  - 1. Cost-Effectiveness
  - 2. Infertility is a disease
  - 3. IVF is a medical need
  - 4. Infertility is a public health concern
  - 5. IVF is a human right
  - 6. Health inequalities are inequitable
  - 7. IVF will increase the country's total fertility rate

- c. If YES to #2a, how does the author frame their support for IVF funding? (secondary)
1. Cost-Effectiveness
  2. Infertility is a disease
  3. IVF is a medical need
  4. Infertility is a public health concern
  5. IVF is a human right
  6. Health inequalities are inequitable
  7. IVF will increase the country's total fertility rate
- LEAVE BLANK IF NONE STATED
- d. If NO to #2a, how does the author frame their opposition to IVF funding? (primary)
1. Cost-Effectiveness
  2. Infertility is not a disease
  3. IVF is not a medical need
  4. Publicly-funded IVF may lead to other public health concerns
  5. IVF is not a human right
  6. Infertility is not inequitable
  7. IVF is experimental
  8. Public funding of IVF threatens the rights of women
- e. If NO to #2a, how does the author frame their opposition to IVF funding? (secondary)
1. Cost-Effectiveness
  2. Infertility is not a disease
  3. IVF is not a medical need
  4. Publicly-funded IVF may lead to other public health concerns
  5. IVF is not a human right
  6. Infertility is not inequitable
  7. IVF is experimental
  8. Public funding of IVF threatens the rights of women
- LEAVE BLANK IF NONE STATED
- f. In general, who does the author cite as the primary “winners” or “losers” from public funding of IVF? (primary)
1. General public
  2. Disease patients
  3. Medical professionals
  4. Government
  5. Interest groups

- g. In general, who does the author cite as the primary “winners or losers” from public funding of IVF? (secondary)
1. General public
  2. Disease patients
  3. Medical professionals
  4. Government
  5. Interest groups
- LEAVE BLANK IF NONE STATED

**3) Actor #\_**

- a. Actor type
1. Politician
  2. Medical professional
  3. Interest group
  4. Member of the general public
  5. Academic
  6. Celebrity
- b. If the actor is an interest group, which type of interest group?
1. Infertility
  2. General health
  3. Professional organization (ex. Society of Obstetrics and Gynecologists of Canada)
  4. Women’s Rights
- c. Name of actor/organization: \_\_\_\_\_
- d. Is the actor quoted with spoken voice?
1. Yes
  2. No
- e. If the author is NOT quoted with spoken voice, who references the actor?
1. Politician
  2. Medical professional
  3. Interest group
  4. Members of the general public
  5. Academic
  6. Celebrity
  7. Writer of the article
- f. Does actor #\_ support public funding of in vitro fertilization?
1. Yes
  2. No
  3. Unclear/Neutral
  4. Cannot determine

- g. If YES to #3b, how does the actor frame their support for IVF funding?  
(primary)
1. Cost-Effectiveness
  2. Infertility is a disease
  3. IVF is a medical need
  4. Infertility is a public health concern
  5. IVF is a human right
  6. Health inequalities are inequitable
  7. IVF will increase the country's total fertility rate
- h. If YES to #3b, how does the actor frame their support for IVF funding?  
(secondary)
1. Cost-Effectiveness
  2. Infertility is a disease
  3. IVF is a medical need
  4. Infertility is a public health concern
  5. IVF is a human right
  6. Health inequalities are inequitable
  7. IVF will increase the country's total fertility rate
- LEAVE BLANK IF NONE STATED
- i. If the debate does not focus directly on IVF, how does the actor frame their support for the legislation?
1. Cost-Effectiveness
  2. Will not cut medically necessary services
- LEAVE BLANK IF NONE STATED
- j. In general, who does the speaker cite as the primary “winners” or “losers” from public funding of IVF? (primary)
1. General public
  2. Disease patients
  3. Medical professionals
  4. Government
  5. Interest groups
- k. In general, who does the speaker cite as the primary “winners or losers” from public funding of IVF? (secondary)
1. General public
  2. Disease patients
  3. Medical professionals
  4. Government
  5. Interest groups
- LEAVE BLANK IF NONE STATED

1. If NO to #3b, how does the actor frame their opposition to IVF funding? (primary)
  1. Cost-Effectiveness
  2. Infertility is not a disease
  3. IVF is not a medical need
  4. Publicly-funded IVF may lead to other public health concerns
  5. IVF is not a human right
  6. Infertility is not inequitable
  7. IVF is experimental
  8. Public funding of IVF threatens the rights of women
  
- m. If NO to #3b, how does the actor frame their opposition to IVF funding? (secondary)
  1. Cost-Effectiveness
  2. Infertility is not a disease
  3. IVF is not a medical need
  4. Publicly-funded IVF may lead to other public health concerns
  5. IVF is not a human right
  6. Infertility is not inequitable
  7. IVF is experimental
  8. Public funding of IVF threatens the rights of women

LEAVE BLANK IF NONE STATED
  
- n. If the debate does not focus directly on IVF, how does the actor frame their opposition to the legislation?
  1. Cost-Effectiveness
  2. Too much government power to define medical necessity
  3. Physicians will cut services if government does not pay

LEAVE BLANK IF NONE STATED
  
- a. In general, who does the speaker cite as the primary “winners” or “losers” from the prevention of IVF funding? (primary)
  1. General public
  2. Disease patients
  3. Medical professionals
  4. Government
  5. Interest groups

b. In general, who does the speaker cite as the primary “winners or losers” from the prevention of IVF funding? (secondary)

1. General public
2. Disease patients
3. Medical professionals
4. Government
5. Interest groups

LEAVE BLANK IF NONE STATED

**4) Additional notes and important quotes:**



# TABLES

**Table 4.2a: Number of Pro-IVF Funding Frames by Stakeholder in Ontario Media**

Pro						
Stakeholder Type	Cost-Effectiveness	Medical Necessity	Social Justice	IVF is Experimental	Population Control	Women's Rights
Politician	0	0	0	0	0	0
Medical Professional	0	0	1	0	1	0
Interest Group	0	4	2	0	0	0
General Health	0	0	0	0	0	0
Infertility Awareness	0	1	2	0	0	0
Professional Organization	0	3	0	0	0	0
Women's Rights	0	0	0	0	0	0
Academic	0	0	1	0	0	0
Celebrity	0	0	0	0	0	0
Member of the General Public	0	0	0	0	1	0

**Table 4.2b: Number of Pro-IVF Funding Frames by Stakeholder in Quebec Media**

<b>Pro</b>						
<b>Stakeholder Type</b>	<b>Cost-Effectiveness</b>	<b>Medical Necessity</b>	<b>Social Justice</b>	<b>IVF is Experimental</b>	<b>Population Control</b>	<b>Women's Rights</b>
Politician	4	3	1	0	2	0
Medical Professional	1	4	4	0	1	0
Interest Group	0	0	0	0	0	0
General Health	0	0	0	0	0	0
Infertility Awareness	1	3	3	0	1	0
Professional Organization	0	4	0	0	0	0
Women's Rights	0	0	0	0	0	0
Academic	0	1	2	0	1	0
Celebrity	0	0	6	0	1	0
Member of the General Public	0	1	6	0	0	0

**Table 4.2c: Number of Anti-IVF Funding Frames by Stakeholder in Ontario Media**

<b>Anti</b>						
<b>Stakeholder Type</b>	<b>Cost-Effectiveness</b>	<b>Medical Necessity</b>	<b>Social Justice</b>	<b>IVF is Experimental</b>	<b>Population Control</b>	<b>Women's Rights</b>
Politician	5	6	0	0	0	0
Medical Professional	1	0	0	0	0	0
Interest Group	0	0	0	0	0	5
General Health	0	0	0	0	0	1
Infertility Awareness	0	0	0	0	0	0
Professional Organization	0	0	0	0	0	0
Women's Rights	0	0	0	0	0	4
Academic	0	0	0	1	0	0
Celebrity	0	0	0	0	0	0
Member of the General Public	0	1	0	0	0	0

**Table 4.2d: Number of Anti-IVF Funding Frames by Stakeholder in Quebec Media**

<b>Anti</b>						
<b>Stakeholder Type</b>	<b>Cost-Effectiveness</b>	<b>Medical Necessity</b>	<b>Social Justice</b>	<b>IVF is Experimental</b>	<b>Population Control</b>	<b>Women's Rights</b>
Politician	0	2	0	1	0	0
Medical Professional	0	0	0	0	0	0
Interest Group	0	0	0	0	0	0
General Health	0	0	0	0	0	0
Infertility Awareness	0	0	0	0	0	0
Professional Organization	0	0	0	0	0	0
Women's Rights	0	0	0	0	0	0
Academic	1	1	0	1	0	1
Celebrity	0	0	0	0	0	0
Member of the General Public	1	2	0	0	0	0

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