A call for policy change: Funding fertility treatments for medical trainees

Medical trainees experience disproportionately high rates of infertility, driven in part by training-related delays in childbearing, and face significant financial and institutional barriers to accessing fertility care, highlighting the need for equitable, standardized policies and insurance coverage for fertility preservation and treatment across Canada.

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Medical trainees make countless sacrifices in pursuit of their careers: weekends, holidays, sleep, and often their own well-being. Are they also sacrificing their ability to achieve their long-term family goals? For women in particular, the answer is often yes. Fertility is strongly age dependent, with a well-recognized steep decline after age 35.[1] Between 2020 and 2024, the average age of female medical school graduates in Canada was 27.3 years.[2] These years of training coincide with their peak reproductive years.

The impact of infertility, however, is not isolated to women. In 2023, the American Society for Reproductive Medicine expanded its definition of infertility to include not only medical inability to conceive but also social infertility. Social infertility includes individuals in same-sex relationships, single parents by choice, and individuals who have undergone gender-affirming medical or surgical care.[3] This broader definition more accurately reflects the growing diversity of individuals seeking assistance with family building.

Fertility care extends beyond treatment of infertility and must be reflected in equitable coverage policies, including elective oocyte cryopreservation. This approach allows trainees to preserve reproductive potential during training and supports a preventive model of care. Elective oocyte cryopreservation mitigates age-related decline in oocyte quality, with the goal of reducing the need for more invasive and costly interventions in the future.

Infertility among physicians is consistently reported at more than double the rate of the general population (24% to 33% versus 12%).[4] Female surgical trainees are especially affected, with one study showing that 84% of female surgeons underwent infertility evaluation and 76% ultimately required assisted reproductive technology to conceive.[5] Physicians—residents in particular—are also at higher risk for adverse pregnancy outcomes, including elevated rates of preterm delivery, preeclampsia, intrauterine growth restriction, and stillbirth.[6,7] Miller and colleagues have even suggested that residents should be considered a high-risk obstetric population.[6]

The University of Calgary's Department of Obstetrics and Gynecology recently surveyed surgical trainees across Alberta. Nearly 85% were childless, yet 82% desired two or more children in the future.[8] Consistent with Canadian and international data, the majority planned to delay childbearing well into their 30s due to career demands, financial barriers, and limited institutional support.[8] Strikingly, many trainees underestimated the impact of age-related fertility decline while overestimating the success rates of assisted reproductive technology.[8] In fact, studies estimate that a couple desiring two children should begin attempting to conceive when the female partner is age 27 at the oldest for a 90% chance of success without intervention.[9] Despite this, the average age of first-time mothers in Canada was 31.7 years in 2023.[10]

Among trainees who sought fertility support during training, access was often limited by a lack of policies and program standards. In British Columbia, the current resident contract includes no specific provisions for fertility-related care, in contrast to the clearer leave structures for prenatal care.[11,12] This disparity leaves trainees who require fertility supports at an even greater disadvantage to meeting their family goals than their peers who conceive without assistance.

Medical trainees dedicate their time and energy to caring for patients, and they deserve comparable support in achieving their family-building goals. Trainees earn incomes that are comparable to, or only modestly above, the median individual income in Canada and British Columbia, with most carrying substantial educational

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debt.[13] In Canada, a single cycle of in vitro fertilization (IVF) costs approximately $18 000 to $25 000, including medications and embryo transfer.[14] Oocyte cryopreservation is similarly expensive, at approximately $15 000 to $20 000 per cycle.[14] This leaves fertility treatment largely inaccessible to trainees without insurance coverage.

Beyond financial considerations, access to fertility care is logistically challenging for trainees. Treatment requires frequent appointments for cycle monitoring, egg retrievals, and embryo transfers, as well as recovery time, necessitating time away from clinical duties. In the absence of standardized policies and program support, trainees may face major scheduling difficulties, limiting access to care.

Nearly 83% of surgical trainees in Alberta reported that they would consider oocyte cryopreservation or infertility treatment if insurance coverage were available.[8] Other studies echo this finding, with almost 40% of medical students indicating that fertility benefits would influence their choice of residency program.[8,15-17] Given the substantial physician shortage in British Columbia, the inclusion of fertility benefits represents a meaningful incentive to attract and retain trainees.[18]

This issue is not isolated to BC. Across Canada, fertility coverage remains inconsistent, with most medical trainee programs offering little or no fertility support. Ontario and Nova Scotia provide some trainee-specific benefits: members of the Professional Association of Residents of Ontario receive full coverage for fertility medications, while Maritime Resident Doctors members are eligible for up to $15 000 in fertility drug coverage.[19-25] These models establish a precedent for expanding trainee-specific fertility benefits across Canada and support a broader adoption of similar benefits.

At the provincial level, funding models also vary widely. Ontario and Quebec both fund one cycle of IVF and unlimited coverage for intrauterine insemination. Other provinces offer partial funding or reimbursement models: Manitoba and Nova Scotia fund approximately 40% of treatment costs, with a defined annual and lifetime maximum, while Saskatchewan funds 50% of coverage up to a lifetime maximum. Prince Edward Island offers income-based reimbursement up to $10 000 annually, and Newfoundland and Labrador provides up to $20 000 in lifetime funding. New Brunswick offers a one-time grant of up to $20 000 for IVF or $10 000 for intrauterine insemination, while Yukon provides a tax credit covering 40% of treatment costs up to $10 000 annually. In contrast, Alberta, Nunavut, and the Northwest Territories currently provide no public funding.[26]

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The recent introduction of a publicly funded IVF program in British Columbia, which covers one funded cycle for eligible applicants, emphasizes the growing recognition of fertility care as a public health priority. However, this program is currently structured as a temporary initiative and includes eligibility criteria such as age (18–41 years) and household income below $250 000.[27] While most trainees meet these eligibility criteria, access remains limited due to the timing and structure of treatment during medical training. Coverage is also restricted to individuals actively attempting conception, excluding fertility preservation strategies.[27] Further, demand for such services far exceeds the current budget provisions, and without supplemental insurance coverage, fertility treatment remains unattainable for most trainees.

Pacific Blue Cross, the insurance provider for BC medical trainees, has promoted its commitment to family planning, partnering with the BC Women's Health Foundation to launch a new plan that expanded family planning benefits.[28] Yet, this is not the plan offered to residents. The current Resident Doctors of BC contract explicitly excludes fertility drugs and treatments, aside from a $500 annual health savings account.[11]

Over the past 3 decades, female representation in medicine has increased by 27%, with women now comprising more than half of medical graduates.[2] Canada is also home to 1.3 million individuals who identify as part of the 2SLGBTQ+ community (4.4% of the population), more than 40% of whom desire children.[29] Without fertility coverage, many of these individuals sacrifice their reproductive goals to pursue medical training. The consequences extend beyond personal hardship—ultimately influencing specialty choice, exacerbating physician shortages, and increasing the burden of high-risk pregnancies on the health care system.

Fertility preservation and treatment must be recognized as essential components of reproductive health, alongside prenatal care and parental leave. Provincial and national standards are urgently needed to ensure equitable, transparent, and consistent access for trainees. By addressing these barriers through education, counseling, and insurance coverage, we can support the health and wellness of future physicians. In doing so, we allow trainees to pursue both their professional and personal aspirations, ultimately strengthening the medical workforce and the communities it serves. ■

Competing interests

Dr Mazza has no competing interests to declare. Dr Tallon is the medical director of Olive Fertility Centre Victoria and co-director of Olive Fertility Centre Vancouver.

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