CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
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- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

A tax on infertility?

SIR,—It was with great consternation that we read the latest communication from the Human Fertilisation and Embryology Authority sent to all directors of centres. This contained details of the licence fees that will apply, from 1 August, to all centres practising in vitro fertilisation and donor insemination. A licence to practise therapeutic in vitro fertilisation will require an initial fee of £250, to be submitted with the application, followed by an additional fee of £30 per cycle of in vitro fertilisation, and £7 per cycle of donor insemination, which is to be paid annually retrospectively.

In the private sector this additional cost of in vitro fertilisation will inevitably be passed on to the patient. The few centres that are funded directly by district health authorities receive limited funding, so the extra cost will reduce that which is available for treatment.

In centres such as ours at King's College Hospital, which receive no public money and nevertheless treat large numbers of non-payng patients, this extra cost will be particularly difficult to accommodate. We raise money by treating a quarter of our patients privately and through the fund raising activities of our support group, which is a registered charity. This enables us to undertake 750 non-paying treatment cycles each year, which means that our annual "additional fee" will be in the order of £22 500.

The additional fee presents us with three equally unsatisfactory alternatives. Firstly, we could increase our income from private patients, either by treating more, at the cost of treating fewer non-paying patients, or by increasing the charges. Secondly, we could ask the support group to raise the extra money, bearing in mind that it can barely meet the current demands that we make on it. Finally, we could pass the £30 charge directly to all the patients we treat.

We have struggled for eight years to provide free treatment to as many patients as possible and have always maintained the hope that, ultimately, funding for in vitro fertilisation would be provided by the NHS. We now find ourselves confronted with quite the reverse: a government tax on in vitro fertilisation. We know of no other health problem penalised in this way. If the Human Fertilisation and Embryology Authority's additional fee is accepted by the profession, and by the general public, it will set a dangerous precedent, undermining the ethos of the NHS.

The Human Fertilisation and Embryology Authority was established to protect patients' interests and allay public anxiety, and as such it is to be respected and supported. From 1 August it will perform the functions carried out with great effectiveness during the preceding six years by the voluntary, then Interim, Licensing Authority. Whereas the Interim Licensing Authority functioned at an annual cost of less than £100 000, however, the annual running costs of the Human Fertilisation and Embryology Authority are estimated at £1·17m.[1] Half of this amount is to be raised from licence fees.

All other government regulatory bodies are funded wholly by the Treasury. It is ironic that the latest government watchdog should reduce the services available to the very people it was established to protect.

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1 Bottomley V. Parliamentary written answer. *House of Commons Official Report (Hansard)* 1991 July 18;**195**:cols 194. (No 148.)

SIR,—On 1 August the Human Fertilisation and Embryology Authority with its statutory powers takes over from the previous voluntary body, the Interim Licensing Authority. Infertility units currently holding a licence from the Interim Licensing Authority must apply for a new licence from the Human Fertilisation and Embryology Authority in order to continue to provide in vitro fertilisation treatment. As the medical director of such a unit, I have recently received details of the licence fee from the Human Fertilisation and Embryology Authority and find to my dismay that, as well as the initial fee of £250, there is to be an additional fee of £30 payable to the authority for each cycle of in vitro fertilisation treatment performed in any unit.

Owing to the scandalous lack of facilities for in vitro fertilisation funded by the NHS many in vitro fertilisation units, like ours, ask patients to make a contribution in an attempt to provide desperate infertile couples with reasonably priced treatment on a non-profit making basis. These patients are already paying for treatment, which, it could be argued, should be freely available, and they will now be faced with an extra cost as the extra "licence fee" can come only from them.

One of the main reasons for instituting a statutory licensing authority was to allay perceived public concern regarding in vitro fertilisation and human embryo research. In my opinion, if the public is genuinely concerned about these issues then the public and not the infertile population should be prepared to pay for the reassurance gained from knowing that such clinical work is being properly controlled and supervised by the Human Fertilisation and Embryology Authority.

I have some sympathy for the authority as it may be that the Department of Health and the Treasury have refused to fund it from central government. Let no one be in any doubt, however, that unless the proposed system of funding is radically altered then, from 1 August, this country will be in the disgraceful position of having what amounts to a tax on infertility on its statute books.

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SIR,—In his editorial Dr Nigel Oswald succinctly portrays the dilemma facing undergraduate education.[1] Rightly, he argues in favour of basing the bread and butter teaching in the community and thus compliments the General Medical Council's recommendations (referred to by Professor Robin Fraser[2]): the council found in favour of general practice for achieving 16 of its 20 recommendations on undergraduate education.

The huge resources for teaching in the community should be tapped with the help of computerised practices with their disease registers and databases. In my practice I would envisage devoting a day each week to undergraduate teaching, with three or four home visits for teaching at the bedside in the morning (the patients being selected as relevant to the topic currently being taught); this would be in groups of perhaps four students. The afternoon could consist of "outpatient" consultations with patients attending the surgery. Here, the process of learning from first principles the techniques of history taking and physical examination can be practised.

Where I disagree with Dr Oswald is in his statement that this group of general practice teachers should have undergraduate education as their main professional activity. In fact, general practice trainers, whose practices and records are regularly scrutinised, would be ideally placed for the task, and the two interests are not mutually exclusive.

The first problem that would have to be surmounted in collaboration with the teaching hospitals is the obvious one of financing the general practitioner's locum for his or her day of "absence" from the practice. The curriculum and standardised methods of evaluation would have to be agreed mutually. The students' expenses and transport costs would be a matter for their local authorities to discuss.

The initiative, skills, and good will are abundant, and the material is certainly there; it is the coordination and financial resources that are in short supply. These must be addressed seriously and soon if our enviable standard of undergraduate education is to be maintained.

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1 Oswald N. Where should we train doctors in the future? *BMJ* 1991;**303**:71. (13 July.)
2 Fraser RC. Undergraduate medical education: present state and future needs. *BMJ* 1991;**303**:41-3. (6 July.)