Defining Infertility

Anne T. Fidler and Judith Bernstein present a thoughtful and comprehensive review in their article, "Infertility: From a Personal to a Public Health Problem" [Public Health Rep 1999;114:494-511].

The authors point out an important concern—the lack of a consistent definition of infertility. In the insurance debate, infertility is often referenced as a "condition" rather than a "disease." Resolve has worked to promote a consistent definition of infertility—one that not only focuses on the length of time it takes to conceive but also takes into account physiological factors. Infertility is a disease of the reproductive systems of both men and women that can result in the inability to conceive or to carry a pregnancy to a live birth. With this definition, infertility should be properly addressed as a disease.

There are several important considerations with regard to the complex issue of regulations. Currently, a good deal of regulation does exist in the field of infertility. The Fertility Clinic Success Rate and Certification Act has brought vital information to consumers and provides a system of checks and balances that has improved the quality of patient care. Clinics are mandated to report their success rates, which are presented in a government publication and are periodically validated. Yet, as technology expands, there are new data and new treatments to evaluate in terms of the best interests of patients and resulting children.

The National Coalition for the Oversight of Assisted Reproductive Technologies (NCOART) was formed to review some of the critical issues in the use of these technologies. Participants include government agencies such as the Centers for Disease Control and Prevention and the Food and Drug Administration, medical societies such as the American Society for Reproductive Medicine and the associated Society for Assisted Reproductive Technology, and consumer groups such as RESOLVE, the National Infertility Association. NCOART represents all of the "partners" in the evaluation of infertility treatment and provides a forum in which the concerns of each can be discussed and debated.

As this debate continues, we must not lose sight of the personal and private nature of infertility and family-building while at the same time viewing the best interests of patients and resulting children from a public health perspective.

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Not-So-Sweet Charity

Sweet Charity: Emergency Food and the End of Entitlement by Janet Poppendieck (Viking Press; 1998) is finally beginning to receive the attention it deserves. My hope is that this book will provoke discussion in the nonprofit hunger industry, but Larry Brown's safe summary [Public Health Rep 1999:114:381-3] just ratifies the obvious.

The nonprofit hunger industry acts as though hunger were an emergency, rather than a chronic problem. There is no food shortage in the United States. Many low-income people have a problem of access to food, just as they have difficulty accessing housing, health care, employment, education, and child care. The problem is not that low-income people have *no* money for food; they simply don't have *enough* money.

Janet Poppendieck and Larry Brown, who are part of the academic branch of the nonprofit hunger industry, are wedded to government funding for programs that require financial verifications and rob low-income people of their dignity. Low-income people, especially low-income working families, do not want to and should not have to spill their financial guts and depend on charity *or* government for their next meal. Charities and government are too busy making people prove their poverty, spending money and energy on obtaining verifications that could be spent providing access to food.

In *Sweet Charity,* Poppendieck understates the impact of the "corporatization" of the hunger network. Second Harvest, the national network of food banks, has become so institutionalized that local food banks can't work with innovative local programs without violating their relationship with the network.

The hunger network in my state, Massachusetts, acts out the pathology of the national hunger network. A local hospital has three pantries because individual egos will not work together. Some pantries turn away working low-income people. Few pantries are open weekends and evenings because volunteers and paid staff don't want to work those hours.

To find a solution to hunger in America, we need to look at the problem in new ways. Low-income people need access to *affordable* food. We need to begin to look at affordable models that can restore pantries to their original role: an emergency source of food in a true crisis such as a natural disaster, job loss, or hospital bill that swallows up the monthly food money. Massachusetts has two such programs—SHARE New England, a food co-op, and Fair Foods, which distributed approximately eight million pounds of bread, fruits, and vegetables to low-income people in 1999. Both programs require no income verifications, encourage low-income peo-

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