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BROCHER SYMPOSIUM: PERSPECTIVES ON ACCESS TO REPRODUCTIVE HEALTHCARE

Introduction ☆

The articles in this Symposium are the product of an interdisciplinary meeting 'Between Policy and Practice: Interdisciplinary Perspectives on Assisted Reproductive Technologies and Equitable Access to Health Care', which was held at the Brocher Foundation, Hermance, Switzerland, 5–7 July, 2015.


The Symposium brought together a diverse, interdisciplinary group of scholars and experts involved in research, publication and advocacy work in the area of assisted reproductive technology (ART) policy, healthcare policy, bioethics, patient rights, and patient experiences with ART. Our aim in organizing the Symposium was to examine ART in Europe from a multi-disciplinary as well as a cross-national perspective, and consider ways in which ART health policies could be improved and harmonized with specific legislative solutions and advocacy efforts. In addition to policy questions, we were also interested in engaging with current debates about 'on the ground' experiences and challenges in clinical and advocacy areas, ethical concerns, and directions for future scholarship. The Symposium therefore convened both scholars and nongovernmental organization advocates, with a range of speakers covering five disciplinary areas: (i) medical anthropology, (ii) bioethics, (iii) law, (iv) sociology, and (v) health advocacy. Moreover, participants' expertise included experiences and research from a range of geopolitical contexts, from nations that currently have comprehensive ART policies to those that have recently introduced and/or inadequate regulation or subsidies for infertility care.

This Brocher Symposium encompassed 4 specific goals: (i) to identify the key areas of concern regarding the legal, ethical, health, and social impacts of inadequate ART regulation and reimbursement, (ii) to isolate and discuss practical effects of implementing specific policies in particular national contexts in European nations, (iii) to

identify the advantages and challenges of particular policy solutions regarding ART by comparing policy and provision in various European nations, and (iv) to establish which advocacy efforts are both feasible and effective in different socio-political contexts with the goal of improving equitable access to reproductive health and rights.

The papers, which were presented during the meeting, address these goals, and in particular focus on various forms of mobility and transformation: patients travelling to seek care, emerging new actors, changing legal systems, and transformation of the terms and concepts of ART debates. As we suggest, ART should be recognized not as a stable field or concept, but as dynamic assemblages (Collier and Ong, 2005) between and beyond the countries, policies and practices. Charis Thompson argues for an understanding of ART in the clinical context as an 'ontological choreography' which displays 'the dynamic coordination of the technical, scientific, kinship, gender, emotional, legal, political, and financial aspects of ART clinics' (Thompson, 2005, 8). We suggest that this dynamic coordination also has a place in the larger assemblages outside of the ART clinics, in the domains of regulation, advocacy, and transnational circulation of discourses, healthcare services, and patients.

An important thread that runs through most papers in this Symposium is the question: What is the role of the state in a liberal democracy in shaping/ensuring access to healthcare and regulating its safety, but also in dealing with questions of equality and discrimination in this arena? Fundamentally, many of the papers lead us to ask how to address collective forms of suffering in an era of individualized responsibility promoted by neoliberal ideals about self-care as a way to justify cutbacks in social services, healthcare included. The role of the state links with complex questions of national sovereignty to shape national policy according to the local

☆ The Brocher Symposium 'Between Policy and Practice: Interdisciplinary Perspectives on Assisted Reproductive Technologies and Equitable Access to Health Care' was held at the Brocher Foundation, Hermance, Switzerland in July 2015. The Brocher Foundation's mission is to encourage research on the ethical, legal and social implications of new medical technologies. Its main activities are to host visiting researchers and to organize symposia, workshops and summer academies. More information on the Brocher foundation programme is available at www.brocher.ch. 

cultural and historical specificities, especially within the EU, whereas Jill Allison (Allison, 2017-this volume) by way of contrast shows, some transnational conventions apply, including human rights. But we can also ask: What is the role of the supranational legal system in shaping policies at the national level when such policies vary dramatically? What about the role of the World Health Organization (WHO) and other international health actors? To address this question, Charis Thompson (2015) proposes to launch a multidisciplinary international data collection project to first arm ourselves with data on inequities, then pursue ways of remedying more concrete examples of inequities, but the question arises – is this a vision for supranational or national-level governance? In contrast, it might be reasonable to argue, as Guido Pennings (2015) has, that a uniform European legislation is impossible and ethnocentric, and that cross-border reproductive care (CBRC) is the solution to uneven regulation as patients seek what they need across national borders. But should we essentially agree with the inequalities experienced on the ground? What about the exploitation of some poorer nations with less restrictive laws? After all, as patients take advantage of inexpensive infertility care by traveling abroad (for example to Eastern European nations), the local population there might find the same care unaffordable because of lack of state subsidies for infertility treatment. What is affordable to foreigners therefore becomes at the same time emblematic of structural inequalities and particular politics of morality at play in the local healthcare systems (Mishtal, 2015). The export side of this cross-border equation also raises concerns. If we agree that CBRC is the answer to uneven access, will we become like the ‘old people’ in Norway, described by Renate Kurszus (2015), who prefer to ‘export’ their health and social problem to be remedied by other states? Or will this be, as Pennings (2015) argues, a rather democratic free flow of services and a kind of homeostatic distributive justice where local cultural specificities can be respected via diverse laws (restrictive or otherwise), while at the same time seekers of ART can find services in a country as suits their needs?

Infertility ‘tourism’, reshaping language

The use of ART in the European Union (EU) has grown dramatically in the last 20 years, and is expected to rise further as a result of fertility decline and population aging trends. Yet, the EU represents a highly uneven policy landscape for ART, due to diverse social, political, economic, and religious traditions of member states. This includes both policies that regulate ART procedures, as well as policies that define the degree to which these health services are state subsidized. The main reproductive health organization in the EU, European Society of Human Reproduction and Embryology (ESHRE), established guidelines for best clinical practice in the area of ART, which have been adopted in some, but not other, European nations. Consequently, access to ART treatment is highly unequal across and within nations, and often favours the wealthier strata of populations. Furthermore, inadequate (or non-existent) regulation in some nations means that standards of care vary and there is little assurance that protocols for treatment are evidence-based or monitored.

ART regulation across member states is increasingly relevant for the EU, raising new and complex policy and healthcare utilization questions concerning equality of access to healthcare and concerns relating to patient safety.

In the last decade a number of policy efforts have been made to promote the regulation of ART and the harmonization of laws and standards of care. In 2004, the EU released its ‘Tissues and Cells Directive’ to harmonize regulation, requiring nations to control harvesting and storage of human tissue, and declaring ART oversight as necessary to protect public health through improved safety of clinical standards across states. In 2008, ESHRE released the ‘Good Clinical Treatment in Assisted Reproduction’ guidelines to promote harmonization of care across states. Moreover, the WHO and the International Committee for Monitoring Assisted Reproductive Technology also revised the glossary of ART terminology because such definitions varied widely in different settings, making it difficult to compare medical procedures in different nations. Despite these policy and regulatory efforts, a significant proportion of ART services in the EU are provided in private clinics in Eastern Europe, especially in Poland and Lithuania, where ART services remain or remained unregulated (in Poland until 2015).

A Europe-wide study shows that the less expensive and unrestricted ART services offered in Eastern Europe attract growing ‘infertility tourism’ or CBRC especially from Norway, Germany, and Italy. But unregulated care also means that patients from those EU states where clinical safety guidelines would limit length, extent or type of treatment, can access unlimited procedures in countries where such guidelines are not enforced. As Michelle Bayefsky (Bayefsky, 2017-this volume) asserts, ‘While CBRC can be viewed as a useful option for patients seeking access to treatments prohibited at home, the practice also poses a number of health risks to patients and offspring’. This issue is even more pressing with the publication of the 2013 EU Cross-Border Health Directive, which allows EU citizens to seek healthcare in other states and have costs reimbursed by their home nations. However, still ‘one major concern is the relocation of risk to less restrictive, “new” EU countries and to nations outside the EU’ as Tracie Wilson argues (Wilson, 2017-this volume).

Simultaneously, infertility ‘tourism’ could be understood as facilitating exploitation of a woman’s body or new dimensions of stratified reproduction (Ginsburg and Rapp, 1995), denoting various forms of injustice in those countries where regulation of ART is inadequate (or non-existent) and therefore the state fails to protect and support patients’ choices and needs. But, one can also demonstrate that infertility travel constitutes new forms of labour. Thus, should we move beyond the reproductive exploitation paradigm and the reproductive liberalist paradigm, in our interpretations of CBRC?

The issue of infertility ‘tourism’ also raises questions regarding the language that is used in the scholarship and debates on ART. On the one hand, we seek to analyse private and public language around ART, and on the other hand it is necessary to consciously formulate our academic discourses and de-naturalize some terms, for example, reproductive tourism or travel. It’s not tourism. Men and women go abroad to pursue infertility care as a form of ‘circumvention travel’ (Cohen, 2012) rather than for leisure, and even if they can afford to do so, they may encounter stigmatisation

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