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COMMENTARY


Patient pressure: is the tide of cross-border reproductive care beginning to turn?



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Abstract Two important explanations exist for cross-border reproductive care: restrictive legislation at home and limited access to affordable treatment. Both have recently been subject to patient pressure, favouring domestic and not cross-border services. The oppressive effect of regulation has been best illustrated in Italy, where legislation introduced as Law 40 in 2004 imposed restrictions on embryo freezing and embryo selection. After a decade of legal challenges by patients, the components of Law 40 have now been deemed unconstitutional in Italy. Similarly, a paucity of donor gametes in the UK has left many patients with few options but to seek donors and treatments overseas. Yet new techniques of donor recruitment and a revised allowance of compensation now means that some UK clinics can meet all requirements for donor gametes and patient matching from their own resources. 

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Introduction

In a recent paper in *Reproductive Biomedicine Online*, Benagiano et al. (2014) considered the legal ruling in Italy, which in April 2014 withdrew the national ban on gamete donation. The restrictions had been imposed in 2004 when Italy's infamous Law 40 had been introduced to bring some form of regulation to a country, which until then had been described as the 'wild west' of reproductive medicine. Also proscribed in this draconian legislation were embryo freezing, pre-implantation genetic diagnosis (PGD) and the fertilization of more than three oocytes in a given treatment cycle combined with the compulsory transfer of all the resulting embryos.

Reversal of Law 40 in Italy

Law 40 was to have immediate catastrophic effects on assisted reproduction techniques in Italy. Mean pregnancy rate

per transfer declined and the rate of multiple pregnancies increased (Benagiano et al., 2014). Overnight, there was an exodus of Italian fertility patients looking for appropriate treatments overseas. Italy would be transformed from a net importer of reproductive tourists to a net exporter, as patients turned to Spain, Slovenia, Ukraine and other overseas destinations in search of PGD, gamete donation or even routine IVF and intracytoplasmic injection (ICSI) if patients wanted to avoid the likelihood of multiple pregnancies. In one of the few studies of this 21st century phenomenon, The European Society of Human Reproduction and Embryology (ESHRE)'s Task Force on Cross-Border Reproductive Care found that patients from Italy made up the greatest proportion of patients (31.8%) visiting clinics in six European countries and that 'legal reasons were predominant' (Shenfield et al., 2010).

It has now taken 10 years and several constitutional and local challenges to dismantle many of the legislative components of Law 40. Indeed, in 2012, the European Court of Human Rights ruled that Italy's ban on embryo screening [by PGD] breached two articles of the European Convention of

Human Rights, including the right to respect for family and private life. The ruling followed the challenge of an Italian couple whose first child had died from cystic fibrosis (Benagiano et al., 2014).

It is significant, as Benagiano et al. (2014) note, that these challenges came not from doctors but from patients. Significant too is that all the legal rulings to withdraw the restrictions were made in the interests of patients and their rights – to have children, to ‘self-determination’, and to health. At the practical level, the consequence now is that desperate Italian patients need no longer be forced to travel to overseas destinations for donor eggs or other forms of previously forbidden treatments, unless they choose to do so for personal reasons. Italy, thanks to the perseverance and justifiable self-interest shown by its patients, can once more practise its reproductive medicine on a playing field which is now deemed to be more level.

Cross-border travel, public pressure and donor compensation

One other explanation for the trend in crossing borders, identified by the ESHRE study, was to gain ‘better access to treatment than in the country of origin’, an objective also highlighted in a comprehensive symposium reported in this journal in 2011 (Gürtin and Inhorn, 2011). The question of better access, the ESHRE investigators suggested, ‘may also be linked to the regulatory limits of compensation to donors’, and they noted at the time of their study (in 2010) that the UK allowed very limited compensation to both egg and sperm donors. By contrast, Spain was reported to be paying its egg donors around 900 Euros per cycle, and the Czech Republic around 500 Euros. It was for these reasons of discrepancy in supply, long waiting lists at home and cross-border traffic to Spain and elsewhere that the UK’s Human Fertilisation and Embryology Authority (HFEA) announced a public consultation in 2011 to address the problems inherent in the UK’s limited provision of gamete donation. The perennial question of appropriate payments to gamete donors had already been the subject of three previous public consultations between 1997 and 2009 (Human Fertilisation and Embryology Authority, 2011). The aim this time, said the HFEA, was to ‘focus on what it meant to people – to those born of assisted reproduction, to donors, to patients wanting desperately to have a baby and to the public in general’. Independent public and patient consultations on the subject were also conducted by The Nuffield Council on Bioethics (2011) and other academic institutions (Gürtin and Inhorn, 2011). After considering the evidence, the HFEA in April 2012 raised compensation to £35 ‘per visit’ for sperm donors, and to £750 per cycle for oocyte donors; the revised fees, said the HFEA, should be viewed ‘not in terms of crude sums but in terms of the value of donation’.

Reversal of donor gamete shortages in the UK

Our own figures from the London Women’s Clinic in London (and its affiliated London Egg Bank) suggest that the revised policy introduced by the HFEA is now beginning to have a ben-

eficial effect on egg donation trends and finally bringing some relief to the former chronic shortages. During the period January 2013 to July 2014, for example, eggs were collected from 220 registered non-patient donors, which was 10 times the number of non-patient egg donors we had recruited in any of the previous 2 years (unpublished data). This resulted in 222 completed recipient treatments (with a single attempt pregnancy rate of 59% per recipient). Surplus embryos when available were vitrified and stored for future use in 75% of recipients. Such figures, although satisfactory in terms of success and volume, remain far below those recorded by some Spanish clinics: at the 2014 Annual Meeting of ESHRE, Cobo reported that, in 2013 alone, 946 donors at IVI Valencia had vitrified 10,690 oocytes for the egg bank, and that, since vitrification had been introduced for egg banking, more than 50,000 oocytes had been warmed for use in 4907 cycles (See <http://www.eshre2014.eu/Media/Press-conference-schedule/Ana-Cobo.aspx>). Nevertheless, at our own clinic in London, we are now able to meet the demand (and matching preferences) of all patients requiring egg donation. None are forced to travel abroad or face long waiting lists at our clinic, which was the case before April 2012 when, in the absence of compensation, egg sharers (i.e. patient donors seeking reduced fee treatment in return for donating a proportion of their eggs) were the predominant source of donor eggs (Ahuja et al., 2000; Ahuja, 2012; Human Fertilisation and Embryology Authority, 2014).

Similarly, sperm donation is progressively non-reliant on the ‘Viking invasion’ of donor sperm (sperm imported to the UK from Danish banks), as some have claimed in describing shortages in the UK (<http://www.bbc.co.uk/programmes/b04hvx5>). The latest figures from the HFEA for 2010 record that 24% of all registered sperm donors were from ‘overseas’, which has prompted some commentators to warn that ‘this was limiting patient choice and increasing waiting times’ (see <http://www.hfea.gov.uk/3412.html>). Although this was true in the past, again it has not been the case recently at our own clinic. As early as 2011 at our own sperm bank (www.londonspermbank.com), we demonstrated that a programme reliant on good communication and personalized customer care could generate a significant increase in donors (Bahadur et al., 2011). In the past 3 years, this trend has escalated to such levels that demographically the outcome now provides a far wider range of donors from all walks of life than ever seen before. Despite an increasing demand for donor sperm, we have been able to meet all our patient requests for donor matching online and have completed over 5000 treatments since 2010. Patients can now access donor sperm from a regulated sperm bank and check donor characteristics from an online platform, rather than depend on unlicensed private donations or on supplies from abroad. Our own efforts would be greatly supported by the popular announcements in August 2014 of a national sperm bank in the UK run by the National Gamete Donation Trust and Birmingham Women’s Hospital to provide a supply of donor sperm to UK patients without reliance on overseas sources (Byrne, 2014).

The most recent UK analysis of the availability of gamete donors provides further support for this trend (Table 1). The results published by the HFEA show over 50% growth over 5 years in the availability of non-patient gamete donors in the UK (Human Fertilisation and Embryology Authority, 2014). The HFEA attributed this significant increase in registered donors

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