



Consequences and suggested measures: fight it or accept it?

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My talk

- Assisted Reproduction Technologies (ART)
 - Present status and likely development
- Cross border reproductive care
 - Scale
 - Drivers
 - Future
- Is it a problem?
 - Will try to see it from different angles
 - Patients. Governments
- Measures?

My talk

- Assisted Reproduction Technologies (ART)
 - A treatment cycle:
 - Hormonal stimulation (started cycle)
 - Oocyte recovery
 - Fertilization *in vitro*
 - Embryo replacement (completed cycle)
 - Patients are usually offered several treatment cycles

My talk

- Assisted Reproduction Technologies (ART)
- *In vivo* fertilization
 - Hormonal stimulation and coitus
 - Insemination (incl. donor semen)
- *In vitro* fertilization
 - IVF/ICSI
 - Replacement of frozen embryos
 - Oocyte/semen donation
 - Surrogacy

What should we call it ?

- Patient tourism?
- Patient migration?
- Cross border reproductive care?

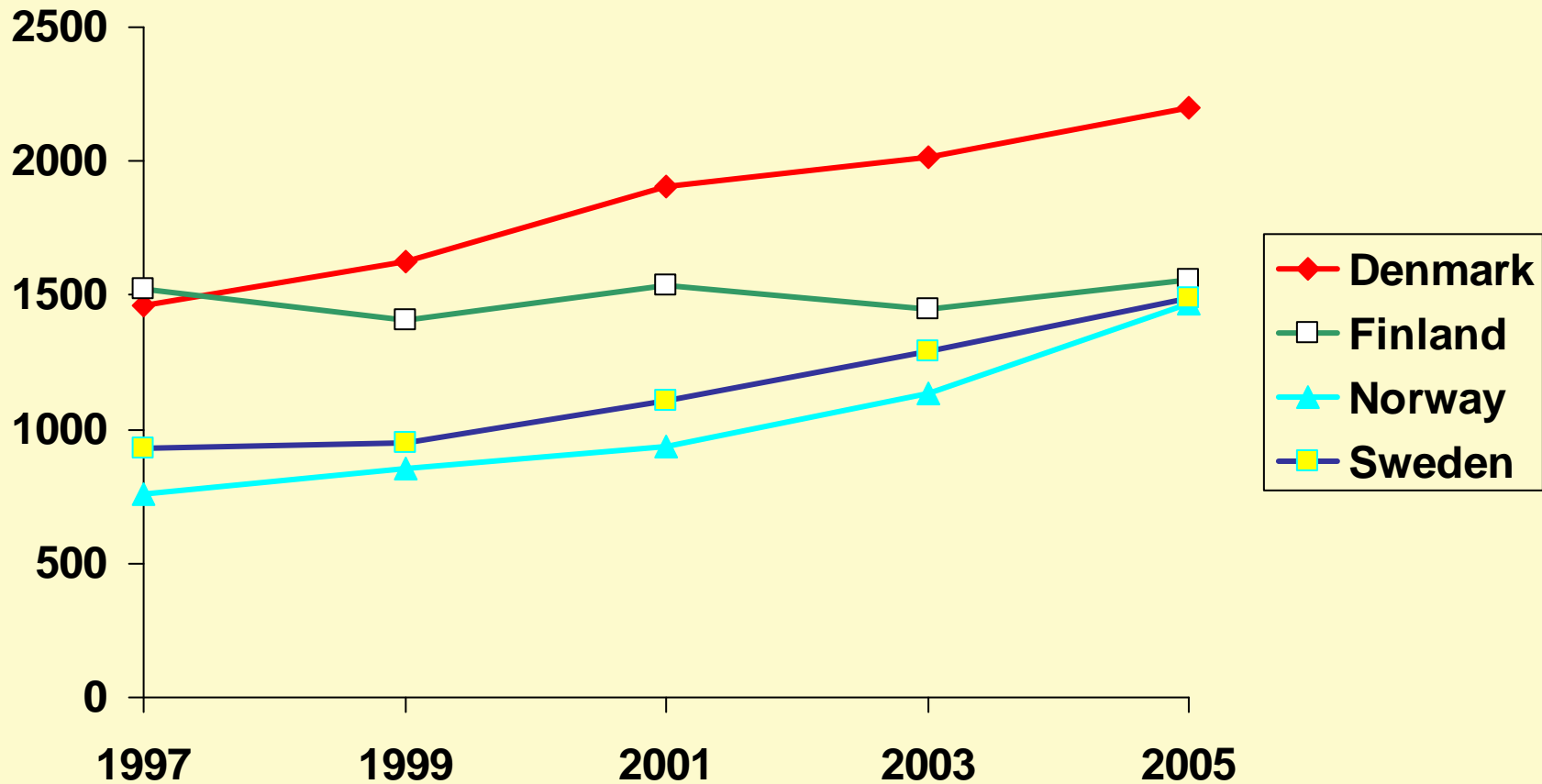
Cross border reproductive care?

- Will use Norway as example of a “donor” country
 - Norwegian infertile couples have for many years chosen to be treated outside of Norway. Reasons:
 - Accessibility
 - Waiting lists domestically
 - Availability
 - Donor oocytes
 - Donor semen (anonymous)
 - Single women, lesbian couples
 - Marketing
 - Foreign clinics: “We’re better than the Norwegians (morons)”
 - Norwegian doctors with financial incentives from abroad



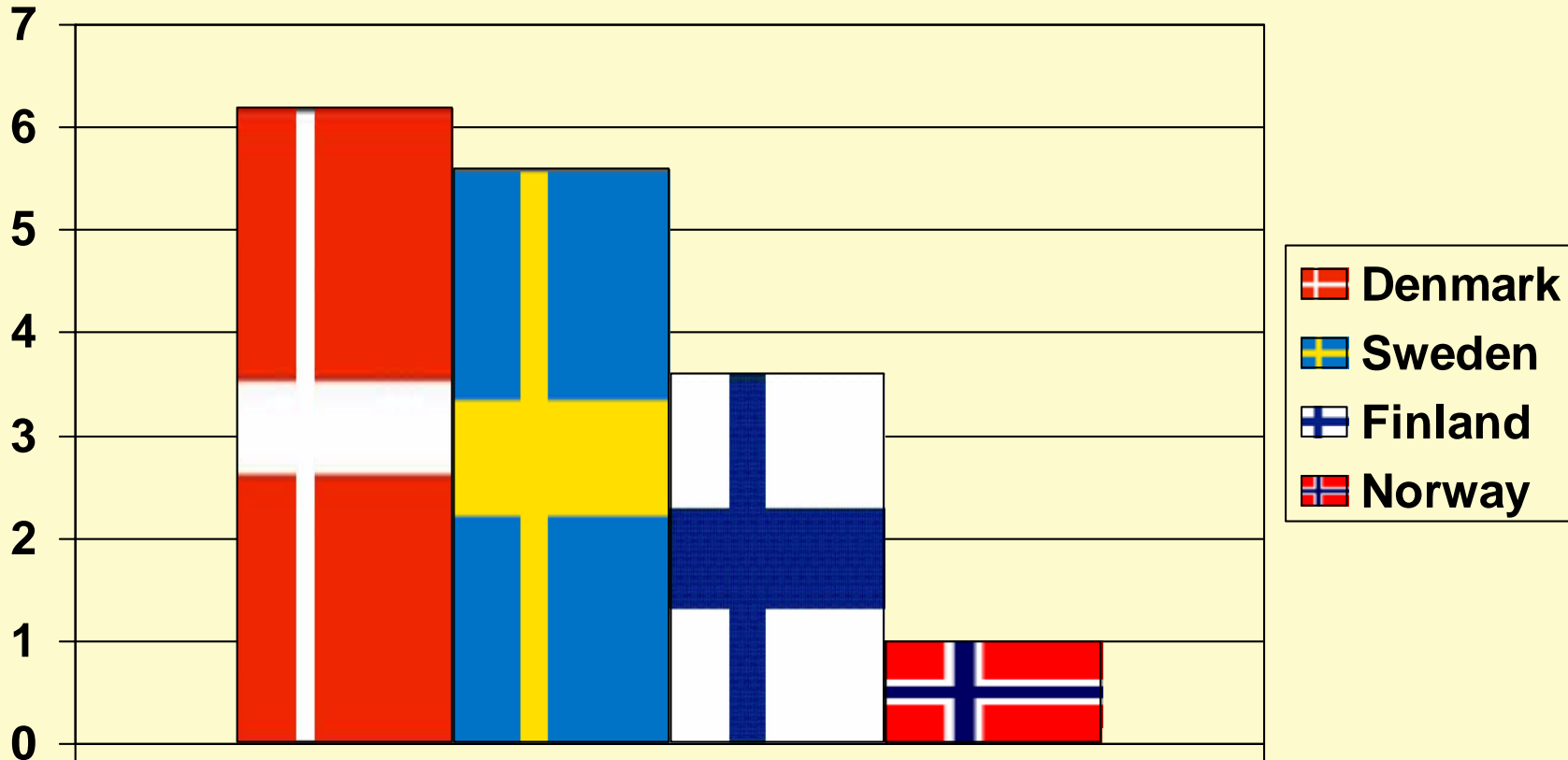
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Number of ART cycles per million inhabitants in the Nordic countries 1997 – 2005



Governmental support of public ART-units in the Nordic countries per capita per year

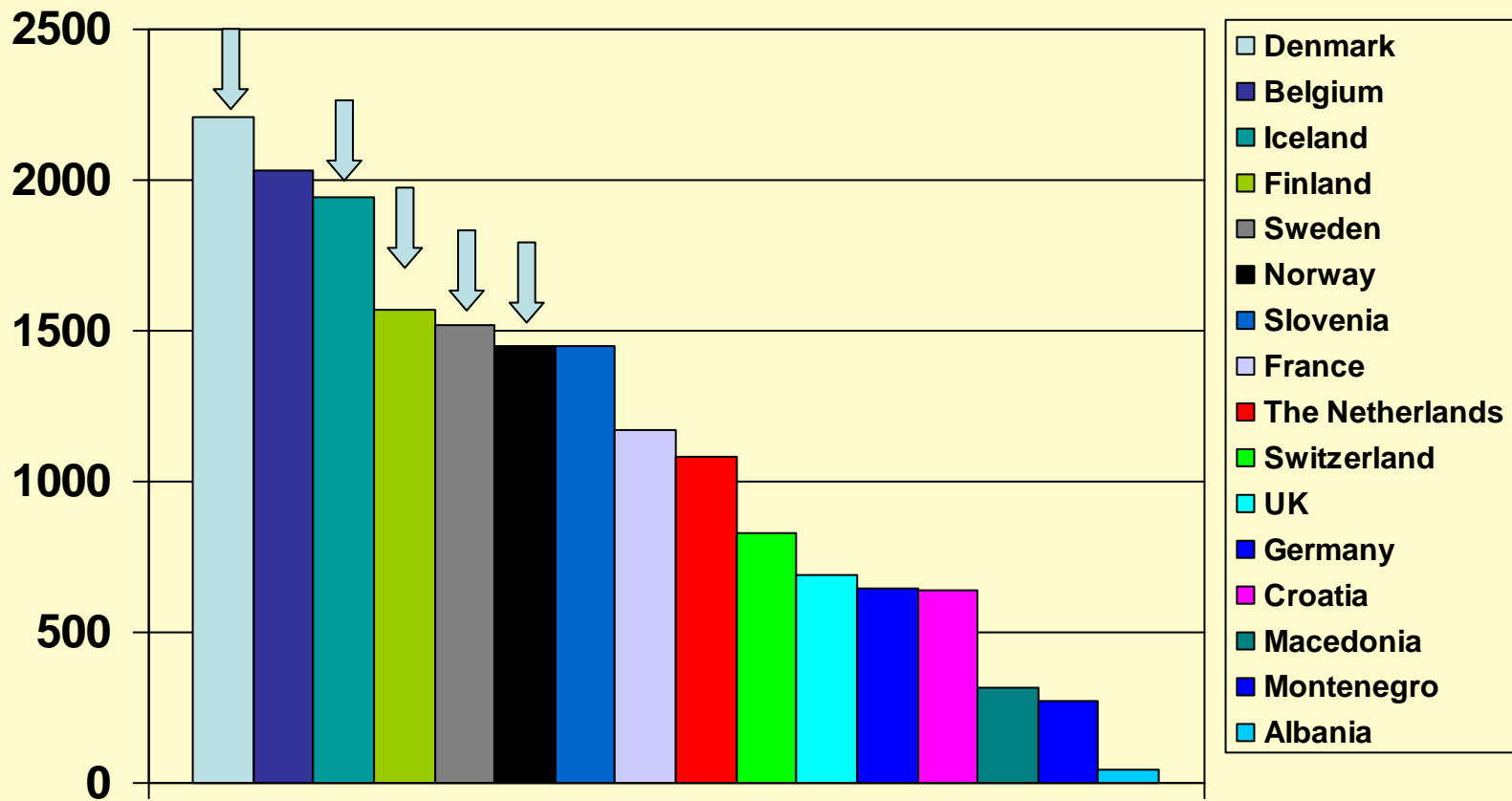
Funding/capita/year relative to Norway



* Estimate based on number of ART cycles and reimbursement of the Clinics

Number of ART treatment cycles per million inhabitants in 2005

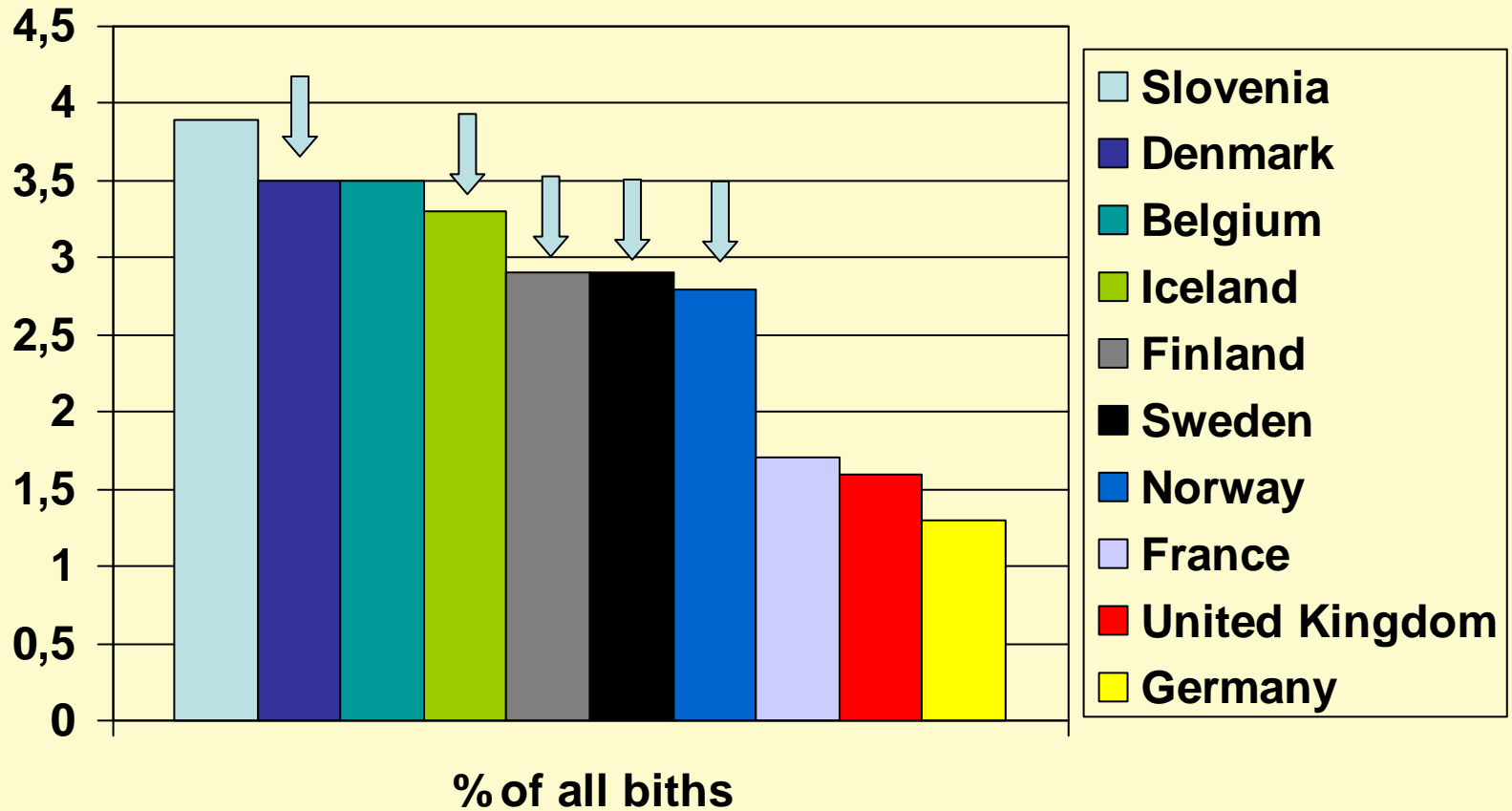
Countries where all clinics report





Births after ART as % of all births in 2005

Countries where all clinics report



Number of ART treatment cycles in Norway

- In 2005:
 - 7679 ART treatment cycles in Norway
 - 1404 deliveries
 - 1665 children
- From treatments abroad
 - ??? No data available
 - Guesstimate:
 - More than 1000 cycles
 - >150 deliveries



Clinics treating Norwegians abroad

- **Governmental university clinics who offer treatment to private patients**
 - Culture:
 - “Evidence based medicine”
- **Private clinics run by people with cultural background from Public hospitals**
 - Culture:
 - similar to public units, but need to be a bit more flexible towards wishes from the patient
- **Private units run by business entities**
 - Culture:
 - as any other businesses
 - “if the client pays too much for too little; well that’s their problem.”

From the patients perspective

Domestic or abroad?

- Support to the Norwegian patients from the government is less generous than in many countries
 - Difference in cost between public or private treatment less
 - Norwegian couples can get governmental support for ordinary ART-treatments abroad
 - a Norwegian speciality
 - Norway have had a very restrictive Law governing ART
 - Not same-sex couples
 - No oocyte donation
 - Only semen donation with known donor
 - No surrogacy





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Patient migration from Norway

- **Phase 1**
- "The Danes"
 - A lot from the Southern part
 - Efficient Danish marketing
 - Economic incentives for Norwegian doctors
- Some to UK, Sweden and Finland



Patient migration from Norway

- **Phase 2**
- Denmark still popular
- Finland and Spain enters the scene
 - Oocyte donation
- Some to US
 - surrogacy
- PGD treatment abroad paid by the Norwegian government



The EU-Directive” a new driver

- **The EU Directives concerning ”Safety and Quality ” of donation of cells are implemented in most European countries.**
- **Aim**
 - Protecting the patients
 - Very detailed and demanding
 - Professional Quality management
 - Specific requirements concerning serologic testing, traceability , personnel and premises
- **Effect**
 - Increased cost for clinics (and patients) especially for clinics involved in donation of gametes
- **Implemented very differently in different countries**
 - This will most likely led to increased migration of patient
 - Within EU
 - Tough or lenient implementation?
 - Outside of EU
 - Less expensive



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Patient migration from Norway

- **Phase 3 – next phase**
 - Expansion outside EU/EEA
- **New players**
 - Russia
 - Ukraine
 - India
- Often organised by clinics within EU/EAA

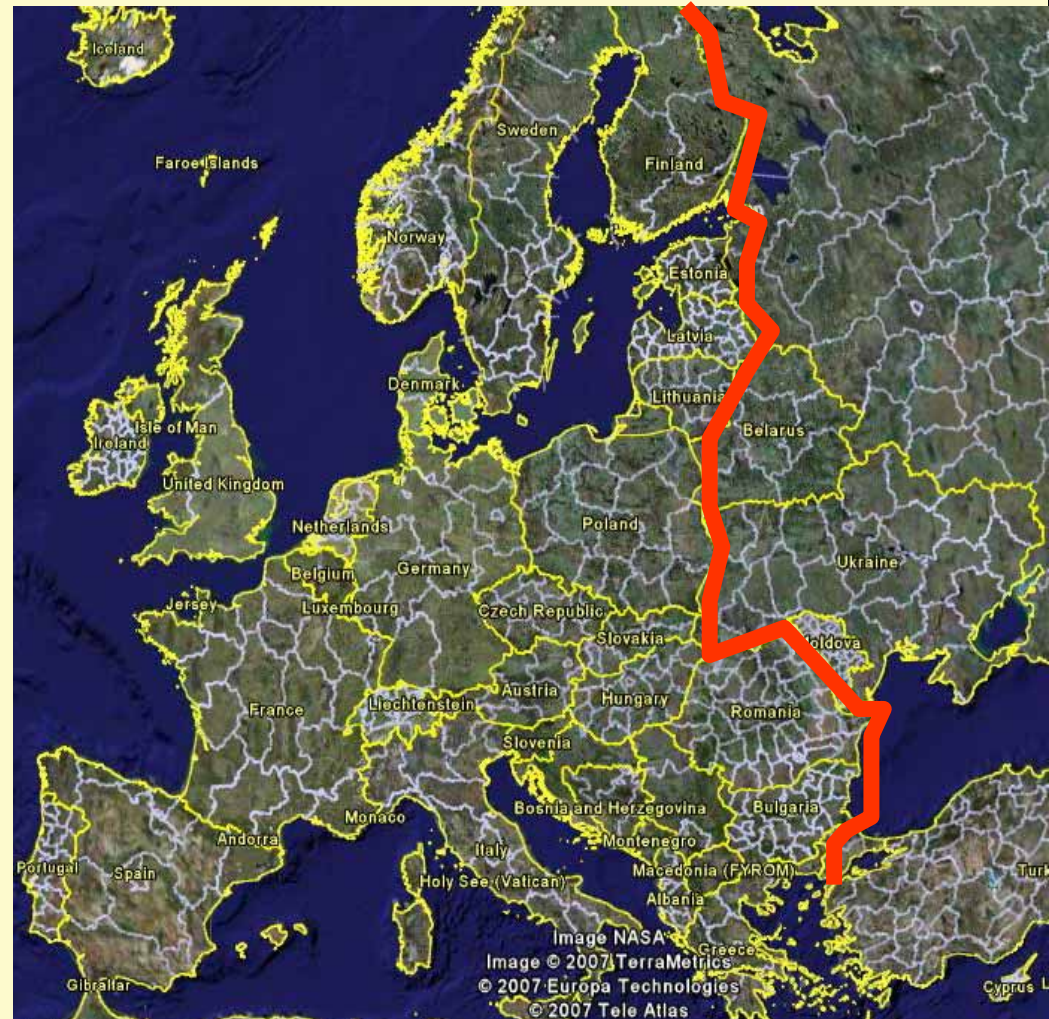


Image NASA
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A change in the structure of fertility clinics in Europe

- The pioneer generation disappears
 - Clinics run by strong Egos - “in it for the fun of it”
 - Small and large clinics
- The emergence of large business structures
 - Multinational companies
 - “one-stop shop”
- This is a natural maturation of Fertility services as a business sector.

Fertility service as business

- Patients
 - Want value for money
 - Willing to pay more to get more
- Clinic
 - Competition and marketing
 - Maximizing profit
- This is quite natural and should not come as a surprise to anyone
- The society's perspective and wishes is relevant only to the extent it has given
 - Legislative constraints
 - Economic constraints or incentives

Cost associated with ART

- Cost
- Drugs
- Procedures
- Pregnancy surveillance
- Delivery
- Follow-up

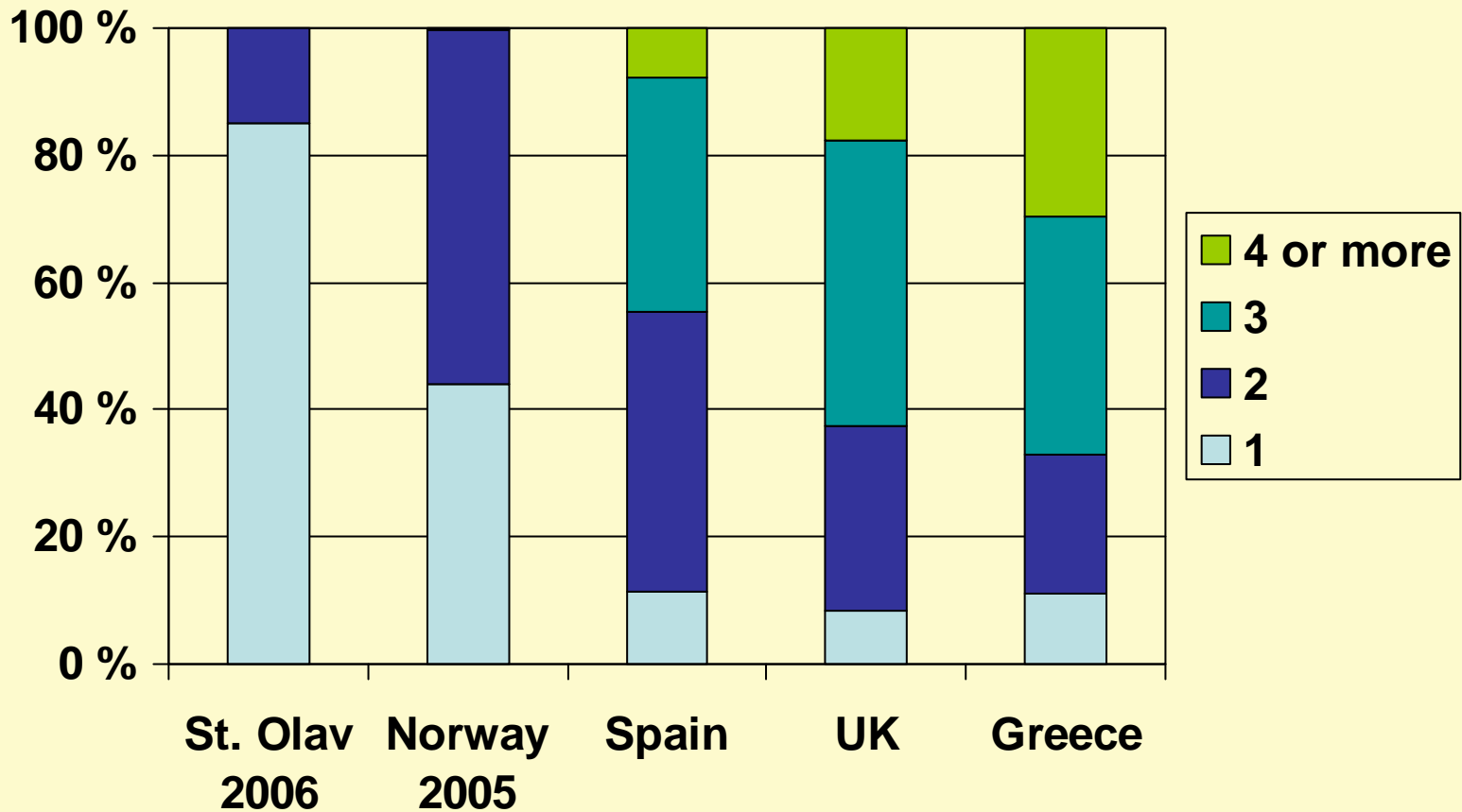
- Covered by:
- Health provider and/or Patients
- Health provider

When patient have to bear the cost for drugs and procdures

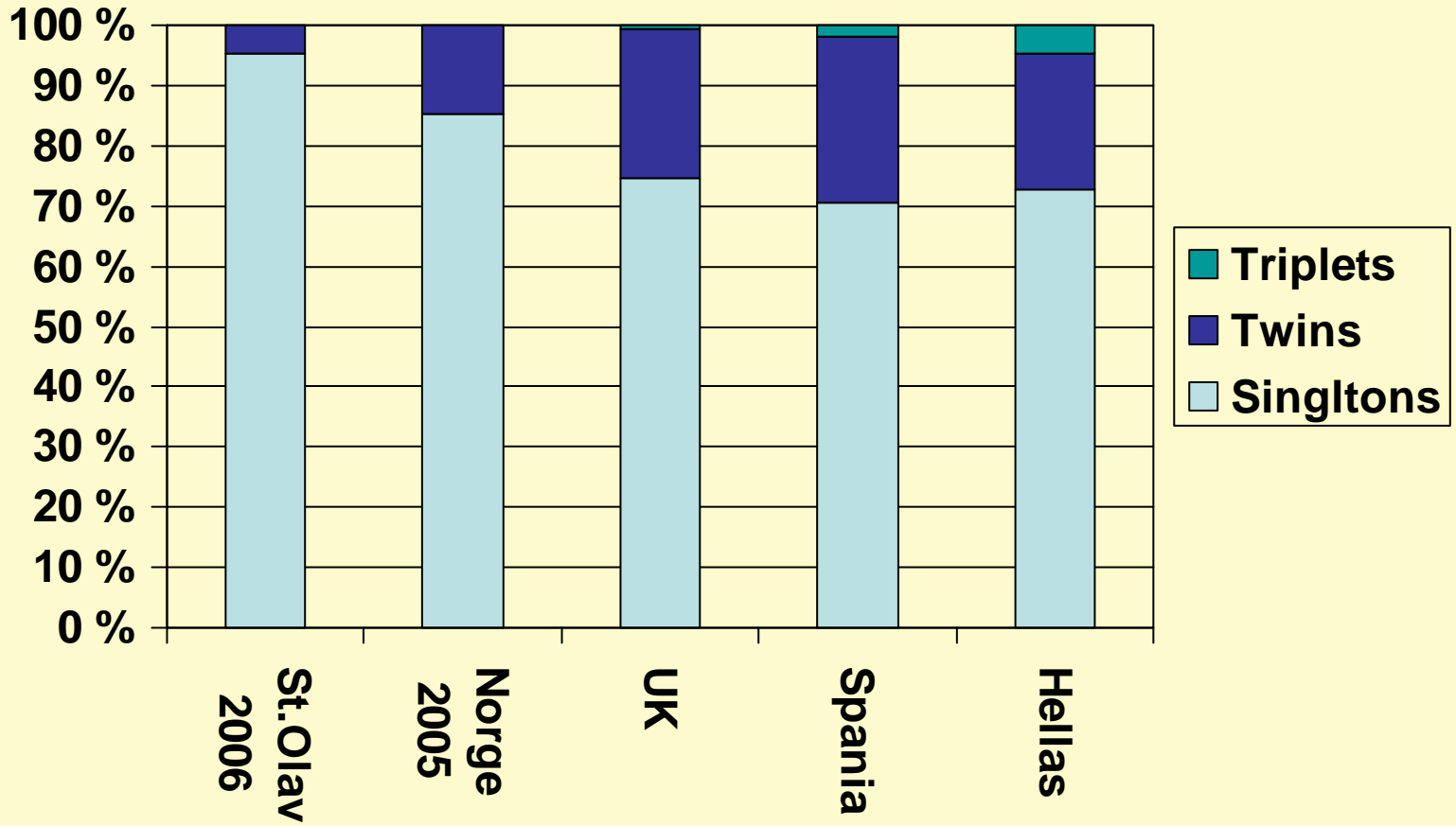
- Private clinics have to be competitive
 - Often bench-marked on pregnancy rates
 - Tough world out there
 - Replacing many embryos
 - High pregnancy rate – high multiple pregnancy rate
 - Selective reduction (abortion) when too many fetuses.
- When the patients have to bear a high proportion of the cost of drugs/procedure
 - They accept a 40% multiple pregnancy rate
 - "two for one"–



Number of embryos replaced

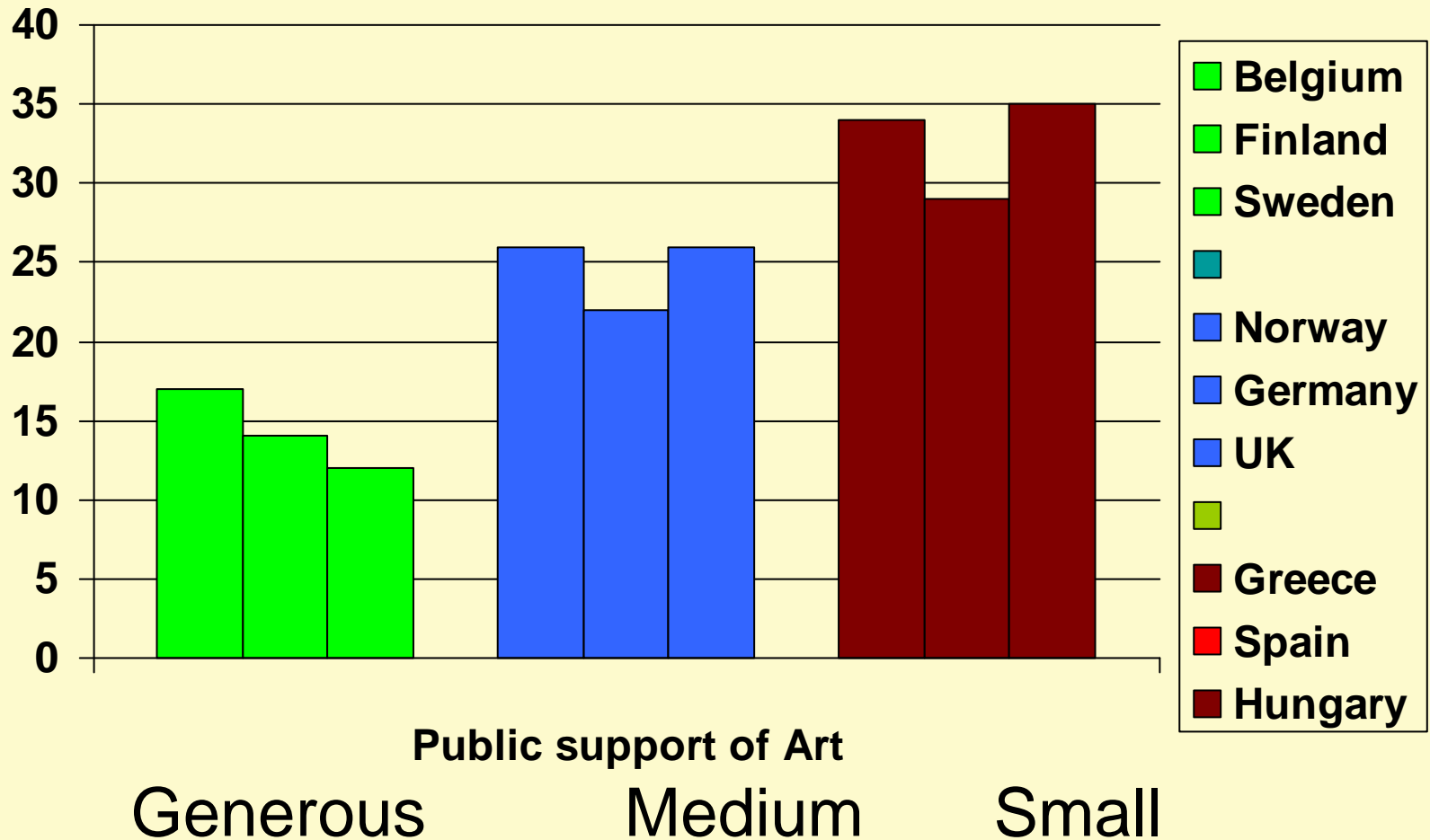


Multiple pregnancies



Egne data og fra Human Reproduction Vol.22, 1513–1525, 2007

Multiple pregnancy rates 2003*



*Human Reproduction Vol.22, 1513–1525, 2007



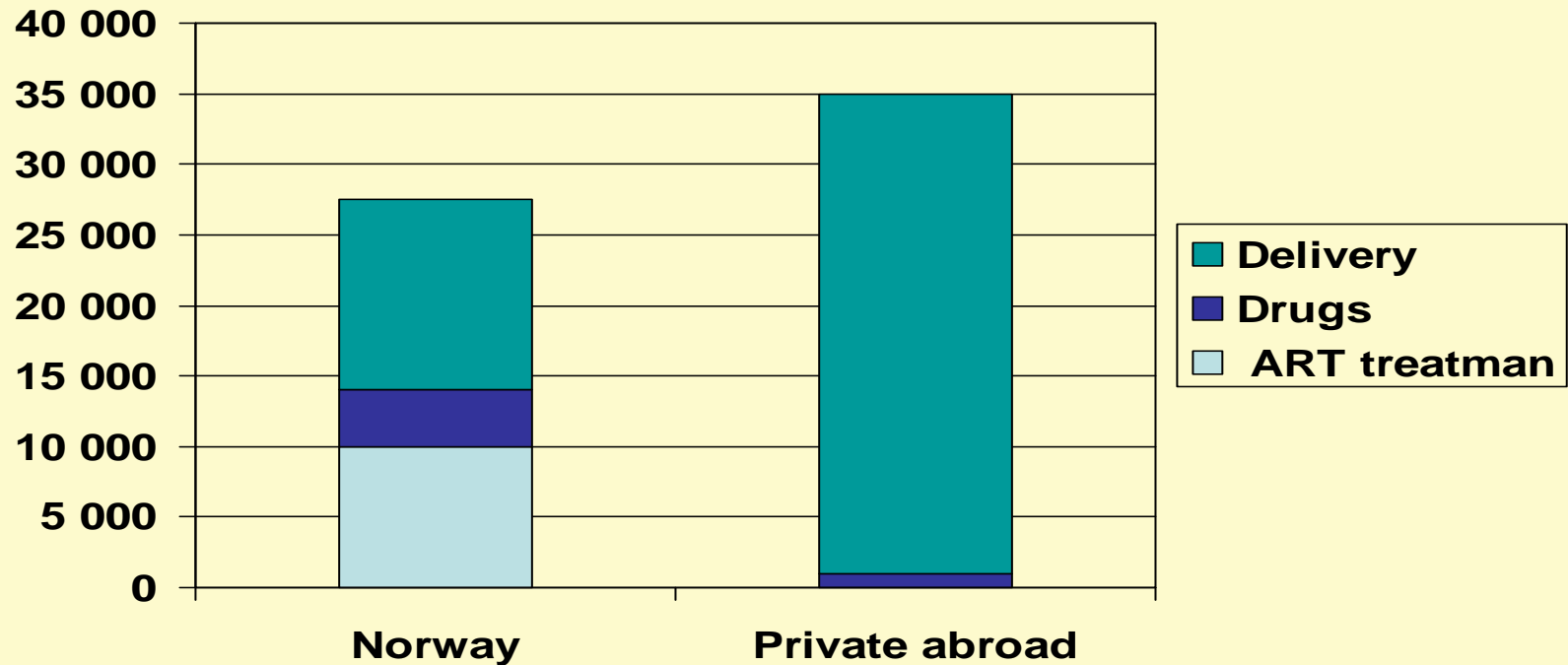
Cost of pregnancy care and delivery including 1.st neonatal week*

- Singleton
 - Approx. EUR 4 400
- Twins
 - Approx. EUR 25 000
- Triplets
 - Approx. EUR 100 000
 - France

*European mean

100 treatment cycles domestic or abroad

Mean cost/cycle for the Government (NOK)

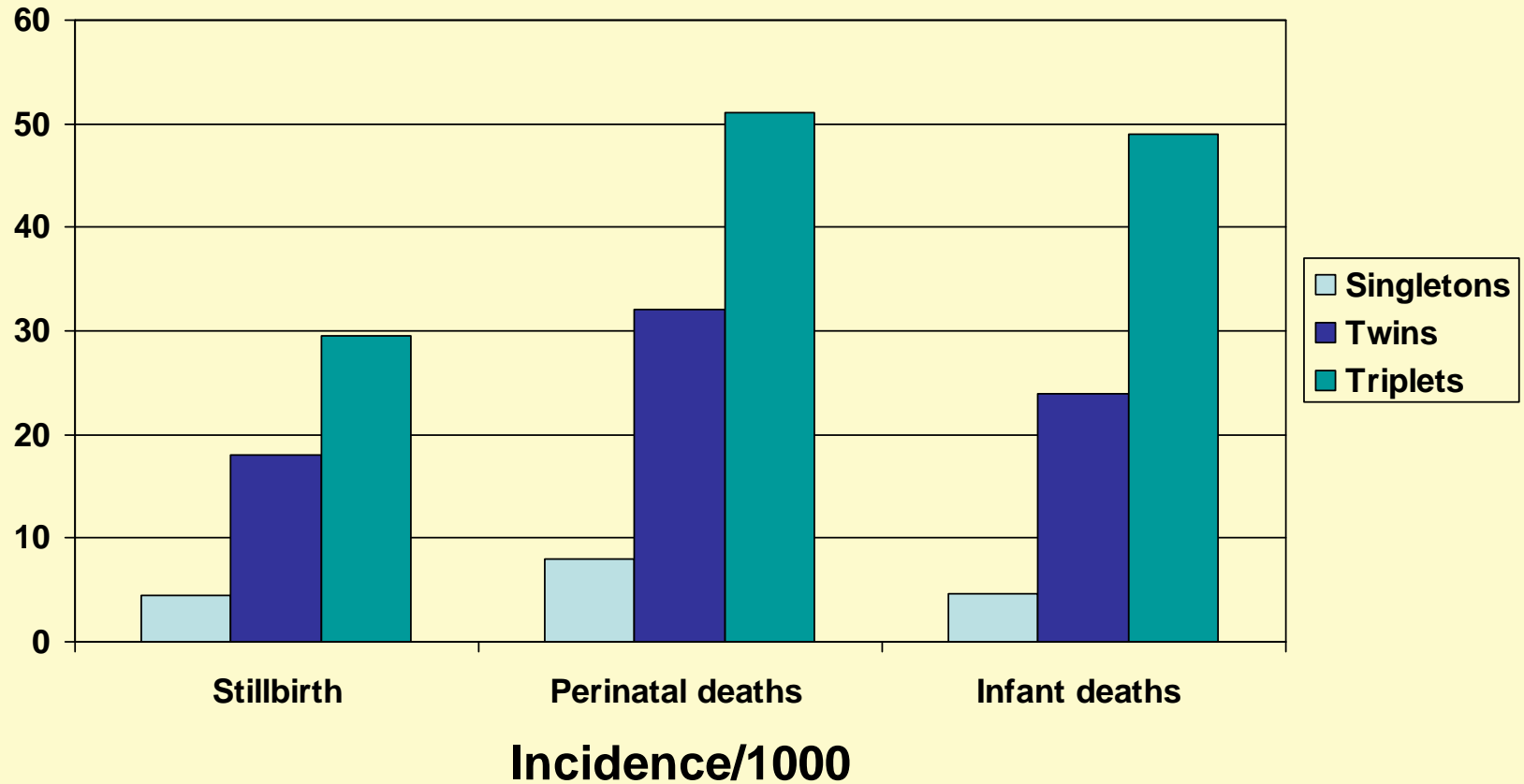


Governmental subsidy of drugs
Governmental support to public fertility clinics
Pregnancy care, delivery and 1st neonatal week

Treated at St. Olav's Hospital or in Central/Southern Europe



Multiple pregnancies



Cross border reproductive care

Patients perspective

- Advantages
- A security valve
 - Access
 - Availability
- Discretion
- "Get what they want"

- Disadvantages
- Cost
 - Not reimbursed
 - Unnecessarily costly
- Can be exploited
- Multiple pregnancies and hyperstimulation syndrome



Cross border reproductive care

Governments perspective

- Advantages
- A security valve
 - Governmental clinics shorter waiting lists
 - Demands for a change of laws and regulations less


- Disadvantages
- Loss of information
 - Outcome and side-effects of ART unknown
- Total cost to society increased

Paradox

- The debate about public spending on ART in Norway has to a large extent been focused on reducing then public spending
 - "low priority" . "not a disease"
 - Reimbursement in Norway not very generous
- This and the strict Laws has encourages Norwegian patients to seek treatment abroad
- Total cost to the society larger than if these patients have been offered treatment domestically



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Infertile couples are modern Archetype of the future patient?

- Cross border reproductive care since end of 70-ties
- Lot of information on the Internet
- Most (all) private clinics have beautiful web-sites
 - Mixture of facts and pure marketing
- Infertile very active "chatters"
 - Often they trust their peer more than the professionals
 - A lot of misunderstandings and misinformation
- **Misinformation: In my opinion a big problem**

Cross border fertility care – a problem ?

- Unfair – the rich vs. the less fortunate
- National ambitions
 - provide health care for the citizens
- National health care priorities
 - loss of control
- Domestic cost
 - multiple pregnancies and malformations
- Loss of control/surveillance
- Exploitation of patients and donors



Options

- Legislation
- Economic incentives/disincentives
- Increase domestic infertility service
- Information





Cross-border patient migration

- A pan-European law on ART ?
- Politically impossible
 - futile to work towards that
- Is it really desirable ?
 - not everybody thinks so...
- It is however a case for harmonization

Cross-border reproductive care possible action points

- Argue for Legal harmonization and at least partial reimbursement
- Agree on a minimum flow of information
 - To the patients
 - To the treating clinic
 - To the health service in the resident country
- Open pragmatic attitude from the local health/social service
- Accreditation/Certification systems



Cross-border patient migration

- Economic incentives/disincentives
 - Government should do a realistic cost estimates which includes the cost/benefit of cross border migration
- Offer affordable and accessible treatment at home less costly for the government?
 - A more pragmatic approach



Cross-border patient migration

- Information
 - Empower the patient
 - Create independent and dynamic information databases in collaboration with patient groups
 - Must be perceived as
 - » Independent from the governmental and political motives
 - » Independent of the interest of domestic clinics

Summary

- Cross border health care is here to stay
 - Most likely it will increase
- Patients will want to be autonomous
- Protection of donors and patients important
- Health care as a maturing business sector
 - Multinational companies
- Traditional paternalistic and legislative approached will not work
- Pragmatism and collaboration can work
 - The informed and empowered patient