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GREAT BRITAIN’S NATIONAL HEALTH SERVICE AND ASSISTED REPRODUCTION

Joan Mahoney†

Access to assisted reproduction in the United States depends on one of two things: good health insurance coverage or sufficient personal wealth. Sometimes it may require both. A couple or an individual seeking fertility treatments, artificial insemination, or in vitro fertilization (IVF) may exhaust the insurance benefits available and then turn to private resources to continue funding the project of conception, or they may find that their insurance does not cover the cost of IVF.¹

When the government provides the medical care, however, the situation is different.² Since the birth of the first “test tube baby,”³ which, coincidentally, or maybe not, took place in Great Britain, the British government and its National Health Service (NHS) have made decisions about the amount of funding to provide, as well as the most ethical and equitable ways to provide fertility services. The ability to fertilize an egg outside the mother’s body and implant it creates a number of legal, medical, and ethical issues: Should the National Health Service support such treatment? Who should they support? How many attempts should each couple be eligible to receive? Should the treatment be limited to couples or should it be available to single women? How many fertilized eggs


¹. See, e.g., Alex Kuczynski, Her Body, My Baby, N.Y. TIMES, Nov. 30, 2008, § MM (Magazine), at 42 (discussing both IVF and gestational surrogate).

². There are some similarities. Just as insurance companies ration the amount of assisted reproduction services they will provide (presumably to have the resources to fund more people), the National Health Service agencies in countries with government-provided health services attempt to equitably divide the available resources. The difference is, in the latter situation, the debate over how much to provide often takes place publicly.

should be implanted at each attempt? What should happen to embryos that are no longer needed? Should embryos be discarded, given to other couples, or used for research? What if the couple separates and one member wants to use the embryos, but the other does not?

In the case of Louise Brown, the doctors used Mrs. Brown’s egg and Mr. Brown’s sperm to create a baby that was genetically, as well as gestationally, theirs. But IVF creates many possibilities involving multiple parents. For example, if Mr. Brown was infertile, the doctors could have used another man’s sperm. Or if Mrs. Brown was infertile, they could have used another woman’s egg. Perhaps Mrs. Brown could produce eggs but was unable to carry a child because her uterus was removed, but not her ovaries. In that case, the doctors could have implanted a pre-embryo created from the Browns’ genetic material into another woman’s uterus. Once the possibility of separating genetic from gestational motherhood exists, it becomes necessary to define which person is the mother in case a dispute arises. Surrogate motherhood can exist without technology, but IVF makes it more appealing since couples can arrange for a baby that is genetically related to both of them. This of course raises issues such as whether to allow surrogacy contracts at all, whether to allow them for money, whether to enforce the contracts, or whether to allow men (single or in couples) to use surrogacy to create a family.

Because Great Britain has both a national health system and centralized authority, these issues are treated in a more systematic method in Great Britain than they are in the United States. The questions outlined above, when addressed in the United States, have been left to a patchwork of private insurance and enterprise, state law, and federal regulation. In contrast, in 1982 the British

4. Id.

5. See, e.g., Johnson v. Calvert, 851 P.2d 776 (Cal. 1993) (resolving a custody dispute between a couple and a woman in whom the couple’s fertilized egg had been implanted).

6. See, e.g., Genesis 2:3 (recounting the biblical story of Sarah, Abraham, and Hagar).

7. See, e.g., Susan B. Apel, Access Denied: Assisted Reproductive Technology Services and the Resurrection of Hill-Burton, 35 WM. MITCHELL L. REV. 412 (2009) (discussing federal regulations requiring access to assisted reproductive technologies at funded clinics and hospitals); Theresa M. Erickson & Megan T. Erickson, What Happens to Embryos When a Marriage Dissolves? Embryo Disposition and Divorce, 35 WM. MITCHELL L. REV. 469 (2009) (discussing the United States Supreme Court’s denial of writ of certiorari on the issue of embryo disposition, ultimately leaving the law
Government appointed a committee to inquire into the medical and ethical issues raised by advances in assisted reproduction. The Committee of Inquiry into Human Fertilisation and Embryology was headed by Dame Mary Warnock, Mistress of Girton College, Cambridge, and Senior Research Fellow, St. Hugh’s College, Oxford. The committee included judges, doctors, social workers, and academics. When they completed their work, they published their findings in a report commonly known as the Warnock Report (the Report) titled “A Question of Life.”

The Report is divided into two parts: the first and most extensive part deals with methods of alleviating infertility; the second addresses research and advocates for the pursuit of knowledge to benefit society at large rather than specific individuals. The Report considers whether the NHS should provide infertility treatment, and ultimately concludes that it should. In reaching this conclusion, the Report examines and rejects arguments that IVF is an unmoral “deviation from normal intercourse” and that IVF unacceptably brings more embryos into existence than are transferred into a womb.

Another problem the Report addresses, which is important both for ethicists and the NHS, is the decision regarding eligibility for infertility treatment. The committee considered the extreme positions of restricting treatment to married couples, versus recommending it for single women, lesbian couples, or through

9. Id. at iv.
10. Id.
11. Id.
12. Id. at chs. 1–8.
13. Id. at chs. 9–13.
14. Id. at 32.
15. Id. at 31.
surrogacy for single men or gay couples. The ultimate recommendation was to restrict treatment to heterosexual couples, married or not, on the theory that children do better with a two-parent family consisting of one mother and one father. Even then, a practitioner may decline treatment to a particular patient due to his or her own social judgments. In such a case, the Report recommends that the practitioner give the patient a full explanation of the reasons. Finally, the Report recommended that individual health authorities, essentially local subdivisions of the NHS, establish specialist infertility clinics, separate from routine gynecology clinics, wherever possible.

The remainder of the Report deals with the collateral issues of infertility treatment—the status of children conceived through artificial insemination by a donor (AID), anonymity of sperm donors, limits on donation, the use of donated eggs, embryo donation, surrogacy, and the use of embryos for research purposes.

Following the Warnock Report, Parliament passed the Human Fertilisation and Embryology Act of 1990 (HFEA or the Act). The Act established the Human Fertilisation and Embryology Authority (the Authority) to supervise treatments provided by the Act and restricted the performance of fertility treatments to doctors and organizations licensed by the Authority. The Act went on to define “mother” as the person who carries a child after an embryo or sperm and egg are placed in her uterus, without reference to the origin of the genetic material. In the event of AID or IVF, the

16. Id. at 11.
17. Id. at 12.
18. Id. at 14.
19. Id. at 26.
20. Id. at 24.
21. Id. at 27.
22. Id. at 37.
23. Id. at 40.
24. Id. at 47.
25. Id. at 58–69.
27. Id. § 5–11.
28. Id. § 27.
29. In the United States case Johnson v. Calvert, the California Supreme Court granted custody to the genetic mother, not the gestational surrogate. 851 P.2d 776, 782 (Cal. 1993). The Act’s definition of mother as gestator, as opposed to the genetic parent, would appear to lead to a different result in Great Britain if that
carrying woman’s husband shall be treated as the father of the child, so long as he consented to the treatment. The sperm donor is not treated as the father. 30 Nevertheless, a court may make an order treating the genetic parents as the sole parents if their genetic material was used with their consent to create an embryo carried by another woman (a gestational surrogate), as long as no money changes hands other than for reimbursement of expenses. 31

The Warnock Report, embodied in HFEA, answered many of the questions about assisted reproduction and allowed the NHS—along with licensed private clinics—to begin providing fertility treatment including IVF. The HFEA, however, did not resolve all IVF issues. The NHS is funded by the central government, but it is divided into local units, called Primary Care Trusts, each of which has substantial control over the spending of resources. While HFEA permitted the NHS to provide fertility services, it did not mandate services be provided, resulting in what is known in Great Britain as a “postcode lottery.” 32 In other words, access to IVF and other fertility treatments within the NHS depended largely on where a couple lived. 33

In 1999, the government established an independent agency, the National Institute for Clinical Excellence (NICE), to make recommendations on the clinical and cost effectiveness of proposed medical remedies. 34 In 2000, NICE was asked to consider guidelines for fertility treatments under the NHS. 35 It produced a report in 2004, recommending that the NHS provide couples with three attempts at IVF. 36 Despite the recommendation, a survey in 2006 indicated that some Primary Care Trusts were not funding any IVF treatments, and that the vast majority were funding no more

same conflict were to arise between a gestational surrogate and the genetic intended parent.

30. HFEA 1990, § 28. This changed the common law rule that a child born as the result of AID was illegitimate. Id.
31. Id. § 30. In other words, although the gestator is legally the mother, a surrogate may (but cannot be forced to) turn the child over to the intended parents who can get a court order recognizing them as mother and father. Id.
32. The postcode is the British equivalent to the U.S. zip code.
35. Id.
36. Boseley, supra note 33.
than one. Even where such treatments were provided, the NHS restricted their services to women under forty. Because of this restriction and the lack of availability of infertility treatment, the majority of infertile couples in Great Britain were finding it necessary to use private clinics rather than the NHS.

In 2006, the British Fertility Society (BFS) did a survey of Primary Care Trusts to determine the level of fertility assistance that the NHS was providing. They found, in addition to the limits on treatment described above, some clinics were rejecting women who had previously had a child, and others turned down women who smoked or were overweight. The BFS followed their study with a series of recommendations: (1) that treatment be restricted to women under forty; (2) that single women and same sex couples be eligible for treatment on the same basis as heterosexual couples; (3) that women not be excluded from treatment if they had previous children; and (4) that the severely overweight women should go on a weight reduction program before receiving treatment.

A subsequent survey was carried out by the BFS in 2008 to commemorate the thirtieth birthday of Louise Brown. The survey questioned fertility experts in the Great Britain. While the majority worked for private clinics, more than 70% of the respondents believed that the NHS should cover fertility treatments. On the other hand, over 45% of those surveyed believed that IVF should be denied to people with unhealthy lifestyles, specifically smokers and those who are overweight. Finally, the experts who were surveyed overwhelmingly believed that new infertility treatments lacked proof that the treatments work, and they believed more...

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37. Id.
39. Mark Henderson, Infertile Couples Denied Full IVF as NHS Offers Them Just One Chance, TIMES (London), June 24, 2008, at 3 (“[A]lmost 45,000 cycles of IVF are performed in the UK each year, but the level of NHS provision means that more than 30,000 of these are conducted privately, at an average cost of about £2,000 per cycle.”).
40. Boseley, supra note 33.
41. Id. The last recommendation was based on the fact that infertility treatment is less likely to be successful if the woman is severely overweight. Id.
43. Id.
clinical trials should be carried out to test the effectiveness of these treatments.\footnote{44}{\textit{Id.}}

Although HFEA was quite clear on the need for both parents to consent to the use of stored embryos,\footnote{45}{HFEA 1990, c. 37, § 12, sched. 3 (Eng.).} the Act was challenged as inconsistent with the Human Rights Act 1998.\footnote{46}{Human Rights Act 1998, c. 42 (Eng.).} In \textit{Evans v. Amicus Healthcare, Ltd.}, Natalie Evans used her eggs to create embryos for future use, after which she had surgery that left her infertile. Before she could use the embryos, she and her partner separated. He contacted the clinic to tell them they could dispose of the embryos. Ms. Evans sought an injunction to prevent their destruction, arguing that not allowing her to use them would violate Article 8 of the Human Rights Act, ensuring respect for private and family life.\footnote{47}{Evans v. Amicus Healthcare, Ltd., [2004] EWCA (Civ) 727, [2005] Fam. 1 (Eng.).} The Court of Appeal decided against her on the ground that the statute quite clearly required the consent of both parties. The court went on to find that the Human Rights Act did not require a different result on the ground that Mr. Johnston’s wish not to be a father was entitled to as much respect as Ms. Evans’ interest in becoming a mother.\footnote{48}{\textit{Id.} ¶¶ 41, 69, 74. One United States case similarly held that a man’s right to not procreate is just as important as a woman’s right to procreate. See Davis v. Davis, 842 S.W.2d 588 (Tenn. 1992) (applying a constitutional analysis in a dispute between divorcees to grant custody of embryos to the man, who intended to discard them, over the woman who wanted to use them in order to conceive a child).} Although the \textit{Evans} case dealt with a private clinic, the result would be the same for an IVF performed under the NHS, as both are governed by HFEA. The \textit{Evans} case and a companion case were appealed to the House of Lords, which rejected the claim.\footnote{49}{See Evans v. United Kingdom, 2006 Eur. Ct. H.R. 200, ¶ 22.}

HFEA was amended in 2008 largely to address new developments in science since the first statute was passed. Among the major changes is a provision allowing persons over the age of sixteen to obtain information about their genetic parentage, and allowing the Authority to set up a register through which people that consent may receive information about their genetic parents or siblings. The most significant changes to HFEA, however, involved the definitions of parents. The Act continues to define

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\end{itemize}
the mother as the gestational parent. But it makes provision for the recognition of a woman as the second parent (another mother) if the woman being treated is in a civil partnership at the time of the treatment, or the woman being treated consents to another woman being recognized as a parent and no man is treated as a father under the terms of the statute. Men are treated as fathers under the terms of the statute if they are married to the mother and consent to the treatment, even if another man’s sperm is used. Further, a man’s sperm or embryos created with his sperm while he was alive can be used after his death as long as he consented and did not withdraw his consent prior to his death. The statute recognizes both technological changes that have occurred since 1990, such as the ability to use sperm and embryos after the death of the donor, and social changes, such as same-sex civil partnership. While the Warnock Report and the first statute reserved fertility treatment for heterosexual couples, the new statute recognizes that some children will have no legal fathers under the terms of the Act.

The question is whether having the NHS changes the practice of assisted reproduction and the answer is yes and no. Although fertility services are theoretically available from the NHS, studies, as shown above, have made it clear that in practice very little help is available. The ideal, such as offering three attempts at assisted reproduction, is not met in many places in Great Britain, and some Primary Care Trusts do not offer even one attempt. In this sense, British couples dealing with infertility are left to use private clinics much the same way as most American couples. In addition, even those Primary Care Trusts that offer treatment have a cut off age of forty. Therefore, women who are the most likely to have fertility problems have no NHS treatment available.

On the other hand, the existence of the NHS may be the

51. Id. § 42. Great Britain has recognized civil partnerships between same-sex couples since 2004. Civil Partnership Act, 2004, c. 33 (Eng.).
52. HFEA 2008, § 43. This would apply, for example, if the gestational mother was not married and the sperm was provided by a sperm donor who consented to the use of his sperm for that purpose.
53. Id. § 35.
54. Id. § 39. This practice would presumably have an impact on the Rule Against Perpetuities.
55. WARNOCK, supra note 8, at 11.
56. See HFEA 2008, § 42.
reason why the British have established more central control and regulation of fertility treatment. In the United States, surrogacy is clearly legal in some states but may not be legal in others. The recognition of a woman’s female partner as a parent is left to state law, as is the decision whether the genetic parent or gestational parent is considered the mother. The issues arising from posthumous use of sperm or embryos is similarly left to the vagaries of each state’s decision-making process. Great Britain, on the other hand, tends to take a systematic approach to bioethical issues. Two of the most important issues of the twentieth century—the decriminalization of abortion and same-sex sexual activity—were accomplished through Supreme Court decisions in the United States, while both were the result of statutory changes in Great Britain. Similarly, when IVF became a possibility, the British government appointed a commission to study the problem and passed legislation that largely tracked the report of the commission. When new developments in technology created new issues in assisted reproduction, the statute was amended to provide for those new issues. While access to assisted reproduction may not be that different between the two countries—although there is increasing pressure on the NHS to provide better access—the issues regarding the treatment and its possible consequences are more clearly delineated in Great Britain than they are in the United States.


58. Hofman, supra note 7, at 455 (discussing California’s acknowledgment of same-sex parentage).


60. Indeed, the comprehensive use of statutes to regulate many areas of the law, from employment rules to the rights of children and parents, is one of the ways in which Great Britain, although the origin of the common law, is becoming more like civil law countries. This process has presumably been accelerated by membership in the European Union and the close cooperation with civil law countries. The former colonies, particularly Canada and the United States, may be the last bastions of the common law.