

Gamete (egg, sperm) and embryo storage limits

BPAS submission to the Department of Health and Social Care

BPAS is a reproductive health charity that sees around 100,000 patients a year for reproductive health services including pregnancy options counselling, miscarriage management, abortion care, STI testing and contraception, at clinics in England, Wales and Scotland. We also campaign and advocate for reproductive choice and evidence-based, patient-centred care. BPAS is the home of the Centre for Reproductive Research and Communication (CRRC), which has a mission to emphasise patient experiences of issues relating to reproductive health and pregnancy. Our research includes a two-year, Wellcome-funded project called Wrisk, which seeks to understand and improve the communication of risk on issues relating to pregnancy.

Consultation questions

Possible changes to the 1990 Act

Question 1

Should the statutory storage period for frozen embryos, eggs and sperm change from the current limit of 10 years?

Yes

Question 2

Do you think the limit should be increased or decreased?

Increased

Question 3

If you think the limit should be increased, what should the new limit be:

55 years. This is already the maximum storage limit in cases of premature infertility. It should be extended to all patients, irrespective of their reason for freezing.

Question 4

Why do you think that the limit should be increased?

The recent decision to extend the storage limit by two years, to assist women whose reproductive decision-making has been put on hold due to COVID-19, is very welcome. However, it serves to underline the arbitrary nature of the current storage limit of ten years, and unfortunately for the majority of women it will be immaterial. We therefore recommend a much larger change – that the storage limit is extended to 55 years for all patients – for the following reasons:

1. The distinction between medical and non-medical freezing is misleading

The distinction between medical and non-medical freezing is by no means clear, and the discrepancy in the current law fails to reflect the complex factors and motivations that shape people's use of this technology. The separation of medical freezing as a separate practice worthy of its own time limit is unjustifiable and unnecessarily value-laden. As noted by the ESHRE Task Force on Ethics and Law, the application of egg freezing technology to combat a natural decline in fertility for women should not be considered beyond the limits of medicine but rather a reflection of the Hippocratic ethical principle of beneficence. Our notions of health and disease are socially mediated, and cannot be defined on the basis of biological function alone. From this holistic perspective, fertility preservation for ovarian aging can be understood as a medical treatment for involuntary childlessness, rather than dismissed as non-health-related (Dondorp et al., 2012). Women's reproductive choices, too, are socially embedded and cannot be understood in isolation from their social context. Frequently used terminology which describes social egg-freezing as a "lifestyle choice" is value-laden and risks exaggerating the level of reproductive control afforded to women in society (Petropanagos, 2010).

The 2009 Human Fertilisation and Embryology (Statutory Storage Period) Regulations already make provision, rightly, for women who are not deemed to be ‘prematurely infertile’ to access the longer storage limit of 55 years if they are freezing their eggs for somebody else’s future use, for example a mother whose daughter has Turner Syndrome. In this scenario the donor herself has no medical need to access the longer limit, but she is granted access in order to offer her daughter an opportunity to bear children in the future.

The distinction between “medical” and “social” freezing is specious, and we would like to see the maximum storage limit of 55-years extended to all patients, regardless of their reason for freezing.

2. The current storage limit engages women’s human rights

As argued by the Progress Educational Trust and leading academics in the field of medical law, the current law stands as violating the fundamental human rights of women. While Article 8, the right to respect for private and family life, is not absolute, an arbitrary storage limit, though made in accordance with the law, represents an unjustified interference. As Emily Jackson notes, such a limit cannot be deemed as falling within the secondary qualification of “necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others” (Jackson, 2016). There is a distinct lack of evidence demonstrating how an extension of the current limit poses a risk to the rights of others or to the “health and morals” of society, and consequently the current law stands as an “anomalous limit” which disadvantages women in the UK (Bowen-Simpkins et al., 2018).

The current law further engages issues of equality, most plainly seen in the differences in fertility of men and women. Due to the inherent age-related fertility decline which women face, the typical opportunities of biological parenthood are already markedly more limited than those of men. The current storage limit represents a further undue restriction on women’s reproductive choices, which is not felt by men. In order to facilitate equal treatment, the storage limit should be increased to support the equal opportunities of both men and women in making their reproductive choices.

3. The basis of the current law is no longer relevant

The current law is not underpinned by scientific evidence. The maximum storage limit of ten years fails to reflect the fact that gametes and embryos can remain viable if cryopreserved for far longer, especially since the introduction of vitrification which yields better results than slow freezing. Perversely, the current limit of ten years encourages anti-scientific practices, since women are incentivised to delay freezing until the final decade of their reproductive lifetime, when their eggs are less fertile. According to the HFEA, the most common age at which women undergo egg freezing is 38, and only 1 in 3 women who freeze their eggs do so before the age of 35 (HFEA, 2019). A longer storage limit would facilitate earlier freezing, increasing the chances of success.

Society has also shifted since the current storage limit was agreed, with the consequence that the law no longer reflects the demand for, and use of, egg freezing technology. The average age of first-time motherhood has increased steadily over the last decade, as has the use of egg freezing technology, which is now the fastest growing fertility treatment in the UK (ONS, 2019; HFEA, 2019). These trends are the consequence of increased gender parity in society as more women participate in higher education and the workplace, but they also reflect increased anxiety among women around fertility decline (Baldwin, 2019). The current storage limit of 10 years exacerbates this anxiety by forcing women to make difficult decisions about when to freeze their eggs, weighing up the clinical benefits of freezing them early against the fear that the storage limit will expire before they are ready to use them. It also places women in impossible situations as their storage period reaches an end, forcing them to decide between destroying their eggs or becoming parents before they are ready to do so (Bowen-Simpkins et al., 2018).

Question 5

~~If you think the limit should be decreased, what do you think the limit should be:~~

- ~~• 8 years~~
- ~~• 5 years~~
- ~~• other – please specify~~

Question 6

Why do you think that the limit should be decreased?

Question 7

Why do you think the limit should stay the same?

Question 8

Should any conditions be applied to those seeking to freeze embryos or gametes beyond a certain limit?

No, the limit should be 55 years for all patients.

Question 9

What do you think these conditions should be? (For example, that the patient should be under a certain age or that they should undergo additional welfare checks as part of fertility treatment.)

Question 10

Should embryos, eggs and sperm each have their own storage limit?

No. There is no clinical reason why this should be the case: there is no decline in survival rates over time for eggs, sperm or embryos.

Question 11

If they should each have their own limit, what should that be? Please state the limit for each below:

- embryos:
- eggs:
- sperm:

Possible changes to the 2009 storage regulations

Question 12

Do you think that the provisions in the regulations need updating?

Yes

Question 13

Do you think the criteria that permit storage extension for those who are prematurely infertile are still appropriate and should remain?

No. There should not be any criteria. Anybody who requests a renewal after 10 years should be granted one, up to a maximum storage limit of 55 years. This should be the case for all patients, regardless of their reason for freezing.

Question 14

Are there other additional criteria that might be appropriate to include? If so, please specify what these may be.

No

Question 15

Is the 10-year frequency of renewal still appropriate?

Yes

Question 16

If not, what period of time do you think is more appropriate and why?

Question 17

Is the 55-year maximum storage limit still appropriate?

Yes

Question 18

If not, what maximum period of time for those who may be prematurely infertile would be appropriate? For example, would the donor's lifetime be an appropriate limit?

Question 19

Should embryos, eggs and sperm each have their own storage limit?

No

~~**Question 20**~~

~~If they should each have their own limit, what should that be? Please state the limit for each below.~~

- ~~• embryos:~~
- ~~• eggs:~~
- ~~• sperm:~~

Question 21

Do you have any other comments on gamete and embryo storage limits not covered in these questions?

Yes.

1. Women must be given evidence-based information

Extending the storage limit would benefit women by allowing them to keep their eggs and embryos until they are ready to use them. It would also allow younger women who want to freeze their eggs the opportunity to do so without worrying that the limit will expire before they are ready to become parents. However it may also create opportunities for private clinics to expand their business by encouraging more young women to freeze their eggs. As discussed above, there is widespread anxiety among women about fertility decline, and as the UK's largest provider of abortion care we know from experience that many women tend to underestimate their own fertility. This should not be exploited by private fertility clinics to encourage women to undergo a needless procedure, especially one as costly and invasive as egg freezing. Women in their twenties have every right to freeze their eggs should they wish to do so, but in the vast majority of cases this will likely prove unnecessary. Women must be given realistic, unbiased information about their natural fertility in order to make that decision for themselves.

Simultaneously, women who do opt for egg freezing must be given realistic information on their chances of having a successful pregnancy. Success rates for egg freezing have improved in recent years, but they remain low at roughly one live birth per 20-25 vitrified oocytes (Dondorp et al., 2012). Women must be given transparent, evidence-based information on success rates to aid their decision making and avoid false hope.

2. Egg freezing is costly

The process of egg freezing is financially burdensome, costing between £7,000-£8,000 on average, which is likely to be unmeetable for the majority of women. Moreover, concerns have been raised in the media that private clinics are not transparent about the cost of the procedure, or clear about additional charges, with the consequence that patients find the costs spiral once they have started (Guardian, 2019; BBC World Service, 2018). Clinics offering egg freezing must be regulated to ensure they are transparent about the costs involved to allow patients to make informed choices.

3. Egg freezing is not a panacea

The storage limit of ten years is by no means the only barrier that prevents women from starting a family. Research conducted by BPAS found that women who wish to become parents worry about the financial cost of doing so, particularly the cost of childcare, and the perceived difficulty of balancing paid employment with motherhood (BPAS, 2015). For these women, who would likely struggle to afford egg freezing in the first place, extending the storage limit will do nothing to assist them to start a family.

4. Egg freezing must go hand in hand with comprehensive access to IVF services

An extension to the storage limit does nothing to help women who cannot access IVF services at the end of the storage period. Any extension to the limit must therefore go hand in hand with moves to ensure comprehensive access to IVF services across the UK, so that women and couples have a realistic means of using their frozen eggs once they are ready to become parents.

NHS funding for fertility services is inconsistent across the UK, with CCGs making independent decisions on whether to fund fertility treatment for women and couples trying to conceive. Research conducted by BPAS (forthcoming) has found that a high proportion of CCGs do not comply with NICE guidance that women under the age of 40 should be offered three cycles of IVF, and some CCGs are offering no IVF treatment at all. Several CCGs were found to be imposing an upper age limit of 35, which is unlikely to be of use for women who wish to use frozen eggs. Moreover, last year NHS South East London was criticised by a coalition of charities, including BPAS, for denying IVF to single parents on the grounds that they “do not give the best outcome for the child.” It is worth noting that even in cases of “medical” egg freezing, which is funded by the NHS, patients still need to meet their CCG’s eligibility criteria for assisted conception in order to use their frozen gametes (NICE, 2013, section 1.16.1.6). We welcomed Secretary of State Matt Hancock’s comments in February that IVF provision should be determined nationally to end this unfair postcode lottery, but action on this has not yet been forthcoming.

Meanwhile, similarly to egg freezing, concerns have been raised that private IVF clinics do not offer patients transparent information on either prices or success rates, and many have been criticised for offering patients unproven add-on treatments and unnecessary diagnostic tests at great expense (HFEA, 2020; CMA, 2020). For women who struggled to meet the cost of egg freezing in the first place, funding their IVF as well may prove a bridge too far.

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