Subsidised oocyte donation in Israel (1998–2000): results, costs and lessons


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BACKGROUND: Israeli law stipulates that all women aged 45–51 who need oocyte donation are entitled to as many donations as necessary, up to the birth of one child. Only oocytes donated by women who themselves are undergoing assisted reproduction are allowed. The government subsidises all oocyte donation cycles through the medical insurer of the recipient, whether or not the procedure is performed in a public or private institution. The aim of the present study was to investigate the success of oocyte donation cycles in Israel for the period 1998–2000 and to estimate costs and pregnancy rates. METHODS: Data were derived from the Dan District Registry of the General Health Services (Sheirutei Bri’ut Clalit), the largest medical insurer in Israel. RESULTS: 171 women underwent 254 oocyte donation cycles within these 3 years, and 45 babies were born, for a positive outcome of 17.7%. Average annual cycle cost was US$1742 and average annual cost per patient, US$2521. The total annual cost for the district accounted for only 0.05% of the budget. CONCLUSIONS: These findings suggest that IVF with donated oocytes is relatively efficient and that government funding of oocyte donation cycles ensures a reasonable cost.

Key words: cycles/insurance/oocyte donation/outcome/payment

Introduction

The 1995 Israeli Health Law entitles every citizen to government-subsidised medical care through one of the four recognized home management organizations. One of the medical services covered by the law is IVF—as many cycles as necessary—until the birth of two children for women up to age 45, and as many oocyte donation cycles as necessary until the birth of one child for those aged 45–51 or younger women who cannot use their own oocytes. The treatment must be performed in the country, and only oocytes donated by women who themselves are undergoing assisted reproduction are acceptable. Personal payment for oocyte donation is prohibited, although two private centres in Israel offer benefits to women donating oocytes in the form of treatment services (Schenker, 1997).

Oocyte donation, originally applied only in women with premature ovarian failure or surgical castration, is now also commonly used in menopausal women (Shulman et al., 1999). The last decades have witnessed a steady increase in the demand for oocyte donations by women who defer childbearing to later years, when their natural fecundity has declined (Ahuja et al., 1996). Though there is theoretically no age limit to oocyte donation treatment if the general and uterine health of the woman is good (Sauer, 1998), Israel, like other countries (Flamigni, 1993), stipulates 51 years as the maximum age in the interests of the future child. Some authors favour raising the maternal age to 60 years (Mori, 1995).

Since oocytes from aborted fetuses and cadavers are not acceptable for oocyte donation (Kazem et al., 1995), oocytes from live donors remain the only option. This supply is limited, however, by legal and ethical considerations. Legally, in Israel, the pool of oocyte donors is restricted to women who themselves undergo assisted reproduction cycles. Practically, this is against the donors’ best interests since it reduces the number of oocytes available to them for fertilization. The problem is exacerbated by the prohibition on financial compensation for potential donors, thereby decreasing their incentive. This is also true for other countries, such as the UK, where the Human Fertilisation and Embryology Act of 1990 states in its licensing conditions that ‘no money or other benefit shall be given or received in respect of any supply of gametes or embryos’ (Human Fertilisation and Embryology Authority, 1990).

The General Health Services (Sheirutei Bri’ut Clalit) is the largest medical insurer in Israel, covering ~60% of the population (3.6 million people). The service is divided by district, of which the Dan District is the largest, with a population of 500,000. The Dan District owns two hospitals and is affiliated with a third, government-owned hospital, all of which have advanced fertility units. The Dan District has

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maintained a registry of oocyte donation treatments since 1998. In the present study, we examined the results of oocyte donation cycles in the district from January 1, 1998 to December 31, 2000, and estimated the costs of treatment, as well as recording the outcome.

Materials and methods
From January 1, 1998 to December 31, 2000, every woman eligible for assisted reproduction treatment with donated oocytes at the General Health Services, Dan District, was registered. Patient age, annual number of oocyte donation cycles, cost of each cycle, and outcome were recorded. All recipients and donors met the criteria of the Israeli law. All treatments were performed in private institutions (and not in the hospitals of the insurer; see Discussion), and all preparations were done in accordance with Israeli standards, with minor modifications, as previously described (Shulman et al., 1999).

Donors are ‘matched’ to recipients on the basis of skin colour and ethnic origin only. Each recipient receives ~3–5 oocytes from the same donor, and all the embryos formed are transferred to the recipient. Each donor is entitled to donate to one recipient. Since the donor provides advance notice of her willingness to contribute, there is ample time to prepare the recipient; therefore, no frozen–thawed cycles were necessary in the period under study here. Informed consent is received from both donors and recipients prior to donation or treatment. Although the women are officially entitled to one child in subsidised oocyte donation cycles, there is an internal regulation of the medical insurer to allow a second child by this method if requested. During the study period, no such request was submitted. The recipients pay the medical institution directly, according to its rates, and then present the original receipts to the medical insurer to get reimbursed in accordance with the rates set by the Israeli Ministry of Health.

Results
From January 1, 1998 to December 31, 2000, 171 women aged 45–51 years (mean 47.23 ± 1.78 years) underwent 254 oocyte donation cycles. The annual number of patients and oocyte donation cycles (total and average per patient), and annual cost of the cycles (individual, total and average per patient), total annual number of deliveries resulting from oocyte donation cycles, and annual cost of every baby born are shown in Table I. Costs are presented in US$ (US$1 = ~4.35 NIS).

Discussion
As many as 90% of women can expect a live birth from oocyte donation treatment by their fifth attempt (Ahuja and Simons, 1996). Furthermore, studies have shown that neither implantation nor pregnancy rates are affected in oocyte donation cycles in women aged 40–52 years compared with women aged ≤39 years who shared the donated oocytes (Abdalla et al., 1997). The positive outcome (i.e. babies born) of such a treatment according to our registry is 17.7% (45 deliveries in 254 cycles, for a ratio of 1:5.64), close to the 24.1% reported in Denmark (38 deliveries in 158 cycles) (Westergaard et al., 2000).

Table I shows that the average cost to the medical insurer for each oocyte donation cycle in Israel was US$1742 (range US$1550–1975). The price is determined by the Ministry of Health based on their economic calculations and is updated each year; hence the differences in prices paid per cycle in each year. The true cost for the recipient is approximately another US$1000 for each cycle plus about US$100 for medications during treatment—the average price demanded by the private hospitals that are licensed to perform such treatments in Israel. This addition can normally be afforded by the women, the average salary in Israel being ~US$1500 per month. The average annual cost of all patients in the Dan District was US$182 592 (range US$52 700–$223 175). This represents about 0.05% of the total annual budget of the Dan District—-a tolerable rate, considering the reason. Notably, these expenses seem to be declining, perhaps as a consequence of the deterioration in the political and economic conditions in Israel over the last 2 years, as well as a public debate about oocyte donation triggered in mid 2000 which affected both physicians and patients.

Only four European countries specifically permit oocyte donation. These are Denmark, France, Spain, and the UK (Gunning, 1998). In each country, oocyte donation is addressed within broader legislation covering assisted reproduction. While eligibility for donation varies, there is a consensus that oocyte donors should not be paid for their contribution (Gunning, 1998). In Israel, IVF treatments are subsidised by the government through the medical insurers, provided that they are performed by the public medical system and in the country. Since patients who are treated in public institutions (such as those owned by the medical insurer) cannot choose their attending physician, many opt to have these treatments in private hospitals, where they can. In these circumstances, the patients may be offered a reduction in cost if they donate some of their ‘spare’ oocytes (usually when they have more than 15 oocytes per cycle) (Schenker, 1997). The government, through the recipient’s medical insurer, covers the deduction. This explains why, in...
our study, all the oocyte donation cycles were executed in private institutions. In the UK, the HFEA Act of 1990 is probably the most comprehensive of all European legislation addressing assisted reproduction. One of its principal elements is the establishment of a statutory voluntary body, the Human Fertilisation and Embryology Authority (HFEA), which is charged with licensing centres and drawing up a code of practice. Nevertheless, despite the advances of assisted reproduction on the one hand, and the well-documented shortage of donated oocytes (Murray and Golombok, 2000) on the other, the HFEA is currently seeking to redefine gamete donation as a free and voluntary ‘gift’ and to phase out payments to donors (Human Fertilisation and Embryology Authority, 1998a). It has been suggested (Ahuja et al., 1996) that to overcome the problem in the UK, oocyte-sharing schemes should be established whereby women undergoing IVF are offered free or reduced treatment in return for donating some of their oocytes. Though the HFEA initially raised concerns (Human Fertilisation and Embryology Authority, 1998a), it later decided to permit oocyte sharing on the grounds that it can be ‘enormously beneficial to both sharer and receiver’ (Human Fertilisation and Embryology Authority, 1998b). This is very similar to the practice of oocyte donation in Israel, described here, except that in Israel, the government, through the medical insurer of the recipient, covers the savings in treatment cost enjoyed by the donor. Our policy can be understood in light of the recommendation of most international ethics committees that gamete donors be reimbursed (Schenker, 1997). Indeed, in North America, gamete donors are routinely compensated for their time and effort (Kingsberg et al., 2000). Furthermore, limiting donors exclusively to women who themselves are undergoing assisted reproduction treatment precludes unnecessary donor risk.

In a survey of 64 clinics in the UK licensed to recruit semen and/or oocyte donors, it was found that oocyte donations were made by 1400 women during the 12-month period preceding the survey (Murray and Golombok, 2001). Payments ranged from £15–500 sterling and represented compensation for travelling expenses, childcare and accommodation. In clinics that practised oocyte sharing, the donors received amounts equal to the cost of an IVF cycle. Most of the clinics (71%) recruited donors known to the recipients (relatives, friends); however, in 82% of these cases, donors reported having felt pressured to offer their oocytes. Even though the authors concluded that ‘without exception, it was thought that women donated for altruistic reasons’, in the same study, about 75% of the potential oocyte donors were deterred by the mandatory explanation of the potential hazards of the procedure. Furthermore, the authors concluded that ‘the most pressing need appears to be for oocyte donors’ and that most clinics have a ‘waiting list’ for oocyte donation of 1–3 years. These data indicate, in our opinion, that under the current British policy of oocyte donation, there are still some problems that need to be solved if this issue is to be addressed.

We believe that the Israeli method described here combines self-interest, financial gain and altruism. Only women who are already undergoing assisted reproduction—and thereby exposing themselves to the potential risks of controlled ovarian hyperstimulation and the additional surgical hazards of the procedure—are allowed to donate oocytes. They cooperate out of both altruism and the benefit gained by the reduced price for each cycle, performed under private medicine conditions and by their preferred physician. Payment, in turn, is regulated by the state so every recipient who needs to can receive donated oocytes regardless of economic status, and treatment rates are generally maintained within reasonable and affordable limits.

In summary, our experience suggests that government subsidy of oocyte donation cycles can be beneficial in terms of sufficient oocyte supply, reasonable treatment costs, equal opportunity for all social/economic strata, justified treatment as monitored through the medical insurer, and avoidance of a direct financial relationship between donor and recipient. Perhaps the potential effects of the UK Human Rights Act of 1998, which came into effect in 2000 (Bahadur, 2001), as well as the Israeli strategy, will help promote a change in HFEA policy regarding payments to oocyte donors.

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Submitted on June 5, 2001; resubmitted on October 19, 2001; accepted on December 17, 2001