This L&RS Note presents data on a range of treatments, procedures and policies related to Assisted Human Reproduction (AHR) in Ireland and internationally. It is presented in advance of the publication of the Assisted Human Reproduction Bill 2022 (forthcoming). Its content is influenced by the provisions of the General Scheme of the Bill published in 2017. A glossary of technical terms is provided.
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation / Meaning in this paper</th>
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<tr>
<td><strong>Assisted Human Reproduction (AHR)</strong></td>
<td>All treatment of procedures that involve the handling of gametes and embryos for the purposes of establishing a pregnancy.</td>
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<td><strong>Assisted Human Reproduction Technologies (ART)</strong></td>
<td>The technologies employed in the pursuit of AHR.</td>
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<td><strong>Cryopreservation</strong></td>
<td>Procedure used to preserve and store embryos, sperm and ova (eggs) by freezing to very low temperatures.</td>
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<td><strong>Donor-assisted AHR</strong></td>
<td>An assisted human reproduction procedure using a donated gamete(s) (sperm and/or egg).</td>
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<td><strong>Embryo</strong></td>
<td>Means a human embryo formed by the fertilisation of a human egg by a human sperm.</td>
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<tr>
<td><strong>Frozen Embryo Transfer (FET)</strong></td>
<td>The transfer of frozen thawed embryos from a previous IVF cycle. Frozen embryos are thawed and transferred into the womb after suitable preparation of the lining of the womb.</td>
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<td><strong>Gamete (human)</strong></td>
<td>Means:</td>
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<td></td>
<td>(a) A human sperm (spermatozoa) which is formed in the body of and provided by a man, or</td>
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<td></td>
<td>(b) A human egg (ova) which is formed in the body of and provided by a woman.</td>
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<td><strong>Intracytoplasmic Sperm Injection (ICSI)</strong></td>
<td>This treatment is exactly the same as with IVF (see below). The only difference is that instead of mixing the sperm with the eggs and leaving them to fertilise, an embryologist (embryo specialist) will inject a single sperm into the egg. (Source: UK Human Fertilisation and Embryology Authority webpage <a href="http://www.hfea.gov.uk">here</a>). This maximises the chance of fertilisation taking place as it bypasses any potential problems the sperm will have in getting inside the egg.</td>
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<tr>
<td><strong>Intra Uterine Insemination (IUI)</strong></td>
<td>Artificial insemination is a treatment for infertility. It involves directly inserting sperm into a woman’s womb.</td>
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<tr>
<td><strong>In Vitro Fertilisation (IVF)</strong></td>
<td>In Vitro Fertilisation is a method of assisted human reproduction that surgically removes an ovum (egg) from woman’s ovary and combines it with sperm in a laboratory. If the ovum is fertilised the resulting embryo is subsequently placed in the woman’s uterus where implantation may take place.</td>
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</table>
Ovum, Oocyte, Egg | Female reproductive cell

Pre-implantation Genetic Diagnosis (PGD) | Means a procedure for genetically testing embryos for specific genetic or chromosomal mutations prior to transfer – involving the biopsy of embryos to remove one or more cells, and the selection of embryos for transfer on the basis of the results from the arising analysis.

Sperm | Gametes produced by the male gonads.

Sperm / Egg donation | The donation of sperm/eggs for use by another person/people in AHR or for research.

Treatment cycle | A single round of treatment aiming to result in a pregnancy.

Key messages

➢ The Health Service Executive (HSE) estimates that “around 1 in 6 heterosexual couples in Ireland may experience infertility”.
➢ Worldwide, it is estimated that there are approximately 2.5 million assisted reproduction cycles each year, resulting in the delivery of 500,000 babies.¹
➢ Unlike in all other EU countries, in Ireland there is no specific legislation governing the area of Assisted Human Reproduction.²
➢ In 2017, the then Government published the General Scheme of the Assisted Human Reproduction Bill. The Joint Oireachtas Health Committee³ undertook pre-legislative scrutiny of the General Scheme and, in 2019, issued its report offering recommendations. The subsequent Bill is a ‘priority’ bill on the Government’s Spring 2022 Legislative Programme.
➢ Infertility treatment, such as IVF, takes place in private and not-for-profit clinics in Ireland.
➢ High costs are a concern to patients/potential patients. In 2017, the cost of a single IVF cycle in Ireland was between €4,100 and €5,900 and the cost of an ICSI treatment was between €5,200 and €6,400.
➢ There is no public funding available for treatments - though drugs costs may be covered and tax relief claimed on medical expenses. Public funding in other jurisdictions has been shown to increase access.
➢ A publicly-funded ‘model of care’ is being developed at present.
➢ The number of treatment cycles per annum in Ireland grew the period 2009-2020, from 7,589 in 2009 to a peak of 11,359 in 2018.⁴ There were fewer treatment cycles in 2019 and 2020, with a total of 9,878 recorded in 2020 (the last year available). The 10.6% drop in the number of treatment cycles between 2019 and 2020 may be the result of pandemic-related disruption.
➢ Looking at the number of IVF cycles involving donor gametes, there were 3,658 cycles started in the period 2009 to 2020. There has been an upward trend over this period – with
485 IVF cycles started in 2020 using non-partner gametes compares with 158 cycles in 2009 – an increase of more than 200%. There was no drop-off in this activity in 2020.

➢ Though these figures show the level of treatment activity, they do not tell us anything about the outcomes from that treatment. Individual clinics publish ‘success rates’ but it can be difficult to compare between them and there is no central, verified data source at present.

➢ The General Scheme of the Assisted Human Reproduction Bill provided for the establishment of an Assisted Human Reproduction Regulatory Authority. Among its functions was a duty to collect and publish data on treatments and outcomes.

➢ The Joint Committee on Health recommended (amongst other things) that the proposed powers of the Authority be amended to include a research function, specifying that the Authority would conduct and publish research on services, demand, patient experience, short and long-term health and well-being of patients and children born through AHR and the broader social, ethical, health, legal and economic implications of AHR.

Introduction and context

In 2017, the then Government published the General Scheme of the Assisted Human Reproduction Bill. The Joint Oireachtas Health Committee undertook pre-legislative scrutiny of the General Scheme and, in 2019, issued its report offering recommendations for further improvement of the legislation. The subsequent Bill has yet to be published but is listed as a priority for publication this parliamentary session in the Government’s Spring 2022 Legislative Programme. In addition to this regulatory development, the Government plans to introduce a publicly funded ‘model of care’ for infertility treatment.

Unlike in all other EU countries, there is no specific governing legislation in the area of Assisted Human Reproduction in Ireland. Much of the data presented in this report was obtained from the Health Products Regulatory Authority (HPRA) which has a role to play in this field. In 2016, this body was designated as the competent authority for SI No. 158 of 2006 (Quality and Safety of Human Tissues and Cells) Regulations, which governs the quality and safety standards in the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells, including gametes and embryos. These regulations empower the HPRA to authorise and monitor tissue establishments, which include some fertility clinics.

More specific legislation has long been called for by parties including the Commission on Assisted Human Reproduction (which reported in 2005), providers of services and patients. This was recognised by the then Minister for Health, Simon Harris, TD, commenting on the publication of the General Scheme:

“This new legislation is the first time that a comprehensive package of measures has been drafted for the area of AHR as a whole. It has been long called for and is a very important milestone. This legislation is needed to protect, promote and ensure the health and safety of parents, and children born as a result of AHR treatment, as well as other parties who may be involved such as donors and surrogates. Consideration of the welfare and best interests of children born through AHR is a key principle underpinning the Scheme.”
This General Scheme encompassed a number of key elements, including those set out in the box below

**Box 1: Key aims of the General Scheme of the Assisted Human Reproduction Bill**

"This comprehensive General Scheme encompasses a number of key elements, including:

- providing for the establishment of the Assisted Human Reproduction Regulatory Authority as a dedicated, independent body to oversee this sector;
- outlining the conditions relating to the donation of gametes and embryos for use in AHR treatment by others and/or for use in research;
- permitting posthumous assisted reproduction (PAR), where gametes provided by a deceased person, or embryos created using those gametes, may be used by that person’s surviving female partner as part of her AHR treatment, provided specific criteria are met;
- outlining the specific conditions under which surrogacy in Ireland will be permitted, including a requirement for all surrogacy agreements to be pre-authorised by the AHR Regulatory Authority. The Scheme also sets out a court-based mechanism through which the parentage of a child born through surrogacy may be transferred from the surrogate (and her husband, if applicable) to the intending parent(s);
- specifying the conditions under which research involving embryos, embryonic stem cells and induced pluripotent stem cells may be permitted, subject to obtaining a licence from the AHR Regulatory Authority."


This *Note* does not attempt to provide background to all of the policy measures indicated above. Rather it presents data on activity in the field of Assisted Human Reproduction medicine in Ireland and supplements this with some information allowing for international comparisons. The international data includes information on the types of services and parameters that apply to AHR in other European countries. It is presented in the following sections:

- Data on infertility
- Data on infertility treatment
- Donor-assisted AHR data
- Issues with data and proposals in the General Scheme
- Costs of fertility treatment
- Attitudes to fertility treatment
- Cross-border healthcare
- International comparison – policy parameters in other jurisdictions
- Conclusions
Data on infertility

The World Health Organization defines infertility as:

“...a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse.”

One in six couples worldwide experience some form of infertility problem at least once during their reproductive lifetime, according to the European Society of Human Reproduction and Embryology (ESHRE). The Health Service Executive (HSE) estimates that “around 1 in 6 heterosexual couples in Ireland may experience infertility”, is directly in line with this. The current prevalence of infertility lasting for at least 12 months is estimated to affect between 8-12% for women aged 20-44 worldwide. As well as those with infertility problems, individuals or same-sex couples may also seek AHR services in order to have children.

There are a number of issues that can cause fertility problems (see Figure 1 below). Some of these problems can be treated. In some cases, no cause of infertility is ever found.

**Figure 1: Causes of infertility**

20-30% - male physiological* causes

20-35% - female physiological causes

25-40% - causes in both partners

10-20% - no cause found

*Physiological – relating to physiology (a branch of biology that deals with the functions and activities of life or of living matter (such as organs, tissues, or cells) and of the physical and chemical phenomena involved).

The World Health Organization (WHO) notes that environmental and lifestyle factors such as smoking, excessive alcohol intake and obesity can affect fertility. In addition, exposure to environmental pollutants and toxins can be directly toxic to gametes (eggs and sperm), resulting in their decreased numbers and poor quality, leading to infertility.

Data on infertility treatment

It is 43 years since the birth of Louise Browne, the first baby born with the assistance of the then controversial new in-vitro fertilisation (IVF) treatment. Since then it is estimated that more than eight million babies have been born via IVF worldwide (2019 estimate). Most AHR treatment takes place in women aged 30-39. It is estimated that there are approximately 2.5 million assisted reproduction cycles each year worldwide, resulting in the deliver of 500,000 babies.

In 2018, it was reported that the number of treatment cycles performed in developed countries had grown by 5-10% in the previous few years, but that growth had shown signs of slowing.

In Ireland, ARH treatments are provided by private and not-for-profit clinics. Data from the Health Products Regulatory Authority (HPRA) show that the number of treatments and the number of
embryos transferred has increased considerably over time. The statistics also show that there was some fall-back in activity in 2020. This may due be to pandemic-related disruption to services.

The number of treatment cycles per annum in Ireland grew the period 2009-2019, from 7,589 in 2009 to a peak of 11,359 in 2018. There were fewer treatment cycles in 2019 and 2020, with a total of 9878 recorded in 2020 (the last year available). The drop in the number of treatment cycles in 2020 may be because of the impact of the pandemic, the smaller reduction in 2019 could be the beginning of a levelling-off of demand but it is too early to say. The proportion of the drop between 2019 and 2020 was 10.6% - indicating that the pandemic may have been responsible for a reduction / delay in treatment of this size.

Figure 2 (below) shows this trend for overall number of treatments as well as data on the individual types of treatments - IVF, Frozen Embryo Transfers (FET) (which have grown) and Intra-uterine Insemination (IUI) (which has reduced) in this period.

**Figure 2: Number of Assisted Reproduction Cycles commenced, 2009-2020**

There has been a similar increase over the long-run in the number of embryos transferred per year (see Figure 3, below). This trend showed in the figure represents a 102% increase between 2009 and 2019 (from 4,163 to 8,420). However the total number of embryos transferred in 2020 was lower at 6,637 – a drop of 21% on 2019 – again this may be the impact of the Covid-19 pandemic related restrictions.
The increase in the proportion of frozen embryo cycles (shown in Fig. 2) and embryo transfers (Fig. 3) is in line with what has been seen internationally – where the number of frozen cycles is increasing and success rates improving due to improved techniques.\textsuperscript{26}

**Figure 3: Number of Embryos Transferred by Treatment, IVF and Frozen Embryo Transfer 2009-2020**

![Graph showing number of embryos transferred by treatment, IVF and frozen embryo transfer from 2009 to 2020.](image)

*Source: Oireachtas Library & Research Service using data supplied by the Health Products Regulatory Authority (February 2022).*

Figure 4 (below) shows the number of gametes frozen in Ireland from 2009-2017. The data show that though there has been a good deal of variability, this practice has grown over time. Of particular note is the growth in egg freezing. There were no eggs frozen in 2009 and the number of units in 2017 was 1,391. About one in four of these (347 units) were preserved due to the patient needing to undergo treatment for cancer. Combined with the number of sperm units preserved due to cancer treatment (1,503), this means 1,850 units of gametes were frozen in order to preserve the potential of these patients to have genetic children of their own in the future.

**Figure 4: Cryopreservation of gametes, 2009-2017**

![Graph showing number of gametes frozen from 2009 to 2017.](image)

*Source: Oireachtas Library & Research Service using data supplied by the Health Products Regulatory Authority.*
Donor-assisted AHR data

Looking at the number of IVF cycles involving donor gametes, there were 3,658 cycles started in the period 2009 to 2020. There has been an upward trend over – with 485 IVF cycles started in 2020 using non-partner gametes compares with 158 cycles in 2009 – an increase of more than 200% - see Figure 5 (below). The figure also shows the trends in relation to number of embryos transferred and number of cycles resulting in cryopreservation (freezing for future use).

The Child and Family Relationships Act 2015 (Parts 2 and 3) provides the legal framework for aspects of donor-assisted human reproduction including registering the births of children who are born in the State as a result of AHR involving donated eggs or sperm or embryos. These provisions came into effect on 4 May 2020.27

Figure 5: IVF with non-partner (donated) gametes, 2009-2020

(source: Oireachtas Library & Research Service using data supplied by the Health Products Regulatory Authority (February 2022).

There is also data available on the number of sperm units imported and the number of IVF cycles using non-partner gametes (using donor gamete(s)). Figure 6 (below) shows that the number of units imported has been variable, with a peak in 2011. There were 70% more units imported in 2017 than in 2009. The total number of sperm units imported over this nine-year period is 9,858. The Figure also shows that the number of units arriving from outside the European Economic Area is a small proportion of the total but also increased over this period.

No corresponding data on donated eggs was identified, though fertility clinic websites indicate that donated eggs are also imported.
Issues with data and proposals in the General Scheme

Though the HPRA statistics provided above tell us about activity levels in this field, they do not shed light on outcomes from AHR. Individual clinics may publish ‘success rate’ data. However it can be difficult to compare one clinic with another and no central, verified data sources with information on outcomes from AHR across all clinics in Ireland could be identified for this research. Such data could include: number of pregnancies (and therefore pregnancy rate), and number of live births, number of complications and number of multiple births. Having this type of information available would provide a stronger evidence base for policy making, provide important information for potential clients seeking to compare service providers, and have potential for driving good practice as local and international comparisons could be made.

In the UK, the statutory body responsible for this function is the Human Fertilisation and Embryology Authority. It publishes data on individual fertility clinics including:

- how inspectors rate clinics;
- how patients rate clinics;
- pregnancy and birth rates from different fertility treatments;
- multiple birth rates; and
- waiting times for donated eggs, sperm or embryos.

The treatment data shown above do not shed light on outcomes from treatments. Individual clinics publish ‘success rates’ but it can be difficult to compare between them and there is no central, verified data source at present.
Part 8 of the General Scheme of the AHR Bill provides for the establishment of an Assisted Human Reproduction Regulatory Authority (AHRRA). Among the proposed functions for this new Authority was the collection and publication of statistical information including on outcomes and the activities of service providers (Head 67).

One the recommendations arising from the Joint Oireachtas Health Committee’s pre-legislative scrutiny of the General Scheme was that consideration be given to extending the functions and powers of the proposed Authority, see Box 1 below.


<table>
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<th>Committee Recommendation No. 11</th>
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<tr>
<td>The Committee recommends that further consideration be given regarding the powers and functions of the Authority (Part 8 [of the General Scheme]), with specific attention given to:</td>
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<td>• investigating consumer complaints;</td>
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<td>• protecting against financial exploitation;</td>
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<td>• collecting and providing information regarding success rates between service providers and providing information on infertility and related support;</td>
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<tr>
<td>• protecting the financial interests of patients in the case of the closure of a service provider and a role in safeguarding patients’ gametes/embryos;</td>
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<tr>
<td>• amending the proposed powers of the Authority to include a research function, specifying that it will conduct and publish research on services, demand, patient experience, short and long-term health and well-being on patients and children born through AHR and the broader social, ethical, health, legal and economic implications of AHR.</td>
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Costs of fertility treatment in Ireland

At present high costs are a concern to those seeking fertility treatment. Research by the Health Research Board (2017), noted the following prices for fertility treatments:

> “The cost of a single in vitro fertilization cycle in a private Irish fertility clinic ranges from €4,100 to €5,900, whereas intracytoplasmic sperm injection costs between €5,200 and €6,400.”

Diagnostic tests and additional, treatments or services such as sperm or egg donation would increase costs.

In 2017...

The cost of single IVF cycle in Ireland was between €4,100 and €5,900.

The cost of an ICSI treatment was between €5,200 and €6,400.
The average cost of an IVF cycle in Europe is thought to be about €4,000–€5,000.\textsuperscript{34}

There are limited public financial supports available to people seeking fertility treatment in Ireland. And while, as noted above, the Government has committed to it and the HSE is working towards this\textsuperscript{35}, there is no publicly-funded provision of fertility treatments such as IVF in place at present.

However, fertility drugs may be funded in part (this is of considerable benefit as hormone therapies in particular are expensive)\textsuperscript{36}. Tax relief may also be claimed on medical expenses. In terms of other supports available - some plans by some private health insurers offer fertility-related benefits.

Dr Gerald O’Nolan, Researcher at the HRB Evidence Unit, has said:\textsuperscript{37}

“The pressure on those seeking fertility treatment, due to its cost in relation to average take-home pay, is immense, particularly for lower income groups.”

Dr O’Nolan was among the authors of a 2017 Health Research Board (HRB) report ‘Assisted reproductive technologies: International approaches to public funding mechanisms and criteria. An evidence review’. Box 2 below sets out some key findings from this research. It highlights that while public funding is available in other jurisdictions, there are varying levels of generosity (this is also evident in the section below on ‘international comparison’).

**Box 2: HRB evidence review – Approaches to public funding of AHR in other jurisdictions (2017)**

<table>
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<th>The outcomes (of the review)\textsuperscript{38}</th>
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<td>“We now know that, for the countries included in the review:</td>
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<td>• Full public funding for ART [assisted reproductive technology] is available in six countries in Europe and in Israel, New Zealand and Ontario (Canada). Within Europe, 19 countries offer partial public funding and Australia provides partial funding.</td>
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<td>• Public funding for ART can increase access and the overall economic cost to society is relatively modest in the context of public spending from the overall health budget.</td>
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<td>• Since 2008, the number of countries providing public funding for ART has increased, but individual countries’ level of public funding has decreased and out-of-pocket payments have increased.</td>
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<td>• Criteria used to determine access to funded ART are clinical and social, and national policies are a hybrid of political, cultural and economic pressure combined with clinical evidence.”</td>
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**Source:** Health Research Board, Evidence Centre Feature
Attitudes to fertility treatment in Ireland

Results from the most recent Irish opinion poll identified on attitudes to assisted human reproduction in Ireland are presented below. This was a 2013 telephone survey of a nationally representative sample of over 1,000 people. This research found that:

- 94% of respondents had no experience with medical fertility therapy.
- More than three out of four respondents (77%) agreed that any fertility treatment offered internationally should also be available in Ireland.
- There was a majority (63%) in favour of legislation for AHR.
- The support for gamete donation ranged from 53% to 83% depending on the how donor privacy and disclosure options were presented.
- Just over half (52%) were in favour of surrogacy (though respondents were not presented with options detailing what policies they would support around this).

There were lower proportions in favour of some other practices provided for in the General Scheme, as follows:

- Only 46% of respondents were in favour of pre-implantation diagnosis (which the General Scheme proposes to permit); and
- Just one in five (21%) were in favour of allowing sex selection as part of PGD (though this was a general question and did not ask if people favoured it in cases where diseases were known to be more common in one sex – the only type of sex selection the General Scheme proposes to permit).

This survey provides an interesting snapshot of opinions however, it has limitations. The questions in this survey, as reported, did not provide a great deal of detail explaining the terminology describing procedures enquired about and it is not clear how much or what additional information the polling staff undertaking the survey provided. However, the authors do note that the staff were experienced in researching other sensitive topics (such as abortion and immigration).

As such these survey results present a limited picture of public opinion in 2013.

Cross-border healthcare data

Cross-border reproductive healthcare (CBRC) takes place when people travel outside their home country to avail of fertility treatments or arrangements.

The full extent of CBRC in Europe is not known, however, based on surveys over a ten-year period it has been estimated that around 5% of all fertility care in Europe involves cross-border patients.40

In Europe, Spain and Belgium are the most common destinations, while worldwide the USA is the most popular destination country.
There is no official data source on the total number of people travelling from Ireland for fertility treatments abroad. In the Health Committee hearings examining the General Scheme of the AHR Bill, Dr John Kennedy, National Fertility Centre, Rotunda Hospital, stated:

“I would estimate there are probably in the region of 3,000 women travelling abroad [from Ireland] every year for fertility treatment in Europe.”

**International comparison – policy parameters in other jurisdictions**

A study undertaken on behalf of the European Society of Human Reproduction and Embryology (ESHRE) published in 2020 looked at how ART and IUI is regulated, funded and registered in European countries (data are from 2018). It received data from well-placed informants in 43 out of 44 European countries where AHR treatments and IUI are performed. Among the key findings were:

**Legislation:** Thirty-nine countries reported specific legislation on Assisted Human Reproductive Technology (ART), and artificial insemination was considered an ART technique in 35 of them. Ireland has no specific legislation at present.

**Eligibility for treatment:** Accessibility is limited to infertile couples in 11 of the 43 countries. A total of 30 countries offer treatments to single women and 18 to female couples. In five countries ART and IUI are permitted for treatment of all patient groups, being infertile couples, single women and same sex couples, male and female.

**Donated gametes:** Use of donated sperm is allowed in 41 countries, egg donation in 38, the simultaneous donation of sperm and egg in 32 and embryo donation in 29.

**Preimplantation Genetic Testing (PGT):** Preimplantation genetic testing (PGT) for monogenic disorders or structural rearrangements genetic disorders [e.g. such as cystic fibrosis, Huntington’s Disease] is not allowed in two countries, and PGT for aneuploidy [having missing or extra chromosomes] is not allowed in eleven;

**Surrogacy:** Surrogacy is accepted in 16 countries.

**Age range for treatment:** With the exception of marital/sexual situation, female age is the most frequently reported limiting criteria for legal access to ART—minimal age is usually set at 18 years and maximum ranging from 45 to 51 years with some countries not using numeric definition. Male maximum age is set in very few countries.

**Gamete donors and donations:** Where permitted, age is frequently a limiting criterion for third-party donors (male maximum age 35 to 55 years; female maximum age 34 to 38 years).

Other legal constraints in third-party donation are the number of children born from the same donor (in some countries, number of families with children from the same donor) and, in 10 countries, a maximum number of egg donations.
How countries deal with the anonymity is diverse—strict anonymity, anonymity just for the recipients (not for children when reaching legal adulthood age), mixed system (anonymous and non-anonymous donations) and strict non-anonymity.

**Public funding:** Public funding systems are extremely variable. Four countries provide no financial assistance to patients. Limits to the provision of funding are defined in all the others, i.e. age (female maximum age is the most used), existence of previous children, maximum number of treatments publicly supported and techniques not entitled for funding. In a few countries, reimbursement is linked to a clinical policy. The definition of the type of expenses covered within an IVF/ICSI cycle, up to what limit and the proportion of out-of-pocket costs for patients is also extremely dissimilar.

The limitations of this study include that while data was provided by informants in each country and cross-checked, there is no official source to verify. Another limitation is that the data is from one point in time, and the area of AHR practices and laws is developing all the time, so there may be trends or developments not picked up on in this survey.

**Conclusion**

Data across a wide-range of indicators presented here demonstrate that Assisted Human Reproduction has been a growing field in Ireland. However, apart from the limited role of the Health Products Regulatory Authority (HPRA), these services have developed in the absence of specific legislation to govern key aspects of AHR treatments and their parameters. This is in contrast to the vast majority of other European countries where such services are available. The Government intends to legislate in this area, with an Assisted Human Reproduction Bill listed a ‘priority legislation for drafting and publication this session’ on the its [Spring 2022 Legislative Programme](https://www.gov.ie/en/cabinet/spring-2022-legislative-programme/). Care is provided in private or not-for-profit clinics and the high cost of treatment is a concern to patients / prospective patients. No direct public funding or provision of treatments is available, although patients may have their drugs costs covered by HSE schemes and some plans offered by private health insurers may offer relevant benefits.

The Government is progressing plans for a system of publicly provided/ funded provision of fertility treatment.

The Joint Oireachtas Health Committee (2019) made a number of recommendations arising from its pre-legislative scrutiny of the General Scheme of the Assisted Human Reproduction Bill. These included a call for a more comprehensive role for the proposed statutory regulator – the Assisted Human Reproduction Regulatory Authority.

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1 Fauser, “Towards the Global Coverage of a Unified Registry of IVF Outcomes.”
3 Of the 32nd Dáil and 25th Seanad.
4 Data supplied to the Oireachtas Library & Research Service by the Health Products Regulatory Authority, February 2022.
5 Of the 32nd Dáil and 25th Seanad.
6 See Programme for Government commitment and Dáil Debate [written answers] 2 November 2021, Minister for Health, Stephen Donnelly, TD.
8 See for instance the 31 submissions made to the Joint Oireachtas Committee on Health to inform their pre-legislative scrutiny of the General Scheme of the Assisted Human Reproduction Bill.
12 European Society of Human Reproduction and Embryology (ESHRE)(undated) Factsheet – ART. Available at: https://www.2.hse.ie/conditions/fertility-problems-treatments/
13 https://www.2.hse.ie/conditions/fertility-problems-treatments/
14 ESHRE (undated) as before.
15 https://www.merrion-webster.com/dictionary/physiology
16 WHO (2020) (as before).
17 WHO (2020) (as before).
18 https://www.britannica.com/biography/Louise-Brown
20 ESHRE (undated) as before.
22 ESHRE (undated) as before.
23 In 2006 the Health Products Regulatory Authority (HPRA) was designated as the competent authority for SI No. 158 of 2006 (Quality and Safety of Human Tissues and Cells) Regulations, which govern the quality and safety standards in the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells, including gametes and embryos. These regulations empower the HPRA to authorise and monitor tissue establishments, which include some fertility clinics.
24 Data supplied to the Oireachtas Library & Research Service by the Health Products Regulatory Authority, February 2022.
25 ESHRE (undated) as before.
26 Fertility treatments and assisted human reproduction in Ireland (citizensinformation.ie)
28 There is a European-wide registry of treatments and outcomes but Irish clinics are not well represented (with data from just three out of seven clinics included in the latest reported results (on treatments 2014, published in 2018): Ch De Geyter et al., “ART in Europe, 2014: Results Generated from European


32 This treatment is exactly the same as with IVF. The only difference is that instead of mixing the sperm with the eggs and leaving them to fertilise, an embryologist (embryo specialist) will inject a single sperm into the egg. (Source: UK Human Fertilisation and Embryology Authority webpage here.) This maximises the chance of fertilisation taking place as it bypasses any potential problems the sperm will have in getting inside the egg.


34 ESHRE (2017) Regulation and legislation in assisted reproduction, Fact Sheet 2.


36 Through the General Medical Services (Medical card), Drugs Payment Scheme or High-Tech Drugs Scheme.

37 Public funding increases access to Assisted Reproductive Technology (hrb.ie)

38 Public funding increases access to Assisted Reproductive Technology (hrb.ie)


41 Dr John Kennedy appearing before the Joint Oireachtas Committee on Health, 28 February 2018.
