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COMMENTARY

China's model of egg donation is a policy lesson for Britain

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Abstract In a move designed to increase the UK's supply of donor eggs, the Human Fertilisation and Embryology Authority has recently agreed to a fixed-sum compensation policy for donors "which better reflects their expenses" and inconvenience. Such a policy, however, which is reliant on non-patient donors for its success, is in contrast to what appears the system in China, where egg donors can only be recruited from those having IVF (i.e. patient donors) and on a conditional egg-sharing basis. Commitment to an egg-sharing policy in the UK would provide a more equitable system of egg donation than a compensation policy. 

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Wherever in the world, egg donation is rarely far from controversy. Charges of "eggs-ploitation" are levelled at schemes reliant on little more than free-market economics, while clinics in tightly regulated systems invariably face a shortage of donors and donor oocytes. The latest US figures from the [Centers for Disease Control and Prevention \(CDC\)](#) show that donor eggs or embryos were used in around 12% of all assisted reproduction treatment cycles in 2008; in the UK, where both payment and anonymity have been tightly regulated, no more than 3% of treatments were with fresh or frozen donor eggs in 2010 ([Human Fertilisation and Embryology Authority, 2011a](#); [Centers for Disease Control and Prevention, 2008](#)). The one system puts an exorbitant price on donor eggs, while the other sends desperate patients overseas in their search for a scarce resource.

In a bid to improve its supply of donor gametes, and after a four-month consultation, the Human Fertilisation and Embryology Authority (HFEA), the UK's regulatory authority, finally agreed in October to compensate sperm donors by a fixed sum of £35 per visit and egg donors by a fixed sum of £750 per cycle of donation ([Human Fertilisation and Embryology Authority, 2011b](#)). The move, said the HFEA, was "a

proactive approach to donor recruitment, retention and care" which provides donors with a level of compensation "which better reflects their expenses" and their inconvenience. The policy will become effective from 1 April 2012.

The fixed-sum policy is indeed a new approach. Until now, UK policy had allowed sperm and egg donors to claim reasonable expenses, such as travel costs, and for loss of earnings up to a maximum of £61.28 for each full day (the same as for jury service), with a limit of £250 for each course of sperm or egg donation.

In announcing the one-off fixed sum, the HFEA was emphatic in removing any hint of payment or inducement from the new policy; this was strictly compensation, set, according to HFEA's chairman Professor Lisa Jardine, "not in terms of crude sums but in terms of the value of the donation". The fixed-sum, she added, "... will not deter those interested in donation but will retain donors already in the system, without attracting those who are merely financially motivated." ([HFEA, 2011b](#)).

Also on the agenda of the consultation were "benefits in kind", most usually evident in the provision of free or subsidised IVF treatment in exchange for oocyte donation –

which in the UK has effectively meant “egg sharing”. In its build-up to the consultation the HFEA had surprisingly described egg sharing as “controversial”, despite two decades of problem-free experience, involving over 30,000 patients, an official “review” (HFEA, 2000) the published support of the [British Medical Association](#) and [Nuffield Council on Bioethics](#) (2011), and the formal backing of the HFEA itself (HFEA, 2000). Yet here was egg sharing once again under the HFEA spotlight. Not surprisingly, the HFEA “decided that [egg sharing] should be allowed to continue”, with the provision that “guidance should be reviewed with a view to making it clear to clinics what benefits might be included” – presumably with the addition of oocyte or embryo storage, fast-tracking through the waiting-list, or stem-cell storage from cord blood in addition to subsidised fertility treatment.

In the light of these developments in the UK it is interesting to read the contribution of [Cai et al. \(2012\)](#) from the First Affiliated Hospital of Nanjing Medical University in China on an egg-sharing programme made “easier” by vitrification. We learn from the paper that oocyte donation is strictly controlled in China (by legislation of 2003 and 2006) and that donor oocytes can only be provided by women actually having IVF treatment themselves – that is, all oocyte donors must also be egg sharers. However, this sharing/donation is only permitted when the patient has 20 or more mature oocytes retrieved, and when at least 15 oocytes can be retained for her own use. Only then may any surplus oocytes be donated, following vitrification and 12-month storage, to a recipient in a fresh cycle – and only if at least 3 months have passed after the delivery of a healthy baby to the sharer. All other forms of egg donation are prohibited in China, without prior approval from the government agencies.

It is tempting to ask why, instead of such stringent regulations, China did not adopt the more universally applied egg donation schemes as practised in Spain or the USA, or even implicit in the UK’s newly approved policies. Over the past 20 years, egg sharing has often been described as the fairest and safest system of egg donation ([Ahuja et al., 1999](#)) and we imagine such considerations lie behind the China model. Thus, with such unambiguous regulations in place, it is impossible in China to recruit non-patient donors for oocyte donation, nor can they donate their oocytes to another couple before confirming their own pregnancy first. What the Chinese policy thus seems to be is an exercise in risk reduction for the donor, and fairness for all parties involved.

Such considerations seemed absent from the most recent deliberations of the HFEA, which excluded from its entire policy review the potential long-term risk faced by non-patient egg donors from ovarian stimulation. This risk could be especially pronounced for the young fertile donors recruited in countries where commercial payments are permitted; these are the younger women likely to respond robustly to gonadotrophins and thereby face a potential risk of ovarian hyperstimulation syndrome or, on rare occasions, more serious complications ([Spar, 2007](#); [Rimington et al., 2003](#); [Schneider, 2008](#); [Nuffield Council on Bioethics, 2011](#)).

Information presented by the HFEA at its public meeting prior to the policy announcements in October showed that

40% of eggs donated in the UK now come from egg-sharing schemes. However, these figures should not imply that 60% of donor eggs come from anonymous non-patient volunteers; for there are still many cases in the UK – as in other countries – of sister-to-sister donation, and it thus seems likely that egg sharing may already be the single biggest source of donor eggs. Yet the HFEA merely allowed “egg sharing to continue”, ignoring the data on its psychological acceptability to sharers and recipients, its comparable success rates, and its mutual clinical benefit to both groups ([Faddy et al., 2011](#)).

For the fact is that egg sharing is a generous act of mutual self-help, not some selfish act of self-benefit; the will to share – to co-operate on behalf of the common good – is inherent in all of us. Indeed, every one of the UK’s 12 regions is home to a successful egg-sharing centre, regardless of the pattern of regional wealth. The location of the UK’s egg-sharing centres licensed by the HFEA ([Figure 1](#)) will further dispel any doubts that sharers are confined to regions of deprivation in the service of their wealthier neighbours.

Such acts of mutual generosity will be given even further scope by the ever greater influence of social media websites. *Twitter* and *Facebook* will inevitably create an online community of engaged recipients and sharers, committed to the technologies of assisted reproduction and to the concept of egg sharing, who need only to contact a clinic to set their transactions in motion. Thus, what the social media sites do for their online communities is provide a digital connectivity which is transparent, legitimate and trustworthy. There is a level playing field for everyone, which lets everyone engage to their best. The published sociological evidence on egg sharing indicates that both sharers and recipients value these transactions and respond to the generosity and predicaments of others.

Cai et al. report that 47 egg-sharing donors were recruited to their hospital scheme after having normal deliveries following their own IVF treatment, and they donated a total of 395 cryopreserved oocytes to 75 recipients. The survival rate of vitrified–warmed oocytes was 83.0%. Following insemination by ICSI, fertilisation and cleavage rates were 83.8% and 89.8%, respectively. From 75 recipients, 71 completed their treatment cycles and 30 became pregnant, with clinical pregnancy and implantation rates of 42.3% and 25.5%, respectively; these are rates comparable with published studies on shared donation without vitrification, and confirmation that a policy of egg sharing favours neither the sharer nor the donor to any advantage over the other.

The egg-sharing schemes in the UK, having become a well-formed nationwide network ([Figure 1](#)), do not make any requirement that the donor must produce a minimum of 20 eggs or that she has given birth to a healthy baby before the donation procedure can begin. This, say Cai et al., is a “cultural” demand: “The very idea of obtaining eggs from an infertile woman is cultural anathema. Postponing treatment of the recipient until 3 months after the delivery of a healthy baby makes egg donation culturally acceptable and emphasizes the flexibility of egg sharing. Furthermore, when the donor receives nothing in cash or kind, the delay in treatment conforms to Chinese cultural norms.” Vitrification, as this China study clearly

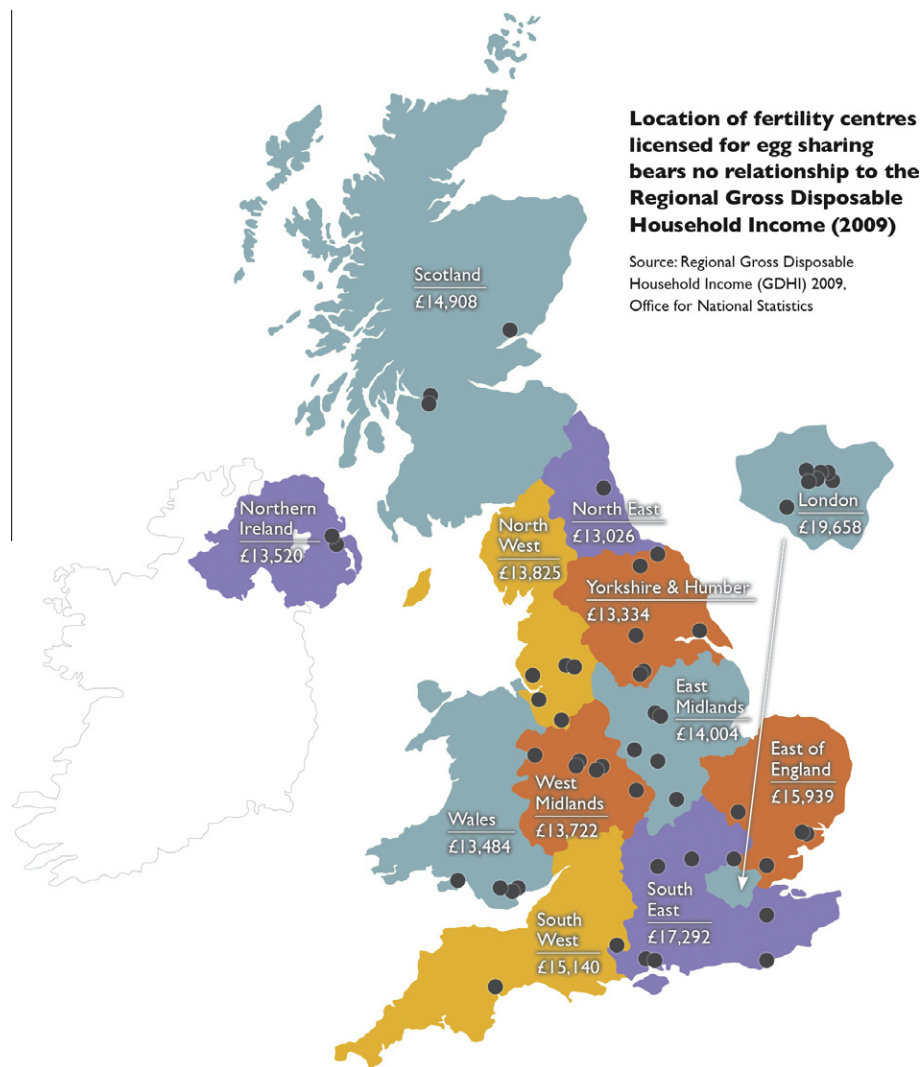


Figure 1 Location of fertility centres licensed for egg-sharing bears no relationship to the regional gross disposable household income in 2009. (Source: Office of National Statistics, Crown Copyright.)

demonstrates, makes this cultural demand that much more realistic.

In view of the success of schemes such as this, and the commitment of the Chinese authorities to egg sharing as an equitable means of egg donation, the HFEA's welcome but token recognition of egg sharing appears to be a missed opportunity for the promotion of egg donation services in the UK. If egg sharing were taken up and promoted by the HFEA as a legitimate policy of egg donation – and not consigned to the footnotes – egg sharing has the potential to go much further than any compensation policy to meet the UK's demand for donor eggs.

References

- Ahuja, K.K., Simons, E.G., Edwards, R.G., 1999. Money, morals and medical risks: conflicting notions underlying the recruitment of egg donors. *Hum. Reprod.* 14, 279–284.
- British Medical Association. Available from: <[http://www.nuffieldbioethics.org/sites/default/files/files/British%20Medical%20Association\(4\).pdf](http://www.nuffieldbioethics.org/sites/default/files/files/British%20Medical%20Association(4).pdf)>.
- Cai, L.-B., Qian, X.-Q., Wang, W., Mao, Y.-D., Yan, Z.-J., Liu, C.-Z., Ding, W., Huang, J., Chai, D.-C., Chian, R.-C., Liu, J.-Y., 2012. Oocyte vitrification technology has made egg-sharing donation easier in China. *Reprod. BioMed. Online* 24, 186–190.
- Centers for Disease Control and Prevention, 2011. ART 2008 Report. Section 4: ART cycles using donor eggs. Available from: <<http://www.cdc.gov/art/ART2008/section4.htm>>.
- Faddy, M., Gosden, R., Ahuja, K., Elder, K., 2011. Egg sharing for assisted conception: a window on oocyte quality. *Reprod. Biomed. Online* 22, 88–93.
- Human Fertilisation and Embryology Authority, 2000, 2009. Guidance for egg-sharing arrangements. Available from: <<http://www.hfea.gov.uk/2706.html>>.
- Human Fertilisation and Embryology Authority, 2011a. Fertility treatment in 2010. Available from: <http://www.hfea.gov.uk/docs/2011-11-16_-_Annual_Register_Figures_Report_final.pdf>.
- Human Fertilisation and Embryology Authority, 2011b. HFEA agrees new policies to improve sperm and egg donation services. Available from: <<http://www.hfea.gov.uk/6700.html>>.
- Nuffield Council on Bioethics, 2011. Human Bodies: donation for medicine and research. Available from: <<http://www.nuffieldbioethics.org/donation>>.

- Rimington, M., Ahuja, K.K., Simons, E.G., 2003. Should non-patient volunteers donate eggs? *Reprod. Biomed. Online* 6, 277–280.
- Schneider, J., 2008. Fatal colon cancer in a young egg donor: a physician mother's call for follow-up and research on the long-term risks of ovarian stimulation. *Fertil. Steril.* 90 (2016), e1–e5.
- Spar, D., 2007. The egg trade — making sense of the market for human oocytes. *N. Engl. J. Med.* 356, 1289–1291.