

**Opinion no. 68 of 14 November 2016 on
the maximum age limit for medically
assisted reproduction.**

Request for an opinion

The following request for an opinion was made by Mrs. Maggie De Block, Minister of Social Affairs and Public Health, in a letter dated 31 March 2016:

'In December 2013, the Advisory Committee for Bioethics issued an opinion on the ethical aspects of so-called "age banking," the freezing of eggs in anticipation of age-related infertility.

In this opinion, the Committee based itself on the maximum age limits for fertility treatments currently in force in this country under article 4 of the Law of 6 July 2007 regarding medically assisted reproduction and the use of excess embryo's and gametes. The ethical questions that arise from a possible raising of these age limits were not examined in the opinion.

In the Netherlands, it is being investigated whether an increase of the age limit to 50 years may be desirable. From a medical point of view, there appear to be no strong contraindications against providing medically assisted reproductive treatment after the age of 47. However, this does not answer the ethical question of whether we should assist women to become mothers at an even more advanced age.

May I ask you, within the term of one year after receiving this letter, to update the afore mentioned opinion no. 57 and extend it to the question: is it ethically acceptable to raise the maximum age limit for fertility treatments? One should take into account, amongst other things, the psychosocial consequences for children born of mothers of advanced age.'

This question was declared to be admissible at the plenary meeting of 18 April 2016. The meeting agreed with the proposal of the Bureau to entrust some members with the task of preparing an answer to this specific question of limited scope.

The opinion

The Committee deems it unnecessary to amend its opinion no. 57 on age-related infertility,¹ as that opinion dealt with the issue of indications while the current question from the minister concerns age limits. Only some of those who are confronted with an age limit are women who have had their eggs frozen because of age, and a number of women who have not had their eggs frozen will be faced with an age limit.

Due to decreasing female fertility (with age), IVF treatment using a woman's own fresh eggs becomes no longer appropriate above a certain age due to the low probability of success. For this reason, reimbursement of an IVF cycle is only provided until the age of 43. The recent Dutch decision to increase the age limit to 50 years was not accompanied by an increase of the age for reimbursement. This is not very logical, either in Belgium or in the Netherlands, given that women over the age of 43 who use donor eggs do not have a lower probability of success. The placement of embryo's is possible in Belgium up until the age of 47, according to the law on medically assisted reproduction.² This is interpreted by the College of Doctors for reproductive medicine as 47 years plus 364 days. Three groups of women might desire treatment after the current maximum age limit of 47: 1) women who have had their eggs frozen at a younger age (from a legal point of view, at the latest before their 46th birthday), 2) women who have had their eggs frozen as part of an earlier IVF treatment, and 3) women who wish to use donor eggs.

It is unlikely that raising the age limit from the current 47 to 50 years would significantly alter the medical and psychosocial risks. This might be the case if a considerably higher maximum age limit were to be introduced (55 or 60 years).

There is barely any information available on the psychosocial consequences of late motherhood for the family, the woman, the partner and the child. The only study on the consequences for the wellbeing of the child is from Bovin *et al.* (2009), cited in opinion no. 57. There is just as little information known about the psychosocial consequences of late fatherhood. A number of elements can indirectly point to possible impacts on the child's wellbeing. The possibility of one of the parents dying during the child's childhood years is probably the most important in this regard. It is known that this can have seriously traumatic consequences for the child (Rostila & Saarele, 2011). The chance of this happening is however very small given the average life expectancy of women in Belgium (see below). Other elements such as the style of raising children, a higher income and a lower divorce rate might indirectly and conversely have a positive impact on the children of late mothers. Most studies consider women over the age of 35 to be older mothers. It

¹ Opinion no. 57 of 16 December 2013 on the ethical aspects of the freezing of eggs in anticipation of age-related infertility. <https://www.health.belgium.be/en/opinion-no-57-social-freezing> .

² Law of 6 July 2007 regarding medically assisted reproduction and the use of excess embryo's and gametes (Dutch: BS 17/07/2007, p. 38575; French: MB 06/07/2007, p.3875).

is not known whether this general conclusion would still hold for women who give birth at the age of 45 or older.

A related issue is the normative meaning given to parenthood: what is expected from a parent? Several visions can be distinguished here. If one assumes that a policy should be based on a reasonable carrying out of the parental role, one can argue that a parent should be able to support his/her child until they reach maturity. The maximum age at which someone could expect with a reasonable amount of certainty to be able to fulfil this task would be the average life expectancy minus 18 years (Pennings, 1995). Incidentally, this criterion should then also be applicable to other groups of women who have a limited life expectancy. The life expectancy of women in Belgium is 83.5 years. However, in order to perform one's parenting role, there must be a minimum number of skills present. We should therefore use a 'healthy life expectancy' instead of the life expectancy in the strict sense of the term. This standard for women is around 76 years. A woman aged 65 in Belgium can expect to enjoy a further 11 healthy years without facing a restriction in her activities (EHLEIS, 2015). 76 years minus 18 is 58 years of age. Being healthy is no guarantee that one also has the capacities to raise a child, but that also applies to countless other parents who have certain characteristics (such as poverty, obesity, ...) which even at a younger age can have a negative impact on their capacities.

Another normative meaning that can be given to parenthood is the expectation of good parents that they have the duty to provide for and raise their children even after the age of majority, until the completion of their studies. In such a case, an average life expectancy of possibly 25 years should be taken into account.

Such calculations assume that there is only one parent. Most children are however born into families with two parents. It is thus defensible to consider the life expectancy of both parents in order to make a decision about an acceptable maximum age limit.

No information is available regarding the opinion of patients regarding the age limit. The number of treatments conducted above the age of 43 is very limited, but this can also be due to the current legislation. The BELRAP report of 2015 (figures from 2013) cites 272 transfers with women above the age of 43 using their own eggs, and 187 transfers using donor eggs (137 fresh and 50 frozen). This amounts to approximately 500 patients of the 18,000 (2.7%) who underwent an IVF/ICSI treatment that year. There will presumably be relatively few candidates above the age of 50. The study of Stoop *et al.* (2015) showed that women who had their eggs frozen for age-related infertility indicated that the maximum age for them to become pregnant was around 44 years. This is well below the current maximum limit. A survey of those who work at fertility centers (N=186) showed that 9 out of 10 respondents agreed with the age limit as stipulated in the law on medically assisted reproduction of 2007 (Vanhaecke *et al.*, 2010).

Conclusion

The Committee sees no decisive ethical objections to an increase of the maximum age to 50 years. On the one hand, the difference with the current age limit is relatively small and not decisive. On the other hand, the medical risks increase with increasing age and overall skills decrease. In other words, it is not ideal nor should it be encouraged, but that does not mean that it should not be allowed. The fact remains that it can be wondered to what extent women in our society are given a real chance to optimally realize their professional and personal plans before a reasonable age limit. The Committee thus refers to the final recommendation of the afore mentioned opinion no. 57 of 16 December 2013, in which it already emphasized the importance of policy measures aimed at removing obstacles so that men and women who so wish are able to have children at the age they want.

References

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The documents concerning the preparation of this opinion are kept on file at the Committee's documentation center, where they are available to be consulted and copied.

This opinion can be consulted on the website www.health.belgium.be/bioeth