EVENING POST

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PAY THE PRICE FOR PREGNANCY

IT is an act which is as natural as breathing itself, turns grown adults into gibbering idiots and is often used as a symbol of hope and continuity which passes from one generation to another.
What I am talking about is the act of producing a child of your own.

Yet at a time when most of the publicity focuses on global population problems and so-called "feckless pregnancies" of teenage girls, it is easy to forget that for large numbers of people in Britain, the nightmare of pregnancy is simply that it doesn't happen.

Almost one in six of all couples of child-bearing age in Britain have to seek specialist help because of difficulties they face in conceiving.

The National Infertility Awareness Campaign, which came to lobby MPs this week, simply wants us to recognise this fact, and to develop a comprehensive health care package which addresses the scale, nature and diversity of the problems which follow.

To begin with, it might be more helpful if we were to talk about sub-fertility as much as infertility.

For the majority of people involved it is about overcoming problems rather than impossibilities.

But until this happens it is hard to describe the doom-laden sense of failure that hangs over this most commonplace and natural of events.

The truth of the matter, though, is that producing a child is by no means as simple as we think.
Human fertility is relatively inefficient. Over-population issues come from the fact that we have become more competent survivors rather than more efficient reproducers.

In the industrial world there is evidence to suggest we are becoming even less efficient at reproducing as time goes by.

This may be an interesting statistical abstract, but for those desperate to produce a child it is not the slightest use or consolation.

Their's is often a world which looks to be exactly the opposite — you only have to enter a room to cause someone (else) in it to become pregnant.

Casual conversations among your peers and friends become social mine fields; at any step, the confirmation of another pregnancy or a discussion about someone else's infants or grandchildren could blow another hole in your own dreams and your sense of personal worth.

It is the exclusion from this most commonplace of "exclusive clubs" which compounds the sense of failure and despair. So what should be done?

The calls of campaigners appear to be as reasonable as they are straightforward.

First of all they want a more open recognition of problems of infertility and sub-fertility.

Despite the numbers of people it effects, tqere is not a single mention of it in the Government's "Health of the Nation" document.

They want a more positive approach to counselling and advice provision; more openness about the treatments available to deal with infertility; and a stronger sense of patient choice in a comprehensive package of treatment which is available within the National Health Service. This is where we move into difficult ground.

There is no single cause of infertility. Different causes require different treatment and at different costs.
But some outlines can be drawn with a degree of confidence. Drug treatment for women with absent periods can restore fertility to near normal levels. Surgery is not generally effective for women with severely damaged fallopian tubes.

It isn't enough to test a man's sperm count without doing a morphology test on the level of abnormality within the sperm itself.

This may sound complex, but it is a common part of the screening process regularly used in the "artificial insemination by donor" (AID) programme.

It is also known that success rates in infertility treatment programmes increase with the number of "treatments" but decrease as people get older.

What we also know is the part that Murphy's Law plays in the treatment of infertility.

At any given stage, including giving up hope altogether, there will be a proportion of people who conceive because something changes their perception of what is possible. Even the abandonment of hope can do this.

But it is in the more earthy grounds of "treatments" themselves that the most painful arguments are to be found.

Treatments aren't cheap. Artificial insemination (AIH) costs £200 per "treatment", plus the cost of drugs. Most courses of treatment involve between four and ten attempts, though some women have tried for far longer. Patients don't have to pay for this themselves because it is available within the NHS.
What does come into question though is its value for money.

For most women the litmus test is quite simple. They want to know what the "take home baby" rate is. And for AIH this does not look to be much more than three per cent.

What the women who lobbied me were really angry about is the divide that they currently have to cross between what is available within the NHS and what is only done if you can pay privately.

In Vitro Fertilisation (IVF), which seeks to fertilise the egg outside the womb and return it for an otherwise normal pregnancy, is not normally offered under the NHS.

For each attempt, a person (or couple) will be charged around £2,200. Nottingham residents can sometimes get this at the discount rate of around £1,500 in total.

Generally this requires at least three attempts and would leave you with a bill of £4.500-£6,600 with or without a pregnancy. But the success rate is around 30%. It is a discrepancy not lost on couples who are desperate for a child.

What concerns me is not just the "health gap" in what should be a comprehensive service, but the "wealth gap" which potentially divides fertility and infertility between those who can pay and those who can't.

Campaigners have their own list of sacrifices and sadnesses associated with this desperate attempt by people to raise the cash to afford the treatment.

I'm not arguing for this as a panacea for infertility or sub-fertility treatment.
But what I do know is that some of the tests involved in IVH can identify grounds on which other treatments would not work in any case.

There are grounds on which monies can be saved rather than extra costs incurred. More than anything, however, I am now much clearer on the rights and wrongs of how to proceed.
It has to be right for there to be a comprehensive fertility service to be available within the NHS.
It cannot be right for wealth to be the final arbiter of pregnancy rights. And an openness and honesty about choices which are available has to be available to people in Britain — a citizens' right based on entitlements rather than a customer right based on cash.

There will still be no guarantee that a couple will be able to conceive the child of their dreams, but artificial barriers, inadequate information and inexplicable financial policies should not be used to deny them the chance. It is all they ask for.

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