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Assisted reproduction regulation in the Netherlands

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Introduction

From the 1950s onwards, innovations in assisted reproduction brought new opportunities for parenthood but also raised questions concerning the conditions under which the law could facilitate the application of such innovations, including the technological aspects. Together with changes in societal values – such as sexual self-determination, gender equality, and the upsurge of forms of cohabitation alternative to the traditional family – such new opportunities destabilized the existing cultural norms concerning procreation and family life. The central questions of this chapter are: What new norms developed out of the use of these new possibilities, how and when have such changes in norms been translated into legislation, and what did this mean in practice?

To investigate the changes, we start with a short introduction to the Dutch political system (first section). The heart of the chapter is the second section. This section addresses the societal and political debates concerning various assisted reproductive techniques (ART). Here the processes of rule formulation regarding four technologies will be described: assisted insemination (AI), in vitro fertilization (IVF), surrogate motherhood, and pre-implantation genetic diagnosis (PGD)[1]. Furthermore, the content of the regulations and the research into their effects are described. In the third section, we describe the infrastructure and use of ART. The chapter concludes with some reflections.

The chapter is based on previous work of the authors (Weyers, 2015, 2016; Zeegers, 2007, 2011). It relies on the analysis of bills, parliamentary debates, and preparatory documents such as publications of political parties and advisory bodies, reports by professional organizations, and the literature on ART in the Netherlands in general. The information was retrieved by systematic research on the internet (by key concepts) and by looking at references.

A country of minorities and political fragmentation

The Netherlands is a centralized consensus democracy (Lijphart, 1999) with a bicameral Parliament in which the Second Chamber is elected directly and

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therefore more important than the indirectly elected First Chamber. Because of the proportional party list system and the low electoral threshold, many parties are represented in the Dutch Parliament. Another consequence of this system is that Dutch governments are always coalition governments. Until the early 1990s, the Christian Democrats had a pivotal position in these coalition governments, reflecting the well-known strong position of Christian parties in countries with a mixed Protestant and Catholic population.[2] However, since 1994, this supremacy has ceased to exist.[3] Ten years later, the entirety of the Dutch political landscape was in flux. In this new century, not only the Christian Democrat Party (CDA) but also the Social Democrats (PvdA) no longer count on solid support. Populist parties like the Freedom Party (PVV) and Forum for Democracy (FvD) have gained importance. Besides these parties, a number of smaller ones ranging from the left (left liberals – D66 and Green Left – GL) to right-wing religious parties (Political Reformed Party – SGP, Reformed Political Alliance – GPV – and Christian Union – CU) also contend for voters.

Advisory bodies play a prominent role in Dutch political decision making. Much policy is partly pre-cooked in a subsystem of policymaking where various interests and professionals are represented in semi-public bodies, such as the tripartite Economic and Social Council, with members from government, employers, and employees.[4] The Health Council and the Public Health Insurance Council are semi-public bodies that deal with the medical, ethical, and financial aspects of health policy (Timmermans, 2004). The Health Council is an independent scientific advisory council with the legal task of advising government and Parliament in the broad field of public health and health care. Based on the state of the science, the council provides government and Parliament with advice, both solicited and unsolicited, on issues across the entire spectrum of public health: from health care, prevention, and nutrition to the environment, working conditions, and innovation and the knowledge infrastructure.[5]

The coming into being and the content of ART regulations

Lifting donor anonymity: an unexpected turn

In the Netherlands, the development of ART started in the 1950s. AI was the first form of doctor-assisted reproduction that became available to couples with fertility problems. At the time, only a few doctors were willing to apply AI[6] and only in cases where the semen of the husband could be used. This fitted quite well into the Dutch cultural outlook at that time: a traditional religious country with rather strict views on family and morals.

At the end of the 1950s, public debate on the topic arose; in the 1960s and 1970s, views on AI quickly changed, and assisted insemination with donor semen (AID) became an accepted practice. This change started in medical practices where doctors were willing to help couples who could not become pregnant because of the poor quality (or total lack) of the husband's semen. The more general acceptance of this change among medical professionals is illustrated by the following statistic:

In the late 1950s, 94% of gynecologists opposed AID, whereas in the early 1980s, a majority (58%) was in favor (Kirejczyk et al., 2001).

Next, in the 1970s and 1980s, access to AID in fertility clinics was no longer restricted to married couples. This reflected the societal change of marriage losing its dominant position, co-habiting without marriage and giving birth to children in such a relationship becoming more normal.[7] Subsequently, feminist organizations took the position that refusing treatment to single and lesbian women should be considered a form of discrimination. Some doctors were willing to treat them, too. The first inseminations of single women and lesbian couples took place in the late 1970s.[8]

Another important change in the mid-1980s concerned the question of whether children should be informed about being donor offspring. Professionals such as psychologists and educationalists argued that it was in the best interests of the child to be informed about the way it was conceived. One, Professor Hoksbergen, stressed this importance by calling AID 'hidden adoption' (1985, pp. 21–22).

Through these developments, AID turned out to be a practice that rocked the foundation of marriage and the family. It is, therefore, no wonder that religious organizations started to problematize its consequences. However, they did so not directly by rejecting the practice as such (as they used to do) but by pointing to one of its consequences: The existence of children who do not know their biological father. In the early years of AID, it was seen as obvious that children should not be told that they were donor offspring (Takes, 2006). Informing them was supposed to raise many problems in education and family. In the late 1980s, those who opposed new family structures abandoned this view (Wetenschappelijk Instituut voor het CDA, 1988). In the Dutch Parliament, the Christian Democrats were the first to propound this view. At the end of the 1980s, the Christian Democrats argued for a mandatory sperm donor registry in Parliament, arguing that this would serve the best interests of the child. Non-denominational parties, for example, VVD and PvdA, did not have a firm position on this issue. They apparently did not oppose the practice. And before considering changing the law, they asked for scientific proof about whether conveying the artificial nature of their conception would be in the best interests of the donor offspring, or at least that not knowing their genetic origins would cause suffering.

The government (a coalition of Christian Democrats and right-wing liberals) decided to propose a bill in which a sperm donor registry would be mandatory. Notwithstanding the reluctance of the VVD mentioned previously, the explanandum accompanying the legislative proposal states quite firmly:

> Not knowing and not be able to know who is your father and mother, affects many heavily, especially those who don't and aren't. Knowledge of genetic origins offers human beings a footing. Without this footing, human beings lack materials which can offer a deeper insight into oneself.[9]

The Christian parties, not only the CDA but also the small Christian parties (SGP, GPV) were happy with the bill. On the other side of the political spectrum, the

social democrats (PvdA) stressed that in the Netherlands, people do not have a right to know their origins. They nevertheless were willing to take into consideration that some persons are troubled by not knowing. They again asked for research into this question. The VVD supported this request and added that adopted children (seeking their roots) differ from donor offspring and therefore cannot be referred to as evidence in this matter. Donor offspring, for instance, genetically relate to one of the parents, and these children are not abandoned but very much wanted. In addition, D66 doubted the necessity of the proposed legislation and asked for more substantiation. Why do only donor offspring obtain the right to information and not, for example, children born out of wedlock? Clearly, the government was not intending to grant such a general right.

Shortly after the parliamentary debate, the Dutch Supreme Court issued the so-called Valkenhorst I ruling (1994). This ruling concerns a woman born in a home for single mothers back in the thirties. She wanted to have information about her biological father, but the institution refused to give it to her. The institution, called Valkenhorst, rejected her claim on the ground that it owed a duty of confidentiality to the mother. According to this duty, the information about the presumed biological father could only be disclosed with the mother's consent. The mother had refused to give this. Whereas the District Court and the Court of Appeals ruled against the daughter by holding that the duty of confidentiality owed by Valkenhorst towards the mother prevailed over the daughter's interest in knowing her paternity, the Supreme Court overturned these decisions and accepted the claim of the daughter against Valkenhorst. The judgment is interesting because the Supreme Court introduced the right to personality as the legal basis, ruling in favor of the daughter. According to the court:

> The point of departure for deciding the case is that the general right to personality, which lies at the roots of such constitutional rights as the right to respect for one's private life, the right of freedom of thought, conscience and religion and the right of freedom of expression, also includes the right to know one's parents. . . . This right gives a person in circumstances such as those of the woman concerned a claim against an institution such as Valkenhorst as to the disclosure, at her request, of the information about her parents.[10]

At the end of 1997, the debate on the legislative proposal was reopened, most probably because of the Supreme Court's judgment.[11] Without this judgment, the installment of the 'purple' government in 1994 (the first government without Christian Democrats) could have led to the silent death of the proposal to prohibit anonymous sperm donation. After all, the three coalition partners had been skeptical about it. However, after the Valkenhorst ruling, D66, one of the architects of the new government, turned out to have changed its position radically. Now D66 took the position that children not only have an interest in knowing their origins but also have the right to know who their biological father is. VVD and PvdA also appeared to have changed their position. They no longer deemed empirical proof necessary but simply assumed that children can have an interest in knowing their

origins and that for those children who have this interest, the possibility of choice should be available. The consequence was that a majority in Parliament now was in favor, and the bill was accepted.[12] In 2004, the Artificial Insemination Donor Data Law came into force. Since then a couple of small – mostly administrative – changes have been adopted.

The basic structure of this law prohibits clinics from working with anonymous donors and provides a structure (an organization that makes sure that donor data are collected and stored) by which children can lay their hands on donor data.

The institution that takes the semen for insemination collects donor information.[13] These institutions must send the information to the national donor data institute. The data collected involve medical data, physical features, education, occupation, data regarding personal characteristics, family name, surnames, date and place of birth, and address. Donor offspring of 16 years and older can receive all the donor information. Donor offspring less than 16 years[14] old can receive data regarding physical (length, hair color, color of the eyes) and social (living situation, education, profession) characteristics.

There are no provisions in the law to limit the kind of patients who can receive donor semen and no formal requirements regarding the situation of the parent's life.[15] The law lacks a provision that makes informing children that they are donor offspring obligatory. The institutions are assumed to inform the prospective parents that informing the child is desirable.

Although in the political debate, the best interests of the child have been a major topic, there is no provision in the law that refers to such interests or to the right of the child to know its origins.[16]

Furthermore, there are no requirements regarding (written) consent and the like. This is partly regulated by other laws (for example, the law on patients' rights,[17] which requires the informed consent of all medical treatment, and the Embryo Law) and by professional standards.

There is no legal limit to the number of children per semen donor. The Health Council advice used to be 25 children at max (which is relatively high). In 2018, the Dutch Association for Obstetrics and Genealogy (NVOG) and Association for Clinical Embryology (KLEM) changed this to 12 families per sperm donor,[18] a view shared by the government.

In 2012 and 2019, the impact of the law on mandatory donor data registration was assessed. It turned out that the prescribed institution – the foundation donor data artificial fertilization (SDKB) – had set up a registration system that was open to the institutions applying assisted reproduction. The SDKB connects the data of the donor with the data given by the institution where the fertilization took place (with the person identifying data of the intended mother).[19] The evaluation of 2012 showed only a few institutions that did not always meet the registration requirement. By 2019, this had been improved. At that time, the investigators principally criticized the SDKB for not being sufficiently prepared for questions regarding donors and for not executing the law properly with respect to the transition from the old to the new situation in 2004. It turned out that all donors were asked again whether they wanted to be anonymous. The result is that some

children whose mothers agreed on a non-anonymous donor ran into the fact that the donor had newly indicated that he wanted to be anonymous.[20]

Because the law is so recent, donor offspring who have the right to information do not exist yet. That the system works can be deduced from the facts that physicians have asked for medical records and an increasing number of parents and children for data on physical and social characteristics and received them.[21] It is unknown whether the data fulfilled their demands. With regard to the openness of parents on the procreation of the child, in 2012, the researchers concluded that most clinics bring it forward as important. They cautiously concluded – this part of the survey was not representative – that the prospective parents endorse and apply openness. The second evaluation makes clear that most clinics find it important to point out to expectant parents that telling the truth about parentage is crucial. The researchers of the first evaluation also looked at an unintended but expected side effect: the reduction in the number of donors. This effect indeed occurred.

IVF: Physicians taking the lead, hardly hindered by temporary decrees

In the Netherlands, the birth of Louise Brown in 1978 was noted with huge interest. Dutch doctors (although in the beginning only one or two) quickly saw opportunities and started with IVF.[22] The discussion after the birth of the first Dutch IVF baby in 1983 made clear that the technique had supporters and opponents.

Doctors performing it were enthusiastic and pointed at the great grief of childlessness.[23] Infertile women were very happy with a new chance to become mothers. When more hospitals were offering IVF, the discussion on whether IVF should be part of a health insurance package started. As usual in the Netherlands, the Health Council was asked for advice. Quickly the council issued an interim report (Gezondheidsraad, 1984). Remarkably, the Health Council almost self-evidently suggested that IVF does not raise ethical questions when used in infertile women in a stable heterosexual relationship. Another striking feature is that the Health Council addressed IVF and AI as comparable issues in this respect, although IVF is more invasive and technically more sophisticated. Both techniques were seen as acceptable ways of becoming pregnant, especially for heterosexual couples.[24]

Part of the feminist movement agreed and thought of the new technique as widening the options for women's self-determination. Another group of feminists, however, put the importance of this new option for realizing motherhood into perspective. They were suspicious about the medicalization of reproduction that would increase the involvement of men, and they feared this would entail a new form of repression of women (Kirejczyk et al., 2001). In particular, those concerned with women's health issues pointed at the dangers of hormone treatment for the women involved, the risks to the embryo, and the societal perils of embryo selection and enhancement. They started to insist on regulating the practice.

Relying, among other things, on the position of the Health Council, the minister of health issued a Temporary Decree on IVF (1985). The aim of the decree was the control of the impending proliferation of the IVF practice. Its essential element was only allowing IVF in institutions that were authorized to do so by

the minister.[25] Through this, the Ministry could determine the total amount of IVF and impose quality requirements on the institutions involved.[26] The decree stimulated discussion of IVF because gynecological clinics and the newly founded patient organization for infertile couples, the Dutch Association for In Vitro Fertilization (NVRB, later renamed Freya), opposed the reduction of the number of clinics, the limitation of the persons who qualify for IVF, and the non-inclusion of IVF in health insurance packages. At that time, confessional political parties also became more and more interested in the topic.[27] Nevertheless, the Ministry of Health dawdled over proposing rules that would be more permanent.

In the second half of the 1980s, the number of IVF treatments increased enormously, from 400 in 1985 to 2,246 in 1988 (Kirejczyk, 1996). The Decree on IVF (1985) was a temporary one, and therefore clearer and more lasting rules became urgent. In 1988, the minister of health proposed to bring IVF permanently under the regime that makes ministerial authorization for the practice obligatory. With respect to content: The minister wanted to be very restrictive regarding research on embryos and was reluctant with respect to IVF for single women and lesbians.[28] This was in line with the view of the Christian Democratic party, the Council of Europe's concept-recommendation on ART, and the 1986 advice of the Dutch Health Council (Holtrust, 1993). The CDA, the only political party at the time that issued a viewpoint on the topic, took the position that political control of reproductive technologies was necessary (Wetenschappelijk Instituut voor het CDA, 1988). Respect for the intrinsic value of life was paramount, in the party's opinion. One of the proposed restrictions was that only a very limited number of embryos should be created, and they all should be implanted in the woman. Destruction of embryos and experiments with embryos should be criminalized, and assisted reproduction should only be allowed if there was a biological reason for childlessness (and therefore not for single and lesbian women).

The proposal of the minister of health was debated in 1989. The minister admitted that the practice of IVF treatments was booming and now estimated the annual demand at 4,500 treatments and the maximum number of IVF laboratories at 11.[29] The committee of the Second Chamber[30] agreed with the minister that the admissibility of IVF (and AID) as such was not the subject at stake. Furthermore, members of Parliament supported the minister's idea of putting the best interests of the child first.[31] The question of whether IVF should be refunded by health care insurance was avoided. The discussion focused on the question whether single and lesbian women were to be allowed access to IVF (the CDA and small religious parties were against and the other parties in favor) and whether research with embryos should be allowed (a similar political dividing line).[32] The new Planning Decree IVF was agreed on.

In 1989, the newly appointed Cabinet (a coalition of Christian Democrats and Social Democrats) announced legislation regarding IVF (and medical research with embryos). At that moment in time, 12 hospitals (eight academic and four general hospitals) were granted a license to carry out IVF. The government announced the proposal of a bill on fertilization techniques in order to regulate the practice.

However, the plan to propose a bill was never carried out by this Cabinet. In the mid-1990s, the 'purple' Cabinet (social democrats and the two liberal parties) started to write a new Planning Decree IVF. Research into the practice of IVF was carried out to give the new decree a better footing. Again, it became clear that the IVF practice had grown fast. The number of IVF treatments carried out in 1993 was twice the intended maximum. Furthermore, women in their 40s were offered IVF, although this was seen as undesirable; the indication for the treatment had been expanded (now also including male infertility); and one of the hospitals was carrying out IVF in combination with pre-implantation diagnosis.[33] Thus practice, once again, had taken its own path.

In 1998, the second 'Purple Cabinet' issued the new IVF Planning Decree. The leading role of the Dutch Association for Obstetrics and Genealogy in defining the direction of the policy to be followed is clearly visible therein.[34]

Meanwhile, public acceptance of homosexual relations in the 90s[35] had grown to such extent that equal access of homosexuals to IVF had become an issue. Access for lesbian couples to IVF treatment had never been explicitly denied by law but had been left for the hospitals to decide, resulting in some of the hospitals refusing such access to lesbian couples as well as single women. In 2000, the Equal Treatment Commission, at its own instigation, did research into hospitals' criteria for access and judged the policy of three of these hospitals refusing such treatments to lesbian couples to constitute direct discrimination on the ground of sexual orientation. The hospitals concerned justified their decisions by declaring that in the interests of the child, they did not want to use donor semen, a sine qua non for such couples. However, according to the Equal Treatment Commission, this reason could not be accepted as justifying discrimination. The commission also concluded about a hospital that refused single women that such a policy entailed unjustified indirect discrimination on the ground of marital status. The minister of health, wellbeing and sports reacted to the Equal Treatment Commission's report by writing: 'the interests of the (future) child has to be the starting point in deciding about each individual application, however, it does not justify the exclusion of lesbian or single women in general'.[36] The minister subsequently asked all hospitals to adapt their policy accordingly, promising further measures in case of non-implementation.

In 2016, the NVOG observed that doctors were more reluctant to assist homosexual couples, transgender, and single persons than heterosexual couples in reproduction involving donated gametes or embryos, notwithstanding their equal right to access (NVOG, 2016, p. 3). The association points to the protocol it formulated in 2010 to support doctors in their decision making (NVOG, 2010). It clarifies what could be a contraindication for giving assistance: Although a marginal assessment of the future parenting situation can be part of the procedure, this can only be a contra-indication if the doctor is convinced that the reproduction poses serious risks to the well-being of the child (NVOG, 2016, p. 7).

The rules for transactions with embryos are codified in the Embryo Law enacted in 2002.[37] The controversial part of this law involved research with embryos and will be addressed in the following.[38] With regard to transactions with gametes and

embryos, the law provides first that the IVF institutions should establish a protocol concerning the control of it. Second, embryos and gametes not or no longer part of a project in which their genetic owners intended to reproduce themselves could be made available for another person's pregnancy or for scientific research. The Embryo Law stipulates who has a say over such decisions: in the case of embryos, both 'parents' for whose pregnancy the embryo initially is created (Zeegers, 2007). Furthermore, the law states that permission to use one's gametes or embryos must be in writing, that the donor must be well informed, and that the donation must be done without payment. With regard to these requirements, the NVOG formulated model regulations in consultation with the Ministry of Health, Welfare and Sports (Kwaliteitsinstituut voor de Gezondheidszorg CBO, 2003). These model regulations indicate, among others, the age limits of potential acceptors (maximum 45 years old) and donors of egg cells (between 18 and 40 years old) and that each procedure requires the permission of the hospital's medical ethics review committee.

The basic structure of the IVF regulations (embryo research excluded) is administrative authorization for clinics to carry out IVF (other clinics are prohibited to do so) under specific requirements (based on the NVOG model protocol). Much is left for the profession to decide. Because this law mostly contains many administrative obligations, the first and second evaluation of the Embryo Law were impact assessments addressing such obligations (Olsthoorn-Heim et al., 2006; Winter et al., 2012).

The most important estimated shortcoming is that some clinics did not design their own institutional protocol (as they should); they use the model protocol of the NVOG. The third evaluation is of a different type (Dondorp et al., 2021). The authors address the new technical possibilities that have developed in research with embryos and reflect on whether the existing rules should be reconsidered because of the promises that new technical possibilities entail for curing diseases and improving the wellbeing of less fertile couples (Dondorp et al., 2021, p. 191). We will come back to this under the fourth section.

A joint opinion on surrogacy

In the report of 1986, the Health Council discussed surrogacy, too.[39] The Council stated that surrogacy under certain conditions could be acceptable (especially in situations of a medical indication of the intended mother who lives in a situation that guarantees a good upbringing). The council stressed that surrogacy should be a free choice; however, commercialization, that is, women being paid for surrogacy, would be undesirable (Kirejczyk et al., 2001). The report addresses the following questions: Can a child have two mothers simultaneously? Is it lawful to become pregnant with the intention to give up the child? Are the arrangements between surrogate mothers and prospective parents binding? Is it allowed to ask for money for surrogacy? Opinions were divided, but the aversion against the possibility of commercial surrogacy in combination with IVF was almost general.

The Cabinet (the earlier mentioned coalition of CDA-PvdA) was even stronger in its rejection of surrogacy and declared surrogacy contracts void.

Remarkably, surrogacy, although it rarely occurred in practice, was the first aspect of ART to be regulated by law. In 1990, the government proposed a bill that aimed to discourage non-commercial surrogacy and to forestall commercial surrogacy.[40] The reasons given for this negative stance were the risks and emotional problems in the long term for the surrogate mother, increased risk of identity problems for the child, a disturbed process of bonding, the risk of disappointment for prospective parents, and difficulties in coming to a good relationship between child and parents. To discourage and prevent surrogacy, the government proposed to add two paragraphs to article 151 of the Penal Law. Together with an addition in the 1950s (article 151a, an article that concerns adoption), these additions were supposed to lead to the desired effect.

In the late 1950s, with the (then new) adoption law, paragraph 151a was added to the Penal Code. This paragraph mandates that placing children in another family would need the supervision of the Council of the Protection of the Child. Paragraph 151a is important for surrogacy because it creates obstacles to the recognition and adoption of a child by the prospective parents.[41] The new proposed paragraphs prohibited professional mediation for surrogacy and advertising therefor (151b) and the mediation of ceding a child (151c).[42]

These proposals were widely supported by the political parties. Nevertheless, they had different ideas concerning the underlying issues. Some parties were not against surrogacy per se but considered commercial surrogacy wrong (D66 and GL). Other parties felt, just like the government, that surrogacy as such is undesirable (VVD), and still other parties (the Protestant parties GPV and SGP) took the position that the government did not go far enough, that all forms of surrogacy should be prohibited. Both chambers of Parliament passed the bill.[43]

The debate on surrogacy has not ended with these Parliamentary decisions. At the end of the 1990s, one of the IVF clinics was permitted to carry out 'high-technological surrogacy'. The rationale for this kind of surrogacy is that this is the only way for women without a (functional) uterus to have their own genetic progeny (NVOG, 1999). In 1998, the new Planning Decree IVF permits surrogate motherhood under the conditions given by the NVOG (Timmermans, 2004). Since 2016, the NVOG has been asking for a new law on surrogacy in the Netherlands to prevent Dutch people going abroad.[44] Nowadays, the Dutch government intends to change the legislation on surrogacy, in response to the report of the State Commission Re-evaluation of Parenthood (2016) that was asked to formulate basic principles regarding the origin of legal parenthood and the creation of a legal possibility of surrogacy (and multiple parenthood). In its response to the report in 2019, the government states that the best interests of the child must come first and places great emphasis on creating the development of lineage identity.[45]

The basic structure of the paragraphs on surrogate motherhood is quite simple: It prohibits (professional) mediation and advertising for surrogacy without specific enforcement regulation. Therefore, police and prosecutorial authorities are the institutions in charge of enforcing compliance. Up to now, no arrests or prosecutions have taken place regarding article 151b and 151c.

That surrogacy takes place (although presumably in very small numbers) has become clear from a research report of the University of Utrecht (Boele-Woelki et al., 2011). In 2012, the Council of the Protection of the Child looked at 12 requests and in 2013 at 19 requests for adoption of a child born after surrogacy.[46] These requests concerned 'low-technological' surrogacy (surrogacy without the involvement of a doctor), as well as high-technological surrogacy and surrogacy abroad (Boele-Woelki et al., 2011). The researchers are convinced that surrogacy took place more often.

Nevertheless a political clash

The practice of creating embryos in IVF treatments brought with it new issues related to ART. As we have seen, the parliamentary discussion of research on embryos started in the late 1980s. In 1989, the government took the position that such research would only be allowed in exceptional cases and only if public health had a huge interest in it. Later on, in 1991, research that would be therapeutic for the embryo itself came to be distinguished from research in which the embryo would be lost, putting a ban on the latter. In 1993, a moratorium followed with the possibility to prohibit the latter kind of research by an Order in Council.

In 2002, the long-expected legislation on embryo research and the use of embryos otherwise as well as the use of human gametes followed. To an extent, these rules concern the donation of human gametes or embryos that have already been addressed under the second section. The rules concerning embryo research were more permissive than the CDA had proposed in 1989; for instance, the use of spare embryos for research is conditionally allowed. Unsurprisingly, in the parliamentary debates, there was opposition from the Christian Democrats and the other confessional political parties. However, the second 'Purple Cabinet' had already anticipated the most controversial issue in this respect by putting a moratorium on specially creating embryos for use in research.[47] In addition, the Embryo Law (2002) first stipulates that scientific research on human embryos would only be permissible when authorized by the Central Committee on Research Involving Human Subjects (CCMO). Second, the Embryo Law contains a ban on sex selection in embryos on non-medical grounds, earlier regulated by an Order in Council.[48] In 2020, the possibilities for sex selection on non-medical grounds were slightly widened, creating space for gender choice in cases where this would prevent offspring from carrying a serious sex-linked disorder.[49]

With respect to research therapeutic for the embryo, a distinction is made between research on the embryo in vivo and research on the embryo in vitro. The latter appeared to be controversial because of the involved selection of embryos, albeit selection on medical grounds, which the law has never explicitly forbidden. The Planning Decree Clinical Genetic Research and Counseling (2003) brought pre-implantation genetic diagnosis explicitly under the Specialist Medical Practice Act (WBMV), article 2. In this Decree, 'an increased risk for the potential parents in an individual case of giving birth to a child with a severe genetic

condition' is the criterion formulated for PGD, which involves such embryo selection.[50] In May 2008, the secretary of state of health, welfare, and sports sought to widen the opportunities for PGD and make it available to parents with families where genetic mutations occur that are responsible for inherited breast cancer.[51] Her proposal led to fierce protests by a minister of the Christian Union (a religious party),[52] who, in addition to opposing her proposal, accused her of a breach of the Coalition Agreement. The CU had agreed to participate in the Cabinet (CDA, PvdA, and CU) on the condition that it would not enlarge the existing opportunities for abortion, euthanasia, and embryo research. The compromise that the secretary of state formulated averted a government crisis (Zeegers, 2011). First, 'a high individual risk of a severe genetic condition or disease' is the criterion for access to PGD laid down in the Regulation PGD, published in early 2009. Second, in deciding about access, medical professionals would have to take four indications into consideration: (a) the seriousness of the disease involved, (b) the treatability of the disease, (c) additional medical aspects, and (d) psychological and ethical aspects. Third, a National Indication Committee PGD, consisting of medical professionals, would be installed that would advise on requests for PGD in cases of genetic conditions for disease that previously had not been given access and for supervising the implementation of the guidelines for decision making, as described previously.[53] The Parliament accepted the inclusion under these conditions.

Human dignity and the principle of respect for life are the starting points of the Embryo Law. Therefore, the Embryo Law does not permit scientific research on human embryos unless deemed necessary by the Central Committee on Research Involving Human Subjects. In addition, it forbids, first, (temporarily) the creation of embryos specifically for research; second, development of the embryo in vitro after 14 days; and third, making changes in the germ line. However, according to Dutch law, the values announced as starting points for embryo research, with technology developing, have to be weighed anew each time against the interests connected to curing diseases and improving the wellbeing of less fertile couples (Dondorp et al., 2021, p. 191).

In line with this consequentialist reasoning, pre-implantation diagnostic (and selection) is not prohibited but conditional. The treatment is implemented for couples who have a high individual risk of giving birth to a child with a severe genetic condition or disease such as Huntington's disease or cystic fibrosis (Steinkamp et al., 2012). The Regulation PGD is the response to the parliamentary debate concerning the widening of access to PGD to include some inherited forms of cancer. This regulation consists of, first, guidelines for medical professionals' decision making on whether a client should be given access to PGD treatment and, second, the installment of a National Indication Committee PGD.

Steinkamp et al. (2012) assessed whether the professionals feel themselves sufficiently supported by the guidelines. The medical professionals answered that this is so to the extent that the indications in the guidelines offer four different angles from which each case can be approached in the decision-making process rather than four different, mutually exclusive criteria that each have to be decided on

separately. With respect to the functioning of the National Indication Committee PGD, the medical professionals indicated they were satisfied and considered them expert and careful. However, Steinkamp et al. (2012) point to two critical notes: First, some medical professionals experienced its role as government interference in the doctor-patient relation. Second, some medical professionals experienced the course of events concerning new requests for access to PGD where they had to await the judgment of the National Indication Committee PGD as a doubling of decision making, as consultations between different disciplines and careful decision making on each case already take place at the PGD hospital itself.

Steinkamp et al. (2012) also call attention to the moral questions involved in PGD: Current developments in genomics make conceivable a quick diagnosis of more genetic conditions for diseases. What are the ethical implications, for instance, with regard to the decisions future parents have to take about testing their embryo?

Dondorp et al. (2021), in the third evaluation of the Embryo Law, point at a new technique that could be reason for reconsidering the ban on germline modification as well as the 14-day limit: the possibility of editing the human genome to prevent children with a severe genetic condition from being conceived (Dondorp et al., 2021, p. 56). The authors suggest that allowing the application of this technique in comparison might be more morally acceptable than the destruction of human embryos with serious genetic abnormality that is involved in pre-implantation genetic testing (PGT).

Infrastructure and use

Currently, the Netherlands has six clinics that collect sperm, three collecting eggs and one collecting embryos. Furthermore, there are 21 clinics that apply AI and 12 clinics that offer IVF (one of the latter offers PGT in addition).

About 350 men yearly donate sperm. Their sperm is kept icebound in one of the seven sperm banks available in the Netherlands. The demand for sperm is much higher than the useful sperm offered this way. About 900 new female clients a year ask for sperm treatment; waiting lists are resulting from this gap between supply and demand. Some sperm banks offer the possibility of using semen from foreign donors. The wait for semen from foreign donors is two-and-a half months against one to two years for semen from Dutch donors.[54]

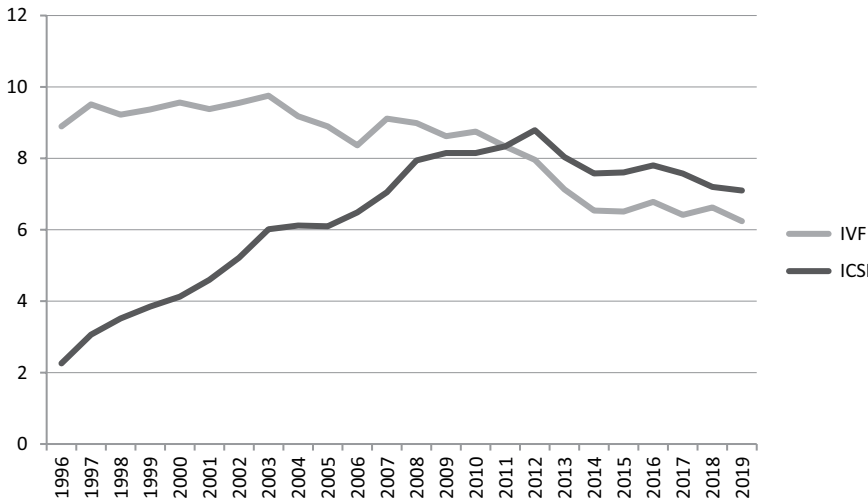
Number of treatments

The number of treatments with donor sperm initially increased but now appears to have started a sharp decline. Something similar happened with egg donation treatments; treatments with embryos appear to be more stable.

As of 2019, 11,803 pregnancies are now registered with the SDKB (this also concerns treatments that took place before 2004): 11,689 as a result of sperm donation, 747 from egg donation, and 185 from embryo donation. More than 1,000 pregnancies are registered every year (Woestenburg et al., 2019, pp. 84–85).

Table 7.1 Numbers of treatments with donated gametes and embryos.[55]

	Semen	*Eggs*	*Embryos*
2010	644	52	6
2011	769	72	8
2012	881	62	17
2013	1003	95	19
2014	1126	65	31
2015	1030	63	28
2016	1180	63	29
2017	1290	53	27
2018	1222	44	30
2019	865	18	21



The total of IVF and intracytoplasmic sperm injection (ICSI) treatments between 1996 and 2008 rose from 11,154 to 16,927 and thereafter decreased to 13,341 in 2019. The proportion of IVF in this total – in 1996 starting out at 80% – has declined considerably. The proportion of ICSI in this total has risen and nowadays exceeds IVF treatment.

Figure 7.1 Numbers of IVF and ICSI treatments.[56]

Source: The graph is based on yearly reports: www.degynaecoloog.nl/nuttige-informatie/ivf-resultaten/

ART tourism from other countries to the Netherlands hardly seems to exist; at least, it is not a topic of debate. To some extent, Dutch citizens go to Belgian and Spanish hospitals for IVF, among other things because of the option to make use of gametes from anonymous donors.

Financing

IVF treatment is covered in health insurance, restricted to three efforts, for women no older than 42. Women younger than 38 are only allowed to have one embryo implanted on the first and second treatments; only in the case of their third treatment can two embryos be implanted. For women older than 38 years, the latter is allowed from the first treatment on.

As requesting payment for gametes is not allowed, sperm donors can get only refunds of the costs made, such as travel expenses. The clinic determines the age limit for sperm donors; there is no legal age limit. Egg cell donors, in addition to refunding of travel expenses and other costs, are allowed to receive an amount (680–900 euro) per treatment for compensation of the effort and any lost income.

ART regulation, the same but different

The debate on assisted reproduction started in the 1960s, a period in which much changed in the Netherlands. From a conventional quiet country, it turned into an experimental garden of all kinds of behavior (drugs, sex, and 'euthanasia'). Churches lost their grip on believers, and self-determination became a hotly debated topic. With respect to sex and reproduction, this in the first instance concerned the liberation of sexuality, resulting in the free sale of contraceptives repealing the crime of adultery, repealing a restrictive provision on homosexuality in the 1970s, and legislating abortion in the early 1980s. Assisted reproduction, although quite different in nature, strongly relates to this epoch of self-determination. If people have a say in not becoming parents, why not also in becoming one?

Assisted reproduction, like the issues mentioned previously, is a morality issue. In the Dutch political system, such issues are often characterized by potential value clashes between religious and secular political parties that make it hard to find compromises. Coalition governments that include religious parties put much emphasis on accommodating the potential conflicts such issues could engender. Delegation of considerations and 'decisions' to expert committees as well as focusing on procedures instead of substantial rules are well-known methods of depoliticization that are applied (Timmermans, 2004).

However, ART differs from these other moral issues in a couple of ways. First, because the way it reached the political agenda. The subject did not reach the political agenda because of the activities of single-issue movements.[57] AID had already been practiced for a few decennia in hospitals before the possible downsides of donor anonymity came to be debated in Parliament. The Christian Democrats was the first political party that through this and other issues expressed an interest in ART regulation. The party thought to protect the traditional family and the dignity of human life against secular views such as self-determination.

Second, assisted reproduction is different to the issues evolving from the liberation of sexuality as described previously because of its technological aspects. The latter aspects make decision making more complex and make it more tenable to leave regulation to a subsystem of medical professionals and advisory bodies.

Third, assisted reproduction differs from most topics mentioned previously because of the involvement of the medical profession. Not only do patients have an interest in the subject, but doctors and medical researchers have, too. Witness to this is the fact that physicians have taken the lead in making reproductive techniques available on such a scale despite the government's effort to restrict the quantity of IVF treatments.

The following norms and legislation developed around the application of the four reproductive techniques in Dutch medical practice. Once AID and IVF treatments were available, accessibility became an issue, and political authorities ended up hammering out equal access, for example, for heterosexual and homosexual partners, as the basic rule to follow in this regard. In all cases, donor registry became mandatory, as donor offspring have the right to know who their genetic parents are. With respect to surrogacy, a joint aversion to commercialization resulted in a legislative ban, but surrogacy as such is possible and became available even in its high-technological form. Whereas the law forbids selection of embryos on nonmedical grounds, it permits selection on medical grounds, as part of PGT, albeit under certain conditions.

How to characterize the political process regarding the norms and rules described previously? The religious-secular divide in the Dutch party system brings with it a large potential for conflict regarding morality issues, but, at the same time, Dutch governments are experienced in accommodating these. We observed examples of (political) actors coping with conflicts, even preventing them from manifesting, in the phase preceding as well the phase during the actual rule making.

In the phase preceding the actual rule making, the Health Council precooked decisions in its advice concerning reproductive technology. In addition, the government tried to delineate the boundaries within which this technology could develop without giving too much room for parliamentary debate, an example being its attempts to regulate IVF practice through Planning Decrees. The rather vague legal concept of 'personality right' in combination with the idea – widely shared among political parties – that the interests of the child should prevail, led to a majority of members of Parliament accepting mandatory donor registry. With respect to surrogacy, the lowest common denominator between parties, forbidding commercial surrogacy is the rule the 1990 legislation was based on. In the bill that led to the Embryo Law, government already anticipated societal support by formulating it as a compromise between those in favor of the use of embryos for research and those against it.

The rules resulting from the actual decision making are often procedural in addition to a few substantial bans: The legislature leaves the ultimate decision to the medical associations, such as NVOG, KLEM, or expert committees established by law, such as the CCMO. In some cases, the legislature, in addition to determining who can take the ultimate decision, also stipulates the values they should take into consideration, such as respect for human life and human dignity.

In sum, the political process regarding the norms and rules concerning assisted reproduction in the Netherlands fits with Dutch political culture. The Netherlands is a country of minorities and political fragmentation, the latter becoming even

more relevant in recent decades. This has led to a political practice of consensus seeking through consultation but also, and even more relevant here, according a central role to expert advice. Whether it is the Health Council or groups of medical professionals, their contribution based on technocratic facts and practical experience is widely accepted as taking precedence over ideological differences. Therefore, according them the role of setting the parameters of legislation and/or taking the ultimate decision concerning ART rules is highly instrumental in keeping the practice developing without too much political contestation.[58]

Notes

1 Pre-implantation genetic diagnosis consists in examining an egg cell or an embryo in vitro for the purpose of diagnosing severe genetic conditions. Since 2017, this technique has been called pre-implantation genetic testing (PGT).
2 The CDA governed with either the right liberals (VVD) or the Social Democrats (PvdA) and other smaller parties.
3 Since 1994, coalitions between the former archenemies VVD and PvdA proved possible.
4 The government is legally obliged to seek their opinion, which usually carries considerable political weight.
5 The Health Council has a chairman, a vice-chairman, and some 130 members. Each member is recruited in a personal capacity and in relation to his or her special expertise in a certain field. Board members are appointed by the Crown. Their membership runs for four years and can be extended. The leadership of the Health Council has a policy, in principle, to prolong membership no more than twice.
6 Both Catholics and Protestants rejected AI (Takes, 2006).
7 Between the top year 1970 and 2003, the annual number of weddings declined by a third, and the number of children born out of wedlock increased by a factor of 14. In the 1960s, of first-born children, less than 1 in 30 was born out of wedlock. In 2003, this was 40% (the parents of these children often marry later on). The percentage of second and further children born out of wedlock was 23% in 2003 (Latten, 2004).
8 In the late 1980s, nearly a fifth of inseminations concerned these women (Kirejczyk et al., 2001).
9 Second Chamber of Parliament 1992/1993, 23 207, p 3.
10 ECLI:HR:1994:ZC1337.
11 There are no clear indications that the signing of the Convention on the Rights of the Child in December 1994 by the Netherlands – and in particular Article 7, which stipulates that children have, as far as possible, the right to know and be cared for by their parents, had an influence on this.
12 Two members of the Second Chamber voted against the bill; the First Chamber accepted the bill without voting [Second Chamber of Parliament 2000/01, 46 (2/6/2001), p 3548–49; First Chamber of Parliament 2001/02, 26 (4/23 2002, p 1322)].
13 In 2018, the Dutch Association of Obstetrics Gynecology and the Association for Clinical Embryology adopted a position setting out the requirements for donors (NVOG en KLEM, 2018). This concerns not only sperm donors but also donors of eggs and embryos. How to deal with these types of tissue is regulated in the Act on Safety and Quality of Human Materials 2003.
14 This age limit is under discussion because it is thought that younger children, too, should have this right.
15 In 2018, one-third of the intended mothers were lesbian, one-third single, and one-third heterosexual. The decline in the proportion of heterosexual couples is partly due to the fact that the use of new techniques makes these couples less dependent on donor sperm (Woestenburg et al., 2019, p. 109).

16 It is worth mentioning in this context that, since 2012, the guidance of children in their search for and contact with donors and half-siblings has been placed in the hands of an institute that specializes, among other things, in parentage issues (FIOM). They have already carried out about 300 projects. It is one of the signs that Article 7 of the Convention on the Rights of the Child is becoming increasingly important (Woestenburg et al., 2019).
17 Law on Medical Treatment Agreement (1994).
18 This is per clinic. It is clear from newspaper reports that some donors evade this by registering at multiple clinics. There is no check on this because there is no central register.
19 As of 2019, 4,292 donors were included in the system.
20 At the moment (2021), the courts are considering this situation.
21 Parents from 83 in 2011 to 450 in 2017; children from 5 in 2011 to 217 in 2017 (Woestenburg et al., 2019, p 87).
22 In 1982, the Dijkzigt Hospital in Rotterdam started with IVF and on May 15, 1983, the first IVF baby was born in the Netherlands.
23 Kirejczyk et al. (2001) state that there was a lot of media attention and that in the media, the feeling regarding infertility was an important element. IVF was seen as the solution to the needs of infertility, and they took the view that insurance companies not paying for the treatment would lead to a disadvantage for people without means, because then they were condemned to permanent childlessness.
24 In its report, the Council asked for legislation regarding property rights and the ways embryos and gametes should be treated (Gezondheidsraad, 1986).
25 They did so by placing IVF (temporarily) under Article 18 WZV (Law on Hospitals). This article makes it possible to prohibit certain operations and the purchase or use of certain equipment. This prohibition should be laid down in an Order in Council. Only hospitals which already carried out IVF were qualified.
26 The result is that carrying out IVF without ministerial authorization is forbidden and that the indication is clear (abnormalities of the fallopian tubes). Hospitals were obliged to collect systematic information on, among other things, the effectiveness and risks of IVF and to report this to the Ministry.
27 Besides the Christian political parties, there were other confessional organizations such as the Dutch Physicians' League who opposed IVF.
28 White Paper Artificial Fertilisation and Surrogacy.
29 Through collaboration with the Ministry of Education and Science, teaching hospitals were also governed by the regulation.
30 Before debate takes place in the Second Chamber, committees of Members of Parliament, consisting of all the parties in Parliament, discuss legislative proposals.
31 Feminists opposed the view that protection of the interests of future children was the central problem. They also saw women's interests. For example, the obligation for written consent of the husband (another CDA idea) gave the man control in a way that did not exist before. They supported the possibility of IVF (and AID) for single and lesbian women. Their argument relies on the prohibition of discrimination. Furthermore, they warned against the medicalization of reproduction by the new technologies and the low chances of success.
32 The number of reimbursed treatments was (and still is) limited to three, and no restrictions would be imposed on the type of indication (Regulation Subsidization Scheme of the Health Insurance Council In Vitro Fertilization 1989). Soon after the parliamentary agreement on the Planning Decree IVF, the commission that selects the treatments that will be refunded by health insurance companies decided to pay for IVF treatments carried out in institutions authorized by the decree.
33 PGD would be regulated in 2003.
34 For example, the Decree states that the application of in vitro fertilization takes place on the basis of the 'Indications for IVF' guideline of the NVOG, and IVF centers must participate in the uniform national IVF registration of the NVOG.

35 The European Value Studies show that in the early 1980s, the acceptance of homosexuality in the Netherlands had a score of 5.91 (on a scale of 1 to 10), which rose to 7.33 in the early 1990s.
36 Letter of Minister E. Borst-Eilers concerning her position on the judgment of the Equal Treatment Commission, CSZ/ZT/2076894, 28 June 2000.
37 Act of June 20, 2002, containing rules on operations with germ cells and embryos (Embryo Law).
38 Legally, an embryo in utero is considered born if his or her interests ask for it. If the fetus dies before birth, legally it is considered not to have lived. After birth, a human being becomes a holder of rights. At that time, the child has the right to a name (article 1:4 BW). With respect to the protection of the embryo, it is worth mentioning that in the Netherlands, abortion is legal until the third trimester if the woman is in a precarious position. What constitutes a precarious position is in practice left to the woman concerned. If the child cannot survive after birth, third-trimester abortion is possible. The doctor can invoke the defense of necessity.
39 In an interim report (1984), the Health Council did not object the use of donor eggs and took the position that surrogacy should not be introduced yet.
40 The government did not choose to ban (commercial) surrogacy because enforcement of the ban was considered very problematic and to be too great a breach of the privacy of parents. It was thought that the rules would have a preventive effect (Second Chamber of Parliament 1990–1991, 21 968 no. 3).
41 Discouraging is, among other things, that no separate scheme for the 'transfer' of the child is made. In the Netherlands, the woman from whom the child is born is the legal mother; the man to whom she is married (or has registered partnership) is the legal father. In cases of surrogacy, the surrogate mother (and possibly her partner too) have to cede the child. That is, they are deprived of parental authority by the court (in this procedure, the Council for the Protection of the Child also plays a role). And the prospective parents must be examined on being capable of raising a child (by the same Council). A slightly different course is taken if the prospective father is the genetic father of the child.
42 The status of surrogacy contracts is not clear. Generally these contracts consist of four provisions: The duty of the surrogate mother to be fertilized, the duty of the surrogate mother to cede the child after birth, the duty of the prospective parents to take the child after birth, and their duty to pay the agreed expenses. It is generally thought that the first three agreements cannot be enforced and that this does nullify the contract (Broekhuijsen-Molenaar, 1991; Schoots et al., 2004).
43 In the Second Chamber, the bill was accepted by CDA, VVD, PvdA, SGP, GPV, and Centrumdemocrats (other parties voted against); the First Chamber accepted the bill without voting [Second Chamber of Parliament 1992–93, 51 (2/3/1993), p 3729; First Chamber of Parliament, 37 (9/14/1993), p 1649].
44 In the Ukraine, for example, it is possible to make the 'wish-parents' the legal parents and therefore to avoid the involvement of the Council for the Protection of the child. Acting in this way is seen as *contra legem* in the Netherlands (van Vlijmen & van der Tol, 2012).
45 Kabinetsreactie op de aanbevelingen op het terrein van Draagmoederschap, meerouderschap en meerpersoonsgezag van de Staatscommissie Herijking ouderschap, 12 juli 2019 (State Commission Re-evaluation of Parenthood).
46 Circumstantial evidence is known through an interview with a judge. Research in 1995 showed that Dutch judges treated 30 cases of adoption after surrogacy in the early 1990s (*Trouw* 3/23/1995 www.trouw.nl/home/-discussie-nodig-over-draagmoederschap-~a3ff7a96/).
47 The Cabinet, in elaborating on the bill, concluded this would not have enough societal support from its consultation with scientific organizations, patient and women's organizations, and organizations with a religious background such as Pro Life and ecclesiastical organizations (Second Chamber of Parliament 2000/01, 27 423, nr. 3, p. 27).

However, all three evaluation reports have since advised lifting the ban on the creation of embryos for research purposes (Dondorp et al., 2021, p. 198).

48 In the Second Chamber, the bill was accepted with the votes of the Socialist Party (SP), PvdA, D66, and VVD in favor; confessional parties voted against. In the First Chamber, confessional parties voted against the bill, too [Second Chamber of Parliament 2001/02 10 (10/9/2001) p 428–29; First Chamber of Parliament 6/18 2002 (2001/02) 32 p 1536–37].

49 Act of 1 July 2020, amending the Embryo Law instead of Act in connection with the amendment of the ban on sex selection and use of gametes and embryos for quality assurance, *Staatsblad* 2020, 229.

50 Planningsbesluit klinisch genetisch onderzoek en erfelijkheidsadvisering (*Staatscourant* 23 januari 2003, 16, p. 11) and the Annex to Article 3 of the Planning Decree brings PGD under article 2 of the Specialist Medical Practice Act. PGD concerns research into the ovum or the embryo in vitro with respect to the diagnosis of constitutionally and hereditary disorders.

51 This was considered controversial because it concerns a hereditary disorder that is not fully penetrant, which means that not every person carrying the faulty gene will develop the condition involved (Zeegers, 2011).

52 The CU bases its politics on biblical principles, whereas the Christian Democratic Party sees the bible as a source of inspiration for individual members.

53 Regeling van de staatssecretaris van Volksgezondheid, Welzijn en Sport van 16 februari 2009, nr. CZ-TSZ-2912089, houdende regels ten aanzien van preïmplantatie genetische diagnostiek (PGD).

54 www.ad.nl/nieuws/het-is-angstig-stil-in-het-masturbatorium~ab8d8d4e/?referrer=www.google.com/

55 Ministerie Volksgezondheid, Welzijn en Sport, 'Jaarverslag 2019 Stichting donorgegevens kunstmatige bevruchting'.

56 The graph is based on yearly reports: www.degynaecoloog.nl/nuttige-informatie/ivf-resultaten/

57 Zeegers's comparative chapter in this book addresses the role of parliamentary politics in ART regulation more generally.

58 At the same time, to the extent rules are formulated, the Dutch government wants them to be followed, as its assessments of the effects bear witness to.

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