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Medically assisted procreation and insurance: an overview of Italian Jurisprudence from the right to reproductive health to the right to procreation

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Abstract EN
The phenomenon of medically assisted procreation arose in the 1970s, overturning the procreative system and the legal cornerstones that made up its structure.
An important means to permit access to Assisted Procreation Technique is represented by Health insurance contract.
Personalized fertility insurance plans that provide solutions including maternity insurance, complication insurance, fertility treatment, testing, services, and fertility pharmacy discounts. Providing the best fertility specialists, the best fertility pharmacy discounts and the best customer care combined with unbeatable prices.

Abstract IT
Il fenomeno della procreazione medicalmente assistita è sorto negli anni '70, stravolgendo il sistema procreativo e i capisaldi giuridici che ne costituivano la struttura.
Uno strumento importante per consentire l'accesso alla Tecnica di Procreazione Assistita è rappresentato dal contratto di assicurazione sanitaria.
Piani assicurativi personalizzati per la fertilità che forniscono soluzioni, tra cui assicurazione maternità, assicurazione per complicazioni, trattamenti per la fertilità, test, servizi e sconti sulle farmacie per la fertilità. Fornire i migliori specialisti della fertilità, i migliori sconti sulle farmacie della fertilità e la migliore assistenza clienti combinati con prezzi imbattibili

SOMMARIO: 1. State of the art in Italy: Medically assisted procreation and insurance. - 2. Jurisprudential interventions. - 3. Access to medically assisted procreation: possible solutions.

1.State of the art in Italy: Medically assisted procreation and insurance

The phenomenon of medically assisted procreation arose in the 1970s, overturning the procreative system and the legal cornerstones that made up its structure.

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An important means to permit access to Assisted Procreation Technique is represented by Health insurance contract.
Personalized fertility insurance plans that provide solutions including maternity insurance, complication insurance, fertility treatment, testing, services and fertility pharmacy discounts. Providing the best fertility specialists, the best fertility pharmacy discounts and the best customer care combined with unbeatable prices.
As well-known, health Insurance is a contract between a company and a consumer. The company agrees to pay all or some of the insured person's healthcare costs in return for payment of a premium.
The contract is usually a one-year agreement, during which you are responsible for paying specific expenses related to illness, injury, pregnancy, or preventative care.
In those years, medically assisted procreation was provided for in Italian public institutions in the form of homologous fertilisation whereby the biological elements used (spermatozoa and oocytes) in artificial fertilisation belonged to the couple of parents of the unborn child. Conversely, heterologous fertilisation, i.e. those cases in which one or both gametes did not belong to the members of the couple, was carried out in private centres, as provided for by the 1985 circular of the Minister of Health, Degan.
Law no. 40 of 19 February 2004, the law on medically assisted procreation, came into force, and the landscape in Italy changed.
Article 5 states that the techniques may be used by: couples of different sexes, married or cohabiting, of potentially fertile age, both living, but not same-sex couples or singles.
It is essential that consent to procreation be given in accordance with the conditions laid down in Article 6, whereby it is compulsory for both spouses or cohabitants to give their consent to fertilisation, and it is important, as a means of guaranteeing bigenitorial rights for the child, that this consent always remain current, so much so that it is not permitted, once fertilisation of the oocyte has begun, to revoke one's will.
The Constitutional Court has ruled that heterologous fertilisation may also be performed in hospital when a pathology has been diagnosed that is the cause of absolute sterility or infertility on the part of a member of the couple of different sex, certified by the doctor. Conversely, the law reiterates the prohibition of post-mortem insemination, i.e. the case in which one of the two components is no longer alive but a pregnancy is nevertheless desired, and the prohibition of surrogate motherhood, i.e. the case in which maternity is carried out by a third person for the couple.
The purpose of Law 40 of 19 February 2004 was to be able to give a chance to those with health problems in being able to have children, to be helped, 'assisted' by the national health system. Since the right to procreation was not recognised[1]

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[1] On this point see G. RECINTO, *Le istruzioni per il futuro delle Sezioni Unite in tema di genitorialità,* in *Famiglia e Diritto*, 2023, 5, 408. In a matter that "raises delicate ethical and moral problems"(), it is necessary to overcome that dangerous "adult-centric" drift, which too hastily is leading us towards the affirmation

but rather the right to reproductive health was protected, this law dealt with its boundaries and requirements in a very rigid manner. It postulates the idea of a traditional family, as provided for in the Civil Code, above all with the intention of pursuing the interests of the child.
Initially, and precisely because of this, the law contained more prohibitions than possibilities; in fact, homologous procreation was considered permissible in the public structure, and the alternative of heterologous procreation was not allowed, but with the intervention of the various courts, but above all with the interventions of the Constitutional Court, this limit was overcome.

2. Jurisprudential interventions

The main rulings were:
- the judgment of 8 May 2009, no. 15113, with which the Constitutional Court removed the ceiling of the - production of three embryos and the obligation of simultaneous implantation, which was found to be incompatible with the principle of physician autonomy and the principle of women's health.
-Journal No. 162 of 10 June 2014, in which the Court ruled on heterologous fertilisation, removing the ban on it, deemed "unlawful in that it violates the right to health: since sterility is a pathology, prohibiting its treatment becomes unconstitutional. But that's not all: the ban also violates the right to self-determination, because the choice to start a parental project is up to the parents themselves and not to the State'.
In this way, the 'evident element of irrationality' was remedied by the fact that, after having assigned to PMA the purpose of 'favouring the solution of reproductive problems arising from human sterility or infertility', the legislator had denied absolutely - with the censured ban on heterologous fertilisation - the possibility of realising the desire for parenthood precisely to 'couples affected by the most serious pathologies, in contrast with the ratio legis'.
This circumstance revealed that the balancing of interests was unreasonable, since,
on the other hand, the needs for the protection of the newborn appeared to be adequately satisfied by the rules in force, in relation both to the "psychological risk" related to the lack of a biological link with the parents (resulting from heterologous fertilisation), and to the possible "violation of the right to know one's genetic identity".
- Judgment No. 9615 of 5 June 2015, in which the Court ruled that the prohibition on carrying out pre-implantation diagnosis on embryos violates the parents' right to information on the embryo's health condition.
This eliminated the other 'blatant antinomy' already censured by the European Court of Human Rights in its judgment of 28 August 2012, Costa and Pavan v. Italy. Law No. 40 of 2004 prohibited the above-mentioned couples from resorting to PMA, with pre-implantation diagnosis, when in fact "our legal

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of a general and uncertain "right to parenthood", destined increasingly to make us "confuse" the "needs" of adults with those of minors.

system allows such couples to pursue the objective of procreating a child not affected by the specific hereditary pathology they carry by means of the undeniably more traumatic modality of the voluntary interruption (even repeated) of natural pregnancies [...] permitted by art. 6(1)(b) of Law No. 194 of 22 May 1978 (Rules for the social protection of maternity and voluntary termination of pregnancy)".
Since these pronouncements, both because of the strong changes produced and because of the change in the sensitivity of the population, the courts have been faced with further demands, concerning the right of access to medical practice. All this confusion has in fact fuelled the courts' pronouncements and the topics over the years have multiplied. If, in fact, initially the focus was only on whether or not heterosexual couples could have recourse to heterologous medically assisted procreation, the question has since expanded to encompass various topics: from access to the technique for same-sex couples, access to the technique after the death of a partner, access to the technique after separation/divorce from the husband, and access to the technique through surrogate motherhood. Let us cite a couple of cases in this respect.
The Constitutional Court's ruling No. 221 of 2019 was one of the first such pronouncements.
In fact, by order of 2 July 2018 (r. o. no. 129 of 2018) questions of constitutional legitimacy were raised by the Ordinary Court of Pordenone, with reference to Articles 2, 3, 31, second paragraph, 32, first paragraph, and 117, first paragraph, of the Constitution - the latter in relation to Articles 8 and 14 of the Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), signed in Rome on 4 November 1950, ratified and made enforceable by Law No 848 of 4 August 1955 - Articles 5 and 12, paragraphs 2, 9 and 10, of Law No 40 of 19 February 2004 (Rules on medically assisted procreation), in so far as they limit access to medically assisted procreation techniques (hereinafter: PMA) only to 'couples [...] of different sexes' and penalise, as a consequence, anyone who applies such techniques 'to couples [...] composed of persons of the same sex'. In fact, the applicants stated that they had been living together more uxorio since 2012 and had entered into a civil partnership in 2017; that over time they had developed a desire for parenthood, so much so that one of them had undertook a course of PMA in Spain, at the end of which she had given birth in Italy to twins; that the other applicant also intended to realise her desire for motherhood, without, however, travelling abroad, at rather high costs, since, in her view, Law No 40 of 2004 - after the judgments of the Constitutional Court No 162 of 2014 and Constitutional Court Rulings No. 162 of 2014 and No. 96 of 2015 and in the light of some important rulings of the jurisprudence of legitimacy - would have allowed same-sex couples to have access to PMA techniques also in Italy; that the applicants had therefore applied to the Azienda per l'assistenza sanitaria no. 5 'Western Friuli', at which a high quality PMA service had been set up; the head of the service had, however, rejected their request, on the ground that Article 5 of Law No 40 of 2004 reserves assisted fertilisation to couples composed of persons of different sexes only.

The Constitutional Court replied that, as had already been emphasised in Judgment No. 162 of 2014 of the Constitutional Court, Law No. 40 of 2004 constitutes the "first organic legislation relating to a delicate sector [...] which undoubtedly involves a plurality of relevant constitutional interests". The relevant questions of constitutionality touch on ethically sensitive issues, in relation to which the identification of a reasonable balance between the opposing needs belongs primarily to the assessment of the legislature.

The case at hand would not, however, concern a hypothesis of "social parenthood", through which a child could be protected, even in the context of same-sex couples, but only the right of an adult to procreate: a right that would not be absolutely guaranteed by the legal system.

The solutions adopted in this regard by Law No 40 of 2004 are, as is well known, restrictive. The 'physiological' infertility of the homosexual (female) couple is in no way homologous to the infertility (of an absolute and irreversible kind) of the heterosexual couple suffering from reproductive pathologies: just as the 'physiological' infertility of the single woman and the heterosexual couple in old age is not. These are clearly and ontologically distinct phenomena. The exclusion from PMA of couples formed by two women is not, therefore, a source of any distortion or even discrimination based on sexual orientation.

The European Court of Human Rights has also specifically expressed this view. It has held, in fact, that a national law reserving artificial insemination to infertile heterosexual couples, attributing to it a therapeutic purpose, cannot be considered a source of unjustified unequal treatment in relation to homosexual couples, relevant for the purposes of Articles 8 and 14 ECHR: this, precisely because the situation of the latter is not comparable to that of the former (European Court of Human Rights, judgment of 15 March 2012, Gas and Dubois v. France).

A pronouncement that has acted as a watershed for many others.

In fact, over the years, requests for access to the assisted procreation technique have also spilled over onto the issue of access to postmortem assisted procreation.

Postmortem procreation, like surrogate procreation, is not contemplated by our legal system and Law 40 of 2004 absolutely prohibits its use.

Those who make use of it contrary to the law are punished, because the ratio legis of the requirement that the members of the couple accessing PMA techniques must be alive seems obvious. The legislator intended to design the subjective requirements for access to PMA techniques in such a way as to ensure that the family unit resulting from the use of these techniques reproduces the constitutional model of the traditional family, characterised by the presence of a double parental figure, a father and a mother. In other words, the aim is to guarantee the child's right to bigenitoriality, preventing the child from being conceived fatherless.

It must now be pointed out that when it comes to post-mortem procreation, there are three scenarios: artificial insemination of the woman with semen taken from the corpse of her spouse or cohabitee; artificial insemination of the woman

with semen taken from her spouse or cohabitee before her death as part of an AMP procedure; intrauterine implantation of the cryopreserved embryo from the couple, formed before the death of the spouse or cohabitee.
The first two hypotheses pertain more properly to cases of post-mortem 'fertilisation', the fertilisation of the ovum occurring after the death of the partner; the third hypothesis pertains to a case of post-mortem 'implantation', being the intrauterine implantation of the embryo formed while both would-be parents were alive and only transferred into the woman's uterus after the death of the partner.
In spite of the silence of the legislature, it seems to be a consolidated opinion that, in the event that the death of the partner occurs after fertilisation and, therefore, after the formation of the embryo, the woman may legitimately request the PMA centre to proceed with the intrauterine implantation of the cryopreserved embryo, formed during the PMA procedure she underwent together with her then deceased partner.
Jurisprudence dealt with it for the first time in 1999 with reference to a case pending before the Court of Palermo. A widow had lodged an appeal against the PMA centre to which she had applied together with her then deceased husband in order for the centre to be ordered to transfer intrauterine embryos cryopreserved there and formed during the PMA procedure to which the couple had had access before the man's death.
The Court of Palermo upheld the widow's appeal, having considered preeminent, in the event of the death of one of the parents, the embryo's right to life over the unborn child's right, guaranteed by article 30 of the Italian Constitution, to be maintained, educated and brought up in a family formed by two parents.
Similarly, the Court of Lecce dealt with this issue by order of 24 June 2019[2]
The Court of Lecce, accepting the applicant's request, ordered the PMA medical centre to perform the intrauterine transfer of the cryopreserved embryos coming from the applicant herself and her deceased husband, considering that the requirements of the permanence of the consent to the techniques and of the subsistence in life of the members of the couple accessing the same as set out in Articles 5 and 6, Law no. 40 of 2004 must exist at the time of fertilisation and not beyond.
No less interesting is the request for access to medically assisted procreation when the couple is now declared separated or divorced. **This is the case of the Court of Capua Vetere**.
The delicate human affair that constituted the premise of the decision took its origins from the story of a couple, by then in the process of separation on the date on which the two decisions were rendered, who had decided to have recourse to the medically assisted procreation technique, and more precisely to

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[2] On the same level see. Cass. civ. Sec. I Sent., 15/05/2019, no. 13000; Court of Oristano 20 May 2022, Court of Bologna 16 January 2015. E. BILOTTI, *La fecondazione artificiale post mortem nella sentenza della 1^ sezione civile della Cassazione n. 13000/2019*, in www.centrostudilivatino.it; R. NATOLI, *L'impianto di embrioni post mortem tra scontri ideologici e prezzi da pagare (a proposito di un'ordinanza palermitana),* in *Dir. fam. pers*., 1999, 1180 ss.

homologous in vitro fertilisation, with cryopreservation of the fertilised embryo and subsequent implantation in the mother's uterus.
In 2018, the couple had gone down the road of separation, but had subsequently reconciled. As a result of their reconciliation, the couple had decided, by mutual agreement, to undergo reproductive procedures at a hospital in Rome.
In particular, precisely in accordance with the provisions of Law 40/2004, both the husband and wife had given informed and conscious consent so that homologous in vitro fertilisation could take place, and also so that it could be carried out.
In particular, on 18 February 2019, the husband's sperm were retrieved and the ovum with the wife's follicles was retrieved from the ovary, after which, on the basis of the consent already validly given by both spouses at the beginning of the treatment and never revoked in the meantime, the ova were fertilised but could not be immediately implanted in the mother's uterus. The impossibility of implanting the fertilised oocyte immediately after fertilisation had been determined by the worsening health condition of the woman, who had had to be urgently hospitalised for internal haemorrhaging resulting from ovarian hyperstimulation. The embryos had therefore been cryopreserved with a view to subsequent implantation as soon as the wife's health improved
In September 2019, the husband served an action for separation on his wife, who had not yet fully recovered, and also informed her, as well as the medical centre, of his unwillingness to allow her to have the fertilised ova implanted in the uterus, revoking the consent he had initially given.
The wife, who was, moreover, already at an advanced age for pregnancy (43 years old), and in view of the existence of the periculum in mora and fumus boni iuris, filed an appeal pursuant to Article 700 of the Code of Civil Procedure with the Court of Santa Maria Capua Vetere in order to obtain a ruling authorising, as a precautionary measure, the continuation of the treatment, ordering the medical centre to proceed with the implantation of the fertilised oocytes into the uterus, even in the face of her husband's dissent.
Both the monocratic judge and the Court of Santa Maria Capua Vetere, acting as a collegial body, rejected the defendant's defence arguments, stating, precisely on the basis of the literal wording of the above-mentioned provision, that the consent given by the husband and wife, prior to fertilisation, is irrevocable once fertilisation has actually taken place, and thus allowing, on the basis of the wife's request, the implantation of the oocytes in the uterus for the continuation of the pregnancy. Not only that: both decisions, in affirming the irrevocability of consent given pursuant to Article 6, paragraph 3 of Law 40/2004, read this provision in conjunction with Articles 8 and 9 of the same law, with the result that the defendant, although dissenting, could not revoke his consent once fertilisation had taken place, and would therefore be required to assume the rights and duties connected with paternity as a result of consent validly given before fertilisation.[3]

[3] G. O. CESARO, *Medically assisted procreation: irrevocable consent. The orders of Tribunale di S.M. Capua Vetere*, in Quotidiano Leggi d'Italia, 09.03.2021. In the opposite sense Court of Bologna, 9 May 2000. Same

A heterogeneity of cases that, precisely in analysing the issues in relation to the possibility now of resorting to the technique now of recognising the child that is the fruit of the technique that is not authorised in our country, has led to an excess in the production of jurisprudential pronouncements, of doctrinal essays that in some way, either out of a desire to enrich the panorama of family law or out of a desire to justify a procreative right, or to change the structure of a system centred on the family as traditionally understood, have enriched the legal landscape around medically assisted procreation with profound reflections and important questions, perhaps even at times discordant and perhaps even harbingers of correct indications.

3. Access to medically assisted procreation: possible solutions

The main question is certainly therefore that relating to the right of access to medically assisted procreation, which we have seen is much debated in the jurisprudential panorama.

We know that in Italy access to medically assisted procreation techniques is allowed, according to the provisions of the law, only to infertile or infertile couples with members who are of age, of different sexes and married or cohabiting at a potentially fertile age. This, of course, as we have seen, has caused quite a few problems.

On the other hand, looking at other countries, one cannot fail to grasp the diversity of views and the desire to broaden this possibility, dictated above all by the change in society that is seeing the age for having children postponed,

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dynamics, a couple, homologous procreation and separation. It states that fertilised but not implanted and cryopreserved ova are, from a biological and legal point of view, very different entities from embryos already placed in the maternal uterus and that the embryos themselves, however viable they may be, do not enjoy the same legal protection and do not have the same legal prerogatives as a person born alive and considering also that the right to procreate or not to procreate is constitutionally guaranteed, especially where there is no pregnancy in progress, it would be in stark contrast with the right not to procreate also recognised to the male parent, to grant the woman alone the right to decide whether to proceed with the implantation of the embryos in utero.

For this reason, according to the Court of Bologna, the woman's right to request the implantation does not exist, given that such an implantation contrasts with the right to an unimposed paternity of the male parent and with the right of the unborn child to benefit and enjoy the dual parental figure, to be instructed, educated and maintained by both parents, within the context of a couple, for the guarantee of a balanced and harmonious psycho-physical development. The distinction made in the judgment between an implanted or non-implanted embryo is important because the conceived, for the writer, and also according to our civil code, which does not take into account I consider pma but natural motherhood is surely such when it takes place in the mother's womb and it is precisely for this reason that the law on abortion has placed the woman at the centre because it is the woman who, with her body, carries the pregnancy forward and therefore, the possible abortion, it is the woman and only she who can define it.

In this case we are at an antecedent moment, we are at the end of the technique and not of procreation. We are in a moment that we might call prodromal and which sees in the first place, this time, both figures with their constitutionally guaranteed right to procreate or not to procreate.

To override, as this judgment has done, this right in the light of the interest of a child who does not yet live, is perhaps excessive.

The indication could certainly, and in order to align with the provisions of the Civil Code, provide for extending the withdrawal of consent up to the moment of implantation because it is only from that moment that a strong bond is actually created between the woman and the embryo: life is created.

more and more, beyond the age of 35, and the difficulty of finding the right partner to make this possible.
France, for example, unlike Italy, with its Projet de loi 2187/19, in Articles 1 and 4, allows single women and same-sex couples the right to have recourse to in vitro fertilisation in the same way as heterosexual couples: Indeed, the slogan is 'PMA pour toutes'.
"L'article 1er élargit l'accès à l'assistance médicale à la procréation aux couples de femmes et aux femmes non mariées. Le critère médical d'infertilité, qui aujourd'hui conditionne cet accès est supprimé. La prise en charge par l'assurance maladie reste identique et est étendue aux nouveaux publics éligibles. L'article supprime également la notion imprécise d'âge de procréer qui figure dans la loi au profit d'une interprétation incontestable de ce critère. Il permet enfin le recours à un double don de gamètes au cours d'une même tentative d'assistance médicale à la procréation.
L'article 2 met fin à la possibilité de conserver des gamètes pour soi-même au moment du don, dispositif qui pouvait être vu comme créant une contrepartie au don et ouvre la possibilité d'une autoconservation de gamètes pour les femmes comme pour les hommes. To avoid any incentive effect, the reform is enshrined in strict implementation conditions (age limits are laid down, activity is reserved for public and private non-profit centres). L'article prévoit la prise en charge des actes afférents au recueil ou au prélèvement de gamètes mais non de la conservation qui reste à la charge des bénéficiaires. Par ailleurs, l'article met fin au recueil du consentement du conjoint lors d'un don de gamètes."
It opens up access to the technique but, above all, it also authorises the possibility of preserving one's gametes, in line with the progress of society, which not only in France but also in Italy feels the need to be able to preserve its biological material with a view to a future pregnancy. In Italy, the problem of cost remains. It is in fact very expensive and the State, except in the case of serious illness, does not finance this possibility.
Like France, Spain has similarly authorised single women and transgender persons to have access to medically assisted procreation, but in both cases the state bears the costs. The trend seems to be towards a shift from a medical infertility right to a social infertility right.
In America the legislation is undefined. There is no law but there are different regulations, depending on the aspect of the assisted reproduction technique that is used.
US constitutional jurisprudence on reproductive technologies is surprisingly scarce. The result is considerable uncertainty as to which forms of regulation of reproductive technology may violate the US Constitution.
Foreign scholarship writes that: The United States has been too often described as the 'wild west' of reproductive technology use. When measured against many of its comparators-Canada, Australia, the UK, Germany, etc.-it is undoubtedly true that more forms of reproductive technology use are permitted in the United States than elsewhere. It is for this reason that the United States has been a frequent destination for "circumvention tourism" or "fertility tourism". At the

same time, it would be wrong to think that reproductive medicine is unregulated in the United States. The chapter argues that it is just that the regulation is more fragmented, both in terms of the locus of control (federal vs. state authority, governmental vs. professional self-regulation, etc.) and also of the legal sources involved (more of a focus on tort law and family law than direct regulation at the statutory or constitutional level)[4].
Certainly, however, unlike countries such as Italy, in America there are fewer limits and the concept of access to the technique is left to the autonomy of individuals.
In America, in particular, and returning to the concept of procreative right, there is not just the recognition of a right but of rights: the right to be a gestational mother, the right to be a biological mother and the right to be a social mother.
Also undefined is the objective requirement of the condition of infertility, which is mentioned but since there is no governmental law on the subject, the whole thing remains vague.
One striking aspect, however, is that in America, the state par excellence for the use of the insurance system, there seems to be very little use of policies to cover the costs of medically assisted procreation techniques.
In fact, it seems that there are not many companies that provide coverage for medically assisted procreation in their insurance policies.
There are few states that offer some form of fertility treatment financed by insurance, but above all the panorama of what can be accessed by insured persons is varied: in some cases the costs of the technique are covered, in others a cycle is only covered when the couple has tried to conceive for a minimum period of five years, in others the treatment is only covered if other services have proved ineffective, and finally there are cases where cycles are covered but not gamete preservation[5].
In Italy, as in America, there are not many policies that cover the risk linked to reproductive capacity, perhaps also because the risk itself is not so well known, there is no right to information that also covers a woman's fertility, its timing, but above all the possible problems associated with advancing age.
In researching insurances in this sense, I found few examples where either only the treatment related to diagnosis and examinations are reimbursed, only in a few cases the service as a whole, and in any case for an amount just over one thousand euros and limited in time to about three times during the woman's entire fertile life cycle.
From the insurance point of view, it is necessary to make additions, and it certainly did not help that the medical service was not guaranteed in all regions, so that the costs also varied, if not inexistent, as did the treatment options.
Only recently did the LEAs come out at the national level that introduce the new tariffs on medically assisted procreation, gene counselling up to services of very high technological content such as Hadrontherapy or recent technology

[4] I. GLENN COHEN, *The Right(s) to Procreate and Assisted Reproductive Technologies in the United States*, The Oxford Handbook of Comparative Health Law, 8 June 2020.
[5] For a more detailed discussion see Fertility Clinic abroad, in www.fertilityclinicabroad.com.

such as enteroscopy with an ingestible microcamera and stereotactic radiotherapy. In particular, the LEA clearly identifies all the services of medically assisted procreation (PMA) that will be provided at the expense of the SSN in outpatient specialist care (until now only provided in inpatient care); it introduces genetic counselling, which makes it possible to explain to the patient the importance and significance of the test when it is performed, the implications of the result when the report is delivered, and, if necessary, to provide the patient with the support needed to cope with often emotionally difficult situations; it introduces new services with a very high technological content, profoundly revises the list of genetic services, and, for each individual service.

In the face of all these legal and social changes, but above all in the face of data that show us a sharp increase in medically assisted procreation techniques, the solutions may therefore be to revise:

- integrative healthcare. State measures that succeed in widening access to the technique by favouring an economic benefit for those who resort to it.
- More comprehensive insurance solutions that do not, however, place absolute time limits or amounts too far removed from the cost of these techniques.