Cross-border reproductive care: an Ethics Committee opinion

Ethics Committee of the American Society for Reproductive Medicine

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Cross-border reproductive care (CBRC) is a growing worldwide phenomenon, raising questions about why assisted reproductive technology (ART) patients travel abroad, what harms and benefits may result, and what duties health-care providers may have in advising and treating patients who travel for reproductive services. Cross-border care offers benefits and poses harms to ART stakeholders, including patients, offspring, providers, gamete donors, gestational carriers, and local populations in destination countries. This document replaces the previous document of the same name, last published in 2013 (Fertil Steril 2013;100:645–50). (Fertil Steril® 2016;■:■–■. ©2016 by American Society for Reproductive Medicine.)

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KEY POINTS

- Cross-border reproductive care (CBRC) refers to the activity surrounding patients who travel outside their country of domicile to seek assisted reproductive services and treatment. CBRC affects both the departure and destination countries from and to which patients travel.
- CBRC is a growing worldwide phenomenon, raising questions about why assisted reproductive technology (ART) patients travel to another country, what benefits and harms may result, and what duties physicians may have in advising and treating these patients.
- The main reasons cited by patients for CBRC are a desire to access broader and higher quality care, a need to reduce the cost of care, an effort to circumvent legal restrictions in a departure country, and a desire for privacy or cultural comfort in a destination country.
- Cross-border care offers benefits and poses potential harms to ART stakeholders, including patients, offspring, providers, gamete donors, gestational carriers, and local populations in destination countries.
- Physicians in departure countries have no independent duty to inform patients about opportunities for CBRC but must not misinform patients when responding to questions about ART options abroad.
- Physicians in destination countries have a duty to uphold local standards of care, legal requirements, and informed consent but have no duty to learn about or disclose the legal, practical, and other nonmedical barriers a patient might face in accessing CBRC.
- Patients considering CBRC should seek out advice from qualified legal experts who can provide guidance on legal aspects of such activity, both in the destination country and upon their return to the departure country.
- Referral to other qualified experts, including mental health professionals, should be considered and is encouraged when appropriate.

Infertility knows no political boundaries, but prevailing policies, costs, and laws within an individual's country of domicile can hamper access to treatment. These formal and informal country-based restrictions on access to ART do little to temper their citizens' desire for biologic parenthood. Increasingly, prospective parents from around the globe who face reduced access to fertility care at home are traveling across national borders to seek ART treatment. This practice, commonly referred to as CBRC, has significant implications for stakeholders in both departure and destination countries. What follows is a discussion of the incidence and reasons for CBRC, its potential benefits and harms, and the ethical considerations that arise in treating or advising patients who leave home to access assisted reproductive care.

THE INCIDENCE OF CBRC

Comprehensive data on the worldwide incidence of CBRC are emerging as researchers, professional organizations, and patient groups delve into the question of who travels to access reproductive care and why. In a 2010 survey of CBRC in Europe, researchers counted

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24,000–30,000 cycles of cross-border treatment annually, involving 11,000–14,000 patients (1, 2). Based on a total of 525,640 treatment cycles during the same period, this means that approximately 5% of all European fertility care involves cross-border travel (3).

Survey data from the United States indicate that 4% of all fertility treatment provided in the country, or approximately 6,000 cycles, is delivered to non-US domiciliaries (2, 4). The largest groups of incoming patients are from Latin America (39%) and Europe (25%). The incidence of US patients traveling abroad for care is estimated to be far lower than the rate of patients coming into the United States (2, 5).

Researchers caution that the volume of CBRC activity is difficult to estimate accurately given the lack of a robust international reporting system (6). Logically, it is easier to collect data in destination countries and regions that maintain ART databases in which a patient's country of origin is included as a variable. Identifying those who leave home to access care requires either high patient response rates to posted surveys or elaborate tracing through multiple foreign ART databases. To date, a precise accounting of global ART travel remains a goal rather than a reality.

THE REASONS FOR CBRC

The factors that motivate patients to travel abroad for fertility care are varied, complex, and often interrelated. The reasons for CBRC fall into four basic categories: 1) access; 2) cost; 3) regulation; and 4) privacy. Each is described briefly below.

Travel to Access Broader and Higher Quality Care

A patient's ability to access fertility care in his or her country of domicile depends upon the supply of ART services, the quality of care offered, the array of treatment options available, and the wait time associated with obtaining care. Survey data suggest that each of these factors plays a role in motivating cross-border fertility travel, particularly in the Middle East, Southeast Asia, and Latin America where ART clinics are sparse (6).

Travel is also more prevalent from departure countries where the supply of donor gametes and gestational services is low (compared with demand), owing primarily to regulatory, compensatory, and/or anonymity policies. Countries that restrict payments to gamete donors and gestational carriers see the majority of their fertility travelers leaving to access these services across borders (5, 7). National policies that require disclosure of donor identity also impact the availability of donor gametes, and hence factor into fertility travel. Patients in Sweden, the United Kingdom, and Norway, for example, report the desire for access to anonymous gamete donors as a factor in their decision to seek care abroad (1, 8). In Canada, 80% of women who travel for ART do so in search of anonymous donor eggs (5).

Patients' desire to access higher quality care also figures prominently in CBRC. A majority of patients who travel abroad for care have received treatment in their home country, often for several years. Treatment failures, along with a perception that clinics abroad employ more highly trained personnel, utilize more up-to-date equipment, and offer more specialized services, incentivize experienced ART patients to seek treatment abroad (7–9). Finally, patients travel to avoid long wait times—a reality in countries that include infertility care as part of their national health service (9, 10).

Travel to Reduce the Cost of Fertility Care

The high cost of ART is a well-described barrier to its use. Because fertility treatment can be prohibitively expensive, it is utilized by only a fraction of those in need of care (11). Even patients who can afford care often incur financial hardship in their quest for parenthood (12). Global price variations are published, with the average price of an in vitro fertilization (IVF) cycle highest in the United States (13) and significantly lower in countries such as India (14, 15). The fiscal impact of ART on patients varies across the globe; patients in countries that fund care as part of a national health service are impacted the least while those in non-reimbursement countries are impacted the most, sometimes incurring lasting financial harm (11, 16).

Disparities in the fees paid to gamete donors and gestational carriers also incentivize travel. Media reports indicate that India has been a popular destination country for accessing gestational surrogacy services due to significantly lower compensation amounts (17). Fees to oocyte donors also vary considerably from country to country (1). Surveys of patients who travel to access third-party reproductive services indicate that cost is a significant factor in their decision to leave home (1, 2).

Travel to Circumvent ART Law

Legal regulation of ART worldwide occurs on a country-by-country basis, with no overarching international treaties or formal laws in place. Logically and empirically, jurisdictions with restrictive laws are more likely to serve as departure countries, while nations with few or no legal restrictions are patronized as destination countries. The act of seeking fertility care outside of one's country of residence to avoid application of prevailing law is sometimes referred to as "circumvention tourism" (18, 19).

ART regulation that motivates CBRC falls into two broad categories: 1) restrictions on who can access fertility care and 2) restrictions on what fertility care can be accessed. Laws addressing "who" typically restrict access based on patient demographics. Restrictions on patient age, marital status, and sexual orientation are embedded in law in some countries, sending older, single, and gay and lesbian patients across national borders. By contrast, in some US states, strict nondiscrimination laws prohibit ART clinics from denying care on the basis of a host of demographic factors, including race, ethnicity, disability, and marital status, sexual orientation, and gender identity (20, 21).

Legal restrictions on "what" services can be offered do little to quash patient desire for these services. Prohibitions on ART services, including preimplantation genetic diagnosis (PGD), sex selection, compensated gamete donation, and