Motivations and experiences of patients seeking cross-border reproductive care: the Australian and New Zealand context

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Objective: To explore the motivations, clinical care, counseling, and support experiences of Australian and New Zealand participants considering or having participated in cross-border reproductive care (CBRC).
Design: Questionnaire-based study.
Setting: Not applicable.
Patient(s): One hundred thirty-seven Australian and New Zealand participants aged 23–53 years.
Intervention(s): None.
Main Outcome Measures(s): Quantitative and qualitative responses to an anonymously completed online questionnaire.
Result(s): Quantitative responses from participants indicated that motivations for engaging in CBRC included limited availability of gamete donors in their home state, difficulty in meeting treatment eligibility criteria, and treatment being legally prohibited. Experiences of CBRC were generally rated positively in terms of medical needs (91.2%), safety (89.4%), and costs (85.7%), although rated more conservatively to emotional needs being met (57.9%). Less than half the sample (47.5%) had accessed some form of CBRC-related counseling. Themes identified in qualitative analysis reflected gamete supply and demand issues, the importance of donor information and disclosure, the personal impact of legislation, and ongoing support needs after CBRC treatment.
Conclusion(s): A greater percentage of participants agreed that their CBRC clinic satisfied their overall medical needs and treatment expectations in comparison with overall emotional needs. Participants indicated access to post-treatment support counseling particularly with regard to their emotional well-being and disclosure issues to donor-conceived children would be useful. The implications of our findings for the provision of best-practice psychosocial counseling support and development of counseling guidelines are highlighted. (Fertil Steril® 2014;102: 1422–31. ©2014 by American Society for Reproductive Medicine.)
Key Words: Cross-border reproductive care, motivations, infertility counseling, donor conception, legislation

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During the past few years increased attention has been paid to cross-border reproductive care (CBRC), an escalating global trend in reproductive medicine whereby infertile patients or collaborators (e.g., egg donors or potential surrogates) cross state and international borders for the purposes of accessing or facilitating reproductive treatment beyond their local medical treatment provider (1, 2). This fertility treatment phenomenon, colloquially known as reproductive tourism, has been explored in the context of European, English, North American, Canadian, Middle Eastern, and Asian cohorts (3–13). At present, the Australian and New Zealand perspective to CBRC remains unexplored.

Research outcomes on varied perspectives to and controversies surrounding CBRC have been reported. Studies exploring patient motivations (4, 11), legal issues (14, 15), ethical

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aspects (16, 17), economic impact (18), religious constraints (13), quality and safety issues (2, 19), and counseling (20, 21), highlight mounting interest in this phenomenon. Of these areas, motivations for CBRC are of particular psychosocial relevance as these promote the impetus to CBRC activity, which may have a profound long-term impact for those involved in the process.

Motivations that influence decision making about CBRC are multifactorial, vary between jurisdictions, and are likely to be contingent on regional factors such as legislation, affordability, and availability of services. Shenfield et al. (11) report that engaging in CBRC for the purpose of law evasion (i.e., the assisted reproductive technique [ART] is either forbidden per se or when a particular group is excluded from treatment due to social characteristics) is a principal motivating factor for CBRC. Furthermore, Culley et al. (4) in their qualitative study of 51 patients from the United Kingdom engaging in CBRC reported that 71% of patients cited a desire for timely and cost-effective treatment with need for donor gametes as being the primary drivers for CBRC. Additional reasons given by participants included more successful treatment outcomes, treatment in a less stressful environment, and dissatisfaction with their local United Kingdom medical system, highlighting the similarity of a report by Inhorn et al. (9), of quite diverse reasons for participating in CBRC.

Unlike many European and American countries that engage in CBRC, Australia has a medical system where health care economic policies subsidize a proportion of medical services associated with fertility care, enabling consumer affordability and utilization of assisted reproductive treatments (22). In New Zealand, patients who meet specific criteria, such as severe or prolonged unexplained infertility, appropriate body mass index (BMI), and the woman's age being less than 40 years, may be eligible for up to two cycles of publicly funded treatment (23). Consequently unlike other international jurisdictions whereby fertility services are either entirely self-funded or financed through private health insurance, in Australia and (for a certain sector of those seeking services) in New Zealand, economic burden is less likely to be an incentive to pursue CBRC. In the context of CBRC, however, the broader meaning of "costs" requires further exploration. For instance, the underestimated longitudinal emotional and social costs brought about through transnational genetic discontinuity are yet to be determined, although can be surmised from the perspectives reported by those individuals conceived from third party reproduction (24–26).

In Australia and New Zealand availability of donor gametes are limited and are insufficient to meet the needs of infertile single women or couples desiring treatment (27). Given the lengthy donor wait lists accompanied by the strong intrinsic drive to procreate, participants are likely to consider more readily available CBRC options. Storage of donor information (including paucity of donor information recorded) in the context of varying Australian and New Zealand legislative requirements may also drive CBRC. For example, in Western Australia, Victoria, and New Zealand, donor registration is obligatory and any donor-conceived child is able to access donor identifying information when reaching maturity. Such registers do not exist within other Australian states and some researchers have argued that sperm donors, in particular, have reduced in numbers due to the lack of anonymity afforded (28, 29). Alternatively, patients may elect to travel overseas preferring the privacy attained by use of anonymous donors, rather than in reaction to donor availability or financial barriers. Whether pursuit of donor anonymity precipitates CBRC activity in Australia and New Zealand is undetermined.

In Australia and New Zealand, commercial surrogacy agreements are prohibited, surrogacy parentage arrangements are not legally binding, and eligibility criteria to surrogacy programs vary according to state laws with certain social groups prevented from accessing treatment (30–32). Strong opposition to surrogacy for commercial gain is such that laws in some jurisdictions preclude citizens from accessing extraterritorial commercial surrogacy treatment. For instance in the Australian states of New South Wales and Queensland, laws have been passed that criminalize those New South Wales or Queensland Australian citizens who undertake or facilitate extraterritorial commercial surrogacy arrangements (33, 34). Consequently, with the fear of potential prosecution, the decision to undergo commercial surrogacy is likely to proceed without the guided liaison and support of local fertility clinics, placing patients at potential medical, financial, and emotional risks and their child at legal risk, with respect to legal parentage and citizenship (35, 36).

Despite Australian and New Zealand legislation, individuals seeking overseas surrogacy arrangements do not appear to be deterred by laws (37, 38), with rapid advance of international surrogacy arrangements noted. Although no Australian and New Zealand published research data or statutory registry exists that captures the fuller extent of CBRC, anecdotal clinical experience of the authors suggests that limited availability of altruistic (not for financial gain) surrogates, social group ineligibility, and avoidance of legislated counseling requirements underlie the primary reasons for surrogacy-related CBRC. Law evasion has similarly been found with regard to gender selection technique for family balancing purposes. Despite the ban on the clinical practice of social gender selection by the National Medical Health Research Council (39) Bowman et al. (40) in their unpublished New South Wales study on 111 couples engaging in CBRC in Thailand, observed an increase in couples proceeding with gender selection for family balancing purposes. The researchers concluded that legislative proscription had limited bearing on decision-making for this form of offshore reproductive treatment. Interestingly, although gender selection techniques for social reasons are legally prohibited within Australian and New Zealand clinics, explicit criminalization laws for those consumers who partake in this form of extraterritorial treatment do not apply, highlighting legal discrepancies. Collectively these observations and those previously discussed in this article reveal limited donor gametes, treatment inequities, and legal nuances as market forces that may potentially initiate CBRC trajectories for Australian and New Zealand residents.

It is also well known that infertility per se and fertility treatments are stressful experiences and are associated with