Reproductive Tourism and the Regulatory Map

Debora Spar, Ph.D.

Consider the case of Sharon Saarinen. In 2002, the 38-year-old hairdresser traveled to Beirut in desperate pursuit of a baby. Four years earlier, she and her husband had had their first high-tech child, a daughter conceived through cytoplasmic transfer. In this process, fertility specialists remove a single egg from the mother-to-be and inject it with cytoplasm from the egg of another (usually younger) woman. The rejuvenated egg is inseminated with the father’s sperm and inserted into the mother’s uterus. The daughter that resulted in the Saarinens’ case was apparently perfectly normal. Yet like any child conceived through cytoplasmic transfer, she carried within her the genes of three people — the typical sets from her mother and father, plus mitochondrial DNA from the donated cytoplasm.

To the Saarinens, their child was a godsend. But the Food and Drug Administration was less sure. In 2001, worried about the long-term prospects of creating genetic hybrids, the agency asserted regulatory authority over cytoplasmic transfer, making even its U.S. inventors wary of continuing their work in the United States. So when Saarinen wanted to conceive again, she left the United States for Beirut, where her Lebanese-born doctor ran a fertility clinic. She underwent the procedure but did not conceive a child.

The Saarinens are hardly alone. Indeed, they are at the forefront of a quiet but burgeoning market in reproductive tourism, one that stretches around the globe and already encompasses thousands of people. These people are not ill in the usual sense, and they generally don’t view themselves as engaged in commercial activity. What binds them together are three shared characteristics: the desire for a child who is genetically “theirs,” the inability to produce this child through natural means, and a willingness to do whatever is necessary to produce one. And thus there are dozens of stories like Saarinen’s: Americans travel to Mexico for an immunologic treatment banned in the United States; Germans acquire donor eggs in Spain; Australian lesbians secure sperm abroad.

At a personal level, such stories are tragic and touching. They reveal a longing so intense that people will do anything to fulfill it. They speak as well to several decades of remarkable scientific progress — from artificial insemination to in vitro fertilization (IVF) and egg donation — that has enabled once-infertile couples to produce children. In the United States, roughly 40,000 babies are born each year as a result of assisted reproduction. Surely, this is a desirable outcome — a fine example of medical science enhancing life. At the same time, though, the explosive growth of high-tech reproduction has led to a lopsided market in baby making and to critical public policy questions: Do parents have the right to procure children by any available means? Should society treat reproductive medicine as a luxury good (like Botox) or a fundamental right (like emergency health care)? And who, most critically, gets to decide?

To understand these issues, we must understand the role governments play in regulating reproduction. Historically, reproduction has been largely a private affair — occurring out of view of any authority and beyond government’s reach. Yet time and again, governments have extended their power into the reproductive realm, determining, for example, the illegitimacy of certain births or the illegality of certain modes of birth control. Even in the United States, where privacy ostensibly reigns supreme, state governments have traditionally wielded authority over such intimate issues as marriage, contraception, and abortion. Meanwhile, state and federal governments have played a steadily expanding role in allocating and providing health care servic-
Reproductive medicine, therefore, attracts government in two different guises: as an arbiter of reproduction and as a regulator of health care. This two-pronged approach has subjected assisted reproduction to a patchwork of competing and conflicting regulations. Even at the most fundamental level, governments disagree about what constitutes “disease” in this field and what defines health. They disagree about the distinction between medical necessity and elective choice and about the permissible bounds of medical intervention. They also split distinctly in the ways in which they permit commerce to come into play and in terms of the portions of the reproductive process that they allow to be bartered, traded, or sold. Take, for example, IVF, a procedure that has produced more than a million babies since its debut in 1978. In Denmark, IVF is regarded as a medical necessity, a pro forma treatment for couples who cannot conceive otherwise. In the United States, by contrast, IVF is generally treated as a medical or personal choice; there are no limits on who can use the treatment, but payment is subject to a baffling array of state-specific insurance provisions. Some states require insurance companies to cover the costs of infertility treatment; some provide for voluntary coverage; and some say nothing at all.

When techniques are newer and less well proven, this patchwork of regulation is even more complex. The acceptability of egg “donation,” for instance, varies sharply across national boundaries. In the United Kingdom, eggs are regulated as a commodity: women may donate oocytes but may not sell them. The German government, by contrast, bans any transfer of eggs, while the U.S. government imposes no rules whatsoever, leaving individual states to preside over widely divergent regimes for selling eggs and disparate egg markets. The liveliest market prevails in California, where a series of court cases have established both the legality of egg transfer and the enforceability of surrogate-mother contracts. As a result, would-be parents who want to acquire eggs from one woman and implant them in another (an option for both severely infertile women and homosexual men) often travel to California in pursuit of a child. Indeed, one leading provider of these services estimates that one third of her firm’s business now comes from outside the country.

This “California syndrome” is hardly confined to that state or to the market for eggs. Instead, prospective parents are increasingly traveling all over the world, searching for particular fertility treatments and providers. Preimplantation genetic diagnosis (PGD), for example, is a sophisticated technique that enables doctors to detect — at the eight-cell stage — whether an embryo is carrying a specific genetic mutation. Parents who suspect that their children are at risk for diseases such as Tay–Sachs or cystic fibrosis now regularly travel to Detroit or Chicago, where leading practitioners of PGD can perform the analyses they need. Other clinics — in Brazil, Spain, and Italy — offer similar types of early-stage analysis, even in controversial cases in

Sex Selection by Means of Preimplantation Genetic Diagnosis.
which the parents are seeking to produce a second child in hopes of saving a first who already has an otherwise fatal disease. A growing number of clinics are also using PGD to allow preselection of a baby’s sex (see diagram). Because such sex selection is illegal in some locales, the clinics are flocking to more permissive spots (Saudi Arabia, for example, and the United States) — followed by a growing legion of international customers.

One might argue that this market for reproductive services is not so remarkable. We trade all kinds of services internationally — why not babies, or the components thereof? One might also argue that the current regulatory patchwork makes political and commercial sense: if Germany wants to ban egg transfer, it should. And if German couples want to avoid this regulation, they should procure their eggs abroad. The problem with this approach, however, is that it turns assisted reproduction into a for-profit business, a lucrative marketplace in which rich couples scour the world in pursuit of high-tech offspring, while poorer would-be parents are consigned to fate. A cross-border market for reproduction also means that societies that oppose assisted reproduction may nevertheless pay its costs. For who can prove that premature quintuplets born in Bremen were conceived in Istanbul?

Currently, there is no easy way of addressing this international imbalance. But as the market for reproductive medicine expands, policymakers in the United States will have to grapple with issues that they have thus far avoided, crafting policies to deal with the burgeoning business of reproductive tourism.

In theory, the ideal policy might be to follow the United Kingdom’s example, establishing a central regulatory agency for the reproductive field. In the United Kingdom, the Human Fertilisation and Embryology Authority licenses fertility clinics and approves procedures for assisted reproduction; it considers controversial techniques on an individual basis and oversees a system in which infertile couples are eligible for one free cycle of IVF. In the United States, however, such a system is politically unfeasible. Americans, with their distrust of bureaucratic authority, would never condone the extension of federal power into the intimate affairs of reproduction. In the current political climate, moreover, any federal foray into this area would probably fall prey to the politics of abortion, squeezing science in the process and limiting options for fertility treatment.

A second approach would be to embrace the laissez-faire policies now in place, leaving U.S. fertility specialists to venture along the technological edge and allowing reproductive tourism to flourish. The implications of such an open market, however, are harsh. Many Americans would not be able to afford reproductive treatments, and society would have no opportunity to debate the broader effects of high-tech reproduction. Do we really want to create children with three sets of DNA or children genetically altered for particular physical characteristics? As science continues to expand our menu of reproductive options, it will be increasingly important to engage in some kind of political debate and to ensure that some consideration stretches beyond the desires of individual parents.

Which leaves us with a final option — a messy one, but one that offers the best chance for bringing public policy and order into the realm of assisted reproduction. This path would involve a combination of minimal federal guidelines and increased oversight by individual states. It would mean encouraging the federal government to periodically release guidelines for assisted reproduction, outlawing procedures that Americans deem abhorrent (reproductive cloning, for example, or human–nonhuman chimeras) and imposing the kind of safety standards that prevail in other areas of medicine. Presumably, some of these regulations could subsequently be agreed upon at the international level, curtailing the most egregious prospects for reproductive tourism. Meanwhile, state legislatures would more actively review the fertility procedures practiced in their states. Rather than leaving these decisions to the courts or the vagaries of the open market, they would tackle the complex process of making public policy — determining, for example, whether sex selection is acceptable, whether insurance companies should cover IVF as a medical necessity, and when procedures for assisted reproduction go too far. If states were to make the “wrong” decision, the combined weight of local lobbying and intrastate competition would most likely force a reversal before too long.

A state-based model would not eliminate reproductive tourism. In fact, it could well expand it, increasing the variation even among neighboring states. But it would also bring such tourism into the open, subjecting novel procedures such as cytoplasmic transfer to the scrutiny of public debate. In the process, it might well create a safer and more certain market for reproductive medicine — one that would force fewer women like Sharon Saarinen to test their luck abroad.