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Cross-border reproductive care in the USA: Who comes, why do they come, what do they purchase?

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Abstract This article explores the participation of non-US-resident patients/clients in the US reproductive market, garnering a picture of cross-border reproductive care (CBRC) into the USA by drawing on the existing literature, identifying the frequency of and motivations for such arrangements, the primary sending countries, and the reproductive services sought. I find that although the expense of US CBRC necessarily limits the patient/client pool, it is largely non-economic factors that drive CBRC into the USA. The US CBRC patient/client base, which is diverse in terms of national origin, race and sexual orientation, is recruited by the US fertility industry and drawn to the full range of assisted reproductive technology (ART) services, such as in-vitro fertilization, surrogacy, oocyte donation and preimplantation genetic screening/preimplantation genetic diagnosis, available in the US market which are often restricted or limited in their countries of origin. CBRC patients/clients enjoy the legal clarity for establishing parentage and citizenship for their children available in the USA, as well as what some view as a medically and ethically superior ART market. 

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Introduction

Cross-border reproductive care (CBRC) is a growing phenomenon in which national boundaries are traversed as people seek reproductive treatment (Inhorn and Gurtin, 2011). Often, it is CBRC patients/clients¹ themselves – those seeking particular healthcare services, such as in-vitro fertilization (IVF), gamete donation, surrogacy or preimplantation genetic screening/preimplantation genetic diagnosis (PGS/PGD) – who cross borders. CBRC [also called ‘reproductive travel’ (Inhorn, 2015), ‘reproductive tourism’ (Martin, 2015; Speier, 2016), ‘transnational reproduction’ (Whittaker, 2009), ‘reproductive trafficking’ (Franklin, 2012) and ‘reproductive exile’ (Inhorn and Patrizio, 2009)]² is increasingly characterized, however, by a diverse flow of actors including patients/clients, doctors, facilitators and workers (gamete donors and surrogates), and reproductive matter (gametes and embryos), journeying across boundaries as new markets open and close, adjusting to new client bases and circumventing regulatory and legal restrictions (Whittaker, 2019).

CBRC is part of the growing globalization and commercialization of health care (Hudson et al., 2011). The global medical market is diverse, also characterized by the circulation of patients, technologies, ideas, biological matter and, importantly, capital. A good portion of ‘medical tourism’ today is elective and driven by the search for more affordable services; less-expensive cosmetic surgery and dentistry top the procedures that patients seek via cross-border health care (Centers for Disease Control and Prevention, 2016). On this global platform, medical care is stratified, with some patients pulled into various markets if they have the social and economic capital and the logistical means to access information, travel and services. This stratified market is particularly evident in CBRC, as access, cost and quality of reproductive care itself is stratified both within and between most national markets.

Similar to medical tourists seeking cheaper dental implants, the medical journeys of many repro-travellers are driven by the search for affordable care. This can be seen, for example, in North Americans who pursue IVF, egg donation and surrogacy in countries around the globe offering these services at considerable discount compared with clinics in the USA (Speier, 2016). The flow of CBRC, however, is not unidirectional towards affordability alone (Inhorn and Patrizio, 2009). As Gurtin and Inhorn (2011: 536) emphasize, ‘CBRC encapsulates a range of highly diverse trajectories, with different constituents, different origins and destinations, different desires and motivations, leading to different concerns and outcomes’. Some repro-travellers, for example, are searching not for cheaper services, but for services inaccessible to them in their home countries. This is the case for gay men desiring oocyte dona-

tion and surrogacy in France, which forbids surrogacy and ‘double donation’ (embryos created with both donated egg and sperm), has relatively few gamete donors, and restricted assisted reproductive technology (ART) services to heterosexual couples until 2019 (Roze Gomez and de La Rochebrochard, 2013: 3104; Shenfield et al., 2010). Economic drivers do not explain these forms of CBRC in the ways they do for most medical tourism (Martin, 2015).

Non-economic drivers to CBRC is especially true of CBRC into the USA, which not only has some of the highest healthcare costs globally but is embedded in a neoliberal commercial ART industry with ‘limited existing [insurance] coverage options’ compared with other national markets (Papanicolas et al., 2018; Seifer et al., 2018: 1082). While US reproductive patients/clients may travel abroad to locations such as Spain, Mexico or the Czech Republic for cheaper IVF or surrogacy services, given the high cost of US reproductive health care, it seems unlikely that repro-travellers into the USA cite low-cost health care as their primary motivator.

Given this, why do CBRC patients/clients come to the USA for reproductive care, especially when most reproductive services are more affordable elsewhere? What exactly are they purchasing? In this article, I examine the participation of non-US-resident patients/clients in the US reproductive market, garnering a picture of CBRC into the USA by drawing on the existing literature, identifying the frequency of such arrangements, the primary sending countries, and the reproductive services sought. I find that although the expense of CBRC in the USA necessarily limits the patient/client pool, it is largely non-economic factors that drive US CBRC, namely a neoliberal US market allowing for relatively quick and procedurally smooth access to controversial and complex ART services prohibited, restricted or seen to be unethically practised elsewhere.

The growing CBRC industry in the USA

The CBRC industry in the USA is growing, servicing patients/clients from nearly 150 countries (Hughes and DeJean, 2010; Levine et al., 2017). The most common source countries are those that border the USA: Levine et al. (2017: 817) found that Canada represented 23.9% and Mexico represented 14.2% of non-US-resident cycles, followed by the UK (10.2%), Japan (9.6%) and the People’s Republic of China (6.5%). The majority of these out-of-country patients/clients seek standard IVF (as do most US residents); however, foreign patients/clients are more likely than US residents to utilize complicated (and socially controversial) ART services, such as compensated oocyte donation, commercial surrogacy and PGS/PGD (Hughes and DeJean, 2010; Levine et al., 2017).

The desire to access services unavailable in home domiciles, to circumvent legal restrictions or bureaucratic hurdles, and to ‘speed up’ a lengthy process have been cited as the primary reasons why people seek CBRC (Ahuja, 2015; Crocchin, 2011; Gurtin and Inhorn, 2011). As others have noted, the political, social, legal and cultural context of the sending country shapes the particular services accessed by CBRC clients (Martin, 2015; Stuvoy, 2018). This helps to explain the finding of Levine et al. (2017) that ART

¹ I use the term ‘patient/client’ to acknowledge that not all people seeking reproductive services undergo medical procedures on their own bodies. Some, such as those seeking oocyte donation and surrogacy (such as gay men), require others to become patients, while they themselves are primarily positioned as clients of fertility clinics.

² For a discussion on the debates regarding various terminology, see the sources cited here.

services by non-US residents vary by country of origin. They found oocyte donation reported in more than 60% of ART cycles by patients from five countries (Japan, Australia, France, Israel, and New Zealand). This was considerably higher than egg donation used in 42.6% of all non-US resident cycles overall and in only 10.6% of all resident cycles. These figures resonate with the fact that compensated oocyte donation is either illegal, highly restricted or logistically complicated in those countries. This is certainly the case in France, where it is illegal to receive compensation for, and to purchase, eggs, resulting in a relatively small available supply (Shenfield et al., 2010).

Gestational surrogacy in the USA is also popular among CBRC clients into the country, especially among residents of countries in which surrogacy is unavailable to them; it was used in more than 40% of cycles from six countries (France, Germany, Spain, Israel, Sweden, and Norway). This compared with only 12.4 of all non-US-resident cycles and 1.6% of resident cycles. PGD/PGS was also much more popular with Chinese and Spanish CBRC patients/clients into the USA (30% of these patients) than it was with the 19.1% of all non-US-resident cycles and 5.3% of US resident cycles (Levine et al., 2017: 817–818). These findings point to the ways in which certain services may be attractive to CBRC patients/clients into the USA due to the particular legal restrictions against such services in their home countries, and the political and social climates which make access of those services in-country impossible or complicated. In France, for example, surrogacy is forbidden, and gamete donation is constrained due to compensation restrictions (Gross et al., 2018; Shenfield et al., 2010). This, coupled with the restriction of ART to heterosexual couples, helps to contextualize the uptake of paid oocyte donation and surrogacy among French CBRC clients into the USA (Rozee Gomez and de la Rochebrochard, 2013; Shenfield et al., 2010). In similar ways to French CBRC patients/clients, those non-US residents with the highest rates of ART cycles in US clinics come from countries in which various commercial ART services are not permitted or are limited (Levine et al., 2017: 819).

There are various reasons why desired services are inaccessible in home countries (thus propelling consumers to the USA). They may be outright 'prohibited or criminalized', they may be regulated to the point of essentially making them unavailable, or they may be 'restricted to certain populations, excluding people on the basis of age, infertility diagnosis, relationship status, and/or sexual orientation' (Martin, 2015: 52). This can be seen, for example, in France where gamete donation is not available to same-sex couples, who must travel out of the country for such services (Courduriès, 2018). For heterosexual couples in France, oocyte donation is available (and reimburseable) but has been challenging due to the long waiting lists resulting from a 'shortage of donors and the very small number of French ART centres practicing oocyte donation' (Rozee Gomez and de la Rochebrochard, 2013: 3108).

Variations in donor anonymity and compensation also facilitate CBRC. Martin (2015: 49–52) notes, for example, that when services are regulated to such an extent that they impinge on intended parents' and/or third parties' privacy or anonymity, fertility patients/clients may seek arrangements elsewhere. This can be seen when anonymous oocyte

donation is prohibited (in the UK, for example), but known donation is available (ESHRE, 2017). In such situations, Martin (2015) argues, the pool of egg donors tends to be smaller, propelling patients across borders. The same holds for surrogacy. As Smietana (2017: 2) found, British and Dutch gay men, who live in countries in which only altruistic surrogacy is available to them (but not compensated arrangements), sought surrogacy in the USA due to 'the prospects of lengthy yet often unsuccessful attempts at finding a surrogate on an altruistic basis allowed in their own countries'. This highlights the ways in which regulations put in place with the goal of protecting reproductive workers (restrictions against anonymity in oocyte donation and commercial surrogacy) actually encourage some ART patients/clients to seek care across national borders where those restrictions are not in place.

Legal clarity regarding citizenship and parental status are two additional important issues drawing repro-travellers to the USA (Martin, 2015). Compared with other repro-hubs, such as India and the Ukraine, König (2018: 283), for example, found that the USA was attractive to German intended parents, who live in a country in which surrogacy is banned, due to US birthright citizenship as their children born via surrogacy 'can enter Germany without any difficulty with [their] US passport[s]'. For these CBRC patients, travel was eased (and therefore the USA was preferred) due to US citizenship for CBRC children born in the USA, coupled with court-recognized parental status on birth certificates and intercountry travel agreements between the USA and their home countries. Smietana (2017: 2) even found that some European gay intended fathers who live in countries in which surrogacy is available preferred CBRC into the USA over domestic surrogacy due to 'the uncertainty of their parenting rights' in their home domiciles that is alleviated by US legal clarity. These men chose costly US CBRC surrogacy over domestically available surrogacy, highlighting the ways in which the decisions foreign CBRC patients/clients make to pursue parenthood in the US ART market can be shaped by factors outside of (perhaps irrelative to?) cost. Of course, the very premise of cost being irrelative is itself shaped by economics, as only those with sufficient capital (or credit) can privilege factors other than the bottom-line.

Legal restrictions and limited markers in countries of residence 'push' people to the USA for reproductive services, while the legal permissiveness in the USA 'pulls' them (Courduriès, 2018; König, 2018; Martin, 2015; Murphy, 2013; Smietana, 2017; Stuvoy, 2018). The USA is particularly attractive for gay intended fathers able to afford US ART services, for example, as they have very few options in other national markets (Smietana, 2017). A niche market has developed to recruit such clients, which facilitates CBRC into the USA (Jacobson, 2018).

The ART industry in the USA: Recruiting international patients/clients

US fertility service providers understand these 'push' and 'pull' factors that bring international CBRC patients/clients into the US market, and they increasingly advertise and recruit directly to foreign clients able to afford their ser-

vices. They do so via international fertility fairs in other countries, conferences (such as those run by the organization 'Men Having Babies'), by hosting local recruitment events internationally, and, as [Bhatia \(2018\)](#) details in her book on sex-selection ART, via partnerships with foreign clinics. They attract foreign patients/clients by catering to them through hiring native coordinators, translating clinic materials into specific languages, and advertising familiarity with and advice about other countries' CBRC-related laws and regulations, such as entry, travel, parentage establishment and citizenship restrictions.

Providers also recruit clients by highlighting the racial and ethnic variation of egg donors available in the USA ([Almeling, 2011](#)). As [Martin](#) notes (2015: 55), in the USA, 'not only is there a high likelihood of finding a young, white egg donor – particularly one who has the education and cultural capital that intended parents often desire – but there are also specific niches of Asian and Jewish egg donors'. This diversity has been framed as a draw for international CBRC clients, and has been used by the media and providers to help explain, for example, the growth in Chinese ART clients in the US market ([Harney, 2013](#)).

Some US clinics recruit internationally by framing their services as superior to those provided in other nations ([Martin, 2015: 55](#)). These providers push the 'safety of American health care' as a reason why CBRC clients should (and do) choose the USA over other countries, such as Thailand. Viewing the USA as a 'luxury brand', as a 'higher quality' location, was one-way in which physicians understood the motivations of their clients to seek CBRC in the USA ([Martin, 2015: 59](#)). This resonates with research on US commercial surrogacy which finds surrogates and surrogacy providers juxtaposing the 'high-quality' service they provided to foreign intended parents compared with that available in other locations, such as India ([Jacobson, 2016](#)).

Structured into the US surrogacy 'journey' is sustained communication and interaction between intended parents and surrogates, which is another successful recruitment tool for the US surrogacy industry ([Berend, 2016](#)). [Stuvoy \(2018\)](#) found Norwegian intended parents choosing the USA (or Canada) as a destination site for surrogacy over India, where such interactions are not encouraged or sustained. [König \(2018\)](#) also found this in her interviews with CBRC German intended parents using surrogacy in the USA, as did [Smietana \(2018, 2017\)](#) in his work with European gay intended fathers. At the same time, the availability of both anonymous and known oocyte donation available in the USA not only enables a robust domestic market but is also a draw for international intended parents ([Almeling, 2011; Martin, 2015](#)). Both surrogates and service providers frame US care as superior due to 'more ethical' practices (such as 'open' programmes in which surrogates and intended parents know each other, and the use of financially stable surrogates alone) and 'cultural similarities' between intended parents, providers and surrogates ([Stuvoy, 2018](#)). These particular experiences can be understood as another aspect packaged by the US ART industry and purchased by foreign reproductive patients/clients.

These recruitment tools point to the less tangible draws of CBRC in the USA which intersect (in perhaps problematic ways) with both racial preferences and concerns over the exploitation of vulnerable populations internationally in

the reproductive market. In other words, framing the US CBRC as superior to reproductive care in other countries not only centres on ideas about medical superiority and US exceptionalism, but activates and then attempts to alleviate anxieties about racial and economic preferences (i.e. framing the USA as preferable because it allows access to 'desirable' white and Asian egg donors and to middle-class white surrogates), and concerns about racial and economic exploitation (i.e. the USA is preferable because poor women of colour are not exploited in the US ART market in ways they are in other countries) ([Briggs, 2017](#)). In this popular discourse, the US reproductive market is strategically framed as not only medically but ethically preferable (and therefore more palatable) to other repro-hubs in ways that align with ideas about US global dominance and superiority, while also greasing the wheels of racialized preferences and global capitalism ([Jacobson, 2016; Roberts, 1997](#)).

US CBRC as a research site

As this article has explored, there are a variety of reasons why repro-travellers journey to the USA in search of reproductive care, despite the associated costs. Most importantly, restricted or limited national markets in home domiciles for particular ART practices and/or for particular people push CBRC clients across borders. While most patients/clients in the USA are seeking basic IVF, CBRC patients/clients have higher rates than US residents of utilizing complex services prohibited or restricted elsewhere, such as compensated surrogacy, PGS and oocyte donation ([Levine et al., 2017](#)). The neoliberal commercial US market, with virtually all current ART services available to all clients able to afford them, regardless of marital status/history, age or sexual orientation, is an obvious draw to these patients/clients ([Jacobson 2018; Martin, 2015; Smietana, 2018](#)).

The robust US ART market attracts a nationally diverse patient/client base, varied in terms of marital/coupled status, age, sexual orientation and race. This population is relatively homogenous, however, along social class lines; while ART has increasingly become accessible to the lower middle-class in other national contexts, the costs associated with US ART services (especially more complex procedures) by default assume the US CBRC clientele is relatively economically privileged ([Briggs, 2017; Inhorn, 2018; Thompson, 2016](#)). These wealthy patients/clients use their purchasing power to weigh various national options against each other when choosing where to seek their care ([Speier, 2016](#)). Proximity may be a factor (recall that Canada and Mexico are the top sending countries into the USA), together with the legal clarity on US citizenship for children and parental status for intended parents ([Courduriès, 2018; König, 2018; Levine et al., 2017; Smietana, 2017](#)). The shutting down of certain ART markets to CBRC clients (such as India and Thailand) directs people to the USA, especially gay men who have few national options outside of the USA ([Jacobson, 2018; Smietana, 2017; Stuvoy, 2018; Whittaker, 2019](#)). Access to racially and ethnically diverse oocyte donor programmes is a factor, as are ideas about US medical superiority and more ethical arrangements, including 'open' surrogacy programmes where intended par-

ents and surrogates are encouraged to know each other and maintain relationships (Jacobson, 2016; Martin, 2015; Stuvoy, 2018; Thompson, 2008).

When weighing these various factors in making reproductive healthcare decisions, CBRC patients/clients in the USA may be attempting to purchase what they understand to be a smoother, quicker and more palatable process to becoming a parent than is available to them in other ART markets (whether the USA actually provides this is an empirical question for further research). Economically privileged clients are able to select into a particular type of CBRC experience, signalling that the process itself, not the 'end product' alone, is something that is purchased (Stuvoy, 2018). This illuminates the fact that not only is reproduction itself and access to ART services stratified, but that the global ART industry is as well, with certain ART markets catering to clients able to afford and willing to spend on the full range of services, concierge style, while other markets provide more limited services and may be bound by time and legal constraints (Briggs, 2017; Davis, 2019; Inhorn, 2018). The robust commercial US market, grounded in a neoliberal ethos, has a breadth and depth, allowing for various levels of service, including those that might be framed as 'lower tier' but also, as Martin (2015) illuminates, more 'elite' service. And it is this – the full range of ART procedures, available to all patients seemingly only restricted by clients' own limitations (money/travel/health/ethics) – that is a primary driver of US CBRC.

Nearly a decade ago, in a 2011 special issue on CBRC in *Reproductive Biomedicine Online*, Inhorn and Gurtin characterized the lack of research on CBRC as an 'empirical deficit in the field' and emphasized the need for 'rigorous data that can illuminate questions surrounding the incidence, experience, and outcomes of CBRC' (Inhorn and Gurtin, 2011: 665–666). Since then, there has been substantial growth in CBRC research. The focus of much of the recent CBRC media coverage and research involving the USA, however, centres on – and problematizes – white, western US (and European) clients seeking services in locations such as India and South-east Asia. As the *Ethics Committee of the American Society for Reproductive Medicine* (2016: 1628) posits, however, CBRC *out* of the USA 'is estimated to be far lower than the rate of patients coming *into* the United States' (italics my own). While the ART industry in the USA primarily services US-based patients [Levine et al. (2017: 817) found that more than 95% of all ART cycles from 2006 to 2013 were performed on US residents], both statistical and ethnographic research point to CBRC into the USA as a growing phenomenon (Hudson et al., 2011; Martin, 2015). Interestingly, although the USA is understood to play a significant role in assisted reproduction and remains a hub for reproductive care globally, as others have noted, the literature on CBRC into the USA is relatively small (Hughes and DeJean, 2010: e19; Levine et al., 2017: 818; Martin, 2015: 19; Thompson, 2016).

The process of US residents and citizens accessing more affordable reproductive care in other repro-hubs around the globe presents interesting dilemmas that should be analysed. However, I would argue that CBRC into the USA, where it is mainly non-economic factors – a neoliberal market allowing for quick and smooth access to controversial and complex ART service prohibited, restricted or seen to

be unethically practised elsewhere – that pull wealthy patients into the country, is also a ripe area for analysis. As this article alludes, CBRC into the USA raises important areas of concern, including citizenship, legal documentation, stratification enabled via racialized global markets, and border-crossing issues for children born in nations other than those in which they are being raised. These are serious issues; for example, in France, where opposition to surrogacy is strong and the majority of 'children born abroad by surrogacy are denied French civil status, and there are delays in the issuing of certificates of French nationality', these issues create both travel and inheritance challenges for these children (Courduriès, 2018: 48). Particularly now, during the Trump era and the COVID-19 global pandemic, in which international travel, border crossing and birthright citizenship are increasingly problematized, CBRC into the USA is situated as a particularly interesting (if not fraught) area for future research.

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