

“Think Globally, Act Ethically”: Towards Normative Assessment of Fertility Tourism Regulation in Europe

Liza Ireni-Saban^{1,*}, Umut Korkut² and Ben Herzberg³

¹Lauder School of Government, Diplomacy and Strategy, Interdisciplinary Center (IDC) Herzliya, P.O. Box 167, Herzliya 46150, Israel

²Glasgow School for Business and Society, Glasgow Caledonian University, G4 0BA, Glasgow, UK

³Department of Political Science, Emory College of Arts and Sciences, 201 Dowman Drive, Atlanta, Georgia 30322, USA

Abstract: In recent years, cross-border reproductive care has become an industry built on reproductive solutions for infertile individuals and couples as well as same sex couples who leave their “home” country to receive fertility treatments abroad. The diverse national policies and regulations across Europe in the field of assisted reproduction represent politically negotiated rationing criteria in states’ health policy decisions. This highly diversified regulatory field opens up a range of transnational ethical issues arising from the adverse consequences and concerns of reproductive services and treatments operating across national boundaries. In this paper, we propose to broaden the scope of the EU’s normative power to include the adverse consequences and concerns of cross-border travel to seek reproductive care. Towards this end, greater investment in accountability mechanisms should be applied at the EU level to equity issues arising from fertility tourism and to assessing the normative appropriateness of policy responses at both state and supranational levels across Europe to guide regulation in this policy domain.

Keywords: European Union, accountability, fertility tourism, regulation, health care.

“We are at a whole new scale of complexity and risk confrontation. It is a scale that requires not only a new invention of global and public health, but a new invention of global international political cooperation.” – Laurie Garrett

INTRODUCTION

In 2005, two Romanian women agreed to sell their eggs to a fertility clinic in the United Kingdom. They received one month’s wages for their eggs, but they were not informed of the considerable risks involved in the medical procedure required to harvest them. After the procedure, both women developed ovarian hyperstimulation syndrome (OHSS), a dangerous condition that can cause kidney failure, stroke, infertility, and death (Steinmann, Sykora, and Wiesing 2009: 212). These Romanian women’s plight inspired the European Parliament to issue a resolution banning trade in human egg cells. The Romanian women’s case exemplifies the complex causes, consequences, and public health risks involved in cross-border reproductive care and fertility tourism (Ireni-Saban 2013).

Fertility tourism offers infertile individuals or couples as well as same sex couples the opportunity to travel globally for reproductive treatments, stretching the scope of patient autonomy and freedom in reproductive choice. Traditionally, assisted reproduction services

have been available only through state healthcare systems. The development of a globalized, commercialized assisted reproduction industry encourages cross-border reproductive care (Collins and Cook 2010; Culley and Hudson 2009; Martin 2009; Nygren *et al.* 2010; Shenfield *et al.* 2010; Spar 2007; Storrow 2010). The growing market for assisted reproduction offers infertility treatment options, allowing individuals choice in a globalizing reproductive care marketplace; legal, social, financial, and ethical barriers in their “home” countries no longer prevent them from getting the care they desire (Blyth and Farrand 2005; Culley *et al.* 2011; Deech 2003; Hudson and Culley 2011; Inhorn and Gürtin-Broadbent 2011; Inhorn and Patrizio 2009; Inhorn and Shrivastav 2010; Pennings 2002, 2004, 2008; Pennings *et al.* 2008; Shenfield *et al.* 2010).

When scholars discuss these barriers, they invoke an intersection of choices made by the state (often problematic) and by individuals (Brazier, 1999). In fact, diverse national assisted reproduction policies and regulations across Europe represent the application of different rationing criteria to states’ distributional choices (Storrow, 2010). Within the EU, there is considerable variation among countries despite the prevalence of social insurance systems. For example,

*Address correspondence to this author at the Lauder School of Government, Diplomacy and Strategy, Interdisciplinary Center (IDC) Herzliya, P.O. Box 167, Herzliya 46150, Israel; Tel: +972-9-952-2875; E-mail: Isaban@idc.ac.il

Sweden, Denmark, and Finland provide coverage for all women, while in France national health insurance covers fertility treatments only for married women. Also, the proportion of the Gross Domestic Production (GDP) allocated to ART-treatment is substantially higher in Denmark, Finland, and Slovenia, compared to Italy, Ireland, Switzerland, and the UK (Zanini 2011).

The member states of the EU often experience difficulties resulting from this highly diversified regulatory field that cannot be resolved within their own borders. States make choices in global contexts; they have legitimate interests in protecting their citizens' welfare and preventing the harmful effects of globalization (Brennan *et al.* 2012; Österle 2007). Fertility tourism offers an interesting case study because individuals' putatively legitimate desire to have children sometimes conflicts with states' legitimate interests in protecting their citizens' welfare and protecting themselves from globalization. This brings us to the ethical challenge arising from the increasingly globalizing fertility industry faced by the EU to take into consideration the socio-political impact of its member states' domestic regulation, the monitoring of these activities, and the promotion of best practices. In this paper we suggest that accountability can become a component of the EU's overall institutional strategy to deal with transnational ethical issues arising from fertility tourism.

Our intention is not to suggest that the EU constitute a comprehensive normative regime but rather that the EU articulate certain universal norms to which states and ART providers can be held accountable. Transnational institutions can provide reliable and transparent information and communication channels between decision makers and stakeholders as well as the capacity to impose sanctions for poor management. Accountability is suggested here as a mechanism to address the challenges that arise when states are displaced as central actors, when market forces are recognized, and when cooperation is considered an integral part of overcoming the collective action problems related to fertility tourism regulation (De Zutter 2010; Manners 2008, 2013; Manners and Diez 2007; Suvarierol, 2011).

In the following sections, we first discuss the public health problems and ethical issues raised by cross-border fertility tourism. Then we address the role of transnational norms in domestic regulatory processes and explain how accountability as a transnational norm might address the concerns associated with fertility tourism. Finally, we evaluate legislative and policy

responses at both national and supranational levels in meeting accountability criteria in the field of fertility tourism.

FERTILITY TOURISM AS A PUBLIC HEALTH PROBLEM

Infertility is traditionally defined as failure to become pregnant after one year of unprotected sex (O'Toole 2003). Infertility may result from biological as well as social reasons. Social-based infertility refers to homosexual couples who want children but cannot conceive for social reasons or single women seeking to mother but not mate. Infertility is a condition shared by couples who are unable to conceive a child together. In November 2009, the World Health Organization (WHO) and the International Committee for Monitoring Assisted Reproductive Technologies (ICMART) announced that infertility should be defined as "a disease of the reproductive system" (Zegers-Hochschild *et al.* 2009). However, critics claim that infertility is not a disease; rather it is a condition, strongly shaped by social, cultural, and psychological factors (Crozier and Martin 2012).

Assisted reproductive technologies (ART) are used to solve infertility for both medical and social reasons. As a general term, assisted reproductive technology (ART) refers to techniques used to achieve pregnancy by artificial or partially artificial means. These include techniques ranging from artificial insemination (AI; a non-surgical procedure where sperm are placed in a woman's cervix or uterus; Tomlinson and Barratt 2004), to *in vitro* fertilization (IVF; retrieving a woman's eggs, fertilizing them, and transferring the fertilized eggs back into the woman's uterus). To date, more than 3 million babies have been born worldwide as a result of IVF, and approximately 350,000 IVF treatment cycles occur in Europe each year (ESHRE 2009).

Since there is no consensus on the definition of infertility, there is no consensus about adequate standards and regulations for assisted reproduction treatments. Different states establish different regulations; as a result, people have diverse motivations for travelling to other countries for reproductive treatments (Appendices A and B). The existing literature groups these motives into four categories: legal and cultural prohibitions; costly and poor quality of service and treatment; lack of safety and efficiency; and personal preferences (Blyth and Farrand 2005; Culley *et al.* 2011; Deech 2003; Hudson and Culley 2011; Inhorn and Görtin-Broadbent 2011; Inhorn and Patrizio 2009; Inhorn and Shrivastav 2010;

Pennings 2002, 2004, 2008; Pennings *et al.* 2008; Shenfield *et al.* 2010).

The ethical challenges result from a highly diversified regulatory field that includes various types of motives, constituents, locations, practices, and triggering agents that broaden the scope of ethics to include the adverse consequences and concerns of fertility tourism (Inhorn and Gürtin-Broadbent 2011). These challenges include lack of knowledge or access to information regarding medical risks associated with fertility treatments (Steinbrook 2006). These risks relate to hyperstimulation syndrome (OHSS), which ovulation-inducing fertility drugs cause (Delvigne and Rozenberg 2002); chromosomal abnormalities; breast cancer and cancers of the female genital tract; and multiple births (Dickenson 2007; Koivurova *et al.* 2007). Clinics often provide inaccurate, unreliable information about medical risks and scientific reports, and test results are difficult to interpret. Because no agency tracks the success and quality of reproductive treatments; consumers (patients), vendors, and children are vulnerable. For example, a recent *Telegraph* report revealed that since 2004, 114 of the 317 British couples that received ART at the Instituto Marques near Barcelona did not give specific consent about how their spare embryos would be handled (Blackburn-Starza 2010). These children would be genetic siblings of the original child and biologically related to the original couple, although they would not be considered the child's legal parents.

Other ethical challenges include stigmatization, discrimination, and exploitation. Many infertile people fear stigmatization and feelings of exclusion from society, especially in traditional and religious communities across the developing world (Inhorn and Shrivastav 2010). The socio-economic consequence of being infertile may lead to blaming the victims for their infertility. Economic incapacity and social isolation often exclude the infertile. This can cause victims to face higher levels of desperation, depression, and anxiety. Cross-border care may intensify these stresses, since they also are distant from the emotional support of family and relatives (Becker 2000; Blyth, Thorn, and Wischmann 2011; Culley *et al.* 2011).

Fertility tourism may intensify existing inequalities already evident in baby sales, as donation of body material is graded by market prices of "desirable" traits. As Pollock suggests (2003), East European women are preferred egg donors because they appear "Caucasian", which matches north European

consumers. The demand for physical similarity in kinship relationships is entrenched in donation and adoption practice as well as in biomedical ethics, where they are regarded as ethically harmless (Becker, Butler, and Nachtigall 2005). Thus, in the gamete market, racial preferences seem natural and acceptable because they enable the resulting family to seem biologically related. However, this may legitimize genetic preferences as natural and acceptable, raising eugenic concerns when human oocytes from donors with "desirable" traits are highly valued (Levine 2010).

Moreover, fertility tourism opens up a new form of exploitation: oocyte vendors become extremely vulnerable "reproductive laborers", exposed to marginal clinical and insurance protection, compensation, and minimal bargaining power to negotiate with clinic practitioners. For example, in 2005, headlines about an egg cell trade between the UK and Romania, as well as cloning projects in South Korea, dominated bioethics media reports (Barnett and Smith 2006). A few years ago, growing concerns of egg trafficking in a Cypriot fertility clinic led to its closing; three Ukrainian women allegedly sold their eggs to the clinic for €1,500 per egg (ESHRE 2009; Labadie 2010). These women were working in Cyprus legally, but according to police they sold their eggs – a violation of Cypriot law, which specifies that donors should only have their expenses covered. Thus, financial incentives could cause a woman, especially an impoverished one, to consider the sale of her ova and unnecessarily risk her life and health. Financial compensation for egg and sperm donors is banned in various countries; donors can only receive payment in lieu of earnings for their action. Since there is a shortage of gamete donors, the major concern is the extent of financial and other inducements offered. Of concern is the fact that financial inducements may become the principal reason for donation. At the same time, if sperm and egg donation is accepted as morally permissible, why put an artificial limit on the price? The price may be required to redress the balance, as the coverage for loss of earnings may be too low. The political choice should address where that limit should be to protect the integrity of donation. According to a pioneering study, the higher costs of UK fertility treatment together with long waiting times related to a shortage of egg and sperm donors are the major motives for British fertility tourism (De Montfort University 2010; Hudson and Culley 2011).

At present, national systems are diverse in the extent of coverage (if any) and access to ART (see

Appendix B). Several European states offer partial or complete coverage of ART: France, Sweden, the United Kingdom, Belgium, Greece, Australia, Austria, and the Netherlands. Other countries (Slovenia, Croatia, and Turkey) started to publicly fund ART to some extent over the past decade. In Turkey, there is a conscious encouragement of ART in both policy and public discourse. The diverging national regulatory patterns result from legal restrictions based on prohibition of certain techniques, or because of inaccessibility due to the characteristics of the patients (e.g., age, sexual orientation, or civil status). Governments in some countries that reimburse ART treatment (Austria, France, Germany, and the United Kingdom) impose age criteria. Italy, Sweden, France, and, until recently, Norway impose marital status and sexual orientation criteria to restrict access to ART (Canoles 2002). Italy, Denmark, and Germany ban all donor gametes and preimplantation genetic diagnosis (PGD) techniques. Turkey provides ART only for married heterosexual couples; it is a crime for single women to receive ART abroad.

Clearly, European states have the discretion to set differing eligibility parameters for ART and make different judgments about how to use their discretion. Further, these differing decisions are political rather than professional in character. The politicization of social, cultural, and other national concerns in ART policy highlights the obligation politicians and decision makers have to justify and explain their decision to fund ART. Citizens have the right to sanction their governments for a failure to provide justification. However, the right to sanction is limited to the right to punish failure on the part of government to provide justification for public expenditure rather than to provide information on the adverse risks, since the scope of states' discretion in this particular area is based on normative and political judgments and not on professional or technical expertise.

Given the above, fertility tourism poses serious public health problems in part because healthcare providers are only held accountable at the national level, that is, to people whose lives are directly affected by their decisions, when they are held accountable at all. It is argued that transnational institutions can hold providers to account through data collection, publicity, and cooperation on fertility tourism policy issues that go beyond the capacity of states to address them individually. The following sections consider how EU supranational rules and domestic policies can be interpreted in ways that meet the accountability criteria

in order to cope with the ethical challenges raised by fertility tourism.

THE ROLE OF TRANSNATIONAL NORMS IN DOMESTIC REGULATION

Transnational norms influence domestic regulatory processes (Barak-Erez and Perez 2013). They influence domestic administrative law not only through public international law but also through private and hybrid sources of transnational law (Barak-Erez and Perez 2013). Norms of this type penetrate the local legal sphere through two main conduits. First, administrative authorities adopt standards that were developed by international organizations. Such adoption takes place through either secondary legislation or by administrative directives. Second, authorities and agencies voluntarily incorporate transnational norms. Voluntary incorporation tends to have a network effect, especially as market leaders adopt certain standards (Barak-Erez and Perez 2013). There have been multiple instances of incorporation of transnational norms into the domestic law in the EU especially in the 2000s as the process of expansion gained pace. The transposition of human rights norms, especially those related to minority and gender rights, has been an organic element of the making of the new Europe. For example, already in 1992 the EU Council issued a recommendation on childcare in order for member states to develop and/or encourage initiatives to enable women and men to reconcile their occupational, family, and upbringing responsibilities arising from the care of children (Verloo and van der Vleuten 2009). Simultaneously, the EU also introduced equality measures to protect pregnant workers and required its member states to guarantee working environments to facilitate child rearing and participation by women in the labor force. Therefore, the EU signaled that pro-natalism should not place gender rights and work participation of women in peril (O'Connor, Orloff, and Shaver 1999: 10).

Orenstein, Bloom, and Lindstrom (2008: 9) pointed at two competing ways transnational actors exert influence. These are rationalist/materialist and constructivist: in the former, actors make choices based on a rational calculation of their material interests, while in the latter, ideas and issue frames influence how actors perceive their interests and behavior. Thereby, as the enlargement to the East illustrated, the EU has the potential to act as a "causal behemoth" of transnational influence in postcommunist politics (Vachudova 2008). Furthermore, gender

policies, to name a few, with respect to work-family policies as well as gender equality (Roth 2008) illustrate the process whereby transnational norms acquired prominence in the wider EU. It is clear that EU membership has been an important incentive for reform in the EU accession states. Yet, Cortell and Davis (2005: 4) argued that the EU accession states constituted a weak test of how international norms can change state behavior through processes of internationalization of new norms, since strong material incentives were embedded in the EU accession process.

This requires us to consider the normative arguments in support of transposition of international norms. The ideas that animate the problem definitions also have an independent influence (Lindstrom 2008), at times in support of improving human rights with moral and intellectual hegemony (Manokha 2008). Yet, viewing politics as a discursive process means that it is not a mechanical process whereby actors formulate a goal, devise a strategy to achieve the goal, and struggle with others as they employ their strategy. Rather, drawing on existing cultural and ideological symbols, actors develop a set of ideas and share them with others, who may challenge these ideas and provide some other alternatives. These discursive interactions prompt them to refine, frame, and reinterpret these ideas. Not only is this iterative and sometimes contentious discourse in play between political and social actors, but it also informs the evolution of political institutions (Korkut, Bucken-Knapp, and McGarry 2013: 3). This evolution paves the way for the incorporation of private transnational norms into domestic law in the EU. Two concepts of authority drive this process: epistemological authority, that is, regulation of the superior knowledge and expertise of the rule-making body; and normative authority, which reflects recognition of the authority of these transnational bodies to produce binding norms. While in technical standards the normative authority is created through endorsement by public treaties, the adoption of private transnational norms is motivated by economic interests, especially in non-hegemonic states, in which local decision makers may have little choice but to adopt the international standards (Barak-Erez and Perez 2013).

Risse and Sikkink (1999: 2) wrote that "Scholars of international relations are interested in studying norms and ideas, but few have yet demonstrated the actual impact that norms can have on domestic politics." Yet, it becomes more obvious that the emergence of global

norms of administrative law has reshaped the administrative state. In many areas, covering diverse topics such as trade, financial regulation, public health, and the environment, various international agencies have acquired increasing influence over domestic regulatory processes. This illustrates that if the "right" conditions are in place and pertain to the interests of the state, states can internalize international regimes and the principles, norms, and rules embedded in them (Risse and Sikkink 1999: 3). Integration with the global arena requires states to forgo some of their regulatory powers and even challenges state rule over society. While the human rights literature presents the importance of the rule of law for the enduring implementation of human rights norms (Risse and Sikkink 1999), more specifically, Barak-Erez and Perez (2013) developed an analytical schema that captures the distinct impacts of global administrative law on the domestic level. This schema distinguishes between three forms of influence: the replacement of domestic administrative discretion by global standards, the emergence of universal standards of due process, and the globally-inspired transference of enforcement responsibilities. Hence, there are various mechanisms through which transnational regulatory processes intervene in the local realm, reshaping the contours of domestic administrative law. Therefore, our discussion resonates the earlier work of Risse-Kappen (1995) on transnational relations, that is, the policy impact of transnationally operating non-state actors on state policies varies according to differences in domestic institutional structures, but notes that the European Union presents a particular case whereby differences in domestic structures are alleviated in the process of integration.

DEFINING ACCOUNTABILITY

Accountability is one of the core components of good governance in applied ethics. In fact, accountability as an idea pre-dates modern democracy and is wider in scope than "democratic" accountability (Grant and Keohane 2005). Philp (2009) defines accountability as follows: "A is accountable with respect to M when some individual, body or institution, Y, can require A to inform and explain/justify his or her conduct with respect to M." This definition denotes the obligation to perform or act as expected or bear the consequences of failure (Dubnick 2006). Accountability in this broad sense comes close to "responsiveness" and "responsibility" used to positively qualify a state of affairs or the performance of an actor.

How can one apply accountability to cross-border reproductive care? Assuming we agree on the broad sense of the concept, accountability belongs to issues of power that weaken the capacity for consumers and suppliers engaged in fertility tourism to exercise their individual and collective will. Issues of power, access to information and services, and control over resources are important in determining people's capacity to cope with the risks of fertility tourism (Inhorn and Gurtin-Broadbent 2011; Spar 2007). Thus, fertility tourism affects various stakeholders differently, based on their coping capacity. This paper calls for bringing the globalizing world, and states in particular, to recognition of their obligation to take responsibility for difficult choices in rationing and allocating resources to the affected public. A set of criteria for assessing accountability practices includes the following conditions (Philp 2009):

- (1) Identifiable agent or institution that must have some discretionary power over a certain issue domain.
- (2) Identifiable agent or institution that informs, explains and justifies decisions and actions with regard to the specified domain even if it is not elected or required to act on behalf of the public interest.
- (3) The possibility of enforcement of sanction of identifiable agent or institution.

These criteria can be used to assess accountability in fertility tourism policies and regulations to help determine which policies produce equity and fairness. It denotes the relational aspect that lies in an accountability mechanism as stated by Bovens (2006): "A relationship between an actor and a forum, in which the actor has an obligation to explain and justify his or her conduct, the forum can pose questions and pass judgment, and the actor may face consequences."

If such an accountability mechanism is to help address the ethical and public health problems associated with fertility tourism in Europe, two conditions must obtain. First, we must show how transnational norms influence domestic law and policy-making. We do this by considering the role of the EU in the spread of gender rights policies and anti-corruption regulations, among other examples. Second, we must specify a plausible institution that can gather the data necessary to hold EU member states and health care providers to account. We suggest that the European

Society of Human Reproduction and Embryology (ESHRE) is well-positioned to fulfill this role.

TOWARD AN EU ACCOUNTABILITY REGIME IN FERTILITY TOURISM

EU activity has focused largely on market constraints. Following the Directives of the European Union (EU), open commercial trade in gametes or embryos is apparently not permitted. The EU Tissues and Cells Directive enjoins members states (European Commission 2006) to see that gametes or embryos are donated voluntarily and that compensation is limited to making good the expenses and inconveniences of donation. In other EU countries (Spain, Cyprus, and the Czech Republic) the "inconveniences" compensation allows for payments of €800 to €1,000. Lack of uniform regulation has raised concerns of what these payments are for – they are not only to compensate for the medical procedure, but also to incentivize future recruits. That is why these countries seem to have no problem in recruiting donors (Merricks, 2011). Consequently, the Human Fertilisation and Embryology Authority (HFEA), a statutory body in the United Kingdom that regulates and inspects all UK clinics, has introduced changes to the strict rules governing egg and sperm donation in order to try to stop more childless couples from seeking treatment abroad (HFEA 2011). This case emphasizes how EU principles for the regulation of commercial trade in gametes or embryos may strengthen the capacity of both consumers and suppliers to hold health care providers accountable for failed treatment or compensation, as they are able to develop policy restrictions justified by a collective, shared notion of public interest.

The European Society of Human Reproduction and Embryology (ESHRE) also made global efforts to incorporate the interests of both consumers and suppliers of fertility treatments and develop an adequate information disclosure policy. Due to the lack of quantitative and qualitative study on the cross-border reproductive care market, ESHRE, as the main European professional and scientific organization in the domain of infertility treatment, has also initiated a special taskforce for investigating this topic (ESHRE 2009). ESHRE's main objective is to secure the safety of patients and gamete donors; it has a history of taking part in debates on an international level, as shown by its statement on the ban of reproductive cloning (ESHRE 2003). Establishing international data collection is part of developing a consumer reporting system that will influence common standards of care,

protocols, and guidelines, and will be responsive to patients who seek fertility treatments at the global level. These international institutions have strong investigative and discretionary power over disseminating adequate and comprehensive information to policy makers. They can assist various stakeholders who are interested in comprehensive research and recommend policy outcomes in locating timely and relevant information. For example, ESHRE recently issued a study (Connolly, Hoorens, and Chambers 2010) that aims to provide financial evaluation of funding Medical Assisted Reproduction (MAR) for society and to guide policy makers on the fiscal implications associated with such technologies in terms of future government spending and tax revenue. Based on the calculation of the average treatment cost of approximately €15,000 to conceive an IVF-child, the study suggested that governments can receive an 8-fold return on investment in MAR (Connolly *et al.* 2010). While the costs involved in MAR treatment embody a substantial proportion of a patient's annual disposable income, from a national healthcare perspective, MAR costs less than 0.10% of total national healthcare expenditure. Expenditures on obesity, in contrast, account for 10% and 2–4% of total health care in the U.S. and Europe, respectively (Connolly *et al.* 2010).

Organizations such as the ESHRE also need to ensure that the information they provide is accessible to all stakeholders by translating the information into a number of different languages. As these institutions' accountability depends on cooperative behavior to establish timely and relevant information, the right to sanction is limited to the institutional internal arrangements to sanction researchers for failure to provide informed professional judgments and investigations.

In addition to academic and professional studies, codes of ethics that articulate the rules of ethical behavior for the members of an organization also maintain the accountability of international organizations. In 2010, the European Society of Human Reproduction and Embryology prepared a Code of Practice (COP) backed by the International Federation of Fertility Societies (IFFS) and the International Federation of Gynecology and Obstetrics (FIGO) to secure the rights of patients, donors, and potential surrogates in the cross-border reproductive care market (Roberts 2010). The COP works to prepare a uniform set of guidelines for fertility centers and health practitioners, and for regulators and policymakers, to

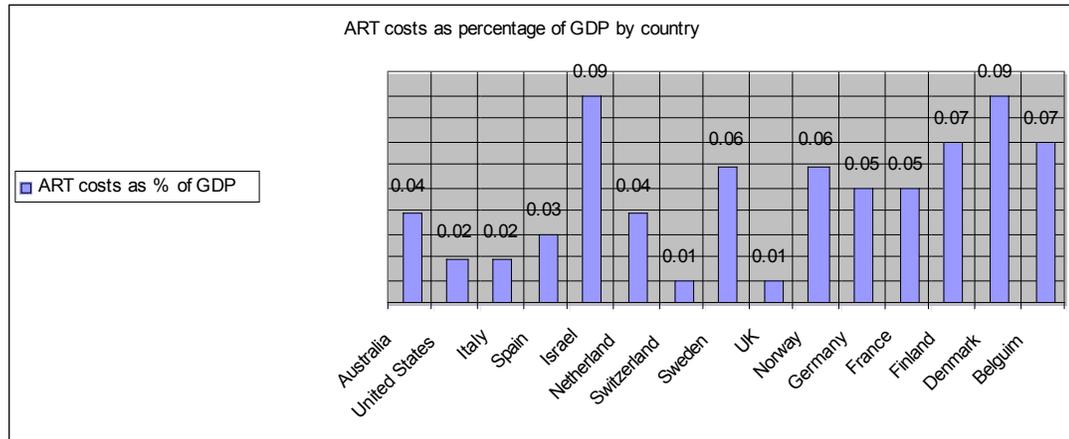
form a legal framework to enable centers to abide by these rules. The guidelines include providing high-quality ART (assisted reproductive technology) treatment; reducing multiple pregnancies; ensuring equity for traveling patients by applying similar protocols, counseling, and fees to those received by domestic patients; efficiency; effectiveness; and transparency; and enhancing open communication between foreign and home clinicians in order to ensure complete medical record information is made available for long-term follow up of treatment. Such collaboration may also save expense through avoiding unnecessary or repetitive tests (European Commission 2006; HFEA 2003; RTAC 2005). The discretionary power of international organizations such as the European Commission over assisted reproductive service and treatment is realized by placement of control over health providers and clinics across the globe to consider norms of fairness and equity in service delivery rather than the desires of the immediate customer. Although a code of practice is generally premised on the development of weaker measures of control and sanction, it has the capacity to harm the reputation of clinics or professionals who violate professional codes of conduct or revoke licenses. By providing common ethical grounds for practices of both foreign and home clinics, codes of practice initiated by international institutions can contribute to the fabric of trust in the international arena and raise the awareness of states to enforce strong measures of control by applying the code of conduct that is in place. This can lead to forcing home clinics to meet resident fertility patients' needs first, before they turn to international care.

CONCLUSIONS

This paper offers a view on how accountability can be actualized as a viable normative framework for cross-border reproductive care policy making in Europe. This paper shows how the issue of cross-border reproductive care provokes significant conflicts over accountability by national and supranational institutions across Europe. As seen, choices of fertility treatment should, and their consequences should not, be left to distributional choices at the national level but to EU normative assessment as well.

This paper suggests that accountability can provide powerful criteria to guide fertility tourism ethics and practice. By drawing on a set of core features of accountability, EU institutions and initiatives share valuable information about the diverse and multiple risks and regulations in the domain of assisted

Appendix A¹: National spending on ART as percentage of GDP in 2006



¹Data adapted from Connolly *et al.* (2010). Economic data on national GDPs available at: http://www.nationmaster.com/graph/eco_gdp-economy-gdp&date=2006

Appendix B: Comparison of National and International Regulation of ART and FERTILITY TOURISM²

Ethical and legal standards			Reimbursement				Measures of Regulation/Level of Regulation
No Ethical Guidelines but Clinical guidelines	Ethical Guidelines	Legislation on ART	Funding for Cross-Border Reproductive Care	No Funding	Partial Funding	Full Funding ³	
Denmark, Ireland, Latvia, Portugal, Slovakia, Spain, Israel, Japan, Switzerland, United States ⁴	Austria, Belgium, Bulgaria, France, Germany, Greece, Italy, Luxemburg, Malta, Slovenia, Sweden, Netherlands, United Kingdom	Austria, Belgium, Bulgaria, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Netherlands, Norway, Portugal, Slovakia, Slovenia, Spain, Sweden, United Kingdom	Belgium, Germany ⁵ , France, Israel, Netherlands	Argentina, Brazil, Canada, Chile, China, Columbia, Ecuador, Egypt, Hong Kong, India, Ireland, Korea, Latvia, Mexico, Philippines, Bangladesh	Australia, Austria, Bulgaria, Croatia, Czech Republic, Denmark, Finland, Germany, Hungary, Italy, Japan, Netherlands, New Zealand, Norway, Portugal, Tunisia, Turkey, United Kingdom	Belgium, France, Greece, Israel, Slovenia, Sweden, Australia ⁶ , Canada ⁷	National Level
ASRM and SART(USA) ⁸	IFFS, FIGO and ESHRE conducted Code of practice, WHO under the UN	ESHRE reports on legislation in EU member states	ESHRE reports on Cross Border Reproductive Care, iCSI and IFIPA call for patients' support and no limitation on access to ART, RAND Corporation reports				International/ Federal Level
Directives of the European Union							Supranational Level

²ART includes *in vitro* fertilization (IVF), Intra-cytoplasmic Sperm Injection (ICSI), Frozen embryo replacement (FER), and Öocyte donations (OD).

³Criteria limiting reimbursement for ART in Belgium is by age of the woman, number of cycles, and number of embryo transfers. Criteria limiting reimbursement to ART in Sweden, Greece, Slovenia, and France are marital status, age of man, age of woman, number of cycles. Criterion limiting reimbursement for ART in Israel is by age of woman.

⁴In the United States, there is a self-regulation mechanism to govern fertility clinics.

⁵Germany reimburses foreign ART only in a few federal states (for example Bavaria).

⁶Australia is the only country in the world that provides full funding for fertility treatments with no limitation.

⁷Ontario is the only province in Canada to provide full funding for fertility treatments with no limitation.

⁸The ASRM and SART conducted voluntary general guidelines for clinical practice.

reproduction care. However, satisfying multiple stakeholders' interests and expectations (consumers, suppliers, practitioners, government actors, and advocacy patient groups) may impose significant costs involved in both monitoring and gathering information for the purpose of outcome assessment and policy justification.

Accountability of EU institutions is also complex when faced with limited capacity to sanction market and state agents and institutions, e.g., pressure for marketization to compromise standards of services, otherwise services provided by the market will be decreased due to cost inefficiency as well as different rationing criteria held by health care systems in the distribution of public goods.

Despite such accountability challenges, EU institutions have already begun to design standards of practice for compliance with state requirements (Article 10a-2h, Reform Treaty 2007). These institutions develop audit systems to ensure accurate documentation of clinic reports, as well as to encourage best practices of providing assisted reproduction treatment. As a result of the increased focus on professional and ethical service delivery, the emphasis on cooperative behavior of states with the capacity to sanction and enforce common standards gains significant impetus. The implementation of COP serves as an example of a useful policy instrument that can work in a rather satisfactory way. In particular, international governance arrangements would appear to be useful if statutory regulations will not reimburse fertility treatments in the short-term, but offer adequate protection to individuals who undergo fertility treatments in foreign countries against unwarranted risks.

In terms of the normative assessment presented in this paper, the international credibility of EU institutions and committees will create trust at the supranational level as well as within countries for assuring that national regulations are consistent with norms of justice and fairness – both in substance and in process. We suggest that raising states' awareness of policy domains where regulation is diverse and thus can generate unintended risks and consequences will increase their willingness to assume state responsibility for what happens in their territory and the EU community.

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