

Reproductive Tourism: Equality Concerns in the Global Market for Fertility Services

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Introduction

Assisted reproductive technology (ART) lures people across borders. The willingness to travel for ART and the practices that facilitate fertility travel are known as “reproductive tourism.”¹ In the past few years, reproductive tourism has expanded rapidly, and has acquired a public profile in the process. The news media has reported on various aspects of reproductive tourism through feature articles,² health bulletins,³ business reports,⁴ and human interest stories.⁵ These stories illustrate, even if they do not directly address, that the underlying global inequalities between geographic regions and their residents—and local inequalities among residents based on gender, class, race, and ethnic hierarchies—enable reproductive tourism.

At the same time, news stories reported from the United States tend to focus on destination spots outside of the United States. India, in particular, has become somewhat fetishized by the media’s depiction of reproductive tourism.⁶ This has the effect

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1. See sources cited *infra* notes 2–5 (discussing various examples of “reproductive tourism”).

2. See, e.g., Felicia R. Lee, *Driven by Costs, Fertility Clients Head Overseas*, N.Y. TIMES, Jan. 25, 2005, at A1 available at <http://www.nytimes.com/2005/01/25/national/25fertility.html> (noting that the high cost of fertility services contributes to reproductive tourism).

3. See, e.g., Brian Alexander, *Health Bulletin: How Far Would You Go to Have A Baby?*, GLAMOUR, May 2005, at 116 (examining the motivation behind reproductive tourism).

4. See, e.g., Heather Won Tesoriero, *Infertile Couples Head Overseas for Treatments*, WALL ST. J., Feb. 19, 2008, at D1 (discussing the impact of reproductive tourism from an economic standpoint).

5. See, e.g., *Good Morning America: Rent a Womb? Extreme Measures to Get Pregnant* (ABC television broadcast Sept. 28, 2007) (discussing the “outsourcing” of surrogacy as an example of reproductive tourism).

6. Media coverage of India’s role in reproductive tourism focuses almost

of situating the inequalities and other problematic aspects of reproductive tourism outside of the West, in non-White jurisdictions. Yet the United States and other Western countries are active participants in reproductive tourism as both destination spots and points of departure.⁷

Prospective fertility patients leave their home jurisdictions to use ART for a complex mix of reasons.⁸ For example, laws or social rules might restrict access at home, or the cost of ART use in other countries may be lower. Some travel to bypass a local dearth of technology, and others seek to use the fruits of third parties' bodies—eggs, sperm, or wombs. Some may simply want secrecy. The supply side of reproductive tourism has formed to satisfy these needs in a sprawling commercial enterprise that is sophisticated in some respects and crude in others.

Yet, the dominant narrative of reproductive tourism, and of ART use generally, speaks of the private sphere desire for family formation. The profile of reproductive tourism, then, is that of the couple or individual who literally travel to the ends of the earth to have a child. This narrative does not mask the commerce, but characterizes it as the fortuitous means of achieving the dream of parentage. In effect, the narrative shifts the gaze from the market to the intimate aspects of family formation. Family and commerce mix in many different ways.⁹ This Article does not condemn the role of the ART market per se. Rather, it challenges the way in which the narrative separates family and market. In doing so, it examines how the human need of family formation interacts with commerce, and how geopolitical differences shape that interaction.

exclusively on surrogacy, and many stories feature the same clinic—the Akanksha Fertilty Clinic in Anand, India. See, e.g., Anuj Chopra, *Childless Couples Look to India for Surrogate Mothers*, CHRISTIAN SCIENCE MONITOR, Apr. 3, 2006, at 1 (discussing couples from other countries who look to Indian women as surrogates); Henry Chu, *Wombs for Rent, Cheap*, L.A. TIMES, Apr. 19, 2006, at A1 (discussing surrogate mothers in India); Abigail Haworth, *Womb for Rent: Surrogate Mothers in India*, MARIE CLAIRE, Aug. 1, 2007, at 124 (discussing “the growing number of Indian women willing to carry an American child”); Krittivas Mukherjee, *Rent-A-Womb in India Fuels Surrogate Motherhood Debate*, REUTERS, Feb. 5, 2007 (examining the debate over Indian women becoming surrogate mothers for women of other nationalities); Sarmishta Subramanian, *Wombs for Rent*, MACLEAN'S, July 2, 2007, at 40 (questioning who benefits from the paid surrogacy relationship).

7. See *infra* Part I.C–D (illustrating the roles of the United States and other jurisdictions in reproductive tourism).

8. See discussion *infra* Part I (describing differing reasons for reproductive tourism).

9. See, e.g., VIVIANA A. ZELIZER, PRICING THE PRICELESS CHILD: THE CHANGING SOCIAL VALUE OF CHILDREN 169–208 (1994) (highlighting “baby farms” and “black market babies” as illustrations of how the concept of family can become a commercial commodity).

ART commerce across jurisdictional lines is fluid. The participants on both the demand and the supply side of the global fertility market change based on legal, medical, and normative innovations (or regressions). Participants include prospective patients, States, countries, providers, health care facilities, sperm banks, egg donors, surrogates, agencies, and brokers. When legal rules, technology, or social norms change, the destination spots and departure points of reproductive tourism change as well. The geographic shifts echo in the identities of the human participants.

The first task of this Article is to set out a snapshot account of reproductive tourism, not for the purpose of providing a definitive description, but to clarify two points. First, while deeply felt human emotions and needs are at stake, the commercialization of ART use in a global market interacts with and informs how individuals act on those emotions and needs. Second, ART use forms the basis of the doctor-patient relationship and of an industry that, in turn, shapes that relationship. Neither of these points is particular to reproductive tourism, but reproductive tourism may exaggerate the dynamics therein.

The second task of this Article is to examine the equality concerns embedded in reproductive tourism through material and normative terms. In many respects, reproductive tourism is just another type of medical tourism. Yet, there are important distinctions between most types of medical tourism and using ART abroad. As indicated, ART use often relies on third parties who provide gametes, or gestate and give birth for others.¹⁰ The differences between fertility travelers and the third-party participants arise from class, race, and gender structures, which often align with geopolitical differences between the points of departure on the one hand and the destination spots of reproductive tourism on the other.¹¹

Part I starts with a brief definition of reproductive tourism. It then describes the various moving parts of reproductive tourism as a global industry. This list of parts includes some of the most in-demand ART, the destination spots and points of departure, the

10. See, e.g., MARY LYNDON SHANLEY, MAKING BABIES, MAKING FAMILIES: WHAT MATTERS MOST IN AN AGE OF REPRODUCTIVE TECHNOLOGIES, SURROGACY, ADOPTION, AND SAME-SEX AND UNWED PARENTS 76–87 (2001) (explaining the processes and ethical implications of third-party gamete donation for ART).

11. See JANICE G. RAYMOND, WOMEN AS WOMBS: REPRODUCTIVE TECHNOLOGIES AND THE BATTLE OVER WOMEN'S FREEDOM 140–44 (1993) (providing examples of how “reproductive trafficking” in poverty stricken areas outside the United States, such as Sri Lanka, Guatemala, and India, aligns with worldwide sexual trafficking patterns between the United States and other areas of the globe).

demand side, and representative commercial entities on the supply side. Part I wraps up with a comparison between reproductive tourism and other types of medical tourism.

Part II discusses the role of law, cost disparities, social norms, and purchaser entitlement as factors in establishing the pathways of reproductive tourism. In addition, Part II delineates the methods by which the market drives the identities of fertility travelers and third parties whose gametes and wombs are used in many ART procedures, and the socio-political differences between these two groups. Finally, Part III discusses normative equality concerns that have received relatively little attention in scholarly and public discussion of reproductive tourism.

I. A Description of Reproductive Tourism

Reproductive tourism is a phenomenon of moving parts. While the description is linear, the reality is interactive. That is, ART, the destination spots and points of departure, the prospective patients, and the commercial entities on the supply side are mutually responsive. As the destination spots and points of departure shift, so do the patients and those providing gametes and surrogacy as third-party participants. When new technologies or commercial practices emerge, the market realigns, expands, or contracts.¹²

This description is simply a snapshot of an industry formed both to satisfy a desire to have children, to become a parent, and/or to form a family. Because the fertility business is primarily profit-based, the supply side entities have a stake in increasing demand.¹³ The growth of reproductive tourism indicates that the fertility business has successfully promoted family formation through ART use. Fertility doctors have not played the role of passive professionals surrounded by a whirl of commercial activity;¹⁴ many have become influential stakeholders who use a combination of medical and commercial practices to enhance their market positions.¹⁵ The role of physician-entrepreneur is not new

12. Third-world countries often serve as the testing ground for new reproduction technologies, which primarily supply expanding markets in the United States and Western Europe. *Id.* at 1–21.

13. *Id.* at 109 (“In an age of competitive research funding and the race for public support, fame, and favorable press coverage, scientists have set up vast public information networks through their respective institutions that have been successful in marketing technology to the public through the media.”).

14. *Id.*

15. *See, e.g.*, Indian Med Guru, <http://www.indianmedguru.com> (last visited Mar. 13, 2009) (marketing reproductive tourism together with sight-seeing and spa

or unique to fertility practice,¹⁶ but the use of therapies that require third-party body parts for non-lifesaving procedures may be.

A. “Reproductive Tourism”: *The Basic Definition*

Both the media and scholars use the term “reproductive tourism” to refer to an interrelated set of practices.¹⁷ “Reproductive tourism” often refers most explicitly to the demand side of the industry—to those who travel outside of their jurisdiction of residence to access reproductive technologies.¹⁸ In this Article, I use “reproductive tourism” narrowly to refer to those seeking ART access for the purpose of becoming parents.¹⁹ Some fertility travelers seek services within their home country,²⁰ while some travel across country borders.²¹ Some fertility travelers use ART in hopes of having a genetically related child.²² Others use technology to have a child, regardless of genetic ties.²³ A long list of market participants forms the supply side of the global market in fertility services. This list includes health care providers, health care facilities such as clinics and hospitals, brokers, and those who provide the raw materials: the men and women who provide gametes, and the women who carry and give birth to

packages in India).

16. The cosmetic surgery industry, for example, has thrived through profit-based businesses such as Transform, a United Kingdom-based cosmetic surgery firm that operates twenty-two clinics and two hospitals. Nick Mathiason, *Enhanced Profits At the Cutting Edge of Cosmetic Surgery*, THE GUARDIAN, June 1, 2008, Business News & Features, at 6, available at <http://www.guardian.co.uk/business/2008/jun/01/healthcare.economicgrowth>.

17. See sources cited *supra* notes 2–5 and accompanying text.

18. See, e.g., Suz Redfearn, *Pursuing A Baby To the Ends of the Earth*, WASH. POST, Jan. 14, 2007, at W16 (recounting the story of a couple’s trip to South Africa for ART services).

19. A broader understanding of reproductive tourism includes travel for purposes of seeking contraception and abortion access. See G. Pennings, *Reproductive Tourism as Moral Pluralism in Motion*, 28 J. MED. ETHICS 337 (2002) (exploring the ethics of reproductive tourism in all of its forms).

20. For example, women in the United States sometimes travel to other states for abortion services. See *id.* at 337.

21. See Redfearn, *supra* note 18.

22. In one case, a 62-year-old French woman traveled to the United States to be inseminated with her brother’s sperm. Pennings, *supra* note 19, at 337.

23. For example, a patient at Ceram, a fertility clinic in Spain, stated, “It’s actually cheaper for me to use a donor egg in Spain than it is to use my own eggs at home.” Louise France, *Fertility Report: Faced With Long Waiting Lists at Home, Infertile British Women are Booking IVF Holidays in the Sun*, OBSERVER, Jan. 15, 2006, at 47, available at <http://observer.guardian.co.uk/woman/story/0,16929,1684149,00.html>.

children according to surrogacy arrangements.²⁴

The most troubling aspects of reproductive tourism arise from the use of third parties who furnish gametes and from surrogates who gestate babies for others. In fact, the strongest critics of these practices use the term “trafficking” rather than “tourism.”²⁵ The use of the term “trafficking” intentionally recalls several illegal and widely condemned types of human trafficking, including sex trafficking and trafficking in human organs.²⁶ Thus, critics highlight the commercial trade in human bodies and body parts, which are a significant part of the industry.²⁷ This Article uses the more media-popular phrase, “reproductive tourism,” and begins by describing a wide range of practices, many of which are less troubling than the use of third-party gametes and surrogates. The purpose of the Article, however, is to identify equality concerns which arise, in part, from the use of women as the industry’s source of raw material.

B. *The ART*

The ART available in the overall global market matches that offered in the most well-supplied jurisdictions such as California, where the fertility industry remains substantially unregulated.²⁸ Some jurisdictions have become niches for particular ART. Spain, for example, has cultivated a reputation for high success rates of in vitro fertilization (IVF).²⁹ The media has highlighted India’s

24. FertilityPlus.org contains an in-depth directory of fertility clinics, hospitals, and even photographs of gamete donors. FertilityPlus.org, Donor Sperm, Donor Egg, Surrogacy & Embryo Adoption Resources, <http://www.fertilityplus.org/faq/donor.html> (last visited Mar. 27, 2009).

25. See, e.g., GENA COREA, *THE MOTHER MACHINE* 213–45 (1979) (explaining how factors such as capitalism, race, and poverty allow “[t]he international traffic in women . . . to expand”).

26. See, e.g., RAYMOND, *supra* note 11, at 138–87 (describing the ways in which reproductive tourism has fueled sex and human trafficking).

27. *Id.*

28. Currently, because of the increasing popularity of fertility clinics, California state representatives are pushing for more regulation. See Press Release, Sen. Gloria Negrete McLeod, California Senate Dist. 32, Greater Oversight of Fertility Clinics and Cosmetic Surgery Centers Sought (Feb. 27, 2009), available at http://dist32.casen.govoffice.com/index.asp?Type=B_PR&SEC={78A8DE90-C93C-4D5E-A988-B5FD4F2384E0}&DE={D7A674B5-A012-4F64-93C6-07D2D381F29D}; see also Emily Withrow, *Trade In Human Eggs Thrives As Infertile Couples Travel the World Seeking Donors*, USA TODAY, Jan. 27, 2007, available at http://www.usatoday.com/news/health/2007-01-27-eggbusiness_x.htm (discussing relatively lax regulation of ART in foreign countries).

29. See Giles Tremlett, *Spain Becomes the Destination of Choice For Fertility Tourists From Britain*, GUARDIAN, May 12, 2006, Top Stories, at 16, available at <http://www.guardian.co.uk/world/2006/may/12/spain.health1>.

surrogacy business.³⁰ Other jurisdictions are emerging markets, formed by a combination of the technologies that they offer and other factors such as cost and national law.³¹ The list of specific ART, like the markets in which they operate, changes frequently.

The assisted conception technologies include IVF,³² assisted insemination,³³ intracytoplasmic sperm injection (ICSI),³⁴ and assisted hatching.³⁵ Some patients use assisted conception technologies with their own gametes.³⁶ Some use third-party gametes such as sperm and oocytes or eggs provided by third parties.³⁷ Others use IVF with “embryo donation”—embryos provided by third parties.³⁸ The vast majority of women and men who provide gametes for others’ use receive compensation,³⁹ even though they are referred to as “donors.”⁴⁰ For many, especially the third parties who provide gametes, “donor” anonymity is preferred.⁴¹

Cryopreservation and storage of sperm,⁴² eggs,⁴³ and

30. See sources cited *supra* note 6.

31. See discussion *infra* Part II.

32. In IVF, sperm and eggs are combined outside the body and one or more of the fertilized eggs are subsequently transferred to the uterus, where the embryo may implant in the uterine lining and result in pregnancy. AM. SOC’Y FOR REPROD. MED., ASSISTED REPRODUCTIVE TECHNOLOGIES: A GUIDE FOR PATIENTS 4 (2008) [hereinafter ASRM GUIDE], available at <http://www.asrm.org/Patients/patientbooklets/ART.pdf>.

33. In assisted insemination, sperm is placed into the uterus or cervix in order to facilitate pregnancy. See *id.* at 11–20.

34. In intracytoplasmic sperm injection (ICSI), a single sperm is injected into an egg in order to facilitate fertilization of the egg. See *id.* at 20.

35. In assisted hatching, the outer membrane of the embryo is partially opened, typically through application of a laser or an acid, in order to promote embryo implantation and pregnancy. See *id.* at 9. This procedure is typically used with older women or couples who have not achieved pregnancy with prior IVF procedures. See *id.*

36. See *id.* at 4–10 (explaining the process by which women may have their own eggs used in IVF procedures).

37. See *id.* at 11–12 (describing IVF performed with third-party gametes).

38. See, e.g., AVA-Peter Infertility Clinic,

<http://www.avapeter.com/en/embryoadooption> (last visited Mar. 27, 2009) (indicating that this clinic, which has offices in Russia, Finland, Portugal and Latvia offers embryo adoption of frozen embryos donated by “younger patients, who have fulfilled their family planning after successful birth.”)

39. See *infra* note 45 and accompanying text.

40. DEBORA L. SPAR, THE BABY BUSINESS: HOW MONEY, SCIENCE, AND POLITICS DRIVE THE COMMERCE OF CONCEPTION 200–01 (2006) (“Sperm [is] . . . almost never ‘contributed’ for free.”).

41. See discussion *infra* note 144–154 and accompanying text.

42. SPAR, *supra* note 40, at 44.

43. *Id.* at 60.

embryos⁴⁴ are also among the services frequently offered to fertility patients. Sperm banks were, in fact, the originating commercial enterprise of the fertility industry.⁴⁵ The practice of banking embryos and ova followed.⁴⁶ Many use cryopreservation and storage in facilities called “banks” to keep excess embryos for later use.⁴⁷ Some have all embryos cryopreserved for transport back to a home-based clinic where a local physician will perform the embryo transfer to the woman hoping to become pregnant.⁴⁸ Egg freezing is a recent technology and is now being marketed to young single women as a form of biological insurance against the possibility that their *in vivo* eggs might expire before they seek motherhood.⁴⁹

ART also includes a screening technology called preimplantation genetic diagnosis (PGD).⁵⁰ PGD is performed on an embryo created *in vitro*, before embryo transfer.⁵¹ PGD can identify the sex of a particular embryo and the presence of certain genetic disorders.⁵² It can also provide genetic information for the purpose of selecting the embryo or embryos to be transferred.⁵³ As others have shown, these uses provide opportunity for discriminatory sex selection, disability discrimination, and eugenics.⁵⁴

44. *Id.* at 88 (describing issues with frozen embryos).

45. *Id.* at 35.

46. *Id.* at 41–42.

47. *Id.* at 88.

48. Lee, *supra* note 2.

49. See Extend Fertility, <http://www.extendfertility.com/egg-freezing.htm> (last visited Mar. 31, 2009) (heavily promoting controlling a woman’s rapidly declining fertility through egg freezing); see also Egg Freezing Center, <http://www.eggfreezingcenter.com/egg-freezing/egg-freezing-for-efc.html> (last visited Mar. 31, 2009) (discussing the use of cryopreservation to delay pregnancy).

50. PGD is a test in which one or two cells are removed from a developing embryo and tested for a specific trait or genetic disease prior to transfer to the uterus. ASRM GUIDE, *supra* note 32, at 9.

51. *Id.*

52. SPAR, *supra* note 40, at 121.

53. ASRM GUIDE, *supra* note 32, at 9.

54. See SPAR, *supra* note 40, at 123–27 (discussing the moral perils of PGD); Judith F. Daar, *ART and the Search for Perfectionism: On Selecting Gender, Genes, and Gametes*, 9 J. GENDER, RACE & JUST. 241 (2005) (discussing the implications of using PGD for medical or sex selection, and the reinvigoration of eugenics); Marcy Darnovsky, *Voluntary Isn’t Working*, MODERN HEALTHCARE, Apr. 13, 2009, available at

<http://www.geneticsandsociety.org/article.php?id=4627> (discussing embryo selection for hair color, eye color, and skin tone); Bratislav Stankovic, “It’s a Designer Baby!”, *Opinions on Regulation of Preimplantation Genetic Diagnosis*, 2005 UCLA J.L. TECH. 3 (2005) (discussing the need for oversight of the use of PGD technologies,

Surrogacy, in both the domestic and international contexts, has probably triggered the greatest media attention. Surrogacy is not a technology per se. Assisted conception is used to impregnate a woman who gestates and gives birth to a child on behalf of an individual or a couple who intend to raise the child as their own.⁵⁵ IVF, with gametes provided by the intended parent(s) and/or third-party donors, results in the birth of a child who has a biological relationship with the surrogate by virtue of pregnancy and birth, but a genetic relationship with others.⁵⁶ The intentional separation of biological and social motherhood, as well as the commercial practices that accompany most surrogacy arrangements, make this practice one of the most controversial services on the market.⁵⁷ The introduction of this form of surrogacy—gestational surrogacy—has increased the demand for women to be surrogates, for third-party gametes, and for IVF.⁵⁸

C. Destination Spots and Points of Departure

Reproductive tourism spans the globe. The destination spots and points of departure in the global fertility market include both developed and developing countries. Australia, Canada, Germany, India, Israel, and South Africa are among the many destination spots.⁵⁹ Fertility travelers hail from a range of countries such as Costa Rica, Japan, Mexico, and the United Kingdom.⁶⁰

Many jurisdictions, such as Australia, Italy, and Germany, are both destination spots and points of departure. The United States is also a major presence on both the supply and the demand side of the market. United States residents travel within the United States to access ART that is not readily available in their home states or regions.⁶¹ United States suppliers also serve many who enter the United States in order to access ART.⁶² At the same time, many United States residents cross borders to seek fertility

especially in the context of “designer babies”).

55. SPAR, *supra* note 40, at 70–72.

56. *Id.* at 79.

57. RAYMOND, *supra* note 11, at xxii (characterizing surrogacy as “reproductive trafficking” and “baby farming”).

58. SPAR, *supra* note 40, at 81.

59. See Alexander, *supra* note 3, at 116 (discussing Canada, Germany, Israel, Italy, and South Africa); Lee, *supra* note 2 (discussing South Africa, Israel, Italy, Germany and Canada).

60. See Alexander, *supra* note 3, at 116; Lee, *supra* note 2.

61. SPAR, *supra* note 40, at 210–14 (discussing the differences between states, regulation, and the market for ART).

62. Debora Spar, *Reproductive Tourism and the Regulatory Map*, 352 N. ENG. J. MED. 531, 531 (2005).

services outside the United States.⁶³

Often, fertility travelers have racial or gender preferences that inform their choice of fertility destination. Many seeking third-party gametes want gametes from individuals whose race matches their own.⁶⁴ As a result, Romania and the Ukraine are among the popular destination spots for egg donation among Whites.⁶⁵ Because of its racial diversity, the United States is popular among travelers from Asia and Latin America, as well as countries with predominantly White populations.⁶⁶ Jurisdictions that permit PGD use for sex selection attract those who wish to choose the sex of their child.⁶⁷

Some destinations are attractive because of their religious or social norms. Fertility clinics in Israel provide ART for Jewish women and couples from other countries who seek assurance that procedures comply with Jewish law.⁶⁸ In some jurisdictions, either legal regulation⁶⁹ or clinic-imposed rules⁷⁰ restrict ART access based on marital status and/or sexual orientation. On the other hand, some clinics have formed for the express purpose of providing access to single people and lesbian and gay couples.⁷¹ Some regions or clinics offer services on an inclusive basis because

63. Lee, *supra* note 2.

64. Anthony Barnett & Helena Smith, *Cruel Cost of the Human Egg Trade*, OBSERVER, Apr. 30, 2006, News, at 6, available at <http://www.guardian.co.uk/uk/2006/apr/30/health.healthandwellbeing/print> (reporting that while most Ukrainian women sell their eggs "in Kiev, others are sent by Ukrainian clinics to Cyprus or even Belize" and that their "Caucasian appearance is turning young East European women into a source for one of the continent's most prized commodities: human eggs").

65. *Id.*

66. See The Reproductive Specialty Medical Center, <http://www.drury.com/DonorProfile.html> (last visited Mar. 31, 2009) (highlighting the racial diversity of the egg donors and requiring customers to travel to the United States to access them).

67. SPAR, *supra* note 40, at 122.

68. Lee, *supra* note 2.

69. See, e.g., ARK. CODE ANN. § 23-85-137 (West 2007) (mandating infertility coverage for legally married couples, a legal status unavailable under state law to gay and lesbian couples); HAW. REV. STAT. § 431:10A-116.5 (2007) (mandating ART coverage only for a woman's eggs being fertilized by her husband's sperm); MD. CODE ANN. INS. § 15-810 (West 2007) (mandating ART coverage only for a woman's eggs being fertilized by her husband's sperm).

70. See, e.g., Lisa Ikemoto, *The In/Fertile, the Too Fertile, and the Dysfertile*, 47 HASTINGS L.J. 1007, 1028 (1995) (discussing fertility clinics screening potential clients based on social criteria such as marital status, sexual orientation, and age, in order to exclude certain groups from use of the reproductive technology).

71. See, e.g., Pacific Reproductive Services, <http://www.parcpro.com/index.php> (last visited Mar. 31, 2009) (touting its fertility clinic as lesbian owned).

it is good for business.⁷² Other jurisdictions have civil rights laws that apply to providers, thus prohibiting them from refusing patients based on marital status and/or sexual orientation.⁷³ As a result, there are destination spots for single women and men, and lesbian and gay couples who want access to ART, such as Belgium, Finland, Greece, India, and the United States.⁷⁴

D. Fertility Commerce Across Borders

ART use is often portrayed solely as infertility treatment. That framing narrows the gaze to the doctor-patient relationship.⁷⁵ The doctor-patient relationship, however, exists within a much larger, wide-ranging set of activities. Many of those activities are commercial in nature and form the basis of an industry—the fertility industry.⁷⁶ Entrepreneurship has played a significant role in creating pathways for ART use across jurisdictional borders.⁷⁷

Additionally, many commentators credit the internet with facilitating reproductive tourism.⁷⁸ Clinics and other entities that enable reproductive tourism often have websites for prospective patients to gather information and contact out-of-jurisdiction providers.⁷⁹ Websites are also used to solicit gamete donors and

72. *Id.* (explaining why a lesbian owned sperm bank is “a positive choice for any woman”).

73. See *N. Coast Women’s Care v. Superior Court*, 81 Cal.Rptr.3d 708, 717 (Cal. 2008) (finding a cause of action under California’s Unruh Civil Rights Act when a physician refused to inseminate a lesbian woman because of religious objections).

74. *IFFS Surveillance 07*, 87 FERTILITY AND STERILITY (Supp. 1) S17 (2007); see Amrit Dhillon, *Surrogacy Debate Rages after Gays ‘Father’ Twins*, SOUTH CHINA MORNING POST, Nov. 30, 2007, at 14; Farah Farouque, *Gay Couples Shop Offshore for Surrogate Mothers*, AGE, Aug. 16, 2003, available at <http://www.theage.com.au/articles/2003/08/15/1060936056512.html>.

75. See RAYMOND, *supra* note 11, at 82–85 (discussing the jurisprudence of the right to privacy as conceived in terms of reproductive issues relating to the doctor-patient relationship).

76. SPAR, *supra* note 40, at 29–35.

77. Spar, *supra* note 62, at 531.

78. See, e.g., Lee, *supra* note 2 (“‘There’s a network of people, and [a] lot of information is on the Internet now,’ said Shannon Abbey of Woodbine, Ga., a 35-year-old Navy wife who had her son Noah Michael Chase last June, after two in vitro cycles at a clinic in Naples.”) (sic); Tesoriero, *supra* note 4 (“The internet has made it easier for women to connect with fertility clinics in diverse locales . . .”). For a discussion of gamete trading over the internet, see Lisa Hird Chung, *Free Trade in Human Reproductive Cells: A Solution to Procreative Tourism and the Unregulated Internet*, 15 MINN. J. INT’L L. 263, 292–94 (2006).

79. See, e.g., The Reproductive Specialty Medical Center, <http://www.drary.com/index.html> (last visited Mar. 31, 2009) (explaining the services available).

surrogates.⁸⁰ On the demand side, those seeking ART share information with each other.⁸¹ Thus, while traditional word of mouth plays a significant role in facilitating reproductive tourism,⁸² digital word of mouth has expanded the speed and scope of patient information sharing.⁸³

The parameters and practices of the fertility industry are fluid and innovative. As a result, it is not possible to provide a comprehensive list of commercial entities that form the industry. The following list is merely representative and of the moment.

1. Clinics and Hospitals

Fertility clinics and hospitals are the most obvious presence in the industry. Many aim their marketing at prospective travelers in other jurisdictions.⁸⁴ Clinics and hospitals have websites in the languages spoken in major points of departure.⁸⁵ For example, this makes it easy for prospective travelers in English-speaking countries to find clinics in Greece, Thailand, and Turkey.⁸⁶ Websites of clinics in the United States may have pages or links to information in French, Japanese, Spanish, and Swedish.⁸⁷ Some clinics emphasize the possibility of combining

80. See, e.g., Nordica, <http://www.nordica.org/composite-361.htm> (last visited Mar. 31, 2009) (seeking gamete donors and surrogates).

81. Lee, *supra* note 2 (noting that some women learned of ART possibilities from friends).

82. See, e.g., *id.* (“Ms. Abbey, for instance, learned that several Navy wives on her husband Kevin’s ship, the La Salle, had gone to Italy for help conceiving.”).

83. See, e.g., Fertility Friends, <http://www.fertilityfriends.co.uk> (last visited Mar. 31, 2009) (providing an online forum for individuals and couples to share their experiences with infertility).

84. The website for Fertility Treatment Center in Arizona states: “Fertility Treatment Center provides infertility diagnosis and infertility treatment to patients from throughout Arizona, the United States and the world, including Canada, China, India, Japan, Mexico, and others.” Fertility Treatment Center, <http://www.fertilitytreatmentcenter.com> (last visited Mar. 31, 2009).

85. See, e.g., Jinemed Hospital, <http://www.ivfturkey.com/Default.aspx?Lng=1&MID=84> (last visited Mar. 31, 2009) (displaying country flags on the welcome page to change the language of the text).

86. See *id.* (identifying a fertility clinic in Turkey); Genesis Athens, <http://genesisathens.gr/index.php> (last visited Mar. 31, 2009) (identifying a fertility clinic in Greece); Sukhumvit Maternity Clinic, http://www.smcfertility.com/WebHome/pages/Eng_index.html (last visited Mar. 31, 2009) (identifying a fertility clinic in Thailand).

87. The Reproductive Specialty Medical Center’s Egg Donor Directory page has a menu that includes a link for “Japanese.” The Reproductive Specialty Medical Center, <http://www.drury.com/DonorProfile.html> (last visited Mar. 31, 2009). The same page contains photos of donors. *Id.* According to the webpage: “Photographs are arranged by ethnicity, Caucasian (Blonde and Brunette), Hispanic, Asian, East Indian and African American.” *Id.*

ART use with vacation time. For example, the Barbados Fertility Centre advertises “A Holiday with a Purpose.”⁸⁸ Others establish a physical presence in the targeted departure point. One Italian clinic has a London office for “first consultations.”⁸⁹ The clinic’s advertisements emphasize that its staff are “drawn from the UK, the USA, Switzerland and Italy, and are all proficient in the English language.”⁹⁰

2. Clinic Affiliations and Partnerships

At least a few clinics have formed innovative affiliations with providers in other jurisdictions.⁹¹ Because third-party eggs are in short supply in jurisdictions that ban or limit payment to donors, many of these affiliations have formed to address the shortage.⁹² The Regional Centre for Reproductive Medicine in Ilford, England received attention when it began flying British patients to the Equipo IVI clinic in Spain to be implanted with eggs.⁹³ The women receive most of their preparation and follow-up treatment

88. Barbados Fertility Center, <http://www.barbadosivf.org/holidays.htm> (last visited Mar. 31, 2009). The text characterizes the holiday aspects of travel with a therapeutic purpose, noting that “psychologists have established that by reducing a couples stress levels while they undergo fertility treatments, a marked increase of a successful outcome is achieved. With that knowledge what better place in the world to reduce your stress than in the exotic island of Barbados in the Carribean.” (sic) *Id.*

89. Casa di Cura Villa del Sole, <http://www.villadelsolenapoli.it/english/londonoffice.htm> (last visted Mar. 31, 2009).

90. Treatment Abroad, <http://www.treatmentabroad.com/infertility-treatment-abroad/italy-infertility/ivf-clinic-italy> (last visited Mar. 31, 2009); *see also* Press Release, Growing Generations, Growing Generations CEO Stuart Miller Offers Surrogacy Consultations in the United Kingdom (Feb. 5, 2009), *available at* <http://www.free-press-release.com/news/print-1233817871.html> (announcing that the CEO of Growing Generations, the largest United States-based surrogacy agency, will be available for consultations in London in March, 2009).

91. *See* Boon Chin Heng, Editorial, *Taiwan (Republic of China) Legitimizes Substantial Financial Remuneration of Egg Donors: Implications for Reproductive Tourism in East Asia*, 2 EXPERT REV. OBSTET. GYNECOL. 545, 545–47 (2007) [hereinafter Heng, *Reproductive Tourism in East Asia*] (discussing the dynamic between Taiwnaese clinics, Vietnemese donors, and Japanese patients); *see also* Boon Chin Heng, Editorial, “*Reproductive Tourism*”: *Should Locally Registered Fertility Doctors be Held Accountable for Channelling Patients to Foreign Medical Establishments?*, 21 HUM. REPROD. 840, 840–41 (2006) (addressing the channeling function played by fertility doctors who refer patients to foreign fertility clinincs).

92. *See* Heng, *Reproductive Tourism in East Asia*, *supra* note 91, at 545–47 (noting the ‘affiliations’ that result from abundant egg supplies in jurisdictions adjacent to locations experiencing egg shortages).

93. *See* *UK Fertility Clinic Sends Patients Abroad to Receive Eggs*, SUNDAY HERALD (Scotland), Oct. 7, 2001, *available at* http://findarticles.com/p/articles/mi_qn4156/is_20011007/ai_n13963909/pg_1 (discussing the clinic’s preference for donor compensation, as allowed by more relaxed Spanish laws).

in Ilford, England but receive donor eggs in Spain.⁹⁴ A 2005 New York Times article described an affiliation between a United States clinic and a Romanian clinic or lab: “By using an egg donor from Romania and having the eggs fertilized in Bucharest and shipped back to the United States, the [couple seeking IVF] cut their costs to \$18,000, including enough fertilized eggs for repeated efforts.”⁹⁵

3. Transnational Clinics

Many of the larger businesses run multiple clinics. Increasingly, those businesses are choosing to locate clinics in multiple jurisdictions.⁹⁶ Nordica IVF Clinics operate in a wide range of countries.⁹⁷ Nordica’s home base is Denmark, where it operates in two cities.⁹⁸ It also has clinics in Lithuania, Nigeria, Uganda, and South Africa.⁹⁹ On the other hand, Equipo IVI in Spain seems to be targeting other Spanish-speaking countries for its international expansion. Its first two clinics outside of Spain were IVI Mexico and IVI Santiago de Chile.¹⁰⁰

4. Service Agencies and Brokers

Various types of agencies have carved a role for themselves in reproductive tourism, including medical agencies and networks. Some of these play the role of a directory—distributing information about reproductive tourism and about providers in other countries.¹⁰¹ Some operate more like brokers. Indian Med Guru, for example, claims to have negotiated special prices for clients who travel to India for fertility services.¹⁰² Quite a few

94. *See id.* (discussing the clinic’s breakdown of treatment between domestic and foreign locations).

95. Lee, *supra* note 2.

96. *See* Danfert Fertility Clinic, <http://danfert.dk/news.aspx?print=Y> (last visited Mar. 31, 2009) (stating that this Danish fertility clinic is establishing a donor program in Spain); IVF at Israel, <http://www.ivf.co.il/ecatalog.htm> (last visited Mar. 31, 2009) (declaring that IVF at Israel does “offer egg donation services overseas”).

97. *See* Nordica IVF Clinics, <http://www.nordica.org/composite-1.htm> (last visited Mar. 31, 2009) (listing Nordica’s geographic locations and global operations).

98. *Id.*

99. *Id.*

100. *See* Equipo IVI, <http://www.ivi.es/eng/centros/index.htm> (last visited Mar. 31, 2009) (noting that the expansion is a consequence of the “continuous training of specialists coming from Latin America at IVI”).

101. *See, e.g.*, Internet Health Resources, www.ihr.com/infertility/provider (last visited Mar. 31, 2009) (listing infertility IVF clinics in the United States and other countries).

102. Indian Med Guru, *supra* note 15 (“[Indian Med Guru has] negotiated special

companies provide specialized travel services. IVF Vacation arranges travel to a particular clinic in the Czech Republic.¹⁰³ Its homepage states, “[w]e will arrange your appointments at the clinic, help you find accommodations to suit your needs, pick you up at the airport, drive you to your appointment, and translate your medical information.”¹⁰⁴ Other agencies are full service agencies. They have agreements with a network of clinics and offer extensive travel assistance.¹⁰⁵ PlanetHospital’s website promises, “PlanetHospital will assist in the arrangements with the doctors, the passports and visas, and flights, hotel transfers and concierge at your disposal,” for a small additional fee.¹⁰⁶

5. Donor and Surrogate Brokers

In the past few years, demand for gametes and surrogates has exceeded supply.¹⁰⁷ Sperm banks are the major brokers of human sperm; they solicit, screen, collect, store, market, and transfer sperm in a largely for-profit sector of the fertility industry.¹⁰⁸ Egg cryopreservation is a recent development, and its efficacy is still uncertain.¹⁰⁹ Egg banking has not become the standard. Instead, most IVF procedures use fresh eggs.¹¹⁰ That requires a supply of young women ready to undergo the rigorous process of egg retrieval.¹¹¹ Surrogacy, for obvious reasons, also requires a supply of young women ready to undergo the process of embryo transfer. Some clinics and some patients who want to use third-party reproduction solicit directly for egg donors and

prices for their clients so that they can have the best medical services at affordable prices . . .”).

103. IVF Vacation, <http://www.ivfvacation.com> (last visited Mar. 31, 2009).

104. *Id.*

105. *See, e.g.*, Indian Med Guru, *supra* note 15 (discussing combined treatment and travel services).

106. Planet Hospital, http://www.planethospital.com/?page=procedure_details&id=176&name=IVF%2FCSI (last visited Mar. 31, 2009).

107. *See* Mary Crane, *The Business of Love, Sperm for Sale*, FORBES, Feb. 9, 2007, available at http://www.forbes.com/2007/02/09/spermbank-fertility-fda-ent-manage-cx_mc0209bizoflovesperm.html (discussing the demand for gametes and the current supply shortage).

108. *See id.* (noting that sperm banks represent the bulk of the \$3.3 billion fertility industry).

109. *See* Egg Freezing Center, *supra* note 49 (discussing cryopreservation for delaying pregnancy, as well as chemotherapy and radiation).

110. *See id.* (noting that “success with freezing eggs has historically been difficult to achieve”).

111. *See* Barnett & Smith, *supra* note 64 (detailing the lengthy and painful process of egg donation).

surrogates.¹¹² But egg donation and surrogacy centers, as well as individual brokers, play a significant role in maintaining the supplies of young women who provide eggs and become pregnant for others' use.¹¹³

Some jurisdictions function as exporters or importers of particular materials. Two of the biggest sperm banks in the global market are located in Denmark and the United States.¹¹⁴ As a result, Denmark and the United States are two of the biggest exporters of human sperm.¹¹⁵ In some egg donation destination spots, brokers will pay women to travel to the center's jurisdiction.¹¹⁶ Egg brokers also target young women from abroad who are on vacation or staying temporarily on student visas.¹¹⁷ Brokers also move women around to bring surrogacy to the intended parents.¹¹⁸ Thus, nations like Spain, the United States, and the Ukraine seem to be allowing the import of third-party egg

112. *See id.* (indicating that third-party solicitation is commonplace).

113. *See* Melinda Beck, *Ova Time: Women Line up to Donate Eggs—for Money*, WALL ST. J., Dec. 9, 2008, at D1 (addressing the dynamic created by brokers and other intermediaries).

114. *See, e.g.,* Lizette Alvarez, *Spreading Scandinavian Genes Without Viking Boats*, N.Y. TIMES, Sept. 30, 2004, at A4 (noting the magnitude of Danish sperm-bank Cryos International); Crane, *supra* note 107 (discussing operations at California Cryobank, one of the world's largest sperm banks).

115. *See* Alvarez, *supra* note 114 (noting that Cryos International, a sperm bank based in Denmark, estimates that its banked sperm has led to 10,000 pregnancies throughout the world since 1987); Crane, *supra* note 107 (noting that California Cryobank, one of the world's largest sperm banks, ships an estimated 2,500 vials of sperm each month throughout the United States and to 29 countries globally).

116. *See* Barnett & Smith, *supra* note 64 (discussing travel arrangements made by brokers); Eric Blyth & Abigail Farrand, *Reproductive Tourism – A Price Worth Paying For Reproductive Autonomy?*, 25 CRITICAL SOC. POL'Y 91, 100 (2005) (anticipating New South Wales's removal of sperm donor anonymity, and discussing the Albury Reproductive Medicine Centre advertised in Canada, which offered a financial package of AU\$7000 including return flight to Australia, two weeks accommodation, and a daily allowance); Kenneth R. Weiss, *The Egg Brokers*, L.A. TIMES, May 27, 2001, at A1 (featuring a young woman named Rachel who has travelled repeatedly from Massachusetts, where she is a Ph.D candidate, to California, in order to provide eggs to others for IVF).

117. *See* JULIA DEREK, *CONFESSIONS OF A SERIAL EGG DONOR* 5 (2004) (discussing an advertisement in the United States seeking egg donors “[p]referably from Northern or Eastern Europe”); *see also* Blyth & Farrand, *supra* note 116 (noting that “[t]here has been extensive reporting of the recruitment by American agencies of British students as egg donors”); Ruth Deech, *Reproductive Tourism in Europe: Infertility and Human Rights*, 9 GLOBAL GOVERNANCE 425, 427–29 (discussing “the attempted export of gametes to a country without restrictions in order to avoid national controls and the import of gametes to overcome national shortages”).

118. *See* Iris Leibowitz-Dori, *Womb for Rent: The Future of International Trade in Surrogacy*, 6 MINN. J. GLOBAL TRADE 329, 331–38 (1997) (noting brokers' actions in bringing surrogacy to intended parents).

donors and surrogates.

E. Comparing Medical Tourism

Reproductive tourism is a category of medical tourism. In medical tourism, patients travel outside their home jurisdictions in order to receive a wide variety of medical services,¹¹⁹ including ART. In fact, many medical tourism agencies that provide more general services serve fertility travelers too.¹²⁰ In addition, many if not all risks associated with medical tourism are relevant to reproductive tourism. Commentators on medical tourism have consistently raised two concerns that illustrate this point. One is the risk that medical travelers will receive substandard care and/or inadequate follow-up care.¹²¹ The other is the risk of uncertainty about foreign patients' legal recourse when something goes wrong.¹²² A woman who undergoes IVF typically receives a battery of hormone injections, and invasive procedures in order to retrieve multiple eggs and/or to transfer the embryo(s).¹²³ If she returns home without adequate instructions for follow-up care and/or a complete medical file for her treatment abroad, her home provider may not be able to provide adequate follow-up care.¹²⁴ At the same time, the uncertainty regarding a foreign patient's ability to enforce quality of care standards may incentivize the use of riskier procedures on foreign patients in order to increase pregnancy and live birth rates, and thus promote future business among travelers.

Yet, reproductive tourism is distinct from other types of medical tourism in at least three ways. First, when successful,

119. See Annette B. Ramirez de Arellano, *Patients Without Borders: The Emergence of Medical Tourism*, 37 INT'L J. OF HEALTH SERVICES 193 (2007) (describing and assessing the phenomenon of medical tourism); Sanjiv N. Singh & Robert M. Wachter, *Perspectives on Medical Outsourcing and Telemedicine – Rough Edges in a Flat World?*, 338 N. ENG. J. MED. 1622 (2008) (noting the fundamentally physical nature of medicine and how this has caused a relative lag in the globalization of medical sciences); Leigh Turner, *'First World Health Care at Third World Prices': Globalization, Bioethics and Medical Tourism*, 2 BIOSOCIETIES 303, 308–13 (2007).

120. See, e.g., Tesoriero, *supra* note 4 (discussing the travel element of reproductive tourism).

121. See Turner, *supra* note 119, at 319 (noting the possibility of dramatic price breaks for Westerners in emerging medical markets).

122. See *id.* (discussing the effects of legal uncertainty on pricing); Singh & Wachter, *supra* note 119, at 1624 (discussing outsourced medicine).

123. See Barnett & Smith, *supra* note 64, (noting the prolonged and invasive nature of egg donation).

124. See Singh & Wachter, *supra* note 119, at 1623 (discussing the risks of privacy breaches and incomplete information in medical outsourcing and how these risks affect follow up care once patient returns home).

reproductive tourism results in the birth of children. Risks arising from legal uncertainty over the parent-child relationships formed by ART use are qualitatively different from quality of care issues. The patient's interests are not the only ones at stake. The child's status and future are also at stake. If gamete donors or surrogates were involved, then their interests are also implicated.

Second, reproductive tourism relies on third parties to contribute their gametes and wombs, and to take health risks in order to enable ART use by others. Traveling to access gamete donors and/or surrogates is similar in some ways to traveling in order to access organs for transplantation. Both rely on the availability of persons who provide the raw materials of therapy from their own bodies. Both raise issues about the source and means of procuring use of others' bodies. Yet, while payment to procure gametes and surrogacy has provoked controversy, it has so far proven less controversial than payment for organ procurement.¹²⁵

Finally, to the extent that reproductive tourism relies on the use of others' bodies, it relies primarily on women's bodies—those of egg donors and surrogates. ART is gendered technology.¹²⁶ Regardless of the cause of infertility, it is the woman who is seen as infertile.¹²⁷ Pregnancy is proof of fertility; its absence marks the woman as infertile.¹²⁸ In addition, most of the treatments are administered to the woman even in cases of male infertility.¹²⁹ ICSI is used to overcome a common cause of infertility—low sperm motility.¹³⁰ Yet it is the woman who undergoes IVF in order to retrieve the eggs that are injected with sperm, and who undergoes egg transfer to achieve pregnancy.¹³¹ Thus, women bear most of the health risks, as egg donors, IVF patients, and surrogates. For many patients, egg donors, and surrogates, there are social risks as well.¹³²

125. See Subramaniam, *supra* note 6, at 40 (discussing the original response to IVF in India and how the surge in surrogacy is a partial reflection of more permissive laws than other localities).

126. Marcia C. Inhorn & Daphna Birenbaum-Carmeli, *Assisted Reproductive Technology and Culture Change*, 37 ANN. REV. ANTHROPOL. 177 (2008).

127. See *id.* at 180 (discussing some cultures' mistaken view that women bear the responsibility for reproductive problems when ART is used).

128. See *id.* (discussing the "proof of fertility" that pregnancy represents).

129. See *id.* (noting that ART is generally applied more invasively to women even when seeking to resolve a so called "male-factor").

130. See Beck, *supra* note 113 (discussing ICSI).

131. See *id.* (noting that "ICSI has revolutionized the treatment of male infertility" and how this new process physically impacts women).

132. See Inhorn & Birenbaum-Carmeli, *supra* note 126, at 182 (addressing the

II. The Drivers of Reproductive Tourism

In the broader phenomenon of medical tourism, most commentators identify cost disparities between departure points and destination spots as the most significant factor for travelers.¹³³ As one commentator stated, “[t]he main selling point of medical tourism is the attraction of ‘First World’ medical treatment at ‘Third World’ prices.”¹³⁴ A wider range of factors, including law and social norms, are significant in shaping the flow of reproductive tourism.¹³⁵ Yet, it is true that less-developed countries figure prominently among the destination spots.¹³⁶

This Part identifies several factors that affect the formation of the global fertility market.¹³⁷ The list includes legal rules and social norms, as well as cost disparities. These factors define the scope of supply and demand. They set the pathways of fertility travelers. They also determine the identities of fertility travelers and the third parties, and the geopolitical differences between them.

A. Legal Rules

In early 2003, the First International Egg Donation Conference was held in London.¹³⁸ Reproductive tourism was a major topic of the conference.¹³⁹ Many conference participants hoped to create a network in order to regulate troubling practices in egg-related reproductive tourism.¹⁴⁰ As the media reported, “[a] key problem facing conference participants is the widely differing legal restrictions in individual countries, which have resulted in couples with a range of different requirements criss-crossing borders to shop for treatment in an unregulated and potentially

health risks faced by women patients, and also noting other stigmatizing effects of participation in ART by patients, donors, and surrogates and how these effects threaten western notions of “motherhood”).

133. See, e.g., Blyth & Farrand, *supra* note 116, at 101–02 (discussing that lower cost is “a reason for the prevalence of foreigners seeking assisted conception in Belgium”); Atul D. Garud, *Medical Tourism and Its Impact on Our Healthcare*, 18 NAT’L MED. J. INDIA 318, 319 (2005) (discussing the potential economic benefits of medical tourism).

134. Garud, *supra* note 133, at 319.

135. See *infra* Parts II.A. and II.C.

136. Garud, *supra* note 133, at 318.

137. See Blyth & Farrand, *supra* note 116, at 96–102 (discussing interrelated factors that promote reproductive tourism).

138. See Sarah-Kate Templeton, *Crackdown on Illegal Fertility Trade*, SUNDAY HERALD (Scotland), Feb. 9, 2003, at 11.

139. See *id.*

140. *Id.*

dangerous international marketplace.”¹⁴¹ This quote captures the role of law in setting the pathways of reproductive tourism. Legal restrictions on the use of ART in one jurisdiction create an incentive to travel to a jurisdiction where the technology is subject to fewer or no restrictions and therefore available for use.¹⁴² A few examples follow.

It is not a coincidence that Swedes, Norwegians, and the Dutch travel to Denmark for sperm.¹⁴³ These points of departure permit only known donors.¹⁴⁴ That is, these countries prohibit anonymous donation.¹⁴⁵ As a result, sperm supply is low in Sweden, Norway, and the Netherlands.¹⁴⁶ Denmark, on the other hand, permits anonymous donation.¹⁴⁷ Supply is high there.¹⁴⁸ In fact, Cryos International (Cryos), one of the world’s largest sperm banks, is located in Denmark.¹⁴⁹ Cryos estimates its banked sperm has led to 10,000 pregnancies throughout the world since 1987.¹⁵⁰ There are many types of regulations that restrict availability of third-party sperm,¹⁵¹ and thus prompt fertility travel. The disclosure requirements nicely illustrate the role of law in promoting reproductive tourism, because distinct travel patterns emerged in response to the restrictions.¹⁵² The adoption of disclosure requirements for sperm donors dramatically changed the flow of sperm commerce.

Spain and Romania are two of the most popular destination spots for IVF and donor eggs in Western Europe.¹⁵³ Both

141. *Id.*

142. See Spar, *supra* note 62, at 531–33; see also June Carbone & Paige Gottheim, *Markets Subsidies, Regulation, and Trust: Building Ethical Understandings into the Market for Fertility Services*, 9 J. GENDER, RACE & JUST. 509, 521–23 (2006) (discussing how the “race to the bottom” phenomenon in global commerce operates in reproductive tourism).

143. See Alvarez, *supra* note 114.

144. *Id.*

145. See SHANLEY, *supra* note 10, at 87–92 (providing a thoughtful analysis of disclosure requirements).

146. See Alvarez, *supra* note 114; see also Matthew Hill, *Sperm Donors ‘Want to Keep Anonymity,’* BBC NEWS: WORLD EDITION, Oct. 15, 2002, <http://news.bbc.co.uk/2/hi/health/2329675.stm>.

147. See Hill, *supra* note 146.

148. See Alvarez, *supra* note 114.

149. *Id.*

150. *Id.*

151. See *IFFS Surveillance 07*, *supra* note 74, at S28.

152. See Alvarez, *supra* note 114; see also Spar, *supra* note 62, at 532–33 (describing clinics and clients heading to more permissive countries).

153. See Carbone & Gottheim, *supra* note 142, at 523 (describing Romania’s popularity for “fertility tourism”); France, *supra* note 23, at 47 (discussing the popularity of British couples travelling to Spain for ART).

countries permit payment to egg donors and donor anonymity.¹⁵⁴ Previously Italy was such a spot. ART use in Italy was substantially unregulated,¹⁵⁵ and at least a few providers were willing to use ART in ways that challenged social norms.¹⁵⁶ For example, Italy had one of the highest number of pregnancies among postmenopausal women due to ART use.¹⁵⁷ In 2004, however, Italy enacted some of most restrictive regulations of ART use.¹⁵⁸ Among the restrictions is a ban on egg and sperm donation, and a ban on the cryopreservation of embryos in most cases.¹⁵⁹ Italy switched positions from a destination spot to point of departure.¹⁶⁰ In 2005, the United Kingdom prohibited payment for eggs.¹⁶¹ A long waiting list for donor eggs and reproductive tourism to Spain and Romania resulted.¹⁶² Even more recently, Taiwan enacted a law that enables payment, in the form of reimbursement, for 'nutritional supplements' to egg donors.¹⁶³ Given bans on payment to egg donors in mainland China and Japan, Taiwan's new law may make that country the premier ART destination spot of East Asia.¹⁶⁴

India and the United States are two additional major destination spots for surrogacy.¹⁶⁵ India permits commercial surrogacy, although restrictive laws have recently been proposed.¹⁶⁶ In the United States, surrogacy is a matter of state

154. See *IFFS Surveillance 07*, *supra* note 74, at S28–S36 (stating that Spain permits these practices by law while Romania allows them to occur unregulated).

155. See Mary E. Canoles, *Italy's Family Values: Embracing the Evolution of Family to Save the Population*, 21 PENN ST. INT'L REV. 183, 190–92 (2002) (discussing Italy's pre-2004 regulatory approach).

156. *Id.* at 192–94.

157. See Alessandra Stanley, *Bill to Regulate Fertility Procedures Gains in Italy*, N.Y. TIMES, May 28, 1999, at A4.

158. See Andrea Boggio, *Italy Enacts New Law on Medically Assisted Reproduction*, 20 HUM. REPROD. 1153 (2005) (describing and analyzing Italy's 2004 law and its impact); Rachel Anne Fenton, *Catholic Doctrine Versus Women's Rights: The New Italian Law on Assisted Reproduction*, 14 MED. L. REV. 73 (2005); Claudio Manna & Luciano G. Nardo, *Italian Law on Assisted Conception: Clinical and Research Implications*, 11 REPROD. BIOMED. ONLINE 532 (2005), available at www.rbmonline.com/Article/2023.

159. See Boggio, *supra* note 158, at 1153–54.

160. See *id.* at 1153; *Italy Reproductive Tourism Up Four Times 2005-2006*, ANSA ENG. CORP. SERVICE, Apr. 24, 2007 (on file with author).

161. See France, *supra* note 23, at 47.

162. *Id.*

163. See Heng, *Reproductive Tourism in East Asia*, *supra* note 91, at 545.

164. *Id.*

165. See SPAR, *supra* note 40, at 83–85 (describing surrogacy laws in the United States); Amelia Gentleman, *India Nurtures Business of Surrogate Motherhood*, N.Y. TIMES, Mar. 10, 2008, at A9.

166. See Shilpa Kannan, *Regulators Eye India's Surrogacy Sector*, BBC NEWS,

law.¹⁶⁷ Some states permit commercial surrogacy.¹⁶⁸ Not surprisingly, states with laws that enable commercial surrogacy have become more popular destination spots. In California, a 1994 state supreme court decision addressed a parentage dispute arising from a gestational surrogacy agreement in which the intended parents were also the gamete donors.¹⁶⁹ The court determined that Crispina Calvert, who provided the eggs and entered the contract for the purpose of having a child to raise, was the legal mother.¹⁷⁰ The outcome of the case, which effectively enforced the contract with respect to parentage, has made California a surrogacy destination spot within the United States and in the global market.¹⁷¹ In addition, neither India nor the United States has laws denying the use of ART based on marital status or sexual orientation.¹⁷² Thus, the two countries are both major destinations and niche markets in reproductive tourism.¹⁷³

B. Cost Disparities

Reproductive tourism often makes ART use affordable, or at least less expensive. The lack of substantial regulation makes the full range of ART available in the United States, but many United States residents travel abroad for ART use.¹⁷⁴ In some jurisdictions, health insurance makes ART use affordable at home for those who could not otherwise pay for it.¹⁷⁵ As of 2007, six countries with national health plans—Belgium, France, Greece, Israel, Slovenia, and Sweden—provided substantial coverage for ART.¹⁷⁶ Of the countries for which there is data, approximately half have no insurance coverage for ART use.¹⁷⁷ In the United States, less than one-third of the states have benefit mandates for ART, and those that do tend to limit coverage to married couples, for a limited range of services.¹⁷⁸ Health insurance, especially

Mar. 18, 2009, available at <http://news.bbc.co.uk/2/hi/business/7935768.stm> (describing reactions to proposed regulation of surrogacy in India).

167. See SPAR, *supra* note 40, at 84–86.

168. *Id.* at 84–85.

169. Johnson v. Calvert, 851 P.2d 776 (Cal. 1993).

170. *Id.* at 778–85.

171. See SPAR, *supra* note 40, at 84–86.

172. See *id.* at 83–86; Dhillon, *supra* note 74, at 14.

173. See SPAR, *supra* note 40, at 84–86; Dhillon, *supra* note 74, at 14.

174. See Lee, *supra* note 2.

175. See *IFFS Surveillance 07*, *supra* note 74, at S14–S16 (providing an overview of insurance coverage laws and guidelines on a country-by-country basis).

176. *Id.* at S14.

177. *Id.* at S15–S16.

178. See Am. Soc’y of Reprod. Med., State Infertility Insurance Laws,

coverage under national health insurance, is not usually portable.¹⁷⁹ As a result, many, if not most, people who use ART pay out of pocket.¹⁸⁰ Travelling abroad to a jurisdiction where IVF, donor gametes, surrogacy, or other services cost significantly less saves money for some. For others, it makes ART financially accessible.

The cost disparity factor has made Eastern European countries like the Czech Republic, Hungary, Romania, Slovenia, Ukraine, and Russia significant destination spots for cost-driven travelers from Western Europe and the United States.¹⁸¹ Barbados, Cyprus, India, South Africa, and Thailand are also on the popular destination list.¹⁸² Reproductive tourism probably makes ART use financially accessible to some who could not afford it at home. Reproductive tourism does not, however, make fertility treatment available to most infertile individuals or couples who have truly low incomes. Most ART use remains a service in the luxury sector of health care.

Differences in cost of living between points of departure and destination spots accounts for the disparities, in part. In fact, scholars have cited lower labor costs as a factor in choosing locations for satellite clinics.¹⁸³ Those differences tend to match the countries' international standing as developed or developing countries. To the extent that cost disparities drive reproductive tourism, fertility tourists are more likely to be from developed nations, and destination spots are more likely to be developing nations.¹⁸⁴ This is particularly true for the surrogacy market.¹⁸⁵

Cost of living differences do not fully account for the cost disparities. The lack of comparable income opportunities for gamete donors and surrogates in destination spots makes them available and affordable to reproductive travelers.¹⁸⁶ At the same

<http://www.asrm.org/Patients/insur.html> (last visited Apr. 3, 2009) (providing an overview of existing United States state laws regarding insurance coverage for fertility procedures).

179. See Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71, 96–98 (2008) (discussing the portability of health insurance).

180. See Carbone & Gottheim, *supra* note 142, at 532–33.

181. See *id.* at 530–32 (describing Eastern European countries catering to Western European countries); Barnett & Smith, *supra* note 64.

182. See *supra* Part I.C (discussing destination spots for reproductive tourism).

183. See Blyth & Farrand, *supra* note 116, at 102.

184. See, e.g., Subramanian, *supra* note 6, at 40 (describing outsourcing pregnancy to India).

185. See *id.*

186. See *id.*

time, the egg and surrogacy fees often are significantly higher than income that these women could earn through other means.¹⁸⁷ Many commentators have raised concerns about the exploitation and coercion of commercial egg donors and surrogates.¹⁸⁸ These concerns are serious. Yet, they do not fully probe the fact that reproductive tourism depends heavily on the cultural and structural inequalities that create conditions in which some women's best economic opportunity is to undergo either egg retrieval, or pregnancy and childbirth for another.¹⁸⁹ For many women, the lack of comparable economic opportunity to earn a living arises from the fact that a woman's biological capacity to reproduce is used to proscribe a woman's role, status and opportunities, including her economic opportunities. Those women stand between two iterations of biological essentialism—that which proscribes their opportunities to earn a secure living, and that which makes their procreative capacity economically valuable.

C. Social Norms

Exclusionary social or religious rules often translate into clinic restrictions. Clinic rules are not enforceable at law, but when widely used, effectively limit access within a jurisdiction. As discussed above, marital status and sexual orientation are commonly used to restrict ART access.¹⁹⁰ In some jurisdictions, those rules are law.¹⁹¹ In others, they have resulted in restrictive clinic policy.¹⁹² For example, in the United Kingdom, clinic refusals to provide services to single women and lesbians have given many reason to travel to other countries where ART is

187. See Richard F. Storrow, *Quests for Conception: Fertility Tourists, Globalization and Feminist Legal Theory*, 57 HASTINGS L.J. 295, 327 (2005); see also Beck, *supra* note 113 (explaining that during the current economic recession, "[s]ome clinics are reporting a surge in the number of women applying to donate eggs or serve as surrogate mothers for infertile couples").

188. See generally Angie Godwin McEwen, *So You're Having Another Woman's Baby: Economics and Exploitation in Gestational Surrogacy*, 32 VAND. J. TRANSNAT'L L. 271 (1999) (examining the potential for exploitation that market incentives can create); Storrow, *supra* note 187 (arguing that inequalities created by reproductive tourism are overlooked due to the global capital that is created through reproductive tourism); Heather Widdows, *Border Disputes Across Bodies: Exploitation in Trafficking for Prostitution and Egg Sale for Stem Cell Research*, 2 INT'L J. FEMINIST APPROACHES TO BIOETHICS 5 (2009) (discussing exploitation in the context of international and transnational feminism).

189. See Storrow, *supra* note 187, at 327.

190. See *supra* text accompanying notes 69–73.

191. See *supra* note 69 and accompanying text.

192. See *supra* note 70 and accompanying text.

available to them.¹⁹³

In some jurisdictions, religion influences the availability of ART.¹⁹⁴ In many South American countries, where the Catholic Church is powerful, only a handful of clinics exist.¹⁹⁵ Catholic doctrine prohibits use of most ART, including IVF and any technology using third-party gametes.¹⁹⁶ Of those countries in which insurance is not available to cover infertility treatment, many are Catholic.¹⁹⁷ So, for residents of these countries who want ART access, travel may be the best means of obtaining it.

In some jurisdictions, and for some individuals in any region, infertility is stigmatized.¹⁹⁸ ART use is sought in secrecy.¹⁹⁹ Travel is a way of avoiding detection. The trip abroad is described to friends, neighbors, and co-workers as a vacation. The trip may also be described as a “fertility holiday,” but its primary purpose is to seek ART use while avoiding the stigma of infertility.

III. Equality Concerns Arising from Reproductive Tourism

This discussion identifies a small handful of concerns about the ways in which reproductive tourism depends on or reinforces inequality. This discussion raises both material and normative effects. The first two subparts not only highlight potential material consequences of reproductive tourism, but also show the

193. See Blyth & Farrand, *supra* note 116, at 98–99; see also Human Fertilisation Embryology Authority, <http://www.hfea.gov.uk/2992.html> (last visited Apr. 27, 2009) (noting that in the United Kingdom, clinic exclusions have been challenged, and that more recently, the law has changed to permit two same-sex partners to be named as parents on the birth certificate of a child resulting from ART use).

194. See Mary Rodgers Bundren, *The Influence of Catholicism, Islam and Judaism on the Assisted Reproductive Technologies (“ART”) Bioethical and Legal Debate: A Comparative Survey of ART in Italy, Egypt and Israel*, 84 U. DET. MERCY L. REV. 715 (2007) (examining the influence of three religions in three countries); John A. Robertson, *Assisted Reproduction in Germany and the United States: An Essay in Comparative Law and Bioethics* (bepress Legal Series, Working Paper No. 226, 2004), available at <http://law.bepress.com/expresso/eps/226> (analyzing the role of history and religion on ART policy and law in Germany).

195. *IFFS Surveillance 07*, *supra* note 74, at S7 (showing in table 1.1 that while there were 20-26 clinics in Argentina and 105-200 in Brazil, there were fewer than 10 in the other surveyed South American countries).

196. See Florencia Luna, *Assisted Reproductive Technology in Latin America: Some Ethical and Sociocultural Issues*, in CURRENT PRACTICES AND CONTROVERSIES IN ASSISTED REPRODUCTION: REPORT OF A MEETING ON “MEDICAL, ETHICAL AND SOCIAL ASPECTS OF ASSISTED REPRODUCTION” 31, 34 (Effy Vanyena et al. eds., 2001).

197. *IFFS Surveillance 07*, *supra* note 74, at S14.

198. See Patricia A. Butler, *Assisted Reproduction in Developing Countries – Facing Up to the Issues*, 63 PROGRESS IN REPROD. HEALTH RES. 1, 3–4 (2003).

199. See Luna, *supra* note 196, at 36–37.

role that normative assumptions play in producing those consequences. The third and fourth subparts highlight the role of narratives and norms. Because narratives and norms seem intangible, the issues discussed in these subparts may seem less substantial to some. But these norms maintain inequalities that make reproductive tourism both commercially and emotionally attractive. However intangible they seem, norms have tangible effects.

A. Inequality of Access to Health Care in Destination Spots

The scholarly commentary on medical tourism raises a set of concerns about the potential impact of medical tourism on access to health care in destination countries. Given that fertility travelers often go to less-developed countries, the medical tourism literature raises questions about reproductive tourism's impact on health care access in those countries.²⁰⁰ One question is whether the effort and resources that are put into fertility clinics and hospitals, in order to attract foreign patients, divert resources to private facilities that provide care for the elite.²⁰¹ In many countries, this could reinforce a pre-existing two-tiered health care system.²⁰² One could argue that the extra revenue generated by reproductive tourism can be used to expand health services for people who are dependent on public health care. There is, however, no evidence that this is occurring.²⁰³

A closely related question is whether a focus on ART use resets health care priorities without regard to domestic health care needs. In both developed and less developed countries, "ART is perceived as a luxury for wealthy couples, and not as a service for anyone wanting a son or daughter."²⁰⁴ In jurisdictions where ART use is not substantially covered by insurance, that perception is based on the reality that persons with low incomes and much of the middle class cannot afford fertility treatment.²⁰⁵ At the least,

200. See, e.g., Garud, *supra* note 133, at 319 (discussing the impact that reproductive tourism has on the health care distribution to those native to India).

201. See Cortez, *supra* note 179, at 110.

202. See Garud, *supra* note 133, at 319.

203. See Cortez, *supra* note 179, at 110–11 (referring to a World Health Organization (WHO) study on medical tourism, which according to Cortez, "found little evidence that countries have actually used revenues from foreign patients to support the public health sector") (citing Rupa Chanda, *Trade in Health Services 1* (Comm'n on Macroeconomics and Health, World Health Org., Working Paper Series, Paper No. WG 4:5, 2001)).

204. Inhorn & Birenbaum-Carmeli, *supra* note 126, at 179; Luna, *supra* note 196, at 32.

205. Inhorn & Birenbaum-Carmeli, *supra* note 126, at 179–80 (discussing class-

expanding a “luxury” sector of health care can trigger the perception of skewed priorities, which causes resentment.²⁰⁶ This is probably more likely in countries that recognize a right or entitlement to health care.²⁰⁷

A third question is whether reproductive tourism lures physicians to private clinics in a well-paying field of practice and away from public hospitals, creating a shortage where health care is most needed.²⁰⁸ Medical tourism scholars refer to this as the “brain drain” problem.²⁰⁹ One response is that medical tourism may be reversing the brain drain in countries like India, where the increase in high tech facilities and other resources that medical tourism has made available has lured physicians back.²¹⁰ Yet, to the extent that prodigals return to work in private facilities or in luxury specialties, the potential imbalance between private and public care remains.

B. Unequal Allocation of Health Risks to Women

As discussed above, ART is gendered technology.²¹¹ As such, it allocates most of the health risks to women. Some of the highest risks arise from egg retrieval and surrogacy.²¹² Both require the administration of pharmaceutical hormones, which creates short-term risks, and for which there is little data on long-term risks.²¹³

based inequalities in access to ART, and stating that “technologically assisted reproduction is largely restricted to global elites, whereas the infertile poor . . . are devalued and even despised as reproducers”).

206. See, e.g., Cortez, *supra* note 179, at 109 (noting that with respect to medical tourism in India, “there is a general perception that there have been adverse effects on the public health care system . . . and that these benefits have been limited to the affluent urban population”) (quoting Rupa Chanda, *Trade in Health Services 1* (Comm’n on Macroeconomics and Health, World Health Org., Working Paper Series, Paper No. WG 4:5, 2001)).

207. Luna, *supra* note 196, at 32 (noting that Argentina and Brazil recognize a right to health care).

208. See Cortez, *supra* note 179, at 109–10; Garud, *supra* note 133, at 319.

209. Cortez, *supra* note 179, at 109.

210. *Id.* at 110.

211. See *supra* notes 126–132 and accompanying text.

212. See Barnett & Smith, *supra* note 64; see also Lars Noah, *Assisted Reproductive Technologies and the Pitfalls of Unregulated Biomedical Innovation*, 55 FLA. L. REV. 603, 652–53 (arguing that the Food & Drug Administration should restrict or withdraw approval for fertility drugs because of the risks of multifetal pregnancy).

213. COMM. ON ASSESSING THE MED. RISKS OF HUM. OOCYTE DONATION FOR STEM CELL RESEARCH, NAT’L ACAD. OF SCI., WORKSHOP REPORT SUMMARY 2–3 (2007) [hereinafter WORKSHOP REPORT SUMMARY]; *Human Cloning and Embryonic Stem Cell Research After Seoul: Examination Exploitation, Fraud and Ethical Problems in the Research: Hearing Before the Subcomm. on Criminal Justice, Drug Policy, and Human Resources of the H. Comm. on Gov’t Reform*, 109th Cong. 76

Both require invasive procedures that produce real, but low, levels of risk.²¹⁴ Surrogacy also places women at risk. The majority of women who give birth experience no adverse health effects.²¹⁵ Pregnancy, however, does present significant risk of a wide range of adverse health consequences.²¹⁶ In addition, most women who carry children for others do so as gestational surrogates.²¹⁷ Typically, a woman undergoing IVF as a gestational carrier takes hormones in order to coordinate her cycle with the embryo transfer, thus increasing the chances that the embryo transfer results in a pregnancy.²¹⁸ While these drugs do not prompt multiple egg production, they may produce side effects and pose long term health risks.²¹⁹

The health risks of egg donation and surrogacy may be greater in the context of less developed countries.²²⁰ The well-established corollary is that lack of wealth correlates with lower health status.²²¹ That is a statistical fact, and is not true for every person in need. But, among even young low-income women in developed countries, morbidity and mortality rates from pregnancy and childbirth are higher than they are for middle class women.²²² Women who provide eggs or become surrogates are usually from lower income groups,²²³ and are therefore subject to higher risk.

A more subtle dynamic may also increase risk to egg donors and surrogates. Egg donors and surrogates provide the valuable

(2006) (statement of Judy Norsigian, Executive Director, Our Bodies Ourselves).

214. WORKSHOP REPORT SUMMARY, *supra* note 213, at 3 (finding that “[b]oth the surgery and the anesthesia carry certain risks” but that “[e]xperience with IVF patients shows that the risks are low”).

215. See Chopra, *supra* note 6, at 11.

216. See Noah, *supra* note 212, at 619.

217. SPAR, *supra* note 40, at 81–82.

218. Noah, *supra* note 212, at 610–12.

219. *Id.* at 620–22.

220. See Jayati Ghosh, “Rent a Womb”: *The Latest Indian Export*, MACROSCAN: AN ALTERNATIVE ECONOMICS WEBCENTRE, Oct. 11, 2006, http://www.macrosan.org/cur/nov06/print/prnt101106Indian_Export.htm.

221. See NAT’L INST. HEALTH, A MORTALITY STUDY OF 1.3 MILLION PERSONS BY DEMOGRAPHIC, SOCIAL, AND ECONOMIC FACTORS: 1979-1985 FOLLOW-UP 26 (1992) (finding that persons with higher incomes tend to live longer than persons with lower incomes); NAT’L RESEARCH COUNCIL, ELIMINATING HEALTH DISPARITIES: MEASUREMENT AND DATA NEEDS 25 (2004); Paul D. Sorlie et al., *U.S. Mortality by Economic, Demographic, and Social Characteristics: The National Longitudinal Mortality Study*, 85 AM. J. PUB. HEALTH 949, 949 (1995) (finding that higher incomes are associated with lower mortality).

222. NAT’L RESEARCH COUNCIL, *supra* note 221, at 25; Chu, *supra* note 6.

223. See, e.g., Mukherjee, *supra* note 6 (stating that “[f]or the surrogates -- usually lower middleclass housewives -- money is the primary motivator”).

raw materials of a for-profit industry. Women can provide eggs and gestational services precisely because of their sex. In addition, while egg donors and surrogates are undergoing medical procedures, they are not the patients undergoing fertility treatment. They are the means to fertility treatment. The resulting interplay between biological essentialism and commodification of the women who are the means to the end may permit a laxness in minimizing risk to those women. It may also foster a willingness to violate good medical practice in order to get results for foreign patients. For egg brokers, clinics, and fertility tourists, the more eggs retrieved per cycle, the better. Higher dosages of ovarian stimulation drugs increase the chances of multiple egg production in women. But higher dosages also increase the risk of ovarian hyperstimulation stress syndrome, which includes nausea, vomiting, accumulation of fluid in the abdomen, kidney and liver dysfunction, and even kidney failure among its symptoms.²²⁴ This normative dynamic creates an inverse relation between the egg donor's intrinsic worth and her extrinsic value in the fertility industry.

C. Reproductive Entitlement in Reproductive Tourism

Reproductive tourism for two high-demand fertility services—IVF with third-party eggs, and surrogacy—depends heavily on a lack of comparable economic alternatives for the women who provide eggs and surrogacy, and significant wealth disparity between those women and fertility travelers. But for those inequalities, fewer women would become egg donors and surrogates. In the current economic recession, in fact, clinics have reported that notably more women are applying to become egg donors and surrogates.²²⁵ In addition, but for those inequalities, the fees for third-party eggs and surrogacy might be too high to justify travel for all but a few individuals.

The causal links between these inequalities and fertility services would seem to indicate that egg procurement and surrogacy are exploitative practices. While some academics assert that exploitation is serious enough to justify regulation of these practices,²²⁶ two other responses have so far prevailed. One

224. WORKSHOP REPORT SUMMARY, *supra* note 213, at 2.

225. Beck, *supra* note 113.

226. See Bartha M. Knoppers & Sonia LeBris, *Recent Advances in Medically Assisted Conception: Legal, Ethical and Social Issues*, 17 AM. J. L. & MED. 329, 356 (1991); McEwen, *supra* note 188, at 292–96 (1999); Storrow, *supra* note 187, at 327–30.

argument locates egg procurement and surrogacy in the intimate sphere of family.²²⁷ As mentioned, a dominant explanatory narrative of ART use situates the technology use and all that accompanies it as a means of family formation. The narrative's main characters are the infertile couples who desperately want children. Within the narrative, their ability and willingness to pay for ART use evidences both their suitability and deservedness as parents. Closely examined, the narrative reveals a market-based test for parental suitability, but the narrative's trick is to shift the gaze to the yearning and need—the story's emotional content. That content is compelling because it is real. Infertility is not simply a medical condition for many. It causes emotional pain, loss of self-esteem, and breaks up relationships.²²⁸ Yet, centering the yearning for family also elides the commercial nature of the practices that enable family formation through ART use. Hence, women who provide eggs for others' use are called "donors," even though they receive thousands of dollars for doing so. They provide a "gift" that is priceless, and yet has been carefully priced.

The second response simply accepts the inequalities on which reproductive tourism depends as natural features of a market economy.²²⁹ After all, these inequalities pre-exist reproductive tourism and would persist without reproductive tourism. The free market narrative directly counters the claim of exploitation in a way that the family formation narrative does not. In the free market narrative, women who provide eggs and bear children for others are free agents. The women who participate opt into the market. Yet volunteers can be exploited. Perhaps more telling is the way that some fertility buyers use this narrative to position themselves as the means of eliminating inequality. In a New York Times story, a surrogacy client explained the decision to travel from the United Kingdom to India: "You cannot ignore the discrepancies between Indian poverty and Western wealth We try our best not to abuse this power. Part of our choice to come here was the idea that there was an opportunity to help someone in India."²³⁰ This explanation reveals the sense of *noblesse oblige* at the core of the market narrative.

227. See, e.g., IVF Vacation, *supra* note 103 (focusing on the family-formation aspect of travelling to use ART in the Czech Republic).

228. See Inhorn & Birenbaum-Carmeli, *supra* note 126, at 179.

229. See, e.g., IVF at Israel, *supra* note 96 (citing less "red tape bureaucracy" governing IVF in Israel than in the United States, and other market considerations such as lower cost of living and lab or material expenses and the strength of the United States dollar, as explanations for IVF@Israel's "Price Difference Rationale").

230. Gentleman, *supra* note 165.

Both narratives express a sense of entitlement. Purchaser's power may account for some of that. Yet the claim to purchaser's power here is not based solely on greater wealth. The use of women for their biological capacity to reproduce, in a context in which geopolitical differences between departure points and destination spots often account for the wealth disparities, supports a sense of entitlement. In addition, well established narratives that describe low-income women, women of color, and women in less developed nations as "too fertile" nourish the claim of the infertile to ART use as their due.²³¹ In other words, the identity of those who provide eggs and gestation for others overlaps with those deemed in need of population control.²³² The population control narrative has already cast the women sought for eggs and surrogacy as subalterns. In doing so, the population control narrative has prepared the ground for claims of entitlement in the family formation and market narratives.

D. Racial Alignment and Racial Distancing in Reproductive Tourism

1. Eggs and Racial Matching

Racial identity figures significantly in ART use. Those who seek third-party gametes often have specific racial preferences.²³³ Many, for example, seek gametes from donors who are of the same race.²³⁴ Racial preference affects demand in the global fertility market. For example, the success of Cryos International, the Danish sperm bank, probably depends in part on the stereotype of Northern Europeans as fair haired, blue eyed Caucasians.²³⁵ The prediction that Taiwan will become the destination spot of East

231. See Ikemoto, *supra* note 70, at 1008.

232. See Inhorn & Birenbaum-Carmeli, *supra* note 126, at 179; Luna, *supra* note 196, at 32. Both the Luna and Inhorn & Birenbaum-Carmeli articles point to the ways in which the population control narrative devalues the poor as reproducers and simultaneously obscures the fact that infertility disproportionately affects low-income women and men, particularly in the non-Western world. Compare Luna, *supra* note 196, at 32, with Inhorn & Birenbaum-Carmeli, *supra* note 126, at 179.

233. See, e.g., The Reproductive Specialty Medical Center, <http://www.drury.com/DonorProfile.html> (last visited Feb. 27, 2009) (indicating in the "Egg Donor Directory" section of the webpage that "[p]hotographs [of available egg donors] are arranged by ethnicity, Caucasian (Blonde and Brunette), Hispanic, Asian, East Indian and African American").

234. Alvarez, *supra* note 114; Kenneth R. Weiss, *Eggs Buy a College Education*, L.A. TIMES, May 27, 2001, at A31.

235. Newser, *FDA Rules Block Import of Prized Danish Sperm*, Aug. 13, 2008, <http://www.newser.com/story/34788/fda-rules-block-import-of-prized-danish-sperm.html>.

Asia is premised, in part, on the role of racial preference in the egg market.²³⁶

In the gamete market, racial preferences seem natural and unobjectionable because they enable the resulting family to look like a biologically-related family. The goal of a racially matched family in a commercial context may have two problematic effects. First, it makes race a commodity in the gamete market. Second, the naturalizing effect of the racial preference is elastic. It makes other genetic preferences seem both natural and acceptable, thus clouding what might otherwise seem to be obvious eugenic preferences.

2. Surrogacy and Racial Distancing

When gestational surrogacy is used, the intended parents or third parties provide the gametes. As a result, the race of the surrogate does not inform the race of any child born from gestational surrogacy. Race matching plays a smaller role in the preferences of fertility travelers who seek surrogates. Hence, racial differences between fertility travelers and surrogates are more common than they are in the egg market.²³⁷ This enables sites such as India to flourish as destination spots for White fertility travelers from Western Europe and the United States.

The racial difference might even make a destination spot more attractive. The character of the mainstream media's attention to India's surrogacy industry illustrates the reasons for this point. The media stories represent the surrogacy business in India as exotic because of racial, cultural, and economic differences between the fertility tourists from the United Kingdom and United States and the Indian surrogates.²³⁸ At the same time, the stories make India's role in reproductive tourism seem like a predictable aspect of India's success in positioning itself as the destination spot for outsourcing the service economy.²³⁹ What these stories express is the persistence of a form of racial distancing that may make hiring a woman to gestate, give birth to, and give up a child psychologically comfortable. It is a post-industrial form of master-servant privilege. In effect, it makes the non-White woman in the non-White country a marketable source of surrogacy.

236. Heng, *Reproductive Tourism in East Asia*, *supra* note 91, at 546.

237. See SPAR, *supra* note 40, at 83.

238. See sources cited *supra* note 6 (providing examples of the media's portrayal of surrogacy in India).

239. See Chu, *supra* note 6; Haworth, *supra* note 6, at 124; Subramanian, *supra* note 6, at 42.

Conclusion

Equality concerns arise from the very way that reproductive tourism works. It might be accurate to say that inequality is a driver of reproductive tourism. That is probably true for other markets as well. But reproductive tourism has two elements that make acknowledging the equality concerns uncomfortable. One is the desired product: a family. Reproductive tourism is a commercial means of acquiring one of the most intimate aspects of human life—the parent-child relationship. The second element of reproductive tourism that groups it with disreputable markets (sex tourism, the organ trade) and distinguishes it from reputable ones, is that it relies heavily on women’s bodies, and in particular, woman’s reproductive capacities. Here, the discomfort arises in part from the fact that a woman’s reproductive work has become part of a formal economy.

Neither the explanatory narratives for reproductive tourism nor the existing scholarship addressing reproductive tourism seems to want to look at the ways that reproductive tourism mixes the commercial and the intimate. So far, most of the discourse embraces protection for the intimate and personal or for the market, but evades a close account of how they intertwine. The ways in which the explanatory narrative of family formation shift the gaze from the commercial aspects make this evasion possible. The alternative has been to embrace the market and the purchaser’s prerogative. Yet that explanation skims the gendered nature of ART use, and ignores the fact that norms and narratives shape the market.

Reproductive tourism is a rapidly shifting set of practices that mix the commercial and intimate in a wide variety of settings that literally span the globe. This does not necessarily suggest that law cannot address the equality concerns. It hopefully suggests two other things. One is that law is only one factor and creates one type of contingency; legal change should be contemplated with humility and attention to both its local and extraterritorial effects. The other is that the equality concerns, as discussed in this Article, are incomplete and contingent on experiences that only the participants in reproductive tourism can recount.