ESHRE fact sheets 1
January 2017

Cross border reproductive care

1. Cross border reproductive care - sometimes referred to as 'reproductive tourism' - describes the provision of fertility services for patients who travel outside their home country for treatment.

2. There are several explanations for this trend among patients: to avoid legal restrictions at home (eg, fertility treatment for single and lesbian women in France, PGD in Germany); to avoid long waiting-lists at home (for egg donation in UK); for less expensive treatment; and to be treated within a more personally suitable framework (eg, gamete donation with donor anonymity).

3. In Europe, Spain and Belgium appear to be the most frequently visited countries for treatment, while the USA remains a popular worldwide destination. Spain in particular - which is by far Europe's most active country in assisted reproduction with around 120,000 cycles performed in 2013 - is noted for its efficient services (minimal waiting times) and plentiful donor gametes. A survey performed by ESHRE in 2010 found that two-thirds of all cross-border patients visiting six European countries for treatment came from Italy (31%), Germany (14%), The Netherlands (12%) and France (9%). At the time, Italy had Europe's most restrictive legislation in IVF.

4. The full extent of cross-border reproductive care in Europe is not precisely known because many national treatment registries do not record the patient's country of origin, only the treatment cycle. However, based on surveys performed over the past ten years it has been estimated that around 5% of all fertility care in Europe involves cross-border patients. A recent study performed by the Centers for Disease Control (CDC) in the USA found that almost 3% of all US cycles in 2013 were in non-US residents, though noting that registry attempts to collect cross-border information from clinics 'have suffered from low response rates and

incomplete data'. Traffic was highest in 'specialised' procedures such as egg donation, PGD and surrogacy.

5. ESHRE recognises the advantages and disadvantages of cross border reproductive care: it enhances patient autonomy in providing an equal opportunity of treatment to all, even if that autonomy may imply national law evasion (though not law-breaking) and variable cost; cross border reproductive care also meets the principle of freedom of patient movement within the EU (as set out in a 2008 Directive of the European Commission).(1) However, in the absence of international standards of care ESHRE notes concerns for health and safety, particularly with respect to the number of embryos transferred (and thus the risk of multiple pregnancies), the quality of patient information, and the potential exploitation of gamete donors and surrogates. Fears have also been expressed that overseas patients, who may well be lost to follow-up, do not receive the same standard of regulated care as domestic patients, though this has not been borne out in studies; the CDC study cited above found no bias in outcome, reporting comparable rates of embryo transfer and live birth for US and non-US residents.

6. ESHRE has repeatedly expressed its views on fertility care and on the equitable provision of IVF as a safe and established treatment of infertility for all, stating:
'As defined by WHO, infertility is a complex pathology that requires appropriate investigation and treatment. One of the most effective treatments is IVF and its related technologies; these techniques cannot be replaced by other procedures and have resulted in the birth of more than 6 million babies throughout the world. Denying the efficacy and accessibility of these treatments to infertile couples is not only unethical, but is also contrary to the principles of evidence-based medicine and good medical practice. All treatments known to be safe and effective should be available to all infertile patients, who should be given the opportunity to make informed reproductive choices on the basis of sound scientific evidence.' ESHRE has in the past expressed its opposition to national legislations which appear to undermine these principles (as in Italy in 2004 and Poland in 2016).

7. In a bid to maintain safe and effective standards in cross border reproductive care ESHRE has developed a good practice guide for practitioners which takes into account the patients themselves, their future child and the interests of third-party collaborators such as gamete donors and surrogates.(2) Such standards require equity in care, high quality and evidence-based treatment, patient involvement and avenues for redress. The guidelines stress that donors (of

eggs) should be treated with minimum risk and screened according to the requirements of the EU Tissue & Cell Directives, and recommend that all donor egg collections and donations should be recorded in a national register and that intermediate agencies should be avoided.

8. On egg donation, ESHRE data studies have found that around 50% of all European egg donation treatments are performed in Spain. It is estimated that most of these treatments are in overseas patients. There is no evidence that donors in Spain are 'exploited' or paid more than elsewhere. An ESHRE study of 2014 found that the payment per donation in Spain was fixed at €900, comparable to most other European countries as compensation for expenses. Data from the Spanish national registry for IVF (for 2014) show that 8.5% of all fertility treatments in Spain were in foreign residents, the majority (66%) egg donation.

9. ESHRE recognises that the ideal in reproductive care is fair access at home to good quality treatment. However, when for any reason this is not possible cross border reproductive care provides a second-best solution, circumventing many of the reasons for restriction. Limited evidence shows that many of the fears associated with cross-border care are not evident in practice.

1. See http://ec.europa.eu/health/ph_overview/co_operation/healthcare/docs/COM_en.pdf
2. Shenfield F, Pennings G, De Mouzon J, et al. ESHRE's good practice guide for cross-border reproductive care for centers and practitioners. Hum Reprod. 2011; 26: