CROSS-BORDER SURROGACY

The Necessity for a National and International Convention

Jordan Kirby

For parents Lesley and John Brown, Assisted Reproductive Technology (ART) transformed their lives and provided them a means of conceiving the family they had long dreamt of. In 1978, Louise Brown, the child of Lesley and John, was born as the first baby conceived with the use of in vitro fertilization (IVF).[1] This ground-breaking event heralded a new era of reproductive medicine, enabling greater reproductive autonomy for both men and women. By 1980, the first successful Australian IVF baby was widely celebrated at Melbourne’s Royal Women’s Hospital, followed closely by the first baby from an egg donor and a frozen-thawed embryo.[2] With 1 in 6 couples and approximately 186 million individuals suffering from infertility worldwide, ARTs have begun to unmask the unprecedented possibilities of conceiving a family for many. [4, 3]

Initially faced with polarising ethical debate, ART has increasingly become more accepted within society, coinciding with evolving modern family dynamics, more accessible IVF subsidies and improved IVF success rates.[5] Currently, over 230,000 Australian babies have been born with the support of ART since the 1980s.[2] Accordingly, 5% of all babies born in Australia today are conceived with the support of reproductive technologies, such as IVF and gamete donation.[6] However, one of the more legally, socially and economically complex forms of ART is surrogacy, with the demand for cross-border surrogacy becoming progressively more prevalent.

Cross-Border Surrogacy

Surrogacy, where a woman bears a child for another person or couple, can take the form of traditional surrogacy or gestational surrogacy. Traditional surrogacy, the earliest form of surrogacy, involves using the surrogate’s own egg (ovum) and a donor’s sperm, resulting in the surrogate being the genetic mother.[7] Gestational surrogacy, the more common form today, involves a surrogate bearing a child for another person or couple where the surrogate is not genetically related to the child. Therefore, the sperm and the ovum from the intended parents are retrieved, fertilised and implanted into the surrogate’s uterus.[7] From an economic perspective, surrogacy can be altruistic, where there is no financial gain for the surrogate, or commercial, where the surrogate profits. In Australia, altruistic surrogacy is the only legal form of surrogacy. [8] Due to legal variations between Australian states and difficulties finding a surrogate, Australians have begun to look overseas, creating the phenomenon known as ‘cross-border surrogacy’. [9]

The acceleration in ART developments during an era of globalization in a multi-cultural world prompted the beginnings of cross-border reproductive care (CBRC). Amongst other forms of ART, cross-border surrogacy has become one of the most pursued overseas reproductive services for both couples and singles looking to achieve their reproductive goals. [9] For women with congenital anomalies of the uterus, cancer patients receiving chemotherapy or radiotherapy, or women who have had a

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previous hysterectomy, surrogacy offers a means of preserving reproductive autonomy.[9, 10] Typically, the parties involved include an individual (or couple) intending to become the legal parent(s), a traditional or gestational surrogate in a foreign country, a team of health professionals, a broker who organises the financial and legal contracts necessary, and a prospective party, the child.[9] The extensive process of cross-border surrogacy entails a multitude of financial, legal, socio-cultural and medical complexities as it transcends political borders and legal frameworks.

Why are Australians looking for cross-border surrogacy?
Globally, an estimated 25,000 couples travel overseas annually to initiate CBRC including IVF and surrogacy.[11] Approximately, 160 million people in Europe do not have access to donor eggs or sperm, further amplifying demand for transnational reproductive care.[12] Those seeking CBRC do so for a number of reasons, including substantially lower costs and more flexible laws overseas.[13] A recent survey of Australian and New Zealand couples found that one of the key motives for seeking CBRC were difficulties with eligibility in their home countries, pushing them to seek a less restrictive legal system for fertility services.[14]

Single women and same-sex couples
With recent changes in social beliefs and the political sphere, the denotation of a modern nuclear family and the consequential rights to reproductive autonomy for single women and same-sex couples have come under the limelight. Whilst 44% of families in the 2016 Australian census were traditional nuclear families consisting of a male and female partner with two children, a substantial 15% of families were one-parent families.[15] Additionally, the data demonstrated a significant 39% increase in the amount of same-sex couples living together since 2011, which has quadrupled over the past 2 decades.[16] The statistics undoubtedly illustrate a growing pluralism in modern family architecture, congruent with shifting societal values and legislative alterations, with same-sex couples legally permitted to marry as of late 2017. However, access to ART, such as IVF and surrogacy, continues to be problematic for single women and same-sex couples.

Prior laws had restricted single women, who were not married nor in a de facto relationship, from accessing ART in a variety of states in Australia. However, a number of legal challenges argued that this contravened the Sex Discrimination Act 1984 (Cth), discriminating on the basis of marital status or sexuality.[17] Consequently, the Victorian Assisted Reproductive Treatment Act 2008 permitted both single women and same-sex couples to access ARTs, such as IVF.[18] However, as ART legislation is under the jurisdiction of the state government, no nation-wide legal consensus exists. Western Australia (WA) still prohibits surrogacy for same-sex couples and single men.[19, 20] Whilst Queensland (QLD) currently allows same-sex couples and singles access to surrogacy,[21] changes in political leadership led to attempts to re-criminalise surrogacy for these marginalised groups in 2012.[22] An ongoing lack of bipartisanship and the tribulations with navigating enigmatic legislation has fuelled the demand for CBRC, particularly for single women and same-sex couples.

Financial adversities
The current expense of IVF and surrogacy in Australia has considerably contributed to the growing popularity of CBRC. A typical cycle of IVF can cost up to $9,828 with out of pocket costs estimated at $4,990 for the first cycle, with couples commonly requiring multiple cycles.[18, 23] For rural and remote individuals, there may be additional costs associated with travel, accommodation and time away from work. Whilst most countries place limits on the number of subsidised IVF cycles, Australia does not, providing Medicare rebates for all subsequent IVF cycles should one require them.[18] However, to be eligible for subsidy, a single woman or a couple must be deemed ‘medically infertile’ by a fertility specialist.[24] Infertility is defined as the inability to conceive and have a baby after 12 months of regular unprotected sexual intercourse if under 35 years, or 6 months of regular unprotected sexual intercourse if 35 years or over.[24] However, many IVF clinics state that an individual (male or female) with no pre-existing fertility ailment and same-sex couples, who are defined in the literature as ‘socially infertile’, do not meet this strict criteria.[24, 25]

In comparison, an IVF cycle overseas can range from $12,400 AUD in the United States to $1,272 AUD in Iran, with extensive variations in medical expertise, insurance coverage and ART success rates. [11] Although commercial surrogacy is illegal in Australia, altruistic surrogacy is not entirely cost free as intended.
parents are expected to cover the costs of medical tests, ultrasound scans, doctor’s consultations, counselling and legal fees.[26] The total cost of a surrogacy is pre-determined and agreed upon prior to entering a legal contract.[26, 27] However, it can cost anywhere from AUD$15,000 to $100,000. [26, 27] In contrast, commercial surrogacy in India ranged from US$10,000 to US$20,000, inclusive of the IVF, antenatal care and financial compensation for the surrogate.[9] Ultimately, large discrepancies in financial expectations and overall costs have driven singles and couples to seek more affordable CBRC in overseas countries, which can potentiate financial vulnerability and exploitation in an unregulated transnational economy.

Defining ART success
As pregnancy encompasses an ever-changing biological journey with constant embryonic development and maternal physiological adaptations, the question of when the process is deemed ‘successful’ can be challenging. A successful IVF procedure, external to the intricacies of the human body, has not yet endured the uncertainties of intra-uterine implantation and months of gestation with the hope of a live birth. A study on Australian and Canadian parents seeking CBRC found that the ambiguity surrounding ART success rates and an inadequacy of available information on surrogacy in their resident country significantly motivated their decision to pursue care overseas.[28] Furthermore, a recent study found 53 fertility clinic websites used 51 various outcome measures to define ART success.[29] Another study, conducted in New Zealand, found various fertility clinics defining success in 32 diverse ways, further blurring the lines on ART outcomes.[30] The study found inconsistencies between clinics, incorrectly using the overall pregnancy rate and live birth rate as measures of ART success interchangeably.[30] Additionally, multiple embryo transfers still commonly occurs overseas despite concerns regarding maternal and neonatal safety.[31] This skews pregnancy success rate data and, subsequently, paints an equivocal image of prosperity for patients, encouraging them to seek CBRC.[32] Fertility clinics may be selectively reporting biased data, leading to poor quality healthcare communication for prospective patients.[30] Whilst the appropriate measure of success will depend on the procedure itself and will vary from patient to patient, couples are finding the reported disparities in international ART success rates disconcerting when attempting to make informed decisions regarding their fertility choices.[30]

The complexities of transnational surrogacy agreements
The international nature of cross-border surrogacy lends itself to further downstream complications, legally, medically and economically. Inconsistencies in legislation between the intending parents’ resident country and the surrogate’s country can lead to lasting legal difficulties, even after the birth. Currently, NSW, QLD and the Australian Capital Territory (ACT) criminalise any individual from engaging in overseas surrogacy, subjecting individuals to extensive fines and imprisonment.[33] Due to legislative restrictions, there are inherent difficulties with determining the citizenship status of the child in the intending parents’ country, generating legal obstacles for parentage rights.[33] In addition, birth certificates under one international jurisdiction are not binding under Australian laws.[33]

Recently, a German court recommended the biological mother of a child who was born from a gestational surrogate in Ukraine, would have to adopt her child in order to gain parental rights back in Germany.[34, 35] The dissonance in surrogacy legislation between Germany and Ukraine, and the fact that neither court’s decision is transferrable to the other country, leaves all parties involved in constant insecurity. Furthermore, disparities in healthcare quality, availability and costs between each party’s country can lead to unfavourable and distressing outcomes when unexpected medical problems ensue.

In 2014, the story of ‘Baby Gammy’ fuelled polarising debate on the ethics of cross-border surrogacy, pushing Thailand to ban foreigners from pursuing surrogacy in Thailand altogether.[36] A young couple had found a willing commercial surrogate in Thailand and during the pregnancy, one of the two foetuses was diagnosed with Down Syndrome. Subsequently, the discussion of abortion, ongoing medical care and the desires of both the intending parents and surrogate led to conflict between the parties involved.[36] The intending parents decided to return to their home country, Australia, with the non-Down Syndrome child only.[36] The surrogate decided against a termination of pregnancy due to an inherent conflict with her Buddhist beliefs.
Prior to the ban of commercial surrogacy for non-Indian citizens and non-Indian residents in India during 2017, the surrogacy economy had become a US$445 million-a-year industry in India alone.[9, 37, 38] The outsourcing of surrogacy overseas and the unregulated nature of the market poses threats to those who are financially vulnerable, causing cross-border surrogacy to walk a fine line between non-maleficence and beneficence from an economic perspective. The inconsistencies in the pricing of surrogacies, associated medical costs and legal fees between clinics and countries can expose intending parents to financial manipulation. Whereas, surrogates can fall victim to economic exploitation, human trafficking and coercion.[39] A survey of commercial surrogates in India found that the key motivation for accepting surrogacy was financial in nature.[40] The interviewed women stated that the stigma from family members often resulted in the surrogates having to relocate away from family after childbirth.[40] Moreover, Schurr and Militz argue that no matter the form of surrogacy, commercial or altruistic, the attachment and detachment of the gestational mother and the emotional and social implications of gestation carry heavy costs for the surrogate.[41] Hochschild, a sociologist, reiterates that modern commercialization of intimate life “reach[es] into the heart of our emotional lives, a realm previously more shielded from the market”, and perhaps, establishing a new, yet potentially dangerous, form of ‘emotional capitalism’.[42, pg.11]

Building multi-national solutions from a top down approach

The phenomenon of CBRC is rapidly growing and inadequacies and inconsistencies in national and international regulations pose risks for all parties involved. From a national perspective, legislating to allow single men, women and same-sex couples to access ART, including surrogacy, will help to address the demand for fertility services. The debate on whether same-sex couples should be eligible for ART subsidy is ethically and economically difficult, requiring further liaison with clinicians and LGBTIQA+ representatives.[43] The Reproductive Technology Accreditation Committee (RTAC), an independent Australian regulatory board formed in 1987, has since aimed to standardise ART success rate communication in Australia. However, the current RTAC guidelines for fertility clinics are not effectively translating into improved patient understanding. [30] To improve ART data transparency and the patients’ understanding, stricter standards on data communication and consistency amongst clinics requires further review from the RTAC.

From an international perspective, despite the ease of outright prohibition, forbidding surrogacy and the ability to pursue CBRC altogether restricts intending parents’ and a surrogate’s reproductive autonomy. As cultural, religious and ethical beliefs markedly differ between countries, instituting transnational unison on surrogacy legislation would be unrealistic. However, an internationally recognised convention, outlined by Trimmings and Beaumont, that establishes minimum medical standards for surrogacy agreements would see improved support and safety for all parties involved.[44] Nonetheless, the level of minimum healthcare enforced is difficult to determine with large discrepancies in healthcare availability, public subsidy and quality between countries. In addressing economic exploitation, a number of countries have prohibited commercial surrogacy and only allow altruistic forms to occur. In countries that allow commercial surrogacy, enforcing one nationally standardised price may prevent parents from being financially manipulated, offering a level of national economic control. However, an internationally set price would be impractical with large variations in currency, economic performance and inflation within dynamic economies.[45]

Conclusion

With the unrelenting rise of a multi-billion dollar international industry, CBRC is multifaceted and calls for urgent stricter regulation. Since the birth of ART during the 1970s, the demand for international reproductive care has substantially increased, yet transnational regulations have failed to keep up, leaving surrogates and intending parents in danger of adverse outcomes. Undeniably, CBRC enables the world to access greater reproductive autonomy and healthcare services. However, the transnational nature precipitates a multitude of inherent medical,
legal and financial risks, engendering a tight-robe balancing act between beneficence and non-maleficence. Arguably, meticulous international regulation is certainly arduous. However, given the intricate ripple effects of cross-border surrogacy, a harm minimisation approach, set by an internationally agreed upon convention, is unquestionably indispensable.

About the Author
Jordan Kirby is a final year medical student completing his clinical years at South West Healthcare, Warrnambool through Deakin University. He is the current president of Deakin University Obstetrics & Gynaecology Society and is enthusiastic about women’s health on a national and global scale. Prior to studying medicine, Jordan completed research in malarial infections in the placenta, appreciating the significance of public health and women's rights advocacy in achieving positive health outcomes.

Conflicts of Interest
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Correspondence
jkirby@deakin.edu.au

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