MAKING BABIES: ETHICAL AND PUBLIC POLICY ISSUES OF GOVERNMENT INTERVENTION IN FUNDING FOR MEDICALLY ASSISTED REPRODUCTION AND ADOPTIONS

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Abstract

This paper discusses and illustrates some of the ethical issues related to assisted reproduction and adoption along with reasons why these issues are controversial. The paper then presents some current government interventions in how assisted reproduction efforts and adoptions are funded along with related ethical questions. Finally, the paper concludes by discussing the role of government and presenting some problems with governments being involved in these interventions.

INTRODUCTION

A second-grader came home from school and told her mother that she learned in school that day how to make babies. The mother was caught off guard, thinking her daughter was much too young to learn about the birds and the bees, especially at school rather than at home. She tried not to look too surprised and upset, but wanting to know more, she said, "Oh yes? How is that?" Her daughter quickly

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replied, "You change the "y" to "i" and add "e-s."
(Source unknown)

While this paper does not focus on spelling rules, it does have to do with making babies. The increasing ability of technology to assist in human reproduction is associated with numerous ethical issues. In addition to natural childbirth and assisted reproduction, families also get children through the adoption process. This process is also surrounded by ethical issues. This paper discusses and illustrates some of the ethical issues related to assisted reproduction and adoption along with reasons why these issues are controversial. The paper then presents some current government interventions in how assisted reproduction efforts and adoptions are funded along with related ethical questions. Finally, the paper concludes by discussing the role of government and presenting some problems with governments being involved in these interventions.

INFERTILITY TREATMENTS AND ETHICAL ISSUES

Those who find themselves unable to have the children they desire to have may seek treatment for infertility. Multiple treatments are now available, and technology continues to advance, allowing increasing possibilities in the search to help individuals have children. While the conception of children has, throughout history, traditionally been a function of the union of the egg from the female and the sperm from the male through natural relations between genetic parents, technologies have been developed which make other methods of conception possible.

Reproduction-aiding techniques can fall into one of two categories: “those in which the roles of genetic, gestational, and social parents remain as they are in natural reproduction; and those in which the provider of sperm, egg, or gestational functions is other than one of the social parents” (Kaplan and Kaplan, 1992, p. 22). The first category includes artificial insemination using the male partner’s sperm and in vitro fertilization (IVF). The second

category includes techniques such as artificial insemination with donor sperm, IVF coupled with egg donation, embryo transfer, and surrogate motherhood (Kaplan and Kaplan, 1992).

Artificial insemination happens when sperm are collected and mechanically introduced into the uterus or the cervix around the date of ovulation. The sperm collected can be either from the male partner or from a donor. With IVF (with or without egg donation), eggs are retrieved, sperm and eggs are united outside the body (in a glass petri dish or "test tube"–thus the term "test tube baby"), and then one or more embryos are introduced into the uterus when implantation is possible. Embryo transfer occurs when a developing, fertilized egg is transferred from one woman to another before implantation. The second woman gestates and gives birth. The first woman may have been artificially inseminated with the sperm from the recipient woman's husband. Typically, surrogate motherhood is the artificial insemination of the surrogate mother with the contracting man's sperm. The surrogate agreement calls for the surrogate mother to give up the rights to the child to the contracting man (and his wife)(Kaplan and Kaplan, 1992).

Where health and fertility conditions allow, it is likely that most couples experiencing either male or female infertility would prefer to have children genetically related who can be carried by the female partner and raised by the couple. These couples may first consider options in the first category mentioned above. If health or fertility conditions do not allow success through one of the options in the first category, options in the second category may be considered.

A number of ethical issues can arise in considering assisted reproduction techniques. Some of these are listed below in no particular order and without the intent that the list is all inclusive. Some of the items in the list are also illustrated by specific cases.

> –Status of embryo–Is it worthy or unworthy of legal protection?
>
> –Access to infertility treatments (marital status, age limitations [post-menopausal or other], handicaps) and who decides who gets treatment? (Shenfield, 1997)

–Linda is in a relationship with another woman and seeks help to have a child. The doctor is uncomfortable accepting Linda as a candidate for assisted reproduction because of his personal beliefs on families (Dooley, et al., 2003).

–Diana is single and is feeling lonely. However, she believes that a serious relationship requires commitment she is unwilling to give. She wants to have a child through donor insemination (Dooley, et al., 2003).

–Status of and "rights" to embryo, sperm, or eggs upon the death of the individual(s) who contributed the genetic material (becoming a parent after one's death)

–Mario and Elsa Rios traveled to Australia for IVF treatment. Three eggs were obtained from Mrs. Rios and were fertilized in vitro with donor sperm. One fertilized egg was implanted, and the remaining two were frozen for possible future use. The implantation resulted in a miscarriage, and Mrs. Rios did not feel emotionally ready for a second attempt at that time. Mario and Elsa were subsequently killed in a plane crash. The question arose as to what should be done with the frozen embryos. It was also discovered that the Rioses had left a considerable estate. Would one of the frozen embryos, if implanted and gestated, have a right of inheritance? Who has the rights to these frozen embryos? Who has the right to decide their fate? (Alpern, 1992).

–Informed consent issues for both parents and children

–A husband and wife had been trying to achieve a pregnancy. The wife died from a reaction to an anesthetic during routine surgery. The husband wanted to have the ovaries removed so the eggs could be harvested later, fertilized, and implanted in

a surrogate. The wife is dead and cannot give her consent (Dooley, et al., 2003).

–Embryo selection for IVF (including pre-implantation diagnosis and selection issues); appropriate disposition of others (cryopreservation for later attempts, donation, research, disposal [For those with beliefs against abortion, does the disposal of an embryo here have the same moral consequence as an abortion?])

–Linda and Philip are both deaf. They are accepted for IVF treatment. During the procedure, they choose to have the embryos with congenital deafness implanted first because they argue that the quality of life is better for the deaf than for those who can hear (Dooley, et al., 2003).

–Creating a child to save another (Pennings and Liebaers, 2002)

–Molly was born with a rare genetic defect. Her only chance of survival is a bone marrow transplant which has a much higher rate of success from a related donor. Molly's parents undertake IVF treatment. Preimplantation genetic diagnosis is used to screen the embryos to eliminate those with the same genetic defect and those which will not have a tissue match for Molly. Molly's brother, Adam, is subsequently born. Blood cells from Adam's umbilical cord were transplanted into Molly. Molly's prognosis is very positive (Dooley, et al., 2003).

–Increased risk with multiple pregnancies (for both mother [and father] and children, both physical and otherwise, both during pregnancy and long-term throughout life)

–Reproductive tourism (going to a jurisdiction that allows the desired treatment because it is not legal/available in one's home state or country)

–Parents at risk (HIV or other viruses)–What differences in reproductive technology assistance are appropriate for at-

risk groups, even if or especially if the assistance is sought to reduce the risk?

–"Preserving" the ability to parent later by preserving genetic material (in case of cancers or other diseases for which the disease or the treatment may impair future fertility)

–Contracting issues for surrogate parenting arrangements—Are the contracts valid? Is this selling a baby? What if multiple parties want the baby? What if nobody wants the baby?

> –William Stern entered into a surrogate parenting arrangement with Mary Beth Whitehead. Mrs. Whitehead was to be artificially inseminated with Mr. Stern's sperm, carry the baby to term, and give up her parental rights so Mrs. Stern could adopt the child. After the birth of a healthy baby girl, Mrs. Whitehead decided not to give up the child. A custody battle ensued (Alpern, 1992).
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> –Mr. Malahoff entered into a surrogate parenting arrangement with Mrs. Stiver. Mrs. Stiver was supposed to be inseminated with Mr. Malahoff's sperm, carry the child to term, and give up her parental rights. The baby was born with severe medical problems, and all parties were much less willing to take responsibility for the child. In addition, it was later learned that the conception was not the result of the artificial insemination from Mr. Malahoff's sperm but from intercourse Mrs. Stiver had with her husband shortly before the insemination (Alpern, 1992).

–Donor issues (right to anonymity of donor, secrecy of donation issues for children, right to know, future health history concerns for genetic inheritance)

> –Sarah and John are married, but John is infertile. Sarah preferred to adopt, but John wanted to try donor insemination to look more like a normal

family. They have two sons, both conceived by donor insemination. However, Sarah and John disagree on what information about the process should be shared with family, friends, and even their children (Dooley, et al., 2003).

WHY ARE ISSUES RELATED TO CREATING LIFE CONTROVERSIAL?

Life and the creation of life can be viewed from religious, social, physiological, psychological, legal, economic, political, human rights, and other perspectives. Because of this variety of possible perspectives and the many different views within each perspective, many issues related to creating life are controversial. Some discussion of religious views will be presented next, including some information about two related cases. Health care and reproductive rights will also be discussed. Then a list of other perspectives and views that may illustrate the controversial nature of assisted reproduction will be presented.

Issues surrounding the creation of human life are very important to most religions. These issues may be at the center of the religious view of human experience. Procreation of life may be seen as humans working with God in the creative process. This perspective results in implications as to how religions view assisted reproduction (Mahoney, 1990). ". . .in some parts of the world such as the Middle East, from where the three major religions, namely Judaism, Christianity and Islam, emerged, religion is still meaningful and influences many behaviors, practices and policies. This also applies to conservative followers of these religions in different parts of the world. All three major religions have encouraged procreation within the frame of marriage" (Serour, 2006, pp. 99). "The Catholic view from Rome, putting an absolute value on the unbreakable nexus between coitus and conception, forbids all members any ART [assisted reproductive technology] practice which bypasses the sexual union

of man and woman" (Serour, 2006, pp. 102). The Catholic view is not necessarily held by other Christian faiths.

Serour (2006, p. 109) describes his general understanding of the view in Oriental cultures (influenced by Confucian, Taoist, and Buddhist perspectives). ". . .reproduction is one of the main concerns, linked with the significant value of the family. Filial piety requires people to extend the life of their ancestors and continue the family line from generation to generation. . . .In general, any intervention in natural reproduction is undesirable because it disturbs the *dao* of nature, but it is more acceptable than being childless."

A huge stigma is attached to infertility in Indian society. According to Serour (2006, p. 110), ART "is perceived as a great scientific achievement among the Hindu."

Because of the importance most religions put on procreation along with the differences in religious teachings in this area, people may feel strongly about issues of procreation and assisted reproduction. The following two cases illustrate some of the dilemmas people may face in their decisions about procreation.

> –Mary and Robert are both carriers of the gene that causes Tay-Sachs disease. Their doctor advises them not to conceive, but they ignore that advice, feeling from a deeply religious viewpoint that God has a plan and that they should not interfere with the genetic makeup of any children they hope to conceive (Dooley, et al., 2003).
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> –Because of a massive untreatable infection in her fallopian tubes as a teenager, Alice had both tubes removed. A few years later, Alice married Martin. They both had a strict Catholic upbringing, but both wanted children. They were told they were ideal candidates for IVF and that this procedure might allow them to have children that were biologically their own offspring. They had to sort out their feelings about IVF in terms of their religious upbringing. Their fourth attempt at IVF resulted in the birth of a daughter (Dooley, et al., 2003).

In addition to discussing the religious views on assisted reproduction, the basic concept of rights must also be addressed. Is health a right? Is health care a right? What is health care? In a situation of limited resources, what priority is given to different demands on the health care system? Consider some of the following possible medical treatments: emergency care (stop bleeding, preserve life from accidents), preventive health care (immunizations, well care), basic medical treatment (treat a basic infection, illness, broken bone), chronic illness (quality of life), fatal illness (pain management and delaying death), mental health care (prevent suicide, treat depression), plastic surgery to correct major deformities, plastic surgery to enhance perceived looks (cosmetic without specific physical health benefits), other elective health care items (laser hair removal), access to reproductive technology. Even those who believe that health care is a right may not believe that the right extends to all of these possible treatments.

How do we treat different groups differently for health care? How do we treat children who are perceived as unable to help themselves? What about the aged? What about those with other disadvantages such as the poor, the weak, the homeless? How do we divide available health care among those in different social classes? A discussion of justice may be helpful in viewing the different perspectives on whether assisted reproduction should be considered a health care right.

> The theoretical discussion of justice, in a sense, begins with Aristotle. Still definitive in this point, Aristotle defines "justice" as treating like cases alike, different cases differently. This is known as the "formal principle of justice," and it still holds in all of the specific forms of justice: distributive justice (how, in a situation of scarcity, things are parceled out among the parties who claim them). . . Although other spheres of justice play a role as well, distributive justice issues are central in a discussion of health-care justice because health

> systems virtually always operate under conditions of scarcity: How should providers parcel out care among patients who need or want it when there are not enough resources to satisfy everyone's needs and desires?
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> The term "social justice" refers to relationships between a society and the groups or individuals that comprise it. Social justice sets out what the society owes to its members and what individuals owe to the whole. . . .
>
> Many discussions of health care and social justice are framed in terms of health and disease. "Health" is often defined as a condition that approximates normal species function. Basing decisions about the allocation of health-care resources on the concept of health makes allocation decisions turn on whether or not to classify some condition as an illness or a disease: Resources are provided only for cure or amelioration of disease. . . . (Rhodes, et al., 2002, pp. v - vi)

Is having children a right? Is every couple or individual entitled to one or more children? Are infertile couples entitled to all possible treatments to have children. Many times, infertility treatments are really treating "childlessness" rather than treating the underlying cause of infertility. Much of the technology enables reproduction in spite of infertility issues, not by resolving the infertility issues. Does this change the thoughts about whether infertility is an illness or disease? Does it change the thoughts about whether couples are entitled to treatment for infertility to allow them to have one or more children?

Warren (2002, p. 427) claims that "Reproductive rights have been recognized as basic human rights by the international community." However, this seems far from certain, especially depending on how rights are defined and how the scope of reproductive rights is considered. "The right to reproductive

freedom includes both the right to have children and the right to avoid having them. Some moral theorists distinguish between negative rights and positive rights. *Negative rights* are entitlements to protection from some specific harm, such as physical assault. *Positive rights* are entitlements to specific benefits, such as health care" (Warren, 2002, p. 427).

If reproductive rights really are a positive right, it would seem necessary for the public, through the instrumentality of the government, to support anyone's reproductive desires. This would require public funding for contraception, public funding for abortion, public funding for assisted reproduction, and perhaps public funding for adoptions. Because of the many controversies surrounding contraception, abortion, and assisted reproduction, it seems quite clear that many do not view these as positive rights.

Some do not even view them as negative rights. Absent from much of the literature relating to the discussion of health care, including assisted reproduction, as a right, is the related issue of responsibilities. Positive rights accorded to one person, a subset of persons, or the general population may require responsibilities of others. For example, if we accord positive rights to assisted reproduction or adoption, we also require the responsibility of the public to fund these efforts, whether or not they agree with the procedure on social, political, or religious grounds.

To supplement the discussion on religious views and views of reproductive rights, the following list illustrates other perspectives and views which add controversy to assisted reproduction.

> –Rights (genetic parents, donors, embryo, child); includes "ownership rights" to eggs, sperm, embryos, fetal tissues, etc. after "donation"–Can they be sold? Inherited? Can healthcare providers contract for these rights for research? What is informed consent and when is it required?
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> > –Some fertilized eggs were deliberately destroyed by the supervisor of a doctor attempting IVF. The parents brought suit seeking "compensation for severe emotional distress and for destruction of

> their personal property." The jury awarded monetary damages for emotional suffering, but no compensation was awarded by the jury for the destruction of personal property (Alpern, 1992, p. 338).
>
> –Risa and Steven participated in three failed IVF attempts in New York. When they moved from New Jersey to California, they requested that the remaining frozen embryo be transferred to an IVF program in California. The New York IVF facility refused, indicating that the agreement Risa and Steven had signed gave them no rights to the embryo outside of the New York IVF Institute (Alpern 1992).
>
> –Junior and Mary Sue entered an IVF program. Nine eggs were fertilized, with two of them being introduced into Mary Sue without success. The remaining seven fertilized eggs were frozen for possible future use. Within a few months, Junior filed for divorce and the disposition of the embryos then became part of the divorce dispute. Mary Sue claimed the right to use the embryos in further attempts to have a child, but Junior did not want to become a father and felt he had the right to withhold consent as to the disposition of the embryos (Alpern, 1992).

–Complex legal issues—Can contracts for the creation of life be made? How can contracts be appropriately stated? What happens when there is a breach of contract or perceived breach of contract, especially when living matter or living humans are concerned?

–Defining infertility and when treatment is appropriate

–Emotional reactions to bearing/having children, infertility, ups and downs of treatment success/failure

–Psychological impact of infertility on couples who want to have children (lack of "manliness" or "fertility" makes me

somehow less of a person, desire to pass own genes on to posterity)
–Psychological impact on "artificially" conceived children in their future
–Feminist issues of reproductive freedom or oppression from reproductive technology—Does ART devalue women or give them more freedom? (Brazier, 1998; de Melo-Martin, 1998; Morgan, 1989)
–Quality of life issues for those severely handicapped
–Economic reality of the huge expense for fertility treatments—How should expensive infertility treatments be funded?
–Other public health, public policy, social, philosophical, political, economic issues

ADOPTION AND ETHICAL ISSUES

While infertility treatments deal with the attempt to conceive a child, adoption deals with the parenting of a child that is already conceived–the genetics and the gestation have already been determined but the social parenting still needs to be determined. Thus the ethical issues related to adoption are often different than the issues relating directly to infertility issues.

Although some adoptive parents have already had one or more children naturally, most first-time adoptive parents have no children. In most of these cases, infertility is the reason. Thus, many who consider adoption, either because infertility treatments have not been successful or because they are not comfortable with assisted reproduction concepts or techniques, have already been through the emotional pain of infertility. Some have also been through the emotional roller coaster of attempts at assisted reproduction.

Potential ethical issues that can arise in the adoption arena include the following, not necessarily in any order of importance:

–Anonymity of birth parents, secrecy of adoption for adopted children, right to know who the birth parents are, rights to a genetic medical history for adopted child
–"Selling babies" to adoptive parents—What costs are paid by adoptive parents to birth mother/parents?
–Termination of birth parents' rights–voluntary or through legal channels—Under what conditions can a terminated birth parent's right be restored? What does this do to the adoption process? What about termination of a birth father's rights when he cannot be located? What legal notice is sufficient? Can he claim rights after the deadline under legal notice?
–"Requirement" for adoptive parents to prove fitness as parents when others do not have this burden
–Process of helping birth mother/parents decide on an adoption versus other alternatives—Who helps the birth parents with this decision? Is it appropriate for "outsiders" (medical personnel, judges, or others) to influence an agreement that has already been made between the birth mother and the adoption agency?

WHY ARE ISSUES RELATED TO ADOPTIONS CONTROVERSIAL?

In adoptions, religious issues may be minimized because, in most cases, the conception has already occurred. Even if the conception didn't occur according to the religion's ideal methods, the adoption itself is not as controversial. For many religions, the concept of family is very important, so providing a family for a child who needs to be adopted may be seen as admirable.

Cultural issues also exist with respect to adoption. In some cultures, adoptive parents are commended for the willingness to parent children who are not biologically related. However, in others cultures, adoption is considered inappropriate, especially outside of the extended family.

Legal issues may be different for adoptions because the child is already born (or the choice is already made for birth rather than abortion). Thus, the child may have more legal rights than those accorded to an embryo or a fetus.

Adoptive parents may have more choice in what types of disabilities they are willing to accept in a child. Potential adoptive parents may have the choice not to accept a child after birth based on the types and severity of disability manifested by the child at birth.

Parents who bear children naturally do not have to prove fitness as parents. Conception can occur from a physical act alone. However, adoptive parents have to "prove" their fitness as potential parents. This fact can have psychological implications for those considering adoption.

In addition, adopted children can also deal with psychological issues. They may feel unwanted by their birth parent(s). They may have difficulty bonding with the adoptive parents. This may occur whether they were adopted as infants or as older children.

The emotional cost of playing the waiting game to adopt a child can be high. The absolute time frame may be long, and once a child becomes available, there may be much less than a nine-month period to prepare for the child. In addition, the emotional toll can be high when a pending adoption falls through.

Adoptions of children with special needs may be more likely to involve abuse (emotional, physical, and sexual) of the child or drug/substance abuse by the parent, leading to long-term treatment needs. Children with special needs, even when not abused, may also be more likely to have developmental delays (physical, mental, or emotional) or disabilities.

SPECIFIC GOVERNMENT INTERVENTION IN THE FUNDING OF ASSISTED REPRODUCTION AND ADOPTIONS

As illustrated previously, many ethical issues and controversies exist relative to assisted reproduction and adoptions. However, even though these issues and controversies exist, because of the potentially high cost of assisted reproduction and adoption, governments may attempt to intervene to help prospective parents pay for these costs. This section discusses some of the funding interventions now existing in the U.S., either because of state or federal government laws.

Assisted Reproductions

The cost for infertility treatments can be quite high, especially if multiple attempts are needed to achieve success or determine that a specific technology will not work or not be likely to work. Jain, et al. (2002) cite some estimates for the direct cost of one IVF cycle between $7,000 and $11,000. However, the sources cited were from 1994 and 1995, so the actual costs may have increased, and since several cycles may be attempted before success is achieved, the total cost may be much higher. In addition, there is no assurance of success even if the costs are incurred. Some states mandate insurance coverage for infertility treatments. The requirements for coverage vary by state. The American Society of Reproductive Medicine (2008) has some information on its website summarizing the states which require insurance coverage and what coverage is required.

Jain, et al. (2002) report some comparisons among states with requirements for complete insurance coverage, partial insurance coverage, or no required coverage of IVF. Based on the information they analyzed, states which require complete coverage have more in vitro cycles performed, more transfers of frozen embryos, and lower transfers of fresh embryos per cycle. These results make sense from a rational economic viewpoint.

If insurance coverage is required, the out-of-pocket cost for an in vitro cycle will be lower, making a higher number of cycles

economically possible for the patient. In addition, if insurance coverage is required, IVF patients may be more likely to transfer fewer embryos per cycle and freeze some for future IVF attempts because these attempts would also be covered by insurance. States which have no required coverage have a higher percentage of cycles resulting in live births and a higher percentage of pregnancies with three or more fetuses.

These results may also make intuitive sense since the "need" to achieve a pregnancy on the first attempt would be greater for those who bear the entire cost of the cycle, so more embryos may be transferred, allowing for a higher percentage of pregnancies but also resulting in more pregnancies with three or more fetuses.

In discussing whether insurance coverage should be mandated for IVF, Guzick (2002, p. 687) expressed concern about the increase in multifetal pregnancies in IVF attempts with no insurance coverage. He stated that "As a matter of clinical practice and public health, rates of multifetal pregnancy from in vitro fertilization must be lowered." Multifetal pregnancies increase the risk to both fetuses and the mother during gestation. "The estimated direct medical expenses of a gestation involving three or more fetuses are about $340,000, and this figure does not include the costs of long-term care and special education for disabilities resulting from prematurity" (Guzick, 2002, p. 687).

Guzick also looks at the economic cost-benefit considerations of public funding of IVF. He says that the average cost of a birth from IVF exceeds $40,000. However, he also shows some calculations that indicate taxpayers in Massachusetts would be willing to pay increased taxes for a public program that would provide access to IVF. His calculations show that the public is willing to pay over $177,000 per birth from IVF. But instead of stating that this automatically means insurance coverage for infertility treatment should be required, he states that "More work is needed to sharpen these statewide estimates and to quantify the benefits and costs of mandated coverage" (Guzick, 2002, p. 688).

Reynolds, et al. (2003, p. 959) responded to the Jain, et al. (2002) article, indicating that they had found some different results by using different data and analyzing it in a different way. "Our findings indicate that mandated insurance coverage may affect embryo-transfer practices, but the heterogeneity of the findings in different states suggests that we must be cautious in speculating about whether or how these patterns in practices translate into health outcomes such as multiple births."

The following list raises some ethical questions related to government interventions into how assisted reproduction are funded.

> –Does the requirement for insurance to cover infertility treatments (in certain states) mean some companies that otherwise would have provided basic health insurance for their employees will be "priced out of the market" for insurance and not offer any health insurance?
>
> –Does the government have the "power" to regulate this type of insurance benefit? Is it appropriate for the government to pay directly for or mandate insurance coverage for procedures that are so controversial for a number of religious, public policy, and other reasons? Should tax dollars (or insurance dollars) from a large pool of taxpayers (or insured persons) be used to fund nonessential but controversial procedures.
>
> –Do the results presented by Jain, et al. (2002) suggest that mandated insurance coverage is appropriate because it may result in fewer higher-risk pregnancies with three or more fetuses?
>
> –How do/can/should the laws distinguish (discriminate) coverage requirements–age, marital status, sexual orientation–for mandated infertility coverage?

Federal Tax Benefits for Adoptions

The cost of an adoption depends on the type of adoption contemplated. The Report to The Congress on Tax Benefits for Adoption (2000, p. 17) cited some data from the National

Adoption Clearinghouse on adoption costs. "Costs for a non-foreign public agency adoption, including travel costs, range from zero to $2,500." "Domestic private agency fees range from $4,000 to $30,000 and more." "Expenses for independent (without an agency) non-foreign adoptions are reported to range from $8,000 to $30,000 and more." "International adoption costs are reported at $10,000 to $30,000 and more."

Foreign adoptions are often more expensive because of the travel costs in addition to the agency fees and other fees required in both countries. In addition, multiple trips to the foreign country may be needed before the child can be placed for adoption and brought back to the United States. Adoptions of children with special needs may often fall under the category of public agency adoptions. Because many of these children are already in state custody, the costs can either be low or may be heavily subsidized. However, even if the actual adoption costs are lower for adoptions of children with special needs, the ongoing costs to raise such a child may be much higher.

Some federal tax benefits for adoptions exist. One is a tax credit. A tax credit is a direct reduction of the amount of taxes otherwise owed. For 2009, the adoption tax credit can be up to $12,150 per adoption of an eligible child. This amount is adjusted annually for inflation. In addition the credit is phased out for those with modified adjusted gross income (AGI) between $182,180 and $222,180 (the lower limit of this phase out range is also adjusted annually for inflation).

The credit is limited to amounts spent for qualified adoption expenses incurred and not reimbursed, with the exception that the entire credit can be available for the adoption of a child with special needs, regardless of expenses incurred. For a foreign adoption, the adoption must be final before the credit is available; also, a foreign child cannot qualify as a child with special needs (IRC, Section 23; IRS, 2008).

The credit is nonrefundable. This means it can reduce the taxes owed down to zero, but not below zero, for a particular year. However, because the dollar amount of the credit is so large, the

credit can be carried forward for up to five years beyond when it is first claimed. This allows more taxpayers to take advantage of more of the credit even if it cannot all be claimed in one tax year. The credit can be claimed in the year after payment for any adoption costs paid before the year of finalization (except costs incurred for a foreign adoption are not eligible for the credit until the year of finalization).

Costs incurred in the year of finalization or after are eligible for the credit in the year paid. For the adoption of a child with special needs, the eligible credit is increased in the year of finalization for any amount up to the $12,150 per adoption finalization which has not been incurred as an adoption expense (IRC, Section 23). Smith and Tew (1999) and Smith (2007) discuss some of the ironies and problems associated with the adoption tax credit.

A second federal tax benefit for adoption is an exclusion from income for employer-provided adoption benefits paid or reimbursed through a qualified adoption assistance program. An exclusion is not a direct reduction of the taxes owed, but it reduces the income that would otherwise be taxable to the taxpayer. Similar to the credit, the exclusion is limited, for 2009, to $12,150 per adoption of an eligible child. This amount is adjusted for inflation. The exclusion is phased out for taxpayers with modified AGI between $182,180 and $222,180, with the lower limit of the range indexed for inflation.

No expenses need be incurred to take the exclusion for taxpayers who adopt a child with special needs. The exclusion is available in the year the amount is paid by the employer except for costs paid for foreign adoptions which are not excluded until the year of finalization. For the adoption of a child with special needs, an exclusion can be taken in the year of finalization for any amounts up to $12,150 not actually paid for adoption expenses (IRC, Section 137; IRS, 2008). Smith and Tew (2001) and Smith (2005a) comment on some problems with the exclusion.

Both the adoption tax credit and exclusion can be claimed for the same adoption. However, they cannot be claimed for the

same expense. If an adoption cost is paid for or reimbursed by an employer, it cannot qualify for the credit.

While the adoption tax credit is a direct government benefit, the exclusion is an indirect benefit. The credit costs the federal government one dollar for every dollar of credit claimed. The exclusion only costs the government the taxes saved by the taxpayer on the amount excluded. Depending on the employer's adoption assistance program, the employer could actually be paying directly for the benefits with the benefits being excluded from taxes for the employee/taxpayer.

In other cases, the employer's adoption assistance program simply allows the taxpayer to use some type of flexible spending arrangement so that the money spent on the adoption assistance is really coming from the employee, but the employee can save the taxes on the amount spent. Smith (2004) comments on the public policy issues of the adoption tax benefits and argues for a government emphasis on the exclusion before the credit.

The tax law for these federal adoption tax benefits has evolved over the past decade. Smith (2002) discusses some of the evolution in the tax law. He shows how changes to the tax code have resolved some of the ambiguities created by prior law. He also suggested additional items that could clarify the tax code even further. In addition, Smith (2001, 2005b) raises and discusses multiple public policy issues related to these federal adoption tax benefits.

Some states also have tax benefits for adoptions. However, these would vary by state and may be either amounts that can be excluded from income or credits against the state tax. They may also be available in some states only for adoptions of children with special needs.

The following list raises some ethical questions related to government interventions into how adoptions are funded.

–The exclusion may be somewhat comparable to the tax benefits that we give for maternity benefits offered under an employer's health insurance plan. Is this an argument for the exclusion to make tax benefits for adoptive parents

more similar to what they may be for those who are insured by an employer with maternity coverage? If so, why is there an income phase out range for the exclusion? The credit does not seem to be comparable to any tax benefit we give to insured people who bear children naturally. Is adoption a right? Should it be publicly funded, at least directly as with the tax credit?

–Are the benefits made available designed to help adoptive parents or specifically to help a child who needs to be adopted? Should benefits be made available in general regardless of a family's ability to pay or should benefits only be offered if they are really going to help the child who would not otherwise be helped? A healthy Caucasian newborn is unlikely to have any difficulty being placed for adoption, with or without government tax benefits.

However, what about those who are in sibling groups, are older, are from minority groups, or have physical or mental handicaps that make them harder to place for adoption? Perhaps government tax assistance in these cases may be more appropriate, especially since these are the more likely cases for savings in other government programs such as Medicaid and welfare benefits. It is also true that there are more programs in place to fund the direct adoption costs for these types of adoptions (adoptions of children with special needs)?

–Should adoption tax benefits in the U.S. be available for foreign adoptions? Is this a response to the "need" of the adoptive parents to adopt or to the "need" of foreign children to be adopted and cared for? Is this just another international aid program? Is the income tax system the best way to provide this aid?

–Is the federal income tax system the best way to offer adoption benefits? Should adoption benefits that pass the public policy test for public funding be paid in some other way?

–Adoptive parents who adopt children with special needs may qualify for tax benefits beyond what they expended. Is this paying the taxpayers to adopt? Is it appropriate? Could it lead to parents adopting for the money?
–Do adoption agencies increase their fees such that the tax benefits for adoption are effectively passed from the adoptive family to adoption agencies and facilitators? Or do they really provide a net benefit to adoptive families (and thus to the adopted child)?
–Since tax benefits for domestic adoptions are, in many cases, available prior to the benefits available for foreign adoptions, will those pursuing adoption be tempted to claim the adoption is a domestic adoption even if they do not yet know whether it will be domestic or foreign?
–Low-income taxpayers, perhaps those who need the most financial assistance with adoptions, may be the ones who lose more of the benefits either because they have no income tax liability even without excluding the employer-provided benefits or because they have no tax liability against which to apply the nonrefundable credit. Is this appropriate?

ROLE OF GOVERNMENT

What is the role of government regarding reproduction and adoption efforts of its citizens? Certainly, governments routinely take action to influence the behavior of their citizens. Tax levies and other economic actions are used to influence citizen behavior. Subsidies for certain actions tend to increase the number of those actions while taxes tend to decrease the number. Therefore, with regard to medically assisted reproduction or adoption, government legislatures, in their role as representatives of the citizens, can take actions to fund reproduction or adoption efforts of their citizens.

As explained earlier, the costs of these efforts can be very expensive. Since individuals making these efforts tend to be very motivated, government assistance would be appreciated. There

are, however, several matters that government officials should at least take into account before getting involved in these matters.

First, as discussed earlier, reproduction issues can be controversial. They involve matters of religion, morality, and family. These matters have a long history which predates the existence of any government or interest group. They may relate to deeply held values which people and their governments have upheld for generations. Governments should take care before enacting policy which promotes or mandates behavior that confronts these closely held beliefs, particularly if the policy requires individuals to take action in direct opposition to those beliefs.

Second, even if the morality of the issue is somehow resolved, it does not necessarily follow that governments should implement taxes or other fiscal policy to pay for these procedures. Even if the public supports the behavior, it does not necessarily follow that they favor transferring the cost from the individuals directly involved to others. Since at least the enactment of the Bill of Rights, the United States has held that people have the right to do certain things. This does not necessarily mean, however, that people have the right to have others pay for them to do those things.

Third, even if the funding of the actions could be politically justified, expenditures for reproduction are often not a very effective form of expenditure. As mentioned earlier, IVF is extremely expensive and not necessarily successful. Therefore, when government mandates the funding of IVF, it is choosing to fund actions that, at least at current medical capabilities, may not always benefit the people intended. This concern could be somewhat alleviated if the government did not fund, but only reimbursed upon successful completion. This is the case with some, but not all, of the current adoption tax benefits. Some adoption expenses are reimbursed only after successful finalization of the adoption. This issue for reproductive technologies could be partially resolved if it is shown that as more IVF or other procedures are completed, their success rates improve.

Fourth is the problem of efficiency. Does government funding assist those it is intended to help or does it benefit others? Efficiency improves as direct recipients of aid participate in the funding. There is also the risk that the economic benefits of government funding will be transferred away from the intended recipients.

Without anticipating the results of such a study, it would be worthwhile to track the change in costs as government funds its support for causes. For example, does increased government funding coincide with increased prices set by the technology providers. Market forces can help alleviate the costs of expensive procedures. For example, in vitro costs are much lower outside than inside the U.S. There are examples of couples traveling to other countries, paying for several weeks of living costs, in vitro fees, and vacation for about the same cost as one in vitro procedure in the United States (*Wall Street Journal*, 2008).

The fifth issue regarding government involvement can be interpreted as either an advantage or disadvantage of government intervention. Government funding for reproduction procedures directly benefits relatively few people. Compared to the population at large, relatively few people seek these expensive medical procedures. These recipients of government funding will benefit to a significantly greater extent than the general population. Conversely, this can be viewed as an advantage of government funding. Expensive medical costs can exceed what a single family is able to pay.

However, government can provide funding with only minor increases to the costs to individuals in the general population. A very small sacrifice for the many produces a large benefit for the few. Citizens are more likely to support this kind of government involvement if they also support the cause even if there were no government subsidies. However, citizens will also certainly oppose granting large sums of money to a select few individuals for purposes which they oppose.

A final consideration that could strengthen or weaken attitudes toward government funding is the perceived equity of

such funding. For example, are reproductive medical or adoption procedures considered necessary in order for people to receive the benefits already available to others? The general population is more likely to support reproductive medical procedures and adoption benefits for those who are medically infertile, especially if these benefits are similar to the maternity benefits that are commonly made available via medical insurance. Conversely, if the expenditures seem to be giving certain people an advantage that others do not have access to, then the expenditures will almost certainly be considered unfavorably.

Governments can certainly use their authority to support reproduction and adoption. Citizens, for a variety of reasons however, may not be supportive of those government actions.

CONCLUSION

Because of infertility and other reasons, numerous individuals have difficulty having children. In the modern, technological age of today, medical advances can be used for reproduction in non-traditional ways. Adoption is also available to add children to families. However, these options tend to be costly. Reproductive alternatives in particular can also be quite controversial. Depending on religious beliefs, political views, and other reasons, one may favor or oppose certain reproductive procedures.

Government can undertake a role to help alleviate the heavy burden of reproduction and adoption costs. Support for this role is based on equity, fairness, and rights. However, acceptance of these roles is not universally shared. Because of the controversies that exist concerning reproduction treatments there is concern regarding whether government should intervene to help fund them. There is also the concern of whether this kind of funding fits within the proper purposes of government. It would be no surprise if, as medical technologies advance in the future, these controversies continue to increase.

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