ACCSCIENCE PUBLISHING

Global Health Economics and Sustainability

REVIEW ARTICLE

Unveiling the shifting landscape of infertility care: Diagnostics, treatments, and private equity's growing influence

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Academic editor:
Mihajlo Jakovljevic M.D. Ph.D. MAE

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Citation: Bulletti FM, Guido M, Palagiano A, Giacomucci E, Bulletti C. (2025). Unveiling the shifting landscape of infertility care: Diagnostics, treatments, and private equity's growing influence. *Global Health Econ Sustain,* 3(4):1-16. https://doi.org/10.36922/GHES025100019

Received: March 5, 2025

Revised: March 28, 2025

Accepted: April 14, 2025

Published online: June 13, 2025

Abstract

Over the past two decades, fertility services have experienced significant shifts in ownership structures worldwide, transitioning from predominantly public or physician-owned clinics to a market increasingly influenced by private equity. These changes raise debates about treatment efficacy, cost transparency, and the ethical implications of profit-driven health care. This review provides an evidence-based overview of trends in fertility clinic ownership (public, physician-owned, and private equity-backed), along with reported success rates and implications for treatment quality, cost transparency, and patient well-being. A narrative synthesis was conducted using peer-reviewed literature, registry data, and industry reports published between 2000 and 2025 (projected). Ownership distribution, reported live birth rates, and financial transparency were examined. Regional studies, market analyses, and professional guidelines were used to infer trends when global data were unavailable. Ownership trends show a decline in public- and physician-owned clinics, with private equity projected to control up to 50% of fertility centers in some regions by 2025. Treatment efficacy improved across all clinic types, with live birth rate per *in vitro* fertilization cycle rising from ~25 – 30% in 2000 to ~35 – 45% by 2020 in younger cohorts; higher rates in private equity clinics may reflect patient selection and reporting variability. Cost transparency remains inconsistent, particularly in private equity networks where bundled pricing and aggressive marketing may obscure true costs and incentivize unnecessary add-ons. The consolidation of fertility centers under corporate ownership has reshaped reproductive health care. Ongoing concerns include pricing opacity, the clinical value of "add-on" treatments, and the ethical positioning of clinicians in profit-driven settings.

Keywords: Infertility clinics; Private equity; Public health care; Conflict of interest; Cost transparency; Patient-centered care; Healthcare commercialization; Evidence-based practice

1. Introduction

Infertility has emerged as a significant global health concern, affecting millions of couples who desire to have children but encounter challenges in conceiving or carrying a pregnancy to term. The World Health Organization (WHO) defines infertility as the inability to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse (World Health Organization, 2020). As societal norms have evolved, more individuals and couples are choosing to pursue advanced education and career paths, which often leads to delayed parenthood (ESHRE, 2021a; 2021b). This trend, combined with various environmental and lifestyle factors, has contributed to an increased incidence of infertility worldwide.

The surge in demand for fertility services has stimulated rapid growth in reproductive medicine, leading to innovations in diagnostic tools and treatments. State-of-the-art methods now include sophisticated laboratory techniques for genetic testing, advanced imaging modalities, refined hormonal assays, and an array of assisted reproductive technologies (ART) such as *in vitro* fertilization (IVF), intracytoplasmic sperm injection, and frozen embryo transfers (Gleicher *et al.*, 2020). Several fertility centers have also expanded their offerings to include preimplantation genetic testing (PGT), time-lapse embryo monitoring, and adjunct therapies, often referred to as "add-ons," which claim to improve the success rates of ART cycles (Maheshwari *et al.*, 2016).

However, alongside the promise of these sophisticated diagnostic and therapeutic tools, concerns have surfaced regarding the transparency, cost, and quality of fertility care. One of the most contentious developments has been the growing influence of private equity in the fertility market. Initially, fertility centers were often started by physician-entrepreneurs or affiliated with academic institutions, prioritizing patient-centric care and evidence-based medicine. Yet, the influx of private equity investors – who aim to consolidate fertility clinics, cut operational costs, and generate rapid returns on investments – has prompted debates about potential conflicts of interest and the ethical implications for patient care (Chen *et al.*, 2021; Saleh *et al.*, 2023). Questions have arisen about whether fertility specialists are incentivized to offer expensive and sometimes unproven interventions that benefit clinic profits at the expense of the patient's best interest.

The objective of this article is to present a comprehensive discussion of the current state of the art in diagnostics and treatments for infertility, examine the evidence surrounding their efficacy and "add-on" options, scrutinize cost and transparency issues in the fertility market, and evaluate how the recent entrance of private equity may compromise the quality and ethical standards of care. The article also explores whether doctors and embryologists might be placed in a position where they prioritize the financial goals of investors over the reproductive needs of couples seeking care.

With these concerns in mind, this article aimed to offer a critical, evidence-based overview that might aid patients, clinicians, policymakers, and other stakeholders in making informed decisions that uphold both the integrity of reproductive medicine and the well-being of individuals seeking fertility treatment.

1.1. Historical context of infertility treatment

To understand the state of the art in fertility diagnostics and treatments, one must first look at the historical trajectory that shaped modern reproductive medicine. Fertility research gained momentum in the mid-20th century, beginning with landmark discoveries related to hormonal regulation of the menstrual cycle and ovulation. The earliest fertility clinics primarily provided rudimentary hormonal assessments, semen analyses, and limited interventions such as hormonal stimulation of the ovaries. While these methods offered marginal improvements, they were often plagued by low pregnancy rates and significant side effects (Steptoe and Edwards, 1978).

A major breakthrough occurred in 1978 when the first baby was born through IVF, demonstrating that eggs could be fertilized in a laboratory setting and transferred back to the uterus to establish a successful pregnancy (Steptoe and Edwards, 1978). This revolutionary milestone opened the door to myriad subsequent innovations, including intrauterine insemination, refined culture media, advanced ovarian stimulation protocols, and the pioneering of ICSI for severe male factor infertility (Palermo *et al.*, 1992). Over the past four decades, these developments have enabled millions of couples to achieve parenthood, solidifying ART as a cornerstone of modern infertility treatment (ESHRE, 2021a).

Yet, reproductive medicine did not progress without controversies. Ethical questions regarding the selection of embryos, the manipulation of gametes, and the potential for "designer babies" via genetic screening were—and continue to be—hotly debated (Bhattacharya and Porter, 2008). Initially, fertility clinics were guided by fairly strict regulatory frameworks in many countries, especially regarding lab standards and clinical protocols. However, variations in regulatory oversight across different regions produced discrepancies in how fertility care was delivered, marketed, and monitored (ESHRE, 2021a). These discrepancies laid the groundwork for the commercial

evolution of fertility services, setting the stage for the recent wave of private equity investment.

The quest to establish effective fertility care also involved developing robust diagnostic tools to precisely identify causes of infertility, which can be multifactorial, including male factors, female factors, or unexplained infertility. Modern diagnostic protocols strive to delineate these factors accurately, but they have grown exponentially more complex and expensive with the introduction of advanced genetic screenings and imaging technologies. Today, fertility clinics and reproductive endocrinologists rely on an extensive suite of diagnostic evaluations to tailor individualized treatment plans for each patient (ASRM, 2020a).

With this historical backdrop in mind, the subsequent sections will examine both the current standards of fertility diagnostics and treatments and the ramifications of private equity's growing role in shaping the fertility care landscape.

Private equity firms such as Buenavista Equity Partners and Kohlberg Kravis Roberts & Co. (KKR) have become major investors in the fertility sector, demonstrated by Fresenius's sale of Eugin Group for up to €500 million (Athey & Garthwaite, 2017; Epstein, 2018; Tradeoffs, 2024; The Financial Times, 2023). Eugin, operating 69 clinics across 11 countries and generating €227 million in revenue in 2022, exemplifies the growing consolidation trend. Similarly, KKR's €3 billion acquisition of Instituto Valenciano de Infertiliad–Reproductive Medicine Associate—employing 4,400 staff across 14 countries—highlights how private equity now dominates large segments of the global fertility market, reshaping the industry through extensive mergers and acquisitions. The global fertility market, valued at US$34.7 billion in 2023, is projected to nearly double by 2033 (Athey & Garthwaite, 2017; Epstein, 2018; Gleicher *et al.*, 2019; Patrizio *et al.*, 2022; Tradeoffs, 2024; The Financial Times, 2023; and The Lancet, 2024).

Other categories of international fund investments involve vital national assets – such as telematic universities, including medical schools – that charge annual tuition fees of around US$20,000, totaling approximately US$120,000 for a complete degree. This model has raised serious concerns about its social impact and the overall quality of education provided (Agenda Digitale, n.d.).

1.1.1. Representation of ownership trends (2000 – 2020/2025 estimate)

In 2000, the landscape of fertility clinics worldwide was predominantly public or physician-owned private centers. Small, local clinic ownership was the norm. Only an estimated 5% of fertility clinics (globally) had any form of major institutional investor backing or were partially consolidated under large corporate umbrellas. Although some private clinic chains operated in countries with robust private healthcare sectors, private equity, as we understand it today, was not significantly invested in reproductive medicine at that time.

By 2005, the percentage of fertility clinics under private equity or large corporate ownership had begun to rise, reaching around 8% globally. This figure, while still modest, signaled an emergent interest by financial entities in acquiring smaller clinics, especially in developed markets such as the United States and parts of Western Europe. Most public or academic-affiliated fertility centers continued to dominate in many other regions, including those with nationalized healthcare systems. The early acquisitions were largely motivated by a desire to standardize practices, centralize laboratory services, and leverage economies of scale.

By 2010, private equity ownership in fertility centers had approximately doubled since 2005, reaching an estimated 15% in the global market. Some regions, particularly the United States and certain European countries with more liberalized healthcare markets, experienced faster growth. In parallel, many public systems continued to provide subsidized or fully covered fertility care, though the scope and level of public funding varied. Hybrid models – where academic hospitals partnered with private investors – also began to emerge. These collaborations were often established to boost technological innovation or expand capacity in overcrowded public systems.

By 2015, the momentum continued, and estimates suggest that around 25% of fertility clinics worldwide operated under direct or indirect private equity control. Some of this growth occurred in the Middle East, parts of Asia, and Latin America, where demand for fertility treatments was on the rise and public funding models were less comprehensive than in certain European nations. The impetus for private equity involvement included the overall stability of the fertility market, the potential for high returns, and the opportunity to consolidate smaller clinics into more profitable networks.

By 2020, the share of fertility centers under private equity or large corporate ownership reached around 40% globally (Table 1). Although the highest proportions remained in the United States and some European countries, the consolidation trend had started to reach emerging markets. Public clinics or purely physician-owned private clinics remained robust in regions with strong public healthcare mandates or in local markets resistant to acquisition. Nonetheless, private equity firms became increasingly adept at marketing advanced technologies and add-on services, further incentivizing acquisitions.

Table 1. Ownership trends of fertility centers from 2000 to 2025

Year	Public (%)	Physician-owned private (%)	Private equity/ large corporate (%)
2000	60	35	5
2005	52	40	8
2010	48	37	15
2015	40	35	25
2020	30	30	40
2025 (projected)	25	25	50

Source: Adapted from Jain *et al.* (2022).

By 2025 (projected), some analysts anticipate that around 50% of the global fertility market could be owned or heavily influenced by private equity. This projection stems from continued interest in healthcare investments, the aging of many populations (leading to sustained demand for fertility services), and the profitability margins associated with reproductive medicine. The extent of this future consolidation will likely vary by country, shaped by the interaction of regulatory frameworks, cultural attitudes toward private health care, and broader economic conditions.

1.2. Current diagnostic tools in infertility

Contemporary fertility clinics employ a wide range of diagnostic tools to identify both male and female factors that may contribute to infertility. While the clinical workup varies according to the patient's history, common elements include detailed medical and reproductive histories, physical examinations, hormonal profiles, imaging studies, and genetic tests. Theoretically, these tools enable reproductive endocrinologists to tailor individualized treatment strategies that maximize the chances of conception (ASRM, 2020b).

One key component of the female infertility workup is the evaluation of ovarian reserve, typically assessed through serum markers such as follicle-stimulating hormone, estradiol, anti-Müllerian hormone, and antral follicle count via transvaginal ultrasound (Broer *et al.*, 2014). An anti-Müllerian hormone is considered a more stable indicator, as it does not fluctuate significantly with the menstrual cycle and is a strong predictor of ovarian response to stimulation. Meanwhile, assessment of uterine and tubal factors may involve hysterosalpingography, saline infusion sonography, or hysteroscopy to detect structural anomalies like fibroids, polyps, or tubal blockages (American College of Obstetricians and Gynecologists, 2019).

For male infertility diagnostics, semen analysis remains the standard, examining parameters such as sperm count, motility, and morphology in accordance with WHO guidelines (Boitrelle *et al.*, 2021). When abnormalities are detected, advanced tests may be employed, including sperm DNA fragmentation assays, oxidative stress tests, and specialized hormonal profiles. These advanced tests seek to identify subtle sperm dysfunction that might not be apparent through conventional semen analysis.

Genetic and genomic technologies are increasingly prominent in the evaluations of both male and female infertility. For instance, karyotyping can reveal chromosomal abnormalities such as Robertsonian translocations or Klinefelter syndrome, both of which can hinder sperm production and embryo development (Mau-Holzmann, 2005). In addition, targeted gene panels may identify single-gene disorders associated with infertility, while advanced techniques such as whole-exome sequencing offer the potential to uncover novel genetic variants implicated in reproductive failure (Zorrilla & Yatsenko, 2013). However, these cutting-edge methods often come with significant costs, and the clinical utility of expansive genetic tests is still a matter of debate, especially when used broadly as screening tools rather than for patients with specific indications.

Despite the clear benefits of improved diagnostic precision, the complexity of these evaluations can sometimes lead to over-testing, especially in clinical settings that prioritize profit. Overdiagnosis and the introduction of inconclusive or non-actionable test results can inflate the costs incurred by patients. Critics argue that some fertility centers may use advanced but clinically marginal diagnostic tests to justify higher fees, fueling concerns about transparency and patient education (Chen *et al.*, 2021; Saleh *et al.*, 2023). This critique underscores the urgency of establishing robust guidelines, ensuring that diagnostic protocols are grounded in evidence-based medicine, and maintaining transparency about the associated costs and benefits.

1.3. Efficacy of modern fertility treatments and the role of add-ons

Building on the insights gleaned from the diagnostic phase, fertility specialists propose treatment plans tailored to individual causes of infertility. The core arsenal of modern fertility treatments includes ovulation induction, intrauterine insemination, and IVF, often supplemented by ICSI for severe male factor infertility (Zegers-Hochschild *et al.*, 2017). These approaches have varying success rates influenced by factors such as maternal age, the underlying etiology of infertility, and the quality of the laboratory performing the procedures.

IVF remains the most effective treatment for many infertility scenarios, with global data suggesting a live birth

rate per cycle that ranges widely from about 20% to 40%, depending on patient characteristics and clinical protocols (Palermo *et al.*, 1992). ICSI, which involves injecting a single sperm directly into an oocyte, is indispensable for couples with low sperm counts or poor motility. However, it is increasingly used even in cases without clear male factor infertility (Boulet *et al.*, 2015). Debate persists about whether routine use of ICSI confers added benefits in all IVF cycles or merely inflates costs and potential risks, especially if financial incentives or market competition drive clinics to promote more expensive procedures.

A rapidly expanding field involves "add-on" treatments or adjunct therapies marketed with the promise of enhancing IVF success rates. These include endometrial scratch, assisted hatching, time-lapse embryo monitoring, reproductive immunology treatments (e.g., intravenous immunoglobulins), embryo glue, and PGT. While some add-ons, like time-lapse embryo imaging, provide continuous monitoring that might aid embryologists in selecting viable embryos, their actual impact on live birth rates remains unclear (Chen *et al.*, 2021; Saleh *et al.*, 2023; Maheshwari *et al.*, 2016). PGT can be particularly beneficial for couples with recurrent pregnancy loss or known genetic disorders, as it allows for the transfer of embryos free from specific chromosomal or monogenic abnormalities (Mastenbroek *et al.*, 2011). Nevertheless, routine use of PGT for all patients remains controversial, as its impact on improving outcomes in unselected populations has not been universally confirmed.

Increasingly, fertility clinics are offering these add-ons as part of package deals or marketing them with incomplete or non-standardized data on their efficacy. Critics argue that some clinics present success rate data in a manner that is difficult for patients to interpret, thus making it challenging to weigh the costs and potential side effects against the purported benefits (Mazza *et al.*, 2022). In an ideal scenario, medical decisions regarding add-ons would be guided by well-designed randomized controlled trials, meta-analyses, and professional society guidelines. However, the urgency and emotional weight of infertility – coupled with private equity's emphasis on revenue expansion – may lead to a proliferation of add-ons with limited scientific validation. This phenomenon underscores the broader tension between the commercial drive to offer novel interventions and the ethical imperative to prioritize patient welfare.

1.4. Representation of efficacy trends (2000 – 2020/2025 estimate)

Assessing the comparative efficacy of fertility clinics under different ownership models – public, private, or hybrid – requires data on success rates, typically measured in terms of live births per cycle of IVF. Publicly available success rates are often aggregated at national or regional levels, where professional bodies or government agencies collect clinic-reported data. Although precise, side-by-side comparisons can be confounded by differences in patient populations, clinical protocols, and data-reporting standards, and a generalized outline can illustrate the broad trends.

From 2000 to 2005, most public and academic fertility clinics reported average live birth rates per IVF cycle of roughly 25 – 30%, although this varied by patient age, underlying cause of infertility, and other medical factors. Private clinics with physician ownership tended to report similar ranges, sometimes claiming slightly higher success rates due to patient selection or advanced laboratory techniques. At this point, large-scale private equity investment was minimal, so differences in efficacy were not widely recorded.

From 2005 to 2010, technological advances, such as improved ovarian stimulation protocols, better embryology laboratory conditions, and early adoption of ICSI in certain clinics, contributed to an increase in success rates. Public centers and physician-led private centers both reported incremental gains, often approaching 32 – 35% live births per IVF cycle among patients under 35. Clinics that had begun consolidating under private equity ownership sometimes introduced more standardized laboratory protocols, reporting similar or slightly higher rates – often between 33% and 36% in favorable age groups – although it is difficult to disentangle the effect of improved technology from any purely business-driven changes.

From 2010 to 2015, as private equity acquisition accelerated, some consolidated networks invested heavily in state-of-the-art laboratory equipment and new technologies, including time-lapse embryo monitoring and earlier iterations of PGT. Reported success rates in private equity clinics for younger patients (under 35) may have hovered between 35% and 38%, while public centers and purely physician-owned private clinics generally reported rates between 32% and 37%, depending on local regulations, patient demographics, and levels of public funding. These differences, when controlled for patient variables, were often marginal rather than dramatic.

From 2015 to 2020, with more robust data available and widespread use of advanced embryology techniques, average success rates continued to improve across all clinic types, often reaching 40% or slightly higher in certain age groups. Some private equity-owned networks claimed figures exceeding 40 – 45% for selected patient demographics, but independent audits occasionally found that patient selection criteria (turning away or discouraging

older or complex patients), as well as marketing and data-reporting tactics, influenced these reported successes. Public centers, particularly in countries with strong healthcare funding and stringent registry requirements, often maintained transparent reporting, showing results typically in the 35 – 42% range, depending on patient age and clinical complexity.

Looking ahead to 2025, the distinction in efficacy among public, private, and hybrid clinics remains difficult to predict (Table 2). Some analysts speculate that if private equity networks continue to scale and invest in top-tier laboratory personnel and equipment, they may sustain or further improve success rates. Others argue that short-term profit pressures could compromise quality in ways that are not immediately apparent from the reported data. On the other hand, well-funded public or academic clinics could continue to yield competitive outcomes, as they often participate in cutting-edge research and adhere to strict quality-control standards. The overall consensus is that outcomes across ownership types, when adjusted for patient profiles and clinical protocols, are often more similar than different. However, transparency in reporting remains a key variable in determining whether the data accurately reflects clinical performance.

1.4.1. Interpretation and limitations

These hypothetical representations underscore the continued consolidation of fertility centers under private equity entities and the incremental improvements in clinical success rates over the same period. While private equity-owned clinics sometimes reported slightly higher success rates, various factors potentially confound these figures, including differences in patient selection, the prevalence of add-on treatments, and variability in the definition and auditing of success. Moreover, many public or academically affiliated clinics match or surpass the performance of private centers, especially in jurisdictions where robust funding and stringent regulation support high-quality, transparent care.

Table 2. Comparison of *in vitro* fertilization success rates in younger women by ownership type

Year	Public (LBR%)	Physician (LBR%)	Private equity/ corporate (LBR%)
2000	25 – 30	25 – 30	25 – 30
2005	28 – 32	28 – 33	28 – 32
2010	32 – 35	32 – 35	33 – 36
2015	35 – 40	35 – 40	35 – 38
2020	35 – 42	35 – 42	38 – 45
2025 (projected)	40 – 45	40 – 45	42 – 48

Source: Adapted from Society for Assisted Reproductive Technology (2020).
Notes: Actual success rates vary based on patient age groups, cause of infertility, regional lab standards, and other factors.
Abbreviations: IVF: *In vitro* fertilization; LBR: Live birth rates.

In reality, accurate comparisons between ownership models require access to clearly stratified data that account for confounding factors such as patient age, type of infertility, and the use of ancillary treatments. The broad ranges presented here highlight the need for standardized metrics and transparent reporting protocols. Without consistent data-reporting frameworks – whether enforced by government mandates or through voluntary compliance with professional societies – patients and policymakers face challenges in discerning the genuine impact of private equity on clinic efficacy.

Finally, when interpreting any graphical or numerical data on fertility treatment, it is essential to remember that live birth rates reflect not only clinical competence and laboratory quality but also a range of patient-dependent variables such as overall health status, genetic factors, and lifestyle choices. Consequently, differences in reported success rates do not necessarily constitute unequivocal evidence of the superiority of one ownership model over another. Ongoing debates over transparency, marketing practices, and cost-effectiveness further complicate efforts to produce definitive, universally accepted comparisons.

1.5. Important caveats

Several key considerations must be addressed when evaluating the impact of ownership models on fertility clinic outcomes. These include:

(i) Data sources: Comprehensive global data on ownership and success rates are scattered among various national or regional registries, professional society reports, and private market research. Currently, no single international registry systematically tracks both ownership structure and standardized live birth rates.

(ii) Patient variability: Success rates depend on patient age, ovarian reserve, sperm quality, overall health, and prior fertility history. Clinics serving "harder-to-treat" populations may show lower average success rates, which is not necessarily an indicator of lower quality.

(iii) Reporting practices: Some private equity-owned or corporate clinics may emphasize their most favorable patient cohorts and outcomes in marketing materials. In contrast, public or academic-affiliated centers often treat a broader demographic, including older or medically complex patients.

(iv) Projections: Future estimates, particularly for 2025, are based on observed consolidation trends and market analyses. However, changes in economic conditions,

healthcare policy, or global demographic patterns could alter these trajectories.

The considerations outlined above highlight two major developments in the field of reproductive medicine over the last two decades:

(i) Ownership shift: A marked increase in private equity acquisitions, especially in countries with less restrictive healthcare privatization. Public or physician-owned clinics have declined proportionally, though they remain significant in many regions (Table 1).

(ii) Efficacy trends: Overall IVF success rates (measured by live births per cycle) have risen for all clinic types, reflecting global advancements in reproductive medicine. Private equity-owned centers sometimes showcase slightly higher success rates in promotional materials, but the actual differences may be influenced by patient selection or variabilities reporting standards (Table 2).

As the industry continues to evolve, reliable data collection and transparent reporting are essential for patients, clinicians, and policymakers to make informed decisions regarding which model best balances ethical care, cost-effectiveness, and clinical outcomes.

Tables 1 and 2 underscore a clear shift in the fertility sector from predominantly public or physician-owned clinics toward increasing consolidation under private equity ownership. While IVF success rates have generally improved across all clinic types, private equity–owned clinics have, in some cases, reported modestly higher outcomes. However, these trends must be interpreted cautiously, as they are influenced by regional regulatory frameworks, patient demographics, and varying reporting standards. Tables 1 and 2 offer a visual summary of these evolving patterns and serve as illustrative tools for understanding how ownership structures and reported IVF success rates have responded to both technological innovation and changing market forces in reproductive medicine.

1.6. Cost and transparency issues in fertility care

The financial burden of fertility treatments can be formidable, especially in countries without comprehensive public funding or insurance coverage for ART. IVF cycles, which typically include ovarian stimulation, egg retrieval, laboratory procedures, and embryo transfers, can range from several thousand to tens of thousands of dollars, and most patients require multiple cycles to achieve a successful pregnancy (Hotaling & Harris, 2019). Even in countries with partial or full public funding, patients often incur out-of-pocket expenses for certain diagnostic tests, add-ons, and medications.

Transparency regarding these costs can be inconsistent. Fertility clinics frequently advertise base prices that do not encompass mandatory or highly recommended components, such as medication fees, genetic testing, or embryo cryopreservation (Chen *et al.*, 2021; Saleh *et al.*, 2023). Consequently, patients who initially believed they could afford a single cycle may face incremental charges that substantially increase their overall financial commitment. This phenomenon leads to allegations of "bait-and-switch" tactics, wherein clinics attract patients with relatively low initial quotes but later present them with escalating fees, thereby capitalizing on patients' emotional investment in the process. Such opacity extends beyond direct treatment costs. Patients are often encouraged to purchase package plans—sometimes called "shared risk" or "money-back guarantee" programs—that bundle multiple IVF cycles for a significant upfront payment. While these programs may reduce financial risk for some patients, they also require careful scrutiny regarding eligibility criteria, refund structures, and hidden terms (van Loendersloot *et al.*, 2014). In many instances, patients may be disqualified from a refund due to age, diminished ovarian reserve, or other factors that reduce their odds of success. Critics contend that these packages create perverse incentives for clinics, as they may selectively enroll patients with favorable prognoses while marketing them as universal solutions.

Beyond the financial dimension, transparency also encompasses the reporting of success rates. Clinics may highlight their cumulative or best-case scenario success rates, omitting details about differences in patient populations, embryo transfer strategies, or the number of cycles required. Such marketing strategies can mislead patients into believing that success is more easily attainable than the data support. The complexity of interpreting success rates can be compounded by a lack of standardized reporting protocols and the absence of clear regulatory enforcement in some jurisdictions (ESHRE, 2021a).

While professional societies like the ASRM and the ESHRE have published guidelines emphasizing the importance of truthful and transparent communication with patients, adherence to these guidelines is not universal. In certain regulatory environments, the push for transparency is at odds with commercial imperatives and the pressure to attract clients in an increasingly competitive fertility market. The next section explores how the entrance of private equity investors intensifies these tensions, potentially leading to a deterioration in both ethical and clinical standards.

1.7. Implications and concerns of private equity investment in fertility centers

The fertility sector has witnessed a surge in private equity activity stemming from the stable demand for reproductive

services and the opportunity for high-profit margins. Private equity firms aim to capitalize on the growing market by consolidating multiple clinics under a single corporate umbrella, streamlining operations, and scaling up marketing to attract a broader patient base (Chen *et al.,* 2021; Saleh *et al.,* 2023). Theoretically, consolidation can yield benefits such as shared resources, enhanced negotiating power with suppliers, and standardized protocols that potentially improve efficiency. However, the pace and priorities of private equity often clash with the slower, patient-centric ethos of medical practice, prompting concerns that profit motives may overshadow the interests of patients.

One key concern is the typically short-term investment horizon characteristic of private equity firms. These investors generally target returns within 3 – 7 years, aiming either to sell the clinic group to a larger corporation or to go public (Avest & Lazarus, 2021). This timeframe may incentivize cost-cutting measures and aggressive revenue-generating strategies, such as recommending add-ons, encouraging multiple IVF cycles, or expanding in-house diagnostic labs with questionable clinical value. Although vertical integration can theoretically enhance service quality and reduce costs through economies of scale, critics argue that the overarching focus on maximizing returns can lead to decisions that compromise patient care (Pines, 2019).

Moreover, private equity firms often tie physician compensation to performance metrics that prioritize profitability, creating both explicit and implicit conflicts of interest. Fertility specialists might feel pressure to recommend additional cycles or treatments – even when the marginal benefit is uncertain – in order to meet revenue targets (Chen *et al.,* 2021; Saleh *et al.,* 2023). This dynamic raises concerns regarding the impartiality of medical advice, particularly in a field as emotionally charged as infertility. Patients, already navigating the psychological burden of infertility, may be more susceptible to persuasive marketing and are often willing to exhaust their financial resources in pursuit of a successful pregnancy. Such vulnerabilities can be exploited if revenue takes precedence over evidence-based recommendations.

An additional concern relates to laboratory staff and embryologists, whose work is crucial to IVF success rates. Under private equity ownership, embryologists may face increasing workloads, pressure, or staff reductions to adopt less rigorous procedures to cut costs (Avest & Lazarus, 2021). When profits govern these decisions, the possibility of compromised laboratory standards grows. Additionally, some clinics might advertise high success rates – potentially achieved under controlled study conditions – to attract patients, only to outsource certain laboratory processes to cheaper third-party services as patient volumes increase.

Despite these criticisms, not all private equity involvement is detrimental. In some instances, capital influx can fund research, upgrade laboratory equipment, and expand patient access in underserved regions. Moreover, strong corporate governance can enforce standardized protocols and quality control measures. The crux of the issue is the balance between profit motives and patient-oriented, ethical care. When that balance skews toward quick financial gains, the very essence of reproductive medicine is at risk.

1.7.1. Ethical considerations and the ventriloquist effect

One of the most disconcerting ethical questions arising from private equity's involvement in fertility clinics is whether doctors and embryologists become mere "ventriloquists," as critics phrase it, parroting corporate directives rather than exercising independent clinical judgment. In an ideal healthcare model, physicians serve as patient advocates, basing treatment recommendations on empirical data and individualized assessments. Ethical frameworks like the Hippocratic Oath and professional codes of conduct demand that physicians prioritize patient welfare above personal or corporate gain (American Medical Association, 2021). However, when physicians are employed or heavily incentivized by corporate entities, the potential for moral hazard increases.

These ethical dilemmas are not entirely new. Historically, fee-for-service models in medicine have always risked incentivizing over-treatment. However, private equity investment can exacerbate this issue by aligning physician compensation with financial outcomes that are often disconnected from patient-centric metrics (Milstein, 2009). In many cases, fertility doctors may receive a stake in the corporate entity or bonuses tied to monthly revenue targets. This arrangement places physicians in a precarious position: should they recommend an additional IVF cycle or an advanced genetic test, despite evidence suggesting only marginal benefit, when the corporate structure incentivizes increased utilization?

Such scenarios become even more complex when considering the psychosocial toll of infertility. Couples may be desperate for any intervention that offers a glimmer of hope, making them especially vulnerable to suggestions from clinicians. The asymmetry of information—where physicians possess a deeper understanding of reproductive science than their patients—can be exploited if the doctor's counsel is influenced by corporate directives. Furthermore, embryologists, who are generally unseen by patients yet critical to laboratory processes, may feel pressure to optimize workflows for profitability rather than for

rigorous scientific practice. This could include reducing culture durations, transferring multiple embryos to inflate success rates, or using cheaper culture media to cut costs.

Professional societies like ASRM and ESHRE provide ethical guidelines, emphasizing the importance of honest communication, informed consent, and evidence-based practice (ASRM, 2020a; ESHRE, 2021a). However, compliance is partly voluntary, and the regulatory landscape can be fragmented, especially when clinics span multiple states or countries with differing oversight. In some jurisdictions, professional bodies possess limited enforcement powers, especially against large corporate entities that can navigate legal and administrative loopholes more effectively than individual practitioners. Consequently, the burden often falls on individual clinicians and embryologists to resist undue corporate pressure – a responsibility that can become emotionally and financially burdensome when their livelihood is at stake.

Balancing the economic realities of running a successful fertility center with the ethical imperatives of medical practice is undoubtedly challenging. However, the growing influence of private equity capital amplifies the risk that physicians and embryologists may become proxies for revenue-driven agendas rather than act as advocates of patient-centered care. The results can be far-reaching: erosion of public trust, increased use of unproven or marginally beneficial treatments, and greater financial and emotional burdens on couples who turn to fertility services as a last resort.

A practical example of profit-driven pressure that subordinates the interests of patients is the expectation that doctors affiliated with private fertility centers manage all infertility cases within the network of clinics owned by a private equity firm, even when a given clinic may not offer the best solution for a particular case. As noted in the guidance from the Human Fertilization and Embryology Authority (HFEA), the most suitable clinic may not always be the one with the highest success rates, but rather one that is transparent, offers clearly defined costs, or simply the most accessible to the patient. When doctors prioritize the patient's best interest over the financial objectives of clinic ownership, the doctors may be asked to terminate their collaboration. The problem with such pressure is that, over the long run, it leads to a divide: On one side, doctors who comply with profit-driven demands, either out of necessity or convenience, and on the other, those who refuse to compromise their ethics and professional integrity, ultimately leaving the practice.

Recent papers by highly reputable authors, most of whom are recruited by private equity, advocate for making the work between public and private centers complementary rather than competitive, demonstrating a forward-looking vision (Garcia-Velasco *et al.*, 2025). However, they also argue that infertility is wrongly framed as a disease, which fuels dissatisfaction with often poor results. If this statement refers to the concept of fertility potential, which is strictly linked to the age and relative euploidy of embryos, then it is acceptable. However, if, as suggested by the text, the intention is to shift infertility out of the framework of psycho-physical suffering, as recognized by the International Federation of Fertility Societies, ASRM, ESHRE, and WHO, then one must question the reasoning behind this shift. In some countries, such as Italy, infertility treatment is covered by the national health service through reimbursement of expenses, as established by Article 32 of the constitution. If infertility were to be redefined as desire without psycho-physical suffering and not classifiable as a disease, it could potentially lose the financial support provided by the national health service, thus shifting a substantial portion of the cost (about 50%) to the private sector (Bulletti & Bulletti, 2025), dramatically increasing the profit of private equity. If the aim is genuine collaboration between the public and private sectors, such position papers should be authored by individuals who do not directly benefit from the outcomes and ideally be published in journals where the authors are not part of the editorial board. Despite these concerns, these contributions remain estimable and valuable.

1.8. Impact on treatment quality and efficacy

The tension between clinical efficacy and profit motives is not merely theoretical. Reports from various jurisdictions indicate a potential downward pressure on treatment quality, particularly when private equity firms seek aggressive expansion strategies. Some consolidated clinic networks focus on marketing and patient acquisition at the expense of robust quality assurance. Staff may be overworked, and high turnover can result in inconsistencies in the handling of gametes and embryos—processes that require meticulous care to ensure favorable outcomes.

One specific area where standards may be compromised is in adherence to laboratory accreditation requirements. Accrediting bodies, such as the College of American Pathologists and the Joint Commission, establish guidelines for the safe and effective operation of embryology laboratories. These standards cover areas including air quality, incubator protocols, staff training, and record-keeping (College of American Pathologists, 2021). If private equity owners perceive certain aspects of compliance as too costly or not immediately revenue-generating, laboratories may experience resource constraints. Over time, the diminished investment in

quality assurance can directly affect fertilization rates, embryo viability, and clinical pregnancy outcomes.

Patients may or may not be aware of these compromises. A couple's main interface is usually with their physician or the clinic's front-desk staff, who might have limited knowledge of changes in laboratory protocols or the reasons behind them. Furthermore, if success rates begin to drop, private equity-owned entities can mask these trends by showcasing aggregated or outdated data in marketing materials. Without rigorous and transparent reporting, it becomes extremely difficult for the public to assess actual treatment quality.

On a more optimistic note, some argue that the private equity influx could stimulate competition, potentially driving improvements in overall quality. The rationale is that clinics with subpar outcomes will lose patients to those with demonstrably higher success rates. However, this market-based argument is hampered by the specialized nature of fertility treatments and the lack of universally accessible, real-time data. Most patients select a clinic based on geographic proximity, referrals from their gynecologist, or online reviews that may be incomplete or manipulated (van Dongen *et al.*, 2020). Consequently, the notion that poor-quality clinics will naturally be weeded out by market forces is overly simplistic, especially when marketing budgets overshadow the availability of unbiased performance metrics.

In summary, the influence of private equity on treatment quality and efficacy remains a double-edged sword. While the infusion of capital can enhance facilities and drive innovation, it can also erode the meticulous scientific and clinical processes that ensure the best outcomes for patients if profit-generation strategies become overbearing. Vigilance from patients, professional organizations, and governmental bodies is crucial to mitigate these risks.

1.9. Patient autonomy and informed consent

At the heart of ethical fertility care lies the principle of informed consent, which demands that patients receive accurate, comprehensible, and unbiased information about the benefits, risks, and alternatives of any proposed intervention (Beauchamp & Childress, 2013). Yet, in an environment where profitability and aggressive marketing are increasingly prevalent, patient autonomy can be compromised. Clinics may present only the most favorable success rates or emphasize the advantages of costly add-on treatments without discussing the limitations, side effects, or supporting evidence. This imbalance of information can sway patients toward more expensive or experimental interventions without a full understanding of their true likelihood of benefit.

Moreover, the emotional dimension of infertility can heighten the vulnerability of patients. Feelings of desperation, grief, and societal pressure often accompany a fertility diagnosis, making it challenging for individuals to critically assess proposed treatment plans. When medical recommendations coincide with the financial interests of corporate entities, the potential for manipulative or incomplete counseling is magnified. Even when clinics offer counseling sessions, the quality and depth of these consultations may vary, and some might serve more as sales pitches than as genuine opportunities for shared decision-making.

Professional guidelines advocate for transparency, yet the regulatory mechanisms to enforce such transparency differ widely across countries and even within regions of the same country De Geyter *et al.*, 2020; Ethics Committee of the American Society for Reproductive Medicine, 2018; Patrizio *et al.*, 2022). Some jurisdictions require fertility clinics to publicly report success rates, complications, and pricing structures. While these policies can foster a degree of accountability, they often do not capture the nuances of patient selection, the burden of additional costs, or the real clinical value of add-on treatments. Without uniform reporting standards and effective oversight, patients remain dependent on the good faith of providers, which is a reliance that can be precarious if private equity priorities overshadow professional integrity.

For patients, navigating this terrain requires a higher level of health literacy, the capacity to question medical recommendations, and possibly seeking multiple opinions before committing to extensive and costly treatment plans. While second opinions may offer broader perspectives, they also add to the overall financial burden and emotional stress. In these circumstances, the role of patient advocacy groups, online communities, and nonprofit organizations grows more important, as they can provide support, resources, and critical reviews outside of corporate influence (Hinton *et al.*, 2019).

1.10. Regulatory and policy responses

Given the growing influence of private equity in the fertility sector, policymakers and professional organizations are grappling with the best approaches to safeguard patient interests. Some regulatory bodies are considering measures such as mandating transparency in cost disclosures, setting upper limits on pricing for routine IVF cycles, and standardizing success rate reporting to minimize the potential for misleading marketing (van Loendersloot *et al.*, 2014). However, the feasibility of implementing and enforcing such measures varies considerably depending on the healthcare framework of each jurisdiction.

In countries where healthcare is largely privatized, there is often less leverage for government intervention, and corporate entities can exploit loopholes in financial and clinical reporting. On the other hand, in more centralized healthcare systems, policymakers can impose guidelines for reimbursement, quality audits, and transparent reporting as prerequisites for licensure or accreditation (ESHRE, 2021a). Yet even within these centralized systems, private equity-owned clinics can find ways to market additional services that fall outside reimbursed packages, effectively circumventing regulatory cost controls.

Professional societies like ASRM have periodically updated guidelines on ethical practice, advertising, and informed consent (ASRM, 2020a; Broer *et al.*, 2014). These guidelines encourage clinics to present accurate success rates, disclose the evidence (or lack thereof) for add-on treatments, and respect patient autonomy in decision-making. Nevertheless, such guidelines are often voluntary and may not be rigorously enforced. Clinics that rely heavily on private funding can find ways to circumvent or superficially adhere to these guidelines, especially if there are no significant legal consequences.

Another area of policy concern is the concentration of clinical data. Fertility treatments generate extensive clinical and laboratory information that could be invaluable for large-scale research, driving improvements in success rates and reducing complications. When private equity firms consolidate clinics, they also consolidate datasets. While this could theoretically expedite research, proprietary data ownership might hinder independent scientific inquiry or lead to selective data disclosure that serves marketing objectives (Pines, 2019). Effective policy measures could require these corporate entities to share anonymized patient data with public registries or academic institutions, balancing commercial confidentiality with the broader public interest.

In health organizations where the number of public patients is decreasing, there are increasing challenges in aligning public waiting lists with those of private (hybrid) contracted services. The length of public sector waiting lists often shifts the burden to private and purely private clinics, which tend to offer quicker treatment responses. A significant portion of infertile couples experiences a time-to-pregnancy parameter that is inversely proportional to the success of treatments. With the increasing awareness of couples through social media, it remains to be seen whether this phenomenon is a casual trend or a more instrumental shift, with future developments likely influenced by regulatory measures of the administrative policy.

1.11. Ethical tensions and professional autonomy in reproductive medicine

A key issue emerges from the intersection of clinical practice and financial strategy: In situations where private equity investment is driving the strategic and financial orientation of a fertility center, potential conflicts may emerge between clinical responsibilities and corporate objectives. The Hippocratic imperative to act in the patient's best interests can come into direct conflict with corporate objectives that may prioritize short-term returns. This tension can manifest in various ways—from subtle pressures to recommend add-ons to overt performance metrics tied to revenue generation.

Physicians and embryologists often enter the field of reproductive medicine out of a desire to help individuals and couples achieve parenthood, which is a profoundly meaningful vocation. However, when these professionals become employees or subcontractors of a private equity-controlled entity, maintaining a patient-centric ethos may become challenging, particularly when it conflicts with the business model (Cookson *et al.*, 2021; Kushnir & Barad, 2021). Some clinicians choose to leave such environments, either to open independent practices or to move into academic settings where profit motives are less dominant. Others remain, endeavoring to balance financial realities with ethical obligations.

Those who stay may attempt to enact internal reforms by advocating for evidence-based practices, transparent reporting, and fair compensation models that reward clinical integrity rather than simple revenue generation. Their success often depends on the willingness of corporate leadership to accommodate these values, which can be challenging if profit margins are the principal priority. In some cases, doctors have formed collectives or partnerships to buy out or negotiate with private equity firms, aiming to restore a sense of professional autonomy and ethical commitment (Chen *et al.*, 2021; Saleh *et al.*, 2023).

Ultimately, the challenges faced by reproductive medicine practitioners reflect broader transformations in healthcare systems worldwide, where the boundary between medical service and commercial enterprise becomes increasingly blurred. The question of whom doctors and embryologists serve is not merely theoretical; it touches on the very integrity of medicine and the fundamental trust that patients place in their healthcare providers. Failure to address these ethical dilemmas risks not only the well-being of patients but also the long-term credibility and sustainability of reproductive medicine itself.

1.12. Future directions and possible solutions

While the concerns about private equity investment in fertility are significant, there remain pathways for reform and realignment that could preserve the integrity of the field. One potential approach involves the development of more robust regulatory frameworks that enforce transparency in pricing, treatment success rates, and the clinical value of add-on treatments. Key stakeholders – policymakers, professional societies, patient advocacy groups, and clinicians – must collaborate to produce standardized reporting metrics that capture both short- and long-term outcomes, including live birth rates, cumulative pregnancy rates, and complication rates (Zegers-Hochschild *et al.*, 2017).

In addition to regulation, there is a pressing need for comprehensive, high-quality research that evaluates the efficacy and cost-effectiveness of new diagnostic tools and add-ons. Well-designed randomized controlled trials and meta-analyses can separate scientifically validated interventions from mere marketing ventures. The dissemination of these findings through open-access journals and professional conferences could empower patients with accurate information and support evidence-based clinical decision-making.

The role of medical education is equally pivotal. Future reproductive specialists and embryologists need training that not only covers cutting-edge technologies but also includes ethical frameworks, patient counseling, and business literacy. By understanding the financial structures that underlie many clinic operations, clinicians can better navigate conflicts of interest and advocate for responsible, patient-centered practices (Beauchamp & Childress, 2013).

Finally, patients themselves hold a measure of power. Collective action, whether through advocacy groups or community forums, can demand higher standards of transparency and ethical practice. Patients who share their experiences – both good and bad – can influence public perception and push clinics to maintain quality. Online review platforms, social media, and non-profit watchdog organizations serve as arenas where individuals seeking fertility services can learn about potential pitfalls and identify reputable providers.

While none of these solutions offer a panacea, their cumulative effect can shift the balance toward a more accountable and ethically consistent fertility market. The next step involves a coordinated effort from all parties—clinicians, embryologists, investors, regulators, and patients—to ensure that the commercialization of fertility services does not overshadow their fundamental purpose: To help individuals and couples build families in a safe, respectful, and ethically sound manner.

2. Methods

This study employed a narrative synthesis methodology to examine trends in infertility diagnostics, treatment efficacy, and the growing influence of private equity investment in reproductive care. The synthesis incorporated data from peer-reviewed literature, registry data, and industry reports published between 2000 and 2025 (projected). Sources included clinical trials, systematic reviews, retrospective cohort studies, and ethical guidelines issued by professional bodies such as the ASRM (ASRM, 2020a; 2020b), the (ESHRE, 2021a; 2021b), and the WHO (WHO, 2020).

Key thematic domains included: (i) temporal trends in clinic ownership types (public, physician-owned private, and private equity/corporate models) (Athey & Garthwaite, 2017; Epstein, 2018; Tradeoffs, 2024); (ii) reported IVF success rates, stratified by age and ownership structure (Boulet *et al.*, 2015; Zegers-Hochschild *et al.*, 2017); (iii) cost transparency and promotion of "add-on" procedures (Chen *et al.,* 2021; Saleh *et al.,* 2023; Mazza *et al.*, 2022).

Where comprehensive global data were unavailable, patterns were extrapolated from national registry outputs, market consolidation reports, and policy publications. Descriptive statistics and trend estimates (2000 – 2025) were derived from historical data snapshots and predictive analyses found in the literature. The narrative synthesis prioritized triangulation and transparency, incorporating diverse data sources to contextualize how market shifts may impact clinical quality, cost structures, ethical practices, and patient autonomy in infertility care (Beauchamp & Childress, 2013; Hinton *et al.*, 2019).

3. Results

3.1. IVF success rates by age group

Success rates for IVF vary significantly by maternal age, with a consistent decline observed as age increases. The following summary outlines average live birth rates per embryo transfer across different clinic types, stratified by age group:

(i) <35 years: Across all clinic types, average success rates per embryo transfer ranged from approximately 30% to 35%. Public clinics and large private centers often reported similar success ranges, while hybrid clinics aligned closely with these figures.

(ii) 35 – 37 years: Success rates generally ranged between 25% and 30%. Differences between public and private clinics were minimal when patient prognosis (e.g., ovarian reserve and partner sperm parameters) was accounted for.

(iii) 38 – 39 years: Success rates dropped to about 20 – 25% in

all clinic types, reflecting the natural decline in fertility.

(iv) 40 – 42 years: Success rates declined further, often to around 15% or lower, regardless of ownership model. Some private clinics reported marginally higher rates, though this was often attributable to the selective inclusion of patients with favorable prognoses.

(v) ≥43 years: Across all clinic types, success rates were typically under 10%. Variations were often attributable more to patient selection than to intrinsic clinic quality.

3.2. Influence of ownership

Clinic ownership models can shape patient experience, financial accessibility, and reported success rates. The following outlines key characteristics associated with public, private, and hybrid fertility care providers:

(i) Public (national health service) clinics: Generally operated under clear regulatory oversight and cost transparency, with well-documented success rates. Patient satisfaction often correlated with comprehensive counseling and reduced financial burden when national health service funding was available.

(ii) Private clinics: Some achieved slightly higher reported success rates, potentially due to patient self-selection. These clinics often featured more complex or bundled fee structures. High-quality private centers excelled in staff accessibility and personalized care; however, concerns persist about potential conflicts of interest in recommending add-on services.

(iii) Hybrid models: Showed intermediate characteristics, combining public funding or partnerships with private investment. Success rates typically reflected national averages, though transparency varied, depending on the proportion of private funding and local regulations.

3.3. Transparency and ethical practices

Transparency and adherence to ethical standards are critical components influencing patient trust and satisfaction in fertility care. The following points summarize key aspects related to cost disclosure, conflicts of interest, and the quality of empathic care across clinic types:

(i) Cost disclosure: Transparent itemization of treatment, medication, and potential add-ons was consistently rated by patients as a crucial factor in deciding a clinic. Public and some hybrid centers were more likely to provide standardized fees, while private clinics frequently listed "base" package costs, with additional fees for certain tests or procedures.

(ii) Conflict of interest: The HFEA encourages clinics to disclose financial ties and referral relationships. While clear disclosure practices were observed in many public and hybrid clinics, private clinics under private equity ownership occasionally demonstrated less uniform reporting of these interests.

(iii) Empathic care and patient satisfaction: Patient feedback consistently highlights compassion, accessibility, and continuity of care as major contributors to satisfaction. Clinics offering comprehensive counseling and psychosocial support—regardless of ownership model—tended to receive higher patient ratings.

4. Conclusion

The landscape of infertility treatment has evolved profoundly over the past several decades, with advancements in diagnostic tools and treatment modalities offering hope to millions of couples worldwide (Zegers-Hochschild *et al.*, 2017). Cutting-edge diagnostics, such as refined hormonal assays, sophisticated imaging, and advanced genetic screening, promise a level of precision that was unimaginable only a few decades ago. Concurrently, ART, especially IVF and ICSI, have matured into reliable options for a wide array of infertility challenges. However, the increasing adoption of add-on treatments – such as time-lapse embryo monitoring and reproductive immunology interventions – has introduced additional complexity and cost, often with limited consensus on efficacy.

Against this backdrop, the surge of private equity investment in fertility centers represents a major inflection point. While capital influx can theoretically enhance resources, infrastructure, and research capabilities, the short-term profit motives and consolidation strategies typical of private equity often collide with the ethical and patient-centered imperatives of reproductive medicine. Doctors and embryologists risk becoming intermediaries for corporate agendas, and patients, already under the emotional strain of infertility, may bear the brunt of inflated costs, opaque marketing, and potentially compromised care. The question of whether clinicians ultimately serve the needs of patients or the revenue goals of shareholders is both urgent and consequential.

To navigate these tensions, stakeholders must prioritize transparency in both cost and efficacy data. Regulatory bodies and professional societies can enforce standardized reporting measures, ensuring that success rates, pricing structures, and the clinical value of add-ons are clearly communicated. Evidence-based guidelines, supported by robust research, can delineate which interventions genuinely benefit patients and which merely serve financial objectives. Clinicians and embryologists, for their part, are called upon to uphold professional ethics, resisting undue pressures to over-diagnose or overtreat in the service of corporate imperatives.

In the final analysis, the fertility field stands at a crossroads. On one hand, it holds the potential to resolve emotional and psychological challenges faced by individuals and couples seeking to build families. On the other, it risks succumbing to commercial exploitation that erodes the foundational trust between patient and provider. The decisions made at this juncture – by practitioners, patients, investors, and regulators alike – will influence not only the quality of care delivered but also the moral character of reproductive medicine itself. Ensuring that patient welfare remains paramount is not just an ethical obligation; it is the foundation upon which enduring success, meaningful innovation, and sustained credibility in fertility care must be built. HFEA data underscore that once confounding factors (particularly age and fertility diagnosis) are taken into account, the difference in average success rates among public, private, and hybrid fertility clinics in the United Kingdom is relatively modest. Age remains the predominant determinant of IVF outcomes; therefore, clinics' "headline" success rates often reflect patient selection strategies rather than intrinsic quality differentials. In light of these similarities, prospective patients frequently weigh non-clinical elements – such as transparent pricing, freedom from conflicts of interest, and an empathic, patient-focused care ethos – more heavily when selecting a provider. Encouraging all clinic types to maintain consistent, clear reporting on costs and outcomes – paired with strong ethical and supportive patient care – aligns with HFEA guidelines and is fundamental to high-quality fertility services.

Acknowledgments

None.

Funding

None.

Conflict of interest

The authors declare that they have no competing interests.

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Ethic approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Availability of data

Not applicable.

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