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Committee Secretary

Senate Standing Committees on Community Affairs

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Dear Committee Secretary

**INQUIRY AS TO UNIVERSAL ACCESS TO REPRODUCTIVE HEALTHCARE**

This submission concerns the following terms of reference:

1. Cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas.
2. Experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare.
3. Availability of reproductive health leave for employees.
4. Any other related matter.

# 1. COST AND ACCESSIBILITY OF REPRODUCTIVE HEALTHCARE

Those who seek to conceive children do so either naturally or through assisted reproductive treatment of some kind. In rough terms, 19 out of 20 children currently born in Australia will be conceived naturally and one child in every 20 (or to put it another way, the equivalent of one child in every classroom) is born through assisted reproductive treatment of some kind[[1]](#footnote-1).

Assisted reproductive treatment (ART) may involve:

* Home insemination.
* Medical assistance, such as artificial insemination or IVF through a clinic.
* Third party reproduction – using an egg, sperm or embryo donor and/or surrogacy.

The *Gorton Review* of Assisted Reproductive Treatment and Surrogacy in Victoria in its interim report (2018) dealt with the issue of affordability of assisted reproductive treatment at length:

*“Cost was a key concern among those who used services and those who support them. Of the 110 surveyed responses received from individuals identifying as recipients of treatment, costs was explicitly identified as the significant issue by 97 people (88%). For the feedback received, affordability of treatment appears to both present a significant barrier to access and to drive decision making about treatment use.”[[2]](#footnote-2)*

*“The Medicare rebate is only available for patients with medical infertility issues, as that is determined by clinical judgment. People who do not have medically diagnosed infertility but who nonetheless require ART to form a family, such as LGBTIQ+ people or single parents by choice, may face significantly higher costs.”[[3]](#footnote-3)*

*“The Review has also heard that costs can have impact on treatment decisions, for example delaying treatment based on financial considerations or favouring more aggressive treatment in hope of limiting the number of cycles required … cost is also significant factor in continuing treatment for many people … the burden of costs for ART is significant. The Review has heard that accessing finance and/or early release of superannuation is common among those seeking reproductive treatment.”[[4]](#footnote-4)*

Early access to superannuation may not, as I understand it, be currently available in cases of surrogacy because the medical treatment, although to assist the intended parent is for the surrogate[[5]](#footnote-5). Therefore, we have the observed example that a person can access their own superannuation for their own IVF treatment, but if they want to create embryos to be implanted in a surrogate, they may not.

The *Gorton Review* was critical in both its interim and final report about taking steps to promote inclusive practice for the diversity of those impacted by ART. Among matters raised in the interim report were:

* Removing discriminatory language from the *Assisted Reproductive Treatment Act 2008* (Vic).
* The 10 woman limit.
* Birth certificates.
* Language in clinic forms and information.
* Staff involved in assisted reproductive treatment.
* Counselling.
* The specific needs of intersex people and assisted reproductive treatment.

These issues were also identified to an extent in the final report[[6]](#footnote-6).

The *Gorton Report* in its final report recommended the public provision of ART in Victoria to improve access and affordability.

## 1.1 MEDICARE PAYMENTS

It has been estimated that the Commonwealth taxpayer spends over $250m a year on Medicare for assisted reproductive services.

The legal basis for doing so is under the *Health Insurance Act 1973* (Cth). The items that are payable are items 13200-13290 which are contained under the *Health Insurance (General Medical Services Table) Regulations 2021* (Cth).

There are three key concepts relevant to assisted reproductive services contained under the Act and Regulations:

1. Clinically relevant service
2. Infertility
3. Exclusion for surrogacy.

### 1.1.1 Clinically relevant service

The service that is provided must be a *clinically relevant service*. *Clinically relevant service* is defined in section 3 of the *Health Insurance Act* as meaning:

*“A service rendered by a medical or dental practitioner or an optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.”*

### 1.1.2 Infertility

When it comes to assisted reproductive services, the clinically relevant service must be for infertility. The traditional definition of infertility is that still used by the World Health Organization[[7]](#footnote-7):

*“Infertility is a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse.”*

That definition, rightly, has been criticised for being heteronormative and therefore excluded singles as well as LGBTIQ+ couples. By way of three examples:

* A gay couple, by that definition, would never be able to access Medicare benefits for assisted reproductive services.
* Nor would a single woman.
* Nor would a lesbian couple in need of sperm donation where the relevant woman or women are medically fertile.

There has therefore been, by virtue of that definition and the requirement for *clinically relevant service*, an artificial dichotomy between:

* Medical infertility.
* Social infertility.

In essence, those who are deemed to be socially infertile would not be able to access Medicare benefits for assisted reproductive services – only those who were deemed medically infertile. That traditional definition of infertility was discussed in *JM v QFG & JK* [1998] QCA 228, a decision of the Queensland Court of Appeal. JM, a lesbian, sought fertility treatment from Queensland’s largest IVF clinic, Queensland Fertility Group. Because JM did not have classical infertility, then the relevant guidelines that applied in Queensland at the time meant that she was denied treatment. JM brought a claim under the *Anti-discrimination Act 1991* (Qld) on the basis of *lawful sexual activity*. In the words of Justice Thomas:

*“The evidence showed that doctors providing services of this kind (including the respondent doctor) endeavour to act upon reports and statements made by various bodies including the National Bioethics Committee. That Committee have published the review that ‘most commonly accepted definition [of infertility] within medicine is the inability of a couple to conceive after 12 months of intercourse without contraception’. That definition on any reasonable view seems to contemplate a failure to conceive after intercourse between members of opposite sexes before infertility is established. The doctor went on to observe:*

*‘My medical definition would follow that. It’s a very good working guideline and when we practice medicine we practice under the HIC and Medicare though the implication always is that you are treating something which has gone wrong or isn’t working. If someone has blocked tubes we can try and fix them; if someone doesn’t ovulate we can fix that; if someone has a very low or absent or defective sperm count we can fix that. Now in this case with lesbians we’re not – our group as a group doesn’t have any views or any antagonism towards lesbian relationships and perhaps that should be stated in case we’re made to look like a sort of bunch of rednecks. We are not. But lesbians cannot have children because they have a biological problem. No two females or two males can have children. Now people may have access and say ‘we would like to get hold of some sperm because we want a child’ and that may or may not be a good thing. We’re not there to comment on that but if they come to us we treat infertility and my understanding is it would be wrong, ethically and under HIC and Medicare to be treating someone who does not have a medical problem under that schedule.’”*

His Honour went on to say:

*“The true basis of the doctor’s refusal to provide services to the patient was not because of her lesbian activity but because of her heterosexual inactivity. Minds may differ on the question, but common sense suggests that many lesbians are also prepared to engage in heterosexual activity. One can only include the quality of heterosexual inactivity in a particular individual if one overworks the term ‘lawful sexual activity’ by adding personal relationship factors such as ‘exclusive relationship’ to the concept.*

*With some slight hesitation, I’m of the view that in s7, ‘sexual activity’ does not include sexual inactivity. For example, the practice of chastity would not ordinarily be regarded as a form of sexual activity. To the contrary, it is abstinence from sexual activity. In the context of such a person approaching a doctor for artificial insemination services, I would find it difficult to be critical of a doctor who says ‘Why do you need me? You have not tried to have a baby. You do not demonstrate any need for this special service. You are not ill or disabled and I have no reason to think you infertile. I’m not going to provide the special services to you.’”*

### 1.1.3 Current Consensus Definition of Infertility

The current international consensus definition of infertility (with the absence of the WHO) was published in 2017 by the International Committee Monitoring Assisted Reproductive Technologies (ICMART) with the support, among others, of the International Federation of Fertility Societies, International Federation of Gynecology and Obstetrics and the Fertility Society of Australia and New Zealand[[8]](#footnote-8). The definition is now defined as:

*“A disease characterized by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or due to an impairment of a person’s capacity to reproduce either as an individual or his/her partner. Fertility interventions may be initiated in less than 1 year based on medical, sexual and reproductive history, age, physical findings and diagnostic testing. Infertility is a disease, which generates disability as an impairment of function.”*

In other words, the definition incorporates the WHO traditional definition, but also broadens it so that in essence anyone needing ART in order to conceive a child is now deemed infertile. The provision of services by medical practitioners to these patients, consistent with that international consensus definition, would therefore be a *clinically relevant service*. To go to those examples above again:

* If a gay couple then seek to create embryos, one would think therefore that they are infertile and can obtain the Medicare rebate. However, there are two barriers (which I discuss below) that may prevent Medicare being available.
* Single woman needing a sperm donor is entitled therefore to Medicare benefits.
* Lesbian couple needing a sperm donor again would be entitled to Medicare benefits.

How the change in definition came about was discussed in a *New Yorker* article: *The case for redefining infertility*[[9]](#footnote-9):

*“In 2015 Barbara Collura, the president and CEO of the US Infertility – Advocacy Group RESOLVE, travelled to Geneva to take part in a series of discussions, led by the International Committee Monitoring Assisted Reproductive Technologies, over the definition of infertility. In 2009, the World Health Organization (WHO) defined infertility as ‘a disease of the reproductive system’; its definition held that infertility could be diagnosed after a year or more of ‘regular unprotected sexual intercourse’ had failed to produce a pregnancy. But, by 2015, there was broad agreement that this language, with its reliance on heterosexual sex is a reference point, excluded many of the people who currently seek fertility treatment, including queer and single patients. The delegates – most of whom represent professional medical bodies, such as the American Society for Reproductive Medicine, the African Fertility Society, and the International Federation of Gynecology and Obstetrics – hoped to redefine infertility in a new, more inclusive way.*

*‘There were several hours of discussion, of wordsmithing,’ Collura said. Eventually, they settled on an expansion of the 2009 WHO definition. The new language explained that infertility could also be diagnosed based on ‘an impairment of a person's capacity to reproduce either as an individual or with his/her partner’. It also noted that infertility generates ‘disability as an impairment of function.’ When the new definition was published, in 2017, in the journal Fertility and Sterility, criticism arose immediately, not just from the right – Josephine Quintavalli, the director of the Conservative Social Trends Institute, had already called it ‘absurd nonsense’ – but from the left. ‘The terminology is kind of offensive in terms of using the term ‘impairment,’’ Cathy Sakimura, the deputy director of the National Center for Lesbian Rights, told me. In her view, the revised definition, even as it encompasses queer couples and individuals, comes perilously close to characterizing being single or queer as a formed disability. ‘There are other ways to get at that, to use a more neutral word,’ she said. Lisa Campo-Inglestein, the bioethicist whose 2018 paper had proposed seeing infertility as a result of ‘social and physiological limitations,’ warn that categorizing social infertility as a diseased pathologizing and medicalizing homosexuality. ‘Medicalization is a double-edged sword’ she said. ‘On the one hand, it gives you access, if you have a medical condition, to treatment. But, on the other hand, it may label something that you don’t think, really, is a disease as a disease.’*

*In theory, social definition of infertility – one laid out in terms of intentions and identities rather than diseases and disabilities – circumvents these problems. But it creates complexities of its own. Last year, researchers from Yale and the University of Haifa, in Israel, shared the results of a study in which they asked one hundred and fifty women who have frozen their eggs to explain the motivation. The overwhelming majority of the women cited what might be called “man problems,” including divorces, breakups, and male partners who weren’t yet ready to have children. It takes a conceptual leap to see a recent divorcee and a woman with endometriosis as equally infertile, but Campo-Inglestein argues that they are “similar enough that they should be treated the same.” In general, she points out, we treat medical conditions with worrying about their origins. “If you never go on any dates, you might never find the person of her dreams, but if you have having lots of unprotected sex, you’re more likely to get a sexually transmitted infection – which, if left untreated, could also cause infertility.” In her view women who can’t have children are united in their condition.*

*‘If we accept the notion that reproduction is a human right, then I think it would be inconsistent if we were to exclude gay men, Eli Adashi, a former dean of medicine and biological sciences at Brown University, and the author of numerous papers on access to ARTs, told me. “Gay men are people, too.” A positive right to the treatment of social infertility, in theory, could require governments or insurance companies to facility surrogacy for gay men who wish to have children.”*

As set out above, the definition of infertility has moved on from the traditional one still used by the WHO.

Nevertheless, it is a lottery for intended parents through surrogacy as to whether their doctor will claim Medicare benefits on their behalf – based on whether or not the doctor viewed the treatment as being for infertility and therefore a clinically relevant service. Some doctors still use the traditional definition.

### 1.1.4 Exclusion of Surrogacy

The Commonwealth has funded assisted reproductive services through Medicare since 1990. Since 1990 there has been a ban on the funding of surrogacy. Whilst that approach in 1990 was consistent with community values, it is now an historical anomaly.

Before I was aware of this inquiry, I recently wrote to the Health Minister, the Hon Mark Butler, seeking the abolition of this historical anomaly. A copy of my letter to the Minister dated 8 November 2022 is **attached**.

Clause 5.2.6 of the *Health Insurance (General Medical Services Table) Regulations 2021* sets out the surrogacy exclusion:

*“Items 13200-13221 do not apply to a service provided in relation to a patient’s pregnancy, or intended pregnancy, that is, at the time of the service, the subject of an agreement, or arrangement, under which the patient makes provision for transfer to another person of the guardianship of, or custodial rights to, a child born as a result of a pregnancy.”*

Again, it is a lottery for intended parents as to whether Medicare benefits will be claimed. If, for example, a gay couple attend upon a doctor to seek the creation of embryos, they have not at that point entered into a surrogacy arrangement (which must be in writing in New South Wales, Queensland, South Australia, Tasmania and Western Australia, and soon the Northern Territory, but may be oral in the ACT and Victoria) then *at the time of the service,* Medicare can be claimed. However, other doctors fearful that the creation of embryos by a gay couple would necessarily involve surrogacy, have refused to claim Medicare rebate for fear that the doctor will be in breach of the exclusion.

The cost of removal of this discriminatory, historical exclusion is less than $1 million a year, in a Medicare budget for assisted reproductive services of more than $250 million a year.

## 1.2 PARTICULAR WOMAN

There is a view that to create an embryo when intended parents have not identified a surrogate is an offence. This means another barrier is put in place for intended parents seeking to create embryos who have not yet been able to locate a surrogate. As set out in my recent letter to the Western Australian Health Department (attached) for every child born via surrogacy in Australia, four are born overseas. The odds are against intended parents locating a surrogate in Australia. They should not be denied the opportunity to make their embryos here.

The advice, from clients, is that some doctors will create embryos for intended parents through surrogacy even though the surrogate has not yet been identified.

Other doctors take a more cautious view, which is that those embryos cannot be created unless the *particular woman* in which the embryo is to be implanted is identified. For intended parents who need to be parents through surrogacy, this in effect requires a surrogacy arrangement to be in existence at the time of the creation of the embryos, and therefore means that the couple will not be eligible to access Medicare due to the surrogacy exclusion.

I am told by one clinic that the Federal Department of Health takes the view that *particular woman* must be able to be identified at the time of creation of the embryos, and not at the time of subsequent implantation in the surrogacy arrangement.

It is common for intended parents at the time that they wish to create embryos not to have a surrogate identified.

The lack of certainty about whether or not embryos can be created is yet another lottery for intended parents- adding to their cost, distress and delay- and encouraging them implicitly to go overseas, where there are not similar barriers to treatment.

Section 12 of the *Prohibition of Human Cloning for Reproduction Act 2002* (Cth) provides:

*“(1) A person commits an offence if the person intentionally creates a human embryo by a process of the fertilisation of a human egg by a human sperm outside the body of a woman, unless either or both of the following apply:*

*(a) the person’s intention in creating the embryo is to attempt to achieve pregnancy in a particular woman;*

*(b) the creation of the embryo by the person is permitted under section 28B of the Research Involving Human Embryos Act 2002 (carrying out activities authorised by mitochondrial donation licenses).*

*Penalty: imprisonment for 15 years.*

*(2) Despite subsection 13.3(3) of the Criminal Code, a defendant does not bear an evidential burden in relation to any matter in subsection (1) of this section.”* (emphasis added)

The *Prohibition of Human Cloning for Reproduction Act 2002* (Cth) is part of a Commonwealth/State/ACT scheme. Only the Commonwealth Act refers to mitochondrial donation. Each of the matching State or ACT laws also require *“the person’s intention in creating the embryo as to attempt to achieve pregnancy in a particular woman”*.

#### TABLE 1 – LAWS AS TO *PARTICULAR WOMAN*

|  |  |
| --- | --- |
| **Jurisdiction** | **Law** |
| Commonwealth | *Prohibition of Human Cloning for Reproduction Act 2002*, section 12(1)(a) |
| ACT | *Human Cloning and Embryo Research Act 2004*, section 10 |
| New South Wales | *Human Cloning for Reproduction and Other Prohibited Practices Act 2003*, section 7(1) |
| Northern Territory | N/A |
| Queensland | *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003*, section 8 |
| South Australia | *Prohibition of Human Cloning for Reproduction Act 2003*, section 7 |
| Tasmania | *Human Cloning for Reproduction and Other Prohibited Practices Act 2003*, section 10 |
| Victoria | *Prohibition of Human Cloning for Reproduction Act 2008*, section 8 |
| Western Australia | *Human Reproductive Technology Act 1991*, section 53H |

If the view of the law expressed to me is right, then this means that fertility preservation for cancer survivors may well be unlawful. It is an extraordinary public policy that would prevent cancer survivors ensuring their fertility preservation.

A case of fertility preservation was that of *LWV v LMH*:

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| ***LWV v LMH* [2012] QChC 26**  I had the honour in that case in representing the surrogate in what became the first case in the world to define conception of a child (being the act of pregnancy, not fertilisation).  The intended parents were husband and wife. The surrogate was the sister of the intended mother. The intended mother, identified in the judgment as AKV, was diagnosed with cancer. She had an emergency hysterectomy. In the words of Judge Clare SC[[10]](#footnote-10):  *“AKV’s eggs were fertilised and preserved before she underwent the emergency procedure that saved her life but left her unable to carry her own children. This was before the Surrogacy Act had come into existence. It was therefore impossible for her to enter into an arrangement under the Act before the embryos were created. The same situation is likely to confront any woman undergoing emergency procedures in the future, notwithstanding the commencement of the Act. A woman, although desirous of having a baby, would have little hope of securing a compliant surrogacy arrangement in advance of an emergency hysterectomy, given the requirements for the identification of a willing surrogate, proper counselling and legal advice with time to reflect on all of the implications. The Act is intended to help such people in genuine need of surrogacy.”* |

It would appear that section 12 of the Commonwealth Act needs to be amended so that it is clear that intended parents through surrogacy can create embryos, even if the surrogate has not yet been identified. Otherwise, if the apparent view of the Department of Health holds true, women in the position of AKV (and their partners), and any doctors treating them will, on the face of it, be committing an offence punishable by up to 15 years’ imprisonment.

## 1.3 EXTRAORDINARY BARRIERS TO SURROGACY

As is demonstrated by the numbers, Australian surrogacy laws are not fit for purpose. Australian Parliaments, including the Commonwealth, are rightly concerned about the exploitation of women, and in the process have imposed two significant barriers on undertaking surrogacy in Australia:

* Egg donors are to be only altruistic: see for example *Prohibition of Human Cloning for Reproduction Act 2002* (Cth), section 21.
* Surrogates are to be only altruistic: see for example *Surrogacy Act 2010* (NSW), section 8.

### 1.3.1 Our egg donor laws

Each state and the ACT have enacted similar laws to the *Prohibition of Human Cloning for Reproduction Act 2002* (Cth) as part of a scheme concerning payment to egg donors.

In addition, each state and both territories have enacted human tissue laws which regulate donation of human tissue (including eggs and sperm), for example, *Transplantation and Anatomy Act 1979* (Qld).

There is, quite simply, a chronic shortage of egg donors in Australia. This has been the case for many years. This chronic shortage has been alleviated to a small degree by the importation of eggs from donors in the United States and the Ukraine, which must comply with Australian standards.

Nevertheless, demand far exceeds supply. For example, in 2016 I visited a fertility clinic in Cape Town. Cape Town is not easy to get to for at least for anyone on the eastern seaboard. It took me approximately 24 hours to get there from Brisbane. Nevertheless, the medical director said that the clinic was seeing 3-5 Australian heterosexual couples seeking egg donation *per business day*. The numbers concerning that clinic alone are staggering.

By virtue of our longarm laws[[11]](#footnote-11) engaging overseas in what might be considered back home to be commercial egg agreement could be a criminal offence back home, other than Tasmania and Victoria.

### 1.3.2 Our surrogacy laws

Each state and the ACT have laws that regulate altruistic surrogacy and criminalise commercial surrogacy[[12]](#footnote-12). The definition for each varies by jurisdiction. An example of such a law is the *Surrogacy Act 2019* (SA).

The Northern Territory, alone, does not regulate surrogacy. That will cease upon the commencement of the *Surrogacy Act 2022* (NT), which is expected to occur by March 2023[[13]](#footnote-13), and must in any event commence by 21 March 2024[[14]](#footnote-14).

The ACT, New South Wales and Queensland criminalise those going overseas for commercial surrogacy[[15]](#footnote-15). In addition, under longarm laws which extend out State jurisdiction, the same applies in South Australia[[16]](#footnote-16) and Western Australia[[17]](#footnote-17). With the commencement of the *Surrogacy Act 2022* (NT) the same will occur there[[18]](#footnote-18). Only in Victoria and Tasmania is there no risk of committing a criminal offence in engaging surrogacy overseas.

Despite the enormous costs with surrogacy, the fact remains that for every child born through domestic surrogacy in Australia, almost four are born overseas[[19]](#footnote-19). No one has ever been prosecuted for undertaking surrogacy overseas. Our overseas extraterritorial laws have been endorsed by the New Zealand Law Commission as a *“failed experiment”[[20]](#footnote-20)*.

Given that over 2,300 children have been born in the last 10 years or so overseas through surrogacy[[21]](#footnote-21) and many of those would have been through commercial surrogacy by residents of those Australian jurisdictions that criminalise that practice overseas, but no one has been prosecuted, those words *“failed experiment”* ring true. The most striking example is that of Western Australia where, due to a combination of barriers, one child a year is born through surrogacy there, but 20 or more children are born to WA residents overseas through surrogacy[[22]](#footnote-22). Another striking statistic is that more Australian children are born in the most expensive place in the world to undertake surrogacy – the United States – than are born domestically through surrogacy in Australia[[23]](#footnote-23).

I was contacted by the officers carrying out the review in Western Australia as to assisted reproductive treatment and surrogacy. I reduced my response to them in writing in the letter to them which is attached to this submission.

The numbers speak volumes over the last decade that Australian laws do not reflect the demand by Australian intended parents – met elsewhere – to become parents through surrogacy.

Whilst the numbers for Western Australia are startling- in broad terms for every child born through surrogacy there, twenty are born overseas, Western Australia is not alone. The figures from New South Wales are also daunting:

#### TABLE 2- A COMPARISON OF INTERNATIONAL AND DOMESTIC SURROGACY: NSW

|  |  |  |
| --- | --- | --- |
| Year | International surrogacy births for NSW | Domestic surrogacy births for NSW |
| 2017 | 55 | 9 |
| 2018 | 57 | 14 |
| 2019 | 77 | 0 |
| 2020 | 92 | 12 |
| 2021 | 75 | 1 |

This data has been compiled in this way:

* The international data has been obtained under FOI from the Department of Home Affairs, which keeps data on the number of children born overseas through surrogacy who have applied for Australian citizenship by descent. The Department does not provide a state by state breakdown. I have taken the national figure and divided it by three on a per capita basis for NSW, as approximately one third of the Australian population lives in NSW.
* The amount of surrogacy births in NSW has been obtained by FOI from the NSW Government. This domestic data comes from the number of parentage orders made in surrogacy matters by the Supreme Court of NSW.

The data reveals a huge gap between the number of children born to NSW residents overseas through surrogacy (even through it is illegal for NSW residents to undertake commercial surrogacy overseas), and the extraordinarily low number of parentage orders made in NSW in 2019 and 2021 – which indicates that the pandemic is not the cause. It is possible that the NSW figures, which are parentage orders made, slightly understate the number of births, as one parentage order would apply when twins are born.

### 1.3.2 Post-birth transfer of parentage for surrogacy

Furthermore, the universal requirement in each State and the ACT, and soon to be taken up in the Northern Territory, is that following the birth of the child, there is no automatic recognition of the intended parents as the parents. The requirement is, instead, that one to six months post-birth an application is made to a state or territory court for transfer of parentage from a surrogate and her partner to the intended parents.

Each of the Law Commissions of England and Wales and Scotland[[24]](#footnote-24) and of New Zealand[[25]](#footnote-25) have instead recommended that there be automatic recognition of intended parents as the parents in non-disputed cases. Research conducted by the Law Commissions of England and Wales and Scotland show that the surrogates (even traditional surrogates) did not consider themselves to be the parents of the children they were carrying, but that the surrogates considered the intended parents to be the parents. The intended parents, not surprisingly, also saw themselves to be the parents.

Auto-recognition at birth is available in other altruistic jurisdictions- in British Columbia and Ontario. The delay in obtaining post-birth recognition can be contrasted with another altruistic jurisdiction, Alberta, where a parentage order is commonly obtained 2-3 business days after the child is born[[26]](#footnote-26).

Pre-birth orders made during the pregnancy by consent are commonly made in most parts of the United States[[27]](#footnote-27) – where the intended parents are recognised as the parents, but also in parts of Mexico and Argentina, and in South Africa.

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| **THE RUSHED REPORT AND THE GO SLOW RESPONSE**  In 2015 and 2016 the relevant House of Representatives Committee, chaired by George Christensen, carried out, first, an informal inquiry and then a formal inquiry as to surrogacy. The formal inquiry report was rushed as it was conducted in the lead up to the 2016 Federal Election.  Nevertheless, it recommended that there be national non-discrimatory surrogacy laws, that Australians remain able to undertake surrogacy overseas and that urgent action be taken, including by COAG[[28]](#footnote-28). The recommendations included that the Australian Law Reform Commission conduct a 12 month inquiry into surrogacy laws. This has not occurred. The Committee also recommended that the Government create a website to give Australian intended parents information about domestic altruistic surrogacy. This hasn’t happened either.  The Commonwealth Government responded belatedly to the inquiry outcome. I understand that there is a working group of the various Attorneys-General as to surrogacy laws. I have no idea at what stage that working group is at as there has been no stakeholder involvement whatsoever. Surrogacy laws across the country remain a mishmash. |

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| --- |
| **REGISTRATION ORDERS IN VICTORIA**  If a child is born in Victoria but a parentage order concerning surrogacy is made interstate, then one would think that at that stage the parents are the intended parents. This is because:   * The intended parents are recognised under the *Family Law Act* *1975* (Cth)as the parents of the child: section 60HB, *Family Law Regulations 1994* (Cth), regulation 12CAA. * The intended parents are recognised as the parents for the purposes of citizenship: *Australian Citizenship Act 2007* (Cth), section 8. * Where a Commonwealth law and a State law are inconsistent, the Commonwealth law has primacy under the Constitution, section 109. * Orders made by State courts are to be recognised interstate: Constitution, section 118:   *“Full faith and credit shall be given, throughout the commonwealth, to the laws, the public Acts and records, and the judicial proceedings of every State.”*   * Faith and credit is to be given to documents properly authenticated: *Evidence Act 1995* (Cth):   *“All public acts, records and judicial proceedings of a State or Territory that are approved or authenticated in accordance with this Act are to be given in every court, and in every public office in Australia, such faith and credit as they have by law or usage in the courts and public officers of that state or territory.”*  Despite all of those provisions, Victoria has said, bluntly, that parentage by those parents of that child born in Victoria will **not** be recognised in the birth register in Victoria unless a registration order is made in the Supreme Court or County Court of Victoria under division 2A, part IV *Status of Children Act 1974* (Vic). Before the court may make a registration order, it must be satisfied that[[29]](#footnote-29):  *“(a) Making the order is in the best interests of the child; and*  *(b) The intended parents did not enter into the surrogacy arrangement for the purpose of avoiding requirements under this Part or the Assisted Reproductive Treatment Act 2008 that would have applied to the arrangement if the child had been conceived in Victoria; and*  *(c) At the time the surrogacy arrangement was entered into, the intended parents had a genuine connection to the Australian state or territory in which the child was conceived; and*  *(d) The child was living with at least one of the intended parents at the time the application of the registration order was made; and*  *(e) The surrogate mother and, if her partner is a party to the arrangement, her partner had not received any material benefit or advantage from the surrogacy arrangement; and*  *(f) The surrogate mother freely consents to the making of the order; and*  *(g) The surrogate mother was at least 25 years of age before entering into the surrogacy arrangement.”*  The process of obtaining a registration order adds costs to intended parents on top of:   * IVF and other assisted reproductive treatment. * The legal costs in obtaining a parentage order interstate. |

### 1.3.4 Parental Responsibility Between Birth of the Child and Making the Order

The intended parents are not the lawful parents of the child born through surrogacy until a parentage order is obtained, which ordinarily is made months after the child is born. The gap between reality and legality manifests itself in three ways:

1. The child’s eligibility for Medicare.
2. Parental responsibility to make medical decisions for the child.
3. Obtaining a passport and travel overseas.

#### 1.3.4.1 Medicare Benefits

Under the *Health Insurance Act 1973* (Cth), the child, being an Australian citizen, is entitled to Medicare benefits and therefore entitled to a Medicare card. To have the child as part of the family Medicare card, the child must be a dependent child of a person, namely, in the custody, care and control of that person: *Health Insurance Act 1973* (Cth), section 10AA. In the past, sometimes my clients have had great difficulty in obtaining Medicare cards for the child, either in the child’s own name or in the name of the family of the intended parents prior to a parentage order being made. At other times, this has been an easy process.

In my own case, my husband Mitchell and I did not apply for a Medicare card for our daughter Elizabeth until after the parentage order was made, as if we had been rejected it would have been just yet another burden to go through in what was already an extraordinarily difficult and complex process. For us, it was just easier to wait.

#### 1.3.4.2 Medical Decisions

Commonly, medical decisions have to be made for children prior to the making of parentage orders. At times this concerns major treatment. On those occasions, prior to the making of a parentage order, it is the surrogate and her partner who are to make those decisions. This does not reflect the reality that the child has been born for the purposes of being a child of the intended parents (who often have a genetic relationship with the child) and who are caring for the child on a daily basis, while the surrogate and her partner typically:

* Do not have a genetic link with the child;
* Did not intend to be the parents, and do not consider themselves to be the parents; and
* Are not caring for the child.

In the absence of automatic recognition of the intended parents as the parents, amendment of the *Family Law Act 1975* (Cth) to allow parenting plans to be entered into by one parent (when there is only one recognised by law) with others concerning the parental responsibility of the child would solve the problem. Currently, the options for intended parents are:

1. In special circumstances, bring the parentage order application forward so that the State court makes those orders. This is possible, for example, in Queensland, as has occurred. It is not possible, for example, under the *Surrogacy Act 2022* (NT).
2. Apply for appropriate orders in the relevant Supreme Court under the *parens patriae* jurisdiction. This should be fairly quick, but expensive, being another cost burden imposed on intended parents on top of an already costly journey.
3. Apply under the *Family Law Act 1975* or the *Family Court Act 1997* (WA) for an order for parental responsibility. This is likely to be a slower process than that in the Supreme Court but also a costly one.
4. Enter into a parenting plan under the *Family Law Act 1975* (Cth) or *Family Court Act 1992* (WA) – which can only occur if the surrogate has a spouse or partner, as there is a requirement for two parents to be parties to the plan. If the surrogate is single, then this option is not available. The Acts have not considered the possibility that sometimes a child has one parent, but that parent may want to enter into a parenting plan with somebody else.

At the time of writing this submission, I have clients who are in this very position. It is expected that the surrogate will give birth, due to medical complications, many weeks prematurely. The surrogate and her partner are the parents of the child. They are the ones who have parental responsibility. The parties are considering entering into a parenting plan so that my clients, the intended parents, will have parental responsibility including as to making medical decisions concerning the child. If the surrogate had been single, this option would not be available and my clients would be obliged to make an urgent application to a court.

In *KRB and BFH v RKH and BJH* [2020] QChC 7 I had the honour to act for the intended parents. The child was born in South Australia. Following the birth, the child needed medical treatment including a medical evacuation. The child was subject to medical evacuation from the hospital in South Australia to a hospital in Queensland. The surrogate was married. The intended parents, surrogate and her husband entered into a parenting plan under the *Family Law Act* so that the intended parents had parental responsibility for the child. The parenting plan was accepted by both hospitals and the medical evacuation authority as giving my clients parental responsibility under the *Family Law Act*.

#### 1.3.4.3 Overseas Travel

Under the *Australian Passports Act 2010* (Cth), section 11, subject to a court order, it is those people who have parental responsibility who consent to the issue of a passport. It is odd, but the current requirements are that prior to the making of the parentage order, it is the surrogate and her partner who have parental responsibility under that Act for the issue of a passport. Therefore, if the intended parents wish to travel with the child overseas (and I have had clients do so) then the intended parents cannot consent to the issue of the passport. The people who must consent to the issue of the passport are the surrogate and her spouse or partner, even though they, typically:

* Do not have a genetic link with the child;
* Did not intend to be the parents, and do not consider themselves to be the parents; and
* Are not caring for the child.

|  |
| --- |
| **MY DAUGHTER ELIZABETH**  My husband Mitchell and I underwent surrogacy in Queensland. Unlike most intended parents through surrogacy, we were fortunate to be able to do surrogacy locally and not internationally. We had a known egg donor and a woman close to us, whom I shall call Roxanne, as our surrogate. Our surrogacy journey was particularly complex. We had medical issues with both our egg donor and surrogate that had to be clarified. The first clinic said that it was going to apply the Medicare rebate to our journey but then advised that it would not after it had obtained legal advice. The change of position would likely have added $10,000 or more to the bill – which we could not afford at the time. We changed clinics. The second clinic was prepared to provide treatment and Medicare rebate on the basis that we met the definition of infertility. While our surrogate was known, we had not entered into a surrogacy arrangement with her at that point.  Embryos were created.  We later into a surrogacy arrangement.  The first pregnancy resulted in a miscarriage. We were all devastated.  The second pregnancy resulted in an ectopic pregnancy and urgent surgery. When I sat beside Roxanne at hospital, I said to her:  *“The whole aim of this journey was to enable us to become parents, not to hurt anyone. I couldn’t live with myself if something bad happened to you. Whether Mitchell and I have a child is beside the point. I love and cherish you and want to make sure you are okay.”*  The surgery was a success. The third pregnancy worked and our daughter Elizabeth was born. She is now 3. Elizabeth almost died in childbirth. The statement of the midwife about our then unborn child: *“Don’t die on me, darling”* will remain with me until I die.  Thankfully Elizabeth did not die and both she and Roxanne recovered quickly.  Elizabeth was born in the early hours of the morning. Late that afternoon the hospital proposed to discharge Roxanne. It was then mentioned that Roxanne was a surrogate. Elizabeth had to stay in overnight for tests. Despite being the busiest maternity hospital in Queensland, which had dealt with many surrogacy births before, this was the first time the hospital had dealt with the possibility that a surrogate might be discharged before the baby. The matter about whether Roxanne could be discharged before Elizabeth went to one, then two, then three midwives, then to one, then two, then three hospital executives, and then to the hospital lawyer.  One of those hospital officials told Roxanne and I in a busy corridor (because that is apparently the place for such intimate conversations) that in the view of the lawyer, Roxanne – who was single- was the only parent, and that it was *“advisable”* as the only parent that she not leave the hospital while the child was in the hospital.  Roxanne immediately burst into tears, was inconsolable, said that she had felt violated and went to her room for the night. I felt as though I was invisible – as though I did not exist. My role apparently was irrelevant even though I was one of the parents. The law did not recognise me as a parent.  Elizabeth was to be discharged the following morning but, as delays often occur in hospitals, was discharged as was Roxanne about 4 p.m.  The message which was implicit given to both Roxanne and me was clear – if Roxanne left the hospital, she would have failed to protect the child of whom she was the only parent, necessitating the hospital to contact the Department of Child Safety. It was a chilling reminder that Mitchell and I were not recognised as our daughter’s parents. The law did not accord with reality.  I hope no one else has to experience what occurred to us. |

# 2. EQUALITY UNDER THE LAW

Australia is a party to several international instruments setting out relevant human rights. I am indebted to Human Rights Watch and the International Women’s Health Coalition for providing a non-exhaustive list of human rights implicated by surrogacy arrangements[[30]](#footnote-30):

* Right to equality and non-discrimination (e.g. UDHR art. 2; ICCPR art. 26; ICESCR art. 2; CEDAW art. 2, CRPD arts. 5 and 6);
* Right to health (e.g. UDHR art. 25, ICESCR art. 12, CEDAW art. 12);
* Right to privacy (e.g. UDHR art. 12; ICCPR art. 17);
* Bodily autonomy (e.g. ICCPR arts. 7 and 17, CEDAW art. 12 and GR 24)
* Reproductive autonomy (e.g. CESCR GC 22, CEDAW art. 12 and GR 24);
* Right to decide number and spacing of children (CEDAW art. 16);
* Right to found a family (e.g. UDHR art. 16; CRPD art. 23);
* Right to information (e.g. UDHR art. 19; ICCPR art. 19);
* Right to benefit from scientific progress (e.g. UDHR, art. 27, ICESCR, art. 15 (b));
* Rights of persons with disabilities (e.g. CRPD arts. 5, 6, 7, 12, 17, 23).

The International Commission of Jurists and human rights experts wrote the *Yogyakarta Principles*, which collate and clarify State obligations under existing international human rights law, in order to promote and protect all human rights for all persons on the basis of equality and without discrimination[[31]](#footnote-31). Principle 24 is the right to found a family:

***“The Right to Found a Family***

*Everyone has the right to found a family, regardless of sexual orientation or gender identity. Families exist in diverse forms. No family may be subjected to discrimination on the basis of the sexual orientation or gender identity of any of its members.*

*States shall:*

*a)     Take all necessary legislative, administrative and other measures to ensure the right to found a family, including through access to adoption or assisted procreation (including donor insemination), without discrimination on the basis of sexual orientation or gender identity;*

*b)     Ensure that laws and policies recognise the diversity of family forms, including those not defined by descent or marriage, and take all necessary legislative, administrative and other measures to ensure that no family may be subjected to discrimination on the basis of the sexual orientation or gender identity of any of its members, including with regard to family-related social welfare and other public benefits, employment, and immigration;*

*c)     Take all necessary legislative, administrative and other measures to ensure that in all actions or decisions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration, and that the sexual orientation or gender identity of the child or of any family member or other person may not be considered incompatible with such best interests;*

*d)     In all actions or decisions concerning children, ensure that a child who is capable of forming personal views can exercise the right to express those views freely, and that such views are given due weight in accordance with the age and maturity of the child;*

*e)     Take all necessary legislative, administrative and other measures to ensure that in States that recognise same-sex marriages or registered partnerships, any entitlement, privilege, obligation or benefit available to different-sex married or registered partners is equally available to same-sex married or registered partners;*

*f)       Take all necessary legislative, administrative and other measures to ensure that any obligation, entitlement, privilege or benefit available to different-sex unmarried partners is equally available to same-sex unmarried partners;*

*g)     Ensure that marriages and other legally-recognised partnerships may be entered into only with the free and full consent of the intending spouses or partners.”*

There remains discrimination in access to assisted reproductive services in three States and two Territories. In one territory the landscape is changing, and hopefully will change soon in two states:

* **Australian Capital Territory**: *Parentage Act 2004* (ACT) mandates that the substitute parents in a surrogacy arrangement must be a couple and that the surrogate must be part of a couple: section 24, section 26.
* **Northern Territory**: *Anti-discrimination Act 1992* (NT) section 4(8) contains an exemption in the provision of a service concerning the carrying out of an artificial fertilisation procedure. That exemption is to be repealed with the commencement of the *Surrogacy Act 2022* (NT), which has been enacted but not yet commenced (but is expected to commence by March 2023).
* **Queensland**: Following *JM v QFG and GK*, section 45A of the *Anti-discrimination Act 1991* (Qld) was inserted, which purports to allow discrimination in the provision of artificial reproductive technology on the basis of sexuality or relationship status. I have previously written to the then Queensland Attorney-General and called for the repeal of that section.

Thankfully, in its recent review, the Queensland Human Rights Commission has called for the repeal of the *Anti-discrimination Act 1991* (Qld), s.45A. The Commission noted that Queensland Fertility Group, being the largest fertility service provider in Queensland, actively advertises to and provide services for same sex couples and single parents[[32]](#footnote-32). The review considered that there was no justification to retain the exemption because it:

* Is redundant.
* Does not meet current community standards.
* May be invalid under the Constitution.
* May be incompatible with the *Human Rights Act*.

It was noted that s.45A of the Queensland Act was inconsistent with the *Sex Discrimination Act 1994* (Cth) [particularly s. 22], which has protected people from sexual orientation discrimination since 2013. In three cases where State laws sought to limit the provision of fertility treatment to married women or those in de facto relationships, the courts upheld the primacy of section 22 of the *Sex Discrimination Act* by virtue of section 109 of the Constitution[[33]](#footnote-33).

* **Tasmania**: *Surrogacy Act 2012* (Tas) requires that each party to the surrogacy arrangement, at the time the arrangement was entered into, was resident in Tasmania: section 16(2)(g), thereby imposing a practical barrier in having an interstate surrogate.
* **Western Australia**: *Surrogacy Act 2008* (WA) prescribes in section 19 that the only people who can access surrogacy are single women, in effect women in a lesbian relationship or heterosexual couples. The *Surrogacy Act 2008* (WA) and the *Human Reproductive Technology Act 1991* (WA) are the subject of a current review being undertaken by the Western Australian Government. Following contact from the officers undertaking that review, I spoke with those officers and then confirmed that advice in writing which is set out in **Attachment A** to this submission.

# 3. PARENTAGE THROUGH POSTHUMOUS USE OF GAMETES AND EMBRYOS

In every State and Territory it is possible to retrieve gametes from someone who is dying and preserve them.

#### TABLE 3 – POSTHUMOUS USE LEGISLATION

|  |  |
| --- | --- |
| **Jurisdiction** | **Law** |
| ACT | *Transplantation and Anatomy Act 1978* |
| New South Wales | *Human Tissue Act 1983* |
| Northern Territory | *Transplantation and Anatomy Act 1979* |
| Queensland | *Transplantation and Anatomy Act 1979* |
| South Australia | *Transplantation and Anatomy Act 1983* |
| Tasmania | *Human Tissue Act 1985* |
| Victoria | *Human Tissue Act 1982* |
| Western Australia | *Human Tissue and Transplant Act 1982* |

Every IVF clinic in Australia is required, by virtue of the *Research Involving Human Embryos Act 2002* (Cth) and matching State and ACT legislation, to be accredited by the Fertility Society of Australia and New Zealand.

The Fertility Society issues a *Code of Practice* which mandates compliance with the law and also compliance with the National Health and Medical Research Council, *Ethical Guidelines on the use of artificial reproductive technology in clinical practice and research* (2021). As the High Court held in 2013, the *Code of Practice* incorporates the NHMRC *Ethical Guidelines[[34]](#footnote-34)*.

The requirements of the *Ethical Guidelines* are that fertility treatment is to be undertaken in posthumous cases only by the surviving partner and only if there was no objection by the deceased.

There have been a series of cases in Australia where the deceased has died suddenly and unexpectedly and the partner, typically the grieving widow, has sought to use the gametes of the deceased in posthumous treatment.

Too often, the recourse of lawyers has been to make application to the local Supreme Court to authorise retrieval of the gametes. Grieving widows who have made those applications or contemplated making those applications with other lawyers, have spent between $14,000 and $25,000 on those applications – at a time that they are grieving the immediate and sudden loss of their loved one and they are at the maximum state of vulnerability.

Courts in New South Wales and Queensland have both held that the Supreme Court does not have jurisdiction to make those orders[[35]](#footnote-35). Nevertheless, those applications continue to be made[[36]](#footnote-36).

The much simpler, cheaper and likely faster way of retrieval is under the relevant statutes set out in the table above.

However, in one case I had last year in regional Queensland, retrieval was not able to be undertaken, due to the unavailability of a scientist, and delays trying to find a doctor who was able to retrieve. I have not seen this difficulty in metropolitan areas.

Once retrieved, too often applications are made to a court for use. One would expect that if the *Ethical Guidelines* applied, which have requirements about when posthumous can and cannot take place, then there would be sufficient safeguards as to usage. Nevertheless, some applications have been made to courts to authorise treatment.

There is no uniform law regulating when posthumous use can occur. The reality for widows living in New South Wales, South Australia, Victoria and Western Australia (and likely the Northern Territory) is that on many occasions the gametes cannot be used in those States. Instead, the gametes or embryos are exported interstate, primarily to the ACT and Queensland (but it could also be Tasmania) with treatment to occur there.

This adds a cost burden to the intended parents as well as inconvenience when treatment should be able to occur at the local IVF clinic rather than interstate. Courts have approved the export of sperm of the deceased by the widow interstate:

* New South Wales[[37]](#footnote-37).
* South Australia[[38]](#footnote-38).
* Victoria[[39]](#footnote-39).
* Western Australia[[40]](#footnote-40).

The ACT, Queensland and Tasmania do not have local legislation in addition to the *Ethical Guidelines* – so the *Ethical Guidelines* govern arrangements for posthumous use.

The Northern Territory similarly does not have local legislation. However, the local clinic, Repromed, is bound by its agreement with the Northern Territory Government for its clinicians to be subject to South Australian licensing conditions.

The barriers to local treatment in post-humous use cases are:

* New South Wales – the deceased must have given consent to use, export and supply to another clinic[[41]](#footnote-41).
* South Australia – before the *“donor”* died, the donor consented to the use of the semen, fertilised ovum or embryo after the donor’s death in the provision of the proposed assisted reproductive treatment and the assisted reproductive treatment is provided for the benefit of a woman who immediately before the death of the donor was living with the donor in a genuine domestic basis[[42]](#footnote-42).
* Victoria – the deceased must have provided written consent as well as patient review panel approval[[43]](#footnote-43).
* Western Australia – posthumous use in Western Australia is prohibited: *Human Reproductive Technology Directions 2021* (WA) at 8.7:

*“No posthumous use of gametes.*

*Any person whom the licence applies must not knowingly use or authorise the use of gametes in an artificial fertilisation procedure after the death of the gamete provider.”*

# 4. EXPERIENCES OF TRANSGENDER PEOPLE, NON-BINARY PEOPLE, AND PEOPLE WITH VARIATIONS OF SEX CHARACTERISTICS ACCESSING SEXUAL AND REPRODUCTIVE HEALTHCARE

Research undertaken in Australia with 409 transgender and non-binary adults show that only a small number of people who completed the survey had preserved their fertility. Nearly all said that fertility preservation should be offered to all transgender and non-binary people. The findings suggest that the option for preserving fertility should be available to all people who are transgender or non-binary. However, not all transgender or non-binary people want to preserve their fertility, or will be able to afford it[[44]](#footnote-44).

Other research involving 25 transmen who had experienced a gestational pregnancy found that exclusion, isolation and loneliness were the predominant features of their experience of gestational pregnancies. Despite anti-discrimination legislation, all of them sought sperm other than through clinics[[45]](#footnote-45).

As recently stated in the Queensland Human Rights Commission Report, *Building Belonging[[46]](#footnote-46)*, the submissions made about the provision being removed were:

* Assisted reproductive services, like other health services, should be available to anyone who needs them regardless of their relationship status or sexual orientation.
* The exception implies that single parents and non-heterosexual couples are not worthy of assistance to become parents and perhaps should not become parents at all, which is contrary to all research in this area, and inconsistent with the introduction of marriage equality.
* Fertility service providers in Queensland do not exclude people based on their sexuality or relationship status and some target their services to the LGBTQ+ community, including Queensland Fertility Group, which shows that the law is not reflecting practice.

Against this is that one survey participant to the Queensland Council for LGBTI Health said when accessing these services:

*“My wife was told she needed a good man.”*

# 5. AVAILABILITY OF REPRODUCTIVE HEALTH LEAVE FOR EMPLOYEES AND INCIDENTAL MATTERS

There is no consistent standard across Australia that parents through surrogacy are recognised as parents and are entitled to parental leave, in the same way that they might be parents by having conceived naturally or through adoption.

It is a difficult process at times, as I have done, to trawl through awards or enterprise bargaining agreements to determine whether or not leave is available. Given the Commonwealth’s responsibilities under the *Workplace Relations Act 1996* (Cth) and other Commonwealth legislation, for example, *Maternity Leave (Commonwealth Employees) Act 1973*, parents through surrogacy should be entitled to have the same parental leave as other parents.

In the words of the Fair Work Ombudsman[[47]](#footnote-47):

*“Parental Leave & Surrogacy Arrangements.*

*Surrogate parents are entitled to unpaid parental leave and related entitlements under the National Employment Standards. They may also be entitled to the Australian Government’s Parental Leave Pay Scheme.*

*The surrogate parents are the woman who gives birth to the child and her spouse or de facto partner.*

*The intended or biological parents aren’t entitled to unpaid parental leave, however they may be entitled to the Australian Government’s Parental Leave Pay Scheme.”*

## 5.1 CONTRAST BETWEEN QUEENSLAND[[48]](#footnote-48) AND NEW SOUTH WALES

Queensland public servants are entitled to parental leave whether it is paid or unpaid by an employee who:

* is pregnant or her spouse is pregnant.
* adopts a child/children.
* is an intended parent under a surrogacy arrangement.

Some years ago a nurse who had undertaken surrogacy overseas and was refused leave by Queensland Health was able to obtain leave by virtue of the provisions of the *Anti-discrimination Act 1991*.

In New South Wales parental leave for public servants can only be obtained if the surrogacy is deemed to be altruistic with *“provision of documentary evidence of the altruistic surrogacy agreement and a statutory declaration advising of the intention to make application for a parentage order as required under the Surrogacy Act 2010. A copy of the parentage order must be provided as soon as it is obtained.”[[49]](#footnote-49)*

Where intended parents in New South Wales undertake surrogacy overseas such as in an altruistic jurisdiction like Canada, they will not be entitled to leave because of the need to obtain an order from the Supreme Court of New South Wales. To put it bluntly, an agreement overseas that says that there should be exclusive jurisdiction in, for example, the courts of Alberta, does not then give the Supreme Court of New South Wales jurisdiction to make an order.

Failure to obtain an order in the Supreme Court of New South Wales means that the intended parent will not be able to obtain leave. In *Long v Secretary, Department of Education* [2022] NSWCATAD 131 Mr Long was, in the words of the judgment:

*“A high school teacher and a homosexual man who is a biological father of twins born via surrogate in Cancun Mexico on 23 March 2022. The applicant has been the primary care-giver for the children since they were born and intended to stay at home for the first 12 months of their life to look after them.”*

Mr Long made application for altruistic surrogacy leave. Fourteen weeks altruistic surrogacy leave was granted on the condition that he provide the New South Wales Department with a parentage order for the children. He did not do so.

Mr Long then lodged a complaint under the New South Wales *Anti-discrimination Act* stating that he had entered into an altruistic surrogacy arrangement and that because he was the biological father of the children there was no need for him to obtain the parentage order.

[On this point, it is noted that the effect of the High Court in *Masson v Parsons* [2019] HCA 21 is that this statement by him is correct. What is unclear is whether he might have been able to apply to the NSW Supreme Court.]

It was alleged that discrimination had occurred because:

*“The requirement for Mr Long to obtain a parentage order is both onerous and costly. Without a parentage order, Mr Long is currently seen in the eyes of the law as his children’s parents. The requirement to obtain a parentage order has the effect of disadvantaging Mr Long.*

*Further, it is telling that a parentage order is an unreasonable requirement imposed by the NSW Department of Education as a parentage order is not a requirement for eligibility for the Centrelink paid parental leave scheme.*

*The policies that have been applied to Mr Long’s scenario are discriminatory as they treat him less favourably than a person who has a different sexual orientation, or a different marital status, or a different sex, for example, than a teacher who was a birth mother (who was not required to be a primary caregiver) or a teacher becomes a parent (and the primary caregiver of the child) by way of adoption.”*

It might be noted at this point that the *Antidiscrimination Act 1977* (NSW) was first enacted when Neville Wran was Premier. It is, to say the least, creaky and has been criticised for not being fit for purpose.

Under the terms of the current Teachers’ Handbook and clauses of the *Maternity Leave Determination* the teacher who is pregnant and gives birth (including stillborn baby) is entitled to 14 weeks’ paid leave (maternity leave). The Education Department admitted that only female teachers could be eligible for maternity leave. A male or female teacher who is the primary caregiver of a child through adoption is entitled to 14 weeks’ paid leave (adoption leave) and a male or female teacher who is a primary caregiver of a child born through *“altruistic surrogacy”* is entitled to 14 weeks of paid leave subject to the provision of certain documents, which are:

*“Altruistic surrogacy leave is available to teachers who are able to demonstrate they are the parent of a child as follows:*

* *intended parent(s) are to notify the Department at least four (4) months before the expected birth and provide a copy of the pre-conception surrogacy agreement, as provided for under the Surrogacy Act 2010 (redacted as necessary to protect the privacy of non-employees);*
* *at the time of assuming the role of primary or secondary care of the teacher is to provide a statutory declaration advising that they are now the primary or secondary carer of the child and intend to make an application for parentage orders as required under the Surrogacy Act 2010;*
* *a copy of the parentage order application (redacted as necessary) is provided as soon as practicable after it is lodged; and*
* *a copy of the parentage order (redacted as necessary) is provided as soon as practicable after it is granted.”*

There are no conditions stated within the Teachers’ Handbook on applicants for maternity leave or adoption leave to demonstrate they are the parent of the child in order to be eligible for those types of paid leave. In 2020 Mr Long emailed HR employees:

*“I’m contacting you directly as I’m seeking your help and assistance with a matter concerning taking (adoption) leave. I have requested the leave and it has been declined as I have stated I will not be supplying the NSW parentage order. I’ve explained multiple times to people at ED Connect (it should have been recorded) that I cannot supply this documentation as I am the biological father and one of the partners being listed on the birth certificate – the other name is the surrogacy (birth mother) name.*

*What the department is asking of me is to adopt my own child and this is not possible due to the fact that I will be the father stated on the children’s birth certificates. If the birth of the twins goes to plan and there are no complications the surrogate has signed a contract stating she will be relinquishing her rights and I’ll be the primary carer for the two children.”*

Mr Long told the tribunal that he had not applied for a parentage order because he was a biological father. The tribunal found that the reason he was not able to obtain a parentage order was not because he was the biological father and *“whatever the reason, the fact is that the applicant has not followed through with the intention he expressed in his statutory declaration to apply for a parentage order, which means he has not complied with the respondent’s requirements under its altruistic surrogacy leave policy”[[50]](#footnote-50)*. The tribunal accepted that Mr Long’s enquiry regarding surrogacy leave entitlements was described in internal Government records as *“weird”* but did not agree that an inference should be drawn that *“weird”* was because he was a male or a homosexual male[[51]](#footnote-51). Only 10 such applications had been made and the obvious more probable and innocent explanation is that the request was *“weird”* because the employee was unlikely to have dealt with a surrogacy leave application before[[52]](#footnote-52).

Mr Long was unsuccessful with his claim and was otherwise only entitled to a one week’s paid leave.

# 6. ABOUT ME

I am a dad through surrogacy. My husband Mitchell and I are parents of a beautiful 3 year old daughter Elizabeth who was born through an altruistic surrogacy process in Queensland.

I was admitted as a solicitor in 1987. My first surrogacy case was in 1988. I have advised in approximately 1,800 journeys since then for clients in every part of Australia and at last count, 36 countries overseas. Approximately one-half of those journeys involved heterosexual couples and approximately one-half involved gay couples with a smattering of single men, single women and a small number of couples who identified as transgender or non-binary. There were two or three lesbian couples who underwent surrogacy.

I have advised in hundreds of known donation cases typically being known sperm donors (who are often gay men) to single women or lesbian couples.

Since 1996 I have been a Queensland Law Society Accredited Family Law Specialist.

In 2012/2013 I was the convenor at Queenslanders For Equality which successfully opposed moves by the then Queensland Attorney-General Jarrod Bleijie to strip away the recognition of lesbian couples as parents, and to criminalise gays, lesbians and singles from undertaking surrogacy.

In 2015 I received the Rainbow Keys Award from the LGBTQI Legal Service in Queensland and the Queen’s Ball LGBTIQ Activist of the Year. In 2016 my then firm received an Equity and Diversity Award from Queensland Law Society. In 2020 I was the recipient of the Inaugural Pride in Law Award from Pride in Law.

Between 2017 and 2022 I lectured in ethics and the law in reproductive medicine at the University of New South Wales, for which I was awarded a teaching prize in 2019.

I am a Fellow of the International Academy of Family Lawyers, including being a member of its Parentage Committee, its LGBT Committee and its Forced Marriage Committee.

I am a Fellow of the Academy of Adoption and Assisted Reproduction Attorneys, the first Fellow outside of the US and Canada. I am a member of its ART Resources Committee.

Since 2012 I have been an International Representative on the American Bar Association’s Artificial Reproductive Technologies Committee. In that role, I was the principal advocate for and co-author on that Association’s policy on a proposed Hague Convention on International Surrogacy arrangements.

I am a Director of Access Australia’s Infertility Network Limited. I am a Director of the Fertility Society of Australia and New Zealand Limited.

I am a member of the LGBTIQ Committee of Australian Lawyers for Human Rights. I am the founder and director of the LGBT Family Law Institute in Australia.

I have written and presented about surrogacy and its assisted reproductive treatment throughout the world, including being a guest lecturer at Hong Kong University, Monash University and the University of Western Cape. My presentations and writings have included for the International Bar Association, American Society for Reproductive Medicine, American Bar Association, International Academy of Family Lawyers, Academy of Adoption and Assisted Reproduction Attorneys, Fertility Society of Australia and New Zealand, Family Law Section, Law Council of Australia, International Journal of Family Law, the Royal Australian College of Obstetricians and Gynaecologists, Canadian Fertility and Andrology Society, Queensland Law Society, Hunter Valley Family Law Practitioners Association, Law Society of South Australia and the Family Law Practitioners’ Association Western Australia, among others.

I have given expert evidence concerning surrogacy and assisted reproductive treatment regulation court cases in the Federal Circuit Court of Australia and twice in the High Court of England and Wales, the last concerning surrogacy regulation in Cambodia.

I have made submissions or testified on many inquiries in this area, including the two House of Representative Inquiries concerning surrogacy and most recently, the Queensland Inquiry concerning the rights of donor-conceived adults. I was a member of the Northern Territory Government’s Joint Surrogacy Working Group, that led to the enactment of the *Surrogacy Act 2022* (NT).

The views expressed in this letter are mine alone.

If asked, I would be available to give evidence.

Yours faithfully

**Stephen Page**

**Page Provan**

***family and fertility lawyers***

***Accredited Specialist Family Law***

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1. There were 309,996 births in Australia in 2021: Australian Bureau of Statistics. There were 19,712 births via assisted reproductive treatment through IVF clinics in Australia reported in 2020: Jade E Newman et al., *Assisted Reproductive Technology in Australia and New Zealand 2020*, University of New South Wales, 2022, p.35. [↑](#footnote-ref-1)
2. Page 36. [↑](#footnote-ref-2)
3. Page 37. [↑](#footnote-ref-3)
4. Page 38. [↑](#footnote-ref-4)
5. *Superannuation Industry (Supervision) Regulations 1994*, regulation 6.19A(1). [↑](#footnote-ref-5)
6. Commencing at page 61. [↑](#footnote-ref-6)
7. <https://www.who.int/news-room/fact-sheets/detail/infertility> viewed on 2 December 2022. [↑](#footnote-ref-7)
8. <https://www.icmartivf.org/glossary/i-m/> viewed 2 December 2022. [↑](#footnote-ref-8)
9. <https://www.newyorker.com/culture/annals-of-inquiry/the-case-for-social-infertility> viewed 2 December 2022. [↑](#footnote-ref-9)
10. At [11]. [↑](#footnote-ref-10)
11. Laws that extend laws outside the jurisdiction, much like a long arm, such as *Crimes Act 1900* (NSW), s.10C, with its effect on *Human Cloning and Other Prohibited Practices Act 2003* (NSW), s. 16, and *Human Tissue Act 1983* (NSW), s.32. [↑](#footnote-ref-11)
12. ACT: *Parentage Act 2004* (ACT); NSW: *Surrogacy Act 2010* (NSW); NT: *Surrogacy Act 2022* (NT)- yet to commence; Qld: *Surrogacy Act 2010* (Qld); SA: *Surrogacy Act 2019* (SA); Vic: *Assisted Reproductive Treatment Act 2008* (Vic); Tas: *Surrogacy Act 2012* (Tas), WA: *Surrogacy Act 2008* (Tas). [↑](#footnote-ref-12)
13. Information provided to me by the NT Health Department. [↑](#footnote-ref-13)
14. S. 2(2). [↑](#footnote-ref-14)
15. *Parentage Act 2004* (ACT), *Surrogacy Act 2010* (NSW), *Surrogacy Act 2010* (Qld). [↑](#footnote-ref-15)
16. *Surrogacy Act 2019* (SA), *Criminal Law Consolidation Act 1935* (SA), s5G. [↑](#footnote-ref-16)
17. *Surrogacy Act 2008* (WA), *Criminal Code 1913* (WA), s.12. [↑](#footnote-ref-17)
18. *Criminal Code 1983* (NT), s.43CA. [↑](#footnote-ref-18)
19. The calculation of this figure is seen in the letter to the WA Health Department. [↑](#footnote-ref-19)
20. ­­New Zealand Law Commission, *Review of Surrogacy*, 2021, [1.18]. [↑](#footnote-ref-20)
21. Source: Department of Home Affairs, applications for citizenship by descent for children born via surrogacy, 2011-2021, obtained by the writer under FOI. [↑](#footnote-ref-21)
22. Set out in the letter to the WA Health Department. [↑](#footnote-ref-22)
23. Ibid. [↑](#footnote-ref-23)
24. Law Commission and Scottish Law Commission, *Building families through surrogacy: a new law*, 2019, at <https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2019/06/Surrogacy-consultation-paper.pdf> viewed on 2 December 2022. [↑](#footnote-ref-24)
25. ­­New Zealand Law Commission, *Review of Surrogacy*, 2021 at <https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC-Report146-Review-of-Surrogacy.pdf> viewed 2 December 2022. [↑](#footnote-ref-25)
26. From the writer’s experience with Australian clients who have undertaken surrogacy in Alberta. [↑](#footnote-ref-26)
27. If the committee seeks it, I can provide a list. [↑](#footnote-ref-27)
28. <https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Inquiry_into_surrogacy/Report> viewed 8 December 2022. [↑](#footnote-ref-28)
29. *Status of Children Act 1974* (VIC), Section 29E(1). [↑](#footnote-ref-29)
30. <https://www.hrw.org/news/2019/06/03/submission-special-rapporteur-sale-and-sexual-exploitation-children?fbclid=IwAR1ij8PIVZ_3qbU1GlScsQIryEKdbIrUta5kkE5QHGMyWAGqGIUERGpiloc> viewed 8 December 2022. [↑](#footnote-ref-30)
31. <http://yogyakartaprinciples.org/introduction/> viewed 8 December 2022. [↑](#footnote-ref-31)
32. Queensland Human Rights Commission, *Building Belonging: Review of Queensland’s Antidiscrimination Act 1991,* 2022,at [388]. [↑](#footnote-ref-32)
33. *Pearce v South Australian Health Commission and Others* (1996) 66 SASR 486; *McBain v State of Victoria* [2000] FCA 1009; *EHT 18 v Melbourne IVF* [2018] FCA 1421. [↑](#footnote-ref-33)
34. *Clark v Macourt* [2013] HCA 56.. [↑](#footnote-ref-34)
35. *Chapman v South Eastern Sydney Local Health District* [2018] NSWSC 1231; *Re Cresswell* [2018] QSC 142. [↑](#footnote-ref-35)
36. For example, *Noone v Genea Limited* [2020] NSWSC 1860. [↑](#footnote-ref-36)
37. For example, *Re Edwards* [2011] NSWSC 478. [↑](#footnote-ref-37)
38. *Re H (No 2)* [2012] SASC 177. [↑](#footnote-ref-38)
39. *YZ v Infertility Treatment Authority (General)* [2005] VCAT 2655. [↑](#footnote-ref-39)
40. *GLS v Russell-Weisz* [2018] WASC 79. [↑](#footnote-ref-40)
41. Assisted Reproductive Technology Act 2007, sections 17, 21, 22, 23. [↑](#footnote-ref-41)
42. *Assisted Reproductive Treatment Act 1988* (SA), section 9(1)(c)(iv). [↑](#footnote-ref-42)
43. *Assisted Reproductive Treatment Act 2008* (VIC), section 46. [↑](#footnote-ref-43)
44. Riggs, DW, Bartholomaeus, C fertility preservation decision-making amongst Australian transgender and non-binary adults. Reprod Health**15, 181 (2018)**, https://doi.org/10.1186/s12978-018-0627-z. [↑](#footnote-ref-44)
45. Rosy Charter, Jane M Ussher, Janette Perz & Kerry Robinson (2018) The Transgender Parent: Experiences and Constructions of Pregnancy in Parenthood for Transgender Men in Australia, International Journal of Transgenderism, 19:1, 64-77, DOI:10.1080/15532739.2017.1399496. [↑](#footnote-ref-45)
46. Supra, at p.399. [↑](#footnote-ref-46)
47. https://www.fairwork.gov.au/tools-and-resources/library/K600431\_Parental-leave-surrogacy-arrangements viewed 2 December 2022. [↑](#footnote-ref-47)
48. https://ppr.qed.qld.gov.au/pp/parental-leave-procedure viewed 2 December 2022. [↑](#footnote-ref-48)
49. <https://arp.nsw.gov.au/m2022-08-paid-parental-leave-parent-with-responsibility-for-care-associated-with-the-birth-adoption-altruistic-surrogacy-or-permanent-out-of-home-care-placement-of-a-child/> viewed 2 December 2022. [↑](#footnote-ref-49)
50. At [75]. [↑](#footnote-ref-50)
51. At [85]. [↑](#footnote-ref-51)
52. At [85]. [↑](#footnote-ref-52)