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Access to Treatment

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Clinical infertility ***is the term used to describe the medical reasons which prevent a woman from becoming pregnant.***

The commission has been asked to enquire into and report on the desirability and feasibility of making changes to the law to expand eligibility criteria for access to assisted reproductive technology (ART). In this chapter, we examine the law that governs access to infertility treatment, including treatment in which donated sperm and/or eggs are used. We consider whether the Act meets its objective of protecting the best interests of any person born as a result of a treatment procedure.

CURRENT LAW

Access to ART treatment procedures in Victoria is governed by the *Infertility Treatment Act 1995*. The Act sets out criteria for access to treatment and contains guiding principles and other requirements relevant to the provision of ART services.[1]

The requirements which must be met before a woman is permitted to undergo assisted insemination or a fertilisation procedure at a licensed clinic are that she must:

- be married and living with her husband or living with a man in a de facto relationship and have the consent of her husband/partner to the treatment
- be 'unlikely to become pregnant' with her own ovum or her husband/partner's sperm, other than by a treatment procedure, or be at risk of having a child with a genetic abnormality.[2]

The operation of these requirements has been modified by the decision in the Federal Court case *McBain v The State of Victoria*.[3] In this case, the court decided that the requirement that a woman be married or in a heterosexual de facto relationship in order to access infertility treatment was inconsistent with the provisions of the federal *Sex Discrimination Act 1984*. When a state law is inconsistent with federal law, state law is legally invalid. This means that as a result of the *McBain* decision, marital status may no longer be used as a reason to exclude a person from treatment. Women who are single, in same-sex relationships or in unmarried heterosexual relationships where they do not live with their partner on a genuine domestic basis can now access ART if they meet the other eligibility requirements.

In the *McBain* case, it was not necessary for the court to make a decision on other eligibility criteria for access to assisted reproduction. In particular, it did not express a view on how the requirement that a person be 'unlikely to become pregnant' should be applied to a woman who does not have a male partner. Two legal opinions have been given on this question.

According to the legal opinion of Peter Hanks QC provided to the Infertility Treatment Authority (ITA) by the Fertility Access Rights Lobby, the expression 'unlikely to become pregnant' should be applied in the same way to women who do not have male partners as it applies to women who are married or in de facto heterosexual relationships.[4]

According to another opinion, provided by Dr Gavan Griffith QC to the ITA, the 'unlikely to become pregnant' criterion applies differently to women without male partners and women in heterosexual relationships.[5] This opinion concluded that the criterion should be determined by reference to the subject matter of the Act, namely the treatment of infertility. According to this interpretation, the only permissible reason for a single woman's inability to become pregnant without treatment is clinical infertility, whereas the explanation for a married woman's inability to become pregnant without treatment may take account of her husband's fertility as well.

The ITA subsequently directed clinics to comply with the advice of Griffith. The requirement that a woman seeking treatment be unlikely to become pregnant is therefore now applied more strictly to single women and women in same-sex relationships than to women who are married or in de facto heterosexual relationships. A clinic can treat a woman who is married or in a heterosexual de facto relationship if she is unlikely to become pregnant because of her own, or her spouse's, clinical infertility, psychological reasons (for example her or her partner's aversion to penetrative sex), or, despite attempts, she has been unable to conceive for no apparent or obvious reason. On the other hand, unmarried women must be clinically infertile, which is generally limited to physiological symptoms which prevent conception (such as endometriosis, blocked fallopian tubes, mature age or a previous diagnosis of infertility).

'Clinical infertility' is a difficult term to define. 'Infertility' is not defined or mentioned in the Infertility Treatment Act. Professor Robert Jansen, Medical Director at Sydney IVF has said that infertility is often unexplained, describing it as a situation where '[p]regnancy seems possible, but it has not yet happened'.[6] In the majority of cases, doctors assess couples' fertility as between low and normal, with only five per cent being regarded as sterile (completely infertile).[7]

The ITA has directed clinics to assess infertility of single or lesbian women based on:

- *A history of the patient's conduct indicating infertility, such as an appropriate number of previous unsuccessful treatments through donor insemination or IVF, or an appropriate period of unprotected heterosexual intercourse without achieving pregnancy; or*
- *A clinical indication of infertility which is either documented in the doctor's referral to the approved practitioner or from an investigation which the approved practitioner has undertaken, or both.*[8]

Applying the 'unlikely to become pregnant' requirement differently to women depending on whether they are married or single may be inconsistent with the provisions of the federal *Sex Discrimination Act 1984*,[9] but this issue has not been tested in court.

In addition to these express eligibility requirements, the Infertility Treatment Act contains a set of guiding principles that must be complied with in carrying out activities regulated by the Act, including the provision of treatment procedures. These principles are:

- The welfare and interests of any person born or to be born as a result of a treatment procedure are paramount.
- Human life should be preserved and protected.
- The interests of the family should be considered.
- Infertile couples should be assisted in fulfilling their desire to have children.[10]

Neither the Act nor the conditions of licence established by the ITA provide any guidance on how these principles are to be applied when a clinic decides who is eligible for treatment. In the absence of guidance, interpretation of these criteria is at the discretion of individual doctors.

During our consultation process, some medical practitioners reported that if it becomes apparent that a child would be at risk, or there were concerns about the capacity of the parents to care for the child, the decision about whether to proceed with treatment would be discussed by a team of doctors, counsellors, a lawyer, and anyone else who may have an interest, on a case-by-case basis.[11] Sometimes, a formal ethics committee may be convened, consisting of these people, as well as a hospital representative or a person with specialist expertise.[12] The patient is made aware of this process. If the patient does not accept the decision of the team there are processes available for making a complaint or for referring the matter to a patient representative of the hospital or clinic.[13]

1 This is discussed in more detail in Chapter 3.

2 *Infertility Treatment Act 1995* s 8.

3 (2000) 99 FCR 116.

4 Legal opinion provided to the Fertility Access Rights Lobby by Peter Hanks QC, 18 August 2000, and supplied to the ITA. Copy provided to the commission by the ITA.

5 Legal opinion provided to the ITA by Dr Gavan Griffith QC, 4 August 2000. Further advice provided, 12 September 2000. Copies provided to the commission by the ITA.

6 Robert Jansen, 'Elusive Fertility: Fecundability and Assisted Conception in Perspective' (1995) 64 (2) *Fertility and Sterility* 252.

7 Jansen distinguishes between sterility (complete infertility), which means that couples who wish to achieve a pregnancy have no chance of doing so, and infertility (relative infertility) which means 'making an arbitrary distinction between normal fertility and low fertility': Ibid 252.

8 Infertility Treatment Authority, *Conditions for Licence: Clinics, Hospitals and Day Procedure Centres* (7th ed, 2006), 15 [4.1].

9 Anita Stuhmcke, 'Access to Infertility Treatments and Single Women: What is the State of Play?' (2001) 9 *Journal of Law and Medicine* 12,13; Kristen Walker, '1950s Family Values vs Human Rights: In Vitro Fertilisation, Donor Insemination and Sexuality in Victoria' (2000) 11 *Public Law Review* 292, 298; submissions CP 156 (Law Institute of Victoria), CP 191 (Equal Opportunity Commission of Victoria).

10 *Infertility Treatment Act 1995* s 5.

11 Access roundtable, 14 October 2004.

12 Access roundtable, 9 February 2006.

13 Access roundtables, 14 October 2004 and 9 February 2006.

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It is a sad indictment upon Australian law that a lesbian celebrates a diagnosis of an undesirable gynaecological condition just so that she can fulfil the legal criteria of 'medical infertility' and gain access to safe, identity traceable donor sperm in Victoria.

A survey of 15 clinics in Victoria and NSW revealed that although it was unusual for clinics to apply a 'fitness-to-parent' test to patients,

> *there were cases in which clinics refused treatment on these grounds, based upon reports from child protection authorities or family services. One clinic had declined to treat a patient with a severe physical handicap who was not seen to be able to cope with a child.*[14]

The Act also contains a number of other provisions aimed at protecting the interests of children. It establishes a regime to enable people born through the use of donated gametes to obtain information identifying their donor.[15] It requires people undergoing treatment to give informed consent and to have counselling.[16] Counselling provides a woman seeking treatment with an opportunity to discuss the implications of the treatment procedure on herself, her partner (if she has one) and on any child to be born. As outlined in Chapter 3, there are also a range of laws and professional guidelines which seek to ensure that the treatment will be of the highest possible medical standard, and that patients and children born as the result of treatment are protected from health risks, including the transmission of infectious diseases. The commission regards these measures as very important safeguards. Our recommendations assume that safeguards designed to ensure the highest standard of clinical practice will continue to apply.

PROBLEMS WITH THE LAW

The commission believes that the law is unsatisfactory in several respects. In particular, it does not protect children adequately, it excludes some women and children from the safeguards offered by the system, it has not kept pace with technology and it lacks consistency and clarity.

Although the guiding principles contained in the Act express a theoretical commitment to the welfare and interests of children conceived through assisted reproduction, there are no provisions which specify how this should be achieved in practice. In particular, the legislation does not specify how the welfare and interests of a child to be born are to be taken into account when a person or couple seek treatment, or what doctors or counsellors should do if they are concerned that the health and wellbeing of a prospective child is, or may be, at risk.

Although the commission is aware that the process adopted by clinics in difficult cases has elements of good practice, it is not formalised and there is no requirement that clinics adhere to it. Clinics are not required to seek advice from child development experts, nor is there any mechanism that would prevent a clinic from treating a person or couple where a child would clearly be at risk. As a result, it is possible for treatment to be provided to people even where it is likely that the best interests of a child to be born will be compromised. Similarly, it is possible for clinics to refuse to treat people on grounds that cannot be objectively supported. As one submission noted, '[c]aution needs to be taken to ensure that clinical discretion and not moral judgement is the criteria used'.[17] There is a lack of transparency and accountability in the way in which clinics are able to make decisions about whether a person should be permitted to proceed with treatment.

The law excludes many women from the benefits and safeguards of the licensed clinic system. Women who are ineligible for treatment (because they do not have a male partner and are not clinically infertile) may therefore choose to self-inseminate or to go interstate or overseas for treatment.[18] If women self-inseminate with sperm from donors who have not been screened for communicable diseases, both their health and the health of any children they conceive may be at risk. The mother of the child and the donor will not receive counselling prior to conception, which may contribute to disputes and litigation about arrangements for the ongoing parenting of the child. If the child is conceived interstate or overseas, information about donors may not be recorded and other safeguards provided by Victorian law may not apply. As a result, children may be unable to trace their genetic origins or to ascertain the identity of their genetic parent(s).

A single woman who wrote to the commission said:

> *I have a son who was born 20 months ago via donor insemination (DI). My son was conceived through a clinic in Sydney because, as a single woman, I was unable to access DI treatment in Victoria at the time. … I was told that if I had 4 unsuccessful treatments in NSW I could undergo treatment in Victoria because I would then be considered clinically infertile. As it happened, I was monitored in Victoria but had to travel to Sydney for the actual insemination. This was extremely frustrating and costly in time and money. I was extremely fortunate that my first insemination was successful, so I only had to travel to Sydney once. I had to use an unknown donor. There were no identified donors available to me (the only one available had nominated that his sperm was to go to a couple only).*[19]

In their submission to the commission, the organisation Prospective Lesbian Parents described the process of obtaining treatment interstate:

> *Deciding to travel interstate to access ART services is not an easy nor realistic option for many lesbian women. Being forced to travel interstate to try and conceive their children—a process that has come to be called 'reproductive tourism'—has a range of impacts on women. The financial and emotional concerns, and time-consuming nature of the process, the difficulty of securing access to ongoing health care with the same person, make it a difficult 'choice' for many women.*[20]

Many women wrote about the personal consequences of travel, including the economic impact:

> *We have been travelling to Sydney so that my partner can undergo treatment at a clinic. So far it has cost us approximately $10,000 to try to conceive. Each trip to Sydney for treatment costs about $1,500, including accommodation and travel.*
> *By contrast, if we were able to access treatment in Victoria it would cost about $800 for each treatment. Monash IVF is just 15 minutes away from where we live. We now have to save up more money before we can continue with treatment in Sydney.*[21]

The current law is also unfair because it applies unevenly. Some women without male partners will be eligible for treatment in Victoria and others will not. A single woman who has a genetic abnormality which could be transmitted to her child is eligible for treatment. A single woman of 45 may be eligible for treatment because her age has made her clinically infertile. By contrast, a single woman aged 35 who does not have clinical symptoms cannot be treated. These distinctions make no sense and bear no relationship to the concept of the health and wellbeing of the child.

The commission heard from many women whose experiences confirmed the uneven application of these laws. For example:

> *It is a sad indictment upon Australian law that a lesbian celebrates a diagnosis of an undesirable gynaecological condition just so that she can fulfil the legal criteria of 'medical infertility' and gain access to safe, identity traceable donor sperm in Victoria.*[22]

14 Kerry Petersen, et al, 'Assisted Reproductive Technologies: Professional and Legal Restrictions in Australian Clinics' (2005) 12 *Journal of Law and Medicine* 373, 382.

15 *Infertility Treatment Act 1995* Part 7.

16 *Infertility Treatment Act 1995* ss 9 and 11; Infertility Treatment Regulations 1997 r 6.

17 Submission PP1 322 (Australian Infertility Support Group).

18 The commission received many submissions from women who had pursued either or both of these options because they were unable to access clinic treatment in Victoria.

19 Submission CP 187 (Brenda).

20 Submission CP 149 (Prospective Lesbian Parents).

21 Submission CP 142 (Kate Just).

22 'Zoe' in submission CP 149 (Prospective Lesbian Parents).

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There are a wide range of views in the community about the eligibility requirements which should apply to people seeking ART treatment. But whatever view is taken it is clear that the operation of the current law produces unfair and irrational results. The Act has been criticised by the Infertility Treatment Authority as lacking a clear policy basis, particularly on issues of access. The Act has not been amended to take account of the *McBain* decision and it is not clear how the 'unlikely to become pregnant' requirement should be applied to women without male partners. This makes it necessary to review the eligibility criteria for people who wish to access ART.

In the following chapter we discuss the ways in which we believe the eligibility criteria should be revised to achieve a fair and balanced framework for access to ART in Victoria.