



Victorian
Law Reform
Commission

Assisted Reproduction & Adoption:
Should the Current Eligibility Criteria in
Victoria be Changed?
Consultation Paper

Victorian Law Reform Commission

GPO Box 4637
Melbourne Victoria 3001
Australia
DX 144 Melbourne, Vic

Level 10
10-16 Queen Street
Melbourne Victoria 3000
Australia

Telephone +61 3 8619 8619
Facsimile +61 3 8619 8600
TTY 1300 666 557
1300 666 555 (within Victoria)
law.reform@lawreform.vic.gov.au
www.lawreform.vic.gov.au

CALL FOR SUBMISSIONS

The Victorian Law Reform Commission invites your comments on this Consultation Paper and seeks your responses to the questions that are raised. If you wish to make a submission to us on this reference, you can do so by mail, email, phone, fax or in person. If your submission is in writing, there is no particular form or format you need to follow. If you prefer to make a submission by phone or in person, contact the Commission and ask to be put through to one of the researchers working on the Assisted Reproductive Technology reference.

You can send your written submissions by post, or by email to <law.reform@lawreform.vic.gov.au>. If you need any assistance with preparing a submission, please contact the Commission. If you need an interpreter, please contact the Commission.

If you would like your submission to be confidential, please indicate this clearly when making the submission. If you do not wish your submission to be quoted, or sourced to you in a Commission publication, please let us know. Unless you have requested confidentiality, submissions are public documents, and may be accessed by any member of the public.

The Victorian Law Reform Commission will be consulting on the issues raised on this paper throughout the first half of 2004.

DEADLINE FOR SUBMISSIONS: 30 JUNE 2004

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The Victorian Law Reform Commission was established under the *Victorian Law Reform Commission Act 2000* as a central agency for developing law reform in Victoria.

This Consultation Paper reflects the law as at 1 December 2003.

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Contents

Preface	v
Contributors	vi
Terms of Reference	vii
Abbreviations	ix
Executive Summary	xi
Questions	xxv
Chapter 1: Introduction	1
What does this Reference Cover?	1
What is Assisted Reproduction?	1
The Purpose of this Consultation Paper	4
The Structure of this Consultation Paper	5
The Commission Seeks Your Views	6
Chapter 2: The Regulatory Framework for Assisted Reproductive Technology in Victoria	7
Introduction	7
The Division of Commonwealth and State Powers with Respect to Children and Relationships	7
The Regulation of Assisted Reproductive Technology in Victoria	12
Chapter 3: Access to Assisted Reproductive Technology in Victoria	23
Introduction	23
Access and Eligibility Criteria for ART in Victoria: The Current Law	23
The Effects of Restrictions on Access to ART	38
Effects of the Current System on People Who Are Not Eligible	40
Effects of the Current Eligibility Criteria on Providers of Reproductive Services	42

Ban on Sex Selection	45
Access to Sperm in the Current Victorian System	47
Restrictions on Donors of Gametes	48
Screening of Donors of Sperm and Eggs	49
Chapter 4: Regulating Eligibility for ART: Options for Reform	53
Introduction	53
The Best Interests of the Child	53
Options for Reform	60
Counselling, Consent and Information	66
Chapter 5: Family Relationships	73
Introduction	73
Why Legal Parentage Matters	74
Who is a Parent?	75
Problems with the Current Law	84
Adoption	96
The Right to Information	100
Registration of Births	104
Chapter 6: Surrogacy	107
What is Surrogacy?	107
Which Aspects of Surrogacy are we Examining?	107
When is Surrogacy through the Licensed Clinic System Possible in Victoria?	108
How Many People Seek to Have a Child through a Surrogacy Arrangement?	114
Options for Reform	114
The Case for Changing Eligibility Provisions as they Apply to Surrogacy	114
Reforming Eligibility Criteria for Altruistic Surrogacy	116
The Legal Status of the Child in Surrogacy: Options for Reform	122

Preface

This Consultation Paper is intended to provide the basis for discussion and community consultation about two main questions which affect people who are infertile. It considers the laws which govern access to infertility treatment in which donated sperm and/or eggs are used, and the laws which determine eligibility to adopt children. It also considers legislation which deals with the parentage of children conceived through assisted reproduction.

Kate Foord, a Research and Policy Officer at the Commission, took primary responsibility for drafting much of the paper. Professor Felicity Hampel SC, Part-Time Commissioner, also played an important role in refining the Paper.

I am grateful to Dr John McBain, Jenny Blood, Head Counsellor and Penny Pitt Counsellor from Melbourne IVF, Dr John Leeton, and Rita Alessi, Counsellor from Monash IVF, who assisted the Commission to understand the technical and practical issues which arise in the context of assisted reproduction. I also thank Adiva Sifris, Lecturer in the Law Faculty at Monash University for reading and commenting on Chapter 5 of the Paper and Dr Chris Bayly, Associate Director, Women's Services, Royal Womens Hospital for her comments on the whole paper.

The Paper could not have been completed without the expert advice and comments on drafts made by Members of the Advisory Committee. The Committee comprised

Dr Ruth McNair, Senior Lecturer, Department of General Practice, University of Melbourne,

Helen Szoke, Chief Executive Officer of the Infertility Treatment Authority

Kristen Walker, Senior Lecturer, Faculty of Law, University of Melbourne

The Honourable Justice Sally Brown, Family Court of Australia

I thank the Advisory Committee for its outstanding contribution.

Contributors

Authors

Kate Foord
Professor Felicity Hampel SC
Professor Marcia Neave AO

Editors

Valina and Tony Rainer

Victorian Law Reform Commission

Chairperson

Professor Marcia Neave AO

Commissioner

Judith Peirce

Part-time Commissioners

Her Honour Judge Jennifer Coate
The Honourable Justice David Harper
Professor Felicity Hampel SC
Professor Sam Ricketson
Paris Aristotle AM

Chief Executive Officer

Dr Iain Ross

Operations Manager

Matthew Carroll

Policy and Research Officers

Kathy Karlevski
Susan Coleman
Kate Foord
Nicky Friedman
Angela Langan
Hilary Little
Siobhan McCann
Victoria Moore
Priya SaratChandran
Simone Marrocco
Ronli Sifris
Julie Bransden
Lorraine Pitman
Jenny Wright

Terms of Reference

1. The Victorian Law Reform Commission is to enquire into and report on the desirability and feasibility of changes to the *Infertility Treatment Act* 1995 and the *Adoption Act* 1984 to expand eligibility criteria in respect of all or any forms of assisted reproduction and adoption; and make recommendations for any consequential amendments which should be made to the:

Status of Children Act 1974

Births Deaths and Marriages Registration Act 1996

Human Tissue Act 1982

Equal Opportunity Act 1995

and any other relevant Victorian legislation

2. In making its enquiry and report, the Commission should take into account, to the extent it decides is necessary or desirable:
 - (i) social, ethical and legal issues related to assisted reproduction and adoption, with particular regard to the rights and best interests of children;
 - (ii) the public interest and the interests of, parents, single people and people in same sex relationships, infertile people and donors of gametes;
 - (iii) the nature of, and issues raised by arrangements and agreements relating to methods of conception other than sexual intercourse and other assisted reproduction in places licensed under the *Infertility Treatment Act* 1995 (“the Act”);
 - (iv) the penalties applicable to persons, including medical and other personnel, involved in the provision of assisted reproduction (whether through a licensed clinic or otherwise); and
 - (v) the laws relating to eligibility criteria for assisted reproduction and adoption and other related matters which apply in other states or countries and any evidence on the impact of such laws on the rights and best interests of children and the interests of parents, single people, people in same sex relationships, infertile people and donors of gametes.
3. In addition, the Commission should consider whether changes should be made to the Act to reflect rapidly changing technology in the area of assisted reproduction.

4. The Commission is also requested to consider the meaning and efficacy of sections 8, 20 and 59 in relation to altruistic surrogacy, and clarification of the legal status of any child born of such an arrangement.

On making its report the Commission should consider the relationship between changes to Victorian legislation and any relevant Commonwealth legislation including the *Family Law Act 1975* and the *Sex Discrimination Act 1984* as well as any International conventions and instruments to which Australia is a signatory.

Abbreviations

AHEC	Australian Health Ethics Committee
ART	Assisted Reproductive Technologies
cl	clause
CROC	Convention on the Rights of the Child
DHS	Department of Human Services
Div	Division
DNA	Deoxyribonucleic acid, the self-replicating material present in nearly all living organisms, which is the carrier of genetic information
eg	for example
ff	and following
FSA	Fertility Society of Australia
gametes	mature cells able to unite with others in sexual reproduction
GIFT	gamete intra-fallopian transfer
HFEA	Human Fertilisation and Embryology Authority
HIV	human immunodeficiency virus
HREOC	Human Rights and Equal Opportunity Commission
ibid	In the same place (as the previous footnote)
ICSI	intracytoplasmic sperm injection
ie	that is
ITA	Infertility Treatment Authority
IVF	In-Vitro Fertilisation
n	footnote
NHMRC	National Health and Medical Research Council
oocyte	egg
para(s)	paragraph(s)

Pt	Part (of a statute)
RMU	Reproductive Medicine Units
RTAC	Reproductive Technology Accreditation Committee
s	section (ss pl)
UN	United Nations

Executive Summary

PURPOSE OF THIS CONSULTATION PAPER

The Attorney-General, the Honourable Rob Hulls MP, has asked the Victorian Law Reform Commission to inquire into two major issues of importance to the Victorian community: eligibility for assisted conception through licensed clinics (including eligibility for a procedure involving a surrogacy arrangement), and eligibility to become adoptive parent/s.¹

In determining whether it is desirable to expand eligibility criteria, we have been asked to take into account several key factors:

- the best interests of children born or adopted into alternative family types;
- the social, legal and ethical issues that arise at present and in the future if access to ART is expanded;
- the nature of arrangements and agreements made by people who are having children without sexual intercourse and without the assistance of licensed infertility clinics; and
- the interests of particular community groups as well as the community at large.

We have published this Consultation Paper in order to:

- inform people of the scope and nature of our inquiry;
- invite public comment; and
- provide people with the necessary background to make informed submissions to the inquiry.

This Consultation Paper raises a series of questions which the Commission has identified as being important to this inquiry. These questions occur throughout the text and are also listed all together at the end of this executive summary. The Commission seeks submissions which specifically address these questions, but we also welcome feedback on any matter relevant to this inquiry.

1 See the terms of reference, page vii.

During the consultation process, the Commission seeks the opinions of Victorians on the range of issues we have been asked to consider. The Commission needs to know the effects of current laws and practices on people so that we can propose reforms that have the capacity to represent community values, to alleviate suffering and redress discrimination. As there is little published research on some aspects of this inquiry, we particularly encourage people with direct experience of the issues we have been asked to consider to contact us. Given the sensitive nature of some of these issues, the Commission assures people that where confidentiality is requested it is guaranteed.

CHAPTER 2: THE REGULATORY FRAMEWORK FOR ART

Assisted reproductive technology in Victoria is primarily regulated by the *Infertility Treatment Act 1995*. The Act regulates fertilisation procedures and donor insemination procedures; access to information about these procedures; and research using human gametes and embryos. It sets out eligibility requirements for treatment using ART through the licensed clinic system. The Act also makes provisions with regard to surrogacy arrangements. The National Health and Medical Research Council's *Ethical Guidelines on Assisted Reproductive Technology* are also relevant to the practice of ART in Victorian clinics, but these are guidelines only and do not have the force of law.

Both Victorian and federal law is relevant to the legal definitions of family relationships, although the Victorian Law Reform Commission only has the power to recommend changes to Victorian law. In Victoria, the *Status of Children Act 1974* defines who is a parent, including who is a parent of a child who has been born as a result of assisted conception (whether the child was conceived through the licensed clinic system or not). The *Adoption Act* regulates the adoption of children, and prescribes who is eligible to be an adoptive parent. With the *Statute Law Amendment (Relationships) Act 2001* and *Statute Law Further Amendment (Relationships) Act 2001*, Victoria incorporated the notion of 'domestic partnership', the members of which can be of the same sex, into most state laws: however, these definitions do not apply in the *Infertility Treatment Act*, the *Adoption Act* and the *Status of Children Act*.

The Commonwealth has responsibility for determining disputes between parents and other significant figures in the child's life, and can make orders about where the child will live, who the child will have contact with and about decision making in relation to the child. The *Family Law Act* and the *Child Support Act* make provision for the support and maintenance of children by their parents, and the

relevant provisions of both Acts regarding who is a parent of a child born as a result of artificial conception procedures is contained in the *Family Law Act*.²

CHAPTER 3: ACCESS TO ASSISTED REPRODUCTIVE TECHNOLOGY IN VICTORIA

The *Infertility Treatment Act 1995* regulates access to ART in Victoria by identifying the people who may undergo treatment and under what conditions they may do so.³

The Act requires that for a woman to have a treatment procedure⁴ she must be married or in a heterosexual de facto relationship. However, since the *McBain*⁵ case, this requirement cannot be imposed.

The Act also includes conditions that must apply before a woman undergoes a procedure⁶:

- in the opinion of a doctor, she must be unlikely to become pregnant with her own egg and her husband's sperm other than by a treatment procedure; or
- in the opinion of a doctor with specialist qualifications in human genetics, she must be likely, if she becomes pregnant with her own egg and her husband's sperm, to give birth to a child with a genetic abnormality or risk communicating a disease to a child unless she undergoes a treatment procedure.

If a woman is married or in a heterosexual de facto relationship, she must have the consent of her husband/partner to undergo the procedure.⁷

The result of the *McBain* case is that a provider cannot discriminate on the basis of marital status in the provision of reproductive specialist services. However, the *McBain* case did not clarify how the 'unlikely to become pregnant' requirement

2 Section 60H.

3 These provisions also apply to people who are undergoing treatment as part of a surrogacy arrangement. See Chapter 6 for detailed discussion of surrogacy issues.

4 A treatment procedure is either a donor insemination procedure or a fertilisation procedure as defined by the *Infertility Treatment Act 1995* s 3(1). See Chapter 3 for full definition.

5 *McBain v The State of Victoria & Ors* [2000] 99 FCR 116

6 *Infertility Treatment Act 1995* s 8(3).

7 *Infertility Treatment Act 1995* s 8.

should be applied to women without male partners, whether single or in same-sex relationships. The result has been that a married woman must be ‘unlikely to become pregnant’, whereas a single woman⁸ must be clinically infertile to be eligible for treatment⁹ or is at risk of transmitting a genetic abnormality or a disease to a person born as a result of the pregnancy.¹⁰

The questions we are addressing regarding eligibility for a treatment procedure concern whether or not eligibility criteria should be expanded, and if so, what criteria, if any, should apply and to whom. The operation of the provisions described in this chapter affects health professionals, women and couples seeking treatment and people seeking to donate sperm, eggs and embryos. We ask whether these effects are justified in ethical and public policy terms.

There are also several eligibility issues related to gametes (sperm and eggs), including access to donor sperm through the licensed clinic system, restrictions on the importing and exporting of gametes, and the prohibition on using the sperm or eggs of a person who has died.

CHAPTER 4: REGULATING ELIGIBILITY FOR ART: OPTIONS FOR REFORM

Where ART is regulated, either in Australia or internationally, the best interests of the child are either paramount or important in any activities governed by the legislation. If we accept that this should be the paramount consideration, how are the best interests of the child to be protected in reforming eligibility criteria for treatment procedures?

One possible approach is to use parenting criteria to determine eligibility. If parenting ability were to be used, there are difficulties in establishing fair and agreed upon criteria given that there are such diverse approaches to parenting and little consensus about what makes a good parent. Our question is whether the arguments for using criteria about parenting ability outweigh the disadvantages. Do the existing legislative models that involve consideration of parenting ability

8 While many areas of State law now recognise same-sex relationships with the concept of ‘domestic partnership’, lesbian relationships are not recognised in the *Infertility Treatment Act 1995* and a woman in a same-sex relationship who presents for treatment is therefore single for the purposes of the Act.

9 Based on an opinion by Gavan Griffith QC provided to the Infertility Treatment Authority, 4 August 2000.

10 Section 8(3)(b).

such as the *Family Law Act* or the *Adoption Act* provide an appropriate basis for legislative eligibility for ART?

We currently have a system that prescribes eligibility through legislation; we could retain this system and either establish new criteria or simply clarify the meaning and applicability of those we have. However, we could also do away with specific criteria in favour of broad principles which express in legislation the aims and values to be applied in the provision of ART without specifying who is to receive treatment. Or we could do away with regulation of eligibility altogether. There are arguments for and against each approach outlined in this Chapter. The other aspects of the regulatory system, including the requirements for counselling for people receiving treatment, their partners and donors, or the consent and information provisions could remain prescribed elements of the treatment process, whichever approach is taken.

Women who wish to have treatment through the clinic system in order to access donor sperm are currently not eligible unless they meet the criteria described in the previous chapter. Asking whether eligibility should be expanded involves examining whether licensed clinics should be licensed also for the provision of treatment to women seeking access to screened donor sperm. These women may wish to use 'identity-release' sperm from the clinic, or may wish to use sperm from a known donor and use the clinic's services in order to ensure that comprehensive screening and testing takes place. Should clinics provide this service? Should this service extend to the provision of tested and screened sperm for the purposes of self-insemination? We also ask whether the current screening procedures appropriately balance the necessity to protect people from infectious diseases with the requirement not to discriminate against certain groups of people, in particular, gay men.

The *Infertility Treatment Act* prohibits the use in an insemination or fertilisation procedure of sperm or eggs from a person who is known to be dead.¹¹ It does not prohibit the use of an embryo formed with the gametes of a person who has since died. In Victoria and in other Australian states, where women have wanted to retrieve the sperm of husbands or partners who have just died, their applications have ultimately been denied. The question for our inquiry is whether or not such access should be permitted.

11 *Infertility Treatment Act 1995* s 43.

The importing and exporting of sperm and embryos is regulated by the *Infertility Treatment Act*, which confers power on the Infertility Treatment Authority to grant or deny requests from people wishing to move gametes or embryos into and out of Victoria. Our inquiry asks whether the ITA should retain this function, or whether legislation should specifically state the circumstances under which gametes and embryos can be moved into and out of Victoria.

CHAPTER 5: FAMILY RELATIONSHIPS IN CURRENT LAW AND OPTIONS FOR REFORM

Whether or not the eligibility criteria for access to ART through the licensed clinic system are changed, the Commission must consider the laws which currently define the rights and responsibilities of family members because children are being born into families where there is uncertainty over these rights and responsibilities. It is in the best interests of these children to have legislation which clarifies the parental status of those who care for them.

Legislation has been enacted in Victoria and at the federal level to create legal parent-child relationships in the context of assisted reproduction. This legislation extinguishes the parental relationship between donors of gametes and the children produced as a result of the donation. However, different rules apply in deciding who are the parents of children born within heterosexual relationships and who are the parents of children born to single women or within lesbian relationships as a result of assisted reproduction.

In federal law, where a couple is married or living in a heterosexual de facto relationship, provided that both the man and the woman consented to the ART procedure, the child is recognised as their child for the purposes of the *Family Law Act* and the *Child Support Assessment Act*.

In Victorian law, the *Status of Children Act* provides that where a child is born to a woman with the consent of her husband or her de facto partner, as the result of assisted reproduction, the partner is presumed to be the father of the child¹² and the donor is presumed not to be the father. This ensures that a child born to a married or de facto couple is recognised as their child for all legal purposes.

In Victorian law, where a woman gives birth to a child as the result of donor insemination, she is the legal mother of the child. The *Status of Children Act* does not deal with the position of a single woman who bears a child who has been

conceived from a donated egg or from transplantation of an embryo conceived from a donated egg. This leaves the status of these children uncertain under State law.

In federal law there is some doubt about the position under federal law of children born to single women (that is, women who do not have a husband or male de facto partner) as the result of assisted reproduction. The federal *Family Law Act* recognises that a person is a parent of such a child, if they are the parent under a prescribed state law¹³; however, there is no prescribed state law which says that a single woman who gives birth to a child as the result of assisted reproduction, involving either donor insemination, the use of donated eggs or an embryo transfer, is the mother of the child. In *the Matter of Mark*¹⁴, the reasoning of Justice Brown suggests if the child is conceived from the mother's egg, the child is the woman's child under the *Family Law Act* as well as under State law. This may not be the case where the child is not the mother's biological child, because there is no prescribed state law to deal with this situation.

Neither the federal *Family Law Act* nor the Victorian *Status of Children Act* deals with the relationship between a child conceived by a woman through assisted reproduction and that woman's female partner. Where a child is conceived by a woman in a heterosexual relationship, as the result of assisted reproduction, the male partner of the birth mother is regarded as the father of the child if he consented to her undergoing the procedure. By contrast, a female partner of the birth mother does not have any legal parental relationship with the child. This has important implications for the child, affecting their rights to child support and inheritance, as well as their legal relationship with the extended family of the partner. The failure of the law to recognise the parental role of the birth mother's partner may also affect the stability of the family.

There are also difficulties in both federal and Victorian law with respect to the status of a sperm donor. In Victorian law, the *Status of Children Act* says that where a woman who conceives a child as the result of 'artificial insemination' is not married or in a de facto relationship, or where a woman's male partner does not consent to her insemination, the semen donor 'has no rights and incurs no liabilities' in respect of the child,¹⁵ unless he later becomes the husband of the

13 In this context, a prescribed law is a Victorian law that is prescribed by the Commonwealth for the purpose of the Act.

14 Unreported decision of Justice S Brown, Family Court of Australia, 28 August 2003.

15 Section 10F.

mother. Unlike the situation where a semen donor donates to a heterosexual couple, the legislation does not say that the donor is not the father of the child.¹⁶

There is no provision in the federal *Family Law Act* which deals with the paternity of a child born as the result of a sperm donation to a single woman or a woman living with a female partner. A number of Family Court decisions have considered the status of children born as a result of a sperm donation and reached conflicting conclusions. In *Re Patrick*¹⁷ Guest J found that a sperm donor is not a parent for the purposes of that Act. In *The Matter of Mark*¹⁸ Brown J took the opposite view. Regardless of which view is correct, a sperm donor who is concerned with the care, welfare and development of the child can apply to the Family Court for a parenting order.

OPTIONS FOR REFORM

STATUS OF THE BIRTH MOTHER'S FEMALE PARTNER

The role of the birth mother's female partner could be recognised in a number of ways:

- The partner could adopt the child, with the result that both she and the birth mother would be the parents.
- Legislation could be enacted to provide that where the couple are living together on a genuine domestic basis the partner is a parent of a child born to the other.
- Legislation could be enacted to provide that the partner is a parent of a child born as a result of a treatment procedure, if the partner consents to the birth mother having the procedure.
- Provision could be made making the birth mother's partner a parent if she was registered as a parent in the Register of Births Deaths and Marriages.

STATUS OF THE SPERM DONOR

In this Chapter we ask whether the *Status of Children Act* should provide that a child born as the result of a semen donation to a single woman or a woman in a

16 See 5.20.

17 (2002) 28 Fam LR 579.

18 Unreported decision of Justice S Brown, Family Court of Australia, 28 August 2003.

lesbian relationship is not the child of the semen donor? Or, should the *Status of Children Act* recognise a known donor of semen to a single woman or a woman in a lesbian relationship as the father of a child born as the result of self-insemination, but provide that a father who is a donor has no rights and responsibilities in relation to the child?

BIRTH CERTIFICATES

The birth registration statement provides for the registration of the child's mother and father. If a child is born to a couple in a lesbian relationship there is no provision allowing two people to be registered as the mothers of the child. Nor can the birth mother's female partner be validly registered as the father. There is no provision for a person to be registered as a parent but neither a mother nor a father.

The birth certificate includes a space in which the name of the 'informant' (that is the person who registers the birth) is recorded. The birth mother's partner could be listed as the informant, but this does not accurately describe her relationship with the child. It may also be possible for the identity of the birth mother's partner to be recorded separately from the Register. If the law were changed to recognise the partner as a parent, the *Births, Deaths and Marriages Registration Act* would need to be amended to provide for the identity of the partner to be recorded on the birth certificate. Some lesbian couples may not wish both the birth mother and her partner to appear on a birth certificate as parents, because this will force the child to produce a document which discloses his or her parents' sexuality whenever and wherever he or she presents it. If the birth mother's partner were recognised as a parent the question arises whether the parents should be able to choose to omit the birth mother's partner's name from the Register (and the birth certificate) but to have it recorded separately.

It is also necessary to decide how the Register should deal with known donors. Where women give birth to children conceived with donor gametes through the licensed clinic system, information identifying the donor or donors will be held in the Infertility Treatment Authority's Central Register, but not recorded in the Register of Births. This means it is not available to any one who searches the Register of Births. Should information about the identity of a donor who donates outside the licensed clinic system be recorded and if so where should this record be kept?

ADOPTION

The Commission has been asked to consider eligibility criteria in general for adoption. The current provisions are:

- Normally a person cannot adopt a child unless they are married or living in a heterosexual de facto relationship for a period of at least two years. Single people can adopt in exceptional circumstances.
- The *Adoption Act* does not allow couples in same sex relationships to adopt children, even if they otherwise meet statutory criteria designed to ensure their capacity to parent.
- The *Adoption Act* does not allow the partner of a parent in a same sex relationship to adopt the child of their partner.

Should same-sex couples be permitted to adopt children? Should this apply in all circumstances in which heterosexual couples can adopt—that is, both known child and placement adoptions? Should a donor (and his partner, if any) be able to adopt a child jointly with a single mother or with a lesbian couple? Should single people be able to adopt in all circumstances in which heterosexual couples can?

To what extent are lesbian and homosexual couples involved in overseas adoptions? What legal difficulties arise in these circumstances?

CHAPTER 6: SURROGACY

The Commission has been asked to examine three particular sections of the *Infertility Treatment Act* in relation to altruistic surrogacy, and we have been asked to consider the legal status of a child born through a surrogacy arrangement.

The three sections of the Act we have been asked to examine in relation to altruistic surrogacy are:

- Section 8, which prescribes who can undergo a treatment procedure
- Section 20, which prescribes conditions under which donor sperm and eggs can be used
- Section 59, which bans any person from giving or receiving payments in relation to a surrogacy arrangement

The Commission has not been asked to consider any other aspects of surrogacy such as provisions that prohibit advertising and which make surrogacy agreements

void.¹⁹ Nor has the Commission been asked to consider surrogacy for commercial gain.

There are therefore three issues for this inquiry.

- Whether the current eligibility provisions in the Act are appropriate for application in surrogacy situations, including situations where donor sperm and eggs are used?
- How should the legal status of the child be clarified?
- Whether the current provisions regarding payment in surrogacy arrangements are appropriate

ELIGIBILITY

The provisions that cover eligibility criteria for treatment procedures also apply to surrogacy treatments. To be eligible to undergo a treatment procedure a woman who intends to bear a child as a surrogate must be unlikely to become pregnant (if married or in a de facto heterosexual relationship) or clinically infertile (if single); otherwise she must be likely to transmit a disease to a child or to have a child with a genetic abnormality. If she is married or in a de facto relationship she must have the consent of her husband or male partner.

The Infertility Treatment Authority sought advice on the use of both donor sperm and donor eggs in a treatment procedure affecting a surrogate mother, where the woman undergoing the procedure is married or in a de facto relationship. The advice was that both the woman (surrogate) and her husband would have to be infertile in order to permit the use of an embryo formed from both donor sperm and a donor egg. That is, in the situation in which a heterosexual couple wishes a surrogate to have a child created from their own sperm and egg, if the surrogate mother is married or in a de facto relationship she must be unlikely to become pregnant, or be likely to transmit a disease to a child or to have a child with a genetic abnormality, if her own eggs *and* her husband or partner's sperm were used.²⁰

These eligibility requirements were intended to apply to people seeking infertility treatment because ordinarily they want to have children for themselves. However

19 *Infertility Treatment Act 1995* ss 60 and 61 respectively.

20 Opinion by Gavan Griffith QC, 16 May 2002. Copy provided to the Victorian Law Reform Commission by the Infertility Treatment Authority.

the provisions also create a barrier to altruistic surrogacy, even though the *Infertility Treatment Act* does not make altruistic surrogacy illegal.

It can be argued that current eligibility provisions should be changed because:

- The application of the general eligibility provisions to surrogacy obscures the development and clarification of real policy objectives in relation to altruistic surrogacy.
- There is no reason to allow only women with fertility problems or who risk transmission of a disease or genetic abnormality to carry children for other people.
- There is no reason to require the husband or partner of the proposed surrogate also to be infertile.

OPTIONS FOR REFORM OF ELIGIBILITY CRITERIA

The alternatives are to:

- prohibit all surrogacy, including altruistic surrogacy;
- correct the anomalies in the application of the current criteria—for example by providing that the eligibility for treatment applies to the commissioning person or couple, rather than the surrogate and her partner (if any)
- provide new criteria which define eligibility for surrogacy itself, rather than linking it to general eligibility criteria for a treatment procedure.

Should altruistic surrogacy be prohibited, and why? If it is not to be prohibited, and the eligibility criteria were changed it would be necessary to consider how to ensure that the rights and interests of all parties were sufficiently protected, including:

- the woman who gives birth to the child
- the children born through such arrangements
- any other children directly involved with any of the parties
- the people who wish to become parents of the child.

Given these concerns, how should access to surrogacy arrangements through licensed clinics be determined? What criteria should be used? To whom should they apply?

PAYMENT

Under the *Infertility Treatment Act*, a woman cannot receive payment for carrying a child for someone else, and nor can someone give or agree to give payment or reward to a woman for carrying a child for them. We have been asked to consider whether the woman carrying the child should be able to receive legitimate expenses from the prospective parents, and whether a person should be able to give or agree to give such payment to a woman who agrees to carry a child for them. If payment is allowed, how would the agreement be regulated so that payment did not exceed the level at which the arrangement could still be said to be altruistic and not commercial? Is it desirable to establish a regulatory authority to oversee surrogacy arrangements and agreements, given the complexity and specificity of the issues involved?

THE LEGAL STATUS OF THE CHILD

If altruistic surrogacy was prohibited, children would not be able to be conceived through a licensed clinic in Victoria under a surrogacy arrangement. Some people might still make surrogacy arrangements in other states or overseas. One issue which the Commission will need to consider is how, if at all such arrangements should be recognised by Victorian law. If altruistic surrogacy is permitted in Victoria, either under the existing law or under laws which expand eligibility for assisted reproduction, consequential changes to parenting laws may be necessary.

OPTIONS FOR REFORM OF THE LEGAL STATUS OF THE CHILD

The parenthood of any child born from a surrogacy arrangement is determined not by any agreement made between the parties but by the *Status of Children Act*.

There are two main options for reforming parenting laws to accommodate situations in which surrogacy has occurred:

- amend the *Adoption Act* to make specific provision for altruistic surrogacy;
- enact legislation governing altruistic surrogacy, which provides a procedure under which commissioning parents may be recognised as parents of the child.

TECHNOLOGICAL CHANGE

The Commission has been asked to consider whether changes should be made to the *Infertility Treatment Act* to reflect rapidly changing technology in the area of assisted reproduction. We have not discussed this issue in the Consultation Paper;

however we are aware that technological changes may result in more people seeking access to assisted reproductive technologies. For example, as techniques for genetic screening of embryos become more sophisticated, people who may otherwise not have considered ART may wish to access treatment.

We particularly seek the views of reproductive technology specialists and other health professionals on the way in which changes in technology might necessitate reform, particularly of laws relating to eligibility.

Questions

CHAPTER 3—ACCESS TO ASSISTED REPRODUCTIVE TECHNOLOGY IN VICTORIA

1. Should there be a prohibition on the use of gametes after a person has died? Or should this prohibition only apply where a person has not specified what is to be done with their gametes after their death?
2. What are the effects on people of the current restrictions to access of ART treatment?
3. Do the restrictions affect the physiological or psychological health of people who are excluded? Are there financial or other material effects? Are there other effects?
4. Are there principles or circumstances that would justify any adverse effects of restrictions to access to donor or treatment programs?
5. Are there legal or other principles that mean that any adverse effects are not justified?
6. Should some or all types of self-insemination be treated as criminal offences? What are the effects of these provisions? Should these activities attract prison sentences?
7. Should ‘self-insemination’ be allowed regardless of who performs the insemination?
8. Do you think there should be a prohibition on sex selection for all purposes except the prevention of transmission of a disease or genetic abnormality to a child?
9. How appropriate is the current regime for balancing the desire of people to donate gametes with the need for the safest possible provision of donated gametes to recipients?
 - Is it still necessary to screen out on the basis of certain high-risk activities, and if so, what are those activities? Are the questions currently asked about sexual activity capable of determining the risk that a person poses in transmission of infectious diseases such as HIV? If not, what are the

appropriate questions to ask? Does the current system unnecessarily exclude sectors of the population, such as gay men, through asking general questions about sexual activity rather than specific questions about particular sexual behaviour that involves risk of HIV infection?

- Is screening for HIV through semen and blood testing guaranteed to eliminate risk of transmission to a recipient or child?

10. Who should be able to donate gametes for reproduction?

CHAPTER 4—REGULATING ELIGIBILITY FOR ART: OPTIONS FOR REFORM

11. To what extent should the Infertility Treatment Act 1995 refer to the above rights and interests?
12. Are there other broad principles that would better protect the best interests of the child yet-to-be-born?
13. Do the principles in the Infertility Treatment Act 1995 express the values and priorities that should apply to assisted reproduction treatment? Do they provide an adequate framework for assessing eligibility for assisted reproduction?
14. Should the Infertility Treatment Act 1995 express broad principles regarding the best interests of the child, or identify specific criteria that are likely to produce better outcomes for children? For example, should specific criteria relating to parenting be included in legislation regulating eligibility for assisted reproduction?
15. If so, what criteria, if any, should be in place? Would the criteria in the Adoption Act 1984 or Family Law Act 1975 (Cth) be useful in assessing whether a person should be eligible for assisted reproduction?
16. What is the best way to regulate access to ART in Victoria?
17. Should eligibility criteria be set out in the Infertility Treatment Act 1995?
18. If so, what criteria should be applied in assessing eligibility? Should anyone be excluded from treatment?
19. Should infertility be a requirement for eligibility for assisted reproduction, and if so, how should it be defined? If not, how should the phrase ‘unlikely to become pregnant’ be interpreted?

20. Alternatively, should the legislation simply express broad principles of eligibility and provide for non-binding guidelines to be made to assist decision-makers?
21. Would it be preferable to simply leave eligibility for treatment to be determined by individual doctors?
22. Should people who are donating semen to an unknown recipient be able to stipulate qualities or characteristics of the recipient?
23. Should people considering donating embryos to an unknown recipient be able to specify the characteristics of the recipients?
24. Should people whose spouses have died should be able to take gametes from the dead person's body for use in ART treatment?
25. Should donated sperm and eggs be able to be used for assisted reproduction after a person has died? If so, what conditions should apply before this can occur?
26. Should the importing and exporting of gametes and embryos be regulated?
27. If so, should this be done by defined rules, or broad principles?
28. Should people who are ineligible for treatment be able to import sperm into Victoria? Should the same regulations that apply to sperm sourced and used within Victoria also apply to imported sperm (for example, the information provisions of the Infertility Treatment Act 1995)?
29. Are there public health and/or other benefits in allowing licensed clinics to provide screened donor sperm to women for the purposes of self-insemination?
30. Should licensed clinics be able to do so?
31. Should there be eligibility requirements for access to donor sperm for self-insemination? If so, what should these eligibility criteria be?
32. Should women wishing to self-inseminate have access to sperm from the clinics or should they be required to find their own donor?
33. Should the provisions of the Infertility Treatment Act that apply before women can undergo a treatment procedure (for example, the counselling requirements) also apply before women can access donor sperm through the clinic system for the purposes of self-insemination?

CHAPTER 5—FAMILY RELATIONSHIPS

34. Should the law recognise the birth mother's female partner as the parent of the child?
35. If so, in what circumstances should the law treat the birth mother's female partner as the parent of the child? Should it be necessary to show that the partner
 - adopted the child;
 - consented to the birth mother undergoing the procedure;
 - was living with the birth mother on a genuine domestic basis at the time the child was born; or
 - was registered as a parent in the Register of Birth's Deaths and Marriages?
36. Are there any other legal means of recognising a relationship between the child and the birth mother's female partner?
37. Should the Status of Children Act 1974 explicitly provide that a child born as the result of a semen donation to a single woman or a woman in a lesbian relationship is not the child of the semen donor?
38. Alternatively, should the Status of Children Act 1974 recognise a known donor of semen to a single woman or a woman in a lesbian relationship as the father of a child born as the result of self-insemination, but provide that a father who is a donor the father has no rights and responsibilities in relation to the child?
39. What kinds of oral or written arrangements do single women and lesbian couples typically make with sperm donors?
40. What is the best way of encouraging people to plan their arrangements in order to minimise future conflict?
41. Should same-sex couples should be permitted to adopt children? Should this apply in all circumstances in which heterosexual couples can adopt—that is, both known child and placement adoptions?
42. Should a donor be able to adopt a child jointly with a single mother or with a lesbian couple?
43. Should a donor and his partner be able to adopt a child jointly with a single mother or with a lesbian couple?

44. To what extent are lesbian and homosexual couples involved in overseas adoptions? What legal difficulties arise in these circumstances?
45. Should there be a legal obligation imposed on parents to inform children that they were conceived through use of donated gametes?
46. Where a birth mother self-inseminates with sperm from a known donor should she be required to notify the name of the donor? If so where should this information be recorded?

CHAPTER 6—SURROGACY

47. Should altruistic surrogacy be prohibited, and why?
48. How should access to surrogacy arrangements through licensed clinics be determined? What criteria should be used? To whom should they apply?
49. Should the woman carrying the child be able to receive legitimate expenses from the prospective parents? If so, how should these expenses be calculated?
50. Should a person be able to give or agree to give such payment to a woman who agrees to carry a child for them?
51. How should the law deal with the regulatory issues that arise in relation to eligibility for surrogacy?
 - Should an approved body, such as the ITA, have statutory responsibility for administering, approving and monitoring surrogacy arrangements? What other types of bodies might take responsibility for aspects of surrogacy regulation?
 - Should a regulatory body be charged with monitoring surrogacy arrangements involving payment?
52. Should single people, women in lesbian relationships, or men in same-sex relationships be able to adopt a child who has been born under a surrogacy arrangement?
53. If so, how should the Adoption Act 1984 be amended to facilitate adoption in these circumstances?
54. What arrangements should be made to deal with adoption of children born as the result of surrogacy arrangements made overseas?
55. Is Victorian law adequate to deal with parental relationships arising from surrogacy?

56. If not, should provision be made to recognise a person who commissions the birth of a child under a surrogacy agreement as the child's parent?
57. If so, should this be done by
- amending the Status of Children Act 1974 to recognise commissioning parent(s) as birth parents of a child conceived under a surrogacy arrangement and, if so, in what circumstances should parentage be recognised;
 - amendment of the Adoption Act 1984 to facilitate adoption by a commissioning parent or parents under a surrogacy arrangement and, if so, in what circumstances should adoption be permitted; or
 - provision for the Supreme Court to make parentage orders to recognise commissioning parent(s) as birth parents of a child conceived under a surrogacy arrangement and, if so, what conditions should regulate the exercise of this jurisdiction?

Chapter 1

Introduction

WHAT DOES THIS REFERENCE COVER?

1.1 The Commission has been asked to report on the laws that govern the use of assisted reproduction in Victoria and in particular the desirability and feasibility of expanding the eligibility criteria for access to assisted reproduction and adoption. As part of this enquiry we will also consider the laws that govern the family relationships that arise as a consequence of assisted reproduction. The full terms of reference for our inquiry are set out at vii–viii.

WHAT IS ASSISTED REPRODUCTION?

1.2 ‘Assisted reproduction’ refers to procedures that are used to help a person to conceive a child when natural conception is impossible or difficult, or carries a risk that a disease or genetic abnormality may be transmitted to the child. Some people provide their own sperm and eggs for the procedure, while other people may need to use donated sperm or eggs²¹ either because they have difficulties conceiving or carry a disease or genetic abnormality, or because they are single or in a same-sex relationship. Donors can be known to the recipients, or anonymous. The use of assisted reproduction is not new: the earliest documented form of assisted reproductive technology, insemination with donor sperm, dates back to 1884.²²

1.3 Today, assisted reproduction may include the use of one or more of the following:

21 Sperm is the male reproductive cell, produced in the testicles. The egg is the female reproductive cell, produced in the ovary and also referred to as the ovum (pl. ova) or oocyte. The term for human reproductive cells is ‘gametes’ (Monash IVF, *Guide to Getting Started* (2003) 29).

22 Ken Daniels and Erica Haimés (eds) *Donor Insemination: International Social Science Perspectives* (1998).

- insemination of a woman
- gamete intra-fallopian transfer (GIFT)
- intracytoplasmic sperm injection (ICSI)
- in-vitro fertilisation (IVF)

Each of these terms is briefly explained below.

INSEMINATION

1.4 A woman may be assisted to conceive if semen is placed in her vagina (birth canal), cervix (the opening to her uterus), or into her uterus. (We call this assisted insemination.) Vaginal insemination does not require medical assistance,²³ whereas intrauterine insemination does as it involves the placement of sperm into the womb using a fine catheter.²⁴ If a woman has access to fresh semen she can do the first of these, vaginal insemination, herself. (We call this self-insemination.²⁵)

GIFT, ICSI AND IVF

1.5 The techniques discussed above (other than self-insemination) are medical procedures, which have been developed by medical practitioners for use to treat infertility.

- GIFT (gamete intra-fallopian transfer): In this process, eggs are collected from a woman but, instead of being taken to the laboratory for fertilisation, the eggs plus the previously collected and washed sperm are placed directly into the woman's fallopian tube using a fine sterile plastic tube.²⁶
- ICSI (intracytoplasmic sperm injection): This is the direct injection of a single sperm into the substance (cytoplasm) of the egg. The microinjection procedure is used for the more severe forms of male infertility or after a cycle with poor fertilisation.²⁷

23 Although, for self-insemination medical assistance is advisable to ensure safety through access to appropriate screening of the donor and appropriate pre-pregnancy health care of the recipient.

24 Monash IVF, *Guide to Getting Started* (2003) 28.

25 Self-insemination involves injecting semen (usually fresh) into the vagina, usually using a plastic syringe (Dr Ruth McNair, Department of General Practice, University of Melbourne).

26 Monash IVF, *Guide to Getting Started* (2003) 27.

27 Ibid 28.

- IVF (in-vitro fertilisation): This is the procedure by which a woman's egg and a man's sperm are mixed in the laboratory. Provided fertilisation occurs in the laboratory and the resultant embryos look normal, the embryos are transferred into the uterus of the woman.²⁸

ASSISTED REPRODUCTION PROCEDURES OTHER THAN INSEMINATION

1.6 If a woman or couple requires treatment other than insemination in order to conceive, this treatment is likely to involve a 'stimulation cycle'. This involves the administration of drugs either by the clinic or by the woman herself or her partner, the aim being to encourage the development of multiple eggs in the woman's ovaries. If one or more eggs do develop, then these will be surgically removed in what is referred to as egg pick-up. The woman may remain in theatre and be given a general anaesthetic, while a fine tube is loaded with a volume of sperm, the eggs, and another volume of sperm. The contents of this tube are then transferred into the woman's fallopian tube (a process known as GIFT). Other types of GIFT procedure do not require general anaesthetic.

1.7 Alternatively (and also if there are remaining eggs from the GIFT procedure), the eggs will be fertilised in the laboratory. This may be done either by the conventional IVF method, which involves mixing the egg with thousands of sperm and allowing the process of fertilisation to take place over a number of hours in a culture dish. If this technique is unlikely to result in fertilisation either because the number of sperm available is insufficient or because there is reason to believe that the sperm will be unable to penetrate the egg, the technique of ICSI is usually applied. If fertilisation is successful, the embryo or embryos will be transferred to the woman's uterus two to three days after egg pick-up.²⁹ No anaesthetic is required.

28 Ibid 28.

29 The definition of 'embryo' is a contentious one among scientists because of differing views about the earliest point at which an embryo can be said to have formed. The NHMRC guidelines define a live human embryo as one that has a human genome or an altered human genome and has been developing for less than eight weeks since the appearance of two pronuclei or the initiation of its development by any other means (not including any period when its development was suspended for any reason). (National Health and Medical Research Council, *Ethical Guidelines on Assisted Reproductive Technology* (1996) 48).

1.8 If there are more than one or two embryos, the remainder after the fresh embryo transfer will be frozen.³⁰ If a woman does not achieve a pregnancy on this first cycle, a subsequent attempt may be made by thawing the embryos at the appropriate time in her cycle and transferring them to her uterus by the same process as the transfer of a fresh embryo.³¹

THE PURPOSE OF THIS CONSULTATION PAPER

1.9 The use of assisted reproduction raises unique moral and legal questions, including to what extent should use of the technology be regulated; who should have access to assisted reproduction; what information about donors should be made available to children born as the result of assisted reproduction; and, who should be treated as the parents of children born as the result of assisted reproduction.

1.10 Victorian legislation dealing with these and various other issues was first enacted in 1984. Victoria was the first state in Australia, and the first in the world, to enact legislation regulating the application of assisted reproduction.³²

1.11 The original legislation, in particular the eligibility provisions, has altered considerably since that time. In addition, some aspects of the legislation have been successfully challenged in the courts. Since the Committee,³³ chaired by Professor Louis Waller, first recommended legislative controls on assisted reproduction there have been significant advances in technology. Significant social change has also occurred.

1.12 The framework for access to assisted reproductive technologies that was appropriate in the 1980s may not be so in the first decades of the twenty-first century. Families have changed and continue to do so. The use of assisted reproductive technology raises social and moral questions about the nature of families. The nuclear family consisting of a married couple and children is one of many possible contemporary forms of family unit. In Victoria, in other states and

30 This process of deep-freezing embryos not transferred fresh to the body of a woman is known as embryo cryopreservation.

31 Melbourne IVF website, Clinical and Scientific Information, accessed 11 November 2003, <http://www.mivf.com.au/clinical.asp>

32 Don Chalmers, 'Professional Self-regulation and Guidelines in Assisted Reproduction' (2002) 9 *Journal of Law and Medicine* 414 420.

33 Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilisation, *Consolidated Reports of the Victorian Inquiry into IVF and Related Issues* (1982–4).

in overseas jurisdictions, a much broader range of family types is now recognised by law. Victoria is a multicultural, multi-religious community. A contemporary framework for access to ART must uphold the values we wish to apply in the regulation of ART itself and reflect the broader social values of our community. It must also find the best model in a context in which community opinion is divergent.³⁴

1.13 The purpose of this Consultation Paper is to explain how the law regulates assisted reproduction, to identify some problems in the current legislation and to provoke community debate on whether and how the law requires further reform to respond adequately to these technological and social changes.

RELEVANCE OF COMMONWEALTH LAW

1.14 Where a child is born as the result of assisted reproduction their family relationships are regulated by Commonwealth as well as State law. For example the *Child Support (Assessment) Act 1989* (Cth) determines who is liable to pay child support. The Victorian Law Reform Commission can only recommend changes to Victorian law. However, the Consultation Paper examines areas of Commonwealth law relevant to assisted reproduction. In the course of our work we will be considering whether it is possible to deal with some areas of conflict between State and Commonwealth law.

THE STRUCTURE OF THIS CONSULTATION PAPER

1.15 The structure of the Consultation Paper is as follows.

- Chapter 2 outlines the current legislation that regulates assisted reproduction in Victoria.
- Chapter 3 contains a detailed discussion of the current laws governing eligibility for assisted reproduction, including for gamete donation. It identifies a number of anomalies and problems and asks questions about possible reforms to the eligibility of donors.

34 See Jeanette Edwards, 'Donor Insemination and 'Public Opinion'' in Ken Daniels and Erica Haines (eds) *Donor Insemination: International Social Science Perspectives* (1998) 153. See Equal Opportunity Commission Victoria, *Same Sex Relationships and the Law*, (1998); see also Leslie Cannold and Lynn Gillam, 'Regulation, Consultation and Divergent Community Views: The Case of Access to ART by Lesbian and Single Women' (2002) 9 *Journal of Law and Medicine* 498

- Chapter 4 identifies options for reform of eligibility criteria and asks questions about preferable models.
- Chapter 5 explains how Commonwealth and State laws deal with family relationships that are created by assisted reproduction and asks how these relationships should be regulated in the future.
- Chapter 6 deals with issues raised by altruistic surrogacy arrangements.

THE COMMISSION SEEKS YOUR VIEWS

1.16 Chapters 3–6 of the Paper contain questions that are intended to focus discussion on issues raised in the Paper and to provide guidance to people who want to make submissions to the Commission. You may wish to raise other issues that fall within our terms of reference, but are not covered in these questions.

1.17 It is not necessary to answer all the questions in the Paper. However, it would be helpful for people to explain their reasons for the views they express, rather than simply answering yes or no to particular questions.

TECHNOLOGICAL CHANGES

1.18 The Commission has been asked to consider whether changes should be made to the *Infertility Treatment Act 1995* to reflect rapidly changing technology in the area of assisted reproduction. We have not discussed this issue in the Consultation Paper, but particularly seek the views of reproductive technology specialists on how changes in technology might necessitate law reform.

Chapter 2

The Regulatory Framework for Assisted Reproductive Technology in Victoria

INTRODUCTION

2.1 This Chapter provides a overview of the legislation relevant to assisted reproduction in Victoria. The Chapter begins by explaining why both Victorian laws and federal laws apply to some aspects of assisted reproduction. It goes on to explain the main features of the *Infertility Treatment Act 1995*, which are discussed in more detail in later Chapters.

THE DIVISION OF COMMONWEALTH AND STATE POWERS WITH RESPECT TO CHILDREN AND RELATIONSHIPS

2.2 The Australian Constitution gives the Commonwealth power to legislate on specified subjects. Once it does so, its legislation overrides inconsistent state laws. The federal parliament has power to make laws about marriage, divorce and in relation to the latter, about parental rights and the custody and guardianship of children. It has legislated to deal with divorce and related matters in the *Family Law Act 1975* (Cth).³⁵

2.3 It is doubtful whether the Commonwealth can make laws about the rights and liabilities created by heterosexual de facto relationships³⁶ and same-sex relationships. State governments can do so.³⁷

2.4 The Commonwealth Government can also make laws on matters referred to it by the states.³⁸ Because of difficulties caused by the constitutional limits on federal power to make laws about the custody, guardianship and access of children

35 *Australian Constitution* s 51 (xxi)(xxii). The extent of these provisions has been defined in cases decided by the High Court over many years.

36 It is arguable that these could be treated as coming within the 'marriage' power.

37 Constitutional Commission, *Final Report* (1988) 672.

38 *Australian Constitution* s 51 (xxxviii).

born outside marriage, the states referred power to the Commonwealth to make laws about these matters to cover all children. The Commonwealth was given the power to legislate about maintenance of children, payment of expenses in relation to children and child bearing, custody, guardianship and access to children and the determination of parentage for the purposes of Commonwealth laws. Following this reference of powers, the *Family Law Act 1975* (Cth) was amended to cover all children, regardless of whether or not their parents were married.

2.5 The reference of powers excludes the power to make adoption laws.³⁹ Thus the Victorian parliament can make laws about adoption and also about assisted reproduction, and the parentage of children conceived through assisted reproduction, for the purposes of other State laws.⁴⁰ The *Infertility Treatment Act 1995* regulates access to assisted reproduction in Victoria through the licensing of certain places and the prescribing of certain conditions, including eligibility for a treatment procedure.

THE RELEVANCE OF STATE LAW TO THE PARENTING OF CHILDREN CONCEIVED THROUGH ASSISTED REPRODUCTIVE TECHNOLOGY

2.6 Until children could be conceived through assisted reproduction, parentage was usually easily determined. Access to assisted reproductive technology (ART) meant rethinking whether biological parentage was the sole, or best way to determine parentage for the purposes of determining who should have parental responsibility. The *Status of Children Act 1974* defines who is a parent for the purposes of Victorian laws, including who is a parent of a child who has been born as a result of assisted conception. These definitions⁴⁰ apply to children born of assisted conception procedures whether they are conceived through the regulated system or not. Other Acts relevant to the child–parent relationship include the *Adoption Act 1984* and the *Infertility Treatment Act 1995*.

WHICH FAMILY RELATIONSHIPS ARE RECOGNISED IN VICTORIAN LAW?

2.7 In broad terms the *Infertility Treatment Act 1995*, the *Status of Children Act 1974* and the *Adoption Act 1984* recognise marriage and heterosexual de facto

39 *Commonwealth Powers (Family Law—Children) Act 1986* s 3. Child protection laws are also excluded.

40 See HA Finlay, Rebecca Bailey-Harris and Margaret FA Otlowski, *Family Law in Australia* (5th ed) (1997) reprinted in 2000 and 2002, paras 2.85–6.

relationships, but do not recognise same-sex relationships.⁴¹ The relationship provisions in these Acts have consequences for the legal recognition of the parent–child relationship and the possibility of forming a parent–child relationship through adoption.⁴²

2.8 Under Victorian law, where a child is born as the result of assisted reproduction, the resulting parental relationship is governed by the *Status of Children Act 1974*. When a child is born with the help of donor sperm or eggs to partners in a marriage or a heterosexual de facto relationship, with the consent of the woman’s partner, the child is the child of both partners to that relationship, and the parental relationship with the donor(s) is extinguished.

2.9 When a child is born as the result of use of donated sperm, to a woman who is not married or in a heterosexual de facto relationship, she is the mother of the child. Where a woman does not have a male partner, the Act says that the donor ‘has no rights and incurs no liabilities in respect of a child born as a result of a pregnancy occurring by reason of the use of [his] semen unless, at any time, he becomes the husband of the mother of the child’.⁴³ It does not specify that the semen donor is not the father of the child, The Act is silent as to whether a single woman or a woman in a same-sex relationship who bears the child conceived with the help of a donated egg, is the child’s mother.⁴⁴ If the birth mother is in a same-sex relationship, her partner is not recognised as a parent of the child.⁴⁵

2.10 The *Adoption Act 1984* regulates the adoption of children. It extinguishes the legal responsibilities of the biological parents, and confers the legal responsibilities of parents on the adoptive parents. It contains criteria for eligibility for adoption, which include relationship status. Single people, including people in same-sex relationships, are not usually eligible to adopt children.⁴⁶

41 For the purposes of the *Adoption Act 1984*, a heterosexual de facto relationship must be of at least two years duration (s 11(1)(c)).

42 See Chapter 2 paras 2.29–2.33, and Chapter 3, on the eligibility provisions of the *Infertility Treatment Act 1995* and the current status of the Act’s requirement that a woman is married or in a de facto heterosexual relationship before she can undergo treatment.

43 Section 10F.

44 Because of the eligibility requirements that currently regulate assisted reproduction, women may go overseas or interstate in order to have access to donated eggs. See 3.45–6.

45 This is explained in more detail in Chapter 5.

46 Eligibility to adopt is discussed in more detail at 5.59–64.

2.11 In Victorian law, same-sex relationships are now recognised in many pieces of legislation, but not in the Acts mentioned above. The notion of ‘domestic partnership’, the members of which can be of the same sex, was incorporated into most relevant Victorian law by the *Statute Law Amendment (Relationships) Act 2001*.⁴⁷ A primary question for this inquiry is whether the concept of the domestic partnership should be extended to laws relevant to the child–parent relationship.

THE RELEVANCE OF COMMONWEALTH LAW TO THE PARENTING OF CHILDREN CONCEIVED THROUGH ASSISTED REPRODUCTIVE TECHNOLOGY

2.12 The *Family Law Act 1975* (Cth) regulates divorce and its financial consequences and the maintenance, custody and access⁴⁸ to children, in all states and territories. Under the Act the Family Court has responsibility for determining disputes between parents and other significant figures in the child’s life. For example the Court can make orders about where the child will live (residence orders), contact between the child, their parents and relatives and other important people in the child’s life (contact orders) and about decision-making in relation to the child (special purpose orders).⁴⁹

2.13 The *Child Support (Assessment) Act 1989* (Cth) provides for the payment of child support for children who fall within the scheme,⁵⁰ according to a statutory formula, regardless of whether the child’s parents were ever married to each other.⁵¹ While parenting, residence and contact orders can be made in favour of people other than the legal parents, only a parent (which means a parent as defined under the *Family Law Act 1975* (Cth)) can be ordered to pay child support for a child under 18.

47 This was followed by the *Statute Law Further Amendment (Relationships) Act 2001*.

48 These terms are no longer used in the *Family Law Act 1975* (Cth), which now refers to residence, contact and special purpose orders.

49 See HA Finlay, Rebecca Bailey-Harris and Margaret FA Otlowski, *Family Law in Australia* (5th ed) (1997) paras 2.85–6.

50 The *Child Support (Assessment) Act 1989* (Cth) applies to claims for child support with respect to children born after 1 October 1989, or, if born before that date whose parents have separated on or after that date, or who have siblings who are eligible children (ss 19–21). The Family Court cannot make a maintenance order for a child who is eligible for child support.

51 The child maintenance provisions of the *Family Law Act 1975* (Cth) apply to children with respect to whom an application for child support cannot be made under the provisions of the *Child Support (Assessment) Act 1989* (Cth) Part VII, *Family Law Act 1975* (Cth).

2.14 Under the *Family Law Act 1975* (Cth) a parent may be required to maintain a child who falls outside the child support scheme.⁵² Only a parent (or in limited situations a step-parent) can be ordered to pay maintenance. For example a parent can be ordered to pay maintenance for a child aged 18 or more while the child is completing tertiary education, or for an adult child with a disability.⁵³

2.15 The *Family Law Act 1975* (Cth) contains specific provisions for the purpose of the Act and of the *Child Support (Assessment) Act 1989* (Cth) which define who are parents of children born as a result of assisted reproduction procedures.⁵⁴ As we discuss in Chapter 5, the *Family Law Act 1975* (Cth) provisions do not cover the full range of situations in which children may be conceived through assisted reproduction.

2.16 The rules under s 60H of the *Family Law Act 1975* (Cth) that determine the parents of a child born through assisted conception are very complex and differ according to whether the woman who bore the child was in a married or de facto relationship with a man or not. If the woman is in a married or de facto relationship with a man, then s 60H makes the man and the woman the parents of the child, where the procedure was carried out with both parties' consent, or the child is a child of the woman and the man under a prescribed State law. The provisions of the *Status of Children Act 1974* which say that married and heterosexual de facto partners are the parents of a child conceived as a result of use of donated semen or eggs, have been prescribed, making them parents for the purposes of Commonwealth as well as Victorian law.

2.17 However, if a woman who is not married or in a de facto relationship conceives a child through use of donated sperm or donated eggs or both, then s 60H has no operation in relation to Victoria.⁵⁵ The consequences of this are unclear, with different Family Court judges taking different views about the position of a sperm donor.⁵⁶ One view is that, because s 60H does not operate, the

52 *Family Law Act 1975* (Cth) s 66E.

53 *Ibid* s 66L.

54 Section 60H.

55 The *Family Law Regulations* (Cth) sch 6 prescribes laws for the purpose of determining the parentage of a child born to a married woman as the result of 'assisted conception'. *Status of Children Act 1974*, ss 10A-10E, are prescribed laws. Section 60H (2) says that a child born to a woman as the result of 'an artificial conception procedure' is to be treated as a child of the women whether or not there is a biological relationship between them, if the child is a child under a prescribed law. No Victorian law is prescribed for that purpose; see *Family Law Regulations 1984* (Cth) Sch 7.

56 See 5.21.

sperm donor is not regarded as a parent. Another view is that, where s 60H does not operate, the sperm donor may be regarded as a parent, at least in some circumstances. This difference of opinion is yet to be resolved. There is also uncertainty whether a single woman who bears a child conceived through use of a donated egg would be regarded as the child's mother under Commonwealth law.

THE REGULATION OF ASSISTED REPRODUCTIVE TECHNOLOGY IN VICTORIA

2.18 The *Infertility Treatment Act 1995* also regulates the use of assisted reproduction in Victoria. The main purposes of the Act are to regulate:

- fertilisation procedures and donor insemination procedures;
- access to information about these procedures; and
- research using human eggs, sperm and embryos.

The Act also makes provisions with regard to surrogacy arrangements, and aims to promote research into the incidence and causes of infertility.⁵⁷

2.19 Although the *Infertility Treatment Act 1995* is the primary instrument regulating ART in Victoria, the National Health and Medical Research Council (NHMRC),⁵⁸ a Commonwealth statutory authority, has issued national guidelines for ethical use of reproductive technology in clinical practice and research through its Australian Health Ethics Committee (AHEC).⁵⁹ However, where there is specific State legislation regulating assisted reproductive technology, the State statutory provisions must be observed, and in situations where both State law and the guidelines are applicable, State law prevails.⁶⁰ AHEC has recommended complementary legislation in all states and territories.⁶¹

57 Part 1.

58 The NHMRC has amongst its functions to raise the standard of individual and public health, foster the development of consistent health standards across Australia, and to foster consideration of ethical issues relating to health (s 3(1) of *National Health and Medical Research Council Act 1992* (Cth)).

59 The guidelines issued by the Council are not legally binding, but there is strong incentive for compliance because of the accreditation system (see para 2.26). These guidelines are currently being revised by AHEC after public comment. The use of embryos for the purposes of research is regulated by the *Research Involving Human Embryos Act 2002* (Cth).

60 This is noted in the guidelines, (para 1.1).

61 National Health and Medical Research Council, *Ethical Guidelines on Assisted Reproductive Technology* (1996), Background, para 5.

GUIDING PRINCIPLES

2.20 There are guiding principles, set out in the *Infertility Treatment Act 1995*, that are to be applied when people are undertaking any of the activities regulated by the Act.⁶²

- 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.

2.21 These are listed in the order of importance they are to be given when carrying out any of those activities. It follows that the welfare and interests of the child are of paramount importance.

2.22 The NHMRC's national guidelines for ethical use of reproductive technology provide similar principles to guide the practices of those people who are engaged in the field of assisted reproductive technology. The principles require consideration of:

- the long-term welfare of foetuses and of children born as a result of these technologies;
- the long-term welfare of the people who have recourse to these technologies;
- limits on embryo experimentation and research in deference to the human nature of the embryo; and
- regard to serving the whole society well with these technologies.⁶³

2.23 As mentioned, Victorian law overrides the guidelines if there is any conflict between the implementation of the Ethical Guidelines and the principles in the *Infertility Treatment Act 1995*.

2.24 In February 2003, the NHMRC released new draft guidelines for public consultation. Once released, these will replace the 1996 guidelines.⁶⁴ These draft

62 Section 5(1).

63 National Health and Medical Research Council, *Ethical Guidelines on Assisted Reproductive Technology* (1996), Introduction.

64 They will replace not only the 1996 guidelines, but also *Supplementary Note 5—The Human Fetus and the Use of Human Fetal Tissue* (1992).

guidelines have been informed by the principles outlined in the 1996 document, as well as the assumption that an adequate consideration of the ethical and social questions involved in ART should include an evaluation of the goals and the motives for which an activity is undertaken; the means used; the likely consequences; and the social significance of the activity.

WHO CAN CARRY OUT MEDICAL PROCEDURES UNDER THE ACT?

2.25 The *Infertility Treatment Act 1995* limits the people who can carry out assisted reproduction procedures. Most procedures⁶⁵ can only be carried out by an approved doctor at a licensed hospital or day procedure centre, or a licensed research institution.⁶⁶ Donor insemination can be performed outside a licensed place by an approved doctor.⁶⁷

2.26 The NHMRC guidelines stipulate that all centres offering assisted reproduction must obtain accreditation by a recognised accreditation body, this body being the Reproductive Technology Accreditation Committee (RTAC) of the Fertility Society of Australia (FSA).⁶⁸ RTAC's responsibilities include setting and monitoring standards for ART centres, and publishing a Code of Practice.⁶⁹ The Infertility Treatment Authority requires that clinics are accredited by RTAC, in order to be eligible for a licence under the *Infertility Treatment Act 1995*. All Victorian clinics are RTAC-accredited and are required to abide by RTAC requirements in addition to complying with Victorian law.

WHAT MEDICAL PROCEDURES ARE REGULATED BY THE ACT?

2.27 With respect to assisted reproductive technology, the *Infertility Treatment Act 1995* regulates certain activities called 'treatment procedures' and 'donor treatment procedures'. A treatment procedure is any one of the following:⁷⁰

65 This applies to 'fertilisation procedures' which are defined in s 3.

66 *Infertility Treatment Act 1995* s 6 and Pt 8.

67 *Ibid* s 6.

68 National Health and Medical Research Council, *Ethical Guidelines on Assisted Reproductive Technology* (1996), para 2.1. The Fertility Society of Australia is the peak body representing scientists, doctors, researchers, nurses, consumer groups, patients and counsellors in reproductive medicine in Australia and New Zealand (<http://www.fsa.au.com/>).

69 See Terms of Reference in Reproductive Technology Accreditation Committee Fertility Society of Australia, *Code of Practice for Centres Using Assisted Reproductive Technology* (Revised ed) (2002) 4.

70 *Infertility Treatment Act 1995* s 3.

- insemination of a woman with donor sperm;
- the transferral of an egg, or sperm, or both to the body of a woman; or
- the transferral to the body of a woman of an embryo formed outside the body.

2.28 A donor treatment procedure includes any of the above that involve the use of donor gametes (sperm or eggs) or donor embryos.

WHO CAN BE TREATED?

2.29 The *Infertility Treatment Act 1995* provides that a woman is only eligible to undergo a treatment procedure if she is married or in a heterosexual de facto relationship. However, this provision was the subject of successful legal challenge and women who are not married or in a heterosexual de facto relationship are now also eligible for treatment in certain situations.

2.30 To be eligible for treatment, a married woman or a woman in a heterosexual de facto relationship must be unlikely to become pregnant otherwise.⁷¹ In the case of a woman who is not in such a relationship with a man, this section of the Act has been interpreted to require that she is ‘clinically infertile’ to be eligible for treatment.⁷² This is discussed in more detail in Chapter 3.

2.31 A woman, whether in a marriage or de facto relationship with a man or not, is eligible for treatment if a genetic abnormality or disease might, in the opinion of a specialist in human genetics, otherwise be transmitted to the child.

2.32 The NHMRC guidelines do not address issues of eligibility for ART, and make clear that such social issues as eligibility, surrogacy, consent for posthumous use of sperm and embryos, genetic diagnosis and selection, and gene therapy, are outside their scope.

2.33 The FSA’s Code of Practice contains no guidelines on eligibility for acceptance into ART treatment programs. The Code does address a couple of specific access issues under the heading of consent.⁷³

71 *Infertility Treatment Act 1995* s 8. See Chapter 3 for more detailed discussion of eligibility criteria.

72 Opinion by Gavan Griffith QC for the Infertility Treatment Authority, 4 August 2000, available from the ITA. Another legal opinion, by Peter Hanks QC, applied a different interpretation. See para 3.9 for details.

73 The guidelines recommend that consent should include a directive from the person providing sperm or eggs as to what should be done with those gametes should the provider die or become incapable of varying or revoking consent. In a situation where an embryo has been formed and one partner of the

WHAT MUST HAPPEN BEFORE A WOMAN UNDERGOES A TREATMENT PROCEDURE?

2.34 The treating doctor must ensure that the provisions of the *Infertility Treatment Act 1995* covering eligibility, consent, counselling, use of donor gametes, and provision of information have been met before a woman undergoes a treatment procedure.⁷⁴ If the treating doctor does not comply with these requirements, the penalty is 480 penalty units or four years imprisonment or both.⁷⁵

CONSENT

2.35 The woman who is to undergo treatment, and her husband or male partner if she has one, must have consented to the kind of procedure to be carried out.⁷⁶ If donor sperm or eggs, or embryos formed from donor sperm or eggs are to be used, the donor/s must have consented to their use in the kind of procedure proposed.

2.36 If embryos are already formed and a woman or couple decides to donate them to another woman or couple, they must no longer be required by the people who formed the embryo or for whom the embryo was formed (where donor gametes were used). If the embryos were formed with donor sperm or eggs, then the man or woman donor must have consented to the use of the embryos formed in the kind of procedure proposed.⁷⁷

2.37 If a donor has a spouse at the time he or she is giving consent to these procedures, then the consent of the spouse must be obtained to the kind of treatment procedure to be carried out.⁷⁸

couple forming that embryo dies, the remaining partner should have responsibility for decisions regarding this embryo, taking into account any advance directive from the person who has died. Where both people have died, any advance directive from them should be complied with where possible, and otherwise the embryo should be allowed to succumb. (National Health and Medical Research Council, *Ethical Guidelines on Assisted Reproductive Technology* (1996) para 3.2.9).

74 These provisions are contained in Divisions 2, 3 and 4 of the Act, and *Infertility Treatment Act 1995* s 36.

75 *Infertility Treatment Act 1995* s 6.

76 *Ibid* s 8(2). The Act specifies the requirements as to consent in s 9.

77 These provisions are all contained in *Infertility Treatment Act 1995* s 12.

78 *Infertility Treatment Act 1995* s 13. The requirement for the spouse's consent does not apply if the donor and that spouse have ceased to live together on a genuine domestic basis at the time of the donation (s 13(2)).

2.38 If a woman or couple wish to use the sperm or eggs of a known donor, the donor (and the donor's spouse if any) must consent to the use of the sperm or eggs in the kind of procedure proposed, knowing that the donor has been identified.⁷⁹

COUNSELLING

2.39 Women who are to undergo treatment and, where applicable, their male partners, must receive counselling from an approved counsellor before receiving treatment.⁸⁰ The matters that must be addressed in counselling are:⁸¹

- (a) the options or choices available to the particular woman and her husband;
- (b) the law relating to infertility treatment in Victoria and the rights of the woman and her husband under that law;
- (c) the psychosocial and ethical issues related to infertility and infertility treatment procedures;
- (d) the possible outcomes of an infertility treatment procedure, including the success rates of such treatment;
- (e) any issue or concern raised by the woman or her husband in relation to the treatment procedure;
- (f) if donated gametes or embryos are to be used in the treatment procedure, the following—
 - (i) relationship issues for the family if one parent is, or both parents are, not the genetic parent or parents;
 - (ii) if applicable, the implications arising from using known donors, including the possible impact on interpersonal relationships;
 - (iii) issues relating to biological siblings born from the same genetic parents but reared in different families;
 - (iv) the information required under the Act for inclusion in the central register; and
 - (v) advising children about their donor origins and rights to information.

79 *Infertility Treatment Act 1995* s 18.

80 *Infertility Treatment Act 1995* s 11. In addition, counselling is required in relation to giving consent to research involving embryos (*Ibid* s 31).

81 *Infertility Treatment Regulations 1997* Reg 6. The regulations also prescribe the matter to be discussed if donated gametes are to be used by the woman or couple.

2.40 As we have explained above a single woman or a woman in a same-sex relationship can only have access to assisted reproduction if she is clinically infertile. The provisions requiring counselling of partners do not apply to same-sex partners.

PROVISION OF INFORMATION

2.41 The treating doctor must have provided information to the woman and her male partner, if any, on the procedure and its alternatives, so that she and her partner can make an informed decision about whether or not the woman should undergo the procedure.⁸² These provisions do not apply to a same-sex partner.

2.42 Before she undergoes the procedure, a woman and her male partner must provide the required information to be recorded by the licensed clinic.⁸³

USE OF DONOR GAMETES

2.43 The *Infertility Treatment Act 1995* prescribes the circumstances in which donor gametes can be used. Donor sperm or eggs, or both, cannot be used unless a woman is unlikely to become pregnant otherwise, or if a genetic abnormality or disease might otherwise be transmitted to the child.⁸⁴

WHO CAN DONATE GAMETES?

HEALTH PROVISIONS FOR DONATION OF SPERM AND EGGS

2.44 There are statutory conditions that apply to the screening of donors and the testing and quarantine of donated gametes. These conditions, and penalties applicable if a donor provides false information, can be found in the *Health Act 1958*.

2.45 The *Health Act 1958* contains provisions to prevent the transmission of human immunodeficiency virus (HIV) and Hepatitis C infection through the use of donated sperm or human tissue (including eggs), and protects a donor from liability for transmission of Hepatitis C and HIV if they comply with this Act. The Act specifies that certain actions must take place in relation to the use of human

82 *Infertility Treatment Act 1995* s10(1).

83 *Ibid* s 10(2).

84 *Ibid* ss 20(1),(2).

tissue or sperm in assisted insemination or a fertilisation procedure.⁸⁵ The donor must have completed a statement in the prescribed form, the donor's blood must have been tested at the time in the approved manner. The results of the testing must have been negative. In the case of the use of donated sperm, the donor's blood must have been tested again upon the expiry of the prescribed period and the sperm must not have been used until after the prescribed quarantine period.⁸⁶ This last provision does not apply to eggs.

2.46 The statement that the donor must complete is called the Tissue/Semen Donation Statement.⁸⁷ This statement contains the statutory requirements for donors of sperm and tissue. 'Tissue' includes both sperm and ova for the purposes of the *Health Act 1958*.⁸⁸ The donation statement must therefore be signed by all donors, whether donating sperm or eggs. As the Act's provisions only apply to Hepatitis C and HIV, the questions in this donation statement are directed towards determining risk for these infectious diseases.⁸⁹

2.47 FSA's Code of Practice contains criteria for eligibility regarding donation of gametes. These guidelines also include a donation statement, called the 'lifestyle declaration'.⁹⁰ This document contains the questions that FSA recommends asking donors of gametes, but they are not statutory obligations.

COUNSELLING OF DONORS OF SPERM, EGGS AND EMBRYOS

2.48 Under the *Infertility Treatment Act 1995* a donor, and his or her spouse (if any) must have consented to the use of the gametes in a treatment procedure.⁹¹ In order to give this consent, the donor and, where there is a spouse, the spouse, must receive counselling.⁹²

85 *Health Act 1958* s 133.

86 The quarantine period prescribed in the *Health (Infectious Diseases) Regulations 1990* is six months.

87 This statement is contained in Sch 7 of the *Health (Infectious Diseases) Regulations 1990*.

88 In Div 7 of the *Health Act 1958* 'tissue' has the same meaning as in s 3(1) of the *Human Tissue Act 1982*: 'tissue' includes an organ, or part, of a human body or a substance extracted from, or from a part of, the human body'.

89 The penalty if a donor makes a false statement is 50 penalty units or imprisonment for two years. (*Health Act 1958* s 136).

90 See Reproductive Technology Accreditation Committee Fertility Society of Australia, *Code of Practice for Centres Using Assisted Reproductive Technology* (Revised ed) (2002) Attachment H, section entitled 'Donor Lifestyle Declaration'.

91 Sections 12, 13(1).

92 Section 16.

2.49 Counselling must include discussion of the prescribed matters:

- (a) the motivation for donating...;
- (b) the requirements of the Act in relation to the disclosure of the identity of the donor to the Authority and to donor-conceived children if they seek that information;
- (c) the possible impact of donation on the donor's children;
- (d) the possible impact of donation on the donor's spouse;
- (e) any issue or concern raised by the donor or his or her spouse in relation to the donation;
- (f) in the case of a known donor, the impact on the donor's relationship with the recipients;
- (g) the general requirements of the Act relating to donors.⁹³

WHAT ARE THE INFORMATION PROVISIONS REGARDING ART PROCEDURES?

2.50 The *Infertility Treatment Act 1995* requires the recording of certain information by licensed centres, by the treating doctor if he or she is treating people at a place other than a licensed centre.⁹⁴ Certain information must be given by these licensed centres and doctors to the Infertility Treatment Authority, including prescribed information about donors and about births that have occurred as the result of donor treatment procedures.⁹⁵ The Authority keeps registers of this prescribed information, and access to these registers for the purpose of obtaining or correcting information is available under certain conditions to donors, parents and children born of donor treatment procedures.⁹⁶

WHAT CAN BE DONE WITH HUMAN REPRODUCTIVE TISSUE?

2.51 The *Infertility Treatment Act 1995* regulates the storage, and import and export of gametes and embryos.

93 *Infertility Treatment Regulations 1997* Reg 7.

94 Sections 62, 63.

95 Sections 66, 67.

96 Sections 68–82.

2.52 The storage provisions of the Act provide for the purpose and place of storage, requirements as to consent to storage, and the removal from storage of gametes and embryos.⁹⁷

2.53 The Act bans both bringing into Victoria and taking out of the State gametes or embryos (if outside the human body). The Infertility Treatment Authority can provide approval for either import or export of gametes or embryos, either on a case-by-case basis, or in circumstances which fit a general case.⁹⁸ If the Authority grants the exemption on the import ban, they may also exempt the gametes or embryos, or the donors of these, from other provisions of the Act, including some of the consent provisions, those relating to objection by a later spouse, counselling for the donor, the donor's giving and receiving of certain information, withdrawal of consent, and storage.⁹⁹ If the Authority grants the exemption from the export ban, they may also exempt a person in relation to the gametes or embryos from compliance with the provisions limiting the use of embryos to treatment procedures and approved research within the terms of the Act, some storage provisions and the confidentiality provisions.¹⁰⁰ These exemptions only apply if the Authority is satisfied that similar procedures have taken place outside Victoria or that there are special circumstances.

WHAT RESEARCH CAN BE DONE?

2.54 The *Infertility Treatment Act 1995* prescribes the conditions under which research can be conducted on human gametes and embryos, and stipulates requirements with respect to people who can undertake such research. It bans certain activities, such as research on non-excess ART embryos.¹⁰¹ We do not discuss issues relating to research in this paper, as they are not within the terms of reference

97 Sections 51–5.

98 Section 56 (1–3).

99 Section 56 (4).

100 Commonwealth legislation now regulates the use of excess ART embryos for research purposes, including research that will harm the embryo (*Research Involving Human Embryos Act 2002* (Cth)). The *Customs (Prohibited Exports) Amendment Regulations (No. 2) 2003* (Cth) No. 44 impose conditions under which embryos can be exported from Australia. An application to export embryos must be made in writing to the Minister for Justice and Customs by the prospective mother or, if she is not alive, by her spouse at the time the embryo was created or donated. This regulation remains in force for a year from its commencement in March 2003.

101 *Infertility Treatment Act 1995* s 24.

WHICH ASPECTS OF SURROGACY DOES THE *INFERTILITY TREATMENT ACT* REGULATE?

2.55 The Act also regulates surrogacy by:

- making all surrogacy arrangements void.¹⁰² This means that any surrogacy arrangement that people make, whether it occurs within a licensed clinic or not, is unenforceable, but not that it is prohibited.
- prohibiting surrogacy for commercial gain.¹⁰³
- prohibiting advertising that either seeks a surrogate mother or offers a person as a surrogate mother.¹⁰⁴

2.56 A surrogacy arrangement not made for commercial gain is subject to all the requirements of the Act. This means that a woman who was to be treated for the purposes of carrying a child for another person (the ‘surrogate’), and her male partner if she has one, are subject to the requirement that she is ‘unlikely to become pregnant’ except with the assistance of a treatment procedure.

WHO ADMINISTERS THE PROVISIONS OF THE *INFERTILITY TREATMENT ACT*?

2.57 The *Infertility Treatment Act 1995* established the regulatory body to oversee the implementation of the Act in Victoria, the Infertility Treatment Authority (ITA). The ITA’s functions include compiling and providing access to records, administering licensing and approvals systems, monitoring compliance, considering requests for extensions to storage periods, and approving the import or export of gametes or embryos.¹⁰⁵

102 Section 61.

103 An opinion provided to the ITA by Gavan Griffith QC states that this provision does not capture payments for medical services (Opinion by Gavan Griffith QC dated 6 June 2001, provided to the Victorian Law Reform Commission by the ITA).

104 Sections 59, 60.

105 Section 122.

Chapter 3

Access to Assisted Reproductive Technology in Victoria

INTRODUCTION

3.1 This Chapter discusses the current eligibility criteria for assisted reproductive technology (ART) in Victoria. It explains who was eligible under the original legislation regulating ART, the challenges that have been made to those criteria, and the current situation. In Chapter 4, we ask you to consider what changes Victoria should make to the eligibility criteria.

ACCESS AND ELIGIBILITY CRITERIA FOR ART IN VICTORIA: THE CURRENT LAW

3.2 The *Infertility Treatment Act 1995* regulates access to ART in Victoria by identifying the people who may undergo treatment and under what conditions they may do so.¹⁰⁶

3.3 The Act requires that for a woman to have a treatment procedure (being either a donor insemination procedure or a fertilisation procedure¹⁰⁷) she must be

106 These provisions apply to people who are undergoing treatment as part of a surrogacy arrangement. See Chapter 6 for detailed discussion of surrogacy issues.

107 As defined by the *Infertility Treatment Act 1995* s 3(1), a ‘treatment procedure’ means—
 (a) artificial insemination of a woman with sperm from a man who is not the husband of the woman; or
 (b) a fertilisation procedure’.
 A fertilisation procedure is defined as:
 (b) the medical procedure of transferring to the body of a woman an embryo formed outside the body of any woman; or
 (c) the medical procedure of transferring—
 (i) an oocyte, without also transferring sperm, to the body of a woman; or
 (ii) sperm (other than by artificial insemination) to the body of a woman; or
 (iii) an oocyte and sperm to the body of a woman’.

married or in a heterosexual de facto relationship. However, since *McBain v The State of Victoria & Ors (‘McBain’)*¹⁰⁸ (described below), this requirement cannot be imposed.

3.4 The Act also stipulates conditions that must apply before a woman undergoes a procedure:¹⁰⁹

- In the opinion of a doctor, she must be unlikely to become pregnant with her own egg and her husband’s sperm other than by a treatment procedure; or
- In the opinion of a doctor with specialist qualifications in human genetics, she must be likely, if she becomes pregnant with her own egg and her husband’s sperm, to give birth to a child with a genetic abnormality or risk communicating a disease to a child unless she undergoes a treatment procedure.

3.5 If a woman is married or in a heterosexual de facto relationship, she must have the consent of her husband/partner to undergo the procedure.¹¹⁰

DOES A WOMAN HAVE TO BE MARRIED OR LIVING IN A HETEROSEXUAL DE FACTO RELATIONSHIP TO BE ELIGIBLE FOR TREATMENT?

3.6 Originally, the Act provided that only a woman who was married was eligible for a treatment procedure.¹¹¹ Eligibility was later expanded to include women in heterosexual de facto relationships, as a result of legal challenges to the marriage requirement.¹¹² In 2000, the *Infertility Treatment Act 1995* requirement

108 [2000] 99 FCR 116.

109 *Infertility Treatment Act 1995* s 8(3).

110 *Infertility Treatment Act 1995* s 8.

111 The first legislation regulating ART in Victoria, the *Infertility (Medical Procedures) Act 1984* enabled access to treatment procedures for married women (s 10(3)(a)). Sections 11(3)(a) and 12(3)(a) provided that a woman undergoing a procedure involving donor gametes must be married. The only situation in which a woman who was not married could have access was when she was living with a man on a genuine domestic basis although not married and she had already begun treatment that would come within the ambit of the Act (Section 2). The 1984 Act was revised and a new Act proclaimed in 1995, the *Infertility Treatment Act 1995*; the marriage requirement did not change but heterosexual de facto couples were made eligible for treatment (*Infertility Treatment (Amendment) Act 1997* s 7).

112 Unmarried heterosexual couples were ineligible for ART treatment in Victoria from 1984 until 1997, when three unmarried couples challenged this limitation (*MW, DD, TA and AB v Royal Women’s Hospital* [1997] HREOCA 6 (5 March 1997)) <http://www.austlii.edu.au>. The basis of the complaint was that the Victorian Act was in contravention of the Commonwealth *Sex Discrimination Act*, s 22,

that a woman had to be married or living in a heterosexual de facto relationship was challenged in the Federal Court by Dr John McBain, a Melbourne specialist in reproductive medicine.¹¹³ The grounds of this challenge were that the conditions of eligibility prescribed by the Act were inconsistent with the provision in the *Sex Discrimination Act 1984* (Cth). Dr McBain could not obey both laws when deciding who to treat: he could not comply with the Commonwealth Act's prohibition of discrimination on the basis of marital status¹¹⁴ and also comply with the Victorian Act that required him to discriminate on that basis. Dr McBain's challenge was successful.¹¹⁵ As a result of this case, a woman is not barred from undergoing a treatment procedure simply because she is not married or not in a heterosexual de facto relationship.¹¹⁶

3.7 The current situation is that a provider cannot discriminate on the basis of marital status in the provision of reproductive specialist services. However, as we discuss below, *McBain* did not clarify how the 'unlikely to become pregnant' requirement should be applied to women without male partners, whether they were single or in same-sex relationships.

which prohibits discrimination on the basis of marital status. The challenge in *MW v Royal Women's Hospital* was successful, and damages were awarded to the three couples. The *Infertility Treatment Act* was amended in 1997 to allow a woman who was living with a man in a de facto relationship to undergo a treatment procedure.

In 1999, a complaint by a single woman was made to the Human Rights and Equal Opportunity Commission on the ground that the Royal Women's Hospital had discriminated against her on the basis of her marital status (s 22 of the *Sex Discrimination Act 1984* (Cth) (*W v D and Royal Women's Hospital* (unreported, Human Rights and Equal Opportunity Commission, NoH97/221, 24 December 1999)). In determining in favour of the complainant and awarding damages, the Commissioner took the same approach as the Commissioner in *MW v Royal Women's Hospital*: that the Victorian Act was no defence against a discrimination claim under the SDA. (See Kristen Walker, '1950s Family Values vs Human Rights: In Vitro Fertilisation, Donor Insemination and Sexuality in Victoria' (2000) 11 *Public Law Review* 292, 294)

113 *McBain v The State of Victoria & Ors* [2000] 99 FCR 116. This decision was unsuccessfully challenged in the High Court ([2002] HCA 16).

114 *Sex Discrimination Act 1984* (Cth) s 22.

115 After the decision in *McBain*, which rendered the marriage requirement of the *Infertility Treatment Act* invalid because it was incompatible with the provisions of the *Sex Discrimination Act 1984* (Cth), the Commonwealth Government introduced into Parliament a bill to amend the Act in order to allow states to discriminate against women on the basis of marital status in the provision of ART services. This bill did not pass.

116 A de facto relationship, as defined in the *Infertility Treatment Act 1995* s 3(1), is necessarily heterosexual: 'de facto relationship' means the relationship of a man and a woman who are living together as husband and wife on a genuine domestic basis, although not married.

DOES A WOMAN HAVE TO BE INFERTILE TO RECEIVE TREATMENT?

3.8 The *Infertility Treatment (Amendment) Act 1997* requires a doctor to decide that a woman is ‘unlikely to become pregnant’ other than by a treatment procedure before she is eligible for assisted reproduction through a licensed clinic. The Act does not require a finding of ‘infertility’ or stipulate that a woman must have a particular type of infertility, such as ‘medical’ or ‘clinical’ infertility. It does not specify any factor a doctor must take into account in determining the unlikelihood of the woman becoming pregnant. Nor does the Act define the phrase ‘unlikely to become pregnant’.

3.9 As a result of *McBain*, the Infertility Treatment Authority (ITA) sought a legal opinion to clarify how the requirement that a woman must be ‘unlikely to become pregnant’ applies to a woman who is neither married nor in a heterosexual de facto relationship.¹¹⁷ The legal opinion, by Gavan Griffith QC, was that a woman who does not have a husband or de facto male partner must be clinically infertile to be eligible for treatment. However, an opinion by Peter Hanks QC contradicting Griffith’s advice was also supplied to the ITA.¹¹⁸ Hanks argued that Griffith’s interpretation reimposes the discrimination on the basis of marital status that the Federal Court decision ruled unlawful. That is, following Griffith’s advice, a married woman or a woman in a de facto relationship does not have to be clinically infertile to be eligible for a treatment procedure, whereas a single woman does have to be clinically infertile to be eligible.

3.10 The Infertility Treatment Authority sought a supplemental opinion from Gavan Griffith, in which he responded to Hanks’ opinion and confirmed his original interpretation.¹¹⁹ The ITA took up Griffith’s advice, and advised licensed clinics that women who were not married or in a heterosexual de facto relationship should not be treated unless they were medically assessed as clinically infertile.

117 Griffith was also asked to consider the operation of the consent provision (s 8(2)) to a woman who does not meet the marriage requirement, and the continued application of the Victorian Act to a woman who complies with the marriage requirement. Opinion by Gavan Griffith QC, 4 August 2000, available from the ITA.

118 Opinion by Peter Hanks QC, 18 August 2000, supplied by the Fertility Access Rights Lobby to the Victorian Government and the ITA. Cited in Kristen Walker, ‘1950s Family Values vs Human Rights: In Vitro Fertilisation, Donor Insemination and Sexuality in Victoria’ (2000) 11 *Public Law Review* 292, 298.

119 Supplemental Opinion by Gavan Griffith QC, 12 September 2000. Copy provided to the Victorian Law Reform Commission by the ITA.

ASSESSING INFERTILITY

3.11 The implementation of Griffith's advice has meant that a term that is not defined or mentioned in the Act—the term 'clinical infertility'—has been necessarily introduced into doctors' deliberations upon eligibility in some cases.¹²⁰ The Act itself only requires a doctor to determine that a woman is 'unlikely to become pregnant', a phrase that is capable of wide interpretation. However, this phrase 'unlikely to become pregnant' is now narrowly interpreted with respect to women who are not married or in heterosexual de facto relationships. It is interpreted to mean 'clinically infertile', a phrase that is not open to wide interpretation. The wording of the Act, however, would leave open the interpretation that a woman without a male partner is 'unlikely to become pregnant' and is therefore eligible for treatment.

3.12 'Clinical infertility' is also a difficult term to define. This difficulty does not arise with the current Act because the term is not used to assess eligibility. In its use of the term 'unlikely to become pregnant', the Act covers the range of difficulties that is often referred to as 'infertility'. The difficulties involved in defining infertility are well known to specialists in reproductive medicine. Robert Jansen, Medical Director at Sydney IVF, says that infertility is often unexplained: 'pregnancy seems possible, but it has not yet happened'.¹²¹ 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).¹²² The adoption of Griffith's advice has meant that a term that is difficult to test—'clinical infertility'—has become the basis of a test for eligibility for some women, and non-clinical or 'social' factors cannot be considered.

3.13 Before the decision in *McBain*, which eliminated the requirement to be married or in a heterosexual de facto relationship, the only people who could access ART treatment were in heterosexual relationships. Therefore, during that time the test for 'unlikely to become pregnant' could be readily applied: where the couple who present for treatment had not achieved a pregnancy with adequate and timely sexual intercourse for at least 12 months, the specialist doctor could assess the

120 *Infertility Treatment Act 1995* s 3 contains the terms defined in this statute.

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

122 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.

problem and determine the appropriate treatment based on the medical examination, which includes taking patient histories.¹²³ The cause of the infertility—whether it was the result of a medical problem or due to some other cause—might or might not be established during consultations and may or may not be established during the course of treatment. Establishing the type of infertility, or the causes of infertility, was not necessary for the couple to be eligible for treatment. This is still the case for married and heterosexual women in de facto relationships seeking treatment.

3.14 Since the decision in *McBain*, women who are not in marriages or de facto heterosexual relationships are eligible to undergo a treatment procedure, but only, since Griffith's advice, if they are clinically infertile.¹²⁴ A test for infertility is difficult to apply to women who do not engage in sexual relations with men, or who do so infrequently. Unless the treating doctor can identify a source of clinical infertility—such as symptoms of endometriosis or blocked fallopian tubes,¹²⁵ or a previous diagnosis of infertility—then the woman is not eligible for treatment. This means that the range of infertilities for which a married or heterosexual de facto couple can be treated does not apply to a woman who does not have a male partner.

3.15 In summary, eligibility of most women¹²⁶ for a treatment procedure is determined by infertility. For married women or women in heterosexual de facto relationships, this infertility has the widest meaning: they must otherwise be unlikely to become pregnant. For women who do not meet the relationship requirements, the type of infertility is 'clinical infertility', a term with much narrower meaning. At the moment, eligibility is therefore largely tied to questions of fertility and infertility.

123 Failure to conceive after 12 months of regular heterosexual intercourse is regarded as the time to initiate medical investigations to determine whether there is a distinguishable and potentially reversible cause for the reduced fertility (Dr Ruth McNair, Department of General Practice, University of Melbourne).

124 See Decision of Sundberg J, *McBain v the State of Victoria & Ors*, [2000] 99 FCR 116, para 10.

125 Endometriosis: a presence of endometrial tissue (the normal uterine lining) in abnormal locations such as the fallopian tubes, ovaries and peritoneal cavity (abdomen). (Monash IVF, *Guide to Getting Started* (2003) 26). The fallopian tubes carry the egg from the ovary to the body of the uterus, and fertilisation occurs in the outer end of the tube. These tubes can become blocked as a result of infection or adhesions. Once damage has occurred it cannot wholly be repaired. (Sydney IVF website, accessed 11 November 2003, http://www.infertility.net.au/fallopian_tube.htm)

126 Other conditions of eligibility are discussed in the following pages.

3.16 'Psychological infertility' is a term that was introduced into public debate in Victoria in 2001 when the Infertility Treatment Authority produced guidelines to address certain aspects of infertility. Such aspects include infertility that results from inability to have sexual intercourse: for example, this covers women who have been sexually abused or assaulted and who cannot contemplate penetrative sex with a man. Women may fall into this category whether they are married or in a heterosexual relationship, single or in a same-sex relationship. A woman in a heterosexual relationship who is unable to have intercourse because of prior sexual assault would currently be eligible for treatment; a woman without a male partner would not be.

3.17 At the time that guidelines regarding psychological infertility were produced, there was also discussion about whether all women in same-sex relationships might be regarded as psychologically infertile. However, the lesbian community as well as many doctors did not support the use of the term 'psychological infertility' in this way, as it risks labelling the women to whom it is applied as having a psychological or psychiatric problem. For example, in order for this 'diagnosis' to be applied, women might be required to see a psychiatrist.¹²⁷

3.18 The ITA's guidelines were withdrawn. A private members bill was subsequently introduced into Parliament to try to address the definition of infertility, but this bill lapsed.

THE ELIGIBILITY CRITERIA IN OPERATION

3.19 The following case studies show a range of situations in which people are or are not eligible for treatment under the current eligibility criteria. The case studies are designed to show the range of situations in which people might be refused treatment, and to provide some examples of the anomalies that arise in the operation of the current eligibility criteria. These cases show the difficulty of applying a two-tiered system of defining infertility depending on whether a woman is married or in a heterosexual de facto relationship or not, and of applying a narrow definition of infertility in some circumstances. Difficulties such as these are experienced by patients and by treating doctors in the current system.

127 Dr Ruth McNair, Department of General Practice, University of Melbourne.



CASE STUDY 1

Devena and Matthew have been married for 12 years. Devena is 32 years old and she and Matthew have been trying to conceive for the past 18 months. A medical interview reveals that Devena and Matthew have been having sex regularly, particularly during the middle (fertile) part of Devena's cycle. She has a past history of two terminations of pregnancy in her early 20s. She has had very painful periods over the past five years or so. A laparoscopy reveals that she has endometriosis, which is treated during the procedure, and blocked fallopian tubes. Matthew and Devena are advised to undergo IVF rather than attempt a surgical procedure to unblock the tubes. Devena achieves a pregnancy on her third embryo transfer.



CASE STUDY 2

Rivka and her partner Margie have been together for 12 years and want to have a child. Margie had a full hysterectomy as a young woman and is therefore unable to either carry a child or produce eggs. Rivka has had painful periods over recent years and, on being referred to a gynaecologist to treat this symptom, was diagnosed with an endometrial cyst. She explained to the gynaecologist that she would like to conceive a child and was told that her chances were likely to improve significantly if the cyst was removed and the endometriosis treated. As these conditions are both positive indicators for treatment through IVF procedures, Rivka is eligible for treatment through the Victorian clinic system. They proceed with IVF treatment using sperm from their friend David, who has agreed to be a known donor.

3.20 In the above case studies, a heterosexual couple and a lesbian couple are both eligible for treatment in Victoria. Both have diagnosed medical or clinical infertility.

*** CASE STUDY 3**

Sue and Marco have been married for four years and would like to have a family. Their sex life has never involved penetrative sex, because Sue has always had an aversion to penetration. Marco has a sperm test which reveals normal fertility. Sue is offered, and accepts, counselling, but does not feel that it has shifted her feelings about penetration. After this, Sue's doctor suggests that Sue undergo insemination with Marco's sperm, and she becomes pregnant four months later.

*** CASE STUDY 4**

Leslie is a 38-year-old woman who has wanted children ever since she can remember. She has had several sexual relationships, but has never met a man she could imagine having a child with, and in the last seven years, she hasn't met a man she has wanted to become involved with. She has a very old friend, Stephen, whom she has known since they were both 18. Stephen has offered many times to help her to have a child, to whom he would like to be a special uncle, and Leslie thinks, at 38, that she probably will not find a partner and can't afford to wait. Leslie and Stephen discuss how they would go about conceiving, and both are adamant that it is important to preserve their friendship. Sex, for both of them, would complicate things enormously. Stephen's partner, Amy, is 44 and has a 21-year-old daughter whom she raised on her own. She is supportive of Stephen's desire to help Leslie and would enjoy having a child around from time to time. But she does not want them to have sex.

3.21 In these case studies there are no medical or clinical reasons for the person seeking treatment not to have sex, however neither of them wish to have sex in order to conceive. Sue is eligible for treatment because she is in a relationship recognised by the Act, whereas Leslie and Stephen are not eligible because Leslie is not in a relationship recognised by the Act.

**CASE STUDY 5**

Dana has been pregnant three times and has had three terminations. She had never been in a stable relationship and had never wanted children but each decision to terminate the pregnancy was harder than the last. She decided to have a tubal ligation, even though several doctors and many friends warned her that it was a very big decision for a relatively young person and one she may regret. She thought at the time that the regret she suffered about the terminations was a sufficient reason to go ahead with it, particularly as she was convinced that she would never wish to have a child. Some years later she met Bradley and realised that her feelings had completely changed. Having met and married the man she loves she now wishes to have children with him. She and Bradley consult a fertility specialist who advises them that it is less invasive and more likely to be successful to undergo IVF treatment than it would be to reverse the tubal ligation and try to conceive through intercourse. They go ahead with IVF and Dana becomes pregnant on the first embryo transfer.

**CASE STUDY 6**

Penny has been with Costas for 10 years, but they have lived separately for most of that time. Costas now lives with his aged mother, and wishes to look after her in her own home for as long as she needs this care. Penny does not wish to live with them, but both Penny and Costas would like to have children. Costas had a vasectomy in his mid-20s, and they have been advised that a reversal would be unlikely to succeed after a period of 13 years. However, Penny has no fertility problems and so is not eligible for treatment as a single woman, and nor is her relationship with Costas recognised by the Act. They are therefore not eligible for treatment with donor sperm.

3.22 In these cases, people have made so-called ‘lifestyle’ choices that have meant that they are infertile. In the first case study, the couple is eligible for treatment because their relationship is recognised by the Act. In the second case study, the couple is not eligible, because their relationship is not recognised by the Act.

*** CASE STUDY 7**

Kylie and Dave have been in a de facto relationship for five years and attempting to get pregnant for the past year. They see a GP. Dave has a sperm test that reveals he has no sperm at all, therefore he is completely infertile or sterile. Kylie is offered donor insemination.

*** CASE STUDY 8**

Sharon and Cheryl have been in a relationship for five years and have unsuccessfully attempted to find a sperm donor for the past year. They see a general practitioner, but learn that they are unable to have donor insemination in Victoria.

3.23 These two cases highlight the fact that the heterosexual couple is regarded as infertile, and the fertile woman can be offered donor insemination, whereas the lesbian couple is not regarded as infertile under the *Infertility Treatment Act 1995* and its current interpretation.

3.24 These case studies illuminate the importance of the question, should infertility be a requirement for eligibility for a treatment procedure, and if so, how should it be defined? If infertility is not a useful term for determining eligibility, should the unlikelihood of a woman becoming pregnant otherwise remain the legislative criterion for eligibility. If so, how should the phrase 'unlikely to become pregnant' be interpreted? These case studies also raise questions about whether eligibility should depend at all on the type of relationship one is in, as is the case in Case Studies 5 to 8.

ARE THERE ANY OTHER CRITERIA FOR ELIGIBILITY FOR ART TREATMENT?***TRANSMISSION OF A GENETIC ABNORMALITY OR DISEASE***

3.25 The *Infertility Treatment Act 1995* provides one other criterion which would allow a woman to undergo a treatment procedure. A woman is eligible if, in

the opinion of a specialist in human genetics, she is at risk of transmitting a genetic abnormality or a disease to a person born as a result of the pregnancy.¹²⁸



CASE STUDY 9

Krista and Judith are a couple. They approached Malcolm to be a sperm donor for them, and Malcolm agreed. Krista is a carrier of (but not herself affected by) haemophilia, a serious medical condition which can only affect her male offspring. Her general practitioner recommends that she seeks treatment in the licensed clinic system so that her embryos may be tested prior to implantation and only female (unaffected) embryos transferred. Malcolm agrees to provide sperm to the clinic for Krista's use only.

3.26 Krista will be eligible for treatment in Victoria; however, her partner Judith will not as she does not have a genetic condition and nor is she clinically infertile. In this case study, a woman in a same-sex relationship who is not clinically infertile is eligible to have a child using donor sperm, because she risks transmitting a genetic abnormality to the child.

IS THERE AN AGE LIMIT FOR ANYONE UNDERGOING TREATMENT?

3.27 In Victoria, no upper age limits apply to a woman undergoing a treatment procedure, and nor does an age limit apply to her husband or de facto partner, if she has one. In those states that have followed the Victorian model, no upper age limits are set. A doctor assesses the appropriateness of treating all women who are eligible for treatment on a case-by-case basis as part of the initial medical examinations. Age may be a relevant clinical factor in this assessment.

3.28 The majority of women seeking treatment at licensed clinics are no older than the mid-40s.¹²⁹ The majority of older women seeking treatment are therefore trying to conceive a child at the less fertile end of their own reproductive capacity. However, if a woman was post-menopausal and was able to access donor eggs, and provided there was no clinical reason for not proceeding, she would be eligible for a treatment procedure under the current eligibility provisions. There have been

128 Section 8(3)(b).

129 Information provided by Rita Alessi, Head Counsellor, Monash IVF.

cases in Australia of women who are well beyond the naturally occurring age-range for conception who have had children through ART. For example, in South Australia in 1998 a 53-year-old woman gave birth to triplets. This case created controversy and prompted a review of the South Australian provisions. No age limit was set but guidelines were produced for assessing risk factors in individual cases.¹³⁰

3.29 Perhaps the most controversial cases have been in Italy. Italian doctor Professor Severino Antinori gained worldwide attention after he began treating post-menopausal women in 1989. In 1994, Antinori carried out IVF on Rosana Della Cortes, who, at 63, became the oldest known woman to have given birth.¹³¹

THE ROLE OF COUNSELLING IN THE ELIGIBILITY ASSESSMENT

3.30 In Victoria, whether or not to treat a woman or a couple is primarily the doctor's decision, having due regard for the statutory requirements. However, women who are to undergo treatment and, where applicable, their partners, must receive counselling from an approved counsellor before receiving treatment.¹³² The primary function of this counselling is prescribed in law, and includes the choices available; the possible outcomes of infertility treatment procedures; a range of issues related to both infertility and infertility treatment procedures; and the rights of the woman and, if applicable, her partner, under the *Infertility Treatment Act 1995*.¹³³

3.31 Counselling does not focus on eligibility. However, counsellors, like all others involved in the provision of ART services, have a statutory obligation to make the interests and welfare of the child to be born paramount in the provision of ART services. During counselling, something may arise that a counsellor thinks could seriously impair a person's functioning as a parent. Such an impairment could be a significant psychiatric condition or intellectual disability, or evidence of significant substance abuse. In such situations, counsellors may seek another expert opinion, such as from a psychiatrist; alternatively, cases may be subject to internal assessment by peers within individual clinics. This process may result in people

130 South Australian Council on Reproductive Technology, *Age and Eligibility Report*, (2000), 2–3.

131 Domenico Pacitti, 'Catholic Church vs Saviour of Childless', *The Times Higher Education Supplement* (London) 6 October 2000

132 *Infertility Treatment Act 1995* s 11.

133 *Infertility Treatment Regulations 1997* Reg 6. The regulations also prescribe the matters to be discussed if donated gametes are to be used by the woman or couple. See Chapter 1 of this Consultation Paper for details.

being told they cannot commence treatment. If treatment is refused, the person can appeal through a patient representative, and this appeals process will be explained to them at the time of the refusal.¹³⁴

SUMMARY OF THE LEGISLATIVE RESTRICTIONS REGARDING ELIGIBILITY FOR TREATMENT PROCEDURES

3.32 In summary, the *Infertility Treatment Act 1995* currently operates in the following way regarding eligibility for treatment procedures:

- A single woman must be clinically infertile to be eligible for a treatment procedure,¹³⁵ or be at risk of having a child with a genetic abnormality.
- A woman in a same-sex relationship¹³⁶ must be clinically infertile to be eligible for a treatment procedure, or at risk of having a child with a genetic abnormality.
- A woman in an unmarried heterosexual relationship who does not live with her partner on a genuine domestic basis (ie a woman who is not regarded as living in a heterosexual de facto relationship) must be clinically infertile to be eligible for a treatment procedure, or must be at risk of having a child with a genetic abnormality.
- A woman who is married or in a de facto heterosexual relationship must be unlikely to conceive with her husband or partner, or be at risk of having a child with a genetic abnormality, and she must have the consent of her husband or de facto partner to undergo a treatment procedure.
- A woman, and, if applicable, her husband or de facto heterosexual partner, must receive counselling before undergoing a treatment procedure.
- There is no upper age limit for a woman undergoing a treatment procedure.

134 Conversations with Jenny Blood, Head Counsellor, Melbourne IVF and Rita Alessi, Head Counsellor, Monash IVF.

135 The requirement for ‘clinical infertility’ is not stipulated in the Act, but is the interpretation of the Act in operation following Sundberg J’s decision and Griffith’s advice. See earlier discussion beginning at para 3.8.

136 While many areas of State law now recognise lesbian relationships with the concept of ‘domestic partnership’, lesbian relationships are not recognised in the *Infertility Treatment Act 1995*. A woman who is in a same-sex relationship and who presents for treatment is single for the purposes of the Act.

ARE THERE ANY OTHER SITUATIONS IN WHICH PEOPLE WHO WISH TO ACCESS TREATMENT CANNOT?

USE OF GAMETES FROM A PERSON WHO HAS DIED

3.33 The *Infertility Treatment Act 1995* prohibits the use in an insemination or fertilisation procedure of sperm or ova from a person who is known to be dead.¹³⁷ It does not prohibit the use of an embryo formed with the gametes of a person who has since died. The Fertility Society of Australia's (FSA) Code of Practice also addresses the question of the use of gametes or embryos from a person or persons who have died. It recommends, under the heading of 'general storage', that any person consenting to the storage of gametes or embryos produced from them should state what is to be done with them if he or she dies or becomes incapable of varying or revoking consent.¹³⁸

3.34 This question arises in a very pressing sense if, for example, a woman's male partner dies and she wishes to retrieve his sperm in order to become pregnant. Such a case occurred recently in Victoria where a woman, known as AB, was ultimately denied this possibility.¹³⁹



CASE STUDY 10

Rochine's husband Peter died in his sleep at the age of 40, with no prior signs of ill-health. The couple already had one child, and had discussed having another. Rochine would like to retrieve semen from Peter so she can try to conceive with his sperm.

137 Section 43.

138 Reproductive Technology Accreditation Committee Fertility Society of Australia, *Code of Practice for Centres Using Assisted Reproductive Technology* (Revised ed) (2002) Attachment D, 'General storage', (para 10.1).

139 In *AB v Attorney-General*. Unreported decision of Justice Gillard, Supreme Court of Victoria, 21 July 1998, referred to in Sheila A M McLean, see below. Gillard J held that the sperm should be removed from the deceased man's body and should not be used for any purpose until further order. Because the man and his wife both resided normally in the Australian Capital Territory, but he was a temporary resident in Victoria for work purposes, Gillard J referred to s 43 of the *Infertility Treatment Act 1995* which allows for the export of gametes with the permission of the Infertility Treatment Authority. This permission was not granted. (See Sheila A M McLean, 'Post-Mortem Human Reproduction: Legal and Other Regulatory issues' (2002) 9 *Journal of Law and Medicine* 429 431.

3.35 The *Infertility Treatment Act 1995* prohibits the use of the sperm of a person who has died.¹⁴⁰ As both Rochine and Peter lived in Victoria, she is unable to attempt to become pregnant in this way.



CASE STUDY 11

Natalia and Misha underwent IVF treatment and had one child, with six embryos remaining in storage. They had discussed having a second child, but had not yet commenced treatment. Misha was killed in a car accident. Natalia would like to try to have another child with the remaining embryos.

3.36 There is no prohibition in the *Infertility Treatment Act 1995* on using embryos created from the gametes of a person who has died.¹⁴¹ Natalia can attempt to have her second child in this way.



QUESTION(S)

1. Should there be a prohibition on the use of gametes after a person has died? Or should this prohibition only apply where a person has not specified what is to be done with their gametes after their death

THE EFFECTS OF RESTRICTIONS ON ACCESS TO ART

FURTHER POSSIBLE LEGAL ACTION BY PEOPLE WHO ARE NOT ELIGIBLE

3.37 Earlier in this Chapter, we discussed the legal action taken so far in relation to the eligibility provisions of the Act. This legal action does not exhaust the possibilities of legal action. The decision in *McBain* has not resolved the issue of marital status discrimination in the application of the *Infertility Treatment Act 1995*. A claim of marital status discrimination could be brought again under section 22 of the *Sex Discrimination Act 1984* (Cth) by a woman who is not

¹⁴⁰ Section 43.

¹⁴¹ The Act did contain a prohibition on the use of embryos formed from the gametes of a person who has died (s 43). This was removed with the *Infertility Treatment (Amendment) Act 2001*.

married or in a de facto heterosexual relationship, on the grounds of discrimination in the provision of goods and services. The Human Rights and Equal Opportunity Commission has the power to conciliate such claims.

3.38 A case along the lines of *McBain* could be brought in the Federal Court. A declaration could be made concerning the Infertility Treatment Authority's interpretation (on the basis of Gavan Griffith QC's advice) of the Federal Court's decision in *McBain*, which applies one criterion ('unlikely to become pregnant') to married women and women in heterosexual de facto relationships and another criterion ('clinical infertility') to women who are not in such relationships. The grounds would be the same as they were in *McBain*. It would be argued that the State Act (the *Infertility Treatment Act 1995*) is inconsistent with the Commonwealth Act (the *Sex Discrimination Act 1984* (Cth)), and that the State Act is invalid to the extent of the inconsistency.¹⁴²

THE EFFICACY OF LEGAL ACTION

3.39 In both the cases already heard by Human Rights and Equal Opportunity Commission (HREOC), damages were awarded against the providers of the service. This outcome could be seen as an unfair one, as the providers of the service could not comply with the provisions of both State and Commonwealth legislation as they were mutually contradictory.

3.40 It may be argued that the best way to achieve change is through litigation. It is independent of party and political processes. It is also a way of achieving quite significant change, where the processes of revising legislation may become the subject of compromise through the political process. It may also be regarded as potentially quicker than legislative change, as one case, when it is brought, can change the interpretation of legislation from that point on. However, litigation is a lengthy and costly process, involving considerable emotional and financial stress for individuals involved, including prospective patients and medical practitioners. Equally, the cost of not challenging may also be high: people excluded from treatment may remain childless, or may feel compelled to make decisions even though they involve considerable hardship. As the process is lengthy, change will be slow, and in the meantime there are people who remain ineligible for treatment.

3.41 Achieving change through litigation is piecemeal, and this may lead to unsatisfactory outcomes. For example, as a result of the decision in *McBain*, and

142 *Commonwealth Constitution*, s. 109.

subsequent legal advice, there is now in operation a system that has anomalies in the way people are assessed for eligibility. No amendments have been made to the legislation to deal with the difficulties now involved with the operation of s 8.

EFFECTS OF THE CURRENT SYSTEM ON PEOPLE WHO ARE NOT ELIGIBLE¹⁴³

3.42 This Chapter has identified a range of people who are excluded from accessing ART by the current eligibility provisions. These are people—including single women, people in same-sex relationships, heterosexual couples who do not cohabit—who are not in relationships recognised by the Act, and who want to have, and in some cases already have, children.

3.43 In some cases, the eligibility provisions will mean that people who wish to do so will not have a child.

3.44 If people pursue their wish to have a child, there are a range of other options available to them. Women who are not in relationships with men, whether single or in same-sex relationships, may choose to have sex in order to have a child.¹⁴⁴ This may expose them and the child to a range of risks, including to infectious diseases. It may also cause emotional hardship.

3.45 Another choice these women have is to travel interstate, or overseas, for fertility treatment. This may cause financial hardship and emotional hardship. The cost of embarking on such a course can be prohibitive, and the travel stressful. Women may also experience a significant impact on their employment, due to the need to take two-to-three days off work per month.¹⁴⁵ It may also mean that people conceive children without having counselling and that their children cannot obtain information about donors, as is the case in the Victorian system.

143 We have not included discussion here of the effects on families of not coming within the Act. The effects of the current system on parents and other family members and people significant to the child with regard to the status of parents and children is discussed in Chapter 5.

144 A Victorian parenting survey of lesbian and bisexual parents and prospective parents showed that sex was the least likely method to be chosen (by 2%), whereas self-insemination was most likely (44%), followed by interstate clinic donor insemination (33%). (Ruth McNair, Deborah Dempsey, Sarah Wise et al, 'Lesbian Parenting: Issues, Strengths and Challenges' (2002) 63 *Family Matters* 40.

145 These factors were all recognised by HREOC in *W and D v The Royal Women's Hospital*, (unreported, Human Rights and Equal Opportunity Commission, No H97/221, 24 December 1999).

3.46 Some people may choose to go interstate or overseas because they want to be in a system where donors remain unknown.¹⁴⁶ They may also attempt to import sperm from interstate or overseas for use in self-insemination.¹⁴⁷ People in heterosexual couples not recognised by the Act can also access reproductive services in states that have no eligibility provisions. If the fertility problem lies with the man, then they must continue their treatment interstate if the man is to retain his status as father of any child born of the procedure. This may cause financial and emotional hardship.

SELF-INSEMINATION

3.47 Women who do not have a male partner and who are not eligible for treatment in Victoria may also make private arrangements. This might involve, for example, men donating sperm to women friends who then use self-insemination to conceive. If these arrangements take place without medical or legal advice, a range of public health and legal issues arise.

3.48 Self-insemination is an activity caught by the provisions of the *Infertility Treatment Act 1995*. A woman who decides to have a child by insemination outside the licensed clinic system is therefore performing an act to which certain statutory provisions apply.

3.49 The *Infertility Treatment Act 1995* can be interpreted as making home-insemination an offence. Section 7 of the Act provides that:

(1) A person may only carry out artificial insemination of a woman using sperm from a man who is not the husband of the woman at a place other than a hospital or centre licensed under Part 8 for the carrying out of donor insemination if he or she—

(a) is a doctor who is approved under Part 8 to carry out donor insemination; and

(b) is satisfied that the requirements of Divisions 2, 3 and 4 and section 36 have been met.

3.50 Many people have assumed on the basis of this section that self-insemination was illegal. Others have been unsure as to whether or not they were committing an offence by engaging in these activities. The operation of this section has created considerable confusion.

3.51 Advice on the legality of the activities caught by s 7(1) was sought by the Infertility Treatment Authority in 2001. Gavan Griffith QC provided an opinion

146 See discussion in Chapter 2 and Chapter 5 on the information provisions of the Act.

147 See 3.64–3.66 for details of the ITA's role in regulating the importation and exportation of sperm.

on the circumstances under which assisted insemination outside a premises licensed under the Act was illegal. In Griffith's view, the wording of this provision implies that where assisted insemination of a woman does not take place in a licensed clinic, this activity is lawful if the woman performs the insemination herself, but any person assisting her in the insemination would be caught by the provisions of this section and would be committing an offence. The maximum penalty for a breach of this section is four years imprisonment.

3.52 For women choosing self-insemination, the effects of the current eligibility provisions include:

- Fear of accessing appropriate health or legal advice because of the assumption that self-insemination is illegal and subject to penalties; and
- Being unable to obtain information from doctors who also assume that it is illegal to provide information that will assist women to self-inseminate.

EFFECTS OF THE CURRENT ELIGIBILITY CRITERIA ON PROVIDERS OF REPRODUCTIVE SERVICES

3.53 For doctors and other health professionals, the current eligibility criteria raise the possibility of:

- being exposed to legal action and liability for damages;
- being exposed to loss of accreditation; and
- the compromising of clinical standards as a result of being obliged to provide treatment that is not optimal for some people, and is appropriate for others.

PUBLIC HEALTH ISSUES RAISED BY THE CURRENT ELIGIBILITY CRITERIA

3.54 There are several public health issues raised by our reference.

3.55 Prominent medical practitioners in the area of reproductive technology have argued that it is in the best interests of women and children to change conditions of access, and have called for immediate reform of the eligibility criteria, arguing that the overturning of discriminatory measures in the *Infertility Treatment Act 1995* is urgent and essential in order to remove a 'dangerous impediment to

the safe treatment of women' and to safeguard their yet-to-be-conceived children.¹⁴⁸

3.56 The impediments to safe treatment are several. The women excluded from treatment through the licensed clinic system are also excluded from a range of other processes which have major health benefits. Unless a woman has ART through the licensed clinic system, there is no compulsory testing of the sperm donor for diseases such as Hepatitis and human immunodeficiency virus (HIV), both of which are serious infectious diseases transmitted in blood and body fluids, including semen. This potentially exposes her to risk of infection if she uses alternative means of insemination. There may not be screening or treating of sperm, which may expose her to a range of other infections or diseases.¹⁴⁹ If she has sex with someone simply in order to conceive, it may expose her to a range of sexually transmitted diseases. There is no counselling of participants regarding the process they have embarked on or the issues involved.

3.57 For the children conceived, there is the risk of contracting HIV or other diseases through lack of testing and screening.

3.58 Women who do not have male partners may not be infertile and are therefore not eligible for treatment through the licensed clinic system. They may, however, wish to access screened sperm through a Victorian clinic for all of the reasons outlined above. They may also wish that their sperm donor's sperm is stored for six months prior to use to guarantee its safety. These are not simply issues for individuals; they become public health issues when the consequences include the risk of contracting communicable and infectious diseases.

3.59 There is a shortage of donor sperm in general. The shortage of sperm donors combined with current exclusions on eligibility for ART treatment and access to donor sperm in Victoria raise issues about genetic diversity, because these exclusions result in diminished access to a genetically diverse pool of sperm. Lesbians ineligible in Victoria may use fertility services outside the state to gain access to sperm for assisted reproduction. The number of new sperm donors

148 Dr Lyndon Hale and Dr John McBain, Letter to the Honourable John Thwaites MP, Minister for Health, copy provided to the Victorian Law Reform Commission by the Infertility Treatment Authority.

149 In the Victorian parenting survey, the majority of women using self-insemination used sperm from a donor who had undergone screening (Ruth McNair, Deborah Dempsey, Sarah Wise et al, 'Lesbian Parenting: Issues, Strengths and Challenges' (2002) 63 *Family Matters* 40). However, it is important to note that when using fresh sperm, there is no quarantine period, therefore the donor may have become infected since his last test and not be aware of this.

available through clinics in Victoria constantly changes. The Infertility Treatment Authority reported that at the beginning of the 2002 calendar year 147 donors had sperm stored and available for treatment and there were 10 new donors recruited during that year.¹⁵⁰ The sperm is from a non-traceable (non-identity-release) donor. Each donor's sperm may be used to produce children in up to 10 families in a particular geographic area.¹⁵¹

3.60 The reasons for such small numbers of sperm donors available to lesbians are complex, however, there are two identifiable factors:

- gay men face significant obstacles in donating through the clinic system in Victoria, and many people believe that gay men are prohibited from donating sperm; and¹⁵²
- donors at some clinics in Victoria and interstate can indicate that their sperm is not to be used for prospective lesbian parents.

3.61 Thus lesbian women have access to only a small number of donors and quite possibly, within a relatively small community, children will be related. This is exacerbated by the fact that most of the currently available donors are not identity traceable and therefore information about genetic kinship may not be obtainable. Given that there are particular suburbs in Melbourne which have higher concentrations of lesbian women, genetic siblings will be (possibly unknowingly) attending the same crèches and schools. These children will socialise with, and may also conduct sexual relationships with each other and possibly reproduce. In some cases this may increase the risk of genetic abnormality in the offspring.¹⁵³

150 Annual Report 2003, Table 5.2.

151 Reproductive Technology Accreditation Committee Fertility Society of Australia, *Code of Practice for Centres Using Assisted Reproductive Technology* (Revised ed) (2002) 29.

152 See discussion paras 3.70–3.71 on conditions for donating gametes.

153 These issues were raised by Dr Zoe McCallum, Paediatrician, Centre for Community Child Health, University of Melbourne and Murdoch Children's Research Institute, Royal Children's Hospital, at the Rainbow Families Conference, Northcote Town Hall, 9 August 2003.

? QUESTION(S)

2. What are the effects on people of the current restrictions to access of ART treatment?¹⁵⁴
3. Do the restrictions affect the physiological or psychological health of people who are excluded? Are there financial or other material effects? Are there other effects?
4. Are there principles or circumstances that would justify any adverse effects of restrictions to access to donor or treatment programs?
5. Are there legal or other principles that mean that any adverse effects are not justified?
6. Should some or all types of self-insemination be treated as criminal offences? What are the effects of these provisions? Should these activities attract prison sentences?
7. Should 'self-insemination' be allowed regardless of who performs the insemination?

BAN ON SEX SELECTION

3.62 The *Infertility Treatment Act 1995* prohibits sex selection when carrying out any form of assisted reproduction. The only exemption to this provision is to avoid the risk of transmission of a genetic abnormality or a disease to a child.¹⁵⁵

154 We do not discuss or ask questions about the effects on children in this Chapter. See Chapter 5 for discussion and questions regarding how to protect the best interests of children born of ART procedures.

155 Section 50.

**CASE STUDY 12**

Harley and Nerida have three sons and would like one more child, but would like to have a daughter. They would like to access ART treatment in order to select the child's sex.

**CASE STUDY 13**

Hosne is a carrier of Fragile X, an inherited genetic disorder resulting in mental impairment. As a carrier, Hosne would pass the premutation to all his daughters but none of his sons, with each daughter then having a 50% chance of passing the gene to her own children. Hosne and his wife Jamila would like to have children, but given Hosne's carrier status, would like only sons.¹⁵⁶

3.63 Hosne and Jamila are able to select the sex of their children because they would thereby be avoiding the risk of transmission of a genetic abnormality. Harley and Nerida are not able to select the sex of their child as there is no risk of transmitting either a genetic abnormality or a disease to the child.

**QUESTION(S)**

8. Do you think there should be a prohibition on sex selection for all purposes except the prevention of transmission of a disease or genetic abnormality to a child?

156 See the Fraxa Research Foundation website at <http://www.fraxa.org/> for more information about Fragile X.

ACCESS TO SPERM IN THE CURRENT VICTORIAN SYSTEM

RESTRICTIONS ON ACCESS TO IMPORTED SPERM

3.64 Women who are not eligible for ART treatment in Victoria may wish to import sperm from interstate or overseas. Neither importing nor exporting sperm can be done legally in Victoria without the approval of the Infertility Treatment Authority, which deals with any requests to import or export sperm on a case-by-case basis.

3.65 It is possible to buy sperm over the internet. However, most sperm banks will only ship sperm to other sperm banks. The California Sperm Bank, will not ship to Victoria because of our State's requirements that sperm donors submit their names to a governmental registry, and they will not release the names of their donors to any other agency.¹⁵⁷

RESTRICTIONS ON EXPORTING GAMETES AND EMBRYOS

3.66 If a couple moves overseas and wishes to continue to try to conceive using their own gametes or embryos already frozen in Victoria, current regulation prohibits them from doing so without approval of their application by the Infertility Treatment Authority. The ITA may approve the application, and may also impose conditions if approval is granted.

RESTRICTIONS ON ACCESS TO SPERM STORED IN VICTORIA

3.67 The Guidelines for Counselling Potential Gamete Donors contained in the RTAC Code of Practice recommend that counsellors obtain information from donors as to their preferences for the recipients of their donation and any wishes for restrictions, taking into account relevant human rights or discrimination legislation.¹⁵⁸

3.68 When donors donate sperm anonymously, they are donating to any woman who may undergo a treatment procedure using donor sperm through that particular clinic.¹⁵⁹ However, current practice at some Victorian clinics allows

157 <http://www.thespermbankofca.org/services/intorder.htm>, last accessed 4 August 2003.

158 Reproductive Technology Accreditation Committee Fertility Society of Australia, *Code of Practice for Centres Using Assisted Reproductive Technology* (Revised ed) (2002) Attachment H.

159 Conversation with Rita Alessi, Head Counsellor, Monash IVF.

sperm donors to restrict recipients of their sperm according to particular characteristics.¹⁶⁰ This practice may mean that some women—most likely, single and lesbian women—have access to fewer donors.

3.69 Commonwealth and State discrimination legislation provides several grounds on which people can claim discrimination in the provision of goods and services. The Infertility Treatment Authority obtained an opinion from the Victorian Government Solicitor on whether a clinic may or may not act on a donor's specification of a particular class of persons to which his or her donated gamete should be supplied. The Government Solicitor's opinion was that a clinic may not pay regard to such a specification on the part of the donor. The opinion said that treating potential recipients less favourably by decreasing the available pool of donor gametes on the basis of race, sexual preference, marital status and age would be in breach of the *Equal Opportunity Act 1995* and on two of these bases it would also be in breach of Commonwealth Acts—the *Racial Discrimination Act 1975* (Cth) (if it was on the basis of race) and the *Sex Discrimination Act 1984* (Cth) (if on the basis of marital status).¹⁶¹

RESTRICTIONS ON DONORS OF GAMETES

3.70 This inquiry requires us to consider the expansion of eligibility criteria with respect to all or any forms of assisted reproduction. Donors of gametes are relevant for two reasons. First, an issue of access and eligibility arises: that is, do all women who are eligible for treatment have equal access to donors; and how women who are not eligible for treatment can access donor sperm. Secondly, people who want to donate gametes through the licensed clinic system may be ineligible. This affects the women who have or may choose them as donors, and also their own desire to contribute to reproducing a child.

3.71 There are several relevant statutes and guidelines that apply in establishing the conditions under which donors can donate gametes.

160 Conversation with Jenny Blood, Head Counsellor, Melbourne IVF. Also, paper delivered by Penny Pitt, Counsellor, Melbourne IVF, at The Missing Link Symposium hosted by the Infertility Treatment Authority, Federation Square, 29 October 2003.

161 Opinion by Victorian Government Solicitor, 8 August, 2000, supplied to the Victorian Law Reform Commission by the Infertility Treatment Authority. The Victorian Government Solicitor noted that, in coming to this conclusion, his advice differed from the advice given to Reproductive Medicine Units by the South Australian Council on Reproductive Technology. That advice was that, provided there were always donor gametes available for single people and treatment was not totally refused, donors could place conditions on donations and clinics could act on those conditions.

- There are legislative provisions relating to the conditions other than health under which donors can donate gametes. Donors of gametes (and their spouses, if applicable) must consent to the use of the donor's gametes in the particular treatment procedures to be carried out. Counselling is mandatory for donors and, if applicable, their spouses.¹⁶²
- Donors of gametes must be tested for HIV and Hepatitis C, and sperm must be quarantined for six months before use. Donors of gametes must complete a Tissue/Semen Donation Statement.¹⁶³
- The gametes (sperm or eggs) of a dead person cannot be used in any insemination or fertilisation procedure.¹⁶⁴
- The gametes of a person under the age of 18 cannot be used, either for a treatment procedure or for research, except in accordance with the regulations¹⁶⁵ (*Infertility Treatment Act 1995*), and the FSA guidelines also recommend that semen donors are excluded if they are younger than 18 or older than 40.¹⁶⁶
- Guidelines recommend screening out from donor programs on the basis of certain medical conditions and behaviours.¹⁶⁷ However, the screening recommended by the Fertility Society is not mandatory.

SCREENING OF DONORS OF SPERM AND EGGS

3.72 Under the *Health Act 1958*, all people donating semen or ova must complete a Tissue/Semen Donation Statement, which asks questions relevant to HIV and Hepatitis C infection.¹⁶⁸ This statement says that there some people who 'must not' donate because their tissue or semen may transmit infections to recipients. However, it does not specify who these people are. The donation

162 *Infertility Treatment Act 1995*.

163 *Health Act 1958* s 133. This provides immunity against legal action of certain procedures are followed.

164 *Infertility Treatment Act 1995* s 43.

165 Section 41.

166 In Attachment D, 'Guidelines for the storage and use of gametes and embryos', the recommendation is that gametes should not be taken for the treatment of others from female donors over 35 and from male donors over 40 unless there are exceptional reasons for doing so (Reproductive Technology Accreditation Committee Fertility Society of Australia, *Code of Practice for Centres Using Assisted Reproductive Technology* (Revised ed) (2002) para 1).

167 Ibid Attachment H.

168 See Chapter 2, paras 2.45–6.

statement requires responses to 13 questions relating to recent sexual activity (male-to-male, with a sex worker, or with someone with haemophilia), possible contact with a person with HIV, injecting drug use, blood transfusions and tattoos. If the donor answers 'yes' to any of these questions, further discussion will be required but the donor is not necessarily excluded from donating.¹⁶⁹ The donor declarations do not ask whether any of the 'high risk' sexual activities occurred with or without protection.

3.73 The Fertility Society of Australia's (FSA) guidelines for screening of gamete donors recommends the minimum criteria for screening and selection of donors. These guidelines include recommendations regarding taking the donor's history, physical examination, egg examination, blood testing, genetic testing, bacteriological testing for communicable diseases, the recording of screening information, the physical characteristics that should be recorded as part of the donor record, the taking of a social history, confidentiality requirements, the withholding period before donated sperm and eggs can be used in a treatment procedure, and use of fresh eggs.¹⁷⁰ The guidelines also contain a questionnaire, the Donor Lifestyle Declaration. Melbourne IVF uses the FSA Lifestyle Declaration as its questionnaire to donors; Monash IVF does not, but asks a similar range of questions.¹⁷¹ There are medical conditions and 'lifestyle' activities for which the FSA recommends rejecting donors.

3.74 The FSA guidelines recommend rejection if any of the donor's blood relatives have conditions including diabetes, epilepsy, mental disease that has required hospitalisation, rheumatoid arthritis, severe eye disorders, and Creutzfeldt-Jacob disease. Also rejected are those who have ever had a test showing certain diseases (including Hepatitis B and C, HIV, HTLV), who have ever had any of a range of sexually transmitted diseases, or who have ever had certain medical treatments (including transplants or grafts, neurosurgery, human growth hormone or human pituitary hormone, or clotting factors). In addition, potential semen donors are ineligible if they have lived for a certain period in the United Kingdom.

169 *Health (Infectious Diseases) Regulations 1990* Sch 7. Tissue/Semen Donation Statement.

170 Reproductive Technology Accreditation Committee Fertility Society of Australia, *Code of Practice for Centres Using Assisted Reproductive Technology* (Revised ed) (2002) Attachment H, 'Guidelines for Screening for Gamete Donation' 34.

171 Information provided by counsellors at Melbourne IVF and Monash IVF, 31 July 2003.

3.75 The ‘lifestyle declaration’ says that there are people who ‘*must not*’ donate because ‘their lifestyle may give rise to conditions that would be detrimental to children born of their sperm/eggs or result in infections in the patients who receive them’. The people are in this high-risk category because they are more likely to be exposed to HIV infection. They are: intravenous drug users (in the last five years), prostitutes of either sex (and their clients), and sexual partners of either of these two categories of people or of bisexual males.

3.76 FSA recommends rejection as a gamete donor of any person, who within the last 12 months has:

- had male-to-male sexual activity;
- engaged in sexual activity with a sex worker; or
- had a blood transfusion.

3.77 Any potential donor who answers ‘yes’ to having ever injected non-prescribed drugs should be rejected.

3.78 The statutory screening processes for HIV and Hepatitis-C for donors of gametes apply both to clinic-recruited donors and donors recruited by the recipient. Melbourne IVF asks all donors to sign the FSA’s lifestyle declaration, but allows, in rare circumstances, a recipient of donated tissue to sign a waiver if desired. Monash IVF requires donors recruited by the clinic to answer its own questionnaire, but practices a case-by-case approach to donors recruited by the recipient.¹⁷²

172 Information provided by counsellors at Melbourne IVF and Monash IVF, 31 July 2003.

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QUESTION(S)

9. How appropriate is the current regime for balancing the desire of people to donate gametes with the need for the safest possible provision of donated gametes to recipients?
 - Is it still necessary to screen out on the basis of certain high-risk activities, and if so, what are those activities? Are the questions currently asked about sexual activity capable of determining the risk that a person poses in transmission of infectious diseases such as HIV? If not, what are the appropriate questions to ask? Does the current system unnecessarily exclude sectors of the population, such as gay men, through asking general questions about sexual activity rather than specific questions about particular sexual behaviour that involves risk of HIV infection?
 - Is screening for HIV through semen and blood testing guaranteed to eliminate risk of transmission to a recipient or child?
10. Who should be able to donate gametes for reproduction?

Chapter 4

Regulating Eligibility for ART: Options for Reform

INTRODUCTION

4.1 In this Chapter, we ask whether the eligibility requirements for assisted reproductive technology (ART) should be regulated. If it is thought that eligibility should be regulated, we also consider how this should be done. How should we determine the criteria by which access is regulated, and the model by which access is best regulated? As the focus of our inquiry is on eligibility criteria ‘in respect of all or any forms of assisted reproduction’ we discuss not only regulatory reform of eligibility for treatment procedures but also access to donor sperm and eligibility requirements for the donation of gametes. The options for reform for the other major eligibility issue of this inquiry—eligibility to become an adoptive parent—are discussed in the Chapter 5.

THE BEST INTERESTS OF THE CHILD

4.2 Where ART is regulated, either in Australia or internationally, the best interests of the child are either paramount or important in any activities governed by the legislation.¹⁷³ In Victoria, section 5 of the *Infertility Treatment Act 1995* and the National Health and Medical Research Council (NHMRC) guidelines make the welfare and interests of the child a major consideration, with the Victorian Act making it ‘paramount’.¹⁷⁴ How does the current legal system interpret and apply the notion of the best interests of the child?

173 See for example the *Human Fertilisation and Embryology Act 1990* (UK), the *Infertility Treatment Act 1995* the *Human Reproductive Technology Act 1991* (WA).

174 As discussed in para 2.20, the *Infertility Treatment Act 1995* sets out guiding principles which are to be applied when people are undertaking any of the activities covered by the Act.

4.3 In the Victorian context, there are several instruments relevant to the rights and interests of the child (including of the child conceived through ART). These are the UN Convention on the Rights of the Child (CROC),¹⁷⁵ the *Family Law Act 1975* (Cth) and the *Infertility Treatment Act 1995*. All these instruments identify the interests of the child as the paramount consideration.

4.4 The *Family Law Act 1975* (Cth) specifies that when the Family Court is making certain orders (such as parenting orders) or setting aside certain orders, the best interests of the child are paramount.¹⁷⁶ The Act also specifies what must be taken into account in determining what is in the best interests of the child when making these orders.¹⁷⁷ However, while the Court must take these factors into account, the determination of what is in the best interests of the child is always a contextual matter requiring consideration of the particular circumstances of each child and the other people involved. This case-by-case approach has been affirmed by the Family Court on numerous occasions.¹⁷⁸

4.5 If we were to regulate access according to the best interests of a child not-yet-born, how would we determine what these interests might be? The particular circumstances of each child cannot be considered, as there is as yet no child, and the circumstances in which he or she is to live are not yet in existence. An approach to eligibility based on the best interests of the child must therefore be one in which either the likely circumstances into which a particular child will be born are construed from known facts at the time of the application for treatment, or in which broad principles are applied in considering any application for treatment.

4.6 The three instruments mentioned above refer to the following rights and interests of the child:¹⁷⁹

- to protection against discrimination, either against oneself or one's parents (Article 2 CROC);

175 Australia is a signatory to CROC, but the Convention is not directly implemented in Australian law; that is, it is not the head of power upon which any Commonwealth statute is founded. However, it is scheduled to the *Human Rights and Equal Opportunity Commission Act 1986* (Cth) been violated can be heard by HREOC.

176 Sections 63H(2), 65E, 65L(2), 67L, 67V, 67ZC(2).

177 Section 68F.

178 For example, *Marriage of Smythe* 1983 48 ALR 677.

179 There has been recent public debate overseas about whether there is a right not to be born. See M Spriggs and J Savulescu, "The Perruche Judgment and the 'Right Not to Be Born'" (2002) 28 *Journal of Medical Ethics* 63.

- to adequate and proper parenting (*Family Law Act 1975* (Cth)) s 60B(1);
- to life, survival and development (Article 6 CROC);
- as far as possible, to know and be cared for by his or her parents (Article 7 CROC);
- to contact with both parents, except where contrary to the child's best interests (Article 9 CROC; *Family Law Act 1975* (Cth)) s 60B(2)(a);
- to preservation of his or her identity (Article 8 CROC);
- to information about one's genetic or biological heritage (*Infertility Treatment Act 1995* Pt 7 Div 3);
- to the best available health care (Article 24 CROC); and
- to express his or her views and for these views to be taken seriously (Article 12 CROC).

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QUESTION(S)

11. To what extent should the *Infertility Treatment Act 1995* refer to the above rights and interests?
12. Are there other broad principles that would better protect the best interests of the child yet-to-be-born?

SHOULD ELIGIBILITY FOR ACCESS TO ASSISTED REPRODUCTION BE REGULATED THROUGH PARENTING CRITERIA?

4.7 Although, section 5 of the *Infertility Treatment Act 1995* states that the welfare and interests of the child are paramount, the Act does not include criteria relating to parenthood. Its eligibility provisions suggest that society can protect the best interests of the child by limiting access to parenthood through assisted reproductive technology according to marital status.¹⁸⁰ These provisions no longer apply because they have been held to be discriminatory.¹⁸¹ Should the Act contain

180 The Act's eligibility provisions originally limited access first to married couples, and then subsequently to married and de facto heterosexual couples. See discussion in Chapter 2, paras 2.29–31 for details regarding marital status and eligibility.

181 See Chapter 3, paras 3.6–24.

parenting criteria to determine who should have access to assisted reproduction? We discuss the arguments for and against regulating access to assisted reproduction through parenting criteria below.

ARGUMENTS FOR REGULATING ACCESS TO ASSISTED REPRODUCTION THROUGH PARENTING CRITERIA

- Parenting criteria are necessary to ensure that the best interests of children are conceived by assisted reproduction are adequately protected.
- Assisted reproduction involves various forms of governmental intervention and responsibility in the conception of children, and so the decision to have a child in this way necessarily involves the state. There should be a higher standard for regulating parenthood through assisted reproduction than there is for reproduction generally, because the state has a responsibility to protect children in order to meet both domestic and international obligations.
- The public has an interest in matters that involve the expenditure of public money, even where this involves the state in the regulation of matters that are otherwise private.
- Eligibility criteria ensure that a consistent standard is applied by treating doctors. Lack of criteria could lead to some doctors discriminating in favour of or against particular types of people, who seek access to assisted reproduction.

ARGUMENTS AGAINST REGULATING ACCESS TO ASSISTED REPRODUCTION THROUGH PARENTING CRITERIA

- Few people would argue that parenthood in general should be the subject of such regulation. If parenthood is not controlled by government, and it is not desirable that it is controlled by government, then there is no reason to regulate in this way parenthood that comes about because of ART.
- There is no consensus on what makes a good parent, and who might possess these qualities.
- There is no reliable and accepted measure to predict parenting ability before someone becomes a parent.
- It is discriminatory to impose criteria for particular methods of having a child but not for others. A decision to have a child naturally is not subject to a test of eligibility for parenthood based on meeting certain criteria, such as marital status, sexual orientation, income testing, or criminal history.

- Other aspects of human reproduction are not subject to regulation.¹⁸² For example a woman does not need to meet any eligibility criteria in order to obtain contraception such as the pill, or to be fitted with contraceptive implants or devices. Her contraceptive needs are a matter for the patient in consultation with her doctor.
- Absence of legislation does not necessitate completely unregulated access to ART. Other states, such as New South Wales, have no legislation specifically regulating ART, and therefore no legislative prescriptions for eligibility. These jurisdictions are regulated by guidelines and accreditation.¹⁸³ Where there is concern about whether a doctor or clinic should provide ART to a person who requests it, decisions can be made on a case-by-case basis by hospital ethics committees. This permits a flexible decision-making structure, in which no class of person is by reason of their class ineligible. The basic assumption is an equitable one, in that people will be able to have treatment, unless it proves necessary not to allow access in particular cases. If there is a risk to a child this can be taken into account.
- Where regulation exists in Australian states, the eligibility criteria discriminate against groups of people. This discrimination is often on the basis of marital status or sexual orientation.

PARENTING CRITERIA

4.8 If the *Infertility Treatment Act 1995* were amended to impose parenting criteria to determine eligibility for access to assisted reproduction it would be possible to draw on existing models, such as the *Family Law Act 1995* (Cth) and the *Adoption Act 1984* both of which contain provisions for the assessment of parenting ability or parenting potential.

THE FAMILY LAW ACT APPROACH TO ASSESSING PARENTING

4.9 The object of Pt VII of the *Family Law Act 1975* (Cth) is to ensure that children receive adequate and proper parenting. Of the eleven factors that must be considered by the Family Court in determining what is in the best interests of the child in making orders, parenting ability is directly relevant to four:

182 On the question of whether there should be regulation at all regarding ART, see Loane Skene, 'Why Legislate on Assisted Reproduction?' in Ian Freckleton and Kerry Petersen (eds) *Controversies in Health Law* (1999).

183 See 4.28–4.29 for details.

- the capacity of each parent to provide for the needs of the child, including emotional and intellectual needs;
- the attitude to the child, and to the responsibilities of parenthood, demonstrated by each parent;
- the need to protect the child from physical or psychological harm; and
- any family violence, or family violence order, involving the child or a member of the child's family.

4.10 Other factors concern the wishes of the child, the characteristics of the child and the nature of his or her relationship with each parent and with others, the likely effect on the child of a change in his or her circumstances, any factors affecting the child's right to contact with both parents, and whether the court should consider making the order least likely to lead to further court proceedings in relation to the child. These other factors do not appear to be relevant in deciding whether a person should be eligible to bring a child into existence through assisted reproduction.

4.11 Obviously marital status is not a relevant consideration in determining the best interests of the child under the *Family Law Act 1975* (Cth). Most people applying for orders in relation to children will be separated or divorced, or in the process of becoming separated or divorced. Nor is sexual orientation a factor: the Family Court has consistently reaffirmed that the sexual orientation of a parent is not a disqualifying factor in residence and contact disputes.¹⁸⁴ As the welfare of the child is the primary focus of the Court in its determinations, the sexual orientation of a parent is a relevant factor only where it affects the welfare of the child.¹⁸⁵

THE ADOPTION ACT APPROACH TO ELIGIBILITY AND PARENTING

4.12 People who apply to adopt a child must meet certain prerequisites, such as type and duration of their relationship.¹⁸⁶ The *Adoption Act 1984* normally allows only married or heterosexual de facto couples who have been together for at least two years¹⁸⁷ to become adoptive parents, and then makes parenting ability the major criterion in assessing suitability to be fit and proper adoptive parents. A

184 See, for example, *Re K* (1994) FLC 92, 80, 774; see also Alastair Nicholson, 'The Changing Concept of Family: The Significance of Recognition and Protection' (1996) 3 *ELaw: Murdoch University Electronic Journal of Law*. <http://www.murdoch.edu.au/elaw/issues/v3n3/nicholso.html>

185 *Doyle and Doyle* (1992) FLC 92-286, 79, 122.

186 See Chapter 5, paras 5.57–64, for detailed discussion of these requirements.

187 *Adoption Act 1984*, s 11 (1)–(4).

single person can adopt under the Act, where the Court is satisfied that ‘special circumstances exist in relation to the child which make it desirable’ to make an adoption order.¹⁸⁸ People in same-sex relationships cannot adopt as a couple; however, one person in the couple could apply to adopt a child that would then be parented by both partners.

4.13 The court must also be satisfied that the adopting parents satisfy certain criteria regarding parenting ability.¹⁸⁹ The Court must consider whether the applicants show, in their relationship with each other and with other family members, all the qualities which would enable them to provide a secure and beneficial emotional and physical environment for the child until he or she reaches emotional and social independence. These qualities include emotional, physical and mental health; maturity; adequate financial stability; and general stability of character.

4.14 In practice, because of the small number of babies available for adoption relative to the number of people wishing to adopt, there is a substantial element of selection in the application of the eligibility criteria. There may be many couples who could be suitable adoptive parents, but who are not selected because the number of parents must be matched with the number of babies and therefore people regarded as ‘ideal’ parents are chosen rather than adequate or suitable ones.

DO THE FAMILY LAW ACT AND THE ADOPTION ACT PROVIDE USEFUL MODELS OF PARENTING CRITERIA?

4.15 The *Family Law Act 1975* (Cth) and the *Adoption Act 1984* (both apply parenting criteria in situations where a child is already born. The *Infertility Treatment Act 1995*, in contrast, regulates eligibility for treatment procedures that may result in the birth of a child. Clearly, assessing parenting ability is a significant part of protecting the best interests of an existing child, where the particular circumstances of that child can be taken into account and where parenting ability is a significant aspect of those circumstances. But is access to parenthood itself, where it is to be achieved through assisted reproductive technologies, something that it is desirable for the government to regulate?

188 Ibid s 11(3).

189 *Adoption Regulations 1998* Reg 35.

4.16 These differences between the situations in which the *Adoption Act 1984* and the *Family Law Act 1975* (Cth) apply may limit the usefulness of these models in determining eligibility for assisted reproduction.

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QUESTION(S)

13. Do the principles in the *Infertility Treatment Act 1995* express the values and priorities that should apply to assisted reproduction treatment? Do they provide an adequate framework for assessing eligibility for assisted reproduction?
14. Should the *Infertility Treatment Act 1995* express broad principles regarding the best interests of the child, or identify specific criteria that are likely to produce better outcomes for children? For example, should specific criteria relating to parenting be included in legislation regulating eligibility for assisted reproduction?
15. If so, what criteria, if any, should be in place? Would the criteria in the *Adoption Act 1984* or *Family Law Act 1975* (Cth) be useful in assessing whether a person should be eligible for assisted reproduction?

OPTIONS FOR REFORM

4.17 So far in this Chapter we have discussed whether access to parenthood should be regulated, and if so, how? But it is also necessary to consider the broader question of whether access to ART be regulated at all and what form should this regulation take? Below we discuss three approaches to regulation of eligibility. These are:

- detailed legislative prescription;
- broad legislative principles; and
- little or no regulation.

The main arguments for and against these approaches are discussed below.

LEGISLATIVE PRESCRIPTION OF ELIGIBILITY

4.18 In Victoria eligibility is prescribed by legislation. Since *John Mc Bain v The State of Victoria & Ors (McBain)*,¹⁹⁰ the *Infertility Treatment Act 1995* has been interpreted to require women who are not married or in a heterosexual de facto relationship to be clinically infertile.¹⁹¹

4.19 One approach to reform would be to retain criteria for eligibility in the Act, but to clarify the meaning of the current criteria and the people to whom it applies. That is, the legislation could provide a clear definition of ‘unlikely to become pregnant’ that would apply in assessment of all cases. If this infertility requirement applied to all patients, and the relationship requirements were deleted, then the problem of discrimination would no longer arise.

4.20 Another approach to legislative prescription would be to change the prescribed criteria. We could do this by developing criteria on the basis of parenting ability, as discussed earlier in this Chapter. Another approach would be for the legislation to impose criteria excluding some people because of the likelihood of serious and identifiable risk to the child. For example, people with convictions for child abuse or a crime of violence could be excluded.

ARGUMENTS AGAINST LEGISLATIVE PRESCRIPTION OF ELIGIBILITY

- It is an inflexible system, which does not allow a doctor to take into account the circumstances of a person seeking treatment.
- It is not readily responsive to changes in community values. It is neither quick nor easy to change legislation.
- The legislative prescriptions regarding eligibility that have been enshrined in the Victorian Act are ineffective: they do not achieve clear policy outcomes and have been the subject of several successful challenges on the basis of discrimination. Further challenges are likely leading to loss of clarity in the application of the legislation.
- People may be excluded from benefiting from technological advances by default: that is, current eligibility criteria may exclude people from benefiting from future technological advances.

190 [2000] FCA 1009. This decision was unsuccessfully challenged in the High Court ([2002] HCA 16).

191 See Chapter 3, paras 3.6–18.

- It is inequitable to assist some people and not others. The consequences of this are also inequitable: some people will not have children as a result of their exclusion.
- Legislative prescriptions are more likely to disadvantage those who are not well-off. Some people may be unable to afford the alternative avenues of treatment; for example, people may not be able to travel interstate.
- As there are states in Australia that do not restrict access, people can and do go elsewhere to obtain treatment.
- Having legislative definitions produces hardship for patients, doctors and clinic staff. This hardship may be financial, emotional and physical.
- There is no general agreement about the nature of family, about what makes up the right kind of family, or what characteristics of parents best protect children in families.

ARGUMENTS FOR LEGISLATIVE PRESCRIPTION OF ELIGIBILITY

- It produces an agreed statement of community values.
- It states clearly who is eligible and who is ineligible, which provides clear guidance to doctors and clinics.
- It ensures that ART treatment is only used as a last resort.

BROAD PRINCIPLES

4.21 An alternative approach would be to include broad principles in the Act, which would indicate the factors to be taken into account in deciding whether a woman should be treated. In the United Kingdom regulation is based on broad principles.¹⁹² The *Human Fertilisation and Embryology Act 1990* (UK) does not enumerate any criteria upon which access to ART treatment is based. Rather, the Act emphasises the broad objectives of ART that should be taken into account in assessing whether to treat a woman:

192 Martin Johnson points out that there are only two objectives of the UK Act and its accompanying Code of Practice: safety, and the welfare of the next generation, and suggests that these are successful in his view for allowing discretion at the level of the individual patient without barring certain categories of people from becoming parents. This flexibility is particularly desired where societal views shift. (Martin H Johnson, 'The Art of Regulation and Regulation or ART: The Impact of Regulation on Research and Clinical Practice' (2002) 9 *Journal of Law and Medicine* 399 413).

A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father), and of any other child who may be affected by the birth.¹⁹³

4.22 This allows doctors to assess suitability for eligibility on a case-by-case basis, with a very broad principle as guidance. No particular category of person is excluded from treatment.

4.23 The Human Fertilisation and Embryology Authority (HFEA), the body overseeing the implementation of the UK Act, maintains a Code of Practice containing guidance for conduct for people whose activities fall within the Act. The Code contains guidance for people providing treatment services about the account to be taken of the welfare of the children concerned.¹⁹⁴

4.24 The Code recommends that centres have clear written procedures for assessing the welfare of the child, expressly noting that the *Human Fertilisation and Embryology Act 1990* (UK) does not exclude any category of woman from being considered for treatment.¹⁹⁵ In other words, should the written procedures contain any proscriptions on eligibility for particular categories of women, this would be against the spirit of the Act itself. The Code specifies that centres should avoid 'adopting any policy or criteria that may appear arbitrary or discriminatory.'¹⁹⁶ The general principle that applies is the welfare of the child, and in developing their procedures for considering people's eligibility for treatment, centres should take note of the 'importance of a stable and supportive environment for any child produced as a result of treatment'.¹⁹⁷

4.25 Neither the Act nor the Code proposes any particular factor as a paramount consideration. The general principles outlined in the HFEA Code of Practice for assessing eligibility for ART treatment are:

- protection from harm to health both for people seeking treatment and children;

193 Section 13(5).

194 This function of the HFEA's Code of Practice is specified in the *Human Fertilisation and Embryology Act 1990* (UK) s 25(2).

195 Human Fertilisation and Embryology Authority, *Code of Practice* (2001) para 3.10.

196 Ibid para 3.3.

197 The Code lists specific factors to be considered, including commitment to having and raising children; medical histories; health and age as factors in the future ability to provide for a child's needs; any risk of possible harm to the child; and the effect on the existing family (para 3.14).

- the welfare of children born as a result of treatment;
- wishes and needs of the people seeking treatment; and
- absence of arbitrary or discriminatory criteria.

4.26 None of these considerations prevails over the others.¹⁹⁸ Failing to observe any provision of the code does not make a person liable to prosecution, but risks variation or revocation of the licence.¹⁹⁹

ARGUMENTS AGAINST BROAD PRINCIPLES IN LEGISLATION REGULATING ELIGIBILITY

- Such principles may be too broad to provide guidance to treating doctors and clinics, particularly in cases where community views are likely to vary about whether the person should be treated.
- They may lead to inconsistent decision-making because of different interpretations of the meaning of the principles.
- They may permit unfair discrimination, but this may not be visible
- It is difficult to ensure that decisions made by those providing treatment are consistent with the principles.

ARGUMENTS FOR BROAD PRINCIPLES IN LEGISLATION REGARDING ELIGIBILITY

- Broad principles express values but decision-making remains flexible. Individual assessment is possible in difficult cases.
- They express community values but provide the scope to respond to social and technological change.
- They exemplify a democratic approach. By default they provide access; exclusion only occurs because of reasons that apply in individual cases.

4.27 If we were to use broad principles as a framework for eligibility, we would need to consider what the principles should be? The principles in the *Infertility Treatment Act 1995* make the interests of the child paramount in the provision of ART treatment, and also refer to the preservation of human life, the interests of the family and assisting infertile couples to have children?²⁰⁰ Are these principles sufficient if other eligibility criteria are abolished? If not, what other principles should apply?

198 para 3.3.

199 *Human Fertilisation and Embryology Act 1990* (UK) s 25(6).

200 These principles are discussed in Chapter 2, paras 2.20–2.

LITTLE OR NO REGULATION

4.28 New South Wales, the Australian Capital Territory, Queensland, Tasmania do not have legislation regulating access to assisted reproduction.²⁰¹ New South Wales has no comprehensive legislation on ART, and no legislation that deals specifically with access and eligibility criteria for ART.²⁰² Treatments carried out through licensed clinics are regulated by the NHMRC guidelines and the Fertility Society Code of Practice. Both of these are silent on questions of access and eligibility. The decision to provide treatment in New South Wales is therefore up to the treating doctor. In the event of difficult decisions, the doctor has recourse to an Institutional Ethics Committee.

4.29 In other words, in New South Wales decisions are left to doctors' discretion on a case-by-case basis. A doctor makes these decisions in the context of the NHMRC guidelines, and any other relevant guidelines prepared by other medical organisations, but these guidelines are not legally enforceable. In this regulatory framework, a doctor's discretion is the primary way in which decisions regarding eligibility would be made. This would mean, for example, that a doctor may decide not to treat a woman on the basis of her age, or conversely, may decide that a woman's age is irrelevant if the technology exists to assist her to achieve a pregnancy.²⁰³ If there was no regulation of access to ART by either legislative prescription or broad principles, then decisions would be made by doctors on a case-by-case basis. The arguments for and against this approach are set out below.

ARGUMENTS FOR NO REGULATION OF ELIGIBILITY CRITERIA

- The starting point is to provide access. This is more equitable than stipulating criteria that necessarily exclude some people.
- This approach allows doctors and patients to make individual decisions.
- It treats people who are infertile in the same way as others seeking treatment in the area of reproductive medicine.

201 The ACT does have legislation dealing with surrogacy (see Chapter 6 paras 6.31, 6.57–63, 6.67 for details), and also has a specific Act dealing with parentage of people born of ART (the *Artificial Conception Act 1985* (ACT)).

202 At the time of writing, a review was being undertaken of the *Human Tissue Act 1983* (NSW), which does deal with some aspects of gamete donation.

203 In this context, it is important to note that under current Health Insurance Commission policy, a rebate is only available for clinically indicated treatment; otherwise the patient bears the full cost of treatment.

- It treats all infertile people (and not just some of them) in the same way as those who can conceive without treatment.
- It does not discriminate against particular groups of people.

ARGUMENTS AGAINST NO REGULATION OF ELIGIBILITY CRITERIA

- In the absence of both legislative prescription and broad principles to guide people's decisions, individual decision-makers may not take sufficient account of the interests of the child.
- Professionals may not take sufficient account of the interests of their patients.
- In the absence of regulation, the limits are only those of the technology and people's individual judgements, and we cannot predict the consequences of this.
- Lack of regulation can lead to arbitrary or discriminatory decision-making.

COUNSELLING, CONSENT AND INFORMATION

4.30 Whichever approach is used to control access to assisted reproduction, it will be necessary to deal with a range of issues other than eligibility for treatment. As we have seen²⁰⁴ the *Infertility Treatment Act 1995* regulates a number of other aspects of infertility treatment:

- counselling is mandatory for a woman, and her male partner if she has one, before she can undergo a treatment procedure.
- consent must be obtained from a woman's partner, if she has one, before she undergoes a treatment procedure.²⁰⁵
- information must be provided by the doctor in charge of the woman's case about the procedure and its alternatives before a woman undergoes a treatment procedure.²⁰⁶

4.31 Even if changes were made to the eligibility requirements for treatment, the legislation could still provide for consent, counselling and provision of information. If so, these could be prescribed criteria for access to ART: that is,

204 See Chapter 2 paras 2.34–42.

205 There are also provisions relating to the withdrawal and lapsing of consent.

206 *Infertility Treatment Act 1995* s 10.

before a woman could undergo a treatment procedure, she would have to submit to the relevant procedures in relation to these matters.

? QUESTION(S)

16. What is the best way to regulate access to ART in Victoria?
17. Should eligibility criteria be set out in the *Infertility Treatment Act 1995*?
18. If so, what criteria should be applied in assessing eligibility? Should anyone be excluded from treatment?
19. Should infertility be a requirement for eligibility for assisted reproduction, and if so, how should it be defined? If not, how should the phrase 'unlikely to become pregnant' be interpreted?
20. Alternatively, should the legislation simply express broad principles of eligibility and provide for non-binding guidelines to be made to assist decision-makers?
21. Would it be preferable to simply leave eligibility for treatment to be determined by individual doctors?

REGULATING ACCESS TO GAMETES AND EMBRYOS: OPTIONS FOR REFORM

4.32 In Chapters 2 and 3 we raised a number of issues relevant to donation of sperm, eggs and embryos.²⁰⁷ One important issue is whether people donating sperm, eggs or embryos should be able to specify the characteristics of the people receiving the donation.²⁰⁸

207 See Chapter 2 paras 2.43–9, Chapter 3, paras 3.47–61.

208 See Chapter 3 paras 3.67–9.



CASE STUDY 14

Gordon is a gay man who has always been interested in being a sperm donor. He has never been willing to say yes because of the legal uncertainties, but he has been thinking about the possibility more and more and finally makes an appointment to donate sperm at an IVF clinic. Gordon has been celibate for five years, and so has no trouble answering the lifestyle declaration and being an acceptable donor. He would like to be contacted by the child if the child and his or her family wish to do so. He wants to make his sperm available to lesbian women only, as he feels that there will be less conflict for a child, particularly if the child wishes to meet him before he or she turns 18.



CASE STUDY 15

After years of trying to conceive Farah and Paul sought medical help, and found that Paul's sperm count was so low that it was unlikely that they would ever conceive without medical assistance. As a result of an IVF treatment cycle, 21 of Farah's eggs were fertilised, and 19 embryos survived. Most of the embryos were frozen and later transferred in ones and twos, eventually resulting in the birth of three children. Farah and Paul decided that their family was complete, but they still had six embryos in storage. Rather than have them thawed and allowed to succumb, they decided that they would like to donate them, but only to a married couple who would consider the possibility of their children knowing about each other, and possibly having some contact, before they reach adulthood.

4.33 Depending on which clinic Gordon, or Farah and Paul attend, they may or may not be allowed to specify the qualities or characteristics of recipients of their gametes or embryos.²⁰⁹ At some Victorian clinics Gordon could specify that his donation could only go to a lesbian woman or couple and the clinic would meet this request. Other clinics do not allow donors to specify. Clinics that provide donated semen according to a request of this kind may be breaching discrimination laws. Should the *Infertility Treatment Act 1995* allow donors to

209 As discussed in para 3.69, if the clinic does allow the donor to specify, the clinic is potentially in breach of the *Equal Opportunity Act 1995*.

specify the qualities of recipients? Should current laws address directed donations of gametes or embryos, and if so, how?

? **QUESTION(S)**

22. Should people who are donating semen to an unknown recipient be able to stipulate qualities or characteristics of the recipient?
23. Should people considering donating embryos to an unknown recipient be able to specify the characteristics of the recipients?

4.34 At present a person's sperm or eggs cannot be used for the purposes of assisted reproduction after they are dead.²¹⁰ A person may wish to have sperm removed from their spouse's body after they have died so that the survivor can conceive a child.

? **QUESTION(S)**

24. Should people whose spouses have died should be able to take gametes from the dead person's body for use in ART treatment?
25. Should donated sperm and eggs be able to be used for assisted reproduction after a person has died? If so, what conditions should apply before this can occur?

IMPORTING AND EXPORTING GAMETES AND EMBRYOS

4.35 The regulation of the import and export of gametes and embryos is an issue related to our inquiry because such regulation affects who can gain access to assisted reproduction. Currently permission is required from the Infertility Treatment Authority before gametes or embryos can be imported or exported.

210 *Infertility Treatment Act 1995* s 43. See also Chapter 3 para 3.71.

4.36 Importing of sperm is also limited by the information provisions of the *Infertility Treatment Act 1995*, which require that information should be available to people conceived through donor gametes if they wish to access that information. Sperm sourced from interstate or overseas is unlikely to have been donated with the understanding that information about the donor would be released to any child born of the procedure. As a result, overseas sperm banks may refuse to provide donor sperm.

?

QUESTION(S)

26. Should the importing and exporting of gametes and embryos be regulated?
27. If so, should this be done by defined rules, or broad principles?
28. Should people who are ineligible for treatment be able to import sperm into Victoria? Should the same regulations that apply to sperm sourced and used within Victoria also apply to imported sperm (for example, the information provisions of the *Infertility Treatment Act 1995*)?

COULD VICTORIAN CLINICS PROVIDE SPERM FOR THE PURPOSES OF SELF-INSEMINATION?

4.37 Currently in the licensed clinic system, a woman who wishes to obtain access to donor sperm must be undergoing a treatment procedure and, if she is not in a partnership recognised by the *Infertility Treatment Act 1995*, in order to be eligible she must be ‘clinically infertile’. However, there is nothing in the Act to preclude a licensed clinic from storing sperm for the purposes of self-insemination for women wishing to have a child with donor sperm who do not meet the current eligibility requirements. If self-insemination is not unlawful, as the opinion from Gavan Griffith QC suggests, then the provision of sperm by a licensed clinic for this purpose, whether from a clinic-recruited donor or a donor who has agreed to provide sperm for a particular woman, would also not be unlawful. If, however, Griffith proved to be incorrect if this provision were challenged in court, then providing stored sperm for the purpose of self-insemination would be illegal.

4.38 The laws applicable to donor gametes would apply if access to donor sperm was extended to allow women to access sperm for self-insemination. This would mean that children conceived in this way could also find out information about

their genetic origins, and once they turned eighteen could make contact with the donor provided they had been told of their donor conception.²¹¹



CASE STUDY 16

Jacky and Meg are in a long-term relationship and have negotiated with Ben (a gay man and an old friend of Meg's) to be their known sperm donor. Ben agreed, but may be transferred to the UK for three years with his work. Ben is also not certain that he can maintain a totally safe lifestyle for the duration of the insemination process, even if he were to remain in Victoria. Jacky is 38 years old and does not want to wait three years to have a child. They are both keen for the child to know Ben and are certain they do not want to use anonymous sperm for the child's sake. They would like to have access to Ben's frozen sperm for self-insemination.



QUESTION(S)

29. Are there public health and/or other benefits in allowing licensed clinics to provide screened donor sperm to women for the purposes of self-insemination?
30. Should licensed clinics be able to do so?
31. Should there be eligibility requirements for access to donor sperm for self-insemination? If so, what should these eligibility criteria be?
32. Should women wishing to self-inseminate have access to sperm from the clinics or should they be required to find their own donor?

211 The Infertility Treatment Authority is currently conducting consultations on the issue of storage of sperm for the purposes of self-insemination.

?

QUESTION(S)

33. Should the provisions of the *Infertility Treatment Act* that apply before women can undergo a treatment procedure (for example, the counselling requirements) also apply before women can access donor sperm through the clinic system for the purposes of self-insemination?²¹²

212 See Chapter 2 for details of these provisions.

Chapter 5

Family Relationships

INTRODUCTION

5.1 In Chapter 3 we discussed the criteria that determine eligibility for access to assisted reproductive technology (ART). Whether or not these criteria are changed, it is important for the Commission to consider the laws that currently define the rights and responsibilities of family members. If eligibility requirements are not expanded, some Victorian women will conceive children through self-insemination. Other people may have children as a result of use of assisted reproduction that occurs interstate or overseas.²¹³ It is in the best interests of these children to have legislation that clarifies the parental status and responsibilities of those who care for them.

5.2 If eligibility requirements are changed to allow a broader range of families to have children through the use of ART, it will also be necessary to reform the laws that define the parents of children conceived through ART.

5.3 This Chapter examines the current legislative definitions of parent which apply in the context of ART and considers changes to these definitions. It also considers associated issues, such as how to encourage birth mothers, their partners and donors to make agreements about their relationship with the child and the information that should be included in birth certificates.

5.4 A parent–child relationship can be created by adoption. The Chapter discusses the current eligibility requirements contained in adoption legislation and whether these laws should be changed to enable single people and people in same sex relationships to adopt children, particularly children who have been conceived by assisted reproduction.

213 See for example *In the Matter of Mark*, unreported decision of Justice S Brown, Family Court of Australia 28 August 2003.

WHY LEGAL PARENTAGE MATTERS

5.5 Because the law confers rights on children in relation to their parents, and imposes duties, powers, authority and responsibilities on parents in relation to their children²¹⁴ it is vital to have clear rules that define those who are legally the children's parents.

5.6 As well as having a right to support while the parent is alive, children (including the adult children of a person) have certain rights to their parent's property after death.²¹⁵ Legislation gives the child a defined share in their parent's property if the parent dies without leaving a will. If the will or the share they receive when their parent dies without a will is insufficient to support them adequately children can also apply to the Court for a share of the deceased parent's property.²¹⁶ Children may also be able to claim an interest under wills made by other relatives, for example grandparents or aunts and uncles.

5.7 The duties and powers imposed on parents include:²¹⁷

- the power to name the child;
- the power to make decisions on behalf of the child, for example decisions about medical treatment, and decisions about whether the child should go on a school trip;
- the power to decide where the child will live, how he or she will be educated and the religion, if any, in which the child will be brought up;
- the power to discipline the child (subject to limitations);
- the responsibility to ensure that the child receives medical treatment when required; and
- the responsibility to support the child adequately.²¹⁸

5.8 The parent–child relationship creates other legal entitlements. For example if a parent dies as the result of a work accident the child may be entitled to compensation.²¹⁹

214 *Family Law Act 1975* (Cth) s 61B.

215 *Administration and Probate Act 1958* s 52.

216 *Administration and Probate Act 1958* Part IV.

217 For a discussion of the common law responsibilities and rights of parents see Helen Gamble, *Law for Parents and Children* (2nd ed) (1986) Chapter 1.

218 *Child Support (Assessment) Act 1989* (Cth) makes parents liable for child support.

WHO IS A PARENT?

5.9 The relationship of parent and child is defined by law. Historically, children born within marriage were presumed to be the children of the woman's husband, unless it was shown beyond reasonable doubt that this could not be the case.²²⁰ The law still presumes that to be so, although this can now be more easily disproved by DNA evidence.²²¹ The law did not recognise the relationship between a child born outside marriage and their father, until the status of illegitimacy was abolished in 1974.²²²

5.10 When a child is adopted, adoption laws extinguish the legal relationship between biological parents and their children and create a new parent–child relationship with the adoptive parents. The adoptive parents have all the responsibilities of biological parents and the legal responsibilities of the biological parents are extinguished when the adoption takes place.²²³

5.11 As in the case of adoption, assisted reproduction using donated gametes enables the creation of families in which people with no biological relationship to the child become the child's social parents. For example, donor insemination enables a woman who is married or in a heterosexual de facto relationship to conceive a child who is not her partner's biological child, which the couple will bring up together.

219 If a parent dies due to a work accident, a child is entitled to compensation if under 16 years old (or under 21 years old and undertaking full time study) and economically dependent on the deceased's earnings, see the *Accident Compensation Act 1985* s 82 and 92A-92B. With respect to a parent who dies due to a transport accident, see *Transport Accident Act 1986* s 59.

220 *Ah Chuck v Needham* [1931]NZLR 551.

221 Under the *Family Law Act 1975* (Cth) where a woman is married, a child born to her during the marriage or within 44 weeks after the marriage is ended is presumed to be a child of the man (see s 69P)). If a child is born to a woman who is living with a man, then the child is presumed to be the child of that man if the couple was cohabiting during the period between 44 weeks and 20 weeks prior to the birth (see s 69Q). These presumptions can be overcome by evidence to the contrary, for example, by a paternity test which shows that the man cannot be the father. Under s 69R a person entered on a State register of births as a parent is presumed to be the parent. Similarly, the *Status of Children Act 1974* s 5 provides that the child born to a married woman during the marriage or within 10 months thereafter is presumed to be the child of the man. In addition if a father's name is entered in the register of births or there is a document that exists that expresses his agreement that he is the father, then both these are also evidence of paternity (see s 8(1)).

222 *Status of Children Act 1974*. Before 1974, however, there were some obligations relating to maintenance and some rights of custody (*Maintenance Act 1965* Pt II Div 1(4, 5) and Div 2(1)).

223 *Adoption Act 1984* s 53.

5.12 Legislation has been enacted in Victoria and at the federal level, to create legal parent–child relationships in the context of assisted reproduction. This legislation extinguishes the parental relationship between donors of gametes and the children produced as a result of the donation. However, as we explain below, different rules apply in deciding who are the parents of children born within heterosexual relationships and who are the parents of children born to single women or within lesbian relationships as a result of assisted reproduction.²²⁴

PARENT–CHILD RELATIONSHIPS WHERE HETEROSEXUAL COUPLES CONCEIVE CHILDREN BY ASSISTED REPRODUCTION

As we explained in paras 2.2–5, family relationships are regulated by both State and Commonwealth laws. In this section we explain how these laws deal with children conceived by assisted reproduction.

COMMONWEALTH LAW

5.13 The *Family Law Act 1975* (Cth) defines the parents of a child for the purposes of that Act,²²⁵ and also for the purposes of the *Child Support Assessment Act 1989* (Cth).²²⁶ The *Family Law Act 1975* (Cth) recognises parent–child relationships in the case of some children born as a result of ‘artificial conception’ which includes, but is not limited to ‘artificial insemination’ and ‘embryo implantation’. It says that if a child is born to a couple who are married, or living together on a genuine domestic basis, then if both the man and woman consent to the procedure, or if there is a prescribed Commonwealth or State law under which the child is a child of a woman or man, then the child is recognised as their child for the purposes of the *Family Law Act 1975* (Cth), or the *Child Support (Assessment) Act 1989* (Cth), even though the child is not biologically related to them.²²⁷

224 The ways in which the law distinguishes are discussed later in the following pages.

225 *Family Law Act 1975* (Cth) s 61C says that each of the parents of the child have parental responsibility for the child. Parental responsibility, in relation to a child, means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children, see s 61B.

226 *Child Support Assessment Act 1989* (Cth) s 5, which says that a parent means a person defined as a parent under the *Family Law Act 1975* (Cth) s 60H.

227 Section 60H(1), (4). The Victorian laws prescribed under this provision are ss 10A–10E of the *Status of Children Act 1974*.

**CASE STUDY 17**

Mary and John have been living together for three years. John is infertile. With John's agreement Mary has a child, Billy, as the result of insemination with sperm from a known donor, Tom. Later the couple separate. John must pay child support for Billy, because he is within the definition of 'parent' under the *Family Law Act 1975* (Cth) and also under the *Child Support (Assessment) Act 1989* (Cth), because John has consented to Mary having the insemination procedure. Tom does not have to pay child support, although he is Billy's biological father.

STATE LAW

5.14 While Commonwealth law determines parentage for some purposes, for example for the purpose of child support, the *Status of Children Act 1974* deals with children born as a result of assisted reproduction for the purposes of state laws. For example the *Status of Children Act 1974* determines parentage for the purpose of inheritance laws and for the purpose of legislation that provides for the payment of compensation to the child of a person who is killed.²²⁸ The Act says that where a child is born to a woman with the consent of her husband or her de facto partner, as the result of artificial insemination, the partner is presumed to be the father of the child²²⁹ and the donor is presumed not to be the father. Similar provision is made to deal with implantation of an embryo which is brought into existence as the result of IVF with the consent of the woman's partner, using the woman's eggs and donated sperm.²³⁰ If both donated eggs and sperm are used to produce an embryo, the woman who has the procedure is presumed to be the mother of the child and her husband or de facto partner is presumed to be the father of the child, so long as the partner consents to the woman undergoing the procedure.²³¹

228 See *Accident Compensation Act 1985* ss 92(2)(b), 92A, which deals with compensation for work accidents and *Transport Accident Act 1986* s 59.

229 *Status of Children Act 1974* s 10C.

230 *Ibid* s 10D.

231 *Ibid* s 10E.



CASE STUDY 18

Frank and Julia are married. They are both infertile. Julia has a child, Evelyn, as the result of an IVF procedure using donated eggs and donated sperm. Frank's mother dies. Her will leaves property to 'all my grandchildren'. Evelyn is entitled to a share of this property because she is a child of Frank under the *Status of Children Act 1974*.

Frank dies as the result of a work accident. Evelyn is entitled to compensation for the death of Frank under the *Accident Compensation Act 1985* because Frank is treated as her parent.

PARENT–CHILD RELATIONSHIPS WHERE SINGLE WOMEN OR WOMEN IN SAME-SEX RELATIONSHIPS HAVE CHILDREN THROUGH ASSISTED REPRODUCTION

5.15 In this section we discuss parent-child relationships where the birth mother is single, or in a same sex relationship. For the purposes of the *Infertility Treatment Act 1995* single women and women in same-sex relationships are both treated as 'single', that is as women who are not married or living in a de facto heterosexual relationship.

*IS A SINGLE WOMAN (INCLUDING A WOMAN IN A LESBIAN RELATIONSHIP) WHO GIVES BIRTH TO A CHILD THROUGH ASSISTED REPRODUCTION THE MOTHER OF THE CHILD?*²³²

5.16 Where a woman gives birth to a child as the result of donor insemination, she is the biological (and also the legal) mother of the child under State law.²³³ The *Status of Children Act 1974* does not deal with the position of a single woman who bears a child who has been conceived from a donated ova or from transplantation of an embryo conceived from a donated ovum. This leaves the status of these children uncertain under State law.

5.17 There is also some doubt about the position under Commonwealth law of children born to single women as the result of assisted reproduction. We have seen

232 We discuss the parent-child relationship where a surrogate mother gives birth to a child of a single man, or a man in a same sex relationship in Chapter 6.

233 *Status of Children Act 1975* s10F deals with paternity, but not maternity in this situation.

that the *Family Law Act 1975* (Cth) recognises that a person is a parent of such a child, if they are the parent under a prescribed State law. There is no prescribed Victorian law which says that a single woman who gives birth to a child as the result of assisted reproduction, involving either donor insemination or a technique using a donated egg or an embryo transfer, is the mother of the child. In *The Matter of Mark*²³⁴ the reasoning of Justice Brown suggests if the child is conceived from the mother's egg, the child is the woman's child under the *Family Law Act 1975* (Cth) as well as under Victorian law. This may not be the case where the child is not the mother's biological child, because there is no prescribed Victorian law to deal with this situation.

IS THE FEMALE PARTNER OF THE BIRTH MOTHER THE CHILD'S PARENT?

5.18 Neither the *Family Law Act 1975* (Cth) nor the *Status of Children Act 1974* deals with the relationship between a child conceived by a woman through assisted insemination and that woman's female partner (we call the latter woman the birth mother's partner). Where a child is conceived by a woman in a heterosexual relationship, as the result of assisted reproduction, the male partner of the birth mother is regarded as the father of the child if he consented to her undergoing the procedure. By contrast, a female partner of the birth mother does not have any legal parental relationship with the child, even if the couple have made a joint decision to have the child. As we discuss in 5.29, any person who is concerned with the care, welfare and development of the child, including the birth mother's partner, can apply for parenting orders under the *Family Law Act 1975* (Cth)²³⁵ The order may give the person rights and responsibilities in relation to the child, but does not make the partner a parent of the child.

WHAT IS THE LEGAL STATUS AND RESPONSIBILITY OF A SPERM DONOR?

5.19 When we refer to a sperm donor, we mean a person who provides sperm for assisted conception. The Family Court has recently confirmed that if a man has sexual intercourse with a woman, and a child is born as a result, he is the father of

234 Unreported decision of Justice S Brown, Family Court Of Australia 28 August 2003. Justice Brown was critical of the reasoning in *Re Patrick* (2002) 28 Fam L R 579, which is discussed below. She argued that the decision that a sperm donor to a single woman was not the child's father under the *Family Law Act 1975* (Cth) would also lead to the conclusion that a biological mother who conceived by assisted insemination would not be the child's mother (see para 46).

235 Section 65E.

the child²³⁶. This is the case even if intercourse was solely to assist the woman to conceive the child. The means by which a woman conceives, and not the motives or intention of the woman or man determine whether he is, at law, the parent.

5.20 As we have discussed above, single women and women living with female partners are not eligible for assisted reproduction treatment in Victoria, unless they are clinically infertile. However the *Status of Children Act 1974* recognises that children may be born as a result of assisted reproductive technology to women who do not have male partners. Except in the case where the woman is clinically infertile, this may occur as the result of self-insemination, or of donor insemination that occurs interstate or overseas. The Act says that where a woman who conceives a child as the result of artificial insemination is not married or in a de facto relationship, or where a woman's male partner does not consent to her insemination, the semen donor 'has no rights and incurs no liabilities' in respect of the child,²³⁷ unless he later becomes the husband of the mother. Unlike the situation where a sperm donor donates to a heterosexual couple, the legislation does not say that the donor is not the father of the child.²³⁸ This provision operates for the purposes of Victorian law.²³⁹



CASE STUDY 19

Lisa, a single woman self-inseminates, using sperm provided by her friend Julian. She has a baby, Charles. Julian dies without leaving a will. Charles is not entitled to an interest in Julian's property as Julian has no rights and incurs no liabilities to Charles. If Julian had intercourse with Lisa, instead of donating sperm so Lisa could self-inseminate, Charles would be his child, and entitled to an interest in his estate.

5.21 There is no provision in the *Family Law Act 1975* (Cth) that deals with the paternity of a child born to a single woman or a woman living with a female

236 *ND and BM* Unreported decision of Justice Kay, 23 May 2003.

237 Section 10F.

238 See 5.14.

239 However, state presumptions are not irrelevant to decisions under the *Family Law Act 1975* (Cth). While Fogarty J in *B v J* (1996) 21 Fam L R 186 suggested in obiter that State presumptions were not relevant, Guest J in *Re Patrick* (2002) 28 Fam L R 579, 645 rejected this conclusion.

partner as the result of a sperm donation.²⁴⁰ A number of Family Court decisions have considered the status of children born as a result of a sperm donation. In *B v J*²⁴¹ the Court held that a known sperm donor was not liable for child support under the *Child Support (Assessment) Act 1989* (Cth), because the definition of parent in that Act did not cover a sperm donor.²⁴²

5.22 However, as we have pointed out earlier (at para 5.19), if conception occurs as a result of sexual intercourse, not assisted insemination, even if the sole purpose of doing so was to assist a single woman, or same sex couple to conceive a child, the male is legally the father of a child born as a result.

5.23 Family Court judges have expressed different views on whether a sperm donor is a parent under the *Family Law Act 1975* (Cth). In *Re Patrick*²⁴³ Guest J found that, under the *Family Law Act 1975* (Cth), a sperm donor was not the parent of a child conceived as the result of self-insemination by a Victorian woman. Guest J said that

in the absence of express provisions in federal law, the *Family Law Act* can and should be read in light of...state and territory presumptions, [that a donor is not a parent]thereby leaving the sperm donor, known or unknown, outside the meaning of 'parent'. Where this leaves individuals such as the father [in this case] is a matter for the legislature.²⁴⁴

5.24 Guest J reached this conclusion even though the *Status of Children Act 1974* does not explicitly say that a sperm donor to a single woman is not the child's father. One reason he gave for this decision was that otherwise an

240 See paras 2.2–17 for a full explanation of the provisions regarding maternity and paternity in the *Family Law Act 1975* (Cth) in relation to the relationship status of the parent or parents.

241 (1996) 21 Fam LR 186.

242 The *Child Support (Assessment) Act 1989* (Cth) s 5 says that when the expression 'parent' is used in relation to a child born because of the carrying out of an artificial conception procedure it means a person who is a parent under s60H of the *Family Law Act 1975* (Cth). In *B v J*, Fogarty J concluded that, because the *Child Support (Assessment) Act 1989* (Cth) says parent 'means' a parent under s 60H of the *Family Law Act 1975* (Cth), a person is only a parent of a child conceived through artificial conception if they come within s60H; ((1996) 21 Fam LR 186). He left open the possibility that the definition of parent for the purposes of the *Family Law Act 1975* (Cth) might be broader. In *Tobin v Tobin* (1999) FLC 92 the Full Court held that the biological parent of a child was the child's parent for the purpose of the maintenance provisions of the *Family Law Act 1975* (Cth). This could mean, for example that a person who was not a parent for the purposes of child support could be liable to pay child maintenance under the *Family Law Act 1975* (Cth). ((1996) 21 Fam LR 186).

243 (2002) 28 Fam LR 579.

244 Ibid 645.

anonymous sperm donor could deposit ‘his semen at a sperm bank only to find that he has parental responsibilities under the *Family Law Act*²⁴⁵ if he was later identified.²⁴⁶

5.25 In *The Matter of Mark*²⁴⁷ Brown J reached a different conclusion about whether a sperm donor was the father of a child, Mark. Mark was born in California under a surrogacy arrangement with Mr and Mrs S. Mrs S was implanted with an embryo created from the sperm of Mr X and an egg obtained from an anonymous woman. The purpose of this arrangement was to create a child for Mr X and Mr Y. After the child was born he was brought back to Australia, where he lived with and was cared for Mr X and Mr Y, who was Mr X’s partner.

5.26 It will be recalled that s 60H of the *Family Law Act 1975* (Cth) says that if a person is the parent of a child born through assisted reproduction under a prescribed State law they are also their parent under the *Family Law Act*. Although there was no ‘prescribed state law’ which made Mr X Mark’s parent Brown J found that Mr X was Mark’s parent.

5.27 Brown J said that s 60H of the *Family Law Act 1975* (Cth), which defines ‘parent’ for the purposes of children conceived through assisted reproduction, was not intended to restrict the meaning of parent, but rather to enlarge it. Mr X, was Mark’s parent within the ordinary meaning of the word and under the Act, even though Mark had been born as the result of a surrogacy arrangement. She pointed out that if the reasoning of Guest J applied, a single woman who was the biological mother of a child, but conceived the child through assisted reproduction, would not be the child’s mother under the Act.

5.28 To conclude, it is clear that a sperm donor is not liable to pay child support. However, under the *Family Law Act 1975* (Cth) it is not clear whether a person who donates sperm to a single woman is the parent of a child born as the result of the donation. Obviously the status of sperm donors should be clarified, although this issue may not be able to be resolved by amendments to State legislation.

245 Ibid.

246 See also *P v P* (1997) FLC 92–790 where a child conceived by a married woman after her husband withdrew his consent to her artificial insemination had only one parent, her mother.

247 Unreported decision of Justice S Brown, Family Court of Australia 28 August 2003.

CAN A SPERM DONOR APPLY FOR RESIDENCE OR CONTACT UNDER THE FAMILY LAW ACT?

5.29 In *Re Patrick*²⁴⁸ Guest J found that a sperm donor is not a parent. In *The Matter of Mark*²⁴⁹ Brown J took the opposite view. Regardless of which view is correct, a sperm donor who is concerned with the care, welfare and development of the child can apply to the Family Court for a parenting order. The order may deal with where the child will live (a residence order) the circumstances in which the child will have contact with the person applying for the order (a contact order) the maintenance of the child²⁵⁰ or with any other aspect of parental responsibility, for example where the child will go to school (a specific issues order).²⁵¹ The Court must always consider the best interests of the child as the paramount consideration when deciding whether to make a parenting order.

5.30 In *Re Patrick*²⁵² disagreement between the birth mother, her partner and the sperm donor about contact between the donor and the child resulted in the donor seeking parenting orders in the Family Court. Initially orders were made by consent, giving the donor limited contact with the child. When these arrangements failed the mother and her partner and the donor made further applications to the Family Court. Guest J made a parenting order that gave the donor substantial contact with the child. He referred to s60(2)(B) of the *Family Law Act 1975* (Cth) which says that children have a right of contact, on a regular basis, with people other than parents who are significant to their care, welfare and development. His decision was that it was in the best interests of the child, Patrick, to have contact with the man who was his biological father and with whom he had previously had some contact. Guest J commented on the failure of the law to deal adequately with children born in families outside ‘the traditional heterosexual model’.

248 (2002) 28 Fam LR 579.

249 Unreported decision of Justice S Brown, Family Court of Australia 28 August 2003.

250 The court cannot make child maintenance orders in relation to a child for whom an application for administrative assessment of child support can be made; *Family Law Act 1975* s 66E. Applications can be made in relation to children over 18 where maintenance is necessary to enable them to complete their education or because of the mental or physical disability of the child.

251 Parenting orders can be made in favour of a parent or of some other person (s 64C). For the types of orders which may be made see *Family Law Act 1975* (Cth) s 64B(2-6).

252 (2002) 28 Fam LR 579.

Not all families using artificial insemination procedures fall into the traditional heterosexual model... Accordingly consideration should be given to review the definition of 'parent' [in the *Family Law Act*]...to take into account that there are varying arrangements between donors and prospective mothers, and that donors of genetic material such as the father in these proceedings may not only consider themselves to be a 'parent', but may also be considered by the recipient of the genetic material to be a parent.²⁵³

He also considered that the definition of parent in State laws should be reviewed.

5.31 In *The Matter of Mark*²⁵⁴ where Mark was conceived under a surrogacy arrangement and cared for by his biological father Mr X (who had donated the sperm) and Mr Y, Mr X's partner, Brown J found that it was in Mark's best interests to make parenting orders under which Mark was to live with Mr X and Mr Y and they were responsible for his long-term and day-to-day care, welfare and development. An order was also made for Mark to have contact with Mrs S, his surrogate mother.

PROBLEMS WITH THE CURRENT LAW

5.32 In this section we discuss problems relating to:

- the legal relationship between the birth mother's female partner and a child conceived through assisted reproduction; and
- the legal relationship between a child conceived using donor gametes, the child's birth mother and the donor.

We discuss the problems with the current law dealing with relationship between a child born under a surrogacy agreement made for the benefit of a single man or male couple and the birth mother in Chapter 6.²⁵⁵

RELATIONSHIP WITH THE BIRTH MOTHER'S FEMALE PARTNER

5.33 Under the current law a birth mother's female partner who performs the role of parent is not legally defined as a parent, regardless of whether she is involved in the decision to have a child or is actively involved in caring for the child when he or she is born. This has important implications for the child,

253 (2002) 28 Fam LR 579, 647–8.

254 Unreported decision of Justice S Brown, Family Court of Australia 28 August 2003.

255 See paras 6.15–17.

affecting their rights to child support and inheritance, as well as their legal relationship with the extended family of the partner. The failure of the law to recognise the parental role of the birth mother's partner may also affect the stability of the family. Examples of problems which may be encountered by these families are set out in more detail below.

PROBLEMS UNDER COMMONWEALTH LAW

5.34 The *Family Law Act 1975* (Cth) says that 'each of the parents of a child who is not 18 has parental responsibility for the child'.²⁵⁶ This provision applies while parents are living together and after they separate, unless a court makes a contrary order. In Case Study 20 below, where the child is conceived using IVF and the couple are married, either the husband or the wife can consent to the child having a medical procedure. By contrast, in Case Study 21, where the child is conceived by a birth mother in a lesbian relationship, the partner cannot consent to the procedure, because she is not defined as a parent. This is the case, even though the partner may have been involved in the decision to conceive the child and have undertaken the full responsibilities of a parent. The partner does not have the legal status to consent to medical treatment, give permission for the child to go on a school trip, or consent to the child having dental treatment.



CASE STUDY 20

Spiro and Toula are married. They have a child, Paris, through IVF. After Spiro goes overseas on an extended holiday the doctor tells Toula that Paris needs an operation to correct a heart problem. Spiro cannot be contacted. Toula can agree to Paris's operation.



CASE STUDY 21

Janine and Maria are a lesbian couple who have had a child, Sanya, born to Maria as the result of assisted insemination. Maria and Sanya have had a serious car accident as the result of which Sanya needs orthopaedic surgery. Maria is very ill and Sanya is only two years old. Janine cannot consent to the surgery.

5.35 If a lesbian couple separates, the birth mother's partner is not liable for child support under the Commonwealth *Child Support (Assessment) Act 1989* (Cth).²⁵⁷ If the couple have made an explicit agreement that the partner will financially support the child this agreement will probably be enforceable,²⁵⁸ but in the absence of an agreement the partner does not have to contribute to the child's maintenance.

5.36 As we have seen, the *Family Law Act 1975* (Cth) allows a person who is concerned with the care, welfare and development of the child to apply to the Family Court for a parenting order, which may include an order about who the child will live with (a residence order), contact with the child (a contact order) or other aspects of parental responsibility (a specific issues order).²⁵⁹ An order can be made in favour of a person who is not a parent.

5.37 One way a lesbian couple can recognise the role of the birth mother's partner is for the couple to seek a residence order under which the child will live with the birth mother and her partner or a specific issues order allowing the birth mother's partner to exercise aspects of parental responsibility in relation to the child.²⁶⁰ Some parenting orders can be made with the consent of the parties. If an order by consent is to be made in favour of people who are not the child's parents

257 *Child Support (Assessment) Act 1989* (Cth) s 5 uses the definition of 'parent of a child born through assisted conception that is used in the *Family Law Act 1975* (Cth) s 60H.

258 If the agreement is a legal contract that requires some 'consideration' it will be enforceable. Alternatively if a promise has been made on which one of the parties has acted to their detriment it will be enforceable under the equitable doctrine of estoppel. *W v G* (1996) 20 Fam LR 49. This case did not recognise the birth mother's partner as a partner, but rather affirmed that an agreement between the two woman which contained child support provisions was enforceable because the partner had undertaken to support the children and the birth mother had acted on this to her detriment.

259 *Family Law Act 1975* (Cth) s 65C(c).

260 *Re Patrick* (2002) 28 Fam LR 579, 645.

the *Family Law Act 1975* (Cth) says that the court cannot make the order unless it is satisfied that the parties have attended a conference with a family and child counsellor or welfare officer to discuss the matter, and the court has considered a report prepared by the counsellor or welfare officer, or the court is satisfied that the order can be made even though these conditions have not been satisfied.²⁶¹ However, if the order is to be made in favour of people who include a parent, these requirements do not have to be satisfied. For example, if the birth mother and her female partner consent to a parenting order, no conference is necessary before an order is made in favour of the birth mother and her partner.²⁶² The Commission understands that some lesbian couples have obtained orders without attending a conference.

5.38 Although applying for a parenting order may be a means of recognising the birth mother's partner as the social parent of the child, this requires the couple to incur legal costs and the expense of obtaining a court order. It may also amount to discrimination, because it imposes a requirement or condition on the birth mother, or subjects her to a detriment by reason of her sexual orientation.

5.39 Where a parenting order is sought the Family Court may order that notice of the proceedings is served on other people, so that they are given an opportunity to participate in any proceedings. *In the Matter of Mark*²⁶³ the application for parenting orders by Mr X and Mr Y was served on the surrogate mother and her husband in California. They advised Mr X and Y that they did not wish to take part in the proceedings. The Family Court could also order that notice of the application be served on a known sperm donor. The Commission has been told of some cases where the sperm donor and his partner were notified of proceedings and provided affidavits consenting to the making of orders in favour of a lesbian couple.

5.40 If a lesbian couple who have a child through assisted reproduction later separate and the couple cannot agree about where the child is to live or who is to have contact with the child the birth mother's partner could apply to the Family Court for a residence or contact order. Similarly either member of a homosexual couple who had a child as the result of a surrogacy arrangement made overseas could apply to the Family Court for a parenting order after separation. The 'best

261 Section 65G.

262 It is assumed that a lesbian woman who conceives through donor insemination is within the definition of 'parent' for the purposes of the *Family Law Act 1975* (Cth) (see 5.15–5.18, 5.27).

263 Unreported decision of Justice S Brown, Family Court of Australia 28 August 2003.

interests of the child' are the paramount consideration in deciding whether a contact or residence order should be made. The Act sets out the factors that must be taken into account in determining the best interests of the child.²⁶⁴ In rare situations it might be found to be in the child's best interests to live with a person other than his or her biological parent.

5.41 Under the *Family Law Act 1975* (Cth) parents are encouraged 'to agree about matters concerning the child rather than seeking an order from the court'.²⁶⁵ They are able to make and register a parenting agreement dealing with residence, contact, maintenance or parental responsibility. When registered a parenting plan has the same effect as court order.²⁶⁶ However a parenting order cannot be made and registered before the birth of a child. In addition, because the partner of the birth mother is not a parent the couple could not make a parenting agreement to deal with these matters after the child was born.

PROBLEMS UNDER STATE LAW

5.42 If the birth mother dies her female partner has no legal status in relation to the child, even though she has been one of the child's carer's for the whole of the child's life. The birth mother can make a will appointing her partner as the guardian of the child, but this does not preclude another relative of the birth mother applying to the Family Court for an order that the child live with him or her.

5.43 Because the birth mother's partner is not recognised as the child's parent under State law, the child is not entitled to a share in the partner's property if the partner dies without leaving a will.²⁶⁷ Nor may the child be able to claim compensation under legislation that gives children financial entitlements when their parent is killed.²⁶⁸

264 Sections 65F and 68F(2).

265 Section 63C.

266 Sections 63C and E. The plan can be set aside by the court in certain situations, including where it is in the best interests of the child (see s 63H).

267 However, the child may be able to apply to the court for a share of the partner's property under the *Administration and Probate Act 1958*.

268 Under the *Accident Compensation Act 1985* ss 82, 92A, where an accident occurs to a worker, 'dependants' are allowed to claim. If a person was 'mainly or partly dependent on the earnings of the worker', or would have been dependent had the worker not been injured (s 5), he or she can claim. This includes situations where the worker injured was the birth mother's female partner, provided the child of that person was a dependant. Note that in certain circumstances a person who is not a child



CASE STUDY 22

Jeanette and Sara are a lesbian couple who conceive a child, Cody, through assisted conception. Jeanette, the birth mother works full time. Sara was the full-time carer for Cody until he went to school and after that worked part-time so she could be home when school hours were over. When Cody was 13 Sara was killed in a car accident. She did not leave a will. Cody is not entitled to transport accident compensation for Sara's death.²⁶⁹ Nor is he entitled to the share of her estate which passes to a child.

Alternatively, assume that when Cody was 19 Sara was murdered. Because he is not her child Cody may not be eligible for victims' assistance.²⁷⁰

THE ROLE OF THE BIRTH MOTHER'S PARTNER

5.44 When considering possible reforms, it is important to recognise the different roles birth mothers' partners may have in the decision of the birth mother to have a child. Some may be fully involved, others may respect their partner's desire to have a child, but not wish to become involved, others may be actively opposed. This is no different from the range of responses to parenting, and accessing assisted reproductive services of heterosexual couples. The *Infertility Treatment Act 1995* requires a husband or male partner to consent to the provision of assisted reproductive services to a woman. We need to consider whether a similar requirement should apply to same-sex couples. Equality before the law principles, and the operation of anti-discrimination laws would suggest that this

may be able to claim as a dependant; See for example *Wrongs Act 1958* s17 which allows dependants to claim compensation for the wrongfully caused death of a person on whom they were dependant.

269 Under the *Transport Accident Act 1986* s 59, Cody would not be entitled to compensation because the Act does not recognise him as a child of the person who died in the accident (see definitions of dependant and partner in the Act, s 3. Arguably the concept of 'child' is extended by the definition of parent in s 3, though this interpretation seems unlikely.)

270 To come within the definition of a related victim under s11 of the *Victims of Crime Assistance Act 1986* a person must be a close family member, which includes a child or step child of the victim or a child of whom the deceased victim was a guardian. A person can also be a related victim if they are a dependant or had an intimate personal relationship with a person who is killed. The latter expression is not defined. If the mother's partner is caring full time for a child under 18, but is not their guardian (and there is no financial dependency) it would be necessary to rely on the 'intimate personal relationship' provision, in order to claim. Similarly if the child was over 18 and not dependent. By contrast if the partner becomes aware of an act of violence to a child under 18 and they are responsible for caring for the child they would come within the 'secondary victim' provision and could claim compensation for themselves if the child was injured (see s 9, 10A and s 25).

should be the starting point for discussion. However, consideration should be given to whether a partner's consent should be required, or whether that interferes with the freedom of the woman who wants to have a child to access treatment. Regardless of whether the partner's consent should be required, consideration should also be given to the different interests of partners. Some may wish to be recognised as a parent, while others may not. Should a partner have the right to choose whether she wishes to be regarded by the law as a parent, and if she has that right, how and at what time should she exercise that right are some further issues that need to be considered. The Commission seeks comment on these questions.

POSSIBLE REFORMS

5.45 The role of the birth mother's partner could be recognised in a number of ways.

- **Adoption.** The partner could adopt the child, with the result that both she and the birth mother would be the parents. Adoption would allow a person who entered into a relationship with the birth mother after the child was born to become a parent, along with the birth mother. Another advantage of this approach is that an adopted child is regarded as a person's child for the purposes of both Victorian and Commonwealth law.²⁷¹ As we discuss below, the partner is not currently able to adopt the child in Victoria. The *Adoption Act 1984* would require amendment to permit this to occur. Western Australia has recently introduced a law permitting same-sex couples to adopt children in the same circumstances as can a heterosexual couple.²⁷² Tasmania has recently passed a law permitting people in same-sex relationships to adopt the child of their partner.²⁷³ We discuss adoption in more detail below (para 5.58 ff).
- **Legislation could be enacted to provide that where the couple are living together on a genuine domestic basis the partner is a parent of a child born to the other.** The *Status of Children Act 1974* could be amended to achieve this effect under State law. This would treat children born as the result of assisted reproduction to women in lesbian relationships in the same way as children born naturally within heterosexual de facto

271 *Family Law Act 1975* (Cth) s 60D defines a child as 'an adopted child'. However, the Family Court may have to give leave for an adoption by a 'parent' who is a prescribed adopting parent under s 60D.

272 *Acts Amendment (Lesbian and Gay Law Reform) Act 2002* (WA).

273 *Relationships (Consequential Amendments) Act 2003* (Tas) Sch 1—Consequential Amendments.

relationships. A possible objection to this approach is that it does not require the birth mother's partner to consent to the procedure, but automatically makes her a parent. This would be the case regardless of the length of the relationship. It would be necessary for this provision in the *Status of Children Act 1974* to become a 'prescribed law' under s 60H of the *Family Law Act 1974* (Cth) for this to apply for the purposes of Commonwealth law.²⁷⁴

- **Legislation could be enacted to provide that the partner is a parent of a child born as a result of a treatment procedure, if the partner consents to the birth mother having the procedure.** A provision of this kind would be similar to current state²⁷⁵ and federal laws which deem a man who consents to his female spouse having treatment to be the father of the child. The *Parentage Bill 2003* (ACT) contains a provision to this effect.²⁷⁶ As with the previous option this would require an amendment to the *Status of Children Act 1974* and that provision would have to be a 'prescribed law' under s 60H of the *Family Law Act 1975* (Cth) for this to apply for the purposes of Commonwealth law. It would also be necessary to define 'partner'. This has already been done in Victoria in acts regulating many other aspects of people's lives by the *Statute Law Amendment (Relationships) Act 2001*.
- **Provision could be made making the birth mother's partner a parent if she were registered as a parent in the Register of Births Deaths and Marriages.** The legislation would allow the birth mother's partner to be registered as a parent and treated as a parent. The Births Deaths and Marriages legislation is discussed in more detail below. Again the *Family Law Act 1975* (Cth) might have to be amended for this provision to apply for the purposes of Commonwealth law.

5.46 If the law is not changed the female partner of a birth mother will have to apply to the Family Court for a parenting order to have her relationship with the child recognised. The Commission would be interested in hearing views about whether the birth mother's partner should be recognised as a parent and if so the best means of achieving this result. Is it common practice for lesbian couples to seek parenting orders, in order to recognise the role of the birth mother's partner

274 See *Family Law Act 1975* (Cth) s 60H.

275 *Status of Children Act 1974* s 10C,D, E; *Family Law Act 1975* (Cth) s 60H.

276 *Parentage Bill 2003* (ACT) cl 11(4) and *Legislation Act 2001* (ACT) s 169. Note that when a child is conceived without use of assisted reproduction, a same sex partner is deemed to be the parent, if they were living with the mother at a specified time cl 8.

in the life of the child? What are the advantages and disadvantages of this process from the point of view of children and parents?

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QUESTION(S)

34. Should the law recognise the birth mother's female partner as the parent of the child?
35. If so, in what circumstances should the law treat the birth mother's female partner as the parent of the child? Should it be necessary to show that the partner
- adopted the child;
 - consented to the birth mother undergoing the procedure;
 - was living with the birth mother on a genuine domestic basis at the time the child was born; or
 - was registered as a parent in the Register of Birth's Deaths and Marriages?
36. Are there any other legal means of recognising a relationship between the child and the birth mother's female partner?

RELATIONSHIP WITH THE SPERM DONOR***PROBLEMS UNDER STATE LAW***

5.47 As we have seen, the *Status of Children Act 1974* says that a donor whose sperm is used to inseminate a woman without a male partner or a woman whose husband does not consent to her insemination, 'has no rights and incurs no liabilities' in respect of the child.²⁷⁷ Unlike the provision that applies where a child is conceived within a heterosexual relationship, the Act does not say that the donor is not the father parent of the child. As we have discussed above, there are conflicting family Court decisions on whether the donor is a parent under the *Family Law Act 1975* (Cth). It is arguable that the *Status of Children Act 1974* should explicitly state that a donor is not the parent of the child. This is the

277 *Status of Children Act 1974* s 10F.

approach taken under the *Artificial Conception Act 1984* (NSW). The effect of such a provision would be that children born to single women and women in same-sex relationships would have a legal mother but no legal father, for the purposes of State law.²⁷⁸

5.48 Helen Gamble has argued that it would be preferable for the law to recognise the biological fact of parenthood, while at the same time ensuring that the sperm donor who is the child's biological father, does not have the rights or responsibilities of a legal father.²⁷⁹ She suggests that this would be consistent with the child's need to know their biological parentage. The *Status of Children Act 1974*²⁸⁰ could be amended to make it clear that the donor is the child's father but has no rights and responsibilities in relation to the child. However such a provision would not be binding for the purposes of Commonwealth law. A sperm donor who was a parent under State law might also be held to have responsibilities under the *Family Law Act 1975* (Cth), for example he might have responsibility to maintain the child.

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QUESTION(S)

37. Should the *Status of Children Act 1974* explicitly provide that a child born as the result of a semen donation to a single woman or a woman in a lesbian relationship is not the child of the semen donor?
38. Alternatively, should the *Status of Children Act 1974* recognise a known donor of semen to a single woman or a woman in a lesbian relationship as the father of a child born as the result of self-insemination, but provide that a father who is a donor the father has no rights and responsibilities in relation to the child?

278 Compare *P v P* (1997) FLC 92–790 where a husband consented to his wife having artificial insemination but later withdrew his consent. Mullane J held that the child had 'only one parent, her mother' (at 84, 741).

279 Helen Gamble, 'Fathers and the New Reproductive Technologies: Recognition of the Donor as Parent' (1990) 4 *Australian Journal of Family Law* 131 140–142. It should be noted that Gamble was writing at a time when there was no provision allowing the child to have access to the donor's identity.

280 The amendment would provide that the donor was the child's father but had no rights and liabilities in relation to the child.

ISSUES UNDER COMMONWEALTH LAW

5.49 When heterosexual couples conceive a child through use of gametes donated anonymously they do not usually intend that the donor will have any ongoing relationship with the child. Once the child turns 18 the child has a right to receive information about the donor's identity. Children so conceived will only be able to exercise this right if they know how they were conceived. In theory, a person who donates sperm to a heterosexual couple could apply to the Family Court for a parenting order. In practice, anonymous donors will not apply for contact orders, because they will not normally know the identity of the couple and the child, while the child is young.

5.50 By contrast, single women and women in lesbian relationships in Victoria often self-inseminate using sperm from known donors. They and their sperm donors may have a variety of intentions about the role that the man will play in the life of the child. Sometimes the woman, her female partner (if she has one) and the donor intend the donor to have an ongoing relationship with the child, in the same way as a family friend or relative, but not to be involved in decision-making about the upbringing of the child. In other situations the birth mother and her female partner (if she has one) may intend to tell the child how he or she was conceived but may not intend the sperm donor to have any contact with the child. Sometimes the birth mother may want the man to share parenting responsibilities with her and her partner. Sometimes the birth mother and her female partner may intend that the sperm donor's male or female partner will be involved in caring for the child. (For example it could be intended that the child has 'two mums and two dads'.) The intentions that the birth mother, her partner if any, the sperm donor and the sperm donor's partner had before the child was conceived may change after the child is born.

5.51 There are difficulties in designing legal rules to fit the wide range of circumstances in which children may be born to single women or women in lesbian relationships as the result of assisted reproduction techniques. Divorce and the consequential rise in blended families have also created a wider range of relationships for children and stepchildren in blended families. However, there are clear legal rules that determine parentage in heterosexual families.

5.52 Because self-insemination occurs outside licensed clinics, single women, lesbian couples and donors may not be aware of all the issues which can arise after the child is born, and may not work through the issues with the assistance of a professional counsellor, as heterosexual couples are required to do before undergoing assisted reproduction. For a few families this may later give rise to

conflicts about the role that the donor is to play in the child's life and to the donor applying for a parenting order in the Family Court.

5.53 In *Re Patrick* Guest J suggested that

Parties to artificial insemination should be able to plan parenting arrangements prior to conception in an endeavour to avoid, or at least minimise, future conflicts in the interests of the prospective child.²⁸¹

However, he also acknowledged that such agreements would not 'dictate the final outcome of a case'.²⁸² For example a provision that a donor should not have any contact with the child could be overridden by a court finding that contact was in the best interests of the child.

5.54 The *Family Law Act 1975* (Cth) allows parents to make 'parenting plans', which when registered take effect as if they are a court order.²⁸³ As only parents can make parenting plans this approach is not available to lesbian couples or to lesbian couples and a known donor.²⁸⁴ In addition, a provision in a parenting plan that the child will live with a non-parent does not have the effect of a court order, so that a provision in a parenting plan for the child to spend periods of time living with the donor would not be enforceable.²⁸⁵

5.55 The parenting plan provisions of the *Family Law Act 1975* (Cth) are relatively rarely used by heterosexual couples, because it is easier for them to consent to parenting orders. Similarly a couple and a donor can obtain parenting orders by consent, subject to the safeguards discussed in 5.37. Such orders cannot be obtained prior to the birth of the child.

5.56 This reference requires us to consider how much weight should be given to the wishes of the birth mother and her partner about the relationship between the child and the donor, and how these wishes should be given effect. The Australian constitutional framework limits the legal means by which the wishes of the birth mother and her partner can be given effect. Even if it were considered desirable to amend the *Family Law Act 1975* (Cth) to allow single women, lesbian couples and donors to make agreements about the relationship between the donor and a child born as the result of the donation, it is beyond the power of the Victorian Law

281 (2002) 28 Fam L R 579, 648.

282 Ibid.

283 *Family Law Act 1975* (Cth) Pt VII Div 4.

284 Section 63C(1)(b).

285 Section 63F (5).

Reform Commission to recommend changes to Commonwealth legislation. In addition, the Court will not be bound by parenting agreements—the criterion for parenting orders remains the ‘best interests of the child’.

5.57 The Commission would welcome views on how families could be assisted to make arrangements prior to conception, which would reduce the risk of disputation after the child is born. In particular the Commission would be interested in hearing views about the extent to which such disagreements would be avoided if counselling were made available to single women, lesbian couples and donors.

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QUESTION(S)

39. What kinds of oral or written arrangements do single women and lesbian couples typically make with sperm donors?

40. What is the best way of encouraging people to plan their arrangements in order to minimise future conflict?

ADOPTION

5.58 One way to create a parental relationship between a child conceived through assisted reproduction and the birth mother’s partner would be to permit the partner to adopt the child.²⁸⁶ In order to make an adoption order, the court must be satisfied that the adopting parents satisfy certain criteria, enumerated in s 35 of the *Adoption Regulations 1998*. These requirements are that:

- (a) the personality, age, emotional, physical and mental health, maturity, financial circumstances, general stability of character and the stability and quality of the relationship between the applicants and between the applicants and other family members, are such that he or she has the capacity to provide a secure and beneficial emotional and physical environment during a child’s upbringing until the child reaches social and emotional independence;

286 For a discussion of the issues relating to adoption by single men and male same sex couples of children born through a surrogacy arrangement, see paras 6.15–17, 6.51.

(b) if an applicant has had the care of a child before applying for approval as suitable to adopt a child, he or she has shown an ability to provide such an environment for the child.

5.59 In Victoria however, the birth mother's female partner is normally unable to adopt the child, even if these criteria are met. The reasons are discussed below. By contrast, in Western Australia, same-sex couples are permitted to adopt in all circumstances in which heterosexual couples are.²⁸⁷ Where a same-sex couple adopt a child in Western Australia, the adoption must be recognised in Victoria.²⁸⁸ As a result of recent legislative changes in Tasmania, a person in a same-sex relationship is now able to adopt the child of his or her partner.²⁸⁹

5.60 The *Adoption Act 1984* contains several obstacles to adoption of children conceived in same-sex relationships. First, the Act normally requires people who wish to adopt to be married or in a de facto relationship of at least two years duration.²⁹⁰ Traditional Indigenous marriages are also recognised, provided they are of at least two years duration. The Act does not provide for same-sex relationships. Single people may only adopt if the Court is satisfied that 'special circumstances' exist in relation to the child, which make adoption of that child by one person desirable.²⁹¹ Where a couple is involved the partners must adopt as a couple.

5.61 Secondly, the Act limits 'known child' adoption²⁹² (adoption of a child by a person who knows the child). This is allowed only in specified situations. The partner (spouse or de facto spouse) of a parent or adoptive parent can apply to adopt a child of that spouse, but the Act specifies that this application should only be granted if making an order under the *Family Law Act 1975* (Cth)²⁹³ would not make adequate provision for the welfare and interests of the child; exceptional

287 The *Acts Amendment (Gay and Lesbian Law Reform) Act 2001* (WA) extends the definition of 'de facto' in s 39 of the *Adoption Act 1994* (WA) to include same-sex couples. This enables same sex couples who have been in a relationship for at least three years to apply to adopt a child under the *Adoption Act 1994* (WA).

288 *Adoption Act 1984* s 66.

289 *Relationships (Consequential Amendments) Act 2003* (Tas).

290 Section 11(1)–(4).

291 Section 11(3).

292 Most adoptions are placement adoptions. The child is placed by an agency with a family that has no connection with the child.

293 The *Adoption Act 1984* s 11(6) refers to a guardianship or custody order under the *Family Law Act 1975* (Cth). These have been replaced by parenting orders.

circumstances exist warranting the making of an adoption order and adoption would make better provision for the welfare of the child than a Family Court order.²⁹⁴ The same criteria apply if the person applying to adopt is a relative of the child.²⁹⁵

5.62 The restriction on ‘known child’ adoption was intended to ensure that people could not make private adoption arrangements, because it was thought that these did not necessarily ensure that the adoption was in the best interests of the child.²⁹⁶ In addition, there was concern that the interests of the other parent might not be sufficiently considered. Although an exception was made for adoption by a spouse or de facto spouse of the parent or by a relative of the child, this form of adoption was also restricted because it was thought the child’s relationship with their biological parent should not usually be extinguished. The *Family Law Act 1975* (Cth) reflects the view that it is normally in the best interests of the child to maintain their relationship with a biological parent, even if that parent cannot care for the child. Instead of severing the relationship with the child’s biological parent it is considered preferable to recognise the other person’s role in the child’s life by use of parenting orders under the Act. For example, instead of the mother’s new spouse (a step-parent) adopting the child, a parenting order may be made in favour of the step-parent.

5.63 Because the birth mother’s partner is neither a spouse or de facto spouse of the birth mother or a relative of the child, the provisions allowing ‘known child adoption’ do not apply. This is despite the fact that the concerns about preserving the child’s relationship with a biological parent do not apply to the case of adoption of a child conceived through assisted reproduction by the birth mother’s partner in a same-sex relationship. Similarly, if a same sex couple and their sperm donor want the donor to have a parental relationship with the child, the provision allowing a relative to adopt does not permit this to occur.

5.64 The third barrier to the use of adoption to create a parental relationship between the child and the birth mother’s partner is that the *Adoption Act 1984* does not allow the birth mother to maintain her parental relationship with the child, if the child is adopted by someone else. For example, if a mother wished her

294 *Adoption Act 1984* s 11(6).

295 Section 12. ‘Relative’ is defined as a grandparent, brother, sister, uncle or aunt of the child, whether the relationship is of whole blood or half-blood or by affinity, and notwithstanding that the relationship depends upon the adoption of any person (s 4).

296 Helen Gamble, *Law for Parents and Children* (2nd ed) (1986) 154.

female partner to adopt the child, she would have to relinquish her own status as parent.²⁹⁷ Similarly, if she and her female partner wished to parent the child with a donor, he could not adopt the child without the birth mother relinquishing her status as parent. The provision that allows a spouse or heterosexual partner of a parent to adopt a child allows both members of the couple to adopt, so that the child becomes the child of both of them. If the Act were amended to allow the birth mother's partner to adopt a child conceived through assisted reproduction it would be desirable for a similar provision to be enacted allowing the child to be adopted and treated as the child of both of them.

5.65 Restrictions on adoption also prevent same sex couples and single women and men from seeking to adopt children who are already born. At present there are very few Victorian children available to be adopted. The *Adoption Act 1984* provides for recognition of overseas adoptions in certain situations.²⁹⁸ The Commission would be interested to hear from lesbian or homosexual couples who have arranged adoptions overseas, about any legal difficulties they may have faced on their return to Australia.

RESTRICTIONS IN THE *ADOPTION ACT 1984*

5.66 In summary, the restrictions in the *Adoption Act 1984* currently are:

- Normally only people who are married or living in a heterosexual de facto relationship for a period of at least two years can adopt a child. Single people can adopt in exceptional circumstances.
- The *Adoption Act 1984* does not allow couples in same-sex relationships to adopt children, even if they otherwise meet statutory criteria designed to ensure their capacity to parent.
- The *Adoption Act 1984* does not allow the partner of a parent in a same sex relationship to adopt the child of his or her partner, without the partner relinquishing their child.

297 Section 53 provides that the adopted child becomes the child of the adopter(s) and ceases to be the child of the person who was the parent before the adoption took place.

298 Section 67 requires the adoption to be effective under the law of the country in which it has occurred and for that country to have been the usual place of abode for the adoptive parent or parents 12 months prior to the adoption, or for the Secretary of the Department of Human Services (DHS) or an approved agency to have approved of the placement of the child with the proposed adoptive parents.

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QUESTION(S)

41. Should same-sex couples should be permitted to adopt children? Should this apply in all circumstances in which heterosexual couples can adopt—that is, both known child and placement adoptions?
42. Should a donor be able to adopt a child jointly with a single mother or with a lesbian couple?
43. Should a donor and his partner be able to adopt a child jointly with a single mother or with a lesbian couple?
44. To what extent are lesbian and homosexual couples involved in overseas adoptions? What legal difficulties arise in these circumstances?

THE RIGHT TO INFORMATION

5.67 It is important to bear in mind that the right to know in this context is the right of a child to know his or her biological origin, not the right of the donor of gametes to know the child born as a result.

5.68 The *Infertility Treatment Act 1995* now recognises the right of children to receive information about their biological origins, although many parents do not tell their children that they were conceived through assisted reproduction.²⁹⁹ Clinics which are licensed to carry out assisted reproduction must keep a register which includes information about a number of matters, including details of donors whose gametes are stored, women who undergo treatment and their husbands and

299 A study conducted by Jenny Blood, Penny Pitt and HWG Baker found that 37% of families surveyed had told their children of their donor conception. However, the authors point out that this figure may not represent an accurate picture of the numbers of people who disclose. It may be that less people would disclose, if one assumes that the low response rate to the survey (25%) could mean that those respondents who agreed to participate were those who were more likely to tell. However, the findings seemed to indicate that there is a trend toward more parents informing their children over the past decade, indicating that a higher rate of disclosure might eventuate (Jenny Blood, Penny Pitt and HWG Baker, *Parents Decision to Inform Children of their Donor (Sperm) Conception and the Impact of a Register which Legislates to Enable Identification of Donors* Royal Women's Hospital Melbourne and the University of Melbourne, unpublished paper, copy provided to the VLRC by Jenny Blood).

partners. Doctors who are authorised to carry out artificial insemination outside licensed clinics must keep similar records.³⁰⁰ Information about births of children as the result of donor treatment must be regularly forwarded to the Infertility Treatment Authority (ITA) by the clinic or doctor every six months.³⁰¹ In addition the woman who gives birth to a child produced from donated gametes, or her husband and any doctor or nurse who attends her and is aware of the fact that donated gametes were used, is required to provide information about the parents and the child to the ITA.³⁰² In practice this rarely occurs.³⁰³ Generally speaking notifications are made by clinics, rather than the child's parents or doctors or nurses outside clinics.

5.69 The ITA is required to keep a central register containing this information, which will include the donor's name and contact details, the name and contact details of parents of offspring conceived through donor procedures, the name and sex of the child, and particulars of any physical abnormality at time of birth.³⁰⁴

5.70 Children conceived from gametes donated since 1 January 1998 have had the right to have access to identifying information about donors,³⁰⁵ when they turn 18.³⁰⁶ Before the child reaches 18, parents or guardians of the child can apply for identifying information about the donor, but the donor's consent must be obtained before this information is provided.³⁰⁷ The *Infertility Treatment Act 1995* also allows donors to apply for information about children born as the result of donations and the parents of those children. Identifying information cannot be

300 *Infertility Treatment Act 1995* ss 62, 63.

301 *Ibid* ss 64, 65.

302 *Ibid* s 67. There is no requirement to notify the name of the donor as this will not normally be known by the woman or her doctor.

303 Information provided by Helen Szoke CEO of the ITA.

304 Part 7 Div 1 of the Act details the type of the information to be given to the ITA by licensed centres, by doctors not at licensed centres, and by parents upon the birth of a child. Under s 68, the ITA is empowered to keep a central register containing the information given to the ITA under this division.

305 *Infertility Treatment Act 1995* ss 79, 80.

306 Part 7 Div 3 covers the circumstances under which information is to be given from the central register. Although the Act was assented to on 27 June 1995, these provisions did not come into effect until 1 January 1998(s 2(4) (as amended by No. 37/1997 section 4)). Government Gazette 31 August 1995 page 2284. These provisions are not retrospective, and therefore only apply to donations where consent was given on or after this date.

307 *Infertility Treatment Act 1995* ss 74, 75.

given to the donor unless the child (in the case of a child over 18) or the child's parent or guardian consents.³⁰⁸

5.71 People who have children following a donation do not always tell them about their origins. Where this occurs an adult who has been conceived through use of a donation will not know of this fact, unless they are contacted for consent to release of information to the donor. The ITA must be satisfied that parents, children and donors have been offered counselling about the potential consequences of disclosure before the information is provided.³⁰⁹

5.72 Since 1 July 1988 a central register has been kept, which records the names of donors of gametes.³¹⁰ If a person who donated gametes after that date consents to the release of information, this information can also be made available to children after they turn 18. The ITA also keeps a donor treatment procedure information register which facilitates the voluntary exchange of information between those involved in assisted reproduction processes, which occurred after 1 July 1988.³¹¹ Donors, children and parents or other relatives can request the Authority to enter their names and addresses on the register and express their wishes about the exchange of information.

5.73 Prior to 1 July 1988 the only information identifying donors was kept in hospital or doctor's records. There is provision for the ITA to keep a register of information about treatment procedures which occurred before July 1 1988.³¹² People born as the result of treatment procedures before that date, donors, parents and relatives can ask the ITA to enter their names and addresses and their wishes about exchange of information.³¹³ Information can only be released in accordance with these wishes.³¹⁴

308 Ibid ss 76, 77.

309 Ibid ss 76-80.

310 *Infertility (Medical Procedures) Act 1984* s 22. The Register was kept by the Health Commission and included information required to be forwarded to it by approved hospitals under s 19. Regulations could be made for release of identifying information with consent of the donor under s 22(3) Under s 198 of the *Infertility Treatment Act 1995* the central register kept under the earlier Act is deemed to be the central register under the latter Act.

311 *Infertility Treatment Act 1995* s 82.

312 Ibid Part 7A, inserted by *Infertility Treatment Amendment Act 2001*.

313 Helen Szoke, meeting with VLRC, 13 March 2003.

314 *Infertility Treatment Act 1995* s 92F

5.74 Children are unlikely to seek access to this information unless they know that they have been conceived through use of donated gametes. There is no legal obligation on parents to tell children that this is the case. In practice it would be impossible to enforce a legal obligation to inform children they were conceived from donated gametes. However a legislative requirement to do so could perhaps serve the symbolic purpose of encouraging parents to tell children about their biological origins. The Commission would be interested to hear views about whether this obligation should be included in the legislation.

5.75 The provisions requiring licensed clinics and doctors to keep records identifying the donor cannot apply where a woman self-inseminates nor where a child is born through assisted reproduction that occurs interstate or overseas. While the *Infertility Treatment Act 1995* requires a woman who bears a child as the result of a 'donor treatment procedure' to notify the ITA,³¹⁵ this probably does not apply to a woman who self-inseminates. Even if this provision could be read as requiring the woman to notify the birth to the ITA, there is no obligation to inform the ITA of the identity of a known donor. This means that some children may not be able to obtain identifying information about the donor. Women who self-inseminate or who have treatment overseas may not be prepared to comply with an obligation to notify this information to the ITA. As mentioned above, women who give birth following a treatment in a licensed clinic rarely notify the ITA, although the legislation requires them to do so.³¹⁶

5.76 It is difficult to justify a situation in which children conceived in licensed clinics have a right to access to information about their parentage through records kept by the ITA but children conceived outside a clinic are not entitled to such information. Giving children access to information about donors requires a mechanism for collecting and retaining this information. To ensure that this right is enforceable it would be necessary to require the birth mother to provide information about a known donor at the time of birth. The Commission seeks views as to whether it should be compulsory to provide this information and if so how people could be encouraged to comply with this obligation.

5.77 If women who self-inseminate were required to notify the identity of the donor, this information could be kept by the Registrar of Births, Deaths and Marriages or recorded and retained in the central register by the ITA, as is the case for information about donors whose gametes are used in licensed clinics. The

315 *Infertility Treatment Act 1995* s 67.

316 See para 5.68.

current practice of holding this information in the central register held by the ITA, rather than in the Registry of Births, Deaths and Marriages was presumably intended to protect the privacy of children born through assisted reproduction and their parents and donors and to ensure that people were informed of the desirability of having counselling before they access this information. The Commission would be interested in hearing views as to where this information should be held in the future.

? QUESTION(S)

45. Should there be a legal obligation imposed on parents to inform children that they were conceived through use of donated gametes?
46. Where a birth mother self-inseminates with sperm from a known donor should she be required to notify the name of the donor? If so where should this information be recorded?

REGISTRATION OF BIRTHS

5.78 The Victorian Registry of Births, Deaths and Marriages registers births in the State, and records and preserves information about births and adoption in perpetuity. When a child is born both parents are responsible for registering the birth and both must normally sign the birth registration statement.³¹⁷ The information which is registered normally appears on the child's birth certificate. For example the birth certificate of a child born to a married couple includes the name of the mother and father. The Registrar can also keep information which is not registrable information, for example information about a person who is named by the mother as the father of the child, but who is dead or missing.³¹⁸ The Registrar can give any person access to the Registers or to other information but in doing so must take account of the reason that access to the Register is sought and the sensitivity of the information.

317 *Births, Deaths and Marriages Registration Act 1996* s 15. The Registrar can accept a birth registration statement from one parent if satisfied that it is not practicable to obtain the signatures of both parents. See also s 16 (1)(b).

318 *Ibid* s 50.

5.79 The birth registration statement provides for the registration of the child's mother and father. If a child is born to a couple in a lesbian relationship there is no provision allowing two people to be registered as the mothers of the child. Nor can the birth mother's female partner be validly registered as the father. There is no provision for a person to be registered as a parent but neither a mother nor a father.

5.80 The birth certificate includes a space in which the name of the 'informant' (that is the person who registers the birth) is recorded. The birth mother's partner could be listed as the informant, but this does not accurately describe her relationship with the child.³¹⁹ It may also be possible for the identity of the birth mother's partner to be recorded separately from the Register. If the law were changed to recognise the partner as a parent, the *Births, Deaths and Marriages Registration Act 1996* would need to be amended to provide for the identity of the partner to be recorded on the birth certificate.

5.81 Some lesbian couples may not wish both the birth mother and her partner to appear on a birth certificate as parents, because this will force the child to produce a document which discloses his or her parents' sexuality whenever and wherever he or she presents it. If the birth mother's partner were recognised as a parent the question arises whether the parents should be able to choose to omit the birth mother's partner's name from the Register (and the birth certificate) but to have it recorded separately.

5.82 It is also necessary to decide how the Register should deal with known donors. The current practice of the Registry is as follows

- Where a known donor has donated through the licensed clinic system (or through a clinic interstate) the Registry does not include his name as a father on the birth certificate.
- If a woman informs the Registry that she has self-inseminated, she will be required to provide the details of the donor to the Registry. The donor's name will normally appear on the birth certificate as the child's father. As a matter of practice the Registry will attempt to contact the donor to confirm that this was the case.
- There is no provision for registration of the donor as a donor. At present the Registry allows a lesbian couple to request that information about a

319 Kristen Walker, 'Birth Certificates for Lesbian Parents in Victoria: The Current Position' (2002) *Lesbiana* 18.

known donor is kept separately and not to include it on the birth certificate. This preserves the privacy of the couple and the child about use of self-insemination, while preserving the child's genetic information. This is consistent with the fact that the *Status of Children Act 1974* says that the donor has no rights and liabilities in relation to the child, but does not say he is not the father.

- There is no provision for two sperm donors to be recorded as fathers in a situation where the parties do not know (and do not wish to know) which donation resulted in pregnancy. If this later became known this information could be provided to the Registrar and separately recorded.
- There is no provision for a male donor's partner to appear on the birth certificate, even if all the parties agree that he should be regarded as one of the child's parents.
- If an anonymous donor is used, no information about the donor can be recorded.

5.83 Where women give birth to children conceived with donor gametes through the licensed clinic system, information identifying the donor or donors will be held in the Infertility Treatment Authority's Central Register, but not recorded in the Register of Births. This means it is not available to any one who searches the Register of Births. In the section above we asked whether information about the identity of a donor who donates outside the licensed clinic system should be recorded and if so where this record should be kept.

Chapter 6

Surrogacy

WHAT IS SURROGACY?

6.1 Surrogacy involves an agreement made with a woman who is, or who is to become, pregnant, (the surrogate mother) who will surrender the child born from that pregnancy permanently to another person or people, who wish to become the child's parents (the commissioning person or couple).³²⁰

6.2 Surrogacy may or may not involve the use of donor gametes. Some surrogacy arrangements involve a woman carrying a child that is her own genetic offspring. Conception (usually with the sperm of the man from a commissioning couple) is achieved either through sexual intercourse or assisted reproduction. Even if assisted reproduction is used, this may not require the assistance of a fertility clinic. Alternatively the woman may carry a child that is the genetic offspring of another woman, who may either be an egg donor to the commissioning couple or the woman who wishes to have the child. This form of surrogacy requires medical assistance and must take place within the licensed clinic system. It will usually be required because the commissioning woman's capacity to carry a child to term is impaired.³²¹

6.3 The Commission has been asked to examine three particular sections of the *Infertility Treatment Act 1995* in relation to altruistic surrogacy, and we have been asked to consider the question of clarification of the legal status of a child born through a surrogacy arrangement.

WHICH ASPECTS OF SURROGACY ARE WE EXAMINING?

6.4 The three sections of the Act we have been asked to examine in relation to altruistic surrogacy are:

320 See *Infertility Treatment Act 1995* s 3 for the full definition of 'surrogacy agreement'.

321 John Leeton, 'The Legal Dilemma of In-vitro Fertilization Surrogate Pregnancy in Victoria: Letter to the Editor' (1988) 149 *The Medical Journal of Australia* 446.

- s 8, which prescribes who can undergo a treatment procedure;
- s 20, which prescribes conditions under which donor gametes can be used; and
- s 59, which bans any person from giving or receiving payments in relation to a surrogacy arrangement.

6.5 There are therefore three issues for this inquiry.

- Are the current eligibility provisions in the Act appropriate for application in surrogacy situations, including situations where donor gametes are used?
- How should the legal status of the child be clarified?
- Are the current provisions regarding payment in surrogacy arrangements appropriate?

6.6 The Commission has not been asked to consider any other aspects of surrogacy including the provisions that prohibit advertising and that make surrogacy agreements void.³²² Nor has the Commission been asked to consider surrogacy for commercial gain.

WHEN IS SURROGACY THROUGH THE LICENSED CLINIC SYSTEM POSSIBLE IN VICTORIA?

ELIGIBILITY CRITERIA FOR A WOMAN UNDERGOING A TREATMENT PROCEDURE AS PART OF A SURROGACY ARRANGEMENT

6.7 The provisions that cover eligibility criteria for treatment procedures also apply to surrogacy treatments. These provisions are contained in section 8, and, where donor gametes or embryos are used, in section 20 of the *Infertility Treatment Act 1995*.³²³

6.8 As we explained in Chapter 3, to be eligible to undergo a treatment procedure a woman who is married or in a de facto relationship must have the consent of her husband or male partner. She must also be unlikely to become pregnant without the treatment procedure, or be likely to transmit a disease to a child or to have a child with a genetic abnormality.³²⁴

322 Sections 60 and 61 respectively.

323 We have discussed the eligibility provisions in detail in Chapter 3.

324 See paras 3.3–5.

6.9 A woman who does not have a male partner, is only regarded as ‘unlikely to become pregnant’ if she is ‘clinically infertile’.³²⁵ She can only undergo a treatment procedure if this is the case, or if she is likely to transmit a disease to a child or to have a child with a genetic abnormality.³²⁶ A single woman could carry a child as a surrogate if she satisfies these eligibility requirements.

6.10 The Infertility Treatment Authority (ITA) sought advice on the use of both donor sperm and donor eggs in a treatment procedure affecting a surrogate mother, where the woman undergoing the procedure is married or in a de facto relationship. Gavan Griffith QC advised that the Act itself is unclear. Interpreting the Act by reference to the intention of the legislators to devise a regulatory system where donor gametes were to be used as a ‘last resort’, Griffith concluded that both the woman and her husband would have to be infertile in order to permit the use of a zygote or an embryo formed from both donor sperm and a donor egg.³²⁷ That is, in the situation in which a heterosexual couple wishes a surrogate to have a child created from their sperm and egg, if the surrogate mother is married or in a de facto relationship she must be unlikely to become pregnant, or be likely to transmit a disease to a child or to have a child with a genetic abnormality, if her own eggs *and* her husband or partner’s sperm were used.

6.11 These eligibility requirements are intended to apply to people seeking infertility treatment because they want to have children for themselves. However, they also create a barrier to altruistic surrogacy, even though the *Infertility Treatment Act 1995* does not make altruistic surrogacy illegal.

HOW CURRENT ELIGIBILITY AND PARENTING PROVISIONS OPERATE

6.12 People may seek surrogacy arrangements for a number of reasons.

- A woman may have fertile eggs, but may be physically incapable of bearing a child. She and her male partner (if she has one) may need another woman to bear the child.
- A man may want to have a child, but have no partner.
- A gay male couple may want to conceive a child, using the sperm of one of them.

325 See paras 3.8–15.

326 See para 3.25.

327 Opinion by Gavan Griffith QC, 16 May 2002. Copy provided to the Victorian Law Reform Commission by the Infertility Treatment Authority.

- A man may want to have a child, using an embryo created before his partner's death.

These situations are illustrated in the following case studies.



CASE STUDY 23

Jackie is a 36-year-old woman who has been married to Theo for five years. Twelve months ago Jackie had a stroke, and doctors have been unable to determine the cause. She has now recovered, and would like to have a second child, but is afraid that her age, combined with her previous health problems, may mean that a second pregnancy and birth puts her at risk of having another stroke, particularly if there are any complications requiring surgery. Jackie has spoken to her older sister Ailyn about a surrogacy arrangement, in which Ailyn is implanted with an embryo made from Jackie's egg and Theo's sperm. Ailyn is willing to consider this provided her husband Pete agrees. She and Pete have two children, 10 and eight years old. They decided after their youngest was born that they would have no more children, and Pete had a vasectomy.

Jackie wants to know if such an arrangement can be made in Victoria and whether she and Theo would be recognised as the parent of the child.³²⁸

6.13 Because Ailyn must have the treatment procedure, the eligibility requirements in the *Infertility Treatment Act 1995* apply to Ailyn, not Jackie. Ailyn's eligibility to undergo a treatment procedure is determined by the likelihood of her becoming pregnant otherwise. As her husband has had a vasectomy, she is unlikely to become pregnant. However, according to advice obtained by the ITA, Ailyn and Pete would *both* have to be infertile in order for Ailyn to be eligible for a treatment procedure using both donor egg and donor sperm through a Victorian clinic.³²⁹ Jackie's egg and Theo's sperm are 'donor' gametes for the purposes of these procedures. Ailyn would not be eligible for a treatment procedure with an embryo formed from Jackie and Theo's gametes. However, Ailyn is 38 years old,

328 Some of the details in this case study are based on an enquiry made to the Infertility Treatment Authority. The name used here is not that of the woman who made the request.

329 Opinion by Gavan Griffith QC, 16 May 2002. Copy provided to the Victorian Law Reform Commission by the Infertility Treatment Authority.

and as being 40 and over is one of the indicators of infertility, if she waited until then she may qualify as infertile and therefore be eligible for treatment.³³⁰

6.14 If Ailyn agreed to the arrangement and had Theo and Jackie's child for them, and was happy to fulfil her agreement once the child was born, the issue of the legal status of the child's parents would arise. Since Ailyn gave birth to the child, under the *Status of Children Act 1974* s 10E she is the child's mother. Since Pete is her husband and he has agreed to the procedure, then he is the child's father. For Jackie and Theo to become parents they would have to be able to adopt the child.³³¹



CASE STUDY 24

Keith is a small-business owner, a 40-year-old man who has always wanted children but has never had a long-term relationship. His friend Barb has never wanted children, and feels for Keith, particularly since she has seen him many times with children and understood how much it would mean to him to have his own child. Barb offers to have a child for Keith to raise.

6.15 Barb and Keith could have the child outside the clinic system, either through sexual intercourse or assisted reproduction. If they had sex in order to conceive, both of them would be the child's parents. If they conceived through self-insemination, the *Status of Children Act 1974* s 10F says that Keith as a donor has no rights and incurs no liabilities in relation to the child, but does not explicitly say that he is not the child's parent. As discussed in paras 5.23–8 it is not clear whether Keith would be regarded as the child's father under the *Family Law Act 1975* (Cth),³³² though Keith would be able to apply for a parenting order. If Barb and Keith had difficulties conceiving, Barb, as a single woman, would have to be clinically infertile to be eligible for a treatment procedure in the licensed clinic system. Again Keith's status as parent would be unclear.

330 John McBain's view that all women more than 40 years of age have medical infertility is supported by Melbourne IVF data on the use of frozen donor sperm in women aged over 40 since 1976 which shows a pregnancy chance of 2% per cycle (email from Dr John McBain to VLRC, 3 December 2003).

331 See paras 5.57–64 for general discussion of adoption provisions and discussion later in paras 6.49–6.68 on adoption in the context of surrogacy.

332 See para 5.57 ff on family relationships and on eligibility provisions for adoption.



CASE STUDY 25

Joshua and his partner Stephen lived together for six years and wanted to have a child. Their preferred way of doing so would have been to have a child with a woman or a lesbian couple who would like to be known to the child, but who do not want to be parents. They were unable to find a woman or a couple in Australia who would enter into this arrangement. They consider putting an ad in the gay and lesbian newspaper, but discover that it is illegal to advertise for a surrogate mother in Victoria.³³³ Finally they decide to have a child in the United States after entering into an arrangement with a surrogate mother under which she is implanted with an embryo made from a donated egg and Joshua's sperm. The child, Mark, is brought back to Australia.

6.16 Joshua and Stephen would only be able to have a child in this way in Australia if they could find a woman who was eligible for infertility treatment, who was also prepared to have a child under their preferred arrangement. As in the earlier examples, the woman, if married or in a heterosexual de facto relationship would have to be 'unlikely to become pregnant' in order to be treated. If not married or in a heterosexual de facto relationship, the woman would have to be 'clinically infertile'.

6.17 Joshua and Stephen entered a surrogacy agreement so that they could have a child. However, under the *Status of Children Act 1974* s 10F, Joshua would have no rights and incur no liabilities in relation to the child. It is uncertain whether he would be recognised as the child's parent under the *Family Law Act 1995* (Cth) (see paras 5.23-8). Stephen would not be the child's parent. The couple could apply to the Family Court for parenting orders which recognise their responsibilities to care for and make decisions on behalf of the child.³³⁴

333 *Infertility Treatment Act 1995* s 60.

334 *Re Patrick* (2002) 28 Fam LR 579; In *The Matter of Mark*, unreported decision of Justice S Brown, Family Court of Australia 28 August 2003.

**CASE STUDY 26**

Susie and Graham were married for 10 years before they finally decided to seek help to conceive a child. They underwent IVF treatment, and had four unsuccessful embryo transfers before they decided to have a break, after which they planned to return to try again with the four remaining embryos. They were involved in a car accident while away, and Susie was critically injured, dying later in hospital. During the months after the accident, Graham develops a close friendship with his neighbours, Rebecca, a 41-year-old single mother, and her two sons, 10-year-old Matt and his younger brother Ben. Graham realises he still wants a child, and that he wants his and Susie's child. Graham asks Rebecca to carry the child.

6.18 There is no prohibition on the use of an embryo formed from the gametes of a person who has died.³³⁵ Where a woman is the surviving partner, she can proceed with a treatment procedure. In this case, however, a man is the surviving partner, and so in order to have the child he would need to find a woman willing to assist him by carrying the child. In order for these embryos to be transferred to the body of a woman whose eggs were not used in the formation of the embryos, Susie must have consented to their use in a donor treatment procedure, before she died.³³⁶ Had she consented to their use in this kind of procedure, the embryos could be used, but only by a woman who fulfilled the eligibility criteria for a treatment procedure.

6.19 Neither the *Status of Children Act 1974* nor the *Family Law Act 1995* (Cth) indicates who is the mother or father of a child born in this situation. Because Graham is the biological father of the child he could be recognised as the child's father for legal purposes. Because Rebecca gave birth to the child she might be treated as the child's mother, even though this may not have been what she intended.

335 Section 43(c) of the *Infertility Treatment Act 1995* which banned the use of embryos formed from gametes of a person who has died, was repealed in 2001.

336 *Infertility Treatment Act 1995* s 12(4).

HOW MANY PEOPLE SEEK TO HAVE A CHILD THROUGH A SURROGACY ARRANGEMENT?

6.20 The numbers of people currently seeking surrogacy arrangements is quite small, although it is difficult to obtain accurate figures on the level of demand. The ITA has received ten letters relating to proposed surrogacy arrangements in Victoria since 1997.³³⁷ This cannot be regarded, however, as an accurate reflection of the actual demand that exists in Victoria for reproductive services involving surrogacy arrangements. This is because in such a tightly regulated environment, people may pursue their arrangements entirely outside the regulatory system. Some people go to Sydney or Canberra to pursue surrogacy arrangements; some accept that the Victorian system prevents them from pursuing their goals in a way that is possible or acceptable for them personally, or that gives them legal status as parents, and do nothing. It is therefore very difficult to obtain an accurate figure of demand. However, Professor John Leeton has estimated that the numbers of people concerned would possibly not reach the hundreds.³³⁸

OPTIONS FOR REFORM

6.21 The alternatives are to

- prohibit all surrogacy, including altruistic surrogacy;
- correct the anomalies in the application of the current criteria for example by providing that the eligibility for treatment applies to the commissioning person or couple, rather than the surrogate and her partner (if any); or
- provide new criteria that define eligibility for surrogacy itself, rather than linking it to general eligibility for a treatment procedure.

THE CASE FOR CHANGING ELIGIBILITY PROVISIONS AS THEY APPLY TO SURROGACY

6.22 The *Infertility Treatment Act 1995* does not prohibit a surrogacy arrangement occurring through the clinic system, but it makes it very difficult. It is difficult because eligibility is determined by eligibility for a treatment procedure: the unlikelihood of becoming pregnant otherwise (if the woman is married or in a

337 Letter to the Victorian Law Reform Commission from Helen Szoke, Chief Executive Officer, ITA, 16 May 2003.

338 Personal communication with Victorian Law Reform Commission, 16 June 2003.

heterosexual de facto relationship), or clinical infertility (if the woman is single or in a same-sex relationship),³³⁹ or the likelihood of the transmission of a disease or genetic abnormality. A woman who meets either of these qualifications would be an unlikely choice for a surrogacy arrangement. These criteria significantly reduce the number of women who may undertake a pregnancy for these purposes;³⁴⁰ in some cases it will also significantly decrease the likelihood of the success of that pregnancy.

6.23 The reality therefore is that the *Infertility Treatment Act 1995* makes surrogacy through the clinic system so difficult as to be virtually impossible. The only in-vitro fertilisation (IVF) surrogacy carried out in Victoria resulted in the birth in 1988 of Alice Kirkman³⁴¹, and there has not been an IVF surrogacy in Victoria since that date.³⁴² Clinics in Victoria are extremely reluctant to perform IVF surrogacies because of this legal environment, and Monash IVF has recently decided it will not offer any treatments involving surrogacy arrangements.³⁴³

6.24 The current eligibility provisions as applied to altruistic surrogacy are irrational and ineffectual.

- The application of the general eligibility provisions to surrogacy obscures the development and clarification of real policy objectives in relation to altruistic surrogacy.
- There is no reason to allow only women with fertility problems or who risk transmission of a disease or genetic abnormality to carry children for other people.
- There is no reason to require the husband or partner of the proposed surrogate also to be infertile.

6.25 The real question therefore is, should altruistic surrogacy be permitted or prohibited. If it is prohibited, the limited opportunities people currently have to

339 See Chapter 3 for a detailed discussion of these eligibility requirements particularly as they are interpreted with regard to marital status.

340 The likelihood of finding a surrogate mother, already limited by the eligibility criteria in the *Infertility Treatment Act 1995* is further diminished by the ban on advertising for a surrogate (*Infertility Treatment Act 1995* s 60).

341 Maggie Kirkman, 'Sister-to-sister Gestational 'Surrogacy' 13 Years On: A Narrative of Parenthood' (2002) 20 *Journal of Reproductive and Infant Psychology* 135.

342 Letter to the Victorian Law Reform Commission from Helen Szoke, Chief Executive Officer, ITA, 16 May 2003.

343 Phone conversation with Dr John Leeton.

achieve pregnancies through surrogacy arrangements through the licensed clinic system will be eliminated. If it is thought that surrogacy should be prohibited, the current eligibility criteria do not explicitly do so and are not justified on that basis. If, however, we wish to allow surrogacy in some situations, the current eligibility criteria do not provide a sound basis for discriminating between cases where surrogacy should be permitted and cases where it should not.

6.26 If the present situation allowing altruistic surrogacy continues, it is necessary to determine what eligibility requirements should apply. For example should eligibility depend upon the infertility of the commissioning person or couple? One argument for permitting altruistic surrogacy, is that this enables it to be regulated in a way that provides an opportunity to manage the range of legal and social issues that arise for people involved in surrogacy situations.

6.27 It has been the experience in other jurisdictions that where a sound policy basis regarding surrogacy is absent, undesirable consequences result. They include: a capricious application of the law; potential for exploitation or coercion; and a blurring of the line between altruistic and commercial surrogacy.³⁴⁴ Regulating eligibility criteria for surrogacy would enable these issues to be dealt with.

6.28 The Commission invites comment on whether the law should continue to permit altruistic surrogacy, and if so, on the eligibility criteria that should apply to people who seek infertility treatment as part of a surrogacy arrangement.

REFORMING ELIGIBILITY CRITERIA FOR ALTRUISTIC SURROGACY

6.29 One option for reforming eligibility criteria for altruistic surrogacy through the licensed clinic system is to retain the current regime and to ask to whom should the requirements of this regime apply in a surrogacy arrangement.

- Is it appropriate when weighing up whether an IVF surrogacy should go ahead, to consider only whether the birth mother and her partner if she has one should be treated? Should eligibility criteria also apply to the commissioning couple?

344 Brazier, Campbell and Golombok say that neither the majority nor the minority recommendations of the 1984 Warnock Report were implemented fully in the UK's 1985 surrogacy legislation, the *Surrogacy Arrangements Act* and that the act rested on 'no coherent basis in policy' (Margaret Brazier, Alastair Campbell and Susan Golombok, *Surrogacy: Review for Health Ministers of Current Arrangements for Payments and Regulation* (1998) 16).

- Are the current criteria appropriate at all for the woman who is to carry the child and to her male partner if she has one? Should the unlikelihood ‘of becoming pregnant otherwise’ be a criterion applicable only to the person commissioning the birth?
- If eligibility criteria for other aspects of assisted reproduction are to change so that the requirement that the woman seeking treatment must be ‘unlikely to become pregnant otherwise’ is removed, should it also be removed as a requirement in a surrogacy arrangement, or should it be applicable either to the women participants in a surrogacy arrangement or only to the woman commissioning the birth, where there is one?
- If the requirement of ‘unlikely to become pregnant’ remains a criterion for a woman commissioning the birth, what criterion is to be applied if a man or a male couple is commissioning the birth? Should the man or one or both members of the couple be ‘clinically infertile’?
- If the requirement ‘unlikely to become pregnant’ is removed both for the woman to give birth and the woman commissioning the birth, should any woman, whether she is capable of bringing a child to term or not, be able to commission a surrogate mother to carry a pregnancy for her?

6.30 A second option is to devise new criteria applicable to people entering into altruistic surrogacy agreements. This requires consideration of the complex social and ethical issues raised by altruistic surrogacy, discussed in paras 6.33–7 below. Given such difficult issues, this option raises the question of how to devise criteria that protect the interests and rights of the woman who is to give birth to and relinquish the child and the interests and rights of the child. These criteria are particularly difficult to identify as there has been little research done on surrogacy and its effects. The Commission would like to hear from researchers who have done work in this area.

6.31 In the United Kingdom and in the Australian Capital Territory surrogacy provisions are contained in legislation. Neither of these jurisdictions have eligibility criteria for assisted reproduction, and nor do any criteria apply to eligibility for treatment procedures that involve surrogacy. Both jurisdictions legislate for surrogacy by making it possible for the commissioning parents to become the legal parents (see below). Models for regulating surrogacy could include the establishment of an agency to approve, administer and monitor surrogacy arrangements. All people who make surrogacy arrangements, whether or not they involve assisted reproduction, could be required to go through this agency.

6.32 This raises the issue of whether it is desirable to enable people to make altruistic surrogacy arrangements at all.

ISSUES RAISED BY ALTRUISTIC SURROGACY

6.33 If we are not to prohibit altruistic surrogacy, we need to consider what values would underpin a preference for one of the remaining options for reform: making the current eligibility provisions appropriate for surrogacy situations, or creating new criteria. Both these options would expand access to assisted reproduction for people wishing to enter into surrogacy arrangements. In relation to infertility treatment in general, there appears to be little disagreement that the primary value should be the best interests of the child.³⁴⁵ In addition, the principles of non-discrimination on the grounds of marital status and sexual orientation should be applied in the development of new legal regimes.

6.34 However, there are specific questions relevant to establishing the values that should underpin eligibility for surrogacy. Surrogacy raises issues which do not necessarily arise in other assisted conception procedures. They include the risk of commercial exploitation of the woman who is asked to bear the child and coercion of a woman in order to assist an infertile parent, sibling or offspring. This pressure can be greater than the risk of commercial exploitation. The rights and interests of any child born of such an arrangement, including the child's relationship with all the parties involved and the child's right to know his or her biological origins may assume greater importance than they do in assisted reproduction generally. The interests of any siblings of a child born through a surrogacy arrangement, and the relationship of that child to the siblings, must also be considered. These issues are likely to be more complex than the issues facing a mother or mother and father who relinquish a child for adoption in other circumstances. Perhaps the most difficult of these issues is the potential for exploitation and coercion of the woman who is to give birth, a potential that exists whether or not a woman is going to benefit financially from the arrangement. For these reasons, surrogacy is not simply another form of IVF.

6.35 In *Re Evelyn*,³⁴⁶ some of the difficulties that can arise in the context of surrogacy resulted in proceedings being instituted in the Family Court. In that case, a woman and her husband (the Ss) offered to bear a child for Mr and Mrs Q, who were unable to have children because Mrs Q had had a full hysterectomy. The

345 In Chapter 4 we have invited comment on this question.

346 *Re Evelyn* (1998) 23 Fam LR 53.

child, 'Evelyn', was conceived with Mrs S's egg and Mr Q's sperm. Evelyn lived with the Qs in Queensland for a short period after her birth. Frictions developed shortly after the child was born, until Mrs S came to the realisation that she could no longer abide by the agreement and relinquish the child. Mrs S travelled to Queensland and removed Evelyn from the Qs' care and returned with her to her home in South Australia. The Family Court ordered that Evelyn reside with the Ss, with the Qs to have contact, and dismissed an appeal by the Qs against this decision. Each couple wanted to raise Evelyn, and as Jordan J noted in the original case, each couple had 'the capacity to provide a very high standard of care', and each of the adults loved the child and was committed to her welfare.³⁴⁷

6.36 *Re Evelyn* illustrates the conflicts that may arise between people who commission the birth and a surrogate mother. Some may regard this as a reason for retaining the eligibility criteria that currently limit the availability of altruistic surrogacy associated with assisted reproduction.

6.37 However, if these criteria were changed we would need to consider how to ensure that the rights and interests of all parties are sufficiently protected, including:

- the woman who gives birth to the child;
- the children born through such arrangements;
- any other children directly involved with any of the parties; and
- the people who wish to become parents of the child.

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QUESTION(S)

47. Should altruistic surrogacy be prohibited, and why?

48. How should access to surrogacy arrangements through licensed clinics be determined? What criteria should be used? To whom should they apply?

347 Quoted in *Re Evelyn* (1998) 23 Fam LR 53, 55.

SHOULD PEOPLE BE ABLE TO GIVE AND RECEIVE PAYMENTS IN ALTRUISTIC SURROGACY ARRANGEMENTS?

6.38 The Commission has been asked to consider the question of payment in relation to altruistic surrogacy. Under the *Infertility Treatment Act 1995* a woman cannot receive payment for carrying a child for someone else, and nor can someone give or agree to give payment or reward to a woman for carrying a child for them.³⁴⁸

6.39 Should a woman who is to give birth as part of a surrogacy arrangement be able to receive payment as recompense? Given that commercial arrangements are unlawful, if she should be able to receive such payments, what are the legitimate expenses for which she should be able to claim recompense? Would it include, for example, loss of income? Does allowing such payments run the risk of increasing the likelihood of exploitation and coercion?

6.40 Experience in the UK suggests that where payment for surrogacy is made possible, it is difficult to stop this from becoming payment on a commercial scale.³⁴⁹ If payment is possible, for example for loss of income, how should the appropriate level of recompense be determined? Is the solution to this to define the purpose of any payments in legislation?



CASE STUDY 27

Cass and Bernard have three children and Bernard had a vasectomy two years ago. Cass is considering going back to work part-time now that all the children are at school. They are very close to Dave and Ingrid, who have tried for many years, unsuccessfully, to have a child. Cass tells Bernard she wants to offer to carry Dave and Ingrid's child, but only if it is their genetic child and not her own. Dave and Ingrid are overwhelmed with the generosity of their friends, and want to at least compensate Cass for the time and energy she will spend in carrying their child. Cass does not want to profit from the arrangement, but admits that the pregnancy will delay her return to work.

348 *Infertility Treatment Act 1995* s 59.

349 Margaret Brazier, Alastair Campbell and Susan Golombok, *Surrogacy: Review for Health Ministers of Current Arrangements for Payments and Regulation* (1998) 3, 43–8.

**CASE STUDY 28**

Hugh is a successful stockbroker, who always vowed that he would leave stockbroking at 40 and lead a different life. He is not married, and, nearing 40, is very keen to have children. A woman in his social circle has recently been left by her husband and he knows she is struggling financially. He offers to pay her a large annual salary if she will have a child for him.

6.41 As it is not legal for payment to be made to the woman who is to carry the child, in both these cases the woman cannot receive the money that would be offered.

**QUESTION(S)**

49. Should the woman carrying the child be able to receive legitimate expenses from the prospective parents? If so, how should these expenses be calculated?
50. Should a person be able to give or agree to give such payment to a woman who agrees to carry a child for them?

SHOULD THERE BE A REGULATORY BODY TO OVERSEE SURROGACY ARRANGEMENTS AND AGREEMENTS?

6.42 There may be an argument for establishing by act of parliament a regulatory authority to oversee surrogacy arrangements and agreements, given the complexity and specificity of the issues involved. What would the functions of such a regulatory body be?

6.43 Should this body:

- monitor the enforcement of eligibility criteria;
- register participants to surrogacy arrangements;
- record information about genetic and social parentage in surrogacy arrangements;
- provide counselling to people entering surrogacy arrangements;

- monitor financial agreements and transactions with respect to surrogacy arrangements;
- conduct and monitor research into surrogacy; or
- make recommendations to government with respect to surrogacy?

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QUESTION(S)

51. How should the law deal with the regulatory issues that arise in relation to eligibility for surrogacy?

- Should an approved body, such as the ITA, have statutory responsibility for administering, approving and monitoring surrogacy arrangements? What other types of bodies might take responsibility for aspects of surrogacy regulation?
- Should a regulatory body be charged with monitoring surrogacy arrangements involving payment?

THE LEGAL STATUS OF THE CHILD IN SURROGACY: OPTIONS FOR REFORM

6.44 In the section above we have discussed possible approaches to altruistic surrogacy. If altruistic surrogacy were prohibited, children would not be able to be conceived through a licensed clinic in Victoria under a surrogacy arrangement. Some people might still make surrogacy arrangements in other states or overseas. One issue the Commission will need to consider is how, if at all such arrangements should be recognised by Victorian law. One possibility is that a commissioning parent or parents might be permitted to adopt a child who has been born as the result of a surrogacy arrangement made elsewhere.

6.45 If altruistic surrogacy is permitted in Victoria, either under the existing law or under laws that expand eligibility for assisted reproduction, consequential changes to parenting laws may be necessary.

WHAT IS THE LEGAL STATUS OF THE CHILD BORN THROUGH A SURROGACY ARRANGEMENT?

6.46 Under Victorian law, any contract between participants in a surrogacy arrangement is void.³⁵⁰ As we have discussed above, the parenthood of any child born from a surrogacy arrangement is determined not by the agreement but by the *Status of Children Act 1974*. This is the case whether the birth mother is the genetic mother of the child or not. The Act provides as follows.

- If a married woman or a woman in a heterosexual de facto relationship has undergone an artificial conception procedure with the consent of her partner involving the use of donor sperm, her husband, and not the sperm donor, is presumed to be the father of that child. The presumption that the husband is the father of the child is cannot be rebutted, but the presumption that he has consented to the procedure is rebuttable.³⁵¹
- If a married woman or a woman in a heterosexual de facto relationship has undergone an artificial conception procedure with the consent of her partner, which involves the use of a donor egg, she is presumed to be the mother of the child.

6.47 This means that if a married woman gives birth to a child under a surrogacy arrangement, then she is the mother of the child, even if the egg was donated by the commissioning woman. If she chooses not to relinquish the child, any agreement made between her and the commissioning person or couple is unenforceable and she remains the mother. If the woman is married and the procedure was with the consent of her husband, he, rather than the commissioning man is the father of the child. The surrogate mother and her husband are also the parents of the child under Commonwealth law.

6.48 If donor sperm is used to inseminate a woman who is not married or who has not obtained the consent of her husband, under a surrogacy arrangement, the man who produced the semen has no rights and no liabilities in respect of the child.³⁵² The *Status of Children Act 1974* does not say that he is not the father. It is not clear whether the man would be regarded as the father under the *Family Law Act 1975* (Cth), but he would not be liable to pay child support as a parent under

350 *Infertility Treatment Act 1995* s 61.

351 *Status of Children Act 1974* s 10E. Under the *Family Law Act 1975* (Cth), consent is also presumed, 'unless it is proved, on the balance of probabilities, that the person did not consent' (s 60H(5)).

352 *Status of Children Act 1974* s 10F.

the *Child Support (Assessment) Act 1989* (Cth). In either of these situations a couple or an individual who commissioned the birth could apply for a parenting order under the *Family Law Act 1975* (Cth). The Family Court must regard the best interests of the child as the paramount consideration in deciding where the child should live, who should make decisions on behalf of the child and who should have contact with the child.

ADOPTING A CHILD BORN THROUGH A SURROGACY ARRANGEMENT

6.49 One way to create a parental relationship between the child and the commissioning parent or parents and to extinguish the parental relationship with the surrogate mother would be to permit the commissioning parents or parent to adopt the child. It is an offence for a private person to arrange an adoption,³⁵³ and so in order for the person or couple commissioning the pregnancy to adopt the child they would have to go through the adoption procedures laid out in the *Adoption Act 1984*.

6.50 In order for an adoption order to be made in favour of the people commissioning the birth, the birth mother must relinquish the child.³⁵⁴ This is the case whether the birth mother is the genetic mother of the child or not. An informal relationship, where the woman who gives birth does not relinquish the child but allows the commissioning couple to take the child into their care can be terminated at any time by the birth mother. If an adoption order is made in favour of the commissioning person or couple, the child becomes the child of the adopter(s) and ceases to be the child of the person who was the parent before the adoption order.³⁵⁵

6.51 Any adoption must be in the best interests of the child.³⁵⁶ A woman relinquishing a child must wait until at least 14 days after the birth of the child before agreeing to an adoption,³⁵⁷ and must receive counselling before she

353 *Adoption Act 1984* ss 119, 122.

354 Schedule 9 of the *Adoption Regulations 1998* outlines the prescribed information for a consent to adoption. This information includes a statement that, in giving consent, the person understands that when the Court makes an adoption order, he or she will lose his or her rights as a parent of the child, and that those rights will be transferred to the person or persons who adopt the child. The child will then be treated in law as the child of the person or persons who adopt the child.

355 *Adoption Act 1984* s 53.

356 *Ibid* s 9.

357 *Ibid* s 33.

consents.³⁵⁸ The criteria regulating eligibility for adoption of the child are discussed in Chapter 5. The adoptive parents—in the case of surrogacy the commissioning person or couple—must meet the selection criteria set out in the Act: they must have been married or in a heterosexual de facto relationship for at least two years,³⁵⁹ must be resident in the State of Victoria and the child must also be present in the State at the time of the order.³⁶⁰ This means that any married couples, or those who are in heterosexual de facto relationships, or single people in ‘special circumstances’ can adopt.³⁶¹ There is no provision that explicitly allows a couple in a same-sex relationship to adopt a child. The Court must decide, taking into account all evidence before it, that the applicants are suitable.³⁶²

6.52 A person may apply to be put on the register of people who are suitable to adopt a child.³⁶³ The applicant is required to sign a statement acknowledging that inclusion on the register does not guarantee that a child will be placed for adoption with the applicant.³⁶⁴ However, there is provision for the adoption of children who are already in the applicant’s care. In this situation, the applicant must satisfy the prescribed requirements for the adoption of a child by having shown the ability while caring for the child to ‘provide a secure and beneficial emotional and physical environment during a child’s upbringing until the child reaches social and emotional independence’.³⁶⁵

6.53 If the law is changed to make it easier for people to enter into altruistic surrogacy arrangements it will be necessary to decide whether these provisions should be modified to take account of the particular issues and potential conflicts that pertain to surrogacy arrangements. Even if the law remains the same, it may be appropriate to amend the *Adoption Act 1984* to deal with situations where people have children as the result of surrogacy arrangements made overseas.

358 Ibid s 35.

359 Ibid s 11.

360 Ibid s 7.

361 Ibid s 11(3).

362 Ibid s 15.

363 Ibid s 13.

364 *Adoption Regulations 1998* Sch 4, Reg 35A.

365 Ibid Part 6, Div 1, Reg 35.

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QUESTION(S)

52. Should single people, women in lesbian relationships, or men in same-sex relationships be able to adopt a child who has been born under a surrogacy arrangement?
53. If so, how should the *Adoption Act 1984* be amended to facilitate adoption in these circumstances?
54. What arrangements should be made to deal with adoption of children born as the result of surrogacy arrangements made overseas?

PARENTHOOD AND SURROGACY IN OTHER JURISDICTIONS

6.54 Relatively few jurisdictions in the world have legislated specifically for surrogacy.³⁶⁶ In this section we briefly discuss two examples of jurisdictions that have legislated with respect to surrogacy, one in Australia and one outside.

6.55 In the United Kingdom, the provisions of the *Human Fertilisation and Embryology Act 1990* (UK) include conditions under which gamete donors can have parental orders made in their favour.³⁶⁷ Section 30 of the Act permits surrogacy in limited situations by defining the circumstances in which a court can make parental orders in favour of gamete donors. The Act provides that a child may be treated as the child of a marriage where an embryo created with the gametes of at least one partner to the marriage has been carried to term by another woman provided:

- that the husband and wife apply for the parental order within six months of the birth;
- that the child is living with the applicants;

366 Some states of the United States have liberal regimes regarding surrogacy; others have legislated to ban commercial surrogacy arrangements.

367 Section 30.

- that the court is satisfied that the legal parents³⁶⁸ have agreed unconditionally with full understanding of what is involved, to the making of the order; and
- that the court is satisfied that no money or other benefit (other than for expenses reasonably incurred) has been given or received by the husband or the wife.

6.56 These provisions enable some commissioning heterosexual couples to obtain recognition as parents under the *Human Fertilisation and Embryology Act 1990* (UK), making it unnecessary in these cases to pursue parenthood through adoption. Surrogacy contracts are void in UK.

6.57 The Australian Capital Territory has legislated to deal with 'substitute parent agreements'. Under the *Substitute Parent Agreements Act 1994* (ACT), commercial substitute parent agreements are prohibited,³⁶⁹ as is procuring a person to enter into an agreement unless the person who procures is also involved in the agreement, advertising a substitute, and facilitating the pregnancy of someone involved in a commercial substitute parent agreement.³⁷⁰

6.58 Any surrogacy contract made between the parties is void,³⁷¹ and the birth mother is the legal mother of the child.³⁷² The birth mother's husband or de facto partner, if she has one, is presumed to be the father of the child although the presumption is rebuttable if he proves he did not consent.³⁷³ If she is single or her partner does not consent, the man who provided the semen 'shall for all purposes be conclusively presumed not to be the father of the child.'³⁷⁴ This is the case even if the arrangement was made with the intention that he should be the child's parent.

6.59 However, the ACT has also enacted legislation allowing parenting orders to be made in favour of a commissioning parent or parents, where 'the gametes of

368 The *Human Fertilisation and Embryology Act 1990* (ss 28–29) defines the meaning of both mother and father in artificial conception procedures: the mother of a child is the birth mother. The husband or male partner of a woman is the father of the child unless it is shown that he did not consent to the procedure.

369 *Substitute Parent Agreements Act 1994* (ACT) s 5.

370 *Ibid* ss 6–8.

371 *Ibid* s 9.

372 *Artificial Conception Act 1985* (ACT) s 6.

373 *Ibid* s 5.

374 *Ibid* s 7.

a woman who is not the child's birth mother and of a man who is not the child's birth father,³⁷⁵ were used to create the embryo. In other words these provisions apply only where the surrogate mother and her partner have no genetic relationship with the child. Under the *Artificial Conception Act 1985* (ACT)³⁷⁶ a commissioning parent or parents can apply to the Supreme Court for a parentage order in relation to the child. If an order is made in favour of a person or couple, the applicants become the parents of the child and the birth parent or parents cease to be the child's parents.³⁷⁷

6.60 For the commissioning parents³⁷⁸ to obtain an order:

- at least one of them must be a genetic parent of the child;³⁷⁹ and
- the application must be made not less than six weeks and not more than six months after the child is born.³⁸⁰

6.61 The Court must make a parenting order in favour of the substitute parents³⁸¹ if satisfied that:

- making the order is in the best interests of a child;³⁸² and
- both birth parents freely, and with full understanding of what is involved, agree to the making of the order.³⁸³

6.62 Before making an order the Court must also consider:

- whether the child's home is and was at the time of the application with both the substitute parents;

375 Ibid s 9. These provisions are to expire on 1 July 2004: See s 9(1). However, on 8 December 2003 there was a Bill before the ACT parliament which will continue their application; *Parentage Bill 2003*, Pt 2, Div 2.5.

376 Ibid s 9.

377 Ibid s14.

378 It is possible for one only of the parents to apply if the other substitute parent freely agrees to the making of the order or if the applicant substitute parent is unable to contact the other to obtain his or her agreement see *Artificial Conception Act 1985* (ACT) s 11 (3)(c).

379 *Artificial Conception Act 1985* (ACT), s 2 defines a substitute parent agreement as an agreement under which a man and a woman have indicated their intention to become the prescribed parent of the child and either the man is the child's genetic father, or the woman is the child's genetic mother.

380 *Artificial Conception Act 1985* (ACT), s 10.

381 Ibid s 11(6).

382 Ibid s 11(a).

383 Ibid s 11(b).

- whether the substitute parents are at least 18 years old;
- if only one of the substitute parents has applied for an order and the other parent is alive at the time of the application, that the other parent has agreed to the making of the order or cannot be contacted;
- whether payment has been given or received in relation to the child, other than for expenses reasonably incurred; and
- whether both legal parents and substitute parents have received appropriate counselling and assessment from an independent counselling service.

The Court may also consider any other relevant matter.³⁸⁴

6.63 Both the United Kingdom and the ACT have identified similar issues to be considered in deciding whether parental orders can be made in relation to people who have entered into surrogacy arrangements.

- In both the UK and the ACT the surrogacy arrangement must be made with a heterosexual couple; in the United Kingdom they must be married, but not in the ACT.³⁸⁵
- Both jurisdictions require at least one of the substitute parents to be a genetic parent of the child.
- Both jurisdictions provide there must be an unconditional and full agreement on the part of the legal parents to the substitute parent arrangement.
- In the UK the child must be living with the applicant parents at the time of the application; this is a factor to be considered in the ACT.
- In both jurisdictions an application must be made shortly after the birth, but not so quickly that sufficient time to consider the arrangement after the birth is not available.
- In the UK payment must not have occurred (other than for expenses reasonably incurred). This is not a requirement in the ACT but is a factor to be considered.

384 Ibid s11(3)–(4).

385 However, in the ACT one of the people who has made the agreement can apply for a parenting order in certain situations. See *Artificial Conception Act 1985*, s11 (3). This could enable a single woman or a lesbian woman to make a substitute parent agreement involving a man, but then to apply for the order on her own behalf. The *Parentage Bill 2003*, if enacted will remove this requirement, see cl 24.

OPTIONS FOR REFORM

6.64 There are two main options for reforming parenting laws to accommodate situations in which surrogacy has occurred:

- amend the *Adoption Act 1984* to make specific provision for altruistic surrogacy; or
- enact legislation governing altruistic surrogacy, which provides a procedure under which commissioning parents may be recognised as parents of the child.

6.65 A number of issues would have to be considered in enacting similar legislation in Victoria. It would be necessary to consider whether the provisions common to the UK and ACT legislation provide adequate protection for all parents and children involved.

6.66 One important issue for consideration is whether the birth mother's right to decide whether or not to relinquish the child should be preserved in all such arrangements, whether she is the genetic mother of the child or not.³⁸⁶ The law in the United Kingdom is clear on this matter. 'A commissioning couple cannot apply for a parental order unless the child is already in their care with the consent of the surrogate... Unless the surrogate is, quite apart from the surrogacy arrangement, entirely unfit to parent the child, she is unlikely to be ordered to give up the child.'³⁸⁷

6.67 Another factor that might be taken into account relates to the effect of such arrangements on other children. This could include children who have a genetic relationship to the child born under the surrogacy arrangement or children of the mother who bears the child, who may not be genetically related to the child. The *Artificial Conception Act 1985* (ACT) says that if the child for whom a parentage application is made has a birth sibling born as a result of the same pregnancy the Supreme Court can only make a parentage order if it also makes a parentage order about the living birth sibling.³⁸⁸ In other words twins cannot be

386 Margaret Brazier, Alastair Campbell and Susan Golombok, *Surrogacy: Review for Health Ministers of Current Arrangements for Payments and Regulation* (1998) 26. As there is a lack of published research on the long-term effects of surrogacy on the birth mother, it is not possible to say whether there are differences in outcome for birth mothers who are genetically related to the child and those who are not; see 33. It is also unclear whether the existence of a genetic relationship affects the children.

387 Ibid 26.

388 *Artificial Conception Act 1985* (ACT) ss 2, 12.

separated. The Act does not refer to other children of the birth mother or other genetic relatives.

6.68 There is little published research, and little available data, on the effects of surrogacy on children, either children born of those arrangements or the children of the birth mother. It has been noted, given this lack of direct evidence of the impact of surrogacy on the psychological welfare of children, that ‘there is nevertheless a clear potential of risk’ to children’s welfare and that research to identify and quantify that risk is urgently needed.³⁸⁹ It has also been noted that, in the absence of such data, the State ‘must act on the precautionary principle’, because the risk is difficult to assess and the State nevertheless has a duty to minimise risk.³⁹⁰ The Commission would appreciate comments on how the interests of existing children should be taken into account if legislation similar to the *Artificial Conception Act 1985* (ACT) were enacted in Victoria.

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QUESTION(S)

55. Is Victorian law adequate to deal with parental relationships arising from surrogacy?
56. If not, should provision be made to recognise a person who commissions the birth of a child under a surrogacy agreement as the child’s parent?
57. If so, should this be done by
 - amending the *Status of Children Act 1974* to recognise commissioning parent(s) as birth parents of a child conceived under a surrogacy arrangement and, if so, in what circumstances should parentage be recognised;
 - amendment of the *Adoption Act 1984* to facilitate adoption by a commissioning parent or parents under a surrogacy arrangement and, if so, in what circumstances should adoption be permitted; or

389 Margaret Brazier, Alastair Campbell and Susan Golombok, *Surrogacy: Review for Health Ministers of Current Arrangements for Payments and Regulation* (1998) 33.

390 Ibid 33.

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QUESTION(S)

- provision for the Supreme Court to make parentage orders to recognise commissioning parent(s) as birth parents of a child conceived under a surrogacy arrangement and, if so, what conditions should regulate the exercise of this jurisdiction?