Reproductive Technology Council

Reproductive Technology Council of Western Australia

Submission on the review of the *Human Reproductive Technology Act 1991 (WA)* and *Surrogacy Act 2008 (WA)*

Introduction

The Reproductive Technology Council ('Council'), established under the *Human Reproductive Technology Act 1991* ('HRT Act'), has a central role in the regulation of assisted reproductive technology and related research in Western Australia, and in advising the Minister on reproductive technology and the administration and enforcement of the HRT Act,[1] and in the implementation of the Surrogacy Act 2008 (WA) ('Surrogacy Act').[2]

This submission addresses the terms of reference ('TOR') that are defined in the current Review of the HRT Act. It will draw upon previous submissions from Council and other states' legislation for reference.

1. Posthumous collection, storage and use of gametes and embryos including: the consent required; conditions for use; and any impact on other legislation such as the *Human Tissue and Transplant Act 1982, Artificial Conception Act 1985, Births Deaths and Marriages Registration Act 1998, Administration Act 1903* and *Family Provision Act 1972*

In 2014, Council carefully considered issues associated with the posthumous collection and use of gametes ('PCUG') and developed a position paper in that regard ('Position Paper').[3] That Position Paper is annexed as reflecting and underpinning Council's submissions as they relate to PCUG. For clarity, the key conclusions are summarised below, and Council's submissions in relation to the posthumous use of embryos are added.

1.1. Gametes collected after death

Council recommends that the HRT Act expressly cover the field[4] in relation to the posthumous collection, use and storage of both gametes and embryos.

For the reasons outlined in the Position Paper, Council does not support:

- the posthumous collection of gametes for reproductive use; or
- the use, for reproductive purposes, of gametes collected posthumously.

[1] Council's functions are set out in HRT Act, s14.
[2] See in particular Surrogacy Act, Division 2.
[3] Reproductive Technology Council, Position on the Collection and Use of Gametes, 18 February 2014 ('Position Paper'), annexed.
[4] That is, the HRT Act should apply, to the exclusion of any other law.

While the latter is currently rolled into the general prohibition of posthumous use of gametes under the Directions,[5] the former has been authorised by the Supreme Court of WA relying on the terms of the *Human Tissue and Transplant Act 1982* ('HTTA').[6] This has given rise to the undesirable result that gametes may be collected posthumously under the HTTA, but cannot be used, or arguably lawfully stored,[7] within this State.[8]

1.2. Gametes and embryos collected prior to death

1.2.1. Gametes

As identified in the Position Paper, Council recognises that in individual cases (including those involving the use of donor gametes) exceptional circumstances[9] may exist in which the posthumous use of gametes may be reasonable.

Any such use should be subject to approval by Council, which should only approve use if it is satisfied that exceptional circumstances exist which are not, on balance, outweighed by considerations of gender equity and/or the welfare of the participants (paying particular regard to the welfare of any resulting child).

1.2.2. Embryos

Council recognises that the use of embryos raises distinct ethical and policy issues.[10] While it remains concerned with the posthumous use of reproductive material to achieve a pregnancy in circumstances where the resulting child may never have contact with his/her genetic parent, Council supports the following:

- if an embryo is created from the gametes of a couple for their own reproductive use and one member of the couple dies before the embryo is so used, then the surviving partner may use or donate the embryo for reproductive purposes;
- if an embryo is created for the benefit of a couple using donated gametes, or if an embryo has been donated to a couple or person *inter vivos*, it is acceptable for the couple / recipient to use that embryo to achieve a pregnancy, including after the death of the gamete/embryo donor/s; and
- if an embryo is donated to a clinic for reproductive use and the clinic has allocated the embryo to a person or couple before the death of the donor/s then the recipient/s may use the embryo to achieve a pregnancy, including after the death of the embryo donor/s. If an embryo donated to a clinic has not already been allocated

[5] *Directions given by the Commissioner of Health to set the standards of practice under the Human Reproductive Technology Act 1991*, WA Government Gazette 201/2004 ('Directions'), 8.9.
[6] *S v Minister for Health (WA)* [2008] WASC 262*; Re Section 22 of the Human Tissue and Transplant Act 1982 (WA); Ex parte M* [2008] WASC 276.
[7] This is because HRT Act, ss 22(1) and (8) require that 'effective consent' to storage comprise consent in writing from the person whose gametes are stored, which cannot be obtained from the deceased person. This provision had not, at the time of writing, been considered judicially in the context of posthumous collection.
[8] See further discussion in *GLS v Russell-Weisz* [2018] WASC 79.
[9] As identified in 3.5, read with 3.6, of the Position Paper.
[10] See, for example, NHMRC, *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research* (2017) at 21.

to a recipient, then Council considered that the embryo should not be used after the death of the donor/s.[11]

2. The storage of gametes, eggs in the process of fertilisation and embryos (including the duration of storage and procedures for extension of storage periods)

Subject to the submissions that follow, Council supports existing legislative policy that reproductive material (embryos and/or gametes):

- may only be stored with the effective consent[12] of the person/s on whose behalf it is being held; and
- should not be stored beyond the period stated in the consent.

2.1. Duration of Storage

Council supports the current position in relation to storage of reproductive material being for a defined period, which may be extended by application. Council does not support the indefinite storage of reproductive material.

2.1.1. Gametes

Council recommends:

- maintaining fifteen years as the defined maximum period of storage for gametes (including donated gametes), subject to any approval by Council (on application) to extend that period; and
- that the definition of 'gametes' under the HRT Act be amended to include testicular and ovarian tissue.

2.1.2. Embryos

Council recommends maintaining ten years as the defined maximum period of storage for embryos, subject to any approval by Council (on application) to extend that period.

2.2. Extension of Periods of Storage

2.2.1. Gametes

Council notes the importance of clinics maintaining contact with gamete providers but recognises that:

- confusion can arise when renewal of a person's consent to store gametes is required before expiration of the period specified in the original consent; and

[11] Council considered that the matters identified as relevant to posthumous reproduction in 2.1 to 2.6 of the Position Paper are also broadly relevant to the posthumous use of embryos and, on balance, weigh against use in circumstances where an embryo has not been allocated for use at the time of a donor's death. Council acknowledges that the distinction between allocated and unallocated donated embryos is fine, but considers that the distress associated with having an embryo allocated for use and then allowing the embryo to succumb following the death of a donor was of sufficient weight to warrant a different outcome.

[12] Within the current meaning of that term in HRT Act, s 22.

- there may be circumstances in which it is not reasonably practicable for a clinic to obtain renewed consent before expiration of the original consent.

Accordingly, Council recommends that:

- the effect of Direction 3.1 be amended such as to align the renewal of a person's consent to store gametes with the expiration of the storage period (up to a maximum of fifteen years) specified in the person's original / existing consent; and
- where there is evidence that a clinic has, despite all reasonably practicable efforts, been unable to contact the gamete provider to ascertain whether s/he wishes to extend the period of storage, that Council have discretion to extend the period of storage for a period of up to 1 year upon the application by the clinic or the gamete provider's next of kin.
- clinics can apply to Births, Deaths and Marriages Register to check if a gamete or embryo provider is still alive when no contact has been established.[13]

2.2.2. Embryos

Pursuant to s 24(1)(c) HRT Act, Council may currently only grant an extension of the period of storage for an embryo before the expiration of that period, in 'exceptional circumstances'.

Council recommends that the HRT Act be amended so that:

- on application made *before the expiration of the relevant period*, Council has discretion to grant an extension of the time allowed for storage on grounds that:
  - the embryo/s have been or will be donated for use by another person or couple, or for research, and the period of the proposed extension is required to give effect to that donation; or
  - the person or couple for whom the embryo is being stored wishes to use the embryo for their own reproductive purposes and have been assessed as likely to remain eligible for in vitro fertilisation ('IVF') treatment over the period of the proposed extension;
- on application made *after the expiration of the relevant period*, Council[14] has discretion to grant an extension of the time allowed for storage if it is satisfied that:
  - the applicant can demonstrate extraordinary circumstances that adequately justify the delay in applying for an extension;
  - if the application had been made before the date of expiration, an extension would have been granted; and
  - the extension is proportionate to the circumstances.

Council also recommends modifying the requirement under s 24(1)(d) HRT Act (to inform the Minister of approvals to extend storage) to clarify that inclusion of that information in the annual report of Council will satisfy the reporting requirement.

[13] This is part of *reasonable steps* to establish contact ,NSW Assisted Reproductive Act 2007 section 24(3)
[14] Or another legislatively appointed body such as a Court or Tribunal.

3. Rights to control gametes and embryos including: rights upon separation or divorce, or the death or the physical or mental incapacity of an individual, or one or both members of a couple; and rights of third parties such as subsequent spouses, and the rights of other relatives

3.1. Death

Council supports the existing legislative position, under s 26(1)(b) HRT Act, that in the event of the death of one member of a couple in whom rights of control are vested, those rights vest solely in the survivor.

Council recommends against the conferral of rights in relation to reproductive material to any third party, unless such conferral is specifically contemplated and included in the written consent of the deceased person. In the absence of such express written consent, and in the absence of s 26(1)(b) applying, the gametes and embryos of the deceased person should be allowed to succumb.

3.2. Uncertain Rights of Control

It is currently unclear who has jurisdiction to determine disputes and/or uncertainties over the control and use of reproductive material[15] and Council recommends legislative conferral of jurisdiction.

Council also supports a mechanism that would allow a clinic in those circumstances, without consent from a gamete provider, to continue storage of:

- reproductive material, in circumstances where a participant who would ordinarily be required to give consent to continued storage or use is, by reason of death or incapacity, unable to give consent; or
- embryos, in circumstances where there is a dispute between the persons for whose benefit the embryo is being stored,

for such period as is required to determine the question of control.

This recommendation in relation to storage does not derogate from Council's recommendations in respect of control rights over reproductive material following death.

4. Management of information / the Reproductive Technology Registers, including confidentiality of information; use of data for research; use of data for purposes of national data collection; access of information about donation, genetic parentage and donor conception; and the Voluntary Register (donor-assisted conception)

Council endorses and encourages the retention of secure, detailed and accurate data. The reviewed HRT Act needs to reflect clarity for the rationale behind data collection, being for the purposes of research, state and national statistics, quality management and access to information about genetic parentage.

[15] See limited treatment under HRT Act, s 26(2).

4.1. Confidentiality of information

Council recognises the need to protect and respect the privacy of individuals, particularly in relation to sensitive health information.

Council also notes a strong public interest in maintaining accurate, complete and reliable data in the Reproductive Technology Registers (Registers).[16]

The HRT Act should state that secure retention of detailed and accurate data is necessary for the purposes of research, state and national statistics, quality management, and access to information about genetic parentage.

Council submits that for the purposes of satisfying the requirement of Part 4 Division 5 of the Act, and for related purposes, the Act should specify that management of the Registers will reside within the Reproductive Technology Unit (RTU).

4.2. Use of data for research

Council supports the use of data on the Registers for research purposes. It recognises that reliable, validated, and complete data that reflects current reproductive technology practices needs to be accessible to researchers. Council believes the Act should charge the RTU with maintaining and managing the Registers for this purpose.

4.3. Use of data for purposes of national data collection

4.3.1. Streamline data collection

IVF clinics are currently required to collect and report data

- to the RTU for the purposes of maintaining the Registers;[17] and
- to the Australian and New Zealand Assisted Reproduction Database ('ANZARD').[18]

Council recognises the value of both collections and, subject to submission at 4.3.2 below, recommends that the RTU should explore options to align reporting timelines, and variables that are common to both.

Council also recognises that the Registers collect more detailed treatment cycle information in line with its statutory purpose of facilitating treatment safety and clinical practice monitoring at the State level. The Act should capture this distinction without limiting the Registers to a single statutory list of data items, allowing the Registers to keep pace with changes in reproductive technology and clinical practice.

[16] Consistent with HRT Act, Part 4 Division 5.

[17] HRT Act, s 47, and Directions, Schedule 2 – Data Structure for Reporting.

[18] For these purposes, it is relevant to note the involvement of RTAC, the national accrediting body, in this data collection https://npesu.unsw.edu.au/data-collection/australian-new-zealand-assisted-reproduction-database-anzard.

4.3.2. Birth outcome data

Council recommends that, in line with relevant NHMRC guidelines,[19] the recording of treatment cycle information include associated birth outcomes. Information on birth outcomes is an important tool to measure clinical effectiveness and quality management.

Council recognises that obtaining this information directly from patients may cause unintended distress where a patient has experienced pregnancy loss or a difficult birth event. Accordingly, it recommends that the HRT Act (and/or subsidiary regulations, as necessary) should:

- provide that birth outcome data, for the purposes of the Register, be obtained as far as possible through internal (Department of Health) linkage of treatment cycle data to the Midwives' Notification System; and
- facilitate and permit that data to be conveyed to ANZARD.

If this recommendation is adopted, then the requirement for IVF clinics to report birth outcome data to the RTU, as specified in the current Directions,[20] should be removed.

4.3.3. Management of data

Information kept on the Registers is detailed, specialised and includes complex relationships (especially as it relates to donors). Council considers that reliable recording and retrieval of this information requires the Registers to be managed directly by the RTU.

4.3.4. Annual Reporting

As noted above, Council recommends that its annual reporting requirements be amended to include birth outcome data. [21]

4.4. Access to information about donation, genetic parentage and donor conception

Council acknowledges the interests of donor conceived persons (DCPs) in accessing information relevant to their genetic parentage and supports processes that would facilitate identification in line with the submissions below.

4.4.1. Donation

Balancing the importance of consent and the interests of DCPs in accessing identifying information, Council:

- endorses existing policy to the effect that donor gametes should not be used unless the donor has given consent to the release of his/her identifying information; and

[19] See NHMRC, *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research* (2017) 9.1.5.
[20] Directions, Schedule 2 – Data Structure for Reporting.
[21] Directions, 4.1 (d) (ii).

- for donations made prior to 2004, recommends release of identifying donor information on an opt-in basis only (that is, where the donor has agreed to release of his or her identifying information).

Council further recommends that Registers include a facility to receive updated health information and updated contact information from donors.

4.4.2. Genetic parentage

Council recognises that parents and DCPs have an interest in basic information about those to whom the DCP may be related (e.g. number of potential siblings or half-siblings, as well as potential consanguinity). The Act should allow access to the Registers to provide such information to DCPs.

4.4.3. Donor conception

Records and information associated with treatment cycles involving donated gametes occurring before 1993 are not covered by the mandatory terms of the HRT Act and are not currently able to be stored in the Registers. To promote and encourage the safekeeping of and access to that information, Council recommends that the Registers be amended to accommodate that data.

Noting 'donor-linking' as an emerging area of practice, Council considers that counselling and support services should be made available to all affected participants (DCPs, their parents and donors). Further, Council recommends that any counselling associated with access to non-identifying information (either through the Registers or the Voluntary Register) should follow ANZICA guidelines.[22]

Consistent with the terms of the Voluntary Register and with the practice in other jurisdictions,[23] Council recommends that the age for release of identifying donor information to DCP be increased from 16 to 18 years of age (legal majority).

4.5. Donor assisted conception - the Voluntary Register ('VR')

4.5.1. Legislation

The Council supports developing a legislative framework for the VR. As submitted above, linkage between key Registers for verification of information would enable the VR to fulfil its functions. A more sophisticated information management system will be required as the VR continues to expand.

4.5.2. Data limitations

Council recognises that there may be limitations with the data recorded to enable identification of a person's genetic heritage. Council supports measures to address these

[22] https://www.fertilitysociety.com.au/wp-content/uploads/20120504-anzica-guidelines-donor-linking-final-version.pdf

[23] See relevant legislation in NSW, Victoria, New Zealand, UK.

limitations (such as DNA matching or data linkage with other databases), and such further measures as may support DCPs (such as counselling).

5. Research and experimentation on gametes, eggs in the process of fertilisation and embryos. In particular consider the current disparity between the Human Reproductive Technology Act 1991 (HRT Act) and relevant Commonwealth legislation and need to adopt nationally consistent legislation regarding excess assisted reproductive technology (ART) embryo research and prohibited practices

Amendments to the HRT Act in 2004 involved the addition of Parts 4A and 4B to align State and Commonwealth legislation regarding research and experimentation on gametes, eggs in the process of fertilisation and embryos.

State and Commonwealth legislation was consistent in this regard until, following the Lockhart review, [24] the Commonwealth Acts[25] were amended in December 2006 to expand the range of research activities involving embryos that may be licensed. Despite the Council of Australian Governments (COAG) committing, at its meeting of 13 April 2007, to endeavor to achieve and maintain national consistency, corresponding legislation is yet to be introduced in WA.

The current misalignment of State and Commonwealth legislation has led to inconsistencies surrounding research related to prohibited practices, and legal uncertainty regarding the authority of the National Health and Medical Research Council (NHMRC) to license and monitor research on excess ART embryos. Consequently, research required to be licensed by the NHMRC is not being undertaken in this State.

In light of the above, Council recommends amendment of the HRT Act to align it with Commonwealth embryo research and prohibited practices legislation.

6. Genetic testing of embryos, saviour siblings, mitochondrial donation and gene editing technology

6.1. Genetic testing of embryos

The 2004 amendments of the HRT Act allowed genetic testing of embryos (PGD) to be available to a couple or a woman whose child would otherwise be likely to be affected by a genetic abnormality or a disease. PGD usually requires the testing of several embryos to increase the likelihood of identifying an unaffected embryo. Licensees currently require Council approval to store more than three embryos of the same biological parentage (Direction 8.7). The vast majority of applications to Council to waive Direction 8.7 have been approved. Most applications to waive Direction 8.7 are on behalf of patients planning PGD.

[24] Following recommendations made in The Lockhart Review of the Research Involving Human Embryos Act 2002 and Prohibition of Human Cloning Act 2002 Report 2005

[25] Research Involving Human Embryos Act 2002; Prohibition of Human Cloning Act 2002

Council notes that:

- neither the NHMRC Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research 2017 (NHMRC Guidelines), nor the legislation in other States and Territories, place a limit on the number of embryos patients may have in storage prior to commencing treatment to create additional embryos; and
- ANZARD data published in 2017 reports an average of 1.9 fresh and or thaw cycles per woman in 2015 which suggests that women are not routinely undergoing multiple embryo batching cycles.

For these reasons Council supports the removal of Direction 8.7.

6.2. Tissue matching - 'saviour siblings'

As noted above, current legislation restricts PGD to a woman or couple whose child would otherwise be likely to be affected by a genetic abnormality or a disease, which precludes testing for the purposes of tissue matching.

Council notes that the NHMRC Guidelines:[26]

- identify that collection of stem cells from umbilical cord blood does not harm the person who would be born;
- on that basis, and subject to the safeguards outlined in the Guidelines, support the use of tissue matching of an embryo for subsequent stem cell therapy for a parent, sibling or relative;
- include requirements that, before tissue matching is undertaken for these purposes, clinicians must seek advice from an independent body which must in turn be satisfied that:
    - there is no evidence to suggest that the person who would be born would not be a welcomed, respected member of the family unit;
    - the use of genetic testing of the embryos will not significantly affect the welfare and interests of the person who would be born; and
    - the medical condition of the intended parent, sibling or other relative to be treated is serious and stem cell treatment is the medically recommended management of the condition.

Council supports amendment of the HRT Act to permit PGD for the purpose of tissue matching in line with the NHMRC Guidelines, with Council to perform the functions of the 'independent body' contemplated therein.

[26] NHMRC Guidelines, Clause 8.17.

6.3. Mitochondrial donation and gene editing technology

6.3.1. Mitochondrial donation

All embryonic mitochondria are derived from oocytes, meaning that all children of a female carrier for mitochondrial disease will be affected by the condition. Mitochondrial diseases tend to have serious consequences, with:

- the most significantly affected organs being those with high energy consumption (such as brain, heart and skeletal muscles);
- neurological abnormalities include loss of vision and hearing, seizures, dementia, motor neuron disease;
- symptoms may appear at birth or have a late onset; and
- the Australian Mitochondrial Disease Foundation data suggest that mitochondrial donation could prevent up to 60 Australian children a year being born with severely disabling and potentially fatal mitochondrial diseases.

Mitochondrial donation involves replacing defective mitochondria from an egg or embryo with healthy mitochondria,[27] with the result that the embryo contains genetic material from three people.

6.3.2. Genome editing

This process involves the insertion, deletion or replacement of genetic material in a cell. The edited genome could be inherited by future generations. [28]

Council notes that:

- the HRT Act currently prohibits both mitochondrial donation[29] and genome editing and related research,[30]
- Commonwealth legislation permits research related to mitochondrial donation under an NHMRC licence; [31]
- Commonwealth legislation prohibits heritable alteration of the human genome;[32] and
- emerging technologies for mitochondrial donation and genome editing, although showing promise, require further research and ethical review.

Council supports the heritable alteration of the human genome for research purposes under an NHMRC licence.

Consistent with its submission in paragraph 5 above, Council supports the alignment of the HRT Act with Commonwealth legislation regarding prohibited practices and embryo

[27] Council notes that the clinical use of mitochondrial donation in the United Kingdom was first approved on 16 March 2017, and that mitochondrial donation is actively supported by the Wellcome Trust.
[28] The Nuffield Council on Bioethics released an ethical review of genome editing in 2016.
[29] HRT Act, s 53I prohibits the creation of embryos with genetic material from more than two people.
[30] Section 53L HRT Act prohibits heritable alteration of genome of a human embryonal cell, human fetal cell and human gametes.
[31] Prohibition of Human Cloning for Reproduction Act 2002, s 23.
[32] Prohibition of Human Cloning for Reproduction Act 2002, s 15.

research, including the use of excess ART embryos to allow this research in WA under a NHMRC licence.

7. The review of the Surrogacy Act to include the effectiveness and operation of the Act and its interaction with other regulatory instruments

7.1. Interaction with the HRT Act

Council supports the eligibility criteria for IVF and surrogacy being aligned with anti-discrimination legislation and practices.

7.1.1. Impending loss of fertility

IVF procedures may not be carried out unless the eligibility criteria in s 23 of the HRT Act are satisfied. Those criteria are directed towards facilitating treatment that would benefit persons who:

- are unable, for medical reasons, to conceive[33] or carry a child;[34] or
- would otherwise be at risk of conceiving a child 'affected by a genetic abnormality or disease'.[35]

Further, the Surrogacy Direction 2009 (WA) ('Surrogacy Directions') prohibit the creation of embryos for a surrogacy arrangement until the surrogacy arrangement has been approved by Council.[36]

Recognising that the legislative policy behind these criteria is to limit IVF procedures to patients who require intervention on medical grounds,[37] Council considers that they do not adequately respond to patients who require urgent medical or surgical treatment that will give rise to those grounds.

Council supports amendment of s 23 HRT Act[38] and Surrogacy Direction 7 so as to facilitate access to IVF procedures in circumstances where a patient, for medical reasons, faces the imminent loss of or significant impairment to:

- fertility; or
- the ability to carry a child.

7.1.2. Compliance with the Sex Discrimination Act 1984 (Cth)

As noted above, the eligibility criteria for IVF (and by extension, surrogacy) are currently directed to medical need.[39] Accordingly, single men and same sex couples are not permitted

[33] HRT Act, s 23(1)(a)(i)-(ia).
[34] HRT Act, s 23(1)(a)(iii), with this latter criterion being directed towards facilitating approved surrogacy arrangements.
[35] HRT Act, s 23(1)(a)(ii).
[36] Surrogacy Directions, Direction 7.
[37] In this regard, Council refers to its submissions at 7.1.2 below.
[38] In line with recommendations made by the Select Committee on the Human Reproductive Technology Act 1991, Report (1999), Recommendation 5b.
[39] HRT Act, s 23. Similar criteria limit eligibility for applying for a parentage order under the Surrogacy Act, s19.

access to IVF procedures (including for surrogacy purposes) under the HRT Act. Those restrictions are likely to be inconsistent with the Sex Discrimination Act 1984 (Cth) ('SDA').

Council supports amendments to s23 HRT Act to ensure compliance with the requirements of the SDA.

7.2. The effectiveness of powers of enforcement and disciplinary provisions under the Surrogacy Act, the adequacy of offences, penalties and timeframe for bringing proceedings

7.2.1. Services connected with surrogacy for reward

Section 11 of the Surrogacy Act provides:

> ***Services connected with surrogacy arrangement that is for reward***
>
> *(1) A person who provides a service knowing that the service is to facilitate a surrogacy arrangement that is for reward commits a crime except in the circumstances described in subsection (2).*
>
> *(2) It is not an offence against subsection (1) if the service is a health service provided to the birth mother after she has become pregnant.*

Council is aware of concerns that, broadly interpreted, subsection (1) may be read as applying to service-providers who have advised participants in connection with a commercial surrogacy arrangement in circumstances where:

- the advice has been given in respect of the legal and other risks associated with such arrangements and against participation in them, but where the participants, contrary to that advice, pursue a commercial surrogacy arrangement; or
- legal advice is provided to a person subsequent to that person's participation in a commercial surrogacy arrangement (for example, in connection with the parentage of a resulting child, or in connection with having committed an offence).

Council supports clarification of the position that the provision of the services outlined above will not offend the prohibition contained in s 11(1) HRT Act.

7.2.2. Information related to Surrogacy

Public awareness of altruistic surrogacy as a viable and acceptable means of family formation, and the options available within Australia, should be promoted. Increased awareness of Australian laws and domestic surrogacy services available through information dissemination and education systems may assist people to access treatment in WA and elsewhere in Australia and discourage overseas forum shopping.

Council recommends the creation of an agency to provide professional support and integrated services to surrogates and arranged parents, and to promote surrogacy awareness in the community.

7.3. The impact on the Surrogacy Act of relevant Commonwealth and State legislation, and aspects of legislation of other jurisdictions which could be incorporated into the Act including consideration of harmonisation of domestic surrogacy legislation

7.3.1. Commonwealth legislation - Medicare

Council notes that, despite a Select Committee reviewing the HRT Act recommending in 1999:

> *[t]hat in the event that surrogacy is formalised in Western Australia, the Western Australian Minister for Health approach the Federal Government with a view to allowing in vitro fertilisation (IVF) surrogacy treatments to be considered by Medicare as any other IVF treatment*, [40]

Medicare rebates are not available for IVF treatments effecting a surrogacy arrangement.

While noting that any change to Medicare rebates is not a matter that can be directly addressed in a review of State legislation, Council supports the recommendation of the Select Committee outlined above.

Second, prior to the transfer of parentage of a child resulting from a surrogacy arrangement,[41] there is confusion about the inclusion of the child on a Medicare card and access to government and social security payments (including who should apply and whether funds should be transferred by the immediate recipients).

Remaining mindful of the scope of this review and associated jurisdictional limitations, Council notes its support for the establishment of an interim process to allow arranged parents access to Medicare benefits for babies born from a surrogacy arrangement.

7.3.2. State legislation - Births Deaths and Marriages Registers

Given differences in the regulation of surrogacy between Australian States, complications associated with the recording and transfer of parentage may arise in circumstances where:

- a surrogate lives in a different State to the arranged parents; or
- a birth unexpectedly occurs in a different State.

Council supports the development of reciprocal arrangements directed towards the:

- State-based Births Deaths and Marriages Registers (BDMRs); and
- Courts responsible for the transfer of parentage,

such as to give effect in those circumstances to an approved surrogacy arrangement.

[40] Select Committee on the Human Reproductive Technology Act 1991, Report (1999), Recommendation 18f.

[41] A period of between 28 days and 6 months.

7.3.3. Extraterritorial reach

Council notes that:

- New South Wales, the Australian Capital Territory and Queensland all have extraterritorial reach in relation to the prohibition of commercial surrogacy;[42]
- Western Australia does not have specific exterritorial provisions in the Surrogacy Act; and
- while prosecution under s 12 of the Criminal Code 1913 (WA) may be possible where any part of a commercial surrogacy arrangement is undertaken in WA, this has little practical effect since overseas-based agents and clinic representatives are seldom in WA for sufficient periods to initiate proceedings.

Council recommends amendment of the Surrogacy Act to give extraterritorial effect to the prohibition of commercial surrogacy, at least insofar as those provisions apply to persons other than the persons who have parental responsibility for a/the resulting child.[43]

7.3.4. Age of arranged parent/s[44]

In approving a surrogacy arrangement,[45] Council considers (amongst other things) whether the arranged parents will be eligible to apply for a transfer of parentage. In WA, at least one arranged parent must have attained the age of 25 years to be eligible to apply for a transfer of parentage.[46] Council notes that this age requirement is one of the highest in Australia.[47]

Council recognises that maturity of participants is desirable given the emotional, social and legal complexity of surrogacy arrangements. However, it also recognises that there may be cases in which some flexibility in a specified age limit may be warranted and desirable.

Council supports the retention of 25 years as the usual requirement, but recommends that persons aged between 18-25 years, who seek to enter into a surrogacy arrangement as the arranged parent/s, have an opportunity to apply to the Court to be assessed as eligible based on legal and psychosocial evaluations.

7.3.5. Advertising for altruistic surrogates

Finding a surrogate can be an insurmountable obstacle for some people. Currently, fertility clinics may accept expressions of interest from women who would consider being a surrogate, but are not permitted to advertise for altruistic surrogates.

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[42] Although there appear not to have been any prosecutions under the relevant provisions.

[43] Noting the paramountcy of the best interests of the child, whose interests may not be served by prosecution of the person/s having parental responsibility.

[44] The term 'arranged parent/s is used here to reflect the current language of the Surrogacy Act. Council refers, however, to its submission at 7.3.8 below which includes a recommendation that the term 'intended parent/s' be substituted to achieve better harmonisation between jurisdictions.

[45] See Surrogacy Act, Division 2.

[46] Surrogacy Act, s 19(1).

[47] Being, for example, 18 years in South Australia and 21 years in Tasmania.

Council notes that:

- clinics may currently advertise for altruistic gamete and embryo donors;
- New South Wales and Tasmania permit advertising for altruistic surrogates; and
- advertising may increase both the number of available surrogates and community awareness of WA surrogacy laws.

Council supports permitting WA clinics to advertise for altruistic surrogates.

7.3.6. Counselling

Implications counselling is a prerequisite for all parties to a surrogacy arrangement.[48] The Surrogacy Regulations stipulate that that counselling is to be provided by an 'approved counsellor'.[49]

Council notes that:

- other States allow implications counselling to be provided by counsellors who are members of the Australia and New Zealand Infertility Counsellor Association (ANZICA); and
- restricting counselling to 'approved Counsellors' may complicate or impede arrangements when the surrogate lives outside Western Australia.

Council recommends that the Surrogacy Regulations be amended to allow, with the approval of Council, the provision of counselling by a similarly qualified mental health professional.

7.3.7. Arranged parent background checks

Council notes the requirement in Victoria for criminal screening of arranged parents. Council does not support the introduction of a similar requirement in this State, and considers that:

- such a requirement would be incongruous given the absence of any similar checks for IVF participants; and
- the current requirements for psychometric assessments, implications counselling and legal advice provide adequate protections for the welfare of participants and resultant children.

7.3.8. Harmonisation of domestic surrogacy legislation

The Standing Committee of Attorneys-General (SCAG) considered a proposal for a national model to harmonise the regulation of surrogacy in Australia in 2009 and recommended the harmonisation of domestic surrogacy legislation.

However, despite sharing the overarching principles of:

- protecting the welfare of children born from surrogacy arrangements; and

[48] Surrogacy Act, s 17(c).
[49] Surrogacy Regulations 2009 (WA) ('Surrogacy regulations'), r 4.

- the prohibition of surrogacy for reward (financial or material),

the regulation of surrogacy differs between States. That lack of harmony results in complications and confusion for those seeking surrogacy arrangements, service providers, and regulators alike, which is amplified where participants[50] reside in different jurisdictions, or when circumstances materially change.[51]

Council supports the SCAG recommendation to harmonise domestic surrogacy legislation.

Consistent with the above recommendation, Council notes that the majority of other jurisdictions adopt the term 'intended parent/s' rather than 'arranged parent/s' and recommends that the language in the Surrogacy Act and Regulations be amended to adopt the former term, so as promote clarity through a shared understanding and language.

Further, a mechanism needs to be developed for transfer of parentage when a birth contemplated by a WA approved surrogacy arrangement occurs in another jurisdiction.

7.4. The need for continued prohibition on commercial surrogacy

In the face of a growing global commercial surrogacy market, 'controlled' payments for domestic surrogacy arrangements have been proposed as a mechanism to increase the availability of surrogates in Australia and so decrease the demand for international commercial surrogacy.

However, Council considers that it is incongruous for discussions about payment for surrogacy to take place in isolation from other contexts that rely on altruism, including the donation of embryos, gametes, tissue and solid organs. There is evidence to suggest that commercialism undermines altruism, and the insidious effects of payment should not be underestimated:

> *Payment for cells, tissues and organs is likely to take unfair advantage of the poorest and most vulnerable groups, undermines altruistic donation, and leads to profiteering and human trafficking.*[52]

In line with the position in most countries, Council considers that:

- the human body and its parts , should not, as such, give rise to financial gain; and
- there should be no incentives that might unduly influence a person to enter a surrogacy arrangement, which would undermine the principles of voluntary consent.

Council's firmly established stance is that the prohibition against commercial surrogacy should not be undermined.

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[50] Specifically, the arranged / commissioning / intended parents, and the birth mother / surrogate.

[51] For example, when a participant moves to, or unexpectedly gives birth in, another State.

[52] World Health Organisation, *Guiding Principles on Human Cell, Tissues and Organ Transplantation*, 2010, Guiding Principle 5.

7.5. International commercial surrogacy arrangements

International surrogacy arrangements (commercial or otherwise) give rise to significant complications when resulting children are brought back to Australia by the arranged parents. Resolution would typically require national rather than State intervention.

Australian citizenship by descent may be granted to the genetic child of an Australian citizen, even where that child is born overseas as the result of a commercial (or other non-approved) surrogacy arrangement. However, issues of parentage and citizenship when the child has no genetic link to an arranged parent need to be clarified.

Transfer of parentage orders can only be made in respect of approved surrogacy arrangements. Accordingly, for international commercial (and other non-approved) surrogacy arrangements, courts are limited to making parental responsibility orders, which operate in relation to the resulting children while they are minors. Once the child turns 18, s/he will have no legal parents in Australia, which can give rise to a range of complications including in respect of inheritance. Additional complexities arise in the event the "arranged parents" separate and if one or both die.

Council supports national regulation of international commercial surrogacy arrangements and the legal sequelae for resulting children in Australia.

7.6. International trade in gametes and embryos

Cross border reproductive care (CBRC) is a growth industry, particularly for surrogacy, but there is currently little capacity to monitor associated trends and outcomes. Council considers that:

- reproductive autonomy is appropriately tempered by considerations of, and protections for, the welfare and interests of participants, particularly any resultant child/ren;[53]
- it is important that outcomes of CBRC are able to be monitored and any associated adverse consequences mitigated against (including by identifying the need for support and directing appropriate resources), and that essential data be collected for this purpose;
- Births, Deaths and Marriages (BDM) and Midwives notification systems may offer practicable mechanisms to collect and record data regarding CBRC, including donor information and birth outcomes.

Council recommends that data be collected through the BDM & Midwives notification systems to enable monitoring of children born in Australia following CBRC.

[53] For example, by considering options for registering donor information to protect the information needs of children resulting from donor conception that has been privately arranged, or with sperm purchased via the internet.

7.7. Import and export of human reproductive material

The HRT Act and Directions outline the requirements for donation of gametes and embryos in WA, which include:

- information that must be collected and recorded, including (amongst other things) the identity of each biological parent;[54]
- subject to Council approval on compassionate grounds, donated reproductive material may not be imported into the State for reproductive use unless the information required to be recorded is available;[55] and
- subject to Council approval in exceptional circumstances, there are no more than 5 recipient families for the gametes of a donor.[56]

When considering applications made to it under the Act or Directions, Council must consider the welfare of any child that may be born, as well as the welfare of participants. Those interests are not always congruent.

In considering applications for the import or use of donor gametes, relevant considerations include, but are not limited to the donation practices in the place of origin (for example, whether commercial trading in gametes and embryos is permitted, and whether donor identifying information is recorded and available to any resultant child).

Council supports restrictions on the import and export of human reproductive material that promote compliance with the requirements of the HRT Act.

8. Paramountcy of the interests of children

Council recommends that the HRT Act and Surrogacy Acts (and any subsidiary regulations) make clear that, although both:

- the welfare of participants; and
- the prospective welfare of any child to be born consequent upon a procedure,[57]

are properly taken into account in the operation, implementation and any discretion exercised under the Acts, the prospective welfare of any child to be born should be the prevailing consideration.

[54] HRT Act, s 45.
[55] Directions, 6.2 and 6.3.
[56] Directions, 8.1 and 8.2.
[57] See, for example, HRT Act, s 4.