STANDING COMMITTEE ON LEGISLATION

HUMAN REPRODUCTIVE TECHNOLOGY AND SURROGACY LEGISLATION AMENDMENT BILL 2019

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 20 MAY 2019

SESSION TWO

Members

Hon Dr Sally Talbot (Chair)
Hon Nick Goiran (Deputy Chair)
Hon Colin de Grussa
Hon Simon O'Brien
Hon Pierre Yang

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Hearing commenced at 12.43 pm

Dr SONIA ALLAN
Legal academic and consultant, examined:

The CHAIR: On behalf of the committee, I would like to welcome you to the hearing. Today's hearing will be broadcast. Before we go live, I would just like to remind all parties that if you have private documents with you, you must keep them flat on the desk to avoid the cameras. Please begin the broadcast. Because we have videoconferencing today, I would like to advise you, Dr Allan, that present with me at this end of the link-up are reporting and committee staff, and members of the committee, whom I will ask to introduce themselves.

Hon COLIN de GRUSSA: Hon Colin de Grussa.

Hon PIERRE YANG: Pierre Yang.

Hon NICK GOIRAN: Nick Goiran.

The CHAIR: Hon Simon O'Brien will be sitting in the chair that I think you can see is vacant in the middle of the screen, when he returns. He has had to leave temporarily.

You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

Dr Allan: Yes, I have.

The CHAIR: These proceedings are being recorded by Hansard and broadcast on the internet. Please note that this broadcast will also be available for viewing online after this hearing. Please advise the committee if you object to the broadcast being made available in this way. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones and try to talk into them. Ensure that you do not cover them with papers or make noise near them. I remind you that your transcript will be made public. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in private session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

Would you like to make an opening statement to the committee?

Dr Allan: No, I have received a list of questions, so I have really focused on preparing for those. I thought I would be happy to proceed without doing so.

The CHAIR: I must thank you on behalf of the committee, and say that we have just had that document handed out to us. It looks as if you have done a magnificent job in a very short time frame, so we do deeply appreciate that. Thank you. My suggestion about how we proceed is that we run through our questions, and you could perhaps talk to the notes that you have made here. I glanced through them, and I think they will give rise to further questions. I think that is probably the best way to proceed. If you are happy with that, I will start with question 1.

For the committee's benefit, could you please outline your qualifications and experience in the areas of assisted reproductive technology and surrogacy?

Dr Allan: I have five degrees. I hold a Bachelor of Laws, Bachelor of Arts in psychology, Master of Public Health, Master of Laws specialising in global health law, and a PhD in law, in which I focused on the regulation of assisted reproduction, stem cell research, human embryo research and cloning. I am trained in qualitative and quantitative research and analysis, and I am an experienced socio-legal researcher. I have, for many years, worked in areas related to or directly about law reform, so I am also very experienced in public consultation and report writing. My first major job in terms of assisted reproduction and surrogacy was for the Victorian Law Reform Commission back in 2003, when I was the sole legal researcher on a reference on ART, surrogacy, legal parentage and adoption for a significant amount of time. Since then, as a legal academic and consultant, I have had a considerable focus on health law, in particular ART, surrogacy and related matters. I have done extensive work also on issues related to donor conception.

In 2011, I was awarded a Churchill Fellowship to conduct research in all countries that release information to donor-conceived people, and to bring those results back to Australia. I conducted this research in 2012, visiting Austria, the Netherlands, Sweden, Finland and the United Kingdom, and consulting with authorities in Switzerland also. I was a global health law fellow at Georgetown University in Washington DC from 2011 to 2012, where my focus was global health law issues and regulation, but I also presented research there on ART, donor conception and surrogacy. In addition to that, I have contributed to all government inquiries at the state and federal level in Australia on ART and surrogacy that have been conducted over the past 15 years, often, like in this situation, being invited to appear before Parliament, but also putting in written submissions based on my research and work in the field. I have also contributed to expert forums on cross-border ART and surrogacy in Australia, The Hague, and for the United Nations Population Fund, the World Health Organization, and the Office of the High Commissioner for Human Rights, most recently at an expert committee in Bangkok, looking at international commercial surrogacy, and issues surrounding women and children.

Since 2014, I have been on the International Federation of Fertility Societies surveillance committee. On that committee, we survey laws, policies and practices around the world on ART and surrogacy, and we produce a report every three years. Our most recent report was this year. From 2015 to 2017, I led the review of the South Australian Assisted Reproductive Treatment Act, having been directly appointed by the then Minister for Health in that state, Hon Jack Snelling. As you are aware, in 2018 I led and conducted the review of the Western Australian Human Reproductive Technology Act and the Surrogacy Act. I would say that I have had 16 to 18 years working in this particular field.

[12.50 pm]

The CHAIR: Thank you, Dr Allan. Recommendation 4 of part 2 of your report recommends that the Minister for Health should "progress interim measures as far as is possible to address issues raised in the review that require urgent attention, recognising further reform is required as a matter of priority." Are the issues which require urgent attention the same as the two broad issues covered by the bill; namely, availability of in vitro fertilisation and surrogacy for likely future infertility, and the extension of surrogacy to single men and male couples?

Dr Allan: Yes, they are two of the issues that I identified as needing attention—urgent attention or attention as a matter of priority.

The CHAIR: Were there other matters not addressed by the bill which the review found require urgent attention?

Dr Allan: Yes, there were; however, in relation to that question, I did want to note that the bill was introduced only a few months after the review had commenced. With the minister and his department, I believe the minister in his statement said that he was of the view that the proposed

changes were needed prior to the conclusion of the review. But then given the actual timing and passage of the bill thus far, and that my review has now been completed, then there are, yes, clearly other matters that are not addressed in the current bill and that I found required urgent attention. I was particularly concerned about the current records and record keeping practices of the department, about ART procedures and donor conception, and I believe that those matters need to be addressed urgently; matters regarding the recording of and access to information about donor conception and surrogacy arrangements by people born as a result; operational issues related to that regarding the donor registers; and then also as a matter of priority rather than urgency—I do believe that this needs to be given priority—I found particular issues around the current regulatory structure which require changes to the model of regulation currently implemented in relation to the regulation of ART and also the legislation with the review finding that the current regulatory model is now overly bureaucratic, burdensome and failing to meet the principles of better regulation; that the Human Reproductive Technology Act and subordinate legislation is particularly outdated and difficult for those being regulated to interpret or comply with; and the Surrogacy Act and subordinate legislation, it is my recommendation that it requires amendment to better support access to lawful altruistic surrogacy arrangements while prohibiting commercial arrangements domestically and abroad. I make recommendations about streamlining the system rather than removing it but making it better and making it function to meet the objectives that it is meant to meet.

Hon NICK GOIRAN: Dr Allan, I noticed that you say that the bill was introduced only a few months after the review had commenced. Can you advise the committee when the review commenced?

Dr Allan: I was appointed in January 2018. The review was on foot, but it had not been completed when the bill was introduced.

Hon NICK GOIRAN: The review was originally intended to be completed around mid-October, from memory.

Dr Allan: Yes. The original schedule that I was given was mid to late October, but the reality was that once I got the terms of reference, which I did not have when I was commissioned or appointed, and I started looking into the details of the matters that were within the terms of reference, the review required far more comprehensive analysis. The consultation was very wide and broad. I received a significant number of written submissions and so it extended beyond October.

Hon NICK GOIRAN: Dr Allan, is it the case that the time line you were given required the provision of a draft report to government by the middle of 2018?

Dr Allan: Yes. I was working, as I said, and as you can see with the final two reports, it was a very extensive review and required a lot of writing. I did give them a draft in September. It was a complete draft of part 1, with my intention then to be able to move onto working on and completing the draft of part 2, which was the focus on surrogacy.

Hon NICK GOIRAN: Were you in discussion with government throughout the course of your review to keep them posted as to your progress?

Dr Allan: Yes, I was.

Hon NICK GOIRAN: So they would have been aware that you were going to provide a draft report to them in September but nevertheless introduced the bill into the Assembly in August.

Dr Allan: Yes, they did.

The CHAIR: Our fourth question is: recommendation 1 of part 2 of your report recommends changes to the law to provide access to IVF procedures where a patient faces impending loss of or impairment to their fertility. How effectively does the bill make those recommended changes?

Dr Allan: My view is that it goes some way to making those recommended changes, but the wording in section 23(1)(a)(i) to (iii) focuses on couples or women who are likely to benefit or who are likely to be unable to conceive a child for medical reasons. It is my opinion the drafting is not very clear, for one, and the wording is a little bit clunky with all the "likelys" in there. I also think that the language could be gender neutral and that there are ongoing questions regarding whether restricting access to women based on medical reasons not to do with age is suitable. It is also unclear to me whether proposed section 23(1)(a)(i) and (ii) are meant to apply in cases where a woman requires surrogacy due to the bill also including proposed paragraph (iv), which specifically relates to surrogacy. For a minute I say I am going to go focus on proposed subparagraph (iv), because of the wording in that section, I do think that there is still scope for interpretation that an existing surrogacy arrangement is required. That is part of the problem with the issue that has been raised in relation to this—we are looking at women who for a whole variety of reasons may need to preserve their fertility early and not have that surrogacy arrangement in place. It is my view, as somebody who works in health law and all of that, that if legislation is unclear or gives rise to potential ambiguity, then it is not effectively drafted, so there is some refinement that would make that better serve reaching the aims that are intended —

[1.00 pm]

The CHAIR: Could you just repeat that last sentence, Dr Allan, please? We had some corruption of the sound.

Dr Allan: Sure. The point I was making was that it is my view that if legislation is unclear or gives rise to points of potential ambiguity, then it is not effectively drafted. It may be the intention of the drafters to address the issue around what happens when a patient faces an impending loss of, or impairment to, their fertility, but I just think that there are some things that are still not clear, and there is the potential for interpretation that an existing surrogacy arrangement is still required.

Hon NICK GOIRAN: Dr Allan, with regard to section 23(1)(a) of the legislation, you have indicated that the wording of proposed section 23(1)(a)(iv) is of concern. I note that each of the paragraphs listed in proposed section 23(1)(a) ends with the word "or". So the procedure would relate to either (i), (ii), (iii) or (iv).

Dr Allan: Yes.

Hon NICK GOIRAN: Would your concern be elevated if they had used the word "and" rather than "or"? It seems to me that if they had used the word "and", it would absolutely be a requirement to have an existing surrogacy arrangement, but perhaps there is an argument that that is not necessary because they have used the word "or"?

Dr Allan: I agree. I mean, if I look at proposed subsection (1)(a)(i) or (ii)—I think it is (i), but I do not have it up in front of me—it could on its own say, okay, any woman who is likely to benefit because she is—what is the wording?

Hon NICK GOIRAN: Likely to be unable to conceive.

Dr Allan: Yes, likely to be unable to conceive. Because they have inserted that word "likely", it puts into play that that is something that could happen in the future, and, standing alone, that that could also apply to somebody who in the future will use—it does not dictate what kind of arrangement they will make in terms of using their eggs or the embryos that are created as a result. So, I do agree with that. It was just that when I was looking at it, I was focusing on proposed subsection (1)(a)(iv),

and that is where I thought that there was still some ambiguity. I suppose the other thing that I would add is I was also cognisant of the fact that the act does not operate in isolation; there is some subsidiary legislation and directions that still require an approved surrogacy arrangement.

Hon NICK GOIRAN: If I understand this concern correctly, you are saying that if somebody is applying for the procedure under categories (i), (ii) or (ii), that as a standalone application is fine. The concern is that if they get through that gateway, which is items (i), (ii) or (iii), there is an argument to say that they cannot then use that procedure at some later stage for a surrogacy arrangement, because, if they wanted to do that, they should have applied under (iv) in the first place.

Dr Allan: Yes. The other thing that I found during the review was that regardless of the department's interpretation of how the act operated, the department does not provide legal advice, and quite clearly held to that, to clinics or to consumers. So you need to take into consideration how those clinics and consumers will interpret the legislation, and how it has been interpreted in the past, where women, if it is unclear what their needs are going to be, were able to undertake procedures for the purpose of preserving their fertility. But we had evidence in the review that as soon as it looked like a woman was going to need a surrogacy arrangement, the clinics would focus on the provisions that related to that and would not provide treatment because there was not a surrogacy arrangement in place.

Hon NICK GOIRAN: That is helpful. Thank you.

The CHAIR: Dr Allan, recommendation 2 of part 2 of your report recommends changes to the law to remove the requirement that a person who needs to preserve their fertility for future treatment in which a surrogacy arrangement may be required must already have a surrogacy arrangement in place before being able to access ART. How effectively does the bill make those recommended changes?

Dr Allan: That is where I say there is some openness to interpretation because of the wording, which requires a lawful—I am just trying to find the wording now.

Hon NICK GOIRAN: It is "for the purposes of a surrogacy arrangement that is lawful and for which there are medical or social reasons under the … Act".

Dr Allan: Yes. It is drafted in the present tense —

> is for the purposes of a surrogacy arrangement that is lawful and for which there are medical or social reasons under the *Surrogacy Act* … section 19(1A);

You need to then ask: what is a surrogacy arrangement that is lawful? Direction 7 stipulates —

> A licensee is not to provide an artificial fertilisation procedure in connection with a surrogacy arrangement unless the arrangement has been approved by the Council in accordance with the requirements in the Surrogacy Act 2008 section 17.

There is then an extensive list of things that people need to do in order for a surrogacy arrangement to be considered lawful. So we can have the proposed amendments, but I am still left with a question as to whether or not that surrogacy arrangement needs to be in place. I mean, it is a simple thing. I would just make it clearer, to say "is for the purposes of an existing or future surrogacy arrangement that is being, or is intended to be, undertaken pursuant to the requirements of the Surrogacy Act".

The CHAIR: Dr Allan, we come to questions 6 and 7, which are related to each other. Can I just draw your attention to some evidence that we received this morning from the health department, which appears to make a clear distinction between the different steps or the point at which IVF or HRT comes into effect. Our specific issue that we raised with the health department this morning was

about egg harvesting. So it might be interesting for us if you could clarify your views about that particular aspect of things as you answer questions 6 and 7. I just make you aware, before you answer those questions, that that is what we heard from the health department this morning.

Hon NICK GOIRAN: It may assist for the purpose of Hansard in future if you can read question 6 out.

The CHAIR: Yes, I will read question 6. We are just fixing some technical issues at our end, Dr Allan. While the staff attend to that, it will help Hansard if I read question 6 to you. On page 50–53 of part 2, you discuss the difficulties in meeting the requirements for an approved surrogacy arrangement in a situation where a woman faces a health crisis which is likely to result in infertility. The bill proposes to delete current section 23(1)(a)(iii) requiring that a woman who is unable to give birth to a child be party to an approved surrogacy arrangement before she can access IVF. On page 58 of part 2, you state —

> The Bill does not, however, amend the requirement that an eligible woman be a party to a surrogacy agreement.

Does this comment relate to the current version of the bill?

[1.10 pm]

Dr Allan: Yes, it does. When I was writing the report, I was also taking into consideration the subsidiary legislation. As I have previously mentioned, the wording did not, to me, appear completely clear because of the way that it was phrased in terms of still requiring a lawful surrogacy arrangement which implicitly, in the present tense, requires a surrogacy agreement—an approved surrogacy agreement—which also implicitly requires numerous other steps to have been undertaken before approval.

The CHAIR: On page 58, you note that —

> In its current form, the proposed legislation would, therefore, continue to prevent women from accessing ART who are, for example:
>
> - too young or too sick to have already entered into a surrogacy arrangement
> - as yet unable to have found a person willing to act as a surrogate mother for them
> - as yet unable to have achieved all the requisite counselling, advice, reports, and approvals to have an 'approved' surrogacy arrangement in place.

Is that correct in relation to the current bill?

Dr Allan: My view is that it could be given that interpretation for the reasons that I have said. It was unclear to me whether proposed section 23(1)(a)(i) and/or 23(1)(a)(ii) are meant to apply in the cases of surrogacy. I take Mr Goiran's point that it is the use of the word "or". But again, the proposed wording of proposed section 23(1)(a)(iv) refers to access to IVF for the purposes of a surrogacy arrangement that is lawful. My previous comments were about the fact that that is drafted in the present tense. At the present time, a surrogacy arrangement that is lawful requires pre-approval by the council, which, in turn, requires that a person has undertaken all of the steps listed in section 17. If you return to that list of examples—somebody who is too young or too sick to have a entered into a surrogacy arrangement; as yet has been unable to find somebody who is willing to act as a surrogate mother for them; or as yet has been unable to have achieved all the requisite counselling, advice, reports, and approvals—then, technically, the IVF could not proceed because there is not a surrogacy arrangement that is lawful. It is based on the interpretation that was being given to the other wording by the clinics and the experience of the people who were making submissions to the review.

The CHAIR: Dr Allan, just to deviate from our script, the department told us this morning that egg harvesting was not IVF, and therefore was not included in section 23. Would you agree with that?

Dr Allan: Even before the bill, this is the discussion that was had in terms of the interpretation and the complaints being made by the people who were trying to access ART for the purpose of egg harvesting, for the purpose of later being able to use that potentially in a surrogacy arrangement. The clinics were telling them, where it was apparent that a surrogacy arrangement would be needed, that they could not harvest their eggs. Again, one of the problems that the review revealed was that sometimes the internal interpretation given to something by the department is not the interpretation that is being given by the clinics or by the people who are trying to harvest their eggs or access ART. If the department, or the reproductive technology unit, refuses to provide that advice to the clinics or to the people who are seeking ART, then whatever interpretation the department makes is moot. We need to look at whether or not people are able to harvest their eggs, are able to access ART or whether they are not, because the legal advice that they are required to get independently is actually telling them otherwise. I hope that that make sense.

The CHAIR: Yes; it does.

Hon NICK GOIRAN: A further question to that, Dr Allan: do you think it is appropriate for the Reproductive Technology Council, which is in a sense the regulator or decision-maker in this matter, to be providing advice to would-be applicants and service providers?

Dr Allan: I think it would be appropriate that if they have a policy or an interpretation of the legislation on a matter that is unclear, that they make that readily available to people who are trying to access ART. It is not that they would be offering legal advice to people, but it would and should be their role to make clear what people can and cannot do under the act.

Hon NICK GOIRAN: A little similar to when the Australian Taxation Office provides some of its rulings and the like and in the end they still always says, "Of course, this is not advice, and we can still do whatever we like afterwards."

Dr Allan: Absolutely. It is the technicality that this is not legal advice and perhaps we could follow up with querying that action later on. But really, you cannot have a department that makes interpretations that are misaligned with those interpretations of clinics and the public and then continues with that position, but it does not resolve the issue of whether or not people can access ART.

The CHAIR: To continue the same theme, I turn to question 8. The department has advised that a surrogacy arrangement does not need to be in place before a woman can access IVF treatment under the proposed amendments. Do you agree that that is the effect of the proposed amendments?

Dr Allan: It could be an interpretation of the proposed amendments. My concern is that there could be another interpretation given to the proposed amendments. Unless that was made clearer, in my mind, do away with the ambiguity; do away with the potential for an alternative interpretation and make clear that we are talking about present or future arrangements. Provided that somebody is harvesting their eggs or accessing ART for the purposes of a present or future arrangement that will be lawful under the Surrogacy Act 2008 in Western Australia, that really would resolve the issue.

The CHAIR: Thank you. Question 9. The bill proposes to delete section 23(2) of the HRT act as it "is no longer required due to the effect of new section 23(1)(a)(iv)". That is from the explanatory memorandum, page 5. Do you agree with that statement?

Dr Allan: Yes. I am not sure that deletion of 23(2) is necessary as part of the current proposals in the bill before the Parliament. When I looked at that, based on this question, I was not sure that the

amendment in 23(1)(a)(iv) does away with the need to clarify that access "does not require that the benefit likely to result from the procedure involves the pregnancy of a member of the couple who are, or the woman who is, likely to benefit". Rather, I think that section 23(2), under the current wording of the proposed legislation, might be pertinent to keep, because it might reinforce that access may be for the purposes of egg collection and storage rather than immediate use for pregnancy, as well as it might be for the purposes of a surrogacy arrangement in which a surrogate mother will become pregnant, carry and birth the child rather than the woman who is accessing treatment.

[1.20 pm]

The CHAIR: Just to be clear, question 10 is: in your view, is section 23(2) currently required?

Dr Allan: I suppose to the extent that it may be considered to make clearer that the access may be for the purposes of egg collection rather than immediate use; or, for the purposes of the surrogacy arrangements, then under the current legislation and with the proposals, yes, I would say it would be technically required, because it helps or potentially serves to clarify the purposes for which these treatments are being had or may be had.

The CHAIR: Would section 23(2) be any less necessary following the proposed amendments to section 23(1) in clause 11 of the bill?

Dr Allan: There I said no based on what I have already said, just around the issues of clarity. I suppose when I look at that section, it is just reinforcing that it is not all about undergoing IVF for the purposes of immediately resulting in a pregnancy.

The CHAIR: Moving to new sections 23(1)(a)(i) and (ii) of the HRT act, if those proposed sections are intended to apply to the harvesting of eggs with a view to likely surrogacy, do you think section 23(2) or an amended version of it should be retained?

Dr Allan: I was not clear on whether those proposed sections were meant to apply in the case of a surrogacy, so I suppose if we ignore that, I still think having something in the legislation that says that the collection of eggs does not in itself need to lead to a pregnancy for the person who is collecting those eggs or the couple, I think that is probably important.

The CHAIR: Question 12: recommendation 3 of part 2 of your report recommends that discriminatory provisions within the HRT act 1991 and the Surrogacy Act 2008, WA, that prevent access to ART or surrogacy on the basis of sex, relationship status, gender identity, intersex status or sexual orientation be repealed and amended as a matter or priority. In your view, which parts of the HRT act and the Surrogacy Act are discriminatory for the purpose of recommendation 3?

Dr Allan: In relation to access, the current legislation and the proposed legislation uses terminology that refers to "woman" and "couple". "Woman" is defined under section 3(1) as "any female human" and "couple" is defined at section 23(1)(c) as persons who are "married to each other" or "in a de facto relationship with each other and are of the opposite sex". The law does not make provisions for access to, or could be interpreted to exclude, people who have differential gender identity for sex, are transgender or have intersex status and therefore may not identify as a woman or be considered a female human. It also excludes people who are not in a couple unless they are also considered or identified as a woman or who are not in a couple who are of the opposite sex to each other. These give rise to a number of potential areas of discrimination based on sex, marital or relationship status, gender identity, intersex status and sexual orientation. It is the gendered nature of the act itself and the exclusion of same-sex couples in light of the commonwealth Sex Discrimination Act.

In terms of the Surrogacy Act, I was not sure. I mean, section 67 is the operative provision that amends the HRT act, and that is the section that says it relates to a woman who is unable to give birth to a child due to medical reasons and is party to a surrogacy arrangement. That is the provision that is now proposed to be changed in the other section that we were discussing. Again, I suppose it is just the gendered nature of those access provisions and the exclusion of same-sex couples where there is a de facto relationship. I thought I would note there that, again, we have the word "or" in subsections (i) and (ii). So, a couple are —

(i) married to each other; or

(ii) in a de facto relationship with each other and are of the opposite sex to each other;

Since the commonwealth marriage provisions have been changed to enable same-sex marriage, it may be possible for same-sex couples who are married to each other, if it was not for other provisions that may limit their ability to access ART, to enter into a surrogacy arrangement under that provision. The words "are of opposite sex to each other" seem to only apply to people who are in a de facto relationship, so again you may have some discrimination between people based on the type of relationship they are in.

The CHAIR: You include a note in your written responses to say that you have restricted your comments to discrimination to access. Are your comments regarding parentage provisions covered in the next question, which is question 13?

Dr Allan: Yes, they are.

The CHAIR: I will ask question 13 to allow you to address the question about parentage provisions. Are parentage orders under section 19 of the Surrogacy Act services for the purpose of the Sex Discrimination Act 1984 and the Equal Opportunity Act 1984?

Dr Allan: I must say I am not the expert on the Sex Discrimination Act or the Equal Opportunity Act. My area of expertise is health. But I did find this to be a very interesting question in terms of whether or not—I think what you are asking is whether the actual making of parentage orders is a service in order to bring it within the realms of the SDA or the Equal Opportunity Act. In the legal profession we refer to legal services. The courts provide numerous services. I am not sure whether the actual making of parentage orders could be considered a service, but we might look at the fact that whether or not they are a service—as we have discussed, it is discriminatory to exclude people from accessing ART services based on their sex, marital or relationship status, gender identity, intersex or sexual orientation. There is case law that demonstrates that state laws preventing access to ART have been declared void to the extent to which they conflict with commonwealth anti-discrimination laws, but I think it is important then, if we are looking at the granting of parentage orders, whether or not they are seen as a service, that the granting of parentage orders' focus should be and is on the child. If you think about it, once you have lawfully allowed access to ART or surrogacy because it would be discriminatory not to, I think the point of discrimination would then arise not in relation to the parent but in relation to the child and the lack of legal recognition of their parents. If you had a decision in the courts that said, "Purely, for no other reason, we are not going to grant a parenting order or a parentage order—legal parentage—because you are intersex or because you are transgender", then that would be considered discriminatory and I imagine would be grounds for appeal.

[1.30 pm]

I thought the question was an interesting one, but it was also a difficult one, because I think the focus is wrong. The focus should be the child. Once you take it from that point, you have to recognise that children who do not have their parent–child relationship recognised, may have reduced rights

or entitlements than other children within the community. For example, if I take the same-sex co-parenting situation, if the same-sex co-parent is not recognised, then they might not have the power to make decisions about medical treatment, they might not be able to appoint a testamentary guardian for the child, they cannot bring about legal proceedings on behalf of the child, they are not allowed to make decisions or meet legal obligations concerning schooling or employment for children under 17, they cannot be a party to child protection hearings, and they cannot be present if the child is being questioned by police. In addition, the child cannot lay claim to that person's estate if that person does not have a will. If the biological parent—the person who has accessed ART or surrogacy—dies, then that child who is being co-parented by the same-sex partner could, in fact, be removed from their family situation and placed with a relative because of the lack of legal recognition of parentage. I really think that the focus needs to be on how that would impact children once you establish the access, based on all of those things. Access to services should be permitted, because not permitting it would be discriminatory. Then it flows on that, for the child's benefit, the court needs to have the power—to me, it is not a given, but the court needs to have the power—to be able to look at that situation and determine whether or not it is in the best interests of that child to make a legal parentage order or a parenting order that enables recognition of all the different family types that we know exist in Australia in the modern day.

Hon NICK GOIRAN: Dr Allan, I note in your written response to question 13, you say in your review report you have recommended that all people who have entered into a surrogacy arrangement, whether in WA or in another jurisdiction, be required to appear before the WA Family Court for determination of legal parentage or parenting orders to determine whether such orders are in the best interests of the child. Can I read from that response then that that is not presently the case and that there is not an obligation for such parties to appear?

Dr Allan: That is right. If you are a party to a domestic surrogacy arrangement in Western Australia, then in order to get legal parentage orders, you need to make application to the court. People who are going overseas and bringing children back into Western Australia are actually being advised by their lawyers and by the surrogacy "support" agencies not to go and apply for parenting orders because it is a costly and unnecessary process at the moment and it is not required. It is my recommendation in the review report that that situation change because there is no scrutiny of people bringing children into Western Australia, other than their application for passports or Australian citizenship for the child. So, yes, I think that you have a system that says that people can enter into—well, it does not say that they can, but people do—surrogacy arrangements elsewhere and bring children back into Western Australia absent of any kind of parenting order. I do believe that they should be required within a certain period of time to have to go to court and have a determination made as to the best interests of the child. I think that would serve everybody, but, particularly, the child. This goes back to my point in terms of the court being able to recognise legal parentage in all different family formations, that that decision is one that needs to be made in the best interests of the child. It is about recognising all family forms but for the purposes of the best interests of the child.

Hon NICK GOIRAN: Yes, I understand the point you are making, particularly with regard to those overseas cases, who then come back to Western Australia and that sort of, shall I say, unregulated environment. But with regard to the regulated environment—the domestic arrangements as you refer to them in Western Australia—you still then recommend that all parties appear before the Western Australian Family Court. Is it the case that even in our current system in Western Australia, for these domestic arrangements, that people are not required to appear?

Dr Allan: Do you mean that the application is a paper-based application?

Hon NICK GOIRAN: Yes.

Dr Allan: Yes.

Hon NICK GOIRAN: So we have a paper-based application as you say—or, if you like, it is decided on the papers by the judge without the attendance of parties—what do you see as the benefits of the parties attending?

Dr Allan: I really think that in situations in which you are trying to determine what is in the best interests of a child, being able to converse with the people who are going to care for that child is really important. I make other recommendations in relation to the process that sits around surrogacy at the moment, because in Western Australia as opposed to a number of other states, there is no assessment of the best interests of the child prior to those parenting orders being made. At the moment, as long as you get your tick from the RTC at the beginning of the process and you move through, as per the requirements of the law, then you make your legal parentage application on paper and you get the orders that the court determines are suitable in the case based on that process. In two of the other states—Queensland and New South Wales, which are very populous and have had surrogacy legislation for some time—there is an added step prior to that court process, which is undertaken by an independent counsellor who has not had anything to do with the surrogacy arrangement prior. That session is focused purely on determining whether or not moving to that next step of legal parentage would be in the best interests of the child. So, in terms of what I recommend for the process—and there are questions on this later as well—I have looked at the way the system operates, and if the best interests of the child are meant to be paramount, then I think there are opportunities along the way to keep checking in to make sure that that is what is actually happening.

Hon NICK GOIRAN: Thank you. I agree entirely.

The CHAIR: I move to question 14. Does the bill repeal or amend the discriminatory provisions as referred to in your recommendation 3?

Dr Allan: No, it does not in terms of all of them. It focuses on discrimination based upon sex, marital or relationship status as it particularly relates to single men and men in same-sex couples. You can see the wording quite clearly only relates to men in terms of the proposed changes. It does not address discrimination based on gender identity or intersex status. It does not include gender-neutral language, referring only to “women”, “men”, “woman “or “man”. It also does not address matters that have not yet been mentioned in this meeting, such as potential age discrimination. Also, what it does is introduce another area of potential discrimination, whereby it creates differential treatment or criteria for men and women regarding access requirements, where it limits women’s access to medical reasons only, as opposed to social reasons for men. There may be social reasons why women cannot have children otherwise. So, I would say the bill—again, the bill was introduced before my review was completed, but it focuses on two particular things, which is single men and men in same-sex couples, and it fails to address a number of other issues which also give rise to discrimination.

[1.40 pm]

Hon NICK GOIRAN: Dr Allan, the second reading speech, which introduced this bill into the Parliament, includes the following statement —

> Failure to respond to this would be unwise due to an unacceptable risk of litigation and the prospect of provisions of the relevant state legislation … being held by a court to be invalid.

Do I take it from what you just said that even if the bill is to pass, there will still be an unacceptable risk of litigation?

Dr Allan: There would be a risk of litigation by people who are still excluded from treatment or who may potentially feel that they are being discriminated against.

The CHAIR: Moving to question 15: regarding the automatic repeal of regulation 5 of the Sex Discrimination Regulations 1984, as amended by the Sex Discrimination Amendment (Exemptions) Regulation 2016 on 1 August 2017, is it correct that prior to its repeal, the exemption in regulation 5 only applied to discrimination on the basis of sexual orientation, gender identity or intersex status and therefore did not apply to discrimination against single men under the HRT act or the Surrogacy Act?

Dr Allan: The exemption regarding the SDA, to which you refer, included that for the purposes of subsection 40(2B) of the act that the Human Reproductive Technology Act and the Surrogacy Act, Western Australia, were prescribed. But that provision noted that subsection 40(2B) provided for an exemption in relation to anything done by a person in direct compliance with a prescribed law from divisions 1 and 2 of part II as applying by reference to the new sections that had been introduced—so, section 5A, sexual orientation; section 5B, gender identity; or section 5C, intersex status.

But when I stopped and thought about this question, the exemption therefore did not apply to section 5, "Sex discrimination" or section 6, "Discrimination on the ground of marital or relationship status". However, this does not mean that the exemption did not apply to some single men. To explain myself in relation to that, section 4 defines sexual orientation, which is included, as a person's orientation towards persons of the same sex, different sex, or same sex and persons of a different sex—so, bisexuality. Gender identity means the gender-related identity, appearance or mannerisms or other gender-related characteristics of a person, whether by way of medical intervention or not, with or without regard to the person's designated sex at birth. You could have a single male who identifies as male or who identifies as female, who is not able to access ART and may therefore raise gender identity discrimination. There exist single men who are, in terms of sexual orientation for example, asexual, homosexual, were designated female sex at birth but identify as male and are therefore unable to conceive a child or carry it for psychological or physical reasons, or were designated male sex at birth and identify as male, who may seek ART or surrogacy for a variety of physical, psychological or social reasons. Prohibitions on providing ART or access to lawful surrogacy services to such men—whether or not they are single—may discriminate against them on the basis of their sexual orientation or gender identity, if you get what I mean. The act was focused on three things, but it does not exclude single men, because single men can fall within those categories.

The CHAIR: Running into question 16: if that is correct, does that mean the discrimination against single men under the HRT act and the Surrogacy Act has always been inconsistent with section 22 of the SDA?

Dr Allan: Yes—again, a very good question and one that with more time I would have liked to have looked at in greater detail. I suppose the first thing that I thought when I read this question—and I do understand that we are looking at a bill that has been presented to Parliament based upon whether or not it is in conflict with the Sex Discrimination Act, and the risk of litigation. But I thought it was pertinent to first step back and ask whether or not it was justified to exclude somebody based on their marital status or their sex, whether or not they could have sued under the discrimination act in today's society and is this acceptable? Given that single men can parent in all sorts of other ways, I really question why there is a continuing limitation in this realm.

To answer your question, which is, I am sure, what you would like me to do, could they have always litigated under the Sex Discrimination Act? In order to answer this, you have to look at the extent

to which the commonwealth has power to legislate within the Sex Discrimination Act—the power of the commonwealth to do so, or the extent to which the SDA applies and how it agrees into which issues need to fall are outlined in section 9(4) of the Sex Discrimination Act. What I have found—if we are looking at the marital status issue to begin with—is that up until mid-2011, section 9(10), which had been used for the marriage litigation, was actually limited only to women, because the power of the commonwealth to legislate in this area was drawn from it being a party to CEDAW—the Convention on the Elimination of All Forms of Discrimination Against Women. And because CEDAW only referred to women, that specific power was seen to be limited to women in this circumstance. So, a single man could not have brought litigation arguing on the basis of marital status, at least under that provision, and there had been examples of that in the past. That said, he may have been able to litigate under the other powers, such as, for example, trade and commerce, if the male was litigating against a clinic that is registered as a corporation within Australia.

In order to bring a course of action, you would have to look at the timing. The question is: would they have always been able to litigate? You would have to look at the particular circumstances in which the discrimination took place and what the actual argument was, and then the power of the government determines the extent to which the Sex Discrimination Act applied. But, as I said, if the complaint fell within the remaining sections 9(5) to 9(9) or 9(11) to 9(21), which reflect the other heads of commonwealth legislative power—and I note are all drafted and give effect to section 22 on a gender neutral basis—then, arguably, a single man could have argued discrimination on the ground of sex or marital status, and post 2011, certainly under 9(10) also.

I think it is also interesting to note that in terms of the medical technologies related to ART and surrogacy, it is a much more recent thing that access has been—I suppose in terms of the progression of the technology that it is not something that was readily available always to single men or same-sex couples. In fact, we did not get surrogacy legislation until 2008 in Western Australia, so, yes, I think you have to put it in the context of time as well. Now that times are changing, there are three jurisdictions that do not allow access by single men. One of those jurisdictions, South Australia, has recently recommended amending that, and there is more of an argument that in the present day a person could bring litigation based on discrimination in relation to marital or relationship status.

[1.50 pm]

On the documents that I have provided, in terms of what I am talking about today, I did actually go through the steps. I thought it would be important to consider this question based on whether a person would have an argument, so I have set out section 4, interpretation of marital relationship status. I will not read them all out, but you can see that it includes “single” at paragraph (a). Section 22 prohibits discrimination of the ground inter alia—amongst other things—of a person’s marital or relationship status in the provision of goods and services.

If we look at a most recent decision of the Federal Court of Australia, EHT18 v Melbourne IVF, it has been stated and recognised by the court that it is common ground that an ART clinic provides a service within the meaning of the SDA. Then I refer you to sections 6(1) and 6(2) which address direct and indirect discrimination on the ground of marital or relationship status respectively. Again, I will not read out those parts of the legislation, but note that if the state law is inconsistent with the Sex Discrimination Act, the state law is considered void to the extent of the inconsistency. Would a single male be able to sue based upon their marital or relationship status? Looking at the fact that single women, women in same-sex de facto relationships, married couples—same-sex male and female, arguably—and heterosexual couples may access ART in Western Australia, one may argue that excluding a single male, or for that matter a male in a same-sex de facto couple, gives rise to

discrimination on the basis of their marital or relationship status, as they are being treated differently, especially to other men who may access treatment but have different marital or relationship status, and also to women who have the same or different marital or relationship status. To that end, I would argue that a single male should be able to access ART for the purposes of entering into a surrogacy arrangement because, otherwise, and in relation to couples, it is very arguable that if this were litigated, the legislation would be void to the extent of the inconsistency with the commonwealth act. The wording "are of opposite sex to each other" would be struck out in the case of same-sex couples, and there is an argument that a single male now could bring a cause of action.

The CHAIR: Hon Nick Goiran has asked a supplementary question here: had it ever been inconsistent due to the exception in section 31?

Dr Allan: Again, this is a very interesting question—whether section 31 applies to ART and surrogacy. I went and looked at that and gave it considerable thought. The section 31 exemption, along with a number of other exemptions that exist in the act, relate to special measures to achieve equality for women who are pregnant, have given birth, or who are breastfeeding. As far back as 1996, the then Sex Discrimination Commissioner, Sue Walpole, issued guidelines explaining what a special measure was and basically defined it as a type of affirmative action. Affirmative action may be defined, she said, as the systematic identification and elimination of the institutional barriers that women and minority groups encounter in areas of public life. She noted that special measures encompassed a broad and diverse range of actions that focus on the root cause of unequal outcomes and are taken to achieve substantive equality between groups. Special measures therefore require us and workplaces and so on and so forth to look at the structural barriers to equality or systemic discrimination and take steps to address those structural barriers for systemic discrimination. In those circumstances, you would have an exclusion from the provisions of the Sex Discrimination Act. You can look at what is listed in section 7D of the SDA and also at the Convention on the Elimination of All Forms of Discrimination Against Women, article 4(2) to get an idea of what sorts of special measures might be taken and what that means.

I submit to you that although the ambit of special measures is broad, the provision of ART services to women clearly cannot be considered an affirmative action that which has the aim of identifying and removing institutional barriers or achieving substantive equality in relation to pregnancy, childbirth or breastfeeding. In fact, I would draw your attention to that fact that the provision of ART services most frequently relates to providing people, both men and women, the opportunity to have biologically related children when otherwise they may not be able to do so. It has nothing to do with identifying or removing institutional barriers or achieving substantive equality; it is to do with treating men and women who may otherwise not be able to have biological children. Therefore, it—a single male trying to access assisted reproduction, just like any male trying to access assisted reproduction and the men who do—would not fall under the section 31 exemptions.

The equivalent Equal Opportunity Act provision emphasises that such exemptions and special measures are about providing equal opportunity to meet special needs in relation to employment, education, and training, of which ART is none.

To support this, I would also point to another exemption, which is about providing services to one sex and not another, just because that provision has been considered judicially. It is the current section 30 of the SDA. It was previously section 32. In McBain v Victoria, in 2000, somebody tried to argue that these exemptions apply in the context of ART and surrogacy. Justice Sundberg clearly stated that it did not apply to ART, as the service is provided to both men and women. His Honour stated—I think this is important when looking at ART as a service—that you have to consider the

nature of the service provided. He made the point that all infertility treatments are dealt with in the one legislative scheme and that Parliament has, in effect, characterised the treatments as being of the same general nature—namely, treatments aimed at overcoming obstacles to pregnancy—and, accordingly, the nature of these treatments is such that they are capable of being provided to both sexes. He said —

> Whether the primary beneficiary of the treatment is a man or a woman, … The fact that for biological reasons the embryo is placed into the body of the woman is but the ultimate aspect of the procedure. To concentrate solely on that aspect is not to view the overall "nature" of the service.

Then he speaks as to the "vice of an argument" that would attempt to do so, because it would be necessary to select from the scope of the service "only that part of it that is provided on or with the assistance of a woman", rather than looking at the whole service, which is able to be provided to men and to women.

Hon NICK GOIRAN: Dr Allan, would you agree with me that the McBain decision does not consider the section 31 exemption?

Dr Allan: No, it does not. I was using that as an example. My argument is that the section 31 exemption is related to special measures in relation to pregnancy, childbirth and breastfeeding, and that ART and surrogacy cannot be considered a special measure in the context in which special measures are able to be taken—an affirmative action. I was talking about the McBain decision and one of the other exemption clauses, which just makes the point that I am making that these services are provided to men and women. In my mind, neither of the exemptions apply.

Hon NICK GOIRAN: Dr Allan, does the McBain decision have authoritative weight in Western Australia?

[2.00 pm]

Dr Allan: No. It is persuasive, obviously, but I am using it as an example of a judgement where the nature of these services was discussed, the point being that the nature of these services is such that they are supplied to both men and women. If you look at the section 31 exemption, you cannot suddenly say that there are special measures that are being taken in the ART context to provide women with fertility services to address structural inequalities, because there are not. That is not the nature of the treatment. In fact, the nature of the treatment is that it is provided to both men and women, so it is not an example of a special measure that is taken to support women who are suffering structural inequalities.

Hon NICK GOIRAN: Are you aware of any judicial decision that contemplates section 31 in respect to ART services?

Dr Allan: I am not, because I do not think that it applies. I am not aware of any.

Hon NICK GOIRAN: Thank you.

The CHAIR: Question 17. Under the amendments proposed by the bill, single females and female couples, unlike single men and male couples, would be required to have medical reasons to be eligible for a parenting order under section 19 of the Surrogacy Act. Similarly, under section 23 of the HRT act, single women and female couples would not be able to access IVF unless they have medical reasons leading to inability to conceive or give birth. Does the requirement for women to have medical reasons give rise to discrimination against women that is inconsistent with section 22 of the SDA?

Dr Allan: Yes. I mean, based on the discussion that we have already had and the reasoning that I have presented to you today, to me, it would make sense to provide access to ART, and access to ART for surrogacy, to all people on an equal basis. The current proposed wording does not do so. In relation to this, I note my suggested wording, and it does not have to be my wording that is adopted. I was trying to give an example in the review that you can actually have wording that is gender neutral, and also treats people equally. So "a person or couple who due to medical or social reasons are unlikely to be able to conceive, carry or bear a child, unlikely to survive a pregnancy or birth, or likely to conceive a child affected by a genetic condition or disorder or that will be unlikely to survive the pregnancy or birth or whose health would be significantly affected by the pregnancy or birth". Then a couple should include "two people who are married or in a de facto relationship with each other". This would encompass anybody who has a medical or social reason to access ART or surrogacy, without saying that women need to have medical reasons; men need to have social reasons; and if you are intersex, transgender or otherwise, you cannot.

The CHAIR: Moving to question 18: is it your understanding that under proposed section 19(1A)(b)(ii) of the Surrogacy Act, both members of a female couple would be required to be eligible women as defined in section 19(2) of the Surrogacy Act in order to be eligible for a parentage order; in other words, would both be required to have medical reasons other than age for being unable to conceive or give birth to a child? A further question: is it your understanding that under current section 19(1)(b)(ii) of the Surrogacy Act, only one member of the female couple is required to have medical reasons for being unable to conceive or give birth to a child?

Dr Allan: I have set out the provisions in the written answers to these questions, but I will give you the short answer, which is yes, to both. In relation to proposed section 19(1A)(b)(ii), it establishes that both members of a female couple would be required to be an eligible woman, meaning that both would need to have medical reasons in order to access surrogacy, whereas the current position is that only one member of a female couple is required to have medical reasons in order to access surrogacy.

Could I comment also on the placement of that eligibility criteria, because, again, it seems like things are really misplaced in terms of where they sit in the act. Technically, does this mean that they can access ART for the purposes of a surrogacy arrangement, they might get approval, but they are not going to get parenting orders if both of them were not medically infertile? I am not sure why the eligibility criteria is linked to parenting orders rather than access in the first place. I mean, the results of those proposed amendments are that two women would be required to have medical reasons for a surrogacy arrangement under the new provisions.

Hon NICK GOIRAN: Dr Allan, if I understand what you are saying to the committee today, it sounds like this bill, whilst trying to eliminate so-called discrimination for two categories of people—that is, single men and male couples—in doing so will actually create discrimination for two other categories of individuals, one being same-sex women and the other being women in general.

Dr Allan: It creates a differential requirement for access to ART and for eligibility for parenting orders.

Hon NICK GOIRAN: Thank you.

The CHAIR: Question 19: the definition of "eligible woman" in proposed section 19(2) of the Surrogacy Act requires medical reasons. Under section 19(3)(a) of the Surrogacy Act, these reasons do not include a reason arising from a person's age. The reason for infertility under proposed section 23 of the HRT act also specifically excludes age; that is, the HRT act, section 23(1)(d). Does this lead to an effective upper age limit for access to IVF and surrogacy by women who have become infertile solely due to age?

Dr Allan: Yes. I mean, as I understand it from talking to the clinics, it is not a strict age limit, because, clearly, with infertility related to age, we are talking about menopause. There is a bracket in terms of age as to when women enter menopause and when women are no longer able to have children—the upper age is around 55; the lower age is around 45. It can be anywhere in between that a woman generally enters menopause. I refer you to part 1 of my report on the review, at chapter 12.2, starting on page 276, where I do make some comments concerning age. There, I note that several clinicians, as well as the ANZICA fertility counsellors, suggested that age restrictions for access to ART should be revised and/or clarified, and that the clinics had also noted that the RTC has been inconsistent regarding when it has viewed a woman's age as acceptable, and that the age of menopause is unclear. It does not create an upper age limit, but the current provisions of the act and the proposed section clearly continue this issue around age for women, not for men. They also raised that there is a need to consider other factors, such as the ability for women to use an egg donor as their age progresses, and thus being able to conceive, providing they are medically fit to do so. That is not a situation where the clinics were saying, "We want to treat 65-year-old women because they can use egg donors", because there would be other clinical indications that they may not be fit to carry a pregnancy. There would be other considerations. But this requirement is something that gives rise to a lot of disagreement. There is a lack of clarity around what it actually means.

The CHAIR: I think that you have answered question 20 as well, but you have included additional comments. Question 20 is about there being no upper age limit applicable to men for access to surrogacy under proposed section 19.

Dr Allan: Yes. That is right.

The CHAIR: The question was: is this likely to result in discrimination against women contrary to section 22 of the SDA?

[2.10 pm]

Dr Allan: Right. My additional comments were that, yes, it has been raised and it was raised with the review that there was a potential discrimination there—that women were being excluded based on this requirement for infertility not relating to age, whereas there was no such exclusion for men, no upper age limits in relation to men. Again, in part 1 of my report, some of the clinics raised with me during consultation that age limits should also apply for men. This was not particularly related to men because of infertility. We know that men can have fertile sperm for much longer than women have the ability to produce eggs, but clinics were concerned. One clinic in particular, as an example, raised an issue around several men who were aged 60 or 70 years of age approaching them to seek treatment with their 30 to 45-year-old partners. They questioned whether they should treat in such circumstances and raised the inconsistency of applying age limits to women but not to men. Others suggested that there should be a combined age limit. It is an issue that is live and one which, during the review, I did not have the opportunity or the means to delve more deeply into, but I did see fit to recommend to the government that it needed to consider not just whether or not it is against the Sex Discrimination Act—there could be some discrimination there—but the basis on which this requirement has been made in the first place, and whether or not it still applies in the modern day, or what other alternatives we might want to be looking at when it comes to whether or not it is appropriate to place limitations based on age and access to ART or surrogacy.

The CHAIR: You have said that you were not able to consider this fully, but question 21—sorry, Hon Nick Goiran, on question 20.

Hon NICK GOIRAN: Dr Allan, if I understand your evidence, in your review you have heard from at least one clinic that they have been approached by several men who are 60 or 70 years of age, seeking treatment.

Dr Allan: Yes.

Hon NICK GOIRAN: So is it the case that the outcome of this bill would be that a 70-year-old male would be able to apply, whereas a 70-year-old female would not be able to apply?

Dr Allan: Yes, on the assumption that we know that a 70-year-old female would have age-related infertility.

Hon NICK GOIRAN: Yes. You know of no case where a 70-year-old female would be able to apply under the existing restrictions?

Dr Allan: No.

Hon NICK GOIRAN: Thank you.

The CHAIR: Question 21: in your view, how should the reference to age in section 23(1)(d) of the HRT act and section 19(3) of the Surrogacy Act be construed? In your report, part 1, you suggest that it is currently interpreted as post–average age of menopause.

Dr Allan: Yes.

The CHAIR: What is your view about that interpretation?

Dr Allan: As I said, it leads to a lack of clarity. I was presented with an example that happened quite a while ago, but one clinic was reprimanded for having treated a woman of a certain age, whereas another clinic had treated a woman who was older. She was on the front page of the news, or it was reported and it was not a situation of reprimand, so it creates a lot of concern amongst practitioners and consumers as to what it means and when they are able to be treated and when they are not able to be treated. My view about the interpretation is that it is really unclear what that means. I make further recommendations in relation to that and I say that if they are going to continue this requirement for age, then it is incumbent upon the Minister for Health and his department to provide some clear and consistent communication regarding how the current age limit should be interpreted and applied. This might occur via the recommended new directions, conditions of registration and/or education of clinics and the community, but beyond that I think there needs to be further research and consultation regarding the current limitation on women not being able to receive treatment post–average age of menopause, and what exactly that means and whether it is appropriate to continue to have such a provision at all.

Hon NICK GOIRAN: Dr Allan, you mentioned that one of the clinics was reprimanded. Reprimanded by whom?

Dr Allan: The RTC.

Hon NICK GOIRAN: Right; thank you.

The CHAIR: Question 22: how would proposed section 23(1)(d) of the HRT act and section 19(3)(d) of the Surrogacy Act operate in relation to anyone suffering from early menopause? To what extent would they be able to access IVF or surrogacy?

Dr Allan: From recollection, I discussed early menopause with the clinics when we were talking about this, and they said that it would be considered to be a medical reason and that treatment could be provided, as it is not age-related. The wording of the act says “age” not “menopause”. The way that it has been interpreted is age-related menopause when it is natural—you know, the usual menopause that a woman enters between 45 and 55—but if it was early menopause, that would be

considered a medical reason and not age-related infertility. I think on these matters it would also be pertinent to check with the clinicians to see how they are interpreting this.

Hon NICK GOIRAN: Dr Allan, as well as the clinicians, would you recommend to the committee that we ask the Reproductive Technology Council about this issue?

Dr Allan: Yes.

Hon NICK GOIRAN: Thanks.

The CHAIR: Question 23: how would section 23(1)(d) of the HRT act and section 19(3)(a) of the Surrogacy Act operate in relation to a woman aged, for example, 55, who has always been infertile due to a medical condition? Would she be an eligible woman, for the purposes of proposed section 19(1)(a) of the Surrogacy Act? Would section 23(1)(d) of the HRT act preclude her from seeking IVF?

Dr Allan: In response to this I would say that your example illustrates once again that a provision that requires the reason for infertility not to be age, or states that medical reasons for being unable to conceive that are referred to in the definition of "eligible couple" is not a reason arising from age—the second one coming from the Surrogacy Act—is incredibly difficult to interpret. What does it mean and who does it apply to? You have given another example. I do not know, to answer that specific question, whether or not the act would be applied—if it is considered now age-related infertility, then yes, but if it is medical infertility, then no, she is not excluded. On the one hand, if it is age-related infertility, then she is not an eligible woman; if it is medically related infertility, then she is. That would be open to interpretation at the time, but perhaps the clinic would say, "Well, you're 55; it's no longer a medical condition. You would now have age-related infertility." I really do not know.

The CHAIR: In your view, would it have been preferable for the bill to have been drafted to amend section 23 of the HRT act and section 19 of the Surrogacy Act using gender-neutral language?

Dr Allan: Yes, and I again refer the committee to my suggested wording, which is but an example of how you might frame a provision using gender-neutral language that treats everybody on an equal basis both by removing gendered language, but also in regard to the requirement for access being equal to "a person" or "a couple", regardless of sex, gender identity, intersex status, sexual orientation, relationship status or marital status.

The CHAIR: Hon Nick Goiran has asked a supplementary question here: if this was done, what implications would it have for the child's birth certificate?

[2.20 pm]

Dr Allan: I have a couple of things to say on this. The Births, Deaths and Marriages Registration Act is worded using gender neutral language. That refers to a parent and it enables registration of single, heterosexual or same-sex couple parents. This occurred and has been the case since the Acts Amendment (Lesbian and Gay Law Reform) Act 2002. That act also enabled both names of de facto and same-sex couples to be placed on the birth certificate once the child was born. The BDM advises that if you are in a same-sex relationship and you would like to add your partner's name—the partner who consented to the artificial fertilisation procedure—to your child's birth registration, the parent's details may be added by completing an application form "Add parent's details to a child's birth registration" and payment of a fee. The fee payable for this application includes the issue of a replacement standard birth certificate. Both parents must also provide appropriate evidence of identity. Of course, if using gender neutral language gives rise to the need to make consequential amendments to other legislation, that would need to be considered. But I note that the Births, Deaths and Marriages Act is drafted using gender neutral language.

The other thing that I would add here, though, and this is my second point, is that it is my recommendation—we talk about this in questions to come—and I think it is really important, that no matter who is on the legal birth certificate, children born as a result of donor conception or surrogacy are able to access information about their biological and genetic heritage. It is my suggestion that, as per children who are adopted and are able to have their adoptive parents on their birth certificate, people who are donor conceived or born as a result of surrogacy should be entitled to request, if they wish to, the issuing of a second birth certificate which shows all the people who were involved in their birth. I am aware that this is something the donor-conceived people would very much like to see. That recommendation goes beyond the question you have asked me, but I did want to bring it to the attention of the committee that there are things that need to be done around birth certificates that move beyond simply the issue of gender of parents.

Hon NICK GOIRAN: Dr Allan, if that was the case, what would be the maximum number of people that could be listed on the birth certificate?

Dr Allan: It is a good question, because the reality of ART and surrogacy is that you can have very many people involved in the birth of a child. You could have a sperm donor—it depends if you are going to list partners as well, but let us include partners—and their partner, if any, but you would not really list the partner; an egg donor; a surrogate mother; her partner, if any, because legally when the child is born, the surrogate mother and her partner are the legal parents; and the commissioning or the intended parent or parents. There could be six people. If you were including partners of donors, there could be up to eight. I have worked extensively for 15 years with people who are donor conceived and not all of them, but a number of them, would like to be able to have the true record of who was involved in their conception and birth on a second birth certificate—not one that they need to show when they go to get their driver's licence, but something that gives them that information about where they came from and how they came about, and is reflective of the modern family formations that actually exist.

Hon NICK GOIRAN: Dr Allan, is that important for the child so that they can be clear on their genetic history?

Dr Allan: There are other ways to inform children of their genetic history. I think it is important to some donor-conceived people because they would like to see truth in the documentation around their circumstances of birth. It is about what is important to donor-conceived people. Yes, it is an avenue of knowing who your genetic parents are, but it has so much more meaning than just that.

Hon NICK GOIRAN: You just listed quite a large number of people who would be on the birth certificate, whether the original or a supplementary one. How many are currently able to be listed in Western Australia?

Dr Allan: I would need to check this, but as I understand it, a maximum of two. It would be the same-sex parents or the heterosexual parents—so, the legal parents. That would be one or two.

Hon NICK GOIRAN: At the time of birth of the surrogate—I will refer to it as the surrogate child for lack of a better definition—would the original birth certificate in Western Australia not list the birth mother, the surrogate mother, and her partner, if any?

Dr Allan: Yes.

Hon NICK GOIRAN: How do we then know whether or not that partner—let us assume that the partner is a male—is indeed the biological father?

Dr Allan: They do not, as far as I understand it, conduct genetic tests on the child that is born, but I am not sure. You would have to talk to clinics around the process that occurs—whether or not and when she is undergoing treatment. Women are not asked to refrain from having sex, but it may be

something that they talk about, or for a period of time while she is undergoing fertility treatment, she may not be having sex with her husband at the same time, but I really do not know.

Hon NICK GOIRAN: So that information would not be brought to the attention of the Family Court when they are making their parentage order at the present time?

Dr Allan: As far as I understand it, they do not do genetic testing on the children to determine biological parentage. It is based on the surrogacy arrangement or the surrogacy agreement that the woman who is giving birth and her partner, if any, are willing to relinquish legal parentage to the other couple or person. It is not around the genetic parents; it is around the surrogacy arrangement having been approved and engaged in and the transfer of legal parentage. It could effectively be transferring a child who has no genetic connection to the people who will become legal parents.

Hon NICK GOIRAN: That is precisely what I am concerned about.

Dr Allan: But that is the case anyway with surrogacy, because you may have situations where, for whatever reason, you cannot use the genetic material of the intending parents and a surrogacy arrangement can still occur. They are not all genetically related.

Hon NICK GOIRAN: That is right, but we are talking here about a situation where they could be genetically related to the birth mother and her partner—let us say, husband—and they are unaware of that and they are relinquishing their biological child unaware that they are doing that. They are not fully informed in that situation.

Dr Allan: Although if they wanted to be informed, they could have genetic testing at the time of birth. Because they are the legal parents, they could request a genetic test because they have the legal entitlement to until that transfer of parentage occurs. So if it was a concern to them, there is potential for them to check that.

Hon NICK GOIRAN: And they can do so unimpeded by any objection by the intending parents?

Dr Allan: Yes. The intending parents are not legal parents and therefore cannot make medical decisions for the child until the transfer of parentage.

Hon NICK GOIRAN: If the intending parents already have—I hesitate to use the word—possession of the child after the birth at the hospital, what right then does the biological mother have to have the genetic testing undertaken?

Dr Allan: It would be, practically, a very difficult situation, because you physically would need to be able to take the child to a doctor and have that checked. You are correct, because most often what happens is the transfer—I hate to talk about it like it is a piece of property—of the child actually occurs pretty immediately after birth rather than it stays with the birth mother for any period of time where she has the ability to take the child to a doctor or have tests undertaken.

[2.30 pm]

The CHAIR: Dr Allan, we are just about out of time, but I understand that the time constraint is at your end; is that correct?

Dr Allan: I can keep going. That is fine. I have discussed that with my daughter and it is fine for us to continue.

The CHAIR: I think the committee has put aside a bit of extra time as well, so if you are happy to keep going, that is great.

Question 25 refers back to question 24 and it was about the desirability of using gender-neutral language. Question 25 says: if that is desirable, what issues may arise as a result of the bill not using gender-neutral language?

Dr Allan: Yes. To me, there is a very clear issue about the act being able to be interpreted as discriminatory for people based on their gender identity or intersex status. It only addresses part of the non-discrimination provisions under the SDA, but not all of them, so that is an issue.

The CHAIR: If the Prohibition of Human Cloning for Reproduction Act 2002, section 19(2), was a reason for not introducing gender-neutral language, would the problem necessarily arise in a surrogacy arrangement? If, for example, the bill did introduce gender-neutral language and an intersex couple wished to access IVF and surrogacy and ultimately obtain legal parentage of the resulting child, they would not breach Prohibition of Human Cloning for Reproduction Act 2002, section 19(2), because they would be implanting an embryo into a woman who is a surrogate. What is your view on this?

Dr Allan: I totally agree. The issue around the Prohibition of Human Cloning for Reproduction Act was raised by the department as a reason for not using gender-neutral language. I am of the view that the proposed amendments should not have been limited to a man or a woman based on the argument that there was a potential that there was a breach of that act. Clearly, in the case of surrogacy, the surrogate mother, it would involve the implanting of an embryo into a woman, so there clearly would not be a breach of the PHCR act. I will save my other comments for the next question around transgender and intersex people.

The CHAIR: The next question is: would the problem necessarily arise if the transgender or intersex person were seeking IVF for the purpose of preserving their fertility?

Dr Allan: As I understand it, the decision of the drafters of the legislation was based on whether it would be possible to treat a transgender or intersex person under the HRT act who did not identify as a woman but had a female reproductive tract. Their argument was that this would potentially conflict with the PHCR act. However, I make the following points around the treatment of transgender and intersex people in Australia, which does occur. There are, in fact, several options available for transgender or intersex people for fertility treatment in Australia and some of that does not involve, anyway, the placing of an embryo into a woman's reproductive tract.

Fertility preservation can be particularly important before a person transitions—for example, retrieving and freezing eggs. Eggs can later be fertilised by sperm from a donor or partner who can provide those sperms. Embryo can then be carried by a surrogate. As you mentioned, that would be implantation in a woman's reproductive tract.

The person may have a female partner who can carry a child or the man himself, if he has chosen not to undergo a hysterectomy, can carry a child. There have been 44 cases of that occurring in Australia where people have used Medicare between July 2015 and July 2016. A person may also create and freeze embryos, retrieve eggs and sperms from a donor or partner. Embryos can then later be carried again by a surrogate, the man himself or their partner who may be male or female or transgender or intersex depending on the circumstances.

Ovarian tissue preservation is also an option, although this process is currently experimental. Transgender men who retain their reproductive organs may be able to become genetic parents following transition if they have preserved their ovarian tissue. This would entail the ceasing of hormone treatments and it is not currently guaranteed to be successful.

As I mentioned, in 2013, Medicare removed restrictions on certain claimable items that had been limited to people of a particular gender, and it has been reported by Medicare Australia and cited by the Australian Psychological Society that between July 2015 and June 2016, 44 men utilised Medicare item No. 16519, "management of labour and delivery by any means". I note Medicare is involved, but they still may have significant out-of-pocket costs. But my point here is if people are

accessing Medicare, which is a commonwealth system and funding system that enables transgender people to have—even where they are male but may have retained their female reproductive tract and have carried themselves, then again you have to question whether or not the PHCR act would be applied in such circumstances.

Beyond that, I note that the intention of the section 19(2) provisions were drafted around the time when, you know, it was all around when Dolly the sheep was cloned and the purposes of the prohibition on human cloning for reproduction and that particular provision was to prevent experiments that involved placing embryos somewhere else in the human body. Can we put an embryo just in their stomach and see what happens? Can we put it in an animal and will it grow? You have to look at the intention behind the act as well, and I do not think any of that had been done. Given that Medicare funding has been available to 44 men, I think it reinforces that it is unlikely that such action or such access would be considered a breach of the PHCR act. In any case, in my review, I said if you really are not sure, have a conversation with the commonwealth and get some information about how they would interpret it. But to me, again, it is not a reason for excluding transgender or intersex people from accessing services which currently in Australia they are entitled to access. I do not know about Western Australia, but, clearly, people are using ART and potentially surrogacy when they have gender identity or intersex status.

The CHAIR: Dr Allan, you talk about people who are accessing services, but at question 28 we are asking you: are you aware of any cases of intersex or transgender people seeking and being refused IVF and/or surrogacy arrangements?

Dr Allan: Because this question is rather broad, my first response to you—and I think, you know, it is a good illustration of what can happen when they are. I took an example from abroad, which is quite recent. In August 2018, in the United Kingdom, the Equality and Human Rights Commission initiated legal proceedings against the National Health Service claiming that the National Health Service's refusal to offer gamete storage as a blanket policy to transgender and intersex people violated the United Kingdom Equality Act, which is a similar act to our Sex Discrimination Act, which protects transgendered people from discrimination. Although the NHS widely offers gamete storage for cancer patients when clinically indicated, transgender patients looking to transition were not always offered these services. There were cases of them being refused. The Equality and Human Rights Commission called for the NHS to enforce a consistent standard of fertility service for transgender people. This year in April, so last month, the legal action was dropped when the National Health Service of England decided to issue strict guidelines that provide strong justification needs to be shown for a refusal to offer fertility preservation to trans patients and that refusals not meeting this standard may be challenged in a court. There is a clear example, and it was one that led to litigation instituted by the Equality and Human Rights Commission.

[2.40 pm]

Then I move to Australia, and there is not a lot of research, so I could not find a lot of data on the situation of whether or not access is available, but, for all intents and purposes, it seems to me that—I am not sure again what the situation is in Western Australia—clearly transgender and intersex people are having the discussion around fertility preservation and some people are accessing them. What I found in a very recent report by Bartholomaeus and Riggs—if you want to talk to an expert on these issues, Damien Riggs from Flinders University in South Australia does a lot of work in this space—is that the situation in Australia is really that there needs to be much more sensitivity and support around the information that is provided to people in these circumstances. They need to be told about the costs, the challenges and the potential outcomes. So access can be difficult both in terms of getting to the services and actually getting the information in the first place.

There is also the counter to that, that you have to not expect that everybody who is transgender wants to preserve their fertility or carry a child, because for some people that is completely against—it does not sit well with their feelings. There were some reports that for some people, their fear is actually that fertility preservation will be a requirement that is imposed upon them before they are allowed to transition. So you have to be very sensitive around not doing that also. Everybody has the choice, but it is not something that is expected, and not everybody will choose to access ART or surrogacy.

The CHAIR: Question 29 is: the bill extends to the Surrogacy Act the current powers in the HRT act to enter, inspect, search and seize to investigate breaches or possible breaches of the act. Do you have any comments on the need for such amendments?

Dr Allan: My comments here are basically what I say in my review report, part 2. While the proposed amendment is consistent with current legislation, and the role of the Reproductive Technology Council in its current form, I note that, in light of the findings and recommendations of the independent review, such a proposal would have to be considered an interim measure, if my findings and recommendations were acted upon. Based on the findings of the review and consultations with a wide array of people around how the current system is working, or not working, I have recommended that the RTC be abolished, and that a new advisory body be established, whose role would not be regulatory in nature, but rather would be advisory to the government, advisory to the community and looking at particularly contentious legal, ethical and social issues. I also recommended that the HRT regulations and directions be repealed, and that new legislation be drafted to create a co-regulatory system for governance of ART. Those recommendations are based on principles of better regulation that have been around and implemented in all forms of government, and at all levels, for at least the last decade, if not 15 years. If the recommendation that the RTC be abolished is implemented, then in future the powers that are proposed under the current bill, I suppose, would and should lie with the Minister for Health, and the minister's delegates.

In relation to the proposed amendments to the HRT act that would extend authority to an officer to investigate a breach or possible breach of the surrogacy act, or permit a justice, where duly satisfied of the evidence, to exercise the same power available under existing section 55 of the HRT act to issue a warrant to an authorised officer or member of the police force, et cetera, et cetera, I would note the regulatory approach that I recommend in my report, and I would emphasise that such a regulatory approach is one that increases or would hopefully increase and emphasise cooperation, mutual respect and oversight, which is responsive and flexible. In this regard, introducing these powers and measures would be fine as long as they were used as a last resort, because the model of regulation that I propose is one that includes regulatory and compliance mechanisms such as education, information, dissemination, good communication and an openness to feedback from those being regulated, rather than this command and control approach, which is all about policing. It is a very different environment, and one that I found was not conducive to supporting people who are accessing ART and surrogacy.

It is a long way of answering your question, but, while it is also a recommendation in part 1 of the report that powers of enforcement continue to be included in the act, and it would be consistent to align the powers in relation to ART and surrogacy, you would have to only exercise such powers when lower-level compliance mechanisms have failed, or where behaviour has been, or is particularly egregious. I have recommended that, if such amendments are enacted, the powers conferred be carried out in a manner consistent with the recommended responsive regulatory model in my report, and then you could say, "Yes, such powers would complement the recommended system of regulation", and you do, in a responsive regulatory system, need that top

level of power in case something is particularly bad or needs that particular enforcement mechanism, but you need to be really cognisant that the majority of the power and the exercise of power should be one that is much more cooperative and takes the co-regulatory approach.

Hon NICK GOIRAN: Dr Allan, it appears that the powers under the Human Reproductive Technology Act require a warrant, whereas that is not intended when it comes to the Surrogacy Act. Are you aware of any reason why they should not mirror each other?

Dr Allan: I do not know.

The CHAIR: Turning now to section 17 of the Surrogacy Act, in your opinion are the requirements for approval of a surrogacy arrangement by the Reproductive Technology Council under that section adequate for the protection of children born as a result of surrogacy, intended parents and birth mothers; and, if not, in what ways are they not adequate?

Dr Allan: This is a big question in terms of the findings of my review, because, overall, I recommend quite a change to the system that is currently in place. I have already mentioned that, in part 1 of the review, when I was looking at specifically the functioning of the Reproductive Technology Council and what is happening in that space, it is my recommendation that that body, which may have been very suitably established in 1991, when the first legislation was being implemented, is no longer functioning in a manner that is required or conducive to the matters mentioned in this question, or otherwise. In relation to the findings of the review, I found that the requirements for approval of a surrogacy arrangement by the RTC under section 17 of the Surrogacy Act were not adequate in the regards that you mentioned. Specifically, I refer you to the findings and recommendations in the review report related to the operation and functions of the RTC, and especially those in part 1, chapter 3, and part 2, chapter 4.

[2.50 pm]

However, to highlight why it was found that the current regulatory model is not adequate, and in relation to the RTC approval process, I note as an example that numerous parties who participated in the review, particularly in the public forums but also via written submissions, reported that the preapproval process was unnecessary. These are their words that were used in describing the current process: unnecessary, bureaucratic, stressful, costly, burdensome, misplaced, inappropriate, yet another hurdle and/or a barrier to access ART. If this process was all of these things, but was equally protective of children, intending parents and surrogate mothers, then you might say that it is all of these things but it is serving a purpose. But in fact, it was not found to serve that purpose and did not seem to do the things that it was intended to do.

So there is a lack of resourcing and there is inadequate provision of information or support. Those things in themselves are not supportive of the people who are trying to access surrogacy or the people who are thinking about whether or not they want to become surrogate mothers. The general treatment of intended parents was reported to be quite poor, as well as—and this goes to the question about children—people born as a result of donor conception also had pretty significant complaints about what was happening when they were approaching the authority for information off the voluntary register. These people were not surrogacy born. We do not have children who are old enough yet, but where there is donor conception involved, that might give us some information about how the system is currently operating.

Notably, the issues raised during the review in relation to the RTC's role and functioning regarding preapproval of surrogacy arrangements were consistent with those raised in relation to the terms of reference discussed in part 1 of the report around its overall functioning. During my review, I heard consistent and extensive complaints raised by donor-conceived people, consumers—being

intended parents, birth mothers, counsellors and clinicians. It was suggested by people who participated in the review that the more appropriate place for exploring the suitability of the arrangements, and whether the parties should proceed, was via the counselling process and clinical assessment by suitably qualified medical practitioners, rather than having a panel doing a paper review and then deciding whether or not people can proceed based upon a process that is not perceived as being very supportive or informative to the people who engage in these processes.

There was significant evidence presented to the review that the numerous requirements for pre-surrogacy reports and RTC approval, which were in addition to counselling and legal advice, were not only barriers to accessing lawful altruistic surrogacy in Western Australia, but they were driving people overseas. I had people say, "It's all too hard", and the RTC/RTU, because I do not think people differentiate between the two, "They don't help and they're not giving us the information we need. It all became so much, it was easier for us to go abroad." That is a real concern. In my review, I started to look at how things were operating and say, well, you said you have lawful altruistic surrogacy, yet you have all this stuff at the front that is not actually conducive to that proceeding. It is driving people overseas, it is making things hard and it is not protective of impending parents, birth mothers or children.

I made pretty extensive recommendations to modernise and streamline the regulatory system in that regard, too, which, in my view, would provide much more adequate protections and support for intended parents, birth mothers and children throughout the process, and putting in place a number of processes that do not stop at the RTC preapproval tick. The counselling would occur consistently throughout a pregnancy. That independent counselling needs to be had by all parties. The birth mother needs to see somebody different to the intending parents; then they can come together for joint counselling sessions, but there needs to be an independent party to make sure that free and fully informed consent can be made, and that changes in terms of intention can occur at any time through the pregnancy. There were birth mothers, women who had acted as surrogate mothers, who were asking that at least one counselling session must occur each trimester of the pregnancy as the pregnancy progresses. They felt like once you get that tick, everybody is left on their own and then you get to the end and you apply for your legal parentage orders: "You can have counselling, but you don't need to."

Also, I think in terms of being protective for children, if you have any concerns, you want to make sure that that legal parentage order at the end is in the best interests of the child, then you need to have ongoing conversations with people about how this arrangement is progressing and what is happening within that and to be able to deal with things as they occur that are particular to the people who are involved in the arrangement. I can refer you to the report. I have listed it in what I have provided to you. But I think the whole system needs to be looked at in terms of how to support intended parents, birth mothers and children, and truly operationalise the principles, and, in particular, the overarching principle that the best interests of the child are paramount in this arrangement.

How do you achieve that? Is it with the tick at the beginning or is it with a system of ongoing information and support throughout a pregnancy and then implementation of different processes? I recommend a public health approach to screening for children in terms of the welfare principal. I mentioned before also a pre-check before legal parentage which would be consistent with the other states—Queensland and New South Wales—around whether or not that order would be in the best interests of a child.

The CHAIR: Thank you for that answer.

Hon NICK GOIRAN: Dr Allan, thank you for that very comprehensive response. I notice that in your written response to this question you mention that the Surrogacy Act 2008 be amended to insert a requirement that a report to the court about the application for a parentage order be prepared by an independent counsellor post-birth which is to include whether the proposed parentage order is in the best interests of the child. You go on to elaborate on that. I think that is the model that you referred to as perhaps the Queensland and New South Wales model?

Dr Allan: Yes, that is correct. I have actually given you a draft provision that is what my recommendations would look like.

Hon NICK GOIRAN: In those states where they have this independent counsellor providing a report to the court on whether the parentage order is in the best interests of the child or not, who pays for that independent counsellor and the provision of that report? Who facilitates it? Who makes it happen?

Dr Allan: As I understand it, the intending parents would—all the states have reimbursement-of-cost provisions. So if there was a cost to the surrogate mother, the intending parents would have to reimburse her for any costs she incurred. Ultimately, it would be the intending parents that are paying for that process.

Hon NICK GOIRAN: If it is the case that in those two states it is a requirement before the Family Court determines the parentage order that the court has before it a report from an independent counsellor, my question is: who has the responsibility for getting that independent counsellor's report and putting it before the court?

Dr Allan: I would have to check on that. I will have to take that on notice. I am assuming that it is the intending parents who put it before the court because it is the intending parents who make the application.

The CHAIR: Thank you, Dr Allan. We will take that as a question on notice.

Dr Allan: Yes. Sure.

The CHAIR: Do you need it repeated to clarify?

Dr Allan: No, that is fine.

The CHAIR: Our remaining questions, 31 to 34, have been drafted by the Hon Nick Goiran. I will hand over to the Hon Nick Goiran to finish the session.

Hon NICK GOIRAN: One submission to the committee has said that WA has a very low surrogacy volunteering rate compared to other states and that this is a fundamental issue the government should resolve. Was this an issue identified in your view?

Dr Allan: Not explicitly. I did not find that Western Australia has a very low surrogacy volunteering rate. I also did not find that it is a fundamental issue that the government should resolve. I would say that I found that Western Australia has had only a very small number of surrogacy arrangements approved in the time since the legislation was enacted. I believe it is around 10. This had a lot to do with the many unnecessary hurdles and barriers to accessing lawful altruistic surrogacy in Western Australia. I do not think that making a finding of whether there is a low volunteering rate compared to other states would be valid because you risk comparing apples with oranges. The eastern states are much more populous, for one, so there may be more women because there are more people—more people entering altruistic surrogacy arrangements simply because the population is larger. But you also have to take into consideration all of the barriers to surrogacy in Western Australia that do not exist in other states.

At the moment, maybe there is a low volunteering rate, maybe there is a low number of altruistic surrogacy arrangements. You have so many confounders that you cannot determine why that may be. I can say it did appear that there were four to five times the number of families in Western Australia going to another state or overseas to engage in surrogacy than those engaging within the state. That, to me, is something that we should be considering because that takes them away from all sorts of things and all sorts of protections; so, too, the child. It may also make it much more difficult for the child to have a relationship with their surrogate mother if they want to have one in the future which is often the case when altruistic arrangements take place where people share a similar environment or live in the same state. There is often more contact than if it is a distance arrangement or an arrangement made commercially overseas and then the child is brought back. There are issues around access and being able to undertake surrogacy in Western Australia that I truly do believe need to be addressed. I am not sure that we can comment on a low volunteering rate.

My other comment on that, that I have not written but just comes to mind is I am always very cautious of the argument that we do not have enough women who volunteer. It is like organ donation. You have to be very careful. It is a very significant decision to become a surrogate mother. Often, those arguments about having very low volunteering rates are then added to the argument that we should have commercial surrogacy. It was not the finding of my review that that should be the case. I just wanted to add that, that you have to be careful of what you are looking at and why.

[3.00 pm]

Hon NICK GOIRAN: I do note that the submission in question was authored by a male. Be that as it may, Dr Allan, the next question is: one submission to the committee has said that a child has a right to know and preserve their biological heritage, both familial and cultural. In fact, that submission was from the Commissioner for Children and Young People. Was this an issue identified in your review?

Dr Allan: Absolutely. There is extensive discussion of this matter. I have made extensive recommendations about these issues in the review report, particular see review report part 1, especially chapters 4, 5 and 6. My recommendations concerning the recording and release of information for donor conception are recommended to apply to people born as a result of donor conception using ART and for surrogacy arrangements. Access to information should include access to information about biological heritage, both familial and cultural information, and should include information about donors, surrogate mothers and siblings. This issue is one of the areas—I go back to where we started—that is in need of urgent attention in relation to the records being kept in Western Australia and the operation of the current system. I have made recommendations to move the registers to Birth, Deaths and Marriages and to establish a much more suitable system for access to information and support.

Personally, I cannot emphasise enough how important it is to think about the children who are born as a result of these arrangements, not only their access to information, but their ability then to make choices about contact, relationships and all the things that come with being a person who is not only the child of the people who care for it, but is a person in their own right who wants to know where they come from, who they are connected to and potentially explore those relationships.

Hon NICK GOIRAN: Are there increased risks to surrogate mothers; and, if so, what are those risks?

Dr Allan: I was not sure here what the comparator was: is there increased risk to other women who become pregnant or —

Hon NICK GOIRAN: Yes.

Dr Allan: Yes. I would say there are risks for surrogate mothers. Some of them share equal risks as with any women who become pregnant, and then there are other risks.

Hon NICK GOIRAN: Just to clarify, I am particularly interested in, shall I call it, the "extra risks" that apply in these situations, not the risks that apply to all women in every pregnancy situation.

Dr Allan: In terms of medical risk, obviously there is the standard risks, but with gestational surrogacies, so where the woman is not conceiving with her own eggs, there are some further medical risks associated with IVF treatment. These can be quite minimal or they can be more severe, depending on the type of hormones that are being had, time of life, and all sorts of things. Some include the fact that if she is having gestational surrogacy, she will be required to inject herself with fertility hormones. Some minor bruising can arise. Some people can have allergies to that; usually quite low level risks in that sense. There can be increased premenstrual syndrome symptoms, cramping or bleeding from embryo transfer procedure and infection can also occur. These are all associated with the treatments that a woman who is becoming a gestational surrogacy is exposed to.

In Australia, as opposed to overseas, there is less risk of a surrogate mother having multiple births, which is risky for the mother and risky for the children. Australia implements a one-embryo transfer policy, so this risk is reduced.

There are emotional risks. This is why I really emphasised, again, my recommendations within my report are for much more supportive counselling. Not counselling focused on the relinquishment of the child, but counselling as the pregnancy progresses over anything and everything that needs to be discussed. Pregnancy is a difficult process. It can be a difficult process for people. Some surrogate mothers may find the pregnancy emotionally challenging because they will not be keeping the child they are carrying. I qualify that because what I have found was that not all surrogate mothers convey having those feelings, but this is a risk for some surrogate mothers.

There are the usual risks also of depression during or post-birth, but there may be a significant experience of grief or loss following the birth of a baby that one gives away, or gives to other people to parent. Again, I recommend post-birth counselling as an important requirement rather than an option in these arrangements. It is important that when you are making these arrangements that there is support from a mental health professional and that it is not just a bureaucratic process of meeting paperwork requirements and then once you have done that, everything is fine. I think the support is really important in light of some of the risks. There is a risk of an impact on the surrogate mother's family. We need not forget them. She may have a partner, so her relationship with her partner needs to be considered. The partner needs to be 100 per cent onboard with the arrangement, the relationship and the planning in terms of what is going to happen after relinquishment, whether or not there is going to be an ongoing relationship with the intending parents, with the child, so on and so forth.

[3.10 pm]

If the surrogate mother has a child, of which it is generally a requirement in Western Australia, you have to look at the impact on the children, if any. Just another thing, which is probably the case for all women who are pregnant, how she is going to meet her home and work commitments alongside all of the extras that come with being a surrogate mother. There are risks in terms of the relationship with the intending parents. There is the risk that the intending parents can change their mind. Interestingly, when you look abroad, everybody worries about the birth mother changing her mind, but sometimes it is the intending parents who decide they do not want the baby or their relationship breaks down and they no longer want to engage in this. These situations do not appear to occur frequently, but when they do occur, they can be very problematic. So the relationship with the

intending parents is important. You would then need also to think that the birth mother risks either having a child that she cannot afford to care for or does not perceive as her own, and then she would have to make decisions about what happens to that child with her partner, if she has one.

The other thing is around relinquishment itself. Under the current law, a surrogate mother is the legal mother of any children born as a result of the surrogacy arrangement. In Western Australia, where there is a traditional surrogacy arrangement, there is no requirement for her to relinquish the child if she changes her mind. There is, however, a clause in the act that says where there is a gestational surrogacy arrangement using the intending parents' gametes or embryos, the court can make an order that is in the best interests of the child. It is not a foregone conclusion that she can change her mind during the pregnancy or after birth and keep the child. It is up to the court to determine what is in the best interests of the child, where there is a gestational surrogacy arrangement. In the latter case, that means that even if the surrogate mother wishes to keep the child, if the court finds that this is not in the child's best interests, she will be required to adhere to the court orders, which might involve the transfer of legal parentage or parental orders, or whatever the court deems appropriate. I have mentioned the issue around if the intending parents change their mind.

Risks to women in terms of surrogacy generally: I do not want to present that altruistic surrogacy is without risk. Sometimes women can be pressured within families, for example, to become an altruistic surrogate for a relative who is unable to bear children. Again, I really think it is important to have a robust pre-surrogacy counselling approach that should explore whether such a situation exists and to support the woman to make informed decisions to ensure that any decisions that are being made are being made freely and voluntarily, as to whether she wishes to act as a surrogate mother or not. It is vital in altruistic arrangements, and we need to remember that although they are lawful, they are not without risk.

There are many more risks for commercial surrogacy, which I recommended not be adopted in Western Australia and that prohibitions continue. There is the risk of exploitation, there is the risk of the commodification of a woman's reproductive capabilities, particularly with women of lower socioeconomic status.

We have seen, and there is evidence, that in countries where commercial surrogacy occurs, there is an increased risk and reality of human trafficking. I am very strong on being aware of those risks because although there are arguments that a woman should be free to do what she wishes with her body, to charge a fee for doing so if she wants to, there are broader societal implications and impacts and real risks for vulnerable women, as well as for children, but the question relates to surrogates.

Hon SIMON O'BRIEN: Can you cite some countries where commercial surrogacy is allowed?

Dr Allan: Very few. Yes, very few. Russia allows commercial surrogacy in heterosexual relationships; the Ukraine allows commercial surrogacy for heterosexual intending parents; and some states in the United States allow commercial surrogacy arrangements. Russia, Ukraine, the US—there are a couple of others. The majority of countries worldwide, if they have law, prohibits surrogacy.

Hon SIMON O'BRIEN: In places we hear about, perhaps some Asian countries not far from here, where there have been some widely reported experiences involving Australians, is that more a case that there is not any regulation in those countries, rather than there is a positive commercial surrogacy arrangement?

Dr Allan: Yes. There was a lack of laws. What happened in those countries, to use India and Thailand as examples because they have been prominent countries that have raised cases in Australia, is in response to those cases and the commercial surrogacy situation that was occurring, they have now

implemented legislation to stop international commercial surrogacy—to prohibit it. Not to facilitate it, not to set up a system that supports it and regulates it, thinking that that will be a better system; those countries have prohibited those arrangements and then limited them to altruistic arrangements with very strict requirements.

Hon NICK GOIRAN: Further to that area on the risks to surrogate mothers, the committee has received a submission, which is public submission number 18 and which provides a number of peer-reviewed articles on this issue. Would you be willing to take on notice a review of submission 18 and provide the committee with your comments on it?

Dr Allan: Yes. I am happy to do that.

Hon NICK GOIRAN: I have only two further questions. Firstly, what did your review conclude about the efficacy of gestational surrogates being informed of such risks under WA's existing regime?

Dr Allan: As I understand it, one is that a surrogate mother should be informed of any medical or psychological risks during medical and counselling sessions, and she should be informed of any legal risks during the legal sessions. My review found that the level of information available, both provided or not provided by the RTU/RTC or clinicians or legal advisers, was varied. There was not a consistent amount of information provided to people, so I could not be 100 per cent sure that people are fully informed of all the risks. What is provided to people was really varied, depending on who they saw and how they were obtaining that information. I have made recommendations, again, about the provision of information, counselling sessions and legal advice and what should be included in those things to ensure that all parties to the arrangement are fully informed and independently supported throughout any surrogacy arrangement and beyond. So post-birth, not just up until the birth and the child is handed over, but what happens afterwards. That is an important part of this consideration.

Hon NICK GOIRAN: Did your review recommend that Western Australia amend its legislation to ensure extra territorial application?

Dr Allan: Yes, it did. I do that for a number of reasons, which I explain in my report. Do you want me to go into them all? I am fully supportive of introducing extra territorial prohibition.

The CHAIR: Do any other committee members have any final questions?

Hon SIMON O'BRIEN: No. It has been very, very comprehensive.

The CHAIR: In that case, Dr Allan, I will formally close the hearing, expressing thanks on behalf of every member here and, I am sure, the staff as well, for the very comprehensive way in which you have addressed our questions. Thank you for attending today. Please end the broadcast.

A transcript of this hearing will be forwarded to you for correction. If you believe that any corrections should be made because of typographical or transcription errors, please indicate these corrections on the transcript. Errors of fact or substance must be corrected in a formal letter to the committee. When you receive your transcript of evidence, the committee will also advise you when to provide your answers to questions taken on notice. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence.

Dr Allan, thank you again. Just as a point of clarification, the committee will need to receive your written answers as evidence before they are referred to elsewhere. We can clarify the follow-up to that with you when we send you your transcript.

[3.20 pm]

Dr Allan: I am sorry, I do not understand.

The CHAIR: We have received a document from you which is your written answers to our questions. You said at the top of it that it was a draft to be amended after the committee hearing and submitted as a written submission.

Dr Allan: Yes.

The CHAIR: The committee now needs to receive that document and determine whether it will be received.

Dr Allan: I understand, yes.

The CHAIR: Sorry, I should have been clearer. Our question to you is: are you happy if we receive this document as you have submitted it, or did you want to do further work on it before we consider it?

Dr Allan: I think if I take the questions on notice, because I received the questions on Friday afternoon, so I just wanted to check through that document, just to double-check that I am happy with everything that is there.

The CHAIR: That is fine.

Dr Allan: I will send it through with my responses to the questions on notice, if that is okay?

The CHAIR: Yes, thank you. That is excellent. That was exactly why I was seeking a clarification from you. Thank you very much, Dr Allan.

Because of our short time line, we should see if we can prevail on you one last time to provide that as soon as possible. What do you think would be a reasonable time frame for you?

Dr Allan: How short a time line do you have?

The CHAIR: Does it help you if I suggest close of business Friday would suit us excellently? Is that doable?

Dr Allan: on 24 May? Yes, that is fine.

The CHAIR: If that is practicable from your point of view, that would suit us very well.

Dr Allan: It might be actually more practicable from my point of view if we could make it the 27 May because it gives me a weekend. I am really busy during the week.

The CHAIR: I am sure you are. That would be excellent. We have just chewed up another weekend for you, but only by agreement with you. Thank you very much, Dr Allan. I will close the hearing now.

Hearing concluded at 3.22 pm

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