Submission to ALRC's Review of Surrogacy Laws: Issues Paper 52 (June 2025)

About us

At Donor Conceived Families Australia (DCFA), we advocate for the rights, wellbeing and recognition of families formed through donor conception. As parents of children who were conceived through donor conception, we want a future where our families are supported, our children are respected, and the rights of our families are protected now and as our children grow through to adulthood. We work to improve laws, systems, and community understanding to ensure donor conception in Australia is ethical, transparent and family-centred.

About this submission

Surrogacy and donor conception often overlap both practically and legally because the majority of surrogacy arrangements involve the use of donated gametes (sperm, egg, or both). Surrogacy is a pathway to family formation that relies on reproductive assistance from a third-party and donor conception is often central to that process. Gestational surrogacy is the most common form of surrogacy. In gestational surrogacy the embryo is created using donated gametes and/or the intended parents' own gametes. Some surrogacy arrangements involve double donation where both egg and sperm donors are used for single parents, same-sex couples, or for those experiencing medical infertility.

According to the Australian and New Zealand Assisted Reproduction Database (ANZARD; 2024) there were 131 surrogacy live births in Australia and New Zealand in 2022. The Department of Home Affairs (2025) estimates that in the same year there were 213 overseas surrogacy births to Australian parents. While the exact number of surrogacy cases involving donated gametes/embryos is not known, we believe that the majority of Australian surrogacy cases involve donated gametes. For example, one study found that 85% of overseas surrogacy arrangements among Australians involved donor eggs (Stafford-Bell, Everingham, & Hammarberg, 2014).

Given that this submission is focused on the intersection of surrogacy and donor conception, we have only responded to the questions relevant to this scope.

DCFA uses the term 'surrogate' for the person who intends to be pregnant and give birth to the child being carried via surrogacy and 'intended parent' for person/s who intend to be the

child's parent. We use the term 'parent' once the child is born recognising that the parent is no longer "intending" (see Question 27 for further discussion on terminology).

Question 3 and 4: Human rights, including children's right to information

The Issues Paper explores the human rights relevant to surrogacy and seeks input into the information that children born through surrogacy should have access to and how this may be provided or facilitated.

We believe children have both a right to know their conception story and a right to privacy, including:

- Access to updated medical information and identifying donor information at age 18
- Consent-based information sharing that respects each child's privacy
- Secure, centralised national registers to manage information across jurisdictions
- Opportunities for same-donor families to connect if all parties consent and desire connecting

Positively, research investigating outcomes of surrogacy undertaken by Australians overseas shows that almost universally, parents intend to disclose the use of a surrogate and/or a donor to their child (Stafford-Bell, Everingham, & Hammarberg, 2014).

DCFA does not support birth certificates being marked or notated in any way that makes private family medical information (including fertility treatment or surrogacy) visible to anyone who views a child's birth certificate (e.g., sports coaches, school staff, childcare centres, passport offices).

While recognising the critical importance of children knowing their parent/s used donor conception, we believe that parents should retain autonomy over how they share the conception story with their children and with whom they share the child's conception story outside the family. This ensures family conception stories are shared in ways that are culturally and socially appropriate for each unique family and cultural and linguistic group.

Robust systems are needed to ensure children and families can access accurate and complete information about donors and surrogates, and we support a federal register to store and facilitate release of this information. State-based registers are a fragmented approach that risks unequal access and duplication of efforts and resources.

Question 5: Barriers to entering surrogacy arrangements in Australia

There are several major barriers that make domestic surrogacy in Australia difficult, and these may lead some intended parents to look for surrogacy options overseas.

Access to donor gametes

As mentioned, many children born through surrogacy are also conceived with the help of a donor – whether that be a donor egg, donor sperm, or embryo donor. It is critical that any review of surrogacy law is informed by the broader context of donor conception law, and vice versa. These areas of law and policy share significant overlaps.

Further, we understand that restrictions on availability and access to donors is also a contributing factor to driving families overseas for their surrogacy journeys. Arguably, if the lack of donors in Australia is not effectively addressed, efforts to create a robust regulatory scheme within Australia could be in vain.

When the New Zealand Law Reform Commission considered surrogacy in that country, it found that limited availability of donor gametes is a key driver for New Zealanders to seek fertility treatment overseas (*Te Kōpū Whāngai: He arotake Review of surrogacy* (2022 - Report No. 146 at 10.118).

Number of surrogacy arrangements that involve a donor

While the exact number of surrogacy arrangements that also involve donated gametes/embryos is not known; the following statistics give us insight into the use of donor conception in surrogacy among Australian parents.

Statistics show that of 398 surrogacy arrangements between 2021-2023, 61% were for heterosexual couples, 34% were for gay couples, and 5% were for single women and single men (Jefford, 2025). Research published by the Australian Medical Journal (Stafford-Bell et al., 2014) showed that 85% of overseas surrogacy among Australians involved donor eggs.

Inconsistent laws in Australia

Unfortunately, laws regulating donor conception are inconsistent and fragmented across the country, and we recommend national approaches to:

- Family limits – the number of families that a donor may donate to
- Storage limits – how long donor gametes or embryos, or embryos created from donor gametes may be held
- The age of release of identifying information about donors – donors are no longer anonymous in Australia and are more accurately referred to as ‘identity-release’ donors
- Collection and storage of private information about donors, children born through donor conception and parents.

For instance, in New South Wales, there is a donor limit per 'woman' rather than a limit by 'family'. This creates inequality for LGBTQ+ parents. When both members of a same-sex female couple are parents, there is no clear rationale for treating them as two separate recipients for the purposes of the donor limit. It is common — and for some deeply meaningful — for both partners to carry children conceived with the same donor, so their children are genetically related. Equally, this law doesn't make it clear how donations are to apply to a male same-sex couple, with additional complexities if more than one surrogate carries the children of the relationship.

While most states and territories which have legislated in this area have limited the number of families conceiving with the same donor to 10 families, others have a 5-family limit. Some limit by family, some by individual recipients, some include the donor's family in that count, and others do not. Other states do not have regulations and rely on the *NHMRC Ethical guidelines on the use of assisted reproductive technology in clinical practice and research*, under which clinics are required to take reasonable steps to minimise the number of families created through donated gamete treatment programs.

Evidence-based regulation

While donor conception is an area that requires thoughtful regulation to protect the rights of people born through donor conception, some recent regulatory settings in Australia have gone beyond what the evidence supports with consequences for access, safety and equity.

Longitudinal research following children born via donor conception into adulthood shows overwhelmingly positive development and psychological outcomes, whether or not a donor was a known or clinic-recruited (anonymous or identity-release) donor. The majority of offspring demonstrated stable and positive psychological adjustment across different stages of development, with behaviours consistently falling within the normal range (Carone, N., Koh, A., Bos, H. M. W., & Rothblum, E. (2025). Two decades of psychological adjustment of donor-conceived offspring of lesbian parents: Examining donor contact and type. *Reproductive BioMedicine Online*, 51(5).)

There are concerns with clinic-recruited donor shortages in jurisdictions that have created tight limits on access, leading to people either seeking treatment outside of the state/territory/country, or finding donors through social media.

Identity-release at age 18 has been well established practice in Australia and internationally. However, some states and territories are now lowering the age of access to this identifying information to 16 — or, in the case of the ACT, allowing access at any age at which a young person is deemed "sufficiently mature." These changes have been made in the absence of compelling psychological evidence to support earlier access, and without due consideration

of the practical and legal consequences. Adolescence is a developmentally sensitive period, and there is no research showing a benefit in lowering the age of access below 18.

In practice, recent legislative changes have had significant unintended consequences. In the ACT, changes to the identity-release age for young people, when combined with a 5-family territory limit have effectively halted access to many international donors, including from the United States, due to uncertainty around whether and when identifying information might be released. This has reduced the availability of donor gametes, placing further pressure on already limited local supply. Families have been forced to delay treatment, travel interstate, or turn to unregulated sources (such as Facebook groups) — each of which creates new risks to health, safety and equitable access.

Given that donor conception and surrogacy frequently occur across state and territory borders, there is little justification for the current patchwork of inconsistent state-based laws. Regulation must be carefully balanced to avoid laws that inadvertently deter clinics from operating or expanding services in certain jurisdictions and can limit equitable access to care — particularly for families in regional areas or those with diverse family structures. While it is crucial that the rights of people born through donor conception are upheld, policy should be based on evidence and should carefully balance the rights of children with the practical, real-world impact on access.

Limited financial support for surrogates and donors

Currently in Australia, surrogates can only be reimbursed for their direct expenses, such as medical expenses associated with the pregnancy and birth, cost of legal advice, costs associated with counselling, travel costs, loss of earnings due to leave taken during pregnancy and around the birth). There's no recognition of the time, effort, or psychological, emotional, and physical toll carrying a pregnancy can involve for the surrogate.

Similarly, donors are not sufficiently compensated in Australia, and particularly egg donors. While we do not agree with encouraging profit-motivation for donating, egg donors go through very invasive, painful and time consuming procedures to help families, and this is not adequately compensated. Taking the UK as a possible model to adopt, while donors are not paid for their donation, they are compensated for expenses at a reasonable, capped amount. Nonetheless, the motivation of donors in the UK remains altruistic - helping people form their families, not economic reasons motivates donors (Human Fertilisation and Embryology Authority. (2022, November). Trends in egg, sperm and embryo donation 2020.)

We consider that capped compensation amounts for both surrogates and donors, in addition to reasonable expenses, would increase the number of people taking on these roles in Australia, and will in turn encourage surrogacy to happen more in Australia.

High treatment and medical costs

Fertility treatments used in surrogacy are currently not covered by Medicare, which makes the process unaffordable for many Australian families. Consequently, there is currently inequitable access to surrogacy based on financial resources. There should be the same level of access to rebates whether a person is using surrogacy to conceive or not.

Unfair rules for who can become parents

In some parts of Australia, the laws make it harder for LGBTQ+ people and single people to become intended parents. These rules are discriminatory and restrictive.

Access to assisted reproductive technology and surrogacy should not be restricted on the basis of relationship status, sex, sexual orientation, or gender identity.

Currently in Western Australia, discriminatory and outdated restrictions mean that only heterosexual couples and single women with a diagnosis or infertility are eligible to access surrogacy. This eligibility criteria excludes LGBTQ+ people and families from accessing surrogacy in Western Australia.

Inflexible laws

It's illegal to advertise for a surrogate, and there are pre-conditions that must be met before a parent can be legally recognised as the parent, making the process harder than it needs to be for parents and families. Advertising restrictions should be reconsidered and no longer criminalised.

Complex legal processes

The steps to get legal recognition as the child's parents can be expensive, take a long time, and be confusing and overwhelming for all parties involved. The current post-birth order system doesn't always put the needs or rights of the child first. Recognition of the role of parents from birth is required to create certainty for parents and surrogates.

Question 27: Other issues

Terminology

Language matters, not only in reflecting the lived experiences and legal realities of Australian families, but in shaping public understanding, attitudes, and beliefs around assisted reproductive technology and surrogacy.

DCFA holds the view that no Australian jurisdiction has fully adopted terminology that accurately or respectfully reflects the nature of surrogacy arrangements.

For example, Victoria continues to use the term *"surrogate mother"*, while other states and territories opt for *"birth mother"* or *"birth parent"*. These terms are problematic. They implicitly suggest that the surrogate is the child's mother — a framing that misrepresents the surrogate's role and reinforces outdated assumptions about genetic or gestational connection equating to parenthood.

Similarly, jurisdictions vary in how they describe the people seeking to become parents through surrogacy. Victoria uses *"commissioning parents"*, Western Australia refers to *"arranged parents"*, and other jurisdictions prefer *"intended parents"*. These inconsistencies not only create legal confusion but also influence how the public conceptualises surrogacy and family formation.

We recommend the standardised use of *"surrogate"* to refer to the person carrying the pregnancy, and *"intended parent/s"* (and, once the child is born, *"parent/s"*) to refer to those who intend to raise the child. These terms are clearer, more accurate, and inclusive — particularly as "surrogate" is gender-neutral and acknowledges that not all people who carry pregnancies identify as women.

Importantly, surrogates do not see themselves as the parent of the fetus they are carrying. Using terms like *"birth mother"* inaccurately conflates pregnancy with parenthood and contributes to misinformation about the surrogate's role and intentions. This can have real-world implications — not only influencing community attitudes and media portrayals about what defines a mother/parent and family but encroaching on the surrogate's autonomy (to carry a pregnancy for the purposes of surrogacy not parenthood) and undermining the parent status of the those who become parents via surrogacy.

Conclusion

We appreciate the opportunity to participate in the initial stages of this review of surrogacy laws in Australia.

We urge the ALRC to create reforms that remove unjust barriers to surrogacy and donor conception, including legal and financial obstacles to parenthood.

With thoughtful, cohesive reform, Australia can create a national surrogacy and donor conception framework that is inclusive, child-focused, and grounded in the realities of modern families.