Submission to the Australian Law Reform Commission (ALRC)

Review of Surrogacy Laws – Issues Paper 52 (2025)

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Introduction

I am a nursing academic and health researcher specialising in maternity and reproductive care, with a particular focus on surrogacy birth care. Drawing from ongoing research and consultation work—including expert collaboration on national surrogacy care guidelines—this submission responds to key issues raised in the ALRC's *Review of Surrogacy Laws* (Issues Paper 52, 2025). It provides an evidence-based perspective on healthcare delivery, legal parentage, and regulatory reform, with the goal of improving equitable and ethical care for all parties involved in surrogacy arrangements.

Surrogacy offers a meaningful and compassionate pathway to family formation. In its altruistic form, it is not coercive or exploitative, but rather a voluntary act of support between parties. Australia has made commendable progress in regulating surrogacy ethically; however, there remains room for improvement. Reform is needed to strengthen domestic surrogacy laws—not by referring to or replicating international models, but by focusing on the needs and rights of Australian citizens. Ensuring safe, inclusive, and well-supported domestic arrangements will reduce reliance on transnational commercial surrogacy and better protect the rights and wellbeing of all involved.

Barriers to Domestic Surrogacy and Equity of Access

(Q5)

Access to domestic surrogacy in Australia is impeded by inconsistent legislation, inequitable access, and a lack of awareness in both the public and healthcare systems. Legal frameworks

vary significantly across states and territories, leading to unequal and at times discriminatory outcomes.

For example, Western Australia currently prohibits same-sex male couples from accessing surrogacy services. This exclusion starkly contradicts the national legalisation of same-sex marriage and the principles of equality enshrined in federal anti-discrimination laws. Surrogacy, as a form of family-building, should be accessible to all individuals regardless of sexual orientation, gender, or marital status. Yet, discriminatory laws effectively prevent legally married same-sex couples from forming families through domestic surrogacy.

(Q7)

Compounding this inequity, New South Wales, the Australian Capital Territory, and Queensland criminalise residents who engage in overseas commercial surrogacy arrangements. While these laws may aim to deter unethical or exploitative practices, they also place intended parents—particularly same-sex male couples—in a precarious legal position. This group is more likely to pursue international surrogacy because they are often excluded from domestic pathways: some states (e.g. Western Australia) ban them from accessing surrogacy altogether, and Medicare policies do not recognise their need for fertility treatment due to the absence of a “medical infertility” diagnosis. As a result, same-sex male couples frequently have no viable domestic alternative and are left to navigate costly and legally risky overseas arrangements.

The criminalisation does not appear to deter demand for international surrogacy but instead creates additional legal and emotional risks for families. More importantly, it may have unintended consequences for the child, such as lack of legal recognition, delays in acquiring citizenship, or issues with birth registration.

Rather than criminalising overseas arrangements, law reform should focus on enabling ethical, safe, and inclusive domestic pathways. Ensuring fair and regulated access would reduce the reliance on international surrogacy arrangements and protect the welfare of all involved, especially children.

(Q14)

As mentioned above, Medicare access is another point of disparity. Fertility treatments and services for surrogacy are generally only reimbursable under Medicare if a medical condition of infertility is present. This framework excludes same-sex male couples and single men, who do not meet the “medical infertility” criteria. However, these individuals are equally part of the reproductive health landscape in Australia. As a country that recognises same-sex marriage and advocates for equality, excluding gay couples from Medicare-funded reproductive services raises serious equity concerns.

This gap in financial support drives many intended parents to consider overseas surrogacy, where costs may be clearer or perceived as more manageable despite additional ethical risks. By failing to support all family forms equally, current policy settings undermine national values of inclusion and fairness.

(Q15)

A critical barrier to domestic surrogacy is the limited availability of willing surrogates. Recent research by Kneebone (2023) found that over 50% of intended parents reported being unable to find a surrogate, highlighting a significant resource gap within the current system (Kneebone et al., 2023). This shortage is not merely a reflection of public disinterest, but rather an outcome of insufficient structural support, legal clarity, and recognition for surrogates.

To address this, we must improve the conditions and supports available to surrogates, which in turn may help promote domestic availability. This does not imply moving to commercial or profit-driven arrangements, but rather recognising the surrogate's physical, emotional, and psychological contributions. The Israeli model is a strong example: surrogacy is regulated through a medical and ethical approval board, and while the arrangement is not considered fully commercial, the law allows payment to compensate the surrogate for her time and suffering (Bashiri et al., 2024; Schuz, 2003). This includes not only the reimbursement of medical and related expenses but also financial recognition of the physical and emotional toll of pregnancy and childbirth. All agreements must be approved by a state-appointed committee, ensuring ethical oversight and compliance with national standards. This framework blends altruistic intentions with regulated financial support. It offers a state-controlled pathway that balances reproductive access with the protection of surrogates and

intended parents. These supports exist within a legally endorsed altruistic model, demonstrating that appropriate reimbursement can coexist with ethical practice.

Recommendation: National law reform should eliminate discriminatory restrictions, harmonise surrogacy access across states, extend Medicare coverage fairly to all family types, and provide regulated physical and psychological reimbursement to surrogates to ethically expand domestic availability.

Gaps in Public and Professional Education (Q11, Q25)

There is a critical lack of awareness about surrogacy laws and practices among both the general public and healthcare professionals. In my professional capacity and informal community interactions, I have routinely encountered the misconception that surrogacy is illegal in Australia. For instance, in conversations with colleagues, many expressed surprise that domestic surrogacy is permitted, assuming instead that international arrangements were the only viable option. One colleague noted that her cousins travelled overseas to pursue surrogacy, under the impression that it was not legally permitted in Australia.

This misunderstanding extends into the healthcare system. I reached out to midwives from hospitals across multiple states to have informal conversations about their experiences and any existing protocols related to surrogacy birth care. The responses were unexpectedly uniform: *"We don't have surrogacy here in Australia. What are you talking about?"* Such statements reflect a concerning lack of awareness and preparation within maternity services. If healthcare professionals—those who are expected to support and deliver surrogacy birth care—are unaware that surrogacy exists within Australia, then intended parents and surrogates face a significant access barrier to safe, respectful, and informed care.

The problem is not merely informational but systemic. Healthcare systems, which are central to reproductive care, are currently not functioning as a primary access point for surrogacy information. As a result, individuals seeking surrogacy must rely on online forums, or overseas agencies (approximately 70%)—none of which offer guaranteed ethical or evidence-based guidance (Hammarberg et al., 2015).

Recommendation: A national public education campaign and professional training program for clinicians, midwives, and maternity care staff is needed to ensure surrogacy care is understood, inclusive, and properly delivered. Healthcare should serve as the primary source of reproductive care guidance—not the internet or unregulated overseas agencies.

Legal Parentage and Healthcare Implications (Q18–19)

Delayed transfer of parentage remains a key legal and clinical issue. In most jurisdictions, the surrogate is considered the legal mother at birth, regardless of the intended parents' involvement in conception and ongoing care. This legal misalignment can delay decision-making authority for newborn healthcare, affect consent for medical procedures, and delay enrolment in Medicare and other services.

In the sensitive postnatal period, legal uncertainty can cause distress for all parties and place unnecessary pressure on the surrogate, who may be asked to act in ways that contradict the emotional intent of the arrangement. Healthcare professionals are left navigating a grey zone (Triviño-Caballero, 2023), often unsure of how to involve intended parents in discharge planning or neonatal care decisions.

Recommendation: A pre-birth legal recognition model should be implemented, where parentage is conditionally granted to the intended parents based on eligibility and agreement, then confirmed post-birth. This model would balance legal safeguards with practical clinical alignment, supporting the rights and needs of all parties.

Surrogate Support and Postnatal Gaps (Q14, Q15)

Surrogates are altruistically motivated, yet the system provides minimal structured support for their well-being. While some employers include surrogacy-related leave in enterprise bargaining agreements (EBAs), others do not. My recent research into EBA policies in higher education found that surrogacy leave varies dramatically between institutions, reflecting a broader inconsistency across sectors (Wikander et al., 2025).

Although Centrelink entitlements exist, the process of claiming them remains ambiguous. Surrogates have reported uncertainty when engaging with staff about their eligibility and entitlements, particularly when there is no child in their custody after birth. This ambiguity discourages claims and leaves surrogates unsupported at a time when their physical and emotional recovery is still ongoing.

In surrogacy cases, there are clear gaps in postnatal follow-up care. Surrogates are typically only followed for a few weeks after hospital discharge, often with one or two check-ins or up to six months (in some practice). After this period, they are no longer engaged by any healthcare organisation, simply because the baby is not in their care. In contrast, maternal and child health services routinely provide support to mothers and babies for up to five years, enabling continued monitoring of both physical and emotional wellbeing. This long-term support also allows for maternal health checks to be embedded into child health follow-up.

Medically, it is acknowledged that the body takes approximately six months to fully recover from pregnancy, and hormonal levels may return to pre-pregnancy levels within three to six months (Fiala et al., 2017). However, recovery does not always follow this expected timeline. In practice, some women experience hormonal fluctuations and associated symptoms well beyond six months. This raises a critical issue: surrogates are biologically vulnerable to postpartum conditions such as depression or hormonal imbalance, yet there are no structured follow-up systems in place to monitor or support them beyond the short post-discharge period.

Recommendation: Laws should require workplace surrogacy leave in EBAs and mandate clear access to Centrelink entitlements. Postnatal care should be expanded to include long-term physical and psychological follow-up for surrogates. Surrogacy-specific postnatal programs should be funded and integrated into existing maternal health services.

Human Rights and Inclusive Postnatal Care (Q27)

Surrogacy arrangements must be governed by human rights principles that protect the autonomy and dignity of all parties. The current healthcare and legal systems fail to

adequately recognise the distinct needs of surrogates and the diverse makeup of intended parent families.

Intended parents, particularly same-sex male couples, often feel excluded from mainstream parenting support programs. While intended parents may be followed up through child and family health services—especially when they have custody of the baby—these programs are typically designed with heteronormative assumptions and maternal language. For same-sex male couples, this creates an uncomfortable and sometimes alienating experience where the language, expectations, and resources do not reflect their family structures (Baptiste-Roberts et al., 2017; Griggs et al., 2021). This lack of inclusivity undermines the support these families receive and may dissuade intended parents from fully engaging with available postnatal services.

This systemic oversight represents another barrier within the domestic surrogacy system. It contributes to the perception that Australia is ill-equipped to support surrogacy, particularly for non-traditional family structures, and may drive prospective intended parents to pursue overseas options where services are perceived to be more inclusive or specialised.

Recommendation: Postnatal services must be reviewed and adapted to ensure inclusivity for all family types, particularly for same-sex male couples and non-biological parents. Training in inclusive language and cultural competence should be integrated into standard postnatal care protocols. These reforms will help align child and family health services with contemporary parenting realities and improve access and retention of intended parents within the healthcare system.

Reform Principles and National Harmonisation (Q2)

Reform must be guided by principles that reflect fairness, practicality, and inclusiveness:

- Equity: Ensure access to surrogacy is available to all, regardless of sexual orientation, gender identity, or relationship status.
- Harmonisation: Replace state-by-state disparity with a national legal framework that provides consistent access, eligibility, and process standards.

- Non-criminalisation: Refrain from criminalising overseas surrogacy engagement, especially when driven by lack of access at home. Legal deterrents should not result in harm to children.
- Health-centred access: Make healthcare the central pillar for information, support, and referral—not a marginal actor in surrogacy.

Conclusion and Recommendations

To address the inequities and inefficiencies in Australia's surrogacy system, a nationally coordinated, health-informed, and rights-based approach is required. This submission highlights the urgent need for:

- National surrogacy birth care guidelines co-designed with healthcare and legal professionals.
- Structured and accredited surrogacy support services.
- Pre-birth legal parentage recognition models.
- Greater investment in public and professional education on surrogacy.
- Expansion of Medicare access and financial support to all eligible families.
- Regulated physical and psychological reimbursement for surrogates.
- Inclusion of surrogates in postnatal follow-up and formal workplace entitlements.

Australia's legal and healthcare systems must align to ensure all parties in a surrogacy arrangement—surrogates, intended parents, and children—are protected, supported, and treated with dignity.

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