The Senate

Community Affairs References Committee

Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia

May 2023

ISBN 978-1-76093-494-1 (Printed version)

Printed by the Senate Printing Unit, Parliament House, Canberra.

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Terms of reference

Barriers to achieving priorities under the National Women's Health Strategy for 'universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies', with particular reference to:

(a) cost and accessibility of contraceptives, including:
    (i) PBS coverage and TGA approval processes for contraceptives,
    (ii) awareness and availability of long-acting reversible contraceptive and male contraceptive options, and
    (iii) options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions;
(b) cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas;
(c) workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals;
(d) best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery;
(e) sexual and reproductive health literacy;
(f) experiences of people with a disability accessing sexual and reproductive healthcare;
(g) experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare;
(h) availability of reproductive health leave for employees; and
(i) any other related matter.

Contents

Abbreviations and acronyms

ACARA	Australian Curriculum and Reporting Agency
ACCHO	Aboriginal Community Controlled Health Organisation
ACM	Australian College of Midwives
ACN	Australian College of Nursing
ACT	Australian Capital Territory
AHMRC	Aboriginal Health and Medical Research Council of NSW
ALHR	Australian Lawyers for Human Rights
AMA	Australian Medical Association
ANMF	Australian Nursing and Midwifery Federation
ANU Hub	Australian National University Law Reform and Social Justice Research Hub
ART	assisted reproductive technologies
ARTG	Australian Register of Therapeutic Goods
AusCAPPS	Australian Contraception and Abortion Primary Care Practitioner Support Network
CALD	culturally and linguistically diverse
Commission	Australian Human Rights Commission
COCP	combined oral contraceptive pill
committee	Community Affairs References Committee
Consensus Statement	*Consensus Statement on Management of Intersex Disorders*
CSE	comprehensive sexuality education
CSRE	comprehensive sexuality and relationships education
Department	Department of Health and Aged Care
EM	endorsed midwife
EN	enrolled nurse
Fay Gale Centre	Fay Gale Centre for Research on Gender at the University of Adelaide
FPAA	Family Planning Alliance Australia
FPNSW	Family Planning NSW
FNWLSQ	First Nations Women Legal Services Queensland, Inc.
GP	general practitioner
Health Insurance Act	*Health Insurance Act 1973*
Human Cloning Act	*Prohibition of Human Cloning for Reproduction Act 2002*
ICF	in vitro fertilisation
IUD	intrauterine devices
LARC	long-acting reversible contraception/contraceptive

LGBTIQA+	lesbian, gay, bisexual, trans/transgender, intersex, queer, asexual, and other sexuality, gender, and bodily diverse
LGBTIQ+ or LGBTQI+	lesbian, gay, bisexual, trans/transgender, intersex, queer and other sexuality, gender, and bodily diverse
LGBTQIA2S+	lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual, Two-Spirit
MBS	Medicare Benefits Schedule
MBS Fee	Medicare Benefits Schedule Fee
MCWH	Multicultural Centre for Women's Health
NACCHO	National Aboriginal Community Controlled Health Organisation
Network	International Student Sexual Health Network
NHMRC	National Health and Medical Research Council
NHRA	National Health Reform Agreement
NSW	New South Wales
NT	Northern Territory
OCP	oral contraceptive pill
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
Pharmacy Guild	The Pharmacy Guild of Australia
QLD	Queensland
QNMU	Queensland Nurses and Midwives' Union
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Reproductive Justice Report	*Towards Reproductive Justice for young women, girls, feminine identifying, and non-binary people with disability (YWGwD)*
RN	registered nurse
SA	South Australia
SECCA	Sexuality Education Counselling Consultancy Agency
STIs	Sexually Transmitted Illnesses
terminations	pregnancy terminations
TGA	Therapeutic Goods Administration
the Department	Department of Health and Aged Care
the Review	National Scope of Practice Review
TRRH	True Relationships and Reproductive Health
WA	Western Australia
WHISE	Women's Health in the South East
Women's Health Strategy	*National Women's Health Strategy 2020–2030*

YEP	Youth Educating Peers

List of recommendations

Recommendation 1

2.131 The committee recommends that the Therapeutic Goods Administration reviews its approval processes to ensure that Australian consumers have timely access to the latest and safest contraceptive methods available internationally.

Recommendation 2

2.140 The committee recommends that the National Scope of Practice Review considers, as a priority, opportunities and incentives for all health professionals working in the field of sexual and reproductive healthcare to work to their full scope of practice in a clinically safe way.

Recommendation 3

2.141 The committee recommends that state and territory governments work towards aligning supply quantities of Pharmaceutical Benefits Scheme (PBS) and non-PBS oral contraceptive pills allowed under state and territory emergency supply legislation.

Recommendation 4

2.145 The committee recommends that the Australian Government reviews, considers and implements options to make contraception more affordable for all people.

Recommendation 5

2.149 The committee recommends that the Australian Government ensures that there is adequate remuneration, through Medicare, for general practitioners, nurses, and midwives to provide contraceptive administration services, including the insertion and removal of long-acting reversible contraceptives.

Recommendation 6

2.156 The committee recommends that the Department of Health and Aged Care and the Pharmaceutical Benefits Advisory Council work with the pharmaceutical industry to consider options to improve access to a broader range of hormonal contraceptives that are not currently Pharmaceutical Benefits Scheme subsidised, including newer forms of the oral contraceptive pill, the emergency oral contraceptive pills and the vaginal ring.

Recommendation 7

2.157 The committee recommends that the Department of Health and Aged Care considers and implements an option to subsidise the non-hormonal copper intrauterine device to improve contraceptive options for people with hormone-driven cancers and people for whom hormonal contraception options may not be suitable.

Recommendation 8

2.164 The committee recommends the Australian Government works with the Royal Australian College of General Practitioners and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to improve access to workforce training for the insertion and removal of long-acting reversible contraceptives to support their increased utilisation in Australia.

Recommendation 9

2.165 The committee recommends that the Australian Government considers the continuation of funding for the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCAPPS) to provide ongoing support and professional development for practitioners.

Recommendation 10

2.170 The committee recommends that the Australian Government considers and implements a separate Medicare Benefits Schedule item number for contraceptive counselling and advice for all prescribers, including midwives.

Recommendation 11

2.172 The committee recommends that the Australian Government and/or relevant organisations support research into the availability and development of contraceptive options for males.

Recommendation 12

3.136 The committee recommends that the Australian, state, and territory governments ensure that maternity care services, including birthing services, in non-metropolitan public hospitals are available and accessible for all pregnant women at the time they require them. This is particularly important for women in rural and regional areas.

Recommendation 13

3.137 The committee recommends that the Australian Government implements outstanding recommendations made by the Participating Midwife Reference Group to the Medicare Benefits Schedule (MBS) Review Taskforce regarding midwifery services and continuity of care.

Recommendation 14

3.138 The committee recommends that the Australian Government works with the sector to increase birthing on country initiatives and other culturally appropriate continuity of care models.

Recommendation 15

3.143 The committee recommends that all public hospitals within Australia be equipped to provide surgical pregnancy terminations, or timely and affordable pathways to other local providers. This will improve equality of access, particularly in rural and regional areas and provide workforce development opportunities.

Recommendation 16

3.146 The committee recommends that the Australian Government develops an implementation plan for the National Women's Health Strategy 2020–2030 with annual reporting against key measures of success. This could include establishing a taskforce as part of the implementation plan.

Recommendation 17

3.149 The committee recommends that the Australian Government, in consultation with state and territory governments, implements a national support, information, and referral model for sexual and reproductive healthcare services.

3.150 The committee envisages that such a national telephone service would leverage the experiences of existing initiatives, such as 1800 My Options and healthdirect, to ensure that it is fit for purpose, delivers accurate local information, and builds on the experiences of services operating in those jurisdictions.

Recommendation 18

3.153 The committee recommends that the Australian Government reviews the existing Medicare arrangements which support medical termination consultations with the aim of ensuring adequate remuneration for practitioners to deliver these services while also ensuring patient privacy.

Recommendation 19

3.157 The committee recommends that the Australian Government continues current Medicare Benefits Schedule telehealth items for sexual and reproductive healthcare, including pregnancy support counselling and termination care.

Recommendation 20

3.161 The committee recommends that the Therapeutic Goods Administration and MS Health review barriers and emerging evidence to improve access to MS-2 Step, including by:

- **allowing registered midwives, nurse practitioners, and Aboriginal Health Workers to prescribe this medication—including pain relief where indicated; and**
- **reducing training requirements for prescribing practitioners and dispensing pharmacists.**

Recommendation 21

3.165 The committee recommends that the Australian Government, in consultation with relevant training providers, reviews the availability, timing, and quality of sexual and reproductive healthcare training in undergraduate and postgraduate tertiary health professional courses, including vasectomy procedures, terminations and insertion of long-acting reversible contraception.

Recommendation 22

3.169 The committee recommends that the Australian Government commissions work to improve its collection, breadth, and publication of statistical data and information regarding sexual and reproductive healthcare, particularly in relation to pregnancy terminations, both medical and surgical, and contraceptive use across Australia.

Recommendation 23

3.170 The committee recommends that the Department of Health and Aged Care works closely with its state and territory counterparts to consider the effectiveness of local programs providing free menstrual hygiene products.

Recommendation 24

4.95 The committee recommends that the Australian Government work with the relevant medical and professional colleges to support the development and delivery of training to health practitioners providing sexual, reproductive and maternal healthcare on:

- **engaging and communicating with people with disability;**
- **providing culturally aware and trauma-informed services to culturally and linguistically diverse migrants and refugees; and**
- **ensuring culturally safe healthcare for First Nations people in mainstream non-community-controlled organisations, by ensuring practitioners are aware of intergenerational trauma, cultural norms and taboos.**

Recommendation 25

4.96 The committee recommends that the Australian Government consider options and incentives to expand the culturally and linguistically diverse (CALD) sexual and reproductive health workforce including leveraging the success of the 'Health in My Language' program.

Recommendation 26

4.101 The committee recommends that the Department of Health and Aged Care consider sexual and reproductive healthcare for LGBTIQA+ people in the context of the 10-year National Action Plan for the Health and Wellbeing of LGBTIQA+ people.

Recommendation 27

4.104 The committee recommends that the Australian Government consult with people with innate variations of sex characteristics regarding surgical interventions in the context of the 10-year National Action Plan on the Health and Wellbeing of LGBTIQA+.

Recommendation 28

4.105 The committee recommends that the Australian Government commissions research into reproductive coercion and abuse with a view to developing clinical guidelines, resources and training for primary care providers.

Recommendation 29

4.107 The committee recommends that the Australian Government works with the sector to develop sexual and reproductive health education programs and resources for people with disability and their families and carers that are accessible, disability inclusive and empowering for young people with disability.

Recommendation 30

4.111 The committee recommends that the Australian Government, in consultation with state and territory governments, consider options for ensuring the provision of reproductive health and pregnancy care services to all people living in Australia, irrespective of their visa status.

Recommendation 31

4.112 The committee recommends that the Australian Government work with relevant overseas health insurance providers to amend Schedule 4d of the Overseas Student Health Cover Deed to abolish pregnancy care related wait periods.

Recommendation 32

4.114 The committee recommends that the Australian Government explores the feasibility of Medicare rebates for in vitro fertilisation (IVF) services for cohorts not currently eligible for subsidised services.

Recommendation 33

4.116 The committee recommends that the Australian Government implement the recommendations of the Medicare Benefits Schedule Review regarding removal of the exclusion of in vitro fertilisation (IVF) services for altruistic surrogacy purposes.

Recommendation 34

5.67 The committee recommends that the Australian Government work with jurisdictions to improve the quality of sexual health and relationships education in schools including building capabilities of educators to deliver this training.

Recommendation 35

5.68 The committee recommends the Department of Health and Aged Care work with jurisdictions and the health sector to implement options for targeted public awareness and sexual health literacy campaigns in target communities, including for the LGBTIQA+ community, community-led initiatives for First Nations and culturally and linguistically diverse groups, and sexually transmitted infections campaigns in vulnerable cohorts.

Recommendation 36

5.72 The committee recommends that the Australian Government considers commissioning research and policy responses on the impact of reproductive health on women's participation in the workforce and the adequacy of existing leave entitlements under the National Employment Standards.

Chapter 1
Introduction

1.1 Access to sexual, reproductive and maternal healthcare is a fundamental human right which contributes to positive health, social and economic outcomes across the whole community. Australia's health system must enable all people to effectively exercise choice and control without fear of discrimination or disadvantage and to be adequately supported in their decisions. Women in regional and remote areas in particular should feel confident that they can access appropriate sexual, reproductive and maternal healthcare without facing excessive barriers of cost or distance.

1.2 Throughout this inquiry, the committee heard that enabling universal access to reproductive healthcare has the profound capacity to improve community health and well-being, develop a culture of inclusion and safety, and enhance workforce participation.

1.3 Reproductive healthcare is an intrinsic part of life, particularly for women, transgender people, and non-binary people, and inadequate access to these services can have significant negative impacts on these individuals' mental, emotional, and physical health. The consequences of this have flow-on effects, and can impact education, gender equality, and the economy. Intersectional and vulnerable groups within the Australian community particularly suffer from these consequences, as the reproductive healthcare system often neglects and overlooks them.

1.4 Prioritisation of universal access to reproductive healthcare, including contraception and sexual health, maternity care, pregnancy terminations (terminations), conditions like endometriosis, and menopause is particularly important in the current environment, with Australia continuing to experience the health, social, and economic impacts of the COVID-19 pandemic and associated government responses.

1.5 The past decade has seen the legalisation of terminations across Australia, however these laws differ amongst jurisdictions. Recent international developments have prompted an examination within Australia of barriers to achieving the outcome of ensuring terminations are not only legal, but are also safe, affordable and widely accessible. The committee also notes the Australian Capital Territory (ACT) Government's recently concluded inquiry into abortion

and reproductive choice,[1] which resulted in that government making termination services free for all its residents.[2]

1.6 As evidence received during the inquiry unequivocally demonstrates, Australians do not currently have consistent access to sexual, reproductive and maternal healthcare services, and that this particularly disadvantages people living in regional and remote Australia.

Structure of the report

1.7 This report contains five chapters as outlined below.

1.8 Chapter 1 is an introductory chapter that provides an overview of the various government supports and initiatives aimed at providing and improving sexual and reproductive healthcare in Australia, with a focus on the *National Women's Health Strategy 2020–2030* (Women's Health Strategy). It also provides information on the conduct of the inquiry, including information on submissions and public hearings.

1.9 Chapter 2 focuses on contraceptives, and their role in minimising unintended pregnancies and improving sexual health. The chapter starts with a discussion of the issue of unintended pregnancies and follows with an overview of the different types of contraceptives available domestically before canvassing the key barriers people commonly face when trying to access contraceptives.

1.10 Chapter 3 focuses on pregnancy care, with a particular emphasis on the accessibility of maternity care and termination services in Australia. It provides an overview of the forms of pregnancy care that women commonly access before detailing the significant barriers that women encounter when trying to access these services.

1.11 Chapter 4 explores the barriers to reproductive healthcare for various groups within the Australian community before analysing how people with these groups are hindered by the accessibility barriers that currently exist.

1.12 Chapter 5 explores the level of sexual and reproductive health literacy across the Australian community and some of the barriers that currently exist to raising literacy levels. This chapter also discusses evidence related to the value of reproductive health leave for employees in Australia, and potential impacts on health and gender equity outcomes for women.

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1 Standing Committee on Health and Community Wellbeing, Legislative Assembly for the Australian Capital Territory (ACT), *Inquiry into Abortion and Reproductive Choice in the ACT*, April 2023, p. 1.

2 Yvette Berry MLA, Deputy Chief Minister and Rachel Stephen-Smith MLA, ACT Minister for Health, 'No cost abortions now available in the ACT', *Media Release*, 20 April 2023, www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/yvette-berry-mla-media-releases/2023/no-cost-abortions-now-available-in-the-act.

Government initiatives and support for sexual and reproductive healthcare

1.13 The Australian Government provides funding to support access to sexual and reproductive healthcare in Australia through a number of mechanisms. Furthermore, it has undertaken various initiatives aimed at improving the provision of these services, including the development of the Women's Health Strategy. These supports and initiatives are discussed below.

National Women's Health Strategy 2020–2030

1.14 The Women's Health Strategy is the Government's national approach to improving health outcomes for all women and girls in Australia. It builds on the *National Women's Health Policy 2010* by taking into account recent changes in the policy environment and utilising the most recent evidence regarding identified gaps and emerging issues in women's health.[3]

1.15 The goal of the Women's Health Strategy is to address the priority health needs of women and girls in Australia by informing targeted and coordinated action at the national and jurisdictional levels.

1.16 A key priority area of the strategy relates to increasing access to sexual and reproductive healthcare information, diagnosis, treatment and services.[4] It works towards this priority area by offering options to women to empower choice and control in decision-making about their bodies. This includes contraception and options for addressing unplanned pregnancies, including access to termination services.[5]

1.17 The Women's Health Strategy has two actions that are both aimed at achieving this priority and that are directly relevant to the inquiry's terms of reference. These include:

> Remove barriers to support equitable access to timely, appropriate and affordable care, including culturally and linguistically sensitive and safe care.
>
> - Work towards universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies, including contraception and options for addressing unplanned pregnancies, including access to termination services.
> - Improve access to and uptake of appropriate contraceptive methods including long-acting reversible contraception (LARC) through education for GPs [general practitioners], nurses and other health care providers, and expansion of service provision.

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3 Department of Health, *National Women's Health Strategy 2020–2030*, 2018, p. 6.

4 Department of Health, *National Women's Health Strategy 2020–2030*, 2018, p. 6.

5 Children by Choice, *Submission 60*, p. 5.

- Expand family planning services for priority population groups, including Aboriginal and Torres Strait Islander women, women with disability, health care card holders, migrants and refugee populations and incarcerated women.

Strengthen access pathways to sexual and reproductive health services across the country, particularly in rural and remote areas.

- Ensure strong referral pathways between primary care services and specialised services and practitioners.
- Invest in and support the development and expansion of telehealth services and new models of care.
- Continue to support women's health services at a national, state and local level.
- Provide education and training to GPs, nurses and other relevant health care providers, to provide comprehensive sexual and reproductive services.
- Develop a suite of approaches for information sharing and access to sexual and reproductive health services for women who have limited access to mobile and digital channels and local services, such as women in rural and remote areas.
- Increase access to government-funded health services that offer sexual and reproductive health services, particularly for women living in rural and remote areas.[6]

Other relevant government strategies, plans, and agreements

1.18 In addition to the Women's Health Strategy, the Australian Government has a number of other strategies, plans, and agreements in place to improve national public health outcomes, including promoting universal access to sexual and reproductive health information, treatment and services. Those relevant to the committee's inquiry include the:

- *Woman-Centred Care Strategy*;
- *Australian National Breastfeeding Strategy*;
- *National Stillbirth Action and Implementation Plan*;
- *National Men's Health Strategy 2020–2030*;
- *National Strategy to Achieve Gender Equality*;
- *National Plan to End Violence against Women and Children 2022–2032*;
- *National Agreement on Closing the Gap*;
- *National Health Reform Agreement*;
- *National Medical Workforce Strategy*;
- *National Aboriginal and Torres Strait Islander Health Workforce Plan*;
- *Nurse Practitioner 10 Year Plan* (currently under development); and the
- *Health Literacy Strategy* (currently under development).[7]

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6 Department of Health, *National Women's Health Strategy 2020–2030*, April 2019, p. 24.

7 For more detail see: Department of Health and Aged Care, *Submission 53*, pp. 3–5.

Funding support for sexual and reproductive healthcare

1.19 The Australian Government supports access to sexual and reproductive healthcare in Australia through three mechanisms:

- funding to states and territories for public hospitals to deliver public services;
- the Medicare Benefits Schedule (MBS) for privately provided services; and
- the Pharmaceutical Benefits Scheme (PBS) for medications.[8]

1.20 The Government also provides direct support for health and medical research through the Medical Research Future Fund and the National Health and Medical Research Council.[9]

1.21 Health and literacy programs and services are also supported by the Australian Government including the Health in My Language program, local sexual health clinics, and Aboriginal Community Controlled Health services.

Public health services

1.22 Under the *2020–25 National Health Reform Agreement* (NHRA), the Australian Government contributes funding to the states and territories for the delivery of public health and hospital services. These services include reproductive healthcare and consist of acute care through hospital emergency departments, sub-acute care, admitted and non-admitted care, and care provided in a variety of community health settings. Importantly, the states and territories determine the availability, types and range of services available, as well as the locations in which they are delivered across their respective jurisdictions.[10]

1.23 Under the NHRA, state and territory governments have committed to provide eligible patients with public hospital services free-of-charge, with access being based on clinical need. States and territories have also committed to put in place arrangements which ensure equitable access to these services, regardless of geographical location. This includes the provision of clinically necessary reproductive health services.[11]

1.24 In 2021–22, the Australian Government contributed a total of $24.1 billion through the NHRA towards the costs of delivering public hospital services.[12]

Medicare Benefits Schedule

1.25 The MBS lists medical services for which the Australian Government provides patients with financial assistance. Total expenditure on the MBS in 2021–22 was

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8 Department of Health and Aged Care, *Submission 53*, p. 6.

9 Department of Health and Aged Care, *Submission 53*, p. 8.

10 Department of Health and Aged Care, *Submission 53*, p. 7.

11 Department of Health and Aged Care, *Submission 53*, p. 7.

12 Department of Health and Aged Care, *Submission 53*, p. 8.

$28.78 billion; however, funding for services primarily associated with sexual and reproductive healthcare was only a small portion of this, at $1.01 billion.[13]

1.26 Although the Australian Government sets the amount of financial assistance it provides each patient through the MBS Schedule Fee (MBS Fee), health practitioners are free to set their own price for the services they deliver. This commonly results in out-of-pocket expenses for the patient.[14]

1.27 For MBS services provided in-hospital, Medicare pays 75 per cent of the MBS Fee and, where a patient has appropriate coverage, private health insurers pay the remaining 25 per cent. For services provided out-of-hospital, Medicare pays 85 per cent of the MBS Fee.[15]

1.28 The MBS also subsidises specialist services through a wide range of consultation and intervention items. In terms of sexual and reproductive health, this includes items in the clinical specialties of gynaecology, obstetrics, midwifery, pathology, and diagnostic imaging. It also includes assisted reproductive technologies (ART);[16] however, it does not subsidise ART processes associated with surrogacy.[17]

Pharmaceutical Benefits Scheme

1.29 Under the PBS, the Australian Government subsidises the cost of medicine for most medical conditions. The majority of listed medications are dispensed by pharmacists and used by patients at home.

1.30 The PBS Schedule lists all medicines available to be dispensed to patients at Australian Government subsidised prices. The schedule is part of the wider PBS managed by the Department of Health and Aged Care (the Department) and administered by Services Australia. In 2021–22, expenditure under the PBS was $14.7 billion.[18]

1.31 Currently, almost 5000 items are listed on the PBS to treat a wide range of conditions, including diverse treatment options to manage sexual and reproductive health issues, such as:

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13 Department of Health and Aged Care, *Submission 53*, p. 6. Please note that this is only expenditure that can be specifically attributed to sexual and reproductive healthcare. Other items that may be used more broadly, such as general attendance items, psychosocial counselling, and anaesthetic items, are not included in this figure as the required data to allow for this is not collected.

14 Department of Health and Aged Care, *Submission 53*, p. 6.

15 Department of Health and Aged Care, *Submission 53*, p. 6.

16 Department of Health and Aged Care, *Submission 53*, p. 6.

17 Surrogacy Australia, answer to question taken on notice, 28 February 2023 (received 20 March 2023).

18 Department of Health and Aged Care, *Submission 53*, p. 7.

- birth control (contraception);
- medical terminations;
- central precocious puberty;
- treatment of sexually transmissible infections; and
- chronic health problems, such as endometriosis.[19]

Conduct of the inquiry

1.32 On 28 September 2022, the Senate referred an inquiry into universal access to reproductive healthcare to the Senate Community Affairs References Committee (committee) for inquiry and report by 31 March 2023.[20] On 28 November 2022, the Senate granted an extension of time to report until 11 May 2023.[21] A further extension was granted on 9 May 2023, extending the time to report until 25 May 2023.[22]

1.33 The inquiry's terms of reference are as follows:

> Barriers to achieving priorities under the National Women's Health Strategy for 'universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies', with particular reference to:
>
> (a) cost and accessibility of contraceptives, including:
>
> (i) PBS coverage and TGA approval processes for contraceptives,
> (ii) awareness and availability of long-acting reversible contraceptive and male contraceptive options, and
> (iii) options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions;
>
> (b) cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas;
> (c) workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals;
> (d) best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery;
> (e) sexual and reproductive health literacy;
> (f) experiences of people with a disability accessing sexual and reproductive healthcare;
> (g) experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare;

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19 Department of Health and Aged Care, *Submission 53*, p. 7.

20 *Journals of the Senate,* No. 15, 28 September 2022, pp. 378–379.

21 *Journals of the Senate,* No. 24, 28 November 2022, p. 719.

22 *Journals of the Senate,* No. 46, 9 May 2023, p. 1334.

(h) availability of reproductive health leave for employees; and
(i) any other related matter.[23]

1.34 The inquiry was advertised on the committee's website and the committee wrote to various organisations and individuals inviting submissions by 15 December 2022. To further facilitate participation in the inquiry the committee also accepted late submissions past this date.

Submissions and public hearings

1.35 The committee received 352 submissions which are listed in Appendix 1. The committee also received 13 confidential submissions.

1.36 The committee held five public hearings as follows:

- Lismore, New South Wales—21 February 2023
- Brisbane, Queensland—22 February 2023
- Canberra, Australian Capital Territory—28 February 2023
- Perth, Western Australia—4 April 2023
- Melbourne, Victoria—28 April 2023

1.37 Transcripts for all public hearings are available on the committee's website, and a list of the witnesses is included in Appendix 2.

Acknowledgements

1.38 The committee thanks all individuals and organisations who contributed to the inquiry by providing written material and appearing at public hearings.

Material that did not engage with the inquiry's terms of reference

1.39 During the inquiry, the committee received a substantial amount of material that objected to the terminology used in the terms of reference and/or commented on the ethics of pregnancy terminations and whether they should, or should not, be allowed in Australia.

1.40 The committee considers that the terms of reference of the inquiry do not engage with these questions of morality or whether pregnancy terminations should be legal or otherwise. The committee notes that pregnancy terminations are currently legal in every state and territory in Australia and that termination services are part of the Women's Health Strategy to empower choice and control in decision making.[24]

1.41 Given this, the committee considered that this material—regardless of whether it advocated for or opposed pregnancy terminations—did not fall within the terms of reference of the inquiry as referred by the Senate. As a result, the committee has chosen to not publish this correspondence.

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23 *Journals of the Senate,* No. 15, 28 September 2022, pp. 378–379.

24 Department of Health, *National Women's Health Strategy 2020–2030*, p. 24.

Coordinated campaigns and form letters

1.42 The inquiry received a large volume of material associated with two coordinated campaigns as outlined below:

- Third-party coordinated campaign:
  - The committee received over 1200 emails from this campaign.
  - Key topics raised by submitters included:
    - support for the overturning of Roe versus Wade in the United States;
    - opposition to abortion and the promotion of alternative options; and
    - appeals to religious justifications for these views.
- Australian Christian Lobby coordinated campaign:
  - The committee received over 320 emails from this campaign, all of which were anti-abortion.
  - Submissions focussed on the following topics:
    - calls for the Government to support pregnancy crisis centres and adoption agencies as alternative pathways to abortion;
    - arguments that psycho-social justifications for abortion are indicative of the Government's failure to support women who unexpectedly fall pregnant; and
    - the dangers associated with taking the medical abortion pill.

1.43 The committee identified three form letters that were organised by various organisations.

- Fair Agenda form letter:
  - The committee received over 130 emails from this campaign, all of which focused on increasing access to abortion.
  - Submissions called for the committee to address barriers to abortion care, including:
    - affordability;
    - lack of clinical services;
    - support for the healthcare workforce;
    - updating medication regulation; and
    - addressing gaps in reproductive healthcare data.
- Surrogacy Australia form letter:
  - The committee received over 25 emails from this campaign.
  - Submissions called on the Government to allow Medicare rebates to be claimed for fertility treatments provided in conjunction with a surrogacy arrangement.

- Cherish Life form letter:
  - The committee received over 30 emails from this campaign.
  - Submissions rejected and critiqued the terms of reference in support of anti-abortion arguments.

1.44 Samples of each coordinated campaign and the three form letters have been published on the inquiry's website alongside a cover page for each summarising the key topics they raised as well as the respective numbers received.

A brief note on the language used within this report

1.45 Throughout this report, the term 'women' is used broadly in recognition that most people who are pregnant, or who are seeking oral or long-acting reversible contraception, identify themselves this way. Notwithstanding this, the committee acknowledges that the relevant material is also applicable to individuals that do not identify as women, including trans, gender-diverse and non-binary people.

1.46 Further, it is also recognised that the content regarding 'male' contraceptives is also relevant to those individuals that may not identify themselves as men, including trans, gender-diverse, and non-binary people.

Hansard references

1.47 In this report, references to Committee Hansard are to proof transcripts. Page numbers may vary between proof and official transcripts.

Chapter 2
Enhancing access to contraceptives

Introduction

2.1 Planned parenthood has important long-term benefits for both maternal and infant health. Empowering choice and control in reproductive decisions, including the use of contraception, forms a vital part of family planning and is a key foundation of the *National Women's Health Strategy 2020–2030*.

2.2 The focus of this chapter is contraception, and how it can be best utilised to minimise unintended pregnancies and pregnancy terminations (terminations) and improve sexual health. The chapter starts with a discussion of the issue of unintended pregnancies. It then follows with an overview of the different types of contraceptives available domestically and a discussion of the benefits of long-acting reversible contraceptives, before considering the current regulatory environment. Finally, key barriers that were identified by inquiry participants are canvassed, followed by the committee's view on approaches to improve accessibility and reduce unintended pregnancies and their associated health and financial costs.

Family planning and unintended pregnancies

2.3 It is estimated that one in four Australian women experience an unintended pregnancy during their lifetime, with rates even higher in non-urban areas.[1] An unintended pregnancy may be either an unwanted pregnancy, where no child was wanted at all, or a mistimed pregnancy, where the pregnancy occurred earlier than desired by the parents.[2] Unintended and unwanted pregnancies may also result from traumatic episodes, including rape, incest and domestic violence.

2.4 Unintended pregnancies may be attributed to non-use of contraception, inconsistent use or contraceptive failure, and can place significant physical, social and financial strains on women and their families. This is a major health issue and an area of unmet demand for Australian women.[3]

2.5 Due to more advanced technologies for reversible forms of female contraception, when compared to their male alternatives, women generally take greater responsibility for their use. This results in women commonly carrying greater financial costs as well as incurring any associated health burdens that

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1 SPHERE, *Submission 5*, p. 4.

2 Organon, *Submission 3*, p. 3.

3 SPHERE, *Submission 5*, p. 4.

may result, such as common negative physical side effects and the consequences of contraceptive failure.[4]

2.6 Contraceptives can be accessed from a variety of different dispensing environments, including primary care, community pharmacies, approved private and public hospitals, and sexual health clinics.[5] Accessibility, however, can be impacted by numerous factors, including socioeconomic status, culture, religion, language, and health literacy.[6] Additionally, women living in rural and remote areas are 1.4 times more likely to experience an unintended pregnancy, suggesting that access to contraception remains a problem in these non-urban regions.[7]

2.7 The Australian Government can play a key role in reducing the financial, social, economic, cultural and geographic barriers that exist, and ensure that all women are able to exercise choice and control in their decision making regarding contraceptive use.[8]

Different forms of contraceptives

2.8 It is estimated that around two in three Australian women between the ages of 18 and 44 years use some form of contraception, with 83 per cent having used contraception at some point in their lives.[9] Younger women are more likely to experience unintended pregnancies and are also likely to use less effective methods of contraception, such as the oral contraceptive pill (OCP) and condoms.

2.9 This section will briefly outline the different forms of contraception available, including oral contraceptives, long-acting reversible contraceptives, emergency contraceptives and contraceptives for men.

Oral contraceptives

2.10 The OCP is one of the most commonly used contraceptive methods in Australia.[10] There are two types available in Australia—the combined pill and the progestogen only pill. The combined pill contains the hormones oestrogen

4 Australian Nursing and Midwifery Federation, *Submission 20*, p. 4.

5 Department of Health and Aged Care, *Submission 53*, p. 10.

6 Royal Australian College of General Practitioners, *Submission 64*, p. 6.

7 Organon, *Submission 3*, p. 3.

8 Australian College of Midwives, *Submission 30*, pp. 4–5.

9 Australian Medical Association, *Submission 71*, p. 2.

10 Family Planning New South Wales, *Submission 56*, p. 6.

and progestogen, whereas the progestogen only pills contain only progestogen. These are hormones similar to those produced by the ovaries.[11]

2.11 Both are taken daily and are available on prescription. They are considered to be very effective forms of contraception when administered properly. If used correctly, they are at least 99 per cent effective and, even allowing for mistakes, they are still 93 per cent effective in preventing pregnancy.[12]

2.12 The OCP can have a number of side effects, including nausea, mood swings, irregular bleeding, thrombosis and bloating.[13]

Long-acting reversible contraceptives

2.13 Long-acting reversible contraceptives (LARCs) include hormonal intrauterine devices (IUDs), non-hormonal copper IUDs and hormonal implants. They are considered to be highly effective and suitable for most women of all reproductive ages. Despite its effectiveness and suitability, the uptake of LARCs is relatively low in Australia, with only 11 per cent of women aged between 15 and 44 years using a form of LARC.[14]

2.14 It is recommended that the insertion of a LARC be completed by an experienced or sufficiently trained health professional. The procedure requires a consultation, various sterile instruments and materials, as well as the availability of a registered nurse or midwife.[15]

2.15 Medical practitioners and nurse practitioners can prescribe hormonal IUDs, while hormonal implants can be prescribed by medical practitioners, eligible midwives, and nurse practitioners. Other registered nurses and midwives cannot currently prescribe LARCs.[16]

2.16 Medical practitioners, nurse practitioners, registered nurses, and midwives who have completed appropriate training and education are also able to insert and remove IUDs and hormonal implants where these interventions are in line with their professional scope of practice.[17] Notwithstanding this, however, nurse practitioners and participating midwives can only access the Medicare Benefits

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11 Better Health Channel, *Contraception—the combined pill,* 17 March 2023, www.betterhealth.vic.gov.au/health/healthyliving/contraception-the-pill (accessed 9 April 2023).

12 Better Health Channel, *Contraception—the combined pill.*

13 True Relationships and Reproductive Health, *Combined oral contraceptive pill (COCP),* www.true.org.au/clinic/health-information/contraception/combined-oral-contraceptive-pill-cocp (accessed 15 May 2023).

14 SPHERE, *Submission 5,* p. 4.

15 Department of Health and Aged Care, *Submission 53*, pp. 10–11.

16 Department of Health and Aged Care, *Submission 53*, p. 11.

17 Department of Health and Aged Care, *Submission 53*, p. 11.

Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) if they have a documented collaborative arrangement with a medical practitioner.[18] As a result, patients using registered nurses or midwives for the insertion of LARCs face higher out-of-pocket expenses.

2.17 The limited availability of health practitioners trained in LARC insertion and removal procedures likely impedes their uptake, particularly in rural and remote areas of Australia.[19]

The benefits of long-acting reversible contraceptives

2.18 While a high proportion of Australian women use contraception, unintended pregnancy rates continue to be high, with approximately 10 per cent of women reporting contraceptive failure. These failures can result in significant individual and societal costs.[20]

2.19 Although the OCP is considered a highly effective form of contraception when taken correctly, it has a relatively greater failure rate due to incorrect usage and the requirement that it be administered daily. The efficacy of LARCs, however, are far less user dependent and can almost eradicate contraceptive failure.[21]

2.20 International evidence suggests that increasing the uptake of these forms of contraception can reduce unintended pregnancy and termination rates across all stages of a person's reproductive life.[22] It is estimated that these types of contraceptives are over 99.5 per cent effective, and, although they require a higher up-front cost when compared to OCPs, LARCS are considered to be more cost-effective over time.[23]

2.21 Modelling suggests that if Australian women currently using the OCP were to switch to LARC methods, in line with the uptake in comparable countries, estimated net savings would be $68 million over five years. Further, if women using no contraception were to adopt LARCs, in line with the uptake in comparable countries, the value of avoided terminations and miscarriages was estimated at $20 million over five years.[24]

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18 Department of Health and Aged Care, *Submission 53*, p. 11.

19 SPHERE, *Submission 5*, p. 4.

20 Family Planning New South Wales, *Submission 56*, p. 7.

21 The Pharmacy Guild of Australia (Pharmacy Guild), *Submission 69*, p. 7.

22 Royal Australian College of General Practitioners, *Submission 64*, p. 5.

23 Family Planning New South Wales, *Submission 56*, p. 7.

24 Family Planning New South Wales, *Submission 56*, p. 8.

Emergency oral contraceptives

2.22 Emergency oral contraception is a method of contraception used after sexual intercourse to prevent pregnancy and is often referred to as the 'morning after pill'. There are two emergency contraceptive pills available in Australia: levonorgestrel and ulipristal acetate. If taken within the recommended timeframe, the emergency contraceptive pill is about 85 percent effective in preventing pregnancy, with ulipristal considered slightly more effective than levonorgestrel.[25]

2.23 Both levonorgestrel and ulipristal are available from community pharmacies without a prescription, and their cost can vary between $15 and $60 depending on whether the product contains levonorgestrel or ulipristal.[26]

2.24 If a person is unable to take either of these pills, they can have a copper IUD inserted by a trained doctor or nurse within five days of unprotected sex. This also has the added benefit of being an effective form of long-term contraception.[27]

Contraceptives for men

2.25 There are currently no hormonal male contraceptive therapeutic goods approved for use in Australia, and either condoms or vasectomies remain the only available forms of contraception for men. Notwithstanding this, there are a number of studies on male contraceptive options, including injections of artificial versions of two naturally occurring male hormones, testosterone and progesterone, that stop the body from producing sperm. Most of these studies have shown that male hormonal contraception is an effective method to prevent pregnancy.[28]

2.26 In its submission to the inquiry, the Department of Health and Aged Care (the Department) stated that the Therapeutic Goods Administration (TGA) was not aware of any male contraceptive products for which regulatory approval is currently being sought. It also noted that, for a new prescription medicine to be approved, a sponsor must submit a comprehensive dossier with clinical and scientific data supporting the safety, efficacy, and quality of the product. This would typically include data from large clinical trials.[29]

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25 Pharmacy Guild, *Submission 69*, p. 4.

26 Pharmacy Guild, *Submission 69*, pp. 4–5.

27 Healthdirect Australia, *'Morning after' pill (emergency contraceptive pill)*, January 2021, www.healthdirect.gov.au/morning-after-pill (accessed 9 April 2023).

28 Department of Health and Aged Care, *Submission 53*, p. 15. Please note that implants, tablets, and gels have also been studied.

29 Department of Health and Aged Care, *Submission 53*, p. 15.

Regulation of contraceptives in Australia

The approval process administered by the Therapeutic Goods Administration

2.27 The TGA is responsible for the assessment and regulation of medicines and products in Australia, including contraceptives.[30] The Australian Government also supports access to these products via PBS subsidies and MBS rebates.[31]

2.28 The TGA assesses and approves two main categories of contraception:

- medicines, including prescription and over-the-counter medicines; and
- medical devices, including products that are not medicines but have a physical or barrier effect on the body.[32]

2.29 For medicines to be lawfully supplied in Australia, a sponsor must submit an application so the TGA can establish the acceptable safety, quality, and efficacy of the medicine. Once the medicine is approved, it can be included in the Australian Register of Therapeutic Goods (ARTG)—a register of therapeutic goods which can be legally supplied in Australia—and distributed in Australia by the sponsor.[33]

2.30 There are a number of regulatory pathways available to sponsors, including some with expedited approval times depending on the circumstances. The prescription medicines registration process involves eight phases, including two rounds of assessment and independent expert advice on issues concerning the application, if applicable.[34]

2.31 There are various types of contraceptive medicines included on the ARTG, including the following:

- combined oral contraceptive pill;
- progestin only oral contraceptive pill;
- transdermal patch;
- vaginal ring;
- hormonal IUD;
- injectables; and
- hormonal implants.[35]

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30 The Therapeutic Goods Administration (TGA) does not regulate procedures, and, therefore, does not regulate contraceptive procedures such as sterilisation.

31 Department of Health and Aged Care, *Submission 53*, p. 9.

32 Department of Health and Aged Care, *Submission 53*, p. 9.

33 Department of Health and Aged Care, *Submission 53*, p. 9.

34 Department of Health and Aged Care, *Submission 53*, p. 9.

35 Department of Health and Aged Care, *Submission 53*, p. 9.

2.32 Contraceptives which are medical devices and included in the ARTG include the following:

- fallopian tube clip/band;
- contraceptive cervical cap or diaphragm;
- contraceptive sponge;
- male/female condom with or without spermicides; and
- non-hormonal IUD.[36]

2.33 Australia has a national classification system, known as scheduling, that controls how medicines and chemicals are made available to the public. Schedules are published in the *Poisons Standard* and are given legal effect through state and territory legislation.[37]

2.34 Contraceptives such as the combined OCP and LARCs are classified as prescription medicines under Schedule 4 of the *Poisons Standard*. Under this standard, a pharmacist can only dispense these types of medicines in accordance with a health practitioner's prescription, unless the law of a local jurisdiction permits otherwise.[38]

Pharmaceutical Benefits Scheme subsidies

2.35 Once a sponsor has a medicine included on the ARTG, it is the sponsor's decision whether to make a submission to the Pharmaceutical Benefits Advisory Committee (PBAC) for approval under the PBS. The PBAC is an independent expert body appointed by the Government, and its members include doctors, health professionals, health economists and consumer representatives. Its primary role is to recommend new medicines for listing on the PBS, and no new medicine can be listed unless it makes a positive recommendation.[39]

2.36 When recommending a medicine for listing, the PBAC takes into account the medical conditions for which the medicine was registered for use in Australia,

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36 Department of Health and Aged Care, *Submission 53*, p. 9.

37 Department of Health and Aged Care, *Submission 53*, p. 10. The *Poisons Standard* is a record of decisions on the classification of medicines and chemicals into Schedules. It also includes model provisions for containers and labels, and recommendations about other controls on medicines and chemicals. For further information, see: TGA, *The Poisons Standard (the SUSMP)*, www.tga.gov.au/how-we-regulate/ingredients-and-scheduling-medicines-and-chemicals/poisons-standard-and-scheduling-medicines-and-chemicals/poisons-standard-susmp-0.

38 Department of Health and Aged Care, *Submission 53*, p. 10.

39 Department of Health and Aged Care, *The Pharmaceutical Benefits Scheme*, 9 March 2023, www.pbs.gov.au/info/industry/listing/participants/pbac (accessed 16 May 2023).

its clinical effectiveness, safety, and cost-effectiveness when compared to other treatments.[40]

2.37 There are some cases where a sponsor may choose to not make a submission to the PBAC for approval under the PBS, for example because of the cost involved and the economic impact on them or because they are still trying to settle into the Australian market.[41]

2.38 There are currently 23 brands of contraceptives listed on the PBS Schedule. The majority of these brands relate to oral contraceptives; however, the schedule also includes LARCs and injectables.[42] Although subsidies are available for hormonal implants, injections, and hormonal IUD LARCs, copper IUDs are not currently covered by the PBS.[43] In total, there are currently 26 contraceptive brands marketed in Australia which are not on the PBS.[44]

2.39 For the majority of PBS-listed medicines, patients make a single co-payment for one month's supply of medicine; however, for PBS-listed oral contraceptives, patients pay only one co-payment for four months' supply. Up to two repeats may also be prescribed, allowing for the provision of up to one year's supply of medication without requiring a new prescription from a prescribing health practitioner.[45]

2.40 From 1 January 2023, general patients who have a Medicare card pay up to $30 for their PBS medicines, whereas concessional patients pay up to $7.30. The Government pays the remaining cost, known as the Commonwealth subsidy, where applicable.[46] In 2021–22, the Government spent over $54 million on PBS-listed contraceptives.[47]

Medicare Benefits Schedule rebates

2.41 The Government also supports access to services associated with the provision of contraceptives through MBS patient rebates for appointments with nurse

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40 Department of Health and Aged Care, *The Pharmaceutical Benefits Scheme*, 9 March 2023, www.pbs.gov.au/info/industry/listing/participants/pbac (accessed 16 May 2023).

41 Adjunct Professor Robyn Langham AM, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard*, 28 April 2023, p. 60.

42 Department of Health and Aged Care, answers to questions on notice, 28 February 2023 (received 30 March 2023).

43 Department of Health and Aged Care, *Submission 53*, p. 10.

44 Department of Health and Aged Care, *Submission 53*, Attachment 1, pp. 1–2.

45 Department of Health and Aged Care, answers to questions on notice, 28 February 2023 (received 30 March 2023).

46 Department of Health and Aged Care, answers to questions on notice, 28 February 2023 (received 30 March 2023).

47 Department of Health and Aged Care, *Submission 53*, p. 10.

practitioners, midwives, and GPs (general practitioners), as well as specialist consultations and procedural services.[48]

Barriers to accessing contraceptives in Australia

2.42 Inquiry participants highlighted numerous barriers that individuals encounter when attempting to access effective contraception in Australia. As discussed in greater detail below, these included:

- a lengthy and expensive TGA approval process;
- regulatory restrictions limiting the role of pharmacists;
- high financial costs;
- inadequate incentives for medical practitioners to bulk-bill;
- contraceptives not available on the PBS;
- ineligibility to enrol in Medicare;
- a lack of community awareness of LARCS and available health practitioner training;
- limited access in rural and remote regions and First Nations communities;
- limited access to relevant services in public hospitals;
- limited support for nurses and midwives; and
- a lack of male contraceptive options.

Regulatory barriers

Lengthy and expensive TGA and PBAC approval processes

2.43 It was argued during the inquiry that the assessment and approval of new and effective contraceptive methods in Australia can be a long and expensive process. Family Planning Alliance Australia (FPAA) stated that this can result in 'significant delays' to the community being able to access new contraceptive options.[49] It submitted that the 12-month vaginal ring and desogestral mini pill are already available in parts of Europe, Asia, and the United States, and that the mini pill also has a low-cost generic option available worldwide, except in Australia.[50]

2.44 Women's Health in the South East argued that the TGA has historically taken a 'very conservative and cautious approach' to the approval of new contraceptives. Given this, it said:

> Australia now lags comparable settings such as the United States and the United Kingdom, where new contraceptive methods, such as the combined

48 Department of Health and Aged Care, *Submission 53*, p. 10.

49 Family Planning Alliance Australia, *Submission 63*, p. 3.

50 Family Planning Alliance Australia, *Submission 63*, p. 3.

> contraceptive patch, and self-administered progesterone injection, have been introduced.[51]

2.45 The Royal Australian College of General Practitioners (RACGP) said that the high costs of registration could be a deterrence for some pharmaceutical organisations entering the Australian market and could potentially result in reduced domestic access to otherwise safe and effective contraceptives that are already available in other similar jurisdictions.[52]

2.46 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) also noted the expensive nature of the approval process and the limiting impact it can have on the accessibility of contraceptives by women in Australia.[53]

2.47 In her evidence to the inquiry, the Chief Executive Officer of Family Planning Australia, Adjunct Professor Brassil, noted the 'length and turgidness' of the approval process, and argued that it could be 'very much speeded up'.[54]

2.48 Several witnesses noted that pharmaceutical companies cannot be compelled to apply to the PBAC for PBS listing of their medications. Asked about particular hurdles that could discourage companies from seeking inclusion on the PBS, a Senior Vice President and National Councillor at the Pharmacy Guild, Ms Natalie Willis of the Pharmacy Guild of Australia (Pharmacy Guild), told the committee:

> I would only be guessing, but I would imagine it is because they have to meet a cost-effectiveness challenge. They have to be put up against existing oral contraceptives that have been on the market for decades, and somehow prove that they are a more cost-effective or more effective option. In the case of contraception, where it either works or it doesn't it's a little bit difficult to prove that it works better. A lot of the other measures of effectiveness are subjective. I think it's probably a difficult process to be able to navigate.[55]

2.49 However, the Department submitted that the costs of the PBAC process are 'in no way prohibitive for pharmaceutical companies' and posited:

> In some cases, pharmaceutical companies choose not to go through a PBS listing because they want to charge a different amount; they want to be able

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51 Women's Health in the South East, *Submission 51,* p. 4.

52 Royal Australian College of General Practitioners, *Submission 64,* p. 5.

53 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Submission 65,* p. 4.

54 Adjunct Professor Ann Brassil, Chief Executive Officer, Family Planning Australia, *Committee Hansard,* 21 February 2023, p. 28.

55 Natalie Willis, Senior Vice President and National Councillor, Western Australia Branch, Pharmacy Guild, *Committee Hansard,* 28 February 2023, p. 35.

> to set their own prices. In some cases, it may be that they don't think the market is big enough. The reasons will vary.[56]

2.50 It was also highlighted that there are duplicative processes between the TGA and the PBAC. On this issue, the TGA's Chief Medical Adviser, Adjunct Professor Robyn Langham AM, stated the following:

> I know that there are often parallel and duplicative processes that run within the two. The PBS often don't just do an evaluation of cost alone, but do have their own almost parallel assessment of efficacy and safety[57]

Regulatory restrictions limiting the role of pharmacists

2.51 Various regulatory restrictions limiting the role of pharmacists were raised as key barriers to contraceptive access across Australia. For example, OCPs are currently listed as prescription medications under Schedule 4 of the *Poisons Standard*, and pharmacists are unable to prescribe these forms of contraception. This requires patients to obtain a prescription elsewhere, commonly through their GP.

2.52 This situation was seen as particularly problematic given the ongoing shortage of GPs, with evidence from the Pharmacy Guild suggesting that 11 per cent of women miss their OCPs due to difficulty in accessing a GP for a new prescription, and that the average number of days that patients wait for their GP appointment had increased in every state and territory in Australia between 2019 and 2022.[58]

2.53 This chronic shortage of GPs was also highlighted in a recently released report by the Australian Medical Association (AMA) which confirmed that the supply of GPs is not keeping pace with growing community demand, and that Australia is facing a shortage of more than 10 600 GPs by 2031.[59] The Senate Community Affairs References Committee also explored this issue for outer metropolitan, rural, and regional areas in an inquiry during the 46th parliament and came to similar conclusions.[60]

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56 Ms Tania Rishniw, Deputy Secretary, Primary and Community Care, Department of Health and Aged Care, *Committee Hansard,* 28 February 2023, p. 51.

57 Adjunct Professor Robyn Langham AM, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard,* 28 April 2023, p. 61.

58 Pharmacy Guild, *Submission 69*, p. 5.

59 Australian Medical Association, 'AMA report confirms staggering undersupply of GPs in next two decades', *Media release,* 25 November 2022, www.ama.com.au/media/ama-report-confirms-staggering-undersupply-gps-next-two-decades (accessed 30 April 2023).

60 For further information, see: Senate Community Affairs References Committee, *Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians,* 30 June 2022.

2.54 The 2023–24 Budget provided significant measures to strengthen and support the medical and health workforce. This included higher incentives to expand multidisciplinary team care in general practice, more Medicare Urgent Care Clinics and better access to after-hours primary care.[61]

2.55 The Pharmacy Guild argued that the requirement for patients to have a valid prescription for the ongoing supply of OCPs, even while stable on therapy, created an additional barrier and may lead to inconsistent administration of oral contraceptives—which could result in an unintended pregnancy.[62]

2.56 The Pharmacy Guild also submitted that patients taking non-PBS listed oral contraceptives are disadvantaged by having to rely on state and territory emergency supply legislation for urgent ongoing medicine supply—with jurisdictional variations in the amount that can be supplied making access inequitable. For example, some jurisdictions only allow a pharmacist to supply three days' worth of medicine, whereas others allow up to one months' worth.[63]

2.57 To improve contraceptive accessibility across Australia, a number of inquiry participants called for an expanded role for pharmacists.[64] On this proposal, Ms Natalie Willis of the Pharmacy Guild, said:

> At a time when Australia's healthcare system is being stretched like never before both financially and in terms of patient access, it's imperative that all healthcare professionals are working to their top of scope. Service gaps in contraceptive and reproductive health care could be addressed by allowing appropriately trained community pharmacists to work to their full scope of practice using their professional training, skills and knowledge to be able to prescribe, dispense, administer and review medicines, including contraceptives.[65]

2.58 It was also noted by the Pharmacy Guild that community pharmacies are the most accessible health destinations in Australia, with approximately 97 per cent of people in capital cities having access to at least one pharmacy within a 2.5-kilometre radius, and 66 per cent of the rest of the Australian population living and working within a 2.5-kilometre radius of one.[66] It was highlighted

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61 Department of Health and Aged Care, *Building a stronger Medicare,* May 2023, https://www.health.gov.au/sites/default/files/2023-05/building-a-stronger-medicare-budget-2023-24_0.pdf.

62 Pharmacy Guild, *Submission 69*, p. 5.

63 Pharmacy Guild, *Submission 69*, p. 4.

64 For example, see: Pharmacy Guild, *Submission 69,* p. 3; Family Planning Alliance Australia, *Submission 63,* p. 3; Family Planning New South Wales, *Submission 56*, pp. 6–7; Children by Choice, *Submission 60*, p. 9.

65 Ms Natalie Willis, Senior Vice President and National Councillor, Western Australia Branch, Pharmacy Guild, *Committee Hansard,* 28 February 2023, p. 32.

66 Pharmacy Guild, *Submission 69,* p. 10.

that the majority of pharmacies have extended opening times, including after-hours and on weekends, and many also have consultation rooms that can provide for private consultations.[67]

2.59 Endorsing the perspective that pharmacists should have an enhanced role, New South Wales (NSW) Health recently announced a state-wide pilot for appropriately trained community pharmacists to prescribe certain medications for urinary tract infections and to allow the resupply of previously prescribed low-risk oral contraceptive medication for women aged between 18 and 35, inclusive.[68]

2.60 A similar trial designed to allow pharmacists to practice to their full scope has also been announced by the Queensland Government for Northern Queensland. This pilot is expected to commence in the latter half of 2023 and run through to May 2025.[69]

2.61 In contrast, the RACGP argued that pharmacists are not trained to conduct consultations regarding contraception and do not have access to a patient's full medical history,[70] and the AMA expressed its strong objection to the down-scheduling of oral contraceptives to permit over-the-counter dispensing and pharmacists being able to prescribe various contraceptive medications.[71]

2.62 It was also noted that two applications submitted to the TGA in 2021 to amend the *Poisons Standard* to down schedule OCPs were unsuccessful, with the delegate deciding at that time that OCPs were unsuitable for down-scheduling due to the complexity of risk factors, adverse effects, and interactions that necessitate regular medical reviews with a GP.[72]

2.63 The Government has announced a National Scope of Practice Review (the Review), which has been designed in response to the Strengthening Medicare Taskforce Report. The Review will commence in late 2023 with the intent to

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67 Pharmacy Guild, *Submission 69*, p. 2.

68 New South Wales (NSW) Health, *NSW Pharmacy Trial*, 15 May 2023, www.health.nsw.gov.au/pharmaceutical/Pages/community-pharmacy-pilot.aspx (accessed 22 May 2023). Please note the trial is restricted to the resupply of low-risk oral contraceptive medication that has been prescribed to women aged from 18 to 35 years, inclusive, for contraceptive purposes in the last two years by a GP or nurse practitioner.

69 Queensland Health, *North Queensland Community Pharmacy Scope of Practice Pilot*, 23 March 2023, www.health.qld.gov.au/ahwac/html/nqpharmacypilot/overview (accessed 16 May 2023).

70 Royal Australian College of General Practitioners, *Submission 64*, p. 7.

71 Australian Medical Association, *Submission 71*, p. 3. Down-scheduling refers to making a medicine more widely available for a variety of reasons.

72 Pharmacy Guild, *Submission 69*, p. 5.

review 'barriers and incentives for all health professionals to work to their full scope of practice'.[73]

Financial barriers

High financial costs for contraceptives

2.64 The high financial costs of accessing contraceptives were seen as a key barrier to their universal access. The Queensland Nurses and Midwives' Union stated that this problem was particularly acute for young, socioeconomically disadvantaged women, and refugees, and that it could be compounded by further associated expenses, such as GP appointments.[74]

2.65 FPAA argued that the cost of LARCs, in particular, could be a prohibiting factor for many people, especially those without access to Medicare.[75] Organon submitted that clinicians servicing rural and remote areas of Australia specifically identified this as an obstacle to increasing their uptake.[76]

2.66 Organon also referenced a study on post-abortion contraception choice which noted that some women—particularly those who were younger or from areas of high socioeconomic disadvantage—may have difficulty finding the extra money required for the upfront payment of their preferred LARC method.[77]

2.67 Given these barriers, numerous participants called for free contraception to be made available in Australia.[78] It was argued that if contraceptives, including condoms, were provided for free, unintended pregnancies and terminations would reduce. It was also noted that such a policy could have the added benefit of reducing sexually transmissible infections within the community.[79]

2.68 Submitters indicated that a number of other comparable countries, including France, Sweden, the United Kingdom, and New Zealand, already offer no-cost

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73 Department of Health and Aged Care, *Summary of strengthening Medicare policies*, 28 April 2023, www.health.gov.au/resources/publications/summary-of-strengthening-medicare-policies (accessed 18 May 2023).

74 Queensland Nurses and Midwives' Union, *Submission 29*, p. 6.

75 Family Planning Alliance Australia, *Submission 63*, p. 3.

76 Organon, *Submission 3*, p. 13.

77 Organon, *Submission 3*, p. 13.

78 For example, see Australian College of Midwives, *Submission 30*, p. 4; Organon, *Submission 3*, p. 13; Women's Health in the North, *Submission 108*, p. 7; South Australian Abortion Action Coalition, *Submission 122*, p. 5; Gippsland Family Violence Alliance, *Submission 123*, p. 6; Victorian Women's Health Services, *Submission 134*, p. 6; Aboriginal Health Council of South Australia, *Submission 144*, [p. 1]; Melbourne School of Population and Global Health, *Submission 84*, p. 4.

79 Australian College of Midwives, *Submission 30*, p. 4.

contraception for various demographics, such as people under a certain age.[80] In France's case, evidence suggested that once contraception was made free, the number of terminations decreased materially—from 9.5 per cent in 2012 to 6 per cent in 2018.[81]

2.69 Research undertaken in the United States also concluded that girls and women who were provided contraception at no cost—and educated about reversible contraception and the benefits of LARCs—had rates of pregnancy, birth, and termination that were much lower than national rates for sexually active teens.[82]

Inadequate incentives for medical practitioners to bulk-bill

2.70 During the inquiry, it was argued that the current MBS rebates for contraceptive procedures performed by GPs do not provide sufficient remuneration for bulk-billed services to be financially viable for GP practices and community service clinics. RANZCOG submitted that this has resulted in service providers having to charge their patients a gap payment to perform these procedures, which can be prohibitive to those individuals with limited financial resources.[83]

2.71 The Southern Regional Medical Officer at True Relationships and Reproductive Health, Dr Danielle Haller, said that the MBS item number for IUD insertions was 'woefully inadequate'. Expanding on this, she said:

> … it takes 45 minutes at least for the consultation, including the paperwork and the insertion. An IUD pack that we need to use for that is $25, and a nurse is required for the full 45 minutes as well. All in all, we get $72 from the MBS for that particular procedure, so that definitely doesn't cover costs there.[84]

2.72 The President of the RACGP, Dr Nicole Higgins, said:

> For the last 10 years [the MBS rebate] has been frozen, and the indexation was at only 1.6 per cent last year. So it is still effectively frozen as inflation goes up. For a long time general practice has subsidised Medicare on behalf of patients, because very often if we are going to bulk bill that means we are accepting that as full payment and we can no longer afford to subsidise.[85]

2.73 In its submission to the inquiry, the RACGP also highlighted that this lack of adequate remuneration was a potential cause for the low number of LARC

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80 For example, see: Peninsula Health, *Submission 124,* p. 2; Women's Health in the South East, *Submission 51,* p. 4.

81 Australian College of Midwives, *Submission 30,* p. 4.

82 Organon, *Submission 3,* p. 13.

83 RANZCOG, *Submission 65,* pp. 4–5.

84 Dr Danielle Haller, Regional Medical Officer, Southern, True Relationships and Reproductive Health, *Committee Hansard,* 22 February 2023, p. 1.

85 Dr Nicole Higgins, President, Royal Australian College of General Practitioners, *Committee Hansard,* 28 February 2023, p. 11.

service providers in Australia, particularly in rural and remote areas.[86] To address this issue and ensure that GPs are adequately remunerated if they choose to bulk-bill, both RANZCOG and RACGP called for increased Medicare benefits.[87]

2.74 The committee notes the recent 2023–24 Budget announcements from the Australian Government, that included $3.5 billion to triple the bulk bill incentive to make healthcare more affordable for 11.6 million children under 16, pensioners and other Commonwealth concession card holders, as well as the introduction of a longer level E consult.[88]

2.75 The committee also notes that through the 2023–24 Budget, the Government has provided a $1.5 billion indexation increase to the Medicare rebates and invested $3.5 billion to triple the bulk billing incentive to address the decline in bulk billing rates over recent years.[89]

2.76 In addition to inadequate remuneration for GPs, other inquiry participants also highlighted the lack of financial support for nurse practitioners and participating midwives in the insertion of LARCs.[90] This issue is discussed further in this chapter.

Contraceptives not available on the PBS

New oral contraceptives

2.77 Oral contraceptives can either contain estrogen and progestogen, together, or progestogen only. For contraceptive use, the PBS only subsidises oral products containing ethinylestradiol (estrogen) combined with either levonorgestrel or norethisterone (progestogen), as well as progestogen only contraceptives containing either levonorgestrel or norethisterone alone.[91]

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86 Royal Australian College of General Practitioners, *Submission 64*, p. 5.

87 RANZCOG, *Submission 65*, pp. 4–5; Royal Australian College of General Practitioners, *Submission 64*, p. 6.

88 Department of Health and Aged Care, *Building a stronger Medicare*, May 2023, https://www.health.gov.au/sites/default/files/2023-05/building-a-stronger-medicare-budget-2023-24_0.pdf; Commonwealth of Australia, *Women's Budget Statement 2023–24*, p. 75.

89 Department of Health and Aged Care, *Building a stronger Medicare*, May 2023, https://www.health.gov.au/sites/default/files/2023-05/building-a-stronger-medicare-budget-2023-24_0.pdf.

90 For example, see: Family Planning New South Wales, *Submission 56*, p. 8; SPHERE, *Submission 5*, p. 4.

91 Pharmacy Guild, *Submission 69*, p. 3.

2.78 Like many medicines, oral contraceptive technologies have continued to evolve over time and products containing newer estrogens and progestogens to those currently listed on the PBS are now available.[92]

2.79 Ms Natalie Willis from the Pharmacy Guild said:

> I don't think an oral contraceptive has been listed on the PBS certainly in my 25 years as a pharmacist. The ones that are there are some of the original ones that are historically the go to. There's been a considerable evolution of technology over that time, and the new pills offer greater benefits to women in terms of reduced side-effects, reduced dosages, better effectiveness for certain medical conditions other than contraception—these sorts of things. None of these oral contraceptives have been listed on the PBS, which is restricting access. Some of them can be as much as $70 or $80 for a three-month course. That is certainly a barrier to access.[93]

2.80 The Chief Executive Officer of the Coffs Harbour Women's Health Centre, Ms Shelley Rowe, said:

> Currently we only have two that are covered by the PBS, one of which is rarely available. The rest of the oral contraceptive pills are private scripts, which is a huge gap in financial costs for women. For some women, that's not viable, because it's the difference between paying $1.50 to $3 a month and paying up to $25 to $29 a month. So it's huge. For some women, that's not doable.[94]

2.81 RANZCOG noted the limiting and inequitable nature of the PBS, which only covers the basic OCPs, when alternative formulations may be more appropriate for particular patients when they help reduce androgen symptoms, such as acne and hirsutism. It argued that with more choice there will be 'higher acceptability, satisfaction, and continuation rates'.[95]

2.82 Dr Danielle Haller, a regional medical officer at True Relationships and Reproductive Health, noted that some PBS-listed OCPs could be less effective as 'clients stop taking the pill because they get moody' or miss pills because of the limited timeframe within which some OCPs must be taken each day to retain their effectiveness. She also noted that a non-PBS listed OCP with no oestrogen 'has a great place for people who can't take oestrogen, because they've had

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92 Pharmacy Guild, *Submission 69*, p. 4.

93 Ms Natalie Willis, Senior Vice President and National Councillor, Western Australia Branch, Pharmacy Guild, *Committee Hansard,* 28 February 2023, pp. 33–34.

94 Ms Shelley Rowe, Chief Executive Officer, Coffs Harbour Women's Health Centre, *Committee Hansard,* 21 February 2023, p. 14.

95 RANZCOG, *Submission 65*, p. 4.

blood clots or migraines' but was significantly more expensive than PBS listed options.[96]

2.83 In its submission, the RACGP stated that not having newer forms of OCP listed on the PBS 'limits access of these contraceptives to people who can obtain a private prescription and pay to receive the script'.[97]

2.84 The Pharmacy Guild highlighted that, although a large study conducted in Europe and the United States found that some newer oral contraceptives have a more favourable safety profile than ethinylestradiol-based oral contraceptives, these contraceptives are only available on non-PBS prescriptions in Australia.[98] It stated that this can 'place an unreasonable financial burden on patients wishing to use them'. The Pharmacy Guild further argued that:

> For individuals where a non-PBS listed product is most appropriate, the cost of non-PBS listed products may become a barrier to the use of effective contraception, limit patient choice and cause inequity of access.[99]

Emergency oral contraceptives

2.85 There are currently two types of emergency oral contraceptive pills available in Australia: levonorgestrel and ulipristal acetate, and, according to evidence from the Pharmacy Guild, if taken within the recommended timeframe, they are approximately 85 per cent effective in preventing a pregnancy.[100]

2.86 The two types of emergency contraceptive pills are available through community pharmacies without a prescription, they are not currently listed on the PBS and can cost anywhere between $15 and $60—depending on the specific vendor and which medication the product contains.[101] This can create a significant financial barrier for many women, especially those on low incomes.

Long-acting reversible contraceptives

2.87 Currently, a number of effective LARCs are not listed on the PBS, including the vaginal ring and the copper IUD. It was argued that this lack of rebate limits access to these forms of long-term, and, in the case of the copper IUD, emergency, contraceptive devices to those who can afford a private prescription.[102]

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96 Dr Danielle Haller, Regional Medical Officer, Southern, True Relationships and Reproductive Health, *Committer Hansard,* 22 February 2023, p. 4.

97 Royal Australian College of General Practitioners, *Submission 64*, p. 5.

98 Pharmacy Guild, *Submission 69*, p. 4.

99 Pharmacy Guild, *Submission 69*, p. 4.

100 Pharmacy Guild, *Submission 69*, p. 4.

101 Pharmacy Guild, *Submission 69*, pp. 4–5.

102 Royal Australian College of General Practitioners, *Submission 64*, p. 5.

2.88 This issue was raised by a number of inquiry participants as a key barrier to accessing contraception, with RANZCOG and Children by Choice advocating for the PBS to subsidise the vaginal ring to improve its affordability. RANZCOG also noted that increasing community awareness of this form of contraception may be beneficial in the future when multipurpose vaginal rings—preventing not only pregnancy, but also, potentially, the human immunodeficiency virus and other sexually transmitted infections—become available.[103]

2.89 Of particular concern to Family Planning NSW (FPNSW) was the exclusion of the copper IUD from the PBS, resulting in higher costs, or total inaccessibility, for patients—even when this form of contraception was assessed as the most effective method for them.[104] FPNSW and RACGP argued for it to be available on the PBS for those requiring, or desiring, a non-hormonal LARC, as well as for those seeking effective emergency contraception with a longer-term application.[105]

2.90 In her evidence to the inquiry, the Acting Deputy Secretary of the Health Products Regulation Group within the Department, Ms Tracey Duffy, indicated that inclusion of the copper IUD on the PBS would not be possible due it being a medical device. On this issue, she said:

> [A copper IUD] is a device and [the] PBS is about pharmaceutical medicines. We don't have an equivalent list for devices, other than the devices that are on the Prostheses List for the purpose of private health insurance. So there's no equivalent PBS for devices.[106]

Inability to enrol in Medicare

2.91 Due to the PBS only being available to Australian residents who hold a Medicare card, temporary migrants, including international students and temporary workers, are not eligible to receive subsidised medication.[107] The Multicultural Centre for Women's Health (MCWH) noted the wide-reaching negative impacts this policy can have on these migrant communities, including basic healthcare needs not being met, additional private health insurance and out-of-pocket expenses, and adverse psychosocial outcomes.[108]

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103 RANZCOG, *Submission 65*, p. 4; Children by Choice, *Submission 60*, p. 9.

104 Family Planning New South Wales, *Submission 56*, p. 8.

105 Family Planning New South Wales, *Submission 56*, p. 3; Royal Australian College of General Practitioners, *Submission 64*, p. 6.

106 Ms Tracey Duffey, Acting Deputy Secretary, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard*, 28 April 2023, p. 62.

107 Multicultural Centre for Women's Health, *Submission 102*, p. 5.

108 Multicultural Centre for Women's Health, *Submission 102*, p. 5. Barriers experienced by migrants are discussed in more detail in Chapter 4.

2.92 The MCWH said that, even if the Government were to include additional contraceptives on the PBS, this would not improve affordability for these ineligible communities. In fact, evidence stated such a policy would likely widen the health inequity across various cohorts of people living in Australia.[109]

2.93 RANZCOG also raised this issue, stating that the cost of contraceptive services can be prohibitive for people who are ineligible for Medicare, especially if they require procedures in the office or under anaesthesia. It called for contraceptive services to be free for all clients 'regardless of visa status'.[110]

2.94 MCWH also called for reform and submitted that:

> Access to free or lower cost contraception, and a wider range of contraceptive options should be widely available to everyone, regardless of visa category. Extending Medicare should not be regarded as a radical or innovative solution but should be seen as a necessary requirement for universal access for all people living in Australia.[111]

Accessing contraceptives

Lack of awareness and training opportunities

2.95 It was argued that Australia has not sufficiently invested in community and professional education about the benefits and higher comparable effectiveness of LARCs over OCPs. FPNSW stated that, because of this lack of investment, neither health practitioners nor women were clear about the relative efficacy of LARCs and, as a result, often chose traditional methods of contraception. It concluded that this resulted in 'higher rates of unplanned pregnancy, higher abortion rates and higher costs for contraception'.[112]

2.96 SPHERE said that this lack of familiarity and misinformation about LARCS among both women and health practitioners was another key barrier to their uptake.[113]

2.97 Evidence also indicated that there are minimal training opportunities available in community settings for the insertion and removal of IUDs and implants, and that there is no integrated approach to the provision of contraceptive care

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109 Multicultural Centre for Women's Health, *Submission 102*, pp. 5–6.

110 RANZCOG, *Submission 65*, p. 4.

111 Multicultural Centre for Women's Health, *Submission 102*, pp. 5–6.

112 Family Planning New South Wales, *Submission 56*, p. 8.

113 SPHERE, *Submission 5*, p. 4.

training.[114] This was identified as a key barrier to the broader uptake of LARCs within the community.[115]

2.98 Professor Danielle Mazza highlighted the importance of the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCAPPS) and called for its ongoing funding—which is due to cease in early 2024. It was noted that this initiative brings together key stakeholders and offers peer networking, support for clinical issues, a resource library, checklists, training links, webinars, podcasts, case discussions, and a database of local providers.[116]

Limited access in rural and remote regions and First Nations communities

2.99 The committee heard that accessing health services continues to be a challenge within rural and remote regions, as well as First Nations communities. Additionally, long wait times to access GPs in these regions and communities remain problematic, especially for people seeking contraception access and script renewals.[117]

2.100 Rural and remote women are also more likely to experience domestic and family violence, and have higher rates of unplanned pregnancies, infant mortalities, and low birthweights and preterm babies. It was reported that these rates also increase with remoteness—an outcome which was thought to be associated with poorer access to health services.[118]

2.101 Contraceptive use among First Nations communities is reportedly lower than for non-Indigenous Australians. A number of contributing factors were suggested for this, including potential apprehension due to historical experience with forced contraceptive use and the removal of children, stigmatisation, lack of sexual health education and limited access to contraceptives.[119]

2.102 While First Nations Australians have a range of options of primary healthcare providers, a large majority prefer to access care through an Aboriginal Community Controlled Health Organisation (ACCHO). This can be due to a variety of reasons, including locality, cultural safety, and holistic service offerings. Although it was reported that condoms are readily available from these organisations, the Aboriginal Health and Medical Research Council

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114 SPHERE, *Submission 5*, p. 4.

115 Royal Australian College of General Practitioners, *Submission 64*, p. 6.

116 Professor Danielle Mazza, *Submission 161*, p. 7.

117 Royal Australian College of General Practitioners, *Submission 64*, p. 6.

118 National Rural Health Commissioner, *Submission 72*, p. 3.

119 Aboriginal Health and Medical Research Council of NSW, *Submission 55*, [p. 3].

of NSW (AHMRC) said the primary challenge was increasing access to LARCs and insertion services.[120]

2.103 The AHMRC noted that ACCHOs are currently restricted in their ability to provide these services due to limited access to GPs, gynaecologists, trained nurses, and midwives who can perform insertions and removals. It also noted the constraints on the reimbursement that can be claimed through Medicare when eligible nurses or midwives perform these services.[121]

2.104 Where an ACCHO is unable to provide these services directly, patients are often referred to non-community controlled services, which may be culturally unsafe and attract out-of-pocket costs—both of which discourage uptake.[122]

2.105 Evidence also suggested that the limited availability of health practitioners trained in LARC insertion and removal procedures in non-metropolitan Australia likely impedes the increased uptake of these effective forms of contraception.[123]

2.106 To address these issues, SPHERE proposed that a comprehensive and integrated approach to regional contraceptive care be developed and implemented. It envisaged that this would identify existing gaps in service provision at the local level, with specific consideration for the needs of regional, rural, and remote communities.[124]

Limited access to services in public hospitals

2.107 Access to private sector healthcare providers is not always possible for people living in rural and remote areas, as well as for those people with limited financial resources. Given this, RANZCOG argued during the inquiry that the provision of public hospital based contraceptive services was important in ensuring equitable access across Australia.[125]

2.108 RANZCOG submitted that public hospitals should have clinics and theatre lists dedicated to the provision of contraceptive services to their communities, and that increasing access to free outpatient procedures, especially in rural and remote areas, was key to reducing the disparities that currently exist across

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120 Aboriginal Health and Medical Research Council of NSW, *Submission 55*, [p. 3].

121 Aboriginal Health and Medical Research Council of NSW, *Submission 55*, [p. 4].

122 Aboriginal Health and Medical Research Council of NSW, *Submission 55*, [p. 4].

123 Professor Danielle Mazza, *Submission 161*, p. 6.

124 SPHERE, *Submission 5*, p. 5.

125 RANZCOG, *Submission 65*, p. 5.

Australia—with rural women being 1.4 times more likely to have an unintended pregnancy.[126]

2.109 In addition to this proposal, a number of inquiry participants advocated for postpartum LARC services to be available at hospitals prior to discharge, complemented by increased access to antenatal and postnatal contraceptive counselling.[127]

Limited support for nurses and midwives

2.110 Although registered nurse-led assessment, insertion and removal of implants and IUDs is already taking place in Australia, limited financial support was seen as a barrier to the provision of these services by these health practitioners. FPNSW submitted that nurses lack access to the MBS and other sustainable funding sources and stated that this severely limits the provision of LARCs and reduces access to these effective forms of contraception in areas of unmet need.[128]

2.111 Adjunct Professor Brassil said that FPNSW had undertaken research demonstrating that registered nurses and doctors who had gone through the same training program had had similar academic and clinical outcomes in the insertion and removal of IUDs and implants. Notwithstanding this, she said that discrepancies in remuneration arrangements continued to exist:

> … there's no income stream for nurses to provide these services, whereas GPs can charge Medicare. There are some very partial arrangements for funding nurses in GP practices, but they don't cover full wages and they're really quite inadequate for nurses to actually be able to sustain a career providing these services.
>
> If we could have these highly trained and competent nurses available, particularly in areas where GPs aren't available, we could provide the same level of services to our clients or our patients.[129]

2.112 A Women's Health Nurse at the Lismore Women's Health Resource Centre, Ms Amala Sheridan-Hulme, said:

> I don't see, in my line of work, a shortage of nurses to actually fill roles, particularly in out-of-hospital community based organisations. The biggest issue that I see is that nurses aren't included in Medicare rebates. So, whilst there are trained staff like me who can do cervical screening tests, Implanon insertions, IUD insertions, just to name a few—and there are a lot of other things that nurses can actually do, particularly midwives—there's no incentive for either private clinics or non-government organisation clinics, I

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126 RANZCOG, *Submission 65,* p. 5.

127 For example, see: RANZCOG, *Submission 65*, p. 5; SPHERE, *Submission 5*, p. 5; Melbourne School of Population and Global Health, *Submission 84,* p. 11.

128 Family Planning New South Wales, *Submission 56*, p. 8.

129 Adjunct Professor Ann Brassil, Chief Executive Officer, Family Planning Australia, *Committee Hansard,* 21 February 2023, p. 25.

> guess, to train up their staff to do this if they can't get those rebates to make it worth their while.[130]

2.113 Dr Haller from True Relationships and Reproductive Health also recognised this lack of utilisation of an existing workforce due to inadequate remuneration arrangements. She said:

> … there is underutilisation of the current resources that we have. For example, nurse practitioners who insert IUDs and Implanons can't actually access the Implanon and IUD insertion MBS item numbers. [T]hey would be a great resource to do … those things.[131]

2.114 SPHERE also commented on this problem, stating the following:

> Although registered nurses, nurse practitioners and registered midwives are well-placed to provide LARC insertion and removal services, as occurs in many other countries and in some settings in Australia, there is no remuneration available to support this model of task-shifting/sharing or to encourage nurses and midwives to undertake the training or provide this service.[132]

2.115 The Chief Executive Officer at Sexual Health and Family Planning ACT, Mr Tim Bavinton, said:

> … the Australian healthcare system does not deploy nurses well the way that Medicare is structured. To exclude most nursing services means we are not making best use of our nursing, from our EN [enrolled nurse], RN [registered nurse], advanced practice and our nurse practitioner workforce in Australia in this area, as in many others.[133]

2.116 The Australian Women's Health Nurse Association stated that by better supporting nurses and midwives to work to their full scope of practice in contraceptive care, Australia's health workforce could be expanded.[134] The Melbourne School of Population and Global Health argued that this would facilitate equitable access to LARCs and that these health practitioners were well placed to provide these services.[135]

2.117 A Senior Federal Professional Officer at the Australian Nursing and Midwifery Federation, Ms Julianne Bryce, said:

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130 Ms Amala Sheridan-Hulme, Women's Health Nurse, Lismore Women's Health and Resource Centre, *Committee Hansard,* 21 February 2023, p. 12.

131 Dr Danielle Haller, Regional Medical Officer, Southern, True Relationships and Reproductive Health, *Committee Hansard,* 22 February 2023, p. 1.

132 SPHERE, *Submission 5*, p. 4.

133 Mr Tim Bavinton, Chief Executive Officer, Sexual Health and Family Planning ACT, *Committee Hansard,* 28 February 2023, p. 6.

134 Australian Women's Health Nurse Association, *Submission 19*, p. 4.

135 Melbourne School of Population and Global Health, *Submission 84,* p. 11.

> It is imperative that the contribution of nurses and midwives to sexual and reproductive health is recognised and their full scope of practice realised to improve the health of women living in Australia. Building on the existing nursing and midwifery workforce, nurse and midwife-led models of care offer a viable solution to the largely medical model to increase access to reproductive healthcare services for women living in metropolitan, regional, rural and remote areas.[136]

Limited prescribing ability for midwives

2.118 The Australian College of Midwives (ACM) submitted that the Australian midwifery workforce is currently an underutilised resource in Australia and that, if adequately supported, could play a crucial role in delivering universal access to reproductive and women's healthcare, underpinned by choice and autonomy.[137]

2.119 The ACM argued that PBS coverage is limited for endorsed midwives (Ems) to provide contraceptives. It said that, although Ems can prescribe contraceptives listed on the PBS for Midwives, this list is 'very limited', and both IUDs listed on the PBS are not available for midwives to prescribe. This restricts accessibility of contraceptives for women in a trusted midwifery continuity of care setting.[138]

2.120 The ACM called this policy 'discriminatory', in that it necessitates private script pricing versus PBS pricing for women prescribed some contraceptives by a midwife. Further, it was argued that these restrictions do not allow the midwifery workforce to work to their full scope of practice, which can limit vital healthcare for women—particularly those living in rural and remote areas, and those with known barriers to access, such as First Nations people, migrant and refugee women, and adolescent mothers.[139]

2.121 The Australian Nursing and Midwifery Federation noted similar concerns, in which it stated that it is imperative for nurses and midwives to realise their full scope of practice to improve the health of Australian women.[140]

Lack of male contraceptive options

2.122 There are currently no hormonal male contraceptive therapeutic goods registered in Australia, and either condoms or vasectomies remain the only available forms of contraception for men. Further, the Department submitted

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136 Ms Julianne Bryce, Senior Federal Professional Officer, Australian Nursing and Midwifery Federation, *Committee Hansard,* 28 February 2023, p. 10.

137 Australian College of Midwives, *Submission 30,* p. 2.

138 Australian College of Midwives, *Submission 30,* pp. 2–3.

139 Australian College of Midwives, *Submission 30,* p. 3.

140 Australian Nursing and Midwifery Foundation, *Submission 20,* p. 6.

that it is not aware of any male contraceptive products for which approval is currently being sought.[141]

2.123 This lack of alternatives was noted by inquiry participants, with FPNSW stating that there are currently 'very limited options' for male contraception, and the responsibility for birth control remains largely with women. It also highlighted that, although vasectomies are a viable option for men, access to this procedure can be very limited and is highly dependent on the availability of trained clinicians.[142]

2.124 FPNSW recommended that the Government provides funding to increase the number of clinicians training in vasectomies and continues to support research into viable options for men.[143]

2.125 The Melbourne School of Population and Global Health submitted that the lack of male-controlled contraceptive options limits men's ability to 'achieve their own reproductive health goals and engagement in pregnancy prevention'. It called for the Government to support clinical trials and studies exploring the development of new male-controlled contraceptive options.[144]

Committee view

2.126 During the inquiry, participants proposed a variety of initiatives aimed at reducing, and potentially eliminating, the barriers that people encounter when trying to access contraceptives.

Addressing regulatory barriers

2.127 The committee strongly supports the TGA's role in ensuring that the medicines available in Australia meet appropriate standards of quality, safety and efficacy. This enables health practitioners to have confidence in the medicines that they prescribe to their patients, and for patients to have peace of mind, knowing that their medication has gone through a robust and rigorous approval process.

2.128 Notwithstanding this, the committee notes that inquiry participants suggested that the current TGA approval processes can be overly lengthy and expensive and present a potential deterrence for pharmaceutical organisations in seeking approval to supply their products in Australia. The committee also notes evidence relating to the potential for efficiency gains between the TGA and PBAC, with the TGA acknowledging that there were parallel and duplicative processes across both entities.

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141 Department of Health and Aged Care, *Submission 53*, p. 15.

142 Family Planning New South Wales, *Submission 56*, p. 9.

143 Family Planning New South Wales, *Submission 56*, p. 9.

144 Melbourne School of Population and Global Health, *Submission 84*, p. 5.

2.129 Given this, the committee is concerned that Australian consumers may not always have access to the most effective and safe contraceptive methods already available internationally and that Australia lags behind other comparable countries, such as the United Kingdom and the United States. The committee does however acknowledge that a sponsor cannot be compelled to make a submission to the TGA or PBAC for consideration.

2.130 The committee considers that there is merit in the TGA reviewing its approval processes for new contraceptives to ensure that Australian consumers are not left behind and have access to the latest, most effective and safest contraceptive options available internationally.

Recommendation 1

2.131 The committee recommends that the Therapeutic Goods Administration reviews its approval processes to ensure that Australian consumers have timely access to the latest and safest contraceptive methods available internationally.

Enhance the role of nurses, midwives, and community pharmacists

2.132 The committee acknowledges there were mixed views on a number of proposals to enhance the role of pharmacists, such as contraceptive prescribing and down-scheduling oral contraceptives. The committee recognises these concerns regarding patient safety, but is also concerned by reports that the average number of days that patients wait for a GP appointment has increased in every state and territory across Australia between 2019 and 2022, and that an estimated 11 per cent of women miss their OCP due to difficulties in accessing their GP for a new prescription. The committee also notes the investments through Budget 2023–24 to strengthen Medicare, including the recently announced National Scope of Practice Review.

2.133 The committee notes that community pharmacies are considered to be one of the most accessible health destinations in Australia, with evidence indicating that they have extended opening hours—including after-hours and on weekends—and that 97 per cent of people in capital cities, and 66 per cent of people outside of capital cities, have access to a pharmacy within a 2.5-kilometre radius of where they live or work.

2.134 The committee supports an increased role for community pharmacists in providing sexual and reproductive healthcare across Australia that would allow them to work to their full scope of practice in this area. The committee believes that the better utilisation of the skills and knowledge of community pharmacists would greatly assist in addressing unmet needs across the Australian community in the provision of contraceptive care and recommends that the Government's recently announced National Scope of Practice Review consider options on how to best achieve this.

2.135 The committee strongly supports the role that midwives play in providing reproductive and women's healthcare in Australia. The committee also shares concerns raised by the Australian College of Midwives that PBS coverage is limited for endorsed midwives to provide contraceptives, thus restricting the ability of midwives to work to their full scope of practice.

2.136 Consequently, the committee acknowledges the importance of enabling nurses and midwives to work to their full scope of practice, as highlighted by the Australian Nursing and Midwifery Federation.

2.137 The committee also notes the recently announced state-wide pilot in NSW that will allow participating pharmacists in that jurisdiction to prescribe medication for urinary tract infections to women under the age of 65 and to resupply low-risk oral contraceptive medication that has been prescribed for contraceptive purposes to women aged between 18 and 35, inclusive, by a GP or nurse practitioner in the last two years—even if the script has expired.

2.138 The committee supports the Australian Government's National Scope of Practice Review, which will investigate barriers and incentives to health practitioners working to their full scope of practice. The Review will enable consideration of opportunities for workforce development and incentivisation. This is a national review working with states and territories and will identify regulatory and legislative barriers and provide recommendations to improve the scope of health practitioners practice in Australia.

2.139 The committee also notes evidence related to the material discrepancies between the supply quantities allowed under state and territory emergency supply legislation and that permitted under existing continued dispensing arrangements. The committee recommends that the Australian Government, in consultation with state and territory governments, looks at how these discrepancies can be addressed.

Recommendation 2

2.140 The committee recommends that the National Scope of Practice Review considers, as a priority, opportunities and incentives for all health professionals working in the field of sexual and reproductive healthcare to work to their full scope of practice in a clinically safe way.

Recommendation 3

2.141 The committee recommends that state and territory governments work towards aligning supply quantities of Pharmaceutical Benefits Scheme (PBS) and non-PBS oral contraceptive pills allowed under state and territory emergency supply legislation.

Ensuring contraceptives are affordable

Make contraceptives more affordable

2.142 Evidence provided during the inquiry indicated that the high costs of contraceptives were seen as a key barrier to their accessibility, and that this issue was particularly acute for younger demographics and those who were socioeconomically disadvantaged.

2.143 To address this issue, the committee notes that a number of countries and jurisdictions have introduced no-cost contraception for all their residents or for certain age groups—such as people under the age of 26 in France. It was indicated during the inquiry that research in the United States concluded that such an approach can be effective, and that girls and women who were provided no-cost contraception, and were educated about LARCs, had lower rates of pregnancy, birth and termination than the national rates for sexually active teens.

2.144 The committee notes support from submitters regarding the proposal to provide free contraceptives, including OCPs, LARCs, and condoms, for people living in Australia under the age of 26. The committee notes the evidence received regarding the benefits of this proposal in reducing unintended pregnancies and terminations, while also lowering the spread of sexually transmissible infections.

Recommendation 4

2.145 The committee recommends that the Australian Government reviews, considers and implements options to make contraception more affordable for all people.

Ensure health practitioners receive adequate remuneration to bulk-bill

2.146 The committee recognises the importance of bulk-billing in promoting access to LARCs and improving their uptake in Australia. The committee agrees that the current remuneration provided by Medicare to perform LARC procedures is completely inadequate to make bulk-billed services financially viable for health practitioners. The committee notes evidence suggesting that the MBS rebate has been frozen for most of the last decade, with only a 1.6 per cent increase last year—well below the inflation rate. This is unacceptable and unsustainable.

2.147 The committee notes the recent Budget 2023–24 announcements that included a $3.5 billion investment to triple the bulk bill incentive, $1.5 billion indexation boost to Medicare rebates and an introduction of a longer, level E consult.

2.148 The committee also supports task sharing through the delivery of contraceptive care by nurses and midwives, including the insertion and removal of LARCs. Nurses and midwives represent the largest health workforce in Australia, are highly educated and capable, and continue to be at the forefront of healthcare

delivery. By financially supporting these practitioners to work to the full scope of their practice, the committee considers that improved remuneration would greatly enhance contraceptive accessibility throughout Australia.

Recommendation 5

2.149 The committee recommends that the Australian Government ensures that there is adequate remuneration, through Medicare, for general practitioners, nurses, and midwives to provide contraceptive administration services, including the insertion and removal of long-acting reversible contraceptives.

Expand the Pharmaceutical Benefits Scheme

2.150 The committee is concerned with evidence suggesting that the PBS is outdated and does not include newer OCPs, the two types of emergency oral contraceptives and a number of effective LARCs. This creates inequities and barriers for people wanting to access different methods of contraception.

2.151 The committee was concerned to hear the evidence that a new OCP has not been listed on the PBS in over 25 years, resulting in women not being about to affordably access more modern forms of the OCP. The committee understands that some modern OCPs may be more appropriate for particular patients, have reduced negative side effects and can be effective in reducing androgen symptoms, such as acne and hirsutism.

2.152 The committee supports calls for the Government to work with industry to provide additional support for people to be able to access LARCS not currently accessible on the PBS. These contraceptive options are proven to be 99.5 per cent effective, less user dependent, and more cost-effective over time. Evidence demonstrated that increasing uptake of LARCs can reduce unintended pregnancies and termination rates across all stages of a women's reproductive life.

2.153 The committee is of the view that increasing community awareness and uptake of the vaginal ring, in particular, may be beneficial for future developments if multipurpose rings become available which, in addition to preventing unintended pregnancies, can also reduce the transmission of sexually transmitted infections. The committee also recognises the effectiveness of the copper IUD and that, in addition to being an effective form of long-term contraception, it can also be utilised as an emergency contraceptive option for women who would prefer, or require, a non-hormonal alternative.

2.154 The committee notes that, although there were calls for the copper IUD to be included on the PBS, evidence from the Department indicated that this would not be possible due it being a medical device. The committee considers that this technical distinction should not restrict women's access to this effective form of contraception and that the Government should look at ways to provide an

equivalent subsidisation to that which would be provided if it were permitted to be included on the PBS.

2.155 In conclusion, while the committee recognises that the TGA and PBAC cannot compel a sponsor to submit an application, the committee considers that improved consumer choice will result in higher acceptability, satisfaction, and continuation rates of effective contraception within the community. Given this, the committee recommends that the Government works with industry to expand and improve the PBS to include newer forms of the OCP, the emergency OCPs, and the vaginal ring, and that an equivalent support be provided for the copper IUD.

Recommendation 6

2.156 The committee recommends that the Department of Health and Aged Care and the Pharmaceutical Benefits Advisory Council work with the pharmaceutical industry to consider options to improve access to a broader range of hormonal contraceptives that are not currently Pharmaceutical Benefits Scheme subsidised, including newer forms of the oral contraceptive pill, the emergency oral contraceptive pills and the vaginal ring.

Recommendation 7

2.157 The committee recommends that the Department of Health and Aged Care considers and implements an option to subsidise the non-hormonal copper intrauterine device to improve contraceptive options for people with hormone-driven cancers and people for whom hormonal contraception options may not be suitable.

Expand accessibility for people ineligible for Medicare

2.158 The committee is concerned about the negative impacts that Medicare ineligibility may have on people residing within Australia, and that this can result in basic healthcare needs being left unmet and additional costs being incurred by vulnerable people.

2.159 The committee notes calls by inquiry participants for effective and low-cost contraceptives to be available to all people residing in Australia, regardless of whether they are enrolled in Medicare, and regardless of their visa status. This issue, as well as the broader problem of sexual and reproductive healthcare access for non-Medicare eligible residents is further discussed in Chapter 4, along with the committee's view and recommendation aimed at addressing it.

Improving access to contraceptives and community awareness

Improve community awareness of LARCs and provide training opportunities

2.160 Given the significant benefits that LARCs can provide, the committee is concerned about the ongoing lack of awareness and knowledge—both at the

broad societal level and within the health practitioner community—regarding the effectiveness of LARCs compared to more traditional contraceptive methods, such as the OCP.

2.161 Evidence indicated that only 11 per cent of Australian women utilise these forms of contraception and that Australia lags behind other comparable countries, such as the United Kingdom where 46 per cent of women utilise these methods.

2.162 The committee notes the significant benefits that LARCs may provide, both clinically and in long-run costs, for women for whom these methods are preferred and appropriate, and supports the proposal for a comprehensive public health campaign to increase community awareness, knowledge, and uptake, and to counter existing social media misinformation.

2.163 The committee also recognises the importance of AusCAPPS and recommends that the Government continues to fund this important initiative past 2024, when the existing funding arrangements are due to cease.

Recommendation 8

2.164 The committee recommends the Australian Government works with the Royal Australian College of General Practitioners and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to improve access to workforce training for the insertion and removal of long-acting reversible contraceptives to support their increased utilisation in Australia.

Recommendation 9

2.165 The committee recommends that the Australian Government considers the continuation of funding for the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCAPPS) to provide ongoing support and professional development for practitioners.

Address service gaps in rural and remote regions and First Nations communities

2.166 The committee recognises that immediate action must be taken to address the completely unacceptable situation that currently exists across regional, rural, and remote Australia, where women and girls living in these communities have poorer health outcomes than their metropolitan counterparts and experience a multitude of additional barriers when attempting to access contraceptive services and products.

2.167 The committee is very concerned that individuals living within these communities continue to experience longer wait times to access their local GPs, and that they are more likely to experience higher rates of unplanned pregnancies, infant mortalities, and preterm babies.

2.168 The committee recognises the importance of ACCHOs in delivering culturally safe and holistic care to their local communities and the role that they play in

improving awareness and uptake of contraceptives. Given their importance, the committee is concerned with evidence indicating that these organisations are restricted in their ability to provide these services.

2.169 The committee considers this to be a priority area for the Government and that it should work with other stakeholders to ensure that these communities receive the same level of choice and access to contraceptives as people living in metropolitan areas. Given this, the committee supports the proposal that the Government develop an integrated regional approach, in consultation with the relevant Primary Health Network for the provision of contraceptive care, with a focus on those individuals living in regional, rural, remote, and First Nations communities. This is discussed in more detail in Chapter 4.

Recommendation 10

2.170 The committee recommends that the Australian Government considers and implements a separate Medicare Benefits Schedule item number for contraceptive counselling and advice for all prescribers, including midwives.

Improve access to male contraceptive options

2.171 The committee notes that the lack of accessible male contraceptive options results in the responsibility of birth control falling on women. Given this, the committee suggests that the Australian Government increases its support for research into other viable reversible contraceptive methods for males.

Recommendation 11

2.172 The committee recommends that the Australian Government and/or relevant organisations support research into the availability and development of contraceptive options for males.

Chapter 3
Reducing barriers to reproductive healthcare

3.1 Pregnancy care encompasses a wide spectrum of reproductive healthcare, including assistance with menstruation; contraception; unplanned pregnancies; preconception; antenatal, intrapartum and postnatal care; menopause; and pregnancy termination (termination) services. Pregnancy care focuses on patient wellbeing, safety, and joint decision-making.[1]

3.2 Overwhelmingly, submitters noted that pregnant women need maternity and birthing services close to where they live, and that when these services don't exist, or cease to exist, risks to pregnant women and their babies increase.[2] Further, when there are inadequate local birthing services, women are also commonly advised to relocate weeks prior to their due date, resulting in them incurring additional costs and giving birth away from home and their support networks.[3]

3.3 Inequities in pregnancy care access are well recognised, especially, in regional, rural, and remote Australia—and access to termination services, in particular, have been described by health practitioners as a 'huge lottery', with many people being reliant on 'local champions'.[4] Although abortion was partly decriminalised in Western Australia in 1998, more than 20 years ago, and has since been decriminalised in every state and territory, funding for termination care is still piecemeal.[5]

3.4 According to Family Planning Alliance Australia (FPAA), approximately one quarter of all pregnancies are unplanned, and one in three of these pregnancies end in termination. Unintended pregnancies have been correlated with a range of negative physical health, mental health, economic, and social outcomes, and when termination services are sought by an individual, but denied to them, they are 'more likely to experience ill health, psychological stress, poverty, and negative impacts on development of existing children'.[6]

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1 Royal Australian College of General Practitioners, *Submission 64*, p. 7.

2 See, for example: National Rural Health Commissioner, *Submission 72,* p. 10; Australian College of Nursing, *Submission 16,* p. 5; Queensland Nursing and Midwives' Union, *Submission 29,* pp 8–9; Australian Medical Association, *Submission 71,* pp. 5–6.

3 National Rural Health Alliance, *Submission 73,* p. 10.

4 Family Planning Alliance Australia, *Submission 63,* p. 4.

5 Mr Jamal Hakim, Managing Director, MSI Australia, *Committee Hansard,* 28 February 2023, p. 1.

6 Family Planning Alliance Australia, *Submission 63,* p. 4.

3.5 Pregnancy terminations are time-critical procedures that increase in complexity and risk as time progresses. Despite this, FPAA argue that termination 'access in Australia is limited and inequitable, with many individuals facing significant and intersecting financial, social, geographical and health provider hurdles to access necessary information, support and medical care'.[7]

3.6 The negative impacts that this lack of access can have on a woman's mental and physical wellbeing was vividly highlighted by a Queensland-based woman, Bianca, who said the following:

> At this point, I was considering walking myself into emergency services at the local hospital and threatening to undertake the procedure myself if no-one would help me … I was stressed and I hadn't kept food down in about five days. I was really sick with nausea. I was exhausted and completely terrified that I wasn't going to be able to access abortion services.[8]

3.7 The focus of this chapter is pregnancy care, with a particular emphasis on the accessibility of maternity care and termination services in Australia. It begins with a brief discussion on how women commonly access these forms of care and then covers various Government supports and initiatives before detailing the significant barriers that women encounter when trying to access these services.

3.8 The chapter concludes with the committee's view and associated recommendations on approaches to mitigate the identified barriers with the aim of materially improving women's access to pregnancy care across Australia.

Accessing maternity and termination care in Australia

3.9 Most Australian mothers give birth in a public hospital, utilising various models of care.[9] Good maternity services aim for a safe and healthy pregnancy and birthing experience for mothers and babies, and also consider the woman's needs and preferences. State and territory governments are responsible for providing publicly funded birthing and maternity services to their respective communities free of charge.[10]

3.10 Evidence was presented to the committee indicating that access to reproductive health services in rural Australia is compromised when maternity services are put on bypass, downgraded, or closed. For example, the committee heard from the Rural Doctors Association of Australia that the maternity service at the local hospital in Gladstone, Queensland, which has historically birthed about

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7 Family Planning Alliance Australia, *Submission 63*, p. 4.

8 Bianca, Private capacity, *Committee Hansard*, 28 April 2023, pp. 68–69.

9 National Rural Health Alliance, *Submission 73*, p. 10.

10 Department of Health and Aged Care, *What we're doing about birth and maternity services*, 16 August 2022, www.health.gov.au/topics/pregnancy-birth-and-baby/birth-and-maternity-services (accessed 19 April 2023).

600 babies per year, was put on bypass for several months. This resulted in expectant mothers having to travel long distances and increased the risk of babies being born before arrival.[11]

3.11 When women don't have access to maternity care that meets their needs within a reasonable travel time, there are consequences. International research has associated travel time to a birthing service exceeding one hour with poorer outcomes for mothers and their babies, as well as increased interventions.[12]

3.12 The Australian Government supports access to pregnancy care primarily via funding through the National Health Reform Agreement (NHRA), Medicare Benefits Schedule (MBS), and Pharmaceutical Benefits Scheme (PBS).[13]

3.13 The Department of Health and Aged Care advised 'the MBS provides rebates for antenatal, intrapartum (birth), and postnatal services provided by or on behalf of specialist obstetricians, GP (general practitioner) obstetricians, and participating midwives, as well as antenatal care by GPs and midwives'. Further, the MBS also includes a range of items used for pathology tests, such as blood and urine tests, and diagnostic imaging services, including pregnancy-related ultrasound and magnetic resonance imaging.[14]

3.14 MBS items support services delivered by private health practitioners under a range of models including combined care, private obstetrician care, GP obstetrics care, private midwifery care, and private obstetrician and private practising midwife shared care. The Department of Health advised that the Australian Institute of Health and Welfare identified 11 categories of maternity models of care, with the institute also finding that:

- approximately 44 per cent of models have midwives as the lead carer during antenatal, intrapartum, and postnatal periods;
- approximately 31 per cent of models have continuity of care, where care is provided by the same named carer across the duration of the maternity period; and
- around six per cent of models include routine relocation of mothers from their communities to other locations prior to labour. This occurs when a woman resides in a rural or remote community with no access to childbirth facilities.[15]

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11 Rural Doctors Association of Australia, *Submission 104*, p. 4.

12 National Rural Health Alliance, *Submission 73,* p. 10.

13 Department of Health and Aged Care, *Submission 53*, p. 23.

14 Department of Health and Aged Care, *Submission 53*, p. 23.

15 Department of Health and Aged Care, *Submission 53*, pp. 23–24.

Termination care

3.15 The most common type of termination is a surgical procedure called a 'suction curette', which involves removing the lining and the contents of the uterus by applying gentle suction with a small plastic tube. Surgical terminations are day-surgery procedures most often performed in the first trimester.[16]

3.16 Healthdirect suggests that a low-risk alternative to surgery for pregnancies earlier than nine weeks is a medication called mifepristone. Medical abortion is a two-stage process, with the first stage involving taking a tablet that blocks the hormone necessary for the pregnancy to continue, followed by a second medication that causes the contents of the uterus to be expelled.[17]

3.17 If a person decides to terminate their pregnancy, they can access medical or surgical termination services through a variety of public and private settings, including primary care providers, family planning clinics, women's health clinics, and public and some private hospitals.[18]

3.18 Evidence presented to the committee suggests accessibility of these services, however, varies significantly according to geographic location—particularly for surgical terminations, which in most cases is the only option available after nine weeks gestation.[19] The actual cost and level of access can also depend on a variety of other factors, including:

- Medicare status of the patient;
- type of termination;
- type of provider, including religious affiliation and the degree of conscientious objection;
- gestation of the pregnancy; and
- any personal risks associated with the health of the individual.[20]

3.19 Although terminations are legal in every Australian jurisdiction, the specific laws relating to these services are a state and territory responsibility and, hence, the circumstances in which they can be legally provided varies between

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16 Healthdirect Australia, *Abortion,* March 2021, www.healthdirect.gov.au/abortion (accessed 16 May 2023).

17 Healthdirect Australia, *Abortion,* March 2021, www.healthdirect.gov.au/abortion (accessed 16 May 2023).

18 Department of Health and Aged Care, *Submission 53*, p. 16.

19 Department of Health and Aged Care, *Submission 53*, p. 16

20 Department of Health and Aged Care, *Submission 53*, p. 17; GenWest, *Submission 107*, pp. 3 and 5; Australian National University Law Reform and Social Justice, Research Hub, *Submission 121*, pp. 13–14.

jurisdictions. Terminations of up to 14 weeks are available Australia-wide, and later-term terminations are available in most states and territories.[21]

3.20 In Australia, medical abortion medication is marketed as MS-2 Step and is distributed by a single provider, MS Health.[22] Currently, medical practitioners and pharmacists must be registered to prescribe and dispense MS-2 Step and are also required to complete an online training course.[23] Nurse practitioners and participating midwives are currently unable to prescribe this product.[24]

3.21 Obstetricians, gynaecologists, and GPs providing obstetric and gynaecological services are trained in the relevant surgical skills to undertake a dilation and curettage, which can be utilised to perform surgical terminations of up to approximately 14 weeks and to manage miscarriages. Late-stage surgical terminations, however, require additional training that can be undertaken by obstetricians and gynaecologists.[25]

Government support

3.22 The Australian Government provides funding for pregnancy termination services through:

- public hospital funding under the NHRA;
- MBS items for surgical terminations, GP and specialist consultations, pregnancy counselling, telehealth, pathology tests, and ultrasounds; and
- PBS listings for medical termination medication.[26]

3.23 The Department of Health and Aged Care (the Department) noted that, while this framework aims to deliver access when and where it is required, funding alone cannot achieve equitable access.[27]

3.24 The MBS subsidises access to surgical terminations through rebates for related clinical consultations, pathology tests, diagnostic imaging, and surgical procedures. Currently, there are four specialist MBS items that can be used for the surgical termination of pregnancy, as well as other procedures. These include for:

- management of pregnancy loss at 14 to 15 weeks and six days;

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21 Department of Health and Aged Care, *Submission 53*, p. 16.

22 The Royal Women's Hospital, *Submission 85*, p. 4; Adjunct Professor Robyn Langham AM, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard,* 28 April 2023, p. 58.

23 Department of Health and Aged Care, *Submission 53*, p. 17.

24 Department of Health and Aged Care, *Submission 53*, p. 17.

25 Department of Health and Aged Care, *Submission 53*, p. 21.

26 Department of Health and Aged Care, *Submission 53*, p. 16.

27 Department of Health and Aged Care, *Submission 53*, p. 16.

- management of pregnancy loss at 16 to 22 weeks and six days;
- evacuation of the contents of the gravid uterus; and
- curettage of uterus (including for incomplete miscarriage).[28]

3.25 The Department noted that claims for MBS items relevant to terminations cover a range of procedures, not limited to surgical terminations. As a result, it is not possible to accurately quantity the number of surgical terminations of pregnancy conducted in private hospitals based on MBS claims..[29]

3.26 The Government provides funding for pregnancy termination services under the NHRA; however, collected data does not distinguish between medical and surgical forms of termination. In 2020–21, there were less than 8900 hospitalisations for induced abortions in public hospitals. This figure includes any intentional termination, at any gestation, through either medical or surgical intervention.[30]

Government initiatives to improve pregnancy care in Australia

3.27 The Government has undertaken various initiatives to improve access to pregnancy care in Australia. A number of these are discussed below.

Pregnancy Care Guidelines

3.28 The Pregnancy Care Guidelines were developed to support Australian maternity services in delivering high-quality, evidence-based antenatal care for women across Australia.[31] They are intended for use by all health professionals who contribute to antenatal care and are implemented at all levels of government to provide consistency in care. The Australian Government has committed to investing $5.9 million across 2022–23 and 2023–24 to update these guidelines and to develop new guidelines for postnatal care.[32]

Women-centred Care Strategy

3.29 The *Woman-centred care: Strategic directions for Australian maternity services* strategy provides overarching national strategic directions to support Australia's maternity care system and enable improvements in line with contemporary practice, evidence and international developments. It aims to

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28 Department of Health and Aged Care, *Submission 53*, p. 21.

29 Department of Health and Aged Care, *Submission 53*, p. 21.

30 Department of Health and Aged Care, *Submission 53*, p. 21.

31 For further information see: Department of Health and Aged Care, *Pregnancy Care Guidelines*, 5 February 2021, www.health.gov.au/resources/pregnancy-care-guidelines (accessed 26 April 2023).

32 Department of Health and Aged Care, *Submission 53*, p. 26.

ensure that maternity services are equitable, safe, woman-centred, informed and evidence-based.[33]

Pregnancy care for First Nations people

3.30 First Nations mothers and their babies experience disproportionately adverse maternal and infant health outcomes compared to non-Indigenous mothers and babies. There is also a material underrepresentation of First Nations people in the maternal health workforce across Australia and an absence of culturally safe and community-based birthing options for these women.[34]

3.31 Recent research has demonstrated that there are material benefits in implementing birthing on country models of care. In particular, women receiving this service are more likely to attend five or more antenatal visits, are almost 50 per cent less likely to have a pre-term birth than those receiving standard care, and are more likely to be exclusively breastfeeding upon their discharge from hospital.[35]

3.32 Given this, the Australian Government has committed $22.5 million for a dedicated *Birthing on Country Centre of Excellence* at Waminda in Nowra, New South Wales. The centre is expected to open in 2025–26 and will be used as a national demonstration site.[36]

Stillbirths and miscarriages support

3.33 The *National Stillbirth Action and Implementation Plan* was released in December 2020 and is the first national plan to strategically address the issue of stillbirth in Australia. From 2019–20 to 2025–26, the Australian Government plans to invest $44.5 million in measures to reduce stillbirths and support affected families. This includes:

- increasing the number of stillbirth autopsies;
- extending the Red Nose Australia's *Hospital to Home* program, which provides targeted support for families who experience stillbirth; and
- the development and implementation of bereavement care for women and families from higher-risk population groups who have experienced stillbirth or miscarriage.[37]

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33 COAG Health Council, *Women-centred care: Strategic directions for Australian maternity services*, August 2019, pp. 4 and 7.

34 Department of Health and Aged Care, *Submission 53*, p. 26.

35 Department of Health and Aged Care, *Submission 53*, p. 26.

36 Department of Health and Aged Care, *Submission 53*, p. 26.

37 Department of Health and Aged Care, *Submission 53*, p. 27.

Perinatal mental health

3.34 The *Perinatal Mental Health and Wellbeing Program* aims to support the mental health of both expecting and new parents, and also supports families experiencing grief after miscarriage, stillbirth, or infant death.[38]

3.35 The program provides a variety of supports, including those delivered digitally and via telephone, a national perinatal mental health triage and referral system, and digital training and support services for particularly vulnerable groups, such as parents living in rural and remote areas. The Government has allocated over $43 million to this program between 2020–21 and 2023–24.[39]

3.36 In the Budget October 2022–23, the Government also provided an additional $26.2 million in funding to the Gidget Foundation Australia to establish a national network of 12 perinatal mental health and wellbeing centres. These centres will provide mental health support to both expectant and new parents.[40]

Family planning grants

3.37 Family planning initiatives aim to support the reproductive health and fertility management of individuals and couples through public education, professional development, and the monitoring of emerging evidence to inform policy direction and program development.[41]

3.38 Through its Family Planning Grant Opportunity, the Government funds four grant recipients to support individuals and couples to attain their desired number of children, and the spacing and timing of their births. Total funding across 2019–20 to 2022–23 of $4.072 million has been provided to Fertility Education Australia; Multicultural Centre for Women's Health; Ovulation Method Research and Reference Centre for Australia; and Victorian Assisted Reproductive Treatment Authority.[42]

Barriers to accessing reproductive healthcare in Australia

3.39 Evidence received during the inquiry highlighted the barriers that some women living in Australia face when attempting to access maternity and termination care. The below discussion covers a number of these key barriers in further detail, including the following:

- a lack of maternity and birthing care services;
- a lack of termination care services;
- high costs for termination care;

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38 Department of Health and Aged Care, *Submission 53*, p. 28.

39 Department of Health and Aged Care, *Submission 53*, p. 28.

40 Department of Health and Aged Care, *Submission 53*, p. 28.

41 Department of Health and Aged Care, *Submission 53*, p. 28.

42 Department of Health and Aged Care, *Submission 53*, p. 28.

- stigmatisation and conscientious objectors;
- inadequate Medicare rebates;
- the upcoming expiry of temporary telehealth support;
- restrictive MS-2 Step requirements;
- legal variations across Australian jurisdictions;
- inadequate practitioner training; and
- a lack of data collection.

Access and cost barriers

Lack of maternity and birthing care services

3.40 Access to maternity and birthing services for women who live outside Australian cities has been decreasing for decades. Evidence received from the National Rural Health Commissioner during the inquiry indicated that there was a 41 per cent reduction in the total number of maternity units in Australia between 1992 and 2011—from 623 to 368—with many of these closures impacting small maternity services located in rural areas.[43] The Royal Australian College of General Practitioners (RACGP) also submitted that some hospitals no longer support birthing deliveries at all.[44]

3.41 Dr Belinda Maier from the Queensland Nurses and Midwives' Union, discussed the Gladstone Hospital bypass (mentioned earlier in this chapter) and told the committee the following:

> When Gladstone stopped birthing, the midwives there could still do low-risk births and they could have continued with those. But when things become very doctor-centric … and the models are medically run and doctor dependent, that becomes a problem when a doctor leaves town and birthing services stop. We saw that at Kingaroy for a long time when birthing services stopped, and yet there were midwives in Kingaroy. Some of them are deskilled, so they're not comfortable birthing women without medical support.[45]

3.42 The committee heard that this was not an isolated situation, with workforce shortages presenting difficulties in providing maternity services to rural communities.[46]

3.43 When there are inadequate local birthing services, women are often advised to relocate and give birth away from home. This removes them from their existing support networks, disrupts continuity of care, and impacts on their ability to

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43 National Rural Health Commissioner, *Submission 72*, p. 10.

44 Royal Australian College of General Practitioners, *Submission 64*, p. 10.

45 Dr Belinda Maier, Strategic Midwifery Research and Policy Officer, Queensland Nurses and Midwives' Union, *Committee Hansard*, 22 February 2023, p. 7.

46 See, for example: Rural Doctors Association of Australia, *Submission 104*, p. 4.

care for family members and undertake paid work. It can also result in relocation to a culturally unsafe environment for First Nations women.[47]

3.44 The National Rural Health Alliance noted that there is a body of evidence suggesting that a lack of local maternity care services can also result in increased levels of psychological distress and financial costs.[48]

3.45 The Chief Executive Officer of the National Rural Women's Coalition, Ms Keli McDonald, said that she would like to see all local towns with hospitals have maternity wards reinstated:

> They had them, and now they do not have them. Why don't they have them? It is the GP shortage. If we take women off country to have their babies, we take away an important time for women to connect to their community, to their families, to themselves. We believe those hospitals need those services back again.[49]

3.46 The National Rural Health Commissioner, Adjunct Professor Ruth Stewart, said that Australia should seek to have maternity services available for any community over a certain size:

> We should seek to have maternity services available for any community over a certain size across Australia, no matter where it is and how remote it is, because if a service employs people with the skills to care for pregnant women and provide intrapartum care, then they can look after women when things go wrong. If you don't have a service and therefore you don't have people with the skills to respond when an emergency occurs, that is when deaths and injury occur. I would like to see a much higher number of rural birthing services in Australia.[50]

3.47 The RACGP also submitted that improving availability of these services within rural and remote hospitals would enhance support for pregnant people.[51]

Lack of termination care services

3.48 It was agreed by a large number of inquiry participants that Australia lacks adequate clinical services for termination care, resulting in people facing long waiting lists and lengthy travel times.[52] The below discussion highlights a number of participants' perspectives on this issue, followed by viewpoints on

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47 National Rural Health Alliance, *Submission 73,* pp. 10–11.

48 National Rural Health Alliance, *Submission 73,* p. 11.

49 Ms Keli McDonald, Chief Executive Officer, National Rural Women's Coalition, *Committee Hansard,* 28 February 2023, p. 41.

50 Adjunct Professor Ruth Stewart, National Rural Health Commissioner, Office of the National Rural Health Commissioner, *Committee Hansard,* 28 February 2023, p. 41.

51 Royal Australian College of General Practitioners, *Submission 64*, p. 10.

52 See, for example: Fair Agenda, *Submission 66,* p. 5; SPHERE, *Submission 5*, pp. 6–7; The Royal Women's Hospital, *Submission 85*, p. 4.

the lack of services provided by public hospitals and across regional, rural, and remote Australia.

3.49 Women's Health East submitted that Australia continues to experience gaps in hospital, GP, and practitioner capability in providing termination services even though there is a clear need for clinical support. It cited data indicating that there are an estimated 88 000 terminations being performed every year and that one in four pregnancies are unplanned.[53]

3.50 The National Health and Medical Research Council (NHMRC) Centre of Research Excellence in Women's Sexual and Reproductive Health in Primary Care, SPHERE, elaborated:

> There are relatively few abortion providers in the primary care setting and hospital system in Australia and even fewer who can manage complex medical and gynaecological cases … About 30% of women in Australia live in regions in which there is no local GP provision of medical abortion including about 50% of women in remote Australia.[54]

3.51 When asked about the reasons why there are so few GPs providing medical terminations in Australia, Professor Danielle Mazza provided the following explanation:

> Currently, there are about 3,000 GPs who are registered to prescribe medical abortion. We think fewer than that are actually doing so. The reasons why more GPs aren't providing abortion are multifactorial. Stigma is one. It's also concern about lack of support from O&G [Obstetrics and Gynaecology] colleagues in the areas and the local hospitals being abrasive and often not helpful if patients suffer complications.[55]

3.52 Fair Agenda stated that:

> … many Australians cannot access safe abortion care in a local clinical setting, such as by visiting their doctor or local hospital. They are left navigating the health care system themselves, trying to understand where and how to seek abortion care. Recent studies have shown this is a significant challenge.[56]

3.53 Family Planning NSW (FPNSW) argued that there is a lack of available services outside of metropolitan areas, and that there is also limited availability of termination medication in pharmacies. Further:

> Groups who are already experiencing disadvantage are amongst the worst affected, including people with low incomes and those in rural and remote

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53 Women's Health East, *Submission 36*, p. 4.

54 SPHERE, *Submission 5*, p. 6.

55 Professor Danielle Mazza, Chair, Royal Australian College of General Practitioners, *Guidelines for Preventive Activities in General Practice (Red Book)*, Royal Australian College of General Practitioners, *Committee Hansard,* 28 February 2023, p. 17.

56 Fair Agenda, *Submission 66*, p. 5.

> areas, Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds.[57]

3.54 Women's Health East called for change at the national level to ensure universal access to termination services, 'regardless of [the women's] location, income, or visa status'.[58]

3.55 FPNSW submitted that women in all geographical locations should have access to 'affordable, appropriately located and safe abortions', and that they need access to unbiased and confidential information which enables them to make choices that are right for them. It concluded that:

> Having abortion services available closer to home is essential in reducing inequities in access to healthcare experienced by rural women.[59]

Limited provision of surgical termination services in public hospitals

3.56 Although surgical termination is now legal in all Australian states and territories, the Royal Women's Hospital noted that many publicly funded hospitals that provide maternity and women's health services do not provide termination services at all. Others only provide very limited services or have 'complicated care and referral pathways', which can cause delays and increase the risks of trauma, costs, and complexity, as gestational growth continues. It further noted that this issue is 'particularly acute for women and girls living in rural, regional, and remote Australia, where access to general hospital services is challenging'.[60]

3.57 The Royal Women's Hospital stated that one of the reasons for this outcome was that public hospitals are not mandated, through state government directives or funding agreements, to provide surgical abortion care.[61]

3.58 SPHERE also commented on this lack of access in the public health system, and highlighted the inequities it creates:

> Inconsistencies and sparse availability of abortion in public hospitals in many parts of Australia create further inequalities in access. The low numbers, or in some cases, complete lack of public and private hospital abortion providers in some regional areas mean few referral pathways exist particularly for surgical abortion. Many hospitals do not perform abortions as it may not be an explicit expectation under their service agreement, and

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57 Family Planning NSW, *Submission 56*, p. 11.

58 Women's Health East, *Submission 36*, p. 5.

59 Family Planning NSW, *Submission 56*, p. 11.

60 The Royal Women's Hospital, *Submission 85*, p. 4.

61 The Royal Women's Hospital, *Submission 85*, p. 4.

> some faith-based public and private hospitals prohibit provision of abortion and contraception.[62]

3.59 A number of witnesses, including a Women's Health Nurse at Lismore Women's Health and Resource Centre, Ms Amala Sheridan-Hulme, recommended the mandating of publicly funded termination services at tertiary public hospitals, including rural tertiary hospitals.[63]

3.60 The Chief Executive Officer of the National Rural Women's Coalition, Ms Keli McDonald, said that women should be able to have terminations in their regional hospital and, hence, every regional hospital must have a termination clinic to facilitate this, stating:

> These are big hospitals; they should be able to provide that service to women. A lot of women have to travel a long way just to get to that place alone. I make that point strongly.[64]

3.61 The Chair of the Sexual and Reproductive Health Special Interest Group at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Professor Kirsten Black, highlighted that the establishment of public hospital pathways would not only enhance equitable access but would also create additional training pathways for health practitioners.[65]

Limited access to reproductive healthcare services in regional, rural, and remote Australia

3.62 Accessing clinical care is often even harder for those people living in regional, rural, and remote areas of Australia. Accessibility can depend on whether a community's local GP provides these services—if not, individuals seeking this form of care may be required to travel significant distances, and even cross state or territory borders.[66] On this issue, the Chief Executive Officer of Children by Choice, Ms Daile Kelleher, said:

> Our clients in [regional and remote areas] travel an average of 200 kilometres to access a [health] service, and abortion specifically.[67]

3.63 Fair Agenda noted that maintaining medical abortion access via telehealth has been helpful in supporting people in this situation; however, it argued that this

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62 SPHERE, *Submission 5*, p. 6.

63 Ms Amala Sheridan-Hulme, Women's Health Nurse, Lismore Women's Health and Resource Centre, *Committee Hansard*, 21 February 2023, p. 10.

64 Ms Keli McDonald, Chief Executive Officer, National Rural Women's Coalition, *Committee Hansard*, 28 February 2023, p. 41.

65 Professor Kirsten Black, Chair, Sexual and Reproductive Health Special Interest Group, The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Committee Hansard*, 28 February 2023, p. 9.

66 Fair Agenda, *Submission 66*, p. 5.

67 Ms Daile Kelleher, Chief Executive Officer, Children by Choice, *Committee Hansard*, 22 February 2023, p. 18.

model of care needed to be accompanied by face-to-face clinical services as telehealth was not appropriate, or preferred, by all patients.[68]

3.64 FPNSW stated that access to healthcare services delivered by GPs is highly variable. In its submission, it referenced a 2017 study which found that, whilst some GPs were willing to provide medical abortions, most thought that they should occur in 'for-purpose clinic settings', rather than general practice. It also highlighted the issue of medical abortion via telemedicine being limited in rural areas due to referral criteria, out-of-pocket costs, and the lack of availability of registered dispensers in rural pharmacies.[69]

3.65 With specific reference to the situation for women living in regional, rural, and remote New South Wales, FPNSW said:

> There are currently no comprehensive medical and/or surgical abortion services within a publicly funded model for regional, rural and remote NSW, and this exacerbates inequity of access. Access to abortion in rural areas is extremely limited and challenging.
>
> Furthermore, a perceived lack of local confidentiality results in women travelling to other areas at significantly higher cost. In these circumstances, there may be a higher likelihood of inadequate postabortion care. In 2016, a NSW-based study found rural women travelled 1 to 9 hours one way to access an abortion.
>
> Another Australian study of 2,326 women aged 16 and over found women who travelled more than 4 hours were more likely to have difficulty paying, were more likely to be Aboriginal and Torres Strait Islander and more likely to present later in the pregnancy.[70]

3.66 SPHERE submitted that 'abortion deserts' are common in rural and remote parts of Australia, resulting in women having to travel to hospitals and private clinics in metropolitan areas, which can pose financial and logistical challenges and delays to their care.[71] It was estimated that more than one in ten women require an overnight stay when accessing an abortion due to the long distance they are required to travel. Further, approximately four per cent have to travel outside the state in which they reside.[72]

3.67 Box 3.1, below, contains a case study that highlights the lack of accessible termination care in regional northern NSW.

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68 Fair Agenda, *Submission 66*, pp. 5–6.

69 Family Planning NSW, *Submission 56*, p. 11.

70 Family Planning NSW, *Submission 56*, p. 11.

71 SPHERE, *Submission 5*, p. 7. An 'abortion desert' is defined as an area where there are neither GP prescribers nor surgical options for pregnancy terminations, and patients have to travel more than 160 kilometres to access a service provider.

72 SPHERE, *Submission 5*, p. 7.

Box 3.1 Case study highlighting the lack of accessible termination care in regional northern New South Wales

Ms Sheridan-Hulme provided the following insight into the lack of medical and surgical termination care options in her local region of northern NSW:

> Within the Lismore community, there are two medical termination providers, with more located closer to the coast. Due to high demand in Lismore, I often have to refer women to private clinics over an hour's drive away. Whilst medical terminations are a good option for many women, they are only available up until nine weeks gestation and have exclusionary medical criteria. They are a self-managed exercise which women complete at home. It can be painful and confronting and is not suitable for all—for example, young people, women with a disability or those who do not have a private house or are homeless.
>
> The cost of a medical termination varies. The Choices clinic provides a bulk-billed service, meaning our patients only pay for the ultrasound and medications, which cost between $6 and $160, depending on whether they have a healthcare card. For a privately billed medical termination, it costs between $300 and $500. For those without Medicare, it costs around $1,000 at a minimum.
>
> Surgical terminations are typically provided within public hospitals and private clinics. The Northern Rivers region has extremely poor access to surgical terminations. Currently, for women to have a surgical termination, they must travel around two and a half hours plus to a Brisbane or Coffs Harbour clinic as our local hospital does not provide this health care. The cost is between $500 and $900 for under 12 weeks gestation at private clinics.
>
> For non-Medicare holders, it costs anywhere from $1,000 to $1,500 for under 12 weeks gestation. Prices increase steeply at each later gestational week. Unfortunately, Brisbane public hospitals are unable to take referrals for New South Wales residents, meaning that northern New South Wales residents must drive nine hours to Sydney for a free surgical termination service or two and a half hours for a private service in Brisbane or Coffs Harbour.
>
> As you can see, the costs and travel needed for surgical terminations is not acceptable in our community.[73]

3.68 The above example is not unique, with other organisations outlining the lack of termination services available across Australia. For example, True Relationships and Reproductive Health submitted that there are currently no surgical termination options available in Rockhampton in central Queensland, and that

[73] Ms Amala Sheridan–Hulme, Women's Health Nurse, Lismore Women's Health and Resource Centre, *Committee Hansard*, 21 February 2023, p. 9.

patients have to travel to the Sunshine Coast, Brisbane, or the Gold Coast—approximately an eight-hour drive or a $600 return flight—to access a service.[74]

3.69 A number of inquiry participants advocated for the establishment of a national taskforce to address the issue of termination service accessibility and to deliver on the broader National Women's Health Strategy's 2020-2030 (Women's Health Strategy) priority of achieving universal access to reproductive healthcare.[75] Fair Agenda argued that, without such an approach, reforms would likely be 'piecemeal' and maintain the existing 'postcode lottery' that characterises reproductive healthcare in Australia.[76]

3.70 The Australian Gender Equality Council submitted that such a taskforce should ensure that a diversity of voices and lived experiences from across Australia are heard.[77]

3.71 The Multicultural Centre for Women's Health called for the taskforce to address the nuanced barriers that various communities, such as migrants, experience, and said that it should involve all states and territories, health experts, community-led organisations, and people with lived experiences.[78]

3.72 The Victorian Women's Health Services Network envisaged that such a taskforce would:

> … enable better planning, monitoring and development of [sexual and reproductive health] services to address population health needs, in alignment with federal and state legislative and policy frameworks. This would enable better policy, funding and legislative coordination across the country to address inconsistencies and gaps more efficiently and effectively.[79]

3.73 In addition to the longer-term approach of establishing a national taskforce, Fair Agenda suggested that an immediate practical step that the Government could take to improve accessibility to termination services is the funding of a national telephone service to provide people with support, information, and referrals. It was proposed that such a service could utilise one of the many existing models currently in place, such as the healthdirect service;

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74 Dr Danielle Haller, Regional Medical Officer, Southern, True Relationships and Reproductive Health, *Committee Hansard,* 22 February 2023, p. 2.

75 See, for example: Fair Agenda, *Submission 66,* p. 16; Family Planning Alliance Australia, *Submission 63*, p. 2; Amnesty International, *Submission 100,* p. 5; Multicultural Centre for Women's Health, *Submission 102,* p. 3; Australian Association of Social Workers, *Submission 113,* p. 5; Women's Health Grampians, *Submission 130,* [p. 1].

76 Fair Agenda, *Submission 66,* p. 16.

77 Australian Gender Equality Council, *Submission 126,* p. 1.

78 Multicultural Centre for Women's Health, *Submission, 102,* p. 3.

79 Victorian Women's Health Services Network, *Submission 134,* [p. 5].

Queensland's Children by Choice, Tasmania's Pregnancy Choices, and Victoria's 1800 My Options.[80]

3.74 It was also proposed that such a telephone service be supported by an interactive national map to make it easier for people to find counselling services about termination care options, as well as prescribing doctors, dispensing pharmacists, and information on services and costs.[81]

3.75 On these proposals Ms Kelleher from Children by Choice said:

> Funding a national service and map to support abortion seekers and health professionals to support their patients would make a huge difference in cutting through the patchwork of abortion in Australia. It would be incredibly useful for abortion seekers who need reliable information quickly and for governments that need to identify where gaps exist.[82]

High costs for termination care

3.76 Numerous inquiry participants highlighted that the high costs of termination care restrict their accessibility.[83] It was argued that the cost of these services often causes emotional distress, can delay time-critical care, and can significantly affect a patient's physical and mental wellbeing.[84]

3.77 As abortion care is not always available in all public healthcare settings, most women need to access private providers and, hence, incur large out-of-pocket costs to access this care. FPNSW mentioned a 2015 Australian study that found that two-thirds of women seeking abortions found two-thirds needed financial assistance, and that the median cost for indirect expenses was $150.[85]

3.78 FPNSW noted that, even though medications for medical abortion are listed on the PBS and rebates are available for surgical abortions under Medicare, total costs incurred often range from between $500 and $8000 for abortion care in Australia—when client costs, such as GP visitations, blood tests, ultrasound scans, prescription medication, and after-care costs, are included.[86]

3.79 Fair Agenda referred to the cost being a 'postcode lottery', as it varied so widely depending on where patients live. It also noted that, for complex cases, costs can

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80 Fair Agenda, *Submission 66*, p. 6.

81 Fair Agenda, *Submission 66*, p. 6.

82 Ms Daile Kelleher, Chief Executive Officer, Children by Choice, *Committee Hansard*, 22 February 2023, p. 18.

83 See, for example: Fair Agenda, *Submission 66*, p. 3; SPHERE, *Submission 5*, p. 7; Women's Health East, *Submission 36*, pp. 5–6; Family Planning NSW, *Submission 56*, p. 10.

84 Fair Agenda, *Submission 66*, p. 4.

85 Family Planning NSW, *Submission 56*, p. 10.

86 Family Planning NSW, *Submission 56*, p. 10.

range up to $17 000.[87] Further, Women's Health East stated that Australian women are currently being charged up to 70 times the manufacturing cost of medical termination of pregnancy medication, resulting in an unnecessary financial barrier.[88]

3.80 The Managing Director of MSI Australia, Mr Jamal Hakim, agreed that women face a lottery when trying to access termination care and that funding remains piecemeal. He also said:

> It can be stressful and costly to access basic health care, particularly for women in regional and remote areas of Australia. We know that the National Women's Health Strategy, released in 2020, agreed to universal access to sexual and reproductive health by 2030, and this strategy has bipartisan support. But sadly, very little has been done to make this a reality.[89]

3.81 In addition to the direct costs, submitters noted there are also significant ancillary costs incurred when accessing termination services, including transportation, childcare, and foregone wages. For those women living in rural and remote areas where there are no local services, costs are generally even higher due to factors such as additional travel and accommodation expenses.[90] It is estimated that two-thirds of women have to obtain financial assistance from one or more sources, such as a partner or family member, to pay for an abortion.[91]

3.82 While Medicare rebates are available for consultations concerned with medical abortion, including, since July 2021, consultations delivered by telehealth, out-of-pocket-costs and gap payments still apply. Importantly, many women are not eligible to enrol in Medicare, including international students and women on temporary visas, and hence, must pay the total cost of their procedure, as well as any additional associated costs.[92]

Stigma and conscientious objectors

3.83 According to a 2019 position statement from the Australian Medical Association, practitioners are entitled to have their own personal beliefs and values. The AMA statement says that while it is acceptable for a healthcare provider to not provide certain medical treatments or procedures based on

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87 Fair Agenda, *Submission 66*, p. 3.

88 Women's Health East, *Submission 36*, p. 5.

89 Mr Jamal Hakim, Managing Director, MSI Australia, *Committee Hansard,* 28 February 2023, p. 1.

90 Family Planning NSW, *Submission 56*, p. 10.

91 SPHERE, *Submission 5*, p. 7.

92 SPHERE, *Submission 5*, p. 7.

conscientious objection, providers do, however, have an ethical obligation to minimise disruption to the delivery of healthcare for the patient.[93]

3.84 Patients reported experiencing institutional, as well as individual, conscientious objection and other manifestations of systemic stigma. Fair Agenda said that this can take various forms, including providers refusing treatment, healthcare staff making judgemental statements or trying to dissuade patients from termination, or healthcare staff assuming a pregnancy was wanted or planned.[94]

3.85 Further, evidence was presented that in some circumstances, GPs do not advertise that they provide termination services due to concerns that they will be stigmatised within their local communities. This results in many women being unable to effectively identify, locate, and access providers of these services in their immediate regions.[95]

3.86 SPHERE provided evidence that there are a significant number of conscientious objectors operating across Australia's health system. The data it cited estimated that in 2009, around 15 per cent of Australian obstetrics and gynaecology fellows and trainees were conscientious objectors of abortion. While more recent data is not available, SPHERE suggested that these numbers may be even higher in regional and rural areas amongst GPs, with one study of regional Victoria indicating that 38 per cent of interviewed GPs referred their patients to a colleague due to a conscientious objection.[96]

3.87 A co-founder of The Abortion Project, Ms Lily McAuliffe, highlighted the issues that pregnant women face when refused termination care due to conscientious objections. She argued that this was a 'really big problem' in Australia and provided an anecdote of a young women who had to travel from Broome to Darwin to have a termination after she was refused treatment by a local provider.[97]

3.88 The impact of this problem was also highlighted by a Queensland-based woman, Charlotte, who initially sought a termination three weeks into her pregnancy. Even after persistent telephone calls to her doctor, she was still pregnant at almost 19 weeks due a required referral not being sent through to the hospital. She stated:

> I was sent to the Royal Women's Hospital. The amount of times I went back to that doctor was ridiculous. From then on, I believed this doctor was against abortions. The referral was never sent. I was nearly 19 weeks

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93 Australian Medical Association, *Position Statement: Conscientious Objection – 2019*, 27 March 2019.

94 Fair Agenda, *Submission 66*, p. 8.

95 SPHERE, *Submission 5*, p. 6.

96 SPHERE, *Submission 5*, p. 6.

97 Ms Lily McAuliffe, Co-Founder, The Abortion Project, *Committee Hansard*, 4 April 2023, p. 17.

> pregnant and they received the referral in the mailbox, which he was supposed to send to the hospital but never did. This was on Christmas Day. I ended up having to give birth on Christmas Day.[98]
>
> …
>
> If he was against abortions, why would he let me go from three weeks to 19 weeks growing a baby in my stomach, rejecting all the times I tried to contact him? Why didn't he just help me from the start?[99]

Medicare rebates for medical terminations

3.89 RANZCOG submitted that, due to the existing MBS rebate being based on length of an appointment, the cost of early medical abortion provision is 'prohibitive' for GPs and community clinics to provide bulk-billed services. It argued that the generic consultation MBS item does not account for the high administrative workload associated with medical termination provision.[100]

3.90 The Deputy Medical Director at Sexual Health Quarters, Dr Samantha Johnson, also spoke about this issue and highlighted the lack of remuneration to provide these services and their administrative-intensive nature. She said:

> There's no incentive for a GP and the community to provide that service—it's quite complex, it takes a lot of time, it's not something that you'd like to rush, and they're not going to do it with the rebates on a time-based consultation. There is a little bit of extra training you need to do beforehand. The way the system is at the moment, trying to access the medication from the pharmacy for patients can be quite time consuming. At a minimum, an MBS item number for medical terminations should be considered.[101]

3.91 RANZCOG also suggested that a specific MBS item for early medical termination provision with a higher rebate could be introduced; however, it said that such a reform would heighten privacy risks, especially for young people who are covered under their parents' Medicare or have private health insurance plans funded by their parents.[102]

3.92 The RACGP also raised privacy as an issue and did not support the introduction of a new specific MBS item:

> While the RACGP supports the need for affordable and accessible medical and surgical abortion services, we do not support the creation of specific MBS items for medical termination of pregnancy services in general practice.

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98 Charlotte, Private capacity, *Committee Hansard*, 28 April 2023, p. 70.

99 Charlotte, Private capacity, *Committee Hansard*, 28 April 2023, p. 71.

100 RANZCOG, *Submission 65*, p. 6.

101 Dr Samantha Johnson, Deputy Medical Director, Sexual Health Quarters, *Committee Hansard*, 4 April 2023, p. 17.

102 RANZCOG, *Submission 65*, p. 6.

> Specific MBS items for abortion could also lead to privacy issues and stigmatise this service, as specific MBS item numbers will appear on the patient's Medicare record.[103]

3.93 As part of a broader package within the 2023–24 Federal Budget, the Government committed $99.1 million to facilitate the creation of a new MBS item for consultations lasting 60 minutes or longer.[104] In the Women's Budget Statement, the Government noted that the extended consultations would 'support improved access and affordability for patients with chronic conditions and complex needs'.[105]

Expiry of temporary telehealth support

3.94 In 2021, the Government introduced eight new temporary telehealth items to the MBS for, amongst other things, sexual and reproductive health consultations via video and telephone. Items for GP sexual and reproductive health services and non-directive pregnancy support counselling were initially extended to 30 June 2023, and in May 2023, the Government confirmed that these items will remain in place until 31 December 2023.[106]

3.95 It was argued that telehealth consultations, supported by Medicare, improve access to medical terminations by removing the need for patients to travel long distances and allows existing health practitioners to provide their services across larger geographical areas.[107] SPHERE noted that:

> … telehealth medical abortion is comparable in safety, efficacy and acceptability to in-person medical abortion services and can improve access.[108]

3.96 The Chief Executive Officer of Coffs Harbour Women's Health Centre, Ms Shelley Rowe, also highlighted the benefit that telehealth can provide for women trying to access other sexual and reproductive health services, such as contraception. She said:

> … I would like to say that telehealth has really improved access to contraception with the benefit of being able to provide appointments for

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103 Royal Australian College of General Practitioners, *Submission 64*, p. 9.

104 Matt Woodley, Royal Australian College of General Practitioners, 'Budget reveals $5.7 billion general practice investment', *newsGP*, 9 May 2023, www1.racgp.org.au/newsgp/professional/budget-reveals-5-7-billion-general-practice-invest (accessed 16 May 2023).

105 Commonwealth of Australia, *Budget 2023–24: Women's Budget Statement*, p. 76.

106 Department of Health and Aged Care, 'Continuing MBS telehealth services: GPs and other medical practitioners', *Factsheet*, 11 April 2023, p. 2; Jolyon Attwooll, 'Reproductive healthcare telehealth items extended', *NewsGP*, 16 May 2023, https://www1.racgp.org.au/newsgp/professional/reproductive-healthcare-telehealth-items-extended (accessed 24 May 2023).

107 SPHERE, *Submission 5*, p. 7.

108 SPHERE, *Submission 5*, p. 7.

> repeat scripts and checking follow-up care with the treating clinician. It really reduces the inconvenience to women who have to travel for appointments in regional areas and might have carer duties or otherwise need to take leave from what is often part-time work. We just really sincerely hope that the telehealth option remains the modality of care to keep access and continuity of access to contraception.[109]

3.97 During the inquiry the RACGP recommended that these items be continued beyond 30 June 2023. It also highlighted the flexibility that they provide for patients, as they do not require an existing clinical relationship with the GP providing the service:

> Enabling access to sexual and reproductive health services via telehealth provides flexibility and choice for patients to consult with their GP (or an alternative GP to their usual GP if they do not provide medical termination of pregnancy or is a conscientious objector) on sensitive health matters.[110]

3.98 As noted above, in the 2023–2024 Budget the items for GP sexual and reproductive health services and non-directive pregnancy support counselling were extended from 30 June 2023 until 31 December 2023.[111]

Regulatory and legislative barriers

Restrictive MS-2 Step requirements and limitations

3.99 Inquiry participants argued that many barriers exist for women trying to access medical abortion in Australia, including prescribing and dispensing restrictions, training requirements for health practitioners, and gestational age limitations.[112]

3.100 Marketed as MS-2 Step in Australia, medical abortion medication is distributed by a single provider. The approved risk management plan for the medication requires both the prescribing GP and dispensing pharmacist to be registered to provide the medication. According to published data, in December 2020 approximately only 10 per cent of GPs and 16 per cent of pharmacists were active prescribers and dispensers, respectively, of this product.[113]

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109 Ms Shelley Rowe, Chief Executive Officer, Coffs Harbour Women's Health Centre, *Committee Hansard*, 21 February 2023, p. 16.

110 Royal Australian College of General Practitioners, *Submission 64*, p. 9.

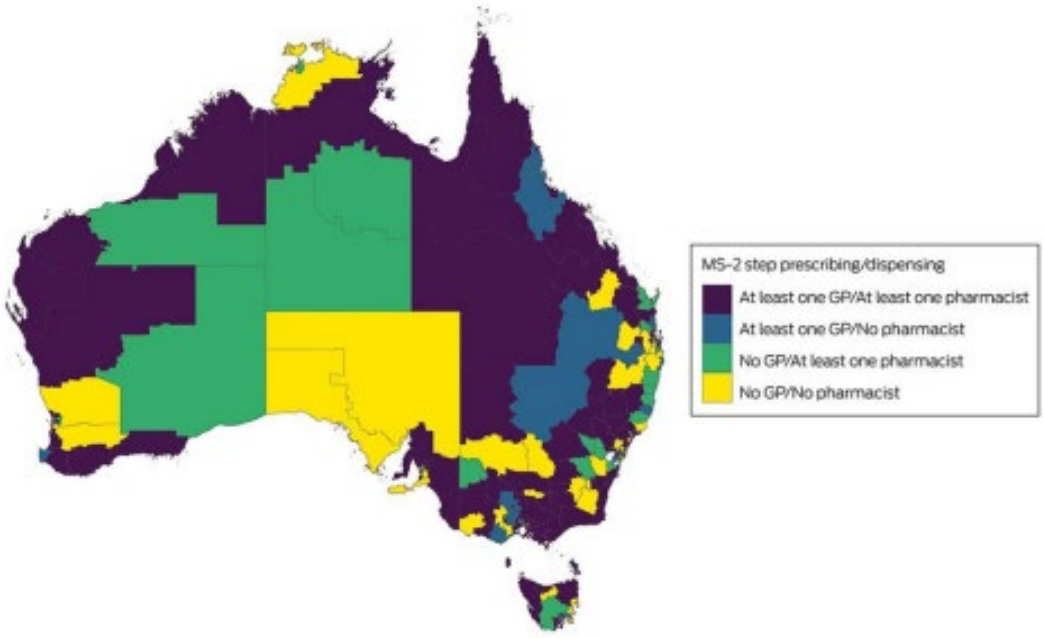
111 Jolyon Attwooll, 'Reproductive healthcare telehealth items extended', *NewsGP*, 16 May 2023, https://www1.racgp.org.au/newsgp/professional/reproductive-healthcare-telehealth-items-extended (accessed 24 May 2023). Note: In the article, the Department of Health and Aged Care advised that updated resources with additional detail on the extension would be published on the MBS Online Website 'as soon as possible'.

112 See, for example: The Royal Women's Hospital, *Submission 85*, p. 4; Fair Agenda, *Submission 66*, p. 11; Family Planning NSW, *Submission 56*, p. 12; Australian Lawyers for Human Rights, *Submission 23*, p. 15.

113 Department of Health and Aged Care, *Submission 53*, p. 17.

3.101 Evidence from SPHERE (Figure 3.1 below) highlights those regions across Australia that have limited or no local provision of MS-2 Step due to either a lack of prescribing GPs or dispensing pharmacists, or both. While this data is several years old, it highlights the risks to access presented by the current training and dispensing rules.

Figure 3.1 MS-2 Step prescribing and dispensing during 2019



Source: SPHERE, Submission 5, p. 7.

3.102 The Royal Women's Hospital described the current regulatory environment as 'highly restrictive' and Fair Agenda said the low uptake by GPs and pharmacists could be partly attributed to 'over regulation' by the Therapeutic Goods Administration (TGA).[114] On this point, Fair Agenda said:

> Abortion medication is highly regulated compared with other medications in Australia and we are trailing behind our counterparts in making it more accessible.
>
> In Canada, medical abortion drugs are prescribed by GPs with no additional regulatory barriers; in Ireland the medication can be prescribed up to 12 weeks pregnancy gestation, in line with international guidelines, which is above the 9-week limit in Australia.
>
> Other countries allow nurses and midwives to prescribe the medication. Yet in Australia, the requirements to prescribe it are unnecessarily onerous, on par with those reserved for medications that carry higher risks of harm.[115]

[114] The Royal Women's Hospital, *Submission 85*, p. 4; Fair Agenda, *Submission 66*, p. 11.

[115] Fair Agenda, *Submission 66*, p. 11.

3.103 The Acting Deputy Medical Director at Sexual Health Quarters, Dr Nicole Filar, highlighted the issues that these restrictions create for young and vulnerable people. She said:

> I, just the other week, had a 16-year-old via telehealth. I was training another doctor, and we spent a good hour just trying to collect all the paperwork and find a pharmacy that actually dispensed it [MS-2 Step], let alone had it in stock. They didn't. It took 24 hours to get there. And then you've got to think about the teenager actually trying to get to the pharmacy, because they don't want their parents to know about it; having an adult's support to get there; and scripts lost via fax. It's just a nightmare. This is for a young and vulnerable patient and, like I said, for that time when it's not just seeing the patient and talking; there's a lot of admin[istration] to it, a lot of training, a lot of forethought. It's just not sustainable.[116]

3.104 The Medical Director at MSI Australia, Dr Philip Goldstone, called the restrictions placed on GPs and pharmacists as potentially 'the biggest barrier' to accessing medical terminations and said his organisation called for their removal. He also noted that, while mifepristone was a relatively unknown medication when it was first registered in Australia in 2012, there is now a vast amount of experience with this medication and that it has been utilised by millions of women around the world.[117]

3.105 Bianca gave evidence to the committee reflecting on her lived experience in navigating the system when seeking a medical termination. She spoke about finding a compassionate GP, but then ultimately being forced to see a different GP as her preferred GP was not registered to prescribe MS-2 Step. She said:

> This system entirely failed me. I was forced to choose a doctor who intentionally discriminated against me and withheld pain relief. If I had been allowed to undertake this process with the original GP I found, I have no doubt that I would have had a much less traumatic experience, guided without personal bias.[118]

3.106 The Royal Women's Hospital referenced cohort studies in the United Kingdom, Canada, and Europe which, it stated, had demonstrated that the removal of prescribing restrictions had improved access without any additional adverse outcomes, while also significantly lowering the gestational age at time of termination—reducing patient risks and decreasing the need for post-procedure clinical management.[119]

3.107 ALHR suggested that only allowing medical practitioners to prescribe MS-2 Step in Australia was restrictive, and that access could be enhanced,

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[116] Dr Nicole Filar, Acting Deputy Medical Director, Sexual Health Quarters, *Committee Hansard,* 4 April 2023, p. 17.

[117] Dr Philip Goldstone, Medical Director, MSI Australia, *Committee Hansard,* 28 February 2023, p. 4.

[118] Bianca, Private capacity, *Committee Hansard,* 28 April 2023, p. 69.

[119] The Royal Women's Hospital, *Submission 85*, p. 4.

particularly in rural and regional areas, by expanding the range of permitted prescribers to include nurse practitioners and midwives.[120] The Queensland Nurses and Midwives' Union, Midwives Australia, and the South Australian Abortion Action Coalition also supported greater involvement of nurse practitioners and midwives to improve access.[121]

3.108 In her evidence to the inquiry, the TGA's Chief Medical Adviser, Adjunct Professor Robyn Langham AM, stated that a Women's Health Products Working Group was created in June 2022 to bring together health professionals, academics, and patient support groups in a 'collaborative forum', and that this group had universally agreed that what was put in place a decade ago for MS-2 Step was no longer relevant, was out of step with current international guidelines, and was not meeting the needs of the Australian community.[122]

3.109 Given this, Dr Langham stated that the TGA has been engaging with the sponsor of MS-2 Step in Australia—MS Health—to reduce the existing restrictions, and that it was currently reviewing an application submitted by the firm to achieve this. She noted that the proposed amendments in the application would eliminate registration requirements for pharmacists and doctors, as well as expand the list of health practitioners that can prescribe this medication. She also stated that this matter could be decided within a 'couple of weeks'.[123]

Gestational limitations

3.110 A number of inquiry participants also called for the gestational age limit of 63 days to be increased. For example, Australian Lawyers for Human Rights (ALHR) said:

> Access could be increased by revising the regulatory framework for prescribing and dispensing MS-2 Step. Research supports the safety and efficacy of mifepristone and misoprostol for early medical abortion up to 77 days' gestation and countries including the United Kingdom allow the use of mifepristone and misoprostol for up to 70 days.[124]

3.111 The Chief Executive Officer of Family Planning Australia, Adjunct Professor Ann Brassil, also called for the gestational age limit to be

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120 Australian Lawyers for Human Rights, *Submission 23,* p. 15.

121 Queensland Nurses and Midwives' Union, *Submission 29*, p. 7; Midwives Australia, *Submission 43,* p. 2; South Australian Abortion Action Coalition, *Submission 122,* p. 14.

122 Adjunct Professor Robyn Langham AM, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard,* 28 April 2023, p. 57.

123 Adjunct Professor Robyn Langham AM, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard,* 28 April 2023, pp. 57–58.

124 Australian Lawyers for Human Rights, *Submission 23,* p. 15. Increasing the gestational age limitation was also endorsed by other inquiry participants, including True Relationships and Reproductive Health, *Submission 45,* [p. 4]; Family Planning Alliance Australia, *Submission 63,* p. 5.

higher. She argued that nine weeks is not currently international best practice, and that someone would have to be very health-literate to recognise that they're pregnant and make a considered decision within this time frame.[125]

3.112 Dr Haller said that other countries provide MS-2 Step up to 10 weeks gestation 'quite safely' and that changing the existing limitation could be an opportunity improve medical termination accessibility.[126]

3.113 On this issue, Adjunct Professor Langham from the TGA said:

> … this is reliant upon the sponsor coming to us with those requests, and my understanding is that MS Health is not at this stage willing to [alter] the gestation time. I understand it's from a risk management perspective: risks increase as gestation increases.[127]

Legal variations across Australian jurisdictions

3.114 The committee heard about the state and territory-based variations in the settings and circumstances by which termination services can be performed.

3.115 FPAA argued that these legislative variations are 'inequitable and confusing' and make access to termination services more difficult and daunting for women.[128]

3.116 GPs are required to be knowledgeable on the legislative variations across each jurisdiction when offering or referring medical and surgical terminations. The RACGP said this inhibits access to these services and suggested that harmonisation of legislation would assist both patients and GPs.[129]

3.117 The Deputy Medical Director of MSI Australia, Dr Catriona Melville, also called for harmonisation, and highlighted the fragility and inadequacy of the existing system:

> We certainly saw a lot of what you could only call health tourism between states pre the pandemic. The fragility of the system really became very apparent during the pandemic when the borders were closed and people could no longer travel interstate to have an abortion at different gestation. We would definitely support harmonisation of the laws, and I think

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[125] Adjunct Professor Ann Brassil, Chief Executive Officer, Family Planning Australia, *Committee Hansard,* 21 February 2023, p. 25.

[126] Dr Danielle Haller, Regional Medical Officer, Southern, True Relationships and Reproductive Health, *Committee Hansard,* 22 February 2023, p. 2.

[127] Adjunct Professor Robyn Langham AM, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard,* 28 April 2023, p. 58.

[128] Family Planning Alliance Australia, *Submission 63*, p. 4.

[129] Royal Australian College of General Practitioners, *Submission 64*, p. 10.

> certainly the Victorian law with a gestational limit of 24 weeks would be what we would support.[130]

3.118 Numerous inquiry participants, including SPHERE, True Relationships, and Children By Choice, called for state and territory governments to harmonise their respective legislative frameworks.[131] Amnesty International also noted that in 2018, the United Nations Committee on the Elimination of Discrimination against Women called for Australia to harmonise its state and territory laws, policies, and practices concerning terminations to guarantee their accessibility.[132]

Training and data barriers

Inadequate undergraduate training

3.119 Evidence presented to the committee noted limitations in training around reproductive healthcare. For example, termination care and training on long-acting reversible contraception (LARC) is not included in some undergraduate degrees for doctors, nurses, and midwives. This results in these health practitioners needing to undertake additional specialised training after graduation to gain the required skills in these areas.[133]

3.120 Dr Johnson from Sexual Health Quarters highlighted the lack of training during medical degrees, saying:

> In terms of training to become a doctor, in your four- to six-year degree, you're lucky if you get a half-hour lecture on abortion care in that whole time.[134]

3.121 The Royal Women's Hospital said that comprehensive abortion and contraception education is required at undergraduate and postgraduate levels to equip medical, nurse practitioner, nursing, and midwifery health professionals with the essential skills and knowledge needed to provide best practice LARC and abortion care.[135]

3.122 Adjunct Professor Brassil from Family Planning Australia said:

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130 Dr Catriona Melville, Deputy Medical Director, MSI Australia, *Committee Hansard*, 28 February 2023, p. 2.

131 See, for example: SPHERE, *Submission 5*, p. 9; True Relationships and Reproductive Health, *Submission 45*, [p. 2]; Children by Choice, *Submission 60*, p. 14; MSI Australia, *Submission 62*, p. 12; Royal Australian College of General Practitioners, *Submission 64*, p. 5; RANZCOG, *Submission 65*, p. 7; Pharmacy Guild of Australia, *Submission 69*, p. 3.

132 Amnesty International, *Submission 100*, p. 4.

133 Family Planning NSW, *Submission 56*, p. 13.

134 Dr Samantha Johnson, Deputy Medical Director, Sexual Health Quarters, *Committee Hansard*, 4 April 2023, p. 18.

135 The Royal Women's Hospital, *Submission 85*, p. 5.

> ... it would be great if undergraduates, doctors in training, were provided with a much greater education in relation to reproductive health.
>
> We'd like to see reproductive health care as a more established part of the health curriculum. At the present time, RANZCOG provides training for its trainee gynaecologists, but it's optional. There are modules they can do but it's not part of their core curricula.[136]

3.123 RANZCOG also called for termination care to be a mandatory component of medical, nursing, and midwifery university curriculum. It argued that student doctors, nurses and midwives who are not exposed to the socio-political, public health, and clinical aspects of termination care may be less aware of the inequities that exist and less likely to be actively involved in providing, assisting, or supporting termination care after graduation.[137]

3.124 Box 3.2 below, highlights the potential consequences of inadequate reproductive healthcare education for health practitioners.

Box 3.2 The potential consequences of inadequate sexual and reproductive health training for practitioners

Dr Filar from Sexual Health Quarters provided a personal experience to the inquiry which highlights the potential consequences of inadequate sexual and reproductive healthcare education:

> I've also come across a situation where, unfortunately … a young teenager came in thinking she was five to six weeks pregnant because the clinician had done some pregnancy bloodwork and thought that that number meant that she was only five to six weeks pregnant. When I saw her, she was absolutely not five to six weeks pregnant. She was about 22 to 23 weeks pregnant. Had the provider actually done an examination at the first point and just palpated her abdomen and felt her uterus and gone, 'We need to act quickly,' then it would been a different story. This young teenager, now, in WA [Western Australia], had to go ahead with this pregnancy. And, by teenager, I mean a 14-year-old, okay?
>
> I remember that consult so vividly because mum was there, I was there, and we were in tears. We were just in shock because of that. It was all because the provider—the clinician at the beginning—didn't have the appropriate training and education when it came to abortion care, contraception, and sexual and reproductive health. It came from that. They didn't understand that and just let this poor, young, vulnerable person navigate it on their own. These are the

[136] Adjunct Professor Ann Brassil, Chief Executive Officer, Family Planning Australia, *Committee Hansard,* 21 February 2023, p. 25.

[137] RANZCOG, *Submission 65,* pp. 7–8.

> things that I see on the ground and that we need to change. A big part of it, for me, is about educating clinicians as well.[138]

Inadequate collection of statistical data

3.125 Although there are joint federal, state, and territory programs which collect healthcare data on many topics, including infectious diseases and cervical screening, it was noted that data on termination care is inconsistently collected at a national level and, hence, the number of abortions each year can only be estimated.[139]

3.126 Fair Agenda argued that this was despite an existing ability to collect these data in a way that considers patient privacy and confidentiality. It contended that:

> Fear mongering about possible data breaches has been used to justify this lack of data collection. Such arguments are problematic as they are reinforce secrecy around abortion, fuelling the harmful shame and stigma surrounding it, rather than recognising abortion care as essential health care.[140]

3.127 The Australian Christian Lobby also highlighted the lack of national abortion figures as being problematic. It said:

> … there are no national abortion figures available, not even from the Australian Institute of Health and Welfare (AIHW) whose very role is to provide meaningful statistics for Australians regarding health matters.
>
> There is only a disparate level of information available at state/territory level (particularly from South Australia (SA), with limited information from Western Australia (WA), Queensland (QLD), Victoria and Northern Territory (NT)). This lack of information is a problem in itself.[141]

3.128 The Australian National University Law Reform and Social Justice Research Hub said:

> … data collection on instances of abortion in Australia is poor. States do not routinely report abortion data, and the national dataset has been incomplete in the past.[142]

3.129 Given this inconsistent data collection, there were calls for improvement in this area. For example, Fair Agenda said in its submission:

> Australia needs to invest in national data collection to enable evidence-based policy, which is essential to end inequities in abortion care access. Data will also provide an indicator of reproductive health, and can

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138 Dr Nicole Filar, Acting Deputy Medical Director, Sexual Health Quarters, *Committee Hansard*, 4 April 2023, p. 18.

139 Fair Agenda, *Submission 66*, p. 13.

140 Fair Agenda, *Submission 66*, p. 13.

141 Australian Christian Lobby, *Submission 188*, p. 3.

142 Australian National University Law Reform and Social Justice Research Hub, *Submission 121*, p. 3.

> help assess the effectiveness of sex education, access to effective contraception, and understanding of fertility and menopause.[143]

3.130 Children by Choice and Ending Violence Against Women Queensland also supported increasing research and data collection on abortion access.[144]

Committee view

3.131 The committee recognises that healthcare is a fundamental human right and barriers to accessing maternal, sexual and reproductive healthcare can have adverse impacts on an individual's mental, emotional, and physical health.

3.132 The committee has heard that Australians face numerous barriers when attempting to access reproductive healthcare services — particularly in regional, rural and remote areas.

3.133 During the inquiry, numerous participants provided various ideas and proposed initiatives aimed at reducing, and potentially eliminating, the existing barriers. The committee considers that people should have genuine choice and be well supported in relation to their sexual, reproductive and maternal healthcare decisions.

Removing access barriers to maternity and termination care

Ensure the provision of maternity care services at public hospitals

3.134 The committee is concerned by the evidence illustrating the lack of maternity and birthing services for women who live in regional, rural, and remote areas of Australia. In particular, it is concerned to hear that women without access to adequate local birthing services must relocate and give birth away from home. The committee highlights evidence showing that this leads to poor outcomes for women and their babies, given that relocation comes with a financial cost, removes them from their support networks and families, and disrupts their continuity of care.

3.135 The committee considers it extremely important that women, regardless of where they live in Australia, have easy access to high quality, culturally safe maternity care. Women and their families should not be disadvantaged for living outside of a metropolitan area.

Recommendation 12

3.136 The committee recommends that the Australian, state, and territory governments ensure that maternity care services, including birthing services, in non-metropolitan public hospitals are available and accessible for all

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143 Fair Agenda, *Submission 66*, p. 13.

144 Children by Choice, *Submission 60,* p. 6; Ending Violence Against Women Queensland, *Submission 38,* p. 5.

pregnant women at the time they require them. This is particularly important for women in rural and regional areas.

Recommendation 13

3.137 The committee recommends that the Australian Government implements outstanding recommendations made by the Participating Midwife Reference Group to the Medicare Benefits Schedule (MBS) Review Taskforce regarding midwifery services and continuity of care.

Recommendation 14

3.138 The committee recommends that the Australian Government works with the sector to increase birthing on country initiatives and other culturally appropriate continuity of care models.

The provision of termination care at public hospitals

3.139 Throughout the inquiry, the committee heard from stakeholders that Australia lacks adequate clinical services for termination care, resulting in women facing long waiting lists and lengthy travel times, often across state and territory borders and under acute time pressures, to access the appropriate care.

3.140 The committee heard that this can cause delays and increase the cost, complexity and risk of trauma. The committee is mindful that these issues were raised as particularly acute for women and girls living in rural, regional and remote Australia, where access to any hospital can be challenging.

3.141 The committees notes the evidence that publicly funded hospitals that provide maternity and women's health services provide no termination services, or only provide very limited services or referral pathways. The committee notes that surgical termination is legal in all Australian states and territories.

3.142 Additionally, it notes the evidence from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists that the establishment of consistent public hospital termination care pathways would enhance equitable access to essential healthcare and also create additional training pathways for health practitioners.

Recommendation 15

3.143 The committee recommends that all public hospitals within Australia be equipped to provide surgical pregnancy terminations, or timely and affordable pathways to other local providers. This will improve equality of access, particularly in rural and regional areas and provide workforce development opportunities.

Implementation plan for sexual and reproductive healthcare

3.144 Throughout this inquiry, the committee heard numerous calls for the establishment of a national taskforce to deliver on the broader Women's Health Strategy. The committee notes evidence suggesting that without such a taskforce, government reforms would be piecemeal and continue the existing postcode lottery that currently characterises reproductive healthcare in Australia.

3.145 The committee notes the proposal to establish such a taskforce and considers it could be an important step in developing a practical plan to address accessibility issues and achieve the priorities set out in the Women's Health Strategy.

Recommendation 16

3.146 The committee recommends that the Australian Government develops an implementation plan for the *National Women's Health Strategy 2020–2030* with annual reporting against key measures of success. This could include establishing a taskforce as part of the implementation plan.

Fund a national telephone and mapping service

3.147 The committee recognises the evidence supporting the development of a national telephone service to provide support to people across Australia regarding pregnancy care and termination services. Options to implement such a measure could include the development of an interactive national map to assist people with finding counselling services about pregnancy care options, termination service providers, medical termination prescribing doctors and dispensing pharmacists, and other relevant information on clinical services, financial costs, and available assistance options.

3.148 The committee considers such a model may assist state and territory governments to identify where service gaps currently exist within their jurisdictions.

Recommendation 17

3.149 The committee recommends that the Australian Government, in consultation with state and territory governments, implements a national support, information, and referral model for sexual and reproductive healthcare services.

3.150 The committee envisages that such a national telephone service would leverage the experiences of existing initiatives, such as 1800 My Options and healthdirect, to ensure that it is fit for purpose, delivers accurate local information, and builds on the experiences of services operating in those jurisdictions.

Provide adequate remuneration for medical termination consultations

3.151 The committee heard evidence regarding the impact of MBS rebate levels and service provision. Existing MBS rebates can mean that the cost of early medication abortion provision is too prohibitive for GPs and community clinics to be able to bulk-bill. The committee understands that this is because MBS rebates are based on the length of an appointment and the generic consultation MBS item does not account for the high administrative workload associated with medical termination provision.

3.152 The committee supports the Government's 2023–24 Budget measures for longer consultations and increased bulk-bill incentives. The committee suggests the Government monitor the impact of these measures to ensure Medicare arrangements supporting medical termination consultations remain adequate.

Recommendation 18

3.153 The committee recommends that the Australian Government reviews the existing Medicare arrangements which support medical termination consultations with the aim of ensuring adequate remuneration for practitioners to deliver these services while also ensuring patient privacy.

Make Medicare-funded telehealth consultations permanent

3.154 The committee supports calls for the temporary telehealth items which facilitate sexual and reproductive healthcare consultations via video and telephone to be made permanent additions to the MBS.

3.155 The committee acknowledges the significant benefits that telehealth can provide the Australian community, especially for those people living in regional, rural, and remote areas where access to a local health practitioner is not always possible.

3.156 The committee is of the view that by making these items permanent, access to sexual and reproductive healthcare would be improved. Importantly, these items are flexible and allow patients to access alternative providers without an existing prior relationship in place. The committee considers this important for a number of reasons, including supporting patient privacy and providing access to alternative practitioners in circumstances where a provider doesn't provide medical termination services or is a conscientious objector.

Recommendation 19

3.157 The committee recommends that the Australian Government continues current Medicare Benefits Schedule telehealth items for sexual and reproductive healthcare, including pregnancy support counselling and termination care.

Reforming regulatory and legislative frameworks

Relax restrictive regulations on MS-2 Step

3.158 The committee notes evidence regarding the lack of GPs and pharmacists able to prescribe and dispense MS-2 Step in Australia, with evidence indicating that approximately 10 per cent of GPs and 16 per cent of pharmacists are active prescribers and dispensers, respectively, of this medication.

3.159 The committee notes that evidence provided during the inquiry suggested that other comparable jurisdictions, such as Canada, the United Kingdom, and Europe, had less onerous prescription regulations and that this had resulted in improved access without additional adverse outcomes—and had in fact lowered gestational age at time of termination.

3.160 The committee recognises that the TGA is currently considering an application submitted by MS Health to reduce the existing restrictions on GPs and pharmacists, as well as a proposal to broaden the health practitioners that can prescribe MS-2 Step.

Recommendation 20

3.161 The committee recommends that the Therapeutic Goods Administration and MS Health review barriers and emerging evidence to improve access to MS-2 Step, including by:

- **allowing registered midwives, nurse practitioners, and Aboriginal Health Workers to prescribe this medication—including pain relief where indicated; and**
- **reducing training requirements for prescribing practitioners and dispensing pharmacists.**

Improving training and data collection

Include reproductive healthcare in university courses

3.162 The committee notes evidence indicating that comprehensive reproductive healthcare, including basic training on termination care and LARCs, is insufficient in undergraduate degrees for doctors, nurses, and midwives.

3.163 As evidence provided to the inquiry showed, inadequate training can have serious consequences for patients who may be forced to continue with an unintended pregnancy or undergo a more invasive procedure to end a pregnancy due to misinformation provided by an insufficiently trained health practitioner.

3.164 The committee considers that enhancing such training could better equip health practitioners with the necessary skills and knowledge to guide, advise and assist their patients.

Recommendation 21

3.165 The committee recommends that the Australian Government, in consultation with relevant training providers, reviews the availability, timing, and quality of sexual and reproductive healthcare training in undergraduate and postgraduate tertiary health professional courses, including vasectomy procedures, terminations and insertion of long-acting reversible contraception.

Improve statistical data collection and information on reproductive healthcare

3.166 The committee agrees with inquiry participants that the lack of data and information on sexual and reproductive healthcare must be addressed as a priority.

3.167 Given this, the committee endorses calls for the Government to work to improve national data collection to enable evidence-based policy responses relating to termination services and other sexual and reproductive healthcare services across Australia.

3.168 The committee also considers that the Department of Health and Aged Care, in collaboration with its state and territory counterparts, should consider the effectiveness of local programs which provide free menstrual hygiene products.

Recommendation 22

3.169 The committee recommends that the Australian Government commissions work to improve its collection, breadth, and publication of statistical data and information regarding sexual and reproductive healthcare, particularly in relation to pregnancy terminations, both medical and surgical, and contraceptive use across Australia.

Recommendation 23

3.170 The committee recommends that the Department of Health and Aged Care works closely with its state and territory counterparts to consider the effectiveness of local programs providing free menstrual hygiene products.

Chapter 4
Delivering appropriate and adapted care

> For reproductive health care to be truly universal it must be able to provide care for everyone and everybody in our communities both confidently and competently. When it comes to reproductive health care, we all have different needs, different histories, different body parts, different partners and different futures. Universal reproductive health care needs to recognise and celebrate differences and approach each patient with a view to understanding their individual healthcare needs, because assumptions, judgement and discrimination have lifelong impacts.[1]

4.1 There is no one-size-fits all approach to reproductive and sexual healthcare. Service provision and care must be appropriate and adapted in order to provide positive reproductive health outcomes for all subsections of Australia's community.

4.2 This chapter explores the barriers to reproductive healthcare for various groups within the community and recommended solutions to improve outcomes. It begins with an examination of transgender, non-binary and people with innate variations of sex characteristics and their experiences within the reproductive health system. It then moves to an analysis of accessibility barriers for people with a disability to reproductive healthcare.

4.3 The chapter then discusses the importance of trauma-informed and culturally appropriate service delivery for culturally and linguistically diverse migrants and refugees and First Nations people. The chapter moves onto examine vulnerable women and their experiences of reproductive violence and concludes by exploring assisted reproductive technologies and barriers to accessing these services. The committee's view and associated recommendations are made at the end of the chapter.

Transgender people, non-binary people, and people with variations of sex characteristics

4.4 The committee heard that accessing reproductive healthcare can be a harmful experience for transgender people, non-binary people, and people with variations of sex characteristics. Furthermore, that reproductive healthcare services are often not affirming or trauma-informed.[2]

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1 Ms Karen Price, Deputy Chief Executive Officer, ACON, *Committee Hansard,* 21 February 2023, p. 2.

2 See for example: Equality Tasmania, *Submission 39,* p. 2; ACON, *Submission 52,* p. 4; Department of Health and Aged Care, *Submission 53*, p. 39; LGBTIQ+ Health Australia, *Submission 67,* p. 5; Australian Medical Association, *Submission 71,* p. 10; Victorian Pride Lobby, *Submission 117,* p. 3; Thorne Harbour Health and Victoria Pride Lobby, *Submission 119,* p. 8

People with variations of sex characteristics

4.5 Intersex Human Rights Australia outlined that Australia has conducted two major national inquiries into the health and human rights of people with innate variations of sex characteristics (also known as intersex).[3] This includes a 2013 report by the Community Affairs References Committee (committee) on the involuntary or coerced sterilisation of intersex people in Australia, and the more recent 2021 Australian Human Rights Commission's (Commission) report, *Ensuring Health and Bodily Integrity*.[4]

4.6 The Government is undertaking a national consultation with LGBTIQA+ people in relation to their experiences when accessing health services, and committed to the development of a 10 Year National Action Plan for the health and wellbeing of LGBTIQA+ people.[5] Within this consultation, the Government will examine the Commission's report, which made recommendations on a human rights approach for people with innate variations of sex characteristics.[6]

4.7 LGBTIQ+ Health Australia submitted that people with innate variations of sex characteristics are often the subject of medical interventions at very young ages, usually before they can express their preferences and agency.[7] Dr Ahmad Syahir Mohd Soffi elaborated that although some interventions are necessary for health reasons, others are conducted to 'normalise' genital appearance based on binary definitions of sex characteristics.[8]

4.8 According to the Commission report, stigmatisation can also arise in clinical guidelines, where justifications for gender assignments and medical interventions are grounded in normalisation. For instance, the Commission highlighted the 2006 *Consensus Statement on Management of Intersex Disorders* (the Consensus Statement), which states that gender assignment can be influenced by genital appearance and views of the family.[9]

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3 Intersex Human Rights Australia, *Submission 61,* p. 7.

4 Senate Community Affairs References Committee, *Second Report: Involuntary or coerced sterilisation of intersex people in Australia*, October 2013; Australian Human Rights Commission, *Ensuring Health and Bodily Integrity*, October 2021.

5 The Hon Mark Butler, Minister for Health and Aged Care, 'Pathway to better health for LGBTIQA+ communities', *Media Release,* 1 March 2023, https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/pathway-to-better-health-for-lgbtiqa-communities.

6 Department of Health and Aged Care, *Submission 53*, p. 39.

7 LGBTIQ+ Health Australia, *Submission 67*, p. 6.

8 Dr Ahmad Syahir Mohd Soffi, *Submission 166,* p. 17.

9 I A Hughes, C Houk, S F Ahmed and P A Lee, 'Consensus statement on management of intersex disorders,' *Pediatrics,* vol. 118, no. 2, pp. 488–500, https://doi.org/10.1136%2Fadc.2006.098319; Australian Human Rights Commission, *Ensuring Health and Bodily Integrity*, October 2021, p. 80.

4.9 Intersex Human Rights Australia reported on many negative sexual and reproductive health implications caused by unnecessary medical interventions. They submitted that many people have been subject to feminising or masculinising surgeries that do not align with their own preferences.

4.10 Intersex Human Rights Australia also reported that some intersex people are unable to orgasm or suffer from pain because their feminising surgeries valued appearance over functionality. Additionally, experiences for those subjected to masculinising surgery also include a reliance on devices inserted into the urethra to urinate.[10]

4.11 Intersex Human Rights Australia submitted that these interventions create flow-on effects for intersex people for the rest of their lives. They explained that the medical trauma of forced intervention, spurred by stigma, can have a deterrent effect on intersex people from engaging in the healthcare system, including accessing sexual and reproductive health services.[11]

Clinician confidence and guidance

4.12 Intersex Human Rights Australia observed that medical trauma fuels a perception that mainstream health services and health practitioners are not familiar with the needs of intersex people.[12] LGBTIQ+ Health Australia echoed similar concerns, submitting that most healthcare providers do not have expertise on intersex variations.[13] Healthcare providers have themselves expressed uncertainty on the needs of intersex people, with only 19 per cent of NSW Health staff expressing confidence.[14] Intersex Human Rights Australia suggested that a lack of understanding of intersex people and their needs can be partly attributed to the use of frames that are applied homogenously to this heterogenous group of people, where they are commonly, and incorrectly, understood to be an identity group or third gender.[15]

Transgender people and non-binary people

4.13 The committee heard that transgender and non-binary people are more likely to experience adverse health outcomes when compared to their cisgendered peers.[16] Factors contributing to these outcomes are explored below.

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10 Intersex Human Rights Australia, *Submission 61*, pp. 24–26.

11 Intersex Human Rights Australia, *Submission 61*, p. 40.

12 Intersex Human Rights Australia, *Submission 61*, p. 40.

13 LGBTIQ+ Health Australia, *Submission 67*, p. 7.

14 Intersex Human Rights Australia, *Submission 61*, p. 40.

15 Intersex Human Rights Australia, *Submission 61*, p. 40.

16 ACON, *Submission 52*, p. 11.

Gendered language and services

4.14 In their submission, LGBTIQ+ Health Australia stated that LGBTIQA+ people underutilise health services due to actual or anticipated experiences of stigma.[17] They explained that this is fuelled by experiences where healthcare providers commonly misgender transgender people, or call them by their birthname which they no longer use, a behaviour known as 'dead-naming'.[18] ACON, an HIV and LGBTIQA+ community health organisation, added that gendered language is also commonly used by health practitioners when referring to anatomy, and incorrect assumptions are routinely made about individuals' bodies.[19] This can be particularly harmful for transgender people. Ms Karen Price, Deputy Chief Executive Officer of ACON, explained:

> Reproductive health affects parts of the body that, while for some people might be a little bit uncomfortable or embarrassing, for trans and gender diverse people can be the site of self-hate, trauma and other complex emotions.[20]

4.15 ACON further demonstrated that gendered language is also used on a wider scale, which is illustrated by the divide between men's health and women's health services. This can act as a deterrent for transgender and non-binary people to engage with these services.

4.16 To address these issues, ACON developed a variety of resources and models to assist health practitioners in becoming more inclusive and affirmative in their treatment of patients. For example, ACON's clear language guide for health practitioners is a comprehensive resource that could be used as a complementary tool for further health practitioner training.[21]

Lack of access to appropriate care

4.17 In addition to the evidence raised around gendered language, the committee heard that transgender and non-binary people also struggle to access appropriate care on a broader scale.

4.18 ACON raised concerns that LGBTIQA+ people report much lower rates of screening, for both sexually transmitted infections and cancer of the sexual organs, than their cisgendered peers. ACON further added that this is particularly pertinent for lesbian cisgendered women and transgender people

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17 LGBTIQ+ Health Australia, *Submission 67*, p. 6.

18 LGBTIQ+ Health Australia, *Submission 67*, p. 10.

19 ACON, *Submission 52*, p. 11.

20 Ms Karen Price, Deputy Chief Executive Officer, ACON, *Committee Hansard*, 21 February 2023, p. 2.

21 ACON, *A Language Guide: Trans and Gender Diverse Inclusion*, March 2019, www.acon.org.au/wp-content/uploads/2019/07/TGD_Language-Guide.pdf.

with a cervix.[22] They outlined that low screening rates are driven by a lack of appropriate information and understanding of the sexual and reproductive health needs of lesbian, transgender and non-binary people.

4.19 A lack of information regarding the health needs of the LGBTIQA+ community was reiterated by Rainbow Families, in which a community member told the organisation that they were:

> … refused an STI and pap smear by a doctor because "lesbian [sic] only kiss each other's bits" and can't catch anything."[23]

4.20 The committee notes that the commitment from the Government to develop with the sector a 10 Year National Action Plan for the Health and Wellbeing of LGBTIQA+ people that will guide how Australia addresses health disparities and makes improvements across the system, including in rural and regional contexts and consider the feasibility of peer support models of care.[24]

People with disability

4.21 Under *Australia's Disability Strategy 2021–2031*, federal, state, and territory governments have committed to improving health services to create better health outcomes for people with disability.[25] Notwithstanding this, it was brought to the committee's attention that people with disability continue to face a range of barriers when accessing reproductive healthcare.

4.22 When giving evidence to the committee, Ms Carolyn Frohmader, Executive Director of Women With Disabilities Australia, explained that women and girls with disability:

> … are subject to widespread discrimination, systemic prejudice, paternalistic and ableist attitudes that denigrate, devalue, oppress and deny us our rights.[26]

Inadequate access to sexual and reproductive healthcare services

4.23 People with disability may struggle to engage with sexual and reproductive healthcare providers due to inaccessibility across a range of services, including

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22 ACON, *Submission 52,* p. 6.

23 Rainbow Families, *Submission 96,* p. 4.

24 The Hon Mark Butler, Minister for Health and Aged Care, 'Pathway to better health for LGBTIQA+ communities', *Media Release*, 1 March 2023, https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/pathway-to-better-health-for-lgbtiqa-communities.

25 Department of Health an Aged Care, *Submission 53*, pp. 33–34.

26 Ms Carolyn Frohmader, Executive Director, Women With Disabilities Australia, *Committee Hansard*, 28 February 2023, p. 25.

general practices, hospitals, local surgeries and clinics.[27] Common barriers to accessing these services manifest in a variety of different ways. For instance, Women With Disabilities Australia raised concerns that physical accessibility is limited in service provider settings. They explained that physical inaccessibility can range from a lack of accessible transport to and from the healthcare provider, to a lack of accessibility in and around the building, or inaccessible equipment relating to things like examination tables and diagnostic equipment.[28]

4.24 Women With Disabilities Australia also noted that barriers to accessing sexual and reproductive healthcare information for people with disability persist. It elaborated that there continues to be a lack of information that is produced by healthcare providers in formats such as 'Easy English' or screen-reader friendly websites. Women With Disabilities Australia explained that these barriers limit the capacity of people with disability to make informed decisions about their health.[29]

Healthcare workforce: training and practices

4.25 Down Syndrome Australia submitted that barriers to accessibility are compounded by inadequate workforce training. For instance, Chief Executive Officer, Mr Darryl Steff told the committee that:

> Even if [health practitioners] understand all the content and the information they're seeking to deliver, they've had 2.5 hours in their whole degree to understand how they might need to tailor that for someone with an intellectual disability.[30]

4.26 Further, Down Syndrome Australia found that most nursing degrees do not have any content specific to intellectual disability.[31] The Public Health Association Australia submitted similar findings, and highlighted that most service providers do not offer training to health practitioners on disability identification, documentation or referral pathways.[32] The committee notes the Government's commitment to establish the National Centre of Excellence in

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27 Women With Disabilities Australia, *Towards Reproductive Justice for young women, girls, feminine identifying, and non-binary people with disability (YWGwD)* (*Reproductive Justice Report*), November 2022, p. 16.

28 Women With Disabilities Australia, *Reproductive Justice Report*, p. 16; Department of Health and Aged Care, *Submission 53*, p. 38.

29 Women With Disabilities Australia, *Reproductive Justice Report*, p. 11.

30 Mr Darryl Steff, Chief Executive Officer, Down Syndrome Australia, *Committee Hansard*, 28 February 2023, p. 28.

31 Down Syndrome Australia, *Submission to Disability Royal Commission Health Issues Paper - Inclusion*, March 2020, p. 6.

32 Public Health Association Australia, *Submission 92*, p. 19.

Intellectual Disability Health, that will bring together experts, resources and research on intellectual disability healthcare. Establishment of this centre is a priority under the National Roadmap for Improving the Health of People with Intellectual Disability.[33]

4.27 The Royal Women's Hospital echoed concerns that many hospitals and healthcare providers lack a basic understanding of the reproductive and sexual health rights and needs of people with disability, which results in ineffective communication when treating and engaging with people with disability.[34] The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability highlighted that health practitioners are typically ill-equipped to engage effectively with people with cognitive and intellectual disability, as they do not communicate healthcare information in accessible ways.[35] This further limits the ability of people with disability to understand their sexual and reproductive health and to consequently make decisions about it.

4.28 In addition to communication barriers and a lack of workforce training, expectant and new mothers with disability face unique barriers of their own in the healthcare system. Tailored pre and postnatal care, as well as parenting support for women with disability, typically does not occur. Evidence provided to the committee by the Royal Women's Hospital explained this is partly caused by a lack of consistent disability identification procedures in healthcare settings:

> There is currently no national standardised way of asking about disability status. National standardised identification and recording of disability status is fundamental to providing appropriate funding, services and support for this at-risk group of women.[36]

4.29 The Royal Women's Hospital stated that there is a need for the development of disability identification, data collection and support services to ensure that all women with disability have access to quality maternal care nationwide.[37] The Royal Women's Hospital has addressed this gap in the healthcare system by establishing the 'Women with Individual Needs Clinic', which supports women with physical, learning and intellectual disabilities by offering specialist

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33 Department of Health and Aged Care, *National Centre of Excellence in Intellectual Disability Health*, 16 February 2023, https://www.health.gov.au/our-work/national-centre-of-excellence-in-intellectual-disability-health (accessed 24 May 2023).

34 The Royal Women's Hospital, *Submission 85*, p. 6.

35 Women With Disabilities Australia, *Reproductive Justice Report*, p. 11; Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability, *Issues Paper: Health care for people with cognitive disability*, p. 3.

36 The Royal Women's Hospital, *Submission 85*, p. 6.

37 Public Health Association Australia, *Submission 92*, p. 19.

midwifery antenatal and postnatal care. However, The Royal Women's Hospital stated that this clinic is the only one of its kind in Australia.[38]

Lack of reproductive and sexual healthcare education for people with disability

4.30 The Public Advocate (Queensland) highlighted that insufficient sexual and reproductive healthcare education is a particularly important factor that prevents people with disability from fully exercising their sexual and reproductive rights.[39]

4.31 Women With Disabilities Australia echoed similar views, noting that young people with disability are likely to be just as sexually active as their peers without disability but are less likely to receive the same standard of sexual education.[40] They attributed poor education outcomes to a lack of schools teaching content on relationships and sexuality.[41]

4.32 Referring more broadly to the Australian curriculum, Dr Jacqui Hendriks, Founder of Bloom-ED, an alliance of teachers, researchers, students, parents and organisations that advocates for improved sexual and reproductive health literacy noted that it is difficult to find terms such as 'sex, sexuality, puberty, menstruation, pregnancy, abortion, contraception, sexually transmissible infection or pornography' in the newly revised Australian curriculum.

4.33 Dr Hendriks commented on the limitations of teacher training programs:

> We've got some really fabulous, engaging, high-quality programs, but our teacher training programs do not cover this area when someone is training to be a teacher, and the access to professional learning once you're out in classrooms is very limited. So people should feel really confident to deliver this stuff, because, if we don't do it well, we actually do more harm.[42]

4.34 Dr Hendriks explained how curriculum content is delivered in schools:

> Just for some clarity on the curriculum: there's a section called the content descriptor, which is mandatory. For every content descriptor, there will be four or five elaborations. These are examples of how you might achieve that content descriptor … If the outcome is personal safety, we could teach about safer sex practices and contraception, or we could teach about road safety. So there's that diversity there. It's basically: 'Choose what you're comfortable with.'[43]

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38 The Royal Women's Hospital, *Submission 85,* p. 6.

39 The Public Advocate (Queensland), *Submission 8*, p. 20.

40 Women With Disabilities Australia, *Reproductive Justice Report*, p. 15.

41 Women With Disabilities Australia, *Reproductive Justice Report*, p. 16.

42 Dr Jacqueline Hendriks, Founder, Bloom-ED, *Committee Hansard*, 4 April 2023, p. 6.

43 Dr Jacqueline Hendriks, Founder, Bloom-ED, *Committee Hansard*, 4 April 2023, p. 8.

4.35 Noting that this education is not mandatory, Women With Disabilities Australia attributed the reluctance to teach such topics due to teachers being anxious, untrained and unwilling to discuss relationships and sexuality with people with disability.

4.36 Additionally, Women With Disabilities Australia commented that when sexual and reproductive healthcare education is provided, it is typically through a narrow lens that is:

> … cis-heteronormative, Eurocentric, body negative, sex negative and concerned with disease and pregnancy prevention.[44]

Self-determination for people with disability

4.37 The committee was informed that people with disability also regularly encounter issues regarding self-determination. The *National Plan to End Violence against Women and Children* highlighted the fact that women and girls with disability are at particular risk of forced or coerced medical interventions, such as sterilisation, contraception, and abortion.[45]

4.38 The Department of Health and Aged Care (the Department) explained that guardianship tribunals make decisions on behalf of individuals with an impaired capacity to make independent decisions, with interventions occurring when it is deemed to be in the individual's best interest.[46]

4.39 However, the Australian Lawyers for Human Rights contended that this can perpetuate harmful stereotypes that women and girls with disability lack the capacity to care for children, manage their own menstruation or control their own sexuality and fertility.[47]

4.40 Women With Disabilities Australia commented that forced intervention can be used to reduce the care burden of an individual with a disability. They explained that women and girls with disability will be presented with fewer contraceptive options than their peers without a disability, in order to favour the convenience of the caregiver at the expense of the individual's autonomy.[48] Additionally, they put forward that the forced use of contraception can also be used to hide sexual abuse of a woman or girl with disability by preventing pregnancy.[49]

4.41 Raising similar concerns, Dr Emily Castell, Clinical Director of the Sexuality Education Counselling Consultancy Agency, told the committee that:

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44 Women With Disabilities Australia, *Reproductive Justice Report*, p. 16.

45 Department of Health and Aged Care, *Submission 53*, p. 39.

46 Department of Health and Aged Care, *Submission 53*, p. 39.

47 Australian Lawyers for Human Rights, *Submission 23,* p. 19.

48 Women With Disabilities Australia, *Reproductive Justice Report*, p. 18.

49 Australian Lawyers for Human Rights, *Submission 23*, p. 19.

> The absolute concern for us is the restrictive and coercive component. Actions like having long-acting reversible contraceptives or sterilisations may be legal and approved; however, they're coercive. So it's what we don't hear about that's particularly concerning. There often is a way to frame it or spin it so that it makes sense, but in fact it is violating someone's rights. Because people with disabilities are unfortunately socialised in some settings and communities to be compliant and to not ask those questions or to not have the opportunity for supported decision-making, we don't equip people with the skills or the knowledge to understand their rights and explore that further.[50]

4.42 The aforementioned lack of accessible reproductive and sexual health information and education for people with disability also promotes a lack of autonomy.[51] If women and girls with disability are unaware of their sexual and reproductive health options, they then lack the ability to exercise their own decision-making, thus restricting their self-determination.

Trauma-informed and culturally appropriate service delivery

Culturally and linguistically diverse migrants and refugees

4.43 The committee was told that culturally and linguistically diverse (CALD) women experience poorer sexual and reproductive healthcare outcomes than non-Indigenous Australian women.

4.44 In response to these gaps, the Department advised that the Government has provided funding to increase access to services, boost community awareness, and provide sexual and reproductive healthcare information under the previous *National Plan to Reduce Violence against Women and their Children 2010–2022*.[52]

4.45 However, the committee heard that gaps in sexual and reproductive health outcomes for CALD migrants and refugees persist.[53] For example, Women's Health East highlighted that CALD migrant and refugee women have lower participation rates in breast and cervical screening and lower sexual and reproductive health literacy compared to non-Indigenous Australian women.[54] The Multicultural Centre for Women's Health submitted similar findings, as those born in non-English speaking countries have the lowest rates of

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50 Dr Emily Castell, Clinical Director, Sexuality Education Counselling Consultancy Agency, *Committee Hansard*, 4 April 2023, p. 11.

51 Australian Lawyers for Human Rights, *Submission 23*, p. 19.

52 Department of Health and Aged Care, *Submission 53*, p. 37.

53 Women's Health East, *Submission 36*, pp. 6–7.

54 Women's Health East, *Submission 36*, p. 7.

contraception use in Australia, relying instead on techniques such as the withdrawal method.[55]

4.46 The Department explained that there are a variety of factors that drive poor sexual and reproductive health outcomes for CALD migrants and refugees, including low health literacy, a lack of understanding of Australia's healthcare system, prior experiences resulting in a lack of trust in the healthcare system, cultural and social norms potentially preventing open and frank discussions about sexual and reproductive health, and language barriers causing miscommunication between the patient and health practitioner, as well as misdiagnosis and inadequate follow-up care.[56]

4.47 Submitters also noted factors that contribute to poor sexual and reproductive health outcome for CALD migrants and refugees. The Multicultural Centre for Women's Health explained that temporary migrants, international students and temporary workers are all ineligible for Medicare, and therefore cannot claim rebates for medicines listed on the Pharmaceutical Benefits Scheme.

4.48 The Multicultural Centre for Women's Health elaborated that temporary migrants face greater out-of-pocket costs if they wish to use contraception, compared to those who are eligible for rebates.[57] They outlined that international students also face structural barriers related to pregnancy care as they are not eligible for Medicare. Additionally, international students must have Overseas Student Health Cover while studying in Australia which has a 12-month waiting period upon arrival for '[h]ospital treatment or hospital-substitute treatment that is for a pregnancy related condition, except for Emergency Treatment.'[58]

4.49 According to the Multicultural Centre for Women's Health, 70 per cent of pregnancy-related claims for international students occur within the first 12 months of cover, thereby negatively impacting international students on a vast scale.[59] As a result, international students potentially face limited options if they unintentionally become pregnant during this 12-month waiting period on overseas student health cover.[60]

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55 Multicultural Centre for Women's Health, *Submission 102*, p. 5.

56 Department of Health and Aged Care, *Submission 53*, p. 36.

57 Multicultural Centre for Women's Health, *Submission 102*, p. 5.

58 Multicultural Centre for Women's Health, *Submission 102*, pp. 6–7; see also schedule 4d of the *Deed for the Provision of Overseas Student Health Cover*, www.health.gov.au/sites/default/files/documents/2022/07/deed-for-the-provision-of-overseas-student-health-cover-1-july-2022.pdf (accessed 28 April 2023).

59 Multicultural Centre for Women's Health, *Submission 102*, pp. 6–7.

60 Multicultural Centre for Women's Health, *Submission 102*, p. 7.

4.50 Trauma-informed care is also paramount when considering how CALD refugees and migrants engage with Australia's reproductive healthcare system. Members of the Australian College of Nursing (ACN) raised concerns that there is a clear lack of trauma-informed training throughout tertiary education. They advised that numerous healthcare providers are not providing sufficient reproductive healthcare to refugee and migrant women.[61]

4.51 The Multicultural Centre for Women's Health mirrored this evidence and emphasised:

> …[the] need to ensure that migrant and refugee communities can navigate the health system and feel informed and empowered to make decisions for their sexual and reproductive health without judgement and stigma.[62]

4.52 Consequently, the ACN argued for improved cultural competency training whilst studying, as well as ensuring that this training continues once qualified as a health practitioner.[63]

4.53 The committee heard about the Health in My Language Program from the Multicultural Centre for Women's Health. The program was developed during COVID-19 to address health information inequities, in which Dr Adele Murdolo, Executive Director of the Multicultural Centre for Women's Health, explained that the program delivers:

> … in-language education on COVID vaccination and information from COVID itself to people in an outreach capacity. [The Multicultural Centre for Women's Health] has supported all of these partner organisations around the country to recruit, train and provide ongoing support and resources to these bilingual, bicultural workers, and then they go out into the community and provide information about COVID.[64]

First Nations people

4.54 The Department provided evidence that First Nations women and girls continue to have poorer health outcomes compared to non-Indigenous women in Australia.[65] The Department also identified that First Nations women and girls have a higher prevalence of sexually transmitted infections, higher rates of teenage pregnancy and birth, as well as significantly poorer maternal health outcomes, with higher rates of maternal mortality and infant deaths.[66]

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61 Australian College of Nursing, *Submission 16*, p. 7.

62 Multicultural Centre for Women's Health, *Submission 102,* p. 9.

63 Australian College of Nursing, *Submission 16*, p. 7.

64 Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, *Committee Hansard*, 28 April 2023, pp. 12–13.

65 Department of Health and Aged Care, *Submission 53*, pp. 35–36.

66 Department of Health and Aged Care, *Submission 53*, pp. 35–36.

4.55 The Department outlined that First Nations women and girls must navigate a health system that is characterised by a lack of culturally safe services and a lack of trained staff who operate in regional and remote areas.[67] This makes it difficult to seek services for pregnancy terminations, tubal ligation and insertion of intrauterine devices.[68]

4.56 Further, First Nation's Women Legal Services Queensland, Inc reported that although First Nations women and girls are proactive in accessing contraception, they face judgement and bias from health practitioners when trying to do so.[69] This was identified as contributing to distrust of doctors,[70] which can manifest in general health service avoidance for First Nations women and girls.[71]

4.57 In recognition of these poor health outcomes, the Department advised that the Government has a range of strategies aimed at addressing these inequities, including the *National Women's Health Strategy 2020–2030*, *Closing the Gap*, and *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031*.[72] The Government has also provided funding to First Nations health professional organisations.[73]

4.58 First Nations people have reported to the First Nations Women Legal Services Queensland, Inc. (FNWLSQ) that some health practitioners in mainstream services still hold biases and misconceptions about First Nations patients.[74] This is compounded by a lack of trust in government services driven by intergenerational trauma for First Nations people, as the FNWLSQ flagged.[75] Further, they highlighted a broader problem where some health practitioners may lack the cultural competency to engage appropriately with First Nations patients. For instance, FNWLSQ submitted that lack of awareness of cultural taboos and men's and women's business was a common issue amongst these health practitioners.[76]

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67 Department of Health and Aged Care, *Submission 53,* p. 35.

68 Department of Health and Aged Care, *Submission 53*, p. 35.

69 First Nation's Women Legal Services Queensland, Inc, *Submission 59,* p. 4.

70 First Nation's Women Legal Services Queensland, Inc, *Submission 59*, p. 4.

71 Department of Health and Aged Care, *Submission 53*, p. 35.

72 Department of Health and Aged Care, *Submission 53*, p. 35.

73 Department of Health and Aged Care, *Submission 53*, p. 34.

74 First Nations Women's Legal Services Qld, Inc, *Submission 59,* p. 16.

75 First Nations Women's Legal Services Qld, Inc, *Submission 59*, pp. 15–16.

76 First Nations Women's Legal Services Qld, Inc, *Submission 59*, p. 13.

4.59 Consequently, the National Aboriginal Community Controlled Health Organisation has highlighted that First Nations people prefer to bypass mainstream services altogether, preferencing Aboriginal Community Controlled Health Organisations (ACCHOs) as their cultural safety can be guaranteed.[77]

4.60 However, as the Institute for Urban Indigenous Health told the committee, ACCHOs have suffered due to a lack of sufficient workers that can provide sexual and reproductive healthcare services.[78] For instance, the Aboriginal Health & Medical Research Council (AHMRC) of New South Wales stated that ACCHOs are experiencing limited access to GPs, gynaecologists, nurses and midwives who are trained on IUD insertion. Consequently, they explain that patients are referred to non-community-controlled services, but as these services are viewed as being culturally unsafe, many First Nations women and girls are deterred from engaging with their services.[79]

4.61 The AHMRC of NSW also reported that limited access to trained GPs and gynaecologists impacts First Nations women and girls who are seeking surgical abortions. They flagged that there are no known ACCHOs in the state that provide surgical abortions, thus forcing First Nations women and girls into non-community-controlled and potentially culturally unsafe abortion clinics.[80]

4.62 To address these issues, submitters contended that continued investment in the First Nations health workforce is fundamental to ensuring that First Nations women and girls have access to maternal, sexual and reproductive care in culturally safe and trauma-informed spaces. Moreover, that to close the gap in health outcomes between First Nations and non-Indigenous Australians, it is imperative that ACCHOs are properly funded and well supported.[81]

Vulnerable women and reproductive coercion and abuse

4.63 Reproductive coercion and abuse are a form of gendered violence, in which a woman's reproductive autonomy is restricted or controlled. The Department explained how this can manifest in various ways, including the sabotage of contraception, pressuring a woman to become pregnant or to continue with a

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77 National Aboriginal Community Controlled Health Organisation, *Submission 75,* p. 10.

78 Ms Donisha Duff, Strategic Policy Adviser, Institute for Urban Indigenous Health, *Committee Hansard,* 22 February 2023, p. 13.

79 Aboriginal Health and Medical Research Council of NSW, *Submission 55,* [p. 4].

80 Aboriginal Health and Medical Research Council of NSW, *Submission 55*, [p. 5].

81 Institute for Urban Indigenous Health, *Submission 35,* p. 12; Aboriginal Health and Medical Research Council of NSW, *Submission 55,* p. 4; Office of the National Rural Health Commissioner, *Submission 72,* p. 13; National Rural Health Alliance, *Submission 73,* p. 15; National Aboriginal Community Controlled Health Organisation, *Submission 75,* pp. 6–7.

pregnancy, or pressuring a woman to have a termination or undergo a sterilisation procedure.[82]

4.64 SPHERE informed the committee that reproductive coercion is a public health concern and is associated with:

> Higher rates of unintended pregnancies, abortion, and negative reproductive, maternal, parental, and child health outcomes.[83]

4.65 Consequently, the National Women's Health Strategy identified a reduction in the rate of reproductive coercion as a key measure of success in addressing the health impacts of violence against women and girls.[84]

4.66 Children by Choice commented that research on reproductive coercion and abuse in Australia is lacking but that this form of gendered violence clearly occurs at a much higher rate across intersectional groups of the community. Children by Choice pointed to current data which suggests that women and girls with disability experience this form of gendered violence at a higher rate than the general population.[85]

4.67 ACON advised that the LGBTIQA+ population can experience reproductive coercion and abuse at a rate that is four times higher than heterosexual and cisgendered members of the community.[86] Additionally, Children by Choice flagged that reproductive coercion and abuse is more prevalent in women who are already experiencing other forms of family and domestic violence, compared with women who are not.[87]

4.68 The Department recognised that primary care providers are usually the first point of contact for victims of reproductive coercion. They noted that the provider's response influences whether that individual continues to seek help. Therefore, the Department argued that it is paramount that primary care providers are well trained to identify and respond to reproductive coercion and abuse.[88]

Barriers to addressing reproductive coercion and abuse

4.69 SPHERE noted that some women are more likely to confide in primary healthcare providers regarding domestic, family and sexual violence than presenting to dedicated support services. They also raised concerns from

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82 Department of Health and Aged Care, *Submission 53,* p. 40.

83 SPHERE, *Submission 5,* p. 10.

84 Department of Health, *National Women's Health Strategy 2020–2030*, 2018, p. 41.

85 Children by Choice, *Submission 60,* p. 28.

86 Ms Karen Price, Deputy Chief Executive Officer, ACON, *Committee Hansard*, 21 February 2023, p. 1.

87 Children by Choice, *Submission 60,* p. 29.

88 Department of Health and Aged Care, *Submission 53*, p. 41.

primary healthcare providers that there is a lack of adequate training and referral services, particularly in regional and remote Australia, to appropriately and effectively respond to reproductive coercion and abuse.[89]

4.70 Children by Choice echoed SPHERE's concerns and stated that reproductive coercion and control continues to be a hidden problem. They argued that a lack of research and information on this form of gendered violence precludes the development of practice guidelines that would assist primary care providers in responding effectively.[90]

Individuals accessing assisted reproductive technologies

4.71 The Department submitted to the committee that approximately one in six couples of reproductive age experience fertility problems and may utilise assisted reproductive technologies (ART). These technologies have, historically, been provided in a private setting and subsidised through the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme. They further explained that access to free services under state and territory government programs has generally been limited.[91]

4.72 The MBS supports access to a range of relevant services involved in the clinical specialities of gynaecology (including ART and services involved in treating female and male infertility), obstetrics, participating midwifery, pathology, and diagnostic imaging.[92]

4.73 From 1 July 2023, the Government will introduce a new payment to subsidise costs associated with the storage of eggs, sperm, and embryos for patients with cancer, and people at risk of passing on genetic diseases or conditions who have undergone MBS-funded preimplantation genetic testing.[93]

4.74 The Government has also invested in a website, 'Your IVF Success', aimed at providing Australian couples with independent advice and information on fertility support services and IVF. Further, over the period between 2000 and 2021, the National Health and Medical Research Council has invested over $219 million towards research regarding fertility and infertility.[94]

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89 SPHERE, *Submission 5,* p. 10.

90 Children by Choice, *Submission 60*, p. 28.

91 Department of Health and Aged Care, *Submission 53*, p. 25.

92 Department of Health and Aged Care, *Submission 53*, p. 25.

93 Department of Health and Aged Care, *Submission 53*, p. 25.

94 Department of Health and Aged Care, *Submission 53*, p. 25.

Access to funded services

4.75 Although Medicare items related to ART services exist, Mr Stephen Page submitted that current practices have created unequal access to these Medicare rebates.[95]

4.76 Section 4 of the *Health Insurance Act 1973* (Health Insurance Act) stipulates that Medicare rebates can be claimed when 'a person renders a professional service'.[96] Section 3 of the Health Insurance Act explains that a professional service must be a clinically relevant service, which means:

> … a service rendered by a medical or dental practitioner or an optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.[97]

4.77 Mr Page explained that the person receiving treatment must be considered infertile for the ART services to be deemed a clinically relevant service under the Health Insurance Act.[98]

4.78 Mr Page outlined how the definition of infertility limited the cohorts of people who can access Medicare rebates for ARTs. Mr Page and Just Equal stated that infertility is traditionally defined as a disease of the male or female reproductive system, characterised by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse.[99] This definition excludes a range of intended parents from claiming Medicare rebates when accessing ART, including, gay couples, single women, and lesbian couples. Mr Page explained that this is because these groups are biologically unable to conceive on their own or with their partner, as opposed to suffering from a physiological condition that renders them infertile.[100]

4.79 Alex and Tom told the committee that the international consensus shifted in 2017 when the International Committee Monitoring Assisted Reproductive Technologies published a revised definition of infertility. They stated that this revised definition, as below, accounts for what is commonly referred to as 'social infertility'[101]:

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95 These services are under items 13200–13290, Health Insurance (General Medical Services Table) Regulations 2021, division 5.2.10; Mr Stephen Page, *Submission 58,* p. 8.

96 *Health Insurance Act 1973*, s. 4.

97 *Health Insurance Act 1973*, s. 3.

98 Just Equal, *Submission 87*, p. 2.

99 Mr Stephen Page, *Submission 58,* p. 4; Just Equal, *Submission 87,* p. 2.

100 Mr Stephen Page, *Submission 58,* pp. 4–7.

101 Alex and Tom, *Submission 57,* p. 7.

> A disease characterized by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or due to an impairment of a person's capacity to reproduce either as an individual or his/her partner.[102]

4.80 Mr Page submitted that the dichotomy of medical infertility and social infertility means that clinics vary in their interpretation of infertility and how it relates to Medicare rebates. He stated that some doctors still use the traditional definition of infertility, whereas others use the social infertility definition.[103] Consequently, same-sex couples face uncertain out-of-pocket costs associated with ART. As Mr Page told the committee:

> You then have a lottery when you turn up at a doctor's office: are you going to claim the Medicare rebate or not? […] you don't know, when you turn up at that particular clinic and that particular doctor, whether you'll get the rebate or not. It's $5,000 a pop.[104]

Same sex couples and surrogacy arrangements

4.81 Altruistic (non-commercial) surrogacy is legal in Australia, however, submitters flagged that the laws surrounding its process creates additional barriers for intended parents.[105] Section 12 of the *Prohibition of Human Cloning for Reproduction Act 2002* (the Human Cloning Act) stipulates that it is an offence to intentionally create a human embryo outside of the body of a woman, unless the person's intention in creating the embryo is to attempt to achieve pregnancy in a particular woman.[106] This section is designed to address ethical concerns regarding the potential use of human embryos. Breaches of the section carry a penalty of up to 15 years imprisonment.[107]

4.82 Mr Page submitted that this becomes difficult for intended parents, whose sole intention in creating an embryo is to conceive a child, when they have not yet formed a surrogacy arrangement. He gave evidence that some doctors accept and acknowledge the intended parents intentions' and will interpret the legislation to mean that eventually the embryo will be implanted in a particular woman in the future.

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102 Mr Stephen Page, *Submission 58,* p. 6.

103 Mr Stephen Page, *Submission 58,* pp. 4–7.

104 Mr Stephen Page, *Committee Hansard,* 22 February 2023, pp. 31–32.

105 Equality Tasmania, *Submission 39,* p. 3; Alex and Tom, *Submission 57,* p. 5; Mr Stephen Page, *Submission 58,* p. 8; LGBTIQ+ Health Australia, *Submission 67,* p. 16; Just Equal, *Submission 87,* p. 2; Surrogacy Australia, *Submission 115,* pp. 1–2.

106 *Prohibition of Human Cloning for Reproduction Act 2002,* s. 12.

107 *Prohibition of Human Cloning for Reproduction Act 2002*, s. 3 and s.12.

4.83 Alex and Tom told the committee that they had encountered this barrier when a clinic told them that they had to identify a particular woman at the time of embryo creation, as to do otherwise would be unlawful. They explained that:

> The delivery of this news … was a complete shock, as all we were trying to do was create a family. It was cruel, offensive, and traumatising to be delivered this news. For the rest of the day, Alex was hysterical. He could barely speak. We do not wish this fate upon anyone. We were being categorised as criminals and being likened to the sorts of people that create embryos for embryo farming purposes.[108]

4.84 Submitters believe this hurdle is an additional layer of unequal access to reproductive healthcare for those whose only option is to conceive via surrogacy.[109]

4.85 The committee heard from Dr Sarah Jefford that the inconsistency of state and territory laws relating to surrogacy further compound access issues, including for same sex couples.[110]

Surrogacy and Medicare rebates

4.86 The committee also heard that once a surrogacy arrangement is in place, further barriers exist for intended parents.[111] Surrogacy can cause immense financial strain as no Medicare rebates exist for ART processes associated with surrogacy, including the extraction of eggs, creation of embryos, or implantation of those embryos.[112]

4.87 Mr Page told the committee that the Government has banned Medicare subsidies for surrogacy since 1990, which he considers to be a historical anomaly.[113] He submitted that the exclusion of surrogacy from Medicare leaves intended parents to suffer greater out-of-pocket costs, where a non-subsidised round of in vitro fertilisation (IVF) costs approximately $8000. However, he gave evidence that IVF that is not for the purposes of surrogacy would allow patients to claim a rebate of approximately $4620.[114]

4.88 Just Equal cited an estimate that to remove the exclusion would cost less than $1 million per year.[115] The 2020 *Medicare Benefits Schedule Review Taskforce Report on*

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108 Alex and Tom, *Submission 57,* p. 5.

109 Alex and Tom, *Submission 57,* p. 5; Mr Stephen Page, *Submission 58*, pp. 8–9.

110 Dr Sarah Jefford, *Submission 331,* pp. 2–3.

111 Alex and Tom, *Submission 57,* p. 8.

112 Surrogacy Australia, answer to question taken on notice, 28 February 2023 (received 20 March 2023).

113 Mr Stephen Page, *Submission 58,* p. 9.

114 Alex and Tom, *Submission 57,* p. 12.

115 Just Equal, *Submission 87*, p. 4.

Gynaecology MBS Items recommended that individuals undergoing an ART stimulated cycle as part of an altruistic egg donation or surrogacy arrangement should be provided MBS funding support.[116]

Committee view

4.89 The committee acknowledges that large cohorts within Australia have been overlooked, underrepresented, or underfunded in sexual and reproductive health policy, service-delivery, and education.

4.90 The committee was concerned to hear that some sectors within the Australian community, as discussed in this chapter, encounter additional barriers to accessing appropriate, accessible, responsive and equitable reproductive health services and education.

4.91 The committee notes the following actions that could address this:

- Working with health practitioners to deliver further training and developing inclusive frameworks that ensure appropriate and adapted care.
- Increasing funding and resourcing for peer support networks and specialist organisations, as well as enhancing education.
- Improving access for a range of individuals who are currently excluded from receiving Medicare subsidised reproductive healthcare benefits.

Working with health practitioners

Providing appropriate training

4.92 Appropriate reproductive healthcare services can only be provided to all sectors of the community if health practitioners delivering the service are adequately trained on the unique needs of the community. The committee acknowledges that this can be complex with different cohorts experiencing different barriers to accessing safe and appropriate reproductive healthcare services. However, the committee is of the view that these barriers can only be overcome by an adequately trained health workforce.

4.93 The committee agrees with submitters that further training is required at the undergraduate and postgraduate level on: treating people with disability; the importance of CALD migrants and refugees accessing culturally appropriate and trauma-informed care, through programs such as Health in My Language; and the need for culturally safe workforce development in the healthcare sector for First Nations people.

4.94 The committee is also mindful that the current sexual and reproductive healthcare workforce is not sufficient to meet the needs of ACCHOs who are often the preferred healthcare providers for First Nations people. As such, the

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[116] Medicare Benefits Schedule Review Taskforce, *Taskforce Report on Gynaecology MBS Items*, December 2020, p. 11.

committee is supportive of exploring mechanisms for increasing access to trained reproductive health practitioners, including GPs and gynaecologists, as well as upskilling of nurses and midwives in these practice settings.

Recommendation 24

4.95 The committee recommends that the Australian Government work with the relevant medical and professional colleges to support the development and delivery of training to health practitioners providing sexual, reproductive and maternal healthcare on:

- **engaging and communicating with people with disability;**
- **providing culturally aware and trauma-informed services to culturally and linguistically diverse migrants and refugees; and**
- **ensuring culturally safe healthcare for First Nations people in mainstream non-community-controlled organisations, by ensuring practitioners are aware of intergenerational trauma, cultural norms and taboos.**

Recommendation 25

4.96 The committee recommends that the Australian Government consider options and incentives to expand the culturally and linguistically diverse (CALD) sexual and reproductive health workforce including leveraging the success of the 'Health in My Language' program.

Frameworks

4.97 The committee recognises that current practices and standards in the healthcare industry can be unaffirming and exclusionary for LGBTIQA+ people. Gendered language can deter LGBTIQA+ people from engaging healthcare providers, and assumptions regarding a patient's anatomy and partner(s) can result in care that is neither appropriate nor adapted.

4.98 The committee acknowledges that the Australian Government has committed to developing and implementing a 10-year National Action Plan for the Health and Wellbeing of LGBTIQA+ people, in consultation with the LGBTIQA+ community. The Plan is expected to 'guide how Australia addresses health disparities and make improvements across the health system.'[117]

4.99 Therefore, the committee recognises the importance of practitioners utilising frameworks that support appropriate treatment of, and communication with, transgender and non-binary people.

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[117] The Hon Mark Butler MP, Minister for Health and Aged Care, *Media release*, 'Pathway to better health for LGBTIQA+ communities, 1 March 2023, https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/pathway-to-better-health-for-lgbtiqa-communities (accessed 19 May 2023).

4.100 The committee is also cognisant that the use of gendered language in reproductive healthcare settings can be exclusionary and therefore create barriers for LGBTIQA+ people to access this healthcare.

Recommendation 26

4.101 The committee recommends that the Department of Health and Aged Care consider sexual and reproductive healthcare for LGBTIQA+ people in the context of the 10-year National Action Plan for the Health and Wellbeing of LGBTIQA+ people.

Best practice guidelines

4.102 The committee acknowledges that current guidance on obtaining consent from individuals for medical or surgical procedures is general in nature and currently no specific guidance exists on obtaining informed consent from intersex people prior to medical interventions.

4.103 The committee also recognises that there is a lack of research on reproductive coercion and abuse. Further, the committee acknowledges that the limited research and understanding of reproductive coercion and abuse contributes to inadequate informational support for health practitioners in responding to this form of violence.

Recommendation 27

4.104 The committee recommends that the Australian Government consult with people with innate variations of sex characteristics regarding surgical interventions in the context of the 10-year National Action Plan on the Health and Wellbeing of LGBTIQA+.

Recommendation 28

4.105 The committee recommends that the Australian Government commissions research into reproductive coercion and abuse with a view to developing clinical guidelines, resources and training for primary care providers.

Education

4.106 The committee acknowledges that the sexual and reproductive health educational gaps for people with disability and their families and carers must be addressed. To do so, the committee considers it necessary to increase reproductive health education programs and resources that are both accessible and disability inclusive. The committee also supports the development of resources that focus specifically on the reproductive health of young people with disability, thus empowering them to exercise their autonomy.

Recommendation 29

4.107 The committee recommends that the Australian Government works with the sector to develop sexual and reproductive health education programs and resources for people with disability and their families and carers that are accessible, disability inclusive and empowering for young people with disability.

Expanding Medicare accessibility

Accessing pregnancy-related care for non-residents

4.108 The committee notes the concerns of the Multicultural Centre for Women's Health regarding temporary migrants and temporary workers being unable to access Medicare, and international students not being covered for pregnancy care within their first 12 months in Australia and its impact on access to reproductive healthcare.

4.109 The committee heard from the Multicultural Centre for Women's Health, Women's Health East, MSI Australia, and Birth for Humankind, that Medicare eligibility should be extended to all people living in Australia, irrespective of visa status. Those submitters considered that extending Medicare eligibility for reproductive health and pregnancy care will further Australia's provision of true universal access to reproductive healthcare.

4.110 Further, the committee recognises the barriers that international students encounter when engaging pregnancy care in Australia. The committee is aware that international students are required to take Overseas Student Health Cover, but that Schedule 4d of the Overseas Student Health Cover Deed imposes a 12-month wait period for students to access pregnancy-related care. This is particularly concerning given that 70 per cent of pregnancy-related claims for international students occur within the first 12-months of cover.

Recommendation 30

4.111 The committee recommends that the Australian Government, in consultation with state and territory governments, consider options for ensuring the provision of reproductive health and pregnancy care services to all people living in Australia, irrespective of their visa status.

Recommendation 31

4.112 The committee recommends that the Australian Government work with relevant overseas health insurance providers to amend Schedule 4d of the Overseas Student Health Cover Deed to abolish pregnancy care related wait periods.

In vitro fertilisation services

4.113 The committee recognises that the current medical definition of infertility is limited to a physiological condition. This definition effectively excludes LGBTIQA+ people from claiming Medicare rebates for IVF. As a result, LGBTIQA+ people can receive inconsistent advice from practitioners and incur greater out-of-pocket costs when engaging IVF services.

Recommendation 32

4.114 The committee recommends that the Australian Government explores the feasibility of Medicare rebates for in vitro fertilisation (IVF) services for cohorts not currently eligible for subsidised services.

Surrogacy-related services

4.115 The committee heard that surrogacy arrangements in Australia create further barriers for same-sex couples to start a family. The committee is aware that since ART services were subsidised through Medicare rebates in 1990, that surrogacy was explicitly excluded from Medicare claims.

Recommendation 33

4.116 The committee recommends that the Australian Government implement the recommendations of the Medicare Benefits Schedule Review regarding removal of the exclusion of in vitro fertilisation (IVF) services for altruistic surrogacy purposes.

Chapter 5
Improving literacy and enhancing employee rights

Sexual and reproductive health literacy

5.1 Health literacy relates to how people access, understand, and use health information in ways to benefit their health. According to the Department of Health and Aged Care (the Department), when individuals have a lower health literacy, they are at a higher risk of worse health outcomes and poorer health behaviours. As such, improving health literacy is recognised as a key element in encouraging individuals to engage with health professionals.[1]

5.2 Submitters highlighted that sexual and reproductive health literacy was important from early childhood onwards in order to provide comprehensive and practical information to individuals to empower them to make informed, safe and autonomous decisions about their health. They emphasised that all Australians needed to have access to accurate sexual and reproductive health information, delivered in an age-appropriate, inclusive and culturally safe manner, that was relevant for the specific needs of diverse cohorts across the population.[2]

5.3 The following section will cover the levels of sexual and reproductive health literacy in the Australian community and some of the barriers to sexual and reproductive health literacy raised by submitters, including:

- the adequacy of the sexual and reproductive health education taught in schools; and
- the opportunity for tailored sexual and reproductive health education strategies to better reach diverse cohorts across the Australian population.

Current state of sexual and reproductive health literacy in Australia

5.4 The committee heard evidence indicating that the sexual and reproductive health literacy of Australians was generally poor. For example, Dr Jacqui Hendriks, Founder of Bloom-ED, an alliance of teachers, researchers,

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1 Department of Health and Aged Care, *Submission 53*, p. 29.

2 See for example: Australian Federation of Medical Women, *Submission 81*, p. 3; cohealth, *Submission 112*, p. 10; Public Health Association of Australia, *Submission 92*, p. 17; Rainbow Families, *Submission 96*, p. 7; Australian Medical Association, *Submission 71*, p. 7; Australian Nursing and Midwifery Federation, *Submission 20*, p. 10; Women's Health Goulburn North East, *Submission 37*, p .16; National Aboriginal Controlled Community Health Organisation, *Submission 74*, p. 11; SHINE South Australia, *Submisson 48*, pp. 3–4; Family Planning New South Wales, *Submission 56*, p. 16; Consumers Health Forum, *Submission 44*, p. 9; Fay Gale Centre for Research on Gender at the University of Adelaide, *Submission 17*, p. 6; Children by Choice, *Submission 60*, p. 9.

students, parents and organisations that advocates for improved sexual and reproductive health literacy, described the situation:

> Universally, the sexual health literacy of Australians is incredibly poor. For many of us, sex, sexuality and issues of sexual and reproductive health are associated with personal embarrassment, shame, stigma or general ignorance. As a society, we don't often speak about sex in an open or a genuine way. We also can't assume the health services will bridge this gap as their workforce development is often grossly inadequate. The very fact that such a central aspect of being human is often ignored or is addressed superficially greatly impacts our individual and collective abilities to understand, access and use health information or to navigate services.[3]

5.5 cohealth, one of Australia's largest community health organisations which delivers care across Melbourne and greater Victoria, provided the committee with a specific example demonstrating the lack of sexual and reproductive health literacy among the population. It advised that its practitioners regularly observed the impact of people relying on social media for their health information, resulting in misinformation and misconceptions about various forms of contraception. It noted that a significant part of the work of its Sexual and Reproductive Health Hub was educating people on the facts about contraception, and correcting negative views heard via hearsay and social media.[4]

The adequacy of the sexual and reproductive health education taught in schools

5.6 Some submitters made particular comment on the inadequacy of the sexual and reproductive health education taught in Australian schools and the flow-on impact this had on the health literacy of young people and the broader community.[5]

5.7 Although state and territory government and non-government education authorities are responsible for the administration and operation of schools within their jurisdictions, age-appropriate sexual education is part of Australia's national curriculum. The Department stated that this curriculum sets the expectations of what all Australian students should be taught, regardless of their geographic location or background.[6]

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3 Dr Jacqueline Hendriks, Founder, Bloom-ED, *Committee Hansard*, 4 April 2023, p. 1.

4 cohealth, *Submission 112*, [p. 10].

5 See for example: Fay Gale Centre for Research on Gender at the University of Adelaide, *Submission 17*, p. 5; Bloom-ED, *Submission 128*, p. 3; Family Planning Alliance Australia, *Submission 63*, p. 7.

6 Department of Health and Aged Care, *Submission 53*, p. 28.

5.8 The Australian National University Law Reform and Social Justice Research Hub (ANU Hub) advised that to a large extent, sexual health literacy in Australia was 'decentralised'.[7] It explained:

> The most salient period of sexual health education occurs at the primary and secondary schooling period. While the Australian Curriculum and Reporting Agency (ACARA) curriculum is accepted by all jurisdictions, each state and territory retains significant authority over that which is taught to students in their jurisdiction. Furthermore, there are a range of provisions per state/territory allowing private and/or religious schools to offer different information to students on sexual and reproductive health.[8]

5.9 The ANU Hub noted that despite the emphasis on sex education in each state and territory, there remained 'worrying signs' regarding the knowledge and understanding of Australian students. It reported that in qualitative reviews, many students recounted the irrelevance of the information they were taught at school, a sentiment particularly shared by members of the LGBTIQA+ community. Ms Jordina Quain, the Education Director of the Sexuality Education Counselling Consultancy Agency, describing the majority of school-based relationships education as 'too little, too late, and too straight.'[9]

5.10 Furthermore, the ANU Hub said that quantitative data demonstrated a moderate to low level of knowledge of Sexually Transmitted Illnesses (STIs) and the risks of unprotected sex. It advised that the inconsistent application of sex education across private and/or religious schools posed a problem for general sexual literacy.[10]

5.11 The Fay Gale Centre for Research on Gender at the University of Adelaide (Fay Gale Centre) stated that a lack of comprehensive sex education was a contributor to poor reproductive health outcomes, including unintended pregnancy.[11]

5.12 It observed that while Australia had an existing national curriculum that endorsed sexuality and relationships education through a positive strengths-based approach (drawing on the World Health Organisation's definition of sexuality), how this was implemented and the content that students had access to varied greatly.[12]

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7 Australian National University Law Reform and Social Justice Research Hub, *Submission 121*, p. 22.

8 Australian National University Law Reform and Social Justice Research Hub, *Submission 121*, p. 22.

9 Ms Jordina Quain, Education Director, Sexuality Education Counselling Consultancy Agency, *Committee Hansard*, 4 April 2023, p. 6.

10 Australian National University Law Reform and Social Justice Research Hub, *Submission 121*, p. 22.

11 Fay Gale Centre for Research on Gender at the University of Adelaide, *Submission 17*, p. 5.

12 Fay Gale Centre for Research on Gender at the University of Adelaide, *Submission 17*, p. 5.

5.13 The Australian Nursing and Midwifery Federation (ANMF) also informed the committee that the quality of sexual and reproductive health literacy programs varied greatly within schools. It detailed:

> Initiatives such as Respectful Relationships and Safe Schools are a good start for improving family violence and LGBTQI+ safety within schools, but they are not dedicated to sexual or reproductive health. As such, schools are left having to bring in outside assistance or teach it themselves. Rural schools are likely to face greater difficulty in accessing sexual health nurses or health promotion officers due to geographic distance from providers.[13]

5.14 Bloom-ED raised concerns with the Australian curriculum, arguing that it still failed to ensure adequate sexual and reproductive health education for students. It detailed:

> You will struggle to find critical terms such as sex, sexuality, puberty, menstruation, pregnancy, abortion, contraception, sexually transmissible infection or pornography in these documents. If they do exist, they sit in the glossary or in the areas of the curriculum that are optional. There is also no requirement for a young person to learn about human reproduction, to learn how their own reproductive system works and how they are potentially capable of pregnancy.[14]

5.15 Ms Lucy Peach, a professional educator on the menstrual cycle, in particular highlighted the lack of focus on menstruation in the health curriculum. She noted that this was a disservice to all students:

> I also think it's really important for boys, people without periods and men to understand the workings of bodies that are different to their own. Until we have men and boys on board we're not going to be able to progress, because I think it's a really important piece of gender equity.[15]

The importance of comprehensive sexuality and relationships education

5.16 The Family Planning Alliance Australia (FPAA) , the peak body for reproductive and sexual health services, informed the committee of the importance of comprehensive sexuality education (CSE) provided through schools, communities and families, given that, if properly done it offered young people a solid foundation to develop lifelong sexual and reproductive health literacy.[16] However, it identified that there were a number of barriers to achieving this via the current Australian curriculum. For example:

- While the curriculum includes components of CSE, the guidelines are 'ambiguous, open to interpretation and omit key topics'.

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13 Australian Nursing and Midwifery Federation, *Submission* 20, p. 10.

14 Dr Jacqueline Hendriks, Founder, Bloom-ED, *Committee Hansard*, 4 April 2023, p. 1.

15 Ms Lucy Peach, private capacity, *Committee Hansard*, 4 April 2023, p. 2.

16 Family Planning Alliance Australia, *Submission 63*, p. 7.

- While research shows that Australian young people perceive school-based CSE as valuable, the inclusion, quality and relevance of the teaching is inconsistent. This may be attributed to the lack of specific CSE guidelines within the curriculum, as well as a deficit in teacher skills and confidence, the absence of school policies, or a non-supportive school culture.[17]

5.17 The Fay Gale Centre also drew the committee's attention to the concept of comprehensive sexuality and relationships education (CSRE) as a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It noted that CSRE is age-appropriate and emphasises autonomy, safety and respect.[18]

5.18 The Fay Gale Centre stated that currently Australian students do not necessarily have access to all components of CSRE. It explained:

> Consistently, the biological aspects of reproduction and the health risks of sexual activity are foregrounded in sex education while social and relational aspects are neglected. Thus Australian young people continue to be dissatisfied with the depth of learning available to them through school-based programs and report difficulties in navigating healthy and equitable relationships (with consent being just one aspect of this).[19]

5.19 It further advised that as well as inconsistent implementation, current sex education is often heteronormative and excludes LGBTIQA+ and gender diverse people. It argued that this was concerning because of the well-documented harms of not accepting gender and sexual diversity in young people, including poor mental health and elevated risk of suicide.[20]

5.20 The Fay Gale Centre posited that access to CSRE was a fundamental human right in relation to sexual health and wellbeing, stating:

> The knowledge and understanding that comes from this education is the foundation of reproductive health literacy which is essential for preventing a range of health problems, including coercive sexual encounters, sexually transmitted infections and unplanned pregnancy.[21]

5.21 It recommended that CSRE be available to all students through all schools, with the appropriate training of teachers and provision of resources, including external support staff where appropriate.[22]

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17 Family Planning Alliance Australia, *Submission 63*, p. 7.

18 Fay Gale Centre for Research on Gender at the University of Adelaide, *Submission 17*, p. 5.

19 Fay Gale Centre for Research on Gender at the University of Adelaide, *Submission 17*, p. 5.

20 Fay Gale Centre for Research on Gender at the University of Adelaide, *Submission 17*, p. 5.

21 Fay Gale Centre for Research on Gender at the University of Adelaide, *Submission 17*, p. 5.

22 Fay Gale Centre for Research on Gender at the University of Adelaide, *Submission 17*, p. 6.

5.22 The FPAA also advocated for the inclusion of CSE within the Australian curriculum and community-based educational programs, with their submission detailing key principles for consideration in program design.[23]

5.23 The committee heard that barriers to sexual and reproductive health literacy were more acute in cohorts who were already marginalised or experienced a lack of access to services. Submitters identified the following cohorts as experiencing particular challenges:

- geographically rural and remote communities;
- young people (particularly girls and young women);
- LGBTIQA+ communities;
- people living with disability;
- culturally and linguistically diverse (CALD) communities (including migrants and refugees); and
- First Nations communities.

5.24 Evidence relating to four of these cohorts are discussed further below.

First Nations communities

5.25 The Institute for Urban Indigenous Health submitted that First Nations communities were at risk of lower health literacy due to factors such as lower school-based literacy and socioeconomic disadvantage across education, employment and income. It noted that this was further exacerbated by a general absence of accessible, evidence-based, culturally appropriate, and age-specific sexual and reproductive health messaging for First Nations people. [24]

5.26 The Institute for Urban Indigenous Health recommended that the Government provide targeted funding for sexual and reproductive health messaging and education to increase the health literacy and reproductive autonomy of First Nations communities. It also recommended that the Government work with state and territory counterparts to better integrate and eliminate barrier to delivering culturally-tailored health education and promotion in schools.[25]

5.27 The National Aboriginal Community Controlled Health Organisation (NACCHO) also strongly advocated for accurate sexual and reproductive health information provided in a culturally safe way. It detailed:

> Awareness campaigns around all aspects of Aboriginal and Torres Strait Islander reproductive health must be appropriately targeted. They must acknowledge the special cultural needs and health gaps experienced by Aboriginal and Torres Strait Islander people. They should explicitly acknowledge the intersectionality of Aboriginal and Torres Strait Islander

23 Family Planning Alliance Australia, *Submission 63*, p. 7.

24 Institute for Urban Indigenous Health, *Submission 35*, p. 13.

25 Institute for Urban Indigenous Health, *Submission 35*, p. 14.

> people and the LGBTQIA2+ community. Where appropriate they should be provided in Aboriginal and Torres Strait Islander languages.[26]

5.28 NACCHO recommended sufficient funding for ACCHOs to codesign a wide range of culturally safe information campaigns to address gaps in reproductive health outcomes for First Nations people.[27]

People with disability

5.29 The Sexuality Education Counselling Consultancy Agency (SECCA) in Western Australia provides counselling, education and resources in the space of sexuality and disability. It advised that in its experience, people with disability frequently presented to its services with very limited sexual and reproductive health literacy, in large part due to inadequate education at school. It emphasised that sexual and reproductive health literacy for people with disability needed to be proactive, accurate and properly targeted, at the individual and at their teachers, families, caregivers and support workers.[28]

5.30 Dr Emily Casttell, SECCA's Clinical Director explained:

> We really see it [appropriate sexual and health education] needs to occur from day 1 right through and at every level. There is a legacy of old ideologies and systems and models that persist today. We see that generationally in our client base as well. Our older clients are still suffering the consequences of very incomplete and harmful education in their early life. It's changing for our younger clients. So we're doing that reactive part, and it just needs to be different from here on out for our young people.[29]

LGBTIQA+ communities

5.31 ACON, a national health organisation specialising in community health, inclusion, and HIV responses for people of diverse sexualities and genders, emphasised that comprehensive sexuality education is required to build sexual and reproductive health literacy. However, it submitted that school-based sexuality education was often inadequate for people of diverse genders and sexualities, who are then required to develop this health literacy outside of school settings. It also highlighted that many diverse populations who engage in sexual practices experience particular forms of stigma such as homophobia, transphobia, racism, ableism, and ageism, and that this negatively impacted their access to appropriate literacy resources and services. [30]

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[26] National Aboriginal Controlled Community Health Organisation, *Submission 74*, p. 11.

[27] National Aboriginal Controlled Community Health Organisation, *Submission 74*, p. 11.

[28] Dr Emily Castell, Clinical Director, Sexuality Education Counselling Consultancy Agency, *Committee Hansard*, 4 April 2023, p. 5.

[29] Dr Emily Castell, Clinical Director, Sexuality Education Counselling Consultancy Agency, *Committee Hansard*, 4 April 2023, p. 5.

[30] ACON, *Submission 52*, p. 10.

5.32 ACON recommended the development of comprehensive sexuality education programs that are age-appropriate, evidence-based, inclusive of diversity, and committed to ending all forms of stigma.[31]

5.33 Rainbow Families echoed this point and stated that it was vital that sexual and reproductive health information provided by educational and other organisations was framed inclusively in its subject matter and language.[32]

Rural and remote communities and CALD communities

5.34 The Rural Doctors Association of Australia pointed out that English language literacy was generally lower in rural and remote areas, with English potentially being the second or third language for people in remote First Nations communities. Given the transmission of health information is heavily dependent on the written word (such as posters, brochures, on web pages or other sources), people who experience difficulties with the English language are therefore likely to have poorer health literacy, including sexual and reproductive health literacy.[33]

5.35 The National Rural Health Alliance emphasised the need for literacy resources and services that were multi-disciplinary, place-specific and grounded in co-design:

> It is important that women can access health information that is easy to understand, is trustworthy and culturally appropriate. What works in one rural community may not work in another and what works in metropolitan areas may not be always be appropriate in rural areas.[34]

5.36 In terms of CALD communities, the Multicultural Centre for Women's Health suggested that the concept of health literacy needed to extend beyond the practice of just providing in-language resources and culturally appropriate service provision (such as working with interpreters). It argued that for migrant and refugee women and gender diverse people, trust, continuity of care, prevention and education were essential elements of health literacy in order to allow individuals to make informed and empowered healthcare decisions.[35]

5.37 The International Student Sexual Health Network (the Network) also told the committee that international students often obtain health information from unreliable resources. The Network suggested that this gap in the health literacy and education of international students in Australia could be addressed by providing education to international students on arrival and for a minimum

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31 ACON, *Submission 52*, p. 10.

32 Rainbow Families, *Submission 96*, p. 7.

33 Rural Doctors Association of Australia, *Submission 104*, p. 9.

34 National Rural Health Alliance, *Submission 73*, p. 16.

35 Multicultural Centre for Women's Health, *Submission 102*, p. 9.

12-month period. They suggested that this education could be delivered in modules that are tied to the curriculum and focus on healthy relationships and addressing service navigation issues.[36] Further, the Network stated that the education modules should be:

> … delivered in a very non-text based way. Rather than relying on a high level of English proficiency, it should be using words and symbols from different languages and having it very animated. It takes out stigma when we use animation. We know this from when we're working with young people from refugee and migrant backgrounds and international students.[37]

The importance of improving the inclusiveness of sexual and reproductive health education

5.38 Submitters reiterated to the committee the need for improved sexual and reproductive health literacy in Australia, both in school and community settings. They noted that the ongoing taboos and pervasive stigma around sexual and reproductive health issues were a persistent barrier to improved literacy, which in turn negatively impacted on health outcomes.

5.39 For example, the ANMF stated while there were many programs targeted at improving sexual and reproductive health literacy in Australia, those programs could only 'go so far' whilst stigma and silence existed around many aspects of sexual and reproductive health across the lifespan. It advocated for the normalisation of sexual and reproductive health needs and increased opportunities for people to explore the options available to them without social stigma and rebuke.[38]

5.40 It recommended the use of modern forms of communication (such as podcasts, apps and social media) to bring sexual and reproductive health into everyday conversations and reach diverse groups who may not engage with established health promotion campaigns and techniques.[39]

5.41 The Illawarra Women's Centre advised through its work with young people in schools and community settings, it had observed that there was still significant taboo and social stigma around many areas of sexual and reproductive health, including menstruation, sex, pleasure, sexuality and gender, different relationship structures, pregnancy, and abortion. As a result, it made clear that

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[36] Ms Alison Coehlo, Director, Coehlo Networks, International Student Sexual Health Network, *Committee Hansard*, 4 April 2023, p. 31. See also International Student Sexual Health Network, *Submission 79*, p. 5.

[37] Ms Alison Coehlo, Director, Coehlo Networks, International Student Sexual Health Network, *Committee Hansard*, 4 April 2023, p. 31.

[38] Australian Nursing and Midwifery Federation, *Submission* 20, p. 10.

[39] Australian Nursing and Midwifery Federation, *Submission* 20, p. 10.

it was imperative that young people not only received accurate information on these matters, but also had opportunities to learn and talk free of judgments.[40]

5.42 Ms Lorna Geraghty, Project Coordinator for the Youth Educating Peers (YEP) Project run by the Youth Affairs Council of Western Australia, advocated for a holistic approach to youth sexual health education that was inclusive, approached from a sex-positive angle and co-designed with its intended audience. She outlined:

> We advocate at YEP for a holistic approach to youth sexual health education, which provides and includes protective behaviours, digital media literacy, navigating dating and relationships consent, STIs [sexually transmitted infections] and BBVs [blood-borne viruses] testing and treatment, safer sex methods and contraception. It's paramount that this education is inclusive of all bodies, genders and sexualities and that it's delivered in a culturally appropriate manner and co-designed with young people. It needs to be facilitated in a fun, evidence-based, harm reduction focused and trauma informed way by a knowledgeable person with a sex positive approach. This education needs to be delivered both in person, in traditional school settings and places that disengaged SHBBV populations are in community, and online through social media. We advocate for the continuation of peer based education services that also upskill the adults that support these young people.[41]

5.43 Ms Peach noted that improved literacy was not just applicable to young people, as often parents or older generations were also mis-or under-informed about what sexual and reproductive health education actually entailed and achieved. She explained:

> I think we also need community education for parents because there's still a lot of fear and there's this idea that talking about things encourages behaviours, whereas all the research shows that the more information you get, the later your sexual debut is because you are actually making an informed decision instead of just getting it out of the way. Instead of something that just happens to you, it's something that you're choosing…This conversation is primarily around young people, but, like you said, we've got older generations and parents who missed out on that education as well. So it kind of has to go both ways.[42]

5.44 The Australian Federation of Medical Women took the view that sexual and reproductive health literacy should encourage autonomy. In particular, it remarked that young people were most likely to receive their sexual knowledge through peers, media, family and community, and formal education. As a result, education systems should ensure that competing ideologies do not negatively

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40 Illawarra Women's Health Centre, *Submission 95*, p. 8.

41 Ms Lorna Geraghty, Project Coordinator, Youth Educating Peers Project, Youth Affairs Council of Western Australia, *Committee Hansard*, 4 April 2023, p. 3.

42 Ms Lucy Peach, private capacity, *Committee Hansard*, 4 April 2023, p. 7.

impact delivery of information and knowledge around sexual and reproductive health.[43]

5.45 Midwives Australia reported that literacy programs often only received short term funding or tended to be micro-specific in focus. Additionally, within some jurisdictions, consumer organisations and non-government organisations tended to take the lead in projects, rather than government. It argued that appropriate and sustainable funding models were required to increase access to education and information.[44]

Reproductive health leave for employees

5.46 The committee heard that there is currently no specific reproductive health leave for employees in Australia.[45] A number of submitters raised this is an issue that needed to be addressed in order to achieve better health and gender equity outcomes for women and expressed general support for the idea of reproductive health leave.

5.47 For example, Midwives Australia argued that the lack of reproductive health leave for employees was an entrenched barrier to gender equity in the workplace. It noted that there were many examples of gender-specific health issues that remained unacknowledged in workplaces, which meant women dealt with them privately at great personal cost.[46]

5.48 The ANMF informed the committee that women were disproportionately affected by sexual and reproductive healthcare issues, and that women were also more likely to perform caring responsibilities. Given these two factors, women tended to access more personal leave than men to deal with these issues. As a result, compared to their male counterparts, female employees typically ended up with less personal leave available for use in other personal circumstances, such as bereavement or general illness. [47]

5.49 The ANMF observed that from the onset of puberty to post-menopause, girls and women deal with sexual and reproductive health conditions that often make it difficult to participate fully in daily activities. It noted that women continue to participate in education, employment and other social or community roles even when unwell due to a number of factors, including the prevalence of a 'soldier-on' mentality, a lack of societal understanding, limited

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43 Australian Federation of Medical Women, *Submission 81*, p. 3.

44 Midwives Australia, *Submission 43*, p. 7.

45 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Submission 65*, p. 12.

46 Midwives Australia, *Submission 43*, p. 8.

47 Australian Nursing and Midwifery Federation, *Submission 2*, p. 11.

or no flexibility in the workplace, and a pervasive taboo around reproductive health conditions often considered too sensitive or private to share.[48]

5.50 The Queensland Nurses and Midwives' Union (QNMU) echoed this point, articulating that for many female employees, experiencing heavy periods and menstrual pain, transitioning through perimenopause and menopause remain taboo experiences that they must 'navigate quietly with minimal support' from their employers. It submitted that this reality contributed to inequitable and unfavourable workplace outcomes compared with employees who did not experience these reproductive health-related issues.[49]

5.51 The Australian College of Midwives also pointed out that women who experience pregnancy, menstrual pain, endometriosis, menopause symptoms or require a hysterectomy are disproportionally affected by the requirement to use personal leave to manage these health issues, compared to those who do not.[50]

The benefits of reproductive health leave

5.52 Some particular submitters, such as the Australian Capital Territory Council of Social Service, suggested that a way to address this particular gender inequity and create better health outcomes for women, as well as productivity outcomes for employers, was to introduce formal reproductive health leave policies. It said:

> Embedding policies supporting reproductive health leave is a progressive step towards gender equity and recognising the significance of reproductive health.[51]

5.53 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) advised that it supported discussions around reproductive health leave being legislated in the National Employment Standards as a universal, protected entitlement.[52]

5.54 The FPAA informed the committee that while reproductive health leave was still 'in its infancy' in Australia, it was likely that the number of employers introducing these forms of leave will increase as they look to either differentiate themselves from their competitors. It hoped that once a standard was established and 'employers of choice' provided reproductive health leave

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48 Australian Nursing and Midwifery Federation, *Submission 2*, p. 12.

49 Queensland Nurses and Midwives' Union, *Submission 29*, p. 12.

50 Australian College of Midwives, *Submission 30*, p. 11.

51 Australian Capital Territory Council of Social Service, *Submission 101*, p. 16.

52 RANZCOG, *Submission 65*, p. 12.

entitlements available, other employers would follow suit in order to remain competitive.[53]

5.55 The FPAA outlined the various benefits that formal reproductive health leave would bring to employers and employees alike:

> There are studies from overseas jurisdictions that demonstrate the productivity losses due to "presenteeism" are greater than those lost to workers taking leave to deal with symptoms associated with reproductive health. Normalising the provision of paid leave for workers who are unable to work due to symptoms associated with reproductive health will be good for workers and good for productivity.[54]

5.56 The Australian College of Midwives said that while the establishment of reproductive health leave, including menstrual leave, IVF leave and menopause leave was an 'emerging approach 'for some employers, for many it still remained a taboo subject.[55]

5.57 It recommended the creation of formal reproductive health leave policies to better accommodate female workers to take care of their reproductive health, without being penalised by the need to use up personal leave or resort to unpaid leave.[56]

5.58 The QNMU also outlined its view that the establishment of formal reproductive health leave and wellbeing policies for employees would enable female workers to take leave associated with menstruation, menopause, endometriosis, pregnancy and fertility treatment, and other reproductive health-related symptoms without being penalised through the use of personal paid leave or the need to take unpaid leave.[57]

5.59 The ANMF was of the view that formal reproductive leave policies should allow workers to take a certain number of days leave to cover the discomfort or treatment related to menstruation, menopause, endometriosis, tubal ligation, hysterectomy, pregnancy or IVF. It argued that this would mean women would not be unfairly punished for these conditions by having to deplete their personal leave, and would also bring benefits for workplaces:

> Such leave has the potential to improve workplace equality, enhance employee job satisfaction, improve conditions for female employees and achieve greater social and gender equity.[58]

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53 Family Planning Alliance Australia, *Submission 63*, p. 7.

54 Family Planning Alliance Australia, *Submission 63*, p. 7.

55 Australian College of Midwives, *Submission 30*, p. 11.

56 Australian College of Midwives, *Submission 30*, p. 11.

57 Queensland Nurses and Midwives' Union, *Submission 29*, p. 12.

58 Australian Nursing and Midwifery Federation, *Submission 2*, p. 12.

5.60 Women's Health in the North asserted that paid reproductive health leave would acknowledge the specific health experiences of people who menstruate and contribute to removing the stigma and taboo surrounding menstruation, menopause and other reproductive health issues.[59] It also made particular reference to the need for leave related to fertility treatments:

> Additional paid leave for people undergoing fertility treatment further recognises the medical, emotional and financial toll associated with building a family through assisted reproductive treatment, and supports women and pregnancy-capable people undergoing fertility treatment to participate in the workforce.[60]

5.61 Women's Health in the South East (WHISE) recommended that reproductive health leave be legislated in the National Employment Standards as a universal, protected entitlement. Noting that this could be a lengthy process, WHISE suggested that in the interim, the Government should quantify the impact of reproductive health on women's participation in the labour market and conduct public consultation around reproductive health leave to 'establish and socialise community interest and support' for the idea. It cautioned that any action to implement such recommendations needed to be conducted in a way that minimise the risk of reinforcing discriminatory employment practices against women.[61]

Committee view

Sexual and reproductive health literacy

5.62 The committee recognises the importance of having high levels of sexual and reproductive health literacy across the Australian population. The committee notes that accurate, inclusive, culturally-safe and age-appropriate sexual and reproductive health information will facilitate better health outcomes across the community.

5.63 The Department informed the committee that the Government is currently developing a National Health Literacy Strategy that will consider sexual and reproductive healthcare information.[62] The committee encourages the Department to take into account the evidence received to the inquiry in order to ensure that the National Health Literacy Strategy includes a specific focus on sexual and reproductive health literacy.

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59 Women's Health in the North, *Submission 108*, p. 5.

60 Women's Health in the North, *Submission 108*, p. 5.

61 Women's Health in the South East, *Submission 51*, [p. 13].

62 A more comprehensive list of activities currently being undertaken by the Australian Government is available in the Department of Health and Aged Care submission to the inquiry.

5.64 The committee considers that comprehensive sexuality and relationships education in schools, if properly done, offers young people a solid foundation to develop lifelong sexual and reproductive health literacy. The committee notes evidence regarding the variability and availability of sex education and health literacy currently taught in schools.

5.65 The committee also recognises the need to ensure that all cohorts across the Australian population have access to tailored sexual and reproductive health information. As a result, it encourages the Government to take practical steps in this area to ensure that particular barriers to literacy are overcome.

5.66 In particular, the committee considers it important that government jurisdictions and the health sector consider implementation of tailored, culturally-safe strategies, guided and implemented by ACCHOs, that seek to increase sexual and reproductive health literacy amongst First Nation communities.

Recommendation 34

5.67 The committee recommends that the Australian Government work with jurisdictions to improve the quality of sexual health and relationships education in schools including building capabilities of educators to deliver this training.

Recommendation 35

5.68 The committee recommends the Department of Health and Aged Care work with jurisdictions and the health sector to implement options for targeted public awareness and sexual health literacy campaigns in target communities, including for the LGBTIQA+ community, community-led initiatives for First Nations and culturally and linguistically diverse groups, and sexually transmitted infections campaigns in vulnerable cohorts.

Reproductive health leave

5.69 The committee is aware that women are disproportionately affected by sexual and reproductive health issues, and that as a result, compared to their male counterparts, female employees typically ended up with less personal leave available for use in other circumstances.

5.70 The committee is also mindful that there are many examples of gender-specific health issues that remain unacknowledged or taboo in the workplace, and that this contributes to the challenges working women face in looking after their reproductive health, while also maintaining their workplace earnings.

5.71 The committee sees merit in the Government exploring how reproductive leave policies could operate in Australian workplaces. It considers the Government has a role to play in bringing visibility to the conversation in the community

about the importance of reproductive health considerations in regard to workplace gender equity.

Recommendation 36

5.72 The committee recommends that the Australian Government considers commissioning research and policy responses on the impact of reproductive health on women's participation in the workforce and the adequacy of existing leave entitlements under the National Employment Standards.

Senator Janet Rice
Chair

Additional comments from the Australian Greens

1.1 The *National Women's Health Strategy 2020–2030* recognises that access to maternal, sexual and reproductive health care is fundamental to positive health, wellbeing, social, and economic outcomes. Yet, as evidence to this inquiry made abundantly clear, the quality, availability and affordability of this healthcare is not the same for everyone. Too often, whether you can access maternal, sexual and reproductive healthcare depends on your postcode, your income, your visa status, or your cultural background.

1.2 This inquiry was motivated by the need to end this postcode lottery. We heard evidence from across Australia about the barriers people face and what needs to be done to address them.

1.3 Around the country, there are examples of maternity services in local hospitals being closed or suspended, forcing families to travel for basic healthcare. Many First Nations women have to travel hundreds of kilometres away from country and family to give birth.

1.4 The efforts of decades of campaigning has seen abortion decriminalised and recognised as healthcare, yet this inquiry heard that abortion services can be prohibitively expensive (particularly if you don't have a Medicare card), or simply unavailable in some regional areas. Access difficulties are compounded by different rules between jurisdictions, conscientious objections, shortages of practitioners trained to provide surgical abortions or registered to prescribe medical abortion, and lack of information. It should not be this difficult to access healthcare.

1.5 Pregnancy care and fertility procedures are healthcare. Contraceptive counselling is healthcare. Menopause treatment is healthcare. Abortion is healthcare. The Greens believe such healthcare should be accessible, affordable, safe, legal, compassionate, and free from stigma, no matter who you are or where you live.

1.6 The Greens are very pleased that the committee has recognised the gravity of the situation and the need for action. The committee recommendations set out an ambitious and comprehensive workplan to tackle the barriers to access, and we urge the Government to get on with this critical task.

1.7 These comments briefly outline opportunities to ensure that the measures outlined in the committee recommendations can effectively ensure universal access to sexual, maternal, and reproductive healthcare.

Free contraceptives

1.8 We heard consistently through the inquiry that cost and information were key barriers to people being able to choose a contraceptive method that was most effective for them, taking account of their personal circumstances, including underlying health conditions, relationship status, travel, and interaction with other medications. What works well for one person may not work well for another.

1.9 Everyone should be able to access the contraceptive option that works best for them.

1.10 Increasing awareness of, and access to, a full suite of contraceptive options has significant health and economic benefits in terms of avoiding unintended pregnancies and terminations. Programs in other countries that have made contraceptives, including oral contraceptives, condoms and long-acting reversible contraceptives, free have significantly increased uptake. This has also lowered the rates of pregnancy, birth, and terminations, particularly amongst younger people.

1.11 We welcome the committee's recommendations for contraceptive counselling and actions to make contraceptives more affordable. As part of the work of reviewing how to make contraception more affordable for all, we encourage the government to follow the lead of France, the UK and others and simply make contraceptives free.

Recommendation 1

1.12 That the Australian Government funds the free provision of all approved contraceptive methods.

No out-of-pocket costs for abortions

1.13 The Greens believe that abortion care is basic healthcare that should be free and available through the public health system.

1.14 The committee heard countless stories of people faced with an unintended pregnancy having to pay many hundreds of dollars, some even as much as $17,000, including direct service costs and the indirect costs of travel, accommodation, time off work, childcare and post-abortion care. Those out of pocket costs present a very real barrier to access.

1.15 We welcome the committee recommendation that public hospitals provide surgical terminations or a timely and affordable local pathway to an alternative provider. However, unless those alternative pathways are fully funded, people who cannot access a termination through their local hospital are at a significant disadvantage. This is likely to most acutely impact people in rural and regional Australia, and those without a Medicare card.

1.16 We recommend that the Government ensure that any pathway to a legal abortion is fully funded, whether through provision in a public hospital or subsidies for alternative access. The ACT Government recently announced that it would deliver free universal access to abortion, and we urge other States and Territories to follow their lead.

Recommendation 2

1.17 That the Australian Government work with states and territories to:

- **ensure abortion services are provided at no cost; and**
- **maintain locally-administered public funds to assist patients to cover indirect costs where services are not provided in the local hospital.**

Harmonisation

1.18 One contributing factor to the postcode lottery for accessing an abortion is the patchwork of different laws across the country. The rules in your state can have a significant impact on the gestational limits for accessing a termination (ranging from 16 - 24 weeks), the medical consent required before an abortion will be performed, and whether you will be required to receive counselling before exercising your bodily autonomy.

1.19 Harmonising laws to achieve consistent, best practice care across Australia would assist patients and practitioners.

Recommendation 3

1.20 That the Australian, state, and territory governments work towards the harmonisation of pregnancy termination legislation across all Australian jurisdictions, based on best practice models of care.

Removing barriers for IVF and surrogacy

1.21 The inquiry heard detailed evidence about current barriers for people seeking to become parents through assisted reproductive treatments and altruistic surrogacy arrangements, including same sex parents. We are encouraged by the committee's recommendation to examine options to extend Medicare rebates for IVF services, and further recommend that the Government remove legal barriers to access.

Recommendation 4

1.22 That the Government remove legal barriers to accessing IVF and altruistic surrogacy arrangements by:

- **amending the definition of infertility to align with the International Committee Monitoring Assisted Reproductive Technologies' definition of infertility; and**

- **deleting the word 'particular' from subsection 12(1) of the *Prohibition of Human Cloning for Reproduction Act 2002*.**

Workforce shortages and scope of practice

1.23 Nurses and midwives are well positioned to administer a range of contraceptives and fill gaps in maternity, sexual and reproductive healthcare services. However, without dedicated MBS items allowing them to recoup their costs, or PBS prescribing rights to ensure their patients can afford the contraception they prescribe, it is not viable for midwives to provide those services.

1.24 For some midwives, exorbitant insurance premiums from a monopoly provider act as a further barrier to the viability of offering birthing services. This restriction is felt acutely in remote health services and ACCHOs who cannot afford to risk midwifery provision. As a result, many people in remote and regional areas have limited options to access local, affordable pregnancy care or continuity of maternity care.

1.25 The Greens support the National Scope of Practice Review, and urge the government to ensure that the review examines MBS and PBS coverage, insurance costs, workforce development strategies and other practical barriers facing practitioners. Enabling nurses, midwives, and pharmacists to perform the full scope of sexual, maternal and reproductive healthcare work that they are capable of doing will have huge benefits for improving access across the country.

More work to be done

1.26 This inquiry has revealed the scale of work needed to achieve universal access to high quality maternal, sexual and reproductive healthcare.

1.27 In addition to the work set out in the recommendations, the Greens will continue to call for more research and investment into menopause, endometriosis, menstrual pain management, infertility, gender-affirming healthcare, and the gendered impacts of conditions like migraines and cancer.

1.28 We will also continue to call for measures to address period poverty by making period products free.

Acknowledgments

1.29 We extend our deep gratitude to all the people and organisations who shared their stories and experiences with the committee as part of this inquiry, and the advocates, practitioners and frontline service providers who continue to fight for safe, affordable access to maternity, sexual and reproductive healthcare for everyone. This is critical work, but it is not easy work, and we thank you for all that you do.

Senator Janet Rice
Chair

Senator Larissa Waters

Additional comments from Labor Senators

1.1 Labor Senators support the report and associated recommendations.

1.2 Labor Senators note that many of the issues discussed in the report remain the responsibility of the states and territories, and that the recommendations reflect the evidence that was presented to the committee. Further, we note that some of the issues discussed are matters of conscience for Members of Parliament.

Senator Marielle Smith
Deputy Chair

Senator Louise Pratt

Additional comments from Coalition Senators

1.1 Coalition Senators express our thanks to the committee and submitters for their efforts in conducting this inquiry. Access to reproductive healthcare and associated issues is of utmost importance to Australians, and we appreciate the attention given to this matter.

1.2 Coalition Senators also recognise and appreciate the diverse range of submissions received during the inquiry, including those from individuals who hold objections to abortions and have taken the opportunity to share their personal stories.

1.3 Coalition Senators firmly believe in the principles of equity and accessibility in our healthcare system. It is essential that all Australians, regardless of their geographic location, have access to the reproductive healthcare services they need.

1.4 We also acknowledge challenges faced by individuals in regional, rural, and remote areas.

1.5 In acknowledging the comprehensive Pharmaceutical Benefits Scheme (PBS) and Medicare Benefits Schedule (MBS) systems, Coalition Senators appreciate the reliance on expert advice to ensure that subsidised treatments and medications are available and appropriately targeted to those who require support in the community.

1.6 We understand the importance of a robust and evidence-based approach in determining the allocation of resources to ensure the greatest benefit for patients across the nation.

1.7 Coalition Senators note the ongoing review into the Therapeutic Goods Administration (TGA). We recognise the significance of timely approval of new medicines and treatments in Australia, and we anticipate the outcomes of the review.

1.8 While this inquiry has shed light on various aspects of reproductive healthcare, we must also acknowledge that many measures relating to reproductive services fall under the jurisdiction of state governments, which remain the appropriate entities to oversee and govern these matters.

1.9 Coalition Senators remain committed to addressing the issues of access and equity in reproductive healthcare and believe in a healthcare system that provides safe, affordable, and inclusive services for all Australians.

Senator Wendy Askew

Additional comments from Senator Tammy Tyrrell

1.1 My position is simple: there should be safe, equitable and affordable access to reproductive healthcare for everyone who lives in Australia.

1.2 What we've heard during this inquiry is that governments, State and Federal, are failing to deliver on this front. As a result, people are having trouble accessing contraception, experiencing difficult pregnancies, and facing hard decisions over their bodies and their future.

1.3 The committee has heard there are people who can't afford their preferred contraceptive. Some people can't easily access a practitioner to insert a long-acting reversible contraceptive (LARC). Others can't afford to pay for a LARC because of the upfront cost of insertion and removal, and the associated costs of consultation with a medical practitioner. In both circumstances, these people will often get the pill instead of a LARC. However, there are also issues with the pill, like side effects and affordability. In many cases, people who can't afford a pill with fewer side effects will instead opt for the cheaper option with more side effects because their preferred pill is not listed on the Pharmaceutical Benefits Scheme.

1.4 Coming from a state that is largely classified as rural and remote, I'm especially concerned about an observation already made in this report, that '[w]omen living in rural and remote areas are 1.4 times more likely to experience an unintended pregnancy, suggesting that access to contraception and abortion services remains a problem in those areas'.[1] Access to contraception is critical for preventing further unwanted interactions with the health system as a result of an unintended pregnancy.

1.5 The committee has also heard that there are people who can't afford to pay for abortion services, because they struggle to pay the upfront fee for which they'll later be rebated. In Tasmania, some people can't afford to pay the $150 out of pocket cost for a medical termination, let alone the $350 upfront cost for which they will receive a partial rebate.

1.6 What is a welcome change, is that surgical abortions are now free in Tasmania. Dr Erica Millar observed that on this issue, 'Tasmania is a leader that other states should be following'.[2] Dr Millar also said that she wasn't aware of data on whether there are more surgical than medical abortions as a result of this change.[3] I would be interested to know if more people are now accessing

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1 Organon, *Submission 3*, p. 3.

2 Dr Erica Millar, *Committee Hansard*, 28 April 2023, p. 65.

3 Dr Erica Millar, *Committee Hansard*, 28 April 2023, p. 65.

surgical abortions instead of medical abortions, simply because they are free. The need for data on this particular issue is reflected across the board: we need to collect more data on reproductive healthcare. If we have more data, we can make more targeted improvements.

1.7 The committee also heard that there are people who face other barriers with access to reproductive healthcare. These include the distance to travel to a service that offers ultrasounds, or the distance to travel to a GP that can prescribe the medical abortion pill, or the pharmacist who dispenses it.

1.8 These problems are happening all over Australia, but they are worse in the regions. The further you are away from a big city, the harder it is to get quality healthcare. That is the case for all healthcare, and reproductive healthcare is no different.

1.9 For example, our Women's and Newborn Health pharmacist workforce in Tasmania is just not good enough:

> The Royal Hobart Hospital employs a Paediatric and Neonatology Pharmacist but does not currently have a Women's or Reproductive Health pharmacist to provide clinical pharmacy services. The maternity ward at Royal Hobart Hospital does not have a clinical pharmacy service attached to it.
>
> Launceston General Hospital has a paediatric pharmacist and no Women's and Newborn Health pharmacist. Similarly in North West Tasmania, there are no Women's and Newborn Health pharmacists despite maternity services being provided through contractual arrangements at North West Private Hospital.[4]

1.10 It's fairly obvious that we don't have adequate health services in Tasmania, and it is no secret that as a result, Tasmanians travel to the mainland for healthcare. This has been happening for some time. Tasmanians mostly go to Victoria, and I learnt that Tasmanians are also accessing a Victorian telephone service, 1800 My Options, because the services in my state are not sufficient to respond to the needs of Tasmanians.[5]

1.11 The committee has heard that there are a lot of problems with reproductive healthcare, but it has also heard that there are a lot of solutions. These solutions should also be available to all people in Australia, regardless of their proximity to the big cities, or visa status.

1.12 In the first instance, all oral contraceptives should be on the PBS, and LARCs should at least be cheaper and easier to access, if not free to access.

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[4] Society of Hospital Pharmacists of Australia, answer to question taken on notice, 28 February 2023 (received 8 May 2023).

[5] Women's Health Victoria, answer to question taken on notice, 28 February 2023 (received 5 May 2023).

1.13 Another solution is that termination services should be freely available, and accessible—both medical termination, and surgical termination.

1.14 Pregnancy care should also be expanded, including through continuity of midwifery care with a known midwife.

1.15 The Federal Government could also do more to expand the powers of midwives and nurse practitioners. Powers could be expanded to allow these medical practitioners to perform LARC insertion and removal. Midwives and nurse practitioners should also be reimbursed for conducting these procedures under the relevant Medical Benefits Scheme item number. This would alleviate the pressure on the healthcare system and increase accessibility to healthcare for individuals.

1.16 Although we are seeing improvements with access to reproductive healthcare, there is a lot that remains to be done. This report contains a number of excellent recommendations that, if implemented, would vastly improve equitable access to reproductive healthcare for all people in Australia, regardless of who they are or where they live. I look forward to working with the Government on progressing these recommendations.

Senator Tammy Tyrrell

Appendix 1 - Submissions and additional information received

1 Healthy Male Ltd
- Attachment

2 National Foundation for Australian Women
3 Organon ANZ
4 Australasian Sonographers Association
5 SPHERE Women's Sexual and Reproductive Health Coalition
6 Family Planning Welfare Association NT
7 Women's Health Tasmania
8 Public Advocate (Queensland)
9 School of Public Health and Preventative Medicine, Monash University
10 IVF Medical Directors Group
11 Birthline Pregnancy Support Inc
12 Finance Sector Union of Australia
13 The Royal Australasian College of Physicians
14 Hudson Institute of Medical Research
15 MJD Foundation
16 The Australian College of Nursing
17 Fay Gale Centre for Research on Gender at the University of Adelaide
18 Pregnancy Help Sydney Inc
19 Australian Women's Health Nurse Association Inc.
20 Australian Nursing & Midwifery Federation
21 Pregnancy Assistance Frankston Inc.
22 Fertility Coalition
23 Australian Lawyers for Human Rights
24 Australian and New Zealand Society of Reproductive Endocrinology and Infertility
25 Women's Health Service Alliance
26 Robinson Research Institute
27 Sexual Health Victoria and Family Planning Alliance Australia
28 Exercise & Sports Science Australia (ESSA)
29 Queensland Nurses and Midwives' Union
30 Australian College of Midwives
31 Ballarat Community Health
32 Australian Federation of AIDS Organisations
33 The Ovulation Method Research and Reference Centre of Australia Ltd
34 Australian Longitudinal Study on Women's Health
35 Institute for Urban Indigenous Health
36 Women's Health East

37 Women's Health Goulburn North East
38 Ending Violence Against Women Queensland
39 Equality Tasmania
40 Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine
- Attachment

41 Rationalist Society of Australia Inc
42 AusDoCC
43 Midwives Australia
44 Consumers Health Forum
45 True Relationships and Reproductive Health
46 Australian Association of Psychologists Inc
47 SA Maternal Neonatal and Gynaecology Community of Practice
48 SHINE SA
49 Preconception Health Network
50 Northern Rivers Women's Health and Wellbeing Interagency
51 Women's Health in the South East
52 ACON
53 Department of Health and Aged Care
- 6 attachments

54 Lismore Women's Health & Resource Centre
55 Aboriginal Health and Medical Research Council
56 Family Planning NSW
57 Alex and Tom
58 Mr Stephen Page
59 First Nations Women's Legal Services Queensland Inc.
60 Children by Choice
- 11 attachments

61 Intersex Human Rights Australia
62 MSI Australia
63 Family Planning Alliance Australia
- Attachment

64 The Royal Australian College of General Practitioners
65 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
66 Fair Agenda
67 LGBTIQ+ Health
68 Down Syndrome Queensland
69 The Pharmacy Guild of Australia
70 Pharmaceutical Society of Australia
71 Australian Medical Association
72 National Rural Health Commissioner
73 National Rural Health Alliance

74 National Rural Women's Coalition
75 National Aboriginal Community Controlled Health Organisation
76 Syndromes Without A Name (SWAN) Australia
77 Northern Health
78 Through the Unexpected
79 International Student Sexual Health Network
80 Men and Family Centre
81 Australian Federation of Medical Women
82 Australasian Sexual Health & HIV Nurses Association
83 Teach Us Consent
84 Melbourne School of Population and Global Health (MSPGH)
85 The Royal Women's Hospital
86 Medicines Australia
87 Just Equal
88 Health Consumers Council
89 Australian Parliamentary Group on Population and Development
90 Family Planning Tasmania
91 MS Health
92 Public Health Association of Australia
93 Down Syndrome Australia; Disability Representative and Advocacy Organisation
94 Tasmanian Government
95 Illawarra Women's Health Centre
96 Rainbow Families
97 Maternal Health Matters
98 Women's Electoral Lobby
99 Castan Centre for Human Rights Law
100 Amnesty International
101 ACT Council of Social Service Inc.
102 Multicultural Centre for Women's Health
103 Catholics for Choice
104 Rural Doctors Association of Australia
- Attachment

105 The Abortion Project
106 Anglican Diocese of Sydney
107 GenWest
108 Women's Health in the North
109 Birth for Humankind
110 National Womens Safety Alliance
111 Pathology Technology Australia
112 cohealth
113 Australian Association of Social Workers
114 Barton Brands

115 Surrogacy Australia
116 Deep End GPs of Canberra
117 Victorian Pride Lobby
118 Espod Geelong Inc.
119 Thorne Harbour Health and Victoria Pride Lobby
120 Evangelicals for Life
121 ANU LRSJ Research Hub
122 SA Abortion Coalition
123 Gippsland Women's Health
124 Peninsula Health
125 Bendigo Community Health Services
126 Australian Gender Equality Council
127 Australian Women's Health Network
- 2 attachments

128 Bloom-Ed
129 Australasian Birth Trauma Association
130 Women's Health Grampians
131 Australian College of Nurse Practitioners; Australian Primary Health Care Nurses Association
132 Australian Federation of Business & Professional Women
133 Australian Midwifery and Maternity Alliance
134 Women's Health Services Network
135 Women's Health Victoria
136 The Society of Hospital Pharmacists of Australia
137 Health Care Consumers Association Inc.
138 Australian Medical Students' Association
139 Maternity Choices Australia
140 Women & Babies Support
- Attachment

141 DLA Piper
142 WHWBSW
143 Australian Healthcare and Hospitals Association (AHHA)
144 Aboriginal Health Council of South Australia
145 University of Melbourne, Department of Rural Health
146 Dr Cassandra Byrnes; Prof Lisa Featherstone; Ms Bridget Andresen
147 Dr Brian Peat
148 Professor Caroline de Costa
149 Professor Susan Davis
- Attachment

150 Dr Brendan Whyte
151 Dr Lydia Mainey
152 Eva's Place Pregnancy & Early Parenting Support Inc.

153 Dr Wendy Hughes
154 Dr Jessica McLaren
155 Ms Lea Shaw
156 Mx Anna Noonan
157 Dr Amanda Cohn
158 Mrs Susanne Armour
159 Ms Madeleine Belfrage
160 Ms Brianna Pike
161 Professor Danielle Mazza
162 Fiona Brown
163 Dr Bob Vickers
164 Nola Savage
165 Margaret Mill
166 Dr Ahmad Syahir Mohd Soffi
167 Ms Heather Daly
168 Dr Erica Millar
169 Dr Hazel Keedle
170 Mr Stephen Bates
171 Ms Christine Smith
172 katrina mathai
173 Hannah Phillips
174 Aidan Ricciardo
175 Anna Walsh
176 Jamal Hakim
177 Dr David Chee
178 Dr Johnny Sakr
179 Bayer Group ANZ
180 *Name Withheld*
181 *Name Withheld*
182 *Name Withheld*
183 *Name Withheld*
184 *Name Withheld*
185 Australian Catholic Bishops Conference
186 Democratic Labour Party of South Australia
- Attachment

187 Cherish Life
188 Australian Christian Lobby
189 Catholic Women's League Australia Inc
190 Dr Joanna Howe
191 Pregnancy Assistance Cares
192 The Right to Life Inc
193 Catholic Women's League Victoria & Wagga Wagga Inc
194 Dr Samara McNeil

195 Transgender Victoria & Transcend Australia
196 Maternity Consumer Network inc
197 GynaeHealth Specialist Care
198 Western Australian Government
199 Veronique Douillard-Fomiatti
200 Debora Doidge
201 Mrs Margaret Smyth
202 Kirsty van Tonder
203 Mrs Suzannah Rees
204 Wellington Baptist Church
205 *Name Withheld*
206 Ann Fayolle
207 *Name Withheld*
208 *Name Withheld*
209 Dr Michele Browne
210 Ms Tamzen Armer
211 Miss Catherine Erskine
212 Ms Ezra Kneebone
213 Mrs Kaye Stacey
214 Monash University
215 Rick Bailey
216 Richard Loveys
217 J & T Leahy
218 Mr Rodney Hutcheon
219 Mrs Anita Swift
220 Mrs Roseanne Masters
221 Adam Feigl
222 Dr Stephen J Fyson PhD
223 Mrs Elizabeth Reeves
224 Mrs Rebekah Reilly
225 Mr Alan Frankham
226 Mrs Margaret Airoldi
227 Mr Michael Fewster
228 Ms Helen Evans
229 Mr John Baxter Snr
230 Kenneth Glasgow
231 Mr Greg Byrne
232 Mrs A. Jones
233 Maree & Chris Rule
234 Mrs Sharon Cousins
235 Les Anderson
236 Jaqueline Jenkins
237 Sue Rhodes

238 Barbara van der Meer
239 Melanie McIntosh
240 Canberra Declaration
241 Judith Alcock
242 Mrs Sandra Callister
243 Atherton Cherish Life Branch
244 Helen Curtis
245 Cherish Life Gympie Branch
246 Mr William Callister
247 Mr Michael Carton
248 Beverley Cains
249 Dr Jesse Durdin
250 David Gawler
251 Colin Corben
252 Anne Buchan
253 Hazel Lee
254 Angela Child
255 Catherine Reilly
256 Bettina Blaxland
257 Lex Stewart
258 Richard Langdon
259 Graham Zerk
260 Graham Turvey
261 M Mascarenhas
262 John Mackenzie
263 Peter Newland
264 Rev. David Maher
265 John Bennett
266 John Martin
267 Australasian Institute for Restorative Reproductive Medicine
268 Cody Mitchell
269 *Name Withheld*
270 *Name Withheld*
271 *Name Withheld*
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290 Dr Melissa Brown
291 Dianne Cowling
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298 *Name Withheld*
299 *Name Withheld*
300 Susan Pollock
301 Dorothy Cook
302 Coalition for the Defence of Human Life
303 Women's Health Matters
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316 Save Gladstone Maternity Ward
317 Erika Hamilton
318 Ms Nina Crawley
319 *Name Withheld*
320 *Name Withheld*
321 *Name Withheld*
322 Jo Millard
323 Nancy Kennedy

324 Keren Witcombe
325 Dr Anna Chaney
326 Ruth McCuaig
327 Ms Erin McBride
328 Queensland Contraception and Abortion Community of Practice
329 Emma Boulton
330 *Name Withheld*
331 Ms Sarah Jefford
- Attachment

332 *Name Withheld*
333 *Name Withheld*
334 *Name Withheld*
335 *Name Withheld*
336 Ms Helen McMartin
337 Tom Bistricic
338 Genesis Pregnancy Support Inc
- Attachment

339 *Name Withheld*
340 Amnesty International Australia Feminist Network
341 Plunkett Centre for Ethics
342 Women's Forum Australia
343 Tawhid Hassanien
- 8 attachments

344 Australian Christian Lobby campaign
345 Unidentified third-party campaign
346 Surrogacy Australia campaign
347 Fair Agenda campaign
348 Cherish Life campaign
349 Mr Konstantinos Panagos
350 Dr Katrina Haller
351 International Planned Parenthood Federation
352 Rare Voices Australia

Tabled documents

1 Alex, document tabled at a public hearing on 22 February 2023.

Additional information

1 Women With Disabilities Australia, additional information, report titled Towards Reproductive Justice for young women, girls, feminine identifying, and non-binary people with disability (YWGwD), November 2022, received 17 November 2022.

2 ACT Government, additional information in relation to the inquiry into the Universal Access to Reproductive Healthcare; received 13 December 2022.

3 Ending Violence Against Women Queensland, additional information in relation to evidence given at a public hearing on 22 February 2023; received 22 February 2023.

4 Dr Danielle Haller, additional information in relation to evidence given at a public hearing on 22 February 2023; received 22 February 2023.

5 Danielle Haller, additional information in relation to evidence given at a public hearing on 22 February 2023; received 1 March 2023.

6 Mr Stephen Page, additional information in relation to evidence given at a public hearing on 22 February 2023; received 3 March 2023.

7 Australian Nursing and Midwifery Federation, opening statement for a public hearing on 28 February 2023; received 1 March 2023.

8 LGBTIQ+ Health, opening statement for a public hearing on 28 February 2023; received 1 March 2023.

9 Royal Australian College Group of General Practitioners, opening statement for a public hearing on 28 February 2023; received 1 March 2023.

10 Surrogacy Australia, opening statement for a public hearing on 28 February 2023; received 1 March 2023.

11 National Rural Women's Coalition, opening statement for a public hearing on 28 February 2023; received 2 March 2023.

12 Pharmaceutical Society of Australia, opening statement for a public hearing on 28 February 2023; received 2 March 2023.

13 Women With Disabilities Australia, opening statement for a public hearing on 28 February 2023; received 2 March 2023.

14 Royal Australian and New Zealand College of Obstetricians and Gynaecologists, opening statement for a public hearing on 28 February 2023; received 2 March 2023.

15 National Aboriginal Community Controlled Health Organisation, opening statement for a public hearing on 28 February 2023; received 2 March 2023.

16 National Rural Health Alliance, opening statement for a public hearing on 28 February 2023; received 3 March 2023.

17 Fair Agenda, opening statement for a public hearing on 28 February 2023; received 3 March 2023.

18 Down Syndrome Australia, opening statement for a public hearing on 28 February 2023; received 5 March 2023.

19 Australian Nursing and Midwifery Federation, additional information in relation to evidence given at a public hearing on 28 February 2023; received 22 March 2023.

20 Dr Erica Millar, additional information in relation to evidence given at a public hearing on 28 April 2023, received 4 May 2023.

21 Julia Argyrou Endometriosis Centre at Epworth, additional information in relation to evidence given at a public hearing on 28 April 2023; received 5 May 2023.

Answers to question on notice

1 Answers to questions taken on notice by ACON at a public hearing on 21 February 2023; received 8 March 2023.

2 Answers to questions taken on notice by Stephen Page at a public hearing on 22 February 2023; received 23 February 2023.

3 Answers to questions taken on notice by Surrogacy Australia at a public hearing on 28 February 2023; received 20 March 2023.

4 Answers to questions taken on notice by the Royal Australian College of General Practitioners at a public hearing on 28 February 2023; received 20 March 2023.

5 Answers to questions taken on notice by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists at a public hearing on 28 February 2023; received 20 March 2023.

6 Answers to questions taken on notice by the Department of Health and Aged Care at a public hearing on 28 February 2023; received 30 March 2023.

7 Answers to questions taken on notice by the ACT Health Directorate at a public hearing on 28 February 2023; received 21 March 2023.

8 Answers to questions taken on notice by WA Health at a public hearing on 4 April 2023; received 28 April 2023.

9 Answers to questions taken on notice by Elly Taylor at a public hearing on 28 April 2023, received 5 May 2023.

10 Answers to questions taken on notice by the Australian College of Nursing at a public hearing on 28 April 2023, received 5 May 2023.

11 Answers to questions taken on notice by Women's Health Victoria at a public hearing on 28 April 2023, received 5 May 2023.

12 Answers to questions taken on notice by SHPERE at a public hearing on 28 April 2023, received 5 May 2023.

13 Answers to questions taken on notice by Julia Argyrou Endometriosis Centre at a public hearing on 28 April 2023, received 5 May 2023.

14 Answers to questions taken on notice by the Royal Women's Hospital at a public hearing on 28 April 2023, received 5 May 2023.

15 Answers to questions taken on notice by the Multicultural Centre for Women's Health at a public hearing on 28 April 2023, received 5 May 2023.

16 Answers to questions taken on notice by the Society of Hospital Pharmacists of Australia at a public hearing on 28 April 2023, received 8 May 2023.

17 Answers to questions taken on notice by Family Planning Alliance Australia at a public hearing on 28 April 2023, received 9 May 2023.

18 Answers to questions taken on notice by the Department of Health and Aged Care at a public hearing on 28 April 2023, received 12 May 2023.

19 Answers to questions taken on notice by Transgender Victoria at a public hearing on 28 April 2023, received 24 May 2023.

Correspondence

1 ACT Government, correspondence in relation to universal access to reproductive health; received 13 December 2022.

Appendix 2 - Public Hearings

Tuesday, 21 February 2023

Southern Cross University
Military Rd, East Lismore, NSW

ACON

- Dr Lucy Watson, Manager, Policy, Strategy, Research
- Ms Karen Price, Deputy Chief Executive Officer
- Ms Elizabeth Duck-Chong, Projects Coordinator, Trans Health Equity

Coffs Harbour Women's Health Centre

- Ms Shelley Rowe, Chief Executive Officer
- Dr Laura Brien, Clinical Lead General Practitioner

Lismore Women's Health and Resource Centre & Choices Reproductive and Sexual Health

- Ms Amala Sheridan-Hulme, Women's Health and Sexual Health Nurse

Intersex Human Rights Australia

- Mr Morgan Carpenter, Executive Director

Family Planning NSW

- Adjunct Professor Ann Brassil, Chief Executive Officer
- Ms Caecilia Roth, Senior Policy Officer

Wednesday, 22 February 2023

Royal on the Park Brisbane
152 Alice St, Brisbane City, Qld

True Relationships and Reproductive Health

- Dr Danielle Haller, Regional Medical Officer - Southern

Queensland Nurses and Midwives' Union

- Dr Belinda Barnett, Research & Policy Officer
- Dr Belinda Maier, Strategic Midwifery Research and Policy Officer
- Ms Denise Breadsell, Professional Officer

Institute for Urban Indigenous Health

- Ms Donisha Duff, Strategic Policy Advisor
- Dr Caroline Harvey, Senior GP, Sexual and Reproductive Health

First Nations Women's Legal Services Queensland Inc.

- Mx Aaminah Khan, Paralegal

Children by Choice

- Ms Daile Kelleher, Chief Executive Officer
- Ms Nicole Huig, Counselling Team Leader

Ending Violence Against Women Queensland

- Ms Bianca Blackmore, Administration and Project Officer for Women's Health and Equality Queensland

Women's Health Service Alliance

- Ms Holly Brennan OAM

Alex, private capacity

Mr Stephen Page, private capacity

Tuesday, 28 February 2023

Parliament House
Canberra, ACT

MSI Australia

- Mr Jamal Hakim, Managing Director
- Mr Philip Goldstone, Medical Director
- Dr Catriona Melville, Deputy Medical Director

Sexual Health and Family Planning ACT

- Mr Tim Bavinton, Executive Director
- Dr Martina Mende, Senior Medical Officer

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

- Professor Kirsten Black, Chair of Sexual and Reproductive Health Special Interest Group

The Royal Australian College of General Practitioners

- Dr Nicole Higgins, President
- Professor Danielle Mazza, Chair of RACGP Guidelines for Preventative Activities in General Practice (Red Book)

Australian Nursing and Midwifery Foundation

- Ms Julianne Bryce, Senior Federal Professional Officer
- Ms Jasmine Kirk, Federal Professional Officer

Fair Agenda

- Ms Alyssa Shaw, Campaign Manager

Surrogacy Australia

- Ms Kate Fitzpatrick, Board Member

LGBTIQ+ Health

- Mx Zed Tintor, Deputy Chief Executive Officer
- Dr Vik Fraser, Executive Director

Women With Disabilities Australia

- Ms Carolyn Frohmader, Executive Director

Down Syndrome Australia

- Mr Darryl Steff, Chief Executive Officer

The Pharmacy Guild of Australia

- Natalie Willis, Western Australia Senior Vice President and National Councillor
- Jessica Seeto, Senior Pharmacist Advisor

Pharmaceutical Society of Australia

- Dr Fei Sim, National President

Australian Medical Association

- Dr Danielle McMullen, Vice President

National Rural Health Commissioner

- Adjunct Professor Ruth Stewart, National Rural Health Commissioner

National Rural Health Alliance

- Ms Susanne Tegen, Chief Executive
- Ms Clare Fitzmaurice, Policy and Data Analysis Officer

National Rural Women's Coalition

- Ms Keli McDonald, Chief Executive Officer
- Ms Anna Noonan, Researcher

National Aboriginal Community Controlled Health Organisation

- Dr Kate Armstrong, Medical Advisor

Department of Health and Aged Care

- Ms Tania Rishniw, Deputy Secretary, Primary and Community Care
- Ms Celia Street, First Assistant Secretary, Population Health Division
- Professor Alison McMillan, Chief Nursing and Midwifery Officer

ACT Health Directorate

- Minister Rachel Stephen-Smith, ACT Minister for Health
- Mr Michael Culhane, Executive Group Manager, Policy, Partnerships and Programs

Tuesday, 4 April 2023

Doubletree by Hilton Perth Northbridge
100 James Street, Perth, WA

Youth Educating Peers

- Ms Lorna Geraghty, Project Coordinator
- Ms Zoe Sullivan, Project Senior Educator

SECCA (Sexuality Education Counselling and Consultancy Agency)

- Dr Emily Castell, Clinical Director
- Ms Jordina Quain, Education Director

Bloom-Ed

- Dr Jacqueline Hendriks, Founder

Ms Lucy Peach, private capacity

The Abortion Project

- Miss Lily McAuliffe, Co-Founder

Sexual Health Quarters

- Ms Debra Barnes, Chief Executive Officer
- Dr Samantha Johnson, Deputy Medical Director
- Dr Nicole Filar, Acting Deputy Medical Director

Women and Newborn Health Service, WA Department of Health

- Mrs Diane Barr, Executive Director, Women and Newborn Health Service
- Dr Ruth McCuaig, Consultant, Women and Newborn Health Service (Clinical Lead – Abortion Care at King Edward Memorial Hospital)

Dr Samara McNeil, private capacity

TransFolk of WA

- Mr Hunter Gurevich

International Student Sexual Health Network

- Ms Alison Coelho, Director
- Ms Karina Reeves, Co-Chair

Ishar Multicultural Women's Health Service

- Ms Andrea Credo, Chief Executive Officer

Friday, 28 April 2023

Jasper Hotel
489 Elizabeth Street, Melbourne, Vic

Australian Longitudinal Study on Women's Health

- Professor Gita Mishra, Director
- Professor Deborah Loxton, Director

Organon ANZ

- Ms Nirelle Tolstoshev, Managing Director
- Ms Samantha Howes, Policy Manager

The Royal Women's Hospital

- Professor Sue Matthews, Chief Executive Officer
- Associate Professor Patricia Moore, Head of Unit Abortion and Contraception Services, Early Pregnancy Assessment

Multicultural Centre for Women's Health

- Dr Adele Murdolo, Executive Director

Society of Hospital Pharmacists of Australia

- Dr Luke Grzeskowiak, Member, Women's and Newborn Health Specialty Practice Leadership Committee
- Mr Jerry Yik, Head of Policy and Advocacy

SPHERE

- Dr Deborah Bateson, Associate Investigator

Family Planning Alliance Australia

- Ms Tracey Hutt, Chief Executive Officer

Julia Argyrou Endometriosis Centre

- Dr Samantha Mooney, Acting Director
- Mrs Nikki Campbell, Endometriosis Nurse Coordinator

Transgender Victoria

- Ms Michelle McNamara, Chair Advocacy Board Committee

Women's Health in the South East (WHISE)

- Ms Kit McMahon, Chief Executive Officer

Australian Federation of Medical Women

- Associate Professor Magdalena Simonis, President
- Dr Marjorie Cross, Executive Member
- Dr Kate Duncan AM, Chair of Governance Committee

- Dr Melanie Dorrington, Young Australian Federation of Medical Women

Women's Health Tasmania
- Ms Lucinda Shannon, Acting Chief Executive Officer

South Australian Abortion Action Coalition
- Ms Brigid Coombe RN MN, Co-Convenor

Women's Health Victoria
- Ms Dianne Hill, Chief Executive Officer
- Ms Carolyn Mogharbel, 1800 My Options Manager

Public Health Association of Australia
- Professor Angela Dawson, Professor of Public Health

Australian College of Nursing
- Adjunct Professor Kylie Ward, Chief Executive Officer
- Mrs Linda Davidson, National Director Professional Practice

Australian College of Midwives
- Ms Helen White, Chief Executive Officer
- Dr Zoe Bradfield, Vice President

Midwives Australia
- Ms Elizabeth Wilkes, Vice President

Therapeutic Goods Administration
- Ms Tracey Duffy, Acting Deputy Secretary, Health Products Regulation Group
- Adjunct Professor Robyn Langham AM, Chief Medical Advisor, Health Products Regulation Group

Victorian Women's Health Services Network
- Ms Elly Taylor, Chief Executive Officer
- Ms Shannon Hill, Sexual Health Advisor

Dr Erica Millar, private capacity

Bianca, private capacity

Charlotte, private capacity