Australian Government
Department of Health and Aged Care

# *Inquiry into universal access to reproductive healthcare*

Submission from the Department of Health and Aged Care
to the Senate Standing Committees on Community Affairs

**21 December 2022**

# Contents

**Abbreviations**

AHRC = Australian Human Rights Commission

AIHW = Australian Institute of Health and Welfare

ARTG = Australian Register of Therapeutic Goods

ANFPP = Australian Nurse-Family Partnership Program

ART = Assisted Reproductive Technology

DVA = Department of Veterans' Affairs

FARE = Foundation for Alcohol Research and Education

FASD = foetal alcohol spectrum disorder

FTE = full-time equivalent

GP = general practitioner

IUD = intrauterine device

LARC = long-acting reversible contraception

MBA = Medical Board of Australia

MBS = Medicare Benefits Schedule

MRFF = Medical Research Future Fund

NDIS = National Disability Insurance Scheme

NHMRC = National Health and Medical Research Council

NHRA = National Health Reform Agreement

NMBA = Nursing and Midwifery Board of Australia

PBS = Pharmaceutical Benefits Scheme

PHN = primary health networks

RANZCOG = Royal Australian and New Zealand College of Obstetrics and Gynaecology

TGA = Therapeutic Goods Administration

## Introduction

The Department of Health and Aged Care (the Department) welcomes the opportunity to make a submission to the Senate Standing Reference Committee on Community Affairs inquiry into Universal access to reproductive healthcare.

The Department consulted with the following Australian Government (Government) agencies and acknowledges their contributions to this submission. Agency input has been included throughout the submission.

- Australian Institute of Health and Welfare (AIHW)
- Department of the Prime Minister and Cabinet, Office for Women
- Department of Education
- Department of Social Services
- National Disability Insurance Agency
- National Health and Medical Research Council (NHMRC)
- National Indigenous Australians Agency.

Supporting, protecting, and promoting the health and wellbeing of all Australians is a key priority for the Government. An integral aspect of this priority is ensuring access to sexual and reproductive health information, treatment, and services that empower Australians, particularly women,[1] to have choice and control in decision-making about their bodies.

National strategies provide guidance on Australia's approach to improving population health outcomes.

The *National Women's Health Strategy 2020–2030* (National Women's Health Strategy)[2] outlines a national approach to improving health outcomes for all women and girls, particularly those at greatest risk of poor health, and aims to reduce inequities in health outcomes. The National Women's Health Strategy proposes action in 5 priority areas; the first priority area within the strategy is maternal, sexual, and reproductive health. It outlines a number of key measures of success including increasing the availability and uptake of long-acting reversible contraception (LARCs) and equitable access to pregnancy termination services.

The *Woman-Centred Care Strategy*[3] and the *Australian National Breastfeeding Strategy*[4] complement the National Women's Health Strategy, by focusing on improving maternity services and breastfeeding support. The *National Stillbirth Action and Implementation Plan*[5]

[1] While the terms 'woman' and 'women' are used intermittently throughout this submission, it is acknowledged that all people including non-binary, intersex, and transgender people may also access the reproductive health care services referenced in this document. It is also acknowledged that, while evidence is limited in some areas, these individuals may face additional barriers and challenges to accessing appropriate services.

[2] Department of Health and Aged Care, *National Women's Health Strategy 2020-2030*, April 2019.

[3] COAG Health Council (Department of Health and Aged Care), *Woman-centred care: Strategic directions for Australian maternity services*, November 2019.

[4] COAG Health Council (Department of Health and Aged Care), *Australian National Breastfeeding Strategy: 2019 and Beyond*, August 2019.

[5] Department of Health and Aged Care, *National Stillbirth Action and Implementation Plan*, December 2020.

(the National Stillbirth Plan) also provides for specific investments and measures to reduce stillbirth and support families affected by stillbirth.

Sexual and reproductive health is also a priority area in the *National Men's Health Strategy 2020-2030* (Men's Health Strategy),[6] which is a framework for action to work towards the goal that every man and boy in Australia is supported to live a long, fulfilling, and healthy life. The Men's Health Strategy recognises that education about safe and consensual sex and sexual health and wellbeing is an important consideration for men and boys, and their partners.

In addition to the National Women's and Men's Health Strategies, a *National Strategy to Achieve Gender Equality* (National Gender Equality Strategy)[7] is being developed to guide whole of Government actions to achieve gender equality. The proposed National Gender Equality Strategy will encompass the wider determinants of health and wellbeing including economic equality and independence, leadership, representation and rights, and balancing family and care responsibilities. The scope of the Strategy will be determined through consultation and will complement other efforts across the Government to achieve gender equality, including the National Women's Health Strategy.

The *National Plan to End Violence against Women and Children 2022–2032* (National Plan)[8] provides a national policy framework to guide the work of governments, policy makers, businesses and workplaces, specialist organisations, family, domestic and sexual violence organisations, and workers in addressing, preventing, and responding to gender-based violence in Australia. The National Plan acknowledges that victim-survivors of family, domestic and sexual violence can experience impacts such as reproductive and sexual health issues.

Other strategies and action plans discussed throughout this submission further support the wider determinants of health and outline national commitments and strategic directions to achieve health equity, particularly for women who are more likely to experience disadvantage. These include:

- The *National Agreement on Closing the Gap* (Closing the Gap),[9] which encompasses specific financial commitments to improving maternal and infant health outcomes for First Nations people, including through access to culturally safe care during pregnancy, birthing, and the post-natal period.
- The *National Health Reform Agreement* (NHRA),[10] through which state and territory public health services are funded to provide maternity services and safe pregnancy termination services.

[6] Department of Health and Aged Care, *National Men's Health Strategy 2020-2030*, March 2019.

[7] Office for Women, Department of Prime Minister and Cabinet, *National Strategy to Achieve Gender Equality*, accessed 14 December 2022.

[8] Department of Social Services, *The National Plan to End Violence against Women and Children 2022-2032*, October 2022.

[9] *National Agreement on Closing the Gap*, July 2020.

[10] Australian Government, *National Health Reform Agreement (NHRA) – Addendum 2020-25*, May 2020.

- Workforce strategies including the *National Medical Workforce Strategy,*[11] the *National Aboriginal and Torres Strait Islander Health Workforce Plan*,[12] and the *Nurse Practitioner 10 Year Plan* (under development) which aim to improve access to and training of the health workforce, including its capacity to deliver improved health outcomes for women.
- The *Health Literacy Strategy,* which is under development, aims to provide consumers with the skills they need to recognise accurate, trustworthy health information, including reproductive healthcare information.

[11] Department of Health and Aged Care, *National Medical Workforce Strategy 2021-2031*, March 2022.

[12] Department of Health and Aged Care, *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031*, March 2022.

**Funding for sexual and reproductive health care in Australia**

Australian Government funding supports access to sexual and reproductive health care through public hospital funding to state and territory governments for publicly provided services, Medicare Benefits Schedule (MBS) items for privately provided services, and the Pharmaceutical Benefits Scheme (PBS) for subsidised medications.

### MBS items

The MBS is a list of the medical services for which the Government will pay a Medicare rebate to provide patients with financial assistance towards the costs of those services.

The total expenditure on MBS in 2021-22 was $28.78 billion across the full range of items and services. Combined, services which are primarily associated with sexual and reproductive health represented $1.01 billion in MBS expenditure 2021-22. This is only expenditure that can be specifically attributed to sexual and reproductive health; other items that may be used more broadly, including general attendance items, psychosocial counselling, and anaesthetic items, have not been included in this figure. It is not possible to differentiate between expenditure for sexual and reproductive health care from the overall expenditure on these broader items as the MBS does not collect specific data on the nature of these consultations.

The Government sets MBS fees to assist patient access, however the Government has no authority to set the fees charged by health practitioners nor can it require them to charge only the MBS fee for a particular service. Health practitioners are free to set their own value on their services, and the actual fee charged is a matter for the health practitioner and patient. It is the health practitioner's responsibility to obtain their patient's informed financial consent prior to the service(s) provided. Health practitioners can consider the personal circumstances of their patients when determining the fees they charge.

The Government supports patients in choosing a doctor by providing consistent and impartial information through the Medical Costs Finder service.[13] This service, which is available through an online portal, assists patients to understand service affordability by providing the different out of pocket costs charged by individual providers for different procedures. This can help inform patient decisions about who they receive care from.

For MBS services provided in-hospital, Medicare pays 75% of the MBS schedule fee and private health insurers meet the remaining 25% of the Medicare Fee where a patient has appropriate coverage. For services provided out-of-hospital, Medicare pays 85% of the MBS fee. MBS benefits are not intended to fully cover the cost of health practitioners' charges.

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 clinical specialties of gynaecology, which includes Assisted Reproductive Technology (ART), obstetrics, midwifery, pathology, and diagnostic imaging.

[13] Department of Health and Aged Care, *Medical Costs Finder*, Department of Health and Aged Care, last updated September 2021.

The Extended Medicare Safety Net[14] is one of two Medicare safety nets funded by the Government that assists patients who incur high out-of-pocket costs for out-of-hospital services provided for under the MBS. The Extended Medicare Safety Net provides an increase in benefits of up to 80% of out-of-pocket costs once an annual threshold has been reached, subject to any Extended Medicare Safety Net caps that have been applied to the specific MBS item/s.

### PBS subsidies

The PBS provides access to necessary medicines at an affordable price, with the aim to improve health outcomes for Australians. Under the PBS, the cost of medicine for most medical conditions is subsidised. Medicines dispensed through the PBS are subject to a patient contribution, known as a co-payment. The co-payment is the amount the patient pays towards the cost of their PBS medicine. The Government pays the remaining cost.

In 2021-22, PBS expenditure was $14.7 billion, covering more than 900 PBS-subsidised medicines. Close to 5,000 items are currently listed on the PBS to treat a wide range of conditions, including diverse treatment options to manage sexual and reproductive health issues such as:

- birth control (contraception)
- central precocious puberty
- treatment of sexually transmissible infections
- chronic health problems such as endometriosis.

In addition to the contraceptive treatment options listed on the PBS, medication for medical termination is also listed on the PBS.

### Public health services

Through the NHRA, funding contributions are provided to assist states and territories with the costs of delivering public health and hospital services, including for reproductive health services delivered through emergency departments, admitted and non-admitted care, sub-acute care, and some community health settings.

Under the NHRA, the state and territory governments have committed to provide eligible patients with the choice to receive public hospital services free-of-charge, on the basis of clinical need and within a clinically appropriate period. States and territories have also committed to have arrangements in place to ensure equitable access to such services, regardless of geographical location. This includes the provision of clinically necessary reproductive health services.

The NHRA recognises that state and territory governments are the system managers of their public hospital systems, responsible for system wide planning and performance and for the day-to-day management of their public hospitals. As system managers, the states and territories determine the availability, types, and range of their public hospital services, including reproductive healthcare, and the locations where they are delivered in their jurisdiction.

[14] Services Australia, *Extended Medicare Safety Net*, last updated July 2022.

In 2021-22, the Government contributed a total of $24.1 billion through the NHRA towards the costs of delivering public hospital services. These include:

- $20.4 billion for activity-based services, such as those delivered through emergency departments, admitted and non-admitted care, and sub-acute care
- $3.2 billion through block grants, which include services delivered in smaller rural and regional hospitals, and teaching, training, and research undertaken in public hospitals
- $460 million towards public health, including youth health services and essential vaccines.

### Health and medical research

The Government is committed to health and medical research and will invest in Australian research and its translation into practice to ensure Australia's entire health system is prepared for current and future challenges. The Government provides direct support for health and medical research through the complementary Medical Research Future Fund (MRFF) and the NHMRC:

- the MRFF funds priority driven research with a focus on research translation
- the NHMRC focuses on investigator-led research.

The MRFF is established under the *Medical Research Future Fund Act 2015* (MRFF Act)[15] to provide grants of financial assistance to support health and medical research, improve health outcomes, quality of life, and health system sustainability. It operates as an endowment fund, where the net earnings serve as a permanent revenue stream for investment in health and medical research and innovation, with the capital preserved in perpetuity. The MRFF reached maturity at $20 billion on 21 July 2020.

Decisions regarding the expenditure of disbursements from the MRFF are guided by the *Australian Medical Research and Innovation Strategy 2021-2026*[16] and related set of *Australian Medical Research and Innovation Priorities 2022-2024*[17] developed by the independent and expert Australian Medical Research Advisory Board following national public consultation.

[15] Australian Government, *Medical Research Future Fund Act, 2015*.

[16] Australian Medical Research Advisory Board (AMRAB), *Australian Medical Research and Innovation Strategy 2021-2026*, November 2021.

[17] AMRAB, *Australian Medical Research and Innovation Priorities 2022-2024*, November 2022.

**Contraceptives in Australia**

The Government, through the Therapeutic Goods Administration (TGA), is responsible for the assessment and regulation of medicines and products to ensure Australians stay healthy and safe. This section outlines the TGA's approval processes and the types of contraceptives that have been approved for use in Australia, including LARCs. The Government supports access to contraception via PBS subsidies and MBS rebates for relevant services.

### Regulation of contraceptives

The TGA assesses and approves two main categories of contraception:

- medicines, including prescription and over-the-counter medicines
- medical devices, including a wide range of products that are not medicines, but have a physical or barrier effect on the body.

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) and supplied in Australia by the sponsor. There are a number of regulatory pathways available, 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). Detailed information on the specific registration process for prescription medicines, including data requirements, can be found on the TGA website.[18]

There are various types of contraceptive medicines included in the ARTG:

- combined oral contraceptive pill
- progestin only oral contraceptive pill
- transdermal patch
- vaginal ring
- hormonal intrauterine device (IUD)
- injectables
- hormonal implants.

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
- non-hormonal IUD.

**Attachment A** provides a list of contraceptive products available in Australia that are registered on the ARTG, including some options covered by the PBS. Whether each product is marketed in Australia is a business decision for sponsors and not a regulatory function of the TGA.

[18] Therapeutic Goods Administration, *Prescription medicines registration process*, last updated August 2021.

Scheduling is a national classification system that controls how medicines (and chemicals) are made available to the public.[19] Schedules are published in the Poisons Standard[20] and are given legal effect through state and territory legislation. Contraceptives such as the combined oral contraceptive pill and LARCs are classified as prescription medicines under Schedule 4 of the Poisons Standard. Under the Poisons Standard, a pharmacist can only dispense a Schedule 4 medicine to a consumer without a medical practitioner's prescription if the law of the local jurisdiction permits it. The NSW government recently announced plans to trial pharmacists prescribing medications, including contraceptives.[21]

The TGA does not regulate procedures, and therefore does not regulate contraceptive procedures such as sterilisation.

### Access to contraception

The Government supports access to services associated with accessing contraception through MBS patient rebates for nurse practitioner, midwife, and general practitioner (GP) appointments, specialist consultations, and procedural services. As outlined at **Attachment A,** there are also a range of contraceptive treatment options that are listed on the PBS to manage contraception including:

- oral treatments, such as single or combined oral contraceptive pills
- LARC methods (hormonal IUDs and implants)
- injectables.

Across Australia, these contraceptive options can be accessed from different dispensing environments such as primary care, community pharmacies, approved private and public hospitals, and sexual health clinics.

PBS subsidies are available for the hormonal implant and hormonal IUD LARC methods. Copper IUDs can be accessed via private prescription but are not covered under the PBS as they do not contain hormones and are consequently regulated as medical devices instead of medicines.

In 2021-22, the Government cost on PBS listed contraception exceeded $54 million.

### Long-Acting Reversible Contraceptives (LARCs)

LARCs are highly effective and cost-effective contraceptives which are available for use for most women of all reproductive ages, and include:

- hormonal IUDs: Mirena and Kyleena
- non-hormonal copper IUDs
- hormonal implant: Implanon-NXT.

[19] Therapeutic Goods Administration, *Scheduling basics*, accessed 14 December 2022.

[20] Therapeutic Goods Administration, *The Poisons Standard*, accessed 14 December 2022.

[21] NSW Health, *Pharmacy reform to expand community health care*, November 2022.

*Access to LARC methods*

LARC methods can be accessed through primary care providers, gynaecology specialists, family planning services, and some sexual health services and hospital run contraceptive clinics. It is recommended that insertion should only be completed by health care professionals who are experienced or sufficiently trained in insertions.[22] The procedure requires a consultation, sterile instruments and materials for IUD insertion, and availability of a registered nurse[23] or midwife.

In Australia, medical practitioners and nurse practitioners can prescribe hormonal IUDs, while a hormonal implant can be prescribed by medical practitioner, eligible midwife, or nurse practitioner. Other registered nurses and midwives cannot prescribe LARC contraceptives.

Medical practitioners, registered nurses, midwives, or nurse practitioners who have completed appropriate training and education are able to insert and remove an IUD or hormonal implant if these interventions are in line with their chosen scope of practice.

In order to access the MBS and PBS both nurse practitioners and participating midwives need to have a documented collaborative arrangement with a medical practitioner, discussed below in the Nurse and Midwife training section.

*MBS rebates for LARC services*

There are a number of MBS items that provide patient rebates specifically for access to LARC services. This includes items for:

- insertion of an IUD by a GP or gynaecologist
- IUD removal where there are no complications. This can be done under GP general consultation items (such as professional attendance by a GP at consulting rooms lasting at least 20 minutes) as well as specialist general consultation items.

There is no specific MBS item for the removal of an IUD when an anaesthetic is not required. In cases where there is no anaesthesia required, general consult items can be used. If anaesthetic is required, there are MBS items that can be used for the removal of an IUD under general anaesthesia by a GP or gynaecologist and where visual guidance is needed.

As part of the 2020 MBS Review Taskforce review of MBS items, the Nurse Practitioner Reference group recommended that additional access to MBS rebates be available for procedures performed by a nurse practitioner, including for the insertion of LARCs.[24] The MBS Review Taskforce did not support the recommendation and instead recommended nurse practitioners work together with their professional bodies to develop a clinical governance framework to be used as a guide for both the profession and others on an

[22] Australian Product Information: MIRENA® (levonorgestrel) intrauterine drug delivery system, last updated 20 September 2021.

[23] Royal Australian College of General Practitioners (RACGP), *Intrauterine device/system: Checklists and patient confirmation form*, accessed 14 December 2022.

[24] Medicare Benefits Schedule Review Taskforce, *Final report from the Nurse Practitioner Reference Group*, 2019.

individual nurse practitioner's scope of practice.[25] The Department is working with professional colleges and other stakeholders to develop a Nurse Practitioner 10 Year Plan,[26] of which access to MBS items for nurse practitioners has been raised as a key issue.

The cost to the individual and available Government subsidies for LARC contraceptives can vary depending on the type of services and contraceptive that is chosen. **Attachment B** outlines the MBS items available for LARC insertion and a breakdown of service volumes by patient location for 2021-2022.

**Table 1. LARC MBS items: MBS fees, benefit, average out of pocket (OOP) cost and proportion of services bulk-billed 2021-22**

| Item | Short Item Descriptor | Schedule Fee | Benefit: % and $ | Avg OOP Patient Cost | % of services bulk-billed |
|---|---|---|---|---|---|
| 14206 | Hormone or living tissue implantation by cannula | $37.65 | 75% = $28.25<br>85% = $32.05 | $33.75 | 72.2% |
| 30062 | Removal of etonogestrel subcutaneous implant | $64.20 | 75% = $48.15<br>85% = $54.60 | $41.21 | 69.2% |
| 35503 | Introduction of an intra-uterine device for abnormal uterine bleeding or contraception | $84.75 | 75% = $63.60<br>85% = $72.05 | $82.55 | 28.8% |
| 35506 | Removal of intra-uterine device under general anaesthesia | $56.75 | 75% = $42.60<br>85% = $48.25 | $61.99 | 40.7% |

Notes: MBS item usage data and cost analysis does not cover procedures provided through public services or provided to Medicare ineligible patients and funded privately and/or via insurance.

Average out of pocket patient costs are calculated manually using the method: Overall fee charged in 2021-22 minus overall benefits paid in 2021-22, divided by total patients for this item in 2021-22.

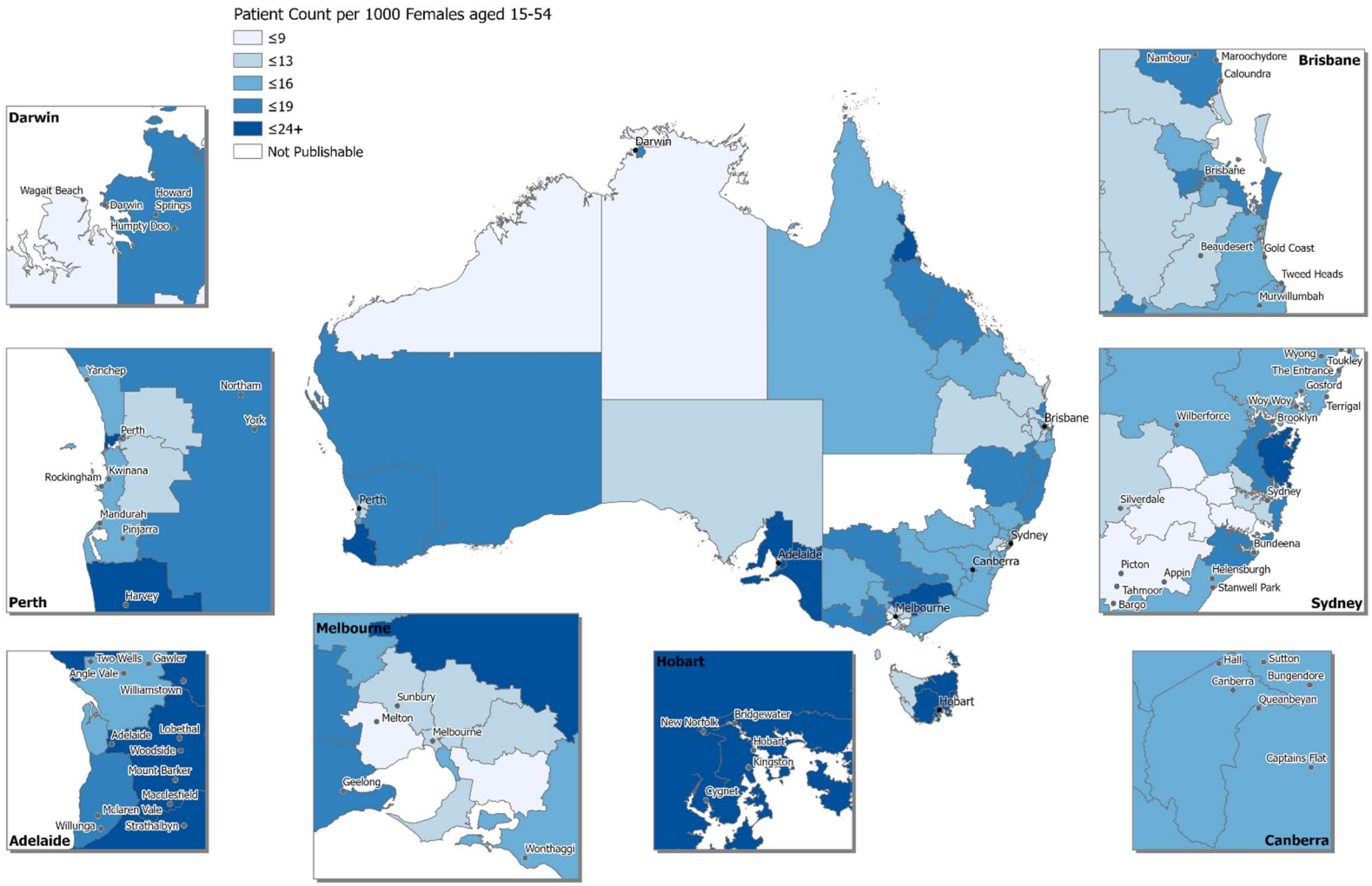
Map 1 below shows the rate of claiming of MBS item number 35503 for introduction of an intra-uterine device for abnormal uterine bleeding or contraception or for endometrial protection during oestrogen replacement therapy from 1 July 2021 to 30 June 2022, calculated per 1000 women aged 15-54. Patients have been mapped to Statistical Area Level 4 (SA4) based on the dominant patient postcode.

As patients may travel to access services in a different location, the rate of claiming MBS item numbers by patient location differs in many areas from the rate of patients claiming calculated using provider location. In Map 2 the rate of claiming has been calculated and mapped to SA4 using the location of the service provider.

[25] Medicare Benefits Schedule Review Taskforce, *MBS Review - Final taskforce reports, findings and recommendations*, December 2020.

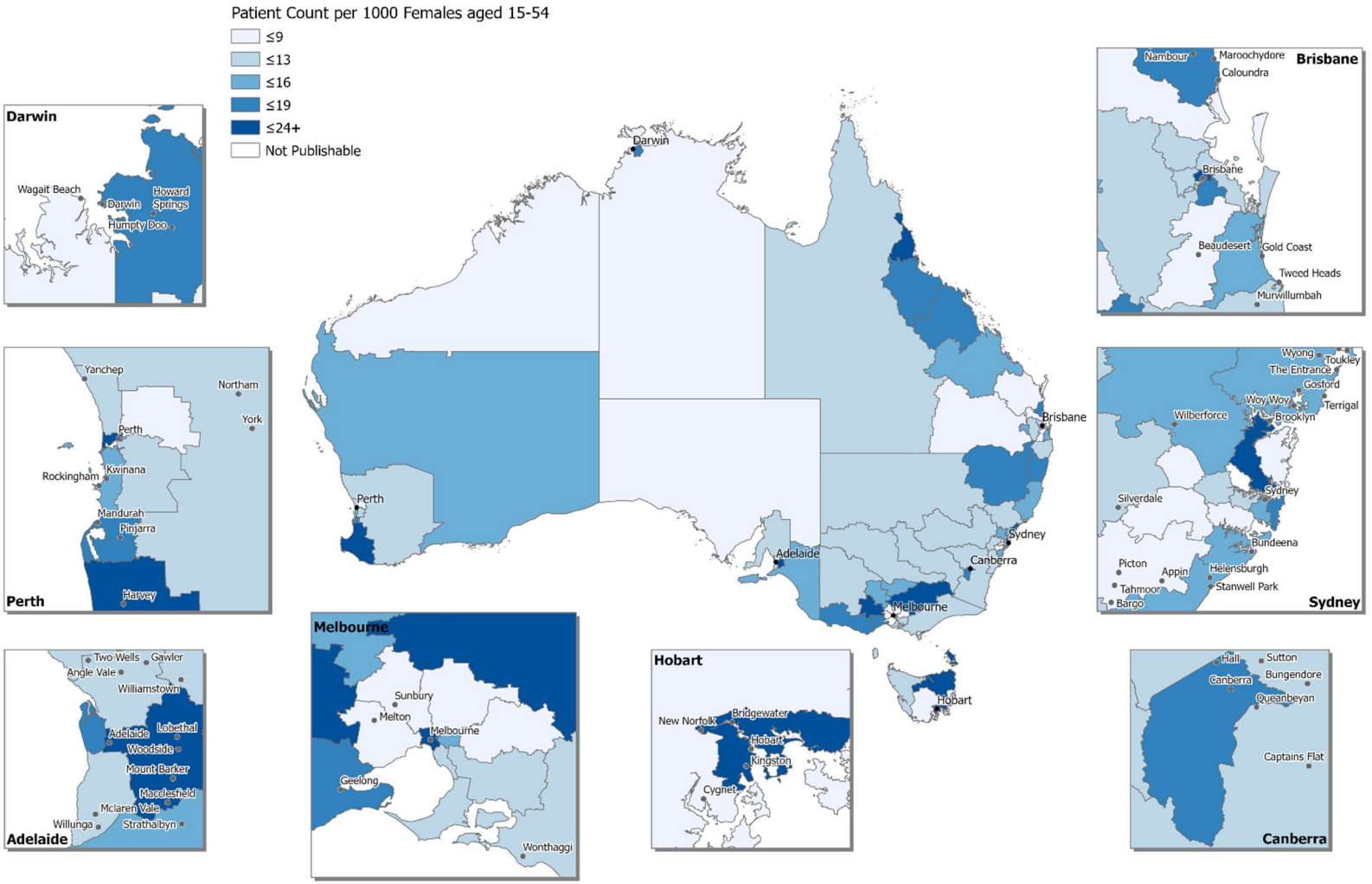
[26] Department of Health and Aged Care, *Nurse Practitioner 10 Year Plan Steering Committee*, last updated May 2022.

**Map 1: MBS Data on Item 35503: Introduction of an intra-uterine device for abnormal uterine bleeding or contraception or for endometrial protection during oestrogen replacement therapy per 1000 women by Level 4 Statistical Area (SA4) (Patient location) 2021-22**




Notes: Data is for the 2021-22 financial year based on date of service including claims processed up to 15 December 2022.
This data captures MBS item number 35503 for insertion of an IUD or abnormal uterine bleeding or contraception or for endometrial protection during oestrogen replacement therapy.
This data only captures insertion of an IUD where a Medicare benefit was paid. It does not include IUD insertion covered by other funding sources, such as in a public setting.
An IUD may be inserted in combination with another procedure but not claimed as a separate MBS item, and these services are not reflected in the data used for these maps.
Where a patient location postcode crosses more than one SA4 area boundary, the area that contains the majority of a postcode is assigned to that postcode.

**Map 2: MBS Data on Introduction of an intra-uterine device for abnormal uterine bleeding or contraception or for endometrial protection during oestrogen replacement therapy per 1000 women by Level 4 Statistical Area (SA4) (Provider location) 2021-22**




Notes: Data is for the 2021-22 financial year based on date of service including claims processed up to 15 December 2022.
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This data only captures insertion of an IUD where a Medicare benefit was paid. It does not include IUD insertion covered by other funding sources, such as in a public setting.
An IUD may be inserted in combination with another procedure but not claimed as a separate MBS item, and these services are not reflected in the data used for these maps.
Where a provider location postcode crosses more than one SA4 area boundary, the area that contains the majority of a postcode is assigned to that postcode.

*Research to support access to contraception and reproductive health services*

The Government also provides funding for research initiatives that assess the availability and models of care for sexual and reproductive health services, including LARC services.

In the 2019-20 financial year, $1.9 million was awarded from the MRFF Primary Health Care Research Initiative to Monash University for the ORIENT study, for research that will evaluate nurse-led models of care aimed at increasing access to reversible contraception and medical abortion services in rural and regional areas.

Through the NHMRC, $1.2 million has been provided to the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCAPPS) Partnership Project for a national project to develop a Community of Practice designed to support GPs, nurses, and community pharmacists to provide LARCs and medical termination of pregnancy.

### Contraception options for men in Australia

In Australia, condoms and vasectomy remain the only available forms of contraception for men. There are no hormonal male contraceptive therapeutic goods registered in Australia.

There are a number of studies on contraceptive options for men, including an injection (implants, tablets and gels have also been studied) which involve a combination of man-made versions of two naturally occurring male hormones – testosterone and progesterone – that would stop the body from making sperm. Most studies have shown male hormonal contraception to be effective in preventing pregnancy.

The TGA is not aware of any male contraceptive products for which regulatory approval is being sought. For a new prescription medicine to be approved by the TGA, a sponsor is required to 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. The Government cannot compel a sponsor to make such an application, nor can evaluation commence in the absence of an application.

### Permanent contraception (sterilisation)

Undergoing a permanent contraception procedure is a personal and clinical choice that suits some people, however there are ethical considerations for certain groups. For children, parents and guardians may consent to medical procedures resulting in permanent contraception only if it is medically necessary to treat a bodily malfunction, disease or psychiatric disorder (that is, if it is therapeutic in nature), and it is supported by the treating medical professional and the child if they are competent to make the decision. Authorisation of courts exercising child welfare jurisdiction is required if there is a dispute about the medical procedure or, if the medical procedure is non-therapeutic, there is a significant risk of making the wrong decision and the consequences of a wrong decision would be particularly grave.

Under the MBS, there are items to support access to permanent contraception surgical procedures, which may include sterilisation procedures or procedures that remove reproductive organs such as hysterectomy (uterus) or oophorectomy (ovary). These procedures can only be provided in-hospital. There is also an MBS item available for a unilateral or bilateral vasotomy or vasectomy that can be provided in or out of hospital.

**Attachment C** provides further information and breakdowns of the MBS items available for permanent contraception procedures.

**Cost and accessibility of pregnancy termination services in Australia**

The National Women's Health Strategy outlines Australia's approach to improving the health of women and girls, including the protection and promotion of sexual and reproductive health and rights of all women and girls. The National Women's Health Strategy suggests actions to achieve universal access to sexual and reproductive health information across a number of key priorities, including access to termination services.

Women can choose to access safe terminations through a range of public and private settings including through primary care providers, family planning clinics, women's health clinics, and public and private hospitals. Legislation relating to access to pregnancy termination is a state and territory responsibility. Early termination (up to 14 weeks gestation) is available Australia-wide and later term terminations are available in most states and territories. Further detail about access to services is provided below, including Government support provided via MBS and PBS subsidies.

### Access to termination services in Australia

Access to termination services varies significantly according to geographic location, particularly for surgical terminations, which is in most cases the only option available after 9 weeks gestation.[27]

In Australia, the laws relating to access to termination services are a state and territory responsibility and are therefore a matter for individual jurisdictions. Abortion is legal in all jurisdictions, however the circumstances in which termination services can legally be provided vary.

### Cost of termination services

The Government provides funding to support access to safe pregnancy termination services through:

- public hospitals through the NHRA
- MBS items for surgical terminations, GP and specialist consultations, pregnancy counselling, telehealth, pathology tests, and ultrasounds
- the PBS listings for medical termination medication.

While these structures seek to deliver access to services when and where they are needed, funding alone cannot achieve equitable access. For example, the MBS is a voluntary scheme for both patients and providers and does not support workforce development or access.

The private sector also provides pregnancy termination services. The fees charged by private providers are not set or controlled by the Government, but services delivered by these providers are eligible for Medicare rebates.

[27] This submission addresses access to early medical termination of pregnancy using MS 2-Step (Mifepristone & Misoprostol), and surgical termination at early and late stages of pregnancy through public and private health systems. Other forms of termination which are rare in Australia are not discussed in this submission, including late termination of pregnancy via induced labour. Late termination of pregnancy is regulated by laws in each jurisdiction. This submission does not address illegal termination procedures.

The cost of abortion varies depending on factors including:

- Medicare status of the patient
- location (state/territory, and proximity to a service provider)
- type of termination (medical or surgical)
- type of provider (for example public versus private hospitals, not-for profit, family planning clinics, and telehealth services)
- gestation of the pregnancy
- any personal risks associated with the health of the individual.

Patient pathways in accessing a pregnancy termination also differ. These pathways can vary from completely private services (which may be subsidised by the MBS, or MBS and PBS) to a combination of services which involve public services and initial primary care and follow-up services funded through the MBS, or entirely public services. For this reason, no one data set can provide a complete picture of medical and surgical termination in Australia. There is no standardised national data collection on numbers of termination of pregnancy.

### Medical termination of pregnancy

In Australia, MS-2 Step® (Mifepristone & Misoprostol) is listed on the PBS for termination of an intrauterine pregnancy. It is available through the PBS if the following criteria are met, consistent with the ARTG registration:

- the condition must be an intrauterine pregnancy of up to 63 days of gestation
- the patient must be treated by a prescriber who is registered with the MS-2 Step® Prescribing Program.

To support patient safety, medical practitioners and pharmacists must be registered to prescribe and dispense MS-2 Step® and are required to complete online training delivered by MSI Australia.

According to published data, in December 2020 only 2,841 of 29,017 registered GPs were active prescribers of MS-2 Step® and 5,347 of 32,393 registered pharmacists were active dispensers.[28] Nurse practitioners and participating midwives are unable to prescribe MS-2 Step®.

The supply of the MS-2 Step® prescribing and dispensing programs are in accordance with the appropriate state or territory legislations.

*PBS support for medical termination of pregnancy*

MS-2 Step® has a PBS listed dispensed price of $353.84, which includes pharmacy and wholesale mark-up and dispensing fees. Through the PBS, where patients meet the PBS subsidy criteria, they pay up to $42.50 per script for general patients (to reduce to $30 from 1 January 2023), or $6.80 for concessional patients (to be indexed in line with Consumer Price Index from 1 January 2023 to $7.30), with the Government covering the remainder of the cost.

[28] AK Subasinghe, K McGeechan, JE Moulton, LE Grzeskowiak, D Mazza 'Early medical abortion services provided in Australian primary care' *Medical Journal Australia,* 2021, 215 (8): 366-370. doi: 10.5694/mja2.51275

From 1 July 2021 to 30 June 2022, 32,401 patients accessed MS-2 Step®, of which 76% of patients were general patients and 24% were concessional patients. The cost to the Government for MS-2 Step® was $10.3 million for the 2021-22 financial year.

**Table 2 – Count of patients, pharmacies, and prescribers for Mifepristone (&) Misoprostol (10211K) by MMM Classification in 2021-22**

| MMM Classification | Patient Count | Pharmacy Count | Prescriber Count |
|---|---|---|---|
| Metropolitan | 24,290 | 692 | 979 |
| Regional | 2,131 | 108 | 235 |
| Large Rural | 2,418 | 133 | 273 |
| Medium Rural | 1,135 | 122 | 225 |
| Small Rural | 341 | <100* | 129 |
| Remote | 283 | <100* | <100* |
| Very Remote | 149 | <100* | <100* |
| Unknown | 1,757 | <100* | 155 |
| **Total** | **32,401** | **1,225** | **1,648** |

Source: PBS data maintained by Department of Health and Aged Care, processed by Services Australia on or before 1 November 2022 for the period 1 July 2021 to 30 June 2022. Data extracted 2 December 2022.

Notes: Does not include supply to Department of Veterans Affairs patients. Figures are subject to change due to late claims and adjustments by pharmacies. PBS data does not capture over-the-counter drugs, private prescriptions (non-PBS) or public inpatient prescriptions.

Patients have been separated by their dispensing pharmacies' MMM indicator in metropolitan, rural, regional (large, medium, and small), remote and very remote areas. The location of patients accessing the PBS may differ from their dispensing pharmacy location.

Unknowns are for patients/pharmacies that could not be linked to an MMM indicator.

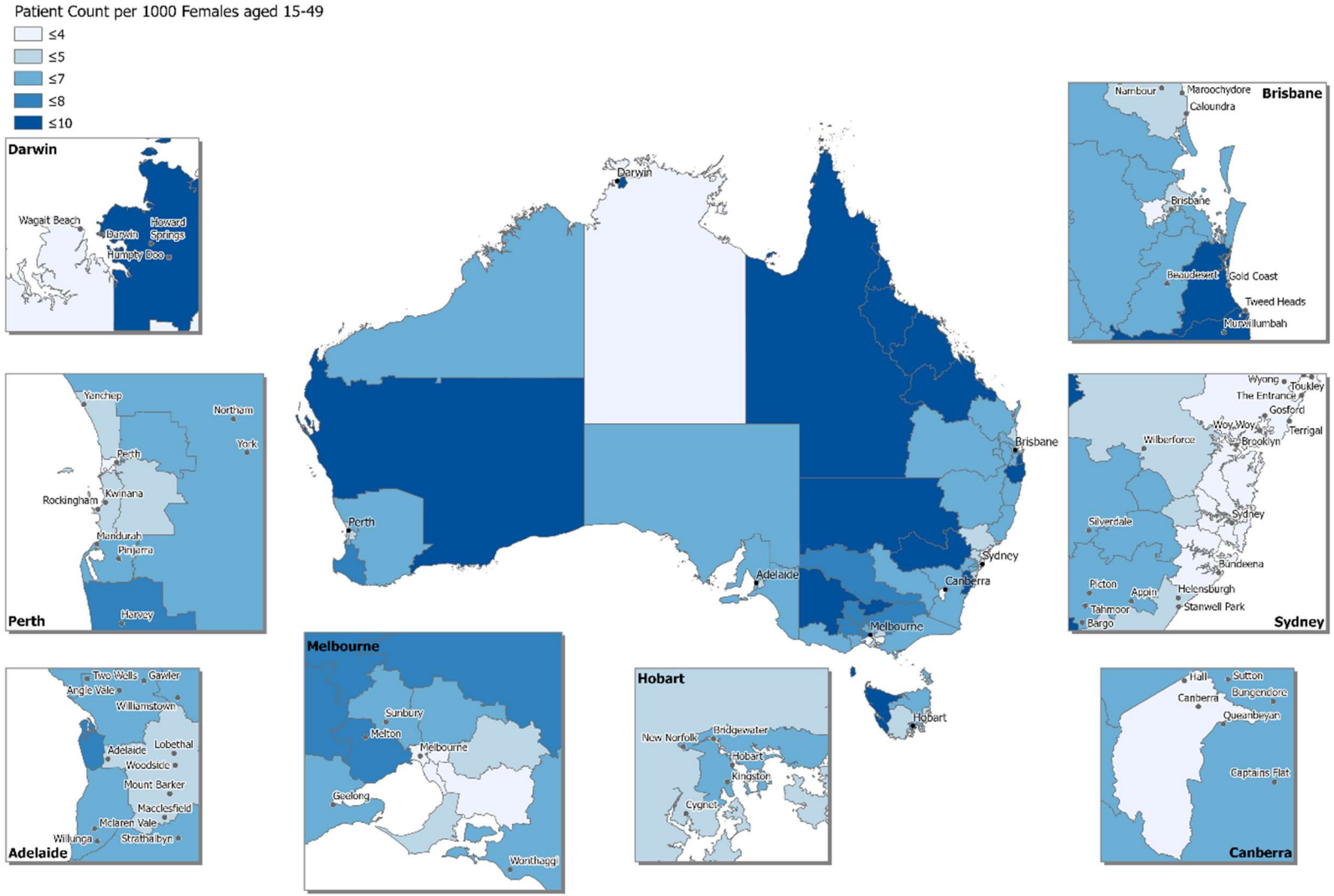
The sum of counts for patients and prescribers may not add to the total provided in the above table (prescribers can have more than one patient and patients can fill their scripts in different postcodes/MMMs).

In MMM location areas where there were fewer than 100 services or service providers in the 2021-22 financial year the actual figure has been obscured for privacy reasons.

### *MBS funded telehealth and support for medical terminations*

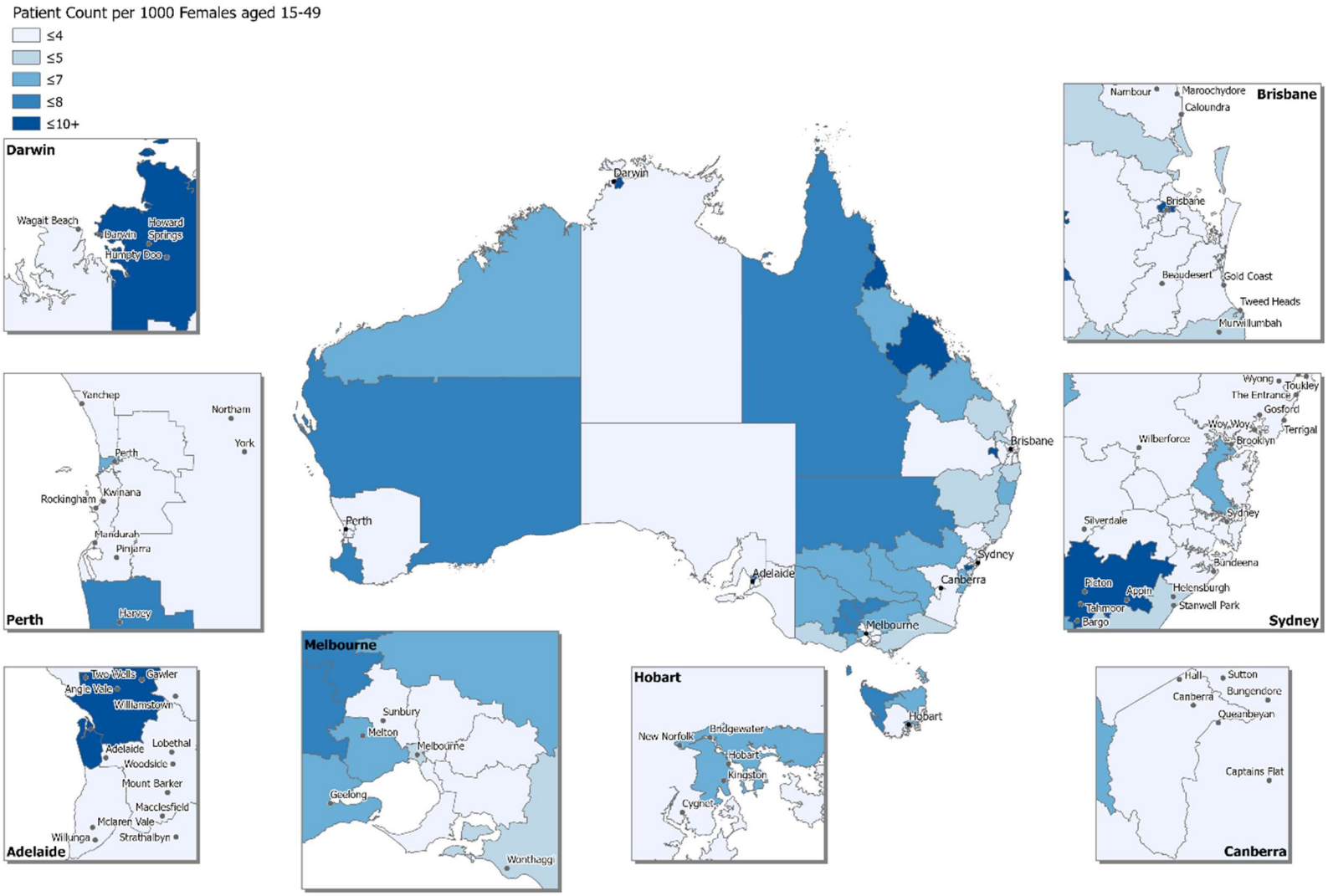
Primary care sexual and reproductive health services and non-directive pregnancy support counselling accessed through phone and video telehealth services is subsidised through the MBS. In July 2021, 24 MBS telehealth items were introduced to ensure continued access to blood borne viruses and sexual or reproductive health services, including for medical termination of pregnancy. This provides an additional avenue of access to medical termination of pregnancy, particularly for people in rural and remote areas, or for whom privacy concerns may prevent access to their regular primary care provider. These items are exempt from the existing relationship rule, where the patient must have seen the primary care provider face-to-face in the preceding 12 months to access telehealth, making these services more accessible.

**Map 3: PBS Data on Mifepristone (&) Misoprostol scripts per 1000 women by Level 4 Statistical Area (SA4) (Patient location) 2021-22**




Notes: PBS data maintained by Department of Health and Aged Care, processed by Services Australia on or before 7 December 2022 for the period 1 July 2021 to 30 June 2022. Data extracted 8 December 2022. Figures subject to change due to late claims and adjustments by pharmacies. Data obtained for Mifepristone (&) Misoprostol for item code: 10211K.
Does not include supply to DVA patients. PBS data does not capture over-the-counter drugs, private prescriptions (non-PBS) or public inpatient prescriptions.
Patient counts of less than 6 for an SA4 area have been set to not published (n.p.) to ensure confidentiality.
Where a patient location postcode crosses more than one SA4 area boundary, the area that contains the majority of a postcode is assigned to that postcode.

**Map 4: PBS Data on Mifepristone (&) Misoprostol scripts per 1000 women by Level 4 Statistical Area (SA4) (Pharmacy location) 2021-22**




Notes: PBS data maintained by Department of Health and Aged Care, processed by Services Australia on or before 7 December 2022 for the period 1 July 2021 to 30 June 2022. Data extracted 8 December 2022. Figures subject to change due to late claims and adjustments by pharmacies. Data obtained for Mifepristone (&) Misoprostol for item code: 10211K.
Does not include supply to DVA patients. PBS data does not capture over-the-counter drugs, private prescriptions (non-PBS) or public inpatient prescriptions.
Patient counts of less than 6 for an SA4 area have been set to not published (n.p.) to ensure confidentiality.
Patients have been mapped to a SA4 area based on pharmacy geocoded data.

Map 3 above shows the rate of scripts dispensed for medical termination of pregnancy using Mifepristone (&) Misoprostol from 1 July 2021 to 30 June 2022, calculated per 1000 women aged 15-49. Patients have been mapped to SA4 based on the dominant patient postcode.

As patients can fill their script in different SA4 areas the pharmacy dispensary locations do not always match patient location. Map 4 shows the rate of scripts dispensed for medical termination of pregnancy, calculated using the location of the dispensing pharmacy. In many instances, the rate of scripts dispensed in an SA4 by pharmacy location differs from the rate of scripts accessed in the same SA4 when calculated using patient location.

## Surgical termination of pregnancy

*Access to surgical terminations*

Any person seeking to practise as a medical practitioner in Australia must be registered appropriately with the Medical Board of Australia (MBA). The MBA requires that all medical practitioners work within the limits of their skills, knowledge, and experience. The MBA does not prescribe which procedures can be included in a medical practitioner's scope of practice, therefore there is no requirement for medical practitioners to register to provide surgical terminations.

Obstetricians and gynaecologists and GP providers of obstetric and gynaecological services will have been trained in the relevant surgical skills to provide a dilation and curettage. These are the same surgical skills required to provide surgical termination up to around 14 weeks gestation and for miscarriages. Late-stage surgical terminations require additional training that can be undertaken by an obstetrician or gynaecologist as part of their training.

*MBS rebates for surgical terminations*

The MBS subsidises access to a surgical termination through rebates for related clinical consultations, pathology tests, diagnostic imaging, and surgical procedures. There are 4 specialist MBS items that can be used for the surgical termination of pregnancy as well as other procedures:

- for management of pregnancy loss at 14 to 15 weeks and 6 days
- for management of pregnancy loss at 16 to 22 weeks and 6 days
- for evacuation of the contents of the gravid uterus
- for curettage of uterus (including for incomplete miscarriage).

It is not possible to accurately quantify the number of surgical terminations of pregnancy conducted in private hospitals as claims for these MBS items do not represent an accurate count of surgical terminations performed.

*Public hospital access to termination*

Funding under the NHRA supports access to safe pregnancy termination services through public hospitals, however the data do not distinguish between medical and surgical forms of termination. In 2020-21, there were fewer than 8,900 hospitalisations for induced abortions in public hospitals. For this analysis, an induced abortion is defined as intentional termination of pregnancy at any gestation through medical or surgical intervention.

**Table 3: Induced abortion hospitalisations by Modified Monash Model areas (public hospitals) 2020-21**

| Modified Monash Model (2019) | Hospitalisations |
|---|---|
| Metropolitan areas | 6,395 |
| Regional centres | 1,135 |
| Large rural towns | 698 |
| Medium rural towns | 151 |
| Small rural towns | <100* |
| Remote communities | 285 |
| Very remote communities | <100* |

Source: Admitted Patient Care (APC) data collection – Australian Institute of Health and Welfare. All data is for the 2020-2021 financial year. Location details obtained from the Hospital Database, Department of Health and Aged Care.

Note: Refers to acute care hospitalisations assigned an abortion related Australian-Refined Diagnosis Related Group (i.e., O05Z, O63A, O63B) but excluding hospitalisations with a diagnosis (ICD-10-AM 11th ed.) related to hydatidiform moles and other abnormal products of conception and spontaneous abortions (O00, O01, O02, O03 and O08).

In Modified Monash Model (MMM) location areas where there were fewer than 100 services in the 2021-22 financial year the actual figures have been obscured for privacy reasons. MMM location areas presented in the table reflect the location of the public hospital where the hospitalisation occurred.

*Costs to individuals/patients*

Costs for access to surgical termination range from free (in public hospitals) to thousands of dollars for non-Medicare card holders in some clinic settings.

Out of pocket costs to individuals vary depending on the circumstances, including the timing of the surgical termination.

**Attachment D** provides examples of different scenarios of out of pockets costs for those MBS items that would be reasonably expected to comprise the commonly accessed services that would be claimed for a surgical termination (for both early surgical termination and later surgical termination).

**Support for reproductive healthcare and pregnancy care in Australia**

The Government supports the provision of reproductive health care services for all Australians as identified in national strategies such as the National Women's Health Strategy and the Woman-Centred Care Strategy, via funding provided primarily through the NHRA, MBS and PBS. The costs associated with MBS items related to provision of maternity services and ART are described below.

### Maternity services

The planning and delivery of Australian maternity services is predominantly undertaken by states and territories, with the Government providing national direction and supporting efforts to improve care and outcomes. Under the NHRA, the Government provides a significant funding contribution to assist states and territories with the costs of public hospital and community health services, including maternity services.

The Woman-Centred Care Strategy provides national strategic direction to support Australia's high-quality maternity care system and enable improvements in line with contemporary practice, evidence, and international developments.

While the majority of the enablers in the Woman-Centred Care Strategy fall under the responsibility of state and territory governments, the Government continues to invest and drive implementation at a national level. To date the Government's work to implement the Woman-Centred Care Strategy has focused on:

- developing and implementing strategies to reduce stillbirth (in line with the National Stillbirth Action and Implementation Plan)
- updating the Pregnancy Care Guidelines and new funding to develop Postnatal Care Guidelines[29]
- maintaining national maternal and perinatal data collections
- programs to reduce the incidence of preterm birth
- improving access to mental health support.

### Maternity services MBS items

The MBS provides rebates for antenatal, intrapartum (birth) and postnatal services provided by or on behalf of specialist obstetricians, GP obstetricians, and participating midwives, as well as antenatal care by GPs and midwives. The MBS also includes a range of items used for pathology tests such as blood and urine tests, and diagnostic imaging services such as pregnancy related ultrasound and Magnetic Resonance Imaging.

MBS items support services delivered by private practitioners under a range of models including combined care, private obstetrician care, GP obstetrician care, private midwifery care, and private obstetrician and private practising midwife shared care. The Australian Institute of Health and Welfare identifies 11 categories of maternity models of care and found a midwife is the lead maternity carer during the antenatal, intrapartum, and postnatal periods across 44% of models. Approximately 31% of models have continuity of carer, in which care is provided across the duration of the maternity period by the same named carer. Around 6% of models of care include routine relocation of mothers from their communities to another location prior to labour. Routine relocation applies where women

[29] Australian Government, *Women's Budget Statement October 2022-23*, October 2022.

reside in a rural or remote community with no access to a birth facility and are routinely relocated to a larger town or city weeks prior to birth.[30]

A list of MBS items that are claimable for maternity services (including items for In-Vitro Fertilisation/ART) and the volume of claims in 2021-22 are at **Attachment E**. Information on MBS fees and rebates, rates of bulk-billing, and average out of pocket costs are at **Attachment F**.

It is important to note that some MBS items can be applicable to more than one clinical scenario or reason for the treatment. Some of the MBS items that would support access to private services for birth are also used to support stillbirth and miscarriage care and pregnancy termination.

### Private health insurance for pregnancy and birth

Private health insurance policies are categorised into Gold, Silver, Bronze, and Basic tiers to help people choose the level of cover that best suits their needs. What is and is not covered in these tiers is based on minimum standard clinical categories. If a policy covers a certain clinical category, then it must cover everything described as part of the category – not only some things. The product tiers and clinical categories give people greater certainty about the services covered by each type of private hospital cover.

Under private health insurance arrangements, 'pregnancy and birth' services are covered under the Gold product tier. However, to increase access to these services, several health insurers provide benefits to policy holders who purchase less comprehensive cover. Services for miscarriage are covered under all Bronze, Silver, and Gold products, providing the majority of policy holders with the assurance of private healthcare and benefits for these treatments. Private health insurance offers people who may require these services a greater ability to choose their own health practitioner and access treatment at the facility of their choice.

The benefits paid for pregnancy and birth are generally of a significant amount, which require higher levels of premiums to cover. The level of benefits paid reflects the fees charged by health practitioner and hospitals. As mentioned earlier in this submission, the Government does not have authority to determine the fees charged by health practitioners, who operate in private businesses and are free to place their own value on the services they provide.

There are a number of Government incentives to support and encourage people to purchase private health insurance:

- Private Health Insurance Rebate: financial assistance to assist with cost of private health insurance
- Medicare levy surcharge: a tax on people that earn over a certain amount and do not have appropriate private health insurance hospital cover
- Lifetime Health Cover: to encourage people to purchase and maintain private health insurance hospital cover earlier in life.

[30] AIHW, *Maternity models of care in Australia*, 2022.

## Assisted Reproductive Technology

Around one in 6 couples of a reproductive age experience fertility problems. Historically, almost all ART services, including In-Vitro Fertilisation (IVF), have been provided in private settings and subsided through the MBS and PBS. Access to no-cost services offered under state and territory government funded programs have been limited in both volume and eligible patients. There have been large investments by the Government through a combination of MBS rebates, PBS subsidies and the Extended Medicare Safety Net.

The MBS supports access to a range of specialist services, which provide further access to a wide range of consultation and intervention items. In terms of sexual and reproductive health, this includes items in clinical specialties of gynaecology, which includes ART and the services involved in treating female and male factor infertility, obstetrics, participating midwifery, pathology, and diagnostic imaging. The Extended Medicare Safety Net contributes to reducing the cost of ART services.

From 1 July 2023, the Government will introduce a new payment to subsidise the additional costs associated with the cost of storage of eggs, sperm, or embryos for:

- patients with cancer
- people at risk of passing on genetic diseases or conditions who have already undergone MBS-funded preimplantation genetic testing.

The Government has also funded the development of the Your IVF Success website to support Australian couples with independent advice and information on fertility support services and IVF. This investment includes $2.5 million over 4 years from 2021-22 for the University of NSW to manage the website.

As of 31 October 2022, $12.2 million from the MRFF has been invested across 4 projects with a focus on fertility and infertility related research. This includes $4.6 million to the University of New South Wales from 2019-20 for the 'Causes and prevention of male infertility' project. The project will apply advanced epidemiological and analytical techniques to answer key questions in male reproductive health and include the development of an online IVF patient predictor tool allowing individuals to estimate their chances of successful treatment, clinical practice guidelines, and a clinical trials portal.

Between 2000 and 2021, the NHMRC has expended over $219 million towards research relevant to fertility and infertility.

**Initiatives to improve reproductive healthcare and pregnancy care in Australia**

The Government is working to improve the provision of reproductive health care services for all Australians. This section outlines a number of programs and initiatives to improve reproductive and pregnancy care.

### Pregnancy Care Guidelines

The Pregnancy Care Guidelines[31] were developed to support Australian maternity services to provide high-quality, evidence-based antenatal care to healthy pregnant women. They are intended for all health professionals who contribute to antenatal care including midwives, obstetricians, general practitioners, nurses, maternal and child health nurses, Aboriginal and Torres Strait Islander health workers, and allied health professionals. They are implemented at national, state and territory, and local levels to provide consistency of antenatal care in Australia.

The Government is investing $5.9 million over from 2022-23 to 2023-24 to update the Pregnancy Care Guidelines and develop new National Postnatal Care Guidelines.

### Pregnancy care for First Nations people

First Nations mothers and their babies disproportionately experience adverse perinatal outcomes compared with non-Indigenous mothers and babies. There is lack of both culturally safe and community-based birthing options, and a significant underrepresentation of First Nations people in the maternal health workforce. Additionally, mainstream maternity services are not improving pregnancy and birth outcomes for First Nations women and babies.

To address this disparity in maternal and infant health outcomes, it is essential to invest in Birthing on Country models of care and programs that return maternity services to communities and First Nations control, and enable self-determination and connection to family, culture, and community throughout pregnancy and birth. Between 2019-2021, researchers established sufficient data to publish the benefits of Birthing on Country, demonstrating that women receiving the service were more likely to attend 5 or more antenatal visits, were almost 50% less likely to have a preterm birth than women receiving standard care, and were more likely to exclusively breastfeed on discharge from hospital.

The Government has committed $22.5 million for a dedicated Birthing on Country Centre of Excellence at Waminda in Nowra, NSW, to support cultural safety during pregnancy, birth, and the postnatal period. The Birth Centre, to be operational in 2025-26, will also be used as a national Birthing on Country demonstration site.

This commitment builds on investment of $32.2 million over 4 years (2021-22 to 2024-25) towards activities that grow the maternal health workforce, redesign maternity services for First Nations people, and support Birthing on Country and culturally safe continuous midwifery care activities for women pregnant with a First Nations baby.

[31] Department of Health and Aged Care, *Clinical Practice Guidelines: Pregnancy Care*, 2020.

In addition, $88.5 million over 4 years (2021-22 to 2024-25) is provided for the continuation and expansion of the Australian Nurse-Family Partnership Program (ANFPP)[32] from 13 to 15 sites. The ANFPP is a comprehensive, structured nurse home visitor program for women pregnant with a First Nations baby and provides support across the perinatal period until their child is two years old. This support also extends to education and awareness about reproductive and contraceptive care. In 2021-22, numerous positive outcomes were reported for mothers and babies participating in the ANFPP. For example, 85% of babies born to ANFPP mothers had a healthy birth weight and 97% of 12-month-old children and 99% of 24-month-old children were fully immunised.

Consistent with the Closing the Gap Priority Reform 1 (Formal Partnerships and Shared Decision Making) and 2 (Building the Community-Controlled Sector), it is critical to the delivery of culturally safe and responsive healthcare that policies and programs are designed and delivered in partnership with First Nations people.

The Government has invested through the MRFF $15 million across 3 projects from 2021-22 which aim to improve access to culturally safe care during pregnancy, birthing, and the post-natal period, including on-country birthing and continuity of family and midwifery care. More than $1 million has been invested from the NHMRC since 2000 to 2021 towards birthing on country related research.

### Stillbirth and miscarriage support

A key priority of the Woman-Centred Care Strategy is to develop and implement strategies to reduce stillbirth. The the National Stillbirth Plan was released on 10 December 2020 and is the first national plan to strategically address the issue of stillbirth in Australia. From 2019-20 to 2025-26, the Government has invested a total of $44.5 million in measures to reduce stillbirths and support families affected by stillbirth under the National Stillbirth Plan. This includes:

- $13.9 million over 3 years from 2022-23 to increase the number of stillbirth autopsies, including funding for workforce and transport costs where this is a barrier
- $4.2 million to extend Red Nose Australia's Hospital to Home Program which offers targeted support services for families who have experienced stillbirth
- $5.1 million to develop and implement holistic and individualised bereavement care for women and families from higher risk population groups who have experienced stillbirth or miscarriage, including, but not limited to:
    - First Nations peoples
    - culturally and linguistically diverse families
    - refugee and migrant communities, including South Asian and African migrants
    - women and families living in rural and remote Australia
    - women younger than 20 years.

[32] *Australian Nurse-Family Partnership Program (ANFPP)*, accessed 14 December 2022.

### Perinatal mental health

The Perinatal Mental Health and Wellbeing Program supports the mental health and wellbeing of expecting and new parents, and supports families experiencing grief after miscarriage, stillbirth, or infant death. This includes digital and telephone-based supports, a national perinatal mental health triage and referral system, and digital training and support services for vulnerable groups such as rural and remote parents. Funding of over $43 million is being provided under the Perinatal Mental Health and Wellbeing Program from 2020-21 to 2023-24.

As part of the October 2022-23 Budget, an additional $26.2 million over 4 years from 2022-23 will be provided to the Gidget Foundation Australia[33] to establish a national network of 12 perinatal mental health and wellbeing centres to provide mental health support to expectant and new parents.

### Family planning grants

The Government's Family Planning Grant Opportunity funds 4 long-term grant recipients to support individuals and couples to anticipate and attain their desired number of children, and the spacing and timing of their births. Total funding of $4.072 million (GST exclusive) over 4 years from 2019-20 to 2022-23 has been provided to:

- Fertility Education Australia[34] for natural family planning education
- Multicultural Centre for Women's Health[35] for sexual and reproductive health promotion to culturally and linguistically diverse communities, including through bilingual health educators
- the Ovulation Method Research and Reference Centre of Australia – Billings Leaders in Fertility Education (LIFE)[36] to deliver education on the Billings Ovulation Method
- Victorian Assisted Reproductive Treatment Authority[37] for health promotion regarding fertility, infertility, and preconception through the Your Fertility website.

Family planning initiatives support the reproductive health and fertility management of individuals and couples through activities such as public education, professional development, and monitoring of emerging evidence to inform new policy directions and program development.

[33] *Gidget Foundation Australia*, accessed 14 December 2022.

[34] *Fertility Education Australian*, accessed 14 December 2022.

[35] *Multicultural Centre for Women's Health*, accessed 14 December 2022.

[36] *Billings Leaders in Fertility Education (LIFE)*, accessed 14 December 2022.

[37] *Victorian Assisted Reproductive Treatment Authority*, accessed 14 December 2022.

**Education to improve sexual and reproductive health literacy for consumers**

Health literacy relates to how people access, understand, and use health information in ways to benefit their health. When individuals have a lower health literacy, they are at a higher risk of worse health outcomes and poorer health behaviours. Improving health literacy is a key element in encouraging individuals to partner with health professionals for better health.

The Government recognises the importance of improving the health literacy of all Australians throughout the life course and funds several campaigns and activities to support individuals to make informed choices about their reproductive health. This section outlines these activities, along with work to improve health literacy through the development of a National Health Literacy Strategy and inclusion of health and sexual education in the national curriculum.

### National Health Literacy Strategy

The development of a National Health Literacy Strategy was identified as an early priority of the *National Preventive Health Strategy 2021-2030*.[38] The National Health Literacy Strategy is under development and will aim to provide consumers with the skills they need to recognise accurate, trustworthy health information, as well as improving the health literacy environment. Targeted consultation on the development of the National Health Literacy Strategy occurred this year, with public consultation on the draft to occur in early 2023 for expected finalisation in mid-2023.

### Health, sexual and reproductive education in schools

All Australians should have access to evidence-based information about how to manage their health and wellbeing across each stage of their life, including at school. Age-appropriate sexual education is part of the national curriculum in Australia. The nationally agreed curriculum sets the expectations for what all Australian students should be taught, regardless of where they live or their background. State and territory government and non−government education authorities are responsible for the administration and operation of schools within their jurisdictions. This includes setting curriculum and assessment standards, day to day delivery of education programs, and the selection and use of educational resources.

Under the Australian Curriculum, students study Health and Physical Education from Foundation (i.e., the first year of compulsory school) to Year 10. Health and Physical Education enables students to develop skills, understanding, and willingness to positively influence the health and wellbeing of themselves and their communities. The relationships and sexuality content in the curriculum addresses physical, social, and emotional changes that occur over time and the significant role relationships, identities, and sexuality play in these changes. The content supports students to develop positive and respectful practices in relation to their reproductive and sexual health and their identities.

Revisions to the curriculum (version 9 was endorsed by Australian Education Ministers on 1 April 2022) have strengthened the teaching of consent and respectful relationships from

[38] Department of Health and Aged Care, *National Preventive Health Strategy 2021-2030*, December 2021.

Foundation to year 10 in age-appropriate ways, including content that addresses the role of gender, power, coercion, and disrespect in abusive or violent relationships.

In addition, the Government is funding $5 million to the Pelvic Pain Foundation of Australia, over 4 years from 2021-22, to deliver the Periods, Pain and Endometriosis Program (PPEP-Talk).[39] PPEP-Talk is a one-hour session delivered to high school students by fully trained educators. It was developed to enable students, teachers, and parents to learn how to recognise when menstruation symptoms are not normal and when to go for advice and help.

### Your Healthy Pregnancy Campaign

The Your Healthy Pregnancy Campaign[40] was launched in 2021 for people who are planning pregnancy, currently pregnant, or supporting someone who is pregnant. It includes a suite of consumer-facing resources including a brochure, factsheets, videos, and social media posts.

The Campaign provides general, high-level advice based on relevant guidelines and evidence across the areas of nutrition, physical activity, and general wellbeing. A second stage of the Campaign, due to be available in early 2023, will include:

- a suite of resources adapted to be culturally appropriate for First Nations audiences
- a suite of resources translated into 4 languages and adapted to be culturally appropriate for culturally and linguistically diverse audiences
- a plain English brochure for low-English literacy audiences.

### Healthdirect's Pregnancy, Birth and Baby service

Funding of $18.2 million over 4 years (2019-20 to 2022-23) is being provided for Healthdirect Australia's Pregnancy, Birth and Baby service[41] to provide a national helpline, videocall, and website service. The helpline is operated by maternal child health nurses, who are both midwives and registered nurses. The website content is clinically reviewed and links to a wide range of content from leading Australian health organisations. The service offers parents reassurance and guidance, and provides non-judgemental support during pregnancy loss, pregnancy decisions, perinatal anxiety, and depression. Incoming calls are assessed according to need and will be transferred to nursing triage services (such as Healthdirect's Health Information and Advice Service), or other relevant health or support services as required.

The service is available to expecting parents, parents, families, and carers of children aged up to 5 years. The helpline is available to all Australians, including people living in rural and remote areas. People with a disability and people from culturally and linguistically diverse backgrounds can access the helpline through the National Relay Service and the Translating and Interpreting Service. The Healthdirect Multicultural Health Connect pilot also supports queries and assists with consumer navigation to the Pregnancy, Birth and Baby service for advice and support.

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[39] Pelvic Pain Foundation of Australia, *PPEP Talk®*, accessed 14 December 2022.

[40] Department of Health and Aged Care, *Your Health Pregnancy*, accessed 14 December 2022.

[41] Healthdirect Australia, *Pregnancy, Birth and Baby*, last updated December 2020.

### Fetal Alcohol Spectrum Disorder (FASD)

Funding of $27.4 million over 5 years (2020-2024) is being provided to the Foundation for Alcohol Research and Education (FARE)[42] to deliver a national campaign raising awareness of the effects of drinking alcohol while pregnant, planning a pregnancy, or breastfeeding. The national awareness campaign includes a suite of resources to support health professionals and the alcohol and drug workforce to provide clear and accurate information and advice to patients in relation to alcohol and pregnancy. This includes an accredited e-learning course on 'Supporting alcohol-free pregnancy and safe breastfeeding'. The campaign is also developing resources for consumers.

Culturally appropriate resources on alcohol and pregnancy are also being developed by FARE in partnership with the National Aboriginal Community Controlled Health Organisation. These resources are designed to support health professionals in remote primary health services to yarn with patients in a non-judgemental, culturally safe way about alcohol use during pregnancy, while planning a pregnancy, or breastfeeding. The resources will launch in February 2023.

### Sexual and reproductive health resources for men

Government funded sexual and reproductive health education resources for men, outside of the material presented on the Health Direct website, are provided through the men's health sector, specifically Healthy Male.[43] Healthy Male (formerly Andrology Australia) has been funded by Government since 1999, and from 2017 has been providing information, awareness, and support to Australian men on a range of key health issues as part of the Male Health Initiative.

In addition to its consumer-focused work, Healthy Male also develops and contributes to a range of health professional education and training courses, including in the sexual and reproductive health space.

[42] *Foundation for Alcohol Research & Education (FARE)*, accessed 14 December 2022.

[43] *Healthy Male - Generations of healthy Australian men*, accessed 14 December 2022.

**Workforce development**

Health professionals, including medical practitioners, registered nurses, midwives, and nurse practitioners, must complete all required qualifications and meet relevant professional standards in order to safely support individuals with their health needs, including for sexual and reproductive health purposes. There are specific requirements that the workforce must meet to deliver particular services, including for medical and surgical terminations. Training for medical terminations is not promoted so health practitioners have to actively seek out information on who provides training.

The Government is committed to workforce development through the *National Medical Workforce Strategy 2021-2031* (National Medical Workforce Strategy) and funding for health professional training.

### National Medical Workforce Strategy 2021-2031

The National Medical Workforce Strategy identifies achievable, practical actions to build a sustainable highly trained medical workforce. The strategy aims to structure and support our workforce in a way that ensures we can meet the current and emerging health needs of Australians.

### Medical specialist training

The National Medical Workforce Strategy informs Government funding for medical workforce training , particularly with regard to under and over supply of specialists, as well as geographic maldistribution.

The Government is working to improve access to specialist services through the Specialist Training Program[44] which supports specialist training positions in regional, rural and remote, and private facilities, aiming to improve future specialist medical workforce distribution. The Specialist Training Program comprises up to 7% of specialist medical training in Australia, with the remainder supported by state and territory governments and the private sector.

The Specialist Training Program supports up to 920 full-time equivalent (FTE) specialist training places and an additional 100 FTE Integrated Rural Training Pipeline places annually, at an overall investment of $708.6 million across 2022-2025. The Specialist Training Program is implemented by 13 specialist medical colleges, including RANZCOG, which is responsible for training obstetrics and gynaecology specialists. Across 2022-2025, RANZCOG will receive more than $26 million to deliver 32 FTE specialist training places and 3 FTE Integrated Rural Training Pipeline places annually.

RANZCOG also receives additional funding under the Specialist Training Program to deliver the General Practitioner Procedural Training Support Program to provide:

- up to 10 GP Fellows to gain a statement of satisfactory completion of Diploma of the Royal Australian and New Zealand College of Obstetrics and Gynaecology
- up to 10 GP fellows to achieve Advanced Rural Skills Training in Anaesthesia, administered by the Australian College of Rural and Remote Medicine.

[44] Department of Health and Aged Care, *Specialist Training Program*, last updated May 2022.

### General practice training

The Government supports the development of the GP workforce through funding a series of training programs supporting doctors to be become fully qualified GPs:

- The Australian General Practice Training program has a yearly intake of 1,500 junior doctors
- The Australian College of Rural and Remote Medicine's Rural Generalist Training Scheme, which has a yearly intake of up to 100 Rural Generalist GP training places
- Funding is also provided for the Remote Vocational Training Scheme has a yearly intake of 32 training places and delivers structured distance education and supervision to doctors, providing general medical services in First Nations communities and rural and remote locations throughout Australia.

Training through these schemes is fully funded, with GP registrars receiving education and training (including supervision of training) to prepare them to gain fellowship.

The Royal Australian College of General Practitioner's Curriculum and Syllabus for Australian General Practice includes pregnancy and reproductive health. The Australian College of Rural and Remote Medicine's Rural Generalist Curriculum includes Obstetrics and Gynaecology and Sexual Health. Additionally, registrars are able to choose to undertake additional training in Obstetrics and Gynaecology.

### Nurse and midwife training

The scope of practice of nurse practitioners and participating midwives is regulated by the Nursing and Midwifery Board of Australia (NMBA) under the *Health Practitioner Regulation National Law Act 2009*.[45] Professional standards define the practice and behaviour of nurses and midwives. These include Codes of conduct and ethics, standards for practice, and safety and quality guidelines.

It is in the scope of practice for midwives and nurse practitioners to work in sexual and reproductive health. Participating midwives and nurse practitioners have the potential to advise, prescribe, and support consumers in sexual and reproductive health. As regulated professionals, midwives and nurse practitioners are responsible for making professional judgements about whether an activity is within their scope of practice. When it is not, they are responsible for initiating consultation and collaboration with, or referral to, other members of the healthcare team.

The NMBA has developed a decision-making framework to guide decision-making relating to scope of practice and delegation. The decision-making framework is clear that decisions about scope of practice should consider (among other things) the health service provider or employer's policies and protocols.

To access the MBS and PBS, both nurse practitioners and participating midwives need to have a documented collaborative arrangement with a medical practitioner that must provide for:

- consultation between the nurse practitioner and a medical practitioner
- referral of a patient by the nurse practitioner to a medical practitioner
- transfer of a patient's care by the nurse practitioner to a medical practitioner.

[45] Queensland Government, *Health Practitioner Regulation National Law Act, 2009*.

Collaborative arrangements do not influence the scope of practice of a nurse practitioner or a midwife. They occur in other forms throughout the health system such as referral from a GP to a gynaecologist.

Nurses and midwives may extend their individual scope of practice through additional education, competency, and endorsement. Whilst there are no regulatory barriers to midwives and nurses providing primary sexual and reproductive health care, there are limited formal qualification pathways to extend their scope. The Government is working with professional colleges and other stakeholders to develop a Nurse Practitioner 10 Year Plan, in which access to MBS items for nurse practitioners has been raised as a key issue.

### Allied health professionals training

Care from a multidisciplinary team is best practice in supporting universal access to sexual and reproductive health information, treatment, and services. In addition to medical practitioners, nurses and midwives, support may be required from allied health professionals such as social workers, psychologists, and physiotherapists specialising in pelvic health. Allied health professionals have a university level qualification of Australian Qualification Framework level 7 or higher in a recognised allied health field that is accredited by their relevant national accreditation body. Training and curriculum related to sexual and reproductive health is dependent on the allied health professional degree that is being undertaken.

### Aboriginal and Torres Strait Islander Health Professional Organisations

The Government funds Aboriginal and Torres Strait Islander Health Professional Organisations $46.6 million over 5 years (from 2018-19 to 2022-23) to support and develop the growing Aboriginal and Torres Strait Islander health workforce. Funding also supports work to increase the cultural capability of the broader health workforce to support better care of Aboriginal and Torres Strait Islander people.

The *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan* was codesigned with First Nations sector leaders. It aims to increase the representation of First Nations peoples in all health roles and locations across Australia to population parity by 2031.

### Increasing the perinatal loss workforce

The National Stillbirth Plan was developed to strategically address the issue of stillbirth in Australia. It includes activities to increase the number of stillbirth autopsies to improve understanding of the causes of these tragic deaths. From 2022-23 to 2024-25, the Government is providing $13.9 million to increase the perinatal loss workforce to include a perinatal loss coordinator or dedicated perinatal pathologist in each state and territory. Funding is also available to support pathologists into perinatal pathology career pathways.

This new commitment builds on an investment of $1.8 million over 4 years from 2021-22 to help increase the number of stillbirth autopsies by increasing health professionals' capacity to undertake stillbirth autopsies and investigations. This consists of $750,000 each to the Royal College of Pathologists of Australasia and the Royal Australian and New Zealand College of Radiologists to ensure that autopsy and investigation services are available to bereaved parents who choose to access them.

## Appropriate and adapted care and services

The National Women's Health Strategy identifies priority cohorts, including First Nations women, women from culturally and linguistically diverse backgrounds, women with disabilities, lesbian, gay, bisexual, transgender, intersex, and queer and questioning (LGBTIQ+) women and women living in rural and remote locations. It recognises that these women may face intersecting types of inequality, including socio-economic disadvantage, low levels of health literacy, geographical distance, and lack of culturally appropriate services, which act as additional barriers to healthcare access and contribute to poorer health outcomes. This section outlines information about care and services for a range of priority cohorts.

### First Nations women and girls

First Nations women continue to have poorer health outcomes compared with non-Indigenous women in Australia. The life expectancy is approximately 8 years lower for First Nations women than non-Indigenous women. There are a number of key national-level Government strategies that include recommendations to improve First Nations women's health outcomes, including the National Women's Health Strategy, the *National Aboriginal and Torres Strait Islander Health Plan 2021-2031,*[46] and Closing the Gap.

Closing the Gap was developed in genuine partnership between the 3 levels of Australian government and First Nations leaders and was released in July 2020. It outlines, in practical and measurable terms, ways to ensure the voices of First Nations peoples are given weight on issues that impact their lives. Closing the Gap is supplemented by 19 socio-economic targets across the areas of education, employment, health and wellbeing, justice, safety, housing, land and waters, and languages.

As the key policy driver of First Nations equality, Closing the Gap ensures the Government is committed to addressing gaps in service delivery and health outcomes for First Nations communities. A significant driver of the disproportionately poorer maternal health outcomes experienced by First Nations families is a lack of both culturally safe and community-based maternal healthcare services available for First Nations people.

First Nations women and girls experience sexual and reproductive health inequities with higher prevalence of sexually transmissible infections, maternal mortality, and infant deaths. First Nations women seeking termination of pregnancy, tubal ligation, and insertion of IUDs face barriers including lack of culturally safe services and lack of appropriately trained staff in rural and remote locations.[47] First Nations women may also experience prejudiced treatment at the practitioner or service level, contributing to poorer health outcomes and resulting in general health service avoidance.[48]

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[46] Department of Health and Aged Care, *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*, December 2021.

[47] SL Larkins, P Page, 'Access to contraception for remote Aboriginal and Torres Strait Islander women: necessary but not sufficient,' *Medical Journal of Australia*, 2016, 205(1):18-9. doi: 10.5694/mja16.00431

[48] CA Kairus, LM Casanelia, K Bennett-Brook, J Coombes, UN Yadav, 'Impact of racism and discrimination on the physical and mental health among Aboriginal and Torres Strait Islander peoples living in Australia: a protocol for a scoping review,' *Systematic Reviews*, 2020, 9(1):223. doi: 10.1186/s13643-020-01480-w.

Teenage pregnancy and birth rates among young First Nations women are higher than non-Indigenous young women, as non-Indigenous young people have greater access to appropriate contraception and termination services.[49] According to the Australian Institute of Health and Welfare, First Nations mothers aged 15-19 years had a birth rate of 38.9 births per 1000 in 2019 compared with non-Indigenous teenage mothers who had a birth rate of 5.8 per 1000 births. Further, the more remote the location, the more the teenage birth rate increased.[50]

Continued investment in the growth of the First Nations maternal health workforce to support culturally safe models of perinatal care is critical to Closing the Gap in maternal and infant health outcomes. A strong First Nations workforce is a powerful driver of change and evidence clearly shows that First Nations designed and delivered health services offer better outcomes for First Nations people.[51]

Government commitments to improve maternity services for First Nations people are outlined above in the Pregnancy care for First Nations people section. The Government has also committed to developing a standalone First Nations Action plan under the National Plan to End Violence against Women and Children, recognising that First Nations women are disproportionately impacted by family, domestic and sexual violence.

### Culturally and linguistically diverse, migrant and refugee women and girls

Culturally and linguistically diverse women require tailored culturally and linguistically appropriate and accessible health resources to improve health behaviours and outcomes.[52] Migrant and refugee women may have low health literacy and poor knowledge of Australia's health system and services, their experiences prior to arrival in Australia may have impacted their trust in the health system, and language barriers may result in miscommunication, misdiagnosis, and lack of appropriate follow-up.[53] Some migrants are ineligible for Medicare due to their visa type or visa status, and thus experience greater financial barriers to health care.

Sexual and reproductive health services are underutilised by migrant and refugee women for a number of reasons, including social and cultural norms which may inhibit open discussion of sexual and reproductive health matters, leading to poor knowledge of and use of contraceptives and sexual health screening.[54] In addition, specific forms of gender-based violence may disproportionately impact women and girls from culturally and linguistically

[49] SL Larkins, P Page, 'Access to contraception for remote Aboriginal and Torres Strait Islander women: necessary but not sufficient,' *Medical Journal of Australia*, 2016, 205(1):18-9. doi: 10.5694/mja16.00431

[50] AIHW, *Australia's Children*, last updated Feb 2022.

[51] AIHW and National Indigenous Australians Agency, *Aboriginal and Torres Strait Islander Health Performance Framework - 3.12 Aboriginal and Torres Strait Islander people in the health workforce*, last updated December 2020.

[52] J-A Hughson, F Marshall, JO Daly, R Woodward-Kron, J Hajek, D Story, *Health professionals' views on health literacy issues for culturally and linguistically diverse women in maternity care: barriers, enablers and the need for an integrated approach,* 2018, 42(1):10-20. doi: 10.1071/AH17067.

[53] Migrant & Refugee Women's Health Partnership, *Enhancing health literacy strategies in the settlement of migrant and refugee women*, 2018.

[54] Western Sydney University, *Sexual and Reproductive Health of Migrant and Refugee Women*, 2017.

diverse communities, migrant and refugee women, and women and girls who are victim-survivors of modern slavery.

To address some of the specific barriers and risks faced by these groups, a number of initiatives were funded under the *National Plan to Reduce Violence against Women and their Children 2010 - 2022* (the former National Plan) to increase access to services, raise community awareness, and provide sexual and reproductive health and rights information. Relevant activities under the former National Plan include:

- an evidence-based National Framework for the Prevention of Dowry Abuse, developed by the Social Policy Group (previously Migration Council Australia) in partnership with the AustralAsian Centre for Human Rights and Health and Harmony Alliance.[55]
- the DV-alert program, which works to build the knowledge and capacity of frontline workers to recognise, respond to, and provide referrals for women experiencing (or at risk of) family, domestic or sexual violence. The program was updated to include content on trafficking and slavery, forced marriage, dowry abuse, and female genital mutilation.
- the Family Safety Pack,[56] is available in 46 languages and provided in visa grant letters for both men and women coming to Australia. It provides information on Australia's laws regarding domestic and family violence, sexual assault and forced marriages, family violence and partner visas, dowry abuse, female genital mutilation and cutting, LGBTIQ+ relationships, and trafficking and slavery.
- the Speak Now project,[57] aims to prevent sexual violence and forced marriage in Australia by engaging and educating community leaders, communities, and services about sexual violence and women's rights to bodily autonomy and choice in relationships.
- the Free Interpreting Service,[58] is delivered by TIS National to provide equitable access to key services for people with limited or no English language proficiency.

*Female Genital Mutilation/Cutting*

Female genital mutilation/cutting is a debilitating practice which primarily affects migrant women. It is the deliberate cutting or altering of the female genital area for no medical reason. It is harmful to women's health and can cause severe pain and bleeding, problems urinating and menstruating, cysts, infections, complications in childbirth, and increased risk of newborn deaths.

The 2022-23 Budget included $0.7 million over 3 years to support the Multicultural Centre for Women's Health (managers of the National Education Toolkit for female genital mutilation/cutting Awareness) to address female genital mutilation/cutting. The Multicultural Centre for Women's Health will establish a Community of Practice, map the

[55] AustralAsian Centre for Human Rights & Health (ACHRH), *National Platform for Prevention of Dowry Abuse*, December 2021.

[56] Department of Social Services, *Family Safety Pack*, accessed 14 December 2022.

[57] Anti-Slavery Australia, *'Speak Now:' A Forced Marriage Education and Prevention Project*, September 2021.

[58] Department of Home Affairs, *Translating and Interpreting Service (TIS)*, accessed 14 December 2022.

health workforce supporting survivors of female genital mutilation/cutting across the nation and develop, and deliver training to increase the Australian workforce's ability to address the health impacts of female genital mutilation/cutting. A further $1 million will be made available through a competitive grants process to support community-led approaches to prevention of Female genital mutilation/cutting.

### Women and girls with disability

Under *Australia's Disability Strategy 2021-2031* (Disability Strategy),[59] all governments have committed to improve prevention and early intervention health services so they are timely, comprehensive, appropriate, and effective to support better overall health and wellbeing of people with disability including maternal, sexual, and reproductive health. The Community Attitudes Outcome Area of the Disability Strategy includes a focus on ensuring that professional workforces, such as the health and the social and community sectors, can confidently and positively respond to people with disability.

The Safety, Rights and Justice Outcome Area of the Disability Strategy has a focus on ensuring the rights of people with disability are promoted, upheld, and protected. This includes their sexual and reproductive rights and encourages the use of policies, processes, and programs for people with disability to promote gender equality and prevent violence against groups at heightened risk, including women and their children.[60,61]

The *National Roadmap for Improving the Health of People with Intellectual Disability*[62] recognises the need to improve support for people with intellectual disability and their families and carers. The Roadmap includes a short-term action for the Commonwealth to work with Primary Health Networks, the National Disability Insurance Agency, and other advocacy organisations to better promote mental health and reproductive health services to people with intellectual disability, and connect existing services to a National Centre of Excellence in Intellectual Disability Health. The Government committed to establishing the National Centre in the October 2022 Budget.

Women and girls with disability may also experience exclusion or under-servicing from sexual and reproductive health care services due to factors including inaccessible venues, lack of transport, lack of appropriate equipment, non-inclusive or inflexible service policies and programs, personnel and provider attitudes, and lack of disability education and training of health providers. Women and girls with disabilities require access to appropriate information and education on sexual and reproductive health in the full range of accessible formats.[63,64]

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[59] Australian Government, *Australia's Disability Strategy 2021-2031*, last updated February 2022.

[60] Australian Government, *National Disability Insurance Scheme Act, 2013*.

[61] NDIS, *Mainstream and community supports*, last updated January 2022.

[62] Department of Health and Aged Care, *National Roadmap for Improving the Health of People with Intellectual Disability*, July 2021.

[63] Women with Disabilities Australia (WWDA) and Women Enabled Inc., *The Sexual and Reproductive Rights of Women and Girls with Disabilities*, July 2013.

[64] WWDA, *Position Statement 4: Sexual and Reproductive Rights*, September 2016.

Over the past two decades, the regulation of sterilisation of persons with disabilities has been subject to a number of inquiries and reviews. Australian, state and territory laws have been significantly reformed to provide better protection for people with disabilities than has historically been the case.

People with disability are able to access sterilisation procedures on the same basis as other people. Where an adult has decision making capacity, in most instances sterilisation procedures are performed by a healthcare provider after the adult patient consents to the procedure. Where the adult does not have decision making capacity, the regulation of sterilisation of adults with disability is primarily a state and territory issue. All jurisdictions have guardianship tribunals to decide a range of matters for people who have an impaired capacity to make independent decisions, including regarding sterilisation. In most Australian jurisdictions, the test applied is whether a procedure is in a person's best interests.

The National Plan to End Violence against Women and Children recognises that women and girls with disability are at particular risk of forced or coerced sterilisation, forced contraception or limited/no contraceptive choices, menstrual suppression, poorly managed pregnancy and birth, and forced or coerced abortion.[65,66] In the 2021-22 Budget, $9.3 million was allocated in 2021-22 to 2023-24 for preventing and responding to violence against women and girls with disability. This funding is being used to develop resources to help reduce violence against women and girls with disability and improve responses when violence occurs.

Within the $9.3 million Budget allocation, $3.5 million in funding was allocated for Sexual Health and Family Planning ACT[67] to enhance the sector's capability to support and educate women with disabilities. This includes improving service reach, delivery of resources and training, expanding different modes of training for women with disabilities, and developing best practice standards for education and training.

### LGBTIQ+ people

LGBTIQ+ communities are diverse and often have unique, complex, and distinctly different sexual and reproductive health needs. This is particularly the case for transgender and gender diverse populations compared with the cisgender population. LGBTIQ+ people face barriers accessing appropriate sexual and reproductive health care including concerns about privacy and confidentiality in relation to their gender, sexuality, or variations in sex characteristics, fear of or experiences of stigma or attitudinal barriers impacting care, and a lack of understanding among many mainstream health care providers about their unique sexual and reproductive health needs.

The Government has committed to measures to support LGBTIQ+ Australians in the 2022-23 Budget, including a national consultation with LGBTIQ+ people on the unique health issues and barriers to access that LGBTIQ+ Australians may face. The national consultation will take

[65] WWDA, July 2013.

[66] The Sexual and Reproductive Rights of Women and Girls with Disabilities, Women with Disabilities Australia and Women Enabled Inc., 2013

[67] *Sexual Health and Family Planning ACT*, accessed 14 December 2022.

a holistic view of LGBTIQ+ health and mental health and will include the views of different LGBTIQ+ communities on access to reproductive healthcare.

The Australian Human Rights Commission (AHRC) released the report *Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics*[68] (AHRC Report) in October 2021. The report makes 12 recommendations to protect and promote the human rights of people born with variations in sex characteristics (also known as intersex[69]) in the context of medical interventions to modify these characteristics.

The Government will examine the recommendations in the AHRC Report in consultation with the intersex community and its advocates to determine next steps. The views of the intersex community on the recommendations in the AHRC report, medical treatment of intersex people, and access to health care appropriate to their needs (including reproductive healthcare) will be sought as part of the national consultation with LGBTIQ+ people.

QLife[70] is funded by the Government to provide Australia-wide free, anonymous LGBTIQ+ peer support and referral for people wanting to talk about a range of issues including sexuality, identity, gender, bodies, feelings, or relationships.

### Family, domestic and sexual violence

Gendered violence can take many forms, including reproductive coercion, in which a woman's reproductive choices are restricted or controlled. It can involve sabotaging contraception, pressuring a woman to become pregnant or continue a pregnancy, and pressuring or forcing her to have a termination or sterilisation procedure. A key measure of success under the National Women's Health Strategy is a reduction in the rate of reproductive coercion, in recognition of the physical and mental health impacts of violence against women and girls.

Coercive control is often a significant part of a person's experience of family and domestic violence, and involves perpetrators using abusive behaviours in a pattern over time in a way that creates and keeps power and dominance over a victim-survivor. The Consultation Draft of the National Principles to Address Coercive Control[71] recognises reproductive coercion as one of a broad range of abusive behaviours that can be used as part of this pattern. The National Principles, when finalised, will help to create a shared national understanding of coercive control.

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[68] Australian Human Rights Commission, *Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristic*, October 2021.

[69] 'Intersex' refers to people who are born with genetic, hormonal, or physical sex characteristics that do not conform to medical norms for 'male' or 'female' bodies. Intersex people have a diversity of bodies and identities.

[70] *QLife*, accessed 14 December 2022.

[71] Attorney-General's Department. Consultation Draft – National Principles to Address Coercive Control. September 2022.

The National Plan also acknowledges that victim-survivors of family, domestic and sexual violence can experience impacts such as reproductive and sexual health issues. The recovery and healing domain is an essential component that recognises victim-survivors need additional, often lifelong supports to recover and heal from trauma and the physical, mental, emotional, and economic impacts of violence.

Primary care providers are often the first point of contact in the health care system for a person experiencing family, domestic and sexual violence, and the way they respond is a critical influence on whether people continue to seek help. The National Plan acknowledges health workers are not consistently trained to identify and respond to domestic, family and sexual violence and provide trauma-informed care. Funding of $48.7 million over 4 years from 2022-23 will provide increased support to primary care providers to assist in the early identification and intervention of family, domestic, sexual violence and child sex abuse, to navigate the health system, and coordinate referrals to support services.

This measure includes the extension and expansion of an existing family and domestic violence pilot underway in 6 Primary Health Networks (PHNs) in Queensland, Victoria and New South Wales. The pilot will be expanded into one PHN in each of the remaining jurisdictions, and 3 of the initial pilot PHNs will add the sexual violence and child abuse system navigation components. The PHNs will trial locally integrated models of response and referral activities, including for priority population groups.

Funding is also provided to develop and implement nationally consistent resources on sexual violence for primary health care providers to be able to support victim-survivors and be referred to appropriate support services.

**Attachments**

A. Therapeutic Goods Administration (TGA) approved contraceptives and availability on the PBS
B. MBS items and service volumes related to long-acting reversible contraceptive LARC insertion 2021-22
C. MBS items, service volumes, fees and costs related to permanent contraception 2021-22
D. MBS items and available PBS subsidies available for medical and surgical pregnancy terminations 2021-22
E. MBS items and service volumes related to obstetric services 2021-22
F. MBS item fees and costs related to obstetric services 2021-22