Submission suggestions

Terms of Reference	Potential themes	Potential recommendation
a. cost and accessibility of contraceptives, including: I. PBS coverage and TGA approval processes for contraceptives, II. awareness and availability of long-acting reversible contraceptive and male contraceptive options, III. options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions;	**BARRIERS:** **LARC's cost barriers** • Cost of purchasing LARC's (Mirena, Kyleena and Implanon) if not HCC holder = $ 40+ • Non-PBS item Copper IUDs $80-120 • Ongoing cost of COCP & Depo scripts – continuously needing appointments for repeat scripts – appointment costs and costs of purchasing contraceptives are a barrier **Insertion cost &MBS rebate barriers** • **Inadequate rebates from Medicare** • Out of pocket costs – most providers charge an out-of-pocket cost to help cover the costs that aren't adequately rebated by MBS ranging from $120 - $350	• Free access to contraception, prioritise LARC and emergency contraception • Free contraceptive stock at GP clinics – so can be used on the day to prevent delay in commencing contraception and reducing the risk of unplanned pregnancies • If rebates are higher there could be more GP's bulk billing for repeat scripts for contraception or make appointments for contraception scripts free Recommendations • Review MBS item numbers to adequately reflect the skill, expertise and time required to provide LARC procedures • Improve MBS rebates for contraceptive consultations and insertion

	• Out of pocket costs mean that the client has to pay the full amount up front – they need to have that amount of money in their bank account, not just the out-of-pocket cost. • LARC insertion usually require nurse assistance - there is no rebate for the nurse's time • GP's income is reduced if they must pay for the cost of nurse assisted procedures and therefore less likely to take on these procedures as it reduces their income. • Lengthy consultations are usually required to establish the most appropriate form of contraception / LARC and are not adequately rebated by Medicare • Nurse Practitioners (NP) that are trained to insert IUD's and Implanon have limited billing MBS options and therefore the time and skills required are inadequately rebated by Medicare making it less likely for an employer / organisation to support these services due to reduced billing capacity vs time required. • Nurse led consultations help to provide appropriate assessment for contraception options – no MBS rebate for this service	• Provide MBS item numbers for Nurse Practitioners to insert LARC device • Provide MBS numbers for Nurse -Led consultations for contraception / sexual health consultations • Provide MBS number / rebate for trained nurses to insert LARC's • Provide adequate rebates for nurse assisted procedures related to sexual health

	however it results in more people starting contraception, due to time spent reducing fears and myths related to contraception choices **Accessibility** • Difficult to even get timely appointments to obtain scripts or insertion appointments In our clinic, clients often see a nurse first and then we arrange for a GP/NP to supply scripts to reduce the time a client has to wait for contraception– we see numerous women with unplanned pregnancies who have been unable to get into their GP to arrange appropriate / suitable contraception • Women often have to travel long distances to access appropriate sexual health services. • Options for LARC insertions are limited in country areas • Access to EMA is very limited in country areas • Non- Medicare card holders – cost of contraception and insertion costs results in no contraception being used and increased risk of unplanned pregnancies • in regional Victoria few GPs perform LARC insertion – due to cost, time required to provide these services vs rebates provided	• Provide free sexual health / upskilling training for GP's who work in regional / remote areas so that they can provide evidence based sexual health services and are skilled to provide LARC services • Subsides lost income for GP's and NP, Nurses who attend training related to sexual health services • Increased rebates for sexual health services will encourage GPs to offer appropriate sexual health services • Provide a nurse rebate for sexual health services will result in part of the work required for LARC's, unplanned pregnancies can be provided by a nurse and therefore taking up less of the GP's time allowing for more available appointments • Provide financial support for sexual health hubs to support / train other GP's and NP and Nurses to provide sexual health services Including EMA services

	• GP's who don't insert LARC's as part of their practice often don't even inform clients of the option to have a LARC often resulting in unplanned pregnancies • Few GP's have completed the training for LARC's insertion • Few options for training of GPs in rural and regional areas in Victoria are available and they must go to Melbourne to do practical training – not financially viable • Poor sexual health training for GP's – we often see women that have been waiting to get their next period before starting contraception as this what they have been advised by their GP – resulting in unplanned pregnancy • Lack of support regionally for ongoing clinical peer support once training is completed • Lack of support for experienced nurses to train to be IUD insertors. Eg: Nurse Practitioners could be trained to insert IUD's / Implanon – expense is a barrier for both the NP and the practice they are employed by. • Poor accessibility for emergency contraception, cost of emergency	• Free emergency contraception available especially for people living in remote areas • Nurse led consultation rebates

	contraception and also age barrier, some chemists will only give emergency contraception if the person is over 16 years old. • Evidence supports nurse led consultations to reduce both fear and stigma when a person is seeking information and support in relation to contraception and sexual health however whilst this results in a client being happier and more confident in their choices there is no MBS item to support this service All of these create greater barriers for women to access appropriate services. The less services that are available the fewer practical choices women really have. Therefore, forcing women to choose between what they can actually afford and how far they can afford to travel to access services results in **postcode lottery for sexual health.** GPs with poor sexual health knowledge and poor discussed LARC insertion processes to debunk some of the myths and fears often result in contraception questions being answered with, "just take the Pill" is an easy option for GPs and people. • Sourcing IUD devices in some pharmacies is difficult – time	

	consuming '-some pharmacies don't stock LARCS but order it in • No opportunity for on the day	
b. cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas	Early medical abortion: onerous authorising environment to supply and prescribe; limited number of prescribers & suppliers. Surgical abortion: Lack of access to and availability of surgical abortion in the public hospital system, i.e., they don't exist, small & over-burdened workforce, when a proceduralist is absent the service is unavailable, ad hoc surgical list, obscure referral pathway. Several "touchpoints" in access to abortion care i.e., access & availability of early dating scan service, results in delays to care	Remove TGA requirement for a prescriber to gain an 'authority script' and supplier to be registered Reduce the cost of early medical abortion medication Remove the supply monopoly held by MSI Extend prescribing rights for NPs Extend funding for nurse led models of early medical abortion care Require a public hospital per region to provide surgical abortion access & availability Mandate public hospitals to provide EMA services Extend the capability of the existing abortion service in the public hospital system, i.e., further resourcing to extend the current service – a weekly dedicated list, extend gestational limit. Requires leadership from the organisation with the support of the Federal and State Departments of Health

		Invest in point of care ultrasound in the S&RH Hubs, requires equipment and training oncosts Eliminate the need for dating USS when there isn't any doubt of gestation Further resource and investment in 1800Myoptions as the state-wide independent database for S&RH services
c. workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals	Limited training options for GPs in rural and Regional Victoria- usually must travel to Melbourne to State funded training centre- this is often at personal cost to GP/Nurse and losing daily wages. Nurse training for LARCs- accessed either online/direct training- limited for nurses especially primary care nurses to get time off to do this- also not a priority of their GP practice as no renumeration for the nurses to train and then do the procedures. Limited capacity of S&RH Hubs due to workforce capacity and resourcing.	More fully funded scholarships for Education/Training and ongoing competency training for GPs and Nurses. Further education and training options for nurses to undertake early medical abortion & LARC procedures Develop a National accredited training program for Nurses-in Reproductive health and LARCs; at present State by State from Family planning Organisations Develop the S&RH hub network as the "local clinical champion" for early medical abortion & LARC expertise. With further investment hubs could offer secondary consultation for early medical abortion procedures & be the local training site for IUD procedures

d. best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery	Limited opportunity for streamlined triaging for sexual health services- often receptionist first line contact- at this stage barriers exist due to cost/previous patient with overdue account/ Difficulty in receptionist knowledge of which clinician offers services and or lack of knowledge to refer onwards. Some GPs in a Practice are Not aware that other GPs provide Medication abortion services as they do not advertise within their own Practice.	Strength based approach education for GP services including training for access to culturally safe and informed health services. Improved use of Interpreters S&RH Hubs resourced to employ First Nations and cultural workers in the clinics Provide free EMA for people without access to Medicare and MBS
e. sexual and reproductive health literacy	Limited access to National and State based health information in community languages as navigating websites challenging and time consuming. Consumer information often manufacturer booklets these are not in plain language, need to consider low literacy of consumers.	Extend investment in health literacy material Extend investment in 1800myoptions for social marketing campaigns to normalise abortion and contraception as healthcare
f. experiences of people with a disability accessing sexual and reproductive healthcare;	S & RH Hubs funded to have adequate physical resources such as electronic chairs for those with physical disabilities to position for LARC procedures. Some clients have to be referred to public hospitals for LARC procedures as not adequate furniture in clinics.	Funded S& R Hubs to have colposcopy chairs to enable LARC and IUD to be performed in Primary care settings.

g. experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare;	Barriers due to siloing of services- for example specialist LGBTIQ+ services in Major cities versus GP services in rural and regional areas- Headspace centres – often care is segregated	Support for GPs/NPs who are motivated to work with Diverse populations in sexual and reproductive health- to sit within or co-locate to other services
h. availability of reproductive health leave for employees	Lack of back filling- planned leave If a Clinician delivering a service is ill/on leave that service halts until they return- examples of regional service Surgical Termination clinics cancelled due to doctor away-	Support for Public funded services to be mandated to continue the service regardless of who provides the care
i. Ability for mobile teams	Mobility of Specialist Nurses- often availability of trained staff an issue in regional and rural areas. Competing barriers for consumers to attend S&RH consults well known-	Integrating mobile S&RH services with capacity for telehealth secondary consults with doctors- as nurse led clinics go to rural health services to provide evidenced based care.