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SUBMISSION

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AMA comments on the Medicare Benefits Schedule Review Advisory Committee on Long-Acting Reversible Contraceptives Draft Report

Consultation closes 11 November 2025

Via Email: LARC.MRAC@health.gov.au

Introduction

The Australian Medical Association (AMA) welcomes the opportunity to comment on the MRAC LARC Working Group's Draft Report and the proposed changes to the Medicare Benefits Schedule (MBS) items for long-acting reversible contraceptives (LARCs). The AMA acknowledges the significant progress made in phase one, particularly the increase in MBS rebates and the introduction of new items to improve access and affordability for women and girls across Australia. These reforms represent a positive step for women's health and reproductive autonomy.

The AMA supports the overarching aim of improving access to LARC services, particularly through general practice, and commends the federal government's commitment to increased funding and bulk-billing incentives. However, we oppose the expansion of MBS access to endorsed midwives (EMs) for intrauterine device (IUD) insertion and removal, as proposed in phase two, due to the significant risk of care fragmentation and the imperative to preserve the central role of general practitioners (GPs), obstetricians and gynaecologists (O&Gs) in women's health.

The AMA further notes that IUD insertion is materially different and significantly more complex than the insertion of a hormonal contraceptive implant, as it requires additional skill, specialised equipment, and intrauterine instrumentation.

The most effective route to improved patient access to LARCs is through addressing persistent GP training bottlenecks and service provision barriers, not adding provider groups. As outlined in our response to the earlier consultation, wait times to access training courses

remain a major issue for GPs. The Department of Health, Disability and Aged Care should invest in addressing wait lists for GPs to undertake LARC insertion training and explore opportunities to improve contraception care within general practice.

The AMA welcomes the government's commitment to improving access to LARC services and acknowledges the positive steps taken to date. We emphasise that any changes to MBS items must uphold the following core principles: no net reduction in funding for existing services, protection of patient access and affordability, and support for GP-centred, O&G-integrated care. These principles underpin our feedback and reflect the AMA's longstanding position on sustainable, evidence-based reform.

Scope of practice for endorsed midwives

The AMA does not support EMs performing IUD insertion or removal. EMs and other midwifery or nursing professionals, though highly skilled, are not trained in intrauterine instrumentation (such as cervical dilation, paracervical block, or managing cervical shock/fainting) and do not have the scope of practice or spectrum of skills required to perform these procedures autonomously or without medical oversight. While we acknowledge the regulatory environment has shifted, the removal of formal collaborative arrangements does not negate the need for integrated care.

LARC procedures, though generally safe, are not without risk, and managing these complications is core to GP training — particularly in the context of comorbidities and complex patient histories. These complications include uterine perforation, migration, dislodgement, infection, device expulsion, and rare events such as heterotopic pregnancies (including tubal or cornual ectopics and co-located pregnancies). Prompt recognition and management of these complications are essential skills embedded in general practice and O&G training, especially when caring for patients with co-morbidities or complex histories.

If any consideration is given to contraceptive implant insertion by EMs, it should only occur where the midwife is also credentialled as a nurse practitioner (NP), with dedicated training and clinical governance comparable to MS-2 Step arrangements, and with clear escalation pathways to GP/gynaecology care. Complications such as migration, infection, and removal-related issues (including vascular and nerve damage, such as to the ulnar nerve) are uncommon but can occur. Managing these complications requires advanced surgical skills and experience.

Given the invasive nature of IUD procedures and the scope of endorsed midwifery, EM involvement should not extend to IUD insertion or removal. Hormonal contraceptive implant insertion may be considered only for NPs under strict governance.

We do not support endorsed midwives independently prescribing LARC devices or medications without medical oversight. The current regulatory context lacks clarity in this regard, and we do not support authorising EMs to prescribe and/or insert LARC devices

without the involvement of a GP or O&G. This could compromise patient safety and continuity of care.

It is concerning the department intends to proceed with substantial policy changes when it is unable to provide robust data on the current extent of LARC services delivered by EMs. Evidence-based reform should be underpinned by a clear understanding of existing service delivery patterns, including the number of EMs performing LARC procedures, the settings in which these occur, and the outcomes for patients. The absence of such data introduces unnecessary risk and uncertainty into the policy process.

Expanding scope without robust governance risks undermining clinical standards. Any policy change must include clear clinical governance frameworks, training requirements, and escalation pathways for complications. Reforms must never prioritise convenience over safety.

Barriers to LARC service provision

Internal consultations with AMA members consistently highlight the principal barrier to expanding LARC access is not a shortage of willing providers, but rather a significant bottleneck in training opportunities for GPs. Many GPs are eager to offer LARC services but face protracted delays — sometimes several years — before they can access accredited training. The recent government commitment of $25.1 million to establish Centres of Training Excellence is a welcome development, but its success will depend on transparent implementation and a clear focus on reducing GP wait times. Innovative approaches, such as mobile training units for rural and remote areas and flexible delivery models, should be prioritised. Furthermore, increasing Medicare rebates for postnatal checks would incentivise GPs to upskill and expand their scope of practice in this area.

An additional barrier is private health insurance coverage. Several insurers do not cover LARC procedures under general anaesthetic in private hospitals, which limits access for women who require general anaesthetic for clinical or trauma-related reasons and consequently reduces uptake. The AMA recommends the department engage with private health insurers to restore or standardise coverage for LARC under general anaesthetic, ensuring equitable access comparable to procedures such as vasectomy.

Expanding provider groups does not automatically improve access in rural and remote areas. Endorsed midwives are concentrated in metropolitan settings, so this proposal will not address the most significant access gaps. Investment in GP training remains the most effective lever for equity.

Appropriateness of new MBS items for endorsed midwives

The AMA does not support the immediate introduction of new MBS items for EMs to claim for LARC insertion and removal. The central issue is system safety and appropriate clinical scope. Expanding EM access to IUD items would compromise standards and fragment care. Access to MBS items for contraceptive implant insertion should be restricted to nurse practitioners

under defined governance arrangements. We urge the department to focus on resolving bottlenecks within general practice before diversifying provider groups. Only once there is a comprehensive understanding of the current and potential contribution of EMs, and once GP access issues are resolved, should the question of new MBS items for EMs be revisited.

LARC provision in the postnatal period

The AMA strongly cautions against granting EMs independent access to MBS items for LARC procedures during the postnatal period. Physiological changes in the postnatal period remodel the reproductive tract, which increases the risk of IUD expulsion and perforation — especially within six weeks after a vaginal birth, 12 weeks after a caesarean section, and during breastfeeding. Given the postnatal scope of EMs is generally limited to less than eight weeks, there is no clear role for EM access to IUD removal or insertion item numbers. GP or O&G involvement is warranted to manage complications, ongoing bleeding/infection, and comprehensive postpartum assessments.

This is a critical window for re-engagement with general practice, where GPs can provide holistic postnatal care, including contraception counselling, management of complications, and broader health assessments. Fragmenting care at this juncture is likely to undermine patient safety and continuity.

Additional considerations

It is important to recognise the number of EMs with a scheduled medicine endorsement remains relatively small — approximately 1,300, or three per cent of the total midwife workforce, according to the 2023–24 Ahpra annual report. Even fewer work in community or marginalised settings, particularly in rural and remote areas where access challenges are most acute. Any policy change must be grounded in a realistic appraisal of workforce distribution and capacity.

The most effective way to improve access is to focus on enabling O&Gs, alongside GPs — who are already embedded in communities nationwide — to deliver these services. We call for transparent reporting on the implementation and impact of phase one reforms and use these results to determine whether further reform remains necessary. Success metrics should include patient outcomes, out of pocket costs, and workforce participation, with a formal review after 12–24 months to identify unintended consequences.

Complexity and MBS item structure

The AMA supports the MRAC's recommendation not to introduce separate MBS items based on procedural complexity. Attempting to stratify LARC procedures by complexity would add administrative burden and risk unintended consequences, such as inequitable patient charges. A general increase in MBS rebates, coupled with the ability to co-claim for related services, is a more pragmatic and equitable approach.

To address genuine complexity without perverse incentives, the AMA proposes adjunct items for specific components when clinically indicated, such as paracervical block, cervical dilation,

and ultrasound-guided intrauterine retrieval. These adjunct items would support safe in-rooms management, reduce theatre dependence and target reimbursement to real clinical inputs, particularly in regional/remote settings.

The AMA recommends the department adopt explicit guidance that consultation items may be co-claimed with LARC procedures as clinically appropriate. This direction should clarify whether insertion and removal may be co-claimed when both occurred at the same encounter (e.g. removal of an existing device with immediate insertion of a different device). This is important to uphold informed consent, clinical standards and support compliance with Medicare requirements.

Pharmacy-based models

The AMA supports MRAC Recommendation 5 not to extend LARC MBS access beyond NPs (phase one) and EMs (under MRAC consideration), thereby excluding other provider groups at this time.

We welcome the government's commitment to improving access to LARC services and acknowledge the positive steps taken to date. However, we urge the department to focus on resolving the training and access barriers faced by GPs before expanding the range of providers eligible for MBS rebates. Any reforms must be grounded in robust data, prioritise patient safety, and support the central role of general practice in women's health. The AMA stands ready to collaborate with the department to ensure policy changes deliver tangible benefits for women across Australia.

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