RACGP submission to the Senate inquiry into universal access to reproductive healthcare

December 2022

RACGP

Contents

1.About the RACGP

The Royal Australian College of General Practitioners (RACGP) is Australia's largest professional general practice organisation, representing more than 43,000 members working in or towards a career in general practice including four out of five general practitioners (GPs) in rural Australia. We cultivate a stronger profession by helping the GPs of today and tomorrow continue their professional development throughout their careers, from medical students and GPs in training to experienced GPs. We develop resources and guidelines to support GPs in providing their patients with world-class, best practice healthcare. Our members are supported to be involved in all areas of care including preventive care, mental health, chronic disease, aged care, and Aboriginal and Torres Strait Islander health. We also provide the knowledge and tools for GPs to establish, manage and enhance their clinical practices so they can run a full-service healthcare offering to their patients, families, and communities they operate in.

2.Introduction

General practitioners (GPs) are the first point of contact for most Australians seeking healthcare. (1) GPs establish continuous and trusting clinical relationships with their patients in all stages of their life. This relationship means that GPs are well positioned to manage sensitive and interrelated issues including relationships, domestic violence, mental health, sexual health, contraception, smoking, alcohol and drug use.

The areas of sexual and reproductive health and pregnancy care constitute a significant proportion of general practice healthcare services. GPs are the core providers of these services and are well placed to reassess the changing needs of people across the reproductive lifespan and discuss alternatives. Furthermore, preventive health advice from GPs has significant individual health benefits and is economically more beneficial for the health system.

The RACGP welcomes the opportunity to provide comments on the Senate inquiry into universal access to reproductive healthcare (the Inquiry). We provide comment on the relevant Inquiry terms of reference that impact on general practice and patients seeking reproductive healthcare, highlight the role of general practice in this care, discuss regulatory and cost barriers to patients seeking access, call attention to workforce and training barriers that impact GPs and outline measures that could be implemented to improve access to reproductive healthcare.

The RACGP publishes the following relevant guidelines:

- Guidelines for preventive activities in general practice (Red Book)
- National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people
- Abuse and violence - Working with our patients in general practice
- Smoking, nutrition, alcohol, physical activity (SNAP).

3.Key messages and recommendations

Regulatory and cost barriers for patients

- There is a need for safe, affordable and accessible medical and surgical abortion services for those who need them.
- The PBS should list new and emergency contraceptives to improve affordability and accessibility to patients; particularly those with limited disposable incomes.
- Access to the full range of contraceptive options is critical and should not be limited by availability (location and timing) or cost.

- Copper IUDs should be available on the PBS for women requiring or desiring non hormonal options and/or emergency contraception.
- The Medicare patient rebate for insertion of an IUD (item 35503) should be increased
- Patients should be able to access all efficacious menopause treatments on the PBS and not be inhibited by price increases for some treatments.

Training and workforce

- Financially supporting GPs that wish to train in surgical abortion provision should be considered.
- Access to skills-based training in the community (ie LARC insertion and removal and medical abortion provision) should be improved.
- Access to training in LARC insertion and removal needs to be supported by appropriate funding such as training incentives as well as improved Medicare funding to support future provision of these services.
- Ongoing support for initiatives such as the AusCAPPs network, which supports primary care practitioners to both initiate and sustain LARC and medical abortion service provision through an online community of practice
- Government incentives be provided similar to what is offered in the Rural Procedural Grants Program for GPs who provide procedural and/or emergency medicine services in unsupervised settings in rural and remote areas
- Government incentives to support GP access to more affordable training opportunities across all areas of reproductive health, particularly in areas of demonstrated workforce shortage.

Measures to improve access

MBS

- The continuation of sexual and reproductive health telehealth item numbers to improve access to GPs and essential sexual and reproductive health care services.
- The RACGP recommends the temporary telehealth items for non-directive pregnancy support counselling (items 92136 and 92138) be extended beyond 30 June 2023.
- Amend rules to allow GPs to bill MBS Level C and D time-based attendance items (36, 44, 91801, 91802, 91894) for antenatal attendances that extend beyond 20 minutes. (Antenatal attendances regardless of the length of appointment are currently only allowed billing under MBS items 16500, 91853 and 91858). The RACGP also advocates for higher rebates for time based items to support GPs to spend more time with their patients on these often complex health issues.

Provision of termination of pregnancy services

- Removing barriers to accessing private abortion services could result in long-term savings to the public hospital system and relieve pressure on state and territory governments.
- Low and no-cost direct pathways through public hospitals must be more transparent and accessible especially for people in rural/remote areas as well as for patients with limited financial means.

Access to care

- Clear regional referral pathways for both medical and surgical abortion services are required so that GPs can confidently provide care and know that assistance from specialist services is available

- Harmonisation of legislation between states and territories on access to termination of pregnancy services
- Ensure access to antenatal care in rural and remote areas (including hospitals) to enhance antenatal support for pregnant people.

Other measures

- Addition of medicines for medical termination of pregnancy to the Prescribers Bag would improve access for those patients in rural and remote areas.
- Expanding the Workforce Incentive Program to provide more funding and flexibility to encourage more general practice-based pharmacists and provide more opportunities for pharmacists to work in a setting with medical supervision.

4.Response to Inquiry terms of reference for universal access to reproductive healthcare

4.1 *Terms of reference a:* Cost and accessibility of contraceptives

4.1.1 PBS coverage and TGA approval processes for contraceptives

4.1.1.1 PBS coverage

The RACGP acknowledges that access to a full range of contraceptive options is critical and should not be limited by availability (location and timing) or cost. Contraceptive agents such as the vaginal ring, newer forms of combined oral contraceptive pills and the new progestogen only pill are currently not listed on the Pharmaceutical Benefits Scheme (PBS). This limits access of these contraceptives to people who can obtain a private prescription and pay to receive the script. Copper intrauterine devices (IUDs) should also be available on the PBS for people requiring or desiring non- hormonal options and/or emergency contraception. The RACGP supports PBS listing for new and emergency contraceptives to improve affordability and accessibility to patients; particularly those with limited incomes.

4.1.1.2 TGA approval process for contraceptives

- The TGA approval process is important but can limit the types of contraceptives available to people in Australia. For example, Sayana® Press is not available in Australia despite evidence of effectiveness and safety,[(2)] likely due to the cost of registration and approval processes. This limits access to available safe and effective contraceptives. The RACGP proposes a revision of registration costs so that other safe contraceptive options can be accessed.
- Established processes and existing mechanisms (Commonwealth medicines policy and the stringent processes of the TGA) that determine the scheduling of medicines and which health professionals can safely prescribe should not be bypassed. Any medicines, including contraceptives, must be appropriately assessed through the TGA process for potential down scheduling to be made available over the counter (Schedule 3).

4.1.2 Awareness and availability of long-acting reversible contraceptive and male contraceptive options

International evidence has demonstrated that long-acting reversible contraceptives (LARCs) can reduce unintended pregnancy and abortion rates across all stages of a person's reproductive life. [(3)] GPs play a vital role in the provision of contraception services and supporting pregnancy options. However, the number of providers delivering LARCs (including copper and progestogen only IUDs, and progestogen subdermal implants and injections) is still very low, particularly in rural and remote areas.[(4)] This is due to a range of reasons, such as lack of training opportunities, appropriate remuneration, access to peer and expert support, and referral pathways. [(5)] A recent Australian study has demonstrated online training with GPs on effectiveness-based contraceptive counselling and the provision of a rapid referral pathway to

LARC insertion clinics resulted in increased LARC uptake by female patients.[3] This study provides a model of care that could be replicated Australia wide to support increased LARC uptake.

There are limited skills-based training opportunities for GPs in LARCs and LARC insertion which has been identified as a barrier to increasing LARC uptake in Australia. [4] The RACGP recommends:

- increased availability of skills-based training in community settings to enable more GPs and GPs in training to train in LARC insertion and removal and medical abortion provision
- government incentives to support training particularly in areas of demonstrated workforce shortage
- ongoing support for communities of practice, such as the AusCAPPs network. This supports primary care practitioners to both initiate and sustain LARC and medical abortion service provision. The RACGP is a partner together with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Department of Health and Aged Care and other key stakeholder organisations in this initiative.

Cost is also a barrier that patients encounter when trying to access LARCs. Contraceptives such as IUDs in Australia vary in price (for example, Copper IUDs are not a PBS item whereas the levonorgestrel IUD is) and the cost of insertion may involve a gap fee. The RACGP recommends:

- cost for Copper IUDs are covered by the PBS
- further increasing the Medicare patient rebate for insertion of an IUD (item 35503) so the rebate truly reflects the cost of providing this service in general practice.

GPs also play a pivotal role in improving health literacy around male contraceptive options. In Australia, condoms and vasectomy are the main forms of contraception with the birth control injection remaining unavailable to the public. Some GPs can perform non-scalpel vasectomy, while others refer patients to appropriate services.

4.1.3 Options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions

4.1.3.1 Barriers to access

A patient's regular GP is best placed to undertake comprehensive patient centred contraceptive counselling on the many contraceptive options that are currently available. The GP can discuss options best suited to the patient's needs, taking into consideration their social, cultural and medical background, and will regularly monitor for potential side effects. As not all patients are able to take the contraceptive pill, the GP who knows their patient can advise on suitable options while managing any other health concerns.

Access to services in Australia is impacted by location, socioeconomic status [6] and factors including culture, religion, language and health literacy. Appropriate access to maternal and infant health services remains a challenge within rural, remote and Aboriginal and Torres Strait Islander communities, which can lead to corresponding negative long-term consequences. [7] For example, long waiting times to access a GP in rural areas are problematic for people who need contraception or scripts renewed.

Access to contraception and termination of pregnancy should not be limited in hospitals (public or private) by historical religious origins of these institutions. Both public and private hospitals receive taxpayer funding either directly or via private health insurance rebates, so it is expected that patient care will be prioritised according to their needs not by historical religious views.

The RACGP recommends the following measures to improve access:

- Indefinitely continuing the recently introduced sexual and reproductive health telehealth item numbers (time-based item numbers which cover Level A to D, telephone, and video consultations and which have no patient restrictions) are of great benefit. Increasing awareness of the availability of these item numbers is required amongst GPs and the public.

- Addition of medicines for medical termination of pregnancy including mifepristone and misoprostol to the Prescribers Bag would improve access for those patients in rural and remote areas.
- Allowing greater quantities of contraceptive pills to be dispensed at one time would potentially decrease discontinuation rates

4.1.3.2 Pharmacist interventions

While pharmacists can play an important role in educating people about correct medication use and potential side effects, they are not trained to conduct consultations regarding contraceptive options and reproductive health and cannot offer or directly connect patients with the full range of contraceptive options. Risks of providing these drugs without a prescription from a medical practitioner often outweigh the benefits of increased convenience. (8)

It is important that recommended treatment guidelines for the provision of emergency hormonal contraception are carefully followed by pharmacists. Emergency contraception is a safe medicine and acceptable to request without prescription. However, many people may experience stigma when they try to purchase emergency contraception or are denied access.

Consultations about termination of pregnancy should be conducted in mainstream general practice, or in specialised women's health clinics where there is access to patient records and ongoing continuity of care.

The RACGP's concerns regarding pharmacist interventions include:

- Pharmacists working in isolation do not have access to full patient history and medical records.
- A solo pharmacist cannot step away into a consulting room. Despite the availability of consultation rooms in some (not all) pharmacies, evidence shows these are not well-utilised and sensitive conversations are happening at the counter. (9-12)
- There is evidence that community pharmacies also lack cultural safety and appropriateness and in some cases community pharmacists seemed to be unaware that Indigenous people often feel uncomfortable entering their pharmacies. (13-18)

Pharmacists could provide free condoms and remind health consumers for the need to reschedule their doctors' appointments when dispensing their last scripts. The RACGP recommends expanding the Workforce Incentive Program to provide more funding and flexibility to encourage more general practice-based pharmacists would provide more opportunities for pharmacists to work in a setting with medical supervision.

4.2 *Terms of reference b:* Cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas

4.2.1 GP role in providing comprehensive reproductive care

GPs are often the first point of contact for people seeking support regarding pregnancy and unplanned pregnancy. Pregnancy care encompasses the full spectrum of reproductive health from menstruation, contraception, unplanned pregnancies, preconception, antenatal, intrapartum, postnatal care, menopause and termination options, with a focus on patient wellbeing, patient safety and joint decision-making. Patient counselling regarding these issues helps facilitate shared decision making so that people can make informed decisions. This requires extended consultation times. As mentioned in section 4.1.3.1, sexual and reproductive health telehealth item numbers (time-based item numbers which cover Level A to D, phone, and video consultations and which have no patient restrictions) are of great benefit in supporting patient access and should be continued indefinitely.

4.2.2 Cost barriers to people seeking Menopause Hormone Replacement Therapy

GPs can assess and promote health as well as counsel patients about Menopause Hormone Replacement Therapy (MHRT). Despite menopause treatments being available on the PBS the cost of these treatments are often out of reach for patients, particularly those with limited income. Recent price increases in some treatments have added a further barrier to this access and enhances healthcare inequality in the Australian health system. (19)

4.2.3 Antenatal care through the Medicare Benefits Schedule (MBS)

Routine antenatal attendances are covered by MBS items 16500 (face-to-face), 91853 (video) and 91858 (phone). These items have a rebate of $42.40 regardless of the duration of the consultation.

Advances in science and technology have seen the provision of antenatal care evolve significantly over the years. There is now much higher expectations of care provision and a greater awareness of mental health issues and the health impacts of domestic violence. Antenatal consultations involve extensive monitoring of health problems and potential complications (eg diabetes, anaemia), providing genetic counselling, advice on nutrition and physical activity, and preparing the mother for childbirth and breastfeeding.

As such, they are often complex consultations and can extend well beyond 20 minutes. This is particularly true among vulnerable and disadvantaged patient groups, such as those in rural and remote communities, Aboriginal and Torres Strait Islander patients and culturally and linguistically diverse patients.

Results from an RACGP member poll of asking, 'What proportion of your antenatal care appointments last longer than 20 minutes?' indicated almost two-thirds of respondents reported more than 75% of their appointments lasted longer than 20 minutes. A further 23% of respondents reported that between 50–75% of their appointments last longer than 20 minutes, supporting that consultations are taking longer than 20 minutes and need to be valued accordingly.

GPs are well placed to provide holistic, individualised care in line with the Department of Health and Aged Care's Pregnancy Care Guidelines, however they must be financially supported to do so. As the COVID-19 pandemic continues, it is more important than ever that we have a well-resourced, sufficiently remunerated general practice workforce able to support our midwifery and obstetric colleagues.

GPs who provide antenatal care are highly skilled and play a pivotal role in areas where there is a lack of other specialists due to workforce shortages, as well as reducing demand on busy hospital outpatient departments. During the pandemic, many patients who previously received antenatal care in a hospital setting have instead accessed this care through the primary care sector. GPs have augmented the work of hospital-based doctors and must be appropriately supported to deliver this critical care.

We understand that our members are restricted to billing MBS items 16500, 91853 and 91858 for antenatal attendances regardless of the length of appointment. To resolve this issue, as a matter of priority, the RACGP recommends that rules be amended to allow GPs to bill MBS Level C and D time-based attendance items (36, 44, 91801, 91802, 91894) for antenatal attendances that extend beyond 20 minutes.

This is a simple and positive step that can be taken to support pregnant patients, children, and families. Patients should be able to access a higher rebate if a consultation is longer or more complex, just as they can for other consultations or conditions. A private survey on this topic conducted last year by Dr Wendy Burton, Chair of the RACGP's Antenatal and Postnatal Care Specific Interests Group, received more than 1000 responses. When asked whether the Medicare rebate is sufficient for an antenatal attendance in 2021, 99.2% of respondents selected 'no'. 89.4% of respondents said antenatal care has become more complex over the course of their medical lifetime, while 99.1% believe GPs should be able to co-claim time- or complexity-based Medicare rebates for elements of antenatal attendances.

It is critical that MBS policy and funding keeps up to date with evidence-based care to ensure the best health outcomes for patients.

4.2.4 Provision of termination of pregnancy services in general practice

The RACGP fully supports the right for women to be able to access abortion when desired or required. Access to safe and affordable medical or surgical abortion services for those who need them is essential.

A GP's involvement in the provision of termination services will be determined by personal, cultural and religious beliefs, and our profession's guiding ethical principles. GPs should always be guided by the principles laid out in the Medical Board's Good medical practice: a code of conduct for doctors in Australia. The right of GPs and other healthcare

providers to conscientiously object from providing such care must be respected – however, if they do object, providers must treat patients with respect and refer them to other services to access this care.

While the RACGP supports the need for affordable and accessible medical and surgical abortion services, we do not support the creation of specific MBS items for medical termination of pregnancy services in general practice. Single disease focussed MBS items tend to be inconsistent with the generalist approach to care GPs are trained to provide. A greater priority for allocation of health funding should be supporting patient access to comprehensive, continuous general practice care, where a patient and their GP can determine which assessments and interventions are required to support the patient to remain well. Specific MBS items for abortion could also lead to privacy issues and stigmatise this service, as specific MBS item numbers will appear on the patient's Medicare record. Likewise, pathology reports, medicines information and other summary documents are uploaded to My Health Record by healthcare organisations, unless a patient explicitly communicates withdrawal of consent for this information to be uploaded.

The RACGP does not support expanding access to abortion services through mandatory bulk billing of MBS items. General practices are small to medium-sized enterprises which have faced significant and sustained viability pressures and increased overheads over the last decade, which have worsened during the COVID-19 pandemic.

Requiring GPs to bulk bill not only goes against the allowance for medical practitioners to set their own fees, but is also inappropriate due to the current inadequate level of patient rebates. Current rebates are not adequate to cover the cost of providing medical abortions, which includes highly skilled person-centred care accounting for factors such as education about all options in unplanned pregnancy, contraceptive needs, interaction with co-morbid health conditions, cultural diversity, trauma, domestic violence, and abortion stigma itself. The rebates also do not cover practice nurse time in supporting medical abortions. If practices become financially unviable and are forced to close, patients will no longer have access to high-quality, local and accessible general practice care. The results of this would be devastating to the health and wellbeing of the community and the capacity of the broader healthcare system.

GPs can be trusted to apply their usual billing practices and exercise discretion (eg if patients are clearly unable to afford out-of-pocket costs).

Low and no-cost direct pathways through public hospitals must be more transparent and accessible for people in rural/remote areas as well as for those of limited financial means. Direct GP phone access to termination clinic teams located in public hospitals would aid timely referral.

Removing barriers to accessing private abortion services could result in long-term savings to the public hospital system and relieve pressure on state and territory governments. Therefore, there could be benefit in state/territory governments funding a mechanism to reimburse patients for costs incurred. However, the RACGP is open to a mechanism to reimburse patient out-of-pocket costs for these services funded at either a federal or state level.

The RACGP also recognises the need to maintain patient choice in terms of having access to either a medical or surgical abortion. GPs should be supported to train in surgical abortion provision so that this service is available in community settings and in rural hospitals so that it is truly an accessible option.

4.2.5 MBS telehealth items for blood borne viruses, sexual and reproductive health services, and pregnancy counselling

On 1 July 2021, eight new MBS GP telehealth items were introduced for blood borne viruses, sexual or reproductive health consultations (video and telephone). These items are time-based and can be used for services related to blood borne viruses, sexual or reproductive health, excluding assisted reproductive technology and antenatal care. Section 100 drugs can be prescribed under these items, if clinically relevant.

Unlike most GP telehealth items, these items do not require a patient to have an existing clinical relationship with the GP providing the service (ie the patient has had a face-to-face consultation in the past 12 months). The RACGP recommends these items be continued beyond 30 June 2023 when they are scheduled to expire. Enabling access to sexual and reproductive health services via telehealth provides flexibility and choice for patients to consult with their GP (or an alternative GP to their usual GP if they do not provide medical termination of pregnancy or is a conscientious objector) on sensitive health matters.

Similarly, we recommend the temporary telehealth items for non-directive pregnancy support counselling (items 92136 and 92138) be extended beyond 30 June 2023. These items are also exempt from the existing clinical relationship requirement for MBS telehealth services.

4.2.6 Rural and remote access to reproductive care

4.2.6.1 Access to termination of pregnancy services

The RACGP recognises the significant access barriers to reproductive healthcare for patients in rural and remote communities across Australia, especially those who wish to access termination of pregnancy services. Cost is a key barrier to accessing these services. Low and no-cost pathways through hospitals and other settings must be more transparent and accessible for these people living in rural and remote communities.

There are also access issues for many rural GPs who want to provide termination services. These include hospital services being too far away, a lack of access to blood products, lack of access to a gynaecologist to provide backup care in the rare event it's needed, as well as difficulty accessing relevant drugs from pharmacies. The RACGP recommends clear regional referral pathways for both medical and surgical abortion services so GPs can confidently provide care and know that assistance from specialist services is available when required and that women will not be turned away if they present to hospitals or emergency departments needing care.

Furthermore, access is inhibited by legislative variations between states and territories which GPs must be aware of when offering or referring for medical and surgical termination. Harmonisation of legislation would assist both patients and GPs.

4.2.6.2 Access to antenatal care in rural and remote areas of Australia

Access to antenatal care in rural hospitals is limited in rural and remote areas, with some hospitals no longer supporting deliveries. Availability of these services within rural and remote hospitals would enhance antenatal support for pregnant people.

4.3 *Terms of reference 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

As healthcare needs of people capable of pregnancy constitute a significant proportion of the general practice healthcare services, GPs need to continue to develop and maintain skills in the areas of sexual and reproductive health, pregnancy care and mental health, and in recognition and provision of support to people who are victims of abuse and violence. Promoting education opportunities and upskilling the medical workforce is vital to increasing the availability of services for people who need them across Australia.

In Australia access is inhibited by poor Medicare funding and a lack of minimum service standards in public hospitals. Access to reproductive healthcare services is improved by the wide distribution of GPs, availability of telehealth, expanded training of GPs and GP-led teams that are supported by practice nurses. Improving access to GP services has additional benefits to patients in less care fragmentation and often less expensive than having substitute providers provide specialised services that then need additional support from hospitals and GPs.

4.3.1 Funding for further GP training

Limited skills-based training opportunities for GPs in LARCs counselling and insertion has been identified as a barrier to increasing LARC uptake in Australia. [3] A recent Australian study demonstrated that online training completed by GPs on effectiveness-based contraceptive counselling and the provision of a rapid referral pathway to LARC insertion clinics resulted in increased LARC uptake by female patients. [2]

Access to training in LARC insertion and removal needs to be supported by appropriate funding such as training incentives as well as improved Medicare funding to support future provision of these services. This includes higher patient rebates for longer consultations, and ongoing availability of telehealth sexual and reproductive health care item numbers. The RACGP recommends government incentives be provided similar to what is offered in the Rural Procedural

Grants Program for GPs who provide procedural and/or emergency medicine services in unsupervised settings in rural and remote areas. This will support GPs with access to relevant educational activities to maintain or update their skills and increase access to appropriate learning opportunities.

4.3.2 Supporting learning opportunities for GPs in training

The RACGP curriculum and syllabus describes the core competencies and learning outcomes of GP education. Within the curriculum, there are units related to pregnancy and reproductive health, sexual health and gender diversity as well as a women's health unit.

The RACGP curriculum and syllabus informs the development and delivery of training programs, including for Continuing Professional Development (CPD). This ensures GPs in training achieve the required competencies to achieve RACGP Fellowship. It is important that GP training includes access to educational activities and skills-based training in these areas for all GPs in training. There are currently limited opportunities to undertake skills-based training in community settings with GPs experiencing long delays. In addition, courses run by external providers incur a significant cost >$2000 with additional loss of income for the time taken to undertake the training.

In addition, during Australian General Practice Training (AGPT) program, GPs in training have the option to complete 6 months in an extended skill placement. This may be in a variety of areas but may include working in a Family Planning clinic or in a hospital post to complete a Diploma of Obstetrics. The Rural Generalist (RG) Fellowship also includes additional rural skills training which may be in Obstetrics. It is important that GPs in training also have access to training in other areas such as LARC insertion and removal and abortion service provision training opportunities in these areas. New approaches to ensure that these skills are developed in all trainees are required.

There are opportunities to support GP skills development in LARC insertion and removal and termination services as well as family planning courses, where they choose to do so. However, appropriate government funding is required to support the provision of the courses as it is expensive and currently only available at the GP's own expense.

The RACGP recommends:

- increased availability of skills-based training in community settings to enable more GPs and GP trainees to train in LARC insertion and removal and medical abortion provision
- government incentives to support training particularly in areas of demonstrated workforce shortage
- Ongoing support for the AusCAPPs network which provides peer support through an online community of practice.

4.3.3 Credentialing

The RACGP does not support micro-credentialing as professionals should work within their scope of practice and seek relevant education to match the need of their patient populations. Credentialling of GPs will only put up more barriers to accessing appropriate reproductive services. There may be circumstances where formalised shared care pathways exist that require a GP to have engaged in learning about local protocols prior to being identified as a provider of shared obstetric care.

4.4 *Terms of reference d:* Best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery

Access to culturally safe, appropriate, and timely family planning and pregnancy services is vital to ensuring positive health outcomes for pregnant people and babies.[20] The RACGP is well placed to have a role in facilitating further training regarding best-practice approaches to sexual and reproductive healthcare.

As mentioned in section 4.3, GPs in training are required to undertake three contextual units focused on sexual and reproductive care. These units are supported by learning outcomes where they need to provide culturally appropriate care as well as trauma-informed care.

The RACGP supports CPD activities focused on sexual and reproductive health. Examples of RACGP educational activities include:

- A recent webinar focused on long-acting reversible contraceptives, GPs and medical abortion challenges barriers and safety and preparing your practice for medical abortion.
- The Australian Journal of General Practice (AJGP) which is the official journal of the RACGP has had editions related to reproductive health and pregnancy.
- Check, which is an independent learning program used as a CPD activity includes case studies with feedback. Each edition has a specific monthly topic; several have been relevant such as sexual health and women's health.
- *gplearning* is an online portal that provides education for GPs. This includes several modules related to pregnancy care.

In addition, the RACGP *Guidelines for preventive activities in general practice* (The Red Book) and the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, Chapter 2 Antenatal care provide guidance and are relevant to pregnancy care.

Furthermore, the RACGP Specific Interests Faculty has a specific interest group for sexual health medicine and antenatal and postnatal care. These groups provide a community of practice that promotes further education in sexual and reproductive healthcare.

5.Conclusion

GPs are the first point of contact for most Australians seeking sexual and reproductive healthcare and play a vital role in the provision of preconception, contraception, pregnancy options, counselling and medical abortion across the country. GPs also play a role in the coordination of these services. However, an integrated health system is required to support and improve patient access to timely sexual and reproductive information and healthcare.

Thank you again for the opportunity to provide feedback on the Inquiry. For any enquiries regarding this submission, please contact Stephan Groombridge, eHealth, Standards and Quality Care Manager on 03 8699 0544 or stephan.groombridge@racgp.org.au.

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