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Royal Australian College of General Practitioners

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10 November 2025

Professor Sally Green
Chair
MRAC Long-Acting Reversible Contraceptive Review Consultation

Via: LARC.MRAC@health.gov.au

Dear Professor Sally Green,

Thank you for providing the opportunity to comment on the Medicare Benefits Schedule (MBS) Review Advisory Committee (MRAC) long-acting reversible contraception (LARCs) working group draft report.

The Royal Australian College of General Practitioners (RACGP) is the voice of specialist general practitioners (GPs) representing more than 50,000 members in our growing cities and throughout rural and remote Australia. For more than 60 years, we have supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

The RACGP welcomed the Federal Government's $792.9 million package for women's health announced earlier this year, including new funding for menopause health assessments and increased funding and GP training for LARCs.

Women across Australia need better access to affordable and comprehensive care for their unique health issues. There is no substitute for the quality care you get from a GP who knows you and your history. Specialist GPs play a vital role in the provision of contraception advice and services. This funding will better reflect the cost of providing this service in general practice and immediately improve access to affordable and high-quality care from GPs for those who need it. This is particularly impactful for women living in rural and remote locations, where access to LARC insertions can be limited.

We have provided specific feedback in our submission to the previous consultation in February 2025. Below is our response to the Phase 2 recommendations (see further details in appendix A, page 3):

- Where non-medical practitioners perform these procedures in the primary care setting it must occur within the context of a multidisciplinary team including a medical practitioner to ensure continuity, ongoing, coordinated care, follow-up, and alignment with the patient's broader health and fertility goals.
- Given the invasive nature of LARC procedures, MBS item access should remain limited to qualified practitioners, with any future expansion contingent on clear evidence of equivalent training, competency, and safety. Any practitioner performing these procedures must be held to the same standards of training, credentialling, indemnity and insurance as expected of other medical professionals.
- Although LARC insertion may appear to be a simple procedure to some patients and non-medical practitioners, the RACGP highlights that it involves inherent clinical risks and may present substantial procedural complexity in particular circumstances or patient population risk.
- Expanding access to comprehensive GP-led postpartum care (including contraception, mental health, pelvic health, breastfeeding support, and sexual health), while strengthening multidisciplinary collaboration with endorsed midwives through increased financial and logistical support, improves reproductive outcomes. Appropriate and safe collaboration ensures safe, skilled insertion of postpartum LARCs, which remain underutilised across Australia.

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- There is an urgent need for interoperable medical records to effectively support multidisciplinary teams, particularly in pregnancy and reproductive health care. Clinical advice regarding pregnancy spacing, contraceptive options, and long-term chronic disease risk is often informed by events during pregnancy and birth. Appropriate information sharing between all health professionals involved in a woman's care is essential to ensure continuity, safety, and quality of care by a GP who knows them best.

We emphasise the critical role of GPs in improving access to reproductive health care. With rising out-of-pocket costs limiting patient access, appropriately funding GP services is a cost-effective way to deliver care. State and Commonwealth initiatives that establish alternative funded services often place greater expense on the overall health system. Supporting GPs to provide services such as pregnancy care, termination services, and LARC provision, including through bulk billing and improved rebates, provides best-practice and sustainable care for women within the community.

More broadly, Medicare funding has not kept up with the cost of delivering care and this is impacting affordability of services for patients. The RACGP continues to call for a 40% increase to Medicare rebates for Level C (20–40 minutes) and Level D (40-minutes plus). To best support complex multidisciplinary team care, RACGP has called on the government to increase the workforce incentive payment by 50% to support the expansion of multidisciplinary care in general practice. Patient rebates are lower per minute for longer consultations, disadvantaging people who require more time with their GP. Currently, many patients seeking bulk billed care can only access shorter consultations, exacerbating access issues for those most in need, including women with complex health issues.

I would welcome the opportunity to discuss this further. Please contact Samantha Smorgon, National Manager – Funding and Health System Reform, on (03) 8699 0566 or via samantha.smorgon@racgp.org.au if you have any questions or comments regarding this letter.

Yours sincerely

Dr Michael Wright
RACGP President

Appendix A: RACGP feedback on Phase 2 of the MRAC's LARC draft report

Phase 2

Recommendation 4: That it is appropriate to expand MBS access to endorsed midwives (EMs) for hormonal (etonogestrel) implant insertion and removal, and for intrauterine device (IUD) insertion and removal, for the primary purpose of contraceptive care.

This recommendation is not supported by the RACGP in its current form.

It is imperative that insertion and removal of long-acting reversible contraception (LARC) is performed by a qualified medical practitioner with appropriate clinical knowledge, competency and experience. This includes the ability to counsel a patient regarding all their contraceptive options, including the benefits and risks of each in relation to a person's medical history and risk profile and the ability to manage potential side effects. Endorsed midwives' lack of clinical expertise beyond maternity care may impact on appropriate counselling of all contraceptive options.

Continuity of care, and ongoing long-term whole-of-person care are central to delivery of high-quality primary healthcare. LARC insertion/removal should represent just one procedure in ongoing, comprehensive, longitudinal, coordinated and safe care. Understanding of the patient's medical history, personal circumstances, and fertility objectives is critical to ensuring safe, patient-centred care, and ensuring that this one procedure is part of a broader, long-term health plan. Midwives and nurses who work in maternity services only provide care to women up to 6 weeks postnatally.

When specialist GPs introduce LARC they provide longitudinal follow-up care – they revisit how the patient is responding to the intervention, and they help with adherence. Midwives introducing LARC would be more likely to be limited to the episodic care postnatally, without the longer-term follow-up.

It is possible that endorsed midwives could be upskilled in Implanon insertion and removal, but for patient safety these procedures would need to be performed in a multidisciplinary team which includes a specialist general practitioner for safe management of any complications.

If MRAC does introduce MBS items for IUD/Implanon insertion/removal to be claimed by endorsed midwives, there must include requirements that the activity must be communicated back to the patient's regular GP.

Recommendation 5: Access to MBS items for LARC administration should not be extended to any other provider groups (other than NPs and EMs) at this time.

This recommendation is supported by the RACGP.

Given the invasive nature of the procedure and the need for specialised training and medical expertise, the RACGP supports limiting current MBS item access to other provider groups, with any future expansion to other provider groups to be considered only if evidence demonstrates appropriate training, competency, and safety.

Any practitioner performing these procedures must be held to the same standards of training, credentialling, indemnity and insurance as expect of other medical professionals performing these procedures.