24 February 2026

Committee Secretary
Senate Standing Committees on Rural and Regional Affairs and Transport
PO Box 6100
Parliament House
Canberra ACT 2600

RE: Rural, regional and remote Medicare access and funding

Dear Committee,

Women's Health NSW (WHNSW) is the peak body for 21 non-government community-based women's health centres (WHCs) in New South Wales (NSW). All our members are funded by NSW Ministry of Health under a Ministerial Approved Grant called the *Women's Health Program*. We work from a primary healthcare model that incorporates the social determinants of health. This sees our members actively work to counter sex role stereotyping and gender bias in medicine, systemic sexism, and violence against women. The women's health sector provides gender-sensitive and trauma-informed care that values women's own knowledge, skills, and their right to make informed decisions about their own health and wellbeing.

In the 2024–25 financial year, our members provided more than 114,549 occasions of service to women across NSW, incorporating more than 223,479 presenting health issues. More than half of those occasions of service (n=58,005) were to women in rural and regional areas, who made up 58.5 per cent of the clients serviced by the women's health sector (n=15,107 of 24,942). For more information about our work, see our latest annual report.

WHNSW appreciates this opportunity to provide the Senate Standing Committees on Rural and Regional Affairs and Transport with a submission relating to the inquiry into Rural, regional and remote Medicare access and funding. We see this Inquiry as presenting a critical opportunity to improve health equity. In the following pages we directly respond to the Terms of Reference for this Inquiry, preceded by a summary of recommendations.

I would be happy to speak further on any of these issues. I can be reached by phone on [redacted] or by email at ceo@whnsw.asn.au.

Regards,

[redacted]

Denele Crozier AM
Chief Executive Officer
Women's Health NSW

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

Summary of Recommendations

Recommendation 1: Look at additional measures to address workforce shortages and service gaps which drive health inequity for all Australians.

Recommendation 2: Ensure regular periodic review and increases to Medicare bulk billing loading for Modified Monash Model (MMM) 3+ locations to keep pace with rising cost of living and cost of providing services in rural, regional and remote areas.

Recommendation 3: Apply Medicare bulk billing loading for Allied Health services in Modified Monash Model (MMM) 3+ locations to reduce service gaps and ensure health equity for rural, regional and remote Australians experiencing socioeconomic disadvantage.

Recommendation 4: Remove restrictions to telehealth provision in rural, regional and remote areas, and provide greater flexibility with telehealth billing for mental health care plans and allied health consultations.

Recommendation 5: Investigate whether the way Medicare gap payments are collected could be reformed to mean patients with socioeconomic disadvantage are only required to have funds available to pay the gap, not the full cost of service.

Recommendation 6: Address service gaps in bulk-billed medical imaging across all regions of Australia to prevent emergency room presentations simply for the purpose of accessing medical imaging.

Recommendation 7: Maintain access to bulk billing for all Medicare-eligible patients in the Bulk Billing Practice Incentive Program (BBPIP) to ensure women experiencing financial abuse as part of domestic, family and sexual violence can access medical treatment.

Recommendation 8: Strengthen Medicare support for multidisciplinary, integrated rural, regional and remote care by valuing nursing, midwifery and allied health roles appropriately, supporting coordinated team-based models, and enabling flexible outreach so visiting specialists can operate effectively.

Recommendation 9: Investigate a Medicare bulk billing number for medical termination of pregnancy (MTOPs) that covers the complexity of these services, and the time invested by clinicians providing appropriate care and support.

Recommendation 10: Reinforce that pregnancy and gestational age can be determined without ultrasonography in rural, regional and remote areas (unless clinically indicated), alongside employing Medicare levers like increased rebates and practice level bonuses to provide greater incentive to sonographers to bulk bill ultrasounds in rural, regional and remote areas.

Recommendation 11: Review and expand Medicare item numbers for nurse practitioners and midwives to deliver a range of consultation types including telehealth, with rebates increased to support the sustainable employment of nurse practitioners and midwives in rural, regional and remote areas.

Recommendation 12: Create Medicare bulk billing items that recognise the provision of complex, trauma-informed care for the full range of healthcare service providers.

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

Recommendation 13: Remove or substantially increase the eight-week post-natal time period under which long-acting reversible contraception (LARC) is covered by Medicare to ensure equity of access for women with traumatic birth experiences, and those in areas where services are limited.

Recommendation 14: Ensure Pacific Australia Labour Mobility (PALM) workers in rural, regional and remote areas have equitable access to reproductive healthcare by implementing all ten calls-to-action outlined in the Australian Women's Health Alliance's 2025 *Reproductive Health and Rights for PALM Scheme Workers Statement*.

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

Over the following pages we respond on behalf of the NSW non-government organisation (NGO) women's health sector to the Australian Government's changes to rural, regional and remote Medicare access and funding. As a sector that operates across NSW, we are acutely aware that women in rural, regional and remote communities experience poorer health outcomes and reduced access to Medicare-funded services compared to women in metropolitan areas.

These disparities are structural and disproportionally impact young women, Aboriginal and Torres Strait Islander women, women with disability, women experiencing domestic, family and sexual violence, migrants and refugees, and women experiencing socio-economic disadvantage, including homelessness. These groups make up a significant proportion of the women who present at women's health centres across NSW.

We see this Inquiry as presenting a critical opportunity to improve health equity. To achieve health equity, Medicare reform must move beyond metropolitan assumptions to:

- Support place-based, multidisciplinary models of care
- Enable equitable access for rural, regional and remote communities
- Better meet the needs of priority populations.

The impact of the 1 November 2025 Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians

Address ongoing barriers to health equity for rural, regional and remote Australians

While all our members operate according to the Principles of Women's Health Care (WHNSW, 2017), each women's health centre has a different operating structure. Some women's health centres have inhouse general practitioners (GPs) as part of their multidisciplinary models, whereas others provide allied health services in conjunction with building referral pathways to GPs in their local community. In some instances, this structure is dictated by which service gaps exist in the community, however for others their ideal structure is impacted by workforce shortages.

Attracting and retaining GPs has been an ongoing challenge for many women's health centres. In our correspondence with Central West Women's Health Centre (situated in an MM3 location in Bathurst) regarding this submission, they wrote:

> *We found it incredibly difficult to attract a GP to our Centre. Our first attempt resulted in a local female GP attending just one morning per fortnight, only to realise her own practice was short-staffed and she couldn't sustain the commitment. We advertised widely, including through the local Primary Health Network (PHN), but to no avail. One Sunday evening, I was ready to give up, thinking that small country towns simply couldn't attract a GP.*
>
> *Then, on Monday morning, Dr Catherine Errey walked through the door. She was relocating from Engadine to Bathurst and had heard about our Centre through the PHN. Attracting and retaining a GP has always been a significant challenge, with workforce shortages, high service demand, and the rural location limiting available candidates. Those who do join face considerable pressures, and long-term retention can be difficult.*
>
> *Dr Catherine's commitment has been extraordinary—working two days per week for 70% of the Medicare rebate, driven by her strong sense of social justice. We are incredibly fortunate to have her, but this did not come without considerable effort and challenge.*

It took Central West Women's Health Centre five years in total to attract a GP to work at the centre.

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

Wagga Women's Health Centre (situated in a MM4 location) does not have a GP onsite, so relies upon local GPs to partner with to support the women they see. At present, they tell us from frontline experience, only four medical practices of the eighteen in Wagga Wagga currently offer full bulk billing options. Unfortunately, it is not uncommon for women to have wait two to four weeks for an appointment, with many of these practices closing their books to new patients due to appointment overload. For the very vulnerable clients this women's health centre sees, who often have experiences of complex trauma and socioeconomic disadvantage, the lack of timely access to affordable healthcare both increases risk and results in poorer health outcomes.

Even for women's health centres on the outskirts of Sydney's metropolitan area, like Blue Mountains Women's Health and Resource Centre, which is classified as a M1 location, there have been difficulties getting enough general practitioners. This women's health centre provides services focusing on women's sexual and reproductive clinical support, with doctors and women's health nurses, prioritising women who are disadvantaged in accessing mainstream services. Recruitment of such skilled doctors has been a difficult process, with 'word of mouth' and payment of incentives within a strained budget being offered to try to secure trained practitioners. Even during the centre's peak time where they had up to four women's health doctors at the centre, this still equated to only 70 per cent full time equivalent, as each doctor had to retain roles outside of the women's health centre for a liveable income. The doctors committed to working at the centre from a belief and commitment to its philosophy of equity, social justice and reversing disadvantages faced by women in accessing health care services.

In our correspondence with the Blue Mountains team regarding this submission, this team was supportive of the Australian Government's commitment to increasing bulk billing as good policy. They felt it should mean access to general practitioners for those requiring appointments in the community, however in practice, it isn't delivering this because even in this MM1 location, there are insufficient numbers of doctors to fill these roles, particularly in our case with the specialised requirements that a women's health centre may need.

All our members report ongoing barriers to health equity for rural regional and remote Australians, including:

- Workforce shortages and service gaps
- Limited access to bulk billing
- Higher out-of-pocket costs
- Significant travel time and expenses to access care.

These barriers have not been significantly reduced by the 1 November 2025 Medicare changes on access to primary care, including telehealth.

Recommendation 1: Look at additional measures to address workforce shortages and service gaps which drive health inequity for all Australians.

A uniform Medicare funding model fails to account for these rural, regional and remote realities and entrenches health inequity. It is our view that Medicare settings must explicitly acknowledge and compensate for rural, regional and remote disadvantage. We would like to see regular reviews and increases to the bulk billing loading for Modified Monash Model (MMM) 3+ locations that take into account the disadvantages of operating and providing services in rural, regional and remote locations. Doing so would ensure increases do not stagnate as cost of living and cost of providing services continue to increase.

Recommendation 2: Ensure regular periodic review and increases to Medicare bulk billing loading for Modified Monash Model (MMM) 3+ locations to keep pace with rising cost of living and cost of providing services in rural, regional and remote areas.

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

Meet growing demand for mental health and specialist support services

Women in the Northern Rivers continue to face significant barriers to timely, affordable Medicare funded care, according to the frontline experience of Women's Health Northern Rivers. Rural health inequities identified by the North Coast Primary Health Network (Healthy North Coast, 2024), which included difficulty attracting, recruiting and training staff, uneven GP workforce distribution across the Local Government Areas they service, a small specialist workforce, and a need for more after-hours GP services, mirror what this women's health centre sees daily. This is a population spread across a large geographic region, with limited service availability, and growing demand, particularly for mental health and specialist support.

Our Northern Rivers team has identified major workforce shortages in psychology, psychiatry, and specialist women's health. For example, in psychological services, North Coast providers report wait times from several weeks to several months, depending upon location and type of clinician sought. The gaps in specialist care sees women needing to travel to Tweed, the Gold Coast or Brisbane to access gynaecology, endocrinology or trauma-informed services. This leads to higher out-of-pocket costs and places some sorts of services out-of-reach for women experiencing socioeconomic disadvantage.

These workforce shortages are echoed in other rural, regional and remote areas, with Wagga Women's Health Centre also reporting that mental health services in their region are absolutely stretched to the limit. Most free or fully bulk billed mental health services, including the centre's own, have wait lists of three to six months. This sort of wait time presents a high level of risk both for the organisation, and most importantly, for the patient. The centre also operates the only free pelvic floor physiotherapy clinic available in Wagga Wagga. While there are a couple of excellent private providers in the area, for most of the women accessing the women's health centre because they are experiencing socioeconomic disadvantage, the cost of privately provided services is prohibitive.

Some of these service gaps could be reduced by applying bulk billing loadings for MM3+ services that extend beyond GP services. For example, the bulk billing loading could be applied to allied health, including psychology, accredited mental health social workers and physiotherapy, when the patient is referred by a GP who bulk bills them because they are facing economic hardship.

Recommendation 3: Apply Medicare bulk billing loading for Allied Health services in Modified Monash Model (MMM) 3+ locations to reduce service gaps and ensure health equity for rural, regional and remote Australians experiencing socioeconomic disadvantage.

Telehealth restrictions do not reflect rural, regional and remote realities

In rural, regional and remote areas, getting to a GP can be difficult, even once every twelve months. For Women's Health Northern Rivers, this was particularly evident during flooding events, and subsequent transport disruptions. This service sees ongoing demand for disaster-related mental health support, elevated distress among their service users, and reduced service access across the region. It is the view of our members that telehealth restrictions still do not adequately reflect rural, regional and remote realities. There is a need for greater flexibility with telehealth billing, particularly for mental health care plans and allied health consultations.

Recommendation 4: Remove restrictions to telehealth provision in rural, regional and remote areas, and provide greater flexibility with telehealth billing for mental health care plans and allied health consultations.

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

The extent to which current Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions in rural, regional and remote areas

Access to bulk billing is a significant issue for women who attend women's health centres across NSW. Women with socioeconomic disadvantage make up an increasing number of our clients. For example, in 2024–25 women on pensions, benefits or student allowances made up more than half of the women we saw (54.5%; n=7,993 of 14,653; data from 13 WHCs), whereas in 2023–24 this group represented only 41 per cent of our service users (n=7,494 of 18,289; data from 16 WHCs) (WHNSW, 2025).

Frontline experience from the Women's Centre for Health and Wellbeing Albury–Wodonga tells us there are not many bulk billing practices locally. When women do locate a bulk billing practice, there are often long waitlists to see a GP. This is the main reason that women in this local area only go to the GP when they really have to, or to Urgent Care (which they cannot access on a regular basis), or to the emergency department. This causes women issues with their health, from not being able to keep up with medical issues.

A further barrier occurs when women need medical imaging, which affects the women we see with socioeconomic disadvantage particularly hard. The current system requires the client to come up with the total cost of medical imaging before they can claim a refund from Medicare. For most women who live on social security benefits, this is unaffordable, so they do not investigate problems further until they are so serious they require an emergency presentation or hospital admission. This could be addressed by reforming the Medicare refund system so patients with socioeconomic disadvantage are only required to pay the gap at the time of service.

Recommendation 5: Investigate whether the way Medicare gap payments are collected could be reformed to mean patients with socioeconomic disadvantage are only required to have funds available to pay the gap, not the full cost of service.

WHNSW recently reformed the way the NSW NGO women's health sector responded to women with experiences of strangulation and sexual choking. This work saw us build referral pathways across the state. For some local areas, referral pathways by necessity involved emergency presentations for injuries resulting from historical strangulation up to nine months after the event. This was largely due to the cost of accessing medical imaging being a barrier to women utilising general practitioners to manage their care when they had ongoing neurological symptoms from the strangulation.

When GPs do not have bulk billing referral options for medical imaging in their local area, women either do not proceed with imaging (and can be totally lost to care), or they present at a hospital where they can have scans bulk billed. This effectively made accessing appropriate healthcare after strangulation a postcode lottery: in some areas the local hospital would accept historic presentations (with up to a 9-month limitation), while in others they would not.

Recommendation 6: Address service gaps in bulk-billed medical imaging across all regions of Australia to prevent emergency room presentations simply for the purpose of accessing medical imaging.

Women with experiences of domestic, family and sexual violence can also fall through the cracks when bulk billing access is solely attached to being in receipt of social security entitlements, like Commonwealth concession cards. Financial abuse is common in this cohort of women and, from our frontline experience, often includes perpetrators restricting women's ability to pay for medical appointments or medical imagery. This can mean women delay accessing healthcare until it is an

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

emergency presentation or requires hospital admission. To this end we support maintaining the November 2025 change to the Medicare Benefits Schedule (MBS) via the Bulk Billing Practice Incentive Program (BBPIP) that expanded eligibility to all Medicare-eligible patients.

Recommendation 7: Maintain access to bulk billing for all Medicare-eligible patients in the Bulk Billing Practice Incentive Program (BBPIP) to ensure women experiencing financial abuse as part of domestic, family and sexual violence can access medical treatment.

The adequacy of Medicare support for the mixed-team models of care required in rural, regional and remote communities, including the role of general practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists

Effective rural, regional and remote care relies upon multidisciplinary, mixed team models. These models include general practitioners, nurse practitioners and nurses/midwives, allied health professionals including psychologists, physiotherapists, occupational therapists, accredited mental health social workers etc, Aboriginal health workers, and visiting specialists. Our members tell us that across NSW, gaps across multidisciplinary care, including shortages of GPs, nurses/midwives, nurse practitioners, psychologists and visiting specialists impact the health equity for women in rural regional and remote areas. This frontline experience of shortages is also reflected in data from Primary Health Networks, including Healthy North Coast, who point to a lower specialist workforce rate of 1 full-time specialist for every 830 residents compared to Australia wide at 1 full-time specialist for every 630 people, and a midwifery workforce that is experiencing difficulties with recruitment and retention (Healthy North Coast, 2024, p.2).

It is the view of WHNSW and our members that current Medicare arrangements undervalue nurses/nurse practitioners, accredited mental health social workers, psychologists, clinical psychologists, credentialed mental health nurses, and other allied health roles. The current system does not adequately fund coordinated, team-based care. It has limited flexibility for the type of place-based service delivery that we know works in rural, regional and remote areas. This contributes to women experiencing fragmented care, and could be addressed by improving system integration between primary care, mental health, and women's health services. Current arrangements also impact women's health by placing limits on telehealth in places where there needs to be wider availability.

Recommendation 8: Strengthen Medicare support for multidisciplinary, integrated rural, regional and remote care by valuing nursing, midwifery and allied health roles appropriately, supporting coordinated team-based models, and enabling flexible outreach so visiting specialists can operate effectively.

Reforms needed to ensure Medicare is fair, workable and sustainably funded for rural, regional and remote Australians, including the requirement for rural stress-testing of future changes; and any other related matters.

WHNSW and our members strongly support rural stress-testing of future changes. We see reproductive healthcare as a key area where there is a strong, and time-sensitive need for reform in Medicare settings.

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

Act to ensure equitable access to pregnancy termination services

The *National women's health strategy 2020–2030* (Australian Government, 2018) identifies equitable access to pregnancy termination services as a key measure of success. In NSW, further action is required to meet the measure set out in the national strategy. Australian evidence shows that women in rural, regional and remote areas are 1.4 times more likely to experience an unintended pregnancy than women living in metropolitan areas (Rowe et al., 2016, p. 108).

WHNSW was recently commissioned by the NSW Ministry of Health to undertake a twelve-month project to improve abortion access in NSW. This project saw us scoping abortion care access barriers across the state, and piloting approaches to improve access for women experiencing financial distress and other barriers, including experiencing domestic, family and sexual violence, and homelessness. The project had a focus on rural, regional and remote NSW.

Multiple members in rural, regional and remote areas noted limited access to surgical termination of pregnancy, with very few local doctors providing this service. This means women in rural, regional and remote Australia must travel long distances, take time off work, arrange childcare, and incur substantial costs to access surgical abortion. Women can also experience higher costs as a result of delays to accessing pregnancy termination services. This experience reflects broader regional service gaps, and the higher travel burden faced by those in rural communities that we discussed above.

Research shows that the availability of medical abortion has improved abortion care access, with women "who lived in outer regional/remote/very remote areas had nearly four times the adjusted odds of having a medication abortion, and women in inner regional areas nearly double the odds, compared with women who lived in major cities" (Edvardsson et al., 2025, p.4). This difference can be attributed to two main factors, the first being limited surgical abortion providers in regional areas, and secondly the waving of the twelve-month restriction on GPs providing telehealth for reproductive health needs, including abortion care.

While telehealth greatly helps women in regional areas access MTOPs there are currently no telehealth abortion providers in NSW that offer bulk billed MTOPs; with only Family Planning NSW doing so on a case-by-case basis. Accessing MTOPs involves two long or extended appointments depending on the complexity of the need, and one short consultation for follow-up. As a result, MTOPs through telehealth requires an upfront payment of $295–$454 with a Medicare rebate of up to $180. As discussed above, hefty up-front payments can put health services out of reach for women experiencing socioeconomic disadvantage. While women's health centres like our members step in where possible to provide financial assistance, some women fall through the gaps.

Seeing a GP in person for MTOPs relies upon the availability of local prescribers. The cost of MTOPs in person ranges from $467–$677 with Medicare rebates of $180–$248. We heard from women's health centres that the likelihood of GPs in regional areas providing MTOPs through bulk billing was rare. While medical termination of pregnancy (MTOPs) options have improved the situation for some women in rural, regional and remote areas, the evidence shows that only a small percentage of GPs, "around 2850 of the 41,000 GPs in Australia are registered to prescribe the mifepristone and misoprostol regimen for medical abortion" (Bateson et al., 2021, p. 187). Our members suggest that a Medicare bulk billing number for MTOPs that covers the complexity of these services, and the time invested by clinicians providing appropriate care and support, should be investigated as a means of improving the number of GPs who choose to prescribe. Recent Australian research supports our frontline experience of "insufficient Medicare remuneration" for medical abortion provision in Australian primary care settings (Skahill & Shankar, 2025, p.108).

We also note that GPs can, within their scope of practice, choose to be conscientious objectors to termination services based on personal moral, religious or ethical beliefs. According to the *Abortion*

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

Law Reform Act 2019 (NSW) GPs are required (at a minimum) to provide an appropriate referral to a patient who wishes to access termination services. Frontline experience from Wagga Women's Health Centre tells us that unfortunately this does not happen in most cases, with most women simply being told no, we do not provide this service. This sort of refusal can impact women's future help-seeking behaviour and cause further delays and additional costs when/if she regains the confidence to continue seeking pregnancy termination. While it may be beyond the scope of the Inquiry, further work is required to ensure GPs are meeting their legal obligations to refer patients to a relevant service provider.

Recommendation 9: Investigate a Medicare bulk billing number for medical termination of pregnancy (MTOPs) that covers the complexity of these services, and the time invested by clinicians providing appropriate care and support.

Improve access to bulk billed ultrasounds required for pregnancy termination

Additional to the cost of any abortion, medical or surgical, is the cost of an ultrasound. While the World Health Organization recommends "against the use of ultrasound scanning as a prerequisite for providing abortion services" (2024, p.47), in Australia, guidelines for doctors do suggest confirming gestational age is non >63 days is "best done via ultrasonography" (Mazza et al., 2020, p. 326). Access for women in rural, regional and remote Australia would be improved by supporting doctors and nurse practitioners to confirm pregnancy and gestational age using a range of methods.

As with other medical imaging discussed above, bulk billing options for ultrasounds are less common in rural, regional and remote areas, resulting in an upfront cost of $250–$280 with a Medicare rebate of $32. Raising funds to cover the full cost of an ultrasound can result in women delaying accessing care, increasing the likelihood of more invasive and costly surgical abortions, and/or being faced with proceeding with a pregnancy not of their choosing. Our members suggest using Medicare levers to support equitable access to bulk billed ultrasounds across rural, regional and remote areas. The evidence suggests providing "additional support for GPs to provide ultrasonography-inclusive models, particularly in rural areas, could alleviate ultrasonography-related delays for medical abortion provision" (Deb et al., 2020).

Recommendation 10: Reinforce that pregnancy and gestational age can be determined without ultrasonography in rural, regional and remote areas (unless clinically indicated), alongside employing Medicare levers like increased rebates and practice level bonuses to provide greater incentive to sonographers to bulk bill ultrasounds in rural, regional and remote areas.

Fairly value reproductive health services provided by nurse practitioners and midwives

Rural, regional and remote women's access to equitable reproductive health care was significantly improved by the Abortion Law Reform Amendment (Health Care Access) Bill 2025 that enabled nurse practitioners and endorsed midwives to prescribe MS-2 Step (mifepristone and misoprostol) for medical abortions. Research suggests that "better access to high quality contraceptive counselling in primary care is fundamental to improving people's capacity to exercise fertility control" (Rowe et al., 2016, p. 108) and reduce instances of unintended pregnancy across rural, regional and remote Australia. It is our experience that nurse practitioners and midwives are often better at dispensing trauma-informed and culturally safe contraceptive counselling than GPs.

This important legislative change provided an avenue for women's health centres to provide MTOPs, improving access for women who have limited financial resources, and in particular, for women who require a trauma-informed and culturally inclusive service. However, while GPs can access Medicare rebates for five levels of consultation, ranging from brief to an hour long ($20.04–$202), nurse practitioners are limited to the one item for short/standard consultations of 6–20 minutes at $27.05.

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

With nurse practitioners' hourly rates being around $70–$75, this makes it very challenging to provide a sustainably funded service to rural, regional and remote women at low or no cost to the women. We suggest there is a need to value the skills of nurse practitioners and midwives fairly, including by recognising the time it takes to provide complex, trauma-informed care. There would also be a benefit to creating Medicare items that recognise the provision of complex, trauma-informed care, in other women's health issues that have similar complexity to MTOPs style presentations.

Recommendation 11: Review and expand Medicare item numbers for nurse practitioners and midwives to deliver a range of consultation types including telehealth, with rebates increased to support the sustainable employment of nurse practitioners and midwives in rural, regional and remote areas.

Recommendation 12: Create Medicare bulk billing items that recognise the provision of complex, trauma-informed care for the full range of healthcare service providers.

Improve rural, regional and remote access to long-acting reversible contraception

Rural, regional and remote realities also impact access to long-acting reversible contraception (LARCs) which are currently covered by Medicare up to eight weeks after birth. Improving access to LARCs is a key measure of success in the *National women's health strategy 2020–2030* (Australian Government, 2018). To improve access for women in rural, regional and remote areas, where limited services are available this time period could be removed or even extended to 12-months. Some women have traumatic birth experiences, for which the healing process (both physically and mentally) can take much longer than eight weeks, so the limited time period is very restrictive.

Recommendation 13: Remove or substantially increase the eight-week post-natal time period under which long-acting reversible contraception (LARC) is covered by Medicare to ensure equity of access for women with traumatic birth experiences, and those in areas where services are limited.

Bolster Pacific Australia Labour Mobility (PALM) worker access to reproductive health

As women's health centres across NSW meet the unique needs of the women in their local communities, some of our members pointed to specific priority populations for whom reproductive health equity lags behind. For example, Coffs Harbour Women's Health Centre, which is situated in a major hub for Pacific Australia Labour Mobility (PALM) workers, highlighted the plight of PALM workers in their correspondence relating to this submission. PALM workers experience significant structural health disadvantage through being excluded from the Medicare system despite working full-time in essential industries. Even though visas are conditional on having private health insurance, navigating rebates can be complex (particularly when English is not the worker's first language), and out-of-pocket costs remain, including travel and accommodation to access contraceptive, pregnancy, abortion, and sexual transmitted infection care.

WHNSW is a member of the Australian Women's Health Alliance (AWHA) who produced the Reproductive Health and Rights for PALM Scheme Workers Statement (AWHA, 2025). WHNSW and all our members support the intent and purpose behind this statement, namely that all women in Australia, even those here temporarily, deserve equitable access to reproductive healthcare.

Recommendation 14: Ensure Pacific Australia Labour Mobility (PALM) workers in rural, regional and remote areas have equitable access to reproductive healthcare by implementing all ten calls-to-action outlined in the Australian Women's Health Alliance's 2025 *Reproductive Health and Rights for PALM Scheme Workers Statement*.

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department

References

Australian Government. *National women's health strategy 2020–2030*. Department of Health. https://www.health.gov.au/resources/publications/national-womens-health-strategy-2020-2030

Australian Women's Health Alliance. (2025). *Reproductive Health and Rights for PALM Scheme Workers – Statement*. AWHA. https://australianwomenshealth.org/2025/05/13/reproductive-health-and-rights-for-palm-scheme-workers/

Bateson, D, McNamee, K., & Harvey, C. (2021). Medical abortion in primary care. *Australia Prescriber*, 44:187–192. https://doi.org/10.18773/austprescr.2021.050

Deb, S., Subasinghe, A. K., & Mazza, D. (2020). Providing medical abortion in general practice: General practitioner insights and tips for future providers. *Australian journal of general practice*, *49*(6), 331–337. https://doi.org/10.31128/AJGP-01-20-5198

Edvardsson, K., Egan, N., Taft, A., Norman, W. V., Harris, M. L., Black, K. I., Bateson, D., Hooker, L., & Shankar, M. (2025). Time trends and characteristics associated with abortion method used by young Australian women. *International journal of epidemiology*, *54*(2). https://doi.org/10.1093/ije/dyaf028

Healthy North Coast. (2024). *Health needs assessment 2025–2028: Health care services*. HNC. https://hnc.org.au/health-needs-assessment-25-28

Mazza, D., Burton, G., Wilson, S., Boulton, E., Fairweather, J., & Black, K. (2020). Medical Abortion. *Australian journal of general practice*, *49*(6), 324–330. https://www1.racgp.org.au/ajgp/2020/june/medical-abortion

Rowe, H., Holton, S., Kirkman, M., Bayly, C., Jordan, L., McNamee, K., McBain, J., Sinnott, V. and Fisher, J. (2016), Prevalence and distribution of unintended pregnancy: the Understanding Fertility Management in Australia National Survey. *Australian and New Zealand Journal of Public Health*, 40: 104–109. https://doi.org/10.1111/1753-6405.12461

Skahill, G., & Shankar, M. (2025). Factors that affect the provision of medical abortion services in Australian primary care: a mixed methods systematic review. *Medical Journal of Australia*, 223(2), 101–110. https://www.mja.com.au/journal/2025/223/2/factors-affect-provision-medical-abortion-services-australian-primary-care-mixed

Women's Health NSW. (2017). *Principles of Women's Health Care*. WHNSW. https://whnsw.asn.au/wp-content/uploads/2018/09/1.4_Principles_of_Womens_Health_Care_and_Service.pdf

Women's Health NSW. (2025). *Annual Report 2024–2025*. WHNSW. https://whnsw.asn.au/wp-content/uploads/2025/11/WHNSW_Annual-Report-2024-25_WEB.pdf

World Health Organization (2024). *Abortion care guideline*, 2nd ed. World Health Organization. https://iris.who.int/handle/10665/382157.

Legislation

Abortion Law Reform Act 2019 (NSW) No 11. (2019). NSW Government. https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-2019-011

PO Box 341 | Leichhardt | NSW | 2040
T: 02 9560 0866
www.whnsw.asn.au

ABN 51 392 627 790
Funded by NSW Health Department