MBS Review Advisory Committee

Long-Acting Reversible Contraceptives Working Group

Draft Report

September 2025

Contents

Summary

The Medicare Benefits Schedule (MBS) Review Advisory Committee (MRAC) is an independent, non-statutory committee. Its role is to advise the Australian Government Department of Health, Disability and Ageing on publicly funded services listed on the MBS. The MRAC members include clinicians, non-clinicians and consumers.

In 2024, the Minister for Health requested that the MRAC undertake a targeted review of MBS items used for long-acting reversible contraceptive (LARC) treatment. A LARC Working Group (LARCWG) was created to inform the MRAC and its recommendations. The LARCWG comprised 6 MRAC members and met 3 times throughout 2024 and 2025.

The LARCWG and the MRAC undertook this review in 2 phases.

Phase one

The LARCWG considered qualitative and quantitative data and targeted stakeholder feedback to develop its recommendations for phase one of this review. The MRAC endorsed the recommendations at its 12th meeting on 20 August 2024. These recommendations were presented to the Australian Government on 3 September 2024.

Note: Phase one recommendations were accepted by the Australian Government and announced on 9 February 2025 as part of the strengthening Medicare and better health care for women package. The following changes are being implemented on 1 November 2025:

- *fee increases for existing MBS items, including the increase for IUD insertion to $215, removal to $134, hormonal implant insertion to $100, and removal to $105*
- *introduction of new MBS items for nurse practitioners allowing them to provide certain LARC services, except for complex IUD removals under anaesthesia*
- *the introduction of two new loading items, one for nurse practitioner LARC services and another for LARC services provided by medical practitioners. The loading items will provide a 40% loading payment of the relevant LARC item fee when the entire LARC service is bulk-billed.*

As part of phase one, the LARCWG considered:

- the appropriateness and accessibility of existing MBS LARC items and whether MBS item changes were required (including to fees and item structure)
- the accessibility of the MBS items, including expanding access for LARC prescribing, insertion and removal to other appropriately trained and qualified health practitioners.

MBS fees

The LARCWG considered the current MBS fees to be too low to recognise and reflect the work done by clinics and clinicians, and that increasing the fees was appropriate. The LARCWG noted the data for out-of-pocket patient costs for LARC items and considered that these costs may be standing in the way of affordable, accessible care. Increasing the MBS fees would also increase access to contraception choices for women from lower socioeconomic backgrounds, in whom unwanted pregnancies are an ongoing health issue.

Recommendation 1

That the fees for MBS LARC items (items 35503, 35506, 14206 and 30062) should be increased.

Patient complexity

The LARCWG acknowledged that some patients present as 'complex'. Complexity may be due to physical (anatomical) complexities or psychosocial issues that make a health service more difficult and time-consuming to deliver. The LARCWG considered that complexity is an important issue for clinicians, but that introducing new items with increased MBS rebates based on the complexity of the patient may create perverse incentives and/or result in further complicating MBS claiming. The LARCWG also noted that patient complexity can be difficult to record clinically, citing privacy issues with, for example, taking photographs to document a complex procedure. Therefore, the LARCWG considered that, rather than basing reimbursement on patient complexity, the issue would be better addressed by an overall increase in MBS fees for LARC services and the ability to co-claim with other appropriate MBS services.

Recommendation 2

Do not introduce separate complex items for LARC services.

Extending access to nurse practitioners

The LARCWG noted the feedback and advice received through stakeholder consultations, which supported the view that some nurse practitioners (NPs) are already qualified and trained in the provision of LARC services. Currently, NPs deliver LARC services through their general attendance MBS items. NPs do not have access to MBS items that support provision of a specific LARC service, which actively disincentivises NPs from delivering these services in primary care settings. The LARCWG supported creating new MBS items for NPs to deliver LARC services, which should mirror the existing LARC items medical practitioners currently access. The fees should remain the same as for other providers, and the new items should align with relevant NP LARC training.

Recommendation 3

That it is appropriate to expand MBS access to nurse practitioners (NPs) by creating new MBS items for NP insertion and removal of LARC (except for complex removal under anaesthesia).

Phase two

Extending access to endorsed midwives

The LARCWG considered extending MBS access to endorsed midwives (EMs) for insertion and removal of LARC.

The MBS supports EMs to deliver high-quality care across the full continuum of the midwifery continuity of care model, including antenatal, intrapartum, and postnatal services. Postnatal care is generally covered for up to 6 weeks after birth, except for MBS item 82140, which can be provided up to 8 weeks postpartum.

The LARCWG considered targeted feedback, including from the Australian College of Midwives, to inform its recommendations. The National Midwifery Board of Australia (NMBA) determines the scope of practice for the midwifery profession. The NMBA has developed detailed guidelines for EMs, which outline clear quality, safety and clinical practice standards governing endorsed midwifery care, including relating to

contraception. EMs have access to the same training available to other providers wanting to train in insertion and removal of LARC, and these services are within their regular scope of practice.

To become endorsed, midwives must have completed at least 5,000 hours of clinical practice and have completed postgraduate study leading to endorsement for scheduled medicines – for example, graduate certificate in midwifery diagnostics and prescribing.

The LARCWG concluded that it is safe and appropriate for EMs to access MBS items for the insertion and removal of hormonal implants (Implanon) and of IUDs for contraceptive purposes only. This conclusion is based on insertion and removal of LARCs, including Implanon and IUDs, being within EMs' scope of practice once appropriate training has been undertaken. The LARCWG supported that appropriately trained EMs could provide LARC administration care within and beyond the postpartum period of 8 weeks for the primary purpose of contraceptive care. However, the LARCWG did not consider it appropriate to extend EMs' access to the MBS for LARC administration that is not for the primary purpose of contraception (such as for heavy menstrual bleeding).

Recommendation 4

Expand MBS access to endorsed midwives for hormonal (etonogestrel) implant insertion and removal, and for intrauterine device (IUD) insertion and removal LARC (except for complex removal under anaesthesia), for the primary purpose of contraceptive care.

Extending access to other provider groups

The LARCWG considered expanding access to other healthcare professions. The LARCWG noted other healthcare provider groups were not considered for inclusion noting the current recommendations have been designed to align with existing structures to ensure feasibility and reduce fragmentation of care. The LARCWG also noted that, although a low-risk procedure overall, inserting and removing LARCs is an invasive procedure requiring specialised training and medical knowledge.

Therefore, the LARCWG did not consider expanding access to other provider groups other than NPs (as recommended in phase one) and EMs. The LARCWG noted that, should these measures prove insufficient in addressing the identified service gaps, future consideration may be given to expanding the scope to include other providers, contingent upon available evidence of relevant training and competency.

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.

Recommendations

Phase one

Phase one recommendations were accepted by the Australian Government and announced on 9 February 2025 as part of the strengthening Medicare and better health care for women package. The following changes are being implemented on 1 November 2025.

Recommendation 1

That the fees for MBS LARC items (items 35503, 35506, 14206 and 30062) should be increased.

Recommendation 2

Do not introduce separate complex items for LARC services.

Recommendation 3

That it is appropriate to expand MBS access to nurse practitioners (NPs) by creating new MBS items for NP insertion and removal of LARC (except for complex removal under anaesthesia).

Phase two

Phase two draft recommendations are under consideration.

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.

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.

Acronyms

EM	endorsed midwife
EN	enrolled nurse
GP	general practitioner
IUD	intrauterine device
LARC	long-acting reversible contraceptive
LARCWG	Long-acting Reversible Contraceptive Working Group
MBS	Medicare Benefits Schedule
MRAC	Medicare Benefits Schedule Review Advisory Committee
NP	nurse practitioner
OOP	out of pocket
RN	registered nurse

Background

In December 2020, the Medicare Benefits Schedule (MBS) Review Taskforce published its report on gynaecology MBS items. Recommendation 35 was to increase the schedule fee for MBS item 35503 (insertion of an intrauterine device [IUD]) so that it 'adequately reimburses patients and clinicians for the level of training, skill, equipment and time required to provide the service'.

Minister's request for this review

In 2024, the Minister for Health requested that the MBS Review Advisory Committee (MRAC) undertake a targeted review of MBS items used for long-acting reversible contraceptive (LARC) treatment. The review was done in 2 phases:

- Phase one (July–August 2024) focused on
  - the appropriateness and accessibility of existing MBS LARC items and whether MBS item changes were required (including to fees and item structure)
  - the accessibility of the MBS items, including expanding access for LARC prescribing, insertion and removal to other appropriately trained and qualified health practitioners.
- Phase two (November 2024 – August 2025) focused on:
  - expanding access to LARC MBS subsidy to a range of appropriately trained health professionals
  - expanding access to rebates for LARC prescribing, insertion and removal to other appropriately trained and qualified health practitioners

LARC Working Group

The LARC Working Group (LARCWG) was established as a subgroup of the MRAC to advise the MRAC on this topic. The LARCWG comprises 6 MRAC members who provide expert, clinician and consumer representative-led advice to the MRAC on the review of MBS LARC items.

The LARCWG met on 3 occasions: 23 July 2024, 5 May 2025 and 22 July 2025.

Appendix A details the Medicare Benefits Schedule Continuous Review and the role of the MRAC.

Qualitative and quantitative data

The LARCWG's discussions and recommendations were based on the following qualitative and quantitative data:

- MBS data from the Department of Health, Disability and Ageing and Services Australia
- an Australian literature review
- targeted stakeholder engagement and feedback (see Consultation and feedback review).

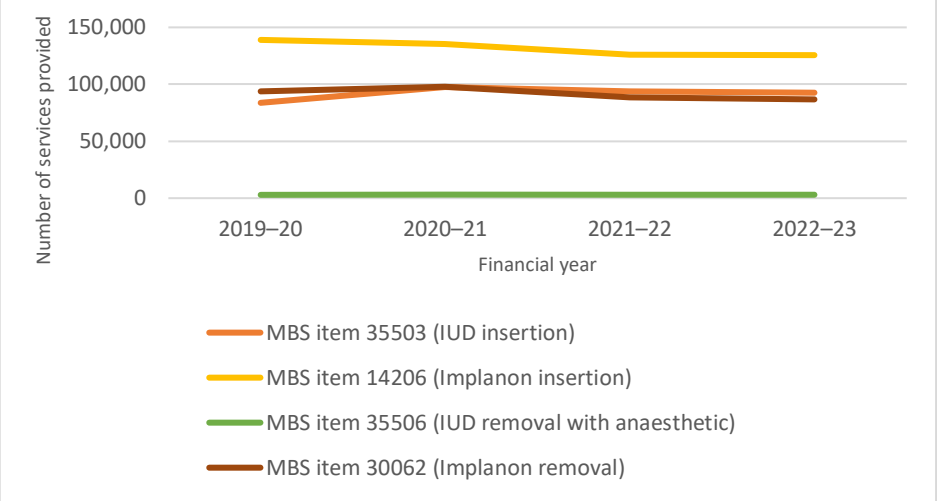
LARC utilisation trends

Four MBS items exist for insertion and removal of LARC, used for either IUD* or hormonal implants (Implanon):

- MBS item 35503: IUD insertion
- MBS item 14206: insertion of subcutaneous implant (common item used for Implanon insertion)
- MBS item 35506: IUD removal with anaesthetic
- MBS item 30062: Implanon removal.

From 2019–20 to 2022–23, utilisation for all 4 MBS items was slightly decreasing (Figure 1).

Figure 1 Utilisation of LARC insertion and removal MBS items, 2019–20 to 2022–23



IUD = intrauterine device; LARC = long-acting reversible contraceptive; MBS = Medicare Benefits Schedule

* Note that MBS IUD items are device-agnostic and can be used for copper IUD as well as hormonal IUDs. Because copper IUD is not a medication, it is not on the Pharmaceutical Benefits Scheme. This means that patients often face higher out-of-pocket costs. It is estimated that a copper IUD costs a patient $70–100.

LARC services are most likely to be performed in a primary care setting, particularly Implanon (MBS items 14206 and 30062). IUD insertion still mostly takes place in primary care, but when IUD removal requires anaesthetic (MBS item 35506), it is most likely to be performed in a specialist setting by an obstetrician or gynaecologist. Providers use general attendance items for removing uncomplicated IUDs, so there is no specific MBS item for this service for comparison.

When delivered in a primary care context, MBS LARC items will often be co-claimed with an attendance item.

In terms of geographical distribution or provider behaviour by area, LARC use followed the same patterns seen elsewhere in health care – that is, people further away from major centres have more travel and higher out-of-pocket (OOP) costs to access LARC.

The data also showed that younger women of reproductive age tend to use Implanon, whereas older women of reproductive age tend to use IUDs. Younger women are more likely to pay more for Implanon than older women, but, again, this reflects common demographic shifts seen in health care more generally. However, as noted in the literature review, younger women are also choosing copper IUDs in preference to hormone-based contraceptives.

LARC costs

On 1 March 2022, the MBS fee for item 35503 was increased from $55.70 to $83.40 in line with the amount recommended by the MBS taskforce. Following indexation, the MBS fee is now $91.35. However, despite the MBS fee increase, OOP costs for patients accessing IUD item 35503 have continued to increase, with OOP costs ranging from $24 to $200. The average OOP costs for other LARC items range from:

- $0 to $97 Implanon insertion (MBS item 14206)
- $9 to $150 for IUD removal with anaesthetic (MBS item 35506).

When considering patient OOP costs for these LARC items alone (that is, without co-claiming), patient OOP costs are generally higher for IUD than Implanon, and there are variations in average OOP in the specialist context as well. However, the LARCWG noted that most insertions and removals are co-claimed with an attendance item. LARC services should not require co-claiming, but the fact that this happens may reflect the low renumeration available for LARC services.

LARC workforce

As of 2022–23, the main LARC-related workforce included:

- general practitioners (GPs), obstetricians and gynaecologists
- nurse practitioners (NPs), endorsed midwives (EMs), registered nurses (RNs) and enrolled nurses (ENs).

NPs currently have access to 5 time-tiered general attendance MBS items, which can be used for providing LARC insertion or removal.

More than 1,400 EMs across Australia have access to prescribe scheduled medicines, but that the operationalisation and training of this access differs across states and territories. The MBS supports EMs to deliver high-quality care across the full continuum of the midwifery continuity of care model, including antenatal, intrapartum, and postnatal services. Postnatal care is generally covered for up to 6 weeks after birth, except for MBS item 82140, which can be provided up to 8 weeks postpartum.

RNs and ENs do not have access to the MBS. The Australian Government supports ENs and RNs in general practice through the Workforce Incentive Program Practice Stream.

There are a small number of primary care MBS items that allow a medical practitioner to bill the MBS when the service is provided by a practice nurse. Examples include MBS item 10997, which can be provided for patients with a Chronic Disease Management Plan, and COVID-19 vaccine support items (if the practice nurse is a nurse immuniser).

Australian research

A literature review found that:

- barriers to LARC use include norms, misconceptions, bodily consequences and access issues. Young women also identified a perceived lack of control over hormones entering the body from LARC devices[1]
- women living in rural and regional Australia often experience difficulties in accessing LARC[2]
- health professionals have limited confidence in and support for LARC insertions. Strategies identified to increase contraceptive knowledge and access included increasing the nurses' role in contraceptive provision and education, improving sex education in schools, and educating parents[1]
- although implant insertion has been integrated into general practice, few GPs insert IUDs[3]

the most notable association with choice of LARC is confidence in knowledge regarding LARC, and adequate access to training and supervision. Most providers recognise a LARC as the first-line option for contraceptive treatment; however, in practice, most prescriptions issued by GP registrars are for non-LARC methods.[4]

Considerations and recommendations

Phase one

The LARCWG considered qualitative and quantitative data and targeted stakeholder feedback to develop its recommendations for phase one. The MRAC endorsed the recommendations at its 12th meeting on 20 August 2024. These recommendations were presented to the Australian Government on 3 September 2024.

Note: Phase one recommendations were accepted by the Australian Government and announced on 9 February 2025 as part of the strengthening Medicare and better health care for women package. The following changes are being implemented on 1 November 2025:

- *fee increases for existing MBS items, including the increase for IUD insertion to $215, removal to $134, hormonal implant insertion to $100, and removal to $105*
- *introduction of new MBS items for nurse practitioners allowing them to provide certain LARC services, except for complex IUD removals under anaesthesia*
- *the introduction of two new loading items, one for nurse practitioner LARC services and another for LARC services provided by medical practitioners. The loading items will provide a 40% loading payment of the relevant LARC item fee when the entire LARC service is bulk-billed.*

Increase in current rebates for specific LARC MBS items

Should consideration be given to an increase in the current rebates for specific LARC items (35503 and/or, 35506 and/or 14206 and/or 30062) and what should this increase seek to recognise?

Recommendation 1

That the fees for MBS LARC items (items 35503, 35506, 14206 and 30062) should be increased.

The LARCWG noted that:

- LARC services are largely delivered in a primary care setting, and increasing fees will support increased availability of, and access to, these important services
- an increase in the fees will improve patient affordability through better recognition of the costs incurred by providers in delivering these services. Specifically, it will promote improved choice of contraception for those who have been previously unable to access a LARC or who find the significant up-front costs of a LARC financially unviable
- increasing the fees will help providers to better support those patients with more complex needs around the insertion and removal of LARC, and will further promote safe, high-quality care for all patients.

The LARCWG noted that there is a wide variation in costs in delivering a LARC service, including drivers such as under-resourcing, throughput and volumes delivered by individual practices, setting of care (that is, primary care provider versus specialist), complexity and geographical location. A fee increase should help address these issues and flow on to reduced costs and, therefore, increased affordability (including improved bulk-billing, which nationally currently sits at 55.6% for these services, with hormonal implant bulk-billing higher than bulk-billing for IUDs).

Splitting MBS items to recognise the complexity of services

Should consideration be given to splitting LARC items to recognise more or less complex provision of LARC services, and what should be the clinical considerations when defining less complex and more complex situations?

Recommendation 2

Do not introduce separate complex items for LARC services.

The LARCWG acknowledged the complexity of some patients, and that complexity may be due to physical (anatomical) complexities or psychosocial issues that make a health service more difficult and time-consuming to deliver. The LARCWG considered that complexity is an important issue for clinicians, but that introducing new items with increased MBS rebates based on the complexity of the patient may create perverse incentives and/or result in further complicating MBS claiming.

The LARCWG noted that patient complexity can be difficult to record clinically, citing privacy issues with, for example, taking photographs to document a complex procedure.

The LARCWG recognised that complexity in LARC insertions and removals was a genuine concern for clinicians. However, the LARCWG determined that complexity should be not time-based and that there were more effective ways of renumerating for complex patients than splitting LARC MBS services into more and less complex. The LARCWG also determined that complexity is unknown before seeing a patient, and that splitting the MBS items and thus renumerating complex patients at a higher fee might result in higher, unexpected OOP costs for patients after the service.

The LARCWG considered that, rather than basing reimbursement on patient complexity, the issue would be better addressed by an overall increase in MBS fees for LARC services and the ability to co-claim with other MBS services.

Access to LARC items for NPs

Should consideration be given to recommending access to current specific LARC items to NPs, and if supported, what (if any) additional considerations are there to enact such a change?

Recommendation 3

That it is appropriate to expand MBS access to nurse practitioners (NPs) by creating new MBS items for NP insertion and removal of LARC (except for complex IUD removals under anaesthesia).

The LARCWG noted the feedback and advice received through stakeholder consultations, which supported the view that some nurse practitioners (NPs) are already qualified and trained in the provision of LARC services. Currently, NPs deliver LARC services through their general attendance MBS items. NPs do not have access to MBS items that support provision of a specific LARC service, which actively disincentivises NPs from delivering these services in primary care settings. The LARCWG supported creating new MBS items for NPs to deliver LARC services, which should mirror the existing LARC items medical practitioners currently access. The fees should remain the same as for other providers, and the new items should align with relevant NP LARC training.

The LARCWG noted that EMs may also seek access to LARC services. The LARCWG considered that a wider consultation in phase two would be appropriate for this issue.

Phase two

The LARCWG considered phase two of this review at its May and July 2025 meetings. The MRAC considered the findings and endorsed the recommendations at its 16th meeting on 19 August 2025.

The LARCWG considered qualitative and quantitative data, targeted consultation feedback and additional data from the department (see Endorsed midwives and current clinical practice) to inform its recommendations for phase two. At its July 2025 meeting, the Australian College of Midwives provided the LARCWG additional information regarding midwives' scope of practice and training to support decision-making.

Endorsed midwives and scope of clinical practice

The LARCWG noted that the National Midwifery Board of Australia (NMBA) determines the scope of practice for the midwifery profession. The NMBA has developed detailed guidelines for EMs, which outline clear quality, safety and clinical practice standards governing endorsed midwifery care, including relating to contraception.

The NMBA states that an endorsed midwife must first hold registration as a midwife in Australia. To become endorsed, midwives must have completed at least 5,000 hours of clinical practice as a midwife and have completed postgraduate study leading to endorsement for scheduled medicines – for example, graduate certificate in midwifery diagnostics and prescribing. An essential core competency for EMs is sexual and reproductive health, which includes:

- counselling patients on contraceptive options
- prescribing and administering contraceptives including the oral contraceptive pill, Implanon and IUDs
- experience with inserting and removing hormonal (etonogestrel) implants including Implanon, and inserting and removing IUDs.

As with all practitioners, being able to safely administer LARC services is contingent on an endorsed midwife completing and maintaining training that meets industry standards and is clinically relevant to midwifery practice in Australia. EMs access the same training as other practitioners, and only those who have undertaken the appropriate training will provide LARC services alongside other local health services.

Miga, an indemnity insurer that covers midwives, has confirmed that privately practising EMs who provide LARC services within their recognised scope of practice are covered by professional indemnity insurance (PII). Miga also confirmed that EMs employed in the public health system are generally covered by their employer's indemnity arrangements and do not require individual PII policies for services provided in that context. Furthermore, there is no legal or policy requirement for services to be funded via the MBS for PII coverage to apply.

Should consideration be given to recommending access to current specific LARC MBS items (35503 and/or 35506 and/or 14206 and/or 30062) to EMs?

Recommendation 4

That it is appropriate to expand MBS access to endorsed midwives for hormonal (etonogestrel) implant insertion and removal, and for intrauterine device (IUD) insertion and removal (except for complex removal under anaesthetic), for the primary purpose of contraceptive care.

The LARCWG recognised the importance of people having a choice between Implanon and an IUD, as well as providing appropriate birth control after birth should someone wish to have this. The LARCWG also recognised the importance of people choosing their

care provider and that many people choose a midwife to provide sexual and reproductive health care throughout their child-bearing years. The LARCWG held some concern about fragmentation of care if private EMs were inserting or removing LARCs. The working group acknowledged that in some models such as Aboriginal Community Controlled Health Organisations (ACCHOs) EMs are part of a team of medical practitioners delivering patient procedures.

The LARCWG considered that Implanon insertion and removal is reasonably straightforward, with few risks associated with insertion postpartum and little risk of removing one. Inserting an IUD at less than 6 weeks postpartum is a slightly riskier – albeit still safe – procedure, because the risk of perforation and expulsion is increased in someone who has recently given birth. Healthcare providers who are highly experienced in IUD insertion and removal are best placed to perform this service in the postpartum period. The LARCWG took the view that, currently, EMs do not have access to MBS items beyond the 8-week postpartum period, but that it may be appropriate for an endorse midwife to provide LARC services the beyond the 8-week postpartum period. The LARCWG has determined that it is safe and appropriate for EMs to access MBS items for the insertion and removal of hormonal implants (Implanon) and intrauterine IUDs, for contraceptive purposes only. This conclusion is based on the recognition that these procedures fall within the scope of practice for EMs, provided they have completed the necessary training.

The LARCWG supports appropriately trained EMs in delivering LARC-related care both within and beyond the 8-week postpartum period, when the primary intent is for contraception. However, the LARCWG does not support extending MBS access for EMs to provide LARC services for non-contraceptive purposes, such as treatment for heavy menstrual bleeding.

Expanding access to other provider groups

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.

The LARCWG considered expanding access to other healthcare professions. The LARCWG noted other healthcare provider groups were not considered for inclusion noting the current recommendations have been designed to align with existing structures to ensure feasibility and reducing fragmentation of care. The LARCWG also noted that, although a low-risk procedure overall, inserting and removing LARCs is an invasive procedure requiring specialised training and medical knowledge.

Therefore, the LARCWG did not consider expanding access to other provider groups other than NPs (as recommended in phase one) and EMs. The LARCWG noted that, should these measures prove insufficient in addressing the identified service gaps, future consideration may be given to expanding the scope to include other providers, contingent upon available evidence of relevant training and competency.

Consultation and feedback review

Consultation with relevant and interested organisations, peak bodies and consumers is considered essential in the formulation of advice to government on recommended changes to MBS items. The MRAC and its working groups seek feedback on their understanding of the existing model of care and issues of consideration, with particular emphasis on any (yet) unidentified consequences that may result from proposed changes.

All feedback provided through consultation processes is considered.

Phase one

Targeted stakeholder feedback

Due to the short timeframes for phase one recommendations, a Targeted Stakeholder Consultation Workshop was conducted on 16 July 2024. The department sought comments and guidance from the following key clinical and consumer external stakeholders regarding the issues identified during phase one:

- Australian College of Midwives
- Australian College of Nurse Practitioners
- Royal Australian College of General Practitioners
- Australian Medical Association
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- National Association of Obstetricians and Gynaecologists
- Australasian Sexual and Reproductive Health Alliance
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives.

Key themes raised regarding phase one included:

- concerns about moving RNs and ENs towards a fee-for-service model. This could impact how some practices employ and fund nurse support, if nurses have limited access to MBS subsidies only for specific procedures. There are also potential issues with indemnity arrangements if nurses are moved towards acting as independent contractors in a fee-for-service model
- the varying complexity of inserting and/or removing LARC (both IUDs and Implanon) in different patient populations, and that this complexity may be inadequately reflected in the structure of MBS items for LARC. In many cases, this may be further compounded as complexity is often not apparent until a procedure is undertaken, and this should be reflected in any consideration of item fees and structure
- in most primary care situations, LARC services include a consultation element and a procedure; however, only consultations reflect differences in time taken. Only time taken for discussion and assessment affects which consultation item is claimed in the primary care context. The MBS rebate is the same regardless of time taken. In the specialist context, the same combination of consultation and procedure is required; however, specialist consultation items are also paid at the same rate regardless of time needed
- the impact of availability, training and infrastructure costs, and the importance of practising the procedures to maintain skills (it was noted these issues may sit as an adjunct to issues with MBS items themselves). As part of this, NP (and, by extension,

endorsed midwife) access to specific LARC items was discussed as a key consideration to improve uptake of LARC by these providers

- differential input costs including set up and consumables. However, the MBS is not designed to fund these elements
- the MBS fees for LARC; while there was no quantum increase to fees discussed, there was general feedback that pointed to the current inadequacy of the fees. This includes both general/simple LARC insertion and removal, as well as LARC insertion and removal in more complex cases.

Phase two

Targeted consultation feedback

Targeted consultation feedback was sought across 6 weeks in early 2025 (14 January to 21 February) for the proposed extension of LARC services to endorsed midwives (EMs). Submissions were received from 7 organisations:

- Australian College of Midwives
- Australian Nursing and Midwifery Federation
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Australian Medical Association
- Royal Australian College of General Practitioners
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- National Association of Specialist Obstetricians and Gynaecologists.

The consultation revealed that:

- there was no agreement as to whether EMs' scope of practice includes insertion and removal of LARCs. Some feedback agreed that the care of a patient's sexual and reproductive health was a core activity and within EMs' scope of practice. Others stated that, without formal medical training, EMs do not have sufficient knowledge to deal with complications associated with LARC services
- the skillsets required for inserting and removing Implanon versus IUDs were not the same, with IUD services considered to be higher risk and requiring medical training
- there was some support for extending EMs' access to services to include insertion of Implanon, with the appropriate training
- there was little to no support for extending EMs' access to services to include insertion and removal of IUDs, as they do not have the required medical training to address many clinical situations such as complex or comorbid patients. Some organisations rejected this proposal outright

there was some acknowledgement that continuity of care with the same midwife may be adversely affected if an endorsed midwife can prescribe LARC on the Pharmaceutical Benefits Scheme (PBS) but cannot claim the insertion service on the MBS

there is limited information as to what LARC services EMs are currently providing, due to claiming under generic MBS items and the predominant provision of these services as part of the public healthcare setting. It is likely that many credentialled EMs are performing these services within and beyond the 6-week postpartum period. Most services provided are the insertion of Implanon.

As the LARCWG membership did not include representatives from the midwifery profession, the LARCWG agreed that it would be appropriate to invite representatives from the Australian College of Midwives to the third meeting in July 2025. As part of this

meeting, the college clarified the type of the clinical care that an endorsed midwife provides to the community.

Appendix A Medicare Benefits Schedule Continuous Review

The Medicare Benefits Schedule (MBS) is a list of health professional services (items) subsidised by the Australian Government for health consumers. MBS items provide patient benefits for a wide range of health services including consultations, diagnostic tests, therapies and operations.

The MBS Continuous Review builds on the work of the MBS Review Taskforce. From 2015 to 2020, the taskforce provided the first extensive, line-by-line review of the MBS since its inception in 1984.

In October 2020, the Australian Government committed to establishing a continuous review framework for the MBS, consistent with recommendations from the Taskforce Final Report.

Established in 2021, the MBS Continuous Review allows for ongoing rigorous and comprehensive reviews of Medicare items and services by experts, on a continuous basis, to ensure that the MBS works for patients and supports health professionals to provide high-quality care.

Medicare Benefits Schedule Review Advisory Committee

The MBS Continuous Review is supported by the MBS Review Advisory Committee (the MRAC). The MRAC's role is to provide independent clinical, professional and consumer advice to government on:

1. opportunities to improve patient outcomes in instances where a health technology assessment by the Medical Services Advisory Committee (MSAC) is not appropriate
2. the safety and efficacy of existing MBS items
3. implemented changes to the MBS, to monitor benefits and address unintended consequences.

The MRAC comprises practising clinicians, academics, health system experts and consumer representatives. The current MRAC membership is available on the Department of Health, Disability and Ageing's MRAC webpage.

MBS Continuous Review guiding principles

The following principles guide the deliberations and recommendations of the MBS Continuous Review:

a) The MBS:

- is structured to support coordinated care through the health system by
  - recognising the central role of General Practice in coordinating care
  - facilitating communication through General Practice to enable holistic coordinated care
- is designed to provide sustainable, high-value, evidence-based and appropriate care to the Australian community
  - item descriptors and explanatory notes are designed to ensure clarity, consistency and appropriate use by health professionals
- promotes equity according to patient need
- ensures accountability to the patient and to the Australian community (taxpayer)

- is continuously evaluated and revised to provide high-value health care to the Australian community.

b) Service providers of the MBS:

- understand the purpose and requirements of the MBS
- utilise the MBS for evidence-based care
- ensure patients are informed of the benefits, risks and harms of services, and are engaged through shared decision making
- utilise decision support tools, Patient Reported Outcome and Experience Measures where available and appropriate.

c) Consumers of the MBS:

- are encouraged to become partners in their own care to the extent they choose
- are encouraged to participate in MBS reviews so patient healthcare needs can be prioritised in design and implementation of MBS items.

The MRAC and its working groups recognise that General Practice general practitioners are specialists in their own right. Usage of the term 'General Practice', both within this report and in the MBS itself, does not imply that general practitioners are not specialists.

The MRAC notes that the MBS is one of several available approaches to funding health services. The MRAC and its working groups apply a whole-of-healthcare-system approach to its reviews.

Government consideration

If the Australian Government agrees to the implementation of recommendations, it will be communicated through government announcement.

Information will also be made available on departmental websites, including MBS Online and departmental newsletters.

References

1 Garrett, C. C., Keogh, L. A., Kavanagh, A., Tomnay, J. & Hocking, J. S. Understanding the low uptake of long-acting reversible contraception by young women in Australia: a qualitative study. *BMC Womens Health* **15**, 72 (2015). https://doi.org/10.1186/s12905-015-0227-9

2 Mazza, D. *et al.* Improving rural and regional access to long-acting reversible contraception and medical abortion through nurse-led models of care, task-sharing and telehealth (ORIENT): a protocol for a stepped-wedge pragmatic cluster-randomised controlled trial in Australian general practice. *BMJ Open* **13**, e065137 (2023). https://doi.org/10.1136/bmjopen-2022-065137

3 Cromer, S. J., Thaweethai, T. & Wexler, D. J. Racial/ethnic and socioeconomic disparities in achievement of treatment goals within a clinical trial: a secondary analysis of the ACCORD trial. *Diabetologia* **66**, 2261–2274 (2023). https://doi.org/10.1007/s00125-023-05997-2

4 Turner, R. *et al.* Associations of anticipated prescribing of long-acting reversible contraception by general practice registrars: A cross-sectional study. *Aust J Gen Pract* **50**, 929–935 (2021). https://doi.org/10.31128/AJGP-09-20-5657