Women's Sexual and Reproductive Health Coalition

A consensus statement on improving abortion affordability in Australia

Recommendations

The SPHERE Coalition recommends that the Australian Government:

1) Introduce a targeted bulk-billing incentive for sexual and reproductive health consultations, available to all abortion providers*. The incentive could be modelled on the 40% loading for long-acting reversible contraception (LARC) insertions and would support the provision of medical abortion care without out-of-pocket costs to patients.

2) Fund no-cost ultrasound for abortion care where ultrasound is required:
    a) For higher-volume community-based abortion services
        i) by providing bedside ultrasound equipment and
        ii) building the capacity of public and community health services to provide ultrasound services through funded scholarships to support training in bedside ultrasound use for abortion providers*
    b) For lower-volume abortion providers*(including community general practitioners (GPs), Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations) by funding Primary Health Networks (PHNs) to commission regional fast-tracked ultrasound services.

3) In relation to navigating to abortion providers*:
    a) Support each state and territory to establish a single consumer-accessible, culturally safe entry point for abortion care through a federated model of state-based navigation services. Building on proven models such as 1800 My Options in Victoria, these navigation services should offer self-referral, GP referral and triage, and be well connected to local sexual and reproductive healthcare providers to facilitate timely, appropriate and culturally safe referrals.
    b) Commission a feasibility study of integrated navigation hubs that coordinate referrals, ultrasound services and medication access, tailored to the needs of each jurisdiction.

4) Improve abortion affordability for people without Medicare by:
    a) Subsidising the cost of abortion medications to the PBS price and funding associated costs of abortion care for people without Medicare, modelled on the Federation Funding Agreement for HIV treatment;
    b) Mandating reform of private health insurance for temporary visa holders (Overseas Student Health Cover and Overseas Visitor Health Cover) at the next renegotiation of these

arrangements, to ensure abortion and associated care are standard covered services with no waiting periods, regardless of the duration of cover; and

c) Establishing a targeted equity fund for abortion care for people without Medicare, implemented at a state and territory level, directed by financial need and supported by clear eligibility criteria and secure, sustainable funding.

5) In relation to the costs of consumables related to medical abortion:
   a) Fund PHNs to supply community-based abortion providers*(including Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations) with consumables packs comprising:
      i) abortion medications,
      ii) analgesia,
      iii) anti-nausea medication and
      iv) low-sensitivity urine pregnancy (LSUP) tests for follow-up; and
   b) Fund public hospitals to provide LSUP tests for abortion care to support cost-effective, patient-led follow-up.

6) In relation to abortion in public hospitals:
   a) Establish a joint federal-state-territory working group with sector, government and consumer representation to identify funding and other incentives, including reviewing activity-based funding and capability frameworks, that may encourage comprehensive abortion care provision in public hospitals and develop a strategy to implement them;
   b) Invest in public hospital capability to provide surgical abortion care in line with population health need, while prioritising patient choice of procedure, by:
      i) requiring surgical abortion provision through accreditation, quality and accountability mechanisms;
      ii) expanding theatre capacity, including staffing, and the range of procedural options available, such as outpatient manual vacuum aspiration models;
      iii) creating training opportunities for the next generation of abortion providers*; and
      iv) supporting the establishment of dedicated surgical abortion lists.

   Integrated public-private service models may remain necessary in jurisdictions where private provision is limited or declining and/or public services impose barriers.

7) Invest in workforce development as a long-term abortion affordability and sustainability strategy by:
   a) Embedding abortion care in national training curricula for healthcare practitioners;
   b) Expanding the availability of fellowships and advanced training for abortion providers*;
   c) Funding training without income loss for abortion providers*;
   d) Supporting nurses, midwives, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers to work to their full scope of practice in abortion care;
   e) Supporting a “clinical champions” approach in each state;
   f) Continuing funding and support for the Australian Contraception and Abortion Primary Care Practitioner Support (AusCAPPS) Network.

8) In relation to the Medicare rebate for surgical abortion:
   a) Increase the Medicare rebate for surgical abortion to reduce financial barriers to access, lower patient out-of-pocket costs, and support the ongoing viability and sustainability of surgical abortion services; and
   b) Explore mechanisms to fund IUD insertion at the time of surgical abortion.

9) Implement an intersectional national data collection framework, with data disaggregated by population group. The framework should capture abortion service provision, costs, access barriers and outcomes to support planning, accountability and evaluation, and align with the Australian Institute of Health and Welfare national sexual and reproductive health monitoring framework and data strategy.

***Note:** Throughout this statement, the term 'abortion providers' refers to the range of health professionals who contribute to abortion care, including general practitioners and rural generalists, gynaecologists, registered and enrolled nurses, nurse practitioners and nurse prescribers, midwives and endorsed midwives, and Aboriginal and Torres Strait Islander Health Practitioners and Health Workers. Abortion care is delivered by multidisciplinary teams across general practice, community health services, Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations, sexual and reproductive health services, and hospitals. Recommendations referring to abortion providers are intended to apply across these professions and settings, and to support each provider to work to their full scope of practice.

Background

SPHERE is the National Health and Medical Research Council (NHMRC) Centre of Research Excellence in Women's Sexual and Reproductive Health in Primary Care, a collaborative research centre comprising national and international experts in sexual and reproductive health.

The SPHERE Coalition is a cross-sectoral, multidisciplinary alliance comprising more than 280 clinician experts, consumers, representatives from peak bodies and key stakeholder organisations, and eminent Australian and international researchers who have a shared vision for improving women's sexual and reproductive health in Australia.

Equitable access to abortion is a key priority of the National Women's Health Strategy 2020-2030.[1] While abortion is decriminalised across all Australian states and territories, and important regulatory reforms have been made, including the permanent retention of Medicare Benefits Schedule (MBS) telehealth items for sexual and reproductive health[2] and the 2023 deregulation of MS-2 Step,[3] affordability remains a substantial and under-addressed barrier to equitable abortion access.

On 19 March 2026, SPHERE, in partnership with Women's Health Victoria, co-convened the National Abortion Affordability Roundtable (the 'Roundtable'), which brought together clinicians, researchers, policymakers and advocates in Melbourne to examine the financial barriers that continue to limit equitable access to abortion care across Australia. The recommendations in this consensus statement emerged from the Roundtable and were subsequently refined and endorsed by the SPHERE Coalition. The sections that follow summarise the key affordability barriers identified during the Roundtable that underpin the recommendations outlined above.

High out-of-pocket costs for medical abortion consultations

Medical abortion (currently available up to 9 weeks' gestation) often requires multiple consultations for assessment, counselling, prescribing, and follow-up.[4] These are often longer consultations, reflecting the complexity of this care. Where medical abortion consultations are not bulk-billed, patients can incur significant out-of-pocket costs, compounding the overall financial burden of accessing abortion care.

The 40% bulk-billing loading introduced for LARC insertion and removal in November 2025 offers a relevant precedent, demonstrating that a targeted loading can make bulk billing viable for providers and remove cost

as a barrier for patients. This bulk-billing incentive approach could be similarly extended to medical abortion care in primary care and community settings. The bulk-billing incentive must be available to all abortion providers* to ensure equitable access to care, particularly in rural and regional areas where nurses, midwives and Aboriginal and Torres Strait Islander Health Practitioners may be the only local providers. Importantly, the incentive should apply to all sexual and reproductive health consultations rather than abortion-specific services to protect patient privacy and minimise the risk of reproductive coercion or surveillance through Medicare records.

High ultrasound costs

Ultrasound is often the largest single out-of-pocket expense associated with abortion care, commonly exceeding $200 in the private sector. For people in rural and regional areas, limited access to local bulk-billed imaging can further increase costs through travel expenses and time away from work, contributing to delays in care. No-test protocols for medical abortion up to 10 weeks gestation where (a) the gestation can be reliably determined from menstrual history and clinical assessment and (b) where the woman is low risk for ectopic pregnancy have been shown to be safe, effective, acceptable to patients, and improve access by reducing wait time[5]. While this approach has been endorsed by the World Health Organization Abortion Care Guideline and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Clinical Guideline for Abortion Care[6-7] this streamlined model of abortion care is yet to become routine practice in Australia. In addition, a recent Australian study assessing the validity and accuracy of an eligibility assessment tool for no-ultrasound medical abortion care found that only 30.4% of participants remained eligible for a no-ultrasound approach[8]. The majority of medical abortions will therefore still require an ultrasound.

Where ultrasound is clinically indicated, government funding must support access to no-cost ultrasound. For higher-volume community-based abortion services, this could include investment in bedside ultrasound equipment within public and community health services. For lower-volume providers, including community GPs, Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations, PHNs could be funded to commission fast-tracked, no-cost ultrasound services in their region. These services could be delivered through arrangements with local private radiology providers and be open to referral from any community provider. A similar approach is used in Ireland.[9-10] In both approaches, funding must also support bedside ultrasound training for abortion providers*. Where a patient prefers to have an ultrasound, this should also be provided at no cost.

Fragmented care pathways create barriers to affordable abortion care

People seeking abortion care often need to navigate multiple providers and services, including telehealth, imaging, pathology, pharmacies and follow-up care. This fragmented system creates additional costs, delays and administrative burden, particularly for people in rural and regional areas.

Establishing a single consumer-accessible entry point in each state and territory would help people identify appropriate providers and navigate care more efficiently. Building on proven services such as 1800 My Options in Victoria, and similar to the Irish model of navigated care,[10] these navigation services must offer self-referral, GP referral and triage. They must also be closely connected to local sexual and reproductive healthcare providers, including Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations, to facilitate timely, appropriate and culturally safe referrals. A federated model of state- and territory-based navigation services, rather than a single national phone line, would better reflect differences in legislation, geography and service availability across jurisdictions.

To be genuinely accessible, navigation services must be available by telephone as well as online, as people without reliable internet access may otherwise be excluded. They must also be culturally safe and available

in languages other than English, with access to interpreting services. Bicultural and bilingual health workers, health educators and peer support workers are often the first point of contact for health information in their communities and should be recognised and supported as important facilitators and navigators of abortion care. While navigation services can improve access to abortion care, requiring people to engage with an additional service may itself create barriers. A feasibility study could therefore explore opportunities to develop more integrated models of care coordination tailored to the needs of each jurisdiction.

Abortion is unaffordable for people without Medicare

People who are not eligible for Medicare face some of the highest costs of abortion care. In this statement, references to people without Medicare include temporary visa holders, Pacific Australia Labour Mobility (PALM) scheme workers, undocumented people, people seeking asylum, international students, tourists, and people incarcerated in immigration detention and female-designated prisons. Without access to Medicare, a medical abortion can cost $600-$800 before ultrasound and other associated costs are included. MS-2 Step (mifepristone-misoprostol) costs approximately $391 for people without Medicare, compared with a PBS co-payment of $25 for Medicare-eligible patients (and $7.70 for a pensioner or any Commonwealth concession card holder), creating a substantial and unavoidable financial barrier to care.

The cost of abortion medications and associated abortion care should be subsidised for people without Medicare. A potential model is the Federation Funding Agreement for HIV treatment,[11] which enables access to testing and treatment regardless of visa status through state-funded services, and demonstrates the feasibility of a sustainable, system-wide approach. Private health insurance products for temporary visa holders, including Overseas Student Health Cover and Overseas Visitor Health Cover,[12] should also be required to cover abortion and associated care without waiting periods. Recent changes to Overseas Student Health Cover removed the waiting period for pregnancy-related care, but only for policies of two years or more, meaning people with shorter cover remain subject to a waiting period. Reform must ensure that no waiting period applies regardless of the duration of cover and could be implemented at the next renegotiation of the Deed for the Provision of Overseas Student Health Cover and Overseas Visitor Health Cover.

States and territories should also establish targeted equity funds to support people accessing abortion without Medicare, allocated according to financial need and supported by clear eligibility criteria. A range of existing initiatives seek to reduce abortion costs for people without Medicare (e.g., Tasmania's Women's Health Fund, the MSI Choice Fund,[13] ACT's no-cost abortion model); however, targeted equity funds must be supported by committed secure and sustainable funding.

Consumables create hidden costs for patients and providers

Under the Health Insurance Act 1973, Medicare rules state that when a provider bulk-bills a Medicare Benefits Schedule (MBS) service, they undertake to accept the official Medicare benefit as full payment for that service. This means that when a consultation is bulk-billed, medical practitioners are legally prohibited from charging any out-of-pocket fees or additional surcharges to the patient for that specific service. This rule strictly prohibits charging extra for any consumables or administrative items necessary to deliver or complete the clinical service.

This means that in the case of medical abortion, even where consultations are bulk-billed, providers cannot separately recover the cost of medications and consumables required to deliver care, including abortion medications, analgesia, anti-nausea medication and the low-sensitivity urine pregnancy (LSUP) tests** used for follow-up. These costs (which include prescription and non prescription items) must therefore be paid by patients or be absorbed by services and is a disincentive to bulk billing.

Commissioning PHNs to supply community-based providers, including Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations, with abortion consumables packs comprising abortion medications, analgesia, anti-nausea medication and LSUP tests, would remove out-of-pocket costs for patients and reduce the financial burden on providers. This is similar to the approach used successfully in Ireland.[10] LSUP-based self-assessment is a clinically appropriate alternative to routine clinic follow-up, and evidence shows that home self-assessment with an LSUP test is non-inferior to clinic follow-up for confirming abortion completion.[14] Funding for LSUP tests must also be extended to public hospitals providing abortion care to support cost-effective, patient-led follow-up.

** Low sensitivity urine pregnancy (LSUP) tests differ from standard retail pregnancy tests because they are calibrated to a higher hCG detection threshold (typically around 1,000–2,000 mIU/mL compared to standard tests at 10–25 mIU/mL). They are primarily used in medical settings for medical abortion to confirm that hCG levels have dropped, rather than to detect an early pregnancy. They cost approximately $30-35 AUD and are only available through medical supply distributors.

Disincentives within the public hospital system suppress abortion provision

Public hospital activity is funded primarily through activity-based funding, under which each episode of care is priced according to a national weighted activity unit (NWAU) set by the Independent Health and Aged Care Pricing Authority and weighted by clinical complexity. Surgical abortion is classified as a non-complex, low-NWAU procedure and attracts a low price relative to other surgical procedures, despite being high-volume and requiring theatre time, staffing, and consumable resources. The same classification applies to surgical management of miscarriage. While this funding model generally reflects the direct cost of care, it may create institutional incentives to prioritise higher-funded procedures over abortion services, contributing to limited public provision and longer waiting times. Other disincentives include having mixed theatre lists, where abortion care competes with other surgical procedures, rather than having dedicated abortion lists. The SPHERE Coalition recommends that a joint federal-state-territory working group with sector, government and consumer representation be established to identify funding and other incentives that may encourage comprehensive abortion care provision in public hospitals and to develop a strategy for their implementation. This could include reviewing activity-based funding and capability frameworks, and considering mechanisms that link abortion provision to hospital funding, accreditation and quality and accountability mechanisms;

Surgical abortion services are limited and unevenly distributed

Surgical abortion services are limited and unevenly distributed across jurisdictions, gestations and settings. Private provision is concentrated in metropolitan and larger regional centres, while public provision is variable and frequently capped below the legislated gestational limit, directing people towards more expensive private care or interstate travel. For those required to travel, transport, accommodation and time away from work can add substantially to the cost of care. Where public services provide surgical abortion, the range of procedures offered varies according to the skills of available proceduralists and the theatre time and staffing allocated to them. The public system also disproportionately cares for the most clinically complex patients, including those with significant comorbidities or complex social circumstances who are not suitable for lower-cost community or telehealth models. However, neither public hospital theatre staffing nor the range of procedural options has kept pace with this demand.

Public provision of surgical abortion must be expanded to meet population health need. This requires securing provision through accreditation, quality and accountability mechanisms so that services cannot opt out, and expanding theatre capacity, including the staffing required to run dedicated lists and the range of procedural options available, such as lower-cost outpatient manual vacuum aspiration models. It also

requires creating training opportunities for the next generation of abortion providers* and supporting clinical champions to establish dedicated surgical abortion lists. Teaching hospitals should be required to provide surgical abortion care, both to ensure equitable provision and to secure these training opportunities. The Victorian experience, where sustained investment and government commitment have expanded surgical abortion provision to 23 public health services across the state, including in regional Victoria, demonstrates that such growth is achievable.[15] This work should align with broader health service planning across the public health system, such as the Victorian Health Service Plan currently underway. While Recommendation 6 is directed at the public hospital system, most surgical abortions in Australia are provided by procedural GPs in community day hospital settings. Expanding public surgical abortion provision should therefore be understood to include public investment in and commissioning of surgical abortion care in community and outpatient settings, rather than only in hospital theatres. Integrated public-private models may remain necessary in jurisdictions where private provision is limited or declining and where public services impose barriers, with patient choice of procedure prioritised throughout. However, reliance on these models may limit opportunities to train future generations of abortion providers* who need experience in providing abortion care.

Surgical abortion is inadequately reimbursed under Medicare compared to procedures of lesser complexity (e.g., IUD insertion)

Inadequate MBS reimbursement for surgical abortion procedures is a significant contributor to the high out-of-pocket costs faced by patients seeking this care. Current Medicare rebates fail to adequately reflect the complexity, time, skill and resources required to provide these procedures.The MBS item number applicable to most surgical abortions is 35643 – evacuation of the contents of the gravid uterus by curettage or suction curettage. The scheduled fee for this item is $260.90, resulting in a Medicare benefit of $195.70 when reimbursed at 75%, as is typically the case for procedures performed in day hospitals.

By comparison, the MBS item number used for IUD insertions, 35503, has a scheduled fee of $221.55, resulting in a Medicare benefit of $188.35 when reimbursed at 85%, as is typical in general practice settings. With the 40% bulk-billing incentive, the Medicare benefit payable for IUD insertion increases even further. IUD insertion is generally an office-based procedure requiring relatively limited equipment, resources and staffing. In contrast, surgical abortion requires substantially greater clinical resources, specialised equipment, theatre facilities, longer procedural times, nursing and support staff, and more intensive perioperative care. Surgical abortion also requires clinicians with advanced procedural skills and training, who face substantially higher medical indemnity costs due to the nature of the procedure. Despite these significantly higher costs and resource requirements, the Medicare benefit for surgical abortion is only $7.35 higher than that for IUD insertion.

The recent increase in the MBS rebate for IUD insertion recognised the time, skill and expertise required to provide this service, while also encouraging greater provider participation and reducing patient out-of-pocket costs. Similar recognition of the complexity, resource requirements and clinical expertise associated with surgical abortion is warranted.

In addition, an IUD insertion cannot be claimed through Medicare at the same time as a surgical abortion, whereas an implant insertion can be claimed*. Inserting an IUD at the time of surgical abortion is best practice and avoids a further appointment and additional cost for the patient, yet the IUD insertion attracts no Medicare benefit. Mechanisms to fund IUD insertion at the time of surgical abortion should therefore be explored.

*Contraceptive implant insertions (e.g., Implanon) are listed under Category 1 (Professional Attendances / Miscellaneous Procedures) rather than Group T8 Gynaecology in the Medicare Benefits Schedule. As a

result, they are not bound by the same group exclusion clause and can be claimed alongside a surgical abortion.

Workforce shortages drive long-term affordability problems

Shortly before the removal of the mandatory registration requirement in 2023, 3,885 GPs were registered to provide medical abortion, with around two-thirds located in metropolitan areas.[16] This uneven distribution leaves an estimated 30% of Australian women living in an area without a GP medical abortion provider, increasing to around 50% in remote areas.[17] Developing a larger and more geographically distributed abortion workforce is therefore essential to improving the affordability and long-term sustainability of abortion care. This should begin with embedding abortion care as core content in national medical, nursing and midwifery curricula, rather than relying on healthcare practitioners to acquire these skills through later specialisation. It should also include expanded fellowships and advanced training pathways for abortion providers*, building on initiatives such as the AusLARC program, the LARC Centres of Excellence, and RANZCOG's advanced training pathway and Advanced Diploma, which is being expanded to include abortion care. The US Complex Family Planning Fellowship leadership training (https://societyfp.org/fellowship/) offers useful lessons and combines advanced clinical training in abortion care with research and leadership development. A comparable Australian program could provide funded one- to two-year positions for practitioners in each state and territory, helping to develop both clinical capacity and future leaders in abortion care.

Workforce investment must also enable community-based abortion providers* to train without loss of income, support nurses, midwives, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers to work to their full scope of practice, and support clinical champions and communities of practice. The Australian Contraception and Abortion Primary Care Practitioner Support (AusCAPPS) Network (https://medcast.com.au/communities/auscapps) provides an established online multidisciplinary community of practice supporting GPs, nurses, pharmacists and midwives to deliver contraception and abortion care, and is well placed, with government funding, to underpin this effort. Building a larger, better-distributed and appropriately remunerated workforce would reduce reliance on a small number of providers, improve service availability and help lower the cost of delivering abortion care.

National data on abortion affordability are inadequate

Efforts to improve abortion affordability are hampered by fragmented and incomplete national data on abortion service provision, costs, access barriers and outcomes. This limits the ability of governments and health services to identify gaps, monitor inequities, evaluate reforms, and ensure accountability. For example, there are no national data on where ultrasounds for abortion care are undertaken, or on the proportion provided through private radiology compared with public services, despite ultrasound being a significant contributor to out-of-pocket costs. Importantly, any data collection on abortion must be designed to safeguard patient privacy and avoid unintended harms to individuals, providers, and services.

A national data collection framework must be established to support planning, monitoring and evaluation of abortion affordability and access. To avoid duplication and build on existing work, the framework must align with the Australian Institute of Health and Welfare's national sexual and reproductive health monitoring framework and data strategy, as well as the Aboriginal and Torres Strait Islander Health Performance Framework. It must also incorporate measures that explicitly capture abortion costs, out-of-pocket expenses, and affordability barriers. The framework must take an intersectional approach, and data must be disaggregated by population group, as existing frameworks often lack adequate indicators for Aboriginal and Torres Strait Islander people, migrants and refugees, and people in rural and remote areas. The framework

must also be developed in consultation with consumers and providers and include robust privacy and data governance protections.

Conclusion

While abortion is decriminalised across Australia and important regulatory reforms have been made, cost remains a significant and under-addressed barrier to equitable abortion access. The recommendations in this consensus statement, many of which build on existing Australian models, provide a coordinated and achievable roadmap to improving abortion affordability. Implementing these recommendations will require sustained investment and coordinated action across federal, state and territory governments. Improving abortion affordability is essential to ensuring equitable and timely access to abortion care, regardless of geography, financial circumstances, or Medicare eligibility, and to achieving the goals of the National Women's Health Strategy 2020-2030.

Further SPHERE Coalition Consensus Statements and recommendations in relation to abortion

- Publicly funded abortion service provision: a duty of care https://www.spherecre.org/images/SPHERE%20Coalition%20Statements/A_consensus_statement_on_publicly_funded_abortion_service_provision_a_duty_of_care.pdf
- Achieving equitable access to abortion care in regional, rural and remote Australia https://www.spherecre.org/images/SPHERE%20Coalition%20Statements/A_consensus_statement_on_achieving_equitable_access_to_abortion_care_in_regional_rural_and_remote_Australia.pdf
- A consensus statement on Google's restriction of advertising sexual and reproductive healthcare services https://www.spherecre.org/images/SPHERE_Coalition_consensus_statement_on_Googles_restriction_of_advertising_sexual_and_reproductive_healthcare_services.pdf

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