Sexual Health Advocates for Reproductive Equity

Committee Secretariat
Select Committee on Cost of Living
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Committee Secretary,

Sexual Health Advocates for Reproductive Equity (SHARE) are writing to make a submission to the Cost of Living Select Committee regarding the need for universal and free access to contraception in Australia. SHARE is a youth-led, non-partisan campaign fighting to make everyone's contraceptive of choice free in Australia, and available to all. SHARE is a powerful movement of diverse young people with lived experience working to increase access to sexual and reproductive healthcare in Australia and enshrine universal access to sexual and reproductive healthcare as a human right.

This campaign is not only a matter of public health but also one of economic fairness as access to affordable contraception plays a critical role in reducing the financial burdens faced by individuals and families, particularly women and gender-diverse people.

Access to contraception is an essential component of healthcare. However, many Australians, particularly younger people and those from lower socioeconomic backgrounds, rural and remote areas, or marginalised communities, continue to face significant barriers to accessing it due to high costs and limited availability. This inequity exacerbates financial pressures, particularly for women and gender-diverse people, by limiting their control over reproductive health, family planning, and, ultimately, their economic well-being.

Universal and free access to contraception would not only alleviate direct out-of-pocket costs for individuals but also contribute to broader economic benefits. By reducing unplanned pregnancies, this initiative could decrease healthcare expenditures related to maternal and child health services, reduce absenteeism from work or education, and enable greater participation in the workforce, especially among women. In the context of rising living costs and economic uncertainty, ensuring that contraception is freely and readily available is a pragmatic and cost-effective public policy solution.

Over the last seven months, SHARE has been undertaking the 'Cost of Contraceptives Survey'. As of October 2024, SHARE has received over 160 responses to the survey representing a diverse cross-section of Australia's population, including a wide range of ages, locations, educational levels, cultural backgrounds, sexual orientations, disability status, First Nations status and citizenship status. The Interim Report and the survey's preliminary results have identified that the prohibitive and rising cost of contraception is significantly impacting people's access to safe and effective contraception.

SHARE has provided the Interim Report, including preliminary survey results, recommendations and background information, below as its submission to the Select Committee. SHARE's recommendations directly link to the Select Committee on the Cost of Living's Terms of Reference section (d) measures to ease the cost of living through the provision of Government services.

SHARE urges the Committee to consider the long-term economic and social benefits of adopting a model of universal and free access to contraception in Australia. By making contraception free, we can advance gender equity, promote public health, and contribute to easing the cost of living for millions of Australians.

Thank you for considering this submission. SHARE welcomes the opportunity to discuss this issue further with the Select Committee and provide any additional information that may assist in the inquiry.

Sincerely,

Sexual Health Advocates for Reproductive Equity

Universal Access to Contraception Now: Cost of Contraceptives Survey Preliminary Report

by Sexual Health Advocates for Reproductive Equity

Acknowledgement of Country

Sexual Health Advocates for Reproductive Equity acknowledge that this report was written on stolen land and sovereignty was never ceded. We pay our respects to the Traditional Custodians and their Ancestors of the unceded lands and waters across this country and elders past and present. We recognise that barriers to sexual and reproductive health and forced contraception and sterilisation have been and continue to be a tool of colonisation. For these reasons, we work in solidarity with Aboriginal and Torres Strait Islander People and support First Nations justice.

About this report

This policy brief has been written by Sexual Health Advocates for Reproductive Equity campaign organisers.

Sexual Health Advocates for Reproductive Equity is a youth-led, non-partisan campaign fighting to make everyone's contraceptive of choice free in Australia, and available to all.

Sexual Health Advocates for Reproductive Equity is a powerful movement of diverse young people with lived experience working to increase access to sexual and reproductive healthcare in Australia and enshrine universal access to sexual and reproductive healthcare as a human right.

Disclaimer

This report is for information purposes only. While every effort has been made to ensure that the information is up-to-date and accurate Sexual Health Advocates for Reproductive Equity accepts no liability for any loss or damage incurred by any person relying on the information.

Overview

Sexual Health Advocates for Reproductive Equity (SHARE) advocates for universal access to reproductive healthcare through access to free contraceptives for all. Contraception is fundamental to empowering women and gender-diverse people to plan pregnancies, manage their health, receive an education, work productively and thrive in all aspects of life.

In Australia, the main forms of contraception are the oral contraceptive pill (28.8%) and male condoms (14%) (United Nations Department of Economic and Social Affairs, 2015). Long-acting reversible contraception (LARCs) such as implants (2.7%) and intrauterine devices (IUDs) (1.5%) is revered as the gold standard for contraception worldwide due to their high efficacy, ability to manage other health conditions (e.g. endometriosis, menopause, polycystic ovary syndrome (PCOS)), and cost-effectiveness but are taken up much less than other developed countries (4.6%). Injectable contraception (2%) is used by many people with disabilities and vaginal barrier methods (0.8%) are also common in Australia. However, withdrawal methods (1.7%), rhythm practices (1.2%) and an additional 10% unmet contraceptive use are high in Australia.

Due to the high cost of contraceptives, women and gender-diverse people, if they are even able to afford contraceptives, are often being restricted to using contraceptives with adverse side effects such as mood changes, irregular bleeding, nausea, headaches, tender breasts, skin changes, weight gain etc. For instance, uterus owners pay around $76.39 for a script of the progestogen-only pill Slinda because other progestogen-only pills such as Microlut which are subsidised by the PBS at $11.99 are often not recommended by doctors as it can be less effective and can cause irregular bleeding (Chrysanthos, 2023). The Pharmaceutical Benefits Scheme possesses a maximum of $30 for a script of oral contraceptives. However, with many outdated products one-third of Australian women are now using non-subsidised contraception with more popular contraceptive pills such as Slinda, Yaz, and Zoely, preferred due to reduced side effects ranging from $76.95-87.99 each script (Skiba et al., 2019). Cost continues to act as a barrier to contraception with an additional average $50 gap fee to

get a renewal form from a general practitioner.

For Australian women and gender-diverse people who choose LARC options to manage their sexual and reproductive health, these costs can range up to $180 for an IUD (without a Medicare card) and cost upwards of $320 for consultation and insertion fees ($510 including general anaesthesia) (MSI Australia, 2024; Women's Health Matters, 2019). For many Australians, these upfront costs make many preferred forms of contraception inaccessible making it impossible to manage their fertility and health conditions such as endometriosis, PCOS, and menopause.

Legislating universal access to contraception will also save taxpayers money. For instance, if 14.8% of women and gender-diverse people at risk of pregnancy adopted LARCs when they were previously using no form of contraception the Australian Government would save $20 million over five years from avoided abortions and miscarriages (Botfield et al., 2020). In other countries such as Finland where contraception is free under 25 years old in certain regions teenage abortions fell 66% from 2000 to 2023 (Kauranen, 2024). In addition, the CHOICE study in the United States of America (Missouri) found that the provision of free contraception reduced the rate of teenage birth within the cohort to 6.3 per 1000 compared to the national rate of 34.1 per 1000 (Peipert et al., 2012). When women and gender-diverse people have universal access to contraception it translates to better social, educational, and financial situations for uterus owners and society at large.

Sexual and reproductive health is a human right (UN General Assembly, 1966). Enshrining universal access to contraception is fundamental to achieving the Sustainable Development Goals of Good Health and Well-being and Gender Equality (Target 3.7 and Target 5.6) (United Nations, 2022; United Nations, 2022). Currently, women and gender-diverse people bear the brunt of the contraceptive burden physically, mentally, emotionally, and economically. Due to the high costs of managing sexual and reproductive health through contraception in Australia, women, girls, and gender-diverse people are disproportionately impacted and possess poorer health outcomes with marginalised groups (e.g. First Nations, disabled, migrant, culturally and

linguistically diverse, low socio-economic, regional and remote, and Queer people) experiencing the worst. Australia will not achieve true good health and gender equity until our women and gender-diverse people can exercise their bodily autonomy without cost barriers restricting their choices and ability to exercise their full sexual and reproductive health rights.

The Australian Government has an opportunity to act on its *National Women's Health Strategy 2020-2030* priority to "remove barriers to support equitable access to timely, appropriate and affordable care for all women" by "work(ing) towards universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies, including contraception options". **As such, we call on the Australian Government to establish a National Special Interest Fund for Universal Access to Contraceptives immediately and implement all recommendations in this report**

A note on the cost of living crisis

The cost of living crisis is creating a sexual and reproductive health crisis in Australia. Currently, 3.7 million (36%) Australian households are already experiencing moderate to severe food insecurity (Foodbank, 2023), and uterus owners are having to choose between contraceptives and food. The survey data below expands on how the cost of contraception now more than ever is out of reach. The time to implement universal access to contraception is now.

Recommendations

Recommendation One: Alleviating financial burden for patients

- Provide free contraception of all forms (e.g. condoms (internal condoms), dental dams, oral contraceptive pills (including emergency/daily contraceptives), LARC (especially copper IUDs), vaginal rings, contraceptive injections, vasectomies, tubal ligation, and hysterectomies), to all people in Australia (including non-Medicare card holders).
- Bulk bill sexual and reproductive health appointments by developing specific Medicare Benefits Schedule (MBS) Item numbers for sexual and reproductive health-related appointments as part of the existing gender-responsive review of Medicare funding and ensuring that these and existing item numbers cover the costs of providing services (e.g. contraception scripts, initial consultations, LARC insertions, contraceptive injections, follow-up consultations, consultations for complex sexual and reproductive health conditions, and ultrasounds when needed). Thus, guaranteeing there is no gap fee for appointments.
- Provide appropriate remuneration for the workforce to provide contraceptive services to cover the difference so that there are no insertion fees for patients.

Recommendation Two: Increasing the capability of the health workforce to improve accessibility

- Provide greater incentives and funding for GPs, nurses, and nurse practitioners to undertake LARC insertion/removal training (especially in regional and rural areas).
- Expand the pilot program nationally to enable trained pharmacists to resupply oral contraceptive pills and the contraceptive ring without a prescription.
- Legislate that emergency contraceptive pills be provided over the counter.

Recommendation Three: Education at all levels

- Develop coordinated public health education campaigns for the general public and health professionals on contraception and reproductive coercion and abuse to improve health literacy.
- Increase the comprehensiveness and inclusiveness of sexual and reproductive health education in high schools with students of all genders including the different types of contraception.

Preliminary survey data breakdown

Over the last 7 months, SHARE has been undertaking the “Cost of Contraceptives Survey”. As of October 2024, we had obtained 162 responses the majority of recruited through our social media accounts and some through personal networks. While a relatively small sample, it represents a diverse cross-section of Australia’s population including a wide range of ages, locations, educational levels, cultural backgrounds, sexual orientations, disability status, First Nations status and citizenship status. The survey’s preliminary results have identified that the prohibitive and rising cost of contraception is significantly impacting people’s access to safe and effective contraception (Note: some quotes have been edited to fix spelling and grammar or to increase clarity).

Of all respondents, **11.7% of people** surveyed stated that they **had not used contraception** in the last six months. Close to **one in three (30%)** of these respondents cited **cost as a primary reason as** to why they had not used contraception, putting themselves at unnecessary risk of unplanned pregnancy and being unable to manage symptoms and other conditions due to financial constraints.

Furthermore, **three in five (61.2%)** respondents reported that the **cost of contraception limited their contraceptive choices**.

Adding to this, nearly **one in four respondents (25%)** stated that they **could not afford their preferred contraceptive method**. The lack of affordable and free contraceptives has resulted in many people compromising their healthcare needs and autonomy. Cost should not impact a person’s choice of contraception.

Additionally, **48.2% of respondents** have had to **make adjustments** to their contraceptive use due to the cost, a fact that has only been compounded by the cost-of-living crisis. This includes **pausing taking contraception, changing to a cheaper contraceptive or stopping the use** of contraception altogether due to difficulties affording it.

However, the cost of contraception does not just limit access to contraceptive choices

but also takes a significant emotional toll on respondents. **Over half** (**53.9%) of all respondents** reported that their **mental and emotional health was negatively impacted by the barriers** they faced in accessing contraception, a statistic that threatens to continue to increase as contraceptive prices increase.

Barriers to accessing contraception do not only affect fertility management, but many of our respondents reported using contraceptives to manage other conditions, including endometriosis and PCOS. The cost of contraception is not just a financial burden, but it also impacts gender equality, family planning, mental health and physical health.

These statistics only paint one part of the picture, however, the testimony that our respondent gave us paints a more powerful picture.

On the impact of cost affecting their choice of contraception, respondents told us:

> "*I would prefer to get an IUD* (intrauterine device) *under general anaesthesia but cannot afford the immediate out-of-pocket costs.* ***It's unfair I should pay nearly $1000 to manage my sexual and reproductive health***."

> "*It's really disappointing that not all pills are PBS-listed and therefore quite expensive. Especially the pill I take* ***(Slinda) which is very expensive but for many people is the only option*** *because they experience migraines with aura which increases the risk of clots when taking oestrogen-containing pills*."

> "*While my current situation means I am able to afford the use of contraception of my choice, in the past, when I was a student and had limited income, this cost was far more prohibitive and led me to* ***choose a method of contraception that wasn't right*** *for me. In addition, I was responsible for bearing the cost of contraception, while* ***my male partners did not have to bear this cost.***"

Respondents also told us that the cost of contraception was felt more significantly by people who had to try multiple contraceptives to find one that worked for them:

"*The seriousness of bad reactions to birth control and birth control procedures has to be taken more seriously. Most women I know have tried multiple different options, changing due to bad experiences.* ***When we talk about providing cheaper access to birth control - the reality that most people seeking birth control options have to go through a cycle of trial and error is always ignored.*** *Many of these options are incredibly expensive, only to have to try a new one soon after. I don't know what the solution is - can affordable "trial periods" really be given when it's medicine or a procedure? I don't really know. But most of the women in my life have had this same experience and had their bank accounts significantly dented as a result*."

Further, respondents who had debilitating conditions, such as endometriosis and PCOS, who utilised contraceptives as a way of managing their symptoms reported that their options for contraceptives were significantly more expensive than other forms:

"***Over years my contraception cost would total thousands of dollars.*** *Most recently I had an IUD inserted during an endometriosis laparoscopy procedure which I paid for privately* ***($3000+ with high-level private health insurance coverage)*** *as I was missing work frequently due to pain and bleeding. For the procedure, I took about a week of work. Subsequently, while the pain has improved, I've experienced ongoing bleeding since insertion. So now I am also on the combined pill to manage the bleeding and starting another round of investigative ultrasounds and appointments that will cost hundreds of dollars more.* ***I use contraception to prevent pregnancy, but more importantly, to manage a medical condition that causes me debilitating pain that impacts my physical and mental health and wellbeing, employment, and really every aspect of my life.*** *In the almost 20 years since I started menstruating at 16, contraception has* ***cost me thousands and thousands of dollars in direct and indirect costs, and it will continue to do so through the decades to come.***"

The cost of contraception was also used as a means and excuse of control among respondents:

> "*I haven't been impacted negatively by barriers to my own access to contraception, however,* ***one of my ex-partners tried to pressure me into buying the progesterone-only pill because he said it was cheaper than condoms (and cheaper because he wouldn't be buying them)****. This impacted my mental health because I felt bad about saying no because he would complain about paying for condoms. So, I guess I have been impacted by someone else's barriers to affording contraception."*

Finally, our respondents articulate why they felt all forms of contraceptives should be free.

> "*I just wish it was free,* ***it's a natural bodily function that I cannot control*** *so I find it unfair that I have to pay for it, not to mention when there were talks of male contraception I'm pretty sure it was going to be free.*"

> "*Contraceptives should be free or at low cost because* ***it should be a woman's right to decide if she wants a pregnancy*** *or not but also* ***it is our right to use it for other purposes,*** *like protecting ourselves from STIs or taking medication that helps with other conditions.* ***It is unbelievable that in 2024 we still need to pay so much for contraceptives because they are not considered essential medicine.*** *I'm lucky because I can still afford them, but many cannot. In addition, there should be more support in researching solutions that involve men -* ***we (uterus owners) are always the ones who need to take responsibility and bear the cost but it shouldn't be like that.***"

International Case Studies

Providing free contraception is not a new concept.

Countries have been providing free contraception for **over 50 years**.

Internationally, many countries include the provision of different forms of contraception in their health systems. Providing free contraception is a significant step towards achieving universal access to sexual and reproductive healthcare. Universal access to sexual and reproductive healthcare improves the holistic health of populations, promotes gender equality, improves workforce productivity and participation, and affirms the right to bodily autonomy and one's ability to choose.

Since 1970 China has provided free contraception, the United Kingdom also introduced this policy in 1974, and even Iran provided free contraception from 1988 until 2021 (Wang, 2012; Simbar, 2010). However, some countries including China and Iran as previously mentioned, require a couple to be married in order to access this form of healthcare. As a result, we will focus mainly on countries similar to the Australian context (e.g. United Kingdom, France, Belgium, Luxembourg etc.) where marital status doesn't determine access to contraception.

The United Kingdom (UK)

Often referred to as the gold standard for access to contraception globally and the closest to universal access to contraception. In 1974 the UK incorporated family planning services into the National Health Service (NHS) and provided nearly all forms of contraception free regardless of age and marital status (French, 2018). Currently, the United Kingdom provides condoms, internal condoms, combined and progestogen-only pills, emergency contraceptive pills, IUDs, contraceptive implants, contraceptive rings, contraceptive patches, contraceptive injections, vasectomies, and tubal ligation etc. with only hysterectomies not included (Pharmaceutical Services Negotiating Committee, 2021). In 2024, this service is now available for young people under 16 years old and all immigration statuses. Free contraception can be accessed in sexual health clinics (also known as family planning or contraception clinics), some GP surgeries, young people services and over-the-counter at pharmacies for the oral contraceptive pill (NHS, 2024).

France

After witnessing a decline in take up of contraception often due to financial reasons the French Government introduced policies to provide free contraception. They opted for a more staged rollout of free contraception with free contraception for uterus owners aged 15-18 years old introduced in 2013. In 2020, this scheme was expanded to

include uterus owners under 15, in 2022 this was extended to uterus owners under the age of 26 years old ((République Française [French Republic], 2022). Finally, in 2023, both internal and external condoms are now provided free in pharmacies for everyone under 26 years old (République Française [French Republic], 2024). This scheme included free-of-charge doctor's or midwife's consultations, examinations or medical procedures in connection with contraception as well as different types of contraception such as oral contraceptive pills, contraceptive implants, IUDs, and emergency oral contraceptives). Internal and external condoms, spermicide creams, contraceptive patches, and vaginal rings are not included. Uterus owners with a social security number (including asylum seekers if they can prove they have been in France for over 3 months, asylum seekers under 18 are not required to do this) can obtain a vitale card (or a certificate of entitlement) or the card of the medical aid of the state (AME) at a pharmacy which when presented to pharmacies can access free contraception (GISTI, 2023).

Luxembourg

Last year (April 2023) the Luxembourg Government announced it would be providing free contraception of all types (combined and progestogen-only oral contraceptive pills, emergency oral contraceptives, contraceptive patches, contraceptive rings, contraceptive injections, contraceptive implants, IUDs, tubal ligation, and vasectomies) minus condoms and hysterectomies (The Luxembourg Government, 2023; Puig, 2023). In addition, the cost of administering the contraceptive shot, inserting and removing the contraceptive implant and IUDs as well as relevant ultrasounds are also reimbursed 100% of the cost. Eligible people must be a Luxembourg citizen, resident, cross-border worker, or holder of a legal resident permit in order to access free contraception under the national health insurance scheme.

Belgium

We could not determine the exact year when free contraception policies were first introduced in Belgium however in 2009 studies reported uterus owners under the age of 20 were able to access free oral contraceptives over the counter at pharmacies (Weisberg & Fraser, 2009). In 2013, uterus owners under 21 years old in Belgium were able to access free oral contraceptive pills and contraceptive implants (Part et al., 2013). Recently in 2020, this scheme was extended to 25-year-old uterus owners and the emergency oral contraceptive pill was announced free for uterus owners of all ages (European Parliamentary Forum for Sexual & Reproductive Rights, 2019).

Ireland

In 2022, the Irish Government established the Free Contraception Scheme to provide free contraception to 17-25-year-olds. This scheme has been expanded an additional four times to include 26-year-olds in January 2023, 27-30-year-olds in September 2023, 31-year-olds in January 2024, and finally 32-35-year-olds in July 2024

(Government of Ireland, 2024). Eligible people include anyone with a uterus living in Ireland. Within the scheme the cost of consultations, cost of contraceptive options such as oral contraceptive pills, emergency oral contraceptive pills, vaginal rings, contraceptive patches, IUDs, contraceptive implants, contraceptive injections and any fittings, removals and checks are free. Continuity of contraception care is also eligible for patients even if they are no longer within the eligible age range. To access the scheme patients must visit their pharmacist or GP with only certain doctors signed up to provide free fittings and removals of LARCs (Citizens Information, 2024).

Albania

Since 1993, the Albanian Government has been providing free contraception in government health centres (European Parliamentary Forum for Sexual & Reproductive Rights, 2020). Currently, oral contraceptive pills, contraceptive injections, IUDs, and condoms are available to everyone (Population Reference Bureau, 2010).

Slovenia

Free contraception is provided by compulsory health insurance which residents and workers of companies in Slovenia can access (Permanent Mission of the Republic of Slovenia, 2015). However, there are concerns that vulnerable people and young people have been left out (European Parliamentary Forum for Sexual & Reproductive Rights, 2020).

Sweden

The Swedish Government has provided free contraception to uterus owners below 21 years of age since 2017 (Niemeyer Hultstrand et al., 2023). From the limited information online this scheme includes the provision of LARCS and oral contraceptives (European Observatory on Health Systems and Policies, 2019).

Norway

In Norway, young people between 16 to 20 years old can receive free contraception (Helsenorge, 2022). This includes the oral contraceptive pill, contraceptive patch, vaginal ring, and contraceptive implant. The Norwegian Government also provides free condoms which can be sent to your door for a small shipping fee (Helsenorge, 2023).

Countries that provide contraception in some regions but not nationally include:

- Canada (British Columbia provides free oral contraceptive pills, IUDs, contraceptive implants, and emergency oral contraception) (Government of Canada, 2024).

- Finland (Helinski provides free oral contraceptive pills and vaginal rings for a year and IUDs and contraceptive implants until 25 years old. Other areas also provide variations of this scheme) (City of Helsinki, 2024).
    - In Finland where contraception is free under 25 years old, teenage abortions fell 66% from 2000 to 2023 (Kauranen, 2024).

Proposed Timeline of Implementation in Australia

Stage 1 (under 6 months)	Stage 2 (6 months to 1 year)	Stage 3 (1-2 years)
Establish a National Special Interest Fund for Universal Access to Contraceptives	Provide free contraception for all forms to people of all ages (including people without access to Medicare)	Develop coordinated public health campaigns for the general public and health professionals on contraception and reproductive coercion and abuse
Free contraception of all forms for people aged under 25 and for people with conditions such as endometriosis and PCOS (including without a formal diagnosis)	Provide appropriate remuneration for the health workforce so that insertion costs for contraceptive devices are free	Increase the comprehensiveness and inclusiveness of sexual a reproductive health education in high schools with students of all genders including the different types of contraception
Enable trained pharmacists to resupply oral contraceptive pills and vaginal rings without a prescription	Incentivise and fund more nurses, and nurse practitioners to undertake LARC insertion/removal training (especially in regional and rural areas)	
Legislate that emergency contraceptive pills be provided over the counter	Bulk bill sexual and reproductive health appointments by creating specific MBS item numbers and ensuring these and existing item numbers cover the cost of appointments.	

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