Barriers to the prescription of LARCs in general practice in New Zealand—a qualitative research study

Orna McGinn, Helen JJ Fulcher, Bruce Arroll, Lesley McCowan

ABSTRACT

AIM: New Zealand has a high rate of unplanned pregnancy but a low rate of uptake of long-acting reversible contraception (LARCs), the most effective forms of contraception. This study aims to determine some of the barriers faced by general practitioners in New Zealand who wish to offer LARCs to their patients.

METHODS: General practitioners (n=17) were interviewed for this qualitative research study. The interviewees were asked about their experiences prescribing LARCs for their patients, any barriers they had experienced and how they felt any barriers described could best be overcome. Recorded interviews were examined using an inductive process of thematic analysis to generate codes to categorise the key patterns emerging from the data, in accordance with Braun and Clarke's six-phase framework.

RESULTS: There were three main themes identified as barriers to the provision of LARCs in general practice in New Zealand: a lack of funding for contraception provision in primary care, resulting in a high cost for LARC insertion for patients; poor access to procedural training; and the current Special Authority criteria for the LNG-IUS (Mirena©) IUS, which restricts its availability as a contraceptive option.

CONCLUSIONS: In order to increase the uptake of LARCs in New Zealand, robust primary care training and funding for contraception will be required. In addition, unrestricted funding for the LNG-IUS (Mirena) would increase the choice of effective LARCs available for all women.

Three different forms of long-acting reversible contraception (LARC), namely the copper intrauterine device (IUD), Mirena intrauterine system (LNG-IUS) and Jadelle implant, have been available in New Zealand for many years. However, the oral contraceptive pill and condoms are still the most commonly used forms of contraception in New Zealand, despite having a higher failure rate of 9% and 18% respectively, when compared with 0.1–0.2% for LARC.[1]

There is a lack of accurate data regarding LARC use in New Zealand, but one recent survey estimated the prevalence of IUD use in New Zealand women over 35 to be 8%, with a much lower rate of use of the contraceptive implant.[2] This estimate is likely to over-represent IUD use and under-represent implant use due to the age of the women surveyed, as older women who have given birth to children are more likely to be offered and to use this method of contraception.

Jadelle and the copper IUD are fully subsidised by PHARMAC. However, in New Zealand the Mirena IUS is funded for heavy menstrual bleeding only. In addition, a woman wishing to have a Mirena IUS for this indication must have tried and failed to improve using other treatment methods and must be anaemic with a haemoglobin of less than 120g/dl or a ferritin of less than 16mcg/l.[3]

LARC use has been promoted for many years by organisations such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the National Institute for Clinical Excellence (NICE) in the UK due to their safety, efficacy and acceptability.[4,5]

 © NZMA

Guidelines recommending their use as a first-line contraceptive in younger and nulliparous women have been produced by NICE, highlighting the positive effect that LARC use has on unplanned pregnancy rates, rates of repeat termination and rates of teenage pregnancy.[5]

Studies from Australia and the US looking at LARC access have highlighted that practitioners face barriers such as a lack of access to training,[6,7] and when trained there can be difficulty reaching a minimum number of procedures per year to maintain credentialed status.[8]

This paper aimed to identify whether similar barriers exist to the uptake of LARCs in primary care in New Zealand, and where barriers have been identified, how they could be overcome.

Methods

Candidates were recruited using purposive sampling, the aim being to recruit a range of general practitioner (GP) participants from around the country who have an interest in women's health and contraception. Attendees at the RNZCGP Rural Health Conference 2018 LARC training workshop were invited to participate in the interview process. Information regarding the study was also disseminated to two New Zealand medical community social media groups, which led to further recruitment.

Each participant was asked to fill in an initial questionnaire which asked about their gender, year and country of qualification, whether they had any postgraduate qualifications in women's health and whether their place of work was urban or rural. The participants were emailed a consent form and participant information sheet explaining the purpose of the study and outlining the process for data collection and storage.

The study was undertaken with an educational grant provided by the Northland branch of the RNZCGP and ethics approval was granted by the University of Auckland ethics committee on 30 October 2018 (reference number 021940).

The participants were interviewed by phone or Skype. Interviews lasted between 30 and 45 minutes. The participants were asked three open questions:

1. What is your experience in prescribing or offering LARCs to your patients?
2. What barriers (if any) have you experienced in being able to do this?
3. How do you think any barriers identified could best be overcome?

The recorded interviews were examined using an inductive approach of thematic analysis to generate codes in which to categorise the key emerging patterns, in accordance with Braun and Clarke's six-phase framework.[9] These codes were then used to group the interview excerpts according to the most common repetitive themes. Coding and analysis were carried out independently and in parallel by the two authors (OM and HF). Repeated reading of the transcripts allowed for the emergence of sub themes, which were agreed on in tandem by the authors.

Results

Of the 17 GPs surveyed, four (23%) worked in rural areas and 13 (77%) in urban areas. Eight of the 20 New Zealand DHBs were represented. Eleven (64%) interviewees had a postgraduate qualification relating to women's health, and four (23.5%) had qualified abroad, three in the UK and one in Germany. Thirteen (77%) of the interviewees were current LARC inserters.

The broad themes which emerged were:

Lack of funding for contraceptive services in primary care

The cost to the patient of having a LARC insertion was a recurrent theme. Although the copper IUD and Jadelle can be provided free for the patient without a prescription, there is usually a cost for the devices to be inserted and removed in general practice. This cost appears consistent around the country due to fixed practice costs such as staffing and materials, and most interviewees mentioned a figure of approximately $150.

"I spoke to (the practice manager), they can't really do it for any less than $100, an IUD. And I think a Jadelle was $65 or something like that. And in a population where we are only charging $18 for a consultation, that's a lot of money." (GP 3 Northland DHB)

© NZMA

Where they exist, funding models for contraception in primary care are complex. They may differ between and even within regions, and can depend on patient age, ethnicity or address, or the primary health organisation (PHO) to which the GP practice belongs. The interviewees described how this 'postcode prescribing' impacted on their practice.

"You don't know what's behind anyone's story. If they need contraception, they need contraception. And they're being sensible going about trying to get it." (GP 14 Hawkes Bay DHB)

GPs talked about being 'creative' in the search for additional funding for patients, sometimes using funds ring fenced for long-term conditions if the patient also happened to have a diagnosis such as asthma. If this was not possible, they would often reduce the cost at the practice, incur a loss or suggest a less suitable contraceptive method based on cost rather than clinical need. Concern was raised that the cost barrier was resulting in unintended pregnancies.

"If they're interested in a Jadelle, I think that costs about $160 for the fitting. I'm a bit soft, I tend to heavily discount this stuff because I know most people can't afford it, so I do it for about 75, 80 dollars." (GP 1 Hawkes Bay DHB)

Family Planning offers free consultations and device insertions to women aged under 22 years and to those who hold a Community Services Card. The cost to other women is subsidised, with Jadelle or IUD fitting being approximately $35–$75.[10] GPs described the frustration of having to redirect patients seeking contraception away from their practice because there was a cheaper service available, though that service may be some distance away, particularly in rural areas. Interviewees highlighted the lack of any Family Planning service in the Hawkes Bay, and the closest Family Planning clinic to an interviewee based in Wanaka is 275km away in Dunedin.

"I want to provide my patients' care. They trust our clinic; they want to come to my clinic. There's a real trust in our clinic and the doctor providing. They all live very local and they're often walking, without cars. I'd like for them to have access at my clinic and I want to be providing that myself with competence and confidence." (GP 7 Counties Manukau DHB)

Lack of specific Mirena IUS funding

Barriers to use of the Mirena IUS were highlighted in all of the GP interviews.

"The women who would benefit from a Mirena as their contraceptive choice, not because they've got menorrhagia, it's so unfair. It's cost effective because fewer women have them out and fewer women have unintended pregnancies." (GP 10 Northland DHB)

Unfunded, the cost of a Mirena is up to $400 on prescription ($340 at Family Planning),[10] excluding the cost of fitting. The GPs interviewed felt that the current criteria for accessing Mirena IUS funding under special authority were not evidence based and created an unnecessary barrier to care. Several interviewees described how patients with menorrhagia and resultant anaemia would be encouraged not to take iron supplements as it would raise their ferritin levels and thereby make them ineligible for a free Mirena.

"Off the record, what you do is, you basically say, look I'm really sorry, let's do this for a few months, then I'll see you in a few months when it [ferritin] has dropped low enough so I can put the [Mirena] in." (GP 16 Auckland DHB)

"You pray for a low iron just to make it easier. "(GP 15 Auckland DHB)

GPs working in areas with high rates of deprivation felt that the current system served their patients particularly poorly. They described having to refer their patients to already overstretched secondary care services for Mirena insertion for contraception or menorrhagia, when the patient could not afford this in primary care, or their own GP was not trained in the procedure.

"They're waiting over four months to be seen [at the hospital]. But they're a population who understand that they have to wait for things, and they don't complain." (GP 7 Counties Manukau DHB)

Lack of available training in LARC procedures

All the GPs interviewed described their frustration at being unable to access LARC training, which would enable them to offer this essential service to their patients, particularly in parts of the country where there can be either a long wait to access Family Planning services or no service at all.

Currently New Zealand has no accredited training scheme for practitioners, unlike other comparable countries such as the UK. Many interviewees described a 'see one, do one, teach one' learning experience, by watching a senior colleague perform a procedure, or by learning through watching a video. No prior women's health experience or qualification is currently required in New Zealand before being taught to insert or remove a LARC, and no system of credentialing exists to maintain minimum standards of competency. GPs described difficulty in accessing information on training with little guidance from professional bodies such as the Royal New Zealand College of General Practice (RNZCGP).

"Jadelle—I was self-taught in the practice. We had a little CD that we use, some of the seniors did it, and then they taught us and that's how we did it." (GP 8 Counties Manukau DHB)

"It's very frustrating —it just feels insurmountable to get some training for something that should be fairly basic and well within my scope of practice." (GP 9 Northland DHB)

Family Planning offers a small number of training places a year to priority groups. GPs who had managed to access this training did not always feel that it prepared them adequately for independent practice, and the cost of a day's training was prohibitively high. Most GPs are independent contractors with no entitlement to study leave or reimbursement of costs incurred in training.

"I contacted Family Planning, it was expensive, and they said there was a year-long waiting list. So, I put my name down but actually it's been over a year and I haven't heard back. It was over a thousand dollars anyway, and there was no guarantee of how many you would do, for the amount of money that you're spending." (GP 3 Northland DHB)

Many GPs used expressions such as 'disappointing' and 'frustrating' when talking about their experiences and described the care they were offering as 'inferior' (GP 4 Waitemata DHB) or 'substandard' (GP 7 Counties Manukau DHB).

"If there are barriers to my training, I can't do it well, I'll go away and up-skill in some other area. And that doesn't solve the massive problem of women's health in South Auckland." (GP 7 Counties Manukau DHB)

The third question asked of interviewees was 'How do you think any barriers identified could best be overcome?'. Many had given thought to this already; some GPs with leadership roles within their PHO had been involved in trialling schemes to improve access to contraception for their population.

Mirena funding restrictions were cited by all 17 interviewees (100%) as the most pressing barrier, the removal of which would result in immediate improvement in access to effective contraception for many women.

"Considering the cost implications of having a pregnancy for women, this should be so easy to fund—it should be on the shelf. The procedure should be funded, the time taken to put it in should be funded." (GP 17 Southern DHB)

All interviewees felt that addressing the funding of contraceptive procedures in primary care would be beneficial.

"On the basis that oral contraception is free essentially apart from the doctor's visit which you might have to have once a year, insertion costs for a LARC should really be covered as well or at least subsidised so that it's no more than an oral contraceptive visit." (GP 10 Northland DHB)

All the interviewees felt that provision of effective training and credentialing in contraceptive procedures would enable them to offer an accessible, safe and effective service.

"A lot of us are procedurally skilled. There's quite a scope there but we need a system to be able to learn these skills and be able to deliver them to a really high standard." (GP 17 Southern DHB)

The interviewees also emphasised that the approach would need to be through a consistent nationally agreed framework, rather than the current fragmentary approach varying between regions.

Discussion

Discussions with the GPs surveyed demonstrated that a number of barriers currently exist which prevent them from providing effective contraception for their patients. Where cost to the patient was an issue, many were offering services at a reduced rate or signposting patients towards cheaper services. In the absence of a LARC training scheme or guidance from their professional bodies, they were attempting to access procedural training via more experienced seniors in primary or secondary care, but they were also aware that in many cases this did not provide enough experience for them to feel confident or competent. In addition, with little funding available for LARC insertion in primary care, many were concerned that they were not able to perform enough procedures to maintain competence.

The restrictions around providing the Mirena IUS were highlighted in all 17 interviews. Lack of funded access to Mirena has a considerable impact on health and disproportionately affects Māori and Pacific women and those living in areas of high deprivation, further entrenching health inequities in these communities. Approximately 70% of Pacific women and 50% of Māori women in New Zealand are obese,[11] making them more likely to suffer from heavy menstrual bleeding and putting them at greatly increased risk of endometrial cancer. A recent paper showed that these women are far less likely to be able to afford the cost of an unfunded Mirena IUS.[12] In another recent paper looking at access to contraception for Māori mothers,[13] the difficulties faced by these young women included financial barriers, lack of integration of services and lack of contraception provision, resulting in them having to make multiple visits to different providers. These same issues have now been highlighted as also being the most pressing barriers from the point of view of primary care providers. The current complex system of funding is difficult for women to navigate and perpetuates inequities in access to contraceptive services.

Being unable to meet the patient's contraception needs at the time of presentation due to cost or lack of expertise was a concern for interviewees. The WHO and the UK Faculty of Reproductive and Sexual Healthcare have recently highlighted the importance of 'quick starting' contraception at the patient's first visit whenever possible.[14] Having to direct the patient to another service may result in a patient losing enthusiasm for the method discussed, forgetting instructions or failing to return for an appointment for the fitting of her chosen contraceptive device, all of which can lead to unintended pregnancy.

"By the time they've got an appointment they've lost interest in it. They've got another priority to deal with. And I appreciate that their life priorities are sometimes nothing to do with health—a lot of the time, nothing to do with health. "(GP 7 Counties Manukau DHB)

The 2013 Ministry of Health review[15] into New Zealand's Sexual and Reproductive Health Services found that the sector had 'funding arrangements that are complex with a fragmented delivery landscape', and this situation remains unchanged. Family Planning receive Ministry of Health Sexual and Reproductive Health funding, which enables them to offer services at a more affordable rate than in primary care.[15] Several GPs interviewed for this study commented on this, highlighting that if they were able to access similar levels of funding for contraception for their patients then they would be able to offer timely procedures closer to home, and at the same time maintain their procedural skills.

The current lack of training opportunities for New Zealand healthcare practitioners appears to have resulted in a workforce lacking the opportunity, confidence and expertise to offer modern forms of contraception to their patients. Funding primary care for LARC counselling, insertion and removal in the community is likely to result in a higher uptake.[16] It would provide an incentive for practitioners to train, and once trained and confident in counselling, practitioners are more likely to offer these effective methods of contraception.[17]

Limitations of the study

With only a limited sample size, other barriers to contraception affecting fewer practitioners may have been overlooked. The GPs in the study self-identified as having an interest in women's health, which may represent only a minority of practitioners, and most (77%) are currently inserting

© NZMA

LARCs, which is a high proportion when compared with the current level of procedural expertise in primary care. However, this fact may also mean that they are likely to be more aware of issues impacting on access to contraception. Though a small sample, there was a wide geographical spread and a mix of urban and rural practitioners and overseas graduates corresponding fairly closely with the current GP workforce.[18]

Conclusion

This paper demonstrates that there are a variety of barriers facing general practitioners who wish to provide an effective contraceptive service to their patients in New Zealand. The failure to implement recommendations from previous reviews has resulted in a continued fragmentation of services, patchy access to contraception and a low number of trained providers. This in turn has led to a poor experience for women, with Māori and Pacific women and those living in deprivation being least able to access long-acting reversible contraception due to cost.

If the aim is for women to have equitable access to contraception, it is recommended Pharmac and the Ministry of Health prioritise funding for general practitioners in the community to provide insertion and removal of LARCs. Without funding for insertion as an integral part of provision, access will continue to be restricted due to cost, even if all forms of contraception including the Mirena IUS are fully funded. Recommendations would also include instigating a national framework of training and clinical governance to help address these issues.

Competing interests:

Nil.

Acknowledgements:

I would like to acknowledge the generosity of the Northland branch of the RNZCGP in awarding a financial grant that enabled me to pursue this research project.

Author information:

Orna McGinn, General Practitioner, Clinical Director of Primary Care, Women's Health, ADHB, Auckland; Helen JJ Fulcher, General Practitioner, Goodfellow Unit Advisor and Academic Tutor, University of Auckland, Auckland;
Bruce Arroll, Department of General Practice and Primary Health Care, University of Auckland, Auckland; Lesley McCowan, Department of Obstetrics and Gynaecology, Faculty of Medical and Health Sciences, University of Auckland, Auckland.

Corresponding author:

Dr Orna McGinn, General Practitioner, Clinical Director of Primary Care, Women's Health, ADHB, Auckland.
ornamcginn@gmail.com

URL:

http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2019/vol-132-no-1507-13-dec-2019/8076

REFERENCES:

1. Trussell J. Contraceptive failure in the United States. Contraception. 2011; 83:397–404.
2. Chang J, Richardson A, Potter J, Coope P. Prevalence of contraceptive use in New Zealand women. N Z Med J. 2016 Oct 28; 129(1444):58–67.
3. Ministry of Health. Application for Subsidy by Special Authority Levonorgestrel - releasing intrauterine system 20mcg/24hr. Form SA1608. 2019. http://www.pharmac.govt.nz/2019/06/01/SA1608.pdf
4. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Long Acting Reversible Contraception. 2017. http://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s Health/Statement and guidelines/Clinical - Gynaecology/

Long-acting-reversible-contraception-(C-Gyn-34)-Review-July-2017.pdf?ext=.pdf Accessed May 28, 2019.

5. National Institutes for Health and Care Excellence (NICE). Long-acting reversible contraception. NICE Clinical Guideline [CG30]. http://www.nice.org.uk/guidance/cg30. Published 2014. Accessed May 25, 2019.
6. Lodge G, Sanci L, Templesmith MJ. GPs perspectives on prescribing intrauterine contraceptive devices. Aust Fam Physician. 2017; 46(5):328–333.
7. Thompson EL, Vamos CA, Logan RG, et al. Patients and providers' knowledge, attitudes and beliefs regarding immediate postpartum long-acting reversible contraception: a systematic view. Women Health. 2019 May 23:1–18.
8. Stewart M, Digiusto E, Bateson D, et al. Outcomes of intrauterine device insertion training for doctors working in primary care. Aust Fam Physician. 2016 Nov; 45(11):837–841.
9. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006; 3:77–101.
10. New Zealand Family Planning. Clinic Fees - Family Planning Ngā utu. http://www.familyplanning.org.nz/clinics/fees Published 2019. Accessed May 28, 2019.
11. Ministry of Health. New Zealand Health Survey 2017/18 Obesity Statistics. http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/obesity-statistics Published 2018.
12. Murray C, Roke C. Who can afford a Mirena® for contraception? J Prim Health Care. 2018; 10:201–206.
13. Lawton B, Makowharemahihi C, Cram F, et al. Pounamu: E Hine: access to contraception for indigenous Māori teenage mothers. J Prim Health Care. 2016 Mar; 8(1):52–9.
14. The Faculty of Sexual and Reproductive Healthcare (FSRH). FSRH Guideline Quick Starting Contraception. 2017. 1fsrh-guideline-quick-starting-contraception-april-2017.pdf
15. Thompson H, Hingatu D. Value for Money Review of Sexual and Reproductive Health Services Final Report. Ministry of Health 2013. www.kpmg.co.nz Accessed May 28, 2019.
16. Arrowsmith ME, Majeed A, Lee JT, Saxena S. Impact of pay for performance on prescribing of long-acting reversible contraception in primary care: an interrupted time series study. PLoS One. 2014 Apr 2; 9(4):e92205.
17. Black K, Lotke P, Buhling KJ, Zite NB. Intrauterine contraception for Nulliparous women: Translating Research into Action (INTRA) group. Eur J Contracept Reprod Health Care. 2012 Oct; 17(5):340–50.
18. The Royal New Zealand College of General Practitioners, New Zealand, 2019. 2018 general practice workforce survey. First published April 2019, revised July 2019. http://oldgp16.rnzcgp.org.nz/assets/New-website/Publications/GP-Workforce/Workforce-Survey2018Report1-revised-July-20194web.pdf