

Increasing access to contraception in New Zealand: assessing the impact of a new funding initiative

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ABSTRACT

AIM: This paper offers a grassroots view of the impact of a recent government initiative designed to increase access to contraception and improve health and social outcomes for women in New Zealand.

METHOD: District health board and primary health organisation project leads were contacted to request information on how each region had chosen to configure contraception services under the new contract in August 2019, a month after the rollout of the initiative, and again in August 2020. In addition, feedback from individual general practitioners was sought via social media groups.

RESULTS: There is significant variation in regional funding and provision of contraception services. Further, complex eligibility criteria can create unnecessary barriers to access for women.

CONCLUSION: Variation in funding and access to contraception continues to be a feature of service provision in New Zealand and may have been exacerbated by the recent Ministry of Health funding initiative. This perpetuates inequity, particularly for vulnerable women. Urgent consideration should be given to a whole-of-system approach with contraception being free at the point of access for all women in New Zealand.

Background: the \$6m 'increasing equity of access to contraception' initiative

In November 2019, New Zealand's long-awaited draft cross-sector Reproductive Health Action Plan was withdrawn. This plan had been in development since 2017. However, email correspondence from the Ministry of Health (MoH) to stakeholders explained that 'given the complexity and breadth of the plan, and the divergence of advice received, an agreement [was] not able to be reached with the sector advisory group on the text of a final plan'. The Ministry of Health instead aimed to

develop a 'sexual and reproductive health work programme document' of unspecified actions with 'a focus on equity and government priorities'.¹

Contraception provision was seen as one of these priority areas, due to New Zealand's relatively high rates of abortion and unplanned pregnancy² and variable access to the most effective methods of contraception, such as long-acting reversible contraception (LARC).³ Cost and a dearth of trained providers have contributed to this lack of access.³

Funding of \$4,500,000 was announced in April 2019 and was distributed between New Zealand's twenty district health boards (DHBs); the amount to each individual DHB varied according to the number of low-income women aged 15 to 44 years

residing within their area. Additionally, \$1,500,000 was allocated to Family Planning New Zealand, a non-governmental organisation (NGO) with 30 clinics around the country. Further discussion of Family Planning's approach is outside the scope of this article.

The intention of the funding, as described in a press release at the time,⁴ was to provide 'better access to free or very low-cost contraception' and increase the ability of women 'to manage their fertility and reduce unwanted pregnancies'. The objectives described in the service specification from the Ministry of Health were:

- Increase equity of access for low-income women and those living in deprivation.
- Reduce poor health and social outcomes for women and infants associated with an unplanned pregnancy and birth.
- Provide more women with support, so that they can make a decision about their fertility and when to have children.⁵

Specifically, the MoH contract service description included provision of free LARC insertion and removal for the target population, low-cost contraceptive consultations and facilitation of a training programme for LARC providers.

The target population was defined as women aged 15 to 44 years who were:

- Community Services Card (CSC) holders
- living with high levels of socioeconomic deprivation, defined as New Zealand Index of Deprivation (NZDep) quintile 5 areas
- at 'higher risk of unplanned pregnancy and poor health and social outcomes'.⁵

The term 'higher risk' was not defined, but it was suggested that priority be given to those accessing mental health or alcohol and drug services, and maternity-service users aged under 25 or of Māori or Pacific ethnicity.

Services were to be 'widely available in primary care settings accessible and convenient to the target population',⁵ and the initiative was to start in July 2019.

Implementation of the contract: where did the money go?

In August 2019, the authors contacted DHB and PHO project leads to request information on how each region had chosen to configure contraception services under the new contract. The providers were then contacted again in August 2020. Eighteen DHBs supplied information including service specifications and details of payment schedules. Two DHBs (Auckland and Waitematā) declined to supply information.

In addition, in July 2020 feedback was sought from individual general practitioners (GPs) via a private New Zealand GP social media group with over 1,000 members.

This research has revealed variable and inconsistent service provision and funding between and within regions, raising concerns about equitable access and the effectiveness of the initiative. Specific issues have been identified relating to eligibility, service configuration and funding. Primary care practitioners continue to report a lack of information on the available training opportunities, and as yet there has been no indication on when the national training scheme (to be administered by Family Planning New Zealand after they were awarded the contract in 2019) will be available.

Eligibility criteria: fair or fragmented?

DHBs apply and enforce a range of eligibility criteria regarding access to funded contraception, which varies widely from region to region and even within the same city: Auckland's three DHBs have different criteria for women accessing LARC in the community. Across the country, these criteria may include: under the care of secondary mental health services; termination of pregnancy within the last five years; at risk of family violence; aged under 30 with more than four children; substance abuse; Māori or Pacific ethnicity; or currently living in a youth justice residence. Several DHBs have chosen to

fund free contraception for all Māori and Pacific women, regardless of income or deprivation status, with the intention of increasing equity of access and reducing the higher rates of unintended pregnancy in these populations. Only one DHB contract (Northland) specifically mentioned funding women with a ‘chronic health condition that could be worsened with pregnancy’ (eg, diabetes).

The approach to women with mental health or substance abuse issues varies by region. A number of DHBs will fund contraception for any women who discloses a mental health or substance abuse issue, while in other areas only women currently under secondary care mental health and addiction services can access funding.

It is perhaps unsurprising that eligibility criteria remain open to such wide interpretation when the service specification identified only ‘*women at higher risk of unplanned pregnancy and poor health and social outcomes*’,⁵ without specifying what this would entail within the context of a robust national reproductive health framework. Many health conditions and their treatments place women at risk of an adverse outcome in pregnancy. These include: women taking teratogenic medication; women with a previous preterm birth; and women with hypertension, renal disease, previous pre-eclampsia, poorly controlled diabetes or obesity, all of which are recognised as contributing to maternal and fetal risk.⁶

There appears to be no consideration of women at risk due to high body mass index (BMI), despite the Royal Australian and New Zealand College of Obstetrics and Gynaecology’s (RANZCOG’s) 2017 statement on pre-pregnancy counselling noting that ‘high BMI (>30) is now one of the commonest and most important risk factors for infertility and adverse pregnancy outcomes’.⁷ There has also been no consideration of women living with disabilities, who can face significant barriers in accessing effective contraception.⁸

Additionally, the application of stringent eligibility criteria and the use of the term ‘target population’ applied to women fulfilling these criteria is of concern. The World Health Organisation (WHO)

states that ‘contraceptive information and services... should not be discriminatory and should aim at eliminating stereotypes and discriminatory attitudes that lead to forced and coercive practices’.⁹ Offering free contraception to targeted groups of women may cause them to feel that their pregnancies are of less worth to society as a whole, and they may feel under ‘implicit pressure’ to choose a particular method.¹⁰ This is of particular importance when offering LARC methods, which are long lasting and not under the control of the user to stop, and particularly where there may be cost barriers to having the method removed, such as with an implant or intrauterine contraceptive device (IUCD). Southern DHB reportedly only funds LARC removal if the insertion took place within that same DHB. Reported volumes of LARC insertions and removals obtained via the Official Information Act (OIA) show that Auckland and Waitemata DHBs have had no LARC removals since the inception of the contract, while smaller DHBs, such as Lakes and Canterbury, report 324 and 377 LARC removals respectively over the same period of time.¹¹ This raises the possibility that significant access barriers exist across Auckland and Waitemata, potentially affecting up to 25% of New Zealand women.

Great care must be taken during contraception counselling to ensure that women’s cultural attitudes to pregnancy and childbirth are understood and respected. Unconscious bias can be introduced when women of specific ethnicities are targeted for contraception programmes, and the possibility of coercion, whether real or perceived, must be avoided. Māori and Pacific families tend to be larger than the families of other ethnicity groups in New Zealand, and targeting these groups of women for contraception could be viewed as an attempt to limit family size.¹²

Previous New Zealand government policy has been to fund LARCs for beneficiaries or the children of beneficiaries; this policy was withdrawn in 2018 as it was considered stigmatising.¹³ Unfortunately, the new contract appears to be encouraging a similar approach.

Service structure

The eighteen DHBs that supplied information all chose to contract contraception services to primary care, with some also funding additional community providers where they exist, such as Youth One Stop Shops, iwi health providers, nurse-led services or high-school clinics (see www.protectedandproud.nz). In some DHBs, all GP practices are eligible for funding, while in other areas only some practices have been offered funding. The process by which practices are commissioned is reportedly unclear in many areas, creating a degree of frustration and confusion among healthcare practitioners.

Northland and the Bay of Plenty have taken a collaborative approach, designing services in partnership with local stakeholders and seeking input from end users (women) themselves. The most striking example of this has been the Bay of Plenty initiative 'Protected & Proud', developed using '*wāhine-centred principles that [inform] service delivery*' and taking account of specific focus-group findings.¹⁴ This has resulted in good availability of accessible services offered by a range of providers.

Notably, Northland is the only DHB to specifically fund postcoital IUCD insertion. Effective up to five days after unprotected intercourse, postcoital IUCD is the 'gold standard' form of emergency contraception, with a far lower failure rate than oral emergency contraception (EC). Its availability is currently highly restricted due to the cost and lack of available practitioners outside Family Planning New Zealand clinics.

Two DHBs, Auckland and Waitematā, have established free community clinics for LARC insertion and removal administered directly by the DHBs. While this appears to be a positive initiative, local providers have raised concerns that these clinics may in fact exacerbate barriers to contraception access, restrict choice and erode the quality of existing primary care contraceptive services over time. The imposition of DHB-led clinics in areas where there is no primary care funding to provide contraception introduces an element of competition for services, and it fails to

acknowledge that up to 80% of women already access contraception from their local primary care practice, via their GP or practice nurse.¹⁵ It implies a lack of local consultation and stakeholder engagement about the most appropriate service configuration. There is also a risk of fragmentation of patient care unless DHB clinics are part of an integrated system with clear referral pathways and information sharing between primary and secondary care. DHB clinics may in addition have limited operational hours or be located centrally, requiring time off work and long journeys to access. This poses an additional barrier to accessing care, particularly for young Māori and those living in rural areas or on low incomes.¹⁶

Contraception is a routine part of the continuum of women's health services provided in primary care over a patient's lifetime, along with human papillomavirus (HPV) vaccination, cervical screening, preconception counselling, maternity care and management of menopause. Primary care is ideally placed to offer this holistic approach of providing local, focused, integrated and intergenerational care for women and their whānau. Contraception may be addressed opportunistically during consultations for other matters. Lack of support for primary care to provide contraception may lead to a loss of valuable LARC insertion and removal skills over time and further restrict a woman's choice of providers.

Another largely unaddressed concern is access to funded contraception post abortion. In New Zealand, the rate of early medical abortion (EMA) as a proportion of all abortions has risen sharply over the last few years, and it now stands at around 45% in Auckland, up from under 10% in 2018.^{17,18} This proportion is likely to rise further following the March 2020 change in abortion law.¹⁹ With abortion now decriminalised, women have the ability to self-refer, and services are being reconfigured such that there will be a wider choice of community providers, enabling easier access. In the UK, the rate of EMA as a proportion of all abortions is 71%,²⁰ and in Australia's Northern Territory, following similar legislative change, it is also over 70%.²¹

Following an abortion, women are routinely offered contraception that is free if dispensed or inserted at the time within the DHB service, and the rate of uptake is high. Following an EMA, a Jadelle implant may be inserted at the time of the first visit to the service, but IUCD insertion must be delayed until abortion is confirmed, and that requires a second visit. In Auckland, 39% of women chose an IUCD post abortion in 2019.¹⁸ With many women having to travel long distances to access their regional abortion centre, there is a substantial risk that they will not return for funded IUCD insertion, increasing the possibility that New Zealand may see a rise in the number of repeat abortions, which has fallen substantially since the offering of post-abortion LARC became routine practice. Only Northland DHB has included funding for post-abortion contraception in primary care as part of the new LARC contract.

Finally, it is clear that New Zealand's current contraceptive-service landscape is highly complex. Women face significant difficulties in navigating to the service of their choice. Family Planning New Zealand's website contains clear information on service location and cost, but many of their services are overstretched and wait times of over two months for an IUCD insertion are common. There is currently no national website where women can find other qualified local contraception providers. If there were, women would find themselves having to disclose sensitive information in order to be eligible for funded services in many areas of the country.

Provider funding

The funding offered by DHBs to providers varies markedly around the country (Table 1). The MoH contract suggested funding LARC procedures at a value (\$150) that was 'tested with a selection of PHOs to confirm feasibility'.⁵ However, this value does not reflect the true cost of providing services. Many GP practices report that they, or their PHO, have declined the contract because it does not cover costs such as materials and staff time, and a patient co-payment is disallowed. In some provider contracts, clauses exist such that providers can claim only one fee if a LARC is removed and a new one reinserted at the same visit.

Table 1: Range of funding offered for LARC insertion and removal across DHBs.

Procedure	Lowest funding amount (\$)	Highest funding amount (\$)
Jadelle insertion	80	156
Jadelle removal	60	160
IUCD insertion	102	200
IUCD removal	60	160

Five DHBs (Canterbury, South Canterbury, MidCentral, Nelson Marlborough and Bay of Plenty) offer more than the MoH suggested funding, implying that they have taken account of feedback from local healthcare practitioners. Some PHOs already fund LARC insertion and removal for certain enrolled patients (eg, aged under 22 years, or 'high needs' (defined as Māori or Pacific ethnicity or residing in a quintile 5 area)). Local providers have little incentive to implement a new service where one already exists with a higher fee payable, even if it would mean that more patients would be eligible for services.

Historically poor data collection means that it is not possible to compare 2019/20 volumes of LARC insertions in New Zealand with those dating to before the introduction of the new contract. However, data obtained via OIA¹¹ illustrate that more than half of the country's DHBs report failing to achieve the number of insertions for which they were funded. These DHBs include all three Auckland DHBs, who collectively have inserted less than 30% of the LARCs for which they were contracted. This raises significant questions about the way in which they have chosen to configure services.

By way of contrast, Lakes and Bay of Plenty DHBs have provided far more contraception services than they were originally contracted for, which suggests that their services are both accessible and acceptable to women. Further work will need to be done to elucidate the factors contributing to these volumes.

Conclusions

The implementation of this initiative has been variable and has resulted in marked regional differences in access to services. In some areas, women must now disclose sensitive personal details in order to access funded contraception—something they are not expected to do when accessing abortion services. There are currently no other medical services in New Zealand that rely on the application of inconsistent non-clinical criteria in order to access funding. Contraception is an entirely predictable healthcare cost required by up to 50% of the population at some point in their lives, often for over 30 years. It is therefore surprising that it is seen as a low priority for health-policy makers rather than a central part of an integrated, well-resourced and country-wide women's health service. Moreover, the benefits of contraception cannot be overstated: they include a reduction in the adverse outcomes associated with unintended pregnancy, improvement in maternal physical and mental health and retention of women in the workplace. A UK report estimated

that these effects result in savings to the NHS of up to £11 for each £1 spent on contraception.²²

It is clear that New Zealand urgently needs a national women's health strategy, which should include addressing the variable funding and provision of contraception services. In addition, DHBs should be held to account where it is clear that they are failing to deliver programmes of work for which they have been contracted. Where DHBs have created successful initiatives for their population, any learnings should be disseminated widely in order to narrow the unacceptable gaps in contraception access across the country, and to avoid 'reinventing the wheel', an all-too-common feature of DHB projects.

If success looks like a reduction in unintended pregnancy and abortion, then clearly a population-wide approach is required. The issue appears to be one of prioritisation, with current restrictive funding criteria enabling an unethical form of rationing. This in turn perpetuates entrenched inequities in contraception access and availability for the women of Aotearoa.

Competing interests:

Nil.

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www.nzma.org.nz/journal-articles/increasing-access-to-contraception-in-new-zealand-assessing-the-impact-of-a-new-funding-initiative

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