



Australian Healthcare and Hospitals Association

A health system that supports contraceptive choice

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Table of Contents

Executive Summary	1
Introduction	3
Background	5
Contraceptive management in Australia’s health system	5
Factors affecting care and strategies for change.....	8
1. Health practitioner knowledge to support patient choice	9
1.1 Guideline adequacy and accessibility.....	10
1.2 Continuing professional development for health professionals	15
1.3 Supporting consumers with informed choices	16
Strategies for consideration	17
2. Contraceptive services in general practice and other primary care settings	18
2.1 Who determines the model of care?	20
2.2 Are LARC methods made available to patients?.....	20
2.3 Opportunities for greater involvement in contraceptive management.....	25
2.4 Adequacy of remuneration or incentive payments	27
Strategies for consideration	28
3. Contraceptive services in a hospital or health service	29
3.1 Who determines the model of care in individual hospitals?	30
3.2 Are LARC methods made available to patients?.....	32
3.3 Opportunities for greater involvement in contraceptive management.....	36
3.4 Adequacy of remuneration or incentive payments	36
Strategies for consideration	37
4. Contraceptive services in pharmacy	38
4.1 What pharmacy services involve contraceptive management?.....	39
4.2 Are LARC methods made available to patients?.....	40
4.3 Opportunities for greater involvement in contraceptive management.....	41
Strategies for consideration	41
5. Coordinated care within the health system	42
5.1 HealthPathways for coordinated contraceptive management in Australia	43
Strategies for consideration	44
Conclusion	44
Appendix 1	45
Appendix 2	46
Appendix 3	50

Executive Summary

Unplanned pregnancy is a key health issue for women in Australia. There has been increasing recognition, nationally and internationally, that a key way to reduce unintended pregnancy is to use more effective and less user-dependent methods of contraception such as the long-acting reversible contraceptive (LARC) methods. Despite evidence for the effectiveness of, and satisfaction with LARC methods, e.g. intrauterine devices and contraceptive implants, as well as support for their use by peak bodies and key opinion leaders in Australia and internationally, use of LARC methods in Australia continues to remain low.

In this paper, the Australian Healthcare and Hospitals Association (AHHA) explores policy, regulatory, workforce and funding factors that enable or hinder the ability of health care providers to support women in their choice for contraception. The following strategies are proposed to improve contraceptive management in Australia:

1. Health practitioner knowledge to support patient choice

- a. Consistent guidelines across health professions and practice environments
 - i. A single 'gold standard' guideline agreed and endorsed by all relevant bodies
 - ii. Comparative review of consistency of content between the 'gold standard' and other guidelines being used, advocating changes in any specific areas where consistency is desired (e.g. the order in which contraceptive methods are presented, how to manage contraindications and precautions)
- b. Improved access to guidelines
 - i. Promotion of the single 'gold standard' guideline across all health professions and practice environments
 - ii. Promotion of availability of online version of single 'gold standard'
 - iii. Improvements to navigation of online version (so can easily access information being sought)
 - iv. Provision of free online access
- c. Support in the application of guidelines
 - i. CPD on the application of the 'gold standard' guideline in a clinical setting across all health professions and practice environments, and through multiple delivery methods
 - ii. Consumer material adapted for those with low literacy, or addressed to specific population groups (e.g. Aboriginal and Torres Strait Islander people, non-English speaking people, people with poor literacy, people with a disability)
 - iii. Improved access to implant/IUD device models for demonstration.

2. Contraceptive services in general practice

- a. Funding models that support equitable access
 - i. Medicare and PNIP funding being inadequate for contraceptive services must continue to be communicated to policy makers. With 'gap' fees increasingly being introduced to cover costs, those who would most benefit from LARC methods are least able to afford the fees, and this is impacting on equitable access

- ii. Consideration must be given to the availability of MBS items associated with insertion and removal of LARC devices being expanded to registered nurses and nurse practitioners
 - iii. Alternative funding models should be explored to ensure equitable access by those most at need (e.g. service incentive payments; social impact bonds).
- b. Practice support. Resources that support practitioners in general practice to assess local need and develop a service model that suits their local population and the resources and funding available to them. Content could address such things as:
 - i. how to identify need in the local population
 - ii. the potential roles that nurses in contraceptive care, including business cases for different models of care for involvement (to motivate GPs and support nurses to lead and implement)
 - iii. service models, including structuring a consult to discuss contraceptive options effectively and efficiently, and overcoming misperceptions about such things as the need for swabs prior to IUD insertion, the need for general anaesthesia for IUD removal, and the need for routine follow-up after implant insertion
 - iv. misperceptions about insurance coverage
 - v. using *HealthPathways* where available.

3. Contraceptive services in hospitals and health services

- a. Strive for equitable access,
 - i. targeting approaches to those most in need;
 - ii. improving waiting times for insertion services to less than four weeks in areas where longer wait times have been reported.
- b. Increase nurse involvement
 - i. Summarise different models of care in hospitals that reflect needs and resources in different local population
 - ii. Promote the roles of nurses in contraceptive care and the training pathways available.

4. Contraceptive services in pharmacy

- a. Review the pharmacist's role in providing contraceptive care
 - i. Education on providing effective and efficient counselling on contraceptive options.
 - ii. Promote models of care that incorporate contraceptive counselling into different (existing) services provided in pharmacy, e.g. Supply of emergency contraception, Clinical Interventions, Staged Supply, HMRs, opioid replacement therapy
- b. Support and guidance to identify pathways of care, e.g.
 - i. How to identify need in the local population and referral pathways
 - ii. Using *HealthPathways* where available.

5. Coordinated care within the health system.

- a. Review the status of *HealthPathways* in those jurisdictions in which it is being implemented, as it relates to contraceptive management
- b. With consideration of the evaluations that have been undertaken, promote its use in contraceptive management.

Introduction

Australians tend to experience good health, having one of the highest life expectancies in the world, as well as living free of disability for increasingly more years of their life.¹ However, in terms of sexual and reproductive health, Australian women experience relatively poor health, with unplanned pregnancy being a key health issue.²

It has been estimated that 50% of Australian women have had an unintended pregnancy during their reproductive lives, despite 60% of those using at least one form of contraception.³ The contraceptive pill was most frequently cited as the contraceptive used by women who had had an unintended pregnancy while on contraception (43%).⁴ There are several options for women facing an unintended pregnancy: parenting, adoption, foster care or abortion. It has been estimated that 80,000 abortions occur each year in Australia.⁵

There has been increasing recognition, nationally and internationally, that a key way to reduce unintended pregnancy is to use more effective and less user-dependent methods of contraception such as the long-acting reversible contraceptive (LARC) methods.^{6,7,8,9} LARC methods include progestogen injections, progestogen-only implants and hormonal and copper intrauterine devices (IUDs). However, for the purpose of this paper, reference to LARC methods is specifically focusing on implants and IUDs, which are more effective than the injections.

Despite evidence for the effectiveness of, and satisfaction with, LARC methods, e.g. intrauterine devices and contraceptive implants, as well as support for their use by peak bodies and key opinion leaders in Australia and internationally, use of LARC methods in Australia continues to remain low.^{10,11}

Clinical guidelines in the United Kingdom (UK) and the United States of America (US) recommend the promotion of LARC methods.^{12, 13} Increasing access to LARC methods is a public health priority in both

¹ Australia's Health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: Australian Institute of Health and Welfare; 2014.

² Marie Stopes International. Real choices: Women, contraception and unplanned pregnancy. January 2008. At: <http://www.drmarie.org.au/wp-content/uploads/2015/02/Real-Choices-Key-Findings.pdf?6494c5> Accessed 18 April 2014

³ ibid

⁴ ibid

⁵ Chan A, Sage L. Estimating Australia's abortion rates 1985-2003. *Med J Aust* 2005;182:447-452.

⁶ Lucke J, et al. Unintended pregnancies: reducing rates by improving access to contraception. *Aust Fam Physician* 2011;40:849.

⁷ Time for a change: Increasing the use of long acting reversible contraceptive methods in Australia. Sexual Health and Family Planning Australia; 2013. At www.fpv.org.au/assets/LARCstatementSHFPFINAL.pdf

⁸ National Collaborating Centre for Women's and Children's Health. Long-acting reversible contraception: the effective and appropriate use of long-acting reversible contraception. London: RCOG Press, 2005.

⁹ American College of Obstetricians and Gynaecologists. ACOG Practice Bulletin No. 121: long-acting reversible contraception: implants and intrauterine devices. *Obstet Gynecol* 2011;118:184-196.

¹⁰ Richters J, Grulich A, de Visser R, et al. Sex in Australia: contraceptive practices among a representative sample of women. *Aust NZ J Public Health* 2003;27:210-216.

¹¹ Mazza D, Harrison C, Taft A, et al. Current contraceptive management in Australian general practice: an analysis of BEACH data. *MJA* 2012;197(2):110-114.

¹² National Collaborating Centre for Women's and Children's Health. Long-acting reversible contraception: the effective and appropriate use of long-acting reversible contraception. London: RCOG Press, 2005. Commissioned by the National Institute for Health and Clinical Excellence 2005. <http://guidance.nice.org.uk/CG30/Guidance/pdf/English> (accessed Apr 2012)

countries, recognising the benefits of long-term effective contraception and minimal maintenance once in place.

In Australia, the Family Planning Alliance Australia (FPAA; formerly Sexual Health and Family Planning Australia) recommends that LARC methods be offered as a first-line contraceptive option and encouraged for all Australian women.¹⁴ This statement has been endorsed by the member organisations of the FPAA (for details, see Appendix 1) and the Public Health Association of Australia. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) also recommends LARC methods as the most effective reversible methods of contraception, noting high continuation and satisfaction rates amongst users.¹⁵

In this paper, the Australian Healthcare and Hospitals Association (AHHA) explores policy, regulatory, workforce and funding factors that enable or hinder the ability of health care providers to support women in their choice for contraception according to best practice. These health system factors have been explored through a desktop review, consultation with peak bodies and key opinion leaders across the sectors, and survey feedback from a broad range of health providers across a variety of practice environments. A summary of these processes is provided at Appendix 2.

It should be noted that a higher than average number of respondents to the survey identified themselves as working in an environment where contraceptive care is already an important focus. Survey results have been, and should be, interpreted with this in mind.

¹³ National Research Council. Initial national priorities for comparative effectiveness research. Washington, DC. National Academies Press, 2009. http://www.nap.edu/catalog.php?record_id=12648 (accessed Apr 2012)

¹⁴ Time for a change: Increasing the use of long acting reversible contraceptive methods in Australia. Sexual Health and Family Planning Australia; 2013. At www.fpv.org.au/assets/LARCstatementSHFPFINAL.pdf

¹⁵ Long acting reversible contraception (C-Gyn 34). The Royal Australian and New Zealand College of Obstetricians and Gynaecologists; 2014.

Background

Contraceptive management in Australia's health system

Contraceptive management is relevant in all levels of Australia's health system: primary, secondary and hospital care. Services may be provided in a number of different environments and by a range of health professionals.

Primary health care

Primary health care is the first level of contact individuals, families and communities have with the health care system. It is delivered in a variety of settings, including general practices, dedicated sexual and reproductive health clinics, Aboriginal and Community Controlled Health Services (ACCHSs), community health centres, abortion services, public hospitals (particularly in rural and regional areas), pharmacies and allied health services.¹⁶ A person does not routinely require a referral for this type of care. Services delivered through primary care are fundamental in ensuring women receive safe, effective and appropriate contraceptive care.

General practice. In general practice, a shift towards prescribing LARC methods has not yet occurred.¹⁷ The combined oral contraceptive pill has been identified as the most frequently prescribed method of contraception, with moderate prescribing of LARC methods, especially among women aged 34-54 years. Rates of contraceptive medication type recorded by age group are identified in Table 1.

Table 1. Rates of contraceptive medication prescribed in general practice¹⁸

Contraceptive	Rate per 100 contraception problems managed in general practice				
	Age group				All ages
	12-24 years	25-34 years	35-44 years	45-54 years	12-54 years
Combined oral contraceptive pill	78.1 (76.4-79.8)	66.3 (64.2-68.5)	58.0 (55.2-60.8)	58.4 (53.8-63.0)	68.6 (67.3-70.0)
LARC methods (combined)	11.8 (10.5-13.1)	15.4 (13.8-17.0)	20.3 (18.2-22.5)	20.8 (17.2-24.4)	15.4 (14.5-16.4)
Progestogen injection	6.1 (5.2-7.1)	8.6 (7.4-9.8)	11.6 (9.9-13.3)	13.0 (9.9-16.1)	8.6 (7.9-9.3)
Progestogen implant	5.3 (4.4-6.3)	4.8 (3.8-5.7)	4.8 (3.7-6.0)	3.2 (1.6-4.7)	4.9 (4.3-5.5)
Hormonal IUD	0.3 (0.1-0.6)	1.9 (1.3-2.5)	3.7 (2.6-4.8)	4.6 (2.8-6.5)	1.9 (1.4-2.3)
Copper IUD	0.0 (0.0-0.1)	0.1 (0.0-0.3)	0.2 (0.0-0.4)	0 (0.0-0.4)	0.1 (0.0-0.2)
Other	4.1 (3.3-4.9)	7.3 (6.2-8.4)	7.2 (5.8-8.6)	5.3 (3.2-7.3)	5.9 (5.3-6.5)

¹⁶ Chapter 2. Australia's health system. In: Australia's health 2014. At <http://www.aihw.gov.au/australias-health/2014/health-system/>

¹⁷ Mazza D, Harrison C, Taft A, et al. Current contraceptive management in Australian general practice: an analysis of BEACH data. MJA 2012;197(2):110-114.

¹⁸ *ibid*

Awareness of LARC methods among Australians does not appear to be the barrier to their use, with a recent survey showing that most have heard of implants (76.5%) and intrauterine contraception (63.7%). Rather, the rates of use reflect that more than half of all respondents did not think implants (56.3%) or IUDs (63.9%) were reliable and most respondents would not consider using them (71.6% and 77.5%, respectively).¹⁹

GPs' views influence the advice they give to potential users, the availability of particular contraceptive methods and the type of contraception selected by women. However, a lack of familiarity and training among GPs with inserting and removing intrauterine devices (IUDs) and implants, and medicolegal concerns, have been reported as factors influencing the advice given, and therefore the low uptake.²⁰

The role of nurses in general practice in contraceptive and sexual health management is increasing.^{21,22,23} The Practice Nurse Incentive Program (PNIP) introduced in January 2012 has supported greater flexibility of nurses' roles, allowing expansion of roles to include more preventive health activities such as in contraception and sexual health services for young people.²⁴ In the UK, practice nurses are able to insert and remove implants and IUDs. In Australia, small numbers of nurse practitioners and women's health nurses are being trained in insertion.²⁵

Dedicated clinics. Primary care is also provided through dedicated sexual and reproductive health care clinics that exist across the country, with contraceptive advice, information and services being a primary role. without requiring a referral.

Aboriginal Community Controlled Health Services. ACCHSs play an important role in sexual and reproductive health, with culturally appropriate information and support services necessary in assisting Aboriginal people make informed choices about contraception.²⁶

Abortion services. Specialised abortion clinics exist in all states and territories and provide services to assist patients with choices when faced with unintended pregnancy, including surgical and medical abortions. These services can be accessed without a referral. These are delivered by not-for-profit organisations and private entities, typically without a referral. Access to LARC methods after abortion is important in assisting women avoid further unintended pregnancies. Marie Stopes International is the largest provider of abortion services in Australia.²⁷

¹⁹ Holton S, Rowe H, Kirkman M, et al. Long-acting reversible contraception: findings from the understanding fertility management in contemporary Australia survey. The European Society of Contraception and Reproductive Health 2015; Early Online: 1-16.

²⁰ Mazza D, Harrison C, Taft A, et al. Current contraceptive management in Australian general practice: an analysis of BEACH data. MJA 2012;197(2):110-114.

²¹ Scott A. The practice nurse's role in contraception choice. Primary Health Care 2013;23(6):16-24.

²² Hart C, Parker R, Patterson E, et al. Potential roles for practice nurses in preventive care for young people. AFP 2012;41(8):618-621.

²³ Family Planning Project. Australian Primary Health Care Nurses. At: www.apna.asn.au/scripts/cgiip.exe/WService=APNA/ccms.r?PageID=12048

²⁴ Hart C, Parker R, Patterson E, et al. Potential roles for practice nurses in preventive care for young people. AFP 2012;41(8):618-621.

²⁵ Time for a change: Increasing the use of long acting reversible contraceptive methods in Australia. Sexual Health and Family Planning Australia; 2013. At www.fpv.org.au/assets/LARCstatementSHFPAFINAL.pdf

²⁶ Evaluation of the NSW Aboriginal Sexual and Reproductive Health Program; April 2015. At: https://kirby.unsw.edu.au/sites/default/files/hiv/attachment/Evaluation%20of%20the%20NPA_IECD%20NSW%20Aboriginal%20Sexual%20and%20Reproductive%20Health....pdf

²⁷ Goldstone P, et al. Factors predicting uptake of long-acting reversible methods of contraception among women presenting for abortion. MJA 2014;201:412-416.

Pharmacies. The role of pharmacists in contraceptive management expanded following the down-scheduling of levonorgestrel for emergency contraception in 2004. Practice protocols for the provision of emergency contraception guide pharmacists to provide advice on ongoing contraception.²⁸ The Continued Dispensing initiative introduced in some states in 2013 allows pharmacists to supply oral contraceptives to prevent treatment interruption due to the inability of a patient to obtain a timely prescription renewal.²⁹ In 2015, there was consideration of down-scheduling contraceptive pills from Schedule 4 to Schedule 3, which would have seen a further extension of the role of pharmacists in contraception management. However it was determined that the current scheduling remained appropriate.³⁰

Secondary health care

Secondary care is medical care provided by a specialist or facility upon referral mainly by a primary care physician. Obstetrics and gynaecology are the specialist branches of medicine involved in reproductive health. Obstetricians provide medical care before, during and after childbirth, while gynaecologists diagnose, treat and aid in the prevention of disorders of the female reproductive system. Although they are concerned with separate aspects of the health care of women, they are usually merged into the one service. One of their roles is to discuss contraceptive methods with their patients and prescribe suitable contraception.³¹

Hospital care

Hospital care is provided by both public and private hospitals, and includes care provided to admitted patients, through out-patient clinics and through emergency departments. Contraception may be a consideration in hospitals for patients admitted for specific reproductive health services, through dedicated sexual and reproductive health clinics, which can be accessed upon referral, or in the management of conditions unrelated to sexual and reproductive health. It may also be a consideration in the provision of paediatric services, with patients up to 18 years of age attending.

Services are provided by obstetricians and gynaecologists, medical practitioners, registered nurses, midwives and pharmacists, but also may be influenced by members of senior management and local facility policies.

²⁸ Guidance for provision of a Pharmacist Only medicine: Levonorgestrel. Canberra: Pharmaceutical Society of Australia; 2015.

²⁹ Continued Dispensing – a new urgent supply option for pharmacists. At: <http://www.guild.org.au/news-page/2013/09/01/continued-dispensing-a-new-urgent-supply-option-for-pharmacists>

³⁰ Reasons for scheduling delegate's interim decision and invitation for further comment for the ACMS, June 2015. At <https://www.tga.gov.au/book/part-interim-decisions-matters-referred-expert-advisory-committee-acms14-11-13#oral>

³¹ What do obstetricians and gynaecologists do? At <https://www.ranzcog.edu.au/the-ranzcog/about-specialty.html>. Accessed 2 April 2016.

Factors affecting care and strategies for change

Factors that enable or hinder the ability of health care providers to support women in their choice for contraception, and potential strategies for change, are explored in this paper according to the following areas of focus:

1. Health practitioner knowledge to support patient choice
2. Contraceptive services in general practice and other primary care settings
3. Contraceptive services in hospitals and health services
4. Contraceptive services in pharmacy
5. Coordinated care within the health system.

For each area, information about the Australian context is provided, and then the results of the survey are reported, followed by strategies that may be considered to improve access to LARC methods and contraceptive choice.

1. Health practitioner knowledge to support patient choice

Guidelines

Clinical practice guidelines represent a significant financial and intellectual investment for both government and the health sector. At any given time there are between five- and six-hundred guidelines in circulation in Australia, covering a wide range of clinical topics and settings, and of varying quality and currency.³²

Clinical practice guidelines have the potential to translate findings from medical research into clinical practice, and when properly implemented have been shown to improve health outcomes. Those using the guidelines have an expectation they will be high quality, free from commercial and intellectual bias and fit for purpose.³³

Funding for guidelines

Australian governments have funded approximately 22% of clinical practice guidelines. The development of other guidelines has been funded by specialty societies (14%), national condition groups (11%), medical colleges (8%) and the National Health and Medical Research Council (NHMRC). However, the way guidelines are prioritised and commissioned in key areas is reported to lack coordination.³⁴

Implementation of guidelines

The effective implementation of guidelines is a key challenge, with ongoing debate about how to ensure effective implementation.³⁵

The Australian Clinical Practice Guidelines Portal is an NHMRC initiative and has been developed to help Australian clinicians and patients access clinical practice guidelines via a single entry point.

Contraceptive guidelines in Australia

Contraception: an Australian clinical practice handbook ('the Contraception handbook') is promoted as providing the latest international research and expert opinion on methods of contraception available in Australia. It aims to support and promote optimal clinical practice by providing GPs, nurses and other healthcare practitioners with evidence-based consensus recommendations on all aspects of contraceptive practice in the Australian setting.³⁶ All medical practitioners undertaking the FPAA Certificate in Sexual and Reproductive Health, delivered by the FPAA member organisations in each state/territory, use this handbook as their primary text. Similarly, nurses undertaking the Certificate in Sexual Health delivered by these organisations also use this text.

Access is via paid subscription to the online version (\$150) or purchase of the book (\$60). A new version will be available in end-2016.

³² National Health and Medical Research Council. 2014 Annual Report on Australian Clinical Practice Guidelines. Canberra: NHMRC; 2014. At https://www.nhmrc.gov.au/files_nhmrc/publications/attachments/nh165_2014_nhmrc_clinical_guidelines_annual_report_140805.pdf Accessed 9 April 2016

³³ ibid

³⁴ ibid

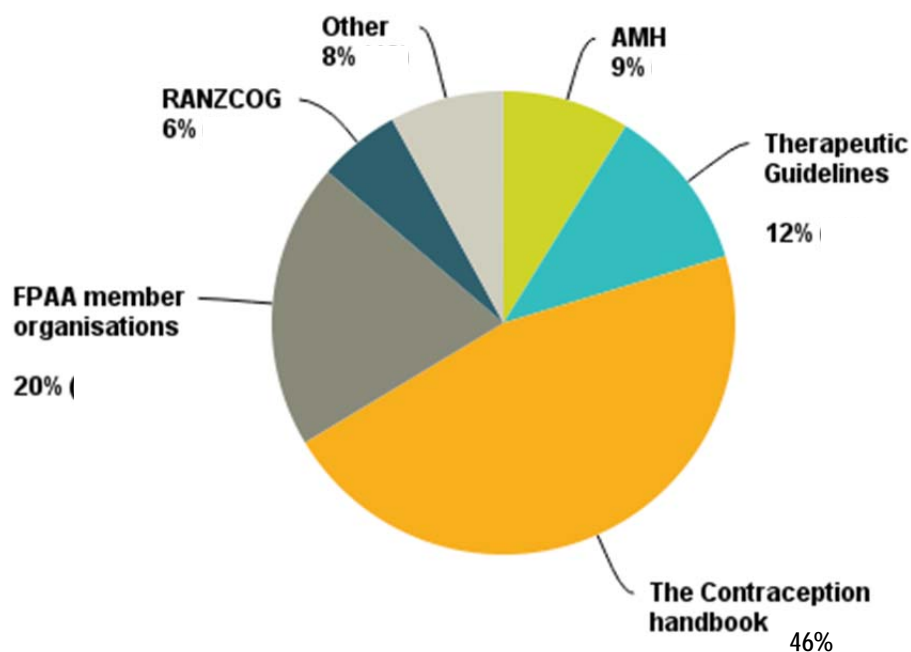
³⁵ ibid

³⁶ Bateson D, Harvey C, McNamee K. *Contraception: an Australian clinical practice handbook*, 3rd edition. Brisbane; 2012. At www.contraceptionhandbook.org.au

1.1 Guideline adequacy and accessibility

The Contraception handbook has been reported to be where guidelines relating to contraceptive management are primarily accessed by health professionals in Australia (see Figure 1).

Figure 1. Guidelines relating to contraceptive management: primary source for health professionals in Australia



Guidance relating to contraceptive management is also sourced from the Family Planning Alliance Australia (FPAA) member organisations (formerly Sexual Health and Family Planning Australia),³⁷ Therapeutic Guidelines (TG),³⁸ the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)³⁹ and the Australian Medicines Handbook (AMH).⁴⁰ Other sources of guidelines reported to be used by health professionals included the Faculty of Sexual and Reproductive Healthcare (United Kingdom),⁴¹ Jean Hailes,⁴² and Royal Women's Hospitals.

While the Contraception handbook was reported to be the most common source of guidelines, the primary source reported varies according to health professional (see Figure 2) and practice environment (see Figure 3).

³⁷ Family Planning Alliance Australia. At <http://familyplanningallianceaustralia.org.au/fpaa/>

³⁸ Therapeutic Guidelines. At: <http://www.tg.org.au/>

³⁹ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. At: <https://www.ranzcog.edu.au/>

⁴⁰ Rossi S (editor). Australian Medicines Handbook. Adelaide: Australian Medicines Handbook Ltd; 2016. At <https://shop.amh.net.au/>

⁴¹ Faculty of Sexual and Reproductive Healthcare. At <http://www.fsrh.org/>

⁴² Jean Hailes. At <https://jeanhailes.org.au/>

Figure 2. Guidelines relating to contraceptive management: access according to health professional

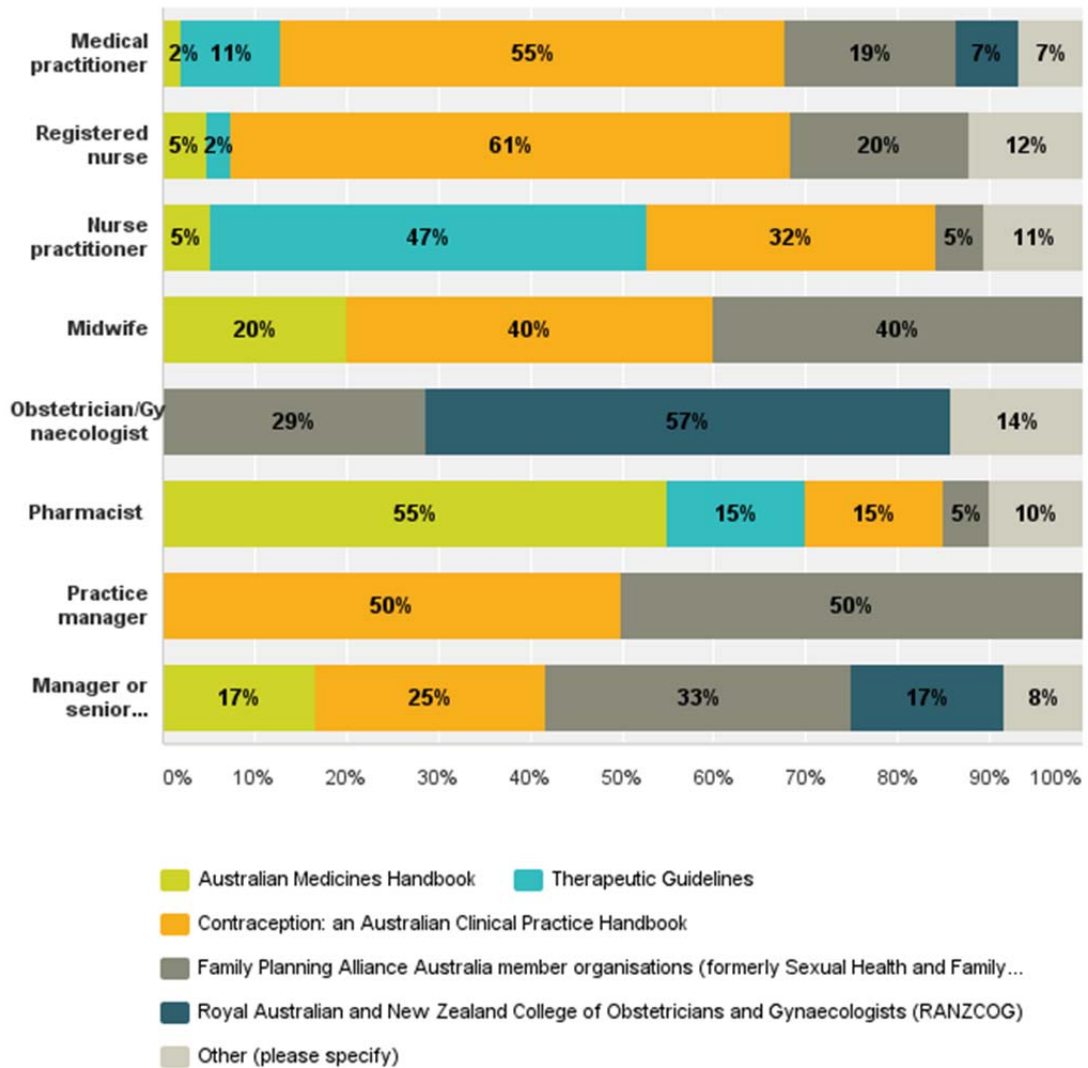
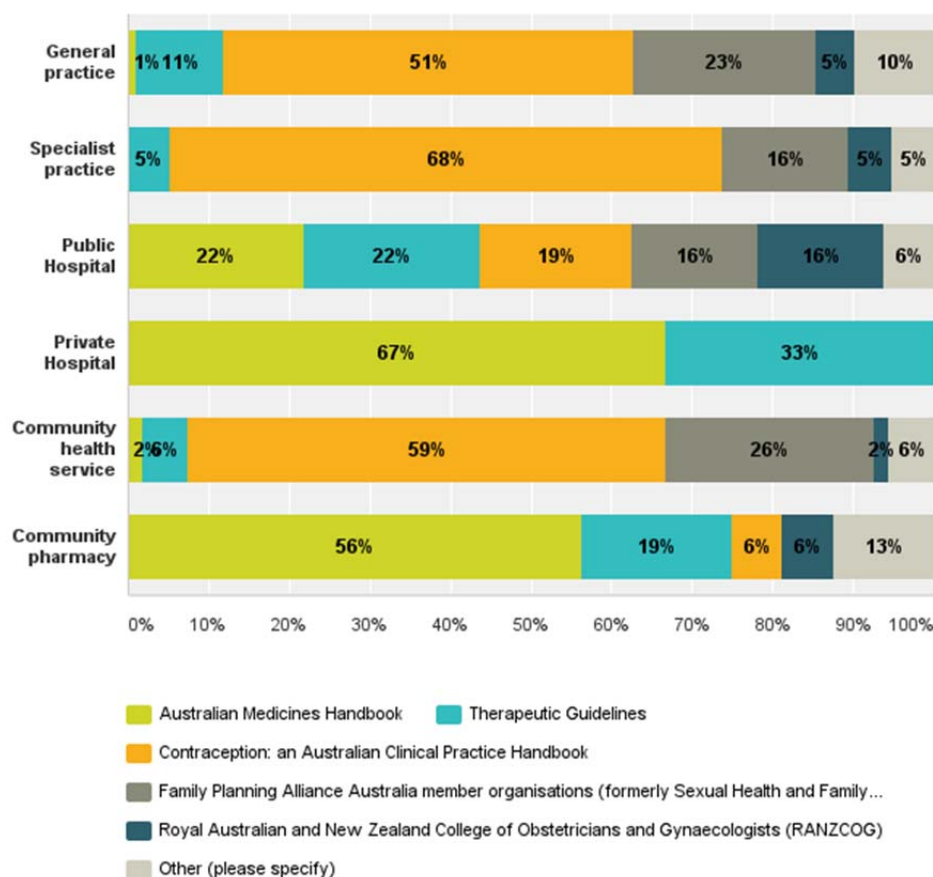


Figure 3. Resources relating to contraceptive management: access according to practice environment



Contraception: an Australian clinical practice handbook

Feedback from health professionals who primarily access the Contraception handbook is displayed in Table 2.

Table 2: Feedback from health professionals who primarily access the Contraception handbook for guidelines relating to contraceptive management

The extent to which the Contraception handbook is...	Very	Somewhat	Not much
■ relevant for their practice environment and local population?	96%	3%	1%
■ adequate for providing guidance about current evidence in contraceptive choice?	87%	12%	1%
■ in an acceptable format?	70%	26%	4%
■ accessible?	69%	27%	4%

Improved access to the Contraceptive Handbook was the most common recommendation reported by health professionals who primarily accessed this resource:

- There were a number of respondents who appeared unaware that online access was already available.
- Free online access was reported as important, similar to how other guidelines are made available.
- Addressing the fee difference between online access and the printed version was recommended, as this was noted as a barrier to health professionals getting their preferred format.
- Access via a smart phone application was recommended.

Navigation was also reported as an area for improvement, e.g. through an improved index, brief summaries, and education at meetings on how to use the handbook in a clinical setting.

There were few recommendations for improvement to content, with suggestions for:

- Endorsement from all relevant bodies, e.g. FPAA, RANZCOG, Royal Australian College of General Practitioners (RACGP), Australia College of Rural and Remote Medicine (ACCRM)
- Being linked to the UK Medical Eligibility Criteria (UK-MEC)
- More frequent (live) updates
- Alerts about updates or changes, including promotion through professional associations for all health professions (to ensure patients receive consistent advice)
- Practice tips for commonly experienced problems
- More detailed information of researched risks and negative outcomes associated to support fully informed choice
- Information presented in an easy to understand table that can be shown to clients, e.g. pull out laminated flow charts
- Multi lingual services identified.

Family Planning Alliance Australia member organisations

Feedback from health professionals who primarily access the FPAA member organisations for guidelines relating to contraceptive management is displayed in Table 3. Improvements to guidelines provided by FPAA member organisations that were reported were largely directed at the Contraception Handbook, as noted previously.

Table 3: Feedback from health professionals who primary access FPAA member organisations for guidelines relating to contraceptive management

The extent to which the Contraception handbook is...	Very	Somewhat	Not much
■ relevant for their practice environment and local population?	67%	33%	0%
■ adequate for providing guidance about current evidence in contraceptive choice?	75%	23%	2%
■ in an acceptable format?	65%	33%	2%
■ accessible?	61%	39%	0%

Therapeutic Guidelines

Feedback from health professionals who primarily access TG for guidelines relating to contraceptive management is displayed in Table 4.

Table 4: Feedback from health professionals who primary access TG for guidelines relating to contraceptive management

The extent to which the Contraception handbook is...	Very	Somewhat	Not much
■ relevant for their practice environment and local population?	54%	38%	8%
■ adequate for providing guidance about current evidence in contraceptive choice?	54%	46%	0%
■ in an acceptable format?	65%	31%	4%
■ accessible?	71%	21%	8%

The only recommendation for improvement reported was for a clearer understanding of all contraceptive options to be provided.

Australian Medicines Handbook

Feedback from health professionals who primarily access AMH for guidelines relating to contraceptive management is displayed in Table 5.

Table 5: Feedback from health professionals who primary access AMH for guidelines relating to contraceptive management

The extent to which the Contraception handbook is...	Very	Somewhat	Not much
■ relevant for their practice environment and local population?	35%	65%	0%
■ adequate for providing guidance about current evidence in contraceptive choice?	25%	60%	15%
■ in an acceptable format?	60%	35%	5%
■ accessible?	80%	15%	5%

Recommended improvements that were reported were mostly focused on application of the guidelines, such as:

- in relation to social circumstances
- for special groups (e.g. dialysis patients)
- in response to comorbidities (e.g. the advice provided for women with VTE is avoid or precaution use of LARC).

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Feedback from health professionals who primarily access RANZCOG for guidelines relating to contraceptive management is displayed in Table 6. No improvements were proposed in feedback.

Table 6: Feedback from health professionals who primary access the RANZCOG for guidelines relating to contraceptive management

The extent to which the Contraception handbook is...	Very	Somewhat	Not much
■ relevant for their practice environment and local population?	67%	33%	0%
■ adequate for providing guidance about current evidence in contraceptive choice?	50%	50%	0%
■ in an acceptable format?	50%	42%	8%
■ accessible?	67%	33%	0%

1.2 Continuing professional development for health professionals

Requirements for CPD

Health professionals who are engaged in any form of practice are required to participate regularly in continuing professional development (CPD) that is relevant to their scope of practice in order to maintain, develop, update and enhance their knowledge, skills and performance to help them deliver appropriate and safe care.⁴³

Providers of CPD

FPAA member organisations and RANZCOG are major providers of education and CPD related to contraceptive management, including implant and IUD insertion courses. Professional organisations are also providers of education.

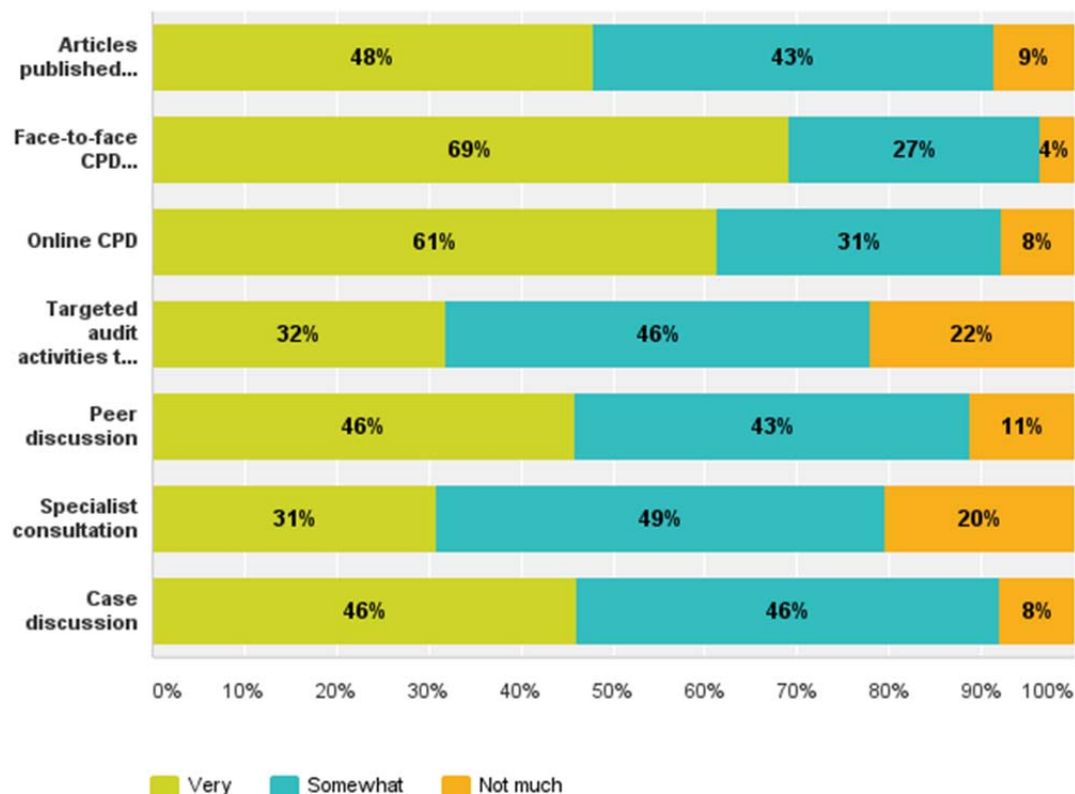
There are no mandatory educational requirements associated with insertion of the contraceptive implant. However, Merck Sharp & Dohme (MSD), the sponsor of *Implanon* in Australia, strongly recommends that all healthcare professionals intending to insert or remove the implant undertake training. From approximately 18 months ago, MSD has offered an online training program, whereas previously only face-to-face training was available. Completion leads to the awarding of a certificate. Previously only face-to-face training was offered.

Practical training sessions and individual sessions are also available from MSD if desired, but these are not mandatory for awarding of the certificate. Where nurses are trained, this is typically through the face-to-face model that incorporates theory and practical training in one session.

⁴³ Australian Health Practitioner Regulation Agency. At: <http://www.ahpra.gov.au/Registration/Registration-Standards/CPD.aspx>

When asked about preferred methods for maintaining current knowledge about contraceptive management, all methods were considered useful to some extent (see Figure 4). However face-to-face CPD in the local area and online CPD were ranked most highly. These results were fairly consistent across all health professions and practice environments.

Figure 4. Maintaining current knowledge – extent to which different methods would be useful



1.3 Supporting consumers with informed choices

Providing patients with information and education has been shown to change practitioner behaviour.⁴⁴ Examples of online patient education and information about contraceptive choice in Australia are provided in Appendix 3.

Health professionals reported that both printed information and websites to refer patients to are useful when providing information to their patients about contraceptive management. Poor access to computers and the internet was reported as needing to be recognised when developing patient information.

It was also reported that much consumer information is too generic and does not have appeal beyond ‘middle aged white women’, including for vulnerable groups. Information is needed that is designed for specific audiences, e.g.:

- Those with low literacy
- Those on low incomes

⁴⁴ National Health and Medical Research Council. A guide to the development, implementation and evaluation of clinical practice guidelines. Canberra: Commonwealth of Australia; 1999.

- Those from culturally and linguistically diverse backgrounds (e.g. refugees, asylum seekers, migrants)
- Aboriginal and Torres Strait Islander people
- Women of varying ages (13 to 50 years)
- Homeless people
- Men.

Physical examples (i.e. demonstration models) of the various contraceptive devices were also reported to be useful when communicating with patients about their contraceptive choices. However, limited access to these models through manufacturers was noted. Other mechanisms reported as being useful when communicating with patients were a short video explaining various contraceptives and the availability of a smart phone application.

Strategies for consideration

The following strategies are for consideration to ensure guideline adequacy and accessibility:

- 1. Consistent guidelines across health professions and practice environments**
 - a. A single 'gold standard' guideline agreed and endorsed by all relevant bodies
 - b. Comparative review of consistency of content between the 'gold standard' and other guidelines being used, advocating changes in any specific areas where consistency is desired (e.g. the order in which contraceptive methods are presented, how to manage contraindications and precautions).
- 2. Improved access to guidelines**
 - a. Promotion of the single 'gold standard' guideline across all health professions and practice environments
 - b. Promotion of availability of online version of single 'gold standard'
 - c. Improvements to navigation of online version (so can easily access information being sought)
 - d. Provision of free online access.
- 3. Support in the application of guidelines**
 - a. CPD on the application of the 'gold standard' guideline in a clinical setting across all health professions and practice environments, and through multiple delivery methods
 - b. Consumer material adapted for those with low literacy, or addressed to specific population groups (e.g. Aboriginal and Torres Strait Islander people, non-English speaking people, people with a disability).
 - c. Improved access to implant/IUD device models for demonstration.

2. Contraceptive services in general practice and other primary care settings

General practice

General practice is central to primary health care. The RACGP describes general practice as providing ‘patient centred, continuing, comprehensive and coordinated whole person healthcare to individuals and families in their communities’.⁴⁵

Health professionals in general practices and other primary care settings

Structures within general practice are changing. In the early 1990s, one-quarter of general practices were solo practices, and a further 40% had two to three GPs.⁴⁶ By 2013, the proportion of GPs in solo practices had declined to less than one in 10.⁴⁷ On average there were 7.5 individual GPs per practice.⁴⁸

It is estimated that 84% of GPs work in a practice that employs nursing staff. Nurses can undertake a broad range of activities in general practice, depending on their individual scope of practice (as determined by their registration, endorsements and notations with the Nursing and Midwifery Board of Australia, and/or through a requirement for additional education/credentialing),⁴⁹ as well as decisions made by the general practice in which they work about their scope of practice.

Nurses in general practice and other primary care settings have a role consulting with patients to promote effective contraception throughout their reproductive life.⁵⁰ Registered nurses, midwives and nurse practitioners may also be trained to insert implants and IUDs. Nurse practitioners have an endorsement to prescribe scheduled medicines. At December 2015, there were 1,319 nurse practitioners in Australia;⁵¹ however it is unknown how many of these practice specifically in the area of sexual and reproductive health.

⁴⁵ What is General Practice? At: <http://www.racgp.org.au/becomingagpp/what-is-a-gp/what-is-general-practice/> Accessed 2 April 2016.

⁴⁶ State of Corporatisation: a report on the corporatisation of general practices in Australia. Australian Government Department of Health and Ageing; 2012. At: [http://www.health.gov.au/internet/main/publishing.nsf/Content/foi-disc-log-2012-13/\\$File/222-1213%20Doc%206%20State%20of%20Corporatisation%20Report%20-%20February%202012.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/foi-disc-log-2012-13/$File/222-1213%20Doc%206%20State%20of%20Corporatisation%20Report%20-%20February%202012.pdf) Accessed 2 April 2016.

⁴⁷ Joyce C, McDonald H, Lawlor-Smith L. General practitioners’ perceptions of different practice models: a qualitative study. Australian Journal of Primary Health. Published online: 9 September 2015.

⁴⁸ Britt H, Miller G, Henderson J, et al. General practice activity in Australia 2014–15. General practice series no. 38. Sydney: Sydney University Press; 2015.

⁴⁹ Nursing in General Practice: A guide for the general practice team. Canberra: Australian College of Nursing; 2015.

⁵⁰ Enhanced capability in family planning for general practice nurses. At <http://www.apna.asn.au/scripts/cgip.exe/WService=APNA/ccms.r?PagelD=12048> Accessed 8 April 2016.

⁵¹ Nurse and Midwife – Registration Data – December 2015. At <http://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx> Accessed 19 April 2016.

Funding for general practices and other primary care settings

Funding for general practice services is primarily provided by the Australian Government through Medicare, Australia's universal health insurance scheme, with a smaller proportion coming from practice incentive payments and patient fees.

Medicare: Professional services provided by general practitioners that attract a Medicare benefit and that are typically used for contraceptive services include:

- Consult Standard Level B <20 minutes (Item 23): Schedule fee \$37.05; Benefit 100%
- Hormone or living tissue implantation by cannula (Item 14206): Schedule fee \$35.60; Benefit 75% or 85%
- Etonogestrel subcutaneous implant – removal (Item 30062): Schedule fee \$60.75; Benefit 75% or 85%
- Intrauterine contraceptive device - introduction (Item 35503): Schedule fee \$53.55; Benefit 75% or 85%
- Intrauterine contraceptive device – removal under general anaesthesia (Item 35506): Schedule fee \$53.70 (Note: there is no specific item number for removal without a general anaesthetic)

Consultations by nurse practitioners can also attract a Medicare benefit, e.g. Item 82205 for professional attendance <20 minutes. However there are no benefits for insertion or removal of implants or IUDs.

Incentive payments: General practices (including Aboriginal Medical Services and Aboriginal Community Controlled Health Services) may be eligible for the Practice Nurse Incentive Payment (PNIP) to offset the costs of employing a practice nurse. The PNIP was introduced to simplify financing arrangements by combining funding from the previous PIP Practice Nurse Incentive and MBS practice nurse items and replacing them with a single payment.⁵² This was also intended to support greater flexibility of roles.⁵³

The PNIP is calculated based on a measure of the practice size, known as the Standardised Whole Patient Equivalent (SWPE) value. The SWPE value is calculated using relevant MBS claims by patients attending the practice during an historical 12 month period. Payments under the PNIP are calculated quarterly with one incentive equating to:

- \$25 000 per year, per 1,000 SWPE where a registered nurse works at least 12 hours 40 minutes per week;
- plus a rural loading for practices in inner regional areas (20%), out regional (30%), remote (40%) and very remote (50%) areas.⁵⁴

Alternative funding mechanisms: Financing options in health care are explored in a recent AHHA Health Policy Issues Brief *Options for Finance in Primary Care*. The brief explores funding approaches that link objectives to outcomes, such as social impact bonds (a mechanism that encourages private investors to take an interest in the health sector through incentives for performance while simultaneously allowing governments to mitigate their financial risk, while promoting innovation and broader social benefits).⁵⁵

⁵² Practice nurse incentive programme. At <https://www.humanservices.gov.au/health-professionals/services/medicare/practice-nurse-incentive-programme> Accessed 2 April 2016

⁵³ Joyce C, Piterman L. The work of nurses in Australian general practice: a national survey. *Int J Nurs Stud* 2011;48:70–80.

⁵⁴ Practice nurse incentive programme. At <https://www.humanservices.gov.au/health-professionals/services/medicare/practice-nurse-incentive-programme> Accessed 2 April 2016

⁵⁵ Fitzgerald J. Deeble Institute Issues Brief: Options for finance in primary care in Australia. Canberra: Australian Institute of Health and Welfare; 2015. At: http://ahha.asn.au/system/files/docs/publications/deeble_institute_issues_brief_no_11_fitzgerald.pdf

Consults to discuss contraceptive choice in general practice and other primary care settings

Tiered contraceptive counselling has been shown to effectively increase awareness of all reversible methods available. It involves a standardised presentation of the range of contraceptive options to women in order of effectiveness (from most to least effective), but also covering duration of action and suitability. This approach, together with removal of cost barriers to the patient, has been shown to result in LARC methods being more commonly selected over other contraceptive methods, with high continuation and satisfaction rates.⁵⁶

Counselling cards have been developed, e.g. by the FPAA⁵⁷, to assist health professionals discuss options effectively and efficiently with patients in this manner.

2.1 Who determines the model of care?

The model of contraceptive care provided in general practice and other primary care settings was reported to be typically determined by the medical practitioners (87%) in that practice. Nurse practitioners were reported to determine the model of care in 3% of practices, while a consultative approach involving a combination of medical practitioners, registered nurses, nurse practitioners and the clinical management team is reported to be used in 9% of cases.

Only 17% of those in general practice and other primary care settings identified that there were local guidelines or protocols that influenced the way contraceptive services were provided. The scope of these was reported to be consistent with the Contraception handbook or guidelines and protocols of the FPAA member organisations.

2.2 Are LARC methods made available to patients?

What drives re-evaluation of a patient's choice of contraceptive?

The majority of health professionals in general practice and other primary care settings who responded to the survey reported they are regularly re-evaluating a patient's choice of contraceptive method. Note, due to respondents being more likely to have an interest in contraceptive services, this is likely to be higher than typical. This was explained by 49% as the writing of every new prescription drove re-evaluation of the patient's choice, with another 22% reporting to use every and any opportunity to re-evaluate. Examples provided included women's health related consultations, all consultations, specific milestones (e.g. post-birth), changes to medical history or patient circumstances, pap smear consults, presenting with symptoms that could relate to pregnancy, following unprotected sexual intercourse, and chronic disease management consults.

⁵⁶ Birgisson N, et al. Preventing unintended pregnancy: the Contraceptive CHOICE Project in review. *J Womens Health* 2015;24(5)349-353.

⁵⁷ Counselling card: Efficacy of contraceptive methods available in Australia. Family Planning Alliance Australia; 2012. At <http://familyplanningallianceaustralia.org.au/wp-content/uploads/2015/08/Contraceptive-Counselling-Card.pdf> Accessed 19 April 2016

However, 29% report re-evaluating a patient’s choice of contraceptive less frequently, with 16% reporting being driven primarily by the patient requesting advice (e.g. if experience adverse effects) and 13% reporting being driven primarily by specific milestones in the patient’s life (e.g. post-birth, certain ages).

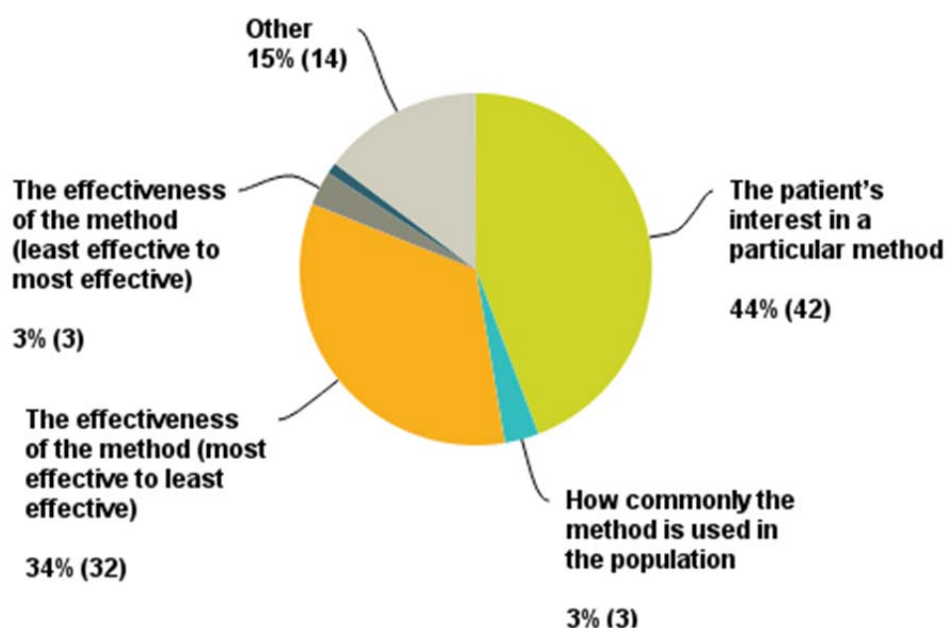
How are options for contraceptive methods presented to patients?

Figure 5 displays how those in general practice and other primary care settings primarily choose the order in which contraceptive method options are discussed with patients. The majority of those in general practice (44%) discuss contraceptive methods with patients according to the patient’s interest in a particular method. While 34% discuss methods in order of their effectiveness, from most to least effective.

Some practitioners reported using different approaches, varying the order depending on the particular patient, e.g. if contraindications or specific health needs or circumstances are known, then this alters how options are presented.

Other practitioners reported using factsheets to guide the discussion with patients. The order in which methods were discussed reflects the order the contraceptive methods appear on the factsheet, e.g. the Family Planning NSW Contraception Choices fact sheet⁵⁸ and True Contraceptive Choices health information webpage⁵⁹ present methods in order of effectiveness (most to least).

Figure 5. How those in general practice primarily choose the order in which contraceptive method options are discussed with patients



⁵⁸ Contraception Choices. At: http://www.fpnsw.org.au/779914_8.html Accessed 6 April 2016.

⁵⁹ Contraceptive Choices. At: <http://www.true.org.au/Reproductive-health/Health-information/Contraception/contraceptive-choices> Accessed 6 April 2016

Are insertion services available?

Contraceptive implant

99% of respondents reported there was someone in their practice trained to insert the contraceptive implant (*Implanon*). Note, due to respondents being more likely to have an interest in contraceptive services, this is likely to be higher than typical. Of these:

- 98% of the practices had at least one general practitioner trained
- 14% of the practices had at least one registered nurse trained
- 10% of the practices had at least one nurse practitioner trained.

While there were only a few practices without a practitioner trained to do insertions, they identified a variety of reasons why this was the case. For nurses, it was primarily the lack of access to general practitioners to provide supervision post-training. However other reasons cited were the lack of training available in the area, a lack of interest by the practitioners in the practice, a low number of requests from patients for insertion, funding to provide insertions being inadequate to justify becoming trained, and an availability of other services in their local area for referral.

One-third of practices could typically offer patients same-day insertion, while the remaining two-thirds could offer insertion within one to four weeks.

The majority of practices (51%) required two consultations for insertion of the contraceptive implant. This typically involved a pre-insertion assessment then a separate insertion appointment. In these practices, the pre-insertion consultation was reported to be necessary to discuss and decide on contraceptive choice and allowed for the patient to get the prescription dispensed. One practitioner noted the pre-insertion assessment could sometimes be undertaken over the phone, rather than in person. Follow-up consultations were not done routinely, only when there was an issue.

One-third of practices typically only required one consultation for insertion services (including initial consultation, insertion and any follow-up associated with the procedure). 15% of practices typically required three consultations. Where routine follow-up consultations were performed, they were identified as being done either at 4 weeks, 6-8 weeks, or 3 months. One practitioner noted a 4-week follow-up was used to exclude pregnancy, others noted they were optional and usually only occurred if the patient was experiencing adverse effects.

When asked what would facilitate improved access to implant insertion services for patients in their practice, suggestions included:

- General practitioners being more proactive and appropriately remunerated
 - 'Ensuring contraception is discussed particularly in [Aboriginal and Torres Strait Islander] annual health checks'*
 - 'More discussion about the device by GPs'*
 - GPs with 'more knowledge about how to access it', and 'encouraged to offer LARCs first line and to stop prescribing COCP to patients.'*
 - 'Improved Medicare rebates for insertions, removals and advice consultations' 'At times cost of 3 appointments is a deterrent'*
- Nurse involvement increased and remunerated
 - 'More nurses trained to insert, so GP can pre-counsel and have the insertion the same day'*

'As a NP in a bulk billing practice I have no access to item number for the procedure. All I can charge is a consult fee. I am highly skilled at this procedure but get no fiscal remuneration for it and patients not prepared to pay a private fee as already been trialled.'

■ Greater public awareness

'Greater patient knowledge of Implanon', 'More acceptance in community', 'Try and get the patient over the prejudices they have against 'something in their body'', 'Better access to information/education in the community', 'Practice wide advertising and promotion that it is an option for patients, and readily available information in areas like the waiting room for patients to access'

■ Streamlined practice models.

'Patients informing reception of the reason for the appointment so that a same-day insertion can be scheduled for the same day'

'Advance notice to allow longer appointment (to source script etc for same day insertion)'

'Easy access to purchase, walk in available, same day; pharmacy guaranteeing stock of implant; 'On site dispensing', Pharmacy having implant available'

'Free Implanons that were kept on site to allow for quick start insertions', 'Onsite Implanon to save patients having to go out to a pharmacy and then return', 'Having on-site implants'

■ More training

'More practitioners' education in the area'

Intrauterine devices (IUD)

73% of those responding identified there was someone in their practice trained to insert IUDs. Note, due to respondents being more likely to have an interest in contraceptive services, this is likely to be higher than typical. Of these:

- 96% of the practices had at least one GP trained
- 3% of the practices had at least one nurse practitioner trained
- 1% of the practices had at least one obstetrician/gynaecologist trained.

A variety of reasons were provided for what was stopping practitioners from getting trained:

- For medical practitioners, the primary reason was the lack of access to skilled practitioners to provide supervision post-training, followed closely by a lack of training available in the area, funding to provide insertions being inadequate to justify becoming trained, and there being other services in the local area where patients can be referred. A low number of requests from patients, a lack of interest by practitioners, insertions perceived as not being covered by the insurer were also cited.
- For nurses, the primary reason was funding to provide insertions being inadequate to justify becoming trained, followed closely by a lack of access to skilled practitioners to provide supervision post-training and a lack of training available in the area. Insertions perceived as not being covered by the insurer, a lack of interest by practitioners, a low number of requests from patients and the practice not providing support for training were also cited.

The majority of practices could typically offer patients IUD insertion within one to four weeks. 15% could typically offer insertion in two to three months, while for 1% there is a wait of four or more months. 1% could offer same-day insertion

The majority of practices require three consultations for IUD insertion. This typically involves a pre-insertion assessment, a separate insertion appointment and a follow up appointment (varying from 3 weeks to 3-4 months post-insertion). In these practices, the pre-insertion consultation was typically identified as necessary to discuss and decide on contraceptive choice and allowed for patient to get prescription

dispensed. One practitioner noted that *'once patient has chosen IUD, they will need swabs (our local public hospital requires these). I usually send the results of these at time of referral, but waiting list is so long that they often need to be done again at the hospital before the patient gets their IUD inserted. If patient is referred privately, many gynaecologists in our area won't insert Mirena in a nulliparous woman without an anaesthetic.'* One practitioner noted the pre-insertion assessment could sometimes be undertaken over the phone, rather than in person. Follow-up consultations were encouraged routinely by the majority of practices, with only one practitioner noting that these were offered under bulk-billing.

In practices where referral to another service was needed for insertion, four or more consultations may occur (i.e. one GP consultation for referral, then a pre-insertion, insertion and post-insertion consultation at the referred service).

When asked what would facilitate improved access to IUD insertion services for patients in their practice, most practitioners responded that access was already good. Other suggestions were:

- Increased GP involvement
'More doctors being interested in providing the service', 'more interest', 'more skilled clinicians', 'another trained doctor to do insertions', 'to do them here', 'more GPs trained in insertion', 'GPs who are trained to do this', 'If the GPs were trained in insertion and removal', 'Increased doctors available for insertions', 'when our second Dr is fully trained for IUD insertion in our organisation', 'More inserting doctors', 'GPs need better access to training in IUD insertion'
- Increased nurse involvement
'Training for nurses to be able to insert/remove', 'Increased number of IUD inserters', access to training for RN working as practice nurses', 'more practitioners able to do it', 'IUD inserter within the practice', 'more practitioners trained, 'more practitioners who can perform the insertion', 'more people trained', 'more trained inserters'
- Increased training opportunities
'Accessible training', 'better access to training', 'more training places available', 'in practice or local training and supervision', 'access to training', 'more training regarding insertion'
- Streamlined practice models
'Shorter waiting list at the public hospital', 'shorter waiting times in public hospital settling', 'shorter waiting times for private gyn appointments', 'Open access referral to specialist for the procedure without the need for private consult (as with endoscopy). This would decrease the number of consults, the time and the expense.' 'same day appointments, greater availability of appointments, i.e. not to wait 6 weeks for an insertion', 'to be able to make an appointment for IUD insertion, at the time of making an appointment to discuss IUD (whether or not that is a same-day appointment)'
'Has to be a nurse triaging bookings in order to book someone in during their period (or being able to confidently exclude pregnancy)', 'nurses being able to do more of IUD assessment freeing up Dr appts; support staff to do sterilising etc'
'Seeing the right GP 1st visit'
'Pharmacy next door', 'the ability to keep Mirena on site (we do have copper IUDs on -site)'
- Modified practice approaches
'More specialists prepared to offer it to nullips without anaesthetic'
- Improved remuneration
'Better remuneration, Medicare rebates to be increased', 'better item numbers for the longer procedures', 'better remuneration for the GP', 'Medicare rebate', 'better rebates', 'definitely increased Medicare rebate would increase IUD insertions', 'putting copper IUD on the PBS would increase uptake',

'better Medicare rebate', increasing the reimbursement available for fitting them so that patients on low income can afford to have them done', 'better funded service'

■ Practice set up and support

'Not sure but would like to discuss options'

'Assistance in setting up practice to insert (equipment, nurse training etc)'

'Decent affordable disposable kits', better quality and more affordable instruments', 'more than one insertion kit -needs sterilizing which takes hours', 'cheaper single use sterile instruments for insertion', 'better equipment - Gynae chair, easily obtainable disposables'

'Also need nurse assistant while inserting. This requires additional nursing staff which is expensive'

'change in professional insurance indemnity cover for GPs'

■ Patient awareness and acceptance

■ More publicly funded clinics/services in the area

■ Removal of District of workforce shortage (DWS) restrictions

'Not applying DWS to specialist family planning clinic locations. Waste of resources as with over 7 yrs of experience I can't work in any of them in Brisbane'

2.3 Opportunities for greater involvement in contraceptive management

To achieve greater involvement in contraceptive management in general practice and other primary care settings, there appears to be a need for it to be valued more in its contribution to health outcomes. One respondent stated *'GPs are overburdened with chronic disease. Opportunities for well woman advice is shrinking as more public services take over parts of what was our whole person care e.g. antenatal care, baby health, immunisations and pap smears which will soon disappear.'*

Opportunities for greater involvement in contraceptive management in general practice include:

■ Running dedicated clinics within the normal general practice day

■ Nurse involvement

'Nurse educators could play an excellent role in assisting women to choose a contraceptive. Nurses have the time, knowledge and skills to be able to facilitate such a service. Perhaps a nursing service whereby the nurse discusses contraceptives with a patient prior to a medical appointment to make them aware of what is potentially available, prior to seeing a doctor for medical management and prescription, then returning to the nurse for insertion/education/post care.'

'More nurse involvement in contraception consultation and implementation also MBS rebatable item no for nurse practitioners as practice managers due to cost of consumables prefer GPs to do procedures due to Medicare payment'

'Properly trained nursing staff to assist with procedures'

'Practice nurse involvement'

'Lots of opportunities if nurses were able to become nurse prescribers and extend their role without having to go to Uni for 4 yrs; UK model much better'

'As a nurse cervical screen provider I can continue to give advice to all my patients of the options available to them. I can also encourage my GPs to discuss the variety of options with their patients, rather than only offering the oral contraceptive pill'

'Training more RNs'

■ Targeted approach for those most at need

'young people aged 15-25 years', 'youth clinics', 'for our young population, effective dissemination of quality contraceptive information is important e.g. leaflets, posters in waiting room; as well as opportunistic discussion of options.'

'Having more funding available for low income patients', 'greater funding for such procedures especially for low income clients' 'cost sometimes prohibits access to some contraceptive methods', this is an opportunity considering the low socio-economic status and low literacy levels', 'education campaigns targeting marginalised groups'

'focus on post partum contraception, for hospitals, midwives and community nurses to promote LARCs' 'Quick access to public hospitals for urgent need (eg high risk patients, emergency insertion of IUDs)'

■ **Opportunistic involvement**

'More education for all clinical staff so opportunistic education/discussions can occur with patients', 'Encouraging all staff to discuss contraception at every opportunity', 'as a female GP, I do a lot of pap smears and this offers me opportunities to discuss contraception with my patients'

■ **Identified pathways of care**

'There is no easily accessible register for IUD inserters - this would be useful so other practitioners could refer locally to GPs in their area who are inserters. This would also be useful for hospitals to have (especially birthing units to give patients on discharge)', 'more access to family planning appts'

■ **Practice set up and support**

'Improved management of reception activities'

'More availability of appointments generally but maintaining reasonable length of appointments so that contraception can be discussed opportunistically'

■ **GP motivation**

'GP willingness to consider contraceptive review and LARCs rather than continuation of a woman's current method'

2.4 Adequacy of remuneration or incentive payments

Only a small proportion of practitioners in general practice and other primary care settings (13%) reported that the remuneration and incentive payments available for contraceptive management and LARC insertion services are adequate. These practitioners typically worked in practices that were funded outside the MBS or charged fees to patients (with Medicare benefits only covering half of the full fee charged). It was noted that practices were increasingly charging fees for these services, although with some provision to bulk bill certain clients. One practitioner noted *'Those who most need reliable contraception are least able to pay.'*

While the MBS items for a standard consult are considered somewhat adequate for supporting management, the MBS items for IUD and implant insertion, as well as the payments under the PNIP, were reported as being not at all adequate.

- *'the MBS rebate for these procedures in no way represents the costs associated with additional training, optimising equipment, nursing time, nor does it appropriately value the expertise'*
- *'It is only possible to offer this service in a private (patient pays) clinical environment and this creates a barrier for accessing the best contraceptives for disadvantaged groups'*
- *'Medicare MBS rebates are woefully inadequate the level of training and skill involved in LARC (particularly IUD) insertion and does not cover the cost of materials and sterilisable equipment.'*
- *'I see a largely very young population without a lot of financial resources. They are often at high risk pregnancy. For me to charge extra fees would often be a barrier to access to contraception.'*
- *'we don't receive any incentive payments. We do LARC because it's our job. We are still struggling with how best to do this in an affordable fashion.'*
- *'the Medicare Indexation freeze was noted as worsening the adequacy of the remuneration.'*

The need for nurse practitioners and practice nurses to be eligible for the MBS rebate for insertion procedures was reported as necessary by many practitioners. An item number for IUD removal (without general anaesthesia) was identified as being needed. A service incentive payment was identified as being an appropriate approach to funding LARC methods.

One respondent stated they *'believe an entirely different (not fee-for-service) system would be better suited to encouraging the provision of appropriate contraceptive services.'*

Strategies for consideration

As there is significant variation in the size, workforce, context and capacity of individual general practices and other primary care settings, no one-size-fits-all approach can be applied.

The following strategies are for consideration to support equitable access to LARC methods:

1. Funding models that support equitable access

- a. Medicare and PNIP funding being inadequate for contraceptive services must continue to be communicated to policy makers. With 'gap' fees increasingly being introduced to cover costs, those who would most benefit from LARC methods are least able to afford the fees, and this is impacting on equitable access
- b. Consideration must be given to the availability of MBS items associated with insertion and removal of LARC devices being expanded to registered nurses and nurse practitioners
- c. Alternative funding models should be explored to ensure equitable access by those most at need (e.g. service incentive payments; social impact bonds⁶⁰).

2. Practice support. Resources that support practitioners in general practice to assess local need and develop a model that suits their local population and the resources and funding available to them. Content could address such things as:

- a. how to identify need in the local population
- b. the potential roles that nurses in contraceptive care, including business cases for different models of care for involvement (to motivate GPs and support nurses to lead and implement)
- c. service models, including structuring a consult to discuss contraceptive options effectively and efficiently, and overcoming misperceptions about such things as the need for swabs prior to IUD insertion, the need for general anaesthesia for IUD removal, and the need for routine follow-up after implant insertion
- d. misperceptions about insurance coverage
- e. using *HealthPathways* where available (see Section 5).

⁶⁰ Fitzgerald J. Deeble Institute Issues Brief: Options for finance in primary care in Australia. Canberra: Australian Institute of Health and Welfare; 2015. At: http://ahha.asn.au/system/files/docs/publications/deeble_institute_issues_brief_no_11_fitzgerald.pdf

3. Contraceptive services in a hospital or health service

Hospitals and health services

In 2013-14, Australia had 747 public hospitals, which are very diverse in size and the types of services they provided.⁶¹

Australia had 612 private hospitals during the same period, with considerable variation in specialised facilities available, location and activity levels. Private hospitals are grouped into two main categories: just over half provide services on a day-only basis while just under half provide overnight care.⁶²

Contraception may be a consideration in hospitals for patients admitted for specific reproductive health services, e.g. post-partum or post-termination, at the point of discharge. Some hospitals also have dedicated sexual and reproductive health clinics, which may be separate to or integrated with the hospital, and can be accessed upon referral. However, contraceptive care may also be a consideration in the management of conditions unrelated to sexual and reproductive health (e.g. where pregnancy is a contraindication to prescribed treatment or relevant to the management of acute or chronic conditions). It may also be a consideration in the provision of paediatric services, with patients up to 18 years of age attending for the management of chronic condition (e.g. cystic fibrosis) or who may require transition to an adult hospital service.

Some hospitals are aligned with religious bodies. For example, over 75 hospitals are operated by different bodies of the Catholic Church within Australia, with 21 being publicly-funded and 54 being privately funded.⁶³ These health services are reported 'to operate in fulfilment of the mission of the Church to provide care and healing to all those who seek it'.⁶⁴ These hospitals commit to being 'faithful to their Catholic identity' and only provide services 'in keeping with the Church's moral teachings',⁶⁵ thus prohibiting contraceptive service provision.

Hospital structures and staffing⁶⁶

Nurses make up 45% of the workforce in public hospitals. Medical practitioners comprise 13% of the population, while diagnostic and allied health professions comprise 14% (combined).

The staffing mix in private hospitals is different, as a reflection of most medical services not being provided by hospital employees and the range of services being different. 57% of staff employed are nurses, 2% are salaried medical practitioners, and 5% are diagnostic and allied health professionals.

⁶¹ Australia's Hospitals 2013-14: at a glance. Canberra: Australian Institute of Health and Welfare; 2015.

⁶² Australian hospital statistics 2012-3: private hospitals. Canberra: Australian Institute of Health and Welfare; 2014.

⁶³ Snapshot: The Catholic Health and Aged Care Sector. At <http://www.cha.org.au/about.html>

⁶⁴ Annual Report. Canberra: Catholic Health Australia; 2015. At

<http://www.cha.org.au/images/reports/CHA%202015%20Annual%20Report%20FINAL.pdf>

⁶⁵ Code of Ethical Standards. Canberra: Catholic Health Australia; 2001.

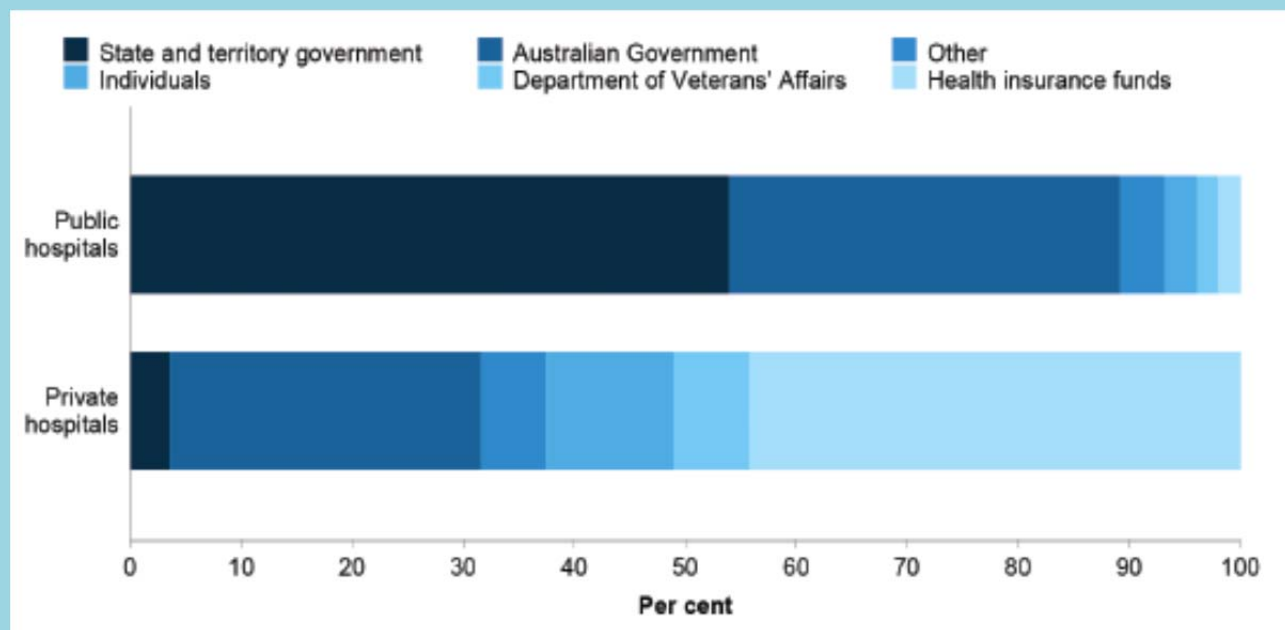
⁶⁶ Australia's Hospitals 2013-14: at a glance. Canberra: Australian Institute of Health and Welfare; 2015.

Hospital funding⁶⁷

Public and private hospitals are funded from a range of different sources, reflecting the types of patients they treat and the services they provide. Figure 6 shows the funding sources for public and private hospitals.

Under the National Health Reform Agreement, states, territories and the Commonwealth are jointly responsible for funding public hospital services.

Figure 6. Funding sources for public and private hospitals, 2012-13

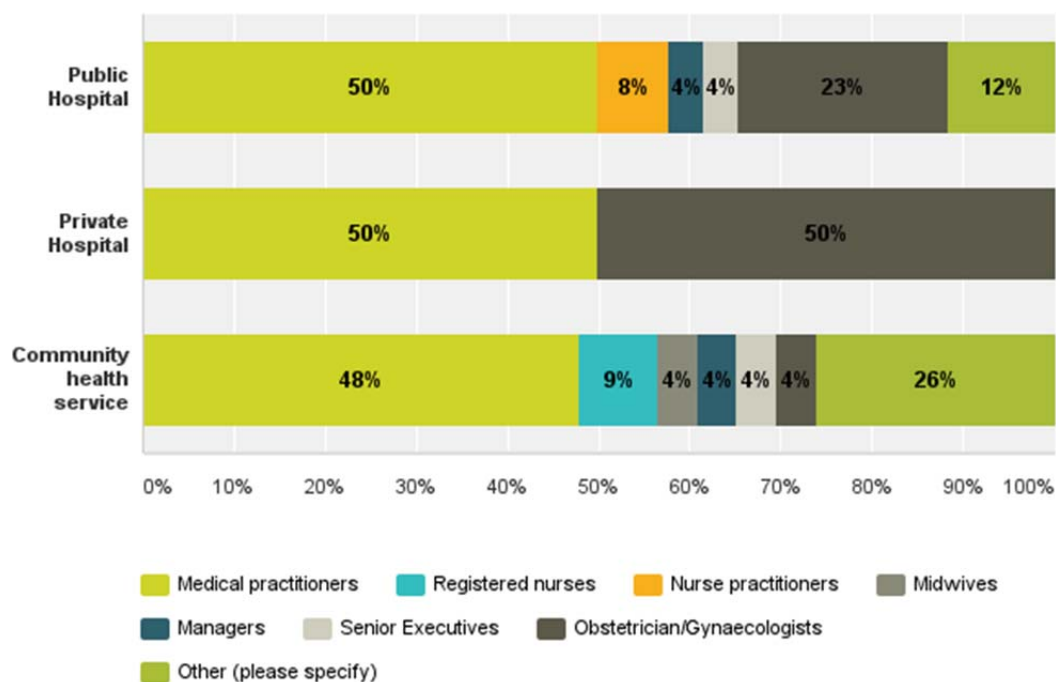


3.1 Who determines the model of care in individual hospitals?

The model of contraceptive care reported by 56% of hospitals and health services is determined by medical practitioners, although various other practitioners may also be responsible, and this varies between public and private hospitals and community health services (see Figure 7).

⁶⁷ Australia's Hospitals 2013-14: at a glance. Canberra: Australian Institute of Health and Welfare; 2015.

Figure 7: Individuals involved in determining the model of contraceptive care



Practitioners in the hospital environment noted that hospital policies and ‘the church’ also influenced the model of care, while in community health services, guidelines and GPs in the community were influencing factors.

Local guidelines or protocols influenced the way contraceptive services are provided or the choice of contraceptive methods offered in one-third of practitioners’ hospitals and health services. One-third of practitioners indicated there were no local guidelines or protocols, and the remaining third were unsure if such guidelines or protocols existed.

Where local guidelines or protocols existed, the scope was reported to cover:

- Reference to published guidelines
 - ‘Copy of guidelines in my room’, ‘Australian contraception clinical practice handbook’, ‘scope of practice guidelines for nurse practitioners’, ‘Contraceptive handbook/reproductive handbook’
- Referral processes
 - ‘Referral to O&G services’
 - ‘mostly women are referred back to GP. We do offer a Mirena service’
- Health professional roles and contraception that could be provided
 - ‘Nurses can give out emergency contraception under standing orders. Only clinics linked to doctors can do this, most women’s health nurses are not linked so cannot. No nurses doing Implanon insertion.’
 - ‘Local scope of work for staff’
- Any restrictions on services or contraceptives offered
 - ‘Tend not to provide contraceptives: generally appropriate for the private sector.’
 - ‘No provisions for Morning After contraception closest centre that provides this service anonymously is 1hr away and to target teen pregnancy that is unrealistic.’
 - ‘Restrictions due to catholic theology - minimal open access to ‘artificial’ contraception, although there are work arounds.’, ‘Patient driven’, ‘Condoms freely available.’

3.2 Are LARC methods made available to patients?

What drives re-evaluation of a patient's choice of contraceptive?

Half of the practitioners in hospitals reported being primarily driven to re-evaluate a patient's choice of contraceptive by a patient requesting advice (e.g. if experiencing adverse effects), while a third were driven by specific milestones in the patient's life (e.g. post-birth, certain ages).

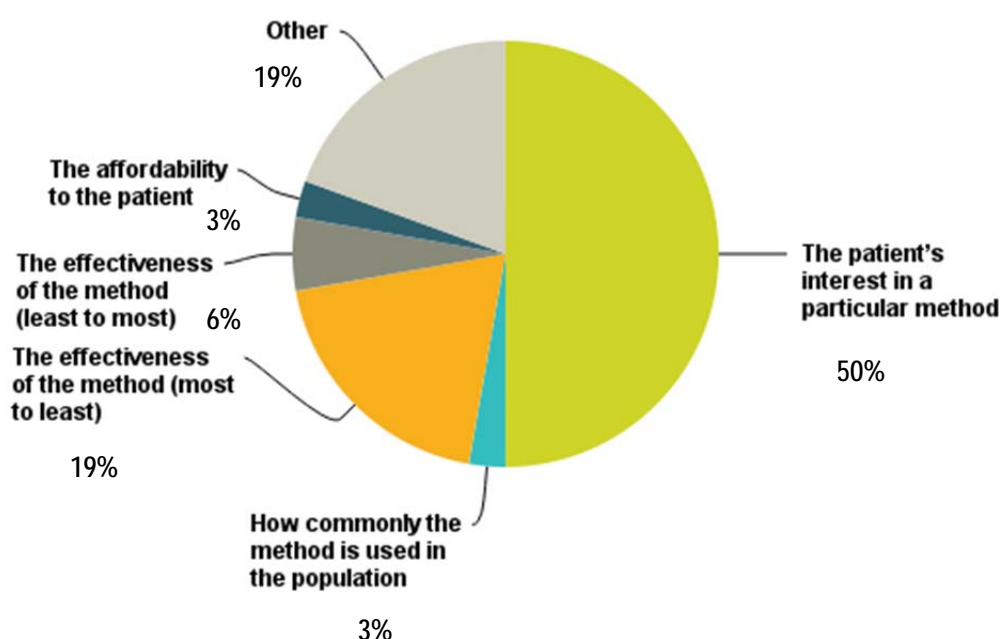
Over half of the practitioners working in community health services reported routinely evaluating a patient's choice of contraceptive, at every consultation and with the writing of each new prescription. One-quarter reported being primarily driven to re-evaluate a patient's choice of contraceptive by a patient requesting advice, while 12% reported specific milestones in the patient's life being the primary driver. One practitioner linked re-evaluation to initiation of specific therapy (e.g. cancer treatment).

How are options for contraceptive methods presented to patients?

Figure 8 displays how those in hospitals and health services primarily choose the order in which contraceptive method options are discussed with patients. The results were fairly consistent across both environments. Half of those in hospitals and health services (50%) reported discussing contraceptive methods with patients primarily in the order of the patient's interest in particular methods, while 19% reported discussing methods in order of their effectiveness, from most to least effective.

A number of practitioners reported using different approaches depending on the individual patient, varying the order based on the information gained when the medical history was taken.

Figure 8. How those in hospitals and health services primarily choose the order in which contraceptive method options are discussed with patients



Are insertion services available?

Contraceptive implant

74% of those responding identified there was someone in their practice trained to insert the contraceptive implant (*Implanon*). Of these:

- 89% of the hospitals/health services had at least one medical practitioner trained
- 18% of the hospitals/health services had at least one registered nurse trained
- 7% of the hospitals/health services had at least one midwife trained
- 11% of the hospital/health services had at least one nurse practitioner trained
- 18% of the hospital/health services had at least one obstetrician/gynaecologist trained.

Of those hospitals and health services without a practitioner trained to do insertions, a variety of reasons were identified as the reason this was the case. These are presented in Table 7. One practitioner who identified that management did not support the provision of implant insertions, noted that policy forbid the service being offered.

Table 7. Reasons for not pursuing training for implant insertions in hospitals and health services

Reason	Proportion of practitioners identifying this reason
Lack of training available in the area	25%
Low number of requests for patients for insertion	21%
Lack of access to skilled practitioners to provider supervision post-training	21%
Lack of support from management	17%
Availability of other services in area where patients can be referred in a timely manner	17%
Not a service we provide	13%
Considered a medical practitioner procedure only	13%
Funding to provide insertions is inadequate to justify becoming trained	13%
Hospital or health service will not provide support for training	8%
Insertions are not covered by insurer	8%
Lack of interest by health care practitioners in the hospital or health service	7%

The majority of practitioners in hospitals and health services (69%) identified that insertion could typically be offered to patients within one to four weeks. One-quarter of practitioners could typically offer same-day insertion in their hospital or health service. 5% identified that a wait of four or months was typical.

One or two consultations were typically required for patients choosing to have an implant in hospitals and health services (42% and 45%, respectively). This typically involved a pre-insertion consultation and the insertion, either combined or separately. 11% of practitioners reported that three consultations were

typical, while 2% reported that four or more consultations. One practitioner noted that the setting for the each of the consultations may vary, with some consultations occurring in general practice.

When asked what would facilitate improved access to implant insertion services for patients in their hospital or health services, suggestions were:

- Identified pathways of care
'Knowing which GPs are able to insert Implanon and knowing whether they bulk bill, waiting times', 'Local partnerships with appropriately trained doctors'
- Nurse involvement increased
'nurses trained to insert Implanon', 'Standing medication order for nurses to insert on same day easily', 'having a nurse practitioner', 'having a nurse trained to do it', 'support for midwives to insert implants, especially when they are trained and qualified'
- Greater public awareness
'Public awareness initiatives', 'Increasing pt demand'
- Streamlined practice models
'Dispensing on site, not held by hospital pharmacy' 'Free Implanon in hospital inpatient so patients wouldn't have to go to community pharmacy and then come back later that day for insertion', 'Free implant insertion to women who are inpatients', 'more outpt clinic availabilities', availability of space in Gynae clinic, funding for the service. We are encouraged to send women back to their GP for this service', 'More appointments available so that patients didn't have to wait as long for their appointment'
- More training
'education', 'more sessions'
- Targeted approaches for those most at need
'Public system reduce barriers such as cost', 'more streamlined approach to disadvantaged women being offered follow up in gynae clinic post birth', 'Bulk billing for service'
- Resources
'adequate space and staff'

Intrauterine devices

72% of those responding identified there was someone in their hospital or health service trained to insert the intrauterine device (IUD). In hospitals, it was twice as likely this practitioner was an obstetrician/gynaecologist (65%) than a medical practitioner (35%). In health services, medical practitioners were most likely to be the trained practitioner (80% of services), while this role was also held by obstetrician/gynaecologists (10%) or registered nurses (10%).

A variety of reasons were provided for what was stopping practitioners from getting trained:

- In hospitals, 25% of practitioners identified a lack of access to skilled practitioners to provide supervision post-training. Other reasons identified by 12% of practitioners included a low number of requests from patients for insertion, lack of interest by health practitioners, appropriate equipment not being available in the hospital, and other services being available in the area for timely referral.
- In community health services, half of practitioners identified that other services being available in the area for timely referral was the primary reason for not pursuing training. A lack of access to skilled practitioners to provide supervision post-training and a lack of training available in the area were identified by more than one-third of practitioners.

50% of hospitals could offer patients IUD insertion within one to four weeks, while 25% could offer same-day insertion. For 20% of practitioners, a wait time of two to three months could typically be offered, while for 10% of practitioners the wait time was typically four or more months.

In community health services, the majority of practitioners (87%) could offer IUD insertion within one to four weeks.

The majority of hospitals (60%) required one consultation for insertion, while 28% reported requiring two, 11% required three and 6% required four or more. Fewer consultations were often associated with use post-birth or with referral from general practice.

In community health services, three consultations were typically required. The process was most commonly one consultation pre-insertion, insertion, and then one consultation post-insertion.

When asked what would facilitate improved access to IUD insertion services for patients in their practice, suggestions were:

- Higher lever policy
'public health services prioritising comprehensive women's health preventative services - I believe we are still prudish and not proactive when it comes to reproductive health, particularly preventative measures'
'change in policy of Q Health would be needed I believe as it happens only in larger centres', 'change in Catholic position'
- Identified pathways of care
'Strong and effective partnerships with local GP who have training in this procedure', 'knowing which GPs can insert locally including those who bulk bill'
- Nurse involvement increased
'Having a nurse practitioner', 'More health care providers inserting them'
- Greater public awareness
'Greater education of the school aged population',
- Streamlined practice models
'more appointment times and more facilities for insertion IUD so that patients didn't have to wait as long for appointments',
- Targeted approaches for those most at need
'streamlined approach for post-natal women before discharge being followed up in the gynae clinic, unsure how this will sit now with the European study regarding increased perforation risk if breast feeding and before 36 weeks post-natal'
- Resourcing
'need more clinics and staff', 'More GPs', 'More Medical Officer availability', 'Allocated clinic time to insert, more people trained to insert', 'more appointment availability', 'more sessions', 'More skilled staff and outpt appointments/ clinics'
- Funding
'incentives for local medical practitioners to undertake this procedure' 'Bulk billing for insertion'

3.3 Opportunities for greater involvement in contraceptive management

Opportunities for greater involvement in contraceptive management in general practice include:

- Targeted approaches for those most in need
'Prioritise access for marginalised groups', 'Monitoring and capturing the target audience', 'more access in the community to IUD and implants inserters that will bulk bill'
'termination services'
- Increased nurse involvement
'better use of nursing staff skills to improve patient throughput', 'using Women's health nurses for advice and implant - very experienced staff who are already giving up to date advice about these matters', 'ability of WHN to write scripts for client's chosen method of contraception', 'support from the health care system to realise that midwives have a unique and opportunistic chance to discuss, educate and provide reliable and timely contraception for women post birth. This opportunity needs to be capitalised on and utilised', more education to midwives and early childhood nurses about contraception', 'our doctors refer patient back to GP. I am hoping we will get a nurse practitioner that can provide this service to our cohort of patients as the specialists are not interested', 'More support for NP to do role'
- Identified pathways of care
'would be helpful to have a community-hospital co-ordinator to make sure information got to the right person and that the patient had been successfully followed up', 'We work with local often vulnerable women who are looking for cheap effective contraception. Local partnerships are the key'
'being next to Mercy hospital since they dont provide contraception to their patient'
'the transition to adult care from paediatric services is an area that needs to be better managed generally'
'Public hospital is too busy with emergencies and other O&G issues to fill appointments with simple contraception. These people are referred to GP or fam pract clinic'
- Higher lever policy
'Generally not a priority in the public system, except for particular instances, such as sexual health clinic'
'insertion being provided in the public sector (bulk billing GPs being light on the ground in reality), change of culture to enable terminations in public hospitals and post procedure LARC insertion'
- Opportunistic approaches
'Regular specific discussion around contraception with clients. More local health promotion too', 'contraceptives being a routine health question on history taking,
- Training
'Education and skill of practitioners', 'Inservice education sessions'

3.4 Adequacy of remuneration or incentive payments

Many health professionals reported they were not aware of the remuneration for these services, so were unable to comment on the adequacy of remuneration.

Executive and management support was reported as necessary, as without a model that was financially viable, the service would not be available. The cost of LARC devices to the pharmacy department was reported to be a hindrance.

Where the service involved Medicare benefits, it was reported that the amount of remuneration was inadequate and nurses need to be eligible for benefits associated with *Implanon* insertions/removals. One respondent also recommended that public employees should be able to access Medicare benefits.

Some health services reported that remuneration does not influence their management.

Strategies for consideration

As there is significant variation in the size, workforce, context and capacity of hospitals, no one-size-fits-all approach can be applied.

The following strategies are for consideration to support equitable access to LARC methods:

- 1. Strive for equitable access,**
 - a. targeting approaches to those most in need;
 - b. improving waiting times for insertion services to less than four weeks in areas where longer wait times have been reported.
- 2. Increase nurse involvement**
 - a. Summarise different models of care in hospitals that reflect needs and resources in different local population
 - b. Promote the roles of nurses in contraceptive care and the training pathways.

4. Contraceptive services in pharmacy

Community Pharmacy

Community pharmacy is an integral part of the Australian health system through its role in the delivery of the Pharmaceutical Benefits Scheme (PBS) and related services.

The PBS Access and Sustainability Package, as referred to in the Sixth Community Pharmacy Agreement (6CPA), describes current pharmacy funding and medicines pricing arrangements and a range of sector improvements to support the National Medicines Policy. The funding and pricing aims to appropriately balance the need to:

- ensure consumers can continue to have access to new and innovative PBS subsidised medicines at an affordable price that are necessary to maintain the health of the community;
- promote and improve the quality use of medicines; and
- ensure a cost-effective and sustainable PBS.⁶⁸

Funded services in pharmacy

Contraceptives are available as PBS-subsidised medicines or as private prescriptions. Emergency contraception (levonorgestrel) is available as a Schedule 3 medicine.

Under 6CPA, there are also a number of Medication Adherence Programmes delivered through community pharmacy, e.g.:

- Clinical Interventions are a professional activity undertaken by a pharmacist directed towards improving quality use of medicines and resulting in a recommendation for a change in the patient's medication therapy, means of administration or medication-taking behaviour. Participating pharmacies receive periodic incentive payments when performing and recording these clinical interventions.⁶⁹ In the case of contraceptive care, a clinical intervention may occur, e.g., when a problem is identified in relation to drug selection or a compliance issue.
- Staged Supply supports the provision of PBS medicines in instalments when requested by the prescriber. The service is particularly targeted to patients with a mental illness, drug dependency or who are otherwise unable to manage their medicines safely. Participating pharmacies receive an annual incentive payment.⁷⁰ In the case of contraceptive care, patients taking contraceptives but receiving medicines by staged supply are likely to benefit from LARC methods.

Opioid dependence substitution programs are delivered through community pharmacies, funded by state/territory governments. The regular contact with primary care providers and those participating in the programs may facilitate opportunities for other healthcare interventions, including related to contraception.⁷¹

Pharmacists also have a role in the community in the provision of Home Medicines Reviews, a service funded under 6CPA. A HMR is a comprehensive clinical review of a patient's medicines in their home by an accredited pharmacist on referral from the patient's general practitioner. Patients are eligible if they are at risk of experiencing medication misadventure. A hospital referral pathway has also been developed.⁷² There is also an emerging role for pharmacists in general practice.⁷³

⁶⁸ Sixth Community Pharmacy Agreement. At: <https://www.guild.org.au/the-guild/community-pharmacy-agreement>. Accessed 10 April 2016.

⁶⁹ Clinical Interventions. At: <http://6cpa.com.au/medication-adherence-programmes/clinical-interventions/> Accessed 19 April 2016

⁷⁰ Staged Supply. At: <http://6cpa.com.au/medication-adherence-programmes/staged-supply/> Accessed 19 April 2016

⁷¹ McDonough M. Opioid treatment of opioid addiction. *Aust Presc* 2013;36:83-7.

⁷² Home Medicines Review. At: <http://6cpa.com.au/medication-management-programmes/home-medicines-review/> Accessed 19 April 2016.

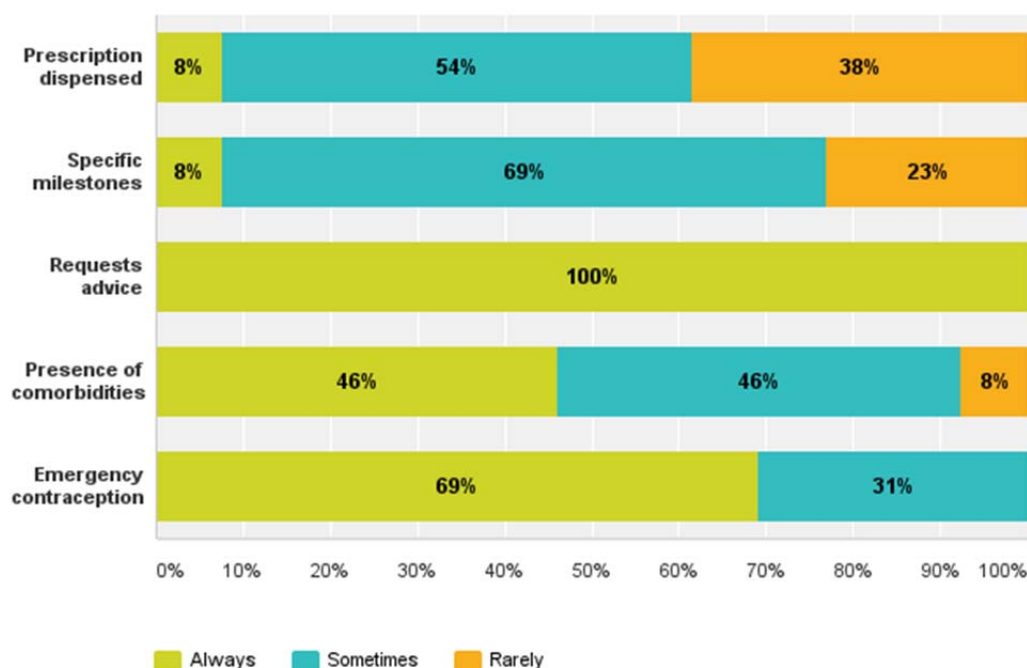
4.1 What pharmacy services involve contraceptive management?

One in five pharmacists identified having local guidelines or protocols influence the way contraceptive advice is provided about contraceptive methods available. These were identified as Therapeutic Guidelines, Australian Medicines Handbook and the protocol⁷⁴ for supply of emergency contraception.

Figure 9 shows how frequently a woman’s choice of contraceptive method is discussed for the following scenarios:

- When a prescription for contraception is dispensed
- When specific milestones in a woman’s life are reached
- When a woman requests advice or notes a concern with current contraception
- When a woman has comorbidities or a lifestyle where LARCs may be beneficial
- When emergency contraception is requested.

Figure 9. Frequency at which pharmacists discuss a woman’s choice of contraceptive method for different scenarios



Is contraceptive advice provided as part of other services?

Pharmacists reported providing contraceptive advice as part of other (funded) services, with:

- 100% had provided advice as part of a Clinical Interventions service
- 13% had provided advice as part of the Opioid Dependence Substitution program
- 25% had provided contraceptive advice as part of a Home Medicines Review.

No pharmacist had provided contraceptive advice as part of the Staged Supply program.

⁷³ Pharmacists in General Practices. At: <https://www.psa.org.au/pharmacy-support/pharmacists-in-general-practices> Accessed 19 April 2016.

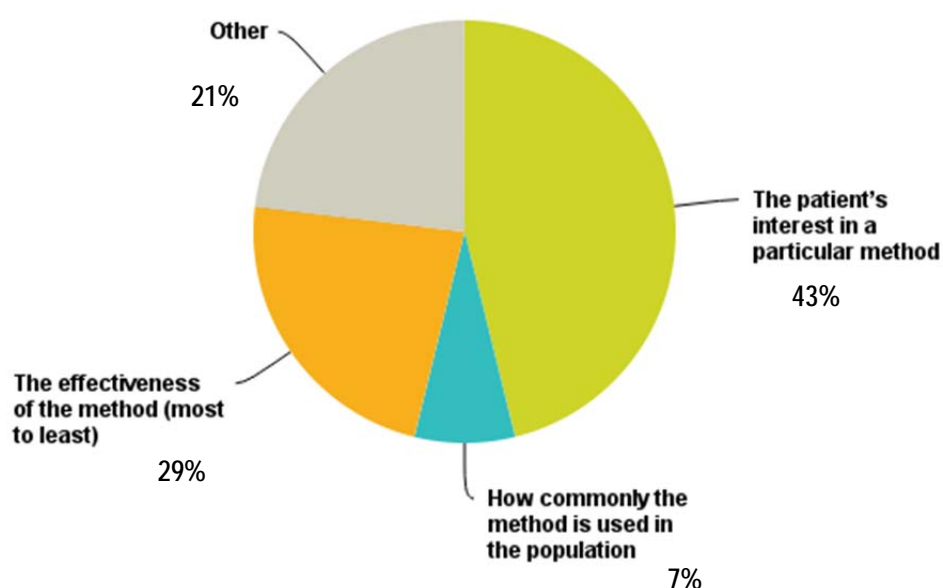
⁷⁴ Guidance for provision of a Pharmacist Only medicine – Levonorgestrel. Canberra: Pharmaceutical Society of Australia; 2015.

4.2 Are LARC methods made available to patients?

How are options for contraceptive methods presented to patients?

Figure 10 displays how pharmacists reported primarily choosing the order in which contraceptive methods options are discussed with patients. The majority discuss contraceptive methods according to the patient's interest in a particular method.

Figure 10. How those in community pharmacy primarily choose the order in which contraceptive method options are discussed with patients



Like with other health professionals, different approaches were also reported depending on, e.g. the side effects/risks to the patient.

Are insertion services available?

Over one-third of pharmacists were unsure how long a patient typically had to wait until an implant insertion could be arranged in their local area. Of those that did know, two-thirds indicated insertion could typically be arranged in one to four weeks, while one-third indicated same day insertion could be arranged.

Almost two-thirds of pharmacists were unsure how long a patient typically had to wait until an IUD insertion could be arranged in their local area. Of those that did know, three-quarters indicated insertion could typically be arranged in one to four weeks, while one-quarter indicated same day insertion could be arranged.

Pharmacists suggested that improved access to IUD and implant insertion services for women using their pharmacist could be achieved with:

- Identified pathways of care
 - 'Knowledge of doctors qualified to insert', 'knowledge of which GP's in the area are able and willing to insert the devices', 'if GP's do not provide these services I think it should be specified on their practice website - with the ability to book appointments online with most GP practices these days I think information about if a GP will use long acting contraceptive is vital to ensure the services are provided in*

a timely manner (and to avoid excess Dr appointments due to them refusing to supply it)', 'Information from local GPs and medical centres about availabilities of Drs for these services and cost of service', 'Information from surgeries to provide us with this information and who to refer to', need to 'initiate a discussion with the local GPs'

■ Streamlined practice models

'We always have them in stock. It is access to the GP that is the rate-limiting step.' *'Having a GP/nurse available on a regular basis for clinic days (e.g. weekly or monthly), particularly when holding Women's Health Promotional clinics', 'We have a female doctor again which helps and greater access with 3 doctors instead of one which has improved things immensely'*

■ Training

'Trained staff in pharmacy', 'I would love more guidelines on helping patients choose methods best for them especially when treating STDs and when providing emergency contraceptives.'

4.3 Opportunities for greater involvement in contraceptive management

Opportunities for greater involvement in contraceptive management in community pharmacy include:

■ Changing perception about the role of pharmacists

'We are not seen as a primary source of information in this area. Visible information to prompt discussion might help', 'be more pro-active in discussing LARCs as an option for contraception with the provision of emergency contraception'

■ When providing emergency contraception

'With requests for MAP, 'When providing emergency contraceptives'

■ Targeted approaches

'More involvement in with University students (our pharmacy is located very close to a university)', 'During Women's Health Promotions/clinics', '15-25 year old ladies'

■ Access to PBS

'The ability for pharmacists to provide contraception under PBS without script.'

■ When dispensing oral contraceptives

'Discussion when dispensing oral contraceptive medications assess for adherence', 'New scripts'

Strategies for consideration

The following strategies are for consideration to support equitable access to LARC methods:

1. Review the pharmacist's role in providing contraceptive care

- a. Education on providing effective and efficient counselling on contraceptive options.
- b. Promote models of care that incorporate contraceptive counselling into different (existing) services provided in pharmacy, e.g. Supply of emergency contraception, Clinical Interventions, Staged Supply, HMRs, opioid replacement therapy

2. Support and guidance to identify pathways of care, e.g.

- a. How to identify need in the local population and referral pathways
- b. Using *HealthPathways* where available (see Section 5).

5. Coordinated care within the health system

Government involvement in the health system

Government involvement in the health system is aimed at efficiently and effectively improving health outcomes for all Australians, and ensuring sustainability of the system to achieve the following outcomes:

- Australians being born and remaining healthy
- Australians receiving appropriate high quality and affordable primary and community health services
- Australians receiving appropriate high quality and affordable hospital and hospital-related care
- Australians having positive health care experiences which take account of individual circumstances and care needs
- Australians having a health system that promotes social inclusion and reduces disadvantage, especially for Aboriginal and Torres Strait Islander Australians
- Australians having a sustainable health system.⁷⁵

Primary Health Networks

Primary Health Networks (PHNs) have been established by the Australian Government with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.⁷⁶

Local Hospital Networks

Local Hospital Networks (LHNs) directly manage single or small groups of public hospital services and their budgets, and are directly responsible for hospital performance under the Performance and Accountability Framework of the National Reform Agreement. Most LHNs are responsible for the provision of public hospital services in a defined geographical area.⁷⁷

⁷⁵ Productivity Commission for the Steering Committee for the Review of Government Service Provision. Report on Government services 2016. Volume E: Health. Commonwealth of Australia; 2016.

⁷⁶ Primary Health Networks. At <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home> Accessed 8 April 2016.

⁷⁷ Local Hospital Network. At: <http://meteor.aihw.gov.au/content/index.phtml/itemId/491016>

Innovation in care coordination with *HealthPathways*

Primary care and hospital care organisations are forming partnerships in a number of jurisdictions to improve coordination of care in Australia.

One example is the implementation of *HealthPathways*, a collaborative initiative between primary and secondary health providers to develop sustainable, clear, concise and localised pathways from a whole-of-system perspective.

Originally developed in Canterbury, New Zealand, a web-based information portal is available to help make assessment, management, and specialist request decisions for over 550 conditions. Each health jurisdiction tailors the content of *HealthPathways* to reflect local arrangements and opinion, and deploys their own instance of *HealthPathways* to their clinical community.

HealthPathways aims to reduce variations of care and improve the quality and timeliness of referral processes and care coordination. *HealthPathways* provides evidence based best practice guidelines and local referral templates for clinicians resulting in a practical on-line manual used at the point of care, primarily by GPs. Included are resources for the clinician, as well as educational resources for the patient.

5.1 HealthPathways for coordinated contraceptive management in Australia⁷⁸

HealthPathways is being implemented in a number of regions in Australia.⁷⁹

- ACT and Southern NSW
- Cairns QLD
- Central Coast NSW
- Eastern Melbourne VIC
- Gippsland VIC
- Hunter New England NSW
- Illawarra Shoalhaven NSW
- Mackay QLD
- Melbourne VIC
- Mid & North Coast NSW
- Murray VIC
- South Western Sydney NSW
- Sydney NSW
- Tasmania
- Townsville QLD
- Western Australia
- Western Sydney NSW
- Western Victoria VIC.

⁷⁸ What is HealthPathways? At <http://www.healthpathwayscommunity.org/About.aspx> Accessed 8 April 2016.

⁷⁹ HealthPathways Community. At: <http://www.healthpathwayscommunity.org/Home.aspx> Accessed 19 April 2016.

'Contraception referral' and 'Termination of Pregnancy' are standard pathways in the Gynaecology clinical stream of *HealthPathways*. However, the development status of the pathway for each region will vary. For example, in Western Sydney, these pathways are in the process of localising the pathway, identified as being at the stage of '1st review' and 60% complete, and 'Developing' and '40% complete', respectively.⁸⁰

Various local evaluations have and are being conducted. Those that have evaluated the initial stages of implementation have demonstrated *HealthPathways* to be an effective enabler for better integrated and coordinated care, e.g. Western Sydney⁸¹, Hunter New England⁸². However, further health economic evaluations are being undertaken to provide evidence around sustainability.

Strategies for consideration

The following strategies are for consideration to support equitable access to LARC methods:

1. Review the status of *HealthPathways* in those jurisdictions in which it is being implemented, as it relates to contraceptive management
2. With consideration of the evaluations that have been undertaken, promote its use in contraceptive management.

Conclusion

Unplanned pregnancy is a key health issue for women in Australia. Policy, regulatory, workforce and funding factors need to be addressed to ensure there is universally accessible, high quality contraceptive management in healthcare in Australia.

⁸⁰ Pathway Progress Western Sydney. At <https://admin.healthpathways.org.nz/Secure/SitePathwaysPublicView2.aspx?show=edb475be-19c8-49be-9a90-675e8d0c54df> Accessed 19 April 2016.

⁸¹ Ritchie A, Bennett P, Mann L. *HealthPathways Sydney Initial Evaluation Progress, Achievements and Reflection after 6 months live*. At: http://www.healthpathwayscommunity.org/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=1214&PortalId=11&TabId=704 Accessed 19 April 2016.

⁸² Hunter and New England *HealthPathways*. At <http://hneproject.healthpathways.org.au/> Accessed 19 April 2016

Appendix 1.

Family Planning Alliance Australia (FPAA) member organisations

ACT: Sexual Health and Family Planning ACT

NSW: Family Planning NSW

NT: Family Planning NT

QLD: True Relationships and Reproductive Health

SA: SHine SA

TAS: Family Planning Tasmania

VIC: Family Planning Victoria

WA: Sexual and Reproductive Health Western Australia

Appendix 2.

Process used in the preparation of this paper

The following information summarises the desktop review, consultation with stakeholders and survey of health care providers used in the preparation of this paper.

The project was supported by funding from Merck Sharp & Dohme (MSD).

AHHA's JustHealth Consultants Project team

The key project team members for AHHA's Just Health Consultants practice were

Name	Project role
Alison Verhoeven	Project sponsor Executive oversight
Kylie Woolcock	Lead author and primary contact
Yasmin Birchall	Project manager Responsibility for managing all work activities, variances, tracking, reporting, and internal coordination with functional managers

Desktop review and consultation with stakeholders

In December 2015, the AHHA undertook a desktop review of various reference sources to support an understanding of the Australian healthcare environment in which contraceptive care is provided:

- Key guidelines used by health professionals
- The websites of peak professional bodies in Australia for general practitioners, obstetricians and gynaecologists, nurses and pharmacists
- The websites of peak bodies in Australia associated with sexual and reproductive health
- Research papers and position statements about the use of LARC methods, with a particular focus on the Australian context.

A paper was prepared to facilitate consultation with key opinion leaders and peak bodies so as to identify strategies for analysis and further exploration.

Key opinion leaders were identified by professional bodies and peak bodies in sexual and reproductive health. Interviews were conducted by phone during December 2015, and January and February 2016.

This work was also informed by attendance at the Contraceptive CHOICE Project workshop in February 2016, hosted by the Department of General Practice at Monash University and with presentations by Professor Jeffery F Peipert on the US study and Professor Danielle Mazza on the upcoming Australian study.

Survey

Information gathered through the desktop review and consultation with stakeholders was used to prepare a survey for health professionals and providers. The survey focused on strategies that assist health care providers to support women in their choice for contraception.

Promotion of survey

The survey was promoted to a broad range of health providers and services through:

- AHHA members and contact lists, including Primary Health Networks, Local Hospital Networks, Victorian Hospital Association, Public Health Association Australia
- Peak professional bodies (e.g RACGP Qld state chapter, APNA, PSA) and peak bodies associated with sexual and reproductive health (FPAA member organisations).

A typical promotional paragraph used was:

SURVEY: SUPPORTING CONTRACEPTIVE CHOICE

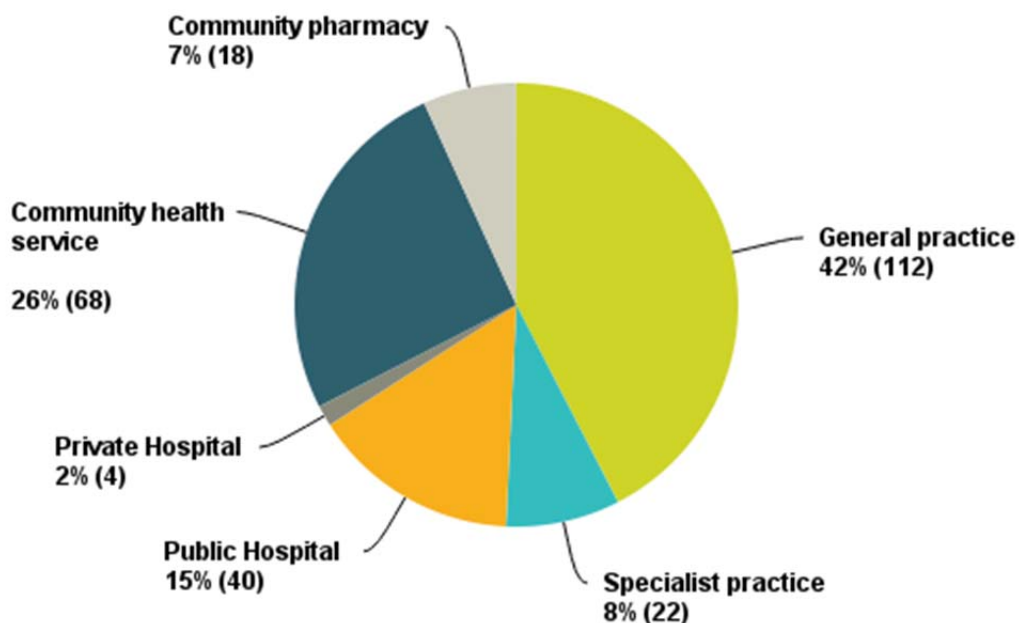
AHHA seeks your views in a survey on the factors that enable or hinder your ability to support women in their choice for contraception according to best practice. Views from a broad range of health providers and services is desired (including general practice, specialists, hospitals, health services, pharmacies), who will have varied backgrounds and experience, and will each bring a unique and important perspective. We ask that you share this survey with any colleagues that may be relevant. The survey takes approximately 10 minutes to complete, and responses are sought by 28 March. Access the survey here. For any questions, email admin@ahha.asn.au.

The survey was open for four weeks to the 28 March 2016.

Respondents to survey

There were 264 respondents to the survey, with practitioners from different practice environments, as shown in Figure 11.

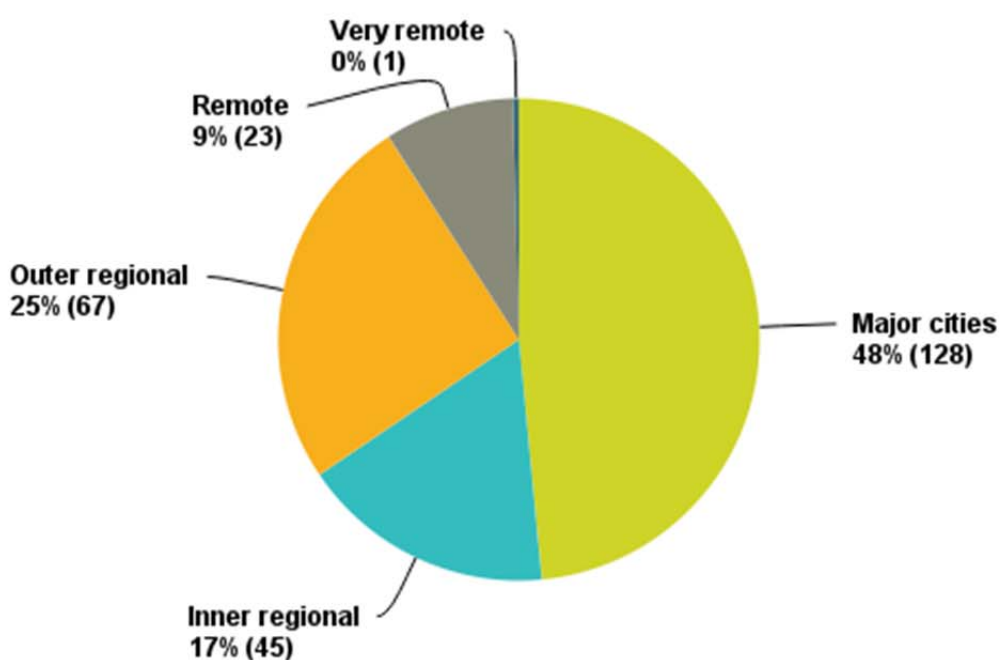
Figure 11. Practice environment of respondents to the survey



64% of respondents identified that they practiced in a specific environment, or in the care of specific populations, where contraceptive care was an important focus. In the general practice environment, approximately half identified themselves as working in a dedicated sexual and reproductive health clinic.

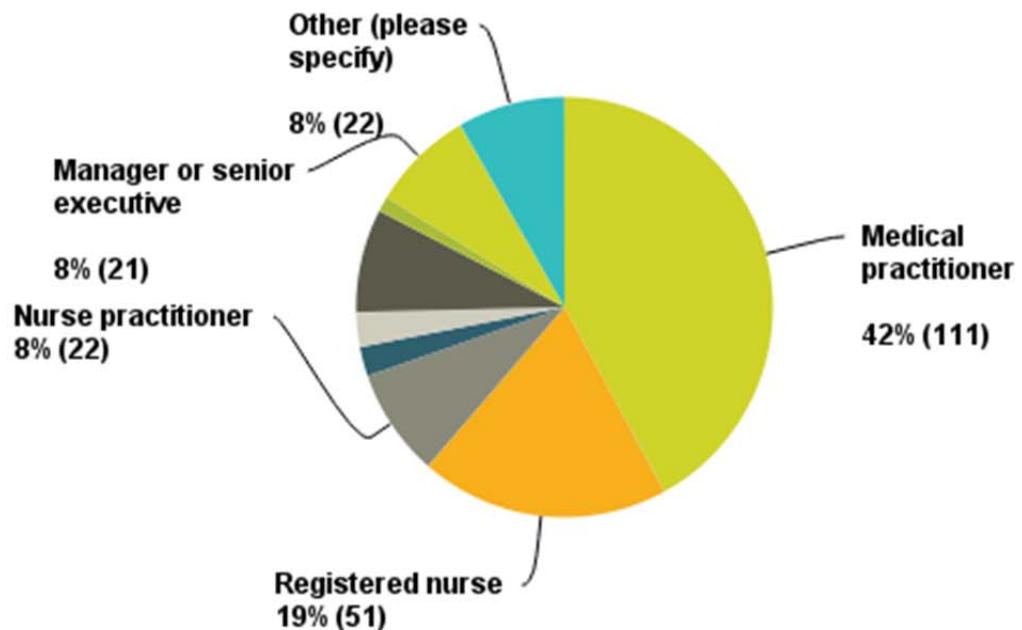
Respondents to the survey reported practising in major cities, inner regional, outer regional and remote areas, as shown in Figure 12.

Figure 12. Location of practice of respondents to the survey



Respondents to the survey described their role as shown in Figure 13.

Figure 13. Role of respondents to the survey



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- Associate Professor Kirsten Black, Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Ms Lisa Collison, Australian Primary Health Care Nurses Association
- Ms Jill Davidson, CEO, SHineSA
- Mr Chris Flood, Pharmacy Guild of Australia
- Ms Lynne Jordan, CEO, Family Planning Victoria and Director, Family Planning Alliance Australia
- Professpr Danielle Mazza, Royal Australian College of General Practitioners
- Ms Trish Russell, Pharmaceutical Society of Australia

Appendix 3.

Online patient education and information

Examples of online patient education and information about contraceptive choice in Australia are currently available from:

- Family Planning NSW: www.fpnsw.org.au/CONTRACEPTION%20CHOICES.pdf
- SHineSA: www.shinesa.org.au/media/product/2015/04/Choices-in-contraception.pdf
- Family Planning Victoria: www.fpv.org.au/assets/Contraception-guideAug-2015002web.pdf
- Family Planning Tasmania: www.fpt.asn.au/advice/contraception/
- Sexual Health and Family Planning ACT: www.shfpact.org.au/sexual-health/contraception
- Sexual and Reproductive Health WA: www.srhwa.com.au/wp-content/uploads/2015/03/Contraception_web.pdf
- True Qld: www.true.org.au/Reproductive-health/Health-information/Contraception/contraceptive-choices
- Family Planning Northern Territory: www.fpnt.com.au
- Family Planning Alliance Australia: <http://familyplanningallianceaustralia.org.au/larc/>
- NPS MedicineWise: www.nps.org.au/medicines/contraceptive-methods
- Victoria State Government: www.betterhealth.vic.gov.au/health/healthyliving/contraception-choices
- Choice: www.choice.com.au/health-and-body/reproductive-health/contraception/buying-guides/contraception
- Health Direct: www.healthdirect.gov.au/contraception-options
- Dr Marie Stopes: www.drmarie.org.au/services/contraception/
- MSD Stop the scares: www.stopthescares.com.au