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Removing the roadblocks: Policies to improve access to long-acting reversible contraceptives (LARCs)

Country Profile: Canada

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CRA Authors: Michele Pistollato, Hannah Armstrong, Angelina Petrova, Jasper Lithgow, Tim Wilsdon

Co-Author: Dustin Costescu, MD, Department of Obstetrics and Gynaecology, McMaster University, Hamilton ON, Canada

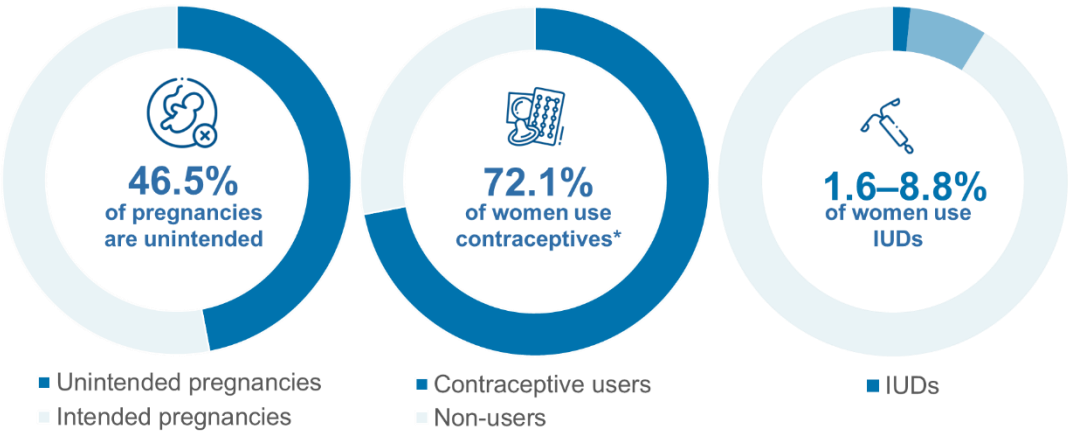
1. Introduction

At a national level, contraceptive use in Canada is high relative to other comparable nations. A 2019 report developed by the United Nations found that the use of any contraceptive method among women of reproductive age is 72.1%, significantly higher than both the European average of 56.1% and the Australian average of 57.2%.[1] Despite seemingly high contraception use, rates of unintended pregnancy in Canada suggest there are still gaps in the effective use of contraception. The Guttmacher Institute reports that 265,000 pregnancies annually are unintended, almost half of the annual total of 570,000 pregnancies.[2] Unintended pregnancies are associated with a large socioeconomic burden for women and for the health system, with literature from Canada estimating the direct cost of unintended pregnancies to be over CA$320 million.[3,4] Additionally, nearly 100,000 of the annual unintended pregnancies end in abortion, which leads to additional stress for the woman and a societal-level economic impact, given the increased health care expenditure and lost productivity.[2]

One of the drivers of such high rates of unintended pregnancy may be the regional disparity in access to contraception experienced by women across Canada; while national statistics can be meaningful for international comparison, they do not capture such information. According to the European Parliamentary Forum (EPF) Global Contraception Policy Atlas, Canadian provinces and territories (PTs) differ substantially in their access to contraceptives and contraceptive counselling and the availability of online information, with British Columbia and Quebec rating very well but Newfoundland and Labrador, Yukon and New Brunswick rating poorly.[5]

A second driver of high unintended pregnancies is the very low use of long-acting reversible contraceptives (LARCs) in Canada. Although a range of factors are considered in making a contraceptive decision, including efficacy, side effects and convenience, the majority of Canadian contraceptive users rely on user-dependent methods, while the uptake of LARCs has been low. The World Health Organization recognises LARCs, such as intrauterine devices (IUDs), contraceptive injections, and contraceptive implants, as among the most effective methods for preventing unintended pregnancy, with a failure rate of less than 1%.[6] However, the literature reports IUD use among women of reproductive age at between 1.6% and 8.8%, respectively (noting that since the publication of these findings, the contraceptive implant was approved in Canada in 2020).[7] There are no updated estimates of contraceptive injections use. Meanwhile a Canadian survey from 2016 (published in 2019) reports condoms and oral contraceptives are used by 48.4% and 33.2% of women, respectively.[7]

Figure 1: Key statistics on contraceptive use and unintended pregnancies



Sources: Guttmacher Institute (2022),[2] United Nations (2019)[1], Black et al. (2019)[7]

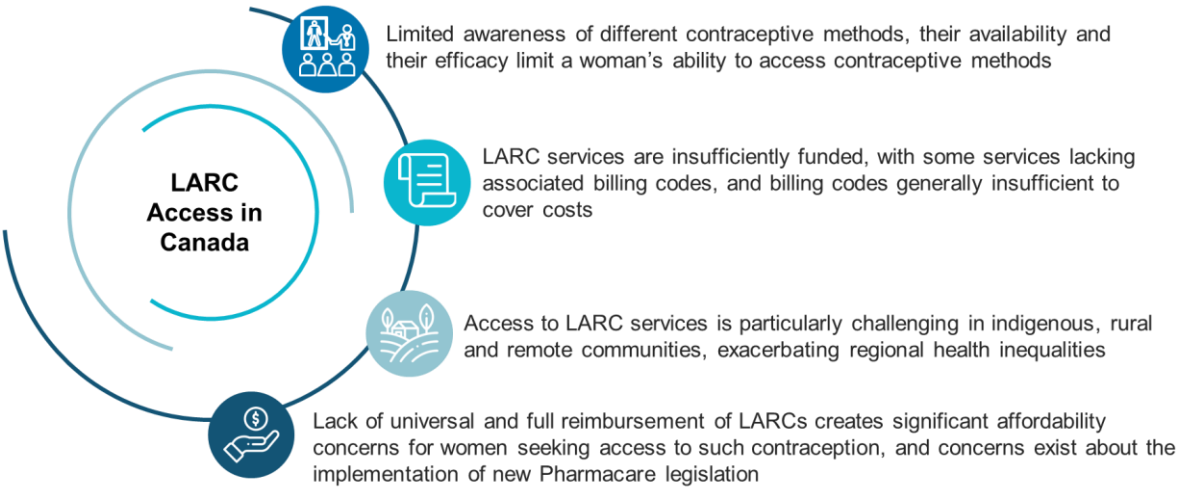
** = The contraceptive implant was not available in Canada until 2020, as referenced by Lao and Connolly (2020)[8]*

In the context of high rates of unintended pregnancy, with LARC use making up only a small proportion of total contraceptive use in Canada, it is important to assess if there are barriers preventing users from accessing LARCs, specifically IUDs and implants. Our study focused on identifying these barriers through a review of recent literature, validation of insights with a leading Canada-based health care professional (HCP) and co-development of actionable policy recommendations to address these challenges in a Policy Forum that included HCPs from nine countries, including Canada. Below, we cover the challenges that are most prominent in Canada, how they manifest, and what policy recommendations could help to provide more women in Canada with access to LARCs. We also noted that there is some debate over which contraceptive methods qualify as LARCs.[9,10] While some sources include contraceptive injections, others exclude them because their effects are not as quickly reversible as those of IUDs and implants.[11] For this reason, not all the available evidence covers contraceptive injections. Therefore, we will mostly focus on IUDs and implants and mention contraceptive injections explicitly when available data permit.

2. Challenges impacting access to LARCs

Insights from the extensive review of recent literature and conversations with expert participants of the Policy Forum revealed that women in Canada face a range of challenges when seeking access to LARCs. To guide targeted and effective policy action, in this paper we describe the four most significant barriers to LARC access in Canada (Figure 2).

Figure 1: Significant policy challenges in Canada



Source: CRA analysis

Limited awareness of different contraceptive methods, their availability and their efficacy limit a woman's ability to access contraceptive methods

There are challenges in Canada with awareness of different contraceptive methods, their availability and their efficacy. In 2016, the Society of Obstetricians and Gynaecologists of Canada (SOGC) surveyed more than 3,200 Canadian women, finding that most were unaware of more than half the contraceptive methods presented in the survey, including some of the most effective options such as IUDs and contraceptive implants.[12] Challenges with awareness and education persist in Canada, particularly in more rural and remote communities, where access to HCPs trained in contraceptive counselling is sparser, resulting in increased reliance on educational sources such as online information or family and friends, which can be associated with an increased risk of misinformation.[13–15]

There are particular issues regarding education and awareness around LARCs. The SOGC survey found that less than a quarter of women thought hormonal IUDs were 'very effective', and fewer than 20% said the same about contraceptive implants.[12] The contraceptive implant was only approved by Health Canada very recently, in 2020; according to the Canadian expert, there are still challenges with awareness about this method and its effectiveness.[16] Furthermore, some women may hold incorrectly biased views about some LARC methods, contributing to hesitancy or reluctance to use LARCs. For example, some may believe that LARCs are only intended for those who have had children, while younger users may perceive IUDs as an 'older' method.[13]

LARC services are insufficiently funded, with some services lacking associated billing codes, and billing codes generally being insufficient to cover costs

In Canada, a clinic receives funding for delivering a LARC service for each patient from a provincial/territorial insurance plan, from a private insurer, or from the patient directly (depending on the patient's coverage).[13]

Disparate coverage of various LARC services may preclude some women from receiving some LARC services. For example, many provincial/territorial insurance plans have a billing code that covers around CA$60 of the costs associated with an IUD placement, but there is no distinct billing code for implant insertion.[13] This forces HCPs to bill this service provision to regular visit/injection codes, which do not cover the full cost of inserting the implant.[13] As a result, either the woman must pay a co-payment towards the cost of the LARC service in the form of a block or user fee, or the clinic operates the service at a loss, which is unsustainable.[13]

While obstetricians and gynaecologists may be able to bill to specialist codes that more adequately cover the cost-of-service delivery, primary care providers (who provide the majority of contraceptive care in Canada) are those most significantly impacted by the gap between costs and revenue. This leads to the financial unviability of service delivery and eventual closure of services, which limits community access for women.[13]

Access to LARC services is particularly challenging in indigenous, rural and remote communities, exacerbating regional health inequalities

Those living in indigenous, rural and remote communities in Canada face persistent health inequities across multiple domains, including in access to LARC services.[17] This disparity is captured in the aforementioned findings of the EPF Global Contraception Policy Atlas, which rated access to contraceptives and contraceptive services as very good in British Columbia and Quebec but described significant challenges with access in Newfoundland and Labrador, Yukon and New Brunswick. [5]

Challenges of access in indigenous, rural and remote communities are driven by issues with HCP training and the financial viability of service operation in these areas. Many rural areas lack access to HCPs trained in LARC provision, meaning women seeking LARCs must travel to larger communities to access these services. This travel adds additional logistical and financial barriers for these women, restricting their contraceptive choice to methods with little to no reliance on services, such as short-acting contraceptives or barrier methods.[13] While some PTs provide funding to cover medical transportation for selected groups, not all women in indigenous, rural and remote communities may be able to access such coverage, and coverage of travel to receive contraception may be limited.[18]

Lack of universal and full reimbursement of LARCs creates significant affordability concerns for women seeking access to such contraception, and concerns exist about the implementation of new Pharmacare legislation

Cost has been identified by Canadian contraceptive care providers as the single most important barrier to access to these products.[19] Although cost-effective in the long term, IUDs and implants may have an up-front cost of hundreds of Canadian dollars for the product alone, before the cost of associated services is accounted for.[19,20] In Canada, both private insurers and many provincial and territorial insurance plans may cover or subsidise some of the cost of LARCs. However, different products are variably covered for different groups of women, resulting in inaccessibility for many.[21]

Regarding private coverage, some women may be covered by an employment-based health benefit plan, but many working in part-time or contract positions often lack access to private coverage. Young people and those with low incomes are more likely to be working in such positions; these groups also experience the highest rates of unintended pregnancy.[4,19,22]

For those not covered by private plans, provincial and territorial plans may provide low-cost contraception for a subset (typically those younger than 25 and those with the lowest incomes). However, there are inevitably many women not covered by private plans but who fall beyond these thresholds for age or income set by provincial and territorial plans. While there are public safety net plans available to cover such groups, the high deductibles and co-payments of these plans mean they typically offer little relief for expenses related to LARC products.[19]

The Canadian government has recently passed legislation for the first phase of the Pharmacare Act, with the 'intention to provide universal, single-payer coverage for a range of contraception medications and devices in collaboration with provinces and territories'.[23] While this represents a significant step towards positive change, there is still concern among expert communities regarding the implementation of this legislation across states with such disparate current statuses of contraceptive access and coverage.[13] In particular, implementation may be significantly delayed in some PTs, while others may choose to not implement this at all given that provinces have primary jurisdiction over health care.

3. Key policy recommendations

Based on our analysis of the identified challenges in Canada, and in close collaboration with HCPs in the field, we have developed a set of targeted policy recommendations designed to address these issues comprehensively (Table 1).

Table 1: Key policy recommendations for Canada

Challenges	Policy recommendations
Limited awareness of different contraceptive methods, their availability and their efficacy limit a woman's ability to access contraceptive methods	• School education should cover the full spectrum of contraception and dispel any myths concerning different forms of contraception (e.g. concerns about insertion and removal of LARCs); it should be funded locally and involve the guidance or support of expert HCPs or medical societies • Reputable online information regarding sexual health and contraceptive options should be provided through a wider range of channels (including public health channels); cross-stakeholder collaboration is needed to identify and actively address mis- and disinformation with accurate social media content
LARC services are insufficiently funded, with some services lacking associated billing codes, and billing codes generally being insufficient to cover costs	• There should be sufficient availability of clinics and HCPs for contraceptive users to be able to access services in a timely manner, including in rural and remote communities
Access to LARC services is particularly challenging in indigenous, rural and remote communities, exacerbating regional health inequalities	• Distinct billing codes should be available for all LARC-associated services, including implant placement and removal • The amount of funding associated with each billing code should be revised to accurate reflect the costs of each LARC-associated service
Lack of universal and full reimbursement of LARCs creates significant affordability concerns for women seeking access to such contraception, and concerns exist about the implementation of new Pharmacare legislation	• Pharmacare legislation should be considerately and consistently implemented across PTs, with particular attention paid to improving access to LARC products in those PTs with currently inadequate access

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Michele Pistollato
Principal
London
mpistollato@crai.com

Hannah Armstrong
Associate Principal
London
harmstrong@crai.com

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