CRA Charles River Associates

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

Country Profile: England

May 2025

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

Expert Co-Author: Farah Chaudhry, MD, Consultant in sexual and reproductive health and co-medical lead at Leeds Sexual Health, England, UK

Expert Co-Author: Stephanie Cook, MD, GP with a special interest in Women's Health, Clinical Lead - Women's Health Hubs - Cheshire & Merseyside, UK; Executive Director – Primary Care Women's Health Forum, UK

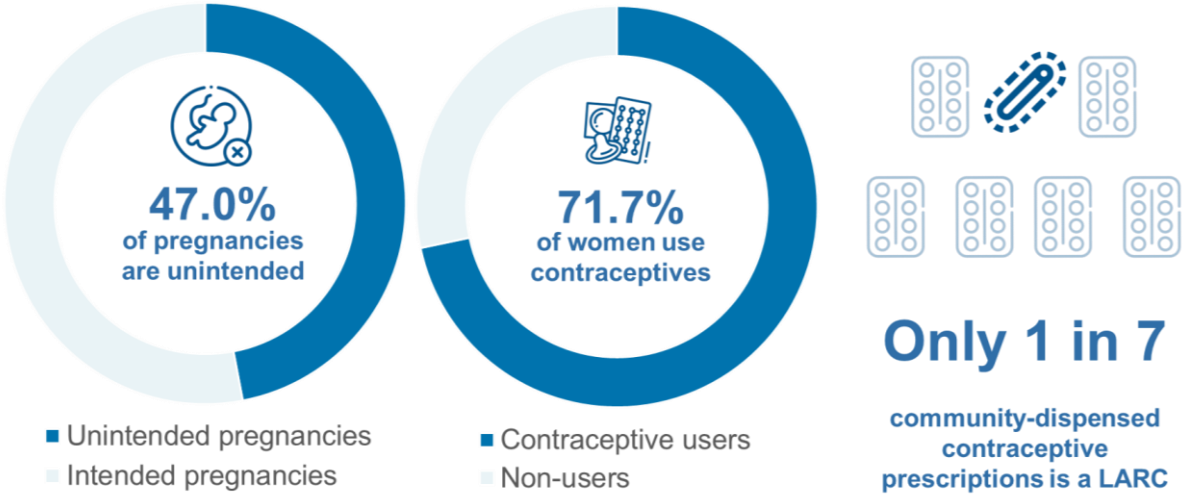
1. Introduction

According to the European Contraception Policy Atlas, the United Kingdom (UK) is consistently ranked among the best in Europe for overall access to contraceptives and contraceptive counselling and availability of online information.[1] A 2019 report developed by the United Nations found that use of any contraceptive method among women of reproductive age is substantially higher in the UK (71.7%) than the European average (56.1%) and higher than the Northern European average (68.4%) (Figure 1).[2]

Despite good access and historically high contraception use, rates of unintended pregnancy suggest there are still gaps in the effective use of contraception. For example, the Guttmacher Institute reports that 545,000 pregnancies annually are unintended (almost half of the annual total of 1.15 million pregnancies) (Figure 1).[3] Unintended pregnancies are associated with a large socioeconomic burden for women.[4] Nearly 200,000 of annual unintended pregnancies end in abortion, which leads to additional emotional impact for women and a societal-level economic impact. Additionally, recent data show that abortions are increasing in number.[3,5]

While a range of factors are considered in making a contraceptive decision, including efficacy, side effects and convenience, the World Health Organization recognises long-acting reversible contraceptives (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] Currently, the vast majority of UK women rely on user-dependent methods such as oral contraceptives, contraceptive patches and contraceptive rings rather than LARCs. Although shorter-acting user-dependent methods innately require more prescriptions, prescriptions for LARCs made up only around one million of the more than seven million community-dispensed contraceptive prescriptions in the UK in 2023.[7]

Figure 1: Key statistics on contraceptive use and unintended pregnancies



Sources: United Nations (2019),[2] NHS England Digital[7]

Note: Data on LARC prescription include IUDs, implants, and contraceptive injections

In the context of high rates of unintended pregnancy, with LARC use making up only a small proportion of total contraceptive use in England, it is important to assess if there are barriers preventing users from accessing LARCs. Our study focused on identifying these barriers through a review of recent literature, validation of insights with leading England-based health care professionals (HCPs) and co-development of actionable policy recommendations to address these challenges in a

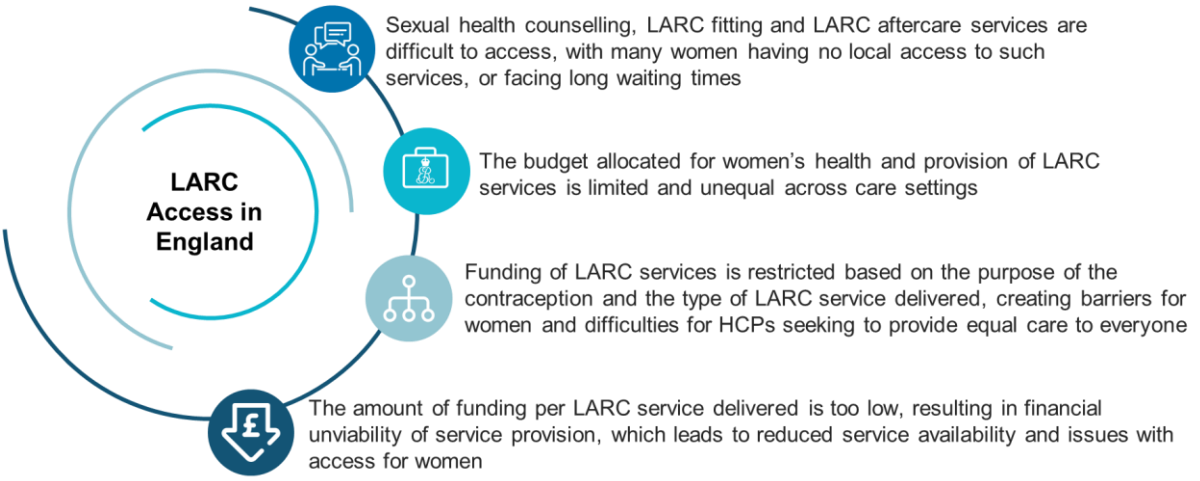
Policy Forum that included HCPs from nine countries, including England. Below, we cover the challenges that are most prominent in England, how they manifest, and what policy recommendations could help to provide more women in the country with access to LARCs. We also noted that there is some debate over which contraceptive methods qualify as LARCs.[8,9] While some sources include contraceptive injections, others exclude them because their effects are not as quickly reversible as those of IUDs and implants.[10] 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.

Note: We focus on the health care system in England. Other devolved nations of the UK are not covered explicitly in this analysis but may experience many of the same challenges.

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 England face a range of challenges when seeking access to LARCs. To guide targeted and effective policy action, in this paper we describe the five most significant barriers to LARC access in England (Figure 2).

Figure 1: Significant policy challenges in England



Source: CRA analysis

Sexual health counselling, LARC fitting and LARC aftercare services are difficult to access, with many women having no local access to such services or facing long waiting times

Access to sexual health counselling varies on a regional basis, depending on the service offerings of individual National Health Service (NHS) trusts and local-authority-funded sexual health clinics, but generally, counselling is considered difficult to access across England.[11] In some areas, dedicated counselling services are not available at all, whereas in others, women face long waits.[11] Waiting times for counselling were highlighted as an issue in a 2020 inquiry by the UK All-Party Parliamentary Group (APPG) on Sexual and Reproductive Health (SRH), which recommended that the UK Department of Health and Social Care should capture data on waiting times for the provision of contraceptive counselling.[12]

Some regions in England have implemented online 'self-counselling' services, allowing users to read about their contraceptive choices and, if desired, book a LARC fitting appointment directly.[13] Such an approach frees up the capacity of sexual health counselling services for those who could most benefit

from an in-person discussion (such as digitally excluded groups), but these online options are not available everywhere.[11]

As with sexual health counselling, appointments for LARC fitting and aftercare (i.e. check-up and removal) are generally challenging to access, especially outside of major urban areas.[11] There are a limited number of LARC fitting appointments, due to both the shortage of trained professionals and the financial unviability of LARC service provision, leading to restricted appointment times (as described below).[14] The impact of too few trained professionals was captured in the UK APPG SRH Inquiry, which found that 'a reduction in the availability of LARCs in General Practice, [leads] to reduced overall provision and long waiting times for women'.[12] It is also important to note that lack of funding for LARC services (especially insufficient tariffs for coil and implant procedures) can directly disincentivise training. For example, if a general practice or primary care network (PCN) is unable to develop a financially viable business case, even motivated HCPs are likely to be actively discouraged or prohibited from training for a service that would leave practices and PCNs out of pocket.[11]

The budget allocated for women's health and provision of LARC services is limited and unequal across care settings. Although commitments have been made in recent years to allocate more funding to women's health, for example, through the establishment of Women's Health Hubs, this money may not always reach the intended users. Many Integrated Care Boards (ICBs) are facing unprecedented financial pressures, with a strong focus on other priorities (such as elective recovery and emergency care) and a subsequent lack of investment in women's health.[11]

The budget is also not equally available across all health care settings, for example, postabortion and postpartum care. A 2022 'Progress Update' on the UK APPG SRH report found that although 'LARC, is included in most abortion contracts . . . providers are finding it challenging to cover this aspect of SRH within abortion consultations', as funding made available in these settings is not sufficient to cover staff time for the fitting and training of LARC methods.[15]

Similarly, the same report found that funding arrangements were not in place for routine postpartum contraception in all maternity settings. Despite the Women's Health Strategy encouraging local commissioner providers to consider the provision of contraception in maternity settings, 'funding has not been made available to support the implementation of such a service'.[15]

Funding of LARC services is restricted based on the purpose of the contraception and the type of LARC service delivered, creating barriers for women and difficulties for HCPs seeking to provide equal care to everyone

Funding of LARC services can also be restricted depending on whether the LARC service is being provided for contraceptive or noncontraceptive purposes and where the service is being provided. In many regions of England, sexual health clinics (funded by local authority public health funding) only receive funding for the provision of LARCs for contraceptive purposes, whereas general practitioner (GP) practices (funded via a mix of income streams but largely through the NHS core contract agreement) only receive funding for the provision of LARCs for noncontraceptive purposes.[11,16] This creates barriers and confusion for women about where they can access LARCs and poses difficulties for HCPs seeking to provide equal care to everyone.

Furthermore, the funding of services does not consistently extend to cover all aspects of LARC service provision, for example, failed LARC insertions or 'did not attends' (DNAs), which places a financial burden on clinics.[11] Some regions in England have successfully implemented additional payments such as a 'failed attempted procedure fee' and a small 'DNA retainer' to help sustainability, but this is not widespread across the nation.[11]

While variable across different regions, the amount of funding per LARC service delivered is generally too low, resulting in financial unviability of service provision, which leads to reduced service availability and issues with access for women

While all GP practices are mandated to provide basic contraception under their core contract (such as contraceptive pills), offering LARCs is an 'opt-in' service, termed a 'locally enhanced service' (LES).[11] While an additional fee is paid to clinics offering the LES, this is typically insufficient to cover the full cost of service provision. The UK APPG SRH report found that while some practices might be paid around £80 for the provision of LARC, the true cost to cover consultation, fitting, follow-up and removal may be closer to £140.[12] In many areas, this financial unviability of service provision means that clinics are forced to offer services at a loss or restrict service provision to times when additional 'top-up' funding is available, such as evenings and weekends.[11]

3. Key policy recommendations

There is an economic benefit to investing in women's health; recent findings from the NHS Confederation demonstrate a potential £11 return on investment for every additional £1 of public investment in obstetrics and gynaecology services per woman in England.[17] In addition, government analysis finds that undertaking gynaecological LARC procedures in Women's Health Hubs instead of secondary care offers an individual appointment cost saving of 68%.[18]

In this context, based on our analysis of the identified challenges in England, 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 England

Challenges	Policy recommendations
Sexual health counselling, LARC fitting and LARC aftercare services are difficult to access, with many women having no local access to such services or facing long waiting times	• There should be greater availability of clinics and trained HCPs for women to receive sexual health counselling, LARC fitting and LARC aftercare; more convenient access may encourage women to seek out trusted advice from HCPs • Sexual health counselling should be available through multiple channels such as online or via telephone, if appropriate, to ensure convenient access for users outside of large cities
The budget allocated for women's health and provision of LARC services is limited and unequal across care settings	• The new Labour government should recommit to funding under the Women's Health Strategy, including further development of Women's Health Hubs, with appropriate ringfencing implemented to ensure money reaches the intended users, and thus delivering on its manifesto commitment: 'Never again will women's health be neglected. Labour will prioritise women's health as we reform the NHS'
Funding of LARC services is restricted based on the purpose of the contraception and the type of LARC service delivered, creating barriers for women and difficulties for HCPs seeking to provide equal care to everyone	• The service via which contraception is accessed should have no impact on the woman's contraceptive options or choices • Adequate funding for LARC provision should be made available across all care settings, including postabortion and postpartum
The amount of funding per LARC service delivered is too low, resulting in financial unviability of service provision, which leads to reduced service availability and issues with access for women	• The amount of money paid to clinics per service should be increased, with decision-making at a regional level, to ensure adequate coverage of the true costs of service provision in each region • Clear funding channels should be available in every region to cover all circumstances of LARC service delivery, including failed insertion and LARC removal

4. Bibliography

1. European Parliamentary Forum for Sexual and Reproductive Rights. “European Contraception Policy Atlas - United Kingdom.” Published February 2024. https://www.epfweb.org/node/757

2. United Nations Department of Economic and Social Affairs. *Contraceptive Use by Method 2019*. United Nations Department of Economic and Social Affairs, 2019.

3. Guttmacher Institute. “Unintended Pregnancy and Abortion—Country Profile: United Kingdom.” Published 2022.

4. Koops, Judith. “Calculating Contraceptive Prevalence and Unmet Need for Family Planning in Low-Fertility Countries with the Generations and Gender Survey.” *Demographic Research* 49, no. 21 (2023): 543–564.

5. Department of Health & Social Care. “Sexual and Reproductive Health Profiles.” Accessed January 31, 2025. https://fingertips.phe.org.uk/sexualhealth.

6. World Health Organization. “Family Planning/Contraception Methods.” Published September 5, 2023. https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception.

7. NHS England Digital. “Statistics on Sexual and Reproductive Health Services (Contraception): Data Tables.” Published September 19, 2024. https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2023-24/data-tables.

8. Hellström, Anna, Kristina Gemzell Danielsson, and Helena Kopp Kallner. “Trends in Use and Attitudes Towards Contraception in Sweden: Results of a Nationwide Survey.” *European Journal of Contraception & Reproductive Health Care* 24, no. 2 (2019): 154–160.

9. Emtell Iwarsson, Karin, Niklas Envall, Isabella Bizjak, Johan Bring, Helena Kopp Kallner, and Kristina Gemzell Danielsson. “Increasing Uptake of Long-Acting Reversible Contraception with Structured Contraceptive Counselling: Cluster Randomised Controlled Trial (the LOWE Trial).” *BJOG* 128, no. 9 (2021): 1546–1554.

10. NHS. What is the contraceptive injection? *https://www.nhs.uk/contraception/methods-of-contraception/contraceptive-injection/what-is-it/* (2024).

11. Charles River Associates (CRA). CRA 1:1 Expert Interviews. June 7, 2024.

12. All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPG on SRH). *Women’s Lives, Women’s Rights: Strengthening Access to Contraception Beyond the Pandemic*. APPG on SRH, 2020.

13. Chelsea and Westminster Hospital. “Book an Appointment.” John Hunter Clinic. Accessed January 31, 2025. https://www.chelwest.nhs.uk/services/hiv-sexual-health/clinics/john-hunter-clinic-for-sexual-health/book-an-appointment.

14. Connolly, Anne, and Lesley Wylde. *On the Brink: The Reality of Long-Acting Reversible Contraception (LARC) Provision in Primary Care*. Primary Care Women’s Health Forum, 2023. https://pcwhf.co.uk/wp-content/uploads/2023/07/PCWHF-LARC-Report-2023-3.pdf.

15. All-Party Parliamentary Group on Sexual and Reproductive Health (APPG on SRH). *Women’s Lives, Women’s Rights: Strengthening Access to Contraception Beyond the Pandemic. A Progress Review*. APPG on SRH, 2022. https://www.fsrh.org/Common/Uploaded%20files/documents/1appg-on-srh-access-to-contraception-2022-progress-update-final.pdf.

16. Baird, Beccy, and Wickens, Charlotte. “GP Contract 2024/25 Explained: Funding, Incentives and the Workforce.” The King’s Fund, September 4, 2024. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/gp-contract-2024-25-explained.

17. Gorham, Bridget, and Olivia Langham. *Women’s Health Economics: Investing in the 51 per Cent*. NHS Confederation, 2024. https://www.nhsconfed.org/publications/womens-health-economics.

18. Department of Health & Social Care. “Women’s Health Hubs: Cost Benefit Analysis.” Updated March 21, 2024. https://www.gov.uk/government/publications/womens-health-hubs-information-and-guidance/womens-health-hubs-cost-benefit-analysis.

About Charles River Associates

Charles River Associates is an economic and strategy consultancy with offices in North America, Europe, Latin America and Australia. CRA offers services to all the key functions of the life sciences industry and specialises in public policy issues. CRA focuses on delivering high quality, robust analysis in a compelling fashion that is accessible to the target audience and has worked for the industry, national trade associations, and individual companies on a wide range of issues over the last 20 years.

www.crai.com/industries/life-sciences/

Michele Pistollato
Principal
London
mpistollato@crai.com

Hannah Armstrong
Associate Principal
London
harmstrong@crai.com

CRA Charles River Associates