Use of pregnancy counselling services in Australia 2007–2012

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Abstract

Objective: To assess the uptake of Medicare Benefit payments for non-directive pregnancy support counselling which commenced in November 2006.

Methods: Counts of services for pregnancy counselling from 1 July 2007 to 30 June 2012, where a Medicare rebate was paid, were used to calculate age-, state- and provider-specific rates per 100,000 women aged 15-44 years, and rates per 100,000 births for each study year.

Results: Rates of Medicare rebates for pregnancy counselling were low, with a mean of 90.6 services per 100,000 women recorded over the study period. GP services were accessed most frequently, while services provided by allied health professionals averaged less than 5% of those for GPs. The overall rate of services fell in all jurisdictions except Victoria/Tasmania, although services provided by allied health professionals remained steady or rose in all jurisdictions over the study period.

Conclusions: There has been a low uptake of pregnancy counselling covered by the Medicare Benefits Item numbers introduced in 2006, especially for services provided by allied health professionals. Due to a lack of available data, the impact on abortion rates is unknown.

Implications: Provision of Medicare rebates for pregnancy counselling does not appear to be an effective way of assisting women with unintended pregnancies.

Key words: pregnancy counselling, Medicare, government policy, unintended pregnancy

In March 2006 the Federal Government announced $35.6 million over four years for new Medicare Benefit payments for pregnancy support counselling by general practitioners (GPs) and, on referral, to social workers, psychologists and mental health nurses. These were introduced in November 2006. A further $15.5 million was made available for a National Pregnancy Support Telephone Helpline to provide professional, non-directive counselling to women, their partners and family members who wished to explore pregnancy options. The then Health Minister was quoted as saying that he wanted these services to exert "downward pressure" on Australia's abortion rates,[1] despite there being an absence of evidence demonstrating unmet need for pregnancy advisory services or a rise in demand for such services. Indeed published evidence indicates that women usually seek out such counselling services for practical assistance in implementing the decision they have made regarding the resolution of an unintended pregnancy rather than for assistance in reaching such as a decision.[2,-4]

According to the Medicare Benefits Schedule the Pregnancy Support Counselling initiative "provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to women who are concerned about a current pregnancy, or a pregnancy that occurred in the preceding 12 months, by an eligible medical practitioner (including a general practitioner (GP), but not including a specialist or consultant physician) or allied health professional on referral from a medical practitioner".[5,6] The service may only be provided by service providers who have completed appropriate non-directive pregnancy counselling training, although what constitutes appropriate training is not specified in the schedule.

For the purposes of services for which a Medicare rebate can be claimed, non-directive pregnancy support counselling "is a form of counselling based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them.'[5]

The Medicare Benefits Schedule stated that the role of the GP was to undertake "a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient" and that "the service may be used to address any pregnancy related issues for which non-directive counselling is appropriate".[5] The Medicare rebate covered up to three non-directive pregnancy support counselling services per patient, per pregnancy, provided by any of the four types of providers.

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Between August and November 2007, research in Victoria that aimed to document available pregnancy advisory services found that most psychologists, social workers and mental health nurses eligible for Medicare pregnancy counselling rebates had never received a referral relating to pregnancy counselling through the Pregnancy Support Counselling initiative and that most pregnancy advisory services did not refer women to the national helpline.[7] Although, subsequently, some changes have been made to the helpline services and training for pregnancy counselling following the change of government in 2008, no formal evaluation of the initiatives has been published. This paper seeks to fill this gap, in part, by reporting on the use of services for pregnancy counselling for which one of the Medicare Benefits Schedule item numbers introduced in 2006 was recorded.

Methods

Data sources

Data used in this study consisted of counts of services for which a rebate was paid through Medicare for Medicare Benefits Schedule (MBS) Item Numbers 4001, 81000, 81005 and 81010, which cover Pregnancy Support Counselling Services provided by general practitioners (GPs), psychologists, social workers and mental health nurses respectively, for financial years for the period 1 January 2007 to 30 June 2012. Data for each item number, classified by women's age group and state/territory of usual residence were accessed and downloaded into Excel spreadsheets from the Medicare Australia website (https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml). Population data for the years 2007 to 2011[8-12] and births data for 2008 to 2012[13-17] were sourced from the Australian Bureau of Statistics (ABS) website. Data for the 2006/07 financial year are not reported as the relevant Medicare item numbers were introduced in November 2006 and thus data are incomplete data for that year.

Data analysis

Age group- and jurisdiction-specific rates of services per 100,000 women were calculated for each item number for each of the study years and graphed in Excel. Age-group-specific rates per 100,000 births were calculated for each year also. As births data are reported on a calendar year basis, whereas Medicare data are reported on a financial year basis, births data for the later year in the financial year were used (e.g. Medicare data for 2007/08 and births data for 2008). The available data were grouped by age and by state/territory, with different groupings used for different item numbers. Consequently, only broad groupings were possible when reporting comparisons between jurisdictions, age groups or types of service provider. Where there were very few services recorded absolute numbers were used. Due to small numbers, services provided for women under 15 years of age were included in the 15 year age group and services for women over 44 years of age were included in the 44 year age group. Where there were low rates of services provided by one or more of the psychologists, social workers or mental health nurses groups, these were combined to form an 'allied health professionals' grouping. Linear tests for trend were performed using χ^2 tests with one degree of freedom in EpiInfo Version 7.1.3.[18]

Results

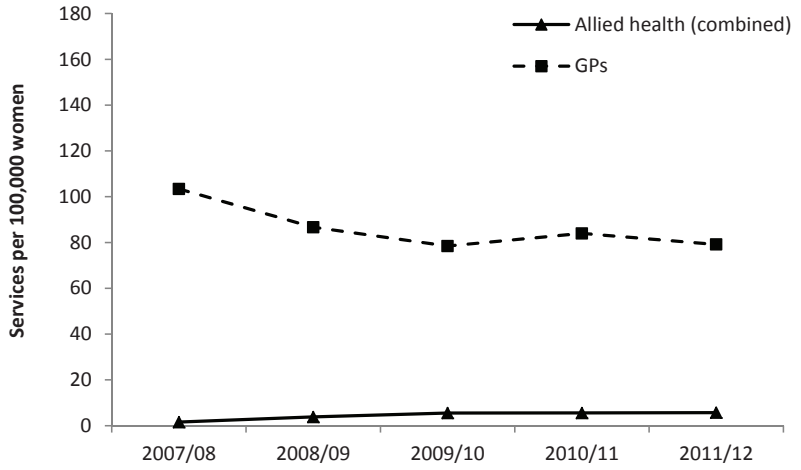
Between July 2007 and June 2012 a mean of 4,160 services per year were provided for pregnancy counselling (range 3,889 to 4,656), a rate of 90.6 per 100,000 women 15 to 44 years of age. The provision of counselling services fell 19% over the five-year period from 104.9 to 84.8 per 100,000 women, although this fall was not statistically significant (χ^2 for linear trend=1.9, p=0.17).

Of the four provider types from whom women could seek pregnancy counselling, GPs services were accessed most frequently, with a mean of 86.2 services per 100,000 women per year over the five year period (range 78.4 to 103.4 per 100,000 per year). Counselling services provided by allied health professionals averaged less than 5% of those for GPs at 4.5 per 100,000 women (range 1.6 to 5.7 per 100,000 per year) (Figure 1). Psychologists provided more than 50% of allied health provider services. In absolute numbers, psychologists provided a mean of 123 services per year nationally (range 44–174), compared with 34 services provided by social workers (range 18–50) and 51 by mental health nurses (range 36–99).

Women aged between 25 and 34 years of age had the highest rate of counselling services provided by all types of providers (mean 134.5, range 120.6 to 158.3 per 100,000 women per year), while the oldest age group (35-44 years) had the lowest rate (mean 57.2, range 51.3 to 65.9 per 100,000 women per year) (Figure 2). While women aged 35 years and older had the lowest rates of counselling services provided by GPs (mean 52.4, range 45.5–64.6 per 100, 000 women per year) they had an intermediate rate of counselling services provided by allied health professionals (mean 4.6 per 100,000 women per year, range 1.2–5.8 per 100, 000 women per year), more than double that of women 15 to 24 years of age (mean 2.1, range 0.8–3.2 per 100,000 women per year).

Counselling services provided by GPs decreased by 24% in all age groups, but reached statistical significance only for the 25 to 34 year age group: 24.5% decrease for 15 to 24 year olds (92.4 to 69.8 per 100,000, $\chi2$ for linear trend=2.7, p=0.10); 24.2% decrease for 25 to 34 year olds (115.7–117.9 per 100,000,: χ^2 for linear trend=4.5, p=0.03); 23.7% decrease for 35 to 44 year olds (64.6 to 49.3 per 100,000, χ^2 for linear trend=3.2, p=0.08). In contrast, services provided by allied health professionals rose for all age groups, although increases, again, were from a very low base

Figure 1: Medicare claims for pregnancy counselling by GPs and allied health professionals 2007/08 to 2011/12.



in 2007/08 and did not reach statistical significance: 288% for 15 to 24 year olds (0.8 to 2.4 per 100,000, χ^2 for linear trend=0.8, p=0.4), 328% for 25 to 34 year olds (2.6 to 8.6 per 100,000, χ^2 for linear trend=3.4, p=0.07) and 477% for 35 to 44 year olds (1.2 to 5.8 per 100,000, χ^2 for linear trend=1.9, p=0.17).

Queensland had the highest rate of pregnancy counselling services at 119.5 per 100,000 women per year (range 101.2 to 130.2) with South Australia/Northern Territory providing the lowest rate at 39.6 per 100,000 (range 28.9 to 66.9 per 100,000 women per year) (Figure 3). NSW/ACT recorded the highest rate of counselling services provided by allied health professionals with a mean of 7.2 services per 100,000 women per year (range 2.1 to 10.8 per 100,000).

Time trends in the number of counselling services varied by state/territory of residence and type of service provider (Figure 1 and 3). Counselling services fell over the five-year period in all states and territories except Victoria/Tasmania, where they rose by 73.2%, a statistically significant rise (χ^2 for linear trend=18.76, p<0.001). The steepest falls were in NSW/ACT where rates fell from 139.2 per 100,000 women in 2007/08 to 76.5 per 100,000 women in 2011/12, a fall of 45% (χ^2 for linear trend=21.9, p< 0.001). In South Australia/Northern Territory rates fell by 55%, from 66.9 to 29.9 per 100,000 women between 2007/08 and 2008/09 before remaining steady for the remainder of the study period.

In contrast to counselling provided by GPs, services provided by allied health professionals remained steady or rose in all states and territories over the study period. Victoria/Tasmania and Queensland both recorded more than five-fold increases, albeit from a very low base (Vic/Tas 660%, χ^2 for linear trend=3.98, p=0.04; Qld 520%, χ^2 for linear trend=6.96, p=0.008). This represented only 56 services in Victoria and 73 services in Queensland by 2011/12. During the study period services for women of different ages showed little variation, with statistically non-significant falls of 22%, 20% and 16% for 15–24 years, 25–34 years and 35 years and over groups respectively (χ^2 for linear trend=2.1, p=0.15; χ^2 for linear trend=2.7, p=0.10; χ^2 for linear trend=1.63, p=0.20; respectively).

Pregnancy counselling services, by all practitioner types combined, were provided at the rate of 1,387 per 100,000 births over the 2007/8 to 2011/12 period. When rates of pregnancy counselling services are considered in relation to birth rates, the pattern, overall and by state/territory of residence, is generally similar as is the decline in the proportion over time (data not shown).

There are, however, notable differences in the pattern of rates of services per 100,000 births in relation to women's ages (Figure 4). Women aged 15 to 24 years had the highest proportion of services relative to births, averaging 2,251 counselling services per 100,000 births (range 2,010 to 2,433), compared with 1,154 (range 1,057 to 1,326) for women 25 to 35 years and 1,314 for women 35 years and older (range 1,184 to 1,571).

Discussion

Overall, we found that the take up of Medicare-rebated pregnancy support

Figure 2: Medicare claims for pregnancy counselling for women of different age groups.

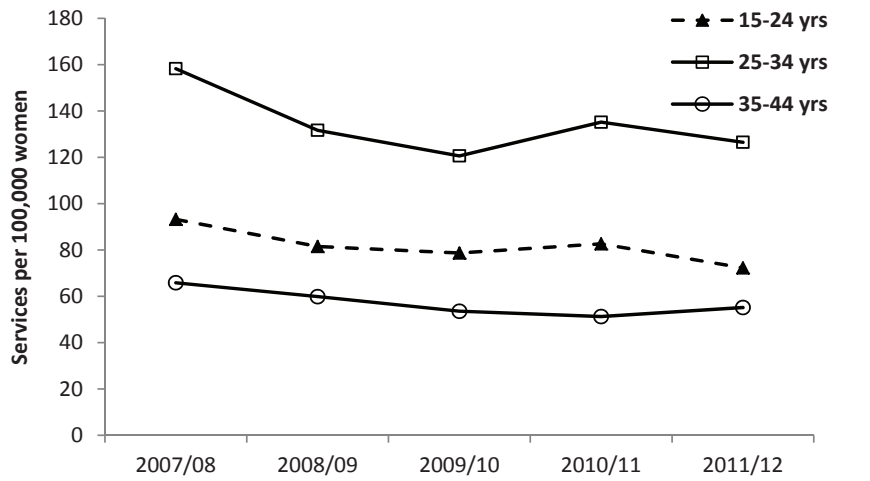
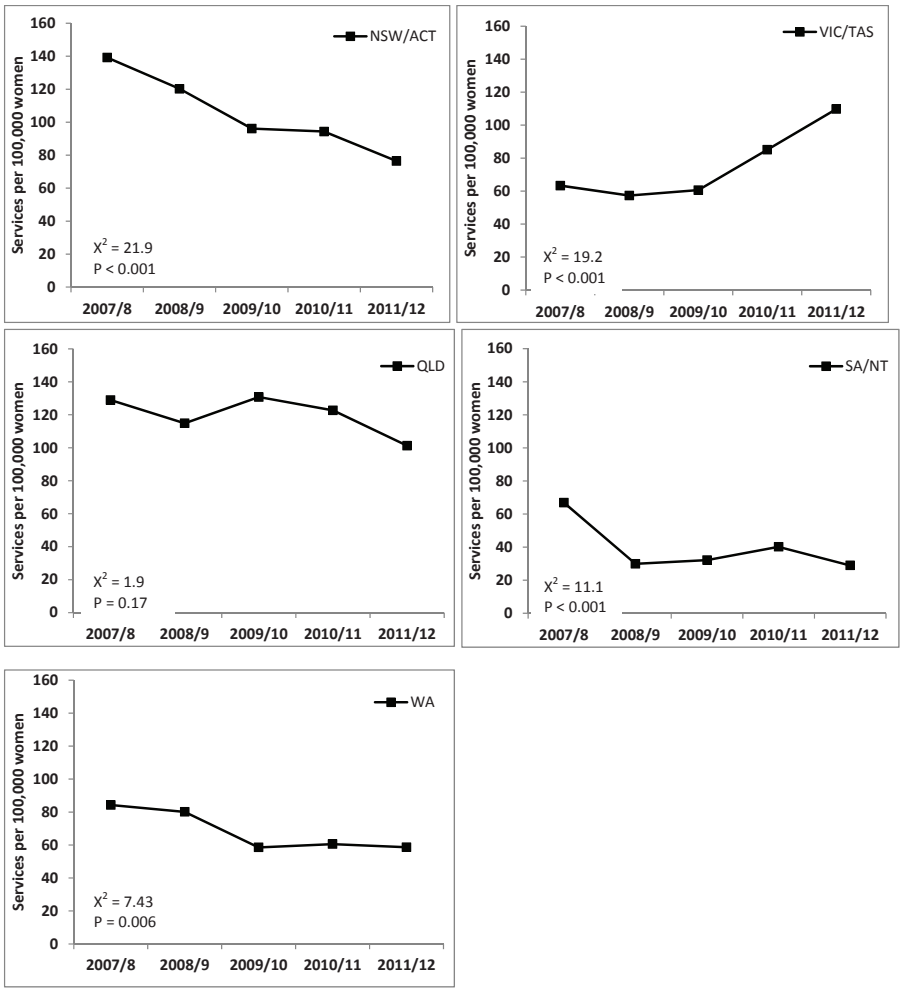


Figure 3: Pregnancy counselling services by women's state/territory of residence 2007/8 to 2011/12.



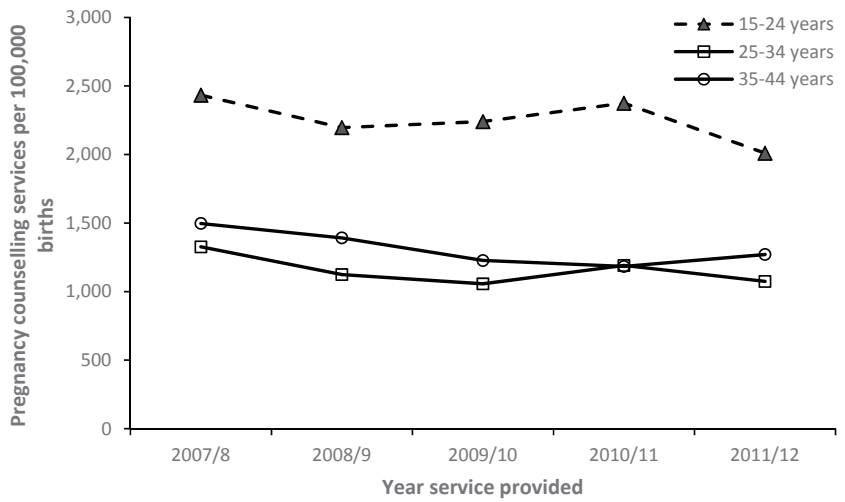
counselling was low, whether considered in relation to the overall female population, or in relation to the birth rate. These findings add to the existing evidence suggesting that few women want counselling in the event of an unintended pregnancy and that women usually seek out pregnancy counselling services for practical assistance in implementing a decision regarding the resolution of an unintended pregnancy rather than assistance with the decision-making process.[2,3,19] The findings also suggest that the largely unspoken assumption that women need better access to help/advice/counselling in the event of unintended pregnancy, with the presumption that 'better' counselling would result in fewer abortions may be unfounded in the Australian setting. This is underlined by the fact that the results of this study most likely represent an overestimate of the numbers of women seeking pregnancy counselling.

Medicare-rebateable pregnancy counselling is available to women in situations other than unintended pregnancy, including post-delivery or termination or following a pregnancy loss. In addition, up to three counselling services can be claimed by each woman for each pregnancy. Consequently, the number of women using the pregnancy counselling services for support or assistance with decision-making in the event of an unintended pregnancy is possibly less than one-third of those presented here. On the other hand, it is possible, that GPs who have always provided pregnancy counselling have continued to do so, without undergoing the government-approved training or using the specific pregnancy counselling item numbers.

Although the number and rate of women making use of the pregnancy counselling services that are rebateable through Medicare was relatively low, the provision of a Medicare rebate for pregnancy counselling services does mean that such services may have been available more widely to younger women and those of lower socioeconomic circumstances than would be possible without the rebates. This is a primary objective of the Medicare system, which it has met effectively.[20,21] It is arguable that the cost of this policy initiative is incurred proportionally to the number of services for which rebates are paid and, consequently, that low uptake of pregnancy counselling is without negative effects once the costs of implementing the codes initially is removed.

Not surprisingly, the rate of services provided by GPs was many times greater than counselling by allied health professionals, given the widespread availability of GPs, lesser availability of allied health professionals with Medicare claiming rights for pregnancy counselling, especially in some rural and remote areas,[22,23] and the requirement that GPs refer women to allied health professionals, thus acting as gatekeepers to those services. The rise in rates of counselling services provided by allied health professionals between 2007/08 and 2009/10, followed by a flattening off, may have been the result of a lag time between the introduction of the Medicare item numbers for pregnancy counselling, completion of training and registration of allied health professionals to provide this service, and the formation of referral pathways between these group and GPs.

Figure 4: Pregnancy counselling services (all providers) per 100,000 births for women of different age groups 2007/08 to 2011/12.



The greater rate of services for women 25 to 34 years of age mirrors the age profile of births and abortions in Australia, both of which have the highest incidence in this age group,[11,24] although abortion data for South Australia for the relevant time period shows the highest incidence in the 20 to 29 year age groups.[25,26] When pregnancy counselling services are considered in relation to the birth rate, however, rates were highest for the youngest age group (15 to 24 year olds), and generally higher for the 35 and over age group than for the 25 to 34 year old group. This may reflect the trends in abortions as a proportion of births plus abortions, the abortion proportion, where the youngest age group has the highest proportion, with a second, smaller peak among older women.[25,26] Unfortunately, there are no readily accessible national data on abortion incidence that would allow an assessment of the impact of the availability of Medicare-rebateable counselling, a situation that exists also in most Australian jurisdictions.

Variations in patterns of services by state and territory are harder to interpret. There was a statistically significant rise in services Victoria/Tasmania, even though all other jurisdictions showed a fall over the study period. It is possible that this reflects the change in the legal status of abortion in Victoria in 2008.[27] The low rate of services for women in South Australia/Northern Territory throughout the study period may be related to the existence of the South Australian based, state government funded Pregnancy Advisory Service, which provides counselling for which individual Medicare claims are not recorded, meaning that fewer counselling services are the subject of Medicare claims. It is quite possible that many or even most of the services reported here are, in fact, from Northern Territory. Although data on pregnancy terminations are reported annually for South Australia, Northern Territory residents do not have access to these services, meaning that there is little to be gained from an examination of changes in South Australian termination rates in relation to changes in the rate of pregnancy counselling. The decline in services provided in Western Australia is consistent with the drop in both the birth rate and the abortion rate over most of the study period.[28] The extent to which the Medicare rebateable pregnancy counselling services contributed to these falls is likely to be negligible, given that pregnancy counselling services represented less than one per cent

of the number of births plus abortions and that many other factors will have affected the abortion rate.

As with all research using Medicare data as its basis, this study has a number of shortcomings. As data are available only as counts of services, the number of women this represents in unclear. As mentioned above, women may have had more than one counselling service. It has been documented in several settings, also, that not all women intend to claim a rebate for an abortion[29,30] and it is possible that reticence or inability to make a Medicare claim has affected the data used in this study. Young women, in particular, have been shown to face real or perceived barriers in making Medicare claims in relation to pregnancy. The grouping of data from NSW and ACT, Victoria and Tasmania, and South Australia and Northern Territory, in the Medicare data available on services provided by GPs, together with the broad age ranges in the available data, limit the specificity of the analyses that could be undertaken. It is curious that data for each individual allied health profession are available for individual states and territories, whereas the data for services provided by GPs, which are much more numerous, are collapsed into the groupings that we have reported here.

The results presented here represent only part of the picture of women's use of pregnancy counselling and advisory services in Australia. However, the National Pregnancy Hotline had a similarly low uptake with a total of 5,500 calls received between May 2007 and June 2010, representing five calls a day over three years at a cost of more than $2,000 each.[31] Further research is needed to ascertain whether other services, including the many online resources, are used instead of face-to-face counselling or the National Pregnancy Helpline, whether there is an unmet need for pregnancy support and advisory services in Australia or whether, like Californian[2] and Irish[3,4] women, Australian women use these services to obtain practical assistance once they have decided on the outcome of their pregnancy.

Conclusions

There has been a low uptake of non-directive pregnancy counselling covered by the specific Medicare Benefits Item numbers introduced in 2006, especially for services provided by allied health professionals. As with other services for which a Medicare rebate is available, the availability of Medicare rebates for pregnancy counselling services may have had the benefit of making such services more widely available to younger women and those of lower socioeconomic circumstances. Due to the grouping of data across states and age groups and a lack of data on abortion both nationally and in most states and territories, the impact on abortion rates is unknown.

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