

## **Use of pregnancy counselling services in Australia 2007 – 2012**

(3,850 words)

### **Abstract** (201 words)

**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.

## Introduction

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 a "downward pressure" on Australia's abortion rates <sup>1</sup>, despite there being no evidence of 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 <sup>2,3</sup>.

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.' <sup>4,5</sup> 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.' <sup>4</sup>

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' <sup>4</sup>. 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.

Between August and November 2007, research in Victoria which 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 <sup>6</sup>. 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](https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml)). Population and births data for the years 2007 to 2011 were sourced from the Australian Bureau of Statistics (ABS) website<sup>7-15</sup>. Data for the 2006/2007 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 (eg Medicare data for 2007/2008 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  $\chi^2$  tests with 1 degree of freedom in EpiInfo Version 7.1.3.<sup>16</sup>.

## Results

Between July 2007 and June 2012 a mean of 4160 services per year were provided for pregnancy counselling (range 3889 to 4656), 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 ( $\chi^2$  for linear trend = 1.9,  $p = 0.17$ ).

(Figure 1 about here)

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 the services provided by allied health providers. In absolute numbers, psychologists provided a mean of 123 services per year nationally (range 44 – 174 services per year), 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).

[Figure 2 about here]

Decreases of 24% in counselling services provided by GPs were observed in all age groups (15 to 19 years:  $\chi^2$  for linear trend = 2.7,  $p = 0.10$ ), 20 to 24 years:  $\chi^2$  for linear trend = 4.5,  $p = 0.16$ ), 24% for 25 to 34 year olds ( $\chi^2$  for linear trend = 4.6,  $p = 0.03$ ; 35 to 44 years:  $\chi^2$  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 in 2007/08 and did not reach statistical significance: 288% for 15 to 24 year olds (0.8 to 2.4 per 100,000,  $\chi^2$  for linear trend = 0.8,  $p = 0.4$ ), 328% for 25 to 34 year olds (2.6 to 8.6 per 100,000,  $\chi^2$  for linear trend = 3.4,  $p = 0.07$ ) and 477% for 35 to 44 year olds (1.2 to 5.8 per 100,000,  $\chi^2$  for linear trend = 1.9,  $p = 0.17$ ).

Queensland had the highest rate of pregnancy counselling services at 119.5 per 100, 000 (range 101.2 to 130.2 per 100,000 women per year) 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).

(Figure 3 about here)

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 ( $\chi^2$  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% ( $\chi^2$  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%,  $\chi^2$  for linear trend = 3.98,  $p = 0.04$ ; Qld 520%,  $\chi^2$  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 and over groups respectively ( $\chi^2$  for linear trend = 2.1  $p = 0.15$ ;  $\chi^2$  for linear trend = 2.7  $p = 0.10$ ;  $\chi^2$  for linear trend = 1.63  $p = 0.20$ ; respectively).

Pregnancy counselling services, by all practitioner types combined, were provided at the rate of 14 per 100,000 births over the 2007/8 to 2010/11 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 (Figure 4). The overall fall in services as a proportion of births is lower, at 11%, than the fall in the rate per 100,000 women in the population (19%).

There are, however, notable differences in the pattern of rates of services per 100,000 births in relation to women's ages (Figure 5). Women aged 15 to 24 years had the highest proportion of services relative to births, averaging 23 counselling services per 100,000 births (range 22 to 24 services per 100,000 births), compared with just under 12 per 100,000 (range 10.6 to 13.3 services per 100,000 births) for women 25 to 35 years and just over 13 per 100,000 for women 35 years and older (range 11.8 to 15.0) services per 100,000 births).

## Discussion

Overall we found that the take up of Medicare-rebated pregnancy support 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 <sup>3,17</sup>. The findings suggest, also, 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 probably represent an overestimate of the numbers of women seeking pregnancy counselling, given that up to three counselling services could be claimed by each woman in respect of each pregnancy, meaning that at the most extreme, the data presented here represent only one-third the number of women as there are services for which a rebate has been paid through Medicare.

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 one of the primary objectives of the Medicare system, which has been shown to be effective in meeting this goal <sup>18,19</sup>. It is arguable, also, 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 <sup>20,21</sup>, and the requirement that GPs refer women to allied health professionals, thus acting as gatekeepers to the services of allied health professionals. 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.

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 <sup>9,22</sup>, although abortion data for South Australia for the relevant time period shows the highest incidence in the 20 to 29 year age groups <sup>23,24</sup>. 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 <sup>23,24</sup>. 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. Whereas all other jurisdictions showed a fall in services over the study period, there was a statistically significant rise in Victoria/Tasmania. It is possible that this reflects the change in the legal status of abortion in Victoria in 2008<sup>25</sup>. 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.

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 is 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<sup>26,27</sup> and it is possible that reticence or inability to make a Medicare claim has affected the data used in this study also. Not surprisingly, 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 which 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 very much more numerous, are collapsed into the groupings which we have reported here.

## 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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