

Emergency Contraception in the United Kingdom And the Netherlands

By Anna Glasier, Evert Ketting, Charlotte Ellertson and Elizabeth Armstrong

In countries where emergency contraception is offered, its availability and use vary widely, according to such factors as regulations and policies regarding the method, providers' and women's understanding of and attitudes toward it, and cost. The experiences with the method in the United Kingdom and the Netherlands illustrate some of the issues involved in introducing and encouraging the acceptability of emergency contraception.

Emergency contraception first became available in Europe in the late 1960s and early 1970s. Today, in the United Kingdom and the Netherlands, the method is an accepted part of family planning practice and is well-known among doctors and women. This acceptance may be partly due to the method's inclusion in the health insurance systems of these countries.

Another factor explaining the established role of emergency contraception, at least in the Netherlands, is the lack of moral debate surrounding the method. Only its side effects and efficacy seem to engender controversy; the need for emergency contraception is acknowledged and accepted even for teenagers, for whom sexual activity is socially sanctioned.

We summarize here information on experiences with emergency contraception in these two countries. We then draw on these experiences to suggest lessons for other countries seeking to introduce or expand the use of this method.

United Kingdom

History of Emergency Contraception

Although British doctors occasionally administered high-dose estrogen or inserted an IUD for the purpose of emergency contraception in the early 1970s, it was not until 1974 and the publication of the first article on emergency contraception using a combined estrogen-progestogen regimen that the method's use became wide-

spread in the United Kingdom.¹ The National Association of Family Planning Doctors met in 1982 to discuss emergency contraception and a year later published a set of clinical guidelines establishing two combined pills, Ovran and Eugynon 50, as the preferred hormonal regimens.²

In 1982, the Department of Health stated that treatment up to 72 hours postcoitally was "probably legal," but that treatment after five days "might be considered an abortion."³ The following year, an anti-abortion lobbying group filed several complaints against clinics providing emergency contraception; the group based its argument on the Offences Against the Person Act of 1861, which made it illegal for a woman or her doctor to "intend to procure a miscarriage." In response, the attorney general ruled that emergency contraception administered within 72 hours after intercourse was not a criminal offense, reasoning that "preventing implantation is not procurement of a miscarriage."⁴

At the request of the Department of Health, the Committee on Safety of Medicines undertook a review of emergency contraception in 1983 and determined that the method was "acceptably safe for occasional use." The pharmaceutical company Schering submitted an application for a product based on Eugynon 50 to the Medicines Division in August 1983 and received a license in January 1984. PC4 (50 mcg of ethinyl estradiol and 0.5 mg of norgestrel in each of four tablets) was on the market by October 1984.

Discussion is under way with regard to making PC4 available from pharmacists without a doctor's prescription, a step that most professional organizations support. The Royal College of Obstetricians and Gynecologists organized meetings about the matter in December 1994 and July 1995. It is up to Schering to apply to change the license, and the company thus far seems reluctant to do so.

Availability and Prevalence

General practitioners are the major source of emergency contraception in the United Kingdom. Everyone in the United Kingdom is entitled to register with a general practitioner. For contraceptive ser-

vices, women may also visit a general practitioner other than the one they are registered with, although this option is not widely known.

Women in most cities and large towns may also seek emergency contraception at National Health Service family planning clinics. Since 1972, these clinics have provided contraceptives free of charge. The clinics offer anonymity to women reluctant to consult their general practitioner and may be open in the evenings and on weekends; however, not all towns—and few villages—have such centers, and at least half of these clinics are open only once a week.

The nonprofit Brook Advisory Centres, which provide services to young people in cities throughout England and in Edinburgh, Scotland, provide emergency contraception. Some hospitals' accident and emergency departments also provide hormonal emergency contraception.

National data on the prevalence of emergency contraception do not exist, but reports from clinics suggest that use has been rising rapidly. Knowledge of emergency contraception is fairly high; surveys from the late 1980s found that 65–75% of women undergoing induced abortion had heard of emergency contraception.⁵ A small, unpublished survey conducted by Schering in 1994 found that 90% of women had heard of emergency contraception. However, many women continue to be unaware of the 72-hour time limit or of the method's ready availability. Levels of knowledge of postcoital IUD insertion are low.

Schering's sales data for PC4 indicate that about 353,700 packets were sold in 1992, and 420,500 were sold in 1993. Schering has sold 2.5 million packets of PC4 since the regimen was licensed in 1984. One clinic in Edinburgh reports that the use of emergency contraception has doubled in the last five years and now accounts for about 4% of the 47,000 visits made to the facility annually.

There is no way of estimating the extent to which Ovran is prescribed for emergency contraception or how many IUDs are inserted for postcoital indications, since these contraceptives are also used on an ongoing basis.

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Cost

All contraception in the United Kingdom, including emergency contraception, is free to the patient. Schering sells the PC4 combination to the National Health Service at a cost of about U.S. \$2.20 per treatment. Many family planning clinics and some general practitioners make up their own supplies using Ovran, at a cost of about 25 cents for the four tablets. The actual cost to the clinic is somewhat higher because of packaging costs. In addition, some clinics provide six tablets, to leave a woman with two spares in case she vomits. Others add an antiemetic, at a cost of around 16 cents per tablet. An IUD costs the National Health Service about \$11–\$16, although clinics that buy in bulk may pay considerably less.

A recent study of the cost-effectiveness of contraception estimated considerable savings to the National Health Service from the use of emergency contraception to prevent unintended pregnancy.⁶ Even on the basis of failure rates as high as 25 births per 100 users of emergency contraception per year, the study estimated that prescribing PC4 costs between \$19 and \$74, depending on the provider, and saves the government health service \$727–\$806. Estimates of costs averted did not include such costs to society as those associated with education and social services.

Netherlands

History of Emergency Contraception

Emergency contraception has been used in the Netherlands since 1964⁷ and is widely known and accepted there. The Netherlands places a high priority on preventing unwanted pregnancy, and information on emergency contraception has always been included in family planning education programs and materials. The level of contraceptive use is generally high, and the incidence of unwanted pregnancy and abortion is low. Thus, while emergency contraception is free of moral debate, is not considered an abortifacient and is considered acceptable for teenagers, the need for it is reduced by the high levels of effective contraceptive use among women of all ages.⁸

As early as 1970, emergency contraception was covered in the first family planning handbook for Dutch doctors,⁹ and within a few years, the method became widely available through general practitioners, who form the backbone of the Dutch health care system. (Every citizen is registered with a general practitioner.) The Dutch Family Planning Association, the Rutgers Stichting, also began

offering the method in the early 1970s. However, overall use of emergency contraception declined by 50% between 1974 and 1983, primarily because of a sharp increase in the use of ongoing methods of contraception after their inclusion in the national health insurance program.

The original emergency contraception regimen used in the Netherlands consisted of five pills of ethinyl estradiol taken for five days—a total dosage of 25 mg, or the equivalent of three years' worth of modern low-dose oral contraceptives. (This regimen is commonly known as the 5x5 method.) In around 1980, the "Yuzpe method" was introduced in the Netherlands. This regimen, which came to be known as the 2x2 method for its two doses of two pills taken 12 hours apart, quickly replaced the 5x5 method; for example, by 1985, 83% of prescriptions for emergency contraception from general practitioners¹⁰ and 97% of those from the Rutgers Stichting were for the Yuzpe method.¹¹ However, over the last 10 years, the side effects and efficacy of both methods have been the subject of vigorous debate among practitioners and researchers. Several specialists feel that the 5x5 method provides far too heavy a hormonal dose, while others are of the opinion that the 2x2 method is not sufficiently reliable.

This debate has spilled over into the general public's consciousness and has at times affected the willingness of physicians to prescribe certain regimens and of women to use them. The 5x5 method, sometimes referred to in the mass media as a "hormonal bomb," has been subjected to particularly harsh criticism. After articles critical of the method were published in 1987, the number of emergency contraception prescriptions written by general practitioners fell by 25% from the year before.¹² Today, some doctors reportedly prescribe their own emergency contraception regimens,¹³ and some women devise their own.

In response to this controversy, in 1987, the Rutgers Stichting adopted a policy of offering women a choice of the 5x5 or the 2x2 regimen or IUD insertion. More recently, there have been calls to make mifepristone available for emergency contraception in the Netherlands.¹⁴

Availability and Prevalence

Partial data on use of emergency contraception in the Netherlands are available through 1991, collected as part of the national sentinel system of general practitioners. General practitioners provide about three-quarters of the prescriptions

for emergency contraception in the Netherlands; in 1991, they wrote 28,000 emergency contraception prescriptions.¹⁵ This level had remained more or less stable since 1985. The Rutgers Stichting probably provides an additional 2,000–7,000 prescriptions annually. Data on IUD insertion for emergency contraception are not available, although use of this method is presumed to be rare because most women requesting emergency contraception are young and have never been pregnant. In total, the use rate is about one per 100 women per year.

In 1991, of all women receiving emergency contraception from general practitioners, about 70% were younger than 25, and 34% were younger than 20.¹⁶ The proportion of emergency contraception prescriptions that are for adolescents is higher (51%) at the Rutgers Stichting clinics.

A pair of studies conducted in Amsterdam¹⁷ suggest that condom failure prompted the request for emergency contraception in 19–29% of cases and that missed pills accounted for 13–25% of requests. Slightly fewer than half of the women in these studies had had unprotected intercourse at mid-cycle, suggesting that many women seek emergency contraception even when the risk of pregnancy is slight.

Cost

The cost to a Dutch woman of emergency contraception is determined by the type of health insurance that covers her. The largest insurance carrier is the Sick Fund, which is publicly controlled but privately administered and covers about 60% of all citizens. The remaining 40% of citizens are privately insured. In addition, all Dutch citizens are covered by the General Law on Exceptional Medical Cost (AWBZ), a national form of insurance intended primarily to cover catastrophic and long-term care, but recently expanded to include the cost of medical drugs. Sick Fund members may receive medication free of charge directly from their pharmacy. Privately insured patients must pay for medications out of pocket, but can be reimbursed by the AWBZ.

At pharmacies, the price of the 2x2 method is about \$7–\$9. The 5x5 method, including an antinausea medication, costs around \$41. In order to receive the prescription, however, women must consult their general practitioner. This visit is free for women covered by the Sick Fund; privately insured women must pay a fee of approximately \$20.

The Rutgers Stichting provides the 2x2 regimen free, but charges a consultation

fee that varies from around \$10 to \$20, depending on whether the woman is older than 18. Women who obtain the 5x5 method from the Rutgers Stichting pay about \$20 for the pills and antinausea medication, in addition to the consultation fee.

Both the Sick Fund and the private insurance system may impose obstacles for adolescents. Young people must either request the Sick Fund card from their parents or pay directly and then request reimbursement, through their parents, from the AWBZ. Consequently, many adolescents seek emergency contraception at the Rutgers Stichting clinics rather than from their general practitioners.

Lessons Learned

The experiences with emergency contraception in the United Kingdom and the Netherlands raise several issues that may be relevant in other countries as well.

As the case studies demonstrate, both providers and potential users need to be well informed about emergency contraception, how it is used and its availability. The importance and the role of emergency contraception can easily be overshadowed by family planning's traditional mission to ensure consistent, effective contraceptive use.

Emergency contraception can become widely used where it is well integrated into general family planning services and information and education efforts. In the United Kingdom and the Netherlands, it has a key place both within family planning's traditional emphasis, as a backup for method or user failure, and as a last resort in the instance of unexpected intercourse.

Furthermore, even though the United Kingdom and the Netherlands have good data on emergency contraception, information about its use is incomplete. Data on emergency contraception should be collected along with other routine family planning statistics. To date, efforts to examine the use of emergency contraception have been complicated by the fact that the

IUD and combined oral contraceptives may be used for either regular or emergency contraception. In the future, efforts should be made to distinguish the different uses of these methods.

Emergency contraception should be available from a variety of sources—certainly general practitioners or family doctors, as well as family planning clinics, which offer more anonymity. The British and Dutch experiences demonstrate the importance of both a network of highly informed, properly motivated, easily accessible service providers and wide dissemination of information among them and the lay public. While the success of emergency contraception in these countries probably cannot be separated from the overall high quality and accessibility of their health care and contraceptive services, it appears that emergency contraception is most widely used when it is well integrated into routine care.

Finally, these two cases reveal that emergency contraception may be particularly important for adolescents. As young people establish their sexual identity and contraceptive practice, they may be likely to use contraceptives ineffectively and subsequently experience contraceptive failure. For them, emergency contraception may provide a crucial safety net in the event of intercourse they did not expect or adequately prepare for, as well as a bridge to more regular and sustained contraceptive use.

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