Should the contraceptive pill be available without prescription?

Two areas in London are piloting over the counter oral contraceptives. Daniel Grossman argues that the policy should be widely adopted but Sarah Jarvis believes it is the wrong approach to reducing unplanned pregnancy.

**YES**

Oral contraceptives are the most widely used hormonal method of contraception globally and the most commonly used reversible method in less developed countries other than China. The pill is highly effective and with perfect use has a failure rate of 0.3% in the first year. But in practice failure is much higher—closer to 8% or 9%. In most countries, women must have a doctor’s prescription to obtain oral contraceptives, although many developing countries do not enforce this and pills are effectively available over the counter.

Data from the United States suggest that, for at least some women, the prescription requirement represents a barrier to both initiation and continuation of hormonal contraceptives. A US national survey of women in 2004 reported that 41% of women not currently using contraception said they would start using the pill, patch, or vaginal ring if it were available directly in a pharmacy. Another study found that travel away from home and running out of pill packs were frequent reasons women missed pills, a common cause of contraceptive failure. Participants in a Scottish study of attitudes to contraception also commented that getting an appointment with a general practitioner can be hard.

**Safety**

Is it safe for women to access oral contraceptives without a prescription? Over 50 years of experience have shown oral contraceptives to be very safe. In every age group, the risk of cardiovascular death among healthy non-smokers who take the pill is lower than the same risk for women carrying a pregnancy to term.

However, the question remains whether women need to visit a clinician to determine whether oral contraception is appropriate for them. Ideally, doctors or nurses screen women for contraindications to the pill using evidence based criteria, such as those of the World Health Organization. But in practice this screening does not always take place.

Research from Mexico, where the pill is widely available without a prescription, found that women obtaining the pill without visiting a clinician were no more

**NO**

The United Kingdom is top of a league in western Europe—and a very undesirable first place it is, too. The league table is that for teenage pregnancies, with rates of teenage motherhood in the UK, at 1.5%, around twice those of Germany (8%), three times those of France (6%), and almost four times those of Sweden (4%).

The implementation of a national teenage pregnancy strategy in 1999 has gone some way to reversing the rising trend of teenage pregnancies, but only by about 2% a year in the first five years after it was implemented. As with other lifestyle diseases such as diabete, however, the UK still ranks far behind the United States, where 22% of women have a child before the age of 20.

Nevertheless, action still needs to be taken to address the underlying causes. The Department of Health Social Exclusion Unit has highlighted complex reasons for the high rates of teenage pregnancy in the UK, including lack of education and mixed messages in the media. Societal attitudes, government housing policy for teenage mothers, and media messages are largely beyond the remit of primary care’s influence. Education about contraception, however, is not. And it is contraceptive use, rather than sexual activity, which correlates most closely with rates of unplanned pregnancy.

**Wrong method**

In 2005, the National Institute for Health and Clinical Excellence (NICE) guidance highlighted low use of long acting reversible contraception (intrauterine contraceptive devices, intrauterine system, progestogen-only subdermal implants, and progestogen-only injectable contraceptives) compared with user dependant methods such as the contraceptive pill as one of the reasons for high rates of unwanted pregnancy. This claim certainly fits with the evidence—about 8% of women of childbearing age in the UK (with a 15% teenage motherhood rate) use long acting contraceptives compared with about 20% in Sweden, where the rate of teenage motherhood is 4%.

Although making the combined oral contraceptive pill available without prescription may be safe, it would not help. Those using the service would not, as the NICE guidance
likely to have contraindications to its use than women who saw a doctor. Two US studies found that women were able to identify if they had contraindications to oral contraceptives using a checklist, although older women were more likely to have unrecognised hypertension. These data are not surprising, given that, other than hypertension, all of the contraindications are based on history and require little clinical judgment. Another concern about making oral contraceptives available without a prescription is women will not use them correctly. Again, few data suggest that clinician counselling is useful, and even when a clinic visit is required, compliance is not perfect. Oral contraceptives are available over the counter in Kuwait, and a study there found that compliance and continuation were no different between women who consulted a doctor and those who did not. A recent analysis of data from California found that women given 13 pill packs when they first started continued the packs when they first started continued the packs when they first started. The national survey mentioned above found that among women not currently using contraception, 88% had had a smear test in the previous 24 months. In fact, given the recent definitive evidence that oral contraceptive use reduces the risk of ovarian cancer, it has been argued that the prescription requirement unnecessarily limits access to this effective chemoprophylactic agent. Although there are concerns in the US about the costs to women of obtaining oral contraceptives over the counter, in some states there is a precedent for maintaining government funding for over the counter emergency contraception for women on low incomes.

Access to care
Would women miss out on other preventive services, such as cervical smear tests or screening for sexually transmitted infections, if they were not required to visit a clinician? Neither of these screening tests is medically required before prescribing oral contraceptives, and there has been a growing movement to unbundle these services in the US. The national survey mentioned above found that among women not currently using contraception, 88% had had a smear test in the previous 24 months. In fact, given the recent definitive evidence that oral contraceptive use reduces the risk of ovarian cancer, it has been argued that the prescription requirement unnecessarily limits access to this effective chemoprophylactic agent. Although there are concerns in the US about the costs to women of obtaining oral contraceptives over the counter, in some states there is a precedent for maintaining government funding for over the counter emergency contraception for women on low incomes.

The prescription requirement is an out of date, paternalistic barrier to contraceptive use that is not evidence based. Making oral contraceptives available without a prescription would not eliminate the option of clinician consultation. Indeed, research in Mexico indicates that women move between provision sources, and more than half of women who obtain their pills from a pharmacy began use under a physician’s care. Women who value a clinician’s input or have questions about their risk profile would still be able to consult with a physician or nurse—but they would not be required to. The prescription requirement is an out of date, paternalistic barrier to contraceptive use that is not evidence based. If governments are committed to addressing the challenge of unintended pregnancy—and the related problem of maternal mortality in the developing world, health systems must create mechanisms to allow freer access to hormonal contraception for all women at low or no cost.

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The availability of emergency contraception without prescription has done little to change the rate of teenage pregnancies. This is hardly surprising, when among under 25s, only 37% use emergency contraception on every occasion that they have unprotected intercourse. Increased uptake of reliable, non user-dependent methods has to be the key. Rather than making a potentially unreliable method of contraception more easily available, our best avenue for reducing unplanned pregnancies is to encourage general practitioners to help their patients to make the best choices.

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