Free markets. Real solutions.

R STREET SHORTS NO. 110

November 2021

ECONOMIC MOBILITY AND CONTRACEPTIVE ACCESS: SOCIETAL EFFECTS

By Courtney M. Joslin & Andrew Kim

This policy brief is 2 of a 2-part series on the relationship between contraceptive access and economic mobility. This series emphasizes two lenses—the individual and the societal costs associated with varying levels of contraceptive access—that highlight how contraceptive access has a holistic effect on individuals, families and communities.

INTRODUCTION

Access to effective contraception has revolutionized family planning for women. Since the introduction of the pill to American markets in the 1960s, women have gained improved education and career prospects, and a better ability to plan families around these goals as they see fit. While modern contraception has brought myriad benefits to individual women, many family planning initiatives are government-funded, so the benefits that modern contraception has on taxpayers should also be analyzed. Improving the availability of effective contraceptive methods has led to fewer unintended pregnancies, unplanned births and abortions. As such, state and federal governments have saved significant amounts of funding due to birth control access. However, this brief argues that there is still significant room to improve contraceptive access that would subsequently save governments additional funding.

CONTRACEPTIVE ACCESS

Pregnancy Costs

It is worth noting the downstream effects of contraceptive access on state-funded family planning program budgets. Governments spend taxpayer funds on both contraceptive and pregnancy-related costs through family planning programs. For example, in 2010, public health insurance programs paid for over half of all births in the United States, and 68 percent of all births stemming from unintended pregnancies.[1] The health care costs associated with these unintended pregnancies totaled $21 billion for federal and state governments combined. If all unintended pregnancies had been prevented, the savings would have totaled an estimated $15.5 billion.[2]

While spending on unintended pregnancy-related healthcare warrants deeper examination, improved contraceptive access has substantially decreased unintended pregnancies in the United States, which has mitigated many resulting costs. Unintended pregnancy in the United States declined significantly from 2008 to 2011, particularly for teenagers, Hispanic women, and those within 100 to 199 percent of the federal poverty level.[3] This decline is largely attributed to better access to and use of effective contraceptive methods.[4] Additionally, a study on California's family planning program spending found that publicly funded contraception ultimately brought substantial savings. For instance, every dollar spent on injectable contraception averted $5.60 in other costs, and every dollar spent on birth control pills saved $4.07 in additional costs.[5] Further increasing the availability of effective contraception can continue to reduce state spending on the health care costs.

Family planning is key to mitigating costs for governments and taxpayers. While an individual with public health insurance who is currently choosing to prevent pregnancy may later choose to try to conceive, studies show that more effective family planning has significant downstream cost implications. For example, data from 2006 shows that publicly funded births were significantly more likely to have stemmed from unintended pregnancies than intended pregnancies. In that same year, 35 percent of births resulting from intended pregnancies were publicly funded, compared with 64 percent of all births from unintended pregnancies.[6] The ability to plan for the expansion of a family essentially ensures that parents are more prepared for a variety of financial stressors related to pregnancy, birth and child rearing.

HISTORIC ECONOMIC OUTCOMES

Improved contraceptive access decreases taxpayer-funded medical care and assistance program-related expenditures.[7] Studies show that prospective mothers who are able to easily access, and thus regularly use, contraceptives are better able to avoid dependence on government-sponsored programs later in life.[8] Prior to the greater widespread availability of oral contraceptive pills in the 1960s, childbearing outcomes diverged between states that were more permissive towards contraceptives and those that were more restrictive. In 1965, shortly after the pill was made publicly available in the United States, an average of 124,600 more births occurred in states that banned selling contraceptives than in those states without the ban.[9] This same study notes that children born in states with more restrictions to contraceptive access tend to face greater financial difficulty in life.[10] Additionally, scaled estimates revealed that increased access to birth control pills was associated with a 20 to 30 percent gain in family incomes, and that children born in areas with greater contraceptive access lived in higher-earning households as adults than their counterparts from more restrictive areas.[11] Decades later, one of the largest savings of taxpayer-borne public health care costs in the United States can be attributed to the increased availability of contraceptive services.

Maternity Costs

A study on the 2008 pregnancy outcomes in the United States found that, without the given level of contraceptive services, an estimated additional $12.5 billion would have been spent that year on publicly funded births from unintended pregnancies.[12] In addition, the average publicly funded cost of maternal care and one year of infant care per unintended pregnancy that year was $12,613.[13] Public expenditure on contraceptives has been linked to outsized gains in pregnancy-related public savings. For every $1 that is spent on family planning, taxpayers save approximately $3.74 of costs stemming from pregnancies.[14] Given that 52 percent of all unintended pregnancies in the United States occur among women who fail to access or adhere to any recognized contraceptive method, improved access to birth control could lower unintended pregnancies and further increase taxpayer savings.

Unintended pregnancies stemming from the failure to fully adhere to proper contraceptive procedures and best practices cost $2.5 billion in healthcare annually.[15] To reduce this expenditure, some experts have advocated for greater use of "set-and-forget" contraceptive methods, including the hormonal birth control injection, intrauterine device or implant, that require little user intervention and therefore will result in even more effective pregnancy prevention. Young women using methods that are effective yet require higher levels of adherence like the birth control pill or patch, are at higher risk of unintended pregnancy than young women using "set-and-forget" methods, meaning there is a higher likelihood of incurring unintended pregnancy and its related health care costs.[16]

Abortion Outcomes

Additionally, the number of publicly funded abortions significantly drops when states provide more access to contraceptive services. Providing contraceptive access to demographics that tend to incur higher abortion rates can result in significant public expenditure savings on abortions. For instance, a 2000 study noted that beginning in 1994, the proportion of women from minority racial groups and from lower socioeconomic backgrounds incurring abortions had increased, with black women reaching a rate of 49 per 1,000 women of reproductive age, Hispanic women at 33 per 1,000, and women with an income level below the federal poverty level at 44 per 1,000.[17] White women and women earning at least 200 percent of the federal poverty level hovered around 13 per 1,000 women.[18] Improved contraceptive access since 2000 has tempered the abortion rate, with one study estimating that the abortion rate today would be at least two-thirds higher nationwide, or twice as high among poorer women, if healthcare-covered contraceptive services were not as widely available.[19]

Higher Risk Pregnancies

At a societal level, widespread contraceptive access has allowed women to better plan the timing and spacing of births, thereby improving the health outcomes of their newborns as well as themselves. Research has shown that shorter intervals between births can bring increased health risks to both expectant mothers and babies, and that unintended pregnancy following a recent birth is common in the United States, particularly for younger women.[20] In 2010, among the 1.1 million estimated unintended births that were avoided by women partaking in publicly funded contraceptive care, an estimated 287,500 births would have been dangerously closely spaced, with 164,190 births likely to have been labeled as premature, low-birth-weight, or both.[21] Research also indicates that better access to contraception can further reduce the risk of closely spaced births resulting from unintended pregnancies, which would also help reduce taxpayer costs.[22]

CONCLUSION

This 2-part policy brief series has explored how contraceptive access affects communities on the individual level and the societal level. Contraceptive access is important for its effects on women's ability to plan for families and careers, but also for its impact on state and federal governments, which take on notable costs related to family planning and rulemaking for contraceptive access. Both individual and societal interests demand that contraceptive access poli-

cies be carefully crafted to maximize planning ability while reducing overall costs.

Lowering the barriers to contraceptive access can both improve family planning and save taxpayer funds. This can be done without increasing the scope of government; leading medical organizations like the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians maintain that many effective contraceptive methods can be deregulated from the current prescription barrier that is in many jurisdictions.[23] By lowering the prescription barrier, women would have greater access to contraception and all the positive results emphasized in this series: an increased ability to plan and space pregnancies, improved economic prospects, better health outcomes and reduced taxpayer spending on reproductive health care.

ABOUT THE AUTHORS

Courtney Joslin is a resident fellow in competition policy at the R Street Institute, where her research focuses on disintermediation in health care policy and licensing.

Andrew Kim is a senior studying Economics and Sociology at Harvard University, where he serves as a Writing Program peer speaking tutor and leads the collegiate Model UN conference as Secretary-General.

ENDNOTES

1. Adam Sonfield and Kathryn Kost, "Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010," Guttmacher Institute, February 2015. https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf.

2. Ibid.

3. Lawrence B. Finer and Mia R. Zolna, "Declines in Unintended Pregnancy in the United States, 2008-2011," *The New England Journal of Medicine* 374:9 (2016), pp. 843-852. https://www.nejm.org/doi/full/10.1056/nejmsa1506575.

4. Ibid.

5. Diana Green Foster et al., "Cost Savings from the Provision of Specific Methods of Contraception in a Publicly Funded Program," *American Journal of Public Health* 99:3 (March 2009), pp. 446-451. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661445.

6. Adam Sonfield et al., "The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates," *Perspectives on Sexual and Reproductive Health* 43:2 (June 2011), pp. 94-102. https://pubmed.ncbi.nlm.nih.gov/21651708.

7. Adam Sonfield and Kathryn Kost, "Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2008," Guttmacher Institute, October 2013. https://www.guttmacher.org/sites/default/files/pdfs/pubs/public-costs-of-UP.pdf.

8. Adam Sonfield, et al., "The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children," Guttmacher Institute, March 2013. https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf.

9. Martha J. Bailey, "Fifty Years of Family Planning: New Evidence on the Long-Run Effects of Increasing Access to Contraception," National Bureau of Economic Research Working Paper 19493, October 2013. https://www.nber.org/papers/w19493.

10. Ibid.

11. Ibid.

12. Sonfield and Kost. https://www.guttmacher.org/sites/default/files/pdfs/pubs/public-costs-of-UP.pdf.

13. Ibid.

14. Ibid.

15. Lawrence B. Finer and Adam Sonfield, "The evidence mounts on the benefits of preventing unintended pregnancy," *Contraception* 87:2 (2013), pp. 126-127. https://doi.org/10.1016/j.contraception.2012.12.005.

16. Ibid.

17. Christine Dehlendorf et al., "Disparities in family planning," *American Journal of Obstetrics and Gynecology* 202:3 (2010), pp. 214-220. https://doi.org/10.1016/j.ajog.2009.08.022.

18. Ibid.

19. Laura Duberstein Lindberg and Jennifer J. Frost, "Reasons for using contraception: perspectives of US women seeking care at specialized family planning clinics," *Contraception* 87:4 (2013), pp. 465-472. https://doi.org/10.1016/j.contraception.2012.08.012.

20. Katherine A. Ahrens et al. "Unintended pregnancy and interpregnancy interval by maternal age, National Survey of Family Growth," *Contraception* 98:1 (July 2018), pp. 52-55. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6379777; Agustin Conde-Agudelo et al., "Effects of birth spacing on maternal health: a systematic review," *American Journal of Obstetrics and Gynecology* 196:4 (April 2007), pp. 297-308. https://pubmed.ncbi.nlm.nih.gov/23743455.

21. Jennifer J. Frost et. al., "Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program," *Milbank Quarterly* 92:4 (December, 2014), pp. 696-749. https://doi.org/10.1111/1468-0009.12080.

22. Alison Gemmill and Laura Duberstein Lindberg, "Short interpregnancy intervals in the United States," *Obstetrics & Gynecology* 122:1 (July 2013), pp. 64-71. https://pubmed.ncbi.nlm.nih.gov/23743455.

23. The American College of Obstetricians and Gynecologists, "Over-the-Counter Access to Hormonal Contraception: Committee Opinion No. 788," *Obstetrics and Gynecology* 134:1 (October 2019). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/10/over-the-counter-access-to-hormonal-contraception; "Over-the-Counter Oral Contraceptives," American Academy of Family Physicians, 2015. https://www.aafp.org/about/policies/all/otc-oral-contraceptives.html.