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Publicly funded contraceptive care: a proven investment

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This year has been a difficult one for the nation's publicly funded family planning programs, which have faced unprecedented threats. Some of these threats appear driven primarily by policy makers struggling to close budget deficits, many of whom have set their sights on Medicaid. During FY 2011, 43 states attempted to reduce Medicaid costs through such steps as cutting provider reimbursement, lowering drug costs or reducing benefits; nearly all governors have proposed additional cuts for FY 2012 [1]. And with Medicaid the dominant source of public support for family planning services, proposals to restructure the program and curtail its public costs would have an enormous impact on family planning providers and clients [2].

Other threats have been in the form of more overtly ideological attacks. In February, the House of Representatives moved to eliminate funding for the Title X program, the only federal program devoted to family planning. A separate provision would have denied all federal funding—notably including Medicaid reimbursement—to Planned Parenthood affiliates. Both extreme positions were blocked by Senate Democrats and President Obama. Family planning opponents have emulated both approaches on the state level, with some success. Montana completely eliminated its family planning budget line item, and New Hampshire and Texas cut family planning funding by 57% and 66%, respectively. Five states—Indiana, Kansas, North Carolina, Texas and Wisconsin—also moved to either limit or deny funding to Planned Parenthood affiliates specifically or specialized family planning providers more generally, although several of those policies are being challenged in court [3].

1. The problem of unintended pregnancy

Whether driven by fiscal constraints or ideology, cuts to family planning programs run counter to a major national priority: reducing unintended pregnancy. About half of all US pregnancies each year are unintended, and more than half are unintended in 29 states and the District of Columbia [4]. Helping women prevent unintended pregnancy has long been a goal for the federal government, which recently set a public health objective of reducing that proportion by 10% by 2020 [5].

The reasoning behind this goal is that problems in planning pregnancy have clear health, social and economic consequences for women and their families. For example, numerous studies point to a causal link between birth spacing and three major birth outcomes measures: low birth weight, preterm birth and small size for gestational age [6]. Similarly, unintended pregnancy has been linked to delayed initiation of prenatal care and to reduced breastfeeding after a child is born. These types of maternal behavior, in turn, can influence outcomes throughout a child's life. Moreover, unintended pregnancy can hinder women's educational and financial success and deprive women and couples of the ability to have children when they feel best prepared.

These issues are particularly acute for low-income families, many of whom are struggling to provide for the children they already have. Unfortunately, poor women in the United States are five times as likely to have an unintended pregnancy as more affluent women, and that disparity has been growing in recent years [7]. This has also translated into fiscal problems for already strained public insurance programs, most notably Medicaid. Because most state Medicaid programs cover pregnancy-related care for women with incomes up to 185% of poverty or higher, public insurance programs pay for 48% of all births in the United States—but they pay

for 64% of all births resulting from unintended pregnancies [8]. Accounting just for medical care during pregnancy and the first year of an infant's life, the one million births from unintended pregnancies cost the federal and state governments about $11 billion annually, half of all public expenditures for births [8,9]. The true cost would be many times higher if other expenses, such as social supports or ongoing medical care, were considered.

2. The role of publicly subsidized contraception

Avoiding unintended pregnancy is a challenge, in large part because it requires decades-long dedication. In trying to achieve her childbearing goals, the typical American woman will spend about 5 years pregnant, postpartum or attempting to become pregnant, and three decades attempting to avoid pregnancy [10]. To that latter end, more than 99% of US women aged 15–44 years who have ever had vaginal sex have made use of contraception at some point in their lives [11]. Contraceptive use can reduce the risk of unintended pregnancy substantially, and correct and consistent contraceptive use almost eliminates it: in any given year, the two thirds of US women at risk of unintended pregnancy who use contraception consistently and correctly throughout the year account for only 5% of unintended pregnancies [12].

Publicly subsidized contraceptive counseling, services and supplies each year put the goal of effective contraceptive use in reach for nine million women and help them avoid about two million unintended pregnancies [12]. To put that in perspective, the rate of unintended pregnancy in the absence of these services would be nearly two thirds higher among US women overall, and nearly twice as high among poor women, than it is today [12]. In the absence of these subsidized

service, the already high cost of unintended pregnancy in this country would be more than 60% higher—roughly $18 billion in a single year [8].

3. Weaving a stronger safety net

The proven track record of family planning programs belies the notion that making cuts to funding or placing restrictions on the provider network—as so many conservative policy makers attempted in 2011—would have any positive outcome. Rather, especially as the fallout from the Great Recession continues, policy makers would be well served to ramp up their support for programs and services that enable low-income women and couples to plan and space their pregnancies.

Additional investment in publicly funded family planning services would further improve maternal and child health outcomes and help more women and couples achieve their fundamental childbearing goals, as well as economic security for themselves and their existing children. And because every public dollar spent to provide family planning services saves almost $4 in Medicaid costs over the following year [13], even a comparatively small additional upfront investment in contraceptives services could substantially reduce pressure on a Medicaid program struggling to meet enrollees' needs.

The money saved by helping women and couples avoid unintended pregnancies could and should be deployed to expand access to health care for low-income women and men, including their reproductive health needs. Medicaid's reproductive health coverage is generally strong. Federal law requires states to cover pregnancy-related care, including prenatal care, labor and

delivery, and 60 days of postpartum care; in addition to basic services such as screening, vaccination and the delivery itself, states cover a range of important counseling and support services, including case management and care coordination; nutritional, psychosocial and genetic-risk assessment and counseling; childbirth and breastfeeding education; and home visiting services [14]. Similarly, all states cover testing and treatment for the full range of sexually transmittted infections, including HIV, as well as pregnancy tests, cervical cancer screening and most other reproductive health services. (The major exception is abortion: Federal law bars federal reimbursement for abortion except in the most extreme circumstances, although states can spend their own funds on abortion.)

In sum, expanding access to contraceptive care would provide a rare opportunity for states to make simultaneous progress in improving their residents' health and well-being and in shoring up the financial sustainability of a health program on which4 in 10 poor women of reproductive age rely [15]. Policymakers should set aside their blinders and biases and take full advantage of this opportunity.

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References

[1] National Governors Association and National Association of State Budget Officers. The fiscal survey of states, spring 2011. Available at: http://www.nga.org/files/live/sites/NGA/files/pdf/FSS1106.PDF. Last accessed July 13, 2011.

[2] Sonfield A, Alrich C, Gold RB. Public funding for family planning, sterilization and abortion services, FY 1980–2006. Occasional Report. Guttmacher Institute; 2008. Available at: http://www.guttmacher.org/pubs/2008/01/28/or38.pdf. Last accessed July 13, 2011.

[3] Guttmacher Institute. Monthly state update: major developments in 2011; July 2011. Available at: http://www.guttmacher.org/statecenter/updates/index.html. Last accessed July 13, 2011.

[4] Finer LB, Kost K. Unintended pregnancy rates at the state level. Perspec Sex Reprod Health 2011;43:78-87. Available at: http://www.guttmacher.org/pubs/psrh/full/4307811.pdf. Last accessed July 13, 2011.

[5] Department of Health and Human Services. Healthy People 2020 topics and objectives: family planning, objectives. Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=13. Last accessed July 13, 2011.

[6] Guttmacher Institute. Testimony of Guttmacher Institute, submitted to the Committee on Preventive Services for Women, Institute of Medicine. Available at: http://www.guttmacher.org/pubs/CPSW-testimony.pdf. Last accessed July 13, 2011.

[7] Finer LB, Zolna MR. Unintended pregnancy in the United States: incidence and disparities, 2006. Contraception 2011. doi:10.1016/j.contraception.2011.07.013.[8] Sonfield A, Kost K, Gold RB, Finer LB. The public costs of births resulting from unintended pregnancies: national

and state-level estimates. Perspec Sex Reprod Health 2011;43:94-102. Available at: http://www.guttmacher.org/pubs/psrh/full/4309411.pdf. Last accessed July 13, 2011.

[9] Monea E, Thomas A. Unintended pregnancy and taxpayer spending. Perspec Sex Reprod Health 2011;43:88-93. Available at: http://www.guttmacher.org/pubs/psrh/full/4308811.pdf. Last accessed July 13, 2011.

[10] Boonstra HD, Gold RB, Richards CL, Finer LB. Abortion in women's lives. Guttmacher Institute; 2006. Available at: http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf. Last accessed July 13, 2011.

[11] Mosher WD, Jones J. Use of contraception in the United States: 1982-2008. Vital Health Stat 2010 Series 23, No. 29. Available at: http://www.cdc.gov/nchs/pressroom/data/Contraception_Series_Report.pdf. Last accessed July 13, 2011.

[12] Gold RB, Sonfield A, Richards CL, Frost JJ. Next steps for America's family planning program: leveraging the potential of Medicaid and Title X in an evolving health care system. Guttmacher Institute; 2009. Available at: http://www.guttmacher.org/pubs/NextSteps.pdf. Last accessed July 13, 2011.

[13] Frost JJ, Henshaw SK, Sonfield A. Contraceptive needs and services, national and state data, 2008 update. Guttmacher Institute; 2010. Available at: http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf. Last accessed July 13, 2011.

[14] Ranji U, Salganicoff A, Stewart AM, Cox M, Doamekpor L. State Medicaid coverage of perinatal services: summary of state survey findings. Kaiser Family Foundation and The George Washington University Medical Center School of Public Health and Health Services,

Department of Health Policy. November 2009. Available at:

http://www.kff.org/womenshealth/upload/8014.pdf. Last accessed July 13, 2011.

[15] Sonfield A. Evidence mounts of recession's impact on women of reproductive age.

Guttmacher Policy Rev 2010;13(4):17-8. Available at:

http://www.guttmacher.org/pubs/gpr/13/4/gpr130417.pdf. Last accessed July 13, 2011.