

Editorial in *Contraception* – Author Version

The evidence mounts on the benefits of preventing unintended pregnancy

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Preventing unplanned pregnancies and enabling women and couples to time their childbearing are central public health goals. Exercising this control is a goal of most individuals and has substantial benefits for the health of women and their children. Yet unplanned pregnancy also has societal-level connections to everything from basic demographic patterns to women's educational attainment to families' economic well-being. Among the best-studied societal impacts are the health care costs from unintended pregnancy that are borne by public and private payers. Three articles in the current issue of *Contraception* build on the existing literature and provide a roadmap to reducing these individual and societal burdens.

Several researchers have highlighted the costs of unintended pregnancy in the United States, reporting billions of dollars in costs to the government or the nation overall.^{1,2,3} Trussell et al. expand on Trussell's earlier estimate of the total U.S. costs of unintended pregnancy — conservatively estimated here to be \$4.6 billion annually — by identifying the portion of those costs that is due to imperfect adherence to contraceptive methods: 53%, or \$2.5 billion each year. That finding highlights the importance of not merely helping women and couples practice contraception but also helping them identify a method that will best fit their current life circumstances and that they will be able to use consistently and correctly. The authors explore that concept by projecting that roughly \$300–400 million of the cost of unintended pregnancy could be averted if even 10% of young women chose to switch to long-acting “set-and-forget” methods, such as the intrauterine device and implant, that require little user intervention and are therefore an order of magnitude more effective than the pill.⁴ Although it is worth noting that this study was funded by and coauthored by several representatives of a pharmaceutical company with a vested interest in that finding, its conclusions echo those from earlier, independent studies that have found substantial reductions in unintended pregnancy from enabling women to choose long-acting methods.⁵

More attention to these highly effective methods would be well deserved. Women aged 18–24 years have the highest rates of unintended pregnancy but are much less likely to use these methods than older women. A recent position statement by the American College of Obstetricians and Gynecologists aims to rectify this situation, drawing on evidence that that these methods are safe and effective and recommending that they be considered “first-line” options for young women.⁶

The passage of the Patient Protection and Affordable Care Act (ACA) of 2010 bodes well for such a shift. The ACA is designed to dramatically expand the number of Americans with comprehensive public or private health coverage. It does so by, starting in 2014, expanding eligibility for comprehensive Medicaid coverage, creating regulated online marketplaces (“exchanges”) for individuals and small businesses to purchase private insurance, and providing federal subsidies for purchasing insurance to uninsured individuals with incomes below 400% of the federal poverty level. Of particular importance for reproductive health, most private insurance plans written after August 1, 2012, including those covering these low-income individuals, are required to include all Food and Drug Administration–approved contraceptive methods without deductibles or copays.

Burlone et al. look forward to these provisions by modeling the impact in Oregon of one part of this expansion: access to subsidized health insurance through the upcoming exchanges. They forecast substantial reductions in unintended pregnancy — the equivalent of 14 per 1000 women 15–44 annually, which would amount to a reduction of nearly one third from Oregon’s current unintended pregnancy rate⁷ — with substantial concomitant savings for public and private insurers. Notably, Burlone et al. do not model the additional potential impact of the ACA’s elimination of out-of-pocket costs for contraception among people who already are privately insured, a policy that should remove a key financial barrier to couples’ choosing methods that they can practice consistently and correctly.

Yet, as Montouchet and Trussell demonstrate, even universal coverage — an outcome the U.S. system will fall far short of achieving even under the ACA — cannot be expected to completely solve the problem of unintended pregnancy. The authors estimate costs to England’s National Health Service, which pays for virtually all unintended pregnancies in that nation. Though England’s population is far smaller than that of the United States and though the authors estimate the English unintended pregnancy rate to be roughly a third of that in the United States, such pregnancies nonetheless result in roughly \$300 million in public expenditures for medical costs related to delivery, abortion, miscarriage and ectopic pregnancy.

Notably, the estimates from all three studies are conservative ones that exclude numerous potential costs. Trussell et al., for example, do not account for the cost of prenatal care or infant care when estimating the cost of unplanned births. More generally, these studies, like most earlier ones in the field, exclude many longer-term government costs that accrue from unintended pregnancies, such as children’s health care costs, welfare payments and food subsidies. Nor do any current studies fully account for the health, social or economic costs of unintended pregnancy to women, couples and families. Additional work to quantify some of these costs, while challenging, would provide a fuller picture of the burden of unplanned pregnancy.

No single contraceptive method is best for all women and couples, but the best scientific evidence suggests that we are underutilizing the methods available now. Empowering women and men with the information, advice and options that they need to make the best use of these methods — for example, by enabling them to switch to long-acting, highly effective methods or helping them to use shorter-term methods more consistently — could achieve goals at both the individual and family levels by reducing unintended pregnancies and their undesirable sequelae. In the process, it could also reap benefits at the population level by reducing costs to public and private payers.

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