THE CASE FOR CONTRACEPTION ACCESS

1. Contraception is critical for women to be able to control how many children they have and when they have them.

2. Pregnancy and childbearing can be extremely detrimental to women’s educational, health, and economic outcomes.
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3. Contraception is critical to women’s educational, health, and economic outcomes
Contraception Use in the US

Source: Bailey and Lindo (forthcoming)
Panel C: Reversible Methods - All Women

- Pill
- Condom
- IUD
- Implant
- Diaphragm
- Other

Source: Bailey and Lindo (forthcoming)
Emergency Contraception Use in the US

Source: Bailey and Lindo (forthcoming)
Contraception Use in the US

Widespread belief that “too few women are using the most effective types” (LARCs = IUDs + implants)

Use of LARCs is lower in the US than in most European countries and many developing countries
Preventing Teen Pregnancy

Few teens (ages 15 to 19) on birth control use the most effective types.
The Case for LARCs

LARCs: Sub-dermal implants and intrauterine devices (IUDs)

Main benefits:
- Eliminates user compliance error → highly effective
- Not visible (Note: 68% of teens report that the primary reason they do not use birth control is because they are afraid their parents will find out)
- Can last up to 12 years → lower cost over time
### The Case for LARCs

**Pregnancy Prevention Rates (1-year)**

<table>
<thead>
<tr>
<th>Method</th>
<th>Typical Use</th>
<th>Perfect Use</th>
<th>Coverage Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization</td>
<td>99.9%</td>
<td>99.9%</td>
<td>Lifetime</td>
</tr>
<tr>
<td><strong>Intrauterine Device</strong></td>
<td>99.9%</td>
<td>99.9%</td>
<td>3-12 years</td>
</tr>
<tr>
<td><strong>Implant</strong></td>
<td>99.9%</td>
<td>99.9%</td>
<td>3 years</td>
</tr>
<tr>
<td>Oral Contraceptive</td>
<td>91%</td>
<td>99.7%</td>
<td>1 month</td>
</tr>
<tr>
<td>Condom</td>
<td>82%</td>
<td>98%</td>
<td>N/A</td>
</tr>
<tr>
<td>No Method</td>
<td>15%</td>
<td>15%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Barriers to Access in the US?

How do we know whether they matter?

By evaluating the effects of relevant policies
The health-insurance/cost barrier

State policies during 1990s increased income limits for Medicaid
\[ \rightarrow \text{contraception use} \uparrow \text{and childbearing} \downarrow \]
(Kearney and Levine 2009)

ACA’s contraceptive mandate
- Required insurers to cover all forms of contraception without cost-sharing
- Religious exemption initially, now religious + moral exemption
- Still many without insurance or on grandfathered plans
- And youth may be unwilling to use parent’s insurance for contraception

Note: approx $1,000 to get an IUD
Other possible barriers

Privacy

Information, particularly about the efficacy and safety of LARCs; CDC outreach has focused on providing this information to medical professionals.

Providers need to be trained for counseling/insertion/removal of LARCs.

Clinics serving low-income women typically cannot afford to stock LARCs.
Recent Evidence: Colorado Family Planning Initiative

$23 million program aimed at expanding access to LARCs through Title X clinics from 2009-2015

Funds used for:

- purchasing IUDs and implants
- training for LARC counseling, insertion, and removal
- technical assistance for coding and billing and other general assistance
Recent Evidence: Colorado Family Planning Initiative

Primary Form of Contraception: Female Clients at Title X Clinics in Colorado

This LARC usage rate only increased to 7.4 percent across the US over the same period of time.

Source: Lindo and Packham (2017)
Recent Evidence: Colorado Family Planning Initiative

This comparison indicates the CFPI reduced teen birth rates 6.4%

Source: Lindo and Packham (2017)
More Recent Evidence:
Texas Cutting Family Planning Funding by 2/3

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Texas Cutting Family Planning Funding by 2/3

Also caused significant increases in births to older women, particularly those who were not married (Lu and Slusky 2016)

The initial rollout of federally funded family planning programs during the 1960s and 1970s provide evidence along similar lines (Bailey 2012)
Theory: Effects on educational and economic outcomes

Without contraception, pay the price of abstinence or cope with uncertainty. Unintended pregnancy risks alter the incentives to invest. Two channels to consider:

1. Unintended pregnancies that interrupt schooling/careers cause some women to discontinue or delay such investments.

2. Risks of such interruptions could discourage women from embarking upon long-term investments.
The theory: Effects on educational and economic outcomes

Without contraception, pay the price of abstinence or cope with uncertainty

Unintended pregnancy risks alter the incentives to invest
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Need to know the *causal* effects to inform policy

Limited experimental evidence, particularly for long-run outcomes

Two main approaches:
- Documenting impacts of policy changes
- Examining effects of *random* shocks to pregnancy
Examining impacts of policy changes

- Typically compare how outcomes change—over time or across successive cohorts—in places where a policy was changed relative to how outcomes change in places where a policy didn't change
- Fine-tune estimates by adjusting for pre-existing trends, demographics, other relevant policies, etc.
Examing impacts of policy changes

- Several studies examining impacts of 1960s and 1970s policies that improved women’s ability to regulate their childbearing
- Changes in state laws allowing physicians to prescribe contraception to unmarried women younger than 21; “early legal access” (ELA)
Estimation: Effects of Contraception/Pregnancy/Childbearing

Estimating the effects of pregnancy and childbearing using random shocks to pregnancy

- Miscarriages: delays childbearing and, for some women, reduces completed childbearing
- Twin births: accelerates childbearing and, for some women, increases completed childbearing
- Slight differences in timing
- Note: none of these are perfect
Effects on education and career choice

ELA to contraception associated with increases in education, especially for women from disadvantaged backgrounds

- An additional 1/2 year on average for women from the bottom third of a socioeconomic status index (Bailey et al 2012)
- Also credited with increasing the enrollment of women in college and professional schools (Goldin and Katz 2002)
Effects on education and career choice

Miscarriage before 18 as opposed to birth: (Ashcraft et al 2013)

- increases the GED completion by 5 percentage points
- increases education levels by 0.15 years on average
- likely understates the effect of unplanned pregnancies b/c it does not account for any detrimental effects of becoming pregnant, the early stages of pregnancy, or miscarriage itself

Birth shortly before expected high school graduation date vs. a few months later: (Sandler and Schulkind 2017)

- 7% less likely to graduate high school
- 5% less likely to have attended college
**Effects on Labor Force Participation (LFP)**

ELA to contraception associated with an 8% increase in women’s LFP between ages 26 to 30 (Bailey 2006)

Miscarriage before age 18 as opposed to giving birth increases subsequent LFP by 5 percentage points (Ashcraft et al 2013)

Women having twins (or higher order multiples) as opposed to a singleton are 4 percentage points less likely to participate in the labor force (Cáceres-Delpiano 2006)
**Effects on Income/Wages**

ELA to contraception associated with 8 percent higher hourly wages during women’s late forties \( \text{(Bailey et al 2012)} \)

- \( \frac{2}{3} \) explained by labor force experience
- \( \frac{1}{3} \) explained by education and occupational choice

Miscarriage before age 18 as opposed to giving birth pushes women closer to—or under—the poverty line \( \text{(Ashcraft et al 2013)} \)

Having twins (or higher order multiples) as opposed to a singleton reduces income, increases poverty, and increases welfare dependency \( \text{(Cáceres-Delpiano and Simonsen 2012)} \)
Health effects

Obviously, preventing unintended pregnancies will reduce health risks associated with pregnancy and delivery.

Access to contraception also reduces abortion

Unplanned births increase the likelihood of suffering from high blood pressure and becoming obese
(Cáceres-Delpiano and Simonsen 2012)
The aforementioned results imply that controlling childbearing is important for the resources available to children.

The initial rollout of federally funded family planning programs during the 1960s and 1970s reduced the share of children living in poverty by 7% (Bailey et al 2017).

Unplanned births increase the likelihood of divorce and have deleterious effects on the IQ of previously born children (Black et al 2010, Cáceres-Delpiano and Simonsen 2012).

Pre-term-birth incidence fell by 13 percent in the counties where the Colorado Family Planning Initiative made LARCss available at no cost relative to other Colorado counties (Goldthwaite et al 2015).
The Bottom Line

The ability to control childbearing has significant impacts on women’s health, education, and economic outcomes.

The impacts extend beyond women: their children, their partners, social assistance programs.

Programs improving reproductive choice can improve these outcomes.