Commentary

Why Investments in Family Planning Are Sound Policy

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POLICYMAKERS HAVE LONG BEEN AWARE THAT PUBLIC investments in family planning services are cost effective. Indeed, this fact helped establish the federal program. In her book *Within Our Reach*, Lisbeth Schorr described the first federal investment in family planning under the War on Poverty launched by President Lyndon Johnson in 1965. He demanded programs that were “demonstrably cost-effective,” and he charged the Office of Economic Opportunity’s (OEO’s) Division of Research, Planning and Program Evaluation with assessing the effectiveness of various program options for reducing the number of people in poverty. Family planning was found to be the most effective program being considered.

Sargent Shriver, the OEO’s director, then courageously decided to fund these services but not before the economist who headed the research and evaluation unit, Dr. James Kershaw, had briefed his wife, Eunice Shriver, and 2 Roman Catholic priests about the cost-benefit analysis one Saturday morning at the Shriver home. Five OEO community projects were initially funded. By 1968 there were 159 such projects, and expansion continued with the passage of Title X of the Public Health Service Act in 1970 under President Richard Nixon, which established a network of family planning providers around the country.¹ From these modest beginnings, the public (federal and state) investment in family planning services for low-income individuals had grown to an estimated \$2.37 billion in fiscal year 2010 for services provided by 8,400 health centers. The majority of this spending now comes from the Medicaid program.²

While family planning is known to save more money than it costs, the question remains of just how much money is saved. Over time, technical approaches to estimating the benefits and cost savings of family planning programs have become more sophisticated. The article in this issue of *The Milbank Quarterly* “Return on Investment: A Fuller Assessment of the

Benefits and Cost Savings of the US Publicly Funded Family Planning Program,” by Jennifer J. Frost and colleagues, reviews previous efforts and provides the most extensive analysis to date of the estimated health benefits and costs averted by current investments in family planning services. The authors focus on both the short-term and longer-term savings that accrue when publicly funded contraceptive care prevents unintended births, and they also consider the additional benefits that are achieved because contraceptive care is usually provided as part of a package of services that includes STD and HIV testing, Pap and human papillomavirus (HPV) testing, and HPV vaccinations. An extensive research literature has examined the cost savings of these other services, and the authors incorporate estimates of savings drawn from these studies into their overall estimates. Developing estimates like these is not for the fainthearted. This article walks the reader through all the assumptions that are being made and all the sources of information used to complete each assumption. As such, the article provides a very detailed description of the methods used, which will be of great use to continuations of this research.

Earlier, Frost and her colleagues estimated that publicly supported contraceptive services resulted in a gross savings of \$5.68 for every dollar spent by averting Medicaid expenditures for deliveries and 12 months of infant care for births resulting from unintended pregnancies.³ Frost and colleagues’ article in this issue of *The Milbank Quarterly* expands this estimate to include the additional expenditures that might result from medical care for abortions and miscarriages, preterm and low birth weight births, and health care for children aged 13 to 60 months associated with unintended pregnancies, and also factors in the cost savings generated by the provision of STD, HIV, and HPV testing and treatment. In all, the public sector’s net savings are estimated at \$13.6 billion, or \$7.09 for every public dollar spent on family planning. The bulk of the additional savings are the averted Medicaid expenditures for health care for children aged 1 through 5.

Even more impressive are the estimates of the numbers of low-income individuals who experience health benefits each year. Approximately 2.2 million unintended pregnancies are averted, including 287,500 births that would be closely spaced and 164,190 that would be preterm or low birth weight. The STD testing is estimated to prevent approximately 129,000 transmissions, including 13,170 cases of pelvic inflammatory disease, which can result in ectopic pregnancies and infertility. Pap tests

and HPV screening and vaccinations are estimated to prevent 3,680 cases of cervical cancer and 2,110 cervical cancer deaths annually.

The scenarios used in these analyses are based on the health care financing environment in fiscal year 2010, when Medicaid accounted for three-quarters of the public expenditures on family planning services. But this program does not uniformly cover the same services or populations across the country. Before passage of the Affordable Care Act (ACA) in 2010, 27 states had expanded Medicaid to cover family planning services under waivers or state plan amendments approved by the US Department of Health and Human Services because these expansions were deemed to be cost-neutral.⁴

Under the ACA, states may expand their Medicaid programs to cover individuals and incomes up to 138% of the federal poverty level. Despite the very attractive financial incentives, only 28 states are implementing these expansions, which would lead to automatic increases in the proportion of the population eligible for publicly supported family planning, a required preventive health service.⁵ As a result, in different states, low-income individuals continue to face very inequitable access to subsidized family planning services. According to the analyses presented in this article, states that do not cover these expanded services are not being financially prudent, as they are essentially choosing to pay later for the substantial public expenditures that will be incurred when unintended pregnancies occur. Even more troubling, however, is their populations' lack of access to the positive health outcomes enumerated in this article.

References

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