Economic Perspectives on
Contraception and Abortion Policy

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Primarily interested in:

- documenting facts
- evaluating policies that have been implemented
- forecasting the effects of potential policies
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Science: “In light of the existing evidence, expanding access to a broader set of contraceptives would likely reduce teen childbearing in Montana.”

Advocacy: “Montana should expand access to a broader set of contraceptives.”
When economists think about childbearing decisions, they think about...

The “if and when” — shaped by preferences, information, expectations

If “not now,” what measures does an individual take?
A ECONOMIC MODEL OF DELAY/PREVENTION

Among other things, having a child depends on choices about

- sexual activity
- contraception prior to intercourse (e.g., pills, IUDs, injectables)
- contraception during intercourse (e.g., condoms, diaphragm)
- contraception after intercourse (e.g., emergency contraception)
- abortion

subject to the constraints an individual faces
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A policy focused on any one of these things may have impacts on others → not always obvious how such a policy will affect outcomes
ECONOMISTS EMPHASIZE SUBSTITUTION

When one thing changes, many things change

Suppose a policy increases the use of birth control pills.
- Is this a result of substitution from implants, IUDs, or injectables? From using none of those?
- Does it change the use of contraception during intercourse, or after intercourse?
- Does it alter sexual activity?

Big implications for the effects on welfare-relevant outcomes: childbearing, abortion, STIs, mental health, etc.

Explains how expanding access to reproductive health care can lead to undesirable outcomes (Buckles and Hungerman 2018)
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Research on Contraception
CONTRACEPTION USE IN THE US

Source: Bailey and Lindo (2018)
Recent Trend: Women Increasingly Opt for IUDs

Source: Bailey and Lindo (2018)
Recent Trend: Emergency Contraception

Source: Bailey and Lindo (2018)
Evidence on effects of access to EC

Prior to any economics research, there were many randomized control trials—none found statistically significant effects of providing EC on pregnancy, abortion, or STIs (Raymond et al. 2007)

Too small in scale to be able to identify effects? Examine policies affecting large populations

Studies evaluating state/federal policies altering OTC access: no effects on childbearing, although they likely have increased STIs and reduced abortions (Bailey and Lindo, 2018)
Widespread belief that “too few women are using the most effective types” of contraception (LARC\(s = \text{IUDs + implants}\))
Preventing Teen Pregnancy

Few teens (ages 15 to 19) on birth control use the most effective types.
Contraception Use in the US

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

LARC use is lower in the US than in most European countries and many developing countries
The Enthusiasm 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>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization</td>
<td>99.9%</td>
<td>99.9%</td>
</tr>
<tr>
<td><strong>Intrauterine Device</strong></td>
<td>99.9%</td>
<td>99.9%</td>
</tr>
<tr>
<td><strong>Implant</strong></td>
<td>99.9%</td>
<td>99.9%</td>
</tr>
<tr>
<td>Oral Contraceptive</td>
<td>91%</td>
<td>99.7%</td>
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<tr>
<td>Condom</td>
<td>82%</td>
<td>98%</td>
</tr>
<tr>
<td>No Method</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>
Barriers to Access

How do we know whether they matter?

By evaluating the effects of relevant policies
THE HEALTH-INSURANCE/COST BARRIER

Approx $1,000 to get an IUD

State policies in the 90s increased income limits for Medicaid → contraception use ↑ and childbearing ↓

(Kearney and Levine ’09)

Did the ACA’s contraceptive mandate remove this barrier?
  - 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
  - Also, privacy-minded youth may be unwilling to use parent’s insurance
  - Answer: not for all
Other possible barriers

Information about the efficacy and safety of LARCs—that CDC brief was aimed at medical professionals

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

Clinics serving low-income women typically haven’t been able to provide 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)
In ongoing work, I find that the effects are concentrated among women living within 5 miles of clinics.

How to expand access for women living farther away?
More evidence on effects of family planning clinics:
Texas cutting Family Planning Funding by 2/3

Teen birth rates in affected TX counties vs rest of US

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

Also caused:

- significant increases in births to older women
- reduced preventative care (breast exams and pap tests)
- and increased abortion

Lu and Slusky 2016, 2018; Fischer et al. 2017
Historical evidence

Initial rollout of federally funded family planning programs during the 1960s and 1970s reduced birth rates (Bailey 2012)

Expanding legal access to contraception and abortion during the 1960s and 1970s led to:

- delays in childbearing and marriage
- reduced completed family size
- increased college enrollment, completion, pursuit of non-traditional occupations
- employment and increased earnings

Goldin and Katz 2002; Bailey 2006; Guldi 2008; Bailey 2009; Guldi 2011; Bailey 2010; Bailey, Hershbein, and Miller 2012; Bailey, Guldi, and Hershbein 2013; Myers 2018
Additional Research on Abortion
Percent responding "yes" to supporting legalized abortion

Source: Bailey and Lindo (2018)
Panel A: By Income Relative to Poverty Line

Source: Bailey and Lindo (2018)
The 334 abortion restrictions enacted by states from 2011 to July 2016 account for 30% of all abortion restrictions since Roe v. Wade.
Recent flurry of work on clinic access

Whole Woman’s Health v. Hellerstedt (2016):

- Regulations in TX were deemed unconstitutional
- Clarified the undue burden standard: “courts must consider the burdens a law imposes on abortion access together with the benefits those laws confer”
- Justice Alito’s dissenting opinion: insufficient capacity or increases in distance caused by HB-2 could constitute an undue burden but it was not proven
Recent flurry of work on clinic access

What constitutes an “undue burden” is outside the realm of economics

However, we can document how changes in clinic access affect the number of abortions

Research has centered on TX—ideal as a large state with lots of closures precipitated by regulation
Abortion Clinic Access, Texas 2009-2015

Source: Cunningham, Lindo, Myers, and Schlosser (2018)
Abortion Clinic Access, Texas 2009-2015

Source: Cunningham, Lindo, Myers, and Schlosser (2018)
Change in distance to nearest clinic, Q2 to Q4 2013

Source: Cunningham, Lindo, Myers, and Schlosser (2018)
Abortion Clinic Access, Texas 2009-2015

On average, increasing distance to the nearest clinic 25 miles reduces abortion rates 6%

Congestion also plays an important role, leading to impacts on highly populated areas where clinics remain

Overall, increases in driving distance and estimated congestion post-HB2 reduced abortions by 16,000 from 2013–2015

- 2013: 2,100
- 2014: 5,800
- 2015: 8,100

Source: Cunningham, Lindo, Myers, and Schlosser (2018)
Concluding thoughts

Economists are not always the first to an issue — rigorous evaluation takes time and there are fewer economists working on these topics than researchers from other disciplines (public health, epidemiology, medicine)

Economists are contributing through rigorous policy evaluation — estimating causal effects

Primed to do more, including randomized control trials and working with new sources of data

We may not always know the biggest issues on the ground