This work is licensed under a Creative Commons Attribution-NonCommercial-ShareAlike License. Your use of this material constitutes acceptance of that license and the conditions of use of materials on this site.

JOHNS HOPKINS
BLOOMBERG
SCHOOL of PUBLIC HEALTH

Copyright 2006, The Johns Hopkins University and W. Henry Mosley. All rights reserved. Use of these materials permitted only in accordance with license rights granted. Materials provided “AS IS”; no representations or warranties provided. User assumes all responsibility for use, and all liability related thereto, and must independently review all materials for accuracy and efficacy. May contain materials owned by others. User is responsible for obtaining permissions for use from third parties as needed.

PFHS-380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Paying for Family Planning: Costs, Cost Recovery, and Cost-effective Investment Strategies

W. Henry Mosley

A. Why subsidize family planning services? (Ref: Lewis, M., 1986)

Reduced fertility has high social benefits as well as individual benefits. But even though individuals have a desire for fewer children, their "demand" for family planning is constrained by their resources, both material (money) and non-material (time, knowledge, beliefs, values, etc.). Because of these constraints, the free market price for contraceptives will generally not meet the social welfare objective. Therefore government subsidies are required to equalize individual and social preferences.

B. What are the User "costs"?

1. Search costs for acquiring correct information
    - a. about methods
    - b. about reliable and trustworthy sources of supply
2. Time costs
    - a. travel (including multiple trips for closed/empty clinics)
    - b. waiting times for services
3. Method variety costs (not getting choice)
    - a. limited methods available
    - b. provider biases
    - c. provider incompetence (technical)
4. Administrative costs
    - a. age, parity, marriage requirements; spousal consent
    - b. needless examinations
    - c. regulatory/bureaucratic restrictions
    - d. unpleasant/unfriendly environment (lack of privacy)
5. Social/cultural costs
    - a. cultural insensitivity (no female providers)
    - family opposition
6. Health and psychic costs
    - a. anxiety due to contravening cultural norms
    - b. physical side effects of the contraception
7. Monetary costs
    - a. for travel
    - b. for services
    - c. for commodities

C. What are usual provider costs? (Ref: Barberis and Harvey, 1997)

Mode of service delivery	Average Cost per CYP US$
Social marketing	2.14
Sterilization	1.85
Clinic services with sterilization	3.89
Clinic services without sterilization	6.10
Community-based distribution	9.99
Clinic services with CBD	14.00

D. What is Elasticity of Demand to Price Changes?

Definition: The price elasticity of demand for a good is the proportional change in the quantity demanded of the good relative to the proportional change in the price.

Example: Matheny (2004) cites 5 studies of the overall price elasticity of demand for contraceptives which showed elasticities in the range of 0 to 0.15. That is, for every 100% increase in the mean price of contraceptives, the contraceptive use decreased by 0% to 15%.

Price elasticity is influenced by many factors including:

1. Type of contraceptive
2. Initial price versus cumulative cost
3. The role of substitutes
4. Non-monetary costs
5. Economic situation
6. Perceptions of value

E. What is the cost-effectiveness of investments in alternative interventions to improve FP use? (Matheny, 2004)

1. Depends on the elasticity of alternative investment strategies – e.g., what will be the proportional change in FP use with a given investment in a FP strategy?:
2. For the most part, data are very poor or not available at all.
3. Where data are available, Matheny (2004) provides the following estimates:
   a. The low elasticities of contraceptive demand with contraceptive price subsidies (as summarized above) lead to an estimate of $61 per couple year of protection in Indonesia, if investments are just made in price subsidies.
   b. Media campaigns in Egypt, Turkey, and Zimbabwe have given estimates of $3.26, $1.36 and $3.57 per CYP.
   c. Strategies to improve quality appear to be very cost-effective, but good empirical data are lacking.

F. Social Marketing – Engaging the private sector to promote and distribute a "public good".

Definition: the design, implementation, and control of programs calculated to influence the acceptability of a social idea and involving considerations of product planning, pricing, communications, distribution, and market research.

1. Contraceptive social marketing:
   - a. uses existing commercial/retail channels
   - b. subsidizes prices (by government/donors) or recover partial costs to:
     - achieve high distribution
     - reach low income groups
2. Coverage and costs
3. Issues
   - a. management must fit local circumstance
     - examples of managers
       - family planning organizations
       - private sector organizations established specifically for CSM
       - quasi-governmental agencies
       - government agencies
   - b. potential customers
     - market segmentation
   - c. products
     - condoms, orals, spermicides, IUDs, injectables
   - d. pricing
     - a balance between assuring wide availability, retailer profitability and cost recovery
   - e. promotion
     - promote products (brands) and providers
     - target promotion to consumers and providers
     - continuous promotion
   - f. evaluation
     - sales
     - couple-year-of-protection (CYP)
     - coverage
     - cost/CYP

Required Readings:

Haws J, Bakamjian L, Williams T, Lassner KJ. Impact of sustainability policies on sterilization services in Latin America. *Studies in Family Planning 23*(2):85-96, March/April, 1992.

Janowitz B, Suazo M, Fried DB, Bratt JH, Bailey PE. Impact of social marketing on contraceptive prevalence and cost in Honduras. *Studies in Family Planning 23*(2):110-117, March/April 1992.

Schuler, SR, Bates, L, Islam, MK. Reconciling cost recovery with health equity concerns in a context of gender inequality and poverty: findings from a new health initiative in Bangladesh. *International Family Planning Perspectives* 28: 196-204, 2002.

Supplementary Readings

Matheny, G., Family planning programs: getting the most for the money. *Internatinal Family Planning Perspectives* 30 (3): 134-138, 2004.

Meekers, D, and Rahaim, S. The importance of socioeconomic context for social marketing models for improving reproductive health: Evidence from 555 years of program experience. *BMC Public Health* 5:10, 2005 (available at http://www.biomedcentral.com/1471-2458/5/10)

Recommended Readings:

Barberis M and Harvey PD. Cost of family planning programmes in fourteen developing countries by method of service delivery. *Journal of Biosocial Science 29*: 219-223, 1997.

Bratt JH, Forheit J, Vargas T. Three strategies to promote sustainability of CEMOPLAF clinics in Ecuador. *Studies in Family Planning* 29(1): 58-68, 1998.

De Silva V, Thapa S, Wilkens LR, Farr MG, Jayasinghe K, McMahan JE. Compensatory payments and vasectomy acceptance in urban Sri Lanka. *Journal of Biosocial Science 20*(2):143-156, 1988.

Forheit KG, and Levine R. Cost recovery and user fees in family planning. *Policy Paper Series No. 5.* OPTIONS for Population Policy II, The Futures Group, Washington, DC, 1993

Gillespie DG, Cross HE, Crowley JG, and Radloff SR. Financing the delivery of contraceptives: the challenge of the next twenty years. Pages 265-295 in SJ Segal, AO Tsui and SM Rogers (eds) *Demographic and Programmatic Consequences of Contraceptive Innovations*. New York and London: Plenum Press, 1989.

Harvey PD. The impact of condom prices on sales in social marketing programs. *Studies in Family Planning 25*(1):52-58, January/February 1994.

Hubacher D, Cardenas C, Hernandez D, Cortes M, Janowitz B. The costs and benefits of IUD follow-up visits in the Mexican Social Security Institute. *International Family Planning Perspectives* 25(1): 21-26, 1999.

Huber SC and Harvey PD. Family planning programmes in ten developing countries: cost effectiveness by mode of service delivery. *Journal of Biosocial Science 21*:267-277, 1989.

Janowitz B, Nunez J, Covington D, Colven C. Why women don't get sterilized: a follow-up of women in Honduras. *Studies in Family Planning 16*(2):106-112, 1985.

Janowitz B, Chege J, Thompson A, Rutenberg N, and Homan R. Community-based distribution in Tanzania: Costs and impacts of alternative strategies to improve worker performance. International Family Planning Perspectives 26(4): 193-195, 2000.

Knodel H, Bennett T, Panyadilok S. Do free pills make a difference? Thailand's experience. *International Family Planning Perspectives 10*(3):93-97, 1984.

Lande RE and Blackburn R. Pharmacists and family planning. *Population Reports* Series J, Number 37. Baltimore, MD: The Johns Hopkins University Center for Communication Programs, November 1989.

Lande RE and Geller JS. Paying for family planning. *Population Reports*, Series J, Number 39. Baltimore, MD: The Johns Hopkins University Center for Communication Programs, November 1991.

Lewis MA. Do contraceptive prices affect demand? *Studies in Family Planning 17*(3):126-135 May/June, 1986.

Lewis MA. Cost recovery in family planning. *Economic Development and Cultural Change 35*(1):161-182, October, 1987.

Mitchell MD, Littlefield J, and Gutter S. Costing reproductive health services. *Internatonal Family Planning Perspectives.* 25 (Supplement): S17-S21 & S29, 1999.

Population Information Program. Contraceptive social marketing: lessons from experience. *Population Reports* Series J, Number 30. Baltimore, MD: The Johns Hopkins University Center for Communication Programs, July-August 1985.

Robinson W, Cleland J. The Influence of Contraceptive Costs on the Demand for Children. Pages 106-122 in JF Phillips and JA Ross (eds) *Family Planning Programs and Fertility.* New York: Clarendon Press Oxford, 1992.

Ross JA and Isaacs SL. Costs, payments, and incentives in family planning programs: a review for developing countries. *Studies in Family Planning 19*(5):270-283, September/October 1988.

Sheon A, Schellstede W, and Derr B. Contraceptive social marketing. Pages 367-390 in RJ Lapham and GB Simmons (eds) *Organizing for Effective Family Planning Programs*. Washington, D.C.: National Academy Press, 1987.

Simmons GB, Baik D, and Faiz KK. A cost effectiveness analysis of family planning programs in rural Bangladesh: evidence from Matlab. *Studies in Family Planning* 22 (2): 83-101, 1991.

Thapa S, Abeywickrema D, and Wilkens LR. Effects of compensatory payments on vasectomy acceptance in urban Sri Lanka: a comparison of two economic groups. *Studies in Family Planning 18*(6):352-360, November/December, 1987.

Tsui AO and Donaldson PJ. The role of private physicians and clinics in Third World family planning. Pages 391-411 in RJ Lapham and GB Simmons (eds) *Organizing for Effective Family Planning Programs*. Washington, D.C.: National Academy Press, 1987.

Vach TH, Bishop A, Hoa VT, Hien LX, Chien TD, and Nguyen TI. The potential impact of introducing pregnancy testing in menstrual regulation services in Vietnam. *International Family Planning Perspectives* 24(4): 165-169, 1998.

Winfrey, W, Healton, L, Fox, T, Adamchak, S. Factors Influencing the Growth of the Commercial Sector in Family Planning Service Provision. *Working Paper Series No. 6,* The POLICY Project, 2000. http://www.policyproject.com/pubs/workingpapers/wps-06.pdf