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Position Statement

OXFORD

Position Statement

Universal access to no-cost contraception for youth in Canada

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Abstract

Timely access to effective contraception reduces the incidence of unintended pregnancy. Cost is a significant barrier to using contraception for youth in Canada. Many must pay out-of-pocket because they have no pharmaceutical insurance, their insurance does not cover the contraceptives they desire, or they wish to obtain contraceptives without their parents' knowledge. To address these barriers and reduce rates of unintended pregnancy, this statement recommends that all youth should have confidential access to contraception, at no cost, until the age of 25. The statement also recommends measures to help achieve this goal across Canada.

Keywords: *Adolescent; Contraception; Health insurance; Universal coverage; Young adult*

UNINTENDED PREGNANCY, RATES, AND COSTS

Access to contraception is recognized as a basic human right (1). Ensuring that women can choose whether or when to have children means they have greater control over their bodies and futures. Unintended pregnancies may derail life plans, particularly for adolescents and young adults. Adolescent parenting is associated with lower lifetime educational achievement, lower income, and increased reliance on social support programs (2). Apart from the personal costs, unintended pregnancies are a costly burden for Canada's health and social service systems.

Most adolescent pregnancies in Canada are unintended (Table 1) (3–5). Extrapolating from a recent calculation of the average direct medical cost of one adult unintended pregnancy, which was $2,129 (6), the direct costs of unintended pregnancies in youth probably exceed $125 million per annum.

Consistent contraception use substantially reduces risk for unintended pregnancy. Yet more than 25% of youth who do not wish to be pregnant report that they do not use contraception at every act of intercourse and some never use it at all (Table 2) (7). Contraceptive types are commonly categorized as follows:

- Barrier methods (condoms and diaphragms);
- Hormonal short-acting reversible contraception (SARCs), used daily (oral), weekly (transdermal), monthly (vaginal) or quarterly (injections); and
- Long-acting reversible contraceptives (LARCs) that act over years (intrauterine systems [IUSs] or intrauterine devices [IUDs] and subdermal implants).

In Canada, the only LARCs currently available are IUDs and IUSs. Because of their typical use failure rate of less than 1% (Table 3) (6,8), LARCs are the recommended first-line contraceptive method (9). Despite the proven effectiveness of LARCs, however, most adolescents use short-acting hormonal contraceptives (7) which have a typical use failure rate between 6% and 9% (8). A CPS statement entitled Contraceptive Care for Canadian Youth provides a guide to optimizing contraception use in youth: https://www.cps.ca/en/documents/position/contraceptive-care (9).

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Table 1. Abortions and births in youth, 2014

Age	All pregnancies*	Abortions	Live births	Unintentional live births (%)	Estimated unintentional live births	Estimated unintentional pregnancies†
<20	19,730	9,069	10,661	>70	7463	16,532
20–24	72,451	22,871	49,580	>40	19,832	42,703

*Including abortions + live births and excluding miscarriages + stillbirths.
†Abortions + unintentional live births.
Data drawn from references (3–5).

Table 2. Birth control use among sexually active women not desiring pregnancy

Age	Never	Sometimes	Usually	Always
15–19	4.0%	9.4%	12.4%	74.2%
20–29	11.0%	8.6%	12.1%	68.3%

Data drawn from reference (7).

COST IMPLICATIONS

Many individual, cultural, and societal factors influence the decision to use contraception, the choice of method and adherence. Canadian contraceptive care providers identify cost as the single most important barrier to access, and youth as the population most disproportionately affected by this barrier (10). Youth are much more likely to use condoms when they are available at no cost (11,12). While the annualized cost of LARCs is lower than that of SARCs (Table 3), their high up-front cost skews contraceptive choice among youth toward SARCs (13–15). However, when offered all methods of contraception at no cost, youth choose LARCs more than two-thirds of the time (16). Providing no-cost contraception has been clearly associated with reducing the incidence of teen pregnancy (16).

WHO PAYS?

Provincial/territorial health care plans cover the cost of drugs on their formularies for women who are economically disadvantaged, receiving social welfare benefits, or both. Indigenous populations are covered under the federal Non-Insured Health Benefits program. However, not all plans cover all contraceptive methods. Because the Canadian Agency for Drugs and Technology in Health's Common Drug Review program has concluded that transdermal contraceptive patches (17) and vaginal rings (18), offer no additional advantage over oral contraceptives, these methods are variably covered. Copper IUDs are considered devices, not drugs, and therefore are also variably covered. Condoms, which are critical for enhancing the effectiveness of short-acting hormonal contraceptives and preventing sexually transmitted infections, are rarely covered.

Women may also be covered under a private pharmaceutical insurance plan through their employer or as the dependent of an employee with private coverage. However, not all private insurers cover contraceptives and when they do, they generally only cover 70% to 80% of the cost. The difference remaining may still be a significant barrier and discourage selection of an intrauterine contraceptive (IUC), for example (13).

In most jurisdictions, a substantial proportion of the population has neither private nor public pharmaceutical insurance, and many youth are forced to pay high up-front costs for contraceptives (Table 3) or go without.

Dependent youth who wish to access contraception confidentially face an additional barrier. When they access private pharmaceutical coverage, a report is made available to the primary policy holder (usually a parent). Thus, youth must often pay out-of-pocket for contraception to preserve confidentiality, despite having access to pharmaceutical insurance.

A patchwork of programs in Canada has attempted to address cost barriers through school-based services, government-run youth clinics, and nonprofit organizations that provide counselling, prescriptions, and low-cost or no-cost contraceptives. Due to budgetary constraints, many of these programs provide a very limited selection of no-cost contraceptives, and IUCs are infrequently offered. Youth who depend on these programs are more likely to use contraception inconsistently because they often receive only a few months' supply at a time (19). Furthermore, requiring youth to use such clinics rather than providing no-cost contraception at all points of contact with the health care system hinders both initiation of and adherence to contraception.

POTENTIAL SOLUTIONS

Cost should not be a barrier to consistent and timely use of effective contraception for youth in Canada. Both the Canadian Medical Association (20) and the Society of Obstetricians and Gynaecologists of Canada (21) have proposed that provincial/territorial and federal health care plans cover 100% of costs of *all* contraceptives for *all* Canadian women. While universal contraception coverage would increase public spending by an estimated $157 million annually (22), this expense would be

Table 3. Cost of contraception in Canada*

Method	Typical use failure rate†	Cost per unit	Units per year	Cost per year
Oral contraceptive	9%	$11	13	$143
Vaginal ring	9%	$15	13	$195
Transdermal patch	9%	$15	13	$195
Intramuscular injection (depomedroxyprogesterone acetate – DMPA)	6%	$27	4	$108
Intrauterine system (IUS) (levonorgestrel 20 mcg/day – effective for 5 years)	0.2%	$319	1	$63
Intrauterine device (IUD) (Copper – effective for 5 years)	0.8%	$60	1	$12
Male condom	18%	$1	83	$83
Female condom	21%	$4	83	$332
Diaphragm	12%	$30	1	$30

*Dispensing fees are not included.

†Based on typical couples who start using any method (though not necessarily for the first time) and experience an unintended pregnancy within the first year (if they do not stop use for any other reason).

Adapted from references (6,8).

more than offset by the $320 million saved in direct medical costs related to unintended pregnancy (6).

Should provinces or territories choose to use a private/public model to provide contraceptive coverage, they must ensure that youth with private pharmaceutical insurance have comparable access to comprehensive, confidential, no-cost contraception. Youth must be able to easily identify and access private family insurance, when available, without involving a parent. Private insurers should cover the full cost of all contraceptives for youth at the point of purchase. Requiring youth to pay out-of-pocket with reimbursement at a later date creates cost and confidentiality barriers. Finally, to protect confidentiality, legislation should be enacted to prevent private insurers from reporting contraceptive use by dependents to primary cardholders. This protection is already in place in some U.S. states (23).

Several organizations in the USA have advocated for over-the-counter (OTC) access to short-acting hormonal contraceptives (the pill, patch or ring) to mitigate intermittent contraceptive use caused by limited access to prescribers (24,25). However, OTC access can also *increase* costs to youth, because insurers tend to discontinue coverage for OTC pharmaceutical items (26,27). If short-acting hormonal contraceptives obtain OTC status in Canada, legislation should ensure that private and public insurance plans continue to cover contraceptives for youth. An alternative to OTC access has been implemented in Quebec, where pharmacists can prescribe short-acting hormonal contraception.

In conjunction with legislative measures, clinical sites where high volumes of contraceptives are prescribed should consider stocking contraceptives to provide to youth at the point of care. Even for adults, providing a year's supply of oral contraceptives at the time of appointment enhances adherence compared with writing a prescription for a similar supply (which, in turn, is better than providing only a few months' worth of contraceptives at a time) (19,28). Further, initiating oral or injectable contraceptives immediately, rather than at time of menses, increases the likelihood of youth using the same method 2 months later (29,30). While comparable data are not yet available for IUCs in youth who have never been pregnant, the prompt insertion of an IUC both postpartum (31) and postabortion (32) is associated with greater likelihood of adherence.

RECOMMENDATIONS

The Canadian Paediatric Society supports the provision of no-cost contraception for all women of reproductive age. Because youth are particularly vulnerable to barriers related to cost and confidentiality, provincial/territorial and federal governments should act promptly to ensure universal, no-cost, confidential access to contraceptives, including intrauterine methods and condoms, for all youth. To achieve this goal:

1. All contraceptives (including condoms) should be covered under provincial/territorial or federal health plans at no cost, until age 25.
2. Health ministries should *also* provide contraceptives at no cost to community-based health care services for youth, to support point-of-care dispensing and simplify access.
3. Health ministries that adopt public-private models to cover contraceptives must ensure that privately insured youth have

equal access to no-cost, confidential contraception. To that end, they must:

a. Create a mechanism for pharmacists to identify a youth's insurance provider, such that contraceptives can be dispensed without a parent's knowledge.
b. Require private insurers to cover the entire cost of all contraceptives for youth at the point-of-sale, until age 25.
c. Require private insurers to protect confidentiality by not reporting the purchase of contraceptives to a primary policy holder.

4. If oral or other short-acting hormonal contraceptives become available over-the-counter, the law should ensure their continued provision at no cost, until age 25, under all government and private pharmaceutical plans.

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This position statement has been reviewed by the Action Committee for Children and Teens (ACCT) and Bioethics Committee of the Canadian Paediatric Society. It was also reviewed by representatives of the College of Family Physicians of Canada, and by members of the Society of Obstetricians and Gynaecologists of Canada's Family Physician Advisory Committee; Canadian Paediatric and Adolescent Gynaecology Committee; and Obstetrics and Sexual Health and Reproductive Equity Committee.

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