

**The Evolution of Contraceptive Pricing in Indonesia
A Final Report to The Policy Project¹**

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¹ This report is submitted in partial completion of Rand's Policy Project-financed project entitled "Contraceptive Pricing and Protecting the Poor."

Foreword

This report completes the work done by RAND on TFGI's Policy Project subcontract "Contraceptive Pricing and Protecting the Poor." This project was initiated in August 1998 with the following broad objectives:

- 1) review evidence of the patterns of Indonesian contraceptive demands, based on data gathered prior to the crisis;
- 2) use this evidence to evaluate the likely impacts of the financial crisis-induced contraceptive price changes on contraceptive demands and fertility, particularly as they influenced the poor; and
- 3) Use this information to discuss how BKKBN can best respond to the crisis, given their current budgetary constraints.

Previous work on this project included three different reports. The first, "Contraceptive Pricing and Protecting the Poor, 1991-1997" was submitted to TFG in January 2000. It summarizes the roles of prices and the contraceptive distribution system in determining the levels and mix of contraceptive use over the period 1991 to 1997, as well as several studies that examine the importance of prices in determining prevalence. The second report, "Contraceptive Demand and Protecting the Poor" was presented to BKKBN and submitted to TFG in March 2000. An additional paper, "Rationalizing Pill and Injectable Contraceptive Procurements" examines the policy implications of the findings on contraceptive pricing. This concluding report summarizes the substantive findings and policy implications in a single, self-contained report.

Background

Since the start of the monetary crisis, consumer costs for government-supplied pill and injectable contraceptives have risen to levels similar to those of unsubsidized contraceptives, with little or no corresponding reduction in prevalence. At the same time, government contraceptive procurement budgets have been severely reduced, leaving it unclear how BKKBN can meet its projected procurement requirements. These two developments suggest a valuable opportunity for the commercial sector to replace

government procured contraceptives, relieving BKKBN's procurement difficulties, *at no increased cost to users.*

However, informal sales of government procured contraceptives provide substantial income for distributors of government contraceptives; income that will be severely reduced if government procurements of pills and injectables are reduced. Without knowing who benefits from these revenues, and how they are used, it is unclear how their removal would influence contraceptive support and promotion.

So the key to relieving BKKBN procurement difficulties by shifting contraceptive procurements to the private sector is to strategically remove government supplies from the areas where private supplies can be most easily substituted. This document reviews reasons this should be done, and proposes a strategy for targeting the easiest areas. These suggestions have important implications for the organization of the program.

The Indonesian family planning program has a long and widely respected history of promoting Indonesian contraceptive use. Since the 1970s the National Family Planning Coordinating Board (known widely by its initials, BKKBN) has coordinated the program. It is widely accepted that the program has been largely responsible for rapid reductions in fertility that have occurred since then, (although its recent impacts relative to those of female educational attainment and economic opportunities are still debated.) Notwithstanding this ongoing debate, BKKBN, which coordinates the family planning program, has been touted as a model of a well organized government agency.

An important component of the early program was the distribution of free contraceptives, in order to assure there were no financial barriers to acceptance. But starting in the early '90s, the strategy of providing free contraceptives was revised, as BKKBN began to explicitly encourage users to pay some of the costs of contraception. This promotion took the form of several explicit policies. These included the marketing of unsubsidized contraceptives, known by their Indonesian acronyms LIBI and LIMAS (for Blue Circle and Gold Circle; REFS.) and others to promote nominal payments for government distributed contraceptives.

These programs had several roles. The LIBI and LIMAS programs were intended to promote the shift from government to privately procured methods. While some resources were devoted to developing these distribution systems, their primary emphasis

was on private marketing – promoting brand recognition and favorable consumer attitudes towards privately procured contraceptives. Despite effective marketing that achieved broad brand recognition, the LIBI program met only limited success in shifting consumers to unsubsidized contraceptives. Blue Circle pills, for example, only made up 7% of total pill use in 1997 (BPS, 1998).

By contrast, the KB Mandiri program had much more modest goals. It promoted payments of small, nominal fees by users of government procured methods. The purpose of these payments was ostensibly to develop among clients a greater sense of personal responsibility towards and ownership of selected contraceptives. These nominal fees were not intended to pay the full costs of contraception; rather they were supposed to be more symbolic than substantial. This latter program has, in some senses, been far more successful. By 1997 only 16% of contraceptives were distributed for free (DHS, 1998.)

An important policy question that lay behind these efforts to promote client payments was the responsiveness of contraceptive demand to the prices clients faced.

A healthy contraceptive demand literature existed well before BKKBN's promotion of user-financed contraceptive distributions. Several studies by Akin and coauthors (Akin and Schwartz, 1986; Schwartz and Akin 1988), had, in the mid to late '80's, argued that contraceptive demands were highly inelastic in such places as the Philippines. Other more recent studies have looked at demand elasticities in Thailand (Asakul, ...) and Indonesia (Molyneaux and Diman, 1989) and have similarly found relatively low elasticities. More recent studies have identified income as an important factor in determining these elasticities (Kak, et al. 1990; Molyneaux & Gertler, 1993). However, in some of these studies, even the price responsiveness of the poorest segments of the population is relatively low. Molyneaux and Gertler, for example, suggested that in 1991, increases in prices to private market levels would only reduce prevalence of the poor by about five percent, or about two percentage points.

Nearly all of these contraceptive demand studies have suggested that contraceptive demand elasticities are quite small. Molyneaux and Gertler suggest that some of the cross-price elasticities are relatively large – especially between similar methods, or the same method between different providers. This suggests that large price

changes might influence contraceptive mix, but they would have little impact on overall prevalence.

What Do The Models Tell Us About Contraceptive Demands?

The econometric models of contraceptive demands, especially in Southeast Asia, typically share several general features. Most consistent among these (though not universal) is the finding that overall prevalence elasticity is relatively low; substantial differences in contraceptive prices have only limited impact on overall prevalence. However, among the studies that have examined cross-price elasticities – both among competing methods, and among competing sources of the same methods – the cross-price elasticities tend to be much higher. That is, consumers are far more likely to switch methods or sources in the face of price increases than to stop using. Most of this measured substitution is among relatively similar methods, or among competing sources for the same methods. For example, substitution between pills and injectables – both supply-based hormonal methods – tends to be quite high in Indonesia. However, no significant substitution can be measured between pills or injectables and IUDs or other long-term methods.

One last relatively consistent finding is that the elasticity for overall use tends to be higher among the poor than the non-poor. However, even the elasticities among the poorest 20% of the Indonesian households has remained quite low – roughly .05. Albeit much higher than that measured among higher income groups.

What Happened During the early to mid '90's

Indonesia's experience with contraception during the early to mid 1990's sheds an important light on the relative importance of prices in determining contraceptive prevalence and mix. Data from the '91, '94, and '97 DHS surveys reveal that real prices of contraceptives increased very rapidly over the period. Overall payments per year of contraceptive protection rose from Rp. 4,000 in 1991 to approximately Rp.7,500 in 1997.²

² The prices quoted are measured in constant 1991 Rupiah. In 1991, the Rupiah exchanged freely at a rate of approximately Rp.2,000/US Dollar. In 1991 Indonesian GDP per capita was approximately Rp.

During this same time period, overall contraceptive prevalence increased substantially, from 49% to 54%. Thus, sharp increases in contraceptive costs did not prevent the continued growth in prevalence. This alone does not imply that the price increases had no effect on prevalence; it only demonstrates that other determinants of demand overpowered any moderating effect of the price increases.

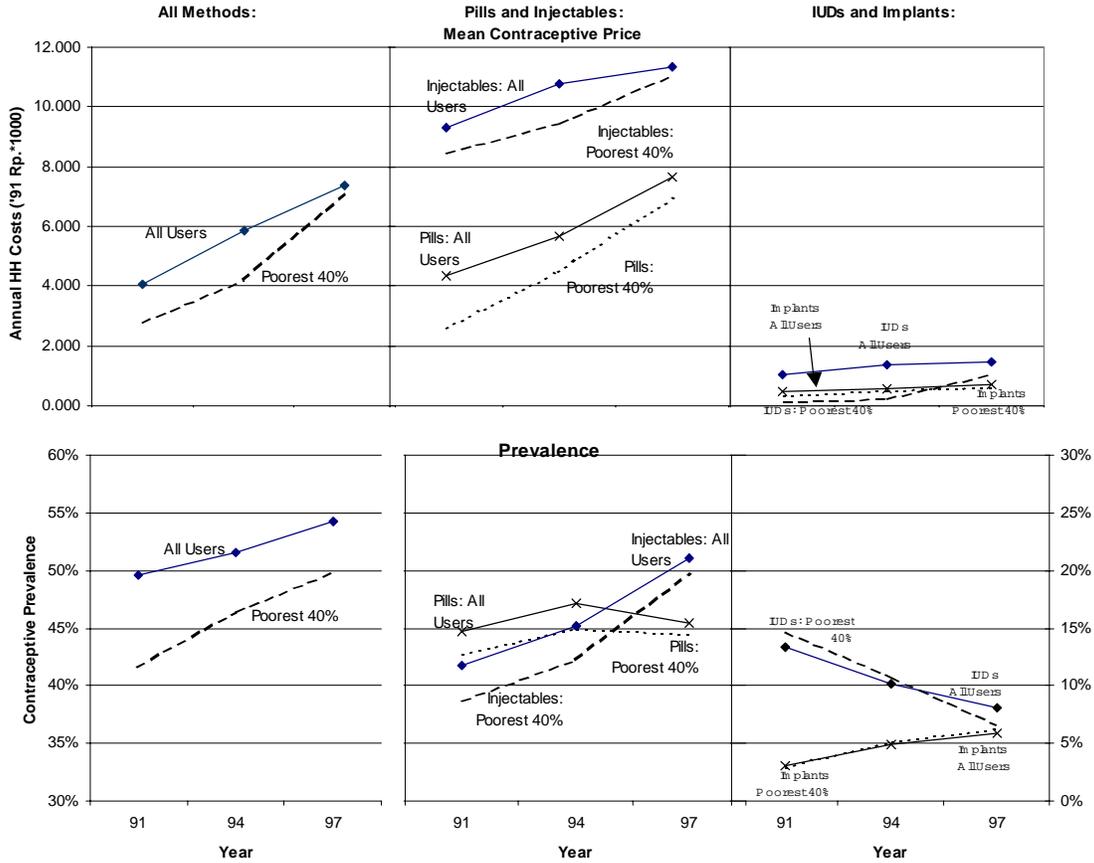
The argument of unimportant prices, however, becomes more compelling when we examine the pattern of prices and prevalence among the poor. In Figure 1 below, the broken lines trace the time patterns of prices and prevalence among the poorest quartile of users.³ These indicate that the prices paid by the poor increased much more rapidly than overall prices; by 1997 prices paid by the poor nearly equaled the overall average. But despite this, prevalence of the poor continued to converge on that of the non-poor.

This does not imply the prices did not affect demand, but particularly because we believe the poor to be more price responsive than the non-poor, it reinforces the impression that prices are not a major determining factor. If we examine the corresponding method-specific time-trends in the right-hand boxes, it also becomes clear that the relative prices of different methods have at most minor effects on method mix.

1,200,000; mean per-capita expenditures of households below the Indonesian poverty line were approximately Rp.500,000 per year.

³ While the DHS data do not permit us to measure either income or expenditures, they provide us with a detailed household roster, including age, and educational attainment of each member. The DHS also identifies the primary source of household income, as well as the specific district, sub-district and village where the household lived. These are identical to the information provided for each household from the annual Indonesian Social and Economic Survey (Susenas). These surveys collect expenditure data from 200,000 households annually. Regressions of logged, per-capita expenditures on these household demographics and sub-district indicators yield R^2 s of nearly 0.70. We therefore applied the Susenas-estimated per-capita expenditure estimating equations to the DHS data to derive predicted per-capita expenditures.

Figure 1. Historical Trends in Contraceptive Prices and Prevalence



What Actually Happened Through the Crisis?

The primary impacts of the crisis were on the financial sector and on the Rupiah prices of internationally traded goods. Most of the country's banks became technically bankrupt; those not declared insolvent ceased new credit activity as they struggled to meet central bank monitored liquidity requirements. The Rupiah fluctuated widely between one half and one fifth of its pre-crisis level, eventually stabilizing at about one-third. Non-agricultural wage and salaried workers – especially those in urban areas – suffered severe reductions in real incomes, as the construction and domestic manufacturing sectors laid off roughly 5% of the labor force, and as the Rupiah costs of internationally traded commodities moved with the cost of the Dollar.

But while there were severe economic impacts of the crisis, not everyone was hurt. And even among those who were hurt, there were substantial adjustments as consumers coped with the new economic conditions. For those working in export-

oriented agriculture, the crisis effectively cut by one-third their costs of services, and domestically produced inputs and consumer goods.

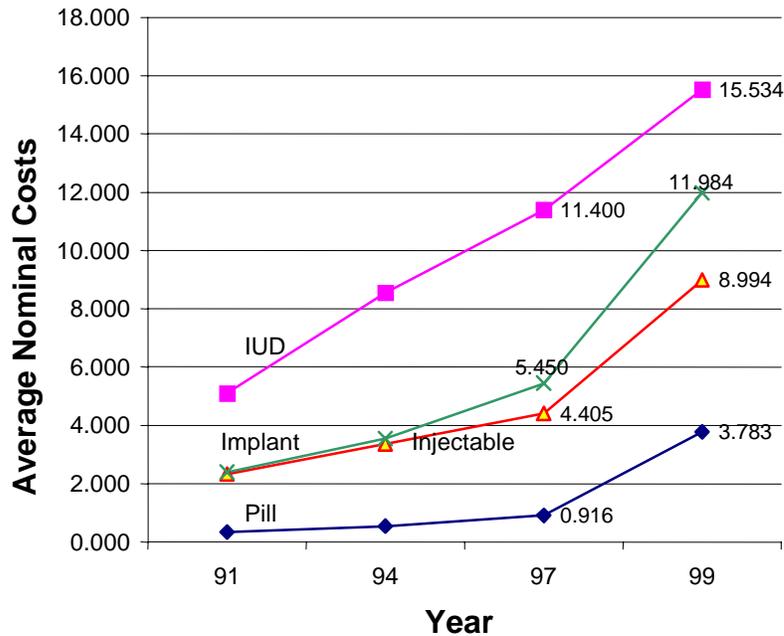
The largest shocks to the economy were in the nominal prices of internationally traded goods. Since the raw materials for most Indonesian contraceptives are internationally traded, contraceptive prices followed suit. As shown in Figure 2, while the cost of living roughly doubled, pill prices increased by a factor of four, and those of injectables also doubled. It should be noted that these price increases were led by the public sector.

This phenomenon of charging relatively high fees by distributors of government procured pills and injectables is not new, nor should it be a surprise. What might be surprising is that there is very little bad news associated with the recent price increases. Beginning in the early 1990's BKKBN initiated the KB Mandiri, and Blue Circle campaigns to increase consumers' ownership of and responsibility over their own reproductive decisions. As the DHS data from 1991, 1994 and 1997 demonstrate in Figure 1, throughout the 1990s, prices paid by consumers to distributors of government distributed pills and injectables have been rapidly converging on commercial sector prices.

The good news coming out of this recent history is that there is little evidence that contraceptive prevalence suffered substantially as a result. Indeed, as Figure 1 also shows, although price increases through the '90s were steepest for the poorest 40% of the population, their contraceptive prevalence continued to catch up with the prevalence of the non-poor. And this catch-up occurred principally through the growth in use of injectables – at that time the most expensive method in common use.

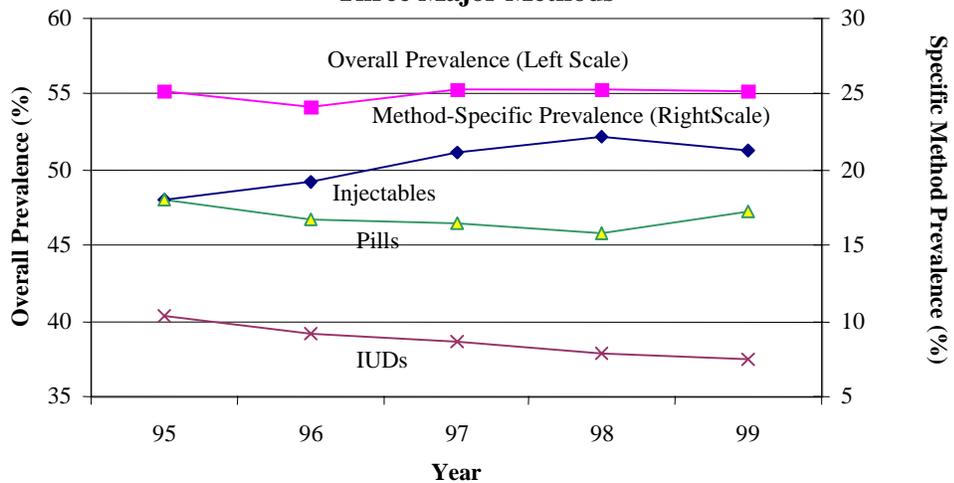
The magnitudes of the most recent price increases are displayed in Figure 2. With the exception of IUD price increases, these increases from '97 to '99 are all much greater than increases in any earlier year. More importantly, the different method prices changed at very different rates. Note that pill prices increased roughly four fold from 1997 to 1999, while injectables and implants only doubled. IUD costs increased only 35% over the period.

Figure 2. Nominal FP Costs, 1991-1999



The most surprising result of these price increases is that despite the dramatic changes through 1999, contraceptive prevalence has remained stable over the period. Figure 3 displays that not only did prevalence not decline, but the share of prevalence due to pills increased sharply, even though pills experienced the largest relative price increase.

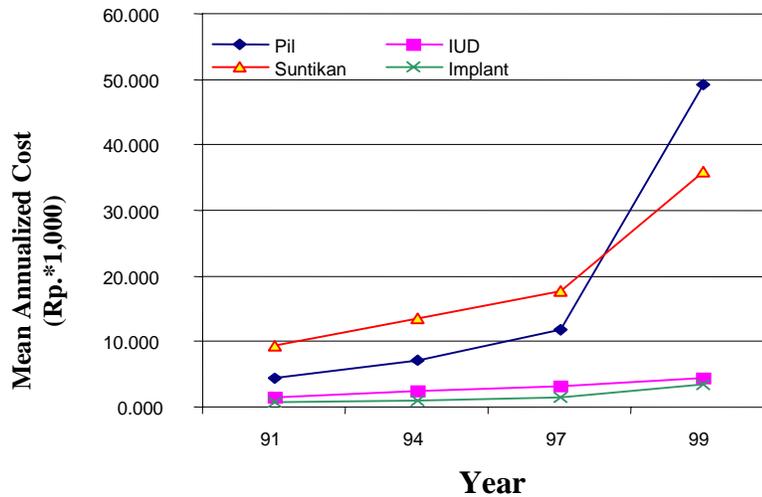
Figure 3. Prevalence Trend: Three Major Methods



An even more surprising result is more evident if we look at the price trends measured as annualized prices (see Figure 4). This figure shows more clearly how much

more expensive the annualized costs of pills and injectables are than IUDs and implants. It also shows clearly how much faster pill prices grew than any other methods. Yet there was no significant shift into the cheapest methods. In fact, IUD prevalence continued its long-term decline.

Figure 4. Annualized Nominal Contraceptive Service & Supply Costs



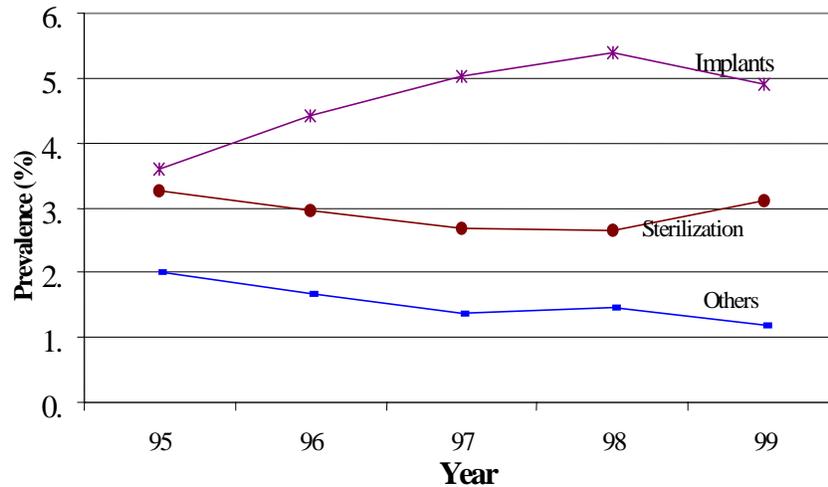
Some have argued that the high up-front costs of the IUD may have forced women to use more expensive methods because they were cash constrained. However, a qualitative study of the feasibility of an installment plan for IUD users yielded a similar response from poor and wealthy households alike. Since even poor households spend roughly Rp.300,000 per-capita monthly, Rp.15,000 IUDs are not expensive enough to warrant financing (Adiotoemo, et al., 1999).

Though IUDs and implants could have served as a very effective safety-net method for those with desperately stretched budgets, users continued their long-term trend out of IUDs and into the much more expensive methods.⁴ Figure 5 shows that even implants experienced their first decline in prevalence since they were introduced. If this puzzling trend is driven by client demand factors, it suggests that either the impact of the

⁴ It should be noted, however, that among the poorest 20% of the population, IUD prevalence did rise. But only by 0.3 percentage points.

crisis on real household incomes was less than initially expected, or that users' cross-price sensitivity is less would have been expected from earlier studies.

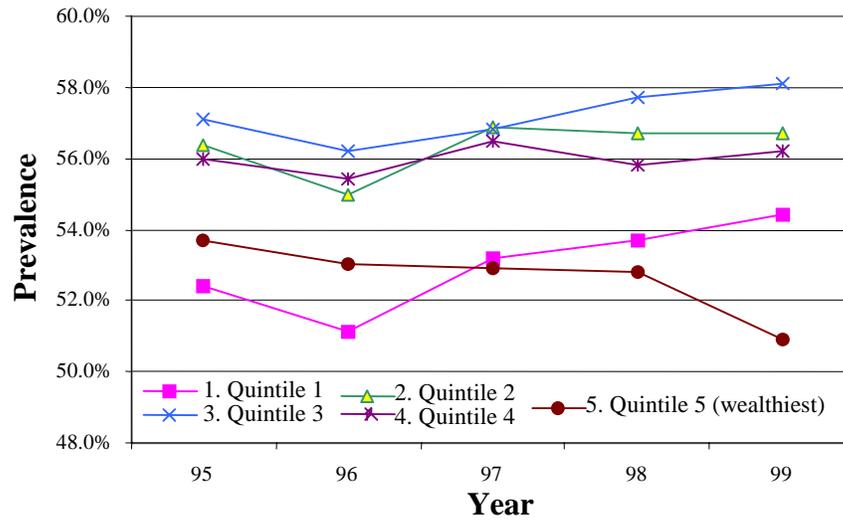
**Figure 5. Prevalence Trend:
Minor Methods**



Source: 1995-1999 Susenas Tabulations

The prevalence trends by income quintile (Figure 6) show some interesting aberrations, but none that refute the basic premise that prevalence was relatively stable. The most interesting aberration is the time-trend of prevalence among the wealthiest quintile. While all of the other quintiles continue to report increasing prevalence, there was a sharp decline in prevalence among the wealthiest. We suspect that this decline is driven more by sample composition factors than by real changes in contraceptive use patterns. Along with the other impacts of the crisis, rural consumers became relatively better off, as many agricultural sources of income actually improved. Consequently, the wealthiest quintile should now have a higher proportion of rural/agricultural households. Since rural areas have always had lower prevalence than urban areas, it appears this decline among the wealthy simply reflects this changed rural/urban composition of the wealthy.

**Figure 6. Prevalence Trends,
By Income Quintile**



Source: 1995-1999 Susenas Tabulations

Apart from this curious aberration, the story emerging is very similar to that which came out of the time trends from 1991 through 1997. Although there are important factors shifting the patterns of contraceptive demand, prices do not appear to be one of them. This result is all the more surprising through the crisis, simply because the nominal price increases were so much higher than anything else we have seen historically.⁵

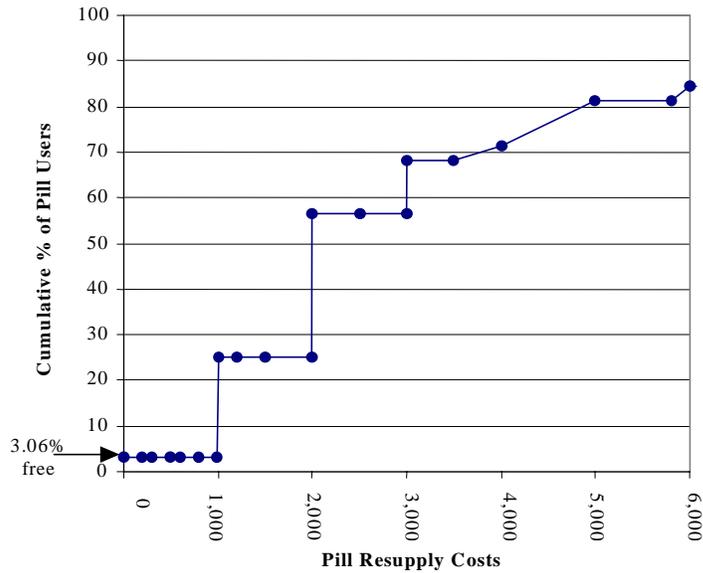
Current Summary

Having looked at the broad patterns of price and prevalence changes, it is now useful to look more closely at the distribution of the major method prices. We are specifically interested in examining the extent to which the poor have been protected, as well as how these rapid price increases have influenced the relative prices of publicly vs. privately procured methods. As is displayed in Figures 7 and 8 below, according to the February 1999 Susenas survey, 75% of pill users paid Rp.2,000 or more for their last re-supply, and 44% paid Rp.3,000 or more. Similarly, 90% of injectable users paid

⁵ A fairly compelling argument against this interpretation is that in *relative* terms most contraceptives, excluding pills, had stable or declining prices. For consumers not tricked by the money illusion of high inflation, it is relative prices that matter. However, pills still showed a major increase in *relative* prices, but still increased significantly in prevalence – still suggesting that contraceptive prices are not that important.

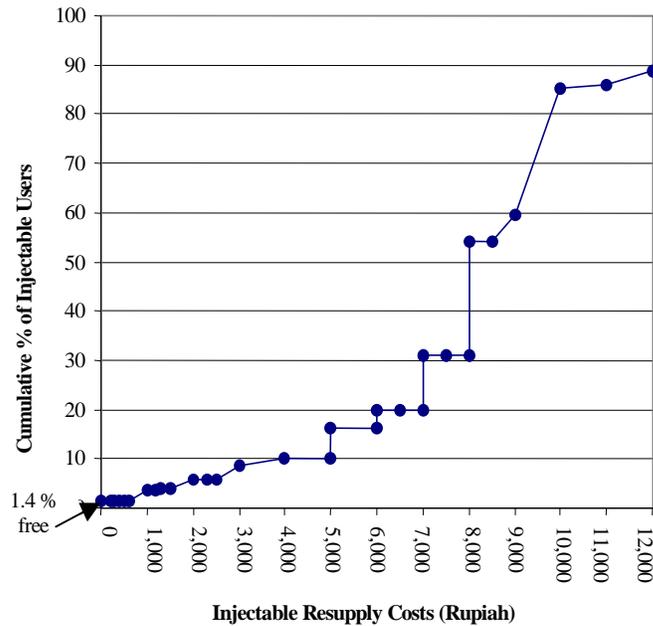
Rp.5,000 or more and 80% paid Rp.7,000 or more. The major social safety net efforts have not been targeted through these two methods. Only 3% of pill users and 1.6% of injectable users received their methods for less than Rp.1,000.⁶

Figure 7. Cumulative Distribution of Pill Resupply Costs



⁶ IUD, implant and female sterilizations all have much higher rates of free distributions, although overall the total receiving free methods was less than 5%.

Figure 8. Cumulative Distribution of Injectable Re-supply Costs



According to private sector estimates, these pill prices compare favorably to the cheapest prices of unsubsidized pills. A market report prepared for USAID by Schering indicated that at least two brands of Gold Circle pills sold for Rp.2,000 or less. (See Table 1.) Moreover, industry sources indicate that increased private sector volume could significantly reduce private sector pill prices. Since BKKBN currently procures roughly 90% of the pills consumed in Indonesia, there is room for very large private sector volume increases, and reduced prices.

The distribution of injectables is quite different from that for pills. BKKBN procurements already account for less than half of the vials consumed annually. Moreover, by the time the vials reach the consumer there is little, if any, distinction between those procured by BKKBN and those by the private sector. More compellingly, less than 10% of injectables are provided at costs under the gold circle commodity prices. Therefore, since the private sector is already a major player in the market, removal of government procured injectables in most markets is unlikely to have any significant effect on injectable prices or use.

Table 1. Retail Prices for Selected Private Sector Brands

Method	Circle	Company	Brand	Price/Unit
Pill	Blue	Schering	Microgynon	Rp.4,575
	Gold	Organon	Marvelon	Rp.6,000
			Exluton	Rp.4,800
		Wyeth	Nordette	Rp.2,000
			Trinodiol	Rp.2,250
		Kimia Farma	Microdiol	Rp.1,800
Injectable	Blue	Upjohn	Depo Provera	Rp.5,930
	Gold			Rp.5,930
		Harsen	Depo Progestin	Rp.4,800
		Triyasa	Depo Geston	Rp.4,600
		Tunggal	Cyclofem	Rp.5,000

Source: Schering report to USAID based on distributor price lists, Feb. '00

But as suggested in the opening section, removal of pill and injectable subsidies would substantially reduce informal income to the current contraceptive supply system. Unfortunately, since most of the fees charged at any levels of the current system are purely informal, little is known about whom the beneficiaries are, much less how their disappearance would impact government distribution.⁷ This is a question that will need to be addressed in strategically targeting subsidy removals.

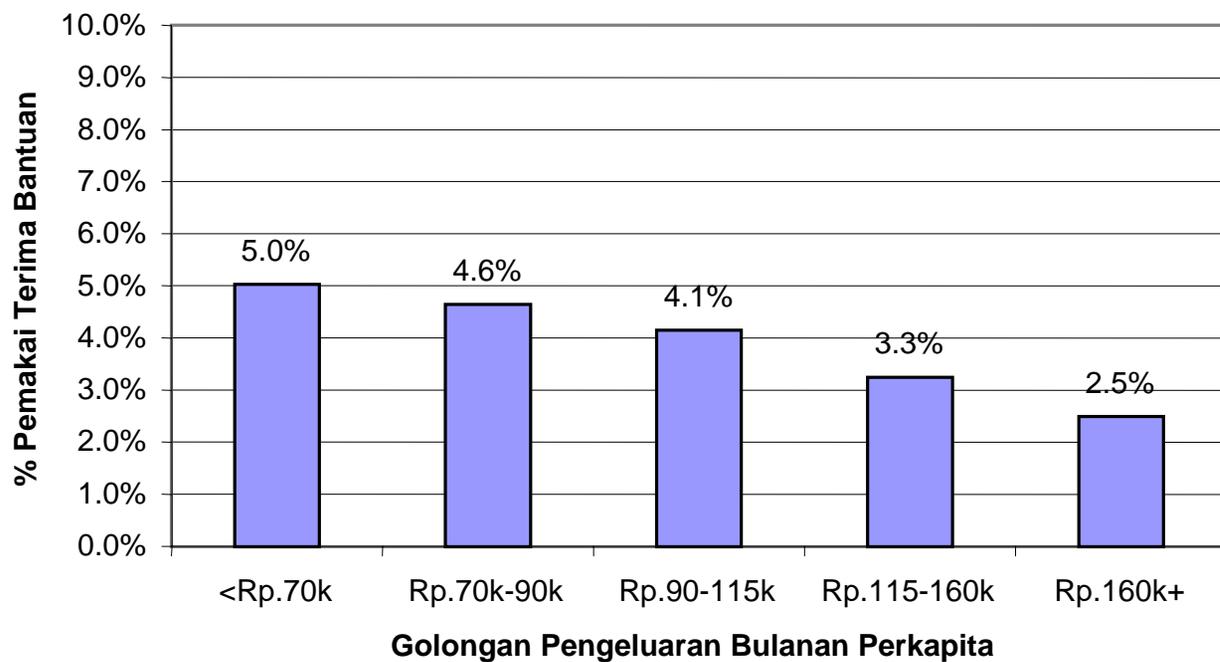
It should be noted that the price question used in the '99 Susenas was poorly formatted. To fit a large number of questions on to a single form, the costs of both contraception and births were coded in the same column of a grid. Consequently, prices were listed in thousands. For pills, half of which sell for under Rp.3,000, the rounding this requires can be a substantial portion of the contraceptive cost. Another issue is that

⁷ One exception is that PUSKESMAS registration fees of approximately Rp.500 are well institutionalized in most of the country. These fees typically provide revenues to the local governments. However, most of the revenues from contraceptive sales are well above these registration fees, and little is known about who benefits from these charges.

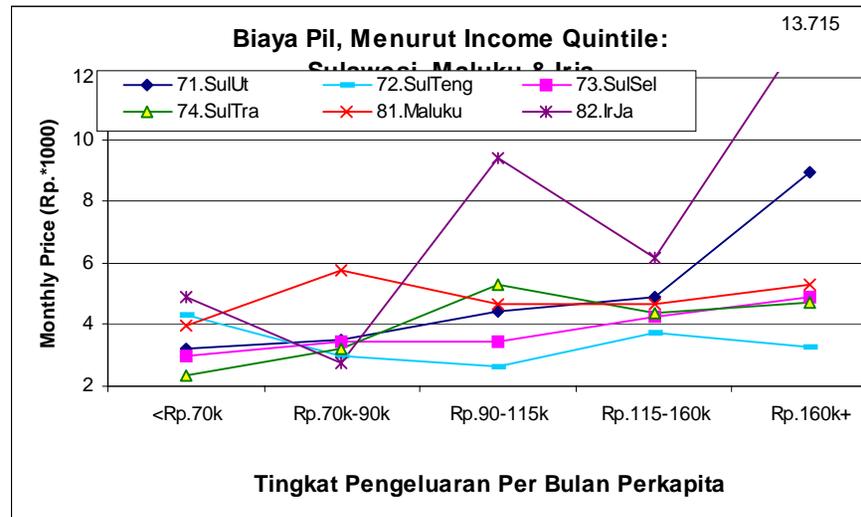
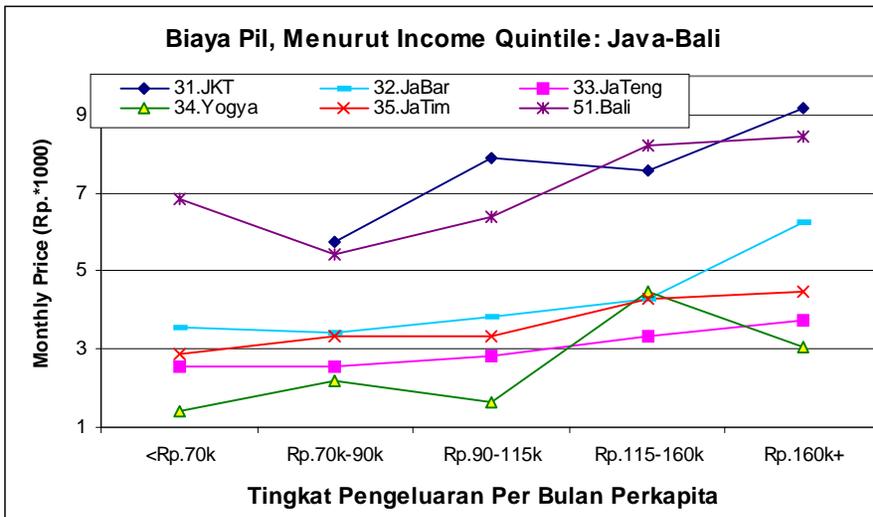
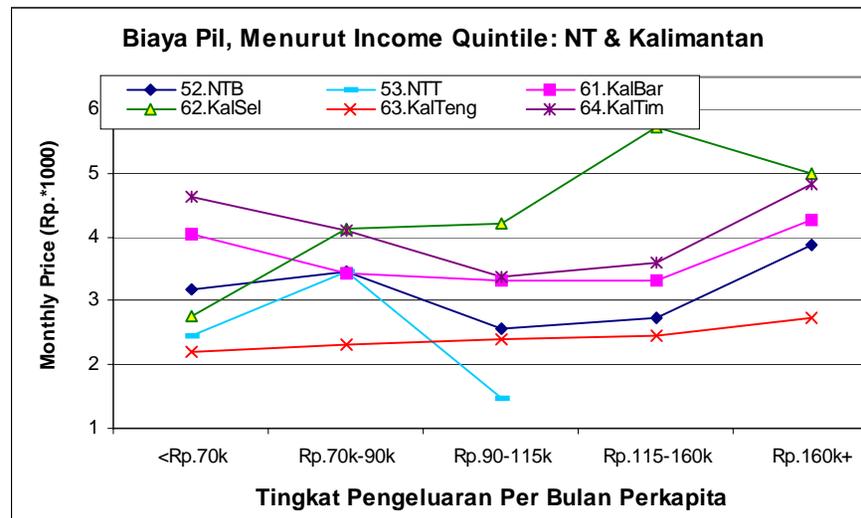
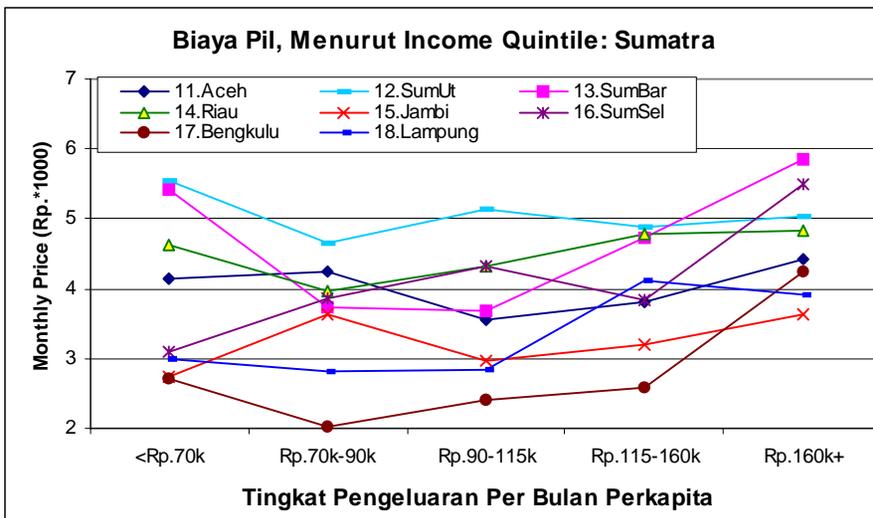
with this format, there is a greater risk of misstated prices. Since it is commonplace for clients who live far from their pill sources to buy three strips in a single visit, it is important that interviewers ensure that the prices quoted are per strip. In the DHS questionnaire, the expected units (i.e., per strip) are written next to the space in which prices are written. This appears to be a useful method to remind interviewers of this units problem. It is not clear how '99 Susenas grid approach influenced the frequency of misstated prices. In these analyses we simply assume that all pill prices are quoted in the correct units. We have no other recourse. It is possible, therefore, that some of the pill price increases are due to a misstated units problem.

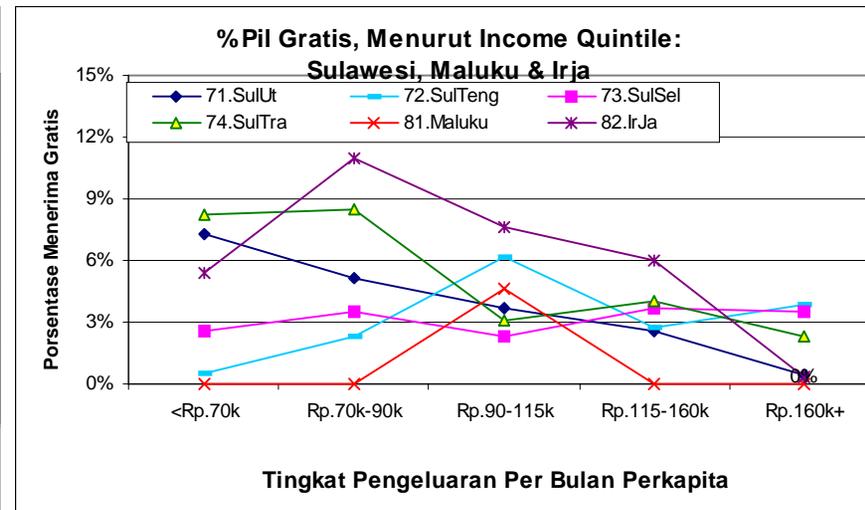
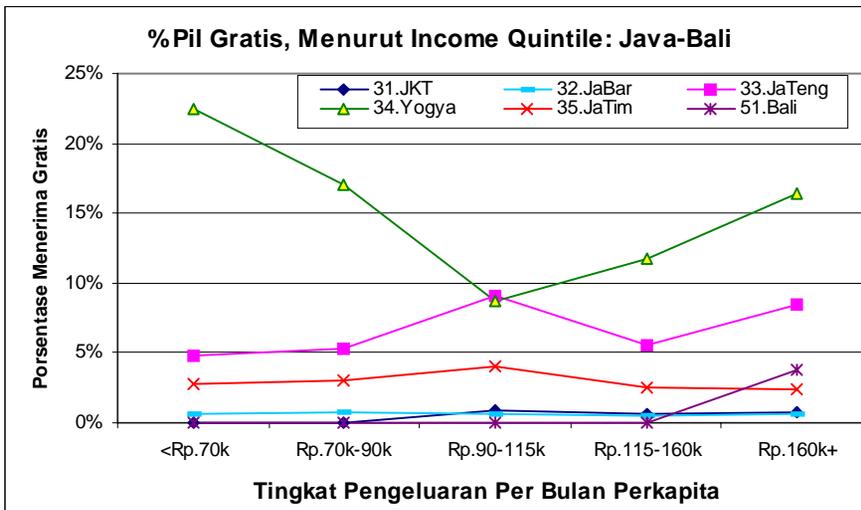
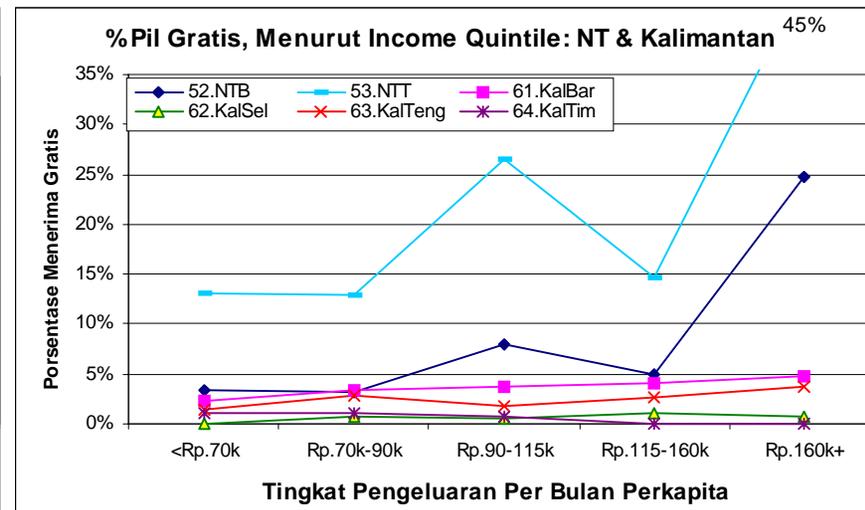
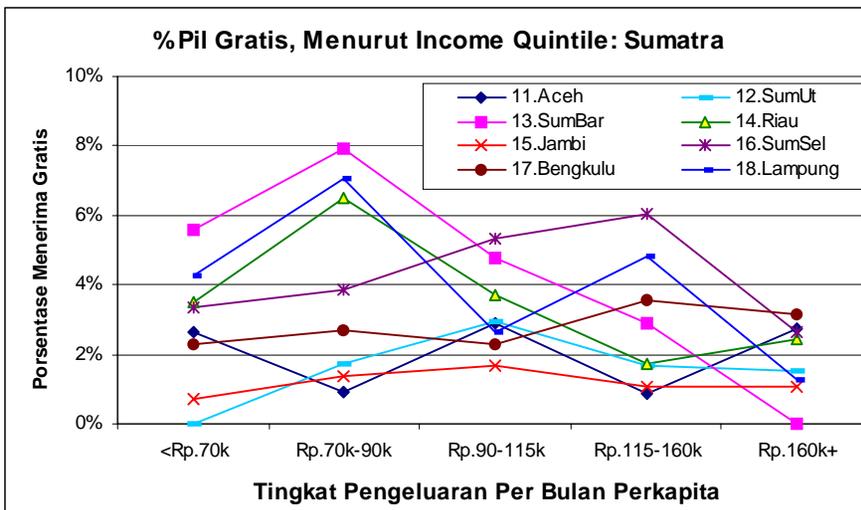
The next several pages display a variety of contraceptive price distributions that focus on the prices paid by the poor, vs. other economic groups. It turns out that in general, very few of the poor get free contraceptives, and that even the portions getting them at significant discounts is not very large. These results vary somewhat by province. NTT, for example, succeeded in keeping the prices of injectables very low throughout the crisis.

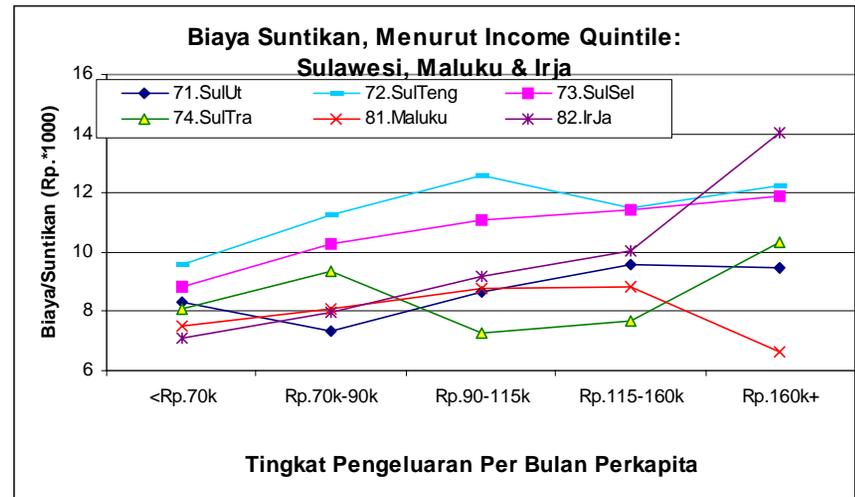
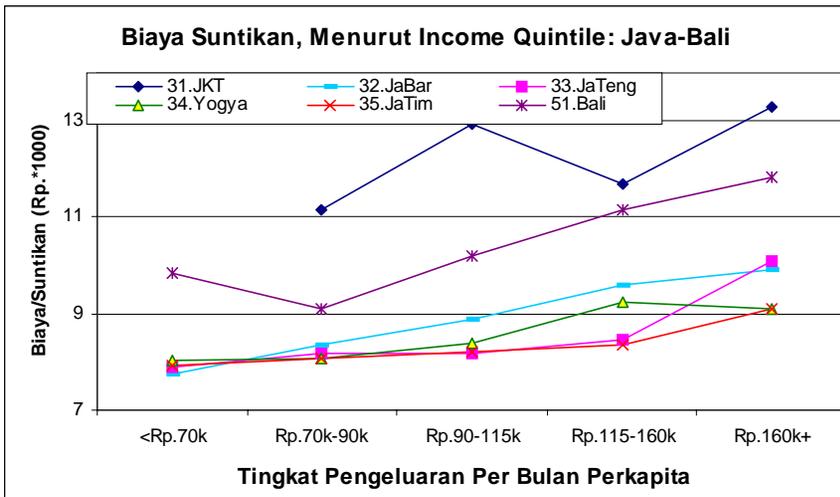
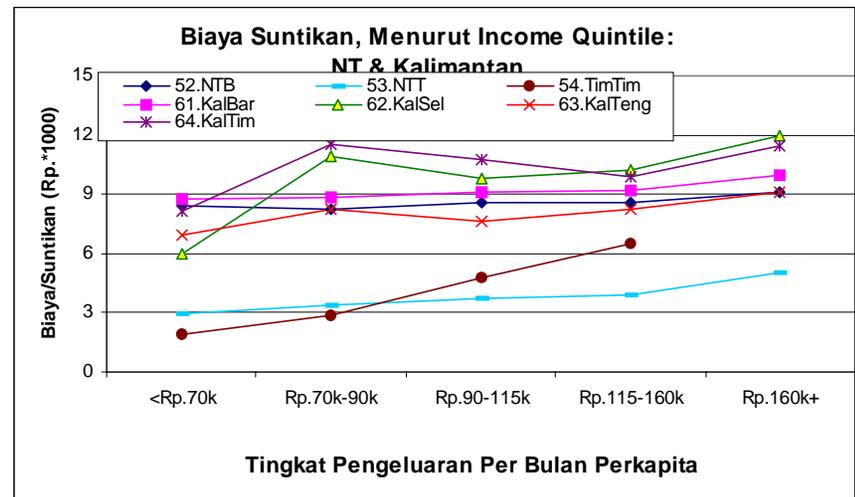
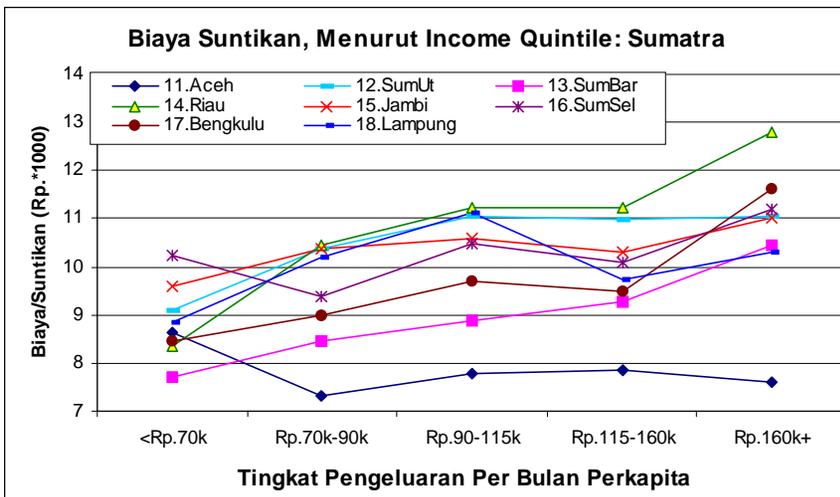
Bagan 3. % Yang Terima KB Tanpa Biaya Menurut "Income Quintile"

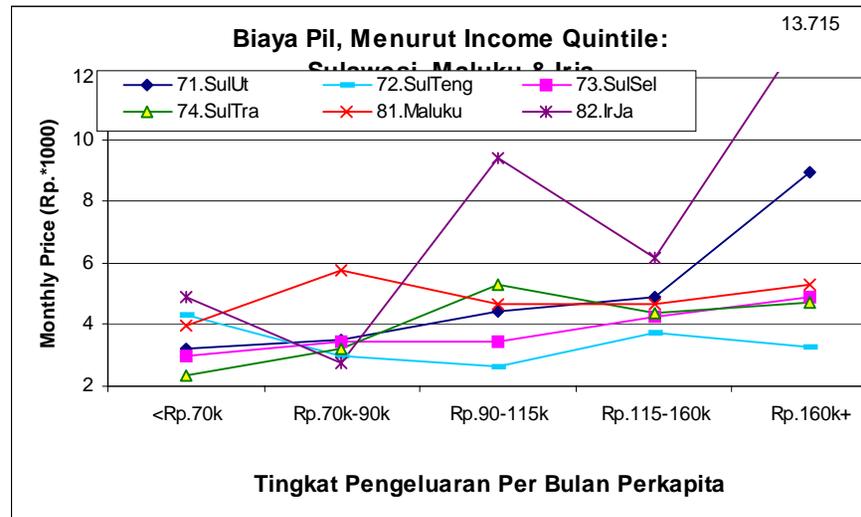
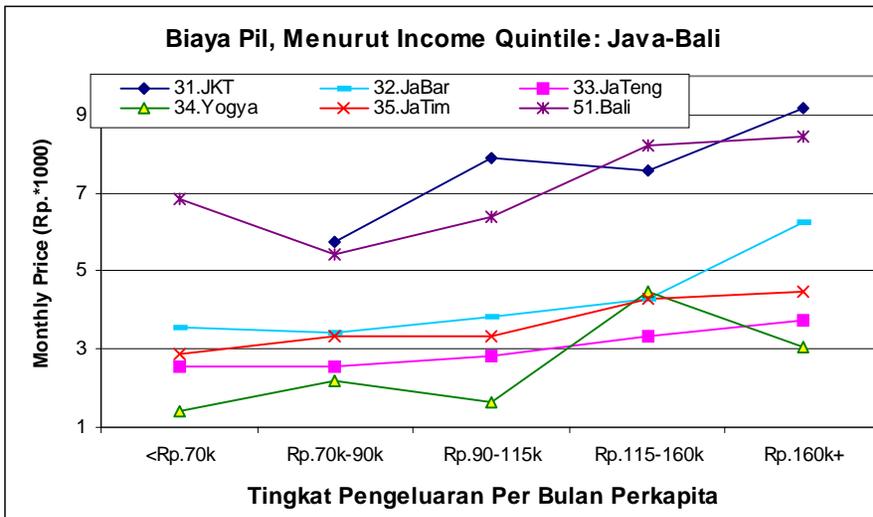
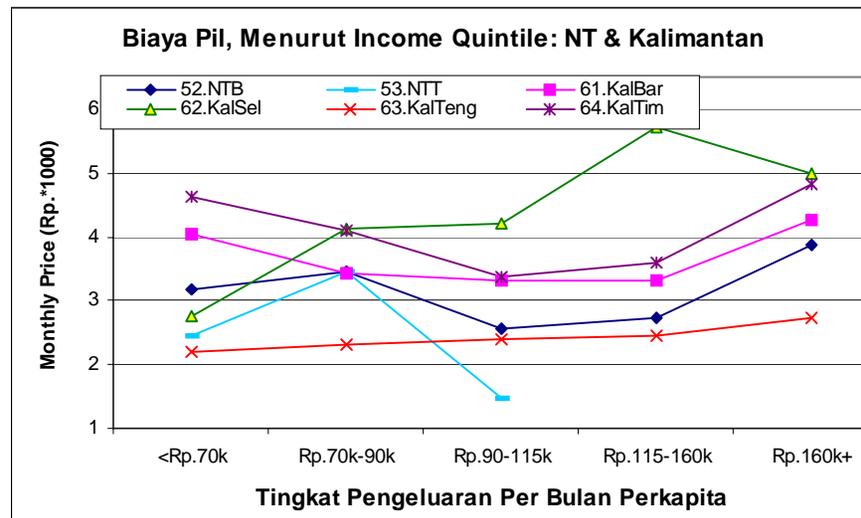
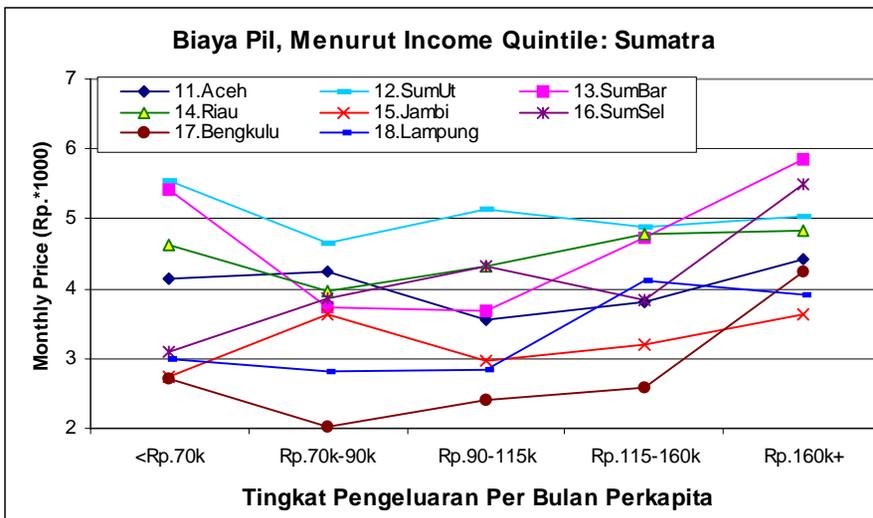


- a. by province, only a few do well at protecting the poor
- b. overall provincial price distributions









Policy Implications -- Current Budget Limitations

BKKBN's fiscal year 2000 budgets for contraceptive procurements are sufficient to pay for only about 13% of projected pill needs and 2.4% of injectable needs.⁸

Currently BKKBN has requested assistance from a consortium of international donors to make up their short-fall. The two largest proposed procurement contributions are in the form of loans from the World Bank and the ADB for \$15m [??? CHECK ON ACTUAL AMOUNTS]. These loans were initially proposed to facilitate Indonesia's recovery from the monetary crisis. But in light of the uncertain need for these contraceptives, it is not clear whether such loans are a productive investment for Indonesia.

Potential Responses

An obvious potential implication of these findings is that current BKKBN pill and injectable procurement targets are unnecessary. The current BKKBN distribution system does little to reduce consumers' pill and injectable costs,⁹ and even if BKKBN could more effectively reduce their costs to consumers, it would have little impact on prevalence.

But at least two issues may complicate this obvious implication. First, the revenues the current distribution system receives from the sales of government procured contraceptives are very large; perhaps their elimination could influence the ability of puskesmas or community-based distributors to support their outreach and promotion efforts. Second, although overall contraceptive price responses are low, among families and geographic regions where small family norms have not been institutionalized, access to a limited number of free contraceptives might still help BKKBN recruit new users. Even in many developed countries, efforts to promote contraceptive use (for example among high-risk women) are enhanced when providers can give an initial supply for free.

To respond to the first issue, there may be a need to directly support contraceptive distributors in areas where contraceptive revenues are currently used to support outreach efforts. But if there is a legitimate need, it should be documented, and budgets should be

⁸ This is based on projections made by BKKBN in preparation for the UNFPA-organized BKKBN Donor's Meeting, April 11 2000.

⁹ Except in selected provinces. See tables in Appendix for details.

allocated specifically for that. To respond to the second, there may remain limited conditions under which government procured contraceptives are productive investments because they influence acceptance. But the numbers involved must be much smaller than they are now, and very strict guidelines should be used in their planning and distribution.

In light of these and other issues, key priorities should be identified in determining how to respond to these new findings. Foremost among these is that BKKBN's primary objective should be the promotion of small, healthy and prosperous families. To that end, BKKBN would benefit from understanding where shifts to commercial distribution would be least disruptive to contraceptive prevalence, and shift in those areas first.

To do this, BKKBN should first review where the impacts of shifting to commercial distribution on consumer contraceptive prices are likely to be the lowest. Summary information on pill and injectable fees paid by consumers by province from the 1999 Susenas is displayed in Tables A1 and A2 in the appendix. These show that there is a large variation in the provincial proportions of users paying commercial-sector prices. In Jakarta, nearly 95% of users pay commercial sector prices, while in Yogyakarta, only 50% do. More detailed tabulations by kabupaten should also be generated before implementing major changes in the distribution system. These tabulations suggest that shifting to commercial distribution in those provinces where at least 80% of pill and injectable users now pay commercial-sector fees would reduce pill procurement costs by 50%, and reduce injectable procurements by 90%.

BKKBN may also want to evaluate the levels of revenues earned by providers and other contraceptive distributors, and determine how these revenues are spent. This could be done in the form of a survey of government contraceptive distributors. Such information should help identify where revenues from contraceptive sales are an important input to outreach and contraceptive promotion activities.

But in addition, such a survey may help identify regions where the use of revenues from contraceptive sales is least transparent. For such areas, BKKBN should be especially strategic, and ensure that their data collection system is timely and accurate. For these may be regions where institutional resistance to privatization may be most effective. Potential forms of resistance could include the disruption of commercial

distribution systems, or false reports to the media of disastrous consequences of commercialization. In either case, an effective and timely data collection system is essential to monitor what is actually happening, and to intervene, if necessary, to correct distribution problems.

On Protecting the Poor

The issue of protecting the poor has figured prominently in BKKBN's justification for continued procurements. It should not. BKKBN's current policy of trying to protect the poor by supplying them with free contraceptives is well intentioned, but ineffective and unnecessarily costly. It is ineffective for two important reasons. First, despite the most complete family-level data collection system in the country, BKKBN's Keluarga Sejahtera data collection system is not effective at targeting free contraceptives to the poor.¹⁰ This is not a criticism of the data collection system, only a practical acknowledgement. Even in countries with relatively complete income information, identifying who is poor is a tricky task; in Indonesia, where income estimates are a data-collector's nightmare, BKKBN's data collection objectives should be more realistic, and geared to questions it can and should answer.

Second, although the poor *are* more sensitive to contraceptive prices than the wealthy, the prices of even commercially provided pills are too low to have much impact on most, even on the poor. To put this into perspective, note that the average Indonesian poor family of four spends roughly Rp.240,000 per month on their total family expenditures. Even commercially distributed pills, the most expensive method commonly used, cost less than one percent of that. For households who understand the importance of family planning, such a small expenditure is rarely an impediment to use. Based on 1991 data, demand estimates suggested that less than 5% of poor users would stop using if prices rose to commercial distribution levels. But based on recent experience, that estimate is probably too low.

Government procurement and distribution of contraceptives can only be a productive investment if their distribution has substantial impacts on prevalence. But we

¹⁰ The 1999 Susenas data reveal that only 5% of users in the poorest quintile received free contraceptives and services, while 2.5% from the wealthiest quintile received them as well.

now understand that as a group the poor are not very price sensitive. So targeting free contraceptives to them, even if we could target them well, would not have much impact. Unless BKKBN can effectively target free contraceptives to a more price-responsive group, government contraceptive procurements will remain a questionable investment.

Conclusion

The 1997/8 monetary crisis has given BKKBN serious new budgetary problems, and a major windfall in the form of new information about contraceptive demands and distribution systems. The biggest budgetary problem shows up in the form of shortfalls for contraceptive procurements. According to UNFPA estimates, current procurement budgets are sufficient for only 13% of this year's pill and 2.4% of this year's injectable procurement needs. Donor support may help with this in the short-run, but BKKBN needs a more sustainable fix for the long run.

The major information windfall includes the following findings:

- **75% of contraceptive pill users now pay commercial-level prices (Rp.2,000 or more) for pill re-supplies**
- **80% of injectable contraceptive users now pay unsubsidized prices (Rp.6,000 or more) for their injections**
- **These price levels were reached with no major reductions in contraceptive prevalence.**

These new problems and new information give BKKBN a valuable opportunity, and strong motivation to shift most contraceptive procurements to the commercial sector. But as with any major policy change there are hazards along with the potentially large budget savings. So BKKBN should be strategic if it implements these changes. If donor contributions permit, they should be implemented in phases, targeting those areas where the impacts should be the smallest first, and learning from those areas how to implement them elsewhere.

If donor contributions and BKKBN budgets do not permit a phased implementation, then BKKBN should be especially careful to rigorously monitor the

effects of commercialization, and to have a coherent strategy for responding to the unavoidable problems with a newly implemented distribution system.

Policy Summary

- 1. Recent findings from the monetary crisis indicate that contraceptive distributions could be largely commercialized, with little effect on contraceptive demand. These findings are summarized as follows:**
 - a. 75% of pill users now pay commercial-level fees (Rp.2,000 or more) for pill re-supply;**
 - b. 80% of injectable users now pay commercial-level fees (Rp.6,000 or more) for FP injections;**
 - c. Despite the recent price increases, contraceptive prevalence has not been significantly affected;**
- 2. To help relieve current budget constraints, BKKBN should consider strategically shifting most contraceptive procurement and distribution to the commercial sector. To be strategic about this, BKKBN should make the following preparations:**
 - a. Determine how revenues from sales of BKKBN contraceptives are currently used;**
 - b. Where these revenues support critical FP field activities, consider budgeting these activities directly;**
 - c. Where the use of revenues are least transparent, be especially cautious of institutional resistance to commercialization;**
 - d. A timely, relevant and accurate data reporting system should be carefully monitored to identify problem areas where prices rise well above anticipated levels, or where contraceptive availability and choice are problematic;**
 - e. BKKBN should be prepared to conduct a reasonable number of rapid, qualitative field studies to quickly understand the sources of problems if and when they arise.**
- 3. BKKBN's policy of targeting free contraceptives to the poor has little effect on prevalence; it should be critically reviewed. It is ineffective for two key reasons:**
 - a. The current targeting and distribution system does not work well – it serves only 5% of the poor, yet it also serves 3-4% of the non-poor.**
 - b. Small family norms are already accepted by most of the poor, so that even commercial sector prices have only small impacts on the poor's contraceptive decisions.**

However, small quantities of free contraceptives may still be a useful tool for introducing FP in areas where small family norms have not been institutionalized. But to be more effective, BKKBN needs to determine which groups of potential users are likely to be recruited with free contraceptives, and how to target them well.

Data Appendix

Table A1, below, indicates the proportion of pill users in each province currently paying Rp.2,000 or more. If subsidies were removed from all provinces with 80% or more pill users paying private sector prices, 50% of pill users would be in provinces with no pill subsidies. Using these statistics I crudely estimate¹¹ this would reduce pill procurement requirements by 50%.

Table A1. Pill Users Paying Rp.2,000 or More, By Province

Province	% of Pill Users Paying Private Market Prices	# Pill Users in Province	% of National Pill Users	
31.JKT	94.6%	223,527	3.7%	3.7%
51.Bali	92.2%	28,586	0.5%	4.2%
12.SumUt	91.6%	291,725	4.9%	9.1%
62.KalSel	91.3%	116,398	1.9%	11.0%
14.Riau	91.2%	143,842	2.4%	13.4%
64.KalTim	90.5%	121,019	2.0%	15.5%
81.Maluku	88.1%	35,071	0.6%	16.0%
82.IrJa	87.9%	21,012	0.4%	16.4%
71.SulUt	87.0%	89,875	1.5%	17.9%
32.JaBar	86.9%	1,544,019	25.8%	43.7%
16.SumSel	82.0%	250,007	4.2%	47.9%
11.Aceh	81.7%	114,714	1.9%	49.8%
15.Jambi	79.2%	128,604	2.1%	51.9%
54.TimTim	78.8%	1,751	0.0%	51.9%
63.KalTeng	77.6%	221,662	3.7%	55.6%
74.SulTra	76.1%	37,779	0.6%	56.3%
61.KalBar	75.0%	182,580	3.0%	59.3%
13.SumBar	73.0%	61,482	1.0%	60.4%
72.SulTeng	73.0%	74,820	1.2%	61.6%
35.JaTim	72.2%	1,019,221	17.0%	78.6%
18.Lampung	68.2%	217,487	3.6%	82.3%
73.SulSel	67.6%	189,278	3.2%	85.4%
52.NTB	55.3%	79,975	1.3%	86.8%
53.NTT	54.8%	21,144	0.4%	87.1%
33.JaTeng	53.2%	682,366	11.4%	98.5%
17.Bengkulu	50.6%	60,130	1.0%	99.5%
34.Yogya	50.5%	29,108	0.5%	100.0%

¹¹ This estimate assumes that BKKBN procurements are proportional to the number of users. A more accurate estimate would adjust for different procurements per user, by province.

A similar tabulation can be done for injectable users. In Table A2 we can see that using a cut-off of 80% privately financed (i.e., price \geq Rp.6,000), 17 provinces, and over 90% of injectable users could be supplied through the private sector.

Table A2. Injectable Users Paying Rp.6,000 or More, By Province

Province	% Injectable Users Paying Private Prices	# of Injectable Users	% of National Injectable Users	
51.Bali	90.8%	93,657	20.0%	20.0%
33.JaTeng	88.7%	1,347,785	1.0%	21.0%
17.Bengkulu	87.6%	65,556	2.6%	23.6%
18.Lampung	87.4%	171,838	0.9%	24.5%
34.Yogya	86.8%	58,600	3.9%	28.3%
16.SumSel	86.2%	261,810	1.3%	29.7%
15.Jambi	86.1%	90,273	4.5%	34.2%
31.JKT	85.7%	302,580	17.9%	52.1%
35.JaTim	85.6%	1,202,438	3.4%	55.5%
12.SumUt	84.9%	227,827	1.5%	57.0%
52.NTB	84.9%	103,525	25.5%	82.5%
32.JaBar	84.5%	1,713,330	1.7%	84.2%
14.Riau	83.2%	114,752	1.0%	85.2%
64.KalTim	83.0%	68,145	1.9%	87.1%
13.SumBar	83.0%	127,506	1.7%	88.8%
73.SulSel	81.1%	115,387	1.6%	90.4%
61.KalBar	80.3%	105,433	0.7%	91.1%
72.SulTeng	78.5%	49,699	1.0%	92.2%
63.KalTeng	76.7%	68,950	0.9%	93.1%
62.KalSel	72.2%	62,802	1.3%	94.4%
71.SulUt	71.3%	86,527	1.3%	95.7%
11.Aceh	70.8%	89,467	0.4%	96.1%
82.IrJa	66.2%	26,678	0.8%	96.9%
81.Maluku	61.2%	51,062	0.4%	97.3%
74.SulTra	60.9%	29,654	0.1%	97.5%
54.TimTim	14.8%	9,968	1.1%	98.6%
53.NTT	10.4%	77,229	100.0%	198.6%