

Challenges Facing Family Planning Clinics And Title X

The Title X family planning program, and the entire U.S. network of family planning clinics, currently face enormous challenges. Rising costs of contraceptives and of state-of-the-art medical technology, as well as the managed care revolution and an increasingly uninsured clientele, complicate the delivery of services to existing clients. At the same time, family planning clinics are being asked to provide a more comprehensive range of services to women, to broaden their outreach to men and to close access gaps among those women who are the hardest and most expensive to reach and serve. Meeting these substantial challenges requires a renewed political and financial commitment to publicly subsidized family planning services—one that is long overdue.

By Cynthia Dailard

In 1970, Congress enacted Title X of the Public Health Service Act, the only federal program—then and now—devoted solely to the nationwide provision of family planning services. Introduced with bipartisan support and signed into law by President Nixon, Title X was designed to make contraceptive supplies and services available to all who want and need them but are unable to afford them without government assistance. The new program sought to fulfill Nixon’s historic 1969 promise that “no American woman should be denied access to family planning assistance because of her economic condition.”

Thirty years after its enactment, the Title X program remains the centerpiece of the U.S. family planning effort. By supporting the clinic infrastructure and clinics’ operating budgets, Title X enables them to draw on other sources of revenue for family planning, such as Medicaid reimbursements and state appropriations. Together, these funds support more than 7,000 family planning clinics nationwide, more than 4,500 of which receive Title X funds. Of the 6.5 million women who

receive subsidized family planning services each year, two-thirds do so at a Title X–supported clinic.

In addition to providing high-quality, affordable family planning services to low-income women, many of whom are uninsured and who would have no other source of care, Title X also established a set of principles that guide the ethical delivery of those services. Those principles require that services be voluntary, confidential and affordable. Accordingly, women must be offered a broad range of contraceptive methods (including natural family planning), and may not be pressured to accept a particular method or any method at all; confidentiality must be guaranteed, even to teenagers (although clinics are required to encourage parental involvement); and services must be offered free of charge to clients with incomes below the federal poverty level (who comprise two-thirds of clients of Title X–supported clinics), and on a sliding fee scale for clients with incomes between 100% and 250% of poverty. (Women with higher incomes pay the full cost of their care.)

Program guidelines specify the range of services to be delivered to women who visit Title X–supported clinics. These include pelvic and breast examinations, blood pressure checks, pregnancy tests, Pap smears and, as indicated, tests for sexually transmitted diseases (STDs) and HIV. The Title X statute specifies that program funds cannot be used for abortion, but that a pregnant woman must be offered “nondirective counseling” about all of her options, “including prenatal care and delivery; infant care, foster care or adoption; and pregnancy termination.”

Title X has been enormously successful in helping American women plan their births and avoid one million unintended pregnancies each year, thus improving the public health (“Title X: Three Decades of Accomplishment,” *TGR*, February 2001, page 5). Yet despite these significant accomplishments, the Title X program—as the central legislative vehicle controlling U.S. family planning policy—has been besieged both politically and financially for most of its life. Funding for the program grew rapidly in the 1970s, as clinics proliferated throughout the country; however, in 1981, shortly after taking office, President Reagan tried to repeal Title X entirely and to send federal family planning funds—and policymaking authority—to the states. While Congress rejected the president’s block grant proposal, retaining Title X as a discrete federal program came at the price of a steep funding cut.

The 1980s saw further controversy emerge when social and religious conservatives began alleging that the very availability of family planning services promoted promiscuity and abortion, and that the provision of confidential services to teenagers encouraged the circum-

vention of parental authority. These controversies, which remain alive today, helped keep funding low throughout the decade. During the 1990s, appropriations began to rise again, but the program never regained the ground it lost during the previous decade. In fact, taking inflation into account, the \$254 million in FY 2000 funding is 58% lower than the \$162 million appropriated in 1980, the final year of the Carter administration. Had spending kept pace with inflation, the program would be funded at \$564 million today.

As a result, family planning providers have struggled on shoestring budgets for two decades to maintain their ability to provide high-quality contraceptive and related preventive health care to as many lower-income women as possible. Today, family planning clinics face greater challenges than ever before due to the rising costs of services and supplies and to changes in health care delivery and financing. These costs are rising just when clinics are being asked to do even more than in the past to improve women's health and to help couples have the number of children they want at the time they feel best able to care for them.

Maintaining Quality

Perhaps the greatest difficulty facing the clinics today is maintaining contraceptive choice—as required by the Title X statute and by medical ethics—in the face of rapidly escalating costs. Historically, Title X clinics purchased contraceptive supplies, notably oral contraceptive pills, from manufacturers at a nominal or low cost. These costs have risen over time, straining clinics' budgets for contraceptive supplies. Financial demands ballooned with the introduction of long-lasting hormonal methods, such as the contraceptive implant, Norplant, and the injectable, Depo-Provera, which have extremely low failure rates but high up-front costs.

For example, women who visit Title X clinics are increasingly requesting Depo-Provera, an injection that remains effective for three months. Introduced into the U.S. market in 1993 and now used by almost one in five women who receive a method from a Title X-supported clinic, the injectable is popular among women who do not want to have to remember to take a pill every day or to use a method at intercourse. Many experts believe that growing reliance on the injectable among high-risk adolescents is one factor responsible for declining rates of teen pregnancy in this country (particularly among those teenagers who have already had a child).

But a clinic can provide three women with an annual supply of oral contraceptives for less than the cost of providing one woman with the injectable for a year. This has forced some clinics to create waiting lists for the method or to cap the amount of money they will

spend on the product. As a result, many clinics are caught between their commitment to offer women a true choice of contraceptives and the realities of what their budgets can afford.

Skyrocketing costs associated with new pharmaceuticals and screening and diagnostic technologies also hamper clinics' efforts to offer their clientele state-of-the-art care. Examples include newer, more powerful antibiotics that can aid in the treatment of STDs, as well as a new DNA-based test for chlamydia that is extremely accurate and easy to use. Yet these options are expensive and offering them may be financially prohibitive for some clinics. Additionally, the new Thin Prep test for cervical cancer and the Digene human papillomavirus test promise improved detection rates for cervical cancer, but often at twice the cost of traditional Pap smears.

Hiring qualified health care personnel poses another major challenge for family planning clinics. Historically, Title X funds supported accreditation programs for nurse practitioners to specialize in women's health, helping to ensure that clinics were appropriately staffed. In fact, between 1972 and 2000, Title X funds were used to provide such training to more than 5,000 nurse practitioners. As a result, nurse practitioners have become the primary providers of Title X-supported services, accounting for an estimated 80% of the services rendered each year. This specialized training of nurse practitioners facilitated the expansion of Title X-supported services into rural and other underserved areas, and often trained individuals who lived in the communities that the clinics served. The training program, however, was recently phased out by the Department of Health and Human Services and was replaced by a more general training program that many in the field believe will not adequately meet clinics' staffing needs. As a result, Title X clinics may find it increasingly difficult—and therefore expensive—to attract and retain qualified family planning providers who have the specialized training necessary to serve the complex needs of an increasingly diverse and often high-risk patient population.

Managed Care and Insurance Trends

The rapid growth of managed care over the last decade—particularly of managed care plans that cover Medicaid recipients—has had significant financial implications for Title X clinics. Between 1988 and 1999, the proportion of individuals with private-sector, employment-based health insurance who were enrolled in managed care plans rose from 29% to 91%. The proportion of Medicaid recipients who were enrolled in managed care rose as well during that time, from 9% to 56% (see related story, page 5).

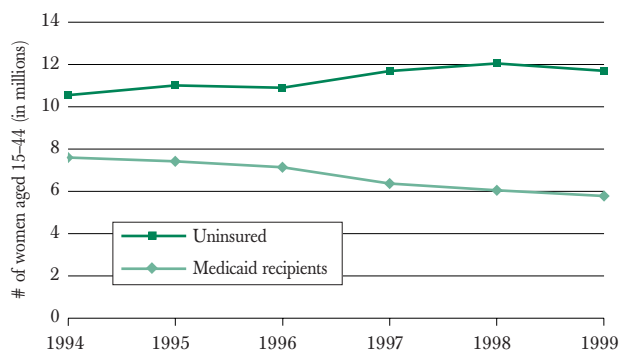
Most family planning clinics, however, have not been able to integrate themselves into managed care networks. In 1999, approximately one-half of all agencies that operated family planning clinics had negotiated a contract to provide contraceptive services to managed care enrollees. This situation has resulted in two inter-related problems for clinics without such contracts: If clients with a source of third-party reimbursement go to their plan's provider rather than to a clinic for family planning care, they draw away a potential source of clinic revenue. But if they seek services from family planning clinics that are not in their plan's network (which some women do because they have a long-standing relationship with the clinic or have concerns about confidentiality), the clinics often receive no reimbursement for the services they provide.

Clinics are also feeling the impact of overall trends in insurance coverage. The number of Americans without any health insurance—public or private—has increased by nine million over the last decade, to an estimated 43 million. Among women of reproductive age, the number of uninsured rose by 1.2 million between 1994 and 1999 (see chart). As many as three in 10 women in their 20s—the peak years for both childbearing and the need for contraception—are uninsured.

Many of the uninsured are low-wage workers whose employers do not offer coverage, or who cannot afford coverage even when it is available because employers ask them to contribute a growing share of steadily rising premiums. And even if women have private insurance, their plans may fail to provide comprehensive coverage of contraception or may have high copayments and deductibles (“The Need for and Cost of Mandating Private Insurance Coverage of Contraception,” *TGR*, August 1998, page 5).

INSURANCE TRENDS

The number of women uninsured has risen as the number covered by Medicaid has fallen.



Source: The Alan Guttmacher Institute (AGI), special tabulations from U.S. Census Bureau Current Population Surveys, March 1995–2000.

Still other women are uninsured because they have lost their Medicaid coverage in the wake of federal welfare reform. Although welfare reform specified that families who meet a state's Medicaid eligibility requirements that were in place prior to welfare reform would remain eligible for Medicaid even if they no longer qualified for cash assistance, many Medicaid-eligible families are nevertheless not enrolled: The number of women of reproductive age who are enrolled in Medicaid fell by 24% between 1994 and 1999—from 7.6 million to 5.8 million. Additionally, women who lose their Medicaid coverage as the result of moving from welfare to work often are employed in low-wage jobs with no employer-sponsored health care benefits. Overall, the increasing number of uninsured clients places a particularly tight squeeze on Title X dollars, since many uninsured women, including most women who lose their Medicaid coverage, are eligible by virtue of their low incomes for subsidized—and in many cases, entirely free—services under Title X.

Expanding Service Delivery

At a time when family planning providers are operating under enormous financial constraints, they are also being pressed to expand their service delivery in ways that may be new and exciting but that nonetheless place further pressures on Title X funds. For example, family planning providers—and their clients—increasingly view contraceptive services in the context of women's overall reproductive health care needs; accordingly, clinics are working to be more responsive to the needs of women throughout their life span rather than just during the childbearing years. With the goal of moving toward more efficient, convenient and coordinated care, these clinics are starting to offer specialized gynecologic care, routine primary care and comprehensive STD services—including enhanced HIV prevention and counseling, given the growing number of women who are infected with or at risk of acquiring the virus. Providers are also beginning to realize their vision of offering screening for breast and reproductive tract cancers and other gynecologic services to postmenopausal women. At the same time, clinics are attempting to better serve pregnant women who seek comprehensive prenatal care or in-depth adoption counseling.

Additionally, family planning providers are taking the major step of expanding services to men. Historically, family planning clinics have had relatively few male clients. Clinic personnel have tended to view men solely in their role as partners of women, and services for men were largely limited to encouraging men to use condoms and to testing and treating the partners of female clients infected with or at high risk of contracting STDs.

Now, however, family planning providers are considering men's reproductive health needs in a broader con-

text and are expanding their efforts to reach and serve them. Clinics are beginning to offer a package of medical and counseling services that are specifically designed to address men's own reproductive health needs. At the same time, clinics are providing counseling services to address the role that men play in decision-making about contraception, and to promote responsible sexual behavior among teenage males that will last throughout their lives.

Even as Title X providers broaden their public health focus and begin serving men, they are intensifying their efforts to reach out to populations of women in need of subsidized family planning services who still face barriers to obtaining care. Among these women are the more than one million with incomes of less than 250% of poverty who have made no recent family planning visit and who do not use contraceptives, even though they are at risk of unintended pregnancy. Some of these women—such as those who abuse drugs or alcohol, are prisoners or are homeless—may be at high risk for HIV infection, mental illness and sexual exploitation, and yet are often beyond the reach of the mainstream health care system. Such women can be hard to locate, difficult to serve, or sometimes both. Often they need a wide range of sophisticated health and social services. They also may be immigrants who are not fluent in English, and cultural factors may shape their attitudes toward contraceptive use and their interactions with family planning providers. All in all, reaching out and serving these subgroups of women, and developing the expertise required to do so competently and effectively, is a time-consuming and expensive proposition.

The Road Ahead

A key obstacle to surmounting these financial and programmatic difficulties has been the enormous political challenges that have long threatened the very existence of the program. These political assaults have largely stemmed from two controversies related to the program's perceived but unfounded relationship with teenage sexual activity and abortion.

Opponents of Title X have long argued that providing confidential services to teenagers encourages them to be sexually active, despite the fact that the average teenager does not visit a family planning provider until 14 months *after* she has become sexually active. And rather than promoting sexual activity among teenagers, family planning has played a major role in helping to reduce the teen pregnancy rate in this country: Research shows that three-quarters of the decline in teen pregnancy rates between 1988 and 1995 was due to improved contraceptive use among sexually active teenagers; one quarter was due to increased abstinence.

Title X opponents also charge that the availability of publicly funded contraceptives results in more abortions by encouraging sexual promiscuity, and that family planning providers have a vested interest in encouraging women facing unintended pregnancies to seek abortions. These attacks persist despite the evidence that subsidized family planning services—and Title X in particular—help *reduce* the need for abortion by enabling women to avoid unintended pregnancies.

To date, the Title X program has been remarkably resilient in withstanding repeated political attacks. Yet in order for family planning clinics to meet the challenges of the present and future—and indeed to just maintain the gains of the past 30 years—there is a need to move beyond the politics that have plagued the program for so long and to acknowledge Title X's distinct and important role in improving the public health by reducing rates of unintended pregnancy, abortion and teen pregnancy. Equally important is to acknowledge those aspects of the program that have led to its success—namely, the national standards and patient protections that ensure that women visiting Title X-supported clinics receive a broad package of confidential, high-quality, affordable services and a full choice of contraceptive methods. Such a renewed political and financial commitment to publicly funded family planning services is long overdue. ☩

This article is adapted from The Alan Guttmacher Institute (AGI) report, Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics. Research for the report was supported in part by the US. Department of Health and Human Services under grant FPR000072-01. The report and its distribution were also supported by a grant from the Open Society Institute. The conclusions and opinions expressed in this article are those of the author and AGI.