Fulfilling the Promise

Public Policy and U.S. Family Planning Clinics

The Alan Guttmacher Institute

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The Alan Guttmacher Institute

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Introduction

Today,...political assaults confront the U.S. family planning clinic system as it stands at a crossroads.

For most of our nation's history, family planning was not considered a proper topic for public discussion, and government support in this area was largely unthinkable. That situation began to change at an extraordinary pace in the 1960s. The oral contraceptive burst onto the U.S. market in 1960, and it was immediately adopted by large numbers of American women who wanted a safe, reliable and convenient means to control their childbearing. In 1965, the Supreme Court recognized the constitutional right of married couples to use contraceptives[1] (a right that was extended to single persons in 1972[2]). Also in 1965, the federal government issued its first grants to subsidize family planning services for low-income women as part of its War on Poverty. By 1970, a national law devoted solely to family planning had been enacted.

The goal of the new law, Title X of the Public Health Service Act, was ambitious: to "assist in making comprehensive, voluntary family planning services readily available to all persons desiring such services."[3] Its enactment sprang from a fundamental recognition that absent government support, only women who could afford a visit to a private physician and the method the physician prescribed would benefit from the new era of modern contraception.

As envisioned, the funding made available under Title X resulted in the rapid proliferation of family planning clinics across the country. By the late 1970s, a network of clinics covered the vast majority of U.S. counties. Over the years, these clinics have provided services to many millions of women—some 6.5 million in 1997 alone.[4] Women served by the clinic system are generally young, and they overwhelmingly have very low incomes. Those who are employed often work at entry-level jobs that offer no health benefits. Many are still in school or are young parents struggling to make ends meet. For substantial numbers of women, a family planning clinic is their only source of health care.

Family planning clinics are a place where women can not only get confidential, sensitive contraceptive counseling and choose from a wide range of methods, but also obtain other important preventive health services. As a result, the clinic network has become an integral part of the American health care system, serving as a major source of Pap smears, breast and pelvic examinations, and screening and treatment for sexually transmitted diseases, as well as contraceptive services and supplies.

The ongoing impact of publicly funded family planning services on the lives and well-being of American women and their families is nothing short of stunning. Each year, subsidized family planning services help American women avoid 1.3 million unintended pregnancies (Chart 1); without this support, the U.S. abortion rate would be 40% higher than it is, and the teenage birthrate would be 25% higher.[5] The widespread availability of family planning services has improved the public health and allowed millions of couples to take advantage of economic opportunity that might not be available to them absent the ability to decide

1960

The Food and Drug Administration (FDA) approves oral contraceptives and the IUD for use in the United States.

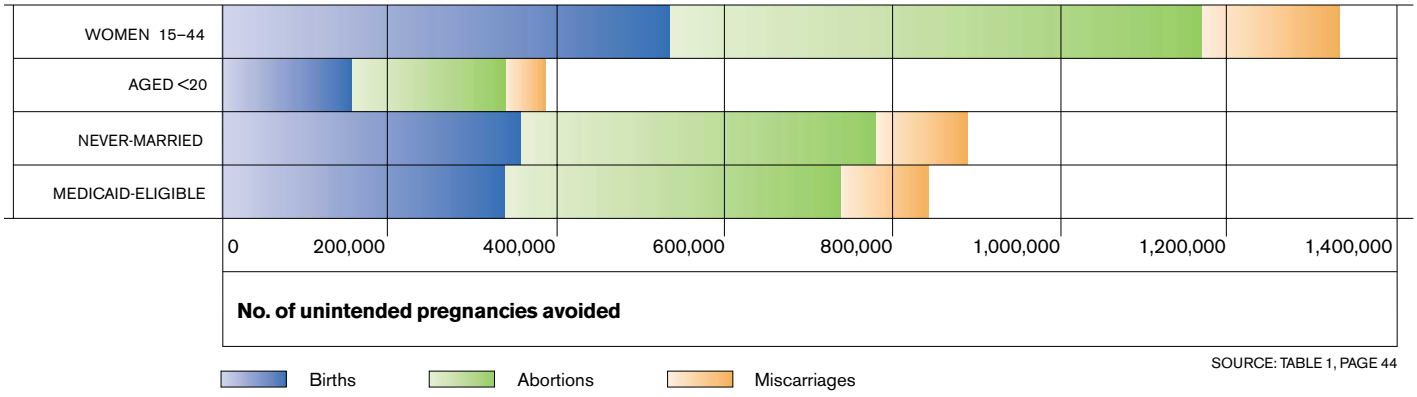
whether and when to have children.[6] And all of this has brought about significant savings: For every dollar that the federal and state governments spend on family planning services, three dollars are saved in Medicaid costs for pregnancy-related and newborn care.[7]

These accomplishments, considerable by any measure, are especially impressive because they have occurred in the face of political controversies that have plagued the family planning effort since its inception. In the earliest days, the challenge—particularly in light of the Catholic Church's potent opposition to "artificial" methods of family planning—was to overcome the perception among legislators and public officials that government involvement in family planning was dangerous political territory. Two major developments of the 1970s invited new controversies that continue today. One was that an increasingly sexually active teenage population came to rely on clinics for confidential contraceptive services. The other was that abortion was legalized nationwide as the result of the Supreme Court's 1973 decision in *Roe v. Wade*.[8]

Social and religious conservatives have kept these issues at the center of the debate about subsidized services for a quarter of a century. They argue that the very availability of family planning services undermines family values and parental control and thereby promotes promiscuity. Inevitably, they say, the result is increased levels of nonmarital sex and teenage pregnancy, as well as women's use of abortion.

Today, these political assaults confront the U.S. family planning clinic system as it stands at a crossroads. The need for clinics remains as strong as it has ever been, with millions of women relying on them for family planning and related health care. Yet clinics face enormous programmatic challenges to delivering high-quality services to all those in need—challenges presented by rising costs associated with new contraceptive methods and medical technology, changes in health care delivery and financing, and a growing uninsured population.

Chart 1. **Publicly supported family planning services help women avoid 1.3 million unintended pregnancies each year—and the births, abortions and miscarriages that would follow.**



SOURCE: TABLE 1, PAGE 44

1961

President Kennedy defines population growth as a "staggering problem" and formally endorses research aimed at making more contraceptive methods available worldwide.

At the same time, family planning providers have a tremendous opportunity—and, indeed, an obligation—to build on the accomplishments of the past 30 years. They are uniquely positioned to close remaining gaps in access to care, offer a more comprehensive range of reproductive health services to women, reach out to men and, ultimately, improve couples' success at having the number of children they want at the times they feel best able to care for them. But realizing these goals will not be possible without renewed political commitment.

This changing social, political and economic landscape invites a comprehensive look at the nationwide network of family planning clinics. Reviewing why and how this network has developed over time, how it functions and what it has accomplished is a major purpose of this report. An even more important purpose, perhaps, is to identify and outline—for both service providers and policymakers—some of the challenges and opportunities that lie ahead. By doing so, this report aims to help the clinic network to fulfill the promise of public support for family planning initiated three decades ago, a goal toward which so much progress has been made.

1963

The National Institute of Child Health and Human Development is established, in part to support and oversee contraceptive research and development.

CHAPTER 1

Origins of the U.S. Family Planning Clinic Network

Women face the possibility of having children for many years of their life. In this country, however, most want only two children.[1] To achieve this goal, the typical American woman spends roughly three decades—or about 75% of her reproductive life (Chart 2)—trying to avoid unintended pregnancy.[2]

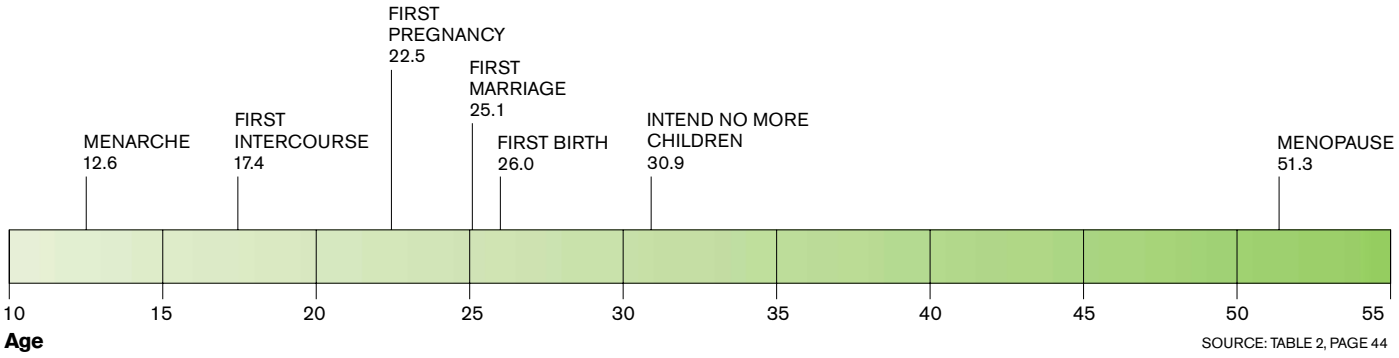
Contraception is key to helping women and their partners realize their family-size goals: Some of the most widely used contraceptive methods reduce the risk of unintended pregnancy by more than 90% (Chart 3).[3] In fact, the likelihood of pregnancy in the absence of contraceptive use is so great that the 7% of American women aged 15–44 using no method while at risk of unintended pregnancy account for nearly half (47%) of all unintended pregnancies (Chart 4, page 12).[4] (Women are considered to be at risk of unintended pregnancy if they are sexually active, fecund and not pregnant, postpartum or seeking pregnancy.)

While most sexually active women rely on contraception to prevent unintended pregnancy, access to contraceptive services—like access to other health care services—has not been equally available to all segments of American society. Historically, women who have the fewest financial resources or are marginalized within society—because they are poor, belong to racial or ethnic minority groups, are immigrants or are young—have been the least able to access or afford family planning care without outside assistance. Yet it is precisely these women for whom the consequences of unintended pregnancy can be most severe.

A Consensus Emerges in Favor of Government Involvement in Family Planning

Forty years ago, the development of increasingly effective and convenient methods of contraception made the prospect of fertility management a reality for the growing majority of American couples who wanted small

Chart 2. **The risk of pregnancy spans many decades of a woman's life.**



SOURCE: TABLE 2, PAGE 44

1965

The Office of Economic Opportunity funds the first federal family planning grants; the Supreme Court strikes down a state law that prohibits the use of contraceptives by married couples *(Griswold v. Connecticut);* the Social Security Act is amended to create Medicaid, under which states may claim reimbursement for family planning services.

families. Contraceptive use grew throughout the 1960s, but many women continued to have more children than they desired—especially if they had low incomes (Chart 5, page 13). Groundbreaking research showed that inequitable access to contraceptives, not a preference for more children, was largely responsible for the differences between lower- and higher-income women's ability to have the number of children they wanted.[5]

At the same time, researchers were beginning to understand the substantial and far-reaching consequences that unintended pregnancy could have for women, families and society at large. They were learning that unintended childbearing—particularly among teenagers—increased women's risk of living in poverty and relying on public assistance, and reduced their ability to participate in the work force or complete an education.[6] And they began to recognize that closely spaced births and childbearing very early or late in the reproductive years could lead to adverse health outcomes for both mothers and their children.[7]

Over the course of the 1960s, a broad-based consensus emerged that helping low-income couples have the small families they desired by equalizing access to contraceptive services would further two important goals: alleviating poverty and improving the health of women and children. The government's involvement in family planning grew out of these distinct, but related, objectives.

Initial government-funded family planning efforts had their roots in the antipoverty programs of the War on Poverty in the 1960s. In 1965, the Office of Economic Opportunity (the federal agency then responsible for promoting community-based poverty prevention programs) made the

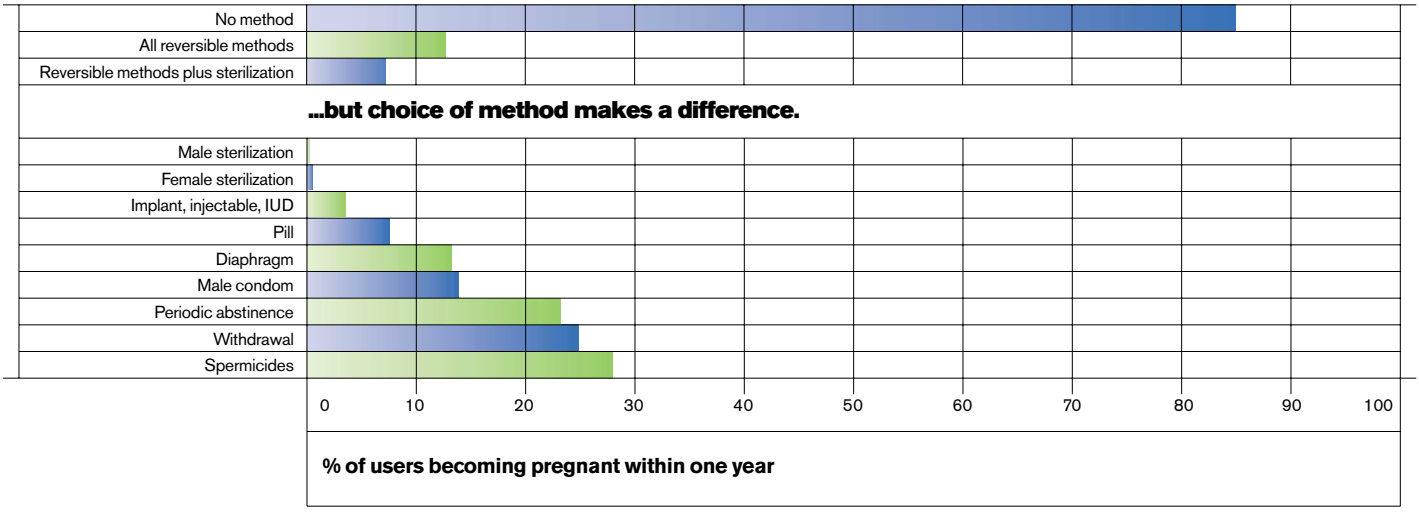
Defining Poverty Status

□ In this report, "poor" is defined as having an annual family income below the federal poverty level for a given year. For example, in 1995, the federal poverty level was $7,470 for a single person, $10,030 for a family of two and $12,590 for a family of three. In 2000, these levels were $8,350, $11,250 and $14,150, respectively.

□ "Low-income" is defined as having a family income that is 100–249% of the federal poverty level. For a single person, this meant a range of $7,470–18,674 in 1995 and $8,350–20,847 in 2000.

□ "Higher-income" is defined as having a family income at or above 250% of poverty—for a single person, $18,675 or more in 1995 and $20,875 or more in 2000.[1]

Chart 3. **Women who use any contraceptive are far less likely to become pregnant than are those using no method,...**

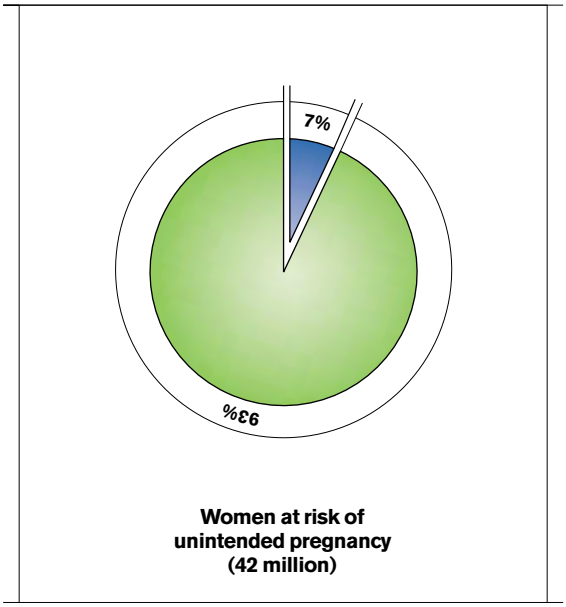


SOURCE: TABLE 3, PAGE 44

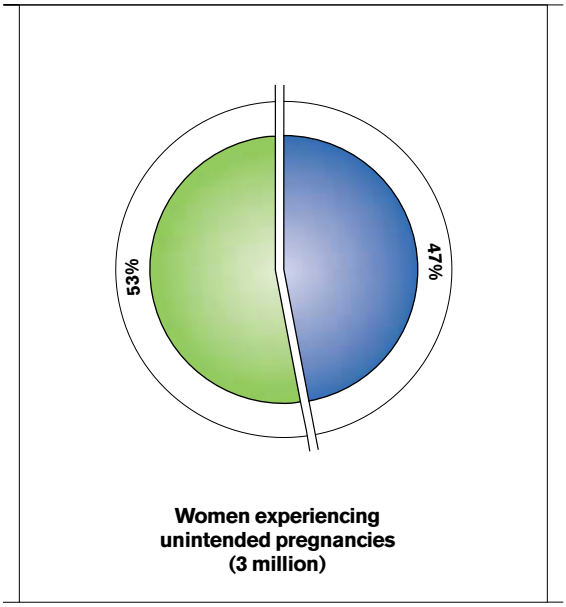
1966

As part of the War on Poverty, President Johnson names family planning one of four critical health problems in the nation needing special attention.

Chart 4. **The small proportion of women who do not use contraceptives…**



…account for roughly half of all unintended pregnancies.



SOURCE: TABLE 4, PAGE 44

Not using Using

first federal grants for family planning. These grants paved the way for other antipoverty initiatives to include provisions designed to improve access to family planning care. Amendments made to the Social Security Act during the second half of the 1960s allowed states to claim reimbursement for family planning services provided under the newly established Medicaid program and required state welfare agencies to make family planning information and services available to welfare recipients.

Other family planning efforts stemmed from a public health perspective. For example, while states had been able to use funding from the federal maternal and child health program for family planning since 1942, Congress in 1967 required that at least 6% of the program's funds be used for this purpose.

Yet over the next few years, it became increasingly clear that the strategy of incorporating family planning services into broader health and welfare programs would not serve all women in need of subsidized care. One problem with this approach was that it required people who administered welfare benefits or other social services to deliver family planning information or services, but they often lacked the expertise or training to do so effectively. Another was that since states largely controlled the little funding available under these disparate programs, service availability, eligibility criteria and benefit levels varied widely across the 50 states.

The Title X Program Is Established to Ensure Access to Contraceptives for All Americans

This uneven landscape changed dramatically, however, with the establishment in 1970 of Title X of the Public Health Service Act, the only federal program—then and now—devoted solely to the provision of family planning services on a nationwide basis. 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 who cannot obtain them without government assistance. The new program sought to fulfill President Nixon's historic 1969 promise that "no American woman should be denied access to family planning assistance because of her economic condition."[8]

Title X not only spurred the development of a nationwide network of clinics that has come to serve as a primary source of high-quality, affordable family planning services for low-income women, but also established a set of principles guiding the ethical delivery of those services. These principles—which have become the standard of care for family planning services throughout the nation—ensure that all clients of Title X–supported clinics receive a broad package of contraceptive and related health services in a voluntary and confidential manner. Title X requires these services to be provided free of charge to poor clients or for a fee based on a client's ability to pay.

1967

The Social Security Act is amended to require that at least 6% of funding nationwide under the maternal and child health program be earmarked for family planning and that family planning services be provided to public assistance recipients who request them.

Title X Remains a Critical Source of Support for Family Planning Services

Over time, the contribution of Title X funding as a proportion of overall public support for family planning services has diminished. In 1980, one in two dollars for publicly funded family planning services came from the Title X program; by 1994, that proportion had dropped to one in five.[9] Yet Title X remains a critical source of dedicated revenue that not only funds direct client services but also supports the initial and ongoing infrastructure needs of clinics.

Title X's contribution to clinics' operating costs enables them to draw on other sources of support for subsidized family planning—notably, Medicaid reimbursements, as well as state appropriations and contributions from two long-standing programs, the maternal and child health block grant and the social services block grant (see box, page 14). Two newer block-grant programs are also potential sources of family planning support: Temporary Assistance to Needy Families (created in 1996, when Congress overhauled the nation's welfare program) and the State Children's Health Insurance Program (created in 1997 to expand health insurance coverage for children younger than 19).[10]

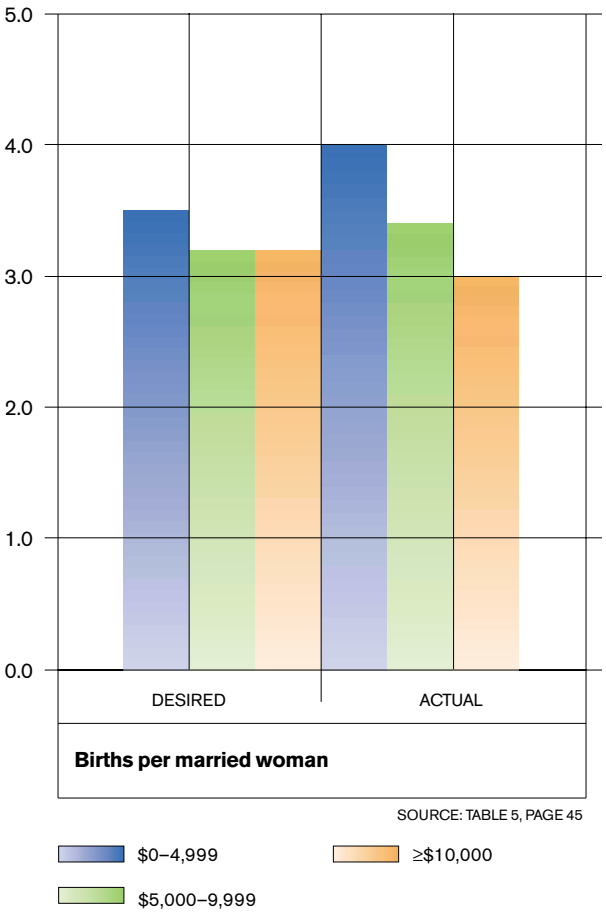
Government Involvement in Family Planning Was Controversial from the Start

As the central legislative vehicle controlling U.S. family planning policy, Title X has for years been besieged politically by those who either oppose government involvement in family planning or take issue with the program's key principles. From the beginning, government involvement in family planning was opposed by the hierarchy of the Catholic Church, which rejected the use of "artificial" methods of birth control; social and religious conservatives, who advocated generally for limiting the role of government in people's lives; and even some minority group leaders, who feared that family planning programs would be put to coercive use to limit childbearing among minority populations or welfare recipients.

Over time, opposition has crystallized around two claims. One is that offering confidential services to teenagers encourages them to be sexually active. The other is that family planning clinics—or the very availability of contraceptives—"promote" abortion (even though federal family planning funds cannot be used to provide abortions). At the same time, religious opposition has widened beyond the Catholic Church hierarchy to include some fundamentalist Christian leaders.

While this vocal opposition has at times threatened the existence of the Title X program—and has spilled over to threaten even clinics that do not receive Title X funding—the publicly subsidized family planning program has always been popular with the American public and traditionally has enjoyed strong bipartisan support.[11] It has also had the ongoing and active support of many Catholic politicians, civil rights leaders

Chart 5. **In 1965, women of all income levels wanted about the same number of children, but the lower their income was, the more children they had.**



SOURCE: TABLE 5, PAGE 45

1968

Pope Paul VI issues an encyclical affirming the Catholic Church's opposition to "artificial" methods of contraception.

Major Federal and State Funding Sources for Family Planning

Together, the federal and state governments spent $715 million on contraceptive services and supplies through a range of programs in 1994 (the most recent year for which data are available for all funding sources).[1]

Title X: Created in 1970 as part of the Public Health Service Act, Title X is a grant program that supports the establishment and maintenance of family planning clinics and the provision of contraceptives and related services to poor and low-income women and teenagers. In 1999, 84 grantees spread across all 50 states and the District of Columbia—including 49 state or local health departments—distributed Title X funds to local clinics.[2] The program also provides key assistance to the family planning clinic system by setting standards for the delivery of care, supporting research to improve the delivery of contraceptive services and funding training programs for clinic personnel. In 1994, Title X contributed 21% of government funds spent on contraceptive services and supplies.[3]

Medicaid: Established in 1965 as Title XIX of the Social Security Act, Medicaid is a joint federal-state program that reimburses health care providers for services rendered to eligible individuals. To qualify for Medicaid, a woman must generally be single, have a child or be pregnant, and have an income below state-set eligibility ceilings, which average 46% of the federal poverty level (or $6,509 for a family of three in 2000[4]). In 1972, Congress required all states participating in Medicaid to include coverage of family planning as a program benefit and committed the federal government to contribute nine dollars for every dollar a state spends on family planning. In 1994, Medicaid accounted for 46% of public funding of contraceptive services and supplies.[5]

Maternal and child health (MCH) block grant: Under Title V of the Social Security Act, the federal government provides state health departments with block grants to support services for women and children. States are allowed to use MCH funds for family planning services, although a requirement that 6% of these funds nationwide be spent on family planning services was eliminated in 1981. In 1997, 42 states spent some of their MCH funds on family planning.[6] In 1994, funding through the MCH program represented 5% of government support for contraceptive services and supplies.[7]

Social services block grant: Through Title XX of the Social Security Act, the federal government provides funding in the form of block grants to state social services agencies for a wide variety of purposes related to reducing dependence on public assistance. States are allowed, but are not required, to use funds from this block grant for family planning services; in 1997, 15 states did so.[8] In 1994, this program contributed 5% of government support for contraceptive services and supplies.[9]

State contributions: State funding for family planning comes from a variety of sources, including dedicated appropriations by state legislatures, general allocations to state health or social services agencies, and some local governments. In 1994, 40 states provided some funding for family planning services, although their contributions varied considerably; these contributions accounted for 23% of government spending on contraceptive services and supplies.[10]

and minority members of Congress, including the Congressional Black Caucus. Notably, many in the civil rights community have always seen expanding access to family planning services as fundamental to the drive for equality and social justice. This sentiment is echoed in the words of Martin Luther King, Jr., when he suggested that by offering black Americans "a fair opportunity to develop and advance as all other people in our society," improved access to family planning would enrich their lives and guarantee them "the right to exist in freedom and dignity."[12]

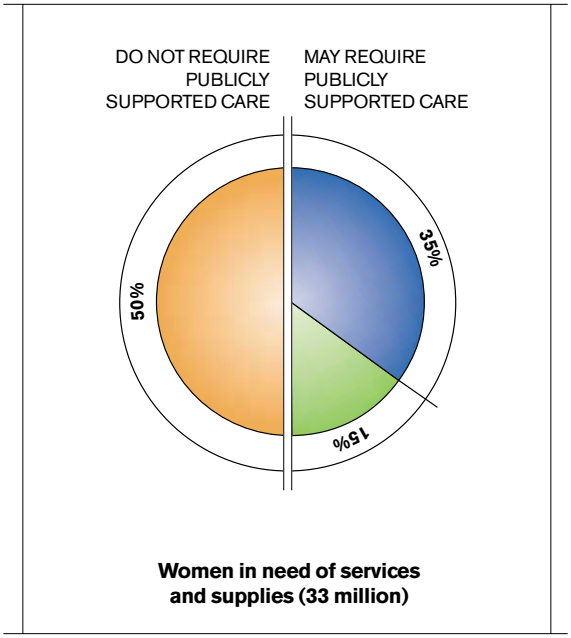
1969

President Nixon calls for increased federal support for domestic family planning services and appoints the Commission on Population Growth and the American Future to report on U.S. population issues.

CHAPTER 2

The Role of Family Planning Clinics Today

Chart 6. **Because of their low income or youth, half of all women in need of contraceptive services and supplies may require access to publicly supported care.**



SOURCE: TABLE 6, PAGE 45

Most American women visit private physicians for their contraceptive care.[1] They typically rely on payments from private, employer-based health insurance to cover at least part of the cost of these services and pay the remainder out of pocket.

Yet having private insurance or being employed does not ensure that a woman can afford to obtain contraceptive care from a private physician. Many insurance plans exclude coverage for at least some contraceptive services or supplies,[2] and many women lack the disposable income necessary to pay out of pocket for services. Moreover, even though they may be employed or have employed spouses, 12 million women aged 15–44—one-fifth of those of reproductive age—lack health insurance of any kind.[3] A considerable proportion are young women working at entry-level or low-wage jobs without health benefits and are struggling to make ends meet.[4]

Medicaid affords some of the poorest women in this country an opportunity to visit private physicians; the program pays for one in 10 contraceptive visits to a private physician.[5] Historically, however, the promise of private-sector care has been largely theoretical for women on Medicaid. Only seven in 10 obstetricians and gynecologists accept Medicaid.[6] And those who accept Medicaid typically see very few patients with this coverage, principally because of the program's low reimbursement rates.[7]

Clearly, because of financial constraints, visiting a private physician is not an option for a considerable proportion of American women. Additionally, some women simply prefer the specialty services offered by clinics to the general services provided by private physicians. They may value the culturally sensitive care available from many clinics or place a high priority on knowing that their care will remain confidential—an especially important factor for teenagers, who may not wish to discuss issues related to their sexual behavior with their parents and may not be able to afford a private physician visit without involving them. For more than 30 years, these women have gone to publicly funded family planning clinics for their contraceptive care.

Millions of American Women Rely on Clinics for Family Planning Care

An estimated 33 million American women need contraceptive services to avoid unintended pregnancy. Half of them—11.6 million poor or low-income adults and 4.9 million sexually active teenagers—may need access to publicly subsidized services (Chart 6).[8]

In 1997, 6.5 million women obtained contraceptive services from publicly funded family planning clinics.[9] Overall, about one-quarter of women who obtain family planning services each year from a medical provider receive their care from publicly supported clinics, but the proportion climbs to four in 10 among members of minority groups and approximately half among poor women and teenagers.[10]

1970 Title X of the Public Health Service Act is enacted.

1972 The Supreme Court strikes down a state law prohibiting the distribution of contraceptives to unmarried people *(Eisenstadt v. Baird);* Medicaid is amended to require coverage of family planning services; U.S. family planning clinics serve 2.6 million people.

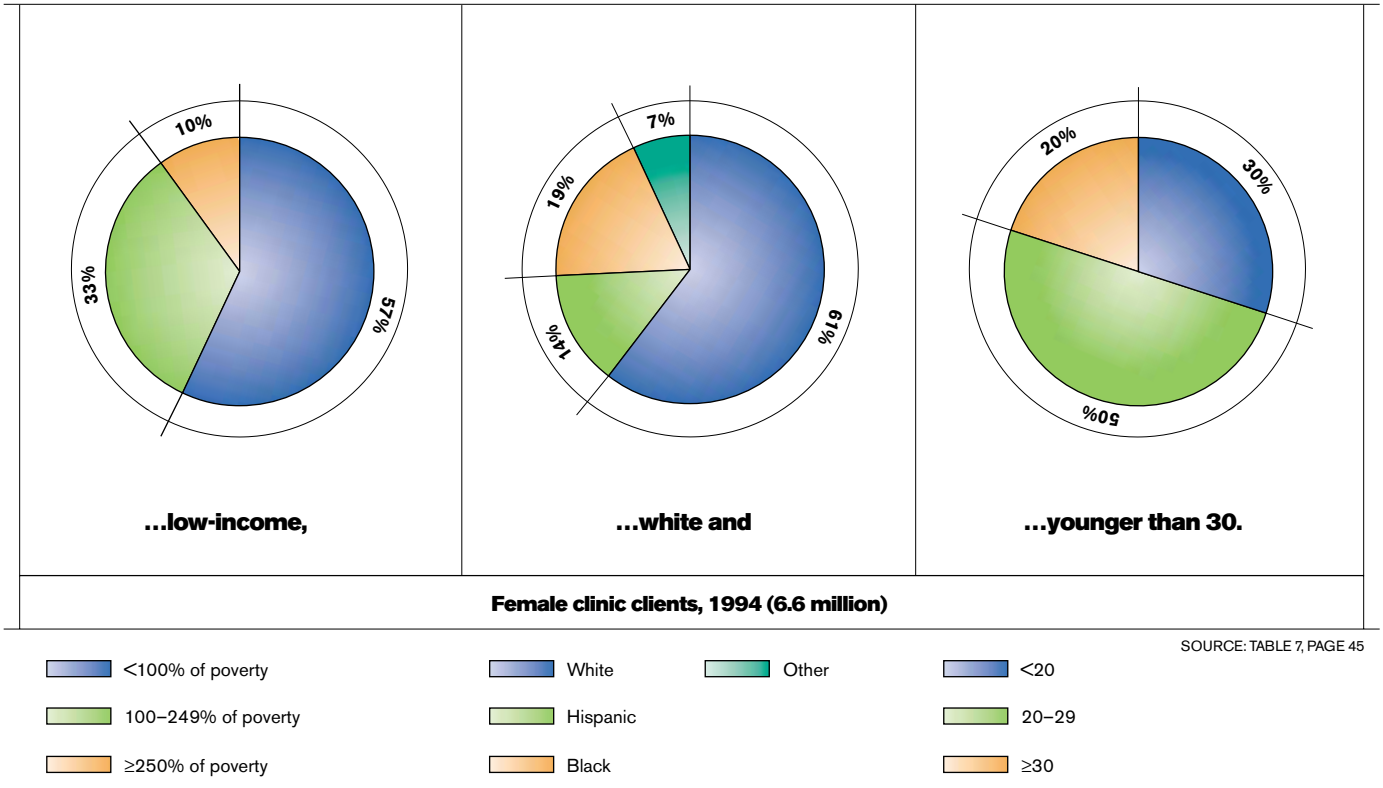
A profile of family planning clinic clients reveals that they are overwhelmingly poor or low-income; nine in 10 have family incomes below 250% of the federal poverty level. They also are predominantly white. However, because poverty status is closely linked with race and ethnicity in this country, women seeking subsidized family planning services are disproportionately from racial or ethnic minority groups: While 29% of women nationwide are minority group members, 40% of women obtaining clinic care are from minority groups. And clinic clients are generally young. Nearly one-third are teenagers, and one-half are women in their 20s (Chart 7).[11]

The Clinic System Is Large and Diverse

The national family planning clinic system is a loose network of more than 3,000 agencies that run more than 7,000 clinics. These clinics are located in 85% of counties across the country, and they are likely to be located in areas where low-income women live—including both urban centers with large minority or immigrant populations and sparsely populated rural areas.[12]

Because they are diverse, locally run organizations that often serve large numbers of clients from a single community, clinics are frequently better

Chart 7. **Most women using family planning clinics are…**

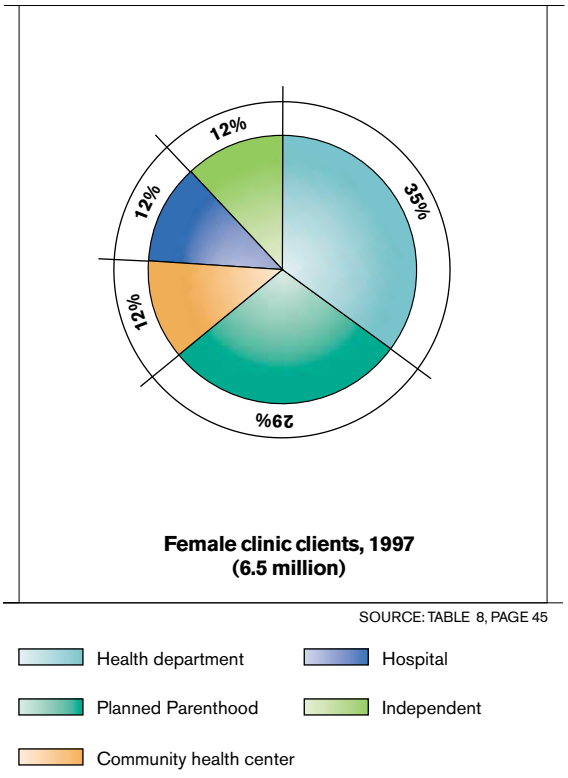


SOURCE: TABLE 7, PAGE 45

1973

The Supreme Court strikes down state laws that prohibit abortion and upholds a woman's right to choose abortion *(Roe v. Wade* and *Doe v. Bolton)*.

Chart 8. **Almost two-thirds of all family planning clinic clients are served at health department or Planned Parenthood sites.**



SOURCE: TABLE 8, PAGE 45

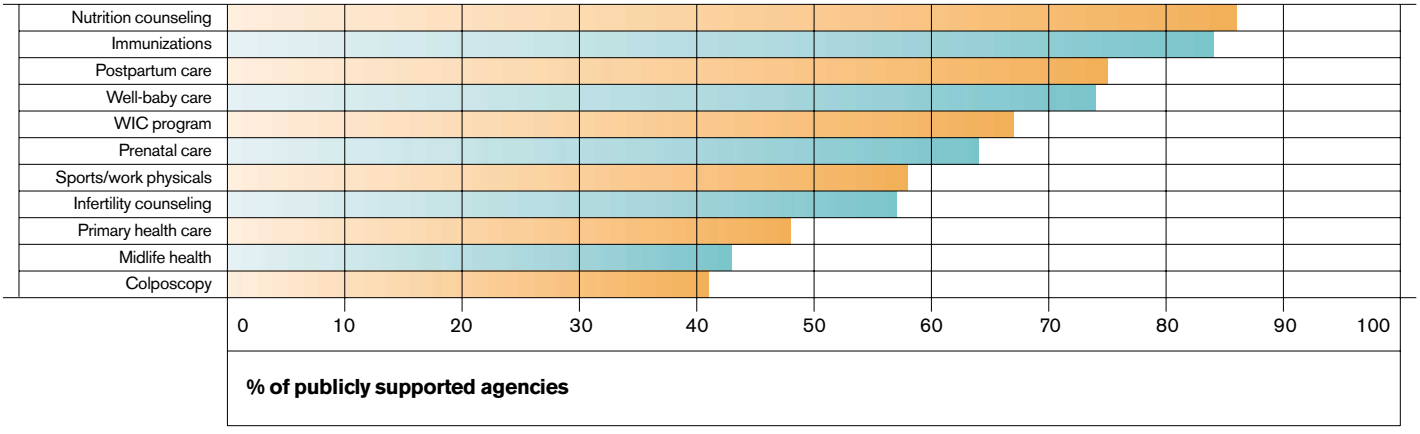
situated than private physicians to meet local public health and social service needs. They typically are equipped to provide culturally sensitive services to minority and immigrant populations, and frequently have health care professionals on-site who can speak the native language of non–English-speaking clients. They also may be more attuned than private physicians to health problems that are prevalent within a particular community. And as part of the fabric of the public health safety net, clinics collaborate with other types of health care and social service providers to bring information and services to hard-to-reach populations.

A wide range of organizations are involved in providing publicly subsidized family planning services. While many clinics are operated by state or local health departments, a large proportion are run by nonprofit, community-based agencies. The relative importance of each type of provider varies from state to state and locality to locality. Nationwide, clinics operated by health departments and Planned Parenthood affiliates each serve approximately one in three clinic clients, while community or migrant health centers, hospital-based sites and independent women's clinics serve the rest (Chart 8).[13]

Publicly Subsidized Family Planning Clinics Offer a Wide Range of Services

Individuals seeking care at publicly funded family planning clinics have access to a wide choice of contraceptive methods. All family planning agencies offer oral contraceptives at one or more of their clinic sites; at least nine in 10 offer the injectable, the diaphragm, spermicides and condoms; and half offer the implant or the IUD. The range of contraceptive methods offered differs significantly according to the type of agency; Planned Parenthood clinics offer the widest selection.[14]

Chart 9. **Family planning agencies offer a range of services beyond contraception.**



SOURCE: TABLE 9, PAGE 46

1976 U.S. family planning clinics serve 4.1 million people.

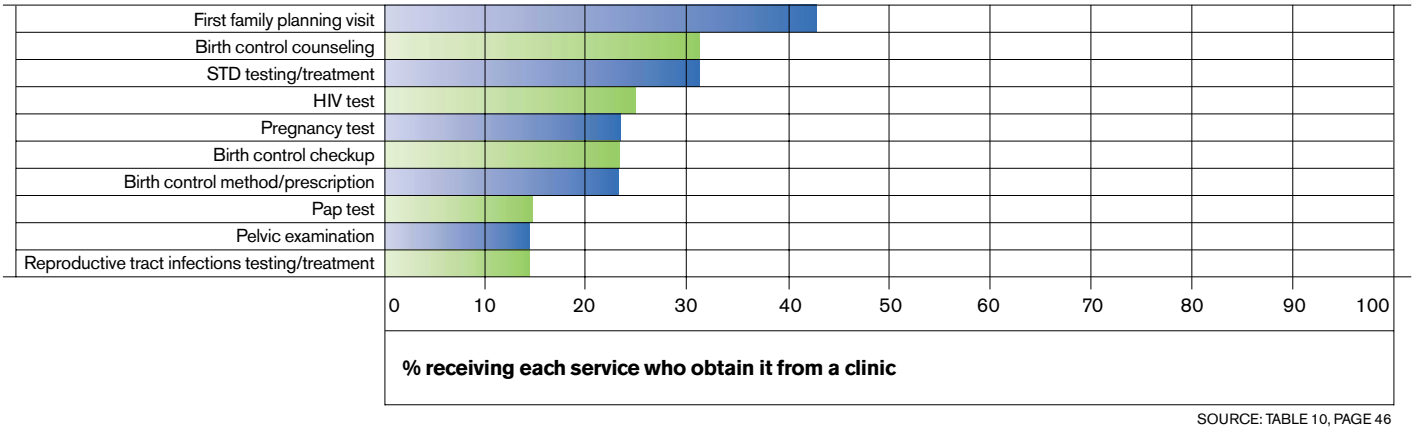
1977 The Supreme Court strikes down a state law that prohibits the sale of nonprescription contraceptives to minors younger than 16 (*Carey v. Population Services International*).

Family planning clinics provide a broad spectrum of health services in conjunction with a contraceptive visit. They all routinely provide Pap smears, breast and pelvic examinations, and blood pressure testing. Some test for sexually transmitted diseases (STDs) if a client requests this service or has symptoms of infection, but others routinely provide STD testing. For example, 64% of agencies test all clients for gonorrhea, and 54% routinely screen for chlamydia. Many clinics also provide testing for anemia, pregnancy and urinary tract infections, and offer such noncontraceptive services as prenatal care, infertility counseling, nutrition counseling and immunizations (Chart 9).[15]

In addition to providing contraceptive and related health care services, family planning clinics provide education and outreach within the community. Clinics universally offer education (including information about risk factors for HIV and other STDs) through individual counseling and printed materials. Almost seven in 10 family planning agencies offer outreach, education or other services designed to meet the needs of teenagers: More than four in 10 run programs that emphasize postponement of sexual activity, and three in 10 have designated hours for teenagers. One in seven offer programs for parents of teenagers; however, the proportion varies considerably among types of agencies, ranging from six in 10 among Planned Parenthood affiliates to only one in 10 among hospitals and health departments.[16]

Finally, 43% of family planning agencies offer programs or services that are specifically tailored to hard-to-reach groups, such as women who are substance abusers or prisoners, and those who are homeless or have disabilities. Planned Parenthood and independent clinics are more likely than other types of providers to serve hard-to-reach populations.[17] These services are vital, given that many of these individuals may have no connection to general health care services and may engage in unsafe

Chart 10. **A significant proportion of women rely on family planning clinics for their reproductive health care.**



SOURCE: TABLE 10, PAGE 46

1978

Congress amends the Title X statute to emphasize the importance of serving teenagers.

behaviors (such as drug use or unprotected sexual activity) or be at high risk for experiencing sexual violence.

Many Women Who Obtain Reproductive Health Services Get Their Care from Clinics

Publicly funded family planning clinics are an important source of services for women who need contraceptive care (Chart 10, page 19). They serve one in every four women in the United States who obtain contraceptive prescriptions or supplies, one in four who receive a checkup for birth control and one in three who obtain birth control counseling each year. Four out of every 10 young women making their first family planning visit to a medical provider go to a clinic.[18]

Clinics are also an important source of reproductive health services other than contraceptive care. Approximately one in seven women of reproductive age who receive Pap smears, pelvic examinations and testing or treatment for gynecologic infections obtain these services from clinics. In addition, clinics account for one in four HIV tests and one in three visits for other STD services among women of reproductive age.[19]

1979

U.S. family planning clinics serve 4.5 million people; the number of clinics reaches 5,200.

CHAPTER 3

The Key Role of Title X

Title X is such an integral part of the family planning clinic network that it is difficult to discuss separately from the whole. Yet it has had a distinctive history, has made unique contributions and remains the focus of most political opposition to government involvement in family planning. For these reasons, its accomplishments and the challenges that lie ahead merit particular attention as the clinic network enters its fourth decade.

Title X Is the Centerpiece of the U.S. Family Planning Program

The need for a program such as Title X became apparent during the late 1960s, when an estimated five million low-income American women needed subsidized family planning services, but only a small proportion received them.[1] Recognizing the significant toll that unwanted childbearing imposed on families and society at large—and noting the special burden that it imposed on the poor—President Nixon in July 1969 set a national goal of providing family planning services to all who wanted but could not afford them within the next five years. Such an effort, he suggested, would involve not only increasing the amount spent on family planning but also ensuring a dedicated source of funding for that purpose. Moreover, a family planning program's effectiveness, the president said, hinged on its ability to respond *flexibly* to women's needs, given that "the life circumstances and family planning wishes of those who receive services vary considerably."[2]

Thirty years after its enactment, the Title X program remains the centerpiece of the national family planning program. As the only federal program dedicated exclusively to family planning, it provides funding that can be used in a variety of ways, such as to pay the salaries of clinic personnel, purchase contraceptives and other medical supplies, and subsidize services to clients who lack another source of payment. It funds a wide array of agencies that run clinics in a host of settings, thus responding to the varying needs of family planning clients.

The Program Ensures That Contraceptive Care Is Affordable, Confidential and Comprehensive

Any woman, regardless of her age, marital status, income or health insurance status, may go to a Title X–supported clinic for family planning services. The amount that a clinic receiving program funds can charge a woman for services depends on her ability to pay: If a woman has an income below the federal poverty level, the clinic must provide services free of charge. If her income is between 100% and 250% of the poverty level, she must be charged on a sliding-fee scale; she pays full fees if her

1980

The Carter administration issues regulations establishing the sliding-fee scale for Title X services.

income is above 250% of poverty. Fees for minors are based on the adolescents' own income, rather than their parents'; as a result, many adolescents receive services free of charge.

The Title X regulations also contain a set of ethical principles governing the delivery of contraceptive services in clinics supported by the program. These principles apply to all clients who receive services from Title X–supported clinics, regardless of their source of payment. A key principle is that all services must be provided on a confidential basis—an essential factor in encouraging some individuals, especially teenagers, to obtain family planning and other reproductive health care.

In addition, the receipt of family planning services and information in Title X–supported clinics must be purely voluntary and may not be made a condition for participation in any other program. As a further way of ensuring that women receive care voluntarily and are not pressured to accept a particular contraceptive method, Title X regulations require clinics to offer patients a range of methods and related counseling services (including information on natural family planning).

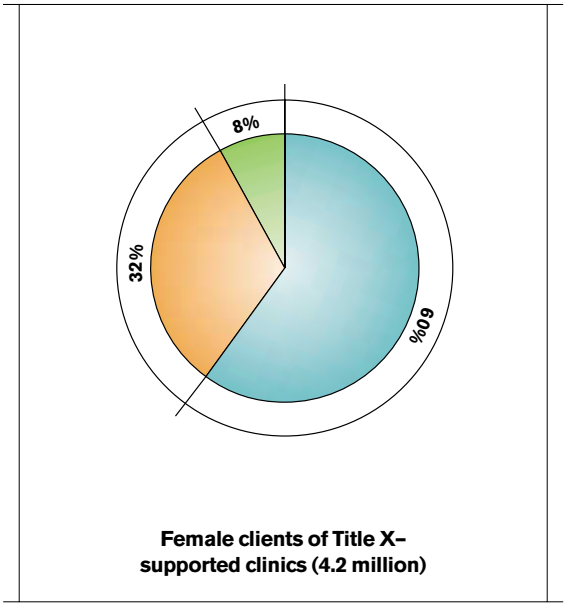
Another central Title X principle is that clients visiting family planning clinics for contraceptive care must be offered related preventive health services. As a result, the program regulations and official guidelines specify a wide range of screening services to be delivered to clients at Title X–supported clinics, including pelvic examinations, blood pressure checks, Pap smears and breast examinations.

The Title X statute has always expressly prohibited using program monies to fund abortion. However, the program guidelines stipulate that a woman facing an unintended pregnancy who asks for information about her options must receive information about *all* of her options, "including prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination," and referrals upon request.[3] Such "nondirective counseling" is intended to convey basic facts about all alternatives in a nonjudgmental manner, so that women can explore their options and decide which best suits their circumstances, values and desires.

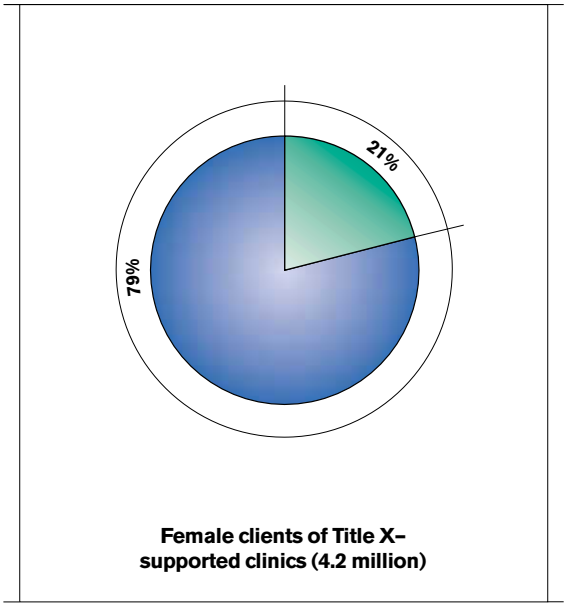
Clinics Supported by the Program Serve a Considerable Proportion of Women in Need of Subsidized Contraceptive Care

Sites that receive Title X support serve more than four million women each year, meeting one-quarter of the estimated need for subsidized family planning services.[4] The vast majority of these women are poor or low-income and are uninsured.[5] In fact, Title X plays an especially vital role in subsidizing services for women who are poor but are not covered by Medicaid[6]—often because they are not poor enough to qualify or they do not already have a child. While three in five clients served by Title X–supported clinics have an income below the poverty level and are eligible for totally subsidized care, only one in five are covered by Medicaid (Chart 11).[7]

Chart 11. **Most clients of Title X–supported clinics are poor,...**



...but few are covered by Medicaid.

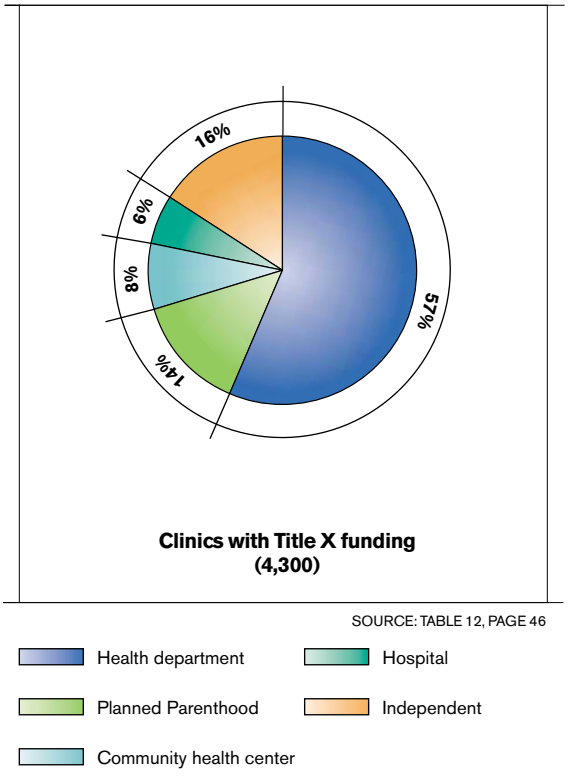


SOURCE: TABLE 11, PAGE 46

1981

Congress rejects the Reagan administration's proposal to fold Title X into a block grant; Congress eliminates the 6% earmark for family planning under the maternal and child health program; the first case of AIDS is reported.

Chart 12. **Health departments run most of the family planning clinics that receive Title X funding.**



SOURCE: TABLE 12, PAGE 46

Funding from Title X Enables Clinics to Conduct Dedicated, Flexible Family Planning Activities

Of the roughly 7,000 family planning clinics nationwide, more than 4,000 receive Title X funds.[8] Some 57% of these sites are run by health departments, 14% by Planned Parenthood and the rest by a variety of types of agencies (Chart 12).[9] In 1998, clinics with any Title X funding received about one-quarter of their revenues from the program.[10]

Sites supported by Title X tend to be "dedicated" family planning clinics—that is, a majority of their clients are contraceptive clients. In contrast, clinics that provide family planning services but do not receive Title X funds (predominantly community or migrant health centers or hospital-based sites) typically offer this care along with many other primary care services. As a result, Title X–supported clinics serve at least 25% more contraceptive clients than do clinics outside the program.[11] In addition, they generally offer a wider range of contraceptive choices than others.[12]

Moreover, clinics supported by Title X often have considerable flexibility in designing services and activities. Such funding enables them to tailor their operations to the specific needs of their clientele—for example, by extending hours for evening and weekend appointments, ensuring short waits for appointments and services, and offering installment payment plans. Moreover, Title X–supported clinics are more likely than others to offer special programs for teenagers, including initiatives that are aimed at encouraging adolescents to postpone sexual activity and improving parent-child communication. Similarly, Title X–supported clinics are more likely to provide the outreach necessary to serve hard-to-reach populations than are clinics that do not receive such funding.[13]

Title X–Supported Services Have Helped Women to Avoid Millions of Unintended Pregnancies and to Protect Their Health

Clinics receiving Title X funds have been at the forefront of the effort to reduce rates of unintended pregnancy and abortion, and their impact has been enormous. Over the last two decades, women attending these clinics have avoided almost 20 million pregnancies, nine million of which would have ended in abortion (Chart 13).[14]

The program has also played a major role in reducing pregnancies among teenagers. By helping to prevent 5.5 million adolescent pregnancies, Title X–supported clinics have helped young women avoid more than two million births and a similar number of abortions over the last two decades. Without Title X, the number of teenage pregnancies would have been 20% higher than it was for this period.[15]

In addition, Title X–supported clinics have helped numerous women detect and obtain early treatment for a range of dangerous, and even

1982

The Reagan administration issues the "squeal rule," regulations requiring Title X–supported clinics to notify parents before dispensing contraceptives to minors; Title X funding is cut by one-quarter.

life-threatening, medical conditions. Between 1995 and 1998, these providers performed 19 million tests for STDs, including 1.4 million for HIV.[16] Over the past 20 years, an estimated 54.4 million breast examinations have been conducted at Title X–supported clinics; providers funded by the program have taken an estimated 57.3 million Pap smears, which resulted in the early detection of as many as 55,000 cases of invasive cervical cancer.[17]

The Program Has Shaped the Delivery of Family Planning Care to All Women Throughout the Country

Title X's impact on health care delivery can be felt beyond the confines of family planning clinics. With its broad focus on preventive and reproductive health services and education, the program is largely responsible for the standardization of contraceptive services across clinics and private physicians' offices nationwide.

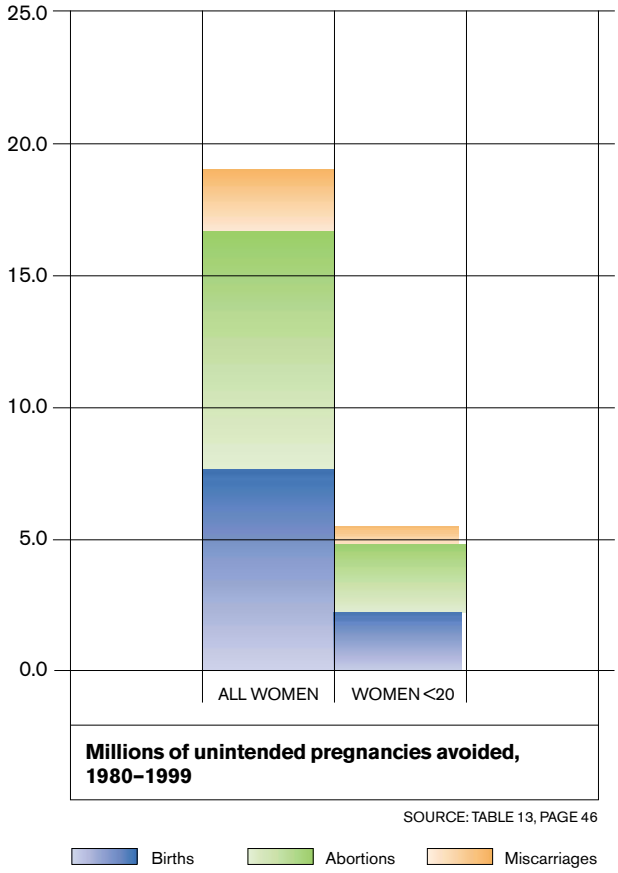
The 1976 Title X protocols for delivering family planning services, developed by the American College of Obstetricians and Gynecologists (ACOG), included what was then the virtually universal practice of family planning clinics to link preventive health care to contraceptive visits. These protocols became incorporated into ACOG's own standards for obstetricians and gynecologists providing contraceptive care throughout the nation in both the public and the private sectors.

In addition, Title X pioneered training for nurse practitioners specializing in family planning and women's health. Between 1972 and 2000, Title X funds were used to train more than 5,000 nurse practitioners in women's health (one of the few accredited nurse practitioner specialties).[18] As a result, nurse practitioners became the primary providers of Title X–supported services, accounting for an estimated 80% of services rendered each year.[19] This development was a key factor in helping clinics remain solvent and facilitated the expansion of Title X–supported services into rural and other underserved areas. Moreover, several schools of nursing collaborated with the Title X nurse practitioner programs, providing participants with significant credits toward a master's degree in women's health.

Political Opposition Plagues Title X

Subsidized family planning services enjoy the support of nine in 10 Americans,[20] yet Title X has been politically controversial for much of its life. Charges that the program promotes teenage sexual activity and abortion have translated into legislative and administrative attacks, in which opponents of the program have sought either to eliminate it completely or to impose restrictions that have the potential to cripple service delivery. These controversies have left a political cloud hanging over all family planning clinics, regardless of whether they receive Title X funds.

Chart 13. **Women getting contraceptives from Title X–supported clinics avoided almost 20 million unintended pregnancies over the last 20 years.**



SOURCE: TABLE 13, PAGE 46

1983

The "squeal rule" is struck down in several court cases *(National Family Planning and Reproductive Health Association v. U.S. Department of Health and Human Services* and others); U.S. family planning clinics serve 5.0 million people.

Despite the resonance of this issue in some political circles, charges that clinics or even the availability of contraceptives promotes sexual activity among teenagers are unfounded.

Concerns About the Program's Influence on Teenagers

Critics of subsidized family planning argue that providing confidential contraceptive services to teenagers encourages them to be sexually active and circumvents parental authority. It is therefore not surprising that opponents of the program have devoted considerable effort to curtailing its ability to deliver confidential contraceptive services to teenagers.

These efforts included the Reagan administration's attempt in 1982 to impose a requirement that Title X–supported clinics notify parents before dispensing contraceptives to minors. This measure, popularly known as the "squeal rule," was ultimately struck down by several courts because it undermined one of the major purposes of Title X (preventing teenage pregnancies) and therefore subverted the intent of Congress.[21] The issue has not gone away, however: It reemerged most recently in the late 1990s, when some congressional leaders repeatedly, but unsuccessfully, attempted to attach a parental consent requirement to the annual legislation funding the program.

Despite the resonance of this issue in some political circles, charges that clinics or even the availability of contraceptives promotes sexual activity among teenagers are unfounded. While confidential clinic services allow adolescents who feel unable to talk to their parents about their sexual activity to protect themselves against unintended pregnancy and STDs, the average teenager does not visit a family planning provider until 14 months after she has become sexually active.[22] This finding not only provides clear evidence that clinics do not encourage teenagers to become sexually active, but points up the need for clinics to reach out to adolescents in order to serve them earlier. Another indication of the importance of expanding this outreach is the finding that three-quarters of the decline in the teenage pregnancy rate between 1988 and 1995 was due to increasingly effective contraceptive use among sexually active adolescents (with the remaining one-quarter due to increased abstinence).[23]

Family planning providers are working with teenagers, parents and communities to reduce adolescent pregnancy rates by narrowing the wide gap between when young people initiate sexual intercourse and when they first visit a family planning provider. Toward this end, they are offering programs that foster parent-child communication, as well as counseling and educational services aimed at supporting and encouraging young people to delay sexual activity while preparing them to protect themselves against unplanned pregnancy and STDs when they become sexually active.

Concerns About the Program's Influence on Abortion

According to a vocal and politically powerful minority, the availability of contraceptives encourages sexual promiscuity, which results in more abortions. Moreover, these critics charge that family planning providers have a vested interest in encouraging women facing unintended pregnancies to seek abortions, and that they therefore downplay the alternative of adoption.

1984 HIV is determined to cause AIDS.

1986 The Supreme Court rules that states may give family planning grants to agencies that provide abortions with their own funds or provide abortion counseling or referral *(Babbitt v. Planned Parenthood of Central and Northern Arizona).*

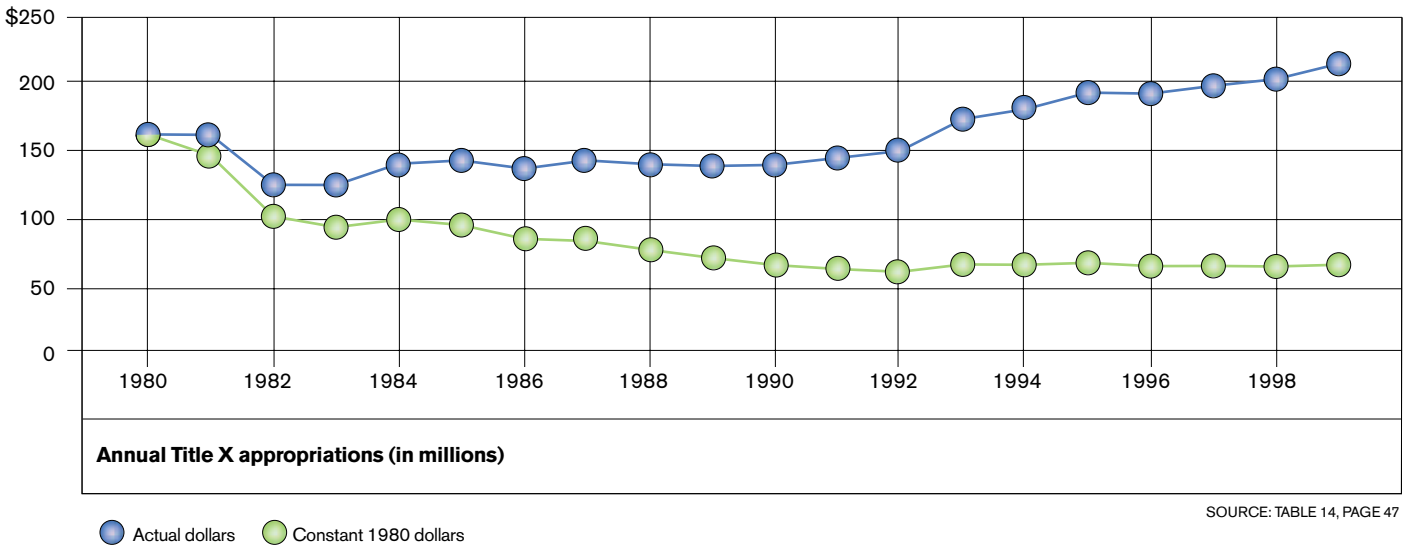
It was not until President Reagan took office, however, that federal policy reflected this antiabortion animus. In 1987, the Reagan administration promulgated federal regulations, which came to be known as the "gag rule," forbidding Title X providers from discussing abortion with clients facing unintended pregnancies, even if women specifically requested such information. In addition to vitiating Title X's nondirective counseling requirement, the regulations stipulated that Title X–supported clinics that used funds from other sources to provide abortions had to erect a physical and financial "wall of separation" between abortion and family planning services.

Opposed at the time by virtually all major medical organizations, 36 state health departments and most members of Congress, in 1991 the gag rule was declared constitutional by the Supreme Court, which ruled that it represented a permissible exercise of executive power.[24] Challenged again in court on procedural grounds,[25] the gag rule was ultimately in effect for only one month and was suspended when President Clinton took office in 1993.

Overcoming Political Controversies Will Require Public Education

While legislative and administrative attacks on Title X have met with varying degrees of success over time, the political opposition has undeniably resulted in a depressed funding level for the program. During the 1980s, the program suffered steep funding cuts, and despite fairly steady increases in appropriations since then, it has never fully recovered. Taking inflation into account, the program's funding level in 1999 ($215 million) was 60% lower than it had been 20 years ago (Chart 14).[26]

Chart 14. **Despite recent increases, Title X funding has decreased 60% since 1980, when inflation is taken into account.**



SOURCE: TABLE 14, PAGE 47

1987

The Reagan administration proposes the "gag rule," regulations prohibiting Title X–supported clinics from discussing abortion with women facing unintended pregnancies and requiring clinics to maintain a "wall of separation" between family planning and abortion services.

As the Title X program enters its fourth decade, family planning providers and supporters of publicly funded family planning services will remain under attack. Fending off these assaults will require a vigorous public education campaign clearly explaining that the availability of contraceptives does not encourage teenagers to become sexually active, and that publicly subsidized family planning programs are integral to the national effort to reduce unintended pregnancy and thereby lower the abortion rate. Such an effort must also convey that women's confidence in clinics rests on the clinics' ongoing ability to provide them with confidential family planning services and impartial information about all of their pregnancy options.

1988

The FDA approves the cervical cap for use in the United States.

CHAPTER 4

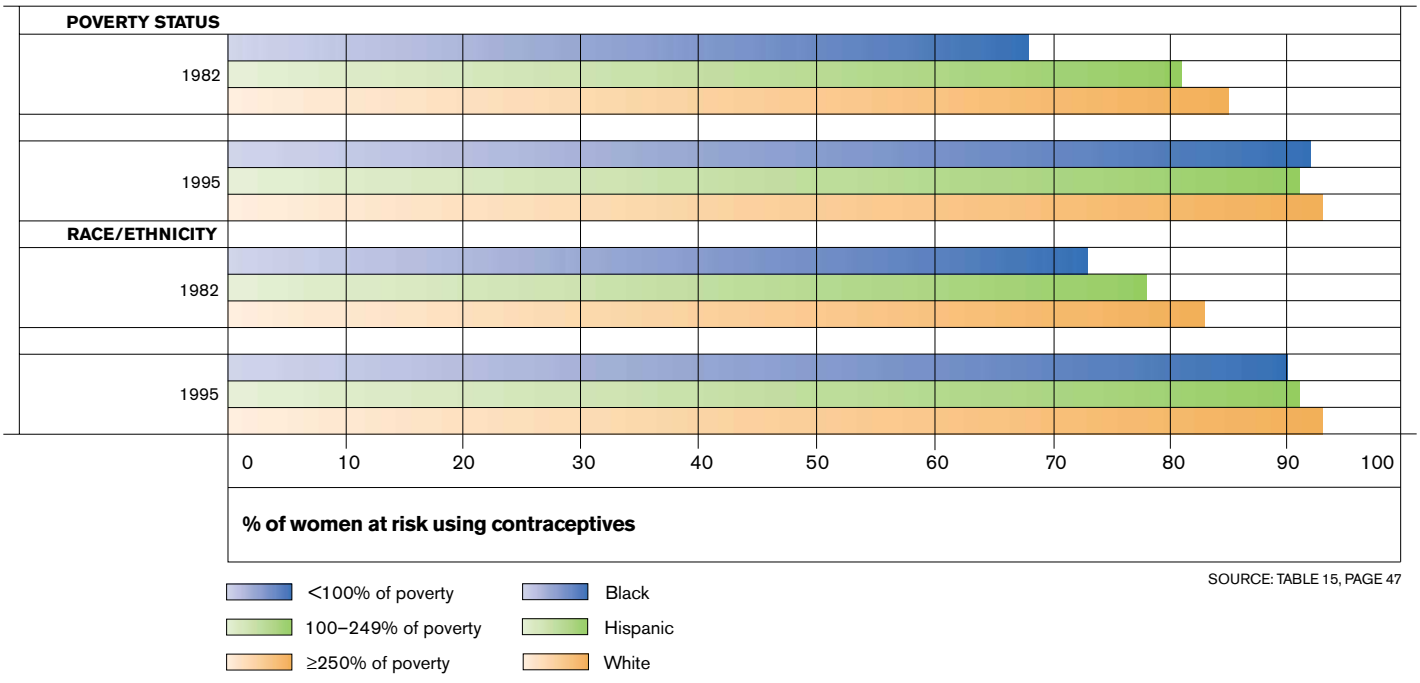
Challenges and Opportunities

The decision 30 years ago to provide government support for family planning services and establish a nationwide network of clinics promised to bring Americans in need of subsidized care the means to achieve their childbearing goals. Indeed, clinics have helped millions of couples avoid unintended pregnancies and the unplanned births or abortions that would follow. In doing so, they have improved the public health and enabled couples to take advantage of economic opportunities that might not have been available to them absent the ability to decide whether and when to have children.[1]

A key achievement of publicly subsidized family planning services is that they have all but eliminated the income and racial disparities in contraceptive use that spurred the government's involvement in family planning. As a result, levels of use are now extremely high among all women at risk of unintended pregnancy.[2] Between 1982 and 1995, the proportion of women at risk of unintended pregnancy who were using a contraceptive method rose from 68% to 92% among poor women, from 73% to 90% among black women and from 78% to 91% among Hispanic women (Chart 15).[3]

Preserving these gains depends on clinics' continued ability to serve the millions of women who rely on them for family planning services—an ability that is complicated by rising costs and dramatic changes in health care financing. While they face these challenges, family planning

Chart 15. **Contraceptive use among poor, low-income and minority women has increased dramatically, to a level matching that of higher-income and white women.**



SOURCE: TABLE 15, PAGE 47

1990

The FDA approves the contraceptive implant for use in the United States.

providers are also building on the gains of the past to meet the needs of the present and future. They are both expanding their mission, to offer broader services to women and men, and redoubling their efforts to close gaps in women's access to contraceptive services and to help women use contraceptives more effectively.

Rising Costs of Service Delivery Challenge Clinics' Ability to Offer the Best Possible Care

Given their limited budgets, clinics are struggling to keep pace with the rising costs of contraceptive methods, medical technology, and recruiting and retaining health care professionals who are qualified to meet their clients' complex needs.

Contraceptive Methods

One of the greatest difficulties facing clinics is maintaining full contraceptive choice—as the Title X statute and the principle of voluntarism require—in the face of rapidly escalating costs. Historically, publicly funded family planning clinics purchased contraceptive supplies (notably, oral contraceptives) from manufacturers at a low cost. These costs have risen over time, straining clinics' supply budgets. Financial demands particularly grew after the introduction of long-lasting hormonal methods—the implant and the injectable—which have extremely low failure rates but high up-front costs.

For example, women who visit family planning clinics are increasingly requesting the three-month injectable. Introduced to the U.S. market in 1993 and now used by 18% of patients at Title X–supported clinics,[4] this method 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. Experts believe that growing use of the injectable among high-risk adolescents is one factor responsible for declining rates of teenage pregnancy in this country.[5]

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.[6] This has forced some clinics to create waiting lists for the method. As a result, many clinics are caught between their commitment to offer women a true choice of contraceptives and the realities of what they can afford to provide.

Medical Technology

Skyrocketing costs associated with new screening and diagnostic technologies also hamper clinics' efforts to offer their clientele state-of-the-art care. For more than a decade, clinics have grappled with increases in Pap test costs that have resulted from federal legislation regulating clinic laboratories.[7] On top of that, newly available technologies promise significantly improved detection rates for cervical cancer, but often at twice the cost of traditional Pap smears.[8] While many providers want to make these new

Preserving [past] gains depends on clinics' continued ability to serve the millions of women who rely on them for family planning services.

1991 The Supreme Court finds the "gag rule" constitutional *(Rust v. Sullivan)*.

technologies available to all clients, the high cost often stands in the way.

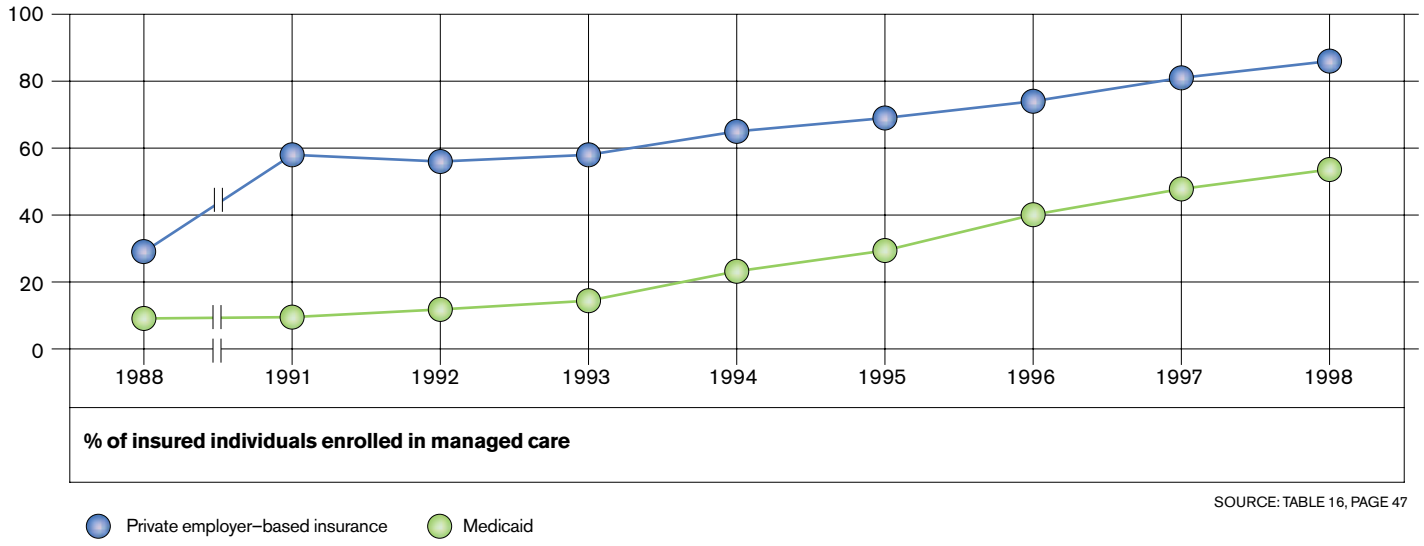
Similarly, many providers want to screen large populations of clients for chlamydia, using new DNA-based tests that are extremely accurate and easy to use. (Chlamydia is an STD that, if left untreated, may lead to pelvic inflammatory disease and infertility; programs that screen and treat clients for this infection are successful in reducing infection rates.[9]) But the new tests are expensive, and offering them to all clients—or even just to all those with specific risk factors—is financially prohibitive for many clinics.

Recruiting Qualified Health Care Personnel

For clinics to adequately and appropriately serve increasingly diverse populations, they must employ staff who can address their clients' complex needs. This involves recruiting and retaining personnel who are fluent in the languages spoken in the local community and who can provide culturally proficient services. And clinics serving hard-to-reach women must have staff trained to address the special problems of these clients. For example, staff must be able to identify signs of domestic violence, to serve and counsel individuals with HIV or with substance abuse or mental health problems, and to provide referrals to specialized health and social services.

The Title X–supported accreditation programs for nurse practitioners specializing in women's health have helped ensure that clinics are appropriately staffed. These programs have been particularly successful because they often have trained individuals from the communities they serve. However, they are being phased out in 2000.[10] As a result, clinics may find that attracting qualified family planning providers with specialized training and cultural proficiency is not only increasingly difficult but also increasingly expensive.

Chart 16. **Managed care enrollment has climbed sharply in the past decade.**



SOURCE: TABLE 16, PAGE 47

1992

The FDA approves the contraceptive injectable for use in the United States; the Supreme Court reaffirms the essential holdings of *Roe v. Wade (Planned Parenthood of Southeastern Pennsylvania v. Casey).*

Changes in Health Care Financing and Growing Numbers of Uninsured People Intensify the Pressures on the Clinic System

In addition to dealing with the financial pressures created by rising service costs, clinics are struggling to find their place in a health care market increasingly dominated by managed care networks and to serve rising numbers of uninsured individuals.

Managed Care

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 family planning clinics. Between 1988 and 1998, the proportion of individuals with private-sector, employment-based health insurance who were enrolled in managed care plans rose from 29% to 86%.[11] The proportion of Medicaid recipients enrolled in managed care rose as well during that time, from 9% to 54% (Chart 16).[12]

Family planning clinics, however, have not been fully integrated into managed care networks. In 1995, only one in four agencies that operated family planning clinics had negotiated a contract with a managed care organization to be reimbursed for seeing their enrollees.[13] This situation has resulted in two interrelated problems for clinics: If clients with a source of third-party reimbursement go to plan providers, rather than clinics, for their 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 concerns about confidentiality), the clinics often receive no reimbursement for the services they provide.[14]

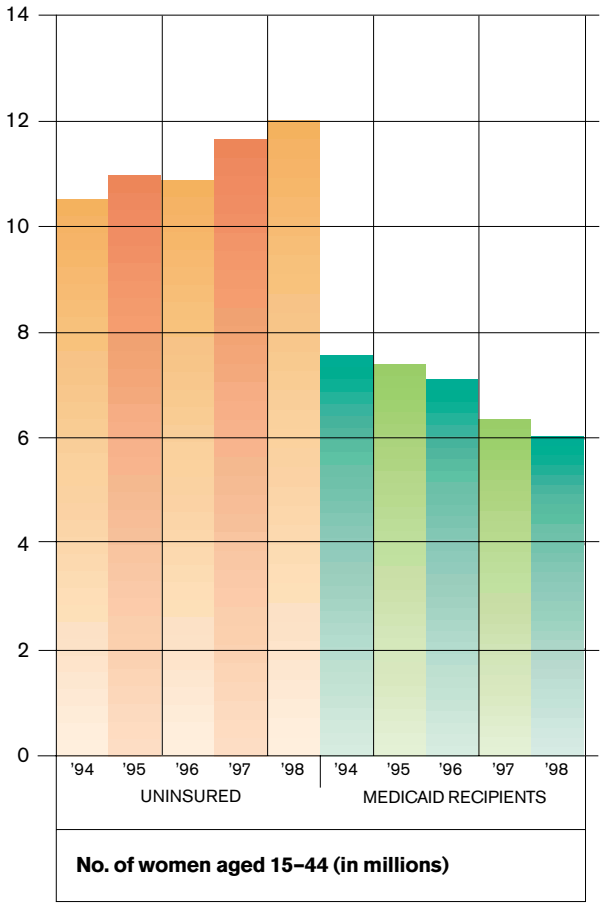
The Rising Number of Uninsured

Clinics are also feeling the impact of overall trends in Americans' insurance coverage. The number of people without any health insurance—public or private—has increased by 10 million over the last decade, to an estimated 44 million. Among women of reproductive age, the number uninsured was 10.5 million in 1994 and had risen 13%, to 12 million, by 1998 (Chart 17).[15] As many as three in 10 women in their 20s, the peak years for both childbearing and the need for contraception, are uninsured.[16]

Many of the uninsured are low-wage workers, whose employers do not offer coverage or who cannot afford coverage 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 copayment requirements and deductibles.[17]

Other women are uninsured because they have lost their Medicaid coverage in the wake of federal welfare reform. Although the welfare reform law

Chart 17. **The number of women uninsured is rising, while the number covered by Medicaid is falling.**

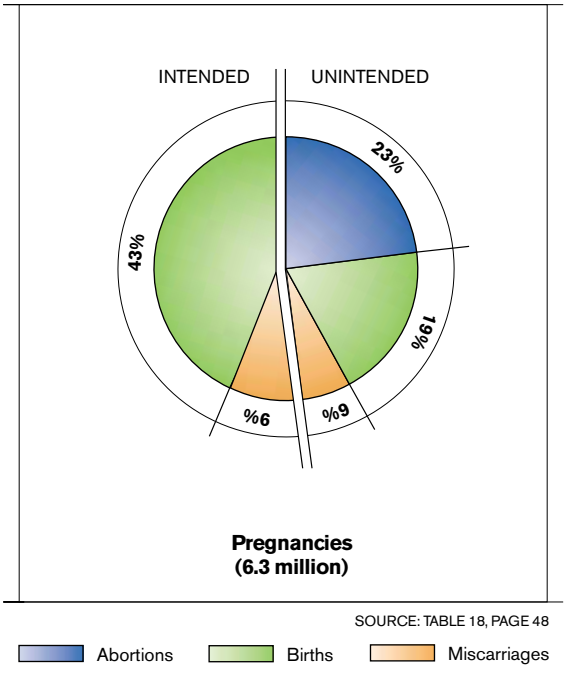


SOURCE: TABLE 17, PAGE 48

1993

President Clinton suspends the "gag rule" during his initial days in office; the FDA approves the female condom for use in the United States.

Chart 18. **Half of all pregnancies in the United States each year are unintended, and one in four end in abortion.**



SOURCE: TABLE 18, PAGE 48

specifies that families who met a state's Medicaid eligibility requirements prior to welfare reform would remain eligible even if they no longer qualified for cash assistance, many of those who are eligible for Medicaid are not enrolled. The number of women of reproductive age who are enrolled in Medicaid fell by 21% between 1994 and 1998—from 7.6 million to 6.1 million.[18] 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.

Clinics Are Expanding Their Mission to Meet Broader Needs

At the same time as family planning providers struggle with these financial pressures, they are stepping up their efforts to move toward more comprehensive models of care. One key objective is to address women's reproductive health care needs more broadly, rather than just meeting their contraceptive needs. Another is, for the first time, to provide men with a wide range of reproductive health services.

Integrating Family Planning and Other Reproductive Health Services

Some family planning providers are adopting a holistic perspective that views contraceptive services in the context of women's overall reproductive health care needs. These clinics are moving toward offering specialized gynecologic care, routine primary care and comprehensive STD services, including enhanced HIV prevention and counseling services. (HIV services are an important feature, given the growing number of women infected with or at risk of acquiring the virus.[19]) By drawing on funding from a variety of sources, providers also are beginning to realize their vision of offering screening for breast and reproductive tract cancers and other gynecologic services to women who are beyond their childbearing years, as well as better serving pregnant women seeking comprehensive prenatal care or in-depth adoption counseling.

Such integration facilitates the efficient delivery of more coordinated and continuous care. The "one-stop shopping" feature is more convenient for some clients than the traditional approach. It also may be more responsive to their needs—from adolescence through adulthood.

Serving Men

Traditionally, family planning clinics have viewed men largely in their role as partners of women, and the services they have offered to men generally have been designed to promote the health of women. For example, clinics test and treat the partners of female clients who are infected with or at high risk of contracting STDs, and encourage men to use condoms to prevent infection with HIV or other STDs.

Now, however, family planning providers are beginning to consider men's reproductive health needs in a broader context and are expanding their

1994

U.S. family planning clinics serve 6.6 million people; the number of clinics reaches 7,100.

efforts to reach and serve men. Clinics are attempting to define and offer a package of medical and counseling services that addresses men's own reproductive health needs, how these needs change with age and the role that men play in decision-making about contraception. Their efforts include figuring out how best to serve teenage males, to promote responsible sexual behavior throughout their lives.

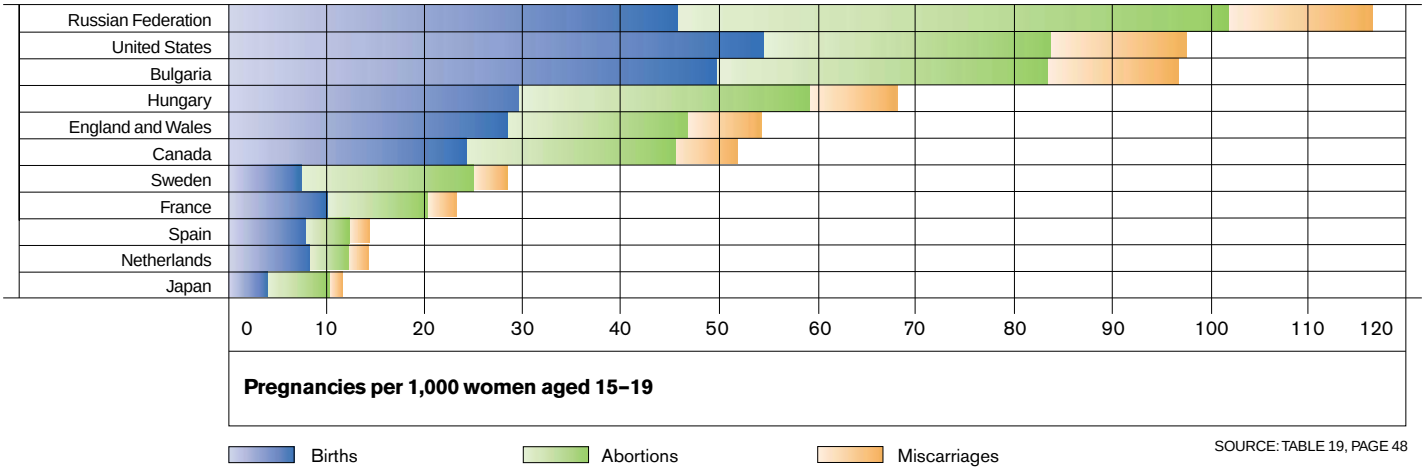
Providing High-Quality Contraceptive Services Remains at the Core of Family Planning Clinics' Mission

Even as family planning clinics broaden their public health focus, much work remains to achieve their goal of eliminating unintended pregnancies. Each year, three million pregnancies—half of all pregnancies in this country—are unintended, and half of unintended pregnancies end in abortion (Chart 18).[20] In addition, while the pregnancy rate among U.S. teenagers declined by 17% from its peak in 1990 to 1996,[21] it is still one of the highest among industrialized nations (Chart 19).[22] Ultimately, addressing these remaining problems will involve a two-pronged approach: closing the remaining gaps in access to care and improving contraceptive use among women.

Closing Access Gaps

Family planning providers are intensifying their efforts to reach out to populations of women in need of subsidized services who still face barriers to obtaining care. Among these are the more than one million women with incomes of less than 250% of the poverty level who have made no recent family planning visit and use no contraceptives even though they

Chart 19. **The teenage pregnancy rate is higher in the United States than in most other industrialized countries.**



SOURCE: TABLE 19, PAGE 48

1996

A law overhauling the nation's welfare system is enacted.

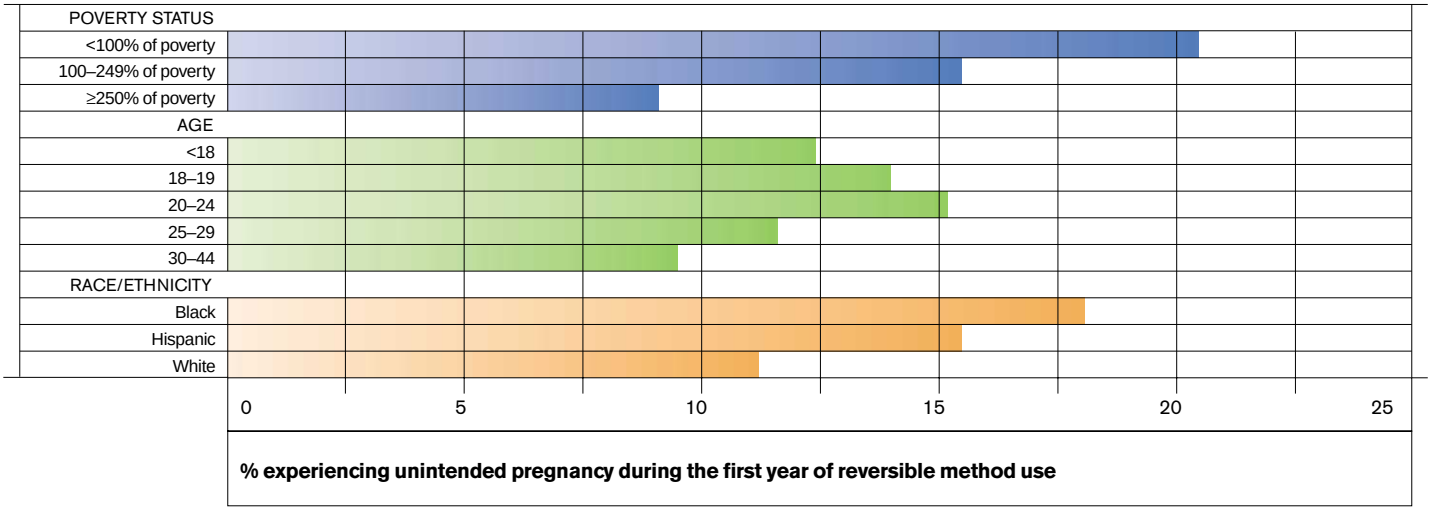
are at risk of unintended pregnancy.[23] Some of these women may be beyond the reach of the mainstream health care system, such as those who abuse drugs or alcohol, are prisoners or are homeless. These groups can be hard to locate, difficult to serve or sometimes both; often, they have multiple health problems and are in need of a wide range of sophisticated health care and social services.

Reaching out and serving increasingly diverse populations poses enormous challenges to family planning providers. Between 1960 and 1990, the proportion of U.S. women of reproductive age who had been born in another country grew by more than 250%; today, one in 10 women living in the United States is foreign-born.[24] Moreover, by 2060, no one racial or ethnic group will constitute a majority of the population.[25] Immigrants and refugees frequently have limited financial resources and therefore rely on publicly funded services for their family planning care. Often they are not fluent in English, and cultural factors may shape their attitudes toward contraceptive use and their interactions with family planning providers. As a result, many clinics are making it a priority to develop the expertise necessary to reach out and provide services competently and effectively to individuals in these subgroups.

Improving Contraceptive Use

As critical as it is, ensuring universal access to family planning services is not enough to eliminate unintended pregnancy. To achieve this goal, it is imperative that family planning providers—and society as a whole—focus on helping women and their partners to use contraceptives more effectively. The risk of contraceptive failure is sometimes inherent to the method itself; often, however, it is due to misuse or inconsistent use.

Chart 20. **Poor women, those younger than 30 and minority women are more likely than others to experience contraceptive failure.**



SOURCE: TABLE 20, PAGE 48

1997

For the first time, the FDA approves a product marketed as an emergency contraceptive.

Certain women experience higher failure rates than others—namely, those who are poor or low-income, young, black or Hispanic (Chart 20).[26]

To help women avoid contraceptive failure, many family planning providers are devoting more time and energy to assisting clients to select the method that is most appropriate for them. Offering the widest possible range of methods—as well as the counseling and education that clients need to choose the method that is best for them and to use it effectively over time—remains critical to this effort.

Helping women to avoid contraceptive failure requires providers to learn more than they have in the past about their clients' lifestyle, needs and desires, as well as about their sexual behavior. For example, many women, especially teenagers, find it difficult to take oral contraceptives every day or to consistently use intercourse-related methods, such as the condom or diaphragm. Others become dissatisfied with their method over time, either because it is not easy to use, they cannot tolerate the side effects, they worry about the method's effectiveness or they do not have their partner's support for using it. Many women undergo contraceptive sterilization at a young age because they have reached their desired family size early—possibly because they have had a mistimed pregnancy as a result of a contraceptive failure—and fear they will not be able to use reversible contraceptives successfully. Some 45% of women who obtained a tubal ligation between 1991 and 1995 were younger than 30.[27]

Helping women avoid unintended pregnancy also entails providing emergency contraception and educating women about the method so they know how to obtain and use it in the event of unprotected intercourse or contraceptive failure.

The Need for Family Planning Clinics Remains Strong

Family planning clinics cannot by themselves solve the complex societal problems that contribute to high rates of unintended pregnancy and poor reproductive health in this country—such as poverty and discrimination, social institutions and practices that leave far too many feeling disenfranchised or without options, a health insurance system that fails to cover many and places a low priority on contraceptive care, a lack of investment in contraceptive research, conflicted societal attitudes toward sexuality, and an unwillingness within families and communities to prepare young people to act responsibly when they become sexually active. Nonetheless, by meeting the need for affordable, high-quality contraceptive and related preventive health care, the nationwide network of family planning clinics has played a vital role in helping millions of couples to achieve their childbearing goals and improve their reproductive health. In doing so, it has had a tremendous impact on American life.

The clinic network—and its core, the Title X program—has been remarkably resilient, striving to carry out its mission in the face of politi-

…the nationwide network of family planning clinics has played a vital role in helping millions of couples to achieve their childbearing goals and improve their reproductive health.

1998

Maryland becomes the first state to mandate comprehensive contraceptive coverage in private insurance plans; Congress requires insurance coverage of contraceptives for federal employees.

cal attack and enormous financial pressure. At a time when the need for subsidized family planning services remains strong, the future of the clinic system will continue to depend on its ability to adapt and to remain financially viable, even in the face of a rapidly changing health care marketplace and an inhospitable political climate.

A renewal of the political and financial commitment to family planning that spurred the government's involvement 30 years ago—and of the commitment to the principles of social justice that lay at the heart of that effort—is crucial to the continued success of subsidized services. Family planning providers stand poised to build on the accomplishments of the past 30 years. Their efforts to help bring to *all* Americans the ability to achieve their childbearing goals and enhance their reproductive health are filled with promise.

1999

The Centers for Disease Control and Prevention cites family planning as one of the top 10 public health achievements of the century.

2000

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The estimate of cervical cancer detection is based on the assumption that screening women every three years would yield 96 cases of invasive cervical cancer for every 100,000 tests performed. (Sources: U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services,* second ed., Washington, DC: DHHS, 1996, p. 110; and International Agency for Research on Cancer Working Group, Screening for squamous cervical cancer: duration of low risk after negative results of cervical cytology and its implication for screening policies, *British Medical Journal,* 1986, 293(6548):659–664.) Thus, the 57.3 million Pap tests performed at Title X–supported clinics would have detected approximately 55,000 cancer cases. An alternative estimate, based on a different screening frequency, would be that annual screening of women with Pap tests would yield 33 cases of cancer for every 100,000 tests performed. Under

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Tables

Table 1. **Publicly supported family planning services help women avoid 1.3 million unintended pregnancies each year–and the births, abortions and miscarriages that would follow.**

Women's characteristics	Unintended events avoided by women obtaining publicly supported family planning services			
	Pregnancies	Births	Abortions	Miscarriages
All women 15–44	1,331,000	534,000	632,000	165,000
Aged <20	386,000	155,000	183,000	48,000
Never-married	888,000	356,000	422,000	110,000
Medicaid-eligible*	842,000	337,000	400,000	105,000

*Includes women currently eligible for Medicaid and those who would become eligible after the birth of a child.

Source: Forrest JD and Samara R, Impact of publicly funded contraceptive services on unintended pregnancies and implications for Medicaid expenditures, *Family Planning Perspectives,* 1996, 28(5):188–195, Table 4.

Table 2. **The risk of pregnancy spans many decades of a woman's life.**

Event	Median age at which event occurs*
Menarche	12.6
First intercourse	17.4
First pregnancy	22.5
First marriage	25.1
First birth	26.0
Intend no more children	30.9
Menopause	51.3

*Age by which half of women have experienced event.

Sources: **All events except menopause:** The Alan Guttmacher Institute (AGI), unpublished tabulations of the 1995 National Survey of Family Growth, New York: AGI, 2000. **Menopause:** Kato I et al., Prospective study of factors influencing the onset of natural menopause, *Journal of Clinical Epidemiology,* 1998, 51(12):1271–1276.

Table 3. **Women who use any contraceptive are far less likely to become pregnant than are those using no method, but choice of method makes a difference.**

Method	% of users aged 15–44 becoming pregnant during first year of use*
No method	85.0
All reversible methods	12.5
Reversible methods plus sterilization	7.1
Male sterilization	0.2
Female sterilization	0.5
Implant, injectable, IUD	3.5
Pill	7.5
Diaphragm	13.1
Male condom	13.7
Periodic abstinence	22.9
Withdrawal	24.5
Spermicides	27.6

*Percentages for reversible methods are estimates based on combined data from 1988 and 1995. Percentages for no method and sterilization are estimates based on various surveys and clinical studies.

Sources: **No method and sterilization:** Harlap S, Kost K and Forrest JD, *Preventing Pregnancy, Protecting Health: A New Look at Birth Control Choices in the United States,* New York: The Alan Guttmacher Institute (AGI), 1991, appendix B, p.120. **All reversible methods and individual reversible methods:** Ranjit N et al., Socioeconomic differentials in contraceptive failure rates in the United States: estimates from the 1988 and 1995 National Surveys of Family Growth, *Family Planning Perspectives,* 2000 (forthcoming); and AGI, unpublished tabulations of the 1995 National Survey of Family Growth, New York: AGI, 2000.

Table 4. **The small proportion of women who do not use contraceptives account for roughly half of all unintended pregnancies.**

Use status	% distribution of women 15–44	
	At risk of unintended pregnancy, 1995 (N=41,796,000)*	Experiencing unintended pregnancies, 1994 (N=3,040,000)
Not using	7.5	47.0
Using	92.5	53.0
Total	100.0	100.0

(Table continues)

(Table 4 continued)

*Women are at risk if they are sexually active, fecund and not currently pregnant, postpartum or seeking pregnancy.

Sources: **Women at risk:** The Alan Guttmacher Institute (AGI), unpublished tabulations of the 1995 National Survey of Family Growth, New York: AGI, 1999. **Unintended pregnancies:** Henshaw SK, Unintended pregnancy in the United States, *Family Planning Perspectives,* 1998, 30(1):24–29 & 46.

Table 5. **In 1965, women of all income levels wanted about the same number of children, but the lower their income was, the more children they had.**

Family income	Births per married woman, 1965	
	Desired*	Actual†
$0–4,999	3.5	4.0
$5,000–9,999	3.2	3.4
≥$10,000	3.2	3.0

*Desired fertility is the number of children a woman would choose if she could have exactly the number she wanted.

†Actual fertility is the number of births a woman already has had plus the number she still expects to have, given her intentions and physical ability to bear children. Among all women, actual fertility included 2.8 previous births plus 0.6 expected births.

Note: In 1965, the poverty level for a family of four was $3,130. Therefore, a family income of $5,000 corresponded to about 160% of poverty, and a family income of $10,000 corresponded to about 320% of poverty.

Source: Ryder NB and Westoff CF, *Reproduction in the United States: 1965,* Princeton, NJ: Princeton University Press, 1971, pp. 19–35 & 59–61.

Table 6. **Because of their low income or youth, half of all women in need of contraceptive services and supplies may require access to publicly supported care.**

Women's age and poverty status	% distribution of women 13–44 in need of contraceptive services and supplies, 1995 (N=33,156,350)*
Aged 20–44/ <250% of poverty	35.0
Aged <20	14.8
Aged 20–44/ ≥250% of poverty	50.2
Total	100.0

*Includes women who are at risk of unintended pregnancy at any time during the year (because they are sexually active, fecund and not currently pregnant, postpartum or seeking pregnancy), but excludes those who are protected by male or female contraceptive sterilization. Women who have a family income below 250% of poverty or are younger than 20 may be in need of publicly supported contraceptive care.

(Table continues)

Source: Henshaw SK, Frost JJ and Darroch JE, State and county estimates of contraceptive needs and services, 1995, in: The Alan Guttmacher Institute (AGI), *Contraceptive Needs and Services, 1995,* New York: AGI, 1997, pp. 5–12.

Table 7. **Most women using family planning clinics are low-income, white and younger than 30.**

Women's characteristics	% distribution of female clinic clients, 1994 (N=6,572,000)
Poverty status	
<100% of poverty	57
100–249% of poverty	33
≥250% of poverty	10
Race/ethnicity	
White	61
Hispanic	14
Black	19
Other	7
Age	
<20	30
20–29	50
≥30	20
Total	100

Source: Frost JJ and Bolzan M, The provision of public-sector services by family planning agencies in 1995, *Family Planning Perspectives,* 1997, 29(1):6–14; and Frost JJ, Family planning clinic services in the United States, 1994, *Family Planning Perspectives,* 1996, 28(3):92–100.

Table 8. **Almost two-thirds of all family planning clinic clients are served at health department or Planned Parenthood sites.**

Type of provider	% distribution of female clinic clients, 1997 (N=6,548,000)
Health department	35.0
Planned Parenthood	28.6
Community health center	11.7
Hospital	12.5
Independent	12.2
Total	100.0

Source: Frost JJ, Family planning clinic services in the United States, 1997, paper presented at the annual meeting of the American Public Health Association, Chicago, Nov. 9, 1999.

Table 9. **Family planning agencies offer a range of services beyond contraception.**

Service	% of publicly supported family planning agencies that provide the service
Nutrition counseling	86
Immunizations	84
Postpartum care	75
Well-baby care	74
WIC program*	67
Prenatal care	64
Sports/work physicals	58
Infertility counseling	57
Primary health care	48
Midlife health	43
Colposcopy	41

*Special Supplemental Food Program for Women, Infants and Children.

Source: Frost JJ and Bolzan M, The provision of public-sector services by family planning agencies in 1995, *Family Planning Perspectives,* 1997, 29(1):6–14.

Table 10. **A significant proportion of women rely on family planning clinics for their reproductive health care.**

Service	% of women who obtain their care from a publicly supported clinic, 1995*
First family planning visit†	42.8
Birth control counseling	31.2
STD testing/treatment	31.2
HIV test	24.9
Pregnancy test	23.4
Birth control checkup	23.3
Birth control method/ prescription	23.2
Pap test	14.7
Pelvic examination	14.4
Reproductive tract infections testing/treatment	14.4

*Based on women 15–44 who obtained each service in the past year.

†Based on women 15–24 who made a first family planning visit in the past five years.

Source: The Alan Guttmacher Institute (AGI), unpublished tabulations of the 1995 National Survey of Family Growth, New York: AGI, 2000.

Table 11. **Most clients of Title X–supported clinics are poor, but few are covered by Medicaid.**

Poverty and Medicaid status	% distribution of female clients, 1994 (N=4,221,000)
Poverty status	
<100% of poverty	60
100–249% of poverty	32
≥250% of poverty	8
Medicaid status	
Recipient	21
Nonrecipient	79
Total	100

Sources: Frost JJ and Bolzan M, The provision of public-sector services by family planning agencies in 1995, *Family Planning Perspectives,* 1997, 29(1):6–14; and Frost JJ, Family planning clinic services in the United States, 1994, *Family Planning Perspectives,* 1996, 28(3):92–100.

Table 12. **Health departments run most of the family planning clinics that receive Title X funding.**

Type of provider	% distribution of Title X–supported clinics, 1997 (N=4,261)
Health department	57.1
Planned Parenthood	14.0
Community health center	7.8
Hospital	5.7
Independent	15.5
Total	100.0

Source: Frost JJ, Family planning clinic services in the United States, 1997, paper presented at the annual meeting of the American Public Health Association, Chicago, Nov. 9, 1999.

Table 13. **Women getting contraceptives from Title X–supported clinics avoided almost 20 million unintended pregnancies over the last 20 years.**

Women's age	Unintended events avoided by women obtaining contraceptive services from Title X–supported clinics, 1980–1999			
	Pregnancies	Births	Abortions	Miscarriages
15–44	18,977,500	7,610,000	9,014,300	2,353,200
<20	5,467,600	2,192,500	2,597,100	678,000

Note: Estimation of unintended events avoided was made using the following methodology: The numbers of female clients served over the period 1980–1998 and adolescent clients in 1995–1998 were obtained by summing annual Title X program statistics (total and adolescent clients in 1999 were assumed to be the same as in 1998). The number of adolescent clients served during the period 1980–1994 was estimated by using the ratio of adolescent clients to total clients that was documented for the period 1995–1998. The total number of unintended events avoided was calculated

using the methodology reported in Forrest and Samara, 1996 (see below), and applying the average number of unintended events avoided per 1,000 women (and per 1,000 adolescents) to the total number of women served over two decades.

Sources: **Clients served:** Title X program statistics from Ku L, Publicly supported family planning in the United States: financing of family planning services, June 1993, report prepared for the Henry J. Kaiser Family Foundation, 1993; and The Alan Guttmacher Institute, Family planning annual report: 1995–1998 summaries, submitted to the Office of Population Affairs, Department of Health and Human Services, 1996–1999. **Methodology for calculating unintended events avoided:** Forrest JD and Samara R, Impact of publicly funded contraceptive services on unintended pregnancies and implications for Medicaid expenditures, *Family Planning Perspectives,* 1996, 28(5):188–195, Table 4.

Table 14. **Despite recent increases, Title X funding has decreased 60% since 1980, when inflation is taken into account.**

Year	Actual Title X appropriation	Inflation-adjusted Title X appropriation*
1980	$162,000,000	$162,000,000
1981	161,671,000	146,069,456
1982	124,176,000	100,548,999
1983	124,088,000	92,387,586
1984	140,000,000	98,183,521
1985	142,500,000	94,037,445
1986	136,372,000	83,723,466
1987	142,500,000	82,038,816
1988	139,663,000	75,474,449
1989	138,320,000	69,391,614
1990	139,135,000	64,012,356
1991	144,311,000	61,067,197
1992	149,585,000	58,936,962
1993	173,418,000	64,493,586
1994	180,918,000	64,221,603
1995	193,349,000	65,677,279
1996	192,592,000	63,212,712
1997	198,452,000	63,359,142
1998	203,452,000	62,943,225
1999	215,000,000	64,259,777

*Constant 1980 dollars, calculated by deflating annual appropriations using the Consumer Price Index for Medical Care.

Sources: Department of Health and Human Services, Family planning program funding history table, <http://www.hhs/progorg/opa/titlex/ofp-hist.html>, accessed Feb. 17, 2000; and Bureau of Labor Statistics, Bureau of Labor Statistics data, <http://www.stats.bls.gov/top20.html#CPI>, accessed Feb. 17, 2000.

Table 15. **Contraceptive use among poor, low-income and minority women has increased dramatically, to a level matching that of higher-income and white women.**

Women's characteristics	% of women 15–44 at risk of unintended pregnancy who use a method*	
	1982	1995
Poverty status		
<100% of poverty	67.8	92.1
100–249% of poverty	80.8	91.4
≥250% of poverty	85.0	93.1
Race/ethnicity		
Black	72.5	89.9
Hispanic	77.6	91.4
White	83.0	93.0

*Women are at risk if they are sexually active, fecund and not currently pregnant, postpartum or seeking pregnancy.

Source: The Alan Guttmacher Institute (AGI), unpublished tabulations of the 1982 and 1995 National Surveys of Family Growth, New York: AGI, 2000.

Table 16. **Managed care enrollment has climbed sharply in the past decade.**

Year	% of insured individuals enrolled in managed care, by type of insurance	
	Private employer–based	Medicaid
1988	29	9.1
1991	58	9.5
1992	56	11.8
1993	58	14.4
1994	65	23.2
1995	69	29.4
1996	74	40.1
1997	81	47.8
1998	86	53.6

Sources: **Private employer–based insurance:** Levitt L, Lundy J and Srinivasan S, *Trends and Indicators in the Changing Health Care Marketplace,* Washington, DC: Henry J. Kaiser Family Foundation, 1998. **Medicaid, 1988:** Calculated from Kaiser Commission on the Future of Medicaid, *Medicaid Enrollment and Spending Growth Factsheet,* Washington, DC: Henry J. Kaiser Family Foundation, 1996; and Kaiser Commission on the Future of Medicaid, *Medicaid and Managed Care: Lessons Learned from the Literature,* Washington, DC: Henry J. Kaiser Family Foundation, 1995. **Medicaid, 1991–1998:** Health Care Financing Administration, National summary of Medicaid managed care programs and enrollment, June 30, 1998, <http://www.hcfa.gov/medicaid/trends98.htm>, accessed Feb. 18, 2000.

Table 17. **The number of women uninsured is rising, while the number covered by Medicaid is falling.**

Year	Women 15–44 uninsured	Women 15–44 on Medicaid
1994	10,545,000	7,596,000
1995	11,011,000	7,415,000
1996	10,901,000	7,137,000
1997	11,687,000	6,372,000
1998	12,050,000	6,050,000

Source: The Alan Guttmacher Institute (AGI), unpublished tabulations of March 1995–1996 Current Population Surveys, New York: AGI, 1999.

Table 18. **Half of all pregnancies in the United States each year are unintended, and one in four end in abortion.**

Intention status and outcome	% distribution of pregnancies, 1994 (N=6,313,800)
Unintended	**48.1**
Abortions	22.6
Births	19.3
Miscarriages	6.2
Intended	**51.9**
Births	43.3
Miscarriages	8.6
Total	100.0

Source: Henshaw SK, Unintended pregnancy in the United States, *Family Planning Perspectives,* 1998, 30(1):24–29 & 46.

Table 19. **The teenage pregnancy rate is higher in the United States than in most other industrialized countries.**

Country	Birth-rate	Abortion rate	Miscarriage rate	Pregnancy rate
Russian Federation, 1995*	45.6	56.1	14.7	116.4
United States, 1996	54.4	29.2	13.8	97.4
Bulgaria, 1996	49.6	33.7	13.3	96.6
Hungary, 1996	29.5	29.6	8.9	68.0
England and Wales, 1995	28.3	18.4	7.5	54.2
Canada, 1995	24.2	21.2	7.0	52.4
Sweden, 1996	7.7	17.2	3.3	28.2
France, 1995*	10.0	10.2	3.0	23.2
Spain, 1995*	7.8	4.5	2.0	14.3
Netherlands, 1992	8.2	4.0	2.0	14.2
Japan, 1995*	3.9	6.3	1.4	11.6

*Pregnancy, miscarriage and abortion rates are underestimated because abortion data are less than 80% complete.

Notes: All rates are per 1,000 women aged 15–19. Miscarriages are estimated as 20% of births plus 10% of abortions.

(Table continues)

Source: Singh S and Darroch JE, Adolescent pregnancy and childbearing: levels and trends in developed countries, *Family Planning Perspectives,* 2000, 32(1):14–23.

Table 20. **Poor women, those younger than 30 and minority women are more likely than others to experience contraceptive failure.**

Women's characteristics	% becoming pregnant during first year of method use
Poverty status	
<100% of poverty	20.5
100–249% of poverty	15.5
≥250% of poverty	9.1
Age	
<18	12.4
18–19	14.0
20–24	15.2
25–29	11.6
30–44	9.5
Race/ethnicity	
Black	18.1
Hispanic	15.5
White	11.2

Note: Includes users of reversible methods only.

Source: Ranjit N et al., Socioeconomic differentials in contraceptive failure rates in the United States: estimates from the 1988 and 1995 National Surveys of Family Growth, *Family Planning Perspectives,* 2000 (forthcoming).