

# **Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics**

The Alan Guttmacher Institute (AGI)

AGI, *Fulfilling the Promise*, 2000

This presentation is based upon The Alan Guttmacher Institute's 2000 report, *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics*. It provides an overview of the history and achievements of the U.S. family planning clinic network, as well as the challenges and opportunities that publicly funded family planning service providers face in the years ahead.

Source: The Alan Guttmacher Institute (AGI), *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics* (New York: The Alan Guttmacher Institute, 2000).

**Women who want  
TWO children  
spend roughly THREE DECADES  
trying to avoid pregnancy**

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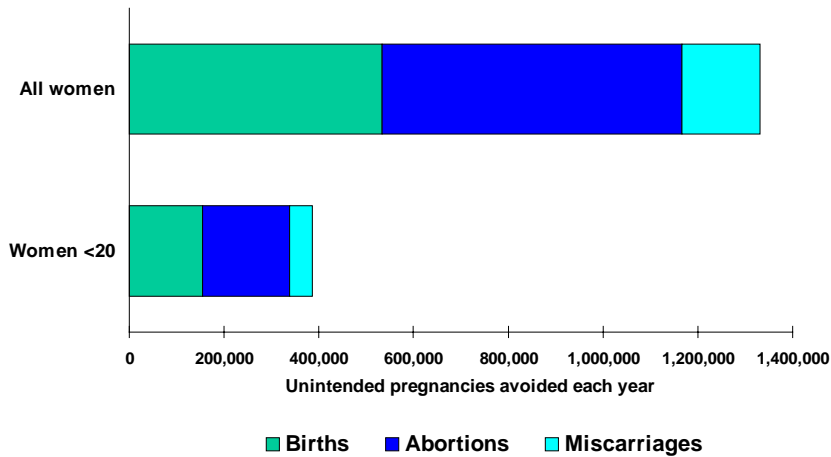
In this country, most women want only two children.\* To achieve this goal, the average American woman spends about three-quarters of her reproductive life (from ages 20-44) trying to avoid unintended pregnancy.

But many women cannot afford contraceptives on their own -- because they are poor, underinsured or uninsured, or young. Many of these women rely on publicly subsidized services.

\**National Center for Health Statistics (NCHS)*, Birth Expectations of Women in the United States, 1973-88, Hyattsville, MD: NCHS, 1995.

Source: AGI, *Fulfilling the Promise*, Table 2, p. 44.

## Publicly supported family planning services help women avoid 1.3 million unintended pregnancies each year



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AGI, *Fulfilling the Promise*, 2000  
Table 1, p. 44

Publicly funded family planning services enable millions of Americans to decide whether and when to have children.

Each year, these services help women avoid 1.3 million pregnancies. Of these, an estimated 534,000 would have resulted in live births, 165,000 in miscarriages, and 632,000 in abortions.

Additionally, 386,000 of the pregnancies that are averted every year due to publicly funded family planning services are to women under the age of 20.

Without these services, the U.S. abortion rate would be 40% higher than it is, and the teenage birthrate would be 25% higher.

Moreover, these services are cost-effective: for every \$1 of public money spent on family planning services, \$3 are saved in Medicaid costs for pregnancy-related and newborn care.\*

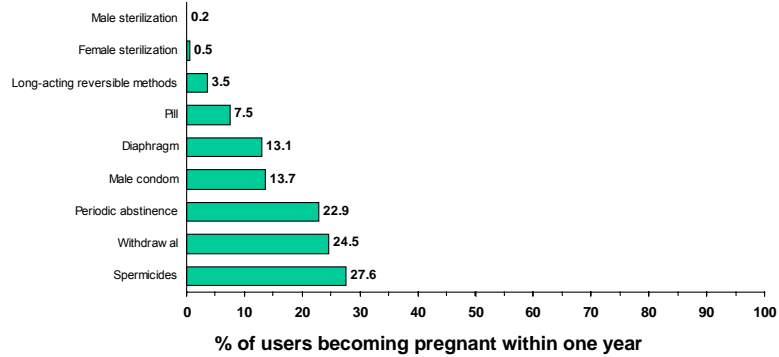
\*Forrest JD and Samara R, *Impact of publicly funded contraceptive services on unintended pregnancies and implications for Medicaid expenditures*, *Family Planning Perspectives*, 1996, 28(5):188-195.

Source: AGI, *Fulfilling the Promise*, pp. 6-7.

## Any contraceptive method is better than none, . . .



## . . . but choice of method makes a difference



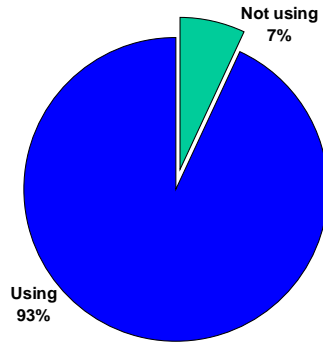
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AGI, *Fulfilling the Promise*, 2000  
Table 3, p. 44

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%.

Source: AGI, *Fulfilling the Promise*, p. 10.

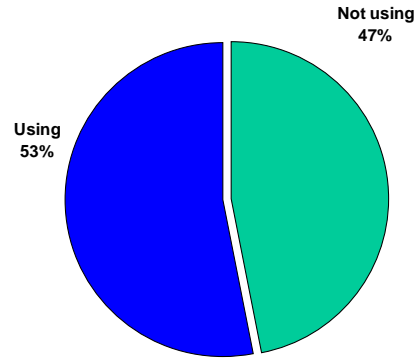
**The small proportion of women who do not use contraceptives . . .**



**Women at risk of unintended pregnancy (42 million)**

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**. . . account for roughly half of all unintended pregnancies**



**Women experiencing unintended pregnancies (3 million)**

AGI, *Fulfilling the Promise*, 2000  
Table 4, p. 44

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.

Source: AGI, *Fulfilling the Promise*, p. 10.

# The Origins of the Family Planning Clinic System

“...no American woman should be denied  
access to family planning assistance  
because of her economic condition.”

President Nixon, 1969

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## Key Developments in the 1960s

- **Modern methods of birth control come on the market (IUD, the Pill)**
- **Groundbreaking research**
  - relationship between income and unintended pregnancy
  - relationship between timing and spacing of pregnancies and maternal-child health

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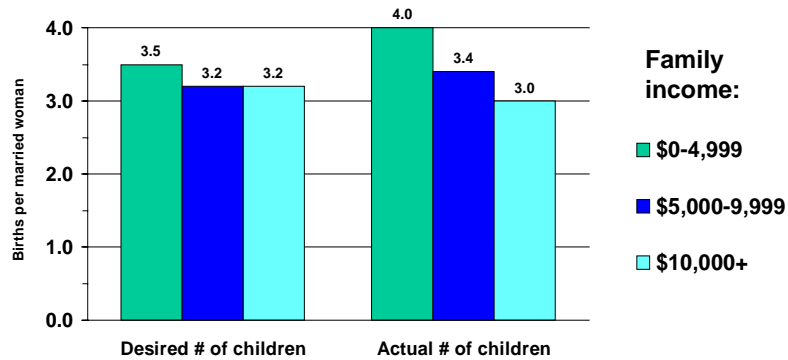
The idea of publicly subsidized family planning services first emerged 40 years ago due to an opportune confluence of circumstances. The 1960s was a time of the women's movement, the civil rights movement, the federal War on Poverty, and concerns over environmental degradation and world population. However, two key developments were most directly responsible for government involvement in this area.

First, the birth control pill and IUD came on the U.S. market, making convenient and reliable methods of birth control a reality for American women.

Second, groundbreaking research disproved the myth that low-income women had larger families because they wanted more children. In fact, the research showed, they had larger families because they could not afford contraceptives, and unintended pregnancies could have serious financial *consequences* for women and their families. At the same time, research also showed that the timing and spacing of pregnancies was closely related to maternal and child health.

Source: AGI, *Fulfilling the Promise*, pp. 10-11.

## In the 1960s, low-income women were likely to have more children than they wanted



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AGI, *Fulfilling the Promise*, 2000  
Table 5, p. 45

Historically, contraception has not been equally available to all women. In the 1960s, many women had more children than they desired - especially if they had low incomes. Research demonstrated that it was unequal access to contraceptives, not a preference for more children, that was responsible for these differences between lower- and higher-income women's family sizes.\*

Research also showed that there were negative health and financial consequences associated with unintended pregnancy.

\**Ryder NB and Westoff CF, Reproduction in the United States: 1965, Princeton, NJ: Princeton University Press, 1971.*

Source: AGI, *Fulfilling the Promise*, pp. 11, 13.

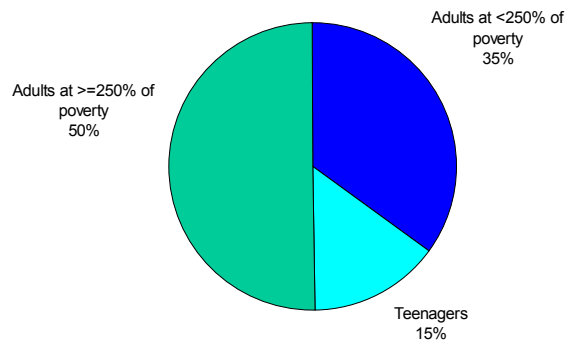


# The Family Planning Clinic System Today

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## Half of all women in need of contraceptive services and supplies may require publicly supported care



**Women in need of services and supplies  
(33 million)**

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AGI, *Fulfilling the Promise*, 2000  
Table 6, p. 45

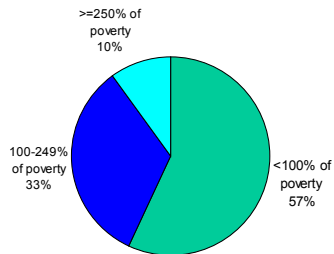
Today, an estimated 33 million American women need contraceptive services to avoid unintended pregnancy.

Half of them may need access to publicly subsidized services because they are poor or low-income (11.6 million American women) or because they are young (4.9 million sexually active teenagers).

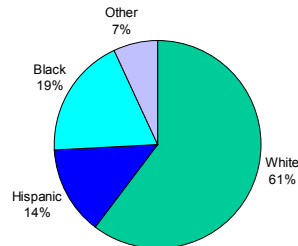
Source: AGI, *Fulfilling the Promise*, p. 16.

## Most women using publicly supported family planning clinics are . . .

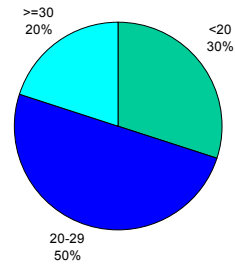
**...low-income,**



**... white and**



**... younger than 30**



**Female clinic clients  
(6.5 million each year)**

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AGI, *Fulfilling the Promise*, 2000  
Table 7, p. 45

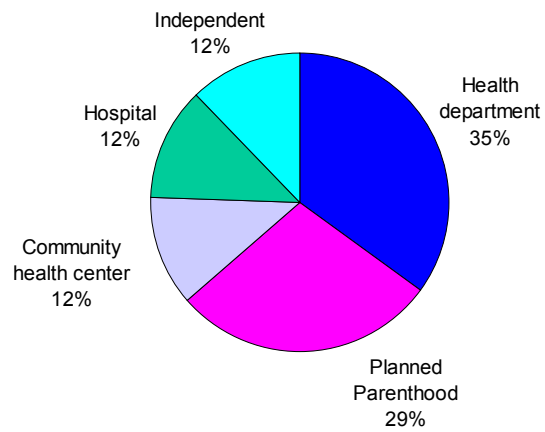
Each year, 7,000 publicly funded clinics serve 6.5 million clients.

Clinic clients are largely low income, white, and between 20 and 30.

Nine in ten clinic clients report family incomes below 250% of poverty (for a single person, up to \$18,674 in 1995 and up to \$20,874 in 2000). One-third are teenagers, and one-half are women in their twenties.

Source: AGI, *Fulfilling the Promise*, pp. 16-17.

## A majority of family planning clinic clients are served at health department or Planned Parenthood sites



**Female clinic clients**

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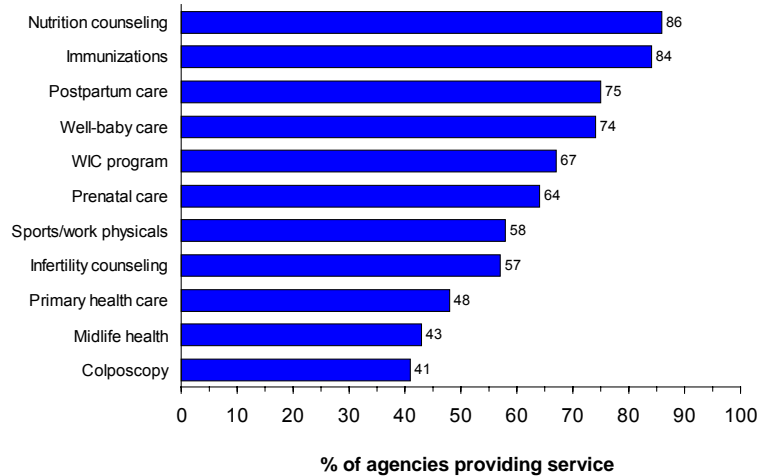
AGI, *Fulfilling the Promise*, 2000  
Table 8, p. 45

Health department and Planned Parenthood sites each serve about one-third of all family planning clinic clients.

Community or migrant health centers, hospital-based sites and independent women's clinics serve the rest.

Source: AGI, *Fulfilling the Promise*, p. 18.

## Family planning agencies offer a range of services beyond contraception



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AGI, *Fulfilling the Promise*, 2000  
Table 9, p. 46

Publicly funded clinics offer both contraceptive and non-contraceptive services.

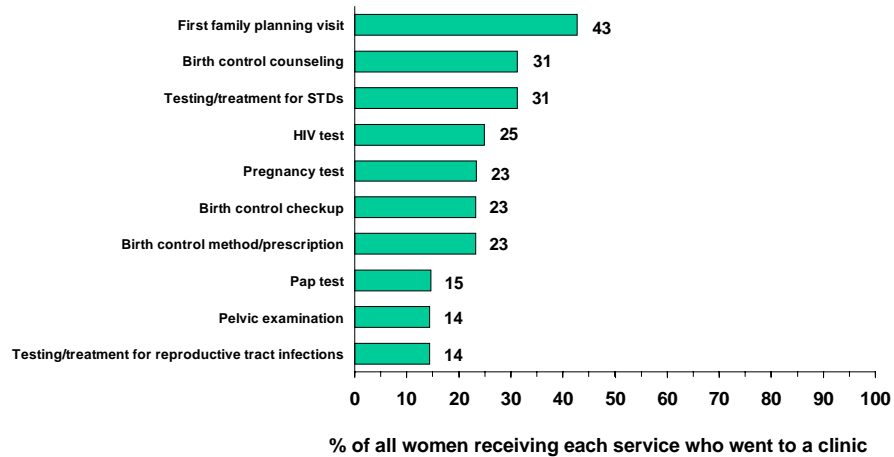
Some of the non-contraceptive services that many clinics provide are nutrition counseling, immunizations, prenatal care, and infertility counseling.

All clinics offer education and outreach within the community, including information about risk factors for HIV and other STDs.

Almost seven in 10 family planning agencies offer outreach, education or other services designed to meet the needs of teenagers and their parents.

Source: AGI, *Fulfilling the Promise*, pp. 18-19.

## Many women rely on family planning clinics for their reproductive health care



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AGI, *Fulfilling the Promise*, 2000  
Table 10, p. 46

Family planning clinics are places where women can get confidential, sensitive contraceptive counseling and choose from a wide range of methods.

The clinic network has also become an integral part of the broader American health care system, offering important preventive health services including Pap smears, breast and pelvic examinations, and screening and treatment for sexually transmitted diseases.

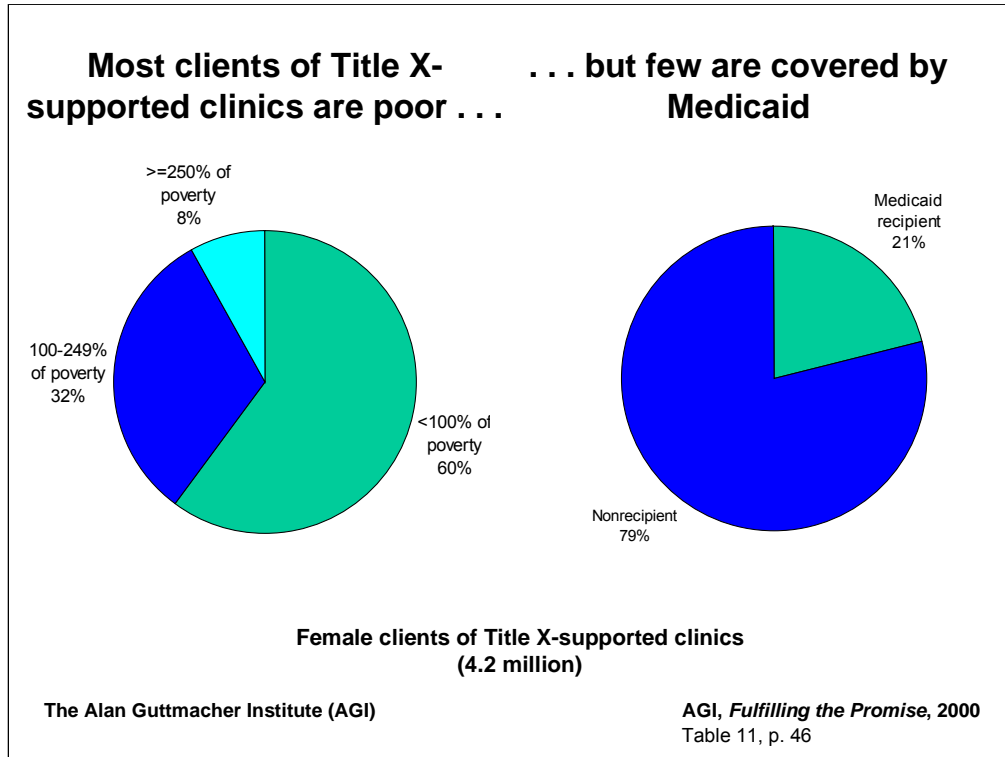
Over four out of 10 women make their first family planning visit to a clinic, rather than a private doctor's office, highlighting just how important clinics are as a source of care for young people. Three in 10 women who get birth control counseling, do so at a clinic. One in four women who obtain birth control checkups and prescriptions do so at a clinic. One in seven women receiving Pap smears do so at a clinic. And one in four women of reproductive age obtaining HIV tests each year, and one in three obtaining other STD services, get these services at a clinic.

Source: AGI, *Fulfilling the Promise*, p. 20.

# The Key Role of Title X

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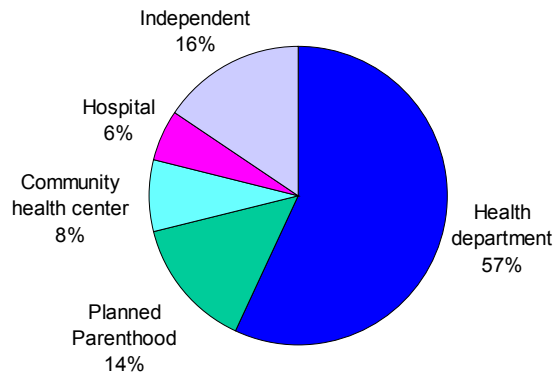
Title X (Ten) is the centerpiece of the national family planning program. It both provides a dedicated source of revenue that helps fund the clinic infrastructure and establishes the principles that guide the delivery of family planning care in this country.

Title X clinics serve more than four million women each year. Over 9 of 10 clients have incomes below 250% of poverty.

Although most clients of Title X-supported clinics are poor, few are covered by Medicaid. Therefore, Title X plays an especially vital role in subsidizing services to uninsured women.

Source: AGI, *Fulfilling the Promise*, p. 23.

## Health departments run most Title X-supported clinics



**Clinics with Title X funding  
(4,300)**

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AGI, *Fulfilling the Promise*, 2000  
Table 12, p. 46

Of the 7000 publicly funded clinics in the United States, more than 4,000 receive Title X funding.

Although Title X is often perceived as a Planned Parenthood program, almost six in 10 clinics receiving Title X funds are health departments. One in seven are run by Planned Parenthood, and one in seven are independent clinics.

On average, clinics with some Title X funding receive about one-quarter of their revenues from the program.

Source: AGI, *Fulfilling the Promise*, p. 24.

## Title X: Program Principles

### ▶ Affordable

- sliding scale fees
- teenagers charged based on their own incomes

### ▶ Method Choice

- range of options to help each individual select the right method
- ensures method choice is voluntary

### ▶ Voluntary

- never a condition for participation in another program

### ▶ Confidential

- especially essential to teenagers seeking care

### ▶ Broad Package of Services

- includes related preventive health care: pelvic exams, blood pressure checks, Pap smears, breast exams

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Title X's principles guarantee that 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.

•To make services **affordable** to all, clients are charged according to their ability to pay. Those with incomes below the poverty line receive services free of charge, while clients with incomes between 100% and 249% of poverty are charged on a sliding scale. Fees for teenagers are based on their own incomes, rather than their parents', so that many adolescents receive services free of charge.

•The Title X regulations also require that 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.

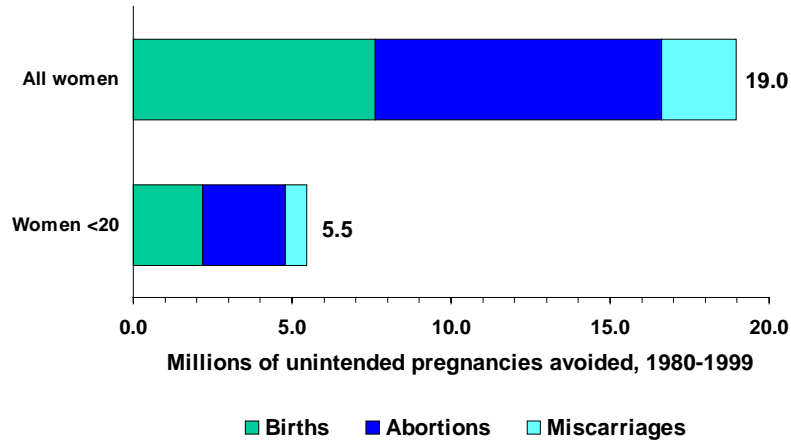
•Clinics must offer patients a **range of methods** to ensure that the method each patient chooses is right for them and that the choice is voluntary.

•All services must be offered on a **confidential** basis. This is an essential factor in encouraging some individuals, especially but not only teenagers, to obtain care.

•Finally, clients visiting Title X-funded clinics for contraceptive care must be offered **related preventive health services**, including pelvic examinations, blood pressure checks, Pap smears and breast exams.

Source: AGI, *Fulfilling the Promise*, pp. 22-23.

**Women getting contraceptives from Title X-supported clinics avoided almost 20 million unintended pregnancies over the last 20 years**



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AGI, *Fulfilling the Promise*, 2000  
Table 13, p. 46

The impact of Title X has been enormous. Over the last two decades, Title X-supported clinics have helped to prevent almost 20 million unwanted pregnancies, nine million of which would have ended in abortion.

The Title X 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 two million 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.

Source: AGI, *Fulfilling the Promise*, pp. 24-25.

## **Title X-supported services protect women's health**

- **STD tests**
  - 19 million between 1995-1998
  - includes 1.4 million HIV tests
- **Breast examinations**
  - 54.4 million over the past 20 years
- **Pap smears**
  - 57.3 million over the past 20 years
  - early detection of some 55,000 cases of invasive cervical cancer

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In addition, Title X-supported clinics have helped many women detect and obtain early treatment for a range of dangerous and even life-threatening medical conditions. Between 1995 and 1998, these providers performed 19 million tests for STDs, including 1.4 million for HIV. Over the past 20 years, an estimated 54.4 million breast examinations have been conducted at Title X-supported clinics, as well as an estimated 57.3 million Pap smears, which resulted in the early detection of as many as 55,000 cases of invasive cervical cancer.

Source: AGI, *Fulfilling the Promise*, pp. 24-25.

## **Political Controversies/Unfounded Accusations**

1. Accusations about teenagers and sex
2. Accusations about abortion

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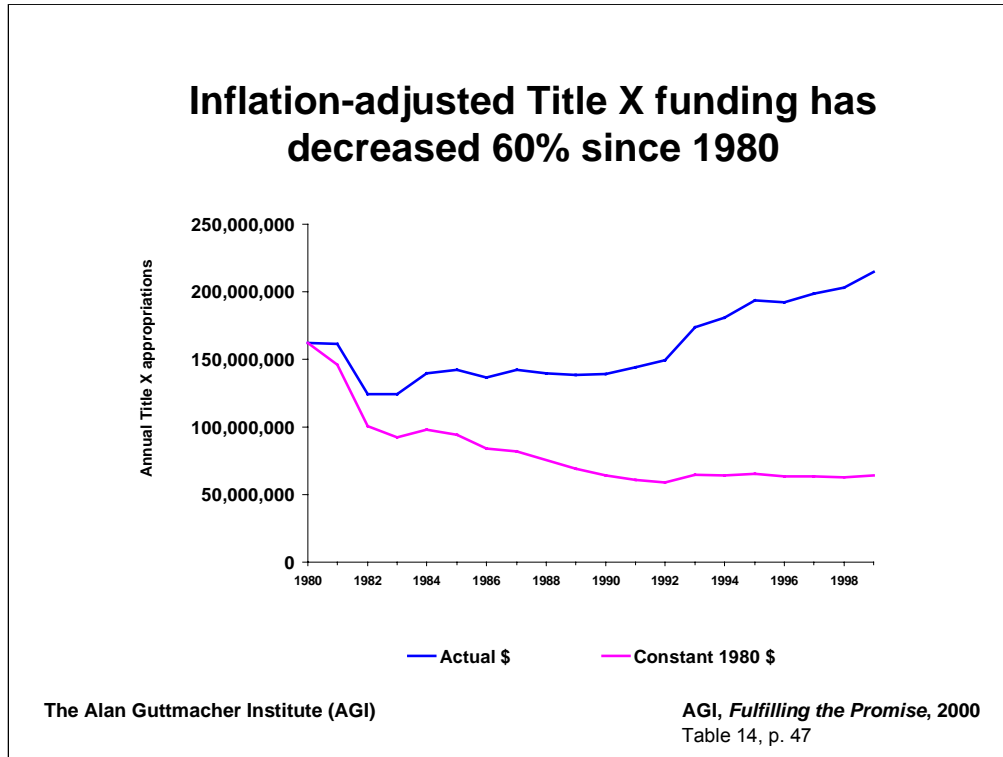
AGI, *Fulfilling the Promise*, 2000

Although nine in 10 Americans support publicly funded family planning, the Title X program has been plagued by political controversy.

One major objection raised by opponents of the Title X program, but unsupported by research data, is that it promotes sexual activity among teenagers. The accusation is unfounded. The availability of contraceptives at clinics does not encourage teenagers to have sex; in fact, the average teenager does not visit a family planning provider until 14 months after she has become sexually active. In addition, 75% of recent declines in teenage pregnancy in the United States is due to improved contraceptive use, rather than increases in abstinence, as critics of the program allege.

The second, similarly unfounded objection Title X opponents raise is that the program promotes abortion, and that family planning clinics have a vested interest in steering women facing an unintended pregnancy towards choosing abortion. To the contrary, non-directive pregnancy counseling ensures that women facing an unintended pregnancy can make the choice that is best for them. Moreover, by law, Title X funds may not be used to pay for abortions. Finally, by enabling women to avoid unintended pregnancies, Title X funding has prevented millions of abortions.

Source: AGI, *Fulfilling the Promise*, pp. 25-27.



Despite their lack of foundation, these controversies have taken a serious toll in terms of depressed program funding. Taking inflation into account, Title X funding in 1999 was 60% lower than it had been 20 years earlier. In annual funding reviews, opponents of Title X have sought either to eliminate the program completely or to impose restrictions that have the potential to cripple service delivery.

For example, in 1982 the Reagan administration imposed a requirement that Title X-supported clinics notify parents before dispensing contraceptives to minors. This “squeal rule” was struck down by several courts, but the issue reemerged in the late 1990s when congressional leaders attempted to attach a parental consent requirement to the annual legislation funding the program.

In 1987, the Reagan administration imposed a “gag rule” forbidding Title X providers from discussing abortion with clients facing unintended pregnancies, even if women specifically requested such information. Several court challenges kept the policy from going into effect, and it was eventually suspended when President Clinton took office in 1993.

These ongoing attacks have cast a cloud over all clinics, not just those with Title X funding, making it more difficult for family planning providers to do their job of providing care to all in need.

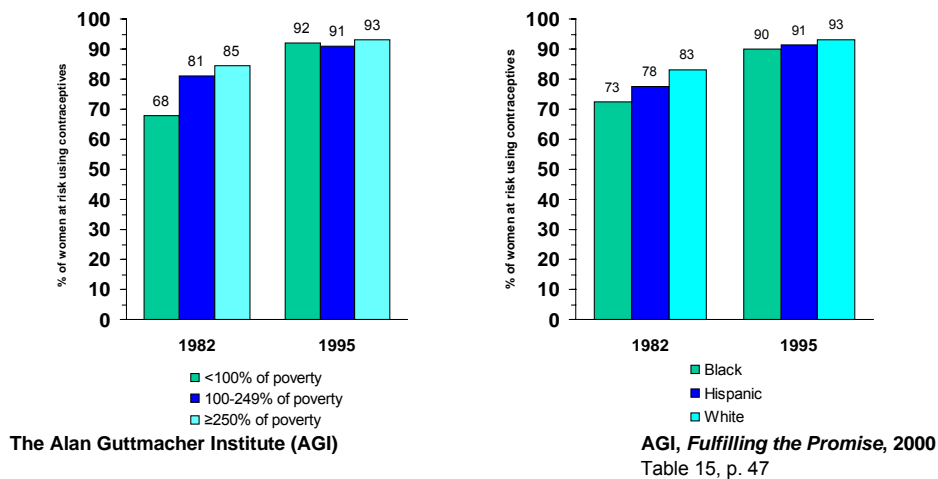
Source: AGI, *Fulfilling the Promise*, pp. 27-28.

# Future Challenges and Opportunities

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## Publicly funded family planning services have nearly eliminated historic differences in contraceptive use



The family planning clinic network has improved the public health and enabled couples to take advantage of economic opportunities that might not have been available to them had they not had the ability to decide whether and when to have children.

A key achievement of publicly funded family planning is that contraceptive use among poor, low-income and minority women has increased dramatically. Between 1982 and 1995, the proportion of women at risk of unintended pregnancy who were using a contraceptive method rose among poor and black and Hispanic women to levels comparable to those among higher-income and white women.

Levels of contraceptive use are now high among all women, regardless of subgroup.

Source: AGI, *Fulfilling the Promise*, p. 30.

## Financial challenges

- **New and rising costs**
  - New contraceptive methods
  - State-of-the-art technology
  - Medical personnel
- **A changing health care marketplace**
  - Rising uninsured population
  - Managed care
  - Caring for increasingly diverse communities

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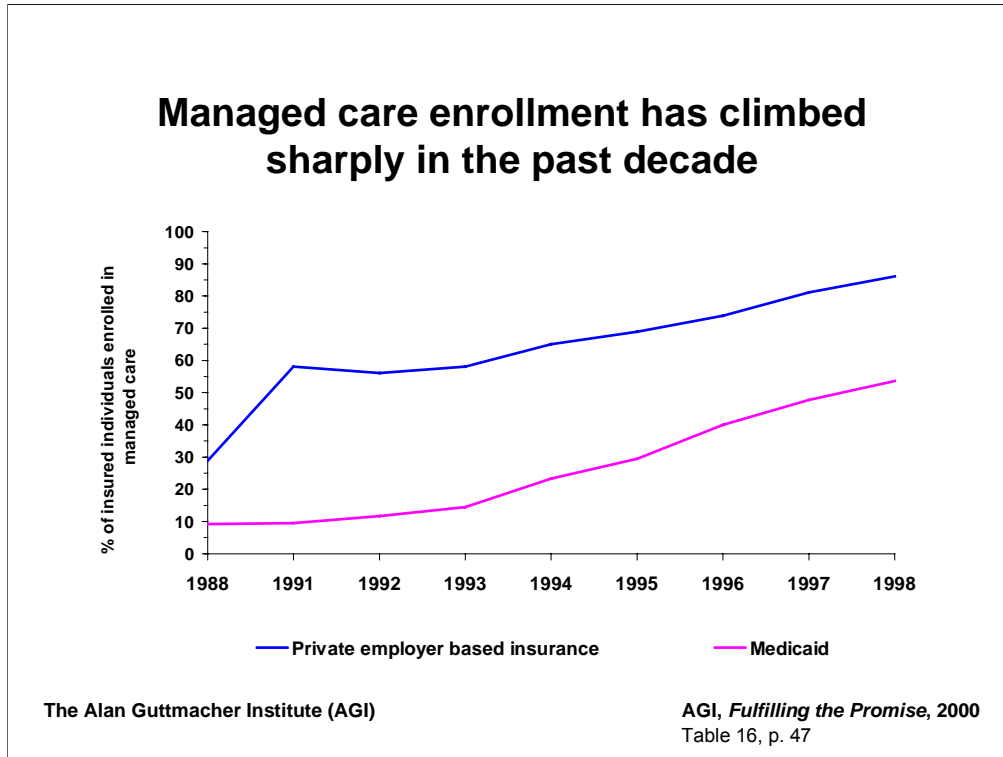
Preserving and building upon the gains of the past 30 years depends on clinics' continued ability to serve the millions of women who rely on them for family planning services, at a time when family planning clinics face serious financial challenges.

Clinics must find ways to pay for extremely effective, but also expensive, new contraceptive methods and technologies for detecting cervical cancer and STDs. For example, a clinic can provide three women with an annual supply of oral contraceptives for less than the cost of providing one woman with the three-month injectable for a year. Yet the injectable is increasingly popular among clinic clients and is now used by 18% of clients at Title X-supported clinics. Clinics are caught between their commitment to offer women a true choice of contraceptives and the realities of what they can afford to provide.

Clinics must also recruit trained personnel who are familiar with the languages and customs of local communities, especially as they attempt to serve increasingly diverse populations. They must also find ways to staff longer hours and weekends to be more responsive to clients' schedules.

And they must serve increasing numbers of Americans without any health insurance, while coping with a rapidly changing health care marketplace that is increasingly dominated by managed care.

Source: AGI, *Fulfilling the Promise*, p. 30-34.



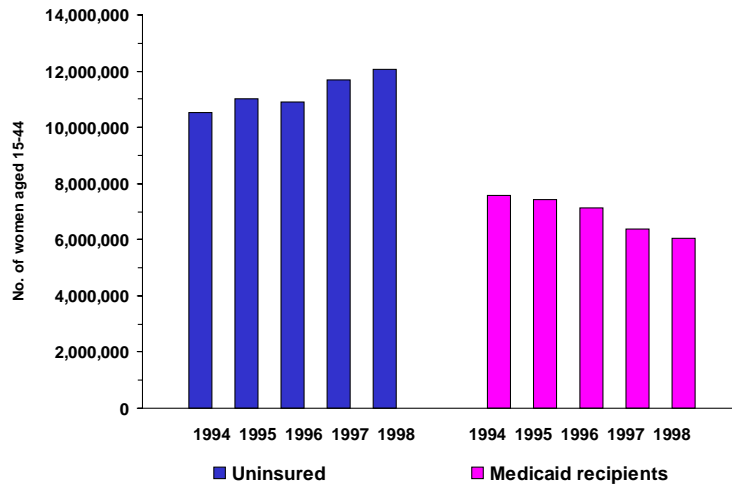
Managed care enrollment has climbed sharply in the past decade in both public and private insurance. But many clinics are not fully integrated into managed care networks, creating two interrelated problems.

First, women with a source of third-party reimbursement who go to plan providers, rather than a clinic, for their family planning care, draw away a potential source of clinic revenue.

Yet if women go out of network to visit a clinic due to a long-standing relationship with the clinic or concerns about confidentiality, the clinics often receive no reimbursement for the services they provide.

Source: AGI, *Fulfilling the Promise*, p. 33.

## The number of women uninsured is rising, while the number covered by Medicaid falls



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AGI, *Fulfilling the Promise*, 2000  
Table 17, p. 48

At the same time, clinics are struggling to meet the needs of a rising uninsured population. The number of uninsured Americans has risen by 10 million over the last decade, to approximately 44 million. This includes 12 million women of reproductive age.

Some of these uninsured women have lost their Medicaid in the wake of welfare reform - and sometimes improperly. Between 1994 and 1998, the number of women of reproductive age enrolled in Medicaid fell by 21%. In addition, 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 benefits.

Many of these uninsured women are eligible for fully subsidized care at Title X clinics because of their low income, placing further financial pressures on clinics.

Source: AGI, *Fulfilling the Promise*, pp. 33-34.

## Expanding the mission

- **To integrate family planning with other reproductive health services**
- **To serve men**

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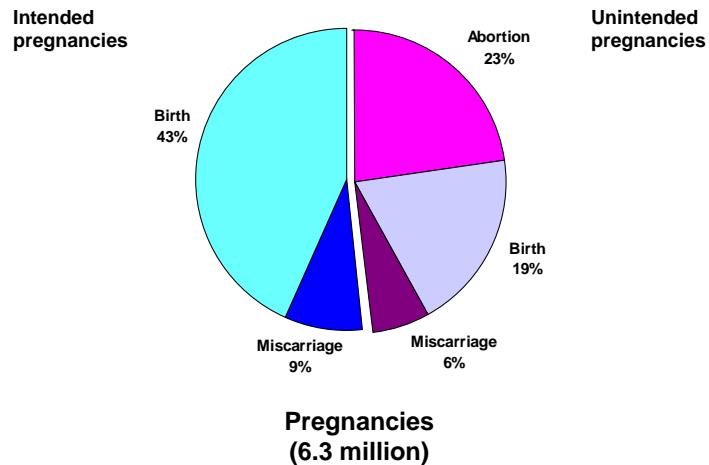
Even during this time of enormous financial pressures, clinics are moving toward more comprehensive models of care.

Some clinics are integrating specialized gynecologic care, routine primary care, comprehensive STD services and cancer screening, in order to deliver coordinated, comprehensive and convenient care.

They are also attempting to better serve men. Although clinics have traditionally viewed men largely in their role as partners of women (for example, testing and treating the partners of female clients who are infected with STDs), they are beginning to consider men's reproductive health needs in a broader context. This includes defining and offering a package of medical and counseling services that addresses men's own reproductive health needs, and figuring out how best to serve teenage males in order to promote responsible sexual behavior throughout their lives.

Source: AGI, *Fulfilling the Promise*, pp. 34-35.

## Half of all pregnancies in the United States each year are unintended



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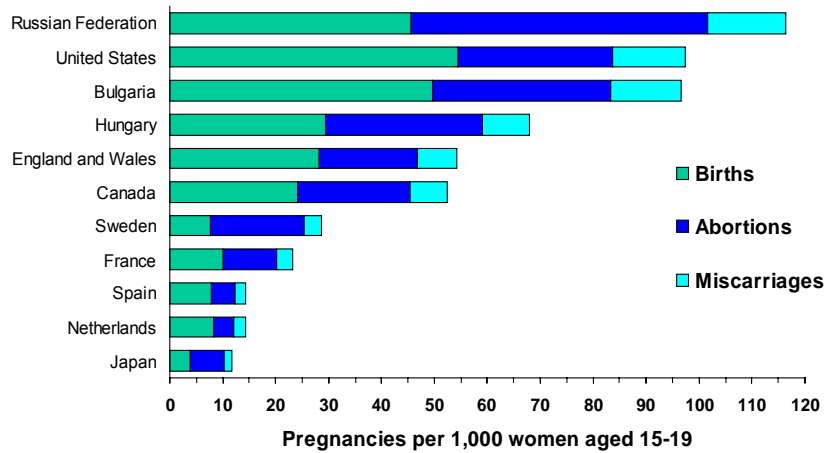
AGI, *Fulfilling the Promise*, 2000  
Table 18, p. 49

Even as clinics work to broaden their public health focus, much work remains to be done to achieve their goal of eliminating unintended pregnancy. Each year, half of all pregnancies in the United States are unintended, and half of unintended pregnancies - or one in four pregnancies overall - end in abortion.

Rates of unintended pregnancy remain highest among young and low-income women -- the groups the publicly funded family planning clinic network serves.

Source: AGI, *Fulfilling the Promise*, pp. 34-35.

## Teenage pregnancy is more common in the United States than in most other industrialized countries



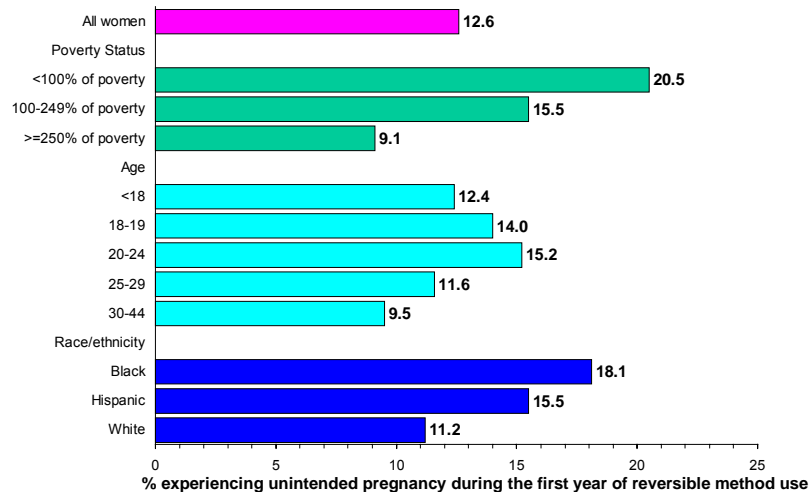
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AGI, *Fulfilling the Promise*, 2000  
Table 19, p. 48

In addition, while the pregnancy rate among U.S. teenagers declined by 17% from its peak in 1990 to 1996, it is still one of the highest among industrialized nations.

Source: AGI, *Fulfilling the Promise*, p. 35.

## Young, poor and minority women are more likely than others to experience contraceptive failure



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AGI, *Fulfilling the Promise*, 2000  
Table 20, p. 48

The risk of contraceptive failure is sometimes inherent to the method itself; often, however, it is due to misuse or inconsistent use.

Certain women experience higher failure rates than others--especially those who are poor or low-income, young, black or Hispanic. These are the groups that clinics are most likely to serve. 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 the effort to help women and their partners use contraceptives more effectively.

Source: AGI, *Fulfilling the Promise*, pp. 36-37.

## Fulfilling the promise

- Closing access gaps
- Improving contraceptive use

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Tackling these remaining problems requires a two-pronged approach.

First, it means reaching out to women who still face barriers accessing care. Many of these women are outside mainstream health care systems and are hard to reach or difficult to serve because they abuse drugs or alcohol, are prisoners or are homeless.

Second, it means working to help women avoid contraceptive failure by devoting more time and energy to helping clients select the method that is most appropriate for them. This requires learning more about their clients' lifestyles, sexual behaviors and number of partners, as well as counseling them about emergency contraception.

Even as they broaden their focus, therefore, clinics have much work left to achieve their original goals. 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 social justice that lay at the heart of that effort - is crucial to fulfilling the promise to give all Americans the ability to achieve their childbearing goals and enhance their reproductive health.

Source: AGI, *Fulfilling the Promise*, pp. 35-38.