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# An Enduring Role: The Continuing Need for a Robust Family Planning Clinic System

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Since the 1970s, publicly subsidized, specialized clinics have played a critical role in providing family planning counseling, contraceptive services and closely related preventive health care to young and low-income women at risk of unintended pregnancy. Currently, nearly 7,700 family planning clinics serve about seven million women annually. Taken together, the clinic system is a major U.S. preventive health care provider and a significant contributor to the nation's health: One in every four women who obtains a contraceptive service in the country does so at a family planning clinic, as does one in three women who obtains an STI service and one in six who obtains either a Pap test or pelvic exam.

Major changes over the last decade in how family planning services are financed are beginning to have significant implications for both the clinic system and its clients. Most dramatically, the role of Medicaid as a source of insurance coverage for family planning services has expanded exponentially over the period. Medicaid now accounts for more than seven in 10 public dollars spent for family planning in the United States (related article, page 24). This growth has come in large part as a result of state-initiated eligibility expansions that make family planning services under Medicaid available to individuals with incomes considerably above the cut-off for program eligibility in general. With states showing that these efforts expand access to care while generating substantial cost-savings, interest in these programs is likely to continue to grow.

Moreover, increasing concerns about the inadequacies of private insurance, and the large and growing number of Americans with no insurance at all, raise the possibility that the United States once again may be ready to take a step toward some form of universal or near-universal health coverage (related article, page 11).

But seismic shifts in insurance coverage for family planning services, actual and potential, raise important issues for the future of the network of family planning clinics. Already, many more low-income women in need of family planning services have a source of third-party reimbursement for their care than was the case only a decade ago. With that coverage, at least theoretically, come expanded options in terms of the providers from whom they could obtain care.

How might this change the provision of family planning services going forward? Will family planning clinics be as important or as necessary in the future as they have been in the past? Or, if given an insurance card—whether under Medicaid or through a private-sector plan—will large numbers of young and low-income women seeking contraceptives and related reproductive health care who have traditionally relied on the clinic system turn to private physicians for their care? These questions are by no means academic. Yet, an examination of the historic willingness of private physicians t serve low-income patients through the Medicaid program, the reasons women who have an alternative source of care give for choosing a family planning clinic, and the attention being given by clinics to those aspects of their service set particularly important to effectively meeting the reproductive health needs of a young and disadvantaged clientele

would indicate strongly that the need for a robust clinic system will be an enduring one.

## States' Experience So Far

Some states have had their Medicaid family planning expansion efforts up and running for the better part of a decade. Data from these states indicate that clients continue to look to family planning clinics for their care nonetheless. In the seven states implementing Medicaid family planning expansions between 1994 and 2001, the proportion of women in need of publicly funded care served at family planning clinics actually rose by 27%, according to Guttmacher Institute data.

California's Medicaid family planning expansion was the first broad-based effort in the nation, and it remains the biggest. The California program intentionally branded itself as a public-private partnership, and has placed a special emphasis on bringing private physicians into the system. The program works hard at provider recruitment through presentations, exhibits, media campaigns, audio conferences and online access to application and orientation materials. These efforts have been successful in bringing large numbers of private physicians into the system; by 2005–2006, these clinicians comprised 63% of all providers participating in the program, giving clients an array of new choices. Yet, these clinicians served only 34% of the clients. In contrast, the 37% of program providers that were clinics served 66% of all clients seen that year.

The continuing reliance on family planning clinics in California's Medicaid family planning expansion, years after its inception, is likely a good predictor of what could be expected in other states as well. "Most physicians," according to Alwyn Cassil of the Center for Studying Health System Change, "treat only a few Medicaid patients; very few physicians treat a lot of Medicaid patients." Indeed, data collected by the center show that among physicians who provide care to Medicaid patients, about 60% derive less than 20% of their total practice revenue from Medicaid.

Moreover, the proportion of private physicians either who have no Medicaid patients currently or who are not accepting new Medicaid patients has been rising steadily, according to the center's Community Tracking Survey. In 2004–2005, 15% of private physicians had no Medicaid patients, and 21% were not accepting new patients covered by the program. In sharp contrast, only 4% of private physicians were not accepting new patients covered by private insurance.

In addition, according to the center, care of Medicaid patients is becoming increasingly concentrated among physicians who practice in large groups, hospitals, academic medical centers and community health centers. When it comes to outpatient services, most of this care is likely delivered in organized programs, such as hospital-based outpatient clinics. More than one in three physicians practicing alone or with only one partner said that they would accept no new Medicaid patients, as did nearly one in four physicians in practices of 3–9 doctors; these proportions have increased significantly in the last decade.

## Why Clinics?

Although some studies have found that women in general would prefer to go to a private physician rather than a clinic for their reproductive health care, a study published in the *Journal of Adolescent Health* in 2000 by Susan Sugerman and colleagues looked specifically at clients at family planning clinics. The study asked women why they were seeking family planning services at a clinic instead of from their usual source of medical care, most often a private physician (see table, page 8). The results of this effort are instructive. Overall, the factors most critical to clients were related to either the cost of care or confidentiality. But clearly, the appeal of family planning clinics goes well beyond those two issues alone: Even if they were able to obtain care elsewhere that was both free and confidential, more than half of the women surveyed said that they still would prefer the clinic.

### *Cost of Care*

Without a doubt, questions of cost are critical. Fortunately, this issue would be greatly diminished under an expanded Medicaid effort, in which clients are not required to pay out-of-pocket for contraceptive services. But the question of cost would be very real under an expan-

sion based on private insurance. According to the Kaiser Family Foundation, an insured worker would, on average, pay $19 for a visit to a primary care provider. The out-of-pocket cost for prescription drugs, on average, ranges from $11 for a generic drug to $43 for a nonpreferred drug. Significantly, the two reasons given most often by adult women in the *Journal of Adolescent Health* study for why they were seeking services from a family planning clinic were related to cost.

*Patient Confidentiality*

Confidentiality is a fundamental principle of the federal family planning effort; it is specifically mandated in the Title X statute and assured in clinics funded through the program. For teens, the desire to obtain confidential services was the reason given most often for choosing a clinic over another health care provider. Yet, a substantial proportion of adults also indicated that confidentiality issues were important.

Although research from the Guttmacher Institute, published in *JAMA* in 2005, shows that most teens report that a parent knows of their clinic visit, it also shows that the consequences of requiring parental involvement would be severe. If parental consent were required for minors to obtain prescription contraceptives, 18% of minors surveyed said they would have sex using no contraceptive method or rely on rhythm or withdrawal; only 1% said that their only response would be to stop having sex.

*Quality and Accessibility*

Quality of care is an umbrella term that encompasses everything from accessibility, communication, client-staff interaction, efficiency and organization, staff competence, physical facilities, contraceptive method choice and patient-centeredness. More than half of the clients interviewed for the *Journal of Adolescent Health* study indicated that quality or accessibility of care were important in their choosing the clinic for their family planning services. Specifically, both teens and adults indicated that care at the clinic was "more personal" or "more convenient" than that available from another type of provider.

Other studies underscore the importance of the personal interaction between the family planning client and the clinic staff. A study published in *Women's Health Issues* in 2002 concluded that if a client receives "personalized" counseling that deals with her individual needs and preferences, she is more likely to be satisfied with the services she receives and more likely to use the contraceptive method she is given at the visit. Similarly, according to a 2004 Guttmacher Institute study, women who reported not feeling comfortable calling their contraceptive provider with a follow-up question were more likely than others to experience a gap in their contraceptive use over the course of a year.

Recognizing that matching a client with the contraceptive method that best fits her life and needs is matching her with the method most likely to be used successfully to avoid an unintended pregnancy, family planning clinics have long emphasized education and counseling. Federal guidelines controlling the care provided under Title X call for "an individualized dialogue with a client" to assist clients "in reaching an informed decision regarding their reproductive health and the choice and continued use of family planning methods and services." In addition, the guidelines specify that counseling be "appropriate to the client's age, level of knowledge, language and socio-cultural background."

## CHOOSING CLINICS

**Women who have a usual source of medical care give a range of reasons for choosing family planning clinics for their reproductive health care.**

| | % citing as reason to choose clinic | |
|---|---|---|
| | Teens | Adults |
| **Cost of Care** | | |
| Usual provider too expensive | 55 | 67 |
| Don't have insurance | 44 | 69 |
| Insurance won't pay | — | 34 |
| **Patient Confidentiality** | | |
| Don't have to involve family | 70 | 31 |
| Usual provider might send records home | 56 | 20 |
| Usual provider might tell family | 55 | — |
| Insurance might send records home | 50 | 16 |
| **Quality and Accessibility** | | |
| Care more personal at clinic | 63 | 52 |
| Clinic more convenient | 58 | 59 |
| **Other** | | |
| Embarrassed to go to usual provider | 37 | — |
| Usual providers are men | 27 | 21 |
| Friends use this clinic | — | 20 |

*Notes:* Among women with usual source of care. Only the top 10 reasons are listed for each group. Women could cite multiple reasons. *Source: Journal of Adolescent Health*, 2000.

According to a study of public and private family planning providers conducted by the Guttmacher Institute in 2005, although all providers reported offering counseling on a wide range of topics at initial visits, private physicians were less likely than clinics to revisit issues such as the patient's experiences, side effects and satisfaction with her contraceptive method at subsequent visits.

Some family planning providers have developed special protocols aimed at getting clients personalized attention. For example, Women and Children's Health Services, a Title X–supported clinic affiliated with Philadelphia's Pennsylvania Hospital, matches each client with a family planning coordinator who helps her navigate through the visit. At the end of the visit, the client has a separate counseling session with her coordinator, in which they go over what the clinician has said, review the contraceptive method chosen and answer remaining questions; the session can take 20–30 minutes. According to Nadine Nelson-Smith, administrative director of the program, the goal is to give each client sufficient time with the coordinator to "develop a relationship, to have someone to call if there's a problem, someone to come back to."

Similarly, clients' comfort level with their provider is an important factor in choosing a provider. Many clinics have taken that message to heart, and underscore the importance of treating clients with the respect they deserve. Jacqui Bannerman, clinical manager at Women and Children's Health Services in Philadelphia, explained "You have to show them that their time is valued. We don't want to keep you here all day. You have to show them that they're valued. That we value you by giving you the information you deserve. That we trust you to give us the information we ask for."

Unfortunately, such an effort is not universal. In fact, some studies have found family planning clinics lacking in this regard. Notably, according to a 1996 evaluation of Title X clinics in the District of Columbia, clinic patients felt that they were not treated with the same level of respect at a clinic as they would be at a physician's office.

Family planning providers often cite the importance of providing services in a language a client understands to being able to provide the level of personal attention a client needs. Nationwide, slightly more than one in 10 clients seen in Title X–funded clinics are considered to have limited English proficiency, although the proportion rises to close to one in three clients in federal region IX, which includes California, Nevada and Arizona. According to Rian Frachele, the state family planning administrator in Oregon, one county health department in the Portland area launched a recruiting effort in the local Latina community, so clients would be able to interact with a clinical and administrative staff whose first language is Spanish. The effort, they found, provides clients with the language assistance they need, while strengthening the agency's ties to the local community.

Family planning clinic staff frequently mention the focused expertise of a family planning clinic, backed up by specialized training and program standards, when discussing quality of care. Although primary care providers are likely to have had general training in reproductive health care, they may not have the specialized training and experience of a staff that provides nothing but that care. Title X providers, in particular, cite the program's standards, which support both a high standard of care and adoption of the latest innovations such as new screening guidelines.

Another set of issues relates to the accessibility of care. In the 1996 study of services in the District of Columbia, access and convenience were cited by women both as important considerations in their choice of providers and as areas in which problems arose when they actually sought care. Family planning providers work hard to address these concerns. For example, Family Practice and Counseling Network, a Title X–funded community health center in Philadelphia, runs shuttle vans from local housing developments to their clinics for clients for whom transportation might be a problem. Other providers have moved to expand clinics located in the communities where their clients live and extend service hours to better meet clients' needs (related article, Spring 2007, page 13).

Still others stress the importance of the "one-stop-shopping" clinics provide. For example, a woman may have an examination at a physician's office, but she would have to make a second trip to a pharmacy to obtain oral contraceptives. Moreover, many pharmacies will only dispense a one-month cycle of pills, meaning that the woman will have to return on time each month to avoid gaps in her contraceptive use. For a woman using either an injectable or an IUD, three trips could be involved: one to the physician for the examination and prescription, a second to the pharmacy for the medication or device and a third back to the physician for the injection or insertion. In contrast, a client generally can obtain an examination and several months' worth of contraceptive supplies in one clinic visit.

## Moving Forward

Efforts to expand coverage in the United States could bring welcome relief to many women. In 2006, 20% of reproductive-aged women—some 12 million women—lacked any form of insurance. Among poor women, the situation is even more dire: Fully 40% of the nine million reproductive-aged women with a family income below poverty were uninsured. Clearly, there is a long way to go.

Yet, as the nation begins to move, however haltingly, to expand access to insurance for contraceptive and closely related services—either through Medicaid expansions or as part of more broad-based health care reform—it is entirely valid to examine the likely role of and need for the network of family planning clinics going forward. If past is prologue, however, there is ample reason to believe that the clinic system will continue to be a critical provider of this care, regardless of changes in how the care is financed.

Data from California, which has a decade of experience with expanded Medicaid eligibility for family planning, and from surveys of physicians generally, raise serious questions about the capacity or willingness of private physicians to play a major role in providing family planning services to a low-income clientele. The extent to which physicians are accepting Medicaid patients at all has been shrinking steadily. And although physicians queried by the Center for Studying Health System Change about their reluctance to accept new Medicaid patients most often pointed to issues related to reimbursement, fully half cited low-income individuals' complicated and specialized needs. These factors are likely to be central in determining physicians' willingness to accept or effectively serve large numbers of low-income family planning clients, for whom Medicaid reimbursement is often insufficient to cover the cost of providing services and for whom time-intensive counseling and language assistance are critically important.

In sharp contrast, family planning provider agencies are specifically designed and organized to serve this clientele, and the staff are specially trained to provide the package of care they need. A focus on community outreach and intensive client counseling and education are hallmarks of their service set. Reflecting changes in their local communities, clinics are increasingly emphasizing language assistance through a range of innovative approaches involving the educational materials available in clinics, as well as the composition of both the clinical and administrative staff.

The decreasing willingness of private physicians to serve Medicaid clients combined with clinics' focus on the specific needs of their client base will likely mean that giving women a source of payment is unlikely to substantially reduce their historic reliance on specialized family planning clinics. Added to that is the inevitable reality that, even under the most optimistic scenario for either a Medicaid expansion or health care reform, large numbers of individuals—including both recent immigrants and those who are here illegally—are likely to be left out entirely. Clearly, the need for a vibrant network of family planning clinics is likely to continue to be as critical as ever. www.guttmacher.org

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