Family Planning Perspectives
Volume 33, Number 3, May/June 2001

Family Planning Clinic Services in the United States: Patterns and Trends in the Late 1990s

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Context: Publicly funded family planning clinics are a vital source of contraceptive and reproductive health care for millions of U.S. women. It is important periodically to assess the number and type of clinics and the number of contraceptive clients they serve.

Methods: Service data were requested for agencies and clinics providing publicly funded family planning services in the United States in 1997. The numbers of agencies, clinics and female contraceptive clients were tabulated according to various characteristics and were compared with similar data for 1994. Finally, county data were tabulated according to the presence of family planning clinics and private physicians likely to provide family planning care and according to the number of female contraceptive clients served compared with the number of women needing publicly funded care.

Results: In 1997, 3,117 agencies offered publicly funded contraceptive services at 7,206 clinic sites. Forty percent of clinics were run by health departments, 21% by community health centers, 13% by Planned Parenthood affiliates and 26% by hospitals or other agencies. Overall, 59% of clinics received Title X funding. Agencies operated an average of 2.3 clinics, and clinics served an average of 910 contraceptive clients per year. Altogether, clinics provided contraceptive services to 6.6 million women—approximately two of every five women estimated to need publicly funded contraceptive care. The total number of providers and the total number of women served remained stable between 1994 and 1997; at the local level, however, clinic turnover was high. Some 85% of all U.S. counties had one or more publicly funded family planning clinics; 36% had one or more clinics, but no private obstetrician-gynecologist.

Conclusions: Publicly funded family planning clinics are distributed widely throughout the United States and continue to provide contraceptive care to millions of U.S. women. Clinics are sometimes the only source of specialized family planning care available to women in rural counties. However, the high rate of clinic turnover and the lack of significant growth in clinic numbers suggest that limited funding and rising costs have hindered the further expansion and outreach of the clinic network to new geographic areas and hard-to-reach populations.

Family Planning Perspectives, 2001, 33(3):113-122

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The authors would like to thank Susheela Singh for comments on earlier versions of this article and Shelby Pasarell, Jamie Cipriano, Elayne Heisler, Vanessa Woog, Lucy Gordon, Ayana Mangum and Andrey Iospa for assistance with data collection, follow-up and data processing. The research on which this article is based was supported in part by the Office of Population Affairs, U.S. Department of Health and Human Services (DHHS), under grants FPR000057 and FPR000072. The conclusions and opinions expressed in this article do not necessarily represent the views of DHHS, however.

County-level data available

In 1995, one in six American women obtaining contraceptive or other reproductive

health care visited a clinic that received public funding for family planning services.[1] This network of clinics is an especially important source of family planning care for millions of American women who are at high risk of unintended pregnancy and who are unable to afford reproductive health care on their own. Women obtaining care from publicly funded family planning clinics are typically eligible for fully or partially subsidized care, usually because their family income is less than 250% of the federal poverty level or because they are teenagers. Almost three in four are younger than 30, and about 70% are unmarried.[2]

Family planning clinics are extremely diverse. They are run by a variety of agencies, including health departments, hospitals, Planned Parenthood affiliates and community or migrant health centers, as well as various agencies (such as women's clinics or community-based health clinics) that are not affiliated with other provider types. Their funding comes from public and private sources that support family planning and other clinic services. Public sources include Title X family planning funds, Medicaid reimbursements, Maternal and Child Health (MCH) and Social Services block grants, and Bureau of Primary Health Care funds (e.g., community or migrant health center funds), as well as state and local funds. Private sources include patient fees, donations and insurance receipts.

Finally, clinics that provide publicly funded family planning care usually offer other services, including preventive and specialized reproductive health care such as Pap tests and pelvic exams; testing and treatment for sexually transmitted diseases; prenatal and postnatal care; and infertility testing, counseling and treatment. Some offer primary care as well.[3]

This article assesses the type and the geographic distribution of publicly funded family planning clinics and their capacity to meet the contraceptive service needs of American women. We present data obtained from a complete enumeration of all publicly funded family planning clinics and clients in the United States in 1997 and examine changes since 1994, when data from the last such enumeration were collected.[4] Data are presented as national totals and, in some cases, by region and state.[*] The importance of clinics at the local level is assessed by presenting the percentage of counties in each state that have clinics and the percentage that have a clinic, but no private obstetrician-gynecologist or family practice doctor, and by the ratio of the number of women served in publicly funded clinics to the number of women in need of publicly funded contraceptive services.

METHODOLOGY

Data Collection

Service data were collected for every agency and for each of its clinic sites that provided publicly funded family planning services in 1997 in all 50 states and the District of Columbia, as well as in six Pacific and two Caribbean territories of the United States. The methodology and definitions used for this study, which are similar to those used in previous surveys,[5] are described fully elsewhere.[†] Basically, family planning agencies are defined as organizations that have operating responsibility for clinics where contraceptive services are provided. An agency qualifies for inclusion in the universe of publicly funded family planning agencies only if it offers contraceptive

services to the general public and provides those services free of charge or at a reduced fee to at least some of its clients, or subsidizes its services with the receipt of public funds (including Medicaid). This definition excludes private physicians and health care centers serving only restricted populations, such as health maintenance organization enrollees, students, veterans and military personnel. It includes sites that provide only education and counseling and dispense only nonmedical contraceptive methods if the sites maintain individual charts for contraceptive clients.

Data collection focused on identifying all publicly funded family planning agencies and clinic sites that provided contraceptive services in 1997 and on obtaining information for that year on the total number of female contraceptive clients and the number of female contraceptive clients younger than 20 served at each site and on clinic receipt of Title X funds. To identify all agencies and clinics fitting our definition, we began with the universe identified in the 1994 enumeration.[6] Using a variety of sources, including lists of Title X-supported clinics, Planned Parenthood Federation of America clinic directories and lists of community and migrant health centers from the Bureau of Primary Care,[7] we then added and updated addresses and names of potential agencies and clinics.

We mailed requests for service data to all Title X grantees and to state family planning administrators—which often collect data for clinic sites falling within their jurisdictions—and to about 2,000 individual agencies. We followed up nonrespondents through additional mailings, faxes and phone calls. Title X grantees and state family planning administrators provided client data for 4,232 family planning clinics, and nearly 1,000 individual agencies reported data for an additional 1,980 family planning clinics. We telephoned all agencies for which we received no data to confirm that they provided publicly funded family planning services.[‡]

Estimating Missing Data

We identified 3,117 agencies and 7,206 clinics that had provided publicly funded family planning services in 1997. Overall, the number of female contraceptive clients was reported for 86% (6,212) of all family planning clinics. The remaining 14% (994 clinics) did not or could not provide or estimate the number of family planning clients they served. For these sites, we used two methods to estimate how many clients had been served in 1997. For 5% of clinics, we estimated that the number was the same as that reported to AGI in earlier surveys, most commonly in 1994. No earlier data were available for the remaining 9% of clinics, so we estimated the number of female contraceptive clients served as the average number served by similar clinics (defined as those in the same region, of the same Title X funding status, metropolitan or nonmetropolitan status and provider type).[§] Most of the sites whose client numbers were estimated using this method were community or migrant health centers or hospitals; none were funded by Title X.

Overall, we used these procedures to estimate 10% of all female contraceptive clients enumerated; for teenagers, the total percentage estimated was 14%. This discrepancy occurred because some clinics could provide total client numbers, but did not have separate figures for teenage clients. For these sites, we used the average percentage of total clients represented by teenagers at similar sites to estimate the number of teenage clients.

Data Analysis

In the following analyses, we present data for agencies, clinics and clients according to the type of provider responsible for clinic operations. Providers are classified as health departments (including state, county, district or local health departments), hospitals, Planned Parenthood affiliates, community or migrant health centers (including only clinics that report or are listed as receiving Bureau of Primary Care 329 or 330 funds) or "other" agencies—community-based clinics that receive other Bureau of Primary Care funds, including those listed as Federally Qualified Health Center Look-Alike sites,[8] or other women's centers or primary care clinics that are not affiliated with any of the other provider types. We also present data according to whether sites received Title X support, by metropolitan or nonmetropolitan location (defined according to metropolitan designation of the county in which they are located) and by region (according to the 10 federally designated regions of the country).

Additional Data Sources

We used the 1998 Area Resource File[9] to classify counties according to the presence of private physicians likely to provide family planning care. This file contains county-specific counts of the number of private obstetrician-gynecologists and family practice physicians—the two physician specialties most likely to provide contraceptive care.** We determined the proportion of counties, nationally and by state, with a clinic, with a Title X-funded clinic, and with clinics but without private providers. Finally, we present previously published estimates of the number of women in need of publicly funded contraceptive services in each state (1995 estimates)[10] and compare these with the number of women served by publicly funded providers in 1997.

Limitations

Although we used rigorous methods to obtain accurate information on publicly funded clinics and the number of contraceptive clients they serve, several limitations may affect our interpretation of these data. First, we believe this to be a near-complete count of all providers fitting our definition; nevertheless, given the rapid changes occurring in health care provision generally, we may have inadvertently omitted a small number of qualified sites. Second, some agencies, generally hospital outpatient departments or community or migrant health centers, provided us with estimates of contraceptive clients served per year because they did not have documented service figures. Finally, for about 14% of clinics, we estimated the number of clients based on either prior data or the experience of similar clinics. Each of these steps may have introduced error into the final counts of providers and contraceptive clients. Although the potential level of error from these factors is unlikely to influence the national or state-level estimates of contraceptive clients, it may have greater implications for county-level estimates.

In addition, these data provide information only on the number of women who obtain care from publicly funded clinics. Women who obtain publicly funded care (for example, care paid for by Medicaid) from private physicians are not included in our analysis. Thus, presentation of the ratio of women served at publicly funded clinics to women in need of publicly funded contraceptive care does not fully reflect women's

use of such care.

RESULTS

National Estimate

The total number of publicly funded providers offering clinic-based contraceptive care to American women remained stable between 1994 and 1997. In 1997, 3,117 agencies administered services at 7,206 clinic sites where publicly funded contraceptive services were offered; in 1994, those figures were 3,119 and 7,122, respectively. Altogether, 6.6 million women obtained contraceptive services from these providers in each year.

•*Agencies.* The distribution of family planning agencies by provider type remained roughly the same over the four-year interval, with nearly half of all agencies being health departments; hospitals, community or migrant health centers and "other" agencies each accounted for about one in six agencies, while only one in 20 agencies were Planned Parenthood affiliates (Table 1). The number of family planning agencies that were hospitals or Planned Parenthood affiliates fell by 12-14% between 1994 and 1997, and the number that were community or migrant health centers grew by 8%; the number of health department agencies remained about the same. Finally, as in 1994, approximately six in 10 agencies reported receiving Title X funding in 1997; 56% had received Title X funds at all of their clinics and 5% at some clinics (data not shown).

•*Clinics per agency*. Overall, in both 1994 and 1997, family planning agencies ran an average of 2.3 clinics, with 60% of agencies responsible for only one clinic, nearly 30% responsible for 2-4 clinics and about 10% operating five or more clinics (data not shown). The average number of clinics per agency, however, varied substantially by agency type. In 1997, the average ranged from 1.6 clinics per hospital agency to 6.7 clinics per Planned Parenthood affiliate, with health departments, community or migrant health centers, and "other" agencies averaging 2.0-2.7 clinics per agency (Table 1). Between 1994 and 1997, the average number of clinics per agency decreased from 2.2 to 2.0 for health departments, while it increased or remained stable for all other types of agencies. The average number of clinics per Planned Parenthood affiliate climbed from 5.9 in 1994 to 6.7 in 1997, and the average per community or migrant health center rose from 2.4 to 2.7.

•*Clinic network composition*. The number of health department agencies providing publicly funded contraceptive services changed little between 1994 and 1997. Nevertheless, because of the decline in the average number of clinics per health department agency, the percentage of all clinics run by health departments fell from 44% in 1994 to 40% in 1997, a net decline of 7% (Table 2, page 116). Conversely, the percentage of all clinics providing family planning care that were run by community or migrant health centers rose from 17% in 1994 to 21% in 1997, a net increase of 23%. This increase reflects both a rise in the number of community or migrant health center agencies providing family planning services and an increase in the number of clinics per agency that offer family planning care. On the other hand, the relatively small decrease in the number of clinics run by hospitals and Planned Parenthood affiliates (3% each, compared with the 12-14% decrease in agency numbers) reflects a general pattern of consolidation of clinics into fewer agencies, rather than large reductions in

clinic sites.

•*Clinic turnover*. The turnover among clinics of all types was substantial, with about one clinic out of seven overall closing or discontinuing family planning service provision between 1994 and 1997 and a similar number of new sites opening or initiating family planning service provision (Table 2). Some 990 clinics included in the 1994 census of publicly funded family planning providers were no longer available to women in 1997: About 46% had stopped offering family planning services, while 54% had closed their doors altogether (data not shown). Health departments reported the largest number of clinics terminating family planning services over the period (390); of these, 44% remained open but stopped providing family planning services and 56% closed altogether. Among hospital and community health center clinics that no longer offered family planning services, most remained open and continued to provide other heath services. In contrast, virtually all of the Planned Parenthood sites that had terminated contraceptive services had closed altogether.

These terminations of service reflect a variety of circumstances—consolidations or mergers of agencies; new organizations or agencies assuming control of clinic services and closing or restructuring service delivery sites; and, in a few states, widespread closing of health department clinics due to shifts away from direct service provision by the state health department. Some agencies reported that some of their sites had closed or stopped providing family planning services, but that the agency had opened new sites. In other cases, clinics had been taken over by a different agency or organization; these are categorized in Table 2 as reclassified clinics. For example, some health department clinics had been taken over by local hospitals and reopened as satellite clinics of the hospital.

Although nearly 1,000 clinics stopped offering family planning services between 1994 and 1997, 1,074 new clinics opened or began providing family planning services during that period. Two-thirds of these new clinics were run either by community or migrant health centers (43%) or by "other" types of agencies (24%).

The proportion of clinics reporting receipt of Title X funds (59%) did not change between 1994 and 1997. Clinic turnover was substantially greater among clinics that did not receive Title X funds. Among clinics with Title X funding, about one in 11 sites providing services in 1994 were no longer doing so in 1997, compared with one in five among clinics without Title X funding. Likewise, one in 12 Title X-funded clinics providing services in 1997 had begun doing so since 1994, compared with one in four clinics that did not receive Title X funds.

Publicly funded family planning clinics are widely distributed across the country. In both 1994 and 1997, slightly more than half (53-54%) of all clinics were located in metropolitan counties (Table 2). The distribution of clinics according to region of the country also remained stable over the period, with the southeastern states (Region IV) maintaining about one of every four publicly funded family planning clinics (23%). Most regions experienced a net change in clinic numbers of 3% or less.

•*Women served*. In 1997, 6.6 million female contraceptive clients were served by publicly funded family planning clinics, virtually the same as in 1994 (Table 3). Health departments and Planned Parenthood clinics together accounted for 64% of all

women served, while hospitals, community or migrant health centers and "other" types of providers each served 10-14% of contraceptive clients.

Overall, the average number of female contraceptive clients served per clinic declined slightly, from 923 in 1994 to 910 in 1997. Planned Parenthood clinics served about twice as many contraceptive clients per clinic (2,056) as hospital clinics (1,077), nearly three times as many as health departments (792) or "other" clinics (782), and more than four times as many as community or migrant health centers (453). The average number of contraceptive clients served per health department clinic rose by 16% between 1994 and 1997 (from 681 to 792); all other provider types experienced declines in average numbers of clients served. Hospital-run clinics experienced the largest decline (from 1,319 clients per clinic in 1994 to 1,077 in 1997), while Planned Parenthood clinics experienced a small decline (from 2,074 to 2,056).

Given changes both in the number of clinics of different provider types and in the average number of clients served at clinics run by different providers, the overall distribution of female clients by provider type shifted somewhat between 1994 and 1997. For health departments, the rise in clients served per clinic more than offset the decline in the number of health department sites nationwide that were providing family planning services. Thus, the total number of female contraceptive clients served by health departments actually rose from 2.1 million in 1994 to 2.3 million in 1997, and the proportion of all female contraceptive clients served by health departments rose from 32% to 35%. The increase in the total number of clients served by community or migrant health centers between 1994 and 1997 primarily reflects the greater number of sites offering family planning services. In contrast, the decline in the number of clients served by hospital clinics between 1994 and 1997 resulted from a decrease in both the number of sites and the average number of clients per site.

In both 1994 and 1997, about two-thirds of all female contraceptive clients served by publicly funded family planning clinics received care from sites funded by Title X (Table 3). Among the 4.3 million women served in 1997 by clinics that received Title X funding, 47% received care at health department clinics, 28% at Planned Parenthood clinics, 14% at "other" clinics, 7% at hospital sites and 3% at community or migrant health centers. In contrast, among the 2.3 million women who obtained contraceptive care from clinics that were not funded by Title X, 12% received services at health department clinics, 29% at Planned Parenthood sites, 12% at "other" clinics, 23% at hospital sites and 24% at community or migrant health centers (data not shown). Among all clients served, 73% received care from clinics located in metropolitan counties.

Regional Estimates

•*Providers.* The distribution of family planning providers by type varies markedly according to region of the country (Table 4). Health department clinics, which made up 40% of all family planning clinics nationwide in 1997, were virtually nonexistent in the northeastern states (Region I) and accounted for only 17% of clinics in Region II (New York and New Jersey). In contrast, they were the dominant provider of publicly funded family planning clinic care in Region IV (the Southeast), where they accounted for 70% of all family planning clinics.

In Region I, two-thirds of all clinics fell into the "other" clinic category (37%) or were community or migrant health center clinics (30%). Region II and Region V (the Midwest) had the highest concentrations of Planned Parenthood clinics (25% and 22%, respectively). Like Region I, Regions VII (the central states) and IX (the Southwest) had higher than average concentrations of "other" clinics (30% and 23%, respectively), while Regions IV and X (the Northwest) had relatively low proportions of such sites (2% and 9%, respectively).

Nationally, three in five clinics received Title X funding for 1997. This proportion was highest in Region III (the mid-Atlantic states, 80%) and lowest in Region IX (41%).

•*Clients.* The average number of clients served per clinic in 1997 (910 overall) varied by both type of provider and by region of the country. The overall variation in average client load among regions (ranging from 649 in the mountain states of Region VIII to 1,188 in Region IX) reflects a number of influences, including differences among regions in the mix of provider types, as well as significant variation in client load among regions within provider type. For example, Regions VII and VIII (the central and mountain states) had the lowest overall average number of contraceptive clients served per clinic, and also had the fewest clients served per health department clinic and per hospital clinic. Moreover, Region VIII had the lowest regional average number of clients served per Planned Parenthood clinic. These differences may reflect, in part, patterns of population density among the regions.

The distributions of female contraceptive clients by type of provider within regions follows a pattern similar to that observed for clinics, once differences in average client load for different provider types are taken into account. Thus, the southeastern states (Region IV), where 70% of sites in 1997 were health department clinics, had the largest proportion of clients served by health departments (77%). This percentage was more than twice the national average (35%). Regions I, II and III (the northeastern and mid-Atlantic states) had higher-than-average percentages of women served at hospital clinics (21%-26%) as well as higher-than-average proportions of hospital clinics (16-22%).

On the other hand, the midwestern states (Region V) had a relatively high percentage of clients served by Planned Parenthood clinics (43%) and a higher-than-average proportion of Planned Parenthood clinics (22%). Higher-than-average percentages of women were served by "other" clinics in the Northeast (Region I, 30%) and the central states (Region VII, 23%). Finally, although nationally two-thirds of all clients obtained care at Title X-funded clinics, more than three-quarters of all clients in the middle Atlantic, southeastern and central states (Regions III, IV and VII) were served at sites with Title X funding (82%, 79% and 78%, respectively).

•*Adolescent clients.* Nationwide, 1.8 million adolescent clients made up 28% of all contraceptive clients served at publicly funded family planning clinics in 1997. This number and the distribution of adolescent clients by provider type remained fairly stable between 1994 and 1997. As was the case for women overall, health department clinics and Planned Parenthood clinics were the providers used most frequently by teenagers in both years (not shown): Health departments served one in three women younger than 20 (33% in 1994 and 36% in 1997), while Planned Parenthood clinics served one in four (27% and 26%). For most provider types and in most regions,

adolescent clients made up approximately one-quarter to one-third of all clients, ranging from 26% of Planned Parenthood clinic clients to 32% of hospital clinic clients nationwide (Table 4, bottom panel). Noteworthy differences occurred in the West (Region IX), where teenagers made up only 18% of health department clients and 20% of Planned Parenthood clients, but 38% of clients served at hospital sites. Teenagers also made up a higher-than-average percentage of clients at hospital clinics in the mountain states (Region VIII, 41%) and at "other" agency clinics in the Southeast (Region IV, 41%).

State and County Estimates

•*Provider coverage.* In 1997, publicly funded clinics providing family planning services were located in 85% of all counties. In general, counties without clinics were sparsely populated. As a result, 98% of the 16.5 million U.S. women estimated to be in need of publicly funded contraceptive care[11††] lived in counties that had publicly funded clinics (Table 5). In some states, however, the percentage of women with clinic access was lower: Fewer than 90% of all women in need of publicly funded contraceptive care in Indiana, Iowa, Nebraska, North Dakota, South Dakota and Virginia lived in counties with a publicly funded family planning clinic.

Overall, the percentage of counties with at least one clinic in 1997 was similar to the percentage in 1994, and the large number of clinics closing and opening was distributed fairly evenly across states and counties. Of the 3,139 counties nationwide, 13% experienced a net loss in the number of clinics between 1994 and 1997 and 13% experienced a net gain. Only about one in four counties experiencing a net change in clinic numbers had a net gain or loss of more than one clinic (data not shown).

Nearly three-quarters (73%) of all U.S. counties had at least one Title X-supported site, and 93% of all women in need of publicly funded contraceptive care lived in counties with Title X-funded sites (Table 5). However, Title X-supported sites were much less accessible in some states: In Alaska, Indiana, Minnesota, Nebraska, North Dakota, South Dakota, Vermont and Wisconsin, just 48-74% of all women in need of publicly funded contraceptive care lived in counties with such a clinic.

Compared with the 7,206 publicly funded family planning clinics, the United States has nearly 30,000 private obstetrician-gynecologists and more than 40,000 family practice doctors who could serve the family planning needs of American women.[12] However, publicly funded family planning clinics are actually distributed more evenly than private obstetrician-gynecologists across U.S. counties, and the number of counties in which they are located is similar to the number for private family practice physicians.

Half of all U.S. counties (in which 92% of all women in need reside) had one or more private obstetrician-gynecologists in 1997, and nearly all of these counties also had at least one family practice doctor and a publicly funded family planning clinic (not shown). In the other half of U.S. counties, which were mostly rural (in which 8% of all women in need live), publicly funded family planning clinics were often the only source of specialized family planning health care available.

Some 36% of all counties had one or more publicly funded family planning clinics, but no private obstetrician-gynecologist (Table 5). And although 80% of these counties

(29% of all counties) also had at least one private family practice physician, 20% (7% of all counties) had neither an obstetrician nor a family practice doctor (not shown). Only 144 counties (5%), accounting for just 0.2% of all women in need of publicly funded family planning services, had no clinic, no private obstetrician-gynecologist and no family practice provider.

In 11 states—Arkansas, Georgia, Idaho, Kansas, Kentucky, Mississippi, Missouri, Nevada, Oklahoma, Tennessee and Wyoming—50% or more of all counties lacked a private obstetrician-gynecologist but did have one or more publicly funded family planning clinics in 1997 (Table 5). Overall, 7% of U.S. women in need of publicly funded family planning services lived in counties with clinics but no private obstetrician-gynecologists; in some states, however, this percentage was much higher. In eight states (Arkansas, Iowa, Kentucky, Mississippi, Missouri, Oklahoma, West Virginia and Wyoming), 20-30% of all women in need of publicly funded family planning care lived in counties with at least one clinic but no private obstetrician-gynecologist. In another five states (Georgia, Idaho, Kansas, Montana and Tennessee), 15-19% of women in need lived in such counties.

•*Coverage of women in need.* Comparing the number of women served at publicly funded family planning clinics to the total number of women estimated to be in need of publicly funded family planning care does not necessarily represent the exact percentage of women needing publicly funded care who were served at clinics.[##] It can, however, be useful in assessing the contribution made by clinics to meeting the contraceptive needs of American women and in identifying regions or states where the relative proportions of women served at family planning clinics are lower or higher than average.

Nationwide, publicly funded family planning clinics play a significant role in meeting the contraceptive needs of low-income women: Of all women estimated to need publicly funded family planning care, 39% are served at publicly funded clinics, including 26% served at Title X-funded clinics (Table 6). Individual states with relatively high ratios of women served in publicly funded clinics include Mississippi (66%) and Montana (62%), as well as Alaska, Arkansas, Idaho, Kentucky and West Virginia (all with ratios of 58-59%). Those with the lowest ratios of women served in clinics are Louisiana (20%), and Nebraska, Ohio and Utah (28% each). In addition, although the ratio of clients served at Title X-funded sites to all women needing publicly funded care averages 26% nationally, the ratio exceeds 50% in some states where Title X-funded clinics play an especially large role in meeting the family planning needs of women: Idaho, Kentucky, Mississippi, Montana and West Virginia.

We found ratios similar to those for all women when we compared the number of adolescents served to the number needing services—38% and 25%, respectively, for all clinics and Title X-funded clinics (Table 7). Although the patterns and ratios for women younger than 20 served at clinics are similar to those found among all women, some noteworthy differences exist, with the ratio of teenagers served at clinics to all teenagers estimated to need publicly funded family planning care varying widely, from a low of 9% in Louisiana to a high of 72% in Alaska and Montana.

DISCUSSION

The network of publicly funded family planning clinics has maintained an important role in meeting the contraceptive needs of American women throughout the late 1990s and continues to serve nearly 6.6 million women each year. Overall, aggregate measures indicate stability in the numbers of providers available to women. However, our analysis reveals a more dynamic situation at the local level. Between 1994 and 1997, about one of every seven publicly funded clinics closed or stopped providing contraceptive care, and similar numbers of clinics opened or began providing such services. On the one hand, if some sites closed and other sites opened in response to changes or reassessments of where women who need care were located, such changes indicate improvements in the accessibility of services. On the other hand, if the impetus for closing or opening clinics was related to broad changes in health care financing or delivery, then the new sites may or may not be more accessible to women. Based on informal reports from some of the respondents who provided data for this analysis, it is likely that both of these situations, as well as a variety of other individual reasons, contributed to the clinic changes observed. Additional information on the local impact of these changes would be necessary to assess further the positive and negative effects of clinic turnover.

This analysis also examined the "face" of publicly funded family planning clinics, focusing on variation in this network among providers, across locations and over time. As in previous studies, we found a diverse network of agencies and clinics that varied across several important categories. One of the most obvious distinguishing characteristics of publicly funded family planning clinics is their variation according to the type of agency responsible for service provision. While health department clinics continue to be the most numerous, clinics run by Planned Parenthood affiliates, hospitals, community or migrant health centers and "other" agencies make up three out of every five clinic sites and serve nearly two-thirds of all contraceptive clients obtaining clinic care. We have documented a decline between 1994 and 1997 in the number of health department clinics providing publicly funded family planning care, which coincided with a rise in the number of community or migrant health center clinics offering such care. Yet, as in 1994, the relative importance of different types of clinic providers varies widely across regions and states, reflecting local needs and long-standing patterns of service delivery.

Publicly funded family planning providers also differ according to agency size (with some offering services at only one site, and others offering services at dozens of sites in different counties and even different states) and according to the number of clients served at each clinic. Over time, there has been a trend toward consolidation or mergers of clinics into fewer agencies, particularly among hospitals and Planned Parenthood affiliates. In addition, although there has been a real decline in the number of health department clinics, remaining health department clinics serve greater numbers of clients per clinic. And while there has been a rise in the number of community or migrant health center clinics, these clinics served, on average, fewer clients per clinic in 1997 than in 1994. As a result, the percentage of all clients served at health department clinics rose slightly between 1994 and 1997, and the percentage served by community or migrant health centers remained about the same.

Receipt of federal Title X funding provides a unifying element for the provision of clinic-based family planning services and was reported by three-fifths of clinics that

provide any publicly funded family planning services. Although Title X funds provide only a portion of the revenue necessary to sustain these sites—25% of revenues reported by Title X grantees come from Title X grants, with most revenue coming from other federal grants (12%), state or local government (30%), and Medicaid (13%)[13]—Title X funds are vital for a number of reasons. They provide clinics with revenue that is not tied to medical services for specific clients (as is the case with Medicaid) and thus can be used to improve clinics' infrastructure and their ability to offer accessible, affordable and culturally appropriate family planning care; to provide educational and outreach services; and to design programs that serve some of the most hard-to-reach populations in the nation.

This analysis illustrates the wide geographic distribution of publicly funded family planning clinics. Clinics can be found in both urban and rural areas, and most U.S. counties have at least one. In fact, nearly all women in need of publicly supported family planning care live in a county that has at least one clinic. Moreover, family planning clinics are sometimes the only source of specialized reproductive health care, particularly in relatively poor, rural, sparsely populated counties of the country.

More than one-third of all U.S. counties—home to more than one million women in need of publicly funded family planning services—have one or more family planning clinics, but do not have even one private obstetrician-gynecologist. On the other hand, more than 300,000 women in need of publicly funded family planning care live in counties that do not have a single publicly funded family planning clinic. More than half of these women reside in states where at least 10% of women in need of publicly funded family planning care live in counties without any clinic provider—Indiana, Iowa, Nebraska, North Dakota, South Dakota, and Virginia. Expanding services in these areas would further reduce the number of women living in counties without public family planning care.

Nationwide, publicly funded family planning clinics provide contraceptive services to 6.6 million women—approximately two out of five women estimated to need publicly funded contraceptive care. In some states, this proportion is much higher, and in others it drops as low as one in five. Although these numbers indicate that publicly funded clinics serve a significant percentage of women in need, they also suggest that the number of clinics currently available may not be adequate to fully meet the needs of poor and low-income women at risk of unintended pregnancy. However, we did not count here the number of women who obtain publicly funded contraceptive care from private providers, paid for by Medicaid or by some other means. Thus, policymakers interested in assessing the adequacy of publicly funded family planning care in local areas need to look both at the availability of clinics and at the availability of private providers who accept Medicaid recipients for contraceptive services or reduce their fees for low-income women.

From a policy perspective, this analysis adds to our understanding of the continuing importance of the network of publicly funded family planning clinics. These clinics are part of an established, long-standing national family planning program that plays a critical role in serving millions of U.S. women.[14] This clinic network has helped to avert millions of unintended pregnancies and has virtually eliminated past racial and income differentials in contraceptive use.[15]

Yet the number of unintended pregnancies in the United States remains high, and the types of women who typically rely on clinics for their contraceptive services continue to have higher-than-average rates of unintended pregnancy and contraceptive failure.[16] Such facts do not necessarily indicate failure of the program, but rather point to the significant challenges that remain—particularly the challenge of ensuring that all poor and low-income women who wish to avoid unintended pregnancy have access to quality contraceptive services. This access should not be limited by rising health care costs or changes in health care delivery systems, or by the lack of private insurance or Medicaid coverage, a situation faced by increasing numbers of women.[17]

The data presented here reflect only part of the clinics' contributions. Other analyses have shown that clinics offering publicly funded family planning services typically provide a range of other reproductive and primary medical care services, as well as nonmedical services such as education, counseling and information outreach.[18]

Future research, including efforts to monitor numbers of clinics and clients, is needed to determine if the overall stability in numbers of providers and clients measured here represents a mature program adequately meeting all of the contraceptive needs of poor and low-income women, or if it indicates that limited funding and rising costs have hindered the expansion and outreach of the clinic network to new geographic areas and underserved, hard-to-reach populations. As clinics strain to do more with the same or reduced resources, are they, in fact, paddling harder to remain in the same place?

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*County-level tabulations of these data are available from The Alan Guttmacher Institute at <**www.agi-usa.org/pubs/3311301app/countydata.html**>.

†For a full description of the definitions provided during data collection, see The Alan Guttmacher Institute, Expanded methodology for the 1997 census of publicly funded family planning clinics, unpublished background document, 2001, available at <**www.agi-usa.org/pubs/expmethods.pdf**>.

‡For additional details on the data collection process, see The Alan Guttmacher Institute, Expanded methodology for the 1997 census of publicly funded family planning clinics, unpublished background document, 2001, available at <**www.agi-usa.org/pubs/expmethods.pdf**>.

§For hospital-based clinics, the number of beds was included in estimating the number of clients served.

**Data on private physicians are not available for 1997 from the Area Resource File, so we used data for 1998. In addition, data on private practitioners are not available for counties in Alaska and for 36 individual counties (cities) in Virginia. Thus, the total number of counties with data on both clinics and private practitioners is 3,074. Territories are not included.

† Women are estimated to be in need of publicly funded family planning services and supplies if their family income is less than 250% of the federal poverty level or if they are younger than 20 and are sexually active, fecund and not currently pregnant or trying to become pregnant. Such women often have difficulty obtaining needed famiy planning care from private physicians because of their inability to pay for services or t0 find a physician who will accept Medicaid clients.

‡ Not all women served at clinics meet the definition of need for publicly funded family planning care. In addition, some women needing subsidized care are served by private providers who are reimbursed through Medicaid.