VIEWPOINT

Access to Adolescent Reproductive Health Services: Financial and Structural Barriers to Care

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Since the early 1970s, adolescent pregnancy rates in the United States, the United Kingdom and other western European countries have dropped significantly, partly because of the availability of more effective contraceptive methods and increases in condom use.[1] Despite this progress, U.S. youth continue to be at greater risk for pregnancy and sexually transmitted diseases (STDs) than their British and other western European peers. Given these disparities, can experiences in other developed countries inform U.S. prevention efforts? We believe that they can, and the results of Stone and Ingham's investigation of when and why British youth seek sexual health services, on page 114 of this issue, provide an instructive starting point.

A country's approaches to prevention are rooted in an interplay of socioeconomic, political and cultural forces. Consequently, to examine the relevance of Stone and Ingham's findings and recommendations in the context of the United States, it is necessary first to review the ways in which these forces impact access to reproductive health care.

ACCESS TO SERVICES

According to a framework that has been used to assess the extent to which five industrialized countries—Canada, France, Sweden, the United Kingdom and the United States—respond to the sexual and reproductive health needs of their youth, one important factor is the accessibility of services and prescription contraceptives.[2] Evidence to date suggests that youth in the United States are much more likely to encounter barriers to access than are their peers in the United Kingdom and other western European countries.[3]

Stone and Ingham observe that over the past 10 years or so, the United Kingdom has seen an increase in initiatives to reduce barriers to sexual and reproductive health services for young people, and a decrease in adolescent pregnancy rates. Although methodological considerations preclude direct comparisons, their investigation supports the notion that the gap between sexual debut and initiation of reproductive health care is far shorter for British youth than for U.S. youth. In Stone and Ingham's sample, three-quarters of female participants aged 21 or younger who had not sought reproductive health care prior to first sex did so within six months of sexual initiation. By contrast, the 1995 National Survey of Family Growth found that the median interval between first sex and first visit for reproductive health care was 22 months for U.S. females younger than 25.[4]

Financial considerations may play a role in determining level of access to sexual and reproductive health services and prescription contraceptive methods. In the United States, adolescents' access depends upon the extent to which they have health insurance coverage (private or public), the ability to pay directly for services, or access to family planning programs funded by Title X (the only national program that offers free or low-cost care for individuals who are uninsured or underinsured and meet income eligibility guidelines). Moreover, because many prescription drug plans do not provide coverage for a full complement of contraceptives, some adolescents who obtain clinical services through the private sector cannot afford the most effective methods. UK and other western European youth, who are eligible for benefits through health insurance systems sponsored or mandated by the government, face fewer financial barriers to services and prescription contraceptives than U.S. youth.

Two types of structural factors also affect access to sexual and reproductive health services and prescription contraceptives: confidentiality of and consent for care, and the service environment.[5] A prominent confidentiality-related concern for many adolescents in the United States is fear of parental notification through provider communications or health benefits notices issued by private insurers.[6] This fear is due in part to confusion regarding current confidentiality statutes, which have been described as a "patchwork of federal, state, and case law."[7]

The U.S. Public Health Service Act contains confidentiality regulations designed to reduce barriers to Title X family planning services for youth who cannot discuss their sexual and reproductive health needs with their parents, and these regulations supersede state law. However, a great deal of variation exists in state laws governing confidentiality and consent for services not funded through Title X. All states and the District of Columbia allow minors to consent for testing and treatment for HIV and other STDs.[8] In contrast, only 27 states and the District of Columbia have laws or policies specifically enabling them to consent for contraception.[9]

Variations in state abortion laws add to the confusion regarding availability of confidential reproductive health care for adolescents. Twenty-three states have statutes requiring parental consent before a minor may obtain abortion services, and 21 have statutes requiring parental notification; these totals include two states that have laws requiring both. The remaining eight states and the District of Columbia encourage, but do not require, parental involvement in minors' abortion decision.[10]

In light of this patchwork of laws, it is not surprising that many adolescents, parents and providers have inaccurate or insufficient information regarding the delivery and avail-

ability of confidential services. For example, in 63% of family medicine, internal medicine and pediatric practices surveyed in and around Washington, DC, responses of office staff answering telephones contradicted those of physicians when callers asked if the practice offers confidential services to adolescents.[11]

In contrast to the United States, the United Kingdom and other western European countries do not require parental consent or notification for sexual and reproductive health services, contraceptives or abortion.[12] However, they do encourage adolescents to discuss their reproductive health needs with their parents.

The service environment is no less important a factor. U.S. and British research points to the relationship between "youth-friendly" environments and service utilization.[13] Although awareness of the importance of youth-friendly services is on the rise in the United States, the United Kingdom has been more successful in launching comprehensive efforts in this area. As Stone and Ingham report, the past decade has seen increases in the United Kingdom both in the availability of youth-oriented sexual health services and in provider knowledge and sensitivity regarding the needs of youth. These positive changes are due partly to the 1990 Health of the Nation initiative, which spurred the creation of more effective adolescent pregnancy and STD prevention strategies at the national level.

IMPLICATIONS OF STONE AND INGHAM'S WORK

Financial Barriers

Notably, financial barriers did not impede access to care for participants in Stone and Ingham's study; this finding underscores the stark contrast between the U.S. and UK experiences in terms of health care financing. The government-sponsored national health insurance system in the United Kingdom eliminates financial barriers to sexual and reproductive health services. Given the reluctance of the U.S. government to institute a universal health financing program, costs will likely remain a critical determinant of adolescents' use of reproductive health services and contraceptives for the foreseeable future.

Annual Title X funding awards fall short of meeting the needs of the program's client population. Because Title X is designed to work in tandem with health insurance programs, U.S. policymakers and advocates on behalf of adolescents must continually act to ensure that initiatives to fill the gap for the uninsured help to lower financial barriers for adolescents seeking reproductive health services. For example, in Pennsylvania, the State Children's Health Insurance Program (SCHIP) does not cover prescription contraceptives and threatens confidentiality by mailing benefits notices to parents or guardians. Such access-related barriers need to be addressed at both the federal and the state levels.

Confidentiality

Stone and Ingham's findings also underscore the need for clear and unambiguous information regarding state- and federal-level confidentiality statutes, as well as the relationship between the two sets of laws. To this end, broad-based campaigns (e.g., the National Campaign to Prevent Teen Pregnancy, the National Organization on Adolescent Pregnancy Prevention, and Health Initiatives for Youth) and local public awareness efforts for youth, parents and health care providers must assign the highest priority to the dissemination of messages about the availability of confidential services for youth. Moreover, they must ensure that these messages are appropriate to target audiences' age, culture and literacy level.

Although health care practitioners have access to evidence-based guidelines to support the provision of confidential and developmentally appropriate reproductive health care for adolescents, the extent to which these guidelines have been incorporated into routine practice has been mixed, partly because of practitioners' attitudes and beliefs.[14] With the new emphasis on privacy of medical records brought on by the Health Insurance Portability and Accountability Act of 1996, it behooves training programs for health professionals to include adolescent confidentiality protections modules in their curricula and to provide guidance on the implementation of confidentiality policies and evidence-based practices.[15]

Youth-Friendly Environments

Stone and Ingham also identified barriers to sexual and reproductive health services that, in our view, can be addressed by a common set of strategies falling under the rubric of "youth-friendly environments": Youth may delay seeking services because they have inadequate or incorrect information regarding the location of services and their eligibility for care, they are not planning to have intercourse or they have easy access to condoms.

In the United States, societal ambivalence about adolescent sexuality has limited creative efforts to institute truly youth-friendly services. Some programs tinker with the traditional medical model by offering drop-in and after-school hours. Some set aside time in a clinic for sessions open only to teenagers. Some communities support reproductive health care as a component of school-based health services. But initiatives rarely take bold steps to reinvent services or adopt educational strategies from a youth perspective. If U.S. youth so persistently delay seeking clinical services, it is imperative to take a hard and different look at why that might be.

Stone and Ingham's findings regarding the relationship between widespread availability of condoms in community settings and delayed initiation of sexual health services corroborate the experience of many U.S. youth.[16] While the importance of easy access to condoms cannot be overstated, youth who consistently use condoms may be less likely than others to access health services and unaware of more effective contraceptive choices. Thus, gaps between first sex and first reproductive health visits should be expected, especially when adolescents do not find these services to be youth-friendly.

One potential solution to this dilemma is a tiered ser-

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vice delivery system for youth that expands and links nonclinical services with clinical services. The concept of a linked model is not new, and research has demonstrated its potential to remove barriers to reproductive health care.[17] While U.S. teenagers generally understand that using condoms helps to prevent pregnancy and STDs, it will be important to incorporate consistent, reinforcing messages regarding consistent condom use at each level of a tiered system.

Ideally, a tiered service delivery system would be designed to reflect a community's culture and values, and would offer confidential counseling and education along with over-the-counter methods, including condoms, in nonclinical settings. The system would also offer STD and pregnancy urine screening tests in these locations for sexually active youth.

Nonclinical models can be located in school and community settings close to where teenagers meet for recreational or other activities. Because these models involve both counseling and behavioral interventions, they can meet the needs of both sexually experienced and inexperienced youth. They can offer abstinence-based messages with strategies for young people who want to delay sexual initiation and who want to know how to handle the pressure in a relationship that might lead to greater intimacy.

For instance, in selected public high schools in Philadelphia, the Family Planning Council, a Title X grantee, administers the Health Resource Center program. Students in these schools can drop in for counseling and education offered by a health care professional from a Title X clinic; the services have all the confidential protections offered by Title X. Students are informed that abstinence is the only sure way to prevent pregnancy and infections, yet those who choose to be sexually involved can receive free condoms or tests for STDs and pregnancy during regular school hours. The program's experience to date suggests that interventions like this can be just as successful in nonschool settings and are well positioned to form linkages with clinical services to ensure that adolescents who need medical care and want more effective contraceptives have an easy transition to that level of care. In this model, young people are informed of the benefits of medical care, are assured of the confidentiality and affordability of that care, and become familiar with service providers in preparation for accessing health services.

We recognize the many formidable challenges involved in launching and sustaining tiered approaches. For instance, payment for nonmedical services represents a critical challenge that requires creative solutions. A recent survey of Title X–funded programs revealed that these programs provide a wide variety of education and counseling activities for youth.[18] However, the current Title X reporting system is designed to capture medical service information. Consequently, there is no way to systematically document education and counseling activities or measure their impact on health outcomes.

To date, the most promising counseling and education interventions have utilized theory-based skill-building strategies, and have integrated pregnancy and STD prevention messages.[19] Therefore, we believe that the integration of consistent, reinforcing behavioral messages and strategies for youth and parents is critical to the success of a tiered system.

In the United States, behavioral strategies need to be integrated more closely with work in preventing teenage pregnancy. Such messages would foster an adolescent's awareness of and ability to delay sex, make contraceptive choices, use condoms along with other contraceptive methods and access reproductive health services. Effective behavioral approaches do not increase young people's sexual risk-taking or promiscuity; instead, they increase the knowledge and skills that teenagers need to make informed sexual and reproductive health decisions and to engage in responsible sexual behavior.[20]

CONCLUSIONS

Differences in young people's age at sexual debut and level of subsequent sexual activity fail to explain why U.S. adolescent pregnancy rates continue to exceed the rates of the United Kingdom and other western European countries.[21] Clearly, the experiences of youth in these countries debunk the popular notion that access to reproductive health services promotes early sexual initiation. Moreover, the disproportionately high adolescent pregnancy and STD rates in the United States, coupled with formidable barriers to reproductive health services, underscore the need to capitalize on lessons learned in other developed countries and to identify innovative strategies to reduce hurdles to care.

REFERENCES

1. Darroch JE and Singh S, *Why Is Teenage Pregnancy Declining? The Roles of Abstinence, Sexual Activity, and Contraceptive Use*, Occasional Report, New York: The Alan Guttmacher Institute (AGI), 1999, No. 1; and Darroch JE, Frost JJ and Singh S, *Teenage Sexual and Reproductive Behavior in Developed Countries: Can More Progress Be Made?* Occasional Report, New York: AGI, 2001, No. 3.

2. Darroch JE, Frost JJ and Singh S, 2001, op. cit. (see reference 1).

3. Ibid.; and Berne L and Huberman B, European approaches to adolescent sexual behavior and responsibility, 1999, <http://www.advocatesforyouth.org/publications/european.pdf>, accessed Feb. 28, 2003.

4. Finer LB and Zabin LS, Does the timing of the first family planning visit still matter? *Family Planning Perspectives,* 1998, 30(1):30–33 & 42.

5. Institute of Medicine, *Access to Health Care in America,* Washington, DC: National Academy Press, 1993.

6. Reddy DM, Fleming R and Swain C, Effect of mandatory parental notification on adolescent girls' use of sexual health services, *Journal of the American Medical Association,* 2002, 288(6):710–714; and Rosen DS et al., Clinical preventive services for adolescents: a position paper for the Society of Adolescent Medicine, *Journal of Adolescent Health,* 1997, 21(3):203–214.

7. Brindis C and Ott MA, Adolescents, health policy, and the American political process, *Journal of Adolescent Health,* 2002, 30(1):9–16.

8. AGI, Minors' access to STD services, *State Policies in Brief,* 2003, <www.guttmacher.org/pubs/spib_MASS.pdf>, accessed Apr. 29, 2003.

9. AGI, Minors' access to contraceptive services, *State Policies in Brief,* 2003, <www.guttmacher.org/pubs/spib_MACS.pdf>, accessed Apr. 29, 2003.

10. AGI, Parental involvement in minors' abortions, *State Policies in Brief,*

2003, <www.guttmacher.org/pubs/spib_PIMA.pdf>, accessed Apr. 29, 2003.

11. Akinbami LJ, Gandhi H and Cheng TL, Availability of adolescent health services and confidentiality in primary care practices, *Pediatrics,* 2003, 111(2):394–401.

12. Ibid.; Darroch JE, Frost JJ and Singh S, 2001, op. cit. (see reference 1); and Berne L and Huberman B, 1999, op. cit. (see reference 3).

13. Reddy DM, Fleming R and Swain C, 2002, op. cit. (see reference 6); and Jaccard J, Adolescent contraceptive behavior: the impact of the provider and structure of clinic-based programs, *Obstetrics & Gynecology,* 1996, 88(3 Suppl.):57S–64S.

14. Cook RL et al., Barriers to screening sexually active adolescent women for chlamydia: a survey of primary care physicians, *Journal of Adolescent Health,* 2001, 28(3):204–210; and Schuster MA et al., Communication between adolescents and physicians about sexual behavior and risk prevention, *Archives of Pediatrics and Adolescent Medicine,* 1996, 150(9):906–913.

15. Lustig JL et al., Improving the delivery of adolescent clinical preventive services through skills-based training, *Pediatrics,* 2001, 107(5): 1100–1107.

16. Finer LB and Zabin LS, 1998, op. cit. (see reference 4).

17. Zabin LS et al., The Baltimore pregnancy prevention program for urban teenagers: how did it work? *Family Planning Perspectives,* 1988, 20(4):182–187.

18. Felice TL et al., unpublished data from national assessment of nonmedical users of Title X funds, Pittsburgh and Philadelphia: Family Health Council and Family Planning Council, 2003.

19. American Academy of Pediatrics, Sexuality education for children and adolescents, *Pediatrics,* 2001, 108(2):498–502; National Institute of Mental Health Multisite HIV Prevention Trial Group, The National Institute of Mental Health (NIMH) Multisite HIV Prevention Trial: reducing HIV risk behavior, *Science,* 1998, 280(5371):1889–1894; and Shain RN et al., A randomized controlled trial of a behavioral intervention to prevent sexually transmitted disease among minority women, *New England Journal of Medicine,* 1999, 340(2):93–100.

20. Kirby, D, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy,* Washington, DC: National Campaign to Prevent Teen Pregnancy, 2001.

21. Darroch JE, Frost JJ and Singh S, 2001, op. cit. (see reference 1); and Berne L and Huberman B, 1999, op. cit. (see reference 3).

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