The Availability and Use of Publicly Funded Family Planning Clinics: U.S. Trends, 1994–2001

By Jennifer J. Frost, Lori Frohwirth and Alison Purcell

Jennifer J. Frost is senior research associate, Lori Frohwirth is research associate and Alison Purcell is research assistant, all with The Alan Guttmacher Institute, New York.

CONTEXT: *It is important to monitor trends among publicly funded family planning clinics to determine where clinics are successfully meeting the contraceptive service needs of low-income women and where more effort is needed.*

METHODS: *Service data for all U.S. agencies and clinics providing subsidized family planning services were collected for 2001 and compared with similar data collected for 1997 and 1994. Trends reflecting clinic structure and capacity were analyzed at the national and state levels. Client numbers were compared with numbers of women needing publicly funded contraceptive services to create a measure of met need for states and groups of states, according to Medicaid family planning waiver status.*

RESULTS: *In 2001, some 7,683 publicly funded family planning clinics provided contraceptive services to 6.7 million women—representing an 8% rise in clinics and a 2% increase in clients since 1994. Change varied by type of provider and clinic location. Health departments and Planned Parenthood affiliates served more clients at fewer sites; community health centers served fewer clients at more sites. One-third of states experienced growth in clinic capacity, with 5–65% increases in met need. In another third of states, met need declined by 5% or more. States with income-based Medicaid family planning waivers served 24% more clients, with met need increasing from 40% to 50%.*

CONCLUSIONS: *Among states, there has been tremendous variation in the ability of publicly funded family planning clinics to serve women. Implementation of income-based Medicaid family planning waivers in some states was associated with clinics' serving greater numbers of women. Further efforts are needed to ensure access to family planning services for low-income women in every state.*

Perspectives on Sexual and Reproductive Health, 2004, 36(5):206–215

Each year, more than 20 million American women obtain contraceptive services from a medical provider.[1] One in four (24%) receive that care from a publicly funded family planning clinic. In addition to providing clients with a broad choice of contraceptive methods, most clinics provide sexually transmitted disease testing and treatment; preventive care, such as Pap tests and pelvic exams; and the information, education and counseling women and couples need to avoid unintended pregnancies and disease, and to plan for wanted children.[2] Publicly funded family planning clinics are, therefore, critical to the provision of accessible and affordable sexual and reproductive health care in the United States today.

The network of clinic providers varies widely in structure, with different types of providers more or less important to each state and region. Funding for clinic providers also varies widely, coming from different combinations of federal, state and local sources that are often dependent on political mood and the financial well-being of state and local governments. The two primary federal programs supporting family planning services are Medicaid and Title X of the Public Health Service Act.

Medicaid is a joint federal-state program that reimburses providers for services delivered to participants. More than eight in 10 family planning agencies receive Medicaid funding for contraceptive services.[3] In recent years, several states have obtained federal approval (through waivers) to expand Medicaid coverage of family planning services to individuals who would not otherwise be covered. Family planning waiver programs typically extend coverage either to postpartum Medicaid recipients for longer periods (1–5 years, compared with 60 days under standard Medicaid eligibility criteria), to individuals who lose Medicaid eligibility for any reason or to individuals solely on the basis of income. A 2004 study found that waiver programs contribute to federal cost savings and, at the same time, increase access to contraceptive care for many low-income women.[4]

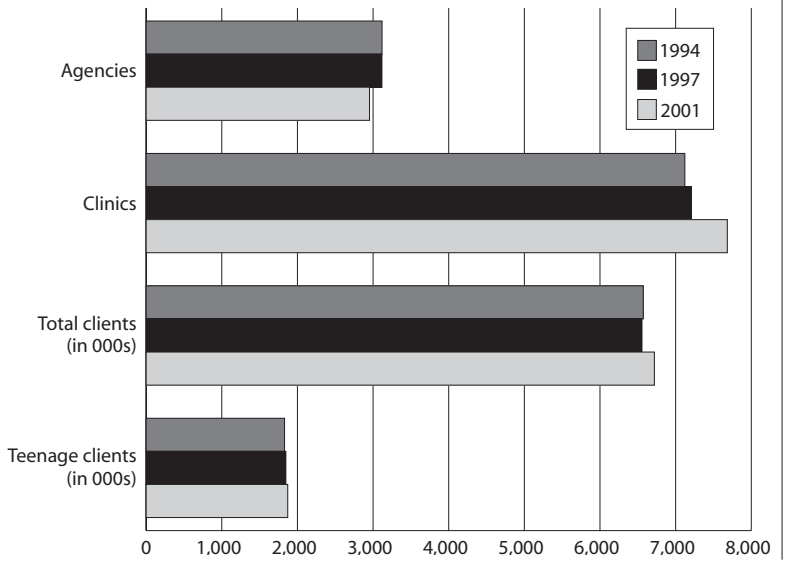
Title X is a federal program that provides dedicated family planning funds directly to clinics to support their programs. Six in 10 family planning agencies receive Title X funding[5]—money that helps bridge the gap left by other payers,[6] allows clinics to engage in outreach and education, and ensures a uniform standard of quality care across the clinic network.[7] Since its inception, Title X has faced a variety of financial and political pressures, with funding appropriations rising and falling depending on the political will of the moment. Despite increases during the late 1990s, inflation-adjusted Title X appropriations are 60% lower now than they were in 1980 and, in recent years, have barely kept pace with inflation.[8] At the same time, clinics are facing a variety of rising medical costs, including those associated

with new contraceptive methods, screening tests and treatment options.[9]

In many states, political pressures and financial crises have resulted in cutbacks for health care in general and family planning specifically.[10] Elsewhere, states have attempted to expand family planning services for low-income women through state-funded programs and Medicaid family planning waivers.[11]

The combination of political and financial pressures facing clinic providers has led many to seek alternative sources of funding and has contributed to various types of restructuring, including agency mergers, shifts in administrative affiliation and incorporation of groups of clinics into different, usually larger, agencies. To better understand the extent and distribution of these changes and to assess whether recent changes have affected the ability of clinics to meet women's contraceptive service needs, it is necessary to monitor the size and structure of the U.S. family planning clinic network. This article provides the most current information available on publicly funded family planning clinic services in the United States.

FIGURE 1. Number of publicly funded family planning agencies and clinics, total number of female contraceptive clients and number of clients younger than 20, 1994, 1997 and 2001



METHODS

Data

We collected service data for calendar year 2001 for all agencies and clinics providing subsidized family planning services in the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and six Pacific U.S. territories.* Details of the methodology and definitions used for our study, which are similar to those used in previous studies,[12] are provided elsewhere.[13] We identified publicly funded family planning agencies and clinics using the list of providers enumerated in 1997 and current lists of Title X–supported clinics,[14] Planned Parenthood Federation of America clinics,[15] and community and migrant health centers.[16]

Data requests were mailed to all Title X grantees and to state family planning administrators—entities that often collect data for clinics falling within their jurisdiction. In addition, more than 1,100 requests were mailed to individual agencies. We asked respondents for the total number of female contraceptive clients and of female clients younger than 20 served at each clinic in 2001 and whether each site received any Title X funding in 2001. We followed up nonrespondents with additional mailings, faxes and phone calls. Title X grantees and state family planning administrators provided client data for 4,801 family planning clinics, and 708 agencies reported data for an additional 2,017 clinics. We contacted clinics with missing data to confirm their provision of publicly funded family planning services in 2001.

This investigation used two new strategies for indentifying clinics and collecting service data. First, the Indian Health Service was able to provide a complete listing of clinics it funds and contraceptive clients served in 2001. Nationwide, nearly 200 clinics were added through this listing, and although many of these are new sites, some may have existed but been missed previously. These added sites are concentrated in Western states, where most Indian reservations are located.

Second, the California State Office of Family Planning was able to use a database for the Family PACT program (California's family planning Medicaid waiver program) to provide a comprehensive listing of participating providers and the number of female contraceptive clients served. We included only public and nonprofit providers listed in the database. We excluded private physician practices that receive Family PACT reimbursement, because they do not meet our definition of a publicly funded family planning provider. Therefore, our numbers represent a subset of female contraceptive clients served under the Family PACT program.

Estimating Missing Data

We identified 2,953 agencies and 7,683 clinics providing publicly funded family planning services in 2001. Overall, the number of female contraceptive clients was reported for 89% of clinics. The 11% of clinics that did not or could not provide or estimate this number were mainly community health centers or hospitals. For these sites, we used two methods to estimate the number of clients served. For 4% of clinics, we used the number of clients reported in earlier surveys, most commonly in 1997. No earlier data were available for the remaining 7% of clinics, so we used the average number served by similar clinics (defined by region, Title X funding status, metropolitan status and provider type). The number of teenage clients served was based on the average proportion of total clients represented by teenagers at similar sites.

*We define family planning agencies as organizations that have operating responsibility for clinics that provide contraceptive services. In this study, we included only clinics that offer contraceptive services to the general public and provide these services free of charge or at a reduced fee to at least some clients. We excluded private physician practices and health care centers serving only restricted populations, such as health maintenance organization enrollees, students, and veterans and military personnel. We included sites that provide education and counseling and dispense only nonmedical contraceptive methods if they maintain charts for contraceptive clients.

TABLE 1. Percentage distribution of publicly funded family planning agencies and clinics, 2001, 1997 and 1994; and percentage change in the number of agencies and clinics between 1994 and 2001—all by selected characteristics

Characteristic	2001	1997	1994	% change, 1994–2001
AGENCIES	(N= 2,953)	(N= 3,117)	(N= 3,119)	–5.3
Provider type				
Community/migrant health center	20.1	17.7	16.4	15.8
Health department	41.2	45.8	45.3	–13.9
Hospital	15.1	15.0	17.1	–16.3
Planned Parenthood	4.3	4.4	5.1	–20.8
Other	19.3	17.0	16.0	13.8
Title X funding				
Yes*	58.4	60.8	59.9	–7.7
No	41.6	39.2	40.1	–1.8
CLINICS	(N= 7,683)	(N= 7,206)	(N= 7,122)	7.9
Provider type				
Community/migrant health center	22.5	20.9	17.1	41.9
Health department	37.4	40.3	43.9	–8.0
Hospital	10.6	10.5	11.0	3.7
Planned Parenthood	11.6	12.7	13.2	–5.1
Other	17.9	15.7	14.9	30.2
Title X funding				
Yes	57.1	59.1	59.0	4.5
No	42.9	40.9	41.0	12.8
Metropolitan location				
Yes	57.2	53.7	53.2	16.0
No	42.8	46.3	46.8	–1.4
Region†				
I	4.2	4.4	4.5	1.6
II	6.7	7.0	6.8	7.1
III	10.1	10.4	11.0	–0.4
IV	21.8	22.9	22.8	3.1
V	13.3	13.8	13.9	2.8
VI	13.4	14.7	14.8	–2.6
VII	5.4	5.7	5.6	4.8
VIII	5.1	4.9	4.9	11.8
IX	14.3	11.5	11.2	37.6
X	5.8	4.7	4.6	34.4
Total	100.0	100.0	100.0	na

*Receives Title X funding at some or all agency sites. †**Region I**—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont. **Region II**—New Jersey, New York, Puerto Rico and the Virgin Islands. **Region III**—Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia. **Region IV**—Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee. **Region V**—Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin. **Region VI**—Arkansas, Louisiana, New Mexico, Oklahoma and Texas. **Region VII**—Iowa, Kansas, Missouri and Nebraska. **Region VIII**—Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming. **Region IX**—Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia and Palau. **Region X**—Alaska, Idaho, Oregon and Washington. *Note:* na=not applicable.

Data Analysis

We present bivariate results for agencies, clinics and clients according to the type of provider responsible for clinic operations. We classified providers as health departments (including state, county, district and local health departments), hospitals, Planned Parenthood affiliates, community health centers (including all community and migrant health center clinics that report or are listed as receiving Bureau of Primary Care 329 or 330 funds) and other clinics (including community-based clinics that receive other Bureau of Primary Care funds, clinics that are listed as federally qualified health center look-alike sites and other women's centers or primary care clinics that are not affiliated with any other provider types). Because these data represent the full universe of clinics and clients, significance testing is not applicable, and all differences are meaningful; only differences that are substantively significant or interesting are highlighted.

We also present data according to Title X funding status, metropolitan status (based on the metropolitan designation of the county), region (based on the 10 federally designated regions) and state. Finally, we examine state data according to whether a Medicaid family planning waiver went into effect between 1994 and 2001.

To assess the capacity of family planning clinics to meet women's need for publicly supported contraceptive care, we compared the numbers of women served at clinics in 2001 with 2000 estimates of the number of women in need of publicly subsidized contraceptive services in each state.*[17] Women were defined as being in need of contraceptive services and supplies if they were sexually active, fecund and not intentionally pregnant or seeking pregnancy. Of the women meeting this definition, we defined those with family incomes below 250% of poverty (estimated to be $42,625 for a family of four) or younger than 20 as needing publicly supported care.

Finally, we have developed national and state-level measures of the number of counties with at least one publicly funded clinic and the number with at least one Title X–funded clinic, and we assess what proportion of all women in need live in counties with clinic access.

RESULTS

Agencies and Clinics

In all, 2,953 publicly funded agencies administered contraceptive services at 7,683 clinics in the United States, Puerto Rico and U.S. territories in 2001 (Figure 1, page 207). Between 1994 and 2001, the overall number of agencies administering contraceptive services declined 5%, and the number of clinics increased 8% (Table 1). Virtually all of this change occurred after 1997. On the surface, these trends in the clinic network suggest relative stability, with a small amount of growth in recent years. Beneath this outward show of stability, however, exists a much more dynamic reality.

The change in number of agencies administering publicly funded family planning services between 1994 and 2001 varied widely according to provider type: The numbers of health department, hospital and Planned Parenthood affiliate agencies declined by 14–21%, while the numbers of community health center and other agencies increased by 14–16%. Even with a loss in numbers, health departments continue to be the most common type of fam-

*Estimates for the number of women in need of publicly subsidized contraceptive services in each state in 2002 are now available, but these data were not completed in time to be included in this article. However, use of the 2002 estimates do not change any of the results presented here. County-level data on the numbers of women in need and clinics and clients served are available at <http://www.guttmacher.org/pubs/win/index>.

ily planning agency, constituting 41% of the agency universe in 2001. In comparison, community health center and other agencies each represent only 19–20% of agencies. Three out of five agencies reported receiving Title X funding at all or some of their contraceptive service sites in 2001.

Despite the overall decline in agencies, the number of clinics providing publicly supported family planning care increased between 1994 and 2001; virtually all of this growth occurred among community health center and other clinics, whose numbers increased 42% and 30%, respectively. The numbers of health department and Planned Parenthood clinics decreased 8% and 5%, respectively. The number of Title X–funded clinics increased 5%, and the number of clinics located in metropolitan counties increased 16%. Growth in the clinic network was concentrated in the West and Northwest: Region IX (California, Arizona, Nevada, Hawaii and the Pacific territories) and Region X (Oregon, Washington, Idaho and Alaska) experienced net increases in clinic numbers of 38% and 34%, respectively. By contrast, two regions experienced small declines in clinic numbers, and the others experienced modest increases of 2–12%.

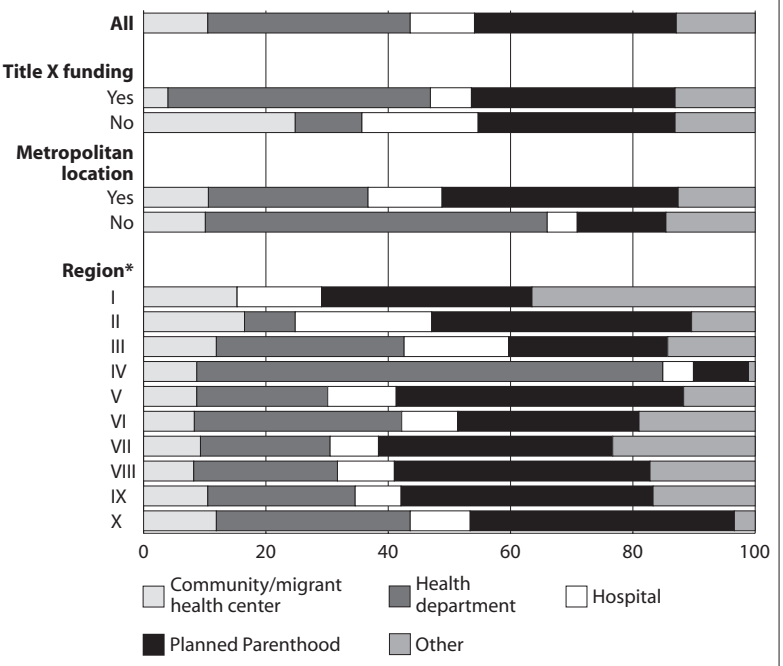
The decline in agency numbers, combined with growth in the number of clinics, suggests a trend toward consolidation, mergers and expansion on the part of agencies. Confirming such a trend, we found that the average number of clinics per agency rose from 2.3 to 2.6 between 1994 and 2001 (not shown). And although the number of clinics per agency varied widely by provider type (from 1.8 for hospitals to 7.1 for Planned Parenthood affiliates), all provider types experienced an increase.

TABLE 2. Percentage distribution of female contraceptive clients served by publicly funded family planning providers, 2001, 1997 and 1994; and percentage change in client numbers between 1994 and 2001—all by selected characteristics

Characteristic	2001	1997	1994	% change, 1994–2001
No. in 000s	6,719	6,555	6,572	na
Provider type				
Community/migrant health center	10.4	10.4	9.1	16.8
Health department	33.1	35.1	32.4	4.4
Hospital	10.4	12.5	15.7	–32.1
Planned Parenthood	33.0	28.6	29.6	14.1
Other	13.1	13.5	13.2	1.4
Title X funding				
Yes	69.2	65.5	64.2	10.2
No	30.8	34.5	35.8	–12.0
Metropolitan location				
Yes	76.6	73.3	74.4	5.3
No	23.4	26.7	25.6	–6.6
Region*				
I	4.9	5.1	5.2	–4.7
II	8.9	8.7	9.5	–3.9
III	8.5	9.4	10.2	–14.4
IV	18.9	20.5	18.4	5.2
V	14.7	15.5	16.1	–7.1
VI	12.9	13.2	12.0	10.1
VII	4.0	4.7	5.4	–23.9
VIII	3.9	3.5	3.5	16.3
IX	17.9	15.0	15.6	18.0
X	5.3	4.4	4.2	28.3
Total	100.0	100.0	100.0	2.2

*See Table 1 for composition of regions. *Note:* na=not applicable.

FIGURE 2. Percentage distribution of female contraceptive clients served at publicly funded family planning clinics, by provider type, according to selected clinic characteristics, 2001



*See Table 1 for composition of regions.

The variation in net clinic change among kinds of providers and regions of the country tells only part of the story and masks a tremendous amount of turnover throughout the period. Between 1994 and 1997, the net change in the number of clinics was 84; however, 990 clinics closed or stopped providing family planning care, and 1,074 clinics opened or added family planning to their service list.[18] Between 1997 and 2001, 968 clinics closed or stopped providing family planning care, and 1,445 clinics opened or began providing contraceptive services (not shown).

Women Served

In 2001, a total of 6.7 million women, including 1.9 million teenagers, received contraceptive services from publicly funded clinics (Figure 1). Both numbers represented 2% increases since 1994. More than one in four clients (28%) were younger than 20—a proportion that has remained remarkably constant over the years.

One-third all clients served in 2001 at publicly funded family planning clinics received care from a health department clinic, and another third from Planned Parenthood clinics (Figure 2). Hospital, community health center and other clinics each served 10–13% of clients. However, these patterns vary widely by providers' funding streams and locations: Health departments served greater proportions of clients at Title X–funded clinics than at non-Title X sites (43% vs. 11%) and at nonmetropolitan clin-

TABLE 3. Number of female contraceptive clients served at all publicly funded family planning clinics and at Title X–funded clinics, 2001 and 1994; and percentage change in client numbers between 1994 and 2001—all by state or territory

State/ territory	All			Title X–funded		
	2001	1994	% change	2001	1994	% change
U.S. total	**6,718,700**	**6,571,830**	**2.2**	**4,650,310**	**4,221,620**	**10.2**
Alabama	113,310	118,410	–4.3	94,410	89,430	5.6
Alaska	24,530	20,370	20.4	10,450	6,690	56.2
Arizona	100,680	132,190	–23.8	46,730	33,330	40.2
Arkansas	81,340	82,670	–1.6	71,770	73,510	–2.4
California	1,014,890	803,970	26.2	672,170	501,080	34.1
Colorado	132,890	105,590	25.9	57,660	50,630	13.9
Connecticut	70,560	92,630	–23.8	47,430	49,810	–4.8
Delaware	20,600	20,850	–1.2	20,600	14,790	39.3
D.C.	19,140	25,660	–25.4	14,390	14,540	–1.0
Florida	266,100	252,790	5.3	197,170	168,640	16.9
Georgia	199,840	202,610	–1.4	178,710	169,880	5.2
Hawaii	9,020	19,490	–53.7	9,020	17,480	–48.4
Idaho	41,720	34,650	20.4	37,090	29,590	25.3
Illinois	206,340	211,660	–2.5	154,620	162,670	–4.9
Indiana	147,260	144,180	2.1	48,970	77,750	–37.0
Iowa	69,230	91,570	–24.4	57,470	74,160	–22.5
Kansas	57,660	70,070	–17.7	43,770	47,720	–8.3
Kentucky	133,450	124,080	7.6	113,650	114,470	–0.7
Louisiana	82,810	79,910	3.6	75,950	58,510	29.8
Maine	49,150	40,970	20.0	30,600	35,510	–13.8
Maryland	82,230	105,870	–22.3	71,410	72,210	–1.1
Massachusetts	138,640	131,620	5.3	73,460	70,530	4.2
Michigan	233,810	239,100	–2.2	187,280	127,170	47.3
Minnesota	103,880	101,300	2.5	44,290	36,520	21.3
Mississippi	121,240	121,110	0.1	102,570	78,920	30.0
Missouri	108,590	164,030	–33.8	76,010	93,500	–18.7
Montana	33,920	35,770	–5.2	28,820	28,380	1.6
Nebraska	35,170	30,300	16.1	33,550	27,110	23.8
Nevada	47,730	33,960	40.5	36,350	17,400	108.9
New Hampshire	30,680	35,050	–12.5	27,890	31,730	–12.1
New Jersey	129,630	141,010	–8.1	103,590	102,010	1.5
New Mexico	68,500	64,120	6.8	34,580	40,170	–13.9
New York	446,500	439,130	1.7	295,360	237,670	24.3
North Carolina	194,250	171,010	13.6	142,230	112,680	26.2
North Dakota	16,010	17,290	–7.4	13,920	14,250	–2.3
Ohio	201,040	212,630	–5.5	136,010	141,290	–3.7
Oklahoma	95,260	78,780	20.9	71,580	53,620	33.5
Oregon	123,270	72,550	69.9	66,700	35,130	89.9
Pennsylvania	293,900	306,450	–4.1	262,810	262,190	0.2
Rhode Island	16,200	21,120	–23.3	13,680	13,150	4.0
South Carolina	139,070	85,280	63.1	121,360	65,810	84.4
South Dakota	22,950	22,770	0.8	15,970	17,070	–6.4
Tennessee	102,870	131,930	–22.0	81,730	101,810	–19.7
Texas	540,620	483,040	11.9	253,960	233,300	8.9
Utah	41,660	32,930	26.5	21,430	15,430	38.9
Vermont	20,620	21,110	–2.3	10,510	9,240	13.7
Virginia	97,150	135,480	–28.3	75,990	79,130	–4.0
Washington	168,510	151,500	11.2	103,150	88,290	16.8
West Virginia	59,400	73,710	–19.4	56,340	70,820	–20.4
Wisconsin	93,010	150,860	–38.3	41,380	79,050	–47.7
Wyoming	16,770	12,940	29.6	13,390	11,080	20.8
American Samoa	4,470	2,690	66.2	4,470	2,690	66.2
Guam	3,180	1,000	218.0	3,180	1,000	218.0
Mariana Islands	3,940	1,930	104.1	3,940	1,630	141.7
Marshall Islands	5,420	3,920	38.3	5,420	3,920	38.3
Micronesia	14,360	21,370	–32.8	14,360	21,150	–32.1
Palau	1,990	1,030	93.2	1,990	1,030	93.2
Puerto Rico	19,160	38,820	–50.6	14,410	30,340	–52.5
Virgin Islands	2,600	3,010	–13.6	2,600	3,010	–13.6

ics than at metropolitan sites (56% vs. 26%).

Regional differences in the distribution of clients by provider type are even more striking. Receipt of care from health department clinics exhibited the greatest variation: No clients in Region I and 76% in Region IV received services from a health department clinic. Hospitals varied from serving 5% of clients in Region IV to 22% in Region II. Planned Parenthood clinics served more than 40% of clients in five regions but only 9% in one. Clinics designated as other providers were more common in Region I, where they served 36% of clients, than in any other region; in contrast, other clinics in Regions IV and X served only 1% and 3% of clients, respectively.

• *Trends by provider characteristics.* Hospital clinics experienced a sharp decline (32%) in the number of clients served between 1994 and 2001 (Table 2, page 209). Planned Parenthood clinics experienced the largest absolute increase in client numbers (nearly 300,000), representing a 14% increase. And although the number of contraceptive clients served by community health centers rose by more than 100,000, or 17%, this change seems modest when one considers that the number of such clinics increased 42% over the period. Similarly, the 1% increase in contraceptive clients served at other clinics contrasts sharply with the 30% increase in the number of such sites.

Change in client numbers has not always matched change in clinic numbers, in part because of the variation among provider types in both average client caseloads and change over time. Community health centers and other clinics served the fewest clients per clinic—averaging 400–640 in 2001, an 18–22% decrease from 1994 (not shown). In comparison, the average client caseloads of health departments and Planned Parenthood clinics are much higher and have risen over the period: In 2001, nearly 800 and 2,500 clients were served, on average, by health department and Planned Parenthood clinics, respectively—a 14–20% increase from 1994.

Overall, Title X–funded clinics served 10% more clients in 2001 than in 1994; clinics not funded by Title X experienced a 12% decrease in the number of clients served over the same period. Consequently, the distribution of clients according to where they were served shifted: Sixty-nine percent of all clients of publicly funded clinics in 2001 were served by Title X–funded clinics, compared with 64% in 1994. And although Title X–funded clinics have always had a larger average annual client caseload than those not funded by Title X, this difference has widened substantially over the years. In 1994, the average client caseload for Title X–funded clinics was 25% greater than that for clinics not funded through the program (1,005 vs. 805—not shown). By 2001, Title X–funded clinics had an average caseload that was 69% higher than that of clinics not funded by Title X (1,060 vs. 628).

Change in client numbers has also varied according to clinic location, with more clients served in metropolitan locations than in nonmetropolitan counties. Regionally, growth in client numbers was highest in the West: Regions VIII, IX and X saw increases of 16%, 18% and 28%, respectively (Table 2). In contrast, Regions III and VII, representing the Mid-Atlantic states and parts of the Midwest, experienced significant losses in the numbers of clients served—14% and 24%, respectively.

• *State variation.* Further evidence of change within the network of publicly funded family planning providers can be found by reviewing trends in the number of contraceptive

clients served in each state (Table 3). In half of states, the number increased between 1994 and 2001, and in half, it declined. Eleven states experienced at least a 20% increase in contraceptive clients served by publicly funded clinics; the same number of states experienced a similarly sized decrease. Nevada, Oregon and South Carolina experienced the largest increases in contraceptive clients served (41–70%); Hawaii, Missouri and Wisconsin experienced the largest losses (34–54%). About one in four states experienced relatively small (less than 5%) changes in the number of contraceptive clients served.

Data on contraceptive clients served at Title X–funded clinics in each state exhibit slightly different patterns. Overall, 30 states experienced a positive change in the number of contraceptive clients served by Title X–funded clinics between 1994 and 2001; four states had increases of more than 50%, including Nevada, where the number of clients served at Title X–funded clinics more than doubled. Two states experienced large declines: Title X–funded clinics in Hawaii and Wisconsin saw 48% fewer clients in 2001 than in 1994.

Change in contraceptive clients served by publicly funded providers was just as variable in Puerto Rico and the U.S. territories included in this analysis as in the states. Five territories experienced increases in contraceptive clients served by both all providers and Title X–funded providers. However, in Puerto Rico and two territories, the number of contraceptive clients served in all publicly funded and Title X–funded clinics declined.

• *Variation by state Medicaid waiver status.* Many factors are likely to impact state variation in the numbers of contraceptive clients served and in changes in these numbers. Clearly, the availability of public funds is key; however, because states differ in the mix and volatility of the federal, state, local and private funds used to pay for family planning services, it is difficult to find a common factor responsible for these trends. However, one critical source of funding for family planning is Medicaid. And because the period of analysis coincided with the period in which many states obtained Medicaid waivers designed specifically to increase the number of women eligible to receive publicly funded family planning care, we examined whether Medicaid family planning waivers were related to rising or falling numbers of contraceptive clients served at family planning clinics.

To this end, we compared states according to whether they had implemented a waiver between 1994 and 2001. States with Medicaid family planning waivers were also separated according to the type of waiver implemented—waivers targeting individuals below 133–200% of the federal poverty level versus those limited to women who had recently lost regular Medicaid coverage after the postpartum period or for any other reason.

States that had implemented the broadest family planning waivers—those based solely on income—were more likely than those without waivers or with less expansive waivers to have experienced an increase in client numbers between 1994 and 2001 (Table 4). Combined, the number of contraceptive clients served by publicly funded providers in the seven states with income-based waivers grew by 24% over the period. In five of these states, client numbers increased.* Two states had small declines (2–4%), although for one of these states the decline occurred prior to the implementation of the waiver (not shown). In comparison, the overall number of contraceptive clients served by states without waivers fell by 2%; and among states that implemented waivers expanding coverage only after the postpartum period or for women losing Medicaid coverage for other reasons, contraceptive client numbers fell by 8%. We had not anticipated a large effect for postpartum or lost coverage waivers because they are much more limited than those based on income alone—increasing eligibility to only a small proportion of poor women.

TABLE 4. Number of female contraceptive clients served at all publicly funded family planning clinics and at Title X–funded clinics, 2001 and 1994; and percentage change in client numbers between 1994 and 2001—by state Medicaid waiver status

Waiver status	All			Title X–funded		
	2001	1994	% change	2001	1994	% change
Income-based waiver*	1,708,890	1,378,500	24.0	1,164,140	893,420	30.3
Postpartum/lost coverage waiver†	1,040,900	1,135,980	–8.4	720,960	633,290	13.8
No waiver‡	3,913,790	3,983,580	–1.8	2,714,840	2,630,140	3.2

*States with income-based waivers are Alabama, Arkansas, California, New Mexico, Oregon, South Carolina and Washington. †States with postpartum waivers or waivers for women who have lost Medicaid coverage for other reasons are Arizona, Delaware, Florida, Maryland, Missouri, New York and Rhode Island. ‡All remaining states and the District of Columbia (excludes territories and Puerto Rico).

Among Title X providers in states with income-based family planning waivers, the number of contraceptive clients rose by 30% between 1994 and 2001. In comparison, increases were much more modest for Title X–funded providers in states with waivers not based on income (14%) or in states with no waiver (3%).

Coverage of Women in Need by State

Another potential explanation for state change in clients served would be a change in the demand for publicly funded care due to change in the size or characteristics of the population. To assess this possibility, we compared the changes in the numbers of women in need of publicly funded contraceptive services and supplies by state between 1995 and 2000 with the changes in clients served between 1994 and 2001. The data were weakly correlated (correlation coefficient=.30), and none of the 11 states with declines in clients served of at least 20% had similarly large negative change in women in need (five of these states experienced increases in the number of women in need, and the other six experienced declines of 1–5%—not shown). On the other hand, seven of the 11 states with increases of 20% or more in clients served had increases in women in need of 2–23%. These findings suggest that although increases

*Oregon and South Carolina had the largest increases (63–70%), followed by California (27%). Because California has the largest Medicaid waiver program, comprising more than half of all contraceptive clients served in states with income-based waiver programs, we also estimated the change excluding California. The result (a 21% increase) was similar to the estimate for all seven states.

TABLE 5. Number of women in need of publicly funded family planning services in 2000 and 1995, percentage of women in need served at all publicly funded clinics and at Title X–funded clinics in 2001 and 1994, and percentage change in met need between 1994 and 2001, all by state and Medicaid waiver status

State and waiver status	No. in need, 2000*	% served, 2001		No. in need, 1995*	% served, 1994		% change, 1994–2001	
		All publicly funded clinics	Title X–funded clinics		All publicly funded clinics	Title X-funded clinics	All publicly funded clinics	Title X-funded clinics
U.S. total	**16,396,050**	**40.6**	**28.1**	**16,512,850**	**39.4**	**25.2**	**3.3**	**11.4**
Alabama	275,750	41.1	34.2	278,510	42.5	32.1	–3.3	6.6
Alaska	32,230	76.1	32.4	32,480	62.7	20.6	21.4	57.4
Arizona	314,600	32.0	14.9	285,720	46.3	11.7	–30.8	27.3
Arkansas	165,250	49.2	43.4	156,590	52.8	46.9	–6.8	–7.5
California	2,110,740	48.1	31.8	2,205,920	36.4	22.7	31.9	40.2
Colorado	229,000	58.0	25.2	224,100	47.1	22.6	23.2	11.4
Connecticut	161,100	43.8	29.4	165,640	55.9	30.1	–21.7	–2.1
Delaware	39,760	51.8	51.8	39,080	53.4	37.8	–2.9	36.9
D.C.	41,260	46.4	34.9	41,430	61.9	35.1	–25.1	–0.6
Florida	848,380	31.4	23.2	804,780	31.4	21.0	–0.1	10.9
Georgia	472,120	42.3	37.9	456,820	44.4	37.2	–4.6	1.8
Hawaii	61,390	14.7	14.7	59,210	32.9	29.5	–55.4	–50.2
Idaho	80,360	51.9	46.1	69,750	49.7	42.4	4.5	8.8
Illinois	694,420	29.7	22.3	701,090	30.2	23.2	–1.6	–4.0
Indiana	357,070	41.2	13.7	363,650	39.6	21.4	4.0	–35.9
Iowa	168,760	41.0	34.1	166,630	55.0	44.5	–25.3	–23.5
Kansas	157,410	36.6	27.8	155,260	45.1	30.7	–18.8	–9.5
Kentucky	240,430	55.5	47.3	247,150	50.2	46.3	10.6	2.1
Louisiana	309,360	26.8	24.6	314,000	25.4	18.6	5.2	31.8
Maine	78,700	62.4	38.9	83,550	49.0	42.5	27.3	–8.5
Maryland	243,480	33.8	29.3	257,430	41.1	28.1	–17.9	4.6
Massachusetts	333,710	41.5	22.0	356,320	36.9	19.8	12.5	11.2
Michigan	562,410	41.6	33.3	599,680	39.9	21.2	4.3	57.0
Minnesota	253,250	41.0	17.5	255,870	39.6	14.3	3.6	22.5
Mississippi	194,380	62.4	52.8	193,330	62.6	40.8	–0.4	29.3
Missouri	342,080	31.7	22.2	338,630	48.4	27.6	–34.5	–19.5
Montana	54,990	61.7	52.4	52,620	68.0	53.9	–9.3	–2.8
Nebraska	102,430	34.3	32.8	100,150	30.3	27.1	13.5	21.0
Nevada	110,030	43.4	33.0	89,620	37.9	19.4	14.5	70.1
New Hampshire	62,840	48.8	44.4	64,870	54.0	48.9	–9.7	–9.2
New Jersey	395,100	32.8	26.2	413,420	34.1	24.7	–3.8	6.3
New Mexico	127,390	53.8	27.1	126,230	50.8	31.8	5.9	–14.7
New York	1,195,150	37.4	24.7	1,199,410	36.6	19.8	2.0	24.7
North Carolina	455,030	42.7	31.3	445,980	38.3	25.3	11.3	23.7
North Dakota	41,810	38.3	33.3	40,300	42.9	35.4	–10.8	–5.8
Ohio	657,860	30.6	20.7	690,270	30.8	20.5	–0.8	1.0
Oklahoma	217,250	43.8	32.9	209,450	37.6	25.6	16.6	28.7
Oregon	196,920	62.6	33.9	187,040	38.8	18.8	61.4	80.3
Pennsylvania	715,330	41.1	36.7	747,280	41.0	35.1	0.2	4.7
Rhode Island	66,370	24.4	20.6	63,350	33.3	20.8	–26.8	–0.7
South Carolina	244,440	56.9	49.6	246,980	34.5	26.6	64.8	86.3
South Dakota	47,370	48.4	33.7	47,260	48.2	36.1	0.5	–6.7
Tennessee	331,390	31.0	24.7	336,410	39.2	30.3	–20.8	–18.5
Texas	1,303,550	41.5	19.5	1,290,080	37.4	18.1	10.8	7.7
Utah	147,120	28.3	14.6	127,900	25.7	12.1	10.0	20.7
Vermont	37,550	54.9	28.0	39,960	52.8	23.1	3.9	21.1
Virginia	365,760	26.6	20.8	386,690	35.0	20.5	–24.2	1.5
Washington	318,990	52.8	32.3	315,200	48.1	28.0	9.9	15.4
West Virginia	110,200	53.9	51.1	116,190	63.4	61.0	–15.0	–16.1
Wisconsin	294,440	31.6	14.1	296,390	50.9	26.7	–37.9	–47.3
Wyoming	29,340	57.2	45.6	27,180	47.6	40.8	20.1	11.9
Medicaid waiver status								
Income-based	3,439,480	49.7	33.8	3,516,470	39.2	25.4	26.7	33.2
Postpartum/ lost coverage	3,049,820	34.1	23.6	3,051,750	38.0	21.2	–10.2	11.6
None	9,906,750	39.5	27.4	9,944,630	39.8	26.3	–0.7	4.3

*Women aged 20–44 who are at risk of an unintended pregnancy and whose income is less than 250% of the federal poverty level, plus all women younger than 20 who are at risk of an unintended pregnancy. *Sources:* **Number of women in need, 2000**—AGI, 2000 (reference 17). **Number of women in need, 1995**—AGI, 1997 (reference 17).

in women in need were sometimes associated with increases in clients served, those states that experienced substantial declines in clients served were clearly not responding to changing demand due to fewer women in need.

To determine the ongoing ability of publicly funded family planning clinics to meet local needs, we estimated what proportion of the need for publicly funded contraceptive services was met by clinics nationally and in each state by

dividing the number served in clinics by the number of women in need. (These proportions are proxies for met need and do not provide a complete measure of unmet need for contraceptive services because they exclude women who receive Medicaid-covered services from private providers, as well as users of nonprescription methods who have not made a visit for contraceptive services. In addition, they include some nonpoor women who are served by publicly funded clinics even though they do not fit the income definition of women in need.) Nationwide, publicly funded family planning clinics met 41% of the need for such services in 2001—a 3% increase from 1994 (Table 5). Title X–funded clinics alone met 28% of the national need for publicly funded family planning services—an 11% increase from 1994.

By state, the proportion of need met by all publicly funded family planning clinics in 2001 varied from 15% in Hawaii to 76% in Alaska. Among clinics funded by Title X, the proportion varied from 14% in Indiana to 53% in Mississippi. The proportion of women in need served by Title X–funded clinics in 2001 exceeded 50% in four states—Delaware, Mississippi, Montana and West Virginia. In five states—Arizona, Hawaii, Indiana, Utah and Wisconsin—this proportion was 14–15%.

Comparing the proportions of need met by clinics in 2001 and in 1994 reveals which states have experienced improved clinic capacity (Table 5). In one-third of states, clinic capacity improved, with met need increasing by 5% or more; in four states (California, Maine, Oregon, South Carolina), the increase in met need exceeded 25%, varying from 27% to 65%. However, in another one-third of states, clinic capacity declined, with met need decreasing by 5% or more; six states (Arizona, Hawaii, Iowa, Missouri, Rhode Island and Wisconsin) and the District of Columbia experienced 25–55% declines in the proportion of need met by clinics. Overall, 21% of U.S. women in need of publicly funded contraceptive care lived in a state where the proportion of need met by clinics declined by at least 5% (not shown).

Finally, we examined change in the proportion of need met by clinics according to state Medicaid waiver status. In 1994, there was no difference by waiver status in the proportion of need met by clinics. However, by 2001, states that had implemented income-based Medicaid waivers since 1994 had experienced a 27% increase in the proportion of need met by clinics (from 39% to 50%). In states without any Medicaid family planning waiver, the proportion remained stable at 40%, whereas in states with postpartum or lost coverage waivers, the proportion decreased from 38% to 34%. Title X–funded clinics in states with income-based Medicaid waivers reported a one-third increase in met need; the proportion rose from 25% in 1994 to 34% in 2001.

TABLE 6. Number of counties, percentage with any publicly funded family planning clinic and with any Title X–funded clinic, and percentage of women in need of publicly funded family planning services living in counties with any publicly funded or Title X–funded clinics, all by state, 2001

State	No. of counties	% of counties		% of women in need living in counties	
		≥1 publicly funded clinic	≥1 Title X–funded clinic	≥1 publicly funded clinic	≥1 Title X–funded clinic
U.S. total	**3,141**	**84.5**	**73.4**	**97.9**	**93.8**
Alabama	67	98.5	98.5	99.5	99.5
Alaska	27	85.2	37.0	98.0	66.6
Arizona	15	100.0	73.3	100.0	95.9
Arkansas	75	100.0	100.0	100.0	100.0
California	58	100.0	65.5	100.0	97.4
Colorado	63	84.1	71.4	99.4	98.0
Connecticut	8	100.0	87.5	100.0	95.4
Delaware	3	100.0	100.0	100.0	100.0
D.C.	1	100.0	100.0	100.0	100.0
Florida	67	100.0	100.0	100.0	100.0
Georgia	159	100.0	100.0	100.0	100.0
Hawaii	5	80.0	80.0	100.0	100.0
Idaho	44	88.6	84.1	96.9	95.7
Illinois	102	69.6	62.7	96.0	93.2
Indiana	92	48.9	27.2	82.0	66.9
Iowa	99	49.5	48.5	82.1	81.0
Kansas	105	76.2	73.3	95.2	94.2
Kentucky	120	100.0	100.0	100.0	100.0
Louisiana	64	98.4	98.4	99.5	99.5
Maine	16	100.0	93.8	100.0	97.5
Maryland	24	100.0	100.0	100.0	100.0
Massachusetts	14	100.0	100.0	100.0	100.0
Michigan	83	97.6	96.4	99.8	99.7
Minnesota	87	81.6	34.5	95.1	65.5
Mississippi	82	98.8	98.8	99.9	99.9
Missouri	115	92.2	62.6	98.7	86.5
Montana	56	58.9	50.0	93.1	87.8
Nebraska	93	24.7	20.4	72.8	70.7
Nevada	17	88.2	82.4	99.8	99.8
New Hampshire	10	100.0	100.0	100.0	100.0
New Jersey	21	100.0	100.0	100.0	100.0
New Mexico	33	97.0	93.9	99.9	99.8
New York	62	100.0	98.4	100.0	99.8
North Carolina	100	100.0	99.0	100.0	93.1
North Dakota	53	37.7	32.1	82.4	77.5
Ohio	88	89.8	72.7	98.1	91.8
Oklahoma	77	89.6	89.6	99.0	99.0
Oregon	36	100.0	97.2	100.0	100.0
Pennsylvania	67	94.0	94.0	99.4	99.4
Rhode Island	5	80.0	80.0	96.2	96.2
South Carolina	46	100.0	100.0	100.0	100.0
South Dakota	66	69.7	56.1	89.7	82.0
Tennessee	95	100.0	100.0	100.0	100.0
Texas	254	68.1	39.8	96.6	87.5
Utah	29	79.3	44.8	98.2	82.9
Vermont	14	92.9	71.4	99.0	58.8
Virginia	135	88.1	85.9	82.3	80.4
Washington	39	89.7	79.5	98.9	97.2
West Virginia	55	100.0	96.4	100.0	98.8
Wisconsin	72	93.1	20.8	97.3	56.1
Wyoming	23	100.0	73.9	100.0	92.9

Clinic Accessibility

In 2001, 85% of all U.S. counties had at least one publicly funded family planning clinic (Table 6). Twenty-one states had at least one clinic in every county; four (Indiana, Iowa, Nebraska and North Dakota) had clinics in fewer than 50% of counties. Counties without clinics were typically the least populated (not shown). Ninety-eight percent of all women in need of publicly funded contraceptive services and supplies lived in counties with at least one clinic; however, in six states, fewer than 90% of women in need lived in counties with a clinic. Nearly three in four U.S. counties had at least one Title X–funded clinic, and 94% of women in need lived in these counties. In five states, two-thirds or fewer of women in need lived in these counties.

DISCUSSION

Limitations

Although we used rigorous methods to obtain accurate information on the number of clinics and contraceptive clients served, some error may have occurred. Given rapid change among U.S. health care providers, some qualified sites may have been omitted. In addition, some agencies provided estimates of contraceptive clients served per year because they did not have documented service figures. Finally, for 11% of clinics, we estimated the number of contraceptive clients served on the basis of prior data or the experience of similar clinics. Each step may have introduced error into the final counts of providers and contraceptive clients. Although the potential level of error is unlikely to be large or to significantly impact national or state-level estimates of contraceptive clients, it may have greater impact on some county-level estimates.

Conclusions

Publicly funded family planning clinics continue to play a critical role in the delivery of contraceptive services and supplies to millions of American women. Over the past decade, this network of clinics has served 6–7 million contraceptive clients each year. However, the relative stability observed when simply counting total women served masks a tremendous amount of fluctuation and turmoil within the system. Between 1994 and 2001, nearly 2,000 clinics—about one in four—closed or stopped providing family planning services. During the same time, more than 2,500 clinics opened or began providing family planning care.

Two broad types of change have occurred in the network of publicly funded family planning clinics. First are structural changes, characterized by changes in the distribution of clinics and clients according to provider type. Second are capacity changes, revealed in the absolute gains and losses in clinics and clients served, and in changes in the proportion of need met by clinics.

Structural change in the clinic network has resulted, in part, because family planning–focused providers have consolidated their operations and are now serving more clients at fewer sites, while primary care–focused providers have dispersed and have a greater number of sites, each serving fewer contraceptive clients. Planned Parenthood and health department clinics—the providers most likely to report a reproductive health focus[19]—have experienced a tremendous amount of restructuring through mergers, site closings and concentration of care at fewer sites. At the same time, the total number of clients served by these sites has risen, indicating that the client base for health department and Planned Parenthood facilities is not shrinking. Community health centers (typically providers of primary health care) and other agencies were the only provider types that experienced net increases in sites between 1994 and 2001. However, because each site serves only a small number of contraceptive clients and, on average, serves fewer contraceptive clients now than it did in the past, the number of clients has not increased proportionately.

From the point of view of women seeking services, the implications of these structural changes are likely to be considerable. High turnover in facilities means that many women will not have a stable source of ongoing care. Some women may lose access to a site they know well or like and may not know of an alternative source; others may need to travel farther to access care when sites close or merge. The increase in numbers of community health center clinics offering contraceptive services could offset some negative consequences of consolidation. And because women may already visit community health centers for other types of primary care, they may find it convenient to obtain contraceptive care from these providers. However, community health centers are usually less likely than other providers to offer a wide choice of contraceptive methods, on-site availability of oral contraceptives or other options, such as delaying pelvic exams when prescribing hormonal methods.[20]

Regional and state trends in the numbers of clinics and clients served reveal evidence of change in the capacity of the family planning clinic network. Clinic closures have not always been compensated for by clinic openings in the same area; some regions experienced net losses in clinics and clients served, while others experienced net gains. Moreover, even within regions, there was considerable state variation between 1994 and 2001 in the numbers of clinics and clients served and in the proportion of women in need who were served by clinics. Although a majority of states either maintained or improved clinic capacity, one-third of states—in which 21% of U.S. women in need reside—had 5–55% declines in the proportion of need met by clinics.

We were able to investigate the contribution of one important factor in these trends—expansion of Medicaid-covered family planning care under state-initiated waiver programs. Between 1994 and 2001, seven states implemented income-based family planning waiver programs that expanded eligibility for Medicaid-covered contraceptive care to low-income women. In these states, one-quarter more clients were served by clinics in 2001 than in 1994, and the proportion of met need increased by 27%, so that 50% of all women in need of publicly funded contraceptive care received such care in clinics. In contrast, states with less expansive or no waivers served fewer clients in 2001 than in 1994, and the proportion of need met by clinics remained at or below 40%.

These findings provide evidence that implementation of income-based Medicaid family planning waivers raises the capacity of local clinic networks and improves access to contraceptive care for more women in need of such care, confirming the results of an earlier evaluation.[21] The impact of waivers on clinic capacity may also help to explain the striking regional variation observed: Three of the seven states with income-based waivers are located in Regions IX and X, and those regions experienced the largest net increases in clinic and client numbers. However, factors other than the waivers may have contributed to improved family planning clinic capacity among waiver states. For example, the same priorities that led some states to seek family planning waivers in the first place—such as a commitment to increasing health care access in general or family planning

care specifically—may be associated with other, unmeasured factors that have improved clinic capacity in these states.

Also vital to the family planning clinic network is continued funding through Title X. Between 1994 and 2001, the number of clinics receiving Title X funding increased by 5%, and the number of contraceptive clients they served rose by 10%. Moreover, in 2001, more than one-quarter of the need for publicly funded contraceptive care was met by Title X–funded clinics—an 11% increase over the period. More impressive is the increased capacity of Title X–funded sites located in states with Medicaid family planning waivers. In these states, the capacity of Title X–funded sites to serve women in need of publicly funded care improved, with met need increasing by 33% between 1994 and 2001 (compared with the 27% increase among all public clinics in waiver states), indicating the added value that Title X funding brings to these providers.

A troubling change is the large number of states that experienced a reduction in the capacity of publicly funded family planning clinics to provide subsidized contraceptive care to low-income women and teenagers, as measured by a decline in met need or a high proportion of women in need living in counties without a publicly funded clinic. Further investigation is needed to learn what circumstances have led to declining clinic capacity, the impact it has had on low-income women and the efforts that are needed to reverse it. At the least, a decline in publicly funded family planning care will likely force some women to seek more expensive care from private physicians, shift to less effective contraceptive methods or forgo contraception and related preventive care altogether.

One can hope that lessons will be learned from the success of states that have implemented income-based Medicaid waiver programs. Not only can clinic capacity be increased and access to care improved, but such programs can save public money by realizing the basic benefits of family planning—prevention of unintended pregnancies and the costs associated with childbearing among poor and low-income women who would have preferred to delay or avoid pregnancy. In a climate where state fiscal crises abound, programs that save public money and increase access to care deserve special attention.

It is also important to remember the critical role that Title X funding continues to play, even for clinics in states with Medicaid waivers. Because Title X funding is not tied to particular services rendered or clients served, it remains one of few sources that clinics can draw upon to cover the gap between Medicaid reimbursements and the actual cost of care, provide educational and outreach activities, and lessen the financial burden caused by increasing costs for new methods and diagnostic testing.[22]

Over time, the network of publicly funded family planning clinics has proved its resiliency, adapting to shifts in health care delivery, structure and financing, while continuing to meet the contraceptive service needs of millions of poor and low-income women. In some states, demonstrated improvements in clinic capacity are welcome news. Elsewhere, fewer clinics, fewer clients served and declines in the proportion of need met by clinics are likely casualties of local and state funding crises combined with political priorities that are either noncommittal or openly hostile to family planning as a public good.

REFERENCES

1. Frost JJ, Public or private providers? U.S. women's use of reproductive health services, *Family Planning Perspectives*, 2001, 33(1):4–12.

2. Finer LB, Darroch JE and Frost JJ, U.S. agencies providing publicly funded contraceptive services in 1999, *Perspectives on Sexual and Reproductive Health*, 2002, 34(1):15–24.

3. Ibid.

4. Gold RB, Doing more for less: study says state Medicaid family planning expansions are cost-effective, *Guttmacher Report on Public Policy*, 2004, 7(1):1–2.

5. Finer LB, Darroch JE and Frost JJ, 2002, op. cit. (see reference 2).

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

7. Department of Health and Human Services (DHHS), Program guidelines for project grants for family planning services, Washington, DC: U.S. Government Printing Office, 2001.

8. AGI, 2000, op. cit. (see reference 6).

9. Gold RB, Nowhere but up: rising costs for Title X clinics, *Guttmacher Report on Public Policy*, 2002, 5(5):6–9.

10. Gold RB, States eye Medicaid cuts as cure for fiscal woes, *Guttmacher Report on Public Policy*, 2003, 6(3):6–9.

11. Gold RB, Medicaid family planning expansions hit stride, *Guttmacher Report on Public Policy*, 2003, 6(4):11–14; and The Henry J. Kaiser Family Foundation and AGI, Medicaid: a critical source of support for family planning in the United States, *Issue Brief*, New York: The Henry J. Kaiser Family Foundation and AGI, 2004.

12. Frost, JJ, Family planning clinic services in the United States, 1994, *Family Planning Perspectives*, 1996, 28(3):92–100; and Frost JJ et al., Family planning clinic services in the United States: patterns and trends in the late 1990s, *Family Planning Perspectives*, 2001, 33(3):113–122.

13. Frost JJ, Frohwirth L and Purcell A, Expanded methodology for the 2001 census of publicly funded family planning clinics, AGI, 2004, <http://www.guttmacher.org/pubs/win/clinicmethods2001.pdf>.

14. Office of Population Affairs, DHHS, *Family Planning Grantees, Delegates, and Clinics: 2001/2002 Directory*, Washington, DC: U.S. Government Printing Office, 2001.

15. Planned Parenthood Federation of America (PPFA), *Directory of Service Providers, 2000*, New York: PPFA, 2000.

16. Health Resources and Services Administration, DHHS, *Bureau of Primary Care Programs Directory: 2001*, Bethesda, MD: DHHS, 2000.

17. AGI, *Contraceptive Needs and Services, 1995*, New York: AGI, 1997; and AGI, Women in need of contraceptive services and supplies, 2000, <http://www.guttmacher.org/pubs/win/index>, accessed Aug. 27, 2004.

18. Frost JJ et al., 2001, op. cit. (see reference 12).

19. Finer LB, Darroch JE and Frost JJ, 2002, op. cit. (see reference 2).

20. Ibid.

21. Gold RB, 2004, op. cit. (see reference 4).

22. Gold RB, 2002, op. cit. (see reference 9).

Acknowledgment

The authors thank Susheela Singh and Lawrence Finer for comments on earlier versions of this article, and Sarah Kirshen, Emily Stone, Claire Evans and Sumitra Mattai for assistance with data collection, follow-up and data processing. The research on which this article is based was supported by the Office of Population Affairs, U.S. Department of Health and Human Services (DHHS), grant FPR 000072. The conclusions and opinions expressed in this article do not necessarily represent the views of DHHS.

Author contact: *jfrost@guttmacher.org*