Guttmacher Policy Review
Winter 2010 | Volume 13 | Number 1
GPR

Recession Taking Its Toll: Family Planning Safety Net Stretched Thin as Service Demand Increases

By Rachel Benson Gold

The ongoing economic turbulence caused by the Great Recession over the past two years is starting to feel like a one-two punch aimed squarely at American women—and at the family planning providers on whom they depend. The recession has had a profound impact on lower- and modest-income women's childbearing goals, even while making it difficult—or sometimes impossible—for them to access the medical care they need to prevent the pregnancies they now want to prevent. Meanwhile, family planning providers across the country struggle to meet the increased demand for the free or reduced-cost services they offer, as tough economic times threaten their own financial stability. This increasingly important component of the nation's social and health care safety net is also increasingly tattered. Repairing the damage is going to take a concerted effort from government at all levels.

Profound Impact

Two recent Guttmacher Institute surveys—one of low- and middle-income sexually active women and the other of publicly funded family planning centers (see box)—shed light on how the current recession has taken its toll. More severe in depth and length than any in this country in decades, it clearly has had a dramatic impact on women's fertility preferences. Nearly half of all women surveyed, and more than half of those with an annual family income below $25,000, said that because of the economy, they wanted to get pregnant later, wanted fewer children or now did not want any more children.

Many women have altered their contraceptive use as a result of the recession (see chart, page 10). Nearly 30% of all women, and more than four in 10 women who reported that their childbearing goals have been affected by the recession, said that they are being more careful about using contraceptives each time they have sex. And some reported considering sterilization or using a long-acting reversible contraceptive, such as the IUD, because of the recession. But for many, economic hardship means having to skimp and even take risks—by doing things like trying to stretch their monthly supply of pills, shifting to a less expensive method, using birth control inconsistently or putting off a visit—to save money.

One in 10 women said that they had switched to a less expensive provider of contraceptive services. This increased demand for lower-cost services was mirrored in the survey responses from family planning providers. Two-thirds of the family planning centers surveyed noted an increase in the number of clients seeking services between the first quarter of 2008 and the first quarter of 2009 (see chart, page 10). Importantly, the vast majority of providers surveyed said they had seen an increase in the number of clients who are poor or low income and, therefore, eligible for free or reduced-fee care from providers receiving any subsidy from the federal Title X program.

More than half the providers reported significant service delivery challenges in meeting clients' needs. Most often, they reported staff layoffs or a hiring freeze during 2009. Many also said that they had been forced to reduce the number of contraceptive methods they are able to offer; more expensive methods such as the IUD, the implant, the patch and some brand-name oral

contraceptives were the most likely to be cut. One in four providers said that waiting times had increased, typically doubling from less than a week to about two weeks.

Rising and Changing Demand

Detailed interviews with 12 family planning providers from across the country conducted for this article further explicate the challenges facing the national family planning provider network in meeting the increased needs of hard-pressed American women seeking to control their childbearing. They illustrate, first and foremost, that the demand for publicly funded family planning services has been rising and changing. Providers interviewed overwhelmingly reported that demand for their agencies' low-cost family planning services rose as local economic circumstances deteriorated. Significantly, this was true even for providers that were forced to scale back their services. For example, visits to the family planning program in Lorain County, Ohio—an area heavily reliant on employment in the automobile industry—increased slightly in 2009, despite the fact that the program needed to reduce clinic hours during the last three months of the year.

Meanwhile, the nature of the clientele has also changed. At the Indiana Family Health Council, 76% of clients are now below the federal poverty level, compared with 71% in 2007. "Fewer women are able to pay for their care," said Gayla Winston, president and CEO of the Council, "and those who are paying are able to pay less."

Although not surprising given that the recession has cost millions their insurance coverage, many providers say that the proportion of clients who are uninsured has gone up as well. According to Ellen Rautenberg, president and CEO of Public Health Solutions, a Title X grantee in New York, the proportion of family planning clients who were uninsured went from 47% in 2007 to 54% in 2009.

The group of women seeking care from publicly funded family planning programs has changed in other ways as well. According to Bette Cox Saxton, president and CEO of Maternal and Family Health Services, a Title X grantee in northeastern Pennsylvania, the agency's typical client has historically been in her teens or early 20s, but they are now seeing more older women, including many former clients. In some cases, women who had transitioned to private physicians are coming back because they can no longer afford private-sector care, often because they have lost their insurance coverage. In other cases, women who had discontinued contraception because they wanted to become pregnant now need to postpone childbearing given their current economic circumstances.

Studying the Recession's Impact

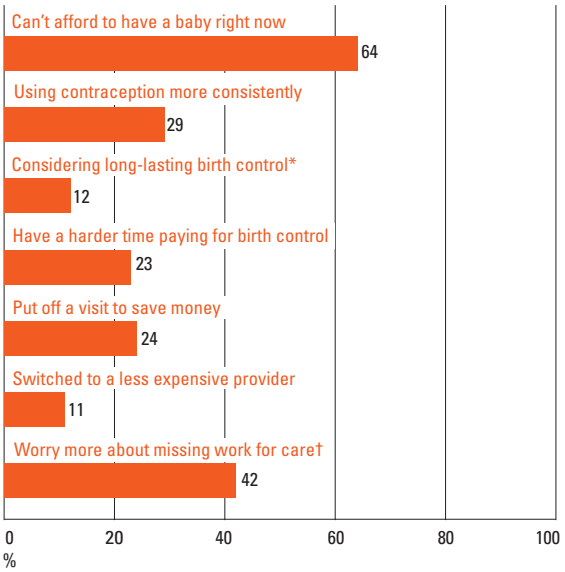
The Guttmacher Institute conducted two studies of the impact of the recession on reproductive health needs and services in 2009; both surveys are available on the Institute's Web site. The first study, A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions, *was a survey of a nationally representative sample of nearly 1,000 women, conducted in July and August of 2009, to determine how current economic conditions have affected them and their families, their views of contraceptive use, their ability to access contraceptives and their decisions on whether or when to have a child. The women included in the survey were aged 18–39 and had an annual household income of less than $75,000.*

The second, A Real-Time Look at the Impact of the Recession on Publicly Funded Family Planning Centers, *was a survey fielded in Spring 2009 of 60 family planning centers located around the nation that receive some funding through the Title X program. The centers surveyed were chosen randomly from all Title X–subsidized family planning sites serving at least 2,000 contraceptive clients a year to form a nationally representative sample of the network of family planning providers.*

To further illustrate how these quantitative findings are playing out on the ground, the surveys were complemented with extensive telephone interviews in December and January with 12 family planning providers that offer some free or reduced-fee services to the public. The officials interviewed represented a wide range of provider types (Planned Parenthood affiliates, state and local health agencies, family planning councils and university-based programs) of various sizes and from various geographic areas.

TOUGH CHOICES

Because of the recession, large proportions of women report that they have changed their attitudes and behavior regarding contraception.



Note: All data are among women aged 18–34 with household incomes less than $75,000. *Among women not currently using a long-term method. †Among women currently employed. *Source:* Guttmacher Institute, 2009.

Saxton reported that her agency, like others, has been scrambling to accommodate this changing need. Nationwide, nearly one in four agencies reported that they are extending clinic hours. Some providers, like Saxton, said that these longer hours are critical, because clients are often unable to come in during the day; many are working, often because their husband is now unemployed.

But Saxton also reported that they have been forced to change their service set in ways they could not have anticipated. For example, when phone calls to clients who missed appointments showed that an inability to afford child care was a mounting issue, the agency began encouraging women to bring their children to appointments. At some of the agency's sites, staff members now supervise children in the waiting room, and senior citizens from the area who had been volunteering to read to children while their parents made visits to the agency for nutrition assistance through the WIC program are now providing the same service for family planning clients. Saxton's program already provided WIC service, but many that had not reported adding the service and redoubling their efforts to provide information and referrals to other community resources as a result of the clear needs of their clients.

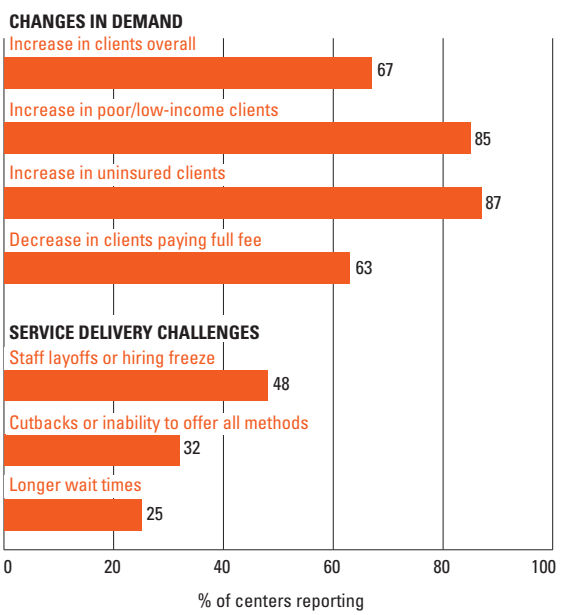
Providers Struggling

The growing and changing demand for services has left providers struggling. The Indiana Family Health Council now has several clinics operating with only two staff, short of the usual three-person complement. Others, like Planned Parenthood of Northeast Ohio, froze salaries to try to make ends meet, according to CEO Tara Broderick. For its part, Planned Parenthood of the Great Northwest has instituted furloughs equivalent to a 4% pay cut and suspended contributions to staff retirement accounts, reported the program's president and CEO, Christine Charbonneau.

Women seeking services at some centers in Indiana now have to wait up to two months for an appointment, compared with 1–2 weeks before the recession. Some agencies, such as the Planned Parenthood in Augusta, Georgia, have slashed operating hours. This can lead to a downward spiral, said Maternal and Family

MORE DEMAND, NEW CHALLENGES

During the first three months of 2009 (compared with the same period a year before), large proportions of family planning centers reported rising demand and challenges to providing care.



Source: Guttmacher Institute, 2009.

Health Services' Saxton: "You cut staff or operating hours to save money, and that leads to a decrease in clients served, which makes it no longer viable to keep the site open at all."

In some cases, agencies have found themselves with no other option but to close sites, severely threatening access to services for women in need. In rural Missouri, two community action agencies that have long run family planning centers are seriously questioning whether, given all the other demands for their services, they will be able to continue to support the family planning operation much longer. If these sites close, women would have to drive as much as an hour and a half for care, to centers that could well become overwhelmed themselves as they meet the influx, according to Connie Cunningham, executive director of the Missouri Family Health Council.

In many cases, family planning agencies have been affected by the trickle-down impact of the recession on their parent organization or community partners. With Arizona among the states hardest hit by the recession, the family planning effort run by the Arizona State University College of Nursing and Health Innovation has suffered both, according to Denise Link, Associate Dean for Clinical Practice and Community Partnerships. Cuts in state funding translated into a 15% cut to all of the college's programs, including the Title X–funded site it runs. Compounding the problem going forward, the Lutheran Church in which the center is located is itself struggling, with costs increasing and collections down sharply, leading the church to cut back on its in-kind contributions to the program.

The situation is also dire in Washington state. Planned Parenthood of the Great Northwest shuttered two clinics in 2009, and if planned state budget cuts occur later this year, it may be looking at even more closures. King County's family planning program, which serves Seattle, closed two clinics in December.

And the reality is that once a site is closed, it can be extremely difficult to reopen. In King County, according to program staff, the health agency would first have to secure significant funding to open and operate even a two-person facility. After that, leasing and building out a space would mean nine months to a year before even a single client could be seen. In New York, an agency would have to go through the entire certificate of need process and then, if a space already designed to code could not be found, it would take 6–12 months to build out a space, at a cost of about $1 million, according to Ellen Rautenberg of Public Health Solutions.

Digging Out

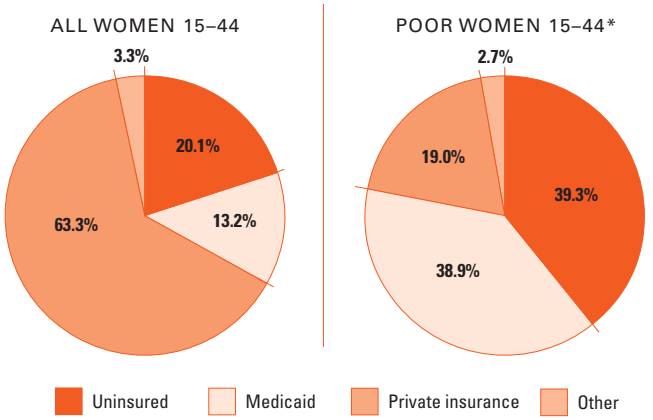
In large measure, the national family planning effort had its roots in the 1960s in recognition of the fundamental relationships between the ability to time and space childbearing and the health and well-being of individuals and families. Ground-breaking research at the time documented the substantial and far-reaching economic consequences that unintended pregnancy could have by reducing a woman's ability to complete an education or participate in the workforce and increasing her risk of poverty and dependency. Notably, the very first federal family planning grants were made as part of the Johnson administration's signature War on Poverty through the Office of Economic Opportunity.

The Great Recession and its ongoing aftermath have made it abundantly clear that these connections are not at all academic. Indeed, they have served to cast the relationships between fertility desires and decisions, on the one hand, and the health and well-being of individuals and families, on the other, in very sharp relief. Yet, the larger fact remains that even in "good" economic times, women and couples—of all income levels—recognize and try to act based on the inherent interconnections they see between their ability to successfully time, space and ultimately limit their childbearing; their physical, social and economic health and well-being; and their ability to provide and care for their children.

It is also true, however, that for many women and families, their entire lives are effectively lived in an economic downturn, in terms of how disadvantaged they are in being able to access the health and social services they need, including reproductive health care. In 2008, even before the

MISSING COVERAGE

Two in 10 women of reproductive age, and twice as many of those who were poor, were uninsured in 2008.



*Individuals in families with incomes below the federal poverty level. *Source:* Guttmacher Institute tabulations from the Current Population Survey, 2009.

depths of the recession, women of reproductive age—and especially young women at the greatest risk of unintended pregnancy—were more likely than Americans overall to be uninsured. And the news for poor women is even worse: In 2008, four in 10 poor women of reproductive age were uninsured, twice as many as among all women of reproductive age (see chart).

To begin to dig out from the devastating impact of the recession, governments at all levels must commit themselves to providing access to the basic reproductive health care and contraceptive services women need to promote long-term health and economic opportunity for themselves and their families. As an important and long-delayed first step, Congress should act to enable states to set their Medicaid income-eligibility levels so that all women eligible for Medicaid-covered pregnancy-related care are also eligible for family planning services under the program. In the absence of congressional action, the Department of Health and Human Services should take steps to ease the process for states seeking to do so to the maximum extent possible. For their part, states should avail themselves of the opportunity to expand their Medicaid family planning programs as soon as possible, to provide increased access to critical services women want in the short-term, while saving considerable public funds in the long run. (Every dollar spent to provide publicly funded family planning services saves $4 in Medicaid costs that otherwise would be necessary.)

Moreover, Congress should address another lingering issue impeding access to care, by ensuring that Medicaid reimbursement rates in all states are sufficient to cover what it costs providers to offer care. This could be done by extending the prospective payment system currently available to community health centers to safety-net family planning providers. This system provides that rates both reflect provider costs and are adjusted annually to account for increases in those costs. Failure to ensure that Medicaid rates fully cover provider costs severely drains the limited funds available through other federal programs, such as Title X, and of state dollars, a revenue stream likely to take the longest to rebound from the recession.

And last, but certainly not least, Congress should provide sufficient resources to the Title X program, to serve the individuals and provide the services Medicaid does not cover—and to make the contribution it alone makes among federal programs to the increasingly tattered physical and human resources infrastructure of the national family planning center network. Both Congress and the administration have fallen short in their support for this critical program. Funding for Title X in 2010, at $317.5 million, is only marginally higher than it was in 2008, even before the recession began, and more than 60% lower, when adjusted for inflation, than it was at its high-water mark in 1980. Although the administration's budget request would add an additional $10 million for the program in the coming year, that 3% increase is far below what providers require to meet the needs of those looking to them for critical health care services that are integrally related to their health and the well-being of themselves and their families.

www.guttmacher.org

This article was made possible in part by a grant from the Educational Foundation of America, and the research upon which this article was based was supported in part by the U.S. Department of Health and Human Services under grant FPRPA006050. The conclusions and opinions expressed in this article, however, are those of the author and the Guttmacher Institute.