Title X Family Planning Clinics Confront Escalating Costs, Increasing Needs

By Cynthia Dailard

The Title X family planning program maintains a proud legacy of improving the health of American women and helping them to avoid unintended pregnancy. Enacted in 1970 with broad bipartisan support, Title X of the Public Health Service Act was signed into law by President Nixon, creating for the first time a comprehensive federal program devoted entirely to the provision of family planning services on a national basis.

In large measure, widespread support for Title X came in response to research conducted in the 1960s showing that rates of unwanted childbearing among low-income women were at least twice those for more affluent women—and that this disparity was due not to a desire by poor and minority women for larger families but largely to inequalities in access to contraceptive services. Republican and Democratic policymakers alike saw government-supported family planning programs as a means to help low-income women to determine for themselves the number and spacing of their children and, in doing so, expand their economic opportunities, avoid or alleviate poverty and welfare dependency, and improve their own health and that of their families.

Over the past three decades, the Title X program has played a major role in helping women prevent unintended pregnancies, abortions and unplanned births. The Alan Guttmacher Institute (AGI) estimates that, each year, one million pregnancies—half of which would end in abortions—are averted among the 4.5 million women attending some 4,400 Title X–funded clinics nationwide. In addition, Title X funds support a wide range of preventive reproductive health care beyond contraceptive services for these women, including pelvic and breast examinations, blood pressure checks, Pap smears, and testing and treatment for sexually transmitted diseases (STDs).

Despite its many successes, the Title X program has been hard-pressed financially for most of its life. Funding for the program grew rapidly in the 1970s, as clinics proliferated throughout the country. Reversing this trend, however, spending was cut radically in the first year of the Reagan administration, and it remained suppressed throughout the 1980s. While appropriations have risen slowly but steadily under the Clinton administration, the program has never fully recovered from the Reagan cuts. To the contrary, taking inflation into account, the FY 1998 funding level of $203 million was still 61% *lower* than the $162 million appropriated in FY 1980, the last year of the Carter administration (see chart, page 2).

As part of his FY 2000 budget request to Congress, President Clinton has requested a $25 million funding increase for Title X. The prospect of a 12% funding boost for the program is obviously welcome news to family planning providers, who have struggled on shoestring budgets for two decades to maintain the ability to provide high-quality contraceptive and related preventive health care to as many lower income women and sexually active teenagers as possible. Still, pressures on the program are such that even if the full increase is approved, which is by no means guaranteed, it would only begin to allow the program to achieve the objectives set forth by the administration: 500,000 new clients served, with expanded efforts to provide care to such "hard-to-reach" individuals as substance abusers and the homeless, as well as to males.

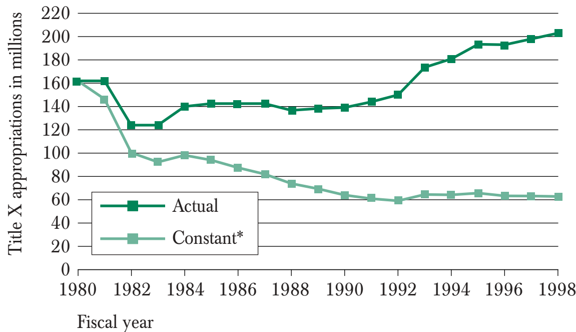
Maintaining Method Choice…

Perhaps the primary challenge facing most Title X–supported clinics today is to maintain the guarantee of full contraceptive choice in the face of rapidly escalating costs. Indeed, access to contraceptive choice is at the heart of what voluntary family planning is all about. Consequently, Title X regulations require clinic patients to be offered a range of contraceptive methods and related counseling, to ensure that women receive services on a purely voluntary basis and are not pressured to accept a particular contraceptive method. To further ensure that cost is not an obstacle to lower income women or teenagers in need of family planning, the amount a clinic can charge a woman for Title X–supported services depends on her ability to pay. If her income is below the federal poverty level, the clinic must provide the services entirely free of charge. If her income is between 100% and 250% of poverty, she must be charged on a sliding-fee scale; she pays full fees if her income is above 250% of poverty.

Yet the increasing costs of contraceptive supplies and diagnostic technologies challenge clinics' ability to fulfill this legislative and ethical mandate. Historically, publicly funded clinics could purchase contraceptive supplies—notably, oral contraceptives—from manufacturers at a nominal or low cost. This dynamic changed, however, following the introduction of long-lasting methods such as the contraceptive

Less Money

When inflation is taken into account, funding for Title X has decreased over the years.



*Deflator based on Consumer Price Index for Medical Care.

implant Norplant® and the injectable Depo-Provera®—methods with high up-front costs but extremely low failure rates.

As one example, women who visit Title X clinics are increasingly requesting Depo-Provera®, which remains effective for three months. Introduced to the U.S. markets only in 1993 and now used by 17% of Title X patients, this method is popular among women who do not want to have to remember to take a pill every day or use a method at every act of intercourse. In fact, many experts believe that increasing use of the injectable among high-risk teenagers is one of the factors responsible for declining rates of teen pregnancy in this country.

But Depo-Provera's® high up-front cost hampers many clinics' ability to provide the injectable to all who request it. While clinics can purchase many commonly used brands of oral contraceptives for under $2 per cycle (for an annual per-patient cost of $26), they must pay approximately $22 per quarterly shot for Depo-Provera® (for an annual per-patient cost of $88). In other words, a clinic can provide three women with an annual supply of oral contraceptives for less than the cost of providing one woman with the injectable.

"Clinics are caught between offering women true choice of contraceptive methods—as required by federal law—and the realities of what they can afford," says Dorothy Mann, executive director of the Family Planning Council of Southeastern Pennsylvania, a federal Title X grantee overseeing 70 clinics in the Philadelphia area. "I currently spend 50% of my budget on the 15% of my patients who use Depo-Provera®," Mann reports. "So far we have squeaked by, but I don't know how long this can continue." Mann notes that providers around the country have been forced to address this dilemma in a variety of ways, such as capping the amount of money they will spend on the injectable or establishing waiting lists for patients.

…and Quality of Care

Clinics also face skyrocketing costs associated with new diagnostic technologies, threatening their ability to provide their clientele with state-of-the-art care. For over a decade now, clinics have grappled with rising Pap test costs as the result of federal legislation regulating clinical laboratories (the Clinical Laboratory Improvement Amendments of 1988). On top of that, newly available technologies offer the promise of significantly improved detection rates for cervical cancer, but often at twice the cost of traditional Pap smears. While many providers want to make these new technologies available to all clients, the high cost stands in the way.

Similarly, improved screening and detection techniques have provided a more accurate picture in recent years of the pervasiveness of STDs, such as chlamydia and gonorrhea, among teenage women, with some studies showing 30–40% of sexually active teenage women infected with chlamydia. If left untreated, these infections may lead to long-lasting problems such as pelvic inflammatory disease and infertility. Given that 85% of these cases are asymptomatic, and given the availability of new, improved urine-based tests that are noninvasive and easy to use, many providers want to screen significantly larger populations of their Title X patients for STDs. Unfortunately, moving toward more routine screening for patients who are *potentially* at risk—rather than just those deemed at highest risk—may be financially prohibitive for many clinics.

The struggle to maintain quality care in the face of increasing costs is summed up by Sylvia Clark, president and CEO of Planned Parenthood of the Rocky Mountains. "With the advent of new technology, the federal government needs to recognize that more funding is necessary for clinics to provide women with the highest quality care," she says. "As it is, we are expected to squeeze the same money harder and harder and harder—and there is a point where we can't do it anymore. On all fronts, our domestic family planning program is falling behind."

Need for Service Expansion

Even as most family planning clinics struggle to maintain their current level of services in the face of escalating costs—indeed, the overall number of Title X clients nationwide has remained relatively stable in recent years—there is a clear need for them to expand their service capacity. One stark indicator of that need is the fact that, according to AGI, at least one million lower income women in the United States (with incomes under 250% of the poverty level) are not practicing any form of contraception even though they are at risk of an unintended pregnancy—that is, they are sexually active and capable of becoming pregnant but not wanting to become pregnant.

Another indicator of this need is the fact that the ranks of the uninsured in the United States continue to swell. The number of Americans without any health insurance coverage—public or private—has increased by 10 million over the last

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decade to an estimated 43 million people. Many of the uninsured are low-wage workers—either individuals whose employers do not offer coverage at all or those who cannot afford coverage when it is offered, as employers ask them to contribute a larger share of steadily rising premiums. Not surprisingly, many of them are young; an estimated 40% of the uninsured are under age 34—a population with significant reproductive health care needs.

At the same time, many uninsured individuals are those who have lost Medicaid coverage—often as a result of welfare reform and in many cases, experts believe, improperly. According to Cindy Mann, senior fellow at the Center on Budget and Policy Priorities, "because of protections in federal law, most of the people denied or terminated from welfare should retain their Medicaid coverage—but we're not seeing that." An additional problem, says Mann, is that "those who move from welfare to work and lose their Medicaid coverage typically find low-wage jobs that have very little incidence of employment-based health care coverage."

These trends in insurance coverage—or the lack of it—present major challenges to family planning providers. They put an especially tight squeeze on Title X dollars, since many uninsured individuals, including most women who lose their Medicaid coverage, are eligible by virtue of their low incomes for subsidized—in many cases, entirely free—services under Title X. Indeed, Dorothy Mann of the Family Planning Council in Philadelphia reports that in recent years she has witnessed a "profound shift" in her clientele, with an increasing percentage lacking insurance of any kind and having very low incomes. "Our population of nonpaying, uninsured patients—those with incomes under 100% of the poverty level—grew by 13% between 1995 and 1998," she says. Nationwide, only one in five clients served by Title X–funded agencies are covered by Medicaid, while approximately two-thirds are poor enough to be eligible for totally subsidized care under Title X.

Meanwhile, providers are also feeling the need to step up their efforts to reach beyond their traditional clientele of largely young, lower income uninsured women. According to the Clinton administration, an unspecified portion of the $25 million increase for Title X would be used to enable clinics to expand their efforts to "promote responsibility for healthy reproductive lifestyles" to such "hard-to-reach" population subgroups as substance abusers and the homeless, as well as to males. Individuals in the former category pose a challenge for providers in that they can be hard to locate, as in the case of the homeless, or difficult to serve, as in the case of substance abusers—or sometimes both. As for males, while most Title X clinics already provide some services for men (such as screening and treatment for STDs and condom education and distribution), males constitute only 2% of the Title X patient population—and their "family planning" needs may go well beyond medical services and traditional counseling. At the very least, then, reaching out and providing services competently and effectively to individuals in these subgroups will be a time-consuming and expensive proposition.

In short, long before it even has been appropriated, the proposed $25 million increase for Title X—needed as it is and welcome as it would be—is looking more and more like a modest down payment on a challenging future and less and less like a massive infusion of new cash.