Technical Reports

Multiagency Participation In Family Planning Administration

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RECENT changes in the Federal guidelines for funding family planning programs are resulting in a number of diverse agencies and groups seeking and receiving funds to conduct these programs. As a result, public health departments that once played a primary role in this field are no longer the leaders in many localities.

Increasingly, it is being realized that any one of several agencies can provide the necessary leadership to deliver family planning services to medically indigent women. In some places, these services are provided solely by OEO (Office of Economic Opportunity), in others solely by health or welfare departments. In yet others, planning is offered almost exclusively by a voluntary organization operating with Federal funds.

Other groups, in addition to concerned public and private agencies, have assumed leadership roles. Planned Parenthood-World Population has been active since the early years of this century when Margaret Sanger was frequently jailed for daring to publicly advocate the use of birth control. In the years after World War II, demographers came to the forefront in analyzing the population problem and the need for family planning services. Then large public agencies, such as the Children's Bureau, and later OEO, entered the field of active leadership which previously had been left to private organizations, such as Planned Parenthood-World Population, and to foundations, such as Ford and Rockefeller. Even more recently, environmentalist organizations, such as the Sierra Club, are emerging in leadership roles.

At present, the following six groups are operating at the local level (*a*) OEO community action agencies, (*b*) social service agencies, (*c*) public health agencies, (*d*) voluntary agencies, (*e*) hospital-based clinics, and (*f*) combinations of all these.

Background

Public health departments have been traditionally in the forefront in developing State-supported family planning programs. Family planning was viewed as a natural part of maternal and child health care, and health departments assumed lead-

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ership in this field as early as the 1930's and 1940's.

Practicing physicians saw firsthand the positive impact on mothers' health of child spacing and limiting the number of children. In addition, contraceptive methods, such as the diaphragm, required the services of a physician. Health departments not only had needed access to physicians but also usually had ongoing organized maternal and child health programs to which family planning care could be logically and conveniently linked. These were the practical and administratively sound reasons why public health departments were seen as the most competent sources of family planning care.

An additional reason for health departments assuming major responsibility was that family planning was considered a physician-patient concern, confined primarily to the maternal and child health setting. Although the focus of the entire program was to help a woman control her fertility, the decision to do so was entirely up to the individual woman. Health departments using a low-key approach offered family planning assistance only if asked for it. Outside events have now changed the acceptability of this low-key approach.

Changing Events

Several phenomena have reduced the nearly monopolistic role of public health departments in public family planning care. At the global level, concern about population growth rates has become a worldwide movement. Furthermore, the growth in the U.S. population is now being evaluated in the context of this concern. The social and economic well-being of entire countries, if not the entire global ecosystem, is now believed to be affected by the individual decisions of the millions of the world's fertile women. Thus family size is no longer entirely a private concern.

At the national level, many Americans for the first time are realizing the dimensions of poverty in the United States. Congressional investigations, books, articles, and White House conferences on nutrition have generated public attention and concern, and the relationship between poverty and family size is now recognized. Not only is the cost of a large family to the public with its direct bearing on the welfare burdens of communities being taken seriously, but also the cost to the individual person of poorer child health in high-parity families is gaining increased attention.

The realization that large families may have undesirable effects on the welfare of both the nation and the individual family has caused, for the first time, family planning to become a national goal with emphasis on comprehensive programs instead of on small isolated efforts. This national recognition that the family planning practices of American couples directly affect the social good came in the President's July 1969 message to Congress on population, in which he argued that the nation has failed to appreciate the demands continued population growth will make on American resources and on the quality of American life (*1*).

A New Hard Look

Many people, because of the aforementioned changes, took a hard look at family planning efforts in the United States and concluded that little was being done about controlling population growth. Such persons as Bernard Berelson and Kingsley Davis have observed that current efforts are lacking (*2, 3*). Those in the OEO antipoverty efforts surveyed the need for subsidized family planning services in each county (*4*).

The survey showed that 74 percent of the 4,305 nonprofit general care hospitals reporting births in 1968 lacked family planning services. Among the nation's public health departments the situation was little better. Roughly 1,000 of the more than 3,000 U.S. counties reported any kind of family planning services, but in the entire United States only 203 counties were serving 500 or more patients a year. The general conclusion of the study was that, using the Dryfuss-Polgar-Varky formula, of the more than 5 million medically indigent fertile American women only 14 percent were being counseled. The 14 percent being served represented the efforts not only of hospitals and health departments but also of all public and private agencies providing family planning services. From these figures, the need for new approaches to providing family planning care for the medically indigent could clearly be seen.

The administration of family planning programs was in a state of flux even before this recent OEO study revealed the actual dimensions of the need. Several community agencies are becoming aware of the relevance of family planning to their work. Departments of social services recognize the effect of larger families on their workloads as do OEO family-action agencies concerned with reducing poverty. Larger families affect schools faced with

educating more and more children and hospitals giving prepartal or post partum care. The number and quality of community services of voluntary agencies are affected by the increased need.

Even within health agencies, homemakers and neighborhood workers are beginning to assume the roles traditionally filled by visiting nurses. In short, many agencies have become aware, not only of the importance of effective family planning to the success of their own programs, but also have come to realize that they themselves may have some responsibility for developing these services.

Concepts are emerging in the administration of public family planning programs. These concepts are taking the shape of new forms of leadership and the need for a multiagency approach.

Unfortunately most of the agencies participating in family planning tend to compete with each other in delivering services. An OEO family planning project may or may not include the public health department. Physicians may be hired to run an OEO clinic independent of, or even in competition with, existing health department clinics. The same situation may also exist in a family planning program sponsored by a welfare agency, and hospital-based clinics are usually self-contained, staffed by their own nurses and clinicians. Sometimes two or three agencies, each cultivating its own clientele, run separate clinics.

The purpose of each agency in establishing a family planning clinic is to serve the needs of the poor. The general assumption has been that most women in America who can afford a physician in private practice for family planning services will not go to a public facility; that public means those who cannot afford to pay for the services of a physician or who otherwise qualify for aid under one of the public assistance programs. Despite this assumption, qualifications for eligibility vary from program to program.

Eligibility in an OEO or hospital project might be based on residence in a particular geographic area and on income, although a welfare agency might base eligibility solely on income. When a number of agencies are trying independently to meet the needs of essentially the same target population, interagency competition (or even simple absence of active interagency cooperation) is highly dysfunctional.

If the health departments have been unable to provide effective family planning care to the 5 million medically indigent women potentially needing this service, no other single agency has been successful in effectively meeting this level of need either. Which public or voluntary agencies (all of which may be receiving Federal money for birth control efforts) have responsibilities for providing public family planning services? Uncertainty about this is not, and cannot be, unexpected.

The Federal Government seems to be indicating rather clearly through its many assistance programs that it wants family planning for every eligible family. A brief review of Federal funding practices illustrates the Government's determination to get family planning assistance to the medically indigent, no matter who the vendor, and helps explain why such a confusing array of groups and agencies have found it possible to obtain money for family planning programs.

Changed Funding and Responsibilities

From 1937 until 1964 only a State health agency could obtain Federal funds for family planning services. These funds were for maternal and child care available through the Children's Bureau of the Department of Health, Education, and Welfare (HEW) and allocated to each State through a formula based on population and financial need. The State health agency then channeled these funds to local health departments. Through the Economic Opportunities Act of December 1964, however, local voluntary agencies for the first time became eligible to receive Federal money for family planning projects.

By 1969, OEO was earmarking $20 million for family planning projects. In addition, $12 million was available from the Children's Bureau, all of which could be given to local voluntary agencies as well as public health departments. Also by 1969, significant sums were available to both public and voluntary agencies through comprehensive programs.

In the area of matching funds the Children's Bureau had $2.5 million and the Community Health Service (first operative in the summer of 1969) projected $10 million, part of which could be used for family planning. Although in 1969 only State health agencies had access to formula grants of $3.5 million from the Children's Bureau and a part of the $66 million from the Community Health Service (HEW), the swing away from any public health franchise on Federal money for family planning during the years 1936–64 was nearly complete.

In a series of recent developments, the family planning administrative responsibilities, formerly under the Children's Bureau, have been transferred to the National Center for Family Planning Services in the Health Services and Mental Health Administration. Overall responsibility for the administrative coordination of family planning efforts at the Federal level, including research, has been assigned to a Deputy Assistant Secretary for Population Affairs in the Office of the Assistant Secretary for Health and Scientific Affairs.

By 1966 any "designated State agency" could get 53 percent to 83 percent Federal matching money for family planning for all recipients of public assistance and other medically indigent persons under title XIX (Medicaid). The only limit in funds was "fluctuation in demand." In 1969 the Social Security Amendments of 1967 (title IV) carried control over family planning moneys one crucial step further away from public health agencies.

Only the State welfare agency was eligible for reimbursement of family planning services purchased from approved vendors on behalf of patients eligible under title XIX (53 to 83 percent Federal matching). With funds limited only by fluctuation in demand and with freedom to select the vendor of services, State welfare departments have been placed in effective control over a large portion of family planning service moneys formerly available only to public health agencies.

Multiagency Approach

Despite both public and private efforts, in July 1970, 85 percent of the need across America remained unmet. Evidence is accumulating that no one agency has been able to provide full family planning services to the community or even to those persons identified as medically indigent.

Similar conclusions were stated by Robert D. Crawford, then the Center for Family Planning Program Development's director of technical assistance, in a speech to the National Advisory Council of the Center for Family Planning Development in May 1969 (*5*). His comments were based on experiences in large metropolitan areas, but they also apply directly to the smaller local programs on which this discussion is focused. Following are his six major conclusions.

1. No single health agency has the capacity to meet all the needs of a community.

2. Patients needing family planning have such differing characteristics, no one channel can reach them all; for example, teenage mothers, post partum women, women without children, and those with problems of high or low fertility.

3. An outreach program, necessary if the women in need are to be served, must be developed systematically (a skill until recently often beyond the capacity of the typical family planning clinic).

4. Competition for Federal funds often results in serving the agency's rather than patients' interests.

5. The different agencies focus their energies on different groups without contributing to a balanced communitywide program (for example, hospitals often focus on teaching and research while health departments typically see family planning as but one aspect of maternal and child health).

6. Seldom does single-agency leadership result in a program coordinated to serve everyone needing family planning assistance.

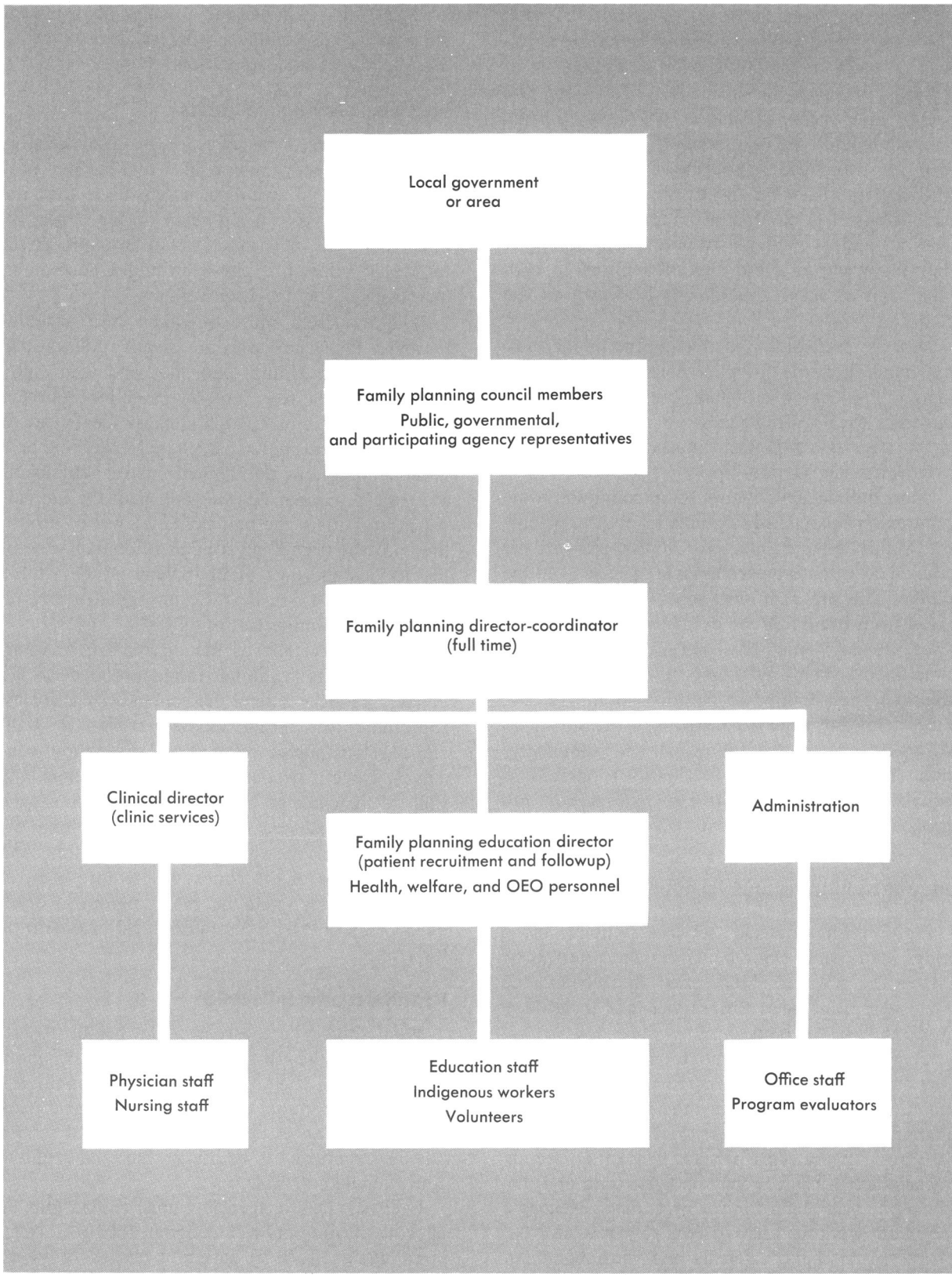
In spite of these evident inadequacies in uncoordinated, single-agency approaches, few successful multiagency programs have emerged. Certainly one reason multiagency programs are slow to develop is the lack of knowledge and experience with such programs. Thus, in developing communitywide multiagency programs, concerned groups not only are hampered by the usual difficulties of overcoming inertia and resolving domain problems but also are uncertain about what ought to be done even if these difficulties were removed.

Planned Parenthood-World Population's Center for Family Planning Program Development has concluded that leadership will vary from community to community in response to the unique conditions and centers of power. For example, in Los Angeles, the center has helped form a new corporation with board representatives from each participating agency, which seemed the best local approach to establishing an effective, communitywide program.

In contrast, in Newark and Dallas the central administrative functions were located in medical schools. Whatever the organizations' structures, however, center staff commented that the attempt has been to build into the project a core staff which would not participate in the day-to-day activities of running clinics but perform some or all the administrative and think-tank functions required for a communitywide effort.

A communitywide effort would ordinarily need to involve major agencies like the health and so-

Elements in a multiagency family planning program



cial services departments, a local hospital, community action program of OEO, and relevant voluntary groups. The presence or absence of such agencies, as well as their differing leadership activities in each community, will determine what working arrangements seem best. Since no one agency or group is capable of providing effective communitywide family planning services, some form of multiagency cooperation is inevitable. Multiagency efforts will need special skills in three dimensions: (*a*) clinical, (*b*) family planning education, and (*c*) administration. One version of the relationship of these three dimensions to each other and to local government is shown in the chart.

Who is responsible for meeting the public family planning needs in a local community? Ultimately, the local government, but for all practical purposes the local agencies are responsible. The chart suggests a functional interagency and agency-government relationship.

The multiagency nature of a communitywide program is recognized organizationally by placing the family planning director under a board or council representing participating agencies and the public. This organizational scheme keeps the program from becoming the exclusive domain of any single agency. Adequate staff headed by a full-time director helps overcome the disadvantages of multiple sponsorship. In contrast to the typical, more clinically oriented program, education (patient recruitment and followup) and administration (including program evaluation) operate as equally vital elements in the multiagency approach.

Responsibilities of an Education Director

Full communitywide services require much more than ample clinic hours or joint referrals by concerned agencies. Most often the women and men who most need this service are those least motivated to seek help.

A planned system to initiate and maintain contact with target populations is an essential additional element. Contacts are the job of the family planning education director, and he requires special training and skills because his task is multidimensional. In each agency he must train and motivate the field staff (for example, the OEO neighborhood workers and welfare department caseworkers) to make referrals. He must coodinate the family planning education and motivation program for the women at the clinic. He has the responsibility for followup efforts after clinic visits. A number of programs now use paid, indigenous, as well as volunteer workers. These persons must be trained and supervised.

Physicians as Administrators

Finally, there is the question of administrative direction and coordination in a multiagency program. The usual assumption has been that the director ought to be a physician. In the best of all possible worlds, each multiagency program director would be both a physician and a competent, imaginative program administrator.

Several factors must be taken into account, however. Physicians who are creative administrators as well as skillful clinicians and who enjoy combining both roles are few and far between. There will never be enough of these ideally suited persons to direct multiagency family planning programs throughout the United States. Physicians are trained to treat illnesses and help the individual person attain the best possible level of health; they are not trained as administrators. In view of the serious shortage of physicians in the United States, should trained physicians spend nearly all their time on administrative duties?

The primary task of the director of a multiagency program is administrative, not medical. He divides the tasks among the cooperating agencies, coordinates the hiring and supervision of staff, and develops public relations and evaluation techniques. Once a woman has come to a clinic, the skills of the clinician become central. Even so, the motivational, demographic, educational, and organizational tasks, which result in the initial and continuing use of the clinic, will require most of the man-hours spent in the program. Consequently, these tasks will require most of the director's time.

Health Department's Role

What should be the role of the health department? Public health agencies are uniquely qualified to lead an effective, multiagency, communitywide family planning effort. The health agency not only has the necessary clinical skills, but it also has the experience in administration and required educational know-how.

Even so, health agencies must realize that an effective communitywide program requires a joint coordinated effort by several agencies of which public health is but one and that the clinical di-

mension is but one of three key elements in such a program.

Staffs of public health departments routinely do not possess the new skills necessary to operate a successful family planning program. Even when they do, the breadth of community contacts essential to successful programs can only come through coordinated multiagency efforts. Inevitably there will be problems of domain as the shape of any multiagency program is hammered out. It will often happen that another agency, such as welfare or OEO, will provide leadership in establishing effective programs of communitywide family planning.

In this circumstance, the health department can and ought to be a strong supporter of these efforts. With experience, expertise, and insight, the local health department can be a most important partner in the effort, leading the group into developing an effective, successfully coordinated program. Any multiagency effort that excludes the health department is less than likely to succeed.

Where no multiagency family planning program exists, health departments are a logical source of initial and continuing leadership. When other agencies attempt to develop a multiagency program, the health department is in a unique position to become one of the most effective and forceful participants.

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With recent recognition of the serious effects of overpopulation on society and on individual well-being, family planning has become by choice and necessity the responsibility of numerous agencies working for the welfare of society. Public health departments, which once had a primary role in such endeavors, have lost their position of leadership in many localities. In addition, the high priority that the Federal Government places on family planning has made Federal funds for family planning programs available for the first time to many groups other than public health departments.

Agency competition for funds and clientele, plus the confusion caused by varying eligibility requirements, tend to thwart the national family planning objective of providing care for 5.3 million medically indigent American women by the end of the next half decade. An additional drawback is the inability of any one group to provide the multifaceted services essential to an effective, comprehensive program.

Such inadequacies in current programs clearly indicate the need for a multiagency approach which could use the unique facilities and expertise of all concerned groups.

In a multiagency approach the clinical, educational, and administrative aspects can be given equal organizational weight, and the interests of all participating agencies and the public can be represented through a central administrative board. Public health departments could logically move to the forefront once again by leading a multiagency approach. With their clinical and administrative skills, they could easily become the core of a new, coordinated, multiagency effort.