Management Issues in the Organization and Delivery of Family Planning Services

ROBERT A. LODDENGAARD, MSPH
THOMAS J. VITAGLIONE, MPh

THIS PAPER STEMS from our experience of working with a Statewide program that has been developing and managing the delivery of family planning activities for 7 years.

The Atlanta Regional Office—Region IV of the Department of Health, Education, and Welfare (DHEW)—has aggressively promoted statewide family planning programs. With this impetus and the support of a number of strong State health departments, State family planning programs have been developed in all eight States of Region IV—Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. Other Statewide programs exist (in Louisiana, Illinois, and Colorado, for example), but the dominant pattern throughout the rest of the United States is one of local projects.

To local projects funded directly through DHEW, it might appear that the interjection of yet another management level would create more problems than benefits. However, in many instances, benefits can be considerable and can include technical assistance to be given to local projects, funding to be distributed more evenly around the State, standards to be set and monitored, a State patient data system to be implemented with rapid turnaround of data, third-party mechanisms to be developed and monitored, the addition of other sources of funds, and the State to engage in lobbying for its fair share of contract funds from the DHEW Region.

The issues addressed in this paper are State support of the program, allocation decisions, impact versus efficiency as program goals, sources of secondary funding, and patient data systems.

State Support for Family Planning

The history of family planning organizations covers a variety of mechanisms for delivering services. These include health departments (particularly in the Southeast), Planned Parenthood affiliates (initially in the East) but spreading to other areas of the United States, hospitals, freestanding clinics, neighborhood health clinics, Community Action Agency programs, contracts with private physicians, and so on. Funding has come from many sources: private donations, foundations, local taxes, the Office of Economic Opportunity, Model Cities, DHEW, regional commissions, and patient fees. The result has been a mixture of service delivery arrangements which, in many areas, appeared random and in others were characteristic of an area; but conclusions about one State's family planning delivery systems could never be applied easily to the next State.

DHEW Region IV is the only Federal Region where officials managed funding so as to cause the creation of State programs. At the same time, the Regional Office pressed hard for the development of multi-county projects. These outcomes were achieved by providing major increases in funding under title X of the Health Services Act, allowing for salaried positions at the State level, encouraging and funding State family planning data systems, gradually transferring existing programs to State jurisdiction, channeling multiple funding sources through the Regional Office, and encouraging local projects. All of these actions were taken to pro-

Mr. Loddengaard is clinical associate professor in the Department of Health Administration, School of Public Health, 201 H, University of North Carolina at Chapel Hill, Chapel Hill N.C. 27514. Mr. Vitaglione is section head, Developmental Disabilities, Division of Health Services, North Carolina Department of Human Resources, in Raleigh. Tearsheet requests to Mr. Loddengaard.

mote family planning on a statewide basis, improve efficiency, and encourage the use of other available Federal funds presently being managed at the State level.

In other States that may be considering similar organizational approaches, the support of the DHEW Regional Office should be solicited and will be helpful. Each Regional Office has considerable flexibility in establishing funding priorities and is clearly in the position of deciding whether to support a statewide program. Considering the possibility that funds are not likely to be increased, a statewide program will likely begin slowly and be dependent on performance, efficiency, and the use of resources other than title X funds.

Commitment and control. The spread of family planning projects across the United States was accomplished in the late 1960s and early 1970s. This feat was largely achieved with the leadership of local administrators strongly committed to the provision of family planning services to people in their community who had little or no access to such services because of geographic location, low income, or lack of knowledge, or because they were minors. It was evidenced by an aggressive search for funding, a rapid expansion of services, and often the accumulation of professional, community, and higher level agency support. Family planning is now the most popular public health program available in most areas of the country. For many people, family planning has become an entry point to the health system.

A strong commitment to family planning is sometimes difficult to obtain from a State system. The distance from direct delivery of service and the proximity to the political process of resource allocation among departments (health being but one of them) mitigates against the emergence of a strong advocate for family planning at the State level. However, a willingness by a State entity to become the fiscal and programmatic intermediary between the Federal Government and local providers in order to support appropriate organizational, fiscal, legal, and legislative steps can be extremely helpful in developing healthy and active programs.

The issue of control becomes an important concern of Federal and local representatives when States decide to become grantees. A State agency needs to show that the commitment to family planning is real and not just a means of increasing its control over health programs. To convince local representatives of their commitment, the State must be willing to lobby with the Federal Government to ensure that a fair share of Federal funds enter the State.

Supplementary funds. A less direct (but nevertheless significant) effect on fiscal support of family planning can be engendered through the use of discretionary funds for health services. Many State legislatures grant appropriations for health services to State and local health departments. Executive decision making at the State and local levels then determines the distribution of those funds. The implications for family planning are obvious.

Another source is in the use of title V (Health Services Act) maternal and child health (MCH) funds. The executive branch can set clear priorities. While Federal regulations require that 6 percent of the MCH appropriations be used for family planning, States can decide to use much larger shares of their MCH funds for this purpose.

Organization at the State level. One of the thorniest issues relating to State support is an organizational niche for family planning at the State level. The most obvious place for a family planning program is the health department. Family planning tends to be viewed exclusively as a clinic, service-delivery program; for States where title XX of the Social Security Act and Medicaid reimbursement are administered by a social services agency, two family planning programs can be developed, one in health and one in social services, with little coordination between them. Family planning could be placed within the department of administration to legitimate its need for many services. If the health department, with its claims on the family planning function, feels slighted or in competition with the department of administration this organizational ploy may be a resounding failure. Within the health department, family planning may be a distinct entity or become part of MCH. The extent to which title V MCH monies and other resources are used for family planning may hinge on such a choice.

However, to bring other agencies, resources, activities, and functions into play, a State coordinating committee with representatives from other agencies can be formed. This committee might be the State management team, the human resources team, or a special committee that provides the overview and policy perspective that can be so useful when confronting a difficult problem which transcends agency boundaries (teenage pregnancies, for example) and suggests the need for political support.

Legislation. Many States still have not legitimated the delivery of medical contraceptive services to minors without parental consent. Although this lack has not stopped teenagers from seeking services, some physicians

and clinics insist upon obtaining parental consent. The consequences have been unserved teenagers, teenagers who lie about their age, and improperly signed parental consent forms. Many physicians will serve minors openly, but the risk is perceived as ever present. Model laws exist and can be modified to suit individual State needs.

The range of State support. Typically, services are supported by a combination of Federal, State, and local funding. The extent of State financial support varies from State to State, and support can also depend on the organization of the health department—whether it is highly centralized or not. Setting up a uniform fee schedule may be a useful function of a statewide system. State support can be measured in financial terms, by laws permitting service to minors, by providing protection to the retarded and the poor (sterilization), by the effectiveness of a family planning council, and by the location of the family planning program in the State government hierarchy.

Sporadic attempts have been made to teach family planning, sex education, and human reproduction in school systems under an array of euphemisms. The time may not yet have arrived for State education systems to incorporate these matters in their curriculums at all levels; however, more efforts are required, particularly in training teachers, to prepare for wider acceptance of such education by the community. In the long run, education may be the only significant way to reduce the incidence of unwanted births to minors.

Allocation of Funds

Federal funding of family planning projects in the late 1960s and early 1970s came from a number of sources; but almost always, funding went directly from a Federal agency to a local provider who understood how to secure Federal funds.

Federal agencies disbursed their funds quickly, but this practice did not assure equitable distribution of funds within a State. This inequity has been the prime force which encouraged many States (including all in Region IV) to become grantees for all Federal family planning project funds.

A major consideration for a State beginning to consider an allocation system is the force of funding history in family planning as well as the State's traditions of funding in health affairs. States will not only find it necessary to adopt an allocation system, but also to consider how to smooth the way for local projects to adapt to the circumstances of a new system. If a State finds that area Z is overfunded in a new allocation system, it may be traumatic to implement the new system completely in one funding cycle. It might be desirable to bring area Z's funding to its appropriate level under the new system gradually in 2 or 3 years.

Fund allocation can be based on a formula, on efficiency, on national evaluation, on the program gaps, or on grantsmanship. One strategy may be selected to be congruent with the leadership style of the State program administrator, while others may be appropriate for different times in the life of the program. Finally, a combination of two or more may be useful.

The formula. An allocation system may be based on the necessity to give each area funds commensurate with its needs. Allocations based on the Dryfoos formula of county need developed at Planned Parenthood is an example of this system. A county with 10 percent of the State's unserved family planning need would receive 10 percent of the State's funds. Other formulas can be based on total population, the number of women of childbearing age, or any other clearly defined arrangement. This system acknowledges political constraints on State administration and is recommended as an initial way of allocating funding until other, more complex or performance-related methods may be used.

Grantsmanship. This time-honored system assumes that a high-quality proposal is indicative of an ability to perform. It tends to be used when there is a minimum of interaction between funder and prospective contractor, and it has distinct advantages for the harried administrator who must fund quickly. It is not recommended if equity and coverage are program aims.

The program gap. Family planning has had a checkered career in most States with projects run by hospitals, health departments, community health service agencies, Planned Parenthood affiliates, and universities and sited in local communities, cities, counties, and multicounty districts. New statewide programs may find it necessary to use new funds to fill gaps in the services. This approach is practical except for third-party reimbursements. Direct payment of earned reimbursement provides an incentive for local projects to incur the costs—both fiscal and administrative—of identifying and serving third-party clients funded through title XX and Medicaid.

Efficiency. Another allocation method gives each area funds commensurate with its providers' capabilities to deliver low-cost services. This system is based on the assumption that all citizens are of equal value no matter where they reside, and it measures the cost per patient per year. However, proponents of rural projects have long argued that the percentage of new clients

who have never before used contraception is much higher in rural than in urban communities, and the higher cost per rural person served is justified. This method is too narrow in its view and should not be used alone.

Evaluation. Administrators who have become enamored with complex evaluation systems may be tempted to base funding allocations upon results of evaluations that use a variety of criteria. Evaluation systems can be helpful in deciding upon training, supervision, technical assistance, and in justifying one's State budget request as well as making funding decisions. The question should not be whether to develop an evaluation system, but how to use it and when. This allocation method is not to be used early in the development of a program.

Conflicting Goals for Programs

The original title X legislation mentions as goals reductions in perinatal mortality, unwanted births, high-risk pregnancies, infant mortality, and mental retardation (*1*). When States in Region IV submitted proposals for title X funding, similar impact goals were set for State programs (*2*). Three or four years later almost all goal statements of family planning projects in the United States no longer included impact statements and referred only to quantities of services to be provided. Applications for continuation, monitoring systems, and performance measures are now almost exclusively service oriented. Faced with a system competing strongly for budget dollars, providers have been diverted from measures of effectiveness; they now focus on conventional clinical services so that next year's application will receive a favorable review.

Aberrations of the numbers game. When service statistics and costs are the primary evaluation measures, the implicit assumption is that all target groups have equal health risks and an equal level of control of their own fertility. Project directors, out of a natural concern to maintain funding, tend to serve the most highly motivated and most easily located groups in order to minimize costs. Problems with this course of action are as follows:

1. All methods of contraception are considered by patient data systems to be equally effective statistically, but they are not.

2. Important differences in effectiveness between sterilization services and contraception are ignored. Programs often provide contraceptive services without acknowledging that the provision of sterilization to persons who have decided that they have completed their families is more cost effective over the long term than providing contraception for 10 to 15 years.

3. Heavy pressure to use resources "efficiently" will eventually eliminate such staff as health educators, nutritionists, and outreach workers from family planning projects.

4. Risk taking and program innovation are definitely discouraged by emphasizing no new projects, no special clients, and no special targets.

5. When Federal officials state that funding will be based 60 percent on last year's funding and 40 percent on efficiency measures, the inference which local and State program administrators make is that clinic service efficiency is the only important measure.

The State role. Local projects cannot be expected to withstand the pressure alone, and it is the State which is in a better position to look at the question of program effectiveness, make funding decisions accordingly, and negotiate with the Federal Region. Ancillary services such as transportation systems, outreach, community education, and linkages to other complementary services (such as nutrition and genetic counseling) often come under the province of the State. With State support, local projects will often be more than willing to use such services without the strain of having to justify them.

It is likely that the reestablishment of goals that measure impact or effectiveness will lead to the designation and definition of high-priority groups to receive services. Identifying these groups and providing them services cost more than serving the most highly motivated new clients, and devoting outreach and recruitment efforts to the high-priority groups is likely to cause a decrease from previous enrollment levels. Leaders of a statewide program must be ready to defend this occurrence, which will alarm the less informed. Coupled with this preparation should be evaluation that encompasses obtaining and analyzing vital statistics, patient data, and special surveys and employing the results to make program decisions.

Secondary Funding

Primary Federal funding has been directly responsible for the development and maintenance of family planning projects across the United States. Matching funds from State and local sources tend to be kept as low as possible consistent with Federal requirements, except in rare cases. Since the inception of Federal funding, project directors have been encouraged to search for alternative sources of funding for family planning services. These informal recommendations were made explicit in the 1974 Health Services Funding Regulations

that require family planning projects to pursue and secure both third-party reimbursement and patient fees.

Third-party reimbursement. In the past, directors of local projects made the first moves toward third-party reimbursement. A few years ago, when family planning became a mandatory service under both title IV-A of the Social Security Act and Medicaid, the movement to secure third-party reimbursement swung into full force. Some States joined the movement and, encouraged by the DHEW Region IV Office, the eight States of the Southeast actively pursued (and all have now secured) statewide reimbursement agreements encompassing all public providers.

The existence of the Health Services Funding Regulations now places at least moral responsibility on States to assist local providers in securing third-party reimbursement. Consideration should be given to the establishment of a statewide reimbursement agreement with the State social services agency, using the State health agency as an intermediary for all local public providers.

Cost data. A major problem that confronted local providers was the necessity of submitting cost data to social services officials to support requested reimbursement rates. A logical response of States beginning these activities is the establishment of a cost analysis system. The advantages of a statewide system over a myriad of local cost systems are clear. Cost determinations will be uniform and more accurate, and audit exceptions will be minimized. Such a cost analysis will easily win for a statewide system the good will of most local providers.

Reimbursement claims. Another consideration is the advantage of combining program reporting and reimbursement claims procedures into a single reporting system. Such a system is not a possibility for local providers, but if the State can offer a combined system, providers' claims and billing problems will be minimized.

Negotiated average statewide reimbursement rates make billing and collection procedures relatively simple, and we recommend their use. However, before it is determined whether reimbursement rates for local projects will be based on actual costs or on a State's average costs, the following should be considered.

If the average State cost is the basis—

1. An efficient provider can make a profit which that provider can then use to serve additional persons.
2. An inefficient provider might be encouraged to become more efficient, or decide that third-party reimbursement efforts are costly and not worth the effort.

If local providers' costs are the basis—

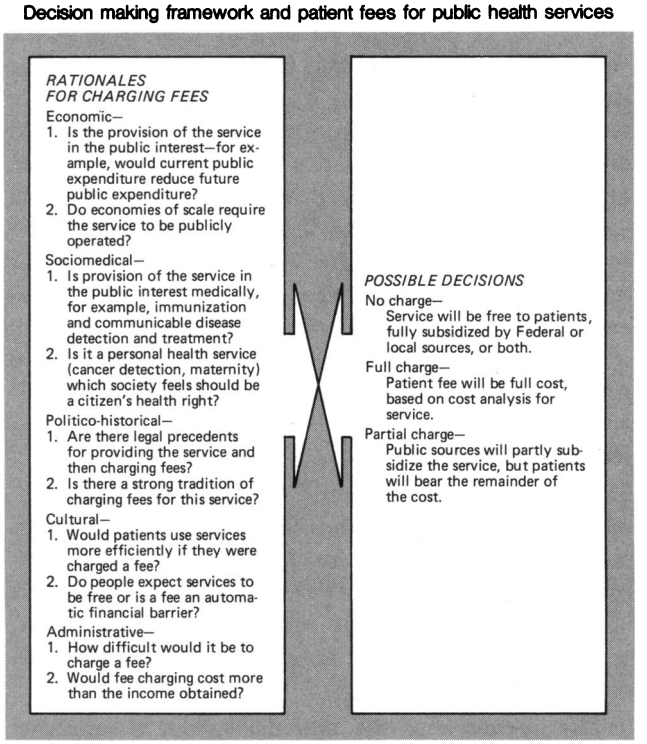
1. A provider with excellent ancillary services (and a higher cost per patient per year) will not be penalized.
2. Neither efficient nor inefficient providers have financial incentives to improve its performance, but both will be expected to use the system fully.

Patient fees. Public health in the United States has a tradition of free services. As pressure on public resources has grown, however, the concept of patient fees has gained more credence, culminating in the Health Services Funding Regulations which require title X family planning grantees to establish fee schedules. Grantees are probably also facing requirements for fee schedules in giving services to some title XX clients. Planned Parenthood affiliates have long experience in how to set, manage, and collect fees and have much sound advice to offer those with little or no experience.

A framework for decision making is necessary so that the most reasonable approach can be taken; it should be applicable to any personal health service. Such a framework is depicted in the chart. Some comments highlighting family planning need to be made in this regard.

Personal health or prevention of unwanted births? In North Carolina, 40 percent of those receiving family planning services in public clinics have no other source of health care. Valid arguments can be made that family planning is essentially a consumer-oriented personal health program. Equally strong arguments can be made that family planning is a preventive service offered on the premise that society is the winner when individuals can control their own fertility. Both can

Decision making framework and patient fees for public health services



be true concurrently, and one view need not be espoused at the expense of the other.

Privacy. The special conditions of privacy which surround the provision of family planning services need to be considered carefully. Many persons (particularly the young) may not have easy access to money. Their need not to disclose to parents the reason for requesting money (to pay clinic fees) may impede the access to services of persons whose family incomes appear to be large enough to afford such charges. Delinquent bills might provoke considerable embarrassment if a critical member of the household was not aware that one of them was receiving such services.

The sliding scale. The establishment of a sliding fee scale assumes that fees will be based upon income. The problems associated with income determination are well known by those who establish title XIX and title XX eligibility. If title XX certification procedures are in effect for all patients in a county to determine "potentials," then additional efforts to set up a fee scale will not be needed; if not, the State must decide whether it wishes to take the word of an individual as to the family income.

Associated with, and implict with, fee setting is the traditional economic theory that the proper fee schedule can maximize total income, which in turn will maximize the number of persons served. Fee setting will undoubtedly require some experimentation, and administrators may wish to examine the theories surrounding the matter of payments, as well as their own biases. Assumptions managers often make are (*a*) people are proud and want to pay a fee, (*b*) the existence of a fee makes the services more valuable than if one did not exist and clients are therefore likely to make use of the contraception more effectively, (*c*) fees will cause some people to stop using the services in order to use their money for other more highly valued goods and services, and (*d*) the costs of collecting fees exceed the income associated with them. The problem is that each assumption may be correct but at different times, in different settings, and for different clients.

Patient Data Systems

In response to a congressional mandate, the Department of Health, Education, and Welfare developed a national reporting system for family planning projects receiving Federal funds. Given the fact that providers of all types and sizes were required to report, the system has remained fairly simple, and only service-oriented data are collected.

The operation of the national system is supported with Federal funds and is therefore cost free to providers. States which decide to establish a State data system (involving input, output, and training costs) must support these systems with funds that could otherwise be used for direct service delivery. The costs are approximately $1 per active patient year.

Data fed back to them are helpful to most providers, but there are drawbacks. The enormous mass of national data has resulted in delays in sending aggregated data to the providers. The greater the delay, the less use is made of the information. Many input problems are compounded by the distance between most providers and the data center. This distance has aggravated a natural lack of communications between patient-oriented providers and computer-data personnel and, in many cases, distance has become isolation.

As a result, some States have developed their own family planning data systems. These State systems receive inputs from all local providers receiving Federal funds and then assume responsibility for supplying the national system with the required information. The State data systems movement began in the Southeast. This leadership was clearly encouraged by the DHEW Region IV Office in Atlanta, and it is supported by the cohesive statewide public health systems in the eight States in the region. In the past few years, these States have provided information concerning the development of data systems to other interested States.

The following information has been gathered from the directors of the eight statewide family planning programs in the Southeast and may be helpful to States contemplating changes in already established State data systems and to States considering the establishment of a new system.

Rapid turnaround of data. Of paramount importance in the establishment of any data system is the rapid turnaround of data. Region IV reports a turnaround time of less than 30 days for monthly and quarterly reports. This performance allows local project administrators to make timely management decisions, and it is a key factor in ensuring local participation in the State data system.

Data quality. State systems can ensure higher quality data than the national system. States can provide training to ensure uniform reporting, and State editing systems can provide quicker correction of data errors.

Special aggregations. Also favoring the establishment of a State data system is the opportunity to generate special outputs attuned to the individual needs of

local providers. These outputs may be lists of delinquents, special analyses, or special aggregates for management purposes. Flexibility in determining data inputs and outputs has allowed Region IV States to develop evaluation systems attuned to the needs of each State's providers. This ability enhances the State's role in lending technical assistance to local providers. The advantage of linking the third-party reimbursement procedures with the State's patient data system has been mentioned earlier.

Program effectiveness. Patient data systems can be adapted to obtain measures of a program's effectiveness. Most data systems are designed to provide service-oriented measures; that is, persons served, visits made, services provided, and percent active patients. The national system is unlikely to be adapted to impact measures, that is, patients' fertility, their pregnancy outcomes, and age-parity shifts among patients.

A State system, however, opens up many possibilities. Linkages could be formed between the patient data bank and the State's vital statistics files. Such linkages would make the measurement of effectiveness objectives a clear possibility (*3*). For States wishing to move in this direction, the establishment of a family planning patient data system takes on new dimensions in judging necessity.

Conclusion

Statewide family planning programs are worth considering because they make maximum use of available resources and distribute them equitably, they can develop a patient data system that produces reports and other useful information quickly, and they can engage in broad evaluation studies. Although most family planning programs are lodged in State health agencies, this locus is not essential.

Disadvantages of State programs are that some local programs lose a certain degree of control, that they may lead to organizational battles within State agencies, that the program's policy may be dominated by State politics, and that funding can be shifted away from strong projects.

There are many uncertainties in the family planning programs. Categorical programs in general are under attack, and their futures are unknown. Persons and agencies concerned with family planning must consider what may happen if the Federal Government were to reduce or eliminate Federal financial support. It is inevitable that most local agencies will request help from their State government.

Without a statewide program, it is unlikely that a family planning advocate will surface, and these services may be seriously reduced. A statewide program can allow for the services to be developed and expanded, can use them efficiently and effectively during static periods, and can maintain the program during a severe reduction of funding.

References

1. Report of the Secretary of Health, Education, and Welfare submitting five-year plan for family planning services and population research programs. U.S. Government Printing Office, Washington, D.C., October 1971.
2. Southeastern Federal Regional Council: Region IV plan for family planning services. Atlanta, Ga., June 1972.
3. Morris, N. M., Udry, J. R., and Chow, D. L.: Shifting age-parity distribution of births and the decrease in infant mortality. Am J Public Health 65: 359–362, April 1975.

SYNOPSIS

LODDENGAARD, ROBERT A. (University of North Carolina School of Public Health), and VITAGLIONE, THOMAS J.: *Management issues in the organization and delivery of family planning services. Public Health Reports, Vol. 94, September–October 1979, pp. 459–465.*

Statewide family planning programs have been developed primarily in the Southeast and in a few other States of the nation. They are managed by State public health agencies with a few exceptions. This paper presents issues which are of importance to persons and agencies interested in developing a statewide family planning program; namely State support, allocation of funds, setting goals based on impact rather than efficiency of services, secondary sources of funding, and patient data systems.

Arguments for a statewide program include the maximum use of available resources (for example, title V maternal and child health funds), the opportunity to distribute resources equitably throughout the State, the development of a statewide third-party reimbursement system, the opportunity to develop evaluation mechanisms, support for starting a system of fee collection, and the use of a statewide patient data system. Arguments against a State program include some loss of local control of a project, possible organizational battles within State agencies, State political domination of program policy, and a possible shift of funding away from existing strong projects.

In the early 1970s, development of statewide systems was coupled with a rapid increase of funding when broad coverage of services and accessibility were key factors. At the present, categorical funding is no longer increasing, and efficiency and maximization of resources are becoming more important.