Family Planning Policies and Activities of State Health and Welfare Departments

DONALD HARTING, M.D., SUE STABLEFORD, A.B., JOHAN W. ELIOT, M.D., and LESLIE CORSA, Jr., M.D.

DURING the summer of 1967, the American Public Health Association and the American Public Welfare Association sponsored surveys of family planning policies and activities of State and Territorial health and welfare departments. Similar surveys of the activities of State and local health departments have been made annually since 1963 (*1*), although annual data have been collected from State welfare departments since 1966 (*2*).

Family planning consists of more than medical care. In this paper, however, we will concentrate on the medical care aspects and, particularly, on contraceptive services provided under medical auspices. State and local health and welfare agency levels of activity during the year ending June 1967 are described, some of the changes that have occurred during the period under study are pointed out, and some program activities that are related to the variation in clinical services provided through State health and welfare agencies are examined.

Methods

Questionnaires sponsored by the public health and the public welfare associations were mailed in July 1967 to the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. (Although D.C. and Puerto Rico are not classified as Territories, we will refer to these two jurisdictions as Territories.) Response, as in previous years, was extremely high—100 percent from the health departments and 98 percent from the welfare departments.

Separate questionnaires were sent to State health officers and State welfare directors. These questionnaires were closely patterned on those of previous years to facilitate comparisons of results for fiscal 1967 with those of previous years. We obtained the name and administrative position of the person who filled out the questionnaire to facilitate followup communication about incomplete or ambiguous responses. As in any survey of this nature, the characteristics of the informants and the likelihood that they can reliably report the information sought become important issues. Although no systematic tests of the characteristics and reliability of the informants were built into the survey instrument or were tested in prior methodological studies, we made the following two observations.

Dr. Harting is director, family planning program, American Public Health Association, New York City, and research associate, Center for Population Planning, University of Michigan School of Public Health, Ann Arbor. Miss Stableford is research assistant, Dr. Eliot is associate professor of population planning, and Dr. Corsa is professor of population planning at the center. *The study was partly financed by a grant from the Ford Foundation.*

First, the variation in political and administrative relationships between big city and State governments and their specialized agencies makes for great variation in the involvement, and therefore knowledge, of State personnel about city activities.

Second, the likelihood that the State agency respondent will have detailed knowledge of local activities in any specific program depends on (*a*) the degree to which his job requires him to know about local programs important at the State agency level, (*b*) his personal interest in a problem independent of State agency interest, and (*c*) the amount of time he has had to learn about the program. The nature (both quantitative and qualitative) of the responses would indicate that our informants differed substantially in respect to these three factors.

To standardize the data before tabulating it, we had to judge the intent of some replies. Judgments were made most frequently in tabulating reporting of legislation or policy, or both, pertaining to family planning activities. The laws, policies, and manuals of procedure for health departments are only those related directly to operational aspects of family planning programs undertaken by health or welfare departments.

Respondents were generally unable to supply two kinds of information. Those in welfare departments were not able to give even approximate numbers of people receiving family planning services, and those in the health departments had serious difficulty in separating the costs of providing related maternal and child health services from the cost of family planning activities.

The data have the advantage of providing important time trends regarding State family planning activities. They also allow comparisons of family planning activities among the States for both health and welfare departments. Generally, results of the survey continue to indicate an overall trend of policy liberalization and service expansion by State health and welfare departments participating in family planning. Major developments have taken place in a few States.

Legislative activity was concentrated in these few States in the period from July 1, 1966, to June 30, 1967. Laws concerning health department family planning programs went into effect during the year in Alaska, Oklahoma, Oregon, and West Virginia, while similar legislation affecting welfare department activity was passed in Alaska, Michigan, Oklahoma, and Oregon. As of July 1967, a total of 10 States had specific legislation in effect on family planning by health departments, and 11 States had passed specific legislation pertaining to family planning activities by welfare departments.

Changes in Departmental Policies

During this period, approximately 14 State and Territorial health departments have adopted new departmental policies, bringing to 35 the total number of States with such policies. These policies vary markedly among the States in both scope and content. California has taken the lead in establishing family planning as a requisite service for the receipt of State financial assistance by local health departments. Some of the policies of other States recommend that local departments make services available; some merely request health department personnel to make referral services available for those who want them.

New manuals of procedure have been adopted in Alabama, Kentucky, Maine, West Virginia, Washington, D.C., and Guam. These detailed program guides show that State health departments have found a variety of creative ways to meet the family planning needs of their residents.

New welfare department policies were instituted in 14 States in fiscal 1967, including several which are modifications of former policies. Thirty-two States and Territories have welfare department policies. These policies contain a variety of approaches to the family planning needs of welfare recipients, but each approach indicates departmental awareness of these needs, and most attempt to define caseworker responsibility in dealing effectively with clients.

As has been true in the past, "freedom from coercion" statements covering both client and caseworker are emphasized. Although these policy changes indicate the increasing involvement of welfare departments in family plan-

ning issues, the additional resources and requirements included in the 1967 amendments to the Social Security Act almost certainly will accelerate this departmental activity.

Levels of Activity

Response to questions designed to measure the effects of State and local efforts to increase family planning services in local health and welfare departments indicated some positive results during fiscal 1967.

Thirty-seven States and three Territories reported that at least some of their local health departments either financed or provided family planning services with 820 health units participating. This figure must, however, be taken with caution. Because there are a variety of administrative mechanisms used to provide services, it is difficult to measure participation. Local departments in many States conduct their own clinics, but others provide referral services that vary greatly in nature and extent of health agency concern.

In some States the physicians or other agencies to which referral is made are substantially independent of the health departments. In other States the physicians, hospitals, or other referral agencies receive pay or use of space, or personnel are assigned from health or other closely related departments of the local government. In these States, family planning services are a part of a coordinated system in which the health department actively participates. Future questionnaires will need to differentiate among these situations.

Comparisons between the data for fiscal 1966 and fiscal 1967 for the number of health department clinic locations offering family planning services and for the total number of clinic sessions per month indicate the direction of change. In those 19 States where data are comparable for the 2 years, the number of clinic locations has increased by 10 percent, and total clinic sessions have increased by approximately 20 percent.

Forty-three States and Territories compared with 40 in fiscal 1966 provided consultation to local health departments developing family planning services in fiscal 1967. Thirty-four States offered inservice training of local health department personnel, as compared with 29 in fiscal 1966.

The States and Territories in which State health departments received periodic reporting of family planning services from local health units increased from 23 in fiscal 1966 to 27 in fiscal 1967. Those departments receiving reports from hospitals or other agencies receiving governmental funds have increased from seven States to 10.

Welfare department activities also increased. Although the number of States reporting that medical care financed from welfare funds for families receiving Aid to Families of Dependent Children (AFDC) is about the same as last year, 44 compared with 43, a total of 33 of these States now include costs of contraceptive services and materials compared with only 24 in fiscal 1966. This increase is striking in a 1-year period.

Twenty-five of the same States also include costs of operations for sterilization, often with certain medical or legal restrictions, or both. Many of the States which do not pay for family planning services through welfare departments traditionally provide more medical care for the poor through health department programs, particularly the programs in the southeastern States.

In the responses to a multiple choice question in the fiscal 1967 survey concerning the degree of initiative permitted caseworkers in discussing family planning with public welfare recipients, a broad spread of departmental practices is evident. One striking comparison with prior data is the number of States that encourage caseworkers to discuss family planning services routinely as part of total welfare services offered. This figure has increased from six States and Washington, D.C., to 11 States and Washington, D.C., in a year's time.

Sixteen States and Puerto Rico report that caseworkers are encouraged to provide information and services when they would seem helpful to the client, although in 16 States and the Virgin Islands caseworkers are "neither encouraged nor discouraged" but left to their own discretion. We think of this last category as the least active position that an administra-

tor can take. Six States report that information and services are offered only at the request of the client. However, none of the States discourage caseworkers from giving information or referrals on family planning services.

Legislation on Abortion

Responses to a new question concerning legislation on abortion in the health department questionnaire yielded particularly interesting information. Twenty-seven health departments reported that legislation to liberalize the medical grounds for abortion had been introduced in their legislature within the past 2 years, and seven of the States also had had legislation on sterilization introduced.

One State, Kansas, had old restrictive sterilization legislation repealed, leaving none on the books there. Connecticut was the only State which had a specific departmental policy on abortion, and only two State health departments, Connecticut and Virginia, reported departmental policies on sterilization.

Research Projects

In this survey public health and welfare associations asked each State department if it had conducted or cooperated in any special research studies or projects related to family planning. Eleven health departments and two welfare departments responded affirmatively.

Several State health departments reported studies on intrauterine devices (IUD's).

- The California department of health is conducting a cooperative study on IUD's with a regional maternal and child health unit at the University of California at Berkeley.
- The Florida health department is engaged in a study comparing the Lippes loop and the Saf-T-Coil based on the results of 2,000 insertions of each device.
- In North Carolina two separate IUD studies are being conducted. A Saf-T-Coil evaluation is being done in Cumberland County, and the Shell modification of the Lippes loop is being studied in Mecklenburg County.
- The Washington department of health with the Seattle-King County Health Department is cooperating with the University of Washington in a research project on the use of IUD's.

Attitudes toward family planning have also been studied in several States.

- In Alabama methods of informing people about the importance of child spacing and attracting clients to the clinic were investigated in a rural health research program. The University of Chicago cooperated in the project.
- In Hawaii a study of motivation in the use of contraceptives is being conducted in the Nanakuli Clinic.
- The Washington, D.C., health department has undertaken a study of low income Negro women who have had a child delivered at the District of Columbia General Hospital between November 1, 1964, and December 31, 1965, to determine why they do or do not register in a birth control program following delivery.

Varying types of studies were reported by other States.

- Kentucky reported an effort to evaluate the impact of a special maternity and infant care project in family planning services to high-risk mothers and infants. The project serves a five-county area in eastern Kentucky.
- In North Carolina a comprehensive evaluation of family planning is being done in Mecklenburg County. The evaluation will include both a study of the family planning clinic and a community survey.
- The Virginia department of health has engaged in two studies on abortion; one, a statewide survey, and the other, a study of abortion in the city of Richmond.
- The health departments of Georgia and Louisiana also report that special projects are underway in their States.

Iowa and Maryland reported that their welfare departments were "presently doing or have already done a special study related to the needs for or effectiveness of family planning services."

- The Iowa department sponsored a study to evaluate the department's efforts in the area of family planning. This study was an effort to evaluate local county welfare agency activity in family planning and to determine the degree of AFDC client participation in their program. The evaluation indicated that a large number of Iowa's welfare clients have been supplied written and oral information about family planning, and it appears that initial efforts have been

effective in providing family planning services for these clients.

• A special project was undertaken by the Maryland department of welfare to examine referrals to family planning services during the period October 1962 through July 7, 1967. The department has concisely reviewed the development of Maryland's family planning program, including a statistical analysis of the expansion of referral services. Estimates of women potentially wishing contraceptive services among AFDC clients are contrasted with actual referrals made, and the estimates indicate that a well-planned referral service will be successful. This department continues to stress the importance of informing all public assistance and medical assistance applicants of childbearing age of the availability of family planning services.

Analysis of Variation in State Activity

The data were analyzed to see if we could explain the great variation in the participation of the State health departments in directly giving contraceptive services to the poor. We did this in the following manner. First, we classified the States' reported volume of family planning services as high, medium, or low, taking into account the estimated size of population needing service. Second, we looked at the differences between the high and low States in the items reported by the States that describe family planning activities but are not direct indicators of persons served (reporting required from local health units, consultation provided to local units, special studies or research, positive health department family planning policy or legislation, and inservice training offered to local units. We also looked at relevant family planning data reported from the welfare departments of the same States (contraceptive service and materials and AFDC families paid from welfare funds, policies encouraging caseworkers to discuss family planning, positive welfare family planning policy or legislation). We examined the data reported independently to the Children's Bureau by the State health departments regarding a closely related clinical service provided primarily for the poor, that is, the number of women receiving "maternity medical clinical services." (Unpublished data, Children's Bureau, Division of Research, special tabulation, 1966). We hypothesized that the existing traditions and administrative mechanisms in the States to provide medical services for the poor would, in general, be important determinants as to the methods used to provide any new medical services, such as family planning.

We decided to group the States into high, medium, and low service States because of the variation in the kinds of relevant data the States were able to provide. The responses to questions

Table 1. Classification of States and Territories in the provision or financing of contraceptive services by official public health agencies

Rank [1]	High service	Rank [1]	Medium service	Rank [1]	Low service	Rank [1]	Isolated service
25	Arkansas	45	Alaska	45	Connecticut	36	Illinois
5	Alabama	6	Arizona	4	Delaware	19	Louisiana
14	California	29	Hawaii	13	Indiana	45	Maine
28	Colorado	45	Idaho	22	Iowa	34	Minnesota
11	Florida	33	Michigan	45	Massachusetts	17	Missouri
8	Georgia	45	Kansas	45	Montana	45	Nebraska
15	Kentucky	9	New Mexico	45	New Hampshire	21	Nevada
3	Maryland	30	Ohio	37	New Jersey	24	New York
10	Mississippi	31	Oklahoma	45	North Dakota	23	Pennsylvania
12	North Carolina	32	Oregon	45	Rhode Island		
18	South Carolina	20	Texas	45	South Dakota		
35	Tennessee	16	Washington	26	Utah		
7	Virginia	27	West Virginia	45	Vermont		
2	District of Columbia		Virgin Islands [2]	45	Wisconsin		
1	Puerto Rico		Guam [2]	45	Wyoming		

[1] The number preceding each State name indicates ranking in the provision of maternity medical clinic service in 1966.

[2] Not ranked.

about the following items were used in making this judgment: (*a*) number of local health departments financing or providing family planning services in relation to total number of local health units, (*b*) number of persons given family planning services during the year in relation to the population needing service, (*c*) number of health department clinic locations giving family planning services, (*d*) total number of clinic sessions per month, and (*e*) sources of financial support for local health department family planning programs in the past year (with dollar amounts when identifiable).

To provide an estimate of the relative number of women in need of service in the various States, the figures calculated by George Varky and Nancy Van Vech, using the Dryfoos-Polgar formula for estimating community needs for family planning services, were used (*3*).

Nine States were particularly difficult to fit into a scale. These were States in which a significant amount of services were provided in a major city of the State, usually quite independent of the State health department's program, and the rest of the State was virtually without services. These were designated "isolated service" States, and no attempt was made to rank them (table 1).

The data reported to the Children's Bureau in 1966 by the State health departments as to the number of women receiving maternity medical clinic service were used in the following manner. A ratio between the number of women reported to have received such service and the estimated number of medically indigent women of childbearing age was derived for each State by using the Dryfoos-Polgar formula.

The States and Territories were then ranked from high to low, number one representing the highest proportion of estimated need for services met and number 45 representing the lowest (15 of the 54 States and Territories reported no maternity services, and they were all assigned the number 45, the median between 37 and 54). In table 1 States and Territories are listed as we classified them by family planning services; the number preceding the name of each State shows rank in maternity medical clinic service.

Table 2 shows the variation between the "high service" and "low service" States, as related to those health department family planning activities that are not direct indicators of people served and relevant items on the welfare department questionnaires. The isolated service States were evenly divided on yes and no answers on all except one of these items. The one exception was the provision of consultation, which had seven yeses and two noes.

Discussion

The amount of family planning clinical service provided by health departments in the States was closely correlated with the amount of maternity medical clinical services (table 1).

Table 2. States with "high" or "low" family planning services related to nonservice items on questionnaire

Health and welfare departments' responses to questions on policies and procedures	High health department family planning services [1]		Low health department family planning services [1]	
	Yes	No	Yes	No
State health department responses:				
Reporting required from local health units	12	3	1	14
Consultation services to local health units	15	0	8	7
Inservice training for local health units	15	0	6	9
Special studies or research	8		0	
Positive public health policy or legislation	12	3	8	7
State welfare department responses:				
Contraceptives included as part of medical costs for AFDC clients	5	10	14	1
Caseworkers encouraged to discuss family planning with clients	13	2	3	12
Positive welfare policy or legislation on family planning	10	5	6	9

[1] The 30 States in the high and low service categories are listed in table 1.

Two interesting exceptions to this generalization occurred. The one State that ranked relatively high for family planning services but ranked low in maternity services was Tennessee. It should be noted that a relatively high ranking does not imply adequate in relation to need in the specific State but simply a comparative ranking of the States and Territories. In this State, the health officer had recently opened a large number of general medical clinics for indigent women. The principal basis of referral to these clinics was for family planning services, but a general medical examination was provided.

The only low service State for family planning that ranked high in maternity services was Delaware. Because the State is small, the local services are provided directly by State personnel. The absence of a maternal and child health director at the State level in recent years has made it difficult for the State health officer to develop new maternity and child health services. This condition is quite likely to be changed in the near future.

As can be seen from table 2, the high and low service States have interesting differences in policies and program activities. The program activities reported by health departments that showed the greatest difference between high and low family planning services were "reporting required from local health units" and "special studies or research." The least discriminating items were "positive public health family planning policy or legislation" and "consultation to local health units," both of which might be expected to precede the development of actual services.

The responses from the State welfare departments for the States classified on the basis of health services provided are clearly different for the high and low service States. There was an inverse correlation between high health department service States and the payment for contraceptive services and supplies for AFDC recipients by the same State welfare departments. This correlation is understandable if one assumes that the various States have developed different traditions and mechanisms for the financing of medical care for the poor. If clinical services for the poor were financed by the State through health departments (as in the southeastern States), it was less likely that the State will finance services through welfare departments and vice versa.

Only five States simultaneously provided a significant volume of family planning services under health department auspices, permitted the use of welfare funds for contraceptives, encouraged welfare caseworkers to discuss family planning with clients, and reported research or studies related to family planning. These States were California, Georgia, Kentucky, North Carolina, and Virginia.

There was a strong positive correlation between those States having high level health department programs and those in which welfare caseworkers were encouraged to discuss family planning with AFDC clients. In 13 of the 15 States, where the health departments had high level family planning programs, welfare workers were encouraged to discuss family planning with their clients, but only three of the 15 States having low level health department family planning programs encouraged this discussion. It would seem that welfare workers are able to play a stronger role in family planning when the local health departments provide family planning services to which welfare workers can refer their clients.

Fourteen of the fifteen low health department service States reported that the welfare departments did pay for contraceptive services for AFDC clients, but 12 of the same 15 States did not encourage caseworkers to discuss family planning with clients. The significance of this observation was not at all clear. As with the health departments, positive welfare policy statements or legislation was more evenly divided between the high and low family planning service States.

Summary

During fiscal 1967, the American Public Health Association and the American Public Welfare Association sponsored surveys of the family planning services of State and Territorial health and welfare departments. There was relatively little change in the number of local health departments classified as providing some service. In the 19 States in which services were provided in 1966 and comparable data were provided for 1967, a significant change took place in the 1-year period. Clinic locations were in-

creased by 10 percent and the number of clinic services increased by 20 percent.

States were classified as to the extent to which their local health units participate and directly provide contraceptive services for the poor. The States that rank high in this clinical service were primarily the States that rank high in the provision of maternity medical services.

There was a significant increase from 24 in fiscal 1966 to 33 in fiscal 1967 in the number of States that reported including costs of contraceptive services as part of medical care provided for Aid to Families with Dependent Children by welfare agencies. This mechanism for financing contraceptive service for the poor tends to be used in States that provide little or no service through health department channels.

REFERENCES

(1) Eliot, J. W.: The development of family planning services by State and local health departments in the United States. Amer J Public Health 56 (supp): 6, January 1966.

(2) Eliot, J. W., et al.: Family planning activities of official health and welfare agencies, United States, 1966. Amer J Public Health 58: 700–712, April 1968.

(3) Five million women—Who's who among Americans in need of subsidized family planning services. Planned Parenthood-World Population, New York, N.Y., 1967.

Availability of Basic Data

Single copies of these five appendices containing additional data from the questionnaire are available from University of Michigan Center for Population Planning, 1225 South University Ave., Ann Arbor, Mich. 48104 or American Public Health Association, 1740 Broadway, New York, N.Y. 10019.

1. *Legislation and policies concerning family planning activities of State health and welfare departments and State abortion sterilization legislative activity—July 1967.* A State-by-State tabulation of policies and legislation pertaining to health and welfare department family planning activities, indicating the year in which the most current legislation or policy took effect and whether or not bills regarding sterilization and abortion have been introduced in the legislature in the past 2 years.

2. *State welfare department requirements for providing family planning information and/or services—as of July 1967.* An analysis of welfare department policies in terms of five variables: age limits, marital status requirements, parity requirements, referral on request, and degree of initiative permitted caseworkers in discussing family planning with public assistance recipients.

3. *Provision of medical care from welfare funds for families receiving AFDC—July 1967.* State-by-State welfare department responses to three questions: Does the State provide or finance medical care for AFDC families from welfare funds? Are the costs or contraceptive services and materials included? Are the costs of operations for sterilization included?

4. *Extent of health department family planning services—as of July 1967.* A State-by-State indication of services provided directly by health departments in terms of five variables: the number of local health departments in the State, the number of local health departments financing or providing family planning services, the number of persons given family planning services during the past year, the number of health department clinic locations offering services, and the total clinic sessions per month.

5. *State health department assistance to local health units and reporting by local health units.* State-by-State indication of the interaction between State and local health units in terms of two variables: Does the State health department offer consultation and inservice training assistance to local health units? Does the State health department receive periodic reporting of family planning services from local health units?