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Public or Private Providers? U.S. Women's Use Of Reproductive Health Services

By Jennifer J. Frost

Context: U.S. women receive contraceptive and reproductive health services from a wide range of publicly funded and private providers. Information on trends in and on patterns of service use can help policymakers and program planners assess the adequacy of current services and plan for future improvements.

Methods: Women who reported in the 1995 National Survey of Family Growth that they had obtained any contraceptive or other reproductive health service in the past year were classified by their primary source of care, and the services they received, their characteristics and their primary source of care were analyzed. Logistic regression was used to test which factors predict women's use of publicly subsidized family planning clinics and of specific types of services.

Results: The percentage of women of reproductive age who obtained family planning services increased slightly between 1988 and 1995, primarily among women aged 30 and older. Nearly one in four women who received any contraceptive care visited a publicly funded family planning clinic, as did one in three who received contraceptive counseling or sexually transmitted disease (STD) testing and treatment. Women whose primary source of reproductive care was a publicly funded family planning clinic received a wider range of services than women who visited private providers; moreover, the former were significantly more likely to report obtaining contraceptive care or STD-related care, even after the effects of their background characteristics were controlled. Young, unmarried, minority, less-educated and poor women were more likely than others to depend on publicly subsidized family planning clinics. Source of health insurance was one of the most important predictors of the use of public family planning clinics: Medicaid recipients and uninsured women were 3-4 times as likely as women with private insurance to obtain clinic care.

Conclusions: Publicly funded family planning clinics are an important source of contraceptive and other reproductive health care, providing millions of U.S. women with a wide range of services. Since women's need for reproductive care and for publicly subsidized care is not likely to diminish, clinics may be financially challenged in their efforts to continue delivering this broad package of services to growing numbers of uninsured or disenfranchised women.

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The provision of comprehensive reproductive health care services, including family planning, to all women was set as a key objective in the Programme of Action advanced at the International Conference on Population and Development, held in Cairo, Egypt,

in 1994. Reproductive health care services should be "affordable, acceptable and convenient to all users."[1] Both internationally and domestically, there is growing appreciation that women who obtain contra- ceptive services often have other reproductive health care needs, that women obtaining other reproductive health care may have unmet contraceptive needs and that the needs of both of these groups of women can often be met best by providers who are able to offer a range of services.

In the United States, contraceptive and other reproductive health care is offered by more than 7,000 publicly funded family planning clinics, nearly 28,000 private-practice obstetrician-gynecologists, many of the more than 40,000 private family practice doctors, and other sources (such as private clinics, military or school or university-based clinics, and hospital-based care not included in the public family planning clinic network).[2]

Women obtaining contraceptive care from publicly funded family planning clinics are nearly always provided with basic preventive gynecologic services, such as pelvic examinations, Pap tests to screen for cervical cancer and either screening or testing for a variety of sexually transmitted diseases (STDs).[3] Women who receive care from these clinics often also obtain other reproductive health services, such as prenatal or postnatal care, and (in some cases) basic primary care services, either in conjunction with their contraceptive care or through an allied service of the same provider. Similarly, analysis of services obtained at office visits to private physicians indicates that contraceptive care is frequently provided in the context of other health care.[4]

This article has two purposes: to assess trends in the percentage of U.S. women ob-taining family planning services from all providers and from publicly funded pro-viders; and to describe patterns of usage of reproductive health services among clients of public and private providers.

We expect that over time, the percentage of women obtaining family planning services may change, as may the percentage of women obtaining family planning care from publicly subsidized clinics. Such change may be driven by many factors, including shifts in the U.S. age structure or in the mix of contraceptive methods. In addition, alterations in health care delivery or financing may influence either the availability of or the need for publicly subsidized family planning care.

Patterns of service provision and the characteristics of women obtaining care may also differ by the type of provider that women visit. We investigate here whether the mix of reproductive health services obtained by women varies by the type of provider from whom care is obtained. In part, such differences may be due to variations in the characteristics of women visiting different types of providers, such as their age or life cycle phase. On the other hand, differences in the mix of services that women obtain from different types of providers may also be due to the pro-viders themselves.

In particular, we examine the role played by publicly funded family planning providers, including Title X-supported clinics,* in meeting the reproductive health care needs of U.S. women. Title X is a federally funded categorical program designed to provide confidential contraceptive and related services to any woman, regardless of her ability to pay for care. In addition, health agencies that receive Title X funds are mandated to provide contraceptive clients with relevant reproductive health screening

and care, and to do so for free or on a sliding scale, depending on the client's family income.

Clinics supported by Title X depend on funds from many other sources as well, including Medicaid and other federal, state or local sources, both for family planning and for noncontraceptive services (which may be delivered either in conjunction with or separate from contraceptive services).[5] Given Title X's focus on contraceptive services, a question of interest is the extent to which women obtaining care at Title X clinics receive reproductive health services other than contraceptive care.

METHODOLOGY

Data

The primary data source used for this analysis is the 1995 National Survey of Family Growth (NSFG).[6] These data contain responses from a large, nationally representative sample of U.S. women aged 15-44, including information on a variety of specific reproductive health care services and on the type of provider from whom each service was obtained. Although the information available in the NSFG does not cover the full spectrum of reproductive health services possible, it represents a wide range of services and defines the scope of reproductive health used in this article. In addition to the 1995 NSFG, we also refer to data published previously from the 1982 and 1988 NSFGs[7] and to data obtained from family planning clinics on numbers of contraceptive clients served.[8]

Definitions

When the 1995 NSFG questionnaire was designed, it was anticipated that women would be classified as current family planning service users if they reported having received during the previous 12 months one or more of five basic contraceptive services (a sterilization operation, a visit to obtain a birth control method or prescription, a check-up related to a birth control method, counseling about birth control or counseling about sterilization).[9]

However, use of these five services alone to identify contraceptive service use is inadequate, for two major reasons. First, it is inappropriate for trend analysis, since this definition differs somewhat from that used in the 1982 and 1988 NSFG surveys: In 1982 and 1988, women were identified as family planning service users if they reported having received one or more of 10 (in 1982) or 11 (in 1988) basic family planning services. Included in this set of services was a pregnancy test, and women who reported having received one (but no other services) during the preceding year were classified as family planning users if they had ever received any other family planning service.[†10] In addition, the earlier definition excluded women who reported never having had sex and women who said that they themselves or their partners had become sterilized prior to the last 12 months, since such women were not asked about family planning service use in 1982 and 1988.

The second reason is related to some methodological problems associated with measuring who obtained contraceptive services in the previous year. In the 1995 NSFG, the question appears to have excluded a sizable number of women whose responses to other questions suggested that they had used contraceptive services, but

who may not have thought about their visit in a way that fits classification using the five specified questions. For example, 40% of current users of reversible methods (9.4 million women) did not report having received any of the five basic family planning services during the past 12 months. Yet 1.6 million of these women reported on a separate question a medical source for their current method, and most of these women (1.0 million) reported having received some other recent reproductive health service (usually a Pap test or pelvic exam) in the past year.

There are a number of reasons why some women may not have responded affirmatively to any of the five questions, despite having received their method from a medical provider. Some may not have thought of their annual gynecologic visit as a "family planning" visit unless they made the visit to switch methods or to talk to a clinician about problems they were having with their method. If women were happy with their current method, they may not have considered a brief conversation with their clinician during an annual exam to be a visit to obtain "a method of birth control" or "counseling about birth control."

We addressed these inadequacies by constructing two separate variables on use of family planning or contraceptive services. The first replicates as closely as possible the definition used in previous analyses of the 1982 and 1988 NSFG and allows time trend analysis. For the second variable, we considered women to be "contraceptive service users" if they reported having received one or more of the five core contraceptive services (a total of 19.8 million women) or if they were current users of a reversible method and reported a medical source for that method (an additional 1.6 million women). We excluded women whose only visit was for a pregnancy test, and we included women who had never had sex or who reported being sterile prior to the past year if they reported contraceptive service use, as defined above.

We defined women to be users of "other reproductive health care" if they reported having received one or more of nine other medical services asked about in the NSFG—a pelvic exam, a Pap smear, a pregnancy test, prenatal care, postnatal care, an abortion, STD testing or treatment, an HIV test, or testing or treatment for some other gynecologic, urinary or vaginal infection. We further classified these services into three groups: routine preventive gynecologic care (a Pap test or pelvic exam[‡]); pregnancy-related care (a pregnancy test, prenatal care, postnatal care or abortion);[§] and STD care (testing or treatment for gynecologic infection, testing or treatment for STDs, or testing for HIV and AIDS).

Source of Care

During the NSFG interview, women were asked if their most recent visit (in the past 12 months) for each of 14 services was at a clinic, a private doctor's office or a health maintenance organization (HMO), or some other place. We classified the responses to these questions into four categories: Title X family planning clinics,[**]non-Title X family planning clinics, private doctors and HMOs, or other pro- viders. Women receiving services from other providers typically reported visiting hospitals, school or university health centers, military health facilities or other unspecified providers, including some abortion clinics or STD clinics that do not also provide family planning services (see Appendix).

In determining the best strategy for classifying women's primary source of care, we looked at the percentage of women who reported having received any service from each type of provider and at the combinations of different provider types that women used. First, we coded women who obtained one or more types of contraceptive services and who reported only one source for those services according to that source. (This accounted for 95% of all users of contraceptive services.)

The remaining women, who reported more than one source for contraceptive services, were hierarchically coded in the following manner: Women reporting receipt of any contraceptive service from a Title X clinic were coded as having received care from a Title X clinic; women citing receipt of any contraceptive service from a non-Title X clinic but not mentioning a Title X clinic were coded as having received services from a non-Title X clinic; respondents mentioning receipt of services from a private doctor or HMO who did not cite a Title X or non-Title X clinic (but who may have mentioned an "other" source) were coded as having received services from a private doctor or HMO; and those reporting receipt of services only from some "other" type of provider were coded as "other."

Among women classified as having obtained contraceptive services because they were currently using a reversible method, those who reported a medical source for their method were coded according to the source of care reported in answer to that question. Finally, to classify women for whom data on their source of contraceptive care were missing but who had also received other reproductive health care, we coded them according to that source. We followed the same hierarchical procedure when coding source of care for women who obtained only other reproductive health care services.

For all who received any care, women were coded first according to their source of contraceptive care; those who reported no contraceptive care first were coded according to their source for preventive gynecologic care and second were coded according to their source for all other reproductive health care. Overall, 89% of women obtaining any of the 14 services reported having received care from only one type of source. The remaining 11% went to more than one type—3% to a Title X clinic plus some other source, 2% to a non-Title X clinic and some other source, and 6% to a private doctor plus some other provider.

Therefore, for women with multiple types of sources, the primary source of care will depend on what services she obtained from each. For example, among the 3% of women obtaining any care who reported having received services from both a Title X clinic and one or more other sources, approximately two-thirds (2%) had their primary source of care classified as a Title X clinic, and one-third (1%) were classified according to another type of source. Typically, this occurred because respondents obtained STD or pregnancy care from a Title X clinic, but reported obtaining contraceptive or routine preventive gynecologic care from the other source.

Measures of Women's Characteristics

We describe the characteristics of women going to different types of providers to assess whether certain characteristics predict women's use of private or public providers or their use of specific types of reproductive health services. We chose three

groups of variables for this analysis: basic demographic variables (age at interview,†† marital status, race and ethnicity, education and poverty status); variables related to women's eligibility for, coverage by or use of public or private health insurance (eligibility for subsidized care, health insurance type and payment type¥¥); and a variable related to women's need for contraceptive health care services—risk for unintended pregnancy (with sexually active women currently not pregnant, postpartum or seeking pregnancy, or not contraceptively or noncontraceptively sterile, considered to be "at risk" of unintended pregnancy, and other women classified as "not at risk," except that the contraceptively sterilized were placed in a separate category).

Statistical Analyses

For time-trend analyses, we compared cross-tabulations of the percentages of women obtaining family planning services by age and poverty status. We tested the significance of change over time using a two-tailed normal test statistic. Standard errors for each year were calculated using the generalized standard error estimates described elsewhere for the 1982,[11] 1988[12] and 1995[13] NSFGs.

Descriptive data on women's receipt of contraceptive or reproductive health care services are presented as cross-tabulations according to the mix of services they received and the type of provider from whom they obtained care. Analyses of women's characteristics and their sources of reproductive care are presented as cross-tabulations. For this analysis and for the multivariate analyses, we included all women who obtained any reproductive health service. (The results of preliminary analyses conducted separately for women who obtained contraceptive services and for those who obtained other reproductive health services only did not differ greatly from those presented here.)

We also used logistic regression analysis to test the importance of women's characteristics in determining their use of publicly subsidized clinics. The dependent variable compared women obtaining care from Title X or non-Title X clinics with all other women obtaining care from private providers and from HMOs or other providers. The final model included all predictor variables described above except eligibility for subsidized care and payment type, which were excluded because they overlapped with poverty status and insurance type. A second set of regression analyses used receipt of specific contraceptive or reproductive health services as dependent variables and tested whether women obtaining care from different types of providers were more or less likely to obtain each service, even after the effects of women's other characteristics were controlled for.

RESULTS

Trends in Family Planning Service Use

The number of women aged 15-44 obtaining family planning services in the prior year increased from 19.8 million in 1982 to 20.0 million in 1988 and 21.9 million in 1995 (Table 1). These changes reflect both population growth and change in the percentages of women obtaining family planning services. Between 1982 and 1988, the percentage of all women aged 15-44 who reported receiving family planning services fell slightly, from 37% to 35%. This change was not statistically significant, nor were

any of the differences between 1982 and 1988 in family planning service use by age or poverty.[14]

Between 1988 and 1995, the percentage of U.S. women reporting having received family planning services during the year prior to the survey increased slightly but significantly, from 35% to 37%. Moreover, the overall rise in contraceptive service use between 1988 and 1995 occurred despite the continued aging of women of reproductive age.

Women in their 20s are the most likely to report having recently used family planning services: more than half of all women aged 20-24 or 25-29 in all three survey years. Between 1988 and 1995, there were no significant changes in the percentage of women aged 15-24 obtaining family planning services; however, among women aged 25-44, this proportion increased significantly, with women aged 30-34 experiencing the largest overall increase—from 35% to 43% (Table 1).

For women aged 30-34, increased use of family planning services can be explained in part by increases in their use of reversible methods (not shown). Among method users aged 30-34 in 1988, 47% reported using female or male sterilization, while in 1995 only 39% of method users aged 30-34 did so. This decline in use of permanent methods by women in their early 30s was accompanied by increases in the proportions of women choosing reversible methods such as the pill or the condom—methods that require ongoing service or supply. For example, pill use rose from 22% to 28% among method users aged 30-34, and condom use rose from 12% to 18%. Overall use of long-acting methods—the IUD, implant or injectable—did not change, with 3% of women in this group using long-acting methods in each year.[15]

Among women who reported having used family planning services during the past year, about one-third obtained one or more of these services in a clinic or a nonprivate setting[§§] (Table 1). Overall, this percentage increased from 31% in 1982 to 36% in 1988, and remained at 36% in 1995. Between 1982 and 1988, the percentage of teenagers and poor women reporting receipt of contraceptive services from clinics increased significantly. However, although young women appear slightly less likely and older women slightly more likely to have obtained family planning care from clinics in 1995 than in 1988, none of these differences were statistically significant.

Current Use of Services

•*Mix of services obtained.* Overall, 44.1 million women reported having obtained contraceptive or other reproductive health services from medical providers during the prior year, representing nearly three-quarters (74%) of all women aged 15-44 (Table 2, page 8). Of these, we classified about half, or 21.4 million women, as contraceptive service users. The other half, 22.7 million, received other reproductive health services only. In all, nearly two-thirds of women aged 15-44 (38.9 million) reported receiving routine preventive gynecologic care (a Pap test or pelvic exam), one in five (11.8 million) reported receiving one or more services related to pregnancy care and one in three (20.0 million) reported having been tested or treated for STDs or gynecologic infections.

Both among women who obtained contraceptive care and among those who received other reproductive health services only, about 85% reported receiving routine

preventive gynecologic care, and nearly half reported some type of STD care.[*][†] Women obtaining contraceptive services, however, were somewhat more likely to also report receiving pregnancy-related care than were those who reported only noncontraceptive reproductive health care (32% vs. 21%). This suggests that women obtaining contraceptive care are more often in their peak childbearing years, while many of the women who obtain only noncontraceptive care have already completed their childbearing or are otherwise not getting pregnant.

Among women who reported obtaining contraceptive services, approximately three-fourths were users of reversible contraceptive methods at the time they received care—mostly prescription methods that require ongoing medical care to continue the method (not shown). In contrast, among women who reported obtaining only noncontraceptive reproductive health care services, nearly three- fourths either were using a permanent method (39%) or did not currently need a method because they were pregnant, postpartum, seeking pregnancy, sterile or not sexually active (35%).

•*Source of care.* Among all 44 million American women who reported receiving any recent contraceptive or other reproductive health care, 17% (or nearly 7.5 million) obtained one or more of these services from a publicly funded family planning clinic (Table 2). The percentage of women obtaining each service from a clinic provider varied according to the service: Nearly one-third of all women who reported receiving counseling about birth control recently or testing or treatment for an STD had gone to a publicly funded family planning clinic, while about one in four women who obtained a birth control check-up or method and prescription, a pregnancy test or an HIV test in the prior year received that care from a publicly funded clinic.

To compare the mix of services obtained from different provider types, we classified women according to their primary source of care for all contraceptive and reproductive health care services received. Overall, 33.9 million women obtained their care primarily from private doctors or HMOs, 7.4 million primarily from publicly funded family planning clinics—4.2 million from Title X clinics and 3.2 million from non-Title X clinics—and 2.7 million from other providers, such as hospitals, schools, military facilities or other clinics (Table 3).

Here we find striking differences in the mix of contraceptive and other reproductive health care services obtained by women, according to provider type. Seven in 10 women obtaining care from family planning clinics received contraceptive services—75% of women served at Title X clinics and 61% of those served at non-Title X clinics. In contrast, fewer than half (44%) of women obtaining services from private doctors or HMOs obtained contraceptive services. Moreover, a higher percentage of women receiving services from family planning clinics reported obtaining any pregnancy or STD care: Thirty-five percent of women obtaining care from clinics reported receiving one or more pregnancy care service, compared with 25% of those going to private doctors; for STD care, these percentages were 56% and 42%, respectively.

Regardless of provider type, approximately one-fifth to one-quarter of all women obtaining care reported receiving contraceptive services only or contraceptive services combined with preventive gynecologic care. However, 44% of all women reporting care from family planning clinics received a combination of contraceptive

services plus pregnancy or STD care (7% contraceptive and pregnancy care; 20% contraceptive and STD care; and 17% contraceptive and both pregnancy and STD care), while only 24% of women receiving care from private doctors or HMOs obtained a broad range of contraceptive and reproductive health services. Women reporting care from private doctors were the most likely to say they received only routine preventive gynecologic care—28% of those reporting services from private doctors, compared with 8% of those going to family planning clinics.

Overall, 41% of women who obtained any contraceptive care reported that they received contraceptive counseling (Table 2). Women who attended clinics for contraceptive services were significantly more likely to report that they received counseling about birth control than were women who obtained contraceptive care from private doctors (57% for Title X clinics, 50% for non-Title X clinics and 37% for private doctors, not shown).

•*Variations in women's characteristics.* Women's characteristics differed widely according to where they obtained contraceptive or other reproductive health care services, resulting in very different client profiles for each provider type (Table 4, page 10). Higher percentages of younger women, unmarried women, minority wo-men, less-educated women and women without private health insurance were served in family planning clinics than by private physicians or HMOs. In fact, half of all women obtaining care from family planning clinics were younger than 25 (54% of those at Title X clinics and 42% of those at non-Title X clinics), compared with only one in five (21%) of those obtaining care from private doctors. In addition, 31% of clinic clients did not have a high school diploma, compared with only 12% of clients of private doctors.

Three in four women (75%) going to private doctors and HMOs were non-Hispanic white, compared with 53% of those at family planning clinics—57% at Title X clinics and 42% at non-Title X clinics. Nearly one-quarter of all clinic clients (24%) were non-Hispanic black, compared with only 13% of women going to private doctors. Finally, Hispanic women made up a higher percentage of clients at non-Title X clinics (26%) than at Title X clinics (15%) or private doctors (9%).

Among the 44 million women obtaining any contraceptive or other reproductive health care, one in five were eligible for fully subsidized care because of their poverty level or young age. This was true of nearly half (45%) of all women obtaining care from family planning clinics, but of fewer than one in six (15%) women obtaining care from private providers.

Overall, one in 10 women obtaining care reported having no health insurance, one in six reported being covered by Medicaid and seven in 10 reported having private health coverage. This distribution was very different among family planning clinic clients: One in five had no insurance, two in five reported Medicaid coverage and only two in five had private insurance. However, women with private insurance were not necessarily covered for contraceptive services, nor were they necessarily insured for all of the prior year. Thus, the proportion all of women who reported that their private insurance plan paid for their contraceptive care (55%) was much lower than the proportion who reported having any private health insurance (72%). Among women who attended a family planning clinic, 16% reported that insurance paid for their care,

while 40% reported having insurance coverage. Finally, among women obtaining care from family planning clinics, the majority reported that care was either free or subsidized by the clinic (35%) or covered by Medicaid (31%).

• Multivariate analysis to predict source of care and services received. We used logistic regression analysis to investigate the extent to which women's characteristics predict whether those who obtain reproductive care go to publicly funded family planning clinics or to private physicians and HMOs and other providers. These analyses confirmed much of what was evident in the bivariate tabulations. Younger women were significantly more likely than older women to have obtained reproductive health care from family planning clinics (Table 4), even when the effects of all other background variables and women's risk for unintended pregnancy were controlled for (odds ratios of 1.6-2.6 for women younger than 30).

In addition, unmarried women, minority women, those with less education, poor women and those who had no health insurance or who were covered by Medicaid were significantly more likely than women in the reference categories for each group to have obtained care from publicly funded family planning clinics. The odds of using a clinic were highest for those covered by Medicaid or having no health insurance; such women were 3.0-3.6 times as likely as women with private insurance to have received reproductive health care from family planning clinics.

To assess differences in the mix of contraceptive and reproductive health services obtained by women visiting different types of providers, we conducted a series of logistic regression analyses that used receipt of four types of services (contraceptive services, preventive gynecologic care, pregnancy-related care and STD care) as dependent variables and included the primary source of care as a predictor (Table 5). The results indicate that among women obtaining any care, those who got care from family planning clinics were significantly more likely to receive contraceptive services (odds ratios of 2.6 for Title X clinics and 1.7 for non-Title X clinics) than were women who obtained care from private doctors and HMOs.

Similar results were found for receipt of STD care (odds ratios of 1.3 and 1.2 for Title X and non-Title X clinics, respectively, compared with private doctors and HMOs), but not for receipt of preventive gynecologic or pregnancy-related care. For these services, clinics did not differ significantly from private doctors, except that women getting care from non-Title X clinics were significantly less likely to have obtained preventive gynecologic care than were women going to private doctors. That these patterns persisted, even when we controlled for women's characteristics, indicates that the provision of specific services to women who visit different types of providers is related in part to provider type itself: Either women choose different types of providers because they are seeking different types of services, or providers of different types are simply more or less likely to offer certain services.

These analyses also suggest which characteristics of women are most important in determining the types of contraceptive or reproductive services they will obtain (among those obtaining any care). Not surprisingly, age was the more important predictor of the receipt of contraceptive, pregnancy-related and STD-related services, but was not important in predicting receipt of preventive gynecologic care.

Non-Hispanic black women were less likely than non-Hispanic white women to have obtained contraceptive services, but were more likely to have obtained preventive gynecologic care. Hispanic women who obtained any care were significantly less likely than white or black women to have obtained preventive gynecologic care, as were less-educated women compared with college-educated women. Poverty status had little impact on what services women obtained once other variables were accounted for. Women without any health insurance were significantly less likely than women with private insurance to have obtained contraceptive services or preventive gynecologic care. Those covered by Medicaid are significantly more likely than privately insured women to have received contraceptive services, pregnancy-related care and STD care.

DISCUSSION

This article provides an updated trend analysis of the numbers and percentages of U.S. women obtaining family planning services each year, extending to 1995 analyses previously published for 1982 and 1988. Overall, the percentage of women of reproductive age obtaining family planning services declined slightly (but not significantly) between 1982 and 1988 and increased slightly between 1988 and 1995.

We examined the impact that changes in the age distribution of women of reproductive age may have had on trends in the percentage of women using family planning services. Applying the 1982 age distribution to the 1988 data raises the proportion for 1988 from 35% to an age-standardized value of 37%, identical to the level reported in 1982. Moreover, the increase recorded between 1988 and 1995 occurred *despite* the aging of the population. Applying the 1988 age distribution to the 1995 family planning service use percentages increases the proportion slightly, from 37% to an age-standardized proportion of 38%.

The increase in women's use of family planning services may be due in part to changes over time in the types of contraceptive methods used by women of different ages, with a decrease in older women's reliance on permanent methods and an increase in their use of methods such as the pill or condoms—methods that require ongoing services and supplies. One possible reason for the shift away from permanent methods among women in their early 30s is the tendency for some women to delay childbearing, thus lengthening the period during which they must rely on reversible methods of contraception.

Overall, there was no change in the total percentage of contraceptive users of all ages relying on permanent methods (male or female sterilization) between 1988 and 1995. Rather, decreased use of sterilization among women older than 30 coincided with changes in the age structure of women aged 15-44 (an increase in the proportion aged 30 or older). These results indicate that the shift towards an older age-distribution among women of re- productive age has not led to fewer women needing ongoing contraceptive care, and that there has been a continued, even growing need for contraceptive care among older women. Providers who once primarily served young women are now increasingly serving older women, both for routine gynecologic care and for ongoing contraceptive care. Our analysis of trend data was limited to women's receipt of family planning services, since the questions on wider use of other reproductive health care services were not consistent across the three surveys.

This article also provides researchers, providers and policymakers with a comprehensive picture of U.S. women's receipt of a range of reproductive health care services and the sources for that care in 1995. Most women of reproductive age receiving contraceptive or other reproductive health services in the prior year obtained multiple types of services, including care related to obtaining or continuing a contraceptive method, routine gynecologic services and a range of pregnancy-related or STD-related services. Our findings illustrate women's multiple needs when it comes to the use of contraceptive and reproductive health care, and indicate that providers should be prepared to attend to the many reproductive health needs of their clients (either directly or through referral).

U.S. women are more likely to receive contraceptive or STD services if they obtain care from a family planning clinic than if they obtain care from a private doctor or HMO—even taking into account that clinic clients are typically younger, less likely to be married and more likely to be at risk for unintended pregnancy. Moreover, wom-en obtaining care from clinics are similar to those obtaining care from private doctors in their receipt of pregnancy-related care and, among clients of Title X clinics, in their receipt of preventive gynecologic care. These findings suggest that women attending family planning clinics obtain a wider range of services than do those whose primary source of care is private providers or HMOs. On the other hand, the finding that women obtaining care from non-Title X clinics are significantly less likely to have obtained preventive gynecologic care (a Pap test or a pelvic exam) is a matter of concern. It is difficult to know, however, whether these differences are due to variation in what services different types of providers offer to their clients, in what services women ask for when they visit different providers or in unmeasured differences among women who typically use each type of provider.

Among all women who received any contraceptive or reproductive health service, 4.2 million (nearly 10%) used a Title X clinic as their primary source of contraceptive and other reproductive health care. In addition, approximately one-half million women who received contraceptive or preventive gynecologic care from a private doctor or other type of provider visited a Title X clinic for pregnancy-related or STD-related care. If we include these women, this brings to 4.7 million (with a confidence interval of plus or minus 176,000[*‡]) the total number of women who made any visit to a Title X clinic during the prior year. Of these, 3.2 million reported receiving contraceptive services.

These NSFG-based estimates of the numbers of women served in Title X clinics can be compared with counts of Title X clients obtained from the providers themselves. In 1995, recipients of Title X funds reported serving a total of 4.4 million female family planning users.[16] Overall, providers supported by Title X report somewhat fewer family planning users than is estimated from women's responses in the NSFG about receipt of any care at a Title X clinic, but slightly more users than the NSFG count of women reporting contraceptive services only. Given differences in definitions and potential variation among women in what they think is a "family planning visit" and in the accuracy of their reports of the timing of a visit, it is encouraging that the numbers of Title X clients obtained from providers and those obtained from NSFG respondents are so similar.

Women obtaining care from Title X clinics typically receive much more than just contraceptive care. Nearly nine in 10 receive preventive gynecologic care, more than half obtain some kind of STD-related services and more than one-third obtain pregnancy-related care. Nearly one in five receive a combination of contraceptive, STD and pregnancy-related care in the course of one year. In addition, although the majority of women are served by private providers, publicly funded family planning clinics provide needed services to a sizable population of women who are young, unmarried, low-income, less-educated, uninsured or covered by Medicaid.

Women's reproductive health care needs are complex and driven by a variety of personal characteristics. We have shown that different type of providers meet these needs in differing ways. We are not able to assess whether the services provided are adequate and fill the needs of all women, nor can we assess whether any women who report having received no services actually had an unmet need for them. But use of contraceptive services has risen over time, as has the percentage of older women obtaining such services. Moreover, publicly funded family planning clinics, particularly those supported by Title X, play an especially important role in serving women and in providing them with a wide range of contraceptive and reproductive health services. With growing numbers of uninsured women in America,[17] growing minority and immigrant populations,[18] as well as a mandate to serve women's multiple reproductive health care needs, the role of publicly funded family planning clinics in meeting these needs is likely to increase. Given these changes, clinics may face financial challenges in continuing to deliver the wide range of services that they are mandated to provide. Policymakers and program planners should consider these factors when allocating public expenditures for these programs.

APPENDIX

The steps taken to identify the type of family planning clinic used by women for family planning and other reproductive health care services are as follows. During the NSFG interview, women who stated that they received care at clinics were asked to specify the clinic name and address, and an attempt was made to identify the clinic using a database of all publicly funded family planning clinics.

Clinics found in the database were classified into two groups: Title X family planning clinics and non-Title X family planning clinics. Clinics that could not be found in the database during the interview were coded as "unknown" and the name and address were "written in" if women could provide that information. Later, the database was reviewed again and additional clinics identified.

When the 1995 NSFG public-use data file was released, we coded 1.6 million women (about 8%) receiving any of the five basic family planning services and 3.7 million women receiving any of the 14 family planning or other reproductive health services as having obtained their service from unknown clinics. (Actual unweighted numbers of respondents were 294 women who were coded as having obtained family planning services from unknown clinics and 698 who were coded as having obtained family planning or other reproductive health services from unknown clinics.)

To more accurately describe the source of care for NSFG respondents, staff at AGI reviewed a special file provided by NCHS containing every unknown clinic "write in"

and reclassified these respondents using the following procedures: First, clinic write-ins were again compared with the clinic database by staff familiar with the database, who were instructed to search for both definite and probable clinic matches. Then, we searched for clinics that still had not been found using on-line Yellow Pages directories. Clinics identified through the Yellow Pages were called so we could ascertain what type of clinic they were and whether they received public funding. (Many located in this manner were found to be private physician groups and not clinics at all.)

Of the 698 respondents who obtained services from unknown clinics, the identity of the clinic was ascertained through these procedures for two-thirds (457). Of these, 13% were found to have received care from Title X clinics, 28% from public clinics not funded by Title X, 46% from private physician offices and 13% from other types of providers (school and military clinics, among others). Most of the remaining respondents who obtained care from unknown clinics provided too little write-in information about the name or address of the clinic for it to be located, either in the database or in the Yellow Pages. (Many had provided little more than the name of the town in which the clinic was located.) Each of these sites was randomly assigned a clinic or private physician type based on the distribution of the "write-in" clinics that were identified.

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*For simplicity, throughout this article we will refer to Title X-supported family planning clinics as Title X clinics; other publicly funded family planning clinics will be referred to as non-Title X clinics.

†Those who reported having made their first family planning visit in the preceding year were not considered to be family planning service users if the only service they received was a pregnancy test.

‡Routine preventive gynecologic care consists of a broader range of services, but information on women's receipt of other preventive gynecologic services, such as breast exams or mammograms, is not available from the NSFG.

§Because abortion has been shown to be substantially underreported in the NSFG, with completeness of reporting varying across women's socioeconomic status (Fu H et al., Measuring the extent of abortion underreporting in the 1995 National Survey of Family Growth, *Family Planning Perspectives*, 1998, 30(3):128-133 & 138), we do not report abortion services alone in this article, but instead include them as part of pregnancy-related care.

**Since publicly funded family planning clinics were identified based on their name and location, women may have received some services, such as STD testing or treatment or pregnancy-related care, from a clinic or department located at the same site as a family planning clinic, but not necessarily together with contraceptive services or funded by public sources for family planning, such as Title X. Thus, Title X and non-Title X designations are most relevant for contraceptive care.

†† This is the respondent's actual age on the date the NSFG interview was conducted, not her age as of April 1, 1995, the age approach that is used in National Center for Health Statistics (NCHS) publications. To use actual age, we excluded women who were 14 or 45 on the day of the interview; thus, our total number of women aged 15-44 is 59,958,000 rather than the 60,201,000 million reported in NCHS publications (such as reference 7).

‡‡ We coded eligibility for subsidized care to reflect women's eligibility for publicly funded contraceptive care under Title X guidelines: "Full subsidy" includes all women aged 15-19, plus adult women (aged 20-44) who reported having a family income less than 100% of the federal poverty level; "partial subsidy" encompasses adult women with a family income between 100% and 249% of poverty; and "no subsidy" consists of adult women with an income at 250% of poverty or higher. Health insurance type refers to coverage in the past year and is coded as private insurance, Medicaid, military or other, or no insurance. Payment type refers to how the women reported paying for contraceptive and reproductive health services: Women who reported using Medicaid to pay for any contraceptive or reproductive health service were coded as "Medicaid" (even if they also reported other sources); women who reported using private insurance to pay for all or part of any service (but who made no mention of Medicaid) were classified as "insurance." Women who reported obtaining free or publicly subsidized services were coded accordingly. Women who used their own income only to cover visit costs were coded as "own income," unless they responded affirmatively to a question about whether a sliding scale was used to determine the cost of their service. Women whose fees were based on a sliding scale were grouped with those reporting free or publicly funded care. Finally, those reporting only that military, school or other sources funded their care were classified accordingly.

§§In 1982 and 1988, women's source of care was coded as either a clinic, a private doctor or HMO, or a counselor (1.3% in 1982 and 0.4% in 1988), and the percentages reported here are those classified as "clinic." In 1995, women's source of care was coded as either a clinic, a private doctor or HMO, a hospital or some other provider type (including military, school or other sources). To allow comparison with the published 1982 and 1988 data, we combined all women who mentioned obtaining any family planning service from a clinic, hospital or other provider and classified them as "clinic" users.

*† It is likely that the actual numbers and percentages of women obtaining STD testing or treatment are somewhat higher, since this service is known to be underreported.

*‡ Applying the generalized standard error (GSE) estimates to this number (0.4 for a percentage of 10 and an unweighted sample size of 8,000) results in a sampling variance of 0.176 million women around the parameter estimate. Thus, the range of women estimated to have obtained any care from Title X clinics in 1994-1995 from the NSFG is 4.511 million to 4.863 million.