REPORT BY THE

Comptroller General

OF THE UNITED STATES

Family Planning Clinics Can Provide Services At Less Cost But Clearer Federal Policies Are Needed

In fiscal year 1980, the Department of Health and Human Services spent about $375 million for family planning services through several programs. The Department could reduce the costs of such programs and make services less costly and more attractive to clients without compromising quality care by eliminating unnecessary medical procedures or tests. The cost of the title X program could be further reduced by more vigorously enforcing fee collections to ensure that only needy persons receive free or subsidized services. Also, the Department needs to resolve conflicts in fee policies between the title X program, which requires fee collections from persons with ability to pay, and the title XX program, which permits free service regardless of client income.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-203522

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

The Honorable Jeremiah Denton
Chairman, Subcommittee on Aging,
Family and Human Services
Committee on Labor and Human Resources
United States Senate

This report is in response to your request that we review several aspects of the Department of Health and Human Services' (HHS') Family Planning program authorized by title X of the Public Health Service Act.

The report identifies several areas in which family planning program costs can be reduced and services made more attractive to clients without compromising quality care. This information will also be useful to the States if the Congress enacts legislation to put the title X Family Planning program into a block grant, as proposed by the administration.

As arranged with your offices, we are sending copies of the report to the Director, Office of Management and Budget; the Secretary of HHS; and other interested parties.

Milton J. Socolar

Acting Comptroller General
of the United States

REPORT BY THE
COMPTROLLER GENERAL
OF THE UNITED STATES

FAMILY PLANNING CLINICS CAN PROVIDE SERVICES AT LESS COST BUT CLEARER FEDERAL POLICIES ARE NEEDED

D I G E S T

In fiscal year 1980, the Department of Health and Human Services (HHS) spent about $375 million for family planning services and contraceptive supplies through several different programs. Title X of the Public Health Service Act authorizes HHS' largest family planning program. Since the title X program was enacted, over $1 billion has been provided for project grants for family planning services. In fiscal year 1980, about $156 million of title X funds went to 218 agencies which funded or operated about 5,125 clinics serving about 3.8 million people.

Other HHS programs which fund family planning services include Medicaid, title XX Social Services, and Maternal and Child Health. In fiscal year 1980, these programs provided an estimated $219 million for family planning services provided by clinics, hospitals, physicians, or other health care providers.

FAMILY PLANNING CLINICS CAN PROVIDE QUALITY CARE MORE EFFICIENTLY

Family planning clinics reviewed in this study were generally providing the medical services required by HHS. However, HHS' guidelines recommended or required:

--Too many clinic revisits by women using oral contraceptives. (See p. 9.)

--Education that does not appear to be needed by all clients. (See p. 14.)

--Some routine medical tests that do not appear to be necessary for all clients. (See p. 17.)

Also, many of the clinics GAO reviewed were performing tests and examinations not

required by HHS or professional medical standards. These include:

--Routine syphilis and gonorrhea tests on all clients when test results do not appear to justify them. (See p. 18.)

--Semiannual routine physical examinations, including pelvic examinations, which are not recommended by HHS or professional medical standards. (See p. 21.)

GAO believes that some of these HHS policies and clinic practices unnecessarily add to program cost and contribute to long waits for appointments and long office visits at some clinics, perhaps deterring initial or continuing participation in the program.

GAO could not determine the costs associated with these practices because relevant nationwide data were not available. However, GAO estimates that the costs of unnecessary clinic revisits could range from $6 million to $13 million annually and that the costs of other questionable practices are substantial. (See p. 12.)

HHS is revising its title X program guidelines. GAO met with HHS representatives on several occasions to discuss suggested changes to its draft revised guidelines. HHS representatives were generally receptive to GAO's suggestions. (See pp. 14 and 21.)

CLINICS COULD RAISE MORE MONEY FROM CLIENT FEES, BUT CONSISTENT POLICIES ARE NEEDED

Family planning clinics have lost revenue and, in some cases, treated clients inequitably because HHS and State policies were not clearly understood or consistent.

Some clinics successfully used sliding fee scales to charge clients who had ability to pay, but many clinics have made little or no effort to generate fee income. Some clinics charged no one, regardless of income, and some clinics charged even low-income clients entitled to free care under title X. Contrary to title X,

in some instances, one grantee was apparently denying service to members of low-income families who could not pay. (See p. 30.)

The divergent practices stemmed from HHS' failure to

--update its official definition of "low-income family" between 1971 and June 1980,

--issue guidance on charging fees to teenagers, and

--uniformly enforce fee requirements. (See pp. 32 to 34.)

In some States, policies adopted for the title XX Social Services program conflicted with title X requirements. For example, title X regulations require grantees to collect fees from clients able to pay. However, some States have chosen, as permitted by title XX, to provide free family planning services to persons regardless of income. (See pp. 32 to 34.)

TITLE X MANAGEMENT INFORMATION SYSTEM LACKS CREDIBILITY

The adequacy of the management information system used to allocate title X funds and monitor program efficiency and productivity is questioned by many HHS and grantee officials. This system, the Bureau Common Reporting Requirements, was established as a uniform reporting system for several different programs administered by HHS' Bureau of Community Health Services.

Its application to family planning projects, however, produces measures of clinic efficiency which are of limited usefulness.

OVERALL MANAGEMENT OF HHS' FAMILY PLANNING PROGRAMS

Title X requires HHS to establish a position, the Deputy Assistant Secretary for Population Affairs, to administer, coordinate, and evaluate all of its family planning programs which provide for or authorize grants or contracts. Although the most recent incumbents in this position

coordinated various efforts, they did not actually administer them and were not in a position to effectively coordinate all departmental family planning activities.

Whether the Deputy Assistant Secretary needs to administer all HHS' family planning programs is questionable. However, GAO believes that the position should be strengthened by clarifying the Deputy's responsibilities and authority in order that the incumbent could more effectively coordinate and evaluate all the component agencies' administration of family planning programs. (See p. 52.)

USE OF FUNDS FOR PROGRAM IMPLEMENTATION RESEARCH

HHS has used funds authorized each year under section 1004 of title X for program implementation research for a variety of activities aimed at improving delivery of family planning services. These activities included studies on how to serve various target groups, technical assistance to grantees, preparation of 5-year plans required by title X, data collection, and training. It is unclear whether all uses of the funds were appropriately classified as research. (See p. 53.)

RECOMMENDATION TO THE CONGRESS

The Congress should reassess whether the Deputy Assistant Secretary for Population Affairs needs to directly administer all HHS' family planning programs which provide for or authorize grants or contracts.

RECOMMENDATIONS TO THE SECRETARY OF HHS

GAO is recommending several actions to HHS to improve family planning clinic efficiency and information used for managing the program. Among other actions, HHS should:

--Revise title X program guidelines to provide for (1) fewer routine clinic visits, (2) greater clinic flexibility in matching client education with client needs, and (3) only those laboratory tests that are medically necessary or justified by local conditions. (See p. 26.)

--More closely monitor grantees to identify those (1) routinely providing medical services or requiring more visits than HHS considers necessary or (2) not conforming with HHS' fee collection requirements. (See pp. 27 and 37.)

--Take appropriate steps to resolve the differences in fee policies between titles X and XX. (See p. 37.)

--Refine existing management information systems to provide data and performance efficiency indicators suited to family planning clinic operations. (See p. 45.)

--Strengthen the role of the Deputy Assistant Secretary for Population Affairs by clarifying the position's responsibilities and instructing component agencies to cooperate with the Deputy. (See p. 52.)

--Formally define program implementation research. (See p. 56.)

AGENCY COMMENTS AND GAO EVALUATION

HHS plans to issue new program guidelines incorporating most changes GAO recommended to improve the efficiency of family planning clinics. These new guidelines will provide for fewer routine clinic visits, more flexibility in providing client education, and a reduction in required laboratory tests. (See p. 27.)

HHS generally concurred with GAO's recommendation to monitor clinics to insure that routine medical services above those recommended by current medical standards were justified and that fee collection policies conformed to HHS' regulations. (See pp. 28 and 37.)

HHS believed that the differences between titles X and XX regarding eligibility for free service provided flexibility to the States and that national eligibility criteria would be undesirable. GAO continues to believe a consistent Federal policy is desirable and needed to eliminate conflicting policies at the clinic level. (See p. 37.)

Tear Sheet

HHS disagreed with the need to refine existing management information systems and to formally define program implementation research. GAO believes that the actions recommended are necessary to provide the fundamental data needed to (1) effectively manage the family planning program and (2) allay congressional concerns about HHS' use of funds for program implementation research. (See pp. 46 and 56.)

HHS agreed to examine the role of the Deputy Assistant Secretary for Population Affairs if the administration's block grant proposals are not enacted. (See p. 52.)

HHS said that these block grant proposals, if enacted, would eliminate the need for congressional and further departmental actions on GAO's recommendations. HHS has already initiated action to implement those recommendations it has agreed with, and GAO believes that the actions recommended in this report relative to clinic efficiency may still be needed under block grants depending on their form and the Federal role established by the Congress. In addition, GAO believes that the information in this report will be useful to both State and Federal governments if block grants are enacted.

GAO received written or oral comments from the grantees whose activities are discussed in this report. These comments were generally of a clarifying or technical nature or discussed changes in procedures that occurred after we completed our fieldwork.

Contents

ABBREVIATIONS

ACOG	American College of Obstetricians and Gynecologists
BCHS	Bureau of Community Health Services
GAO	General Accounting Office
HHS	Department of Health and Human Services
NCHS	National Center for Health Statistics

CHAPTER 1

INTRODUCTION

In fiscal year 1980, the Department of Health and Human Services (HHS) spent about $375 million for family planning services and contraceptive supplies through several different programs. The program authorized under title X of the Public Health Service Act (42 U.S.C. 300) is the largest HHS family planning program. Since its enactment in 1970, HHS has provided over $1 billion for project grants for family planning services under title X. In fiscal year 1980, these funds went to about 5,125 clinics serving about 3.8 million people.

How well these clinics are managed can have a significant effect on the efficiency, effectiveness, and costs of federally funded family planning programs. This report focuses on management improvements needed or in process in several areas to reduce costs, improve efficiency, and possibly enhance effectiveness of HHS-funded organized family planning clinics. The issues discussed are of particular interest to representatives of the congressional committees having jurisdiction over the title X program--the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, and the Subcommittee on Aging, Family and Human Services, Senate Committee and Labor and Human Resources. (See pp. 5 and 6.)

EVOLUTION OF FEDERAL ROLE IN FAMILY PLANNING

Before the 1960s, family planning services were generally available only to those who could afford them through private physicians and clinics. Federal policy concerning family planning services emerged gradually during the 1960s, as recognition of the health benefits associated with such services increased and the desire to provide access to those lacking services gained wide acceptance. Federal funds for family planning services for low-income women were provided under the broad authority of title V of the Social Security Act, the Maternal and Child Health program. These services were made available through maternal and child health formula grants and maternal and infant care project grants.

The Economic Opportunity Amendments of 1967 (Public Law 90-222) established family planning services for low-income persons as a special emphasis of the Office of Economic Opportunity. Family planning services funded by this office were later transferred to HHS.

The Social Security Amendments of 1967 (Public Law 90-248) was the first Federal legislation authorizing project grants specifically for family planning. The law stipulated that at least 6 percent of the funds appropriated under the Maternal and Child Health program be available for family planning services. Authorization for separate Federal family planning project grants under the Maternal and Child Health program lapsed in June 1974, but funding for family planning services was merged into the program's formula grants for States. (See pp. 4 and 5.)

THE TITLE X PROGRAM

The Family Planning Services and Population Research Act of 1970 (Public Law 91-572) added title X to the Public Health Service Act and established what is commonly referred to as the title X Family Planning program. Project grants with public and nonprofit private entities for establishing or operating voluntary family planning projects and clinics are the major component of the program. Other program components include grants or contracts to various public and private organizations for training clinic staff, research, and developing and disseminating informational and educational materials on family planning and population. Fiscal year 1980 funding for these components follows:

Program component	Funding (millions)
Family planning services	$155.9
Training	3.0
Research	a/2.5
Information and education	.6
Total	$162.0

a/Includes funds for program implementation research only. Funding for research not directly related to service delivery, such as contraceptive development or safety, reproduction, etc., is authorized by title X but is administered separately by HHS' National Institute of Child Health and Human Development.

Family planning services funded by title X are provided by a variety of organizations, such as State and local health departments, Planned Parenthood affiliates, and community action agencies. Services provided at clinics typically include:

--Physical examinations, including pelvic examinations.

--Laboratory tests, including those for anemia, venereal diseases, and cancer (pap smears).

--Education and counseling concerning reproductive health and all methods of birth control.

--Prescription and distribution of contraceptives.

--Sterilization.

--Pregnancy tests.

--Pregnancy counseling.

--Infertility services.

--Special services for teenagers.

Title X requires grantees to give priority to low-income families and prohibits charges for services to persons from low-income families, except to the extent that payment will be made by a third-party insurer. The law also requires HHS to define low-income families to ensure that economic status will not deter program participation.

Program administration

The 1970 act established within HHS' Public Health Service an Office of Population Affairs to be directed by a Deputy Assistant Secretary for Population Affairs. The act directed HHS to use the Deputy Assistant Secretary position to administer all HHS' programs related to family planning and population research and to coordinate all domestic and international family planning activities administered by the Federal Government. In practice, however, HHS' family planning programs are administered by component agencies, and the Deputy Assistant Secretary for Population Affairs coordinates efforts.

The Office for Family Planning within HHS' Bureau of Community Health Services (BCHS), Health Services Administration, has overall responsibility for the title X program, except for the research activities carried out by the National Institute of Child Health and Human Development. BCHS sets policy, issues guidance, and allocates funds for services to HHS' regional offices, which are responsible for the day-to-day administration of the family planning service program.

HHS' regional offices directly fund some organizations which provide family planning services. However, most of the title X services funds are awarded to intermediate organizations, often called umbrella agencies or coordinating councils, which, in turn, distribute the funds to delegate agencies--projects or clinics. Projects often operate several clinics. The umbrella organizations are responsible for overseeing the activities of and

consolidating information from their delegate agencies. To illustrate, the Indiana Family Health Council, Inc., an umbrella agency, funds 11 delegate organizations in Indiana, which, in turn, operate 50 clinics. In fiscal year 1980, HHS awarded title X funds for family planning services to 218 grantees which funded or operated about 5,125 clinics.

The program has been governed by regulations (42 C.F.R. 59), first published in September 1971 and revised in June 1980. The regulations have been supplemented by more detailed program guidelines. The current guidelines were issued in 1976, but HHS is now revising them. The guidelines set forth minimum requirements and recommended activities HHS expects of clinics participating in the program.

OTHER HHS PROGRAMS FUNDING FAMILY PLANNING SERVICES

Several other HHS programs provide funds for family planning services. Three of these are the Maternal and Child Health, Medicaid, and Social Services programs, authorized under titles V, XIX, and XX of the Social Security Act, respectively. HHS' estimates of fiscal year 1980 Federal funding for family planning services under these programs and title X are:

Program	Estimated expenditures (millions)
Title X	$155.9
Maternal and Child Health	25.0
Medicaid	122.1
Social Services	72.0
Total	$375.0

The Maternal and Child Health, Medicaid, and Social Services programs are administered by the States, with varying degrees of flexibility in defining the program parameters. However, each of these programs has specific provisions relative to family planning. Following is a brief description of the family planning components of these programs.

--Under the Maternal and Child Health program, HHS provides formula grant funds to States. Title V requires that at least 6 percent of the funds appropriated for the program be available for family planning services. Although title V emphasizes services to low-income persons, others are eligible.

--Under the Medicaid program, administered by HHS' Health Care Financing Administration, the Federal Government shares with the States the costs of providing medical care to poor persons. States are required to provide medical assistance benefits, including coverage of family planning services, to all recipients of specified cash assistance programs, such as Aid to Families with Dependent Children. Within limits, States can cover other medically needy persons in their Medicaid programs. State Medicaid agencies reimburse private physicians as well as family planning clinics. HHS reimburses the States for 90 percent of their allowable expenditures for family planning.

--Although title XX requires States to offer family planning services to recipients of Aid to Families with Dependent Children, States do not have to use title XX funds for family planning services. Title XX allows States to provide family planning services to persons regardless of their incomes and will reimburse the States for 90 percent of the costs of these services.

Other Federal programs fund family planning services, such as those for American Indians, migrant and seasonal farmworkers (Migrant Health Centers), and persons living in medically underserved areas (Community Health Centers). These programs generally fund primary or general health care, including family planning services, for their target populations.

OBJECTIVES, SCOPE, AND METHODOLOGY

In August 1980, we met with representatives of the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, and the Subcommittee on Aging, Family and Human Services (formerly the Subcommittee on Child and Human Development), Senate Committee on Labor and Human Resources, to discuss title X program issues of interest to them. The Subcommittees asked that we prepare a report for their use in early 1981 in considering the title X reauthorization and that we direct our efforts to answering the following questions:

--Do HHS requirements related to clinic practices call for inappropriate physicial examinations, inappropriate laboratory tests, or an excessive number of visits for contraceptive supplies? If so, what effect have those requirements had on cost of services, patient satisfaction, and the ability of the clinics to serve in a timely manner the population seeking services?

--How do types of services offered and their costs compare to those generally provided by the private sector?

--What factors can or do contribute to reportedly high clinic "dropout" rates, and are there any clinic practices which appear to make services unattractive to clients, such as delays in getting clinic appointments or long waiting periods for services at the clinic?

--Are clinics effectively implementing HHS' requirements for sliding fee schedules, and is HHS adequately monitoring compliance with its requirements?

--How useful are data collected and reported under BCHS' Bureau Common Reporting Requirements and HHS' National Reporting System for Family Planning Services?

--How has HHS used the $2.5 million appropriated annually to effect improved program management, and what accomplishments have been made?

--Is the Deputy Assistant Secretary for Population Affairs effectively exercising his responsibility to administer laws related to family planning under Public Law 91-572? If not, why not?

--What coordination exists among the title X family planning program and family planning efforts under titles V, XIX, and XX of the Social Security Act?

Because the Subcommittees needed our report promptly, we did not have enough time to fully explore all the above-mentioned questions, and we had to limit the scope and depth of our fieldwork. We are not reporting on differences in costs between the private sector and federally funded clinics because sufficient time was not available to get complete, comparable data. Also, we limited our review of the coordination among federally funded family planning programs to (1) fee collection policies in titles X and XX programs and (2) the activities of the Deputy Assistant Secretary for Population Affairs. Our January 21, 1980, report 1/ detailed coordination problems among several federally funded family planning programs.

In this review, we were able to include 4 HHS regional offices, 9 umbrella grantees, and 24 family planning projects in seven States. These projects operated a total of 193 clinics, and we visited 26 of them. (See app. II for a list of the clinics.) The States represented in our review accounted for 30 percent of the title X grant funds allocated in fiscal year 1980 and 32 percent of the clients served in 1979, the latest year for which data were available.

1/"Better Management and More Resources Needed To Stengthen Federal Efforts To Improve Pregnancy Outcome" (HRD-80-24).

We selected the 26 clinics judgmentally to provide geographic dispersion and a mix of (1) clinic sponsors--health departments, Planned Parenthood affiliates, a community action agency, a hospital, and an organization serving young people--(2) urban and rural locations, and (3) large and small caseloads. We recognize this sample is not statistically representative of all 5,125 family planning clinics, and our findings cannot be projected to all title X clinics.

We considered taking a stratified random sample representing the types of clinics mentioned above. Based on expected occurrence rates for certain attributes and a desired level of precision and confidence, we would have had to include at least 276 clinics in the sample. Because of the limited time and resources for our study, we decided this approach was not feasible.

Appendix I contains a detailed discussion of the audit approaches we used at the clinics we reviewed.

We also interviewed officials from the following offices and organizations:

HHS

--Offices for Family Planning and Maternal and Child Health, BCHS.

--Office of Human Development Services and Health Care Financing Administration.

--Family Planning Statistics Branch, National Center for Health Statistics.

--Family Planning Evaluation Division and Venereal Disease Control Division, Centers for Disease Control.

--National Institute of Child Health and Human Development.

--Office of Population Affairs.

--Regional offices in New York, Atlanta, Chicago, and San Francisco, regions II, IV, V, and IX, respectively.

Umbrella agencies

--New York State Department of Health.

--Genessee Region Family Planning, Inc.

--Georgia Department of Human Resources.

--Indiana Family Health Council, Inc.

--Southeast Michigan Family Planning Project, Inc.

--Michigan Department of Public Health.

--Ohio Department of Health.

--South Carolina Department of Health and Environmental Control.

--Los Angeles Regional Family Planning Council.

Other organizations

--Alan Guttmacher Institute (research arm of the Planned Parenthood Federation).

--American College of Obstetricians and Gynecologists (ACOG)--a professional organization which issues standards and guidelines on obstetric and gynecologic practice. (We relied heavily on these standards in evaluating routine clinic services.)

--Cincinnati Academy of Medicine and the Cincinnati Obstetrical/Gynecological Society.

--Rocky Mountain Planned Parenthood, which operates clinics without title X funds.

Most of our effort was aimed at evaluating family planning clinic medical service and fee collection policies and practices. Our work at these clinics included (1) interviewing staff, (2) reviewing written policies and procedures, and (3) reviewing judgmental or statistical samples of medical records at several clinics. In addition, at several clinics we obtained information by questionnaire from clients and had clinic staff keep track of the length of visits by new clients. Also, we obtained information by questionnaire from obstetricians and gynecologists in private practice in the Cincinnati, Ohio, area. (See app. I for additional details on this work.)

In a February 6, 1981, letter, the Chairman, Subcommittee on Health and the Environment, House Committee on Energy and Commerce, requested that we expedite our efforts and report our findings as soon as possible.

CHAPTER 2

FAMILY PLANNING CLINICS CAN PROVIDE QUALITY CARE MORE EFFICIENTLY

Family planning clinics we visited were generally providing medical services to clients as required by HHS' program guidelines. Such guidelines, however, recommend more frequent routine clinic visits than required by ACOG's standards, and they recommend extensive educational efforts for all clients without regard to individual circumstances. In addition, many clinics receiving title X funds were routinely doing some medical examinations and laboratory tests which were not recommended by HHS' guidelines and appeared unnecessary. These policies and practices unnecessarily burden clients with extra examinations and tests, add to program costs, contribute to long waits for appointments and long office visits, and may unwittingly discourage clients from initially seeking or continuing to seek clinic care.

BCHS officials have been aware of at least some of these problems and have been drafting changes to program guidelines. We met with these officials on several occasions during our review to brief them on our findings and discuss changes to the guidelines we believe would help alleviate the problems we were identifying. BCHS officials were generally very receptive and made several modifications to their draft revised guidelines as a result of our discussions.

MANY RETURN VISITS TO CLINICS DO NOT APPEAR TO BE MEDICALLY NECESSARY

Many women were making routine revisits to federally funded family planning clinics which appear unnecessary. HHS' program guidelines recommend more routine visits--to obtain oral contraceptives 1/ and limited medical services--than appear necessary based on ACOG recommendations. These visits add to title X program costs, as well as to the costs of other such federally funded programs as title XX and Medicaid. They also add to the costs of care for those clients who pay for services.

Because HHS does not distinguish routine supply visits from other visits made to title X clinics, and because of limitations on the time and resources available for our review, we could not determine the costs associated with these visits. However, using several assumptions, we estimate that over 1 million women could

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1/Women using oral contraceptives comprise about two-thirds of all women served by title X clinics.

be making at least one unnecessary visit to a title X clinic each year at an annual cost of over $6 million. (See p. 12.)

HHS' guidelines recommend too many routine visits

HHS' family planning program guidelines recommend that oral contraceptive clinic clients make two more clinic visits during the first year and another visit during subsequent years than required by ACOG's standards. Also, officials at nearly half of the clinics we visited believed that HHS' guidelines called for too many revisits.

Both HHS' guidelines and ACOG's standards require initial and annual visits, during which physical examinations, laboratory tests, and other services are performed and oral contraceptives are provided or prescribed. However, HHS' guidelines recommend two additional visits during the first year and one during subsequent years as shown below.

Comparison of Recommended Revisit Policies and Standards

HHS guidelines	Months elapsed from initial visit	ACOG standards
1st year:		
Initial examination	-	Initial examination
Limited examination	3	None
Limited examination	9	None
2nd year:		
Annual reexamination	12	Annual reexamination
Limited examination	18	None
3rd year:		
Annual reexamination	24	Annual reexamination

On routine revisits (limited examinations), HHS' guidelines require an update of the client's medical history, an examination of the client's weight and blood pressure, and an interview with the client to discuss possible problems and changes in contraceptive methods. Clients also receive a resupply of oral contraceptives at these visits.

In discussing the differences in frequency of visits between HHS' guidelines and ACOG's standards, ACOG's executive director and director of practice activities told us that, in their opinion, it is advisable to have clients using oral contraceptives for the first time to make one routine revisit during their first year to check for complications. However, they did not believe that two routine revisits during the client's first year, as called for by HHS' guidelines, were necessary for persons who are not expected to experience complications.

A limited survey of obstetricians and gynecologists practicing in Cincinnati, Ohio, disclosed that about two-thirds recommended two visits (initial and revisit) in the first year of oral contraceptive use as recommended by ACOG officials. Only one of the physicians responding said that he routinely saw his oral contraceptive patients a total of three times during their first year as recommended by HHS' guidelines. The table below summarizes the frequency of scheduled office visits reported by the 45 respondents:

Total number of visits	Percent of physicians	
	First year	Second year
1	33	49
2	65	51
3	2	0

In commenting on the responses for the second year, ACOG's director of practice activities said that while a number of obstetricians and gynecologists believe it is desirable to see oral contraceptive clients routinely every 6 months, ACOG does not believe this frequency is necessary. He said that annual revisits for continuing patients, as required in ACOG's standards, is an appropriate standard for routine revisits for women who are not high risk or are not experiencing complications or problems.

Many clinic officials believe HHS' revisit policy should be relaxed

Although most of the clinics we visited were generally following HHS' guidelines for revisits by oral contraceptive clients, officials at many of these clinics believed that the requirements were excessive.

Officials at 12 clinics said that the current HHS policy could be relaxed and that some revisits could be eliminated. They felt one of the first-year visits could be eliminated or that clients could be seen once a year without compromising the quality of care. For example, the medical director at Planned Parenthood World Population in Los Angeles said one of the routine revisits during the first year could be eliminated. The acting clinical director at Grady Memorial Hospital in Atlanta said that he would

prefer to use an annual revisit schedule for experienced oral contraceptive patients. The medical director of the Midlands Health District in South Carolina said that he would like to use annual revisits after the first year. Clinic officials at the Planned Parenthood affiliates in Muncie, Indiana, and Grand Rapids, Michigan, suggested revisit practices identical to those recommended by ACOG's standards.

In each instance, these officials believed that they had no authority to deviate from HHS' guidelines, although they felt some of the revisits were not necessary.

Some clinics required more revisits than HHS recommended

Four of the 26 clinics visited required more frequent revisits than recommended by HHS:

--One required oral contraceptors to return every other month for continuing supplies.

--Two required clients to return every 3 months.

--One, serving primarily teenagers, required monthly visits during the first 3 to 6 months for oral contraceptive clients.

The reasons for these revisit policies varied. According to officials at one clinic, more frequent supply visits were needed because clients would lose their pills if they were given too many at one time. Two clinics serving teenagers believed that teenagers needed more frequent revisits than others for counseling purposes. One clinic had merely misinterpreted HHS' guidelines. Officials at that clinic said that they would reduce the number of routine visits required.

Precise estimate of revisit costs not possible, but total amount is probably substantial

Lack of national or tabulated clinic data on the number of routine clinic revisits versus those for specific medical reasons, along with the limited time and resources available for our fieldwork, precluded us from making a precise estimate of the number or costs of revisits in excess of ACOG's recommendations. However, available data suggest that the number and costs of these visits are substantial. As an approximate measure, we estimate that in 1979, clients of title X-funded clinics may have made about 1.1 million unnecessary supply visits at a cost of about $6 million to $13 million. We developed this estimate as follows:

--Data indicate that in 1979, title X clinics served 3.6 million persons nationally, of which about 2.3 million were taking oral contraceptives and could potentially make at least one unnecessary revisit, either as a first-year or continuing patient.

--Because we were unaware of any information nationally on the number of new or continuing oral contraceptive patients who remain in the program (do not drop out), we assumed that 50 percent of the new and continuing patients stayed in the program long enough in 1979 to have made one unnecessary revisit. 1/ Thus, 1.15 million (one-half of 2.3 million) women made one revisit that may not have been necessary if clinics had used ACOG's recommendations.

--To estimate the costs of unnecessary revisits, we used the fees that several of the clinics we visited would charge full-paying clients for routine supply visits. The fees ranged from $6 to $12. Therefore, the annual cost of the 1.15 million additional revisits could range from $6.9 million to $13.8 million.

Our estimate of the costs associated with unnecessary revisits could be overstated or understated depending on the variability nationally of such factors as the number and timing of client dropout, the types of revisits, and the actual costs of revisits. We discussed our assumptions and methodology for estimating the number and cost of unnecessary visits with Office for Family Planning officials. They believed the estimates and underlying assumptions are reasonable in view of the lack of national data needed to compute the actual costs.

In addition to direct costs of clinic operations, unnecessary visits to clinics increase the inconvenience and costs to the clients. Some clients must take time from work or other activities to travel to and from the clinic and to be served. As another consequence, limited clinic resources are not put to their best use. The clinics could serve others in need of services if efforts were not devoted to scheduling, serving, and keeping records on clients coming for unnecessary visits.

1/The 50-percent estimate is derived from data we obtained on the actual number of routine revisits made in excess of ACOG's recommendations at six of the seven clinics where we made statistical samples of new 1978 clients.

Current HHS' efforts to revise guidelines

In October 1979, HHS awarded a grant to ACOG to help it revise family planning program guidelines. We met with ACOG and BCHS representatives during our review to discuss our findings and the revisions being considered. The most recent draft of the revised guidelines we reviewed--dated January 1981--provided for only one routine revisit during the first year, except for high-risk clients, and annual revisits in subsequent years, again except for high-risk clients.

According to HHS' Office for Family Planning, the current guidelines were established in 1976 and required more frequent routine revisits than required in ACOG's standards because a consensus of health professionals from several organizations, including ACOG, believed title X clients were largely low income, lacked a continuing source of health care, and needed more frequent visits than other clients. In explaining HHS' efforts to revise the guidelines, a BCHS official told us that HHS and its consultants no longer believe this rationale is valid, and HHS' draft guidelines provided for revisit practices similar to those recommended by ACOG officials.

EDUCATIONAL SESSIONS SHOULD BE TAILORED TO THE NEEDS OF THE CLIENTS

HHS' guidelines have been interpreted by many clinics as a requirement to provide extensive education to clients regardless of individual circumstances. At many clinics, clients are required to sit through long education sessions although it is uncertain whether the extensive education is needed or used by clients when choosing contraceptive methods. If HHS revised its guidelines to recommend that clinics tailor client education to individual circumstances and helped clinics streamline how they provide education, it could help (1) reduce the time clients spend at clinics, (2) improve the usefulness of the education, and (3) increase the time available at the clinics for seeing additional patients.

HHS' guidelines recommend education and training for all new clients to help them make an "informed" decision to use family planning services and choose appropriate contraceptive methods. HHS' guidelines recommend that all new clients be given information regarding:

--Reasons why family planning is important.

--Basic information on female and male reproductive anatomy.

--Contraceptive methods, including diaphragm, foam and jelly, condoms, coitus interruptus (withdrawal), natural family planning methods, intrauterine devices, and hormonal contraceptives--the "pill."

--Male and female sterilization.

--Specific factors concerning the method's safety, effectiveness, acceptability, and correct usage.

Need for elaborate education process questionable

A number of clinic officials believed that HHS' education requirements are excessive because many clients do not need instruction on all the subjects required by HHS' guidelines. For example, in commenting on a draft revision of HHS' guidelines, the director of a large grantee in New York State said:

> "One of the concerns patients frequently raise is that they come to our clinics with a method already chosen, but they have to listen to an exposition on other methods that they are, at best, indifferent to. We believe that if a patient has selected a method, and there are no counter indications, we should concentrate our educational efforts to that method. The relevant information will not therefore be buried among other 'noise,' and the patient will better retain it."

Although new clients responding to our questionnaire (277) had few complaints about the educational sessions, 119 clients (44 percent) said that they needed half or less of the instruction provided.

Officials at many of the clinics visited told us that few clients choose a contraceptive method based on the information provided. They said that nearly all come to the clinic knowing the method they want and almost all leave with that method. Our questionnaire confirmed this view. Of the 258 respondents who expressed a preference for a contraceptive method when they came to the clinic, only 9 (or 3 percent) said they changed methods on the basis of the education received.

How education is presented makes a difference

Differences in the way clinics educate clients affect clinic efficiency and the usefulness of the education itself. Sixteen of the clinics visited held group education sessions for all new clients and 10 used individual sessions. In some clinics, teenagers were required to attend lengthy "rap" sessions before

proceeding with the regular visit. Generally, clinics using group sessions had interpreted recommendations in HHS' guidelines as a requirement for all new clients, and they felt compelled to cover all topics regardless of the client's background or circumstances. Some clinics using individual sessions relied on handout material to cover part of the recommended topics and focused counseling on the needs of the individual.

We could not determine with certainty whether group sessions enabled clinics to provide services at a lower cost. In some instances, however, the use of group sessions for new clients (1) created bottlenecks in clinic operations because clients had to wait until the session began and could not receive other services until the session was completed and (2) usually increased the time clients had to spend at the clinic for education and for the entire initial visit, as shown below.

	Average time for education	Average time for initial visits
Clinics with group education (16 clinics)	53 minutes	2 hours 52 minutes
Clinics with individual education (10 clinics)	24 minutes	1 hour 57 minutes

According to an earlier evaluation (see p. 25) of teenager services made for HHS, group education sessions were often mandatory for all new patients, conducted as lectures, and entailed little, if any, group discussion. The report concluded:

> "While information about birth control methods presented by most clinics was very detailed, with a heavy emphasis on oral contraceptives, it was not organized in such a way as to help the teenagers make a decision, or even to communicate to the teenager that such a decision was her responsibility to make. Most presentations were didactic descriptions of what each method is, and how it works. Information on advantages and disadvantages of each method as they relate to one's particular situation * * * was rarely included. As a result, teenagers tended to be bored and impatient."

We discussed clinics' interpretations of HHS' guidelines on education with Office for Family Planning officials. They said that the discussion of client education in the current guidelines was not intended to result in clinics providing education to clients regardless of need. Consequently, they clarified their draft revised guidelines to provide more flexibility to clinics in tailoring education to suit specific needs.

ROUTINE ANEMIA SCREENING QUESTIONABLE

HHS could reduce costs by relaxing or eliminating its requirement and recommendation for routine anemia screening. HHS' guidelines require clinics to do anemia tests on all clients during initial and annual visits. Although the clinics visited were generally performing anemia tests on their clients, as required in HHS' guidelines, several clinic officials believe that the requirement should be eliminated or relaxed.

Anemia screening entails taking a blood sample and testing it for iron deficiency. The tests are commonly called hematocrits or hemoglobins. ACOG's standards for basic gynecologic care call for routine anemia testing. However, the standard is prefaced by the statement that the obstetrician or gynecologist is often the sole physician relied on by women. The portion of ACOG's standards specifically discussing family planning services state that anemia tests should be done only when appropriate. ACOG's director of practice activities told us that he does not believe anemia tests need to be performed routinely on all family planning clients. The results of our survey of Cincinnati gynecologists support this view. Only 8 of 45 respondents said they routinely performed anemia tests on oral contraceptive clients during initial visits and only one said he routinely did such tests during annual visits.

This view was also supported by officials of several title X grantees we visited. For example, the directors of New York State's Bureau of Family Planning and the Cincinnati Health Department's Maternal and Infant Care Program believe that HHS should eliminate the requirement for routine anemia tests and allow them to be done as needed. Officials at Grady Memorial Hospital believe the test should be done every other year. Fayette County, Ohio, Health Department officials suggested that it be done only at the initial visit.

Only 4 of the 26 clinics visited had summary data on the results of anemia testing for recent periods. At three of the clinics, less than 1.5 percent of the clients had test results the clinics considered to be indicative of anemia. At the fourth clinic, which served teenagers, about 12.5 percent of the clients had such test results. However, the clinics did not always use the same standards for defining anemia. For example, the latter clinic considered hematocrit levels below 35 to be indicative of anemia, while another one used a hematocrit level of 33 or below.

The full charges for these tests at the clinics we visited in Ohio, for example, ranged from $1 to $5. Title XX reimbursement for these tests at several of the clinics ranged from $1 to $4. HHS' data indicate that family planning clinics did about 3 million anemia tests in 1978.

HHS' January 1981 draft revision of its family planning guidelines generally would have required anemia tests for all female contraceptive clients during initial visits and recommended such tests annually for all female contraceptive clients. The draft guidelines would have required anemia tests annually for medical reasons for all clients using intrauterine devices. We found that many clinic officials interpret HHS' recommendations as mandates to perform services routinely and believe that they are expected to adhere to HHS' recommendations. Therefore, HHS' recommendations often have the same effect as requirements even though BCHS officials said this was not intended. (See p. 27.)

MANY CLINICS ARE PERFORMING ROUTINE TESTS AND EXAMINATIONS NOT REQUIRED BY HHS

Many family planning clinics funded in part by title X grants and receiving reimbursement from the Medicaid and title XX programs were doing some routine medical examinations and laboratory tests that were not recommended or required by HHS' guidelines. Where data were available, the examination or test results often did not appear to justify their routine performance. Information was not available nationally for us to estimate the costs associated with these procedures.

Clinics were doing these examinations and tests for a variety of reasons. These included (1) State health department requirements that the tests be done, (2) incorrect beliefs by officials that HHS, State, or local health departments required or expected the tests to be done routinely, or (3) beliefs by clinic officials that the procedures were appropriate because of the nature of their client population.

Routine venereal disease tests appear unjustified and are costly

Neither HHS' guidelines nor ACOG's standards recommend routine laboratory tests for syphilis or gonorrhea. However, of the 26 clinics we visited, 14 were routinely testing all clients on initial and annual visits for syphilis and 24 were doing such tests for gonorrhea. In many instances, the results of these tests did not appear to justify routine testing.

Officials at HHS' Centers for Disease Control (hereafter called Centers) told us that the decision to routinely screen for venereal diseases at family planning clinics should be made on a local basis in consultation with State and local health departments based on positive test results and the characteristics of the population. In addition, they said that, given limited resources, they generally did not consider routine gonorrhea testing to be cost effective if it produces less than 2 percent positive results. Centers' officials could not provide a similar guide for

Of 14 clinics giving routine syphilis tests, 8 provided summary information of test results during 1979. At these clinics, the rates of positive test results ranged from 0 to 0.8 percent of those tested, as shown below:

Clinic	Tests made	Positive tests	Percent positive
Central Midlands Health District (S.C.)	7,856	0	0
Lower Savannah II Health District (S.C.)	3,821	6	.2
Detroit Department of Health (Grace Ross Clinic)	1,151	5	.4
The Door - New York City	3,807	29	.8
Macomb County Health Department (Mich.)	1,855	0	0
Kent County Planned Parenthood (Mich.)	1,074	1	.1
Oakland County Health Department (Mich.)	(a)	0	0
Ionia County Health Department (Mich.)	(a)	0	0

a/Data on total number of tests done were not readily available.

The family planning coordinator at the Central Midlands Health District said that they had not detected a syphilis case in the past 5 years, although every client was tested. The director of the East Central Indiana clinic stated that all clients had been routinely tested for syphilis up to early 1980, but the clinic stopped testing routinely after detecting only one potential case in the last 3 years. She added that the case would have been detected in the routine medical history screen.

The Michigan Department of Public Health requires family planning clinics it funds to do syphilis tests only on clients with a high risk of having the disease. However, the director of the Oakland County clinic told us that the clinic routinely tested all clients because she believed the test was a State requirement. Ionia's clinic coordinator said she believed HHS required routine syphilis testing for all patients. Kent County Planned Parenthood officials said they knew the State did not currently require routine syphilis testing and after reviewing test results, discontinued routine testing.

Of the 24 clinics routinely testing for gonorrhea, 17 had summary data on test results. At those clinics, positive test results ranged from 0.3 to 4 percent. At seven clinics, the positive test result rate was below the 2-percent threshold of cost effectiveness recommended by the Centers, as shown on the next page.

Gonorrhea Detection Results

Gonorrhea positive test results rates	Number of clinics
(percent)	
0 to 0.9	2
1.0 to 1.9	5
2.0 to 2.9	8
3.0 to 3.9	1
4.0 to 4.9	1
Total	17

At 10 of the 24 clinics making routine gonorrhea tests, officials said they did them because they thought HHS' guidelines required them. Since 1976, HHS' guidelines have not recommended routine venereal disease tests, except when circumstances indicate the need. The other 14 clinics made routine tests because of local or State requirements.

Cost of routine screening appears substantial

Although the clinic effort required to test any one client is not substantial, the total costs of routine venereal disease screening in cases where it is not justified may be substantial. The syphilis test involves drawing blood from clients and sending it to a laboratory for analysis, as well as completing and filing related paperwork. The gonorrhea test is done by taking a specimen culture during the pelvic examination, and it involves the same type of related efforts as the syphilis test.

Data are not available to estimate the number and cost of questionable routine venereal disease tests done by family planning clinics nationally. According to the Centers, costs of laboratory tests (exclusive of costs for collecting and transporting the samples or specimens) for syphilis range from $0.95 to $1.90 and range from $1 to $1.50 for gonorrhea. Clinics we visited charged clients up to $6 for each syphilis test and maximum charges for the gonorrhea test ranged from $3 to $12. (HHS expects the maximum charge to represent the reasonable cost of the service.) At one Ohio clinic, Medicaid paid $1.50 for collecting the gonorrhea culture, and at an Indiana clinic, the Social Services program paid $3 for a gonorrhea or syphilis test.

California attempts to discourage routine testing

We believe that HHS should follow the lead of the California Department of Health which attempts to discourage routine gonorrhea testing at family planning clinics it funds by restricting reimbursement to those cases where such screening is justified. The State's policy provides:

> "Routine screening for gonorrhea will not be reimbursed. The agency must establish in its medical policy specific indications for gonorrhea testing. When these indications exist, the cost of the test will be reimbursed by the Department. Allowance for routine screening may be granted if the agency can document a high rate of gonorrhea among its target population."

The Whittier, California, Health Department clinic was one of two clinics visited that did not routinely test for gonorrhea. This clinic used various risk factors to select high-risk clients for gonorrhea testing and in 1979 only about one-fourth of their clients were tested. About 1,500 clients had initial or annual examinations without being tested, resulting in a savings of about $6,000.

BCHS' position on routine gonorrhea testing

The January 1981 draft revision to HHS' guidelines did not require routine syphilis testing, but required routine gonorrhea testing during initial visits for all clients, with a provision that this requirement could be waived for clients over 30 years of age. We discussed our findings with BCHS representatives and suggested that they not require gonorrhea testing for all clients during initial visits. BCHS officials subsequently decided to require routine gonorrhea testing only for clients requesting intrauterine devices.

Need for routine 6-month examination questionable

Planned Parenthood of New York City, which operates four clinics, and the International Center for Integrative Studies (called "The Door" and located in New York City) routinely required clients using oral contraceptives to undergo physical examinations, including pelvic examinations, every 6 months. The routine semiannual examinations were not being done at other clinics we visited and are not recommended or required by the national standards of Planned Parenthood Federation, HHS' guidelines, or ACOG.

HHS' guidelines state that pelvic examinations on return visits for supplies should be done only when indicated by the clients' health status or history. Neither The Door nor Planned Parenthood of New York City could provide us with definitive data to support their positions.

New York City Planned Parenthood officials believed their practice was medically justified and that the HHS' guideline was not appropriate in view of the potential side effects of oral contraceptives. The risks associated with using oral contraceptives are not clear; however, our medical advisor questioned the need for routine medical examinations, including pelvic examinations, every 6 months. An ACOG technical bulletin lists the following side effects and possible major complications associated with oral contraceptives:

Side effects

--Nausea and vomiting.

--Breakthrough bleeding.

--Psychic depression.

--Weight change.

--Alteration in menstrual flow and amenorrhea (absence or suppression of menstruation).

--Breast change.

Major complications

--Thrombotic disorders (related to blood clot obstructing a blood vessel).

--Hypertension.

--Postpill amenorrhea.

--Gallbladder disease.

--Hepatoma (a tumor of the liver).

--Use in pregnancy (some risk of congenital anomalies).

According to both our medical advisor and an ACOG official, none of these conditions would occur frequently enough to warrant routine reexamination every 6 months, and none of the conditions would be detected by a pelvic examination.

In 1979, Planned Parenthood of New York City performed about 7,450 semiannual pelvic examinations; the charge to clients was from $11 to $17. Medicaid was also billed for these examinations.

Officials at The Door said they made semiannual pelvic examinations primarily to screen for vaginitis and sexually transmitted diseases. They believed that the teenagers they served had a high risk of gonorrhea. We could not determine the reasonableness of that practice since the available data on positive test results did not distinguish between persons screened annually and at 6-month intervals. The results of all gonorrhea testing in 1979 at The Door showed a positive test result rate of 2.5 percent. After we completed our fieldwork, The Door provided additional data it believed supported the need for its semiannual pelvic examinations. However, in our opinion, these data were inconclusive, and HHS needs to evaluate the extent to which it should fund these routine examinations.

WAITING TIME FOR APPOINTMENTS AND LONG VISITS MAY BE BARRIERS TO SERVICE AND LEAD TO CLIENT DROPOUT

Acting on the assumption that clients of title X funded clinics are entitled to and want quick, efficient service and failure to receive such service affects the client's desire to enter or continue in the program, we evaluated clinic appointment practices and client handling procedures during initial clinic visits. Although we identified high dropout rates at several clinics, the evidence did not prove they were caused by unfavorable clinic practices.

High client dropout rates do not necessarily mean that clinics are inefficient or are doing something wrong. Neither we nor HHS' Office for Family Planning officials were aware of any criteria defining at what point dropout rates became excessive. In addition, determining the reasons clients drop out is very difficult because of confidentiality considerations and problems in locating dropouts and obtaining definitive information. Nonetheless, we believe that clinic inefficiencies and long waits for service can contribute to client dropout and deter some women from enrolling in the program.

Clients frequently drop out

Our statistical samples of new clients making initial visits in 1978 to seven clinics in Ohio, Georgia, New York, Michigan, and California showed that 25 to 48 percent did not return, as shown in the following table.

Retention of Clients at Selected Clinics

	Cumulative percents		
	Made only one visit	Stayed less than 6 months	Stayed less than 1 year
Planned Parenthood of Miami Valley (Dayton, Ohio)	30	49	61
Fayette County Health Department (Ohio)	27	41	53
Pike County Community Action Commission (Ohio)	25	32	45
Coweta County Health Department (Ga.)	31	51	63
Planned Parenthood of New York City (Boro Hall Clinic)	37	69	80
Whittier Health Center of Los Angeles County Health Department	30	48	59
Grace Ross Clinic of Detroit Health Department	48	63	72

Frequent client dropout was also reported in a study by the Los Angeles Regional Family Planning Council. The agency studied the dropout problem at six clinics in Los Angeles by tracking clients who entered the clinics between 1973-75 and found that nearly half the clients made only one visit and never returned. By the end of 1 year, three-fourths of the clients had left the clinics' care.

Long waiting times for appointments can deter participation

At the 26 clinics included in our study, waiting times for initial visits ranged from no wait to 8 weeks. Waiting times were in excess of 2 weeks at seven of the clinics. Clinics with long waits often had high "no-show" rates, which created additional administrative work that led to inefficient use of medical staff.

To illustrate, the Miami Valley Planned Parenthood clinic in Dayton had a waiting period for initial visits of 4 to 6 weeks, and up to 50 percent of the women with appointments did not show

up for those appointments. 1/ The clinic was not "over booking" to compensate for the individuals who would probably not show up, and clinic sessions were being run at less than full capacity. In South Carolina, clients waited 4 to 8 weeks at clinics we visited and 25 to 50 percent of the potential clients did not show up as scheduled. Clinic officials in Ohio and South Carolina believed that women not showing up for appointments often became tired of waiting and either went without family planning services or obtained services elsewhere.

Some clinics appear to be overcoming the no-show problem by scheduling appointments promptly. For example, Planned Parenthood of New York City's Boro Hall clinic generally scheduled its clients for visits within 1 or 2 days of the request, and officials there reported few problems with clients not showing up. As another example, the Rocky Mountain Planned Parenthood Association, which provided services in larger metropolitan areas in four States, generally keeps appointment waits to less than 2 days. The Association's director said almost all of its clients showed up for appointments.

Lengthy clinic visits may discourage some clients from continuing in the program

Initial visits averaged 2 hours or longer at 17 of the 26 clinics we visited. At eight clinics these visits averaged more than 3 hours, with some clients spending 4 or 5 hours to complete their visits.

In some cases, clients making return visits also remained at clinics for lengthy periods. For example, at Planned Parenthood of Sherman Oaks, California, the length of annual client visits ranged from 1 hour 50 minutes to 4 hours 30 minutes and averaged 2 hours 44 minutes. Lengths of supply visits ranged from 10 minutes to 2 hours 25 minutes, with an average time of 43 minutes.

Several grantee officials believed and two HHS contractor studies 2/ indicated that clients' experiences at clinics, such

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1/Subsequent to completion of our fieldwork, the clinic's executive director told us that client waiting periods for appointments had been reduced to 1 to 2 days by extending clinic hours and adding part-time staff.

2/Urban and Rural Systems Associates, Improving Family Planning Services for Teenagers--DHEW Publication (HSA) 78-5628.

JWK International Corporation, Patterns of Utilization of Contraceptive Services for Teenagers--Final Report.

as long waiting times for service or extensive education sessions, contributed to client dropout. For example, officials at the Los Angeles Regional Family Planning Council indicated that lengthy clinic visits caused some clients to drop out. Officials at Planned Parenthood of Kent County, Michigan, had a similar opinion, and believed that excessive education requirements were also a factor.

New clients' responses to our questionnaire during their initial visits did not help clarify why clients do not return to the clinics. About 50 percent of the 277 clients responding to our questionnaire indicated that their visits took longer than a family planning visit to a private physician's office. However, 254 clients (or about 92 percent) said that they intended to return to the clinic. Very few complained or made unfavorable comments about their visit.

CONCLUSIONS

Family planning clinics can provide services to clients more efficiently and at less cost without compromising quality care by (1) eliminating unnecessary services, (2) reducing the number of routine clinic visits, (3) having clinics tailor education to client circumstances, and (4) streamlining client-handling procedures. Whether such improvements will help alleviate the dropout problem is uncertain, but we believe they could.

HHS' family planning guidelines have not been sufficiently clear in distinguishing between requirements and recommendations. We believe HHS' draft revised guidelines, if adopted, should help resolve much of the ambiguity in the guidelines. HHS needs to monitor closely how well clinics implement the guidelines and ensure that clinics desiring to do more than the guidelines require or recommend have appropriate justification.

RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that the Secretary direct BCHS to revise its family planning guidelines to:

--Establish routine revisit policies in line with ACOG's standards and recommendations.

--Eliminate the proposed provision for routine gonorrhea screening and the existing requirement and recommendation for anemia screening and provide that clinics screen based on medical necessity or local conditions. Clinics desiring to screen all clients routinely should be required to justify the need to HHS.

--Clarify clinics' options to tailor education requirements to client status and circumstances.

Also, we recommend that the Secretary:

--Direct BCHS to work with the Centers to prepare guidance on venereal disease screening appropriate for family planning projects. Such guidance should enable projects to decide, in consultation with State and local health authorities, whether to routinely test all clients or to apply criteria for selective testing.

--More closely monitor clinic practices to identify routine visits or medical services that are in excess of those required or recommended and deny Federal financial participation under the title X, Medicaid, Social Services, and other programs for those activities unless they are appropriately justified.

AGENCY COMMENTS AND OUR EVALUATION

In an April 27, 1981, letter, the Acting Inspector General provided comments on a draft of this report on behalf of HHS. HHS stated that new title X program guidelines, planned to be issued in June 1981, will:

--Change medical revisit policies to agree with those recommended by ACOG.

--Make gonorrhea screening a local grantee decision based on medical needs of the population served, except for clients requesting intrauterine devices who must be tested.

--Require routine anemia screening only during initial medical examinations, require annual anemia screening only for intrauterine device users, and provide for a waiver of the requirement for anemia screening during initial examinations if the project's medical director determines that routine screening is not warranted in the client population served.

--Provide flexibility to tailor educational programs to clients based on their age, situation, and knowledge.

HHS' guidelines also eliminate the current requirement for routine urinalysis.

HHS said that BCHS and the Centers were jointly developing guidance for deciding when to screen for gonorrhea. According to HHS, these proposed guidelines for venereal disease screening have been circulated for comment and are expected to be issued in July 1981.

While HHS concurred with our recommendation to closely monitor clinic practices, the actions proposed only partly covered our concern. We did not intend to suggest, as interpreted by HHS, that it review routine client visits and any excess medical services provided by the clinics on a day-to-day basis. Our recommendation was aimed at monitoring medical protocols required in the grant applications to insure only necessary tests and examinations are performed on a routine basis. Since HHS requires grantees to furnish service plans, we believe an evaluation of the need for service over and above those recommended in HHS' guidelines or current medical standards could be closely monitored without an expensive monitoring staff. This step, coupled with the HHS proposal to monitor clinics which generate high costs, could effectively deter unnecessary medical practices at title X-funded clinics.

In an April 28, 1981, letter, HHS informed its regional offices of the forthcoming changes relative to mandatory medical services in its family planning guidelines and permitted regional offices to implement the reductions in required services immediately. HHS also stressed to grantees the importance of balancing minimum Federal requirements and excess costs relative to elective screening of asymptomatic clients.

In commenting on all our recommendations, HHS said that enactment of administration block grant proposals would eliminate the need for further congressional and departmental actions on our recommendations. However, we believe that the need for HHS action on our recommendations may continue under block grants depending on their form and the Federal role established by the Congress. In addition, we believe that the information and recommendations in this chapter and chapter 3 will also be useful to both State and Federal governments in operating efficient programs if block grants are enacted.

In commenting on excerpts from a draft of this report, officials of The Door and Planned Parenthood of New York City maintained that the 6-month medical examinations were medically justified and furnished additional information to support their positions. This information, however, was inconclusive. As we have recommended, we believe HHS should evaluate the medical practices in excess of those required to determine the extent to which it should contribute to their costs.

CHAPTER 3

CLINICS COULD RAISE MORE MONEY FROM CLIENT FEES, BUT CONSISTENT POLICIES ARE NEEDED

Some family planning projects have successfully used sliding fee scales to charge clients who had ability to pay, but many projects have made little or no effort to generate fee income. Although HHS requires projects to have sliding fee scales so that only the needy receive free or subsidized services, the fee policies at clinics we visited varied considerably. Some charged no one, while others charged even low-income clients who should, according to title X, have received free service.

These inconsistencies stemmed in part from:

--Obsolete regulations defining low-income families.

--Lack of workable guidance in applying a family income test to teenagers seeking services without parental knowledge.

--HHS regional officials not uniformly enforcing fee scale requirements.

--Some States adopting title XX policies which conflicted with title X regulations.

--Perceptions by clients and clinic officials that services were free.

With the confusion over the fee policy, some clinics have lost revenues they might have collected, and clients have not been treated equitably according to their incomes. Administrative and possibly legislative actions are needed to achieve more uniformity in fee policies and an effective use of sliding fee scales.

TITLE X PROJECTS ARE TO SERVE LOW-INCOME CLIENTS AT NO CHARGE AND OTHERS BASED ON ABILITY TO PAY

Since enactment, title X has provided that persons from low-income families would not be charged for services and directed HHS to define "low-income family" for purposes of the act (Public Law 91-572). In 1975, the Congress amended title X (Public Law 94-63) and added a provision that "low-income family" shall be defined "so as to insure that economic status shall not be a deterrent to participation in the programs assisted under this title."

HHS issued regulations in September 1971 which defined low-income in terms of specific dollar amounts and family size, such as $5,000 annual income for a family of four. These regulations

permitted projects to charge clients above the low-income level, but required HHS approval of the fee schedule. The definition of a low-income family was not officially changed until HHS amended the title X regulations June 3, 1980 (45 F.R. 37433), defining it as one "whose total annual income does not exceed 100 percent of the most recent Community Services Administration Income Poverty Guidelines." This rule also permitted projects to consider such family members as unemancipated minors according to their individual resources, especially if they were seeking confidential service.

HHS had issued regulations in 1974 which required many grantees, including family planning clinics, to charge clients according to their ability to pay. The June 1980 regulations specified that the reasonable cost of services should be charged to families above 250 percent of the poverty guidelines, and discounts be granted to those between 100 and 250 percent of the poverty level. The Department's comments accompanying the regulations emphasized, however, that projects should not allow fees to become a barrier to service.

CLINIC FEE PRACTICES VARY WIDELY

Family planning clinics vary widely in their policies and practices for collecting client fees. For example, among the 26 clinics reviewed, 4 were providing free service to all clients, 5 charged all clients for supplies, 3 had standard charges for students without regard to income, and at least 4 were making only modest efforts to use their fee scales. One grantee was charging and collecting fees from all except Medicaid clients, including low-income women entitled to free service under program regulations and in some instances, was making fee payment a condition of service.

The following are examples of various situations found at the clinics we visited:

--New York City Planned Parenthood charged all clients for service except those with Medicaid cards. Clients with net incomes over $6,500 per year were charged $25 for initial or annual visits in 1980. Those with incomes under $6,500 were charged $20. All clients were asked to pay $2.50 per monthly cycle for birth control pills. Clients seeking appointments were told over the phone they would be charged for services; if clients said they could not pay, they were sometimes asked to seek service elsewhere. Clients unable to pay their entire bill at the time of their visit were offered deferred payment plans, and in some instances, they were required to sign extended payment agreements which stated that future services were conditional on prompt payment of the balance due. New York City

Planned Parenthood officials acknowledged that low-income clients were charged, but argued that title X funds were insufficient to allow them to offer everyone eligible under title X free service. Region II officials were unaware this grantee was charging low-income clients. They said the grantee's rationale was unacceptable and took corrective action.

--The Door, a project in Manhattan which serves primarily clients age 21 and younger, provided free service to all clients. Project officials believed their clientele have little money and that fees would pose a barrier to service. However, the project's own survey of clients waiting for service showed most would be willing to pay a modest fee per visit. On the basis of a consultant's 1979 evaluation report, the HHS regional office directed The Door to develop a sliding fee scale. A scale was prepared which would charge clients between $1 and $3 per visit if their incomes were between 100 and 250 percent of poverty and $64 per visit if their incomes exceeded 250 percent of poverty. This scale had not been implemented at the time of our visit in November 1980. In April 1981, the Door informed us that it has implemented its sliding fee scale in February 1981.

--South Carolina clinics began charging fees in January 1980 using a sliding scale, but charged everyone the same for supplies. State officials said this was done for administrative convenience, since the supply charges are small amounts (e.g., $1 per cycle for oral contraceptives). HHS regional officials have objected to this practice, however, and South Carolina plans to omit the supply charges for low-income clients soon.

--The Livingston County Health Department in western New York State charged high school students $5 and college students $12 for the initial examination. All clients were charged for supplies and medical revisits regardless of income, but the clinic would waive part or all of the fee if the client's situation warranted. The clinic director believed, based on her experience with clients, that the fees were not a barrier to service and that clients were more conscientious about birth control if they paid for it.

--East Central Indiana Planned Parenthood charged high school and college students and considered them as separate categories in its fee scale regardless of income. The project did this because students generally have family support, but cannot use family income for birth control services. Clinic personnel said they often use title XX funds to defray the cost of examinations for students unable to pay the fees.

--Oakland County Health Department, in suburban Detroit, began collecting fees in July 1980 because of a cut in title X funding. The clinic was collecting $1,000 per week until State officials advised that teenagers must be given free service if their individual income was below the poverty guidelines. This reduced collections to an average $600 per week.

--Detroit Health Department clinics had a fee schedule, but collected only small amounts of money. Clinic officials told us most clients view the services as free (the city advertises them as free), which discourages staff from pressing payment of family planning charges.

FEDERAL AND STATE POLICIES, ALONG WITH PUBLIC PERCEPTIONS, CAUSE THE DIFFERENCES

Several factors contributed to the diverse clinic fee policies. HHS' regulations defining low-income families were not kept current and regional officials did not always emphasize fee requirements. Title XX, a program administered by the States, has been a source of conflict with title X regulations. Finally, the public perception that clinic services are free has discouraged some clinics from implementing fee systems.

HHS regulations were not current

The definition of low-income family for free title X services was not officially changed between September 1971 and June 1980. It remained at the fixed dollar amounts set in the original regulations, and this definition was in the project guidelines in use during our review. Yet regional officials told us they had used an informal definition of low income for several years--150 percent of the current poverty guideline. They were uncertain of the exact source of this policy, but the same definition had been used to classify low-income clients for BCHS' common reporting system, to which family planning projects report.

Regional officials said the inconsistency of HHS policy has contributed to the differing fee practices of family planning clinics. The clinics in our review showed considerable variety in the range of incomes used to classify clients eligible for free or partially subsidized service. Most clinic fee schedules provided for free service for those with incomes up to either 150 or 100 percent of poverty, but a California clinic started at 250 percent because of State title XX policies which are discussed below. At the maximum charge end of the schedule, clinics showed variations ranging from 200 to 470 percent of poverty. HHS defined the parameters of fee scales as 100 to 250 percent of poverty in its June 1980 regulations. However, this followed a period when a Notice of Intent (Apr. 1977) and a Proposed Rule

(Sept. 1978) had suggested 150 percent of poverty as the free-service end of a fee scale. The table below shows dollar amounts listed in the 1971 regulations along with various levels of poverty.

Family size	Low income as defined in 1971 regulations	Current Poverty Guidelines (note a) 100-percent level	150-percent level	250-percent level
1	$2,500	$3,790	$ 5,685	$ 9,475
2	3,400	5,010	7,515	12,525
3	4,200	6,230	9,345	15,575
4	5,000	7,450	11,175	18,625
5	5,800	8,670	13,005	21,675
6	6,400	9,890	14,835	24,725

a/As adjusted by the Community Services Administration for nonfarm families April 21, 1980 (45 C.F.R. 1060.2).

The differing treatment afforded teenagers at clinics stemmed, in part, from lack of workable guidance on how to measure their income, since guidelines and regulations were silent on this issue before 1980. Youths from middle-income families may be reluctant to ask their parents to pay for birth control service. The June 1980 regulation recognized this problem by stating that unemancipated minors could be considered on their own resources rather than those of their family.

HHS regional officials have not uniformly enforced fee regulations

Regional officials have not always insisted clinics use fee schedules, despite a 1974 HHS regulation requiring them (see p. 29). For example, Region II officials did not advise The Door that it needed a fee schedule until December 1979 and one was still not implemented nearly a year later. Region IV did not begin pressing its grantees to collect fees until 1979. Georgia began a system in September 1979, and South Carolina initiated fee collections in January 1980. The Region V program consultant said grantees have chosen their own fee policies in the absence of clear guidance from HHS. Region IX officials told us some California grantees do not charge fees. They attributed this to conflicting title XX policies in the State and the State's practice of licensing some clinics as "free clinics."

State title XX policies often conflict with title X

Title XX permits States to determine eligibility for services, and this has led to conflict with title X regulations in two ways.

First, some States have elected to provide free family planning services under their title XX programs regardless of client income. Second, other States have adopted income standards for eligibility that differ from those specified in HHS' title X program regulations (42 C.F.R. 59.2 and 59.5(a)(7) and (8)). These conflicts have made it difficult or impossible for some clinics to collect fees as required by title X regulations and have resulted in inequitable treatment of clients.

Title XX of the Social Security Act authorizes payments to States for social services and gives States broad authority to set eligibility criteria and determine reimbursement policies for providers. States may adopt income eligibility limits up to 115 percent of the State median income, and they may provide some services, including family planning, regardless of income. The Federal Government pays 75 percent of the cost of most services, but 90 percent for family planning.

Three of the States we visited (California, New York, and Georgia) provided title XX family planning services based on income eligibility, and Georgia stipulated that fees should not be charged to clients eligible for title XX even if title XX funds were not adequate to cover such charges. 1/ The eligibility levels differed substantially from the current title X general rule of providing free service only to clients at or below the poverty level. California, for example, based title XX eligibility on 80 percent of the State median income, a level which is about 225 percent of poverty. The Director of Family Planning for the Los Angeles County Health Department said that few of their clients would be charged using the title XX standard because it makes fee collection impractical.

In two other States (Indiana and Ohio), no income test was used and clinics contracted with State or county welfare agencies to provide a fixed quantity of services with title XX funds. The classification of a client as title XX supported became to some extent a matter of clinic discretion, since State regulations permit free service regardless of income. Thus, clients with similar economic situations may or may not be served without charge depending on the availability of funds under the title XX contract.

South Carolina provided yet another example of inequitable fee policies. The State Department of Social Services adopted a policy in 1980 of using title XX funds to pay for universal free family planning services until the fiscal year's allotment was exhausted. As a result, clinics suspended their 9-month-old

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1/In April 1981, Georgia officials told us that effective July 1, 1981, title XX funds will be used to serve only persons age 19 or younger.

client fee system in September, but expected it to resume by the end of 1980. Clinic officials said the ensuing client confusion would probably make fee collection more difficult. Inequities resulted because some clients were not charged while collections were suspended, and others did not have visits during the free service period. Also, clients with greater ability to pay could receive free service while others with lower incomes would have to pay.

Clients often think services are free

Some clinics have been deterred from charging and collecting client fees because clients believe they offer free service. This is especially true of health departments which offer other services besides family planning. Some staff members at health departments believed fees would deter some clients from seeking service.

Officials at 14 clinics told us most clients expect family planning services to be offered free of charge. Eleven of these were health department clinics which are traditionally viewed as providing an array of free services to needy persons. For example, at the Whittier clinic of the Los Angeles County Health Department, officials said they had no fee scale because the department's policy is to provide free services. Clinic directors in Detroit told us they collect only modest amounts from clients because the city advertises its health department services as free. At a Cincinnati Health Department clinic, staff members said they have not charged for services because many of their family planning clients are "graduates" from the title V prenatal program, which does not require fee payment.

SOME CLINICS HAVE USED FEE SCALES SUCCESSFULLY

Some clinics have implemented workable fee policies and demonstrated their potential to generate additional income. Some of these clinics use techniques which could be applied elsewhere to increase the fee income of title X clinics.

Georgia and South Carolina clinics, which are primarily health departments, began charging fees recently when HHS' Region IV officials insisted that they do so. Georgia implemented a fee system in September 1979. In the first 6 months of 1980, Georgia clinics collected $183,105 compared with $38,793 collected in 1979. This has been accomplished without charging clients who met the State eligibility test for title XX which is about 150 percent of poverty. South Carolina began collecting fees in January 1980, and it had collected $176,040 by the end of June. Charleston County Health Department officials told us that they were surprised at the rate of collections. Charleston collected as much from July through September as in the first 6 months of

1980. Officials said collections were increasing until fees were suspended in September because of the State's title XX policy.

Indianapolis Planned Parenthood was also using fee scales successfully. In 1979 fee collections totaled $108,053, or nearly 10 percent of its total revenue. Collections at the project declined from 1977 to 1979, however, as title XX money became available in large amounts. Cincinnati Planned Parenthood raised $93,982 from fees in 1979, more than 12 percent of its family planning revenue.

The experience of these clinics suggests it is important for clients to know before receiving service that fees are charged based on ability to pay. Indianapolis Planned Parenthood keeps running accounts for clients and expects clients to make payments on the balance. Some of the clinics not collecting much in fees were leaving the subject to the end of the client's visit and were relying on the client to suggest an amount she could afford.

The most successful fee-for-service system we encountered was at Rocky Mountain Planned Parenthood, which operated family planning clinics in Denver and other Colorado cities without title X or XX funds. Although Rocky Mountain's data showed that about 47 percent of its clients were below poverty levels, the clinics have supported themselves largely with client fees. Rocky Mountain's executive director said even low-income clients are willing to pay for service if it is convenient, sensitive, and timely.

Rocky Mountain advised clients when they called for appointments that they would be charged for services according to their income level. The charge for an initial visit ranged from $7 to $30 in 1979. By offering prompt appointments and keeping visits to an hour or less, Rocky Mountain had built its clientele in Denver to nearly 15,000 on essentially a fee-for-service basis. The executive director believed, however, that subsidized clinics are needed for some clients and for sparsely populated areas that cannot generate enough volume for a self-supporting clinic.

CONCLUSIONS

Family planning clinics have lost revenue and treated clients inequitably because they have not uniformly applied sliding fee scales based on the clients' ability to pay. The varying fee practices have come about because HHS did not keep regulations current and had not emphasized fee collections. State title XX policies have often conflicted with title X, and in some areas, clinic officials and clients perceive services as free. HHS resolved part of the problem by issuing new regulations in 1980 which required charging clients above the current poverty level. However, problems still exist in applying fee scales consistently and conflicts

remain between titles X and XX. Some projects have demonstrated that fee collections can be an important source of revenue. We believe administrative and possibly legislative actions are needed to resolve conflicts and achieve consistent, effective use of sliding fee scales.

RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that the Secretary:

--Direct HHS regional offices to assure that title X-funded clinics establish fee scales and collect fees in accordance with title X regulations.

--Take steps to resolve the differences between titles X and XX programs regarding eligibility for free and subsidized family planning service. If necessary, appropriate legislative proposals should be prepared to achieve this.

AGENCY COMMENTS AND OUR EVALUATION

HHS agreed with our recommendation to assure that clinics establish fee scales and collect fees in accordance with title X regulations. It said that its revised guidelines for family planing clinics direct regional offices to ensure that fee requirements are followed by grantees. In April 1981, HHS notified one of the title X grantees we found to be collecting fees from low-income families that its practice was contrary to law and that failure to take corrective action could result in nonrenewal of its grant. The grantee later advised HHS that it would change its practice to comply with title X.

HHS disagreed with our recommendation to resolve the differences in fee policies in titles X and XX programs. It said that current laws do not require that title XX family planning fee policies be consistent with those under title X and that States now have flexibility in family planning programs to meet the particular needs of their citizens. Furthermore, HHS said that State decisionmaking is preferred to setting national criteria for eligibility for family planning services.

We continue to believe that our recommendation is appropriate. Although States do have flexibility under their title XX programs to determine eligibility for free family planning service, they do not have this flexibility under title X. Also, we believe the Federal Government needs to decide to what extent it will subsidize services for persons having the ability to pay.

In our opinion, the most appropriate way to resolve the conflict in fee policies between programs is to consolidate Federal

funding for family planning programs. We have recommended this in previous reports 1/ on federally funded family planning programs and in testimony before the Senate Committee on Labor and Human Resources on March 31, 1981.

The administration's block grant proposals recognize the types of problems created by overlapping categorical programs, including the type of inconsistency discussed in this chapter. However, until legislation is enacted to consolidate Federal family planing programs or to enable States to overcome the problems resulting from differing requirements among categorical programs funding family planning services, we believe that HHS should explore ways to resolve the fee policy conflicts between titles X and XX, as we have recommended.

In commenting on excerpts of a draft of this report, the executive director of New York City Planned Parenthood expressed concern about the clarity and perspective of the information on its activities in the report. Where appropriate, we have clarified our report in reponse to these concerns.

The executive director also said that the practices discussed in our report relating to the Boro Hall clinic's use of extended payment agreements and sometimes making fee payment a condition of service reflected actions that were not in accordance with the policies of New York City Planned Parenthood. He said that although the organization's policy was to charge all clients for services, regardless of income, it was also its policy to encourage clients expressing difficulties in making payments to come to its clinics, receive services, and discuss financial problems, deferring charges and working out payment plans in those cases in which clients are unable to pay. Also, he said that (1) it was not the organization's policy to require clients seeking only contraceptive services to sign extended payment agreements, (2) only a relatively few contraceptive clients have been asked to sign such agreements, and (3) these situations occurred without the knowledge or consent of Planned Parenthood officials.

In a May 11, 1981, letter, New York City Planned Parenthood told HHS that it would change its fee policy to provide low-income clients with free service upon verification of family income status.

1/"Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome" (HRD-80-24, Jan. 21, 1980) and "Administration of Federal Assistance Programs--A Case Study Showing Need For Additional Improvements" (HRD-76-91, July 28, 1976).

CHAPTER 4

THE TITLE X MANAGEMENT INFORMATION SYSTEM LACKS CREDIBILITY

The adequacy of the management information system used, in part, to allocate title X funds and monitor program efficiency and productivity is questioned by many HHS and grantee officials. The system, the Bureau Common Reporting Requirements, was established as a uniform reporting system for all health programs administered by BCHS. Its application to family planning projects, however, produces measures of clinic activity and efficiency which are of limited usefulness. HHS has used the data to make regional allocation of funds, but officials at three of the four regions we visited expressed reservations about its appropriateness and limited their use of the data in making grant awards.

Until the end of 1980, HHS operated the National Reporting System for Family Planning Services. This system attempted to record all clients in organized family planning clinics--not just title X clients--and produced reports on a broad array of demographic factors. The system began in 1968 and was based on a full-count survey until 1977, when it was changed to a smaller probability sample. At the time of our review, only preliminary data were available for 1978 and no data were available for 1979. HHS officials terminated the program in June 1980, because they felt it was duplicative and of limited usefulness. While we did not review the merits of HHS' decision to terminate the program, it was obvious that HHS did not have or use data from that system to manage the title X program in 1979 or 1980. Without the National Reporting System, HHS has little national information on clients served other than their age and income levels.

THE BUREAU COMMON REPORTING SYSTEM SUFFERS FROM DOUBTS ABOUT ITS CREDIBILITY

BCHS developed this system to help manage several of the programs it administers, including the title X program. However, HHS regional office officials who are responsible for managing the program on a daily basis often limit use of the system because of their concerns about the reliability of the data and the appropriateness of the system's productivity measures.

We did not verify the accuracy of the system's data during our review. However, we agree with HHS regional (and grantee) officials' concerns about the data and believe that the questions they raise diminish the data's usefulness.

The system--its purpose and output

The Bureau's system was established to serve as a uniform reporting system for most programs administered by BCHS. The Bureau intended the data to be used to

--assure compliance with legislative mandates;

--report to the Congress on program status;

--allocate resources to the regional offices;

--conduct program evaluations including comparisons among programs, States, and regions;

--provide a data base for objective grant awards;

--facilitate program integration; and

--identify areas where grantees need technical assistance.

The system includes nine tables of information submitted by grantees every 6 months (one table is submitted quarterly). The tables report on

--users (clients) by age, sex, and type of service (medical, dental, family planning, other health);

--staffing levels and staff encounters with clients;

--hospital admissions;

--coverage of certain tests and procedures;

--allocation of costs among functions;

--sources of funds and rate of collection; and

--receipts and expenditures.

Data for this system come, in part, from clinic visit reports generally prepared at the time of a clinic visit. Visits are classified as "medical encounters" when the client is seen by a doctor or nurse.

Family planning grantees are required to complete six of the system's nine tables, but the data used for management come essentially from four tables. One produces a count of family planning "users" (clients) above and below 150 percent of the poverty level and clients under age 20. These data are used by BCHS to allocate title X funds to the regions and by some regions to award funds to grantees. The other three tables report staffing, workload,

and cost data which are used to compute three efficiency indicators. BCHS expects regional offices to use these indicators in allocating funds to grantees and monitoring grantee performance. One of the tables also includes clinical effectiveness data on the extent certain routine services are provided.

The three efficiency indicators are:

--Administrative costs as a percent of total costs. (The BCHS standard of 20 percent was reduced to 16 percent in 1980 with a redefinition of administrative costs.)

--Cost per medical encounter (the standard is $16 to $24).

--Medical encounters per full-time staff physician or equivalent. (The standard is 4,200 to 6,000 per year. A nurse practitioner is counted as one-half a physician in this computation.)

Regional officials doubt the validity of the data and limit their use of it

Several HHS regional officials (and State officials) told us they are hesitant to use the data extensively because they are skeptical of the system's indicators as meaningful measures of project workload and efficiency. Also, they doubt the accuracy of the data. Their doubts stemmed from knowledge of practices similar to observations illustrated below:

--Questionable use of medical encounters to measure productivity because clinics can increase them by scheduling more client visits. The Door, for example, reported a cost per medical encounter of $23 on the December 1979 report, which was within BCHS' standard. However, The Door required its clients using oral contraceptives to return to the clinic monthly during their first 3 to 6 months in the program. Based on our estimates, The Door had the highest overall cost per client of all the clinics we visited.

--Inconsistencies in reporting family planning users. For example, clients obtaining pregnancy tests only are counted as users in Indianapolis and Detroit, but not in Los Angeles.

--Wide and sometimes inconsistent fluctuations in the data for the same grantees from one reporting period to the next. The Los Angeles Regional Family Planning Council, for example, exceeded the administrative cost standard by nearly 50 percent in the December 1979 report. Six months later it reported its administrative costs had dropped from 29 to 9 percent of total cost. At the same time, its reported

cost per medical encounter went from $18 to $26 while its productivity indicator rose 27 percent.

--Large variations in the reported efficiency indicators among grantees. For example, the June 1980 report shows costs per medical encounter ranging from $5 to $83 in Region II, from $2 to $49 in Region V, and from $4 to $67 in Region IX.

--Lack of data on project performance because only consolidated reports are received from State or "umbrella" grantees. The consolidated reports can mask differences among projects. For example, the Georgia Statewide Family Planning Program met all efficiency standards on the June 1980 report and its combined ranking placed it first in Region IV. However, Georgia's own worksheet on its delegate agencies showed many of them out of compliance with BCHS' standards with wide variation in the indicators. The projects' cost per medical encounter ranged from $1.07 to $93.69.

Regional and grantee officials have similar views

Officials at three of the four regional offices included in our review told us that they had little confidence in the validity of the system's indicators and did not consider them useful for management purposes. Several State officials expressed a similar view and most project directors told us they had not found the data useful for managing their operations. Region II officials believe, however, the system's data are useful for management purposes.

Also, three of the four regional offices visited were using some of the indicators in formulas for allocating funds, but their actual impact appeared limited and inconsistent. Region II was using an elaborate formula partly based on the indicators, consisting of 58 steps. However, the actual award of funds to grantees was adjusted with various special amounts. For example, of the nine grantees who should have received a funding cut in fiscal year 1980 according to the formula, five actually received as much as or more than in fiscal year 1979. Region IX used an intricate formula to convert system data to utilization scores and efficiency scores for each grantee. However, the region applied the formula only to increase, not decrease a grantee's funding. It also added a set of qualitative factors including "innovation" and "responsiveness to the regional office" into its funding decisions.

Officials of umbrella grantees were also skeptical of the system. For example, high-level officials of the Los Angeles Regional Family Planning Council said the data were not very useful because they were too easily manipulated by projects. In their

opinion, the system's basic flaw is that it tries to use the same standards to measure the effectiveness of different programs. A South Carolina official said the State's system records medical encounters only to satisfy BCHS' requirements, but he did not consider this a meaningful workload indicator. Officials of the New York State Department of Health said that they believe clinics have misreported data on the poverty level of their clients in order to comply with Region II standards. They also said the medical encounter data were not meaningful. A Georgia health department official indicated the data were of limited use because the reports were completed improperly by many projects and that a training effort was needed.

BCHS' efforts to improve the data

BCHS officials said that they were aware of the concerns about the accuracy and usefulness of the data. However, they said that they have acted to improve accuracy and believe that it has been improving, as shown by recent contractor evaluations. They said they have provided training to grantees and have instructed regional office staff to give more emphasis to this area. Furthermore, they said that they have been developing more sophisticated techniques to analyze the data to make the system's productivity indicators more meaningful.

HHS DISCONTINUED THE NATIONAL REPORTING SYSTEM FOR FAMILY PLANNING SERVICES

HHS decided in June 1980 to terminate the National Reporting System, which had produced data on clients and visits since 1968. The decision was based on a belief among BCHS officials that the system was duplicative and of limited usefulness, since many States had systems which generated similar data. Without the system, Federal officials have little information on the clients served and the type of service provided. Officials operating State and local data systems suggested that they can provide demographic and service data to Federal officials as needed, but these systems do not always produce comparable data.

Late and unreliable data

Our 1975 report on family planning services chronicled the early history of the National Reporting System. 1/ At that time, the system was based on a full count of client visits recorded on input forms called client visit records. The National Center for Health Statistics (NCHS) collected the data and published an annual

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1/"Improving Federally Assisted Family Planning Programs" (MWD-75-25, Apr. 15, 1975).

volume of statistical tables on such subjects as the age, race, pregnancy and contraceptive history of family planning clients, and the medical services and contraceptive methods provided clients. NCHS also furnished selective tables to projects on a monthly and quarterly basis. Our report mentioned several of the problems plaguing the system in the earlier years: untimely submission of data by participating clinics, complaints from clinics about the burden of reporting and the accuracy of the data, and general apathy about using the reports for management purposes.

In an effort to streamline the system and reduce the reporting burden, NCHS transformed it into a sample system in 1977. NCHS stopped sending reports to projects with the end of 100 percent reporting. Thus, for client and visit information, projects became dependent on data systems organized at a State level or by an umbrella grantee. These "local systems" have in turn supplied data to NCHS for its sample, accounting for an estimated 80 percent of the reporting by title X clinics.

In early 1980, the contractor who collected and processed data for NCHS did a study of the quality of reporting. Results of the study raised questions about the reliability of the data submitted, especially by the various automated systems. The contractor pointed out that national system reporting was a low priority for operators of these systems compared to reporting requirements of BCHS and State agencies.

System discontinued because data were not used

The system's condition was discussed at a meeting of 26 Federal and State officials in May 1980. The Deputy Assistant Secretary for Population Affairs, who is charged by the Congress to prepare a 5-year plan for family planning services and population research, claimed to use the system and supported its continuation. However, the 1979 and 1980 plans contain very little system data. For such a basic statistic as the national estimate of clients served by title X clinics in 1978, the plan's authors relied on a figure (3.5 million) supplied by the Alan Guttmacher Institute rather than use the lower estimate (3.1 million) produced by the system.

In June 1980, a joint decision to discontinue the system was made by the directors of BCHS and NCHS; the Deputy Assistant Secretary for Population Affairs; and the Deputy Assistant Secretary for Health Research, Statistics and Technology. Data would not be collected after December 31, 1980, but the 1979 and 1980 data would be compiled and published. This decision will have budgetary implications for both BCHS and NCHS. The data processing contract cost for the 1981 survey was budgeted at $632,049, of which

$382,049 was from BCHS. According to HHS, an additional $500,000 would have been requested to improve quality control procedures had the National Reporting System continued beyond 1980.

Data comparability must be established if State and local systems are used

The National Reporting System had used standard definitions and editing processes to try to assure its data were comparable for all regions and States. Not all State data systems we examined collected the same information or reported it in the same way. For example, South Carolina included readmissions (clients who have returned to a clinic after an absence) in their count of new clients, a practice not followed by the other systems. Michigan projects reported most revisits as "medical revisits," while Ohio made extensive use of the classification, "supply visit." Considerable variation was noted in the counting of clients who received only a pregnancy test. Thus, if Federal officials choose to rely on State and local data systems for information, an effort will be needed to standardize data gathering practices.

CONCLUSIONS

The information system used by HHS to allocate funds and manage the family planning program lacks credibility and has limitations on its usefulness because many officials are skeptical of the performance indicators as meaningful measures of project workload and doubt the accuracy of the data. While we made no attempt to verify the accuracy of the system's data, our review showed inconsistencies in the way clients are counted and wide variations and fluctuations in the various efficiency indicators. These observations and the views of the HHS program officials raise questions about the adequacy and credibility of the Bureau's management information system.

We believe HHS' decision to eliminate the National Reporting System for Family Planning Services was reasonable since the information from the system was not used regularly to manage the program and was not available in time to provide management visibility. Its termination, however, leaves program officials with little national data about clients served and contraceptive methods used.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary direct the Deputy Assistant Secretary for Population Affairs and the Office for Family Planning to refine existing management information systems to provide data and performance efficiency indicators suited to family planning clinic operations. HHS should build on existing automated

systems, and it should include, for example, objective and measurable standards for:

--Accurately counting workload.

--Reporting retention levels and degree of contraceptive protection provided.

--Total cost of providing services.

--Monitoring fee collections.

--The extent to which women served are priority target populations.

AGENCY COMMENTS AND OUR EVALUATION

HHS disagreed with our recommendation, stating that it had no intention of imposing a direct Federal management system on any grantee, as suggested in our report. HHS discussed several aspects of its Bureau Common Reporting Requirements, but did not mention arrangements or plans for obtaining any of the types of data from its National Reporting System for Family Planning Services, which it recently discontinued.

Our report does not recommend, nor did we intend to suggest, that HHS should impose a Federal management system on grantees. Our report discusses several problems with the two reporting systems containing family planning data used by HHS, and the need to obtain more accurate program data and to refine the performance and efficiency indicators now being used so that they are suited to clinics providing family planning services as opposed to comprehensive health services.

Also, our report cites several examples of the type of data we believe should be collected either on a routine or periodic basis. For example, we suggested that HHS collect data on the extent to which persons served are among priority target populations. Title X states that persons from low-income families are one of the priority target populations. HHS has defined low-income families to be those with incomes under 100 percent of the Federal poverty level. Yet, under the Bureau Common Reporting Requirements, title X grantees are required to report women served who are at or below 150 percent of the poverty level. Thus, HHS does not obtain data on the number of women served who have incomes below 100 percent of the Federal poverty level.

The types of data we suggested as appropriate for family planning are similar to the types of data identified as necessary

for evaluating family planning programs in an appendix to a September 1967 report by HHS consultants on implementing family planning and population policy within the Department. The types of data recommended included the number of (1) persons served and services and contraceptive methods provided, (2) new patients, (3) dropouts, (4) return visits, (5) accidental pregnancies, (6) demographic and socioeconomic characteristics of clients, and (7) average costs of various services per client year. This type of information is relevant and fundamental for program management and evaluation, and we continue to believe our recommendation is appropriate.

HHS said that its regional offices rely on other information besides that included in Bureau Common Reporting Requirements to make funding decisions. We did not intend to imply that data in this system were the only types of information used by HHS regional offices and modified our report to help avoid this implication.

CHAPTER 5

THE ROLE OF DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS HAS DIMINISHED

The Deputy Assistant Secretary for Population Affairs has not assumed the leadership role in administering, planning, and directing family planning services and population research activities intended by the Congress. Since being established more than 10 years ago, the incumbents in the Deputy position have often held it on a part-time basis, and duties have been relegated to liaison functions, monitoring, coordinating, and evaluating family planning services and research activities. Several problems have impeded the ability of the Deputy to carry out assigned responsibilities and have limited the Deputy's influence. These include (1) placement of the position in the Public Health Service while other HHS component organizations administered grant programs involving family planning services over which the Deputy had no line authority, (2) a 1971 delegation of authority (which has remained in effect) by the first Deputy to component agencies within the Public Health Service, and (3) lack of full support from high-level management within HHS.

ESTABLISHMENT OF THE POSITION

The Family Planning Services and Population Research Act of 1970 (Public Law 91-572) established the Office of Population Affairs and the Deputy position because the Congress believed that HHS had not given sufficient priority to family planning services and a focal point was needed within HHS with authority to direct family planning activities. The Congress believed there was a need for the Deputy position to control operations and directed that the Secretary use the Deputy in the following areas related to family planning and population research:

--Administer Federal laws which provide for or authorize grants or contracts for which the Secretary of HHS had responsibility.

--Administer and be responsible for research carried on or supported by HHS through grants or contracts.

--Act as a clearinghouse for domestic and international information.

--Provide liaison with the activities carried on by other Government organizations.

--Provide or support staff training for domestic programs.

--Coordinate and be responsible for the evaluation of HHS' programs.

Under this arrangement, the Congress contemplated that one official would be accountable for both policy formulation and administering all family planning activities within HHS and have the staff resources to carry out the above-mentioned functions.

FUNCTIONS HAVE CHANGED OVER TIME

A considerable amount of dialogue occurred during 1978 and 1979 between HHS and the Chairman of the Senate Subcommittee on Child and Human Development concerning the Deputy's authority and responsibilities. Although the functions of the Deputy, as prescribed by law, have remained generally the same since 1970, we were advised that the position is essentially a staff position, and the Office of Population Affairs is a staff office, with no direct line authority and little influence over decisions relating to family planning services and research activities.

The Deputy and the Office of Population Affairs currently participate in a variety of liaison activities and coordination projects on a regular basis and in these areas are the focal points for family planning services and research.

Developments during terms of the three deputy assistant secretaries

The first Deputy held the position from May 1970 through January 1977. This individual had participated in developing the plan that gave the position responsibility and authority over all HHS family planning service and research programs. However, in July 1971, the Deputy delegated certain functions to officials of the National Institutes of Health and the Health Services and Mental Health Administration. 1/ The Deputy simultaneously served as Administrator of the Health Services Administration from early 1976 through January 1977. The position remained vacant from January to April 1977. From April 1977 to September 1978, another HHS official assumed the responsibility for the combined position of Deputy Assistant Secretary for Health Programs and Deputy Assistant Secretary for Population Affairs. The Office of Population Affairs was placed in the Office of Health Programs.

Partly because of congressional attention, HHS reviewed the functions and organizational placement of the Deputy position and Office of Population Affairs and appointed a full-time Deputy in September 1978. This Deputy served on a full-time basis until April 1980. The Deputy and the Office of Population Affairs were organizationally placed directly under the Assistant Secretary for

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1/This agency was reorganized into the Health Services Administration and the Alcohol, Drug Abuse, and Mental Health Administration. The Health Services Administration was given responsibility for the title X program.

Health in 1978. The Deputy and the Office of Population Affairs were also given new responsibilities involving the prevention of unwanted pregnancies (particularly for adolescents), infertility programs, and women's health issues.

The incumbent in the Deputy position between September 1978 and April 1980 told us that during his tenure, the position's functions differed significantly from those described in the law because he had no line authority over the functions that had been previously delegated to the Health Services Administration and the National Institutes of Health. He pointed out that his position description was not consistent with the legislation because it did not provide for direct administration of family planning and population research programs within HHS. Specifically, the revised position description limited his authority to programs within the Public Health Service, although the legislation provided for authority over all HHS' family planning and population research programs involving grants or contracts.

The third Deputy said he had no influence over budget matters and received little support from HHS' high-level management when he attempted to get more involved in family planning service and research activities. The former Deputy told us that he was somewhat successful in coordinating family planning activities. He believed, however, that if he had been given the authority as spelled out in the legislation, he could have carried out his duties with less resistance and been more effective.

Since April 1980, the director of Office of Population Affairs has been acting as the Deputy and has held the two positions concurrently. The acting Deputy characterizes his position as a staff function since he has no direct line authority over program management. He said the Deputy and Office of Population Affairs performed coordination and liaison activities, served as focal points for family planning information, and collaborated with responsible HHS program groups in developing HHS policy and regulations. The acting Deputy cited HHS' new uniform sterilization regulations as an example of his coordination efforts with the HHS groups involved.

The acting Deputy said that he and Office of Population Affairs staff have little opportunity to coordinate the activities of titles XIX and XX family planning service programs largely because both are State-operated programs, and at the Federal level, they are administered by organizations outside the Public Health Service. The States have broad latitude in defining family planning services, establishing eligibility requirements, and setting fees for various services provided. The acting Deputy and Office of Population Affairs, however, were involved in developing and reviewing proposed Federal regulations for the title XIX family planning service program.

The acting Deputy and Office of Population Affairs staff recently have been primarily involved with the family planning and population research programs funded under titles V and X in regard to (1) monitoring program content and (2) coordinating the development and implementation of these programs. The acting Deputy said that although the family planning policy statements for these programs are submitted for his review, he does not have the authority to change the policies of either program. Likewise, he does not administer laws which authorize HHS to make grants or contracts related to family planning and population research. Although his opinion on general policy issues and individual projects is considered along with those of other officials, the Deputy does not directly control research or family planning policy.

CONCLUSIONS

The responsibilities of the Deputy have diminished substantially since they were first established. The most recent incumbent in this position was unable to carry out his responsibility for administering all Federal laws which provide for or authorize grants or contracts for family planning and population research for which HHS is responsible because:

--The first Deputy delegated the authority for administering programs operated by organizations within the Public Health Service to those organizations.

--Neither high-level HHS management nor the component agencies within the Public Health Service fully supported the Deputy in his efforts to exercise his responsibility under title X.

--The Deputy's position, as defined by HHS, does not have line authority for programs, such as Medicaid and title XX, which are administered by HHS agencies outside the Public Health Service.

Also, the latter two problems hindered the Deputy's ability to coordinate and evaluate the HHS family planning and population research activities and contributed to his limited influence over them.

Whether the Deputy needs to actually administer all HHS' family planning and population research programs involving grants or contracts is questionable. It appears improbable to us that a person in the Public Health Service would be able to effectively administer family planning segments of much broader programs--Medicaid and title XX--which are administered by other HHS agencies. It would appear more reasonable to us for the Congress to rely on the Deputy to coordinate and evaluate programs and for the Secretary of HHS to facilitate the Deputy's ability to carry out these responsibilities. Pending possible legislative changes

in the Deputy's responsibilities, the Secretary needs to clarify the current role of the Deputy as set forth by title X and instruct component agencies to cooperate with the Deputy.

RECOMMENDATION TO THE CONGRESS

We recommend that the Congress reassess whether the Deputy Assistant Secretary for Population Affairs needs to administer all HHS' family planning programs which provide for or authorize grants or contracts.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary clarify the responsibilities of the Deputy and instruct component agencies to cooperate with the Deputy to put the Deputy in a better position to coordinate and evaluate all HHS' family planning activities.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on a draft of this report, HHS said it will examine the coordination issue if the administration's block grant proposals are not enacted. HHS said that, if the administration's block grant proposals are enacted, the Deputy's coordination role would no longer be needed. In our opinion, the need for the Deputy's coordination and evaluation roles under block grants is uncertain at this time because the form of the block grants and the Federal role under block grants will not be known until they are enacted. Accordingly, we believe that HHS will need to re-evaluate the need for the Deputy's coordination and evaluation functions after block grants are enacted.

Furthermore, it appears that, if block grants are enacted, funds for family planning services could be provided to the States in several different block grants. Therefore, there may be a need for HHS to promote coordination at the State level if this situation occurs. Also, there may be a need to evaluate whether the Federal Government should authorize use of funds under so many block grants for family planning.

CHAPTER 6

USE OF FUNDS AUTHORIZED FOR PROGRAM IMPLEMENTATION RESEARCH

The Secretary of HHS is authorized under section 1004 of title X to carry out projects for research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population. BCHS has broadly interpreted program implementation research to include such activities as training and technical assistance.

The Committees asked us to review the range of program implementation research activities, commonly referred to as service delivery improvement research by HHS, because it was uncertain of how these funds were being used. Although HHS has provided varying amounts of information on the types of activities it has funded under section 1004 in 5-year plans it annually submits to the Congress, it had not formally defined the parameters of program implementation research. Also, it is not clear whether all the activities are appropriately classified as research. To allay the Committees' concerns, HHS needs to formally define program implementation research.

ACTIVITIES FUNDED UNDER SERVICE DELIVERY IMPROVEMENT

During fiscal years 1975 through 1980, the years for which expenditure data were available, BCHS spent about $13.8 million on program implementation or service delivery improvement research. (See table below.)

Summary of Activities Funded Under Service Delivery Improvement Research (Fiscal Years 1975-80)

Five-year plan for family planning services and population research	$ 485,700
National Reporting System for Family Planning Services	2,836,092
Technical assistance	3,375,762
Projects with the Centers for Disease Control	1,637,226
Management information systems	228,654
Staff training	201,700
Evaluation of services to special groups (e.g., handicapped, males, and teenagers)	3,527,824
Dissemination of information and handbook	359,799
Operational analysis and assistance	499,078
Other	680,246
Total	$13,832,081

It is unclear whether all of the activities funded by BCHS under section 1004 are appropriately classified as research. Some of the questionable activities are: providing data for HHS' 5-year plans, developing and operating a data system, and providing technical assistance or training to personnel at the headquarters office, regional offices, and grantee staffs.

Five-year plan for family planning services and population research

Public Law 91-572 requires HHS to submit to the Congress annually a 5-year plan for family planning services and population research. The legislation set forth the minimum information to be included in the plan each year, but did not state how the plan would be paid for. In the absence of legislative direction, the Deputy Assistant Secretary for Population Affairs and BCHS chose to use service delivery improvement research funds to contract for the provision of data for the 5-year plan. From 1975 to 1980 about $485,700, or an average $81,000 annually, was used for this purpose. According to Office for Family Planning officials, only service delivery improvement research funds have been used to prepare the 5-year plans during these years.

National Reporting System for Family Planning Services

NCHS has been given responsibility to develop and operate a coordinated reporting system for all federally funded and, to the extent possible, private family planning programs in the United States. This system, called the National Reporting System for Family Planning Services, was to provide basic program planning and evaluation data for the development, operation, and evaluation of family planning programs. BCHS shared the costs of this project using service delivery improvement research funds.

Since fiscal year 1975, BCHS transferred about $2.8 million, or an average of $466,600 yearly, to NCHS for the development and operation of the reporting system. According to the fiscal year 1980 memorandum of agreement, NCHS is to:

--Maintain an efficient system for the distribution of forms; the receipt, screening, and processing of data; and the regular and timely distribution of related reports and tables.

--Provide data on services, patient volume, and sources of Federal funding of participating family planning clinics.

--Provide technical assistance, including training, to family planning clinics to improve their data and facilitate their enrollment in the reporting system.

--Inform BCHS of major changes or additions to data collection forms, tables, or reports.

--Hold periodic meetings concerning changes, achievements, products, and problems of the reporting system.

According to Office for Family Planning officials, the principal use of the information in the reporting system is to assist the Deputy in preparing HHS' 5-year plan for family planning and population research. These officials said that service delivery improvement research funds were used by BCHS each year to pay for the reporting system because the information developed was originally distributed to family planning clinics and this information helped them improve service delivery. (See p. 43.)

When the reporting system was first being developed, HHS' use of service delivery improvement research funds appeared reasonable. However, its link to service delivery improvement research has become somewhat hazy.

Technical assistance

From fiscal years 1975 through 1980 about $3.4 million, or an average of $566,600 annually, of implementation research funds were used to fund technical assistance contracts. These contracts were used to provide assistance to HHS headquarters and regional office staffs, as well as to some grantee staffs which were involved in providing family planning services. Assistance was provided for such activities as improving clinic financial management, medical records, or quality assurance programs. According to Office for Family Planning officials, no other funds are appropriated or earmarked under title X for technical assistance and section 1004 has always been the source of funding for such activities.

Other contracts

Several other contracts funded under section 1004 may not be properly classified as research activities. Examples follow:

--A fiscal year 1975 contract for $179,754 to implement cost accounting principles in family planning projects.

--A fiscal year 1975 contract for $47,085 to develop an instruction manual for clinic managers.

--A fiscal year 1979 contract for $115,713 to establish and conduct 10 regional workshops on natural family planning.

--A fiscal year 1980 contract involving $60,517 of section 1004 funds for five training workshops for mental health and family planning service providers.

CONCLUSIONS

HHS has broadly interpreted section 1004 of title X as authorization to conduct a variety of activities that it considers program implementation research. Some of these activities do not appear to be appropriately classified as research and may not be what the Congress envisioned when it enacted section 1004. To allay congressional concerns about the use of funds authorized under section 1004 for program implementation research, HHS needs to formally define the parameters of such research.

* RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary formally define program implementation research in consultation with the House Committee on Energy and Commerce and the Senate Committee on Labor and Human Resources.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on a draft of this report, HHS said that (1) it had defined program implementation research in fiscal year 1972, (2) its definition was consistent with congressional intent as recorded in hearings, and (3) the Congress is aware of the various activities funded under section 1004. Accordingly, HHS said that it did not concur with our recommendation.

We were told by a representative of HHS' Office for Family Planning that the fiscal year 1972 definition referred to in its comments was developed through internal departmental discussions, but was not put into a formal written statement or document. By stating that HHS had not formally defined the parameters of program implementation research, we did not intend to imply that HHS had not provided any information to the Congress on the types of activities funded under section 1004.

HHS' 5-year plans submitted to the Congress each year contain varying amounts of detail on the types of activities funded under section 1004. However, none of the 5-year plan reports we reviewed identified the extent to which section 1004 funds were used for various types of activities. Between fiscal years 1975 and 1980, HHS used about $6.2 million, or about 45 percent of its total

funding under section 1004, for two types of activities--technical assistance and the operation of the National Reporting System for Family Planning Services.

We were asked to examine HHS' use of funds under section 1004 because of the variety of general types of activities HHS reported as program implementation research and uncertainty by the congressional committees about how section 1004 funds were being used. We clarified our report to recognize that HHS has included information on program implementation research in its 5-year plans. However, we believe that the Committees and the Congress will need more information than HHS reports in its 5-year plans to determine whether HHS' use of section 1004 funds is consistent with congressional intent.

ADDITIONAL DETAILS ON METHODOLOGY

ECONOMY AND EFFICIENCY OF CLINIC OPERATIONS

We reviewed the medical protocols used by the 26 clinics we visited. These protocols set forth the medical examination procedures, laboratory tests, and routine visits required or recommended for clients. We compared these protocols and the practices at the clinics with HHS' 1976 title X program guidelines and ACOG's 1974 Standards for Obstetric-Gynecologic Services. These guidelines and standards were in effect at the time of our fieldwork.

To determine the clinics' actual practices, we interviewed officials and staff at the 26 clinics and judgmentally sampled between 15 and 54 client records at 21 of the 26 clinics. The purpose of the sample was to determine any readily identifiable differences between what clinic officials and staffs said they were doing and what was actually being done as reflected in clients' medical records. Although this sample was not statistically projectable, we believe it was sufficient for our purposes.

At six clinics, we selected a statistically projectable random sample of medical records for clients making their first visit in 1978. At one small clinic, our sample included all new clients in 1978. Altogether, we reviewed records for 1,706 clients (16 percent of the total client records) at the seven clinics. Our sample at the six clinics had a 95-percent confidence level with a 5-percent sampling error. We determined the number of routine revisits made by the oral contraceptive clients whose records we sampled at six of the clinics. Records at one clinic did not indicate which client revisits were routine revisits versus those that were for medical problems.

We selected the seven clinics for this detailed review of clients' records generally using the same criteria we used to select the 26 clinics. We did not have time or resources to do similar samples at all 26 clinics. Also, some of the clinics did not maintain their client records in a way that we could easily take a random sample of new clients entering the program in 1978. We chose clients entering in this year so that sufficient time had elapsed to enable us to determine client dropout rates.

In addition, we sent, in cooperation with the Cincinnati Academy of Medicine and the Cincinnati Obstetrical/Gynecological Society, a questionnaire to 87 obstetricians and gynecologists in the Cincinnati area. We received 45 (or 52 percent) usable responses. We obtained information on (1) their routine office visit schedules for a healthy woman 18 to 25 years old desiring oral contraceptives, (2) routine procedures and laboratory tests done during initial, interim, and annual visits, (3) their charges for

these visits, and (4) waiting times for appointments. Their practices may not, however, be representative of obstetricians and gynecologists elsewhere.

We considered replicating this survey in the other cities we visited. Also, we considered sampling obstetricians and gynecologists nationally. However, based on (1) the time necessary to obtain approval from the medical professional organizations in Cincinnati and receive responses to our questionnaire and (2) our discussions with ACOG on the time needed to accomplish these steps nationally, we decided it would not be feasible to replicate the Cincinnati survey.

We discussed medical procedures and appropriate routine office visits for oral contraceptive clients with ACOG's executive director and director of practice activities. They provided their opinions on minimally required routine office visits, medical procedures, and laboratory tests for healthy oral contraceptive patients. We believe that their opinions, along with the opinions of officials of HHS' Centers and ACOG's standards, provide appropriate bases to compare clinic practices and title X program guidelines.

To estimate the number of client revisits that were in excess of ACOG's standards and opinions of ACOG's officials, we used 1978 National Reporting System for Family Planning Services data to determine the percentage of clinic clients who were oral contraceptors. We applied this percentage to the total number of title X clients reported served in 1979 by BCHS. This produced an estimate of the number of title X clients in 1979 who were oral contraceptors. We multiplied this number by 50 percent to estimate the number of clients who could make at least one unnecessary clinic visit. This percentage was derived from our detailed review of medical records of new 1978 clients and reflects actual dropout rates and visits made for medical reasons at six clinics. Because of the lack of sufficient data to make a precise estimate, our estimates should be considered as approximations and as an order of magnitude indicator only.

CLIENT DROPOUT

We computed client dropout rates for seven of the clinics we visited. Also, we discussed this issue with representatives of the clinics and umbrella agencies we visited and reviewed other studies on this issue that were brought to our attention by officials we contacted. We did not, however, do a systematic literature search. Our April 15, 1975, report to the Congress "Improving Federally Assisted Family Planning Programs" (HRD-75-25) discussed client dropout.

Although we identified what we would consider to be deficiencies or inefficiencies in clinic management, our data did not link any of these problems with client dropout rates. Causes of client

dropout are complex, and more effort than we had time to devote is necessary to establish cause and effect relationships.

We interviewed clinic staff to determine the time lapse between a client's request for an appointment and the date of the earliest appointment that could be made. We also obtained an estimate of the time spent at the clinics by clients in this manner. We arranged for clinic staff at 22 clinics to maintain time logs on clients for at least 1 day of our visits.

At 20 clinics, we arranged for new clients to be given questionnaires at the end of their visits. (Satisfactory arrangements for the time logs and questionnaires could not be made at the other clinics.) This produced 277 responses to various questions about clinic experiences. We do not consider this survey to be representative of title X clients generally, since it involved only clients visiting clinics during part of our visits and was not done randomly. We have included this information only to emphasize certain points made by clinic officials. The questionnaires did not give us, as we hoped they might, any insight into why clients "drop out" of the program.

We considered contacting clients who dropped out to ask them why, but rejected this action because of the long time it would take and we were concerned about breaching client confidentiality. Because of this latter factor and the already long time periods spent at clinics by many clients, we decided not to interview randomly selected clients. Instead, we arranged for the clients to respond to our questionnaire who were agreeable to do so. Therefore, it is possible that those clients intending to return to the clinics were more likely to respond.

COLLECTION OF FEES

To determine clinic fee policies and practices, we reviewed clinic fee schedules, policy statements, or procedural manuals and interviewed clinic officials and staff responsible for assessing and collecting fees. We also obtained data on State Medicaid or Social Services coverage and reimbursement rates at the clinics or at State Medicaid or Social Services agencies. Reimbursement rates under these programs were not always comparable because the rates sometimes covered different services in "package" rates. Also, we interviewed HHS regional and headquarters officials about HHS' fee policies and their efforts to monitor compliance.

We had indications that one of HHS' grantees we visited was denying services to persons who could not pay. To verify this, one of our staff called each of the four clinics operated by the grantee twice to try to obtain an appointment, telling clinic personnel that she could not afford to pay for the service.

We tried to determine whether any relationships existed between clinics aggressively charging and collecting fees and clinics that were more efficient. (We assumed that clinics aggressively collecting fees would have more incentive to control costs to keep their fees reasonable.) However, we concluded that good data were not readily available to measure or compare overall clinic efficiency. We could not use such indicators as cost per user or full-time equivalent staffing to user ratios because clinic costs were not always comparable for several reasons or the size of the clinics we visited varied so much that we did not have enough clinics of comparable size to make a fair comparison.

We could not collect sufficient data in the time available for our fieldwork to develop a good comparison of clinic costs and those of private-practice physicians. The principal problems were the lack of readily available data for the private sector and incomparability of costs because (1) the types of services were not always comparable and (2) clinic costs, particularly for health departments, often included costs for other activities besides family planning.

PROGRAM COORDINATION

To determine whether the Deputy was fulfilling his management and coordination responsibilities, we interviewed officials from HHS' component agencies operating family planning programs to identify any coordination problems they had and to discuss their interactions with, or their perceptions of, the Deputy. Also, we interviewed two persons who previously had held that position and reviewed correspondence and other documents relative to the Deputy's duties. In addition, we discussed program coordination with umbrella agency and clinic officials.

USING FUNDS FOR SERVICE DELIVERY IMPROVEMENT AND TITLE X PROGRAM DATA SYSTEMS

We reviewed BCHS' records to determine how funds for service delivery improvement were used. Our analysis was limited to the funds spent between fiscal years 1975 through 1980 because BCHS did not have data on using these funds before fiscal year 1975. Also, we discussed funding award procedures, use of funds, and actual service delivery improvements that resulted from using the funds with Office for Family Planning officials.

To evaluate the usefulness of reporting systems, we interviewed HHS headquarters and regional office officials and officials of grantees we visited on how they used the data and on how they viewed the data's usefulness and reliability. Also, we compared the data reported by these systems with data we obtained from grantees to determine whether they were consistent. Furthermore, we analyzed Bureau Common Reporting Requirements data from a

judgmental sample of clinics to determine their reasonableness over time, and we determined the extent to which the Bureau data were used by HHS in allocating funds.

APPENDIX II

CLINICS VISITED WITH VISIT TIMES LOGGED

State and clinic	Initial visits Range	Initial visits Average	Annual visits Range	Annual visits Average	Supply visits Range	Supply visits Average
California:						
Planned Parenthood Sherman Oaks Clinic	3:00-5:00	4:48	1:50-4:30	2:44	:10-2:25	:43
Whittier Health Clinic	2:55-4:35	3:45	1:10-3:00	2:04	:05-2:00	1:01
Georgia:						
Clarke County Health Department	2:05-2:30	2:15	1:24-2:35	2:06	Not logged	
Coweta County Health Department	2:38-3:16	3:00	1:48-4:09	3:09	:05- :30	:21
Grady Memorial Hospital	:30-3:15	1:56	1:45-3:30	2:23	:30-2:00	1:03
Gwinnett County Health Department	1:33-3:26	2:19	1:38-3:04	2:05	:18-2:25	1:15
Indiana:						
Planned Parenthood of East Central Indiana	2:16-5:03	3:45	1:40-3:55	2:31	:02-1:14	:11
Planned Parenthood of Indianapolis	:45-2:45	1:47	:25-3:10	1:16	:03-1:00	:23
Michigan:						
Detroit Health Department:						
Bruce-Douglas Clinic	2:30-3:50	3:08	1:25-4:20	2:29	:25-1:23	:39
Grace-Ross Clinic	1:45-2:05	1:53	1:55-3:05	2:31	1:05-3:25	1:58
Ionia County Health Department	:55-2:15	1:48	1:05-1:25	1:12	:05- :55	:24
Macomb County Health Department:						
Adult Clinic	Not logged		Not logged		Not logged	
Teen Clinic	1:10-4:26	3:48	:51-3:05	1:48	:15- :35	:23
Oakland County Health Department	1:20-1:30	1:28	:45-1:25	1:05	:10- :35	:25
Planned Parenthood Kent County	1:30-2:41	2:04	1:05-2:44	1:35	Not logged	
New York:						
Livingston County Health Department	2:10-2:25	2:20	Not logged		:15- :45	:30
The Door	:31-3:20	1:41	Not logged		:20- :45	:33
Planned Parenthood New York City Boro Hall Clinic	:45-4:02	2:23	Not logged		Not logged	
Ohio:						
Cincinnati Health Department	1:30-2:08	1:49	1:10-1:52	1:30	:45-1:45	1:08
Fayette County Health Department	Not logged		Not logged		Not logged	
Pike County Community Action Commission	Not logged		Not logged		Not logged	
Planned Parenthood of Cincinnati	2:00-2:30	2:17	1:15-2:45	2:00	:10-1:00	:41
Planned Parenthood of Miami Valley (Dayton)	Not logged		Not logged		Not logged	
South Carolina:						
Central Midlands Health District (Columbia)	1:37-3:48	3:10	:29-2:34	1:32	:03-1:09	:23
Lower Savannah II Health District (Orangeburg)	1:59-4:15	3:15	:20-3:56	1:53	:05- :37	:16
Trident Health District (Charleston)	1:00-2:45	1:53	:40-2:45	1:17	:25-2:30	1:19

APPENDIX III

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

27 APR 1981

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Family Planning Clinics Can Provide Services More Efficiently But Clearer Federal Policies Needed." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan B. Mitchell
Acting Inspector General

Enclosure

APPENDIX III

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT ENTITLED "FAMILY PLANNING CLINICS CAN PROVIDE SERVICES MORE EFFICIENTLY BUT CLEARER FEDERAL POLICIES NEEDED"

General Comments

In February 1981, after the General Accounting Office (GAO) review was conducted, the President proposed that the Congress consolidate a number of categorical programs into basic health care block grants. The Family Planning Program (FPP) is included in the Preventive Health Block Grant. Prompt enactment of the President's proposal would eliminate the need for congressional and departmental actions recommended in this report. However, if the Congress decides not to include the FPP in a block grant, the Department will proceed with the implementation of the proposed actions as presented in the comments to the GAO recommendations cited below.

GAO Recommendation

We recommend that the Secretary direct BCHS to revise its family planning guidelines to: (1) establish routine revisit policies in line with ACOG standards and recommendations; (2) eliminate the proposed provision for routine gonorrhea screening and the existing requirement and recommendation for anemia screening and provide that clinics screen based on medical necessity or local conditions. Clinics desiring to screen all clients routinely should be required to justify the need to HHS; and (3) clarify clinics' options to tailor education requirements to client status and circumstances.

Department Comment

We concur. With respect to routine revisit policies, the departmental policy has been to never exceed American College of Obstetricians and Gynecologists (ACOG) guidelines. ACOG's 1973 Guidelines for Interconceptional Care Clinics provides that:

> "Pill patients should be seen every three to six months for refills and inquiry as to untoward problems. At the time of each refill visit, the weight and blood pressure should be recorded."

In 1976, to update this recommendation, an ACOG committee, working with the Bureau of Community Health Services (BCHS), attempted to establish a guideline schedule of visits consistent with the needs of the clients served. In late 1980, an ACOG committee agreed to revise its guidelines to recommend fewer routine visits. BCHS concurred with the revised 1980 ACOG recommendation.

With respect to gonorrhea screening, BCHS and the Centers for Disease Control (CDC) are jointly developing specific guidance for deciding when to screen for gonorrhea. The jointly proposed publication Guidelines for Diagnosis and Treatment of Sexually Transmitted Diseases requires gonorrhea cultures only for clients requesting IUDs.

Concerning anemia screening, BCHS' Program Guidelines for Family Planning Clinics, in its present final draft form, provides that: (1) anemia screening is required only in the initial medical evaluation of those clients requesting prescriptive methods of contraception (oral contraceptives, IUDs, diaphragms); (2) annual anemia screening is required only for IUD users because of the well-documented incidence of menstrual blood loss in such women; and (3) a waiver from the initial screening may be requested if a project's medical director determines that routine anemia screening is unwarranted in the client population served.

In regard to client education, BCHS research in clinic service delivery improvement has shown the need for more flexible education modes than that offered at many clinic sites. In its new guidelines, BCHS has clarified the clinic's options to tailor client education to client status and circumstances. The guide states, for example, that "the educational approach used should be appropriate to the patient's age, situation, and previously acquired information."

GAO Recommendation

We recommend that the Secretary direct BCHS to work with the Centers for Disease Control to prepare guidance on venereal disease screening appropriate for family planning projects. Such guidance should enable projects to decide, in consultation with State and local health authorities, whether to routinely test all clients or to apply criteria for selective testing.

Department Comment

We concur. BCHS has been working on an ongoing basis with CDC in the development of venereal disease screening guidance. Proposed guidelines have been completed and a second draft has been circulated to appropriate grantees for comments. It is expected that the guidelines will be issued in final form by July 1981.

GAO Recommendation

We recommend that the Secretary more closely monitor clinic practices to identify routine visits or medical services that are in excess of those required or recommended and deny Federal financial participation under the Title X, Medicaid, Social Services, and other programs for those activities unless they are appropriately justified.

APPENDIX III

Department Comment

We concur. The Department will take the necessary steps to positively identify and address those clinics which generate high costs per encounter in order to eliminate excessive services. However, to review routine client visits and any excess medical services provided by clinics on a day-to-day basis would require a prohibitively expensive monitoring staff. In addition, the new program guidelines also provide clinics with clearer instructions for differentiating between recommendations and requirements to eliminate any misunderstandings in the area of required services. The Department agrees with GAO on the need to conserve Federal funds and will place special importance on the monitoring of high cost projects.

GAO Recommendation

We recommend the Secretary direct HHS regional offices to assure that Title X funded clinics establish fee scales and collect fees in accordance with Title X regulations.

Department Comment

We concur. The revised Program Guidelines for Family Planning Clinics for use by regional offices reiterate the provisions of 42 CFR 59, Subpart A. In this connection, it directs the regional offices to assure themselves that Title X clinics collect charges for the cost of services provided in accordance with a fee schedule and a schedule of discounts which must be submitted by the grantee for approval as part of his project plan. Further, the policies and requirements for the grantee's accountability of program income is also brought to the attention of the regional offices as specified in Federal Regulations Title 45 Part 74, Subpart F, Administration of Grants.

GAO Recommendation

We recommend the Secretary take steps to resolve the differences between the Title X and Title XX programs regarding eligibility for free and subsidized family planning service. If necessary, appropriate legislative proposals should be prepared to achieve this.

Department Comment

We do not concur. Current laws do not require that Title XX family planning fee policies be consistent with those of Title X. Presently, under Title XX, each state has broad authority within certain limits to determine: (1) the services to be provided; (2) eligibility criteria; and (3) fee structures. Consequently, states now have the flexibility in family planning programs to meet the particular needs of their citizens. For example, some states classify teenagers as a priority population and other states use income as the eligibility criteria for services under Title XX. Our view is that state decisionmaking is preferable in setting

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criteria for eligibility for family planning services. In addition, a legislative change requiring states to impose a mandatory fee for family planning services would not result in a consistent policy because mandatory fees are not imposed on the states for other preventive health care services.

GAO Recommendation

We recommend the Secretary of HHS direct the Deputy Assistant Secretary for Population Affairs and the (BCHS) Office for Family Planning to refine existing management information systems to provide data and performance and efficiency indicators suited to family planning clinic operations. HHS should build on existing automated systems and should include, for example, objective and measurable standards for: accurately counting workload; reporting retention levels and degree of contraceptive protection provided; total cost of providing services; monitoring fee collections; and the extent to which women served are priority target populations.

Department Comment

We do not concur. BCHS has in operation a uniform Federal reporting system entitled "BCHS Common Reporting Requirements" (BCRR). Each grantee is required to submit semi-annually the BCRR, composed of nine tables. In addition to using the BCRR data collection and reporting for Title X, Family Planning Projects, BCHS uses the BCRR to accomplish the following objectives:

1. assure compliance with legislative mandates;
2. report to the Congress program status;
3. allocate resources to regional offices;
4. conduct program evaluation, including comparisons among programs, states, and regions;
5. provide a data base for objective grant awards;
6. facilitate program integration; and
7. identify areas where grantees need technical assistance.

It should be made clear that the regional offices' role in program management is not to manage family planning clinics directly. Management is the responsibility of the grantee organization itself. If BCHS and the regional offices were to provide management directly to the 218 family planning grantees and its approximate 5,100 clinic sites, the staff time, data collection, and processing involved would be extremely costly.

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In addition to the information supplied by BCRR, regional offices also rely on site visits, technical assistance reporting, grant award reporting as required by the terms and conditions of the grant award instrument, and audit reports.

BCRR reporting is based on the basic management components established and maintained by each individual grantee such as payroll records, patient medical records, general ledgers and subledgers, billing and collection systems, personnel policy manual, quality assurance system, etc.

BCHS requires each grantee to develop and maintain the essential component parts of a sound management system. Therefore, the Department has no intention of imposing a direct Federal management system on any grantee, as suggested in the GAO report.

GAO Recommendation

To put the Deputy in a better position to coordinate and evaluate all family planning activities within HHS, we recommend that the Secretary clarify the responsibilities of the Deputy and instruct component agencies to cooperate with the Deputy (Deputy Assistant Secretary for Population Affairs).

Department Comment

The Administration believes that current categorical project grants and state formula grants for health services do not adequately meet state and local health needs and priorities since they are restrictive in the type of activities to be undertaken. Further, they do not provide appropriate state control of the resources to deliver health services effectively and also do not provide enough flexibility to allow state determination concerning targeting of resources. As a consequence, the Administration has proposed health services, social services, and preventive health block grants which would provide funds to the states to assist them in undertaking health services, social services, health promotion and disease prevention activities, including family planning, as each state finds appropriate. Title X of the Public Health Service Act and Titles V and XX of the Social Security Act are included in these proposed block grants. Consequently, there would no longer be a need for this coordination role. If the block grant legislation is not enacted, the Department will examine the coordination issue.

GAO Recommendation

We recommend that the Secretary define program implementation research and inform the Congress of its definition.

Department Comment

We do not concur. The Department's position on this recommendation is that: (1) the program implementation research has been defined; (2) that it complies with congressional intent and is consistent with the Department's philosophy; and (3) the Congress is aware of the various activities under services delivery improvement (SDI) research reported through the Five Year Plan.

In FY 1972, with the passage of the law, the Office of Deputy Assistant Secretary for Population Affairs (DASPA), and the National Center for Family Planning Services (NCFPS) defined program implementation research funded under section 1004 authority as SDI research based on an analysis of congressional intent, as recorded in the hearings. DASPA and NCFPS, therefore, agreed to refer to all activities funded under the "Program Implementation Research" as SDI research. This position is consistent with all departmental budget requests and reports to the Congress.

Program implementation research, defined as SDI, thus includes the following broad areas of activity.

1. Needs assessment.
2. Operational or action research.
3. Demonstration programs.
4. Development and testing of tools and techniques.
5. Gathering of information for planning purposes.
6. Technical assistance.
7. Evaluative research where feasible.

The Department formally submits Five Year Plan Reports to the Congress in compliance with the requirements of section 1009 of Title X of the Public Health Service Act (as amended by P.L. 94-63). In the first Five Year Plan Report, the Secretary discussed services research, planning and evaluation, and stated that "Research focussed on family planning services development should be closely associated with the process of overall program planning and with the development of evaluation systems to assess achievement of program objectives..." Other Five Year Plan Reports also refer to SDI research. The lastest Five Year Plan Report was submitted to the Congress in May 1980 wherein SDI research is addressed (page 30), including goals and plans for the years 1980 - 1985.

When the National Center for Family Planning Services was assigned responsibility for the planning and implementation of the program implementation research, discussions were held with the DASPA to define the scope of

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services that would fall within the broad range of the requirement and responsibility for program implementation research. Since the Congress had not elaborated on the definition, the committee report hearings on S.2108, S.3219, H.R.15159, H.R.9108, H.R.1909, H.R.15691, as well as H.R.11123 were reviewed. Based on testimony of witnesses and congressional reaction to the testimony as well as reports such as Harkavy Report and a report prepared by the Ad Hoc Group on Population Research, Office of Science and Technology, Executive Office of the President, it was agreed that in order to keep it simple and straight forward, program implementation research under section 1004 authority would be referred to as service delivery improvement research.

Data concerning service delivery improvement research activities are discussed in the following documents.

1. Hearings before the subcommittee on Public Health and Welfare of the Committee on Interstate and Foreign Commerce, House of Representatives, 91st Congress, second session on H.R.15159 et. al.

2. Hearings before the subcommittee on Health of the Committee on Labor and Public Welfare, United States Senate, 91st Congress, first and second sessions in S.2108 and S.3219, December 8, 9, 1969 and February 19, 1970.

3. Ibid., Appendix E
"Report to the Federal Council for Science and Technology" prepared by Ad Hoc Group on Population Research (Parts I and II). July 1, 1969 Executive Office of the President, Office of Science and Technology.

4. Five Year Plan Reports to the Congress as submitted in compliance with Section 1009 of Title X of the Public Health Service Act (as amended by P.L. 94-63).

Technical Comments

The last sentence in the second paragraph on page 70 should be corrected to read:

> These local systems have in turn supplied data to NCHS for its sample, accounting for an estimated 80 percent of the reporting by Title X clinics.

The second sentence in the last paragraph on page 70 should be corrected to read:

> Final results of the study . . .

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The last sentence in the second paragraph on page 71 should be corrected to read:

> The data processing contract cost for the 1981 survey was budgeted at $632,049 of which $382,049 was from BCHS. Funding of an additional $500,000 would have been requested to improve quality control procedures had the National Reporting System continued beyond calendar year 1980.

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