A Comparative Analysis of Factors Influencing the Implementation of Family Planning Services in the United States

JOHN T. GENTRY, MD, MPH
ARNOLD D. KALUZNY, PhD
JAMES E. VENEY, PhD

The provision of family planning services by hospitals and health departments was surveyed by questionnaire to ascertain implementation levels of family planning and referral arrangements, and the role of planning, funding, and regulatory agencies.

Introduction

The health planner and administrator interested in extending the availability of family planning services require two types of information: (1) the level at which family planning services have already been implemented by service providers; (2) various community, organizational, and personal variables that facilitate or impede the provision of these services. This paper describes the provision of family planning services by short term acute hospitals and health departments. It also defines variables associated with implementation level.

The family planning services and activities selected for the purpose of this paper include: (1) provision of family planning services as a separate entity; (2) provision of family planning services in conjunction with other health services such as pre- and postnatal clinics and well baby conferences; (3) routine educational and case-finding activities for maternity or other patients; (4) systematic follow-up procedures involving the use of postcards, telephone reminders, or home visits; and (5) community case-finding activities using indigenous workers.

The paper describes a portion of a larger research project dealing with innovation and diffusion of health care programs in samples of hospitals and health departments selected nationally and in New York State. The objective of the larger project is to examine significant social, psychological, and economic factors that influence the introduction of health service programs and service linkage mechanisms that contribute to the comprehensiveness and effectiveness of community health services.

An extensive literature is available that reviews innovation and diffusion of various kinds of information and activities.[1-5] With but few exceptions, however, the diffusion of family planning services has not been studied.[6-8]

Methods

Data used in the study were collected from three

Drs. Gentry, Kaluzny, and Veney are associated with the Department of Health Administration, School of Public Health, University of North Carolina, Chapel Hill, North Carolina 27514. This research was supported by the Health Services Research Center of the University of North Carolina through Research Grant HS-00239 from the National Center for Health Services Research and Development, Department of Health, Education, and Welfare.

TABLE 1—U.S. Implementation of Family Planning Services in Hospitals and Health Departments by Size of Hospital and Size of Health Department Jurisdiction*

Services	Hospitals: Number of Beds				Health Departments: Size of Jurisdiction			
	≤500		>500		<250,000		≥250,000	
	Yes	No	Yes	No	Yes	No	Yes	No
Family planning serviees	76 (18.5)	335 (81.5)	49 (71.0)	20 (29.0)	104 (65.0)	56 (35.0)	31 (68.9)	14 (31.1)
Provision of family planning clinic as a separate entity	29 (7.1)	382 (92.9)	27 (39.1)	42 (60.9)	61 (38.1)	99 (61.9)	24 (53.3)	21 (46.7)
Provision of family planning services in conjunction with other health services	52 (12.7)	359 (87.3)	43 (62.3)	26 (37.7)	65 (40.6)	95 (59.4)	24 (53.3)	21 (46.7)
Routine educational and case-finding activities	34 (8.3)	377 (91.7)	34 (49.3)	35 (50.7)	39 (24.4)	121 (75.6)	15 (33.3)	30 (66.7)
Systematic follow-up procedures involving postcard or telephone reminders or home visits	31 (7.5)	380 (92.5)	33 (47.8)	36 (52.2)	75 (46.9)	85 (53.1)	27 (60.0)	18 (40.0)
Community case-finding activities using indigenous workers	9 (2.2)	402 (97.8)	13 (18.8)	56 (81.2)	40 (25.0)	120 (75.0)	19 (42.2)	26 (57.8)

* Numbers in parentheses indicate percentage.

sources. The first consisted of national samples of 6,520 short term acute hospitals (N = 627) and 1,642 health department jurisdictions (N = 286). Stratified probability samples were proportional to approximate population coverage.* Information was obtained from hospital administrators and health officers by mail questionnaire. The overall response rate exceeded 75 per cent of the hospital sample (N = 480) and 72 per cent of the health department sample (N = 206). Analysis of nonrespondents based on stratification variables indicates that there are no significant differences from those organizations that did participate in the survey.

The second source comprised 25 county and four city health jurisdictions in New York State, exclusive of New York City, and a sample of 70 short term acute hospitals located within respective political jurisdictions. Information was obtained from all participating hospital administrators and health officers by structured interviews. In addition, information from self-administered questionnaires was obtained from 93 per cent of participating hospitals (N = 65) and 97 per cent of participating health departments (N = 28). Hospital questionnaire data were obtained from respective administrators (N = 48), trustees (N = 371), administrative staff (N = 347), controllers (N = 44), and medical staff (N = 529). Health department questionnaire data were obtained from health officers (N = 24), professional staff (N = 127), board of health members (N = 106), staff public health nurses (N = 204), and county legislators and city councilmen (N = 65). Questionnaire response rates for individual respondent categories ranged from a high of 86 per cent for health officers and health department professional staff to a low of 46 per cent for elected officials.

The third source consisted of information from administrators of planning, funding, and regulatory bodies serving respective New York State study organizations and was obtained by self-administered questionnaires and telephone interviews. Participating agencies included area health planning agencies (314), health councils, and regional hospital councils; Blue Cross, Blue Shield, and commercial health insurance carriers; and regional offices of the New York State Health Department and State Welfare Department.

Survey instruments used for the national samples were designed to encompass five major areas:

- Presence or absence of study services and activities;
- Whether study services were being provided by another agency;
- Information regarding study organization's relationships with other community agencies providing study services;
- Administrator's attitudes concerning the relative importance of specific services and activities for meeting community health needs; and
- Limited sociodemographic data concerning respective administrators and health officers.

The interview schedule used with New York State organizations provided additional information regarding:

* For hospitals the final selection procedure was based on the number of beds per hospital to ensure that sampling units approximated population coverage. Final health department selection was based on the actual population size of the jurisdiction. Thus the analysis of program implementation is relative to population coverage and not just a reflection of the presence or absence of programs in the universe of health care organizations.

TABLE 2—U.S. Implementation of Family Planning Services in Hospitals and Health Departments by Region and Size of Community in Which Organization Is Located

Region and Implementation	Hospitals: Community Size					Health Departments: Community Size					Total Hospitals and Health Departments by Region
	≥250,000	<250,000 but ≥25,000	<25,000 SMSA*	<25,000 Non-SMSA	Total by region	≥250,000	<250,000 but ≥25,000	<25,000 SMSA	<25,000 Non-SMSA	Total by region	
Northeast											
Yes	19	12	4	3	38	4	12	2	0	18	56
	82.6†	46.2	33.3	18.8	(49.4)	40.0	44.4	100	0	(43.9)	(47.5)
	(50.0)‡	(31.6)	(10.5)	(7.9)		(22.2)	(66.7)	(11.1)	0		
No	4	14	8	13	39	6	15	0	2	23	62
	17.4	53.8	66.7	81.2	(50.6)	60.0	55.6	0	100	(56.1)	(52.5)
	(10.3)	(35.9)	(20.5)	(33.3)		(26.0)	(65.2)	0	(8.7)		
North Central											
Yes	16	12	0	2	30	11	10	3	4	28	58
	38.1	24.0	0	4.8	(20.8)	68.8	40.0	100	28.6	(48.3)	(28.7)
	(53.3)	(40.0)	0	(6.7)		(39.3)	(35.7)	(10.7)	(14.3)		
No	26	38	10	40	114	5	15	0	10	30	144
	61.9	76.0	100	95.2	(79.2)	31.3	60.0	0	71.4	(51.7)	(71.3)
	(22.8)	(33.3)	(8.8)	(35.1)		(16.7)	(50.0)	0	(33.3)		
South											
Yes	17	17	2	8	44	8	26	5	24	63	107
	40.5	25.4	13.3	13.8	(24.2)	72.7	89.7	83.3	82.8	(84.0)	(41.6)
	(38.6)	(38.6)	(4.6)	(18.2)		(12.7)	(41.3)	(7.9)	(38.1)		
No	25	50	13	50	138	3	3	1	5	12	150
	59.5	74.6	86.7	86.2	(75.8)	27.3	10.3	16.7	17.2	(16.0)	(58.4)
	(18.1)	(36.2)	(9.4)	(36.2)		(25.0)	(25.0)	(8.3)	(41.7)		
West											
Yes	6	3	3	1	13	8	11	1	6	26	39
	37.5	9.4	30.0	5.3	(16.9)	100	73.3	100	85.7	(83.9)	(36.1)
	(46.2)	(23.0)	(23.0)	(7.7)		(30.8)	(42.3)	(3.8)	(19.2)		
No	10	29	7	18	64	0	4	0	1	5	69
	62.5	90.6	70.0	94.7	(83.1)	0	26.7	0	14.3	(16.1)	(63.9)
	(15.6)	(45.3)	(10.9)	(28.1)		0	(80.0)	0	(20.0)		

* Standard Metropolitan Statistical Area.

† Percentage is of total of yes and no responses within community size and region of country.

‡ Percentage is of total of yes or no responses within region of country.

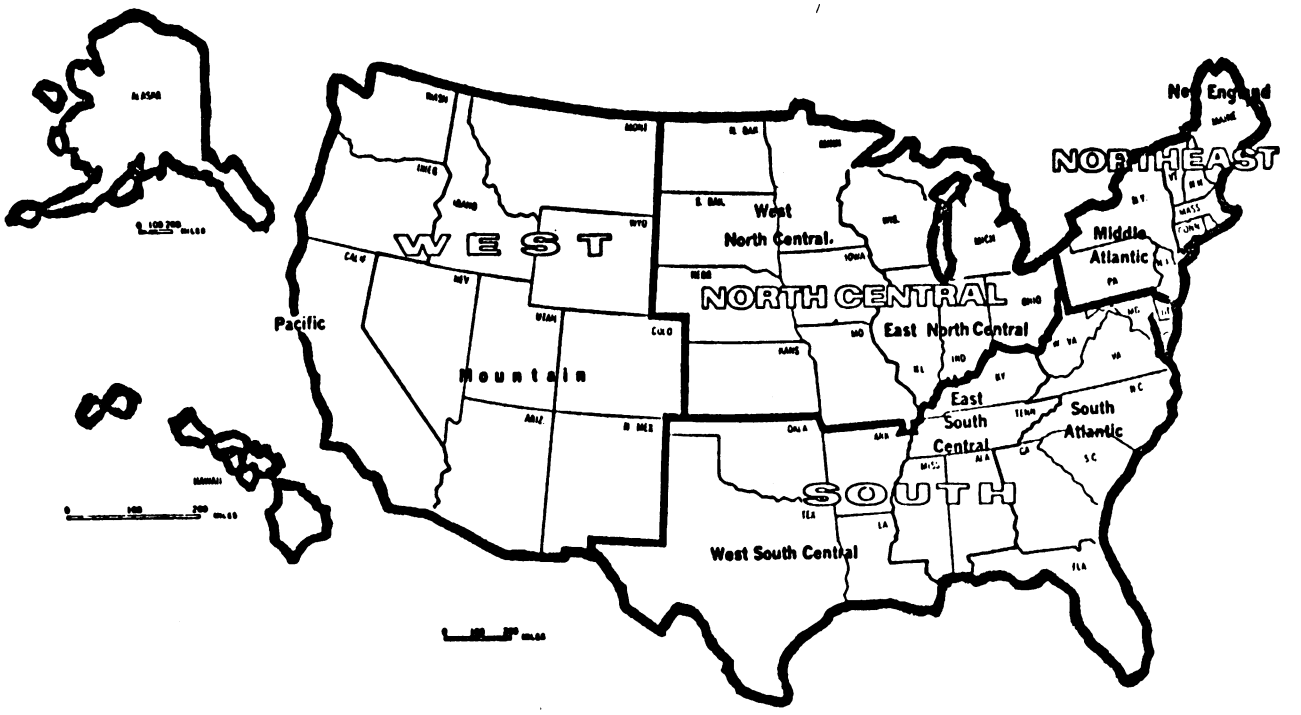

FIGURE 1 Regions of the United States.

- Factors that may have influenced decisions to implement or not implement services;
- The priority at which implementation of new services would be placed if funds were made available; and
- The level at which community health needs for respective study services were satisfied.

The self-administered questionnaire schedule used with the New York State portion of the study provided additional information concerning characteristics of the organizations with which respondents were affiliated, and the relationships between respective study programs and planning, funding, and regulatory bodies. Respondents were queried regarding whether specific health services were or were not provided, the level at which community needs were met, and reasons why services were not implemented.

Information regarding geographic region and rural-urban nature (termed type of community) was obtained from data available in the City-County Data Book published by the Bureau of the Census.[9] Data regarding hospital administrative control and hospital size were obtained from information available in the Master Facility Inventory of the National Center for Health Statistics.

Findings

Study findings are summarized under the following headings: (1) implementation levels; (2) factors perceived as influencing implementation and referral arrangements; and (3) the role of planning, funding, and regulatory agencies.

Family Planning Service Implementation Levels

Information concerning the level of implementation of the specific family planning services under study is summarized in Table 1. U.S. data are reported for both hospitals and health departments by size of hospital and size of health department jurisdiction. Without exception, large hospitals are more likely to have implemented family planning services than small hospitals. Seventy-one per cent of hospitals having over 500 beds have implemented one or more family planning services. In contrast, only 19 per cent of hospitals with less than 500 beds have implemented services. This same relationship holds for implementation of each of the specific services as well. A similar but less pronounced difference is associated with size of health department jurisdiction. Sixty-nine per cent of health departments with jurisdictions of over 250,000 people and 65 per cent of health departments with jurisdictions of less than 250,000 people have implemented services.

The proportion of organizations providing specific services and activities also varies by type of organization. Larger hospitals exceed health departments in the provision of family planning services in conjunction with other health services (62 per cent) and routine educational and case-finding activities (49 per cent). In contrast, a greater proportion of large health departments have systematic follow-up procedures (60 per cent), and a greater proportion of both large and small health departments undertake community case-finding activities using indigenous workers (42 and 25 per cent, respectively).

Table 2 illustrates the level of implementation of family planning services by region of the country and size

of the community in which study organizations are located. Although not as pronounced as for organizational and jurisdictional size, implementation of family planning services is related to the size of the community in which study organizations are located. The proportion of larger communities providing family planning services is consistently higher than the proportion not providing such services. This relationship between implementation level and community size does not occur for health departments. Regional configurations are illustrated in Figure 1.

Regionally, implementation of family planning services is highest for hospitals in the Northeast and lowest in the West. In contrast, the highest level of implementation of services by health departments occurs in the South and West. The Northeast region is lowest for health departments. Additional data concerning hospital sponsorship and rate of implementation have been described in other study reports.[10,11]

Aggregate implementation levels for the United States, the Northeast region, and New York State are summarized in Table 3. The implementation level of family planning services is higher for both hospitals and health departments in the Northeast region than in New York State. Implementation levels of hospitals in New York State are similar to the national level for all study services and activities. In contrast, New York health departments are considerably below national implementation levels except for community case-finding using indigenous workers.

New York State implementation levels are summarized in Tables 4 and 5. Information for hospitals is provided by hospital size, hospital sponsorship, and state region. Health department data are similarly provided by size of jurisdiction and region. In general, the implementation of family planning services tends to follow patterns already noted for the nation as a whole. State regions are identified in Figure 2.

Implementation for New York hospitals is largely proportional to hospital size. For all services, large hospitals (>350 beds) have the highest proportion of implementation. The latter ranges from a high of 53 percent for voluntary female sterilization to a low of 6 per cent for community case-finding using indigenous workers.

With the exception of service integration, city and county hospitals recorded the highest proportion of implementation. Implementation ranged from a high of 57 per cent for voluntary female sterilization to a low of 14 per cent for each of three study services: separate clinics, services in conjunction with other health services, and community case-finding. Of all services provided by voluntary hospitals, the highest level of services was for voluntary female sterilization at 26 per cent.

Implementation for New York health departments with jurisdictions greater than 250,000 population greatly exceeded smaller jurisdictions, 86 per cent versus 14 per cent.

Differences in implementation between the regions comprising New York State were dependent upon type of services. The Northeast and Central regions had the lowest

TABLE 3—Number of Hospitals and Health Departments in the United States, Northeast Region, and New York State Providing Family Planning Services

	United States				Northeast				New York State			
	Hospitals		Health departments		Hospitals		Health departments		Hospitals		Health departments	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family planning services	125	26.0	135	65.9	38	49.4	18	43.9	18	26.9	9	32.1
Provision of family planning clinic as separate entity	56	11.7	85	41.5	23	29.9	8	19.5	8	11.9	9	32.1
Provision of family planning services in conjunction with other health services	95	19.8	89	43.4	27	35.1	16	39.0	14	20.9	8	28.6
Routine educational and case-finding activities	68	14.2	54	26.3	26	33.8	9	22.0	11	16.4	5	17.9
Systematic follow-up procedures involving postcard or telephone reminders or home visits	64	13.3	102	49.8	25	32.5	11	26.8	10	14.9	8	28.6
Community case-finding activities using indigenous workers	22	4.6	59	28.8	10	13.0	10	24.4	1	1.5	9	32.1
Total	480		205		77		41		67		28	

TABLE 4—Hospitals in New York State Providing Family Planning Services by Number of Beds, Sponsorship, and Region of State

Services	Total		Number of Beds						Sponsorship						Region					
			<150		150–350		>350		Government		Voluntary		Proprietary		Western and Rochester		Northeast and Central		Northern Metropolitan	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family planning Services																				
Yes	18	26.9	1	6.7	9	25.7	8	47.1	4	57.1	14	25.5	0	0	7	30.4	4	21.1	7	28.0
No	49	73.1	14	93.3	26	74.3	9	52.9	3	42.9	41	74.5	5	100.0	16	69.6	15	78.9	18	72.0
Oral contraceptives																				
Yes	13	19.4	2	13.3	5	14.3	6	35.3	2	28.6	11	20.0	0	0	4	17.4	2	10.5	7	28.0
No	54	80.6	13	86.7	30	85.7	11	64.7	5	71.4	44	80.0	5	100.0	19	82.6	17	89.5	18	72.0
IUD																				
Yes	14	20.9	2	13.3	5	14.3	7	41.2	2	28.6	12	21.8	0	0	5	21.7	2	10.5	7	28.0
No	53	79.1	13	86.7	30	85.7	10	58.8	5	71.4	43	78.2	5	100.0	18	78.3	17	89.5	18	72.0
Family planning clinic as a separate entity																				
Yes	8	11.9	2	13.3	2	5.7	4	23.5	1	14.3	7	12.7	0	0	2	8.7	1	5.3	5	20.0
No	59	88.1	13	86.7	33	94.3	13	76.5	6	85.7	48	87.3	5	100.0	21	91.3	18	94.7	20	80.0
Family planning services in conjunction with other health services																				
Yes	14	20.9	3	20.0	5	14.3	6	35.3	1	14.3	13	23.6	0	0	5	21.7	2	10.5	7	28.0
No	53	79.1	12	80.0	30	85.7	11	64.7	6	85.7	42	76.4	5	100.0	18	78.3	17	89.5	18	72.0
Systematic follow-up procedures involving postcard or telephone reminders or home visits																				
Yes	10	14.9	2	13.3	1	2.9	7	41.2	2	28.6	8	14.6	0	0	4	17.4	2	10.5	4	16.0
No	57	85.1	13	86.7	34	97.1	10	58.8	5	71.4	47	85.5	5	100.0	19	82.6	17	89.5	21	84.0
Voluntary female sterilization																				
Yes	18	26.9	4	26.7	5	14.3	9	52.9	4	57.1	14	25.5	0	0	5	21.7	3	15.8	7	28.0
No	49	73.1	11	73.3	30	85.7	8	47.1	3	42.9	41	74.6	5	100.0	18	78.3	16	84.2	18	72.0
Voluntary male sterilization																				
Yes	15	22.4	4	26.7	4	11.4	7	41.2	2	28.6	13	23.6	0	0	7	30.4	3	15.8	5	20.0
No	52	77.6	11	73.3	31	88.6	10	58.8	5	71.4	42	76.4	5	100.0	16	69.6	16	84.2	20	80.0
Community case-finding activities using indigenous workers																				
Yes	1	1.5	0	0	0	0	1	5.9	1	14.3	0	0	0	0	0	0	0	0	1	4.0
No	66	98.5	15	100.0	35	100.0	16	94.1	6	85.7	55	100.0	5	100.0	23	100.0	19	100.0	24	96.0
Routine educational and case-finding activities																				
Yes	11	16.4	1	6.7	3	8.6	7	41.2	2	28.6	9	16.4	0	0	4	17.4	3	15.8	4	16.0
No	56	83.6	14	93.3	32	91.4	10	58.8	5	71.4	46	83.6	5	100.0	19	82.6	16	84.2	21	84.0
Total number of hospitals	67		15		35		17		7		55		5		23		19		25	

TABLE 5—Health Departments in New York State Providing Family Planning Services by Size of Jurisdiction and Region

Services	Total		Size of Jurisdiction: ≤250,000 but >25,000		Size of Jurisdiction: >250,000		Region: Western and Rochester		Region: Northeast and Central		Region: Northern Metropolitan	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family planning services												
Yes	9	32.1	3	14.3	6	85.7	3	33.3	2	20.0	4	44.4
No	19	67.9	18	85.7	1	14.3	6	66.7	8	80.0	5	55.6
Oral contraceptives												
Yes	9	32.1	3	14.3	6	85.7	3	33.3	2	20.0	4	44.4
No	19	67.9	18	85.7	1	14.3	6	66.7	8	80.0	5	55.6
IUD												
Yes	9	32.1	3	14.3	6	85.7	3	33.3	2	20.0	4	44.4
No	19	67.9	18	85.7	1	14.3	6	66.7	8	80.0	5	55.6
Family planning clinic as a separate entity												
Yes	9	32.1	3	14.3	6	85.7	3	33.3	2	20.0	4	44.4
No	19	67.9	18	85.7	1	14.3	6	66.7	8	80.0	5	55.6
Family planning services in conjunction with other health services												
Yes	8	28.6	2	9.5	6	85.7	2	22.2	2	20.0	4	44.4
No	20	71.4	19	90.5	1	14.3	7	77.8	8	80.0	5	55.6
Systematic follow-up procedures involving postcard or telephone reminders or home visits												
Yes	8	28.6	2	9.5	6	85.7	2	22.2	2	20.0	4	44.4
No	20	71.4	19	90.5	1	14.3	7	77.8	8	80.0	5	55.6
Voluntary female sterilization												
Yes	1	3.6	1	4.8	0	0	0	0	1	10.0	0	0
No	27	96.4	20	95.2	7	100.0	9	100.0	9	90.0	9	100.0
Voluntary male sterilization												
Yes	1	3.6	1	4.8	0	0	0	0	1	10.0	0	0
No	27	96.4	20	95.2	7	100.0	9	100.0	9	90.0	9	100.0
Community case-finding activities using indigenous workers												
Yes	9	32.1	3	14.3	6	85.7	3	33.3	2	20.0	4	44.4
No	19	67.9	18	85.7	1	14.3	6	66.7	8	80.0	5	55.6
Routine education and case-finding activities												
Yes	4	14.3	1	4.8	3	42.9	0	0	2	20.0	3	33.3
No	24	85.7	20	95.2	4	57.1	9	100.0	8	80.0	6	66.7
Total number of health departments	28		21		7		9		10		9	

implementation levels for all study services and activities. These differences prevailed for both hospitals and health departments.

In addition to the implementation of services by study organization, the study also obtained information concerning the existence of referral relationships with other agencies providing such services. This information was obtained because of the opportunity for patients to receive services through other agencies. The proportion of hospitals and health departments with affiliation with other community agencies providing family planning services is summarized for the United States in Table 6. Only 53 per cent of hospitals providing study services have any type of referral relationship with other agencies providing family planning services. Fifty-seven per cent of health departments had referral relationships. For hospitals and health departments without family planning services, only 23 per cent and 40 per cent, respectively, have referral relationships with other community agencies providing such services. New York study data indicate that relatively few

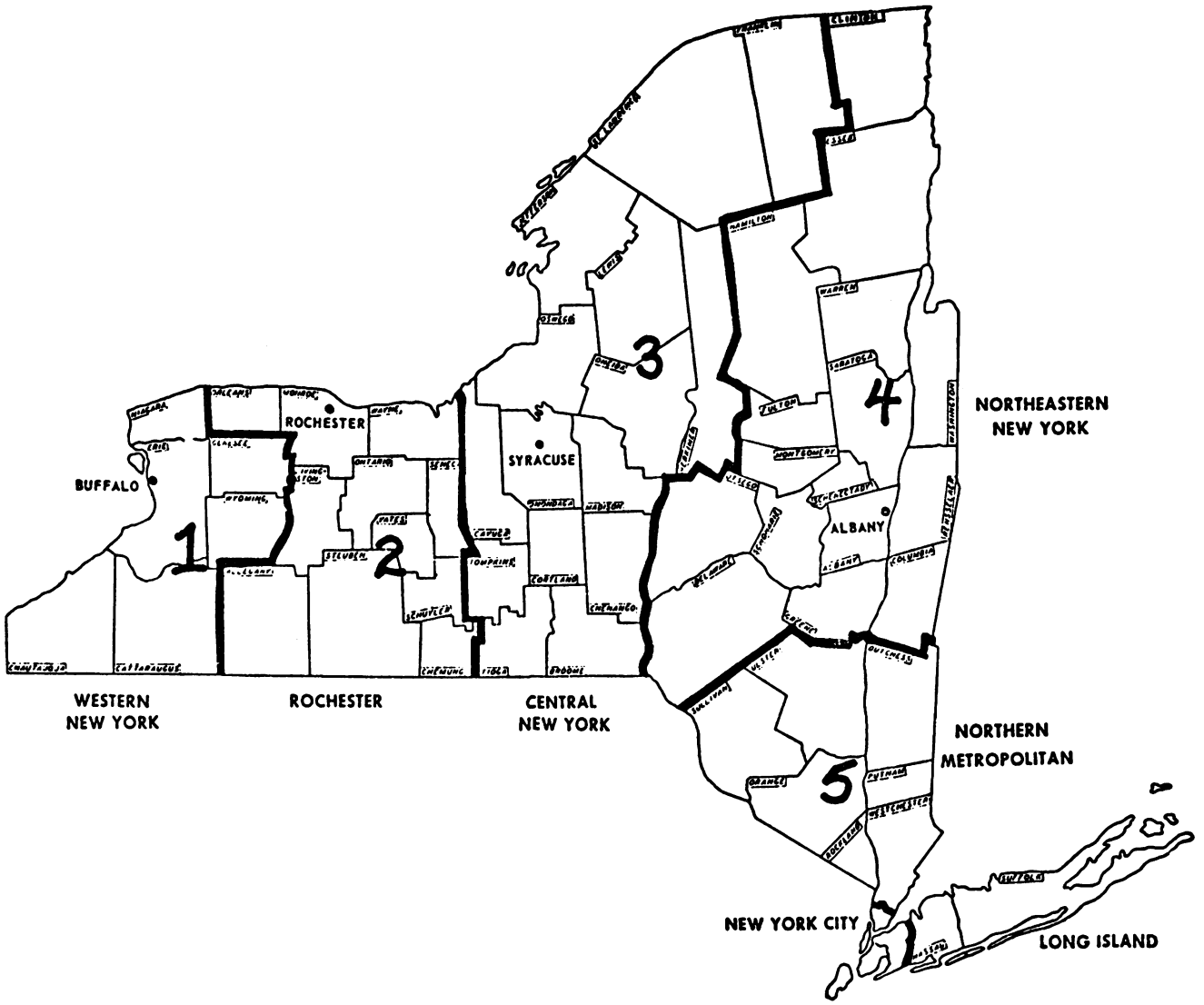

FIGURE 2 Health service regions of New York State.

study organizations that do provide family planning services share these services through referral relationships with other community health agencies that do not have such services.

Factors Perceived to Influence Implementation and Referral Arrangements

The importance of family planning services was reported by hospital administrators and health officers participating in the national survey. These data are summarized in Table 7 by size of hospital and health department jurisdiction. With but one exception, the administrators of large hospitals see family planning services as more important than do the administrators of small hospitals. In contrast, there were more limited differences by size of health department jurisdiction. With the exception of routine educational activities and case-finding for patients within hospitals, health officers exceeded hospital administrators in viewing family planning services as very important.

New York data concerning perceptions of need for services, community demand, availability of resources, and appropriateness of services for a particular agency are summarized by respondent categories.

THE VIEW OF THE ADMINISTRATOR

Eighteen New York hospitals and nine health departments have implemented family planning services. "Community demand" was named by one-third of the hospital administrators and one-third of the health officers as the reason for implementation of these services. "Encouragement by professional health workers associated with voluntary agencies" was named by 16 per cent of hospital administrators and one-third of health officers. When asked whether community needs for family planning services were

TABLE 6—Referral Relationships between U.S. Hospitals and Health Departments and Other Agencies Providing Family Planning Services

	Hospitals: Number of Beds								Health Departments: Size of Jurisdiction							
	Total		<250		250–500		>500		Total		<25,000 and Non-SMSA		≥25,000–180,000 and SMSA*		>180,000	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Number of hospitals and health departments that provides services	125	26.0	34	12.4	42	30.7	49	71.0	135	65.9	36	66.7	60	62.5	39	70.9
1. Services also provided by other community agencies	104	83.2	23	67.7	36	85.7	45	91.8	81	60.0	11	30.6	37	61.7	33	84.6
a. Number that have referral relationships with other providing agencies	55	52.9	15	65.2	15	41.7	25	55.6	46	56.8	8	72.7	17	45.9	21	63.6
b. Number that do not have referral relationships with other providing agencies	49	47.1	8	34.8	21	58.3	20	44.4	35	43.2	3	27.3	20	54.1	12	36.4
2. Services are not provided by any other community agencies	21	16.8	11	32.4	6	14.3	4	8.2	54	40.0	25	69.4	23	38.3	6	15.4
Number of hospitals and health departments that do not provide services	355	74.0	240	87.6	95	69.3	20	29.0	70	34.1	18	33.3	36	37.5	16	29.1
1. Services are provided by other community agencies	215	60.6	122	50.8	75	79.0	18	90.0	40	57.1	4	22.2	26	72.2	10	62.5
a. Number that have referral relationships with providing agencies	50	23.3	26	21.3	17	22.7	7	22.7	16	40.0	0	0	11	42.3	5	50.0
b. Number that do not have referral relationships with providing agencies	165	76.7	96	78.7	58	77.3	11	61.1	24	60.0	4	100.0	15	57.7	5	50.0
2. Services are not provided by any community agencies	140	39.4	118	49.2	20	21.0	2	10.0	30	42.9	14	77.8	10	27.7	6	37.5
Total number of hospitals and health departments in sample	480		274		137		69		205		54		96		55	

* Standard Metropolitan Statistical Area.

being adequately met by existing resources, 31 per cent of the 67 hospital administrators and 28 per cent of the 28 health officers responded that needs were being entirely met. These responses are recorded in Table 8.

Various reasons were given why hospitals and health departments did not provide family planning services. Both hospital administrators (40 per cent) and health officers (63 per cent) gave "provided by another agency" as the major reason for not implementing family planning services. Response data are summarized in Table 9. When respondents were asked at what priority level family planning services would be implemented if adequate funds were provided, 84 per cent of hospital administrators and 58 per cent of health officers indicated that this would be at a low priority. "Provided by another agency" was named by 46 and 82 per cent of respective respondents as the reason for the low priority. Additional reasons given for low priority were associated with "community needs met," "low demand," and "an inappropriate responsibility to assume." Responses regarding individual study services varied by respective service and the organization with which a respondent was affiliated. Hospital administrators, for example, cited "inappropriate responsibility to assume" as a major factor in not undertaking case-finding activities.

The reasons given for not developing a formal referral relationship with other agencies providing services included the existence of "informal relationships," "no specific reasons," and "not important."

THE VIEWS OF HOSPITAL TRUSTEES, MEMBERS OF BOARDS OF HEALTH, AND ELECTED OFFICIALS

When hospital Boards of Trustees were queried about reasons for nonprovision of oral contraceptives for the poor, the single most frequent factor was that it was "provided by another agency" (32 per cent). The second was "an inappropriate responsibility to assume" (26 per cent). These reasons were followed by various considerations such as "low demand," "not important," and lack of funds and staff. Physician respondents indicated "lack of staff" and "limited funds" as primary reasons.

A similar pattern was seen with members of Boards of Health. Forty-one per cent named "provided by another agency," while 11 per cent indicated that it was an "inappropriate responsibility to assume." Over 50 per cent of the elected officials responding to this question did not know why these services were not implemented. An additional 24 per cent indicated that it was "inappropriate."

The Role of Planning, Funding, and Regulatory Agencies Serving New York State

Administrators of planning, funding, and regulatory agencies were queried about provision of hospital-based case-finding and educational activities within their respective jurisdictions and the level at which needs for respective services were being met. Among the 13 planning agency respondents, 23 per cent indicated that their agencies were involved in promotional activities only, 23 per cent provided funds, and 53 per cent were inactive in this health service area. Forty-three per cent indicated that inaction was associated with "limited funds," while 28 per cent named "inappropriate," "low demand," and "provided by another agency."

Twenty per cent of funding agency respondents indicated that benefits were available for this type of activity. Others indicated "inappropriate" and "low priority" as reasons for their inactivity. In contrast, 88 per cent of regulatory agency respondents indicated provision of funds. The remainder promoted this activity and did not finance because of "limited funds."

Responses to the question of whether needs were met varied by the agency with which respondents were associated. Whereas only 12 per cent of the administrators of regulatory agencies indicated that they did not know whether needs were met, or did not respond to the question, 60 per cent of funding and planning agency personnel fell within these response categories. Of those individuals responding directly to this question, over one-third of administrators from funding and planning agencies considered service needs met. In contrast, none of the administrators of regulatory agencies responded in this fashion.

Discussion

Implementation differences by size of institution, population, region, and hospital sponsorship illustrate community and organizational variables that have contributed to these differences. The findings, and the rates of implementation that have been experienced over the past decade, provide baseline data for the planner, administrator, and educator interested in projecting future implementation levels and necessary budgetary and manpower requirements.

Findings are of strategic value for individuals interested in accelerating the rate of growth of family planning services in general, particularly in areas where services are limited or not available. It is assumed that this type of information also has relevance for individuals concerned with expanding the availabity of abortion services. Differential implementation levels, such as relatively limited case-finding and educational activities, provide identification of possible priorities for further promotional and developmental activities.

The reasons given for not implementing specific services similarly identify areas for additional study or attention. It would be helpful to understand more adequately the basis for a respondent's suggestion that "provided by another agency," "inappropriate to assume," and "not important" are responsible for nonimplementation. The implications of these findings for educators responsible for the preparation of health services administrators has been reported in another paper.[12]

TABLE 7—Perceived Importance of Family Planning Services for U.S. Hospital Administrators and Health Officers by Size of Hospital and Health Department Jurisdiction

Hospitals: Services	Total		Number of Beds						Sponsorship						Region							
			<250		250–500		>500		Government		Voluntary		Proprietary		West		North Central		Northeast		South	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family planning services in general																						
Very important	210	43.8	105	38.3	63	46.0	42	60.9	69	60.0	131	38.5	10	40.0	35	45.5	65	45.1	41	53.2	69	37.9
Not very important	270	56.3	169	61.7	74	54.0	27	39.1	46	40.0	209	61.5	15	60.0	42	54.5	79	54.9	36	46.8	113	62.1
Provision of IUD or pill																						
Very important	157	32.7	90	32.8	45	32.8	22	31.9	47	40.9	100	29.4	10	40.0	25	32.5	54	37.5	28	36.4	50	27.5
Not very important	323	67.3	184	67.2	92	67.2	47	68.1	68	59.1	240	70.6	15	60.0	52	67.5	90	62.5	19	24.6	132	72.5
Provision of family planning services in conjunction with other health services																						
Very important	202	42.1	100	36.5	58	42.3	44	63.8	63	47.8	129	37.9	10	40.0	28	36.4	67	46.5	42	54.5	65	35.7
Not very important	278	57.9	174	63.5	79	57.7	25	36.2	52	45.2	211	62.1	15	60.0	49	63.6	77	53.5	35	45.5	117	64.3
Systematic follow-up procedures involving any of the following steps—postcard or telephone reminders or home visits																						
Very important	176	36.7	85	31.0	51	37.2	40	58.0	51	44.3	115	33.8	10	40.0	27	35.1	58	40,3	40	51.9	51	28.0
Not very important	304	63.3	189	69.0	86	67.8	29	42.0	64	55.7	225	66.2	15	60.0	50	64.9	86	59.7	37	48.1	131	72.0
Community case-finding activities using indigenous workers																						
Very important	73	15.2	32	11.7	25	18.2	16	23.2	17	14.8	51	15.0	5	20.0	8	10.4	29	20.1	15	19.5	21	11.5
Not very important	407	84.8	242	88.3	112	81.8	53	76.8	98	85.2	289	85.0	20	80.0	69	89.6	115	79.9	62	80.5	161	88.5
Routine educational and case-finding activities																						
Very important	111	23.1	48	17.5	36	26,3	27	39.1	40	34.8	69	20.3	2	8.0	12	15.6	35	24.3	33	42.9	31	17.0
Not very important	369	76.9	226	82.5	101	73.7	42	60.9	75	65.2	271	79.7	23	92.0	65	84.4	109	75.7	44	57.1	151	83.0
Total number of respondents	480		274		137		69		115		340		25		77		144		77		182	

TABLE 7—Continued

Health Departments: Services	Total		Jurisdiction Size: <25,000 and Non-SMSA*		Jurisdiction Size: ≥25,000–180,000 and SMSA		Jurisdiction Size: >180,000		Region: West		Region: North Central		Region: Northeast		Region: South	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family planning services in general																
Very important	163	79.5	42	77.8	73	76.0	48	87.3	27	87.1	62	80.5	30	73.2	44	78.6
Not very important	42	20.5	12	22.2	23	24.0	7	12.7	4	12.9	15	19.5	11	26.8	12	21.4
Provision of IUD or pill																
Very important	149	72.7	40	74.1	66	68.8	43	78.2	26	83.9	55	71.4	25	60.9	43	76.8
Not very important	56	27.3	14	25.9	30	31.3	12	21.8	5	16.1	22	28.6	16	39.1	13	23.2
Provision of family planning services in conjunction with other health services																
Very important	141	68.8	33	61.1	65	67.7	43	78.2	21	67.7	55	71.4	26	63.4	39	69.6
Not very important	64	27.3	21	38.9	31	32.3	12	21.8	10	32.3	22	28.6	15	36.6	17	30.4
Systematic follow-up procedures involving any of the following steps—postcard or telephone reminders or home visits																
Very important	140	68.3	36	66.7	67	69.8	37	67.3	22	70.9	54	70.1	24	58.5	40	71.4
Not very important	65	31.7	18	33.3	29	30.2	18	32.7	9	29.1	23	29.9	17	41.5	16	28.6
Community case-finding activities using indigenous workers																
Very important	69	33.7	12	22.2	36	37.5	21	38.2	12	38.7	27	35.1	18	43.9	12	21.4
Not very important	136	66.3	42	77.8	60	62.5	34	61.8	19	61.3	50	64.9	23	56.1	44	78.6
Routine visits by Public Health Nurses																
Very important	57	27.8	8	14.8	33	34.4	16	29.1	11	35.5	19	24.7	10	24.4	17	30.4
Not very important	148	72.2	46	85.2	63	65.6	39	70.9	20	64.5	58	75.3	31	75.6	39	69.6
Total number of respondents	205		54		96		55		31		77		41		56	

* Standard Metropolitan Statistical Area.

TABLE 8—Perceived Level of Community Family Planning Needs in New York State Met by Available Services

	Level of Community Needs Met									
	Entirely		Partially		Not met		No answer		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Health administrators	21	31.3	36	53.7	3	4.5	7	10.4	67	100
Health officers	8	28.0	16	57.1	3	10.7	1	3.6	28	100

TABLE 9—Reasons for Nonimplementation of Family Planning Services Named by New York State Hospital Administrators and Health Officers

	Hospitals			Health Departments	
Reasons	No.	%	Reasons	No.	%
1. Provided by another agency	21	42.9	1. Provided by another agency	12	63.2
2. Low community demand	11	22.5	2. Did not answer	2	10.5
3. Inappropriate responsibility to assume	6	12.2	3. Lack of appropriations	1	5.3
4. Community needs met	4	8.2	4. Lack of board approval of funds	1	5.3
5. Opposition by board	2	4.1	5. Community needs met	1	5.3
6. In process of instituting	2	4.1	6. Opposition by physicians	1	5.3
7. Not enough time to institute	1	2.0	7. Not enough time to institute	1	5.3
8. Personal opposition by administrator	1	2.0			
9. Did not answer	1	2.0			

* Standard Metropolitan Statistical Area.

The relatively large number of respondents who did not know whether services were either provided at all, or provided at a level necessary to meet community needs, is suggestive of limited familiarity by some respondents with the nature and scope of family planning services. The limited promotion and funding of family planning services by planning and third-party funding agencies suggest that certain family planning services may be viewed by some as being of relatively little importance. It is noteworthy that state regulatory agencies provided more promotional and funding support of family planning services than either planning or third-party funding agencies. These findings are particularly applicable in the area of case-finding and educational activities.

Additional findings worthy of attention pertain to the number and type of organizations identified in the national sample as having established referral relationships with other agencies providing family planning services. These findings are of special importance concerning the relative level at which community family planning services are coordinated, whether the most effective use is being made of available resources, and whether those individuals seen by hospitals and health departments without family planning services are being serviced by other available resources. Whereas one would assume that referral relationships would be most important for those organizations that do not provide family planning services, the reverse situation prevails. In contrast to national experience, the relatively higher proportion of the organizations in the New York portion of the study that have initiated referral arrangements illustrate the achievement level that is possible. Limited adoption of follow-up activities further suggests that "continuity" of patient care services requires additional attention and a relatively higher priority than has heretofore been placed on this activity.

Although family planning workers can be pleased that "community demand" and "encouragement by health workers associated with voluntary agencies" were the most influential factors named as contributing to family planning program implementation, additional attention would appear to be required for the factors named as reasons why services have not been implemented. "Provided by another agency" was the most frequent reason given for nonimplementation. This finding raises the question of whether responsibility for all family planning services should be centralized in one community agency or whether all health providers should be responsible for certain family planning case finding, referral, and follow-up activities. A related question is whether potential recipients of services do or do not have the capacity to initiate "demand" for family

planning services. This latter question is relevant for the manner in which community planning decisions for family planning programs are made and priorities are set.

References

1. Rogers, E. M. Diffusion and Innovation. Free Press of Glencoe, Glencoe, Illinois, 1962.
2. Carlson, R. E. Adoption of Educational Innovations. Center for the Study of Educational Administrations, University of Oregon, Eugene, 1967.
3. Lionberger, H. F. Adoption of New Ideas and Practices. Iowa University Press, Ames, 1960.
4. Miles, M. B. (ed.). Innovation in Education. Bureau of Publication, Teachers' College, Columbia University, New York, 1964.
5. Kaluzny, A. D. Innovation in the Health System: A Selective Review of System Characteristics and Empirical Research. Presented at the National Institute of Health Conference on Medical Innovation, Cornell University, September 24–27, 1972.
6. Eliot, J. W. The Development of Family Planning Services by State and Local Health Departments in the United States. Am. J. Public Health 56:6, 1966.
7. Mytinger, R. E. Innovation in Local Health Services. PHS Publication No. 1664-2. U.S. Government Printing Office, Washington, D. C., 1968.
8. Meyers, B. A., et al. The Medical Care Activities of Local Health Units. Public Health Rep. 83:757, 1968.
9. U.S. Bureau of the Census. County and City Data Book, 1967. U.S. Government Printing Office, Washington, D. C., 1967.
10. Kaluzny, A. D., et al. Diffusion of Innovative Health Care Services in the United States. Med. Care 8:6, 1970.
11. Veney, J. E. et al. Implementation of Health Programs in Hospitals. Health Services Res., 1971.
12. Gentry, J. T., et al. Perceptual Differences of Administrators Regarding the Importance of Health Service Programs. Am. J. Public Health 60:6, 1970.

RESOLUTIONS AND POSITION PAPERS

Position papers and resolutions proposed for consideration by APHA's Governing Council during the 102nd Annual Meeting must be submitted to the Division of Program Services at APHA headquarters by June 15. In a change from the procedure of past years, position papers and resolutions will be processed in exactly the same manner, with no preliminary outline required for position papers. Following receipt at APHA, each resolution and position paper will be assigned to one of four reference committees: personal health services, the environment, manpower and training, or social factors and health. Each reference committee consists of two members from the Action Board and two from the Program Development Board, plus a chairperson appointed by the APHA president from the membership in general.

The reference committees will review the position papers and resolutions and, by July 20, will prepare comments on each. Later that week, each position paper and resolution will be reviewed by the Joint Policy Committee, consisting of the chairpersons of the Action Board and Program Development Board, and three members from each of those boards. Whether approved, approved with recommended revisions, or recommended for rejection, the reviews will be mailed to the submitters by July 26. Submitters will have until August 30 to redraft their statements, if necessary, and return them to APHA headquarters.

Copies of the proposed policy statements will be distributed at the time of registration for the Annual Meeting. Proposed position paper and resolutions will *not* be published in *The Nation's Health* this year.

Position papers are general expositions of APHA's viewpoint on broad issues affecting the public's health. They may represent an entirely new area of policy, or a major revision of existing policy, and may call for specific action. Authors are requested to adhere to the following standard format in drafting a position paper.

Position papers should contain a statement of the problem, the purpose of the paper, objectives hoped to be obtained, specific action desired by APHA, and a statement of the methods to be used for implementation. Position papers should not be longer than 10 typed double-spaced pages.

Resolutions, which are concise statements of APHA's position on specific health issues, will not have to follow a standard format, but should include a call for specific actions by the Association.

Late-breaking resolutions *must* be submitted to the chairperson of the Joint Policy Committee, for referral to the correct public hearing during the Annual Meeting. All such resolutions must be considered during these hearings.