

## The Origin and Development of Maternal and Child Health Programs in the United States

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### Introduction

In this paper, emphasis will be given to major policy issues which were met in the development and administration of the maternal and child health programs authorized by Title V of the Social Security Act. A review of the early legislative history of maternal and child health in the United States has been provided by Schmidt.<sup>1</sup>

It was primarily the surge of knowledge of bacteriology and communicable diseases toward the end of the 19th century which led to a more dynamic view of child health and illness prevention than previously held. Medical inspections of children in schools became widespread, primarily for the purpose of controlling the spread of communicable diseases.<sup>2</sup>

The prevalence of dirty, contaminated milk and the recognition of its relationship to diseases of infancy and childhood and the shockingly high infant mortality provided a dramatic opportunity to demonstrate the possibilities of the prevention of communicable diseases and infant deaths. Beginning in 1892, Nathan Straus opened in New York City the first of nearly 300 milk stations in the US and abroad to provide clean, wholesome milk for children.<sup>2</sup>

During this period, one is impressed by the long delay in using newly acquired medical information for the prevention of disease.\* The relationship of contaminated milk and water to diseases and mortality was known for decades before effective action began to be taken. The use of silver nitrate for the prevention of gonorrheal ophthalmia was developed in 1881, but physicians and midwives were slow to adopt it. It was pointed out in 1906 that one-fourth of the children in the New York State School for the Blind had been blinded by ophthalmia neonatorum, "almost none of whom would

\*The obverse of this will be followed as a thread through much of this review.

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have lost his sight had simple prophylactic measures been employed.<sup>2</sup>

By the end of the 19th century, it was well understood that if preventive health services for children were to be effective, they must be accompanied by educational measures to help parents to appreciate and adopt fundamental concepts and procedures of child hygiene. Such measures were included in milk stations and were a major part of the nursing care of children in their own homes and subsequently in public schools which was provided by the Henry Street Visiting Nurse Association in New York, established by Lillian Wald.

Much of the emerging national concern for the health of children had its origin in the exploitation of children through child labor. The rapid industrialization of the nation following the Civil War led to the increased employment of children in a considerable variety of occupations, many of them hazardous. According to the 1870 Census, about one in eight children aged 10 to 15 years was gainfully employed. By 1900 it was one in six, 40 per cent of them in industry and 60 per cent in agriculture. In the southern mills, one-third of the workers were children, many less than 10 years old.<sup>2</sup>



Children working in a glass factory at night, ca. 1906. (Photo credit: National Library of Medicine)

At the same time, the concept of childhood as a period of growth and development was emerging in contrast to the generally prevailing view of children as chattels or little adults. Thus the voices being raised against child labor and for the protection of children came from several sources, including education, psychology, medicine, and public health, as well as labor and social work. The developing science of psychology, for example, emphasized the close relationship of physiology, psychology, and play to normal

growth and development at a time when the social reform movement opposed child labor because, among other reasons, it deprived children of their natural right to play and to learn.

These multi-disciplinary forces which were instrumental in gaining the enactment of the statute establishing the United States Children's Bureau continued to be a pervasive influence in the administration of the maternal and child health and child welfare grants-in-aid programs.

Passed in 1912, the Act directed the Children's Bureau "to investigate and report . . . upon all matters pertaining to the welfare of children and child life among all classes of our people and shall especially investigate the questions of infant mortality, the birth rate, orphanage, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment, legislation affecting children in the several states and territories."<sup>3</sup>

This legislation constitutes the first recognition that the federal government has a responsibility to promote the welfare of the nation's children. From the outset, the Children's Bureau's studies focused on the child and developed the principle that workers with children and their families concentrate on the child rather than on rules and procedures.<sup>4</sup>

Grace Abbott, speaking to the National Conference of Social Work in 1932, said of Julia Lathrop, the first Chief of the Children's Bureau, that with a very broad authority and limited resources Miss Lathrop's program of work for the Bureau set up prevention as the goal from the beginning. She held that as a democracy the United States must seek continually new ways of ensuring the optimum growth and development of all American children, but the existing temporary importance of palliatives was never ignored.<sup>5\*\*</sup>

The first annual report states that, although it was the Bureau's function to serve all children, "it is a matter of common experience that the greatest service to the health and education of normal children has been gained through efforts to aid those who were abnormal or subnormal or suffering from physical or mental ills. . . . Thus all service to the handicapped children of the community . . . also serves to aid in laying the foundations for the best service to all children of the Commonwealth."<sup>5</sup>

Early Children's Bureau studies included such subjects as juvenile delinquency; child labor; day care; working mothers; institutional care; infant and maternal mortality; illegitimacy; mental retardation; mother's aid; the nutrition of children; the health of preschool children in selected cities; height and weight of children including children with heart disease, rickets, and malnutrition; vocational guidance; maternity benefits in European countries; provisions for the care of crippled children in 14 states; as well as numerous other subjects.

#### *The Maternity and Infancy Act of 1920-1929*

The legislative history of the Act of 1912 establishing the Children's Bureau made it clear that it was the intent of the Congress that the findings of its studies and reports should be used to help state and local groups to take appropriate action to improve the care of pregnant women and children.<sup>7</sup> The precedent establishing studies of infant and maternal deaths, showing the relationship of social and economic

factors to the medical causes of death, provided the basis for the Children's Bureau to propose and justify a continuing grants-in-aid program to assist state health agencies to establish and improve services to promote the health of mothers and infants. The studies of reduction of mortality through better care, instruction of mothers in maternity and baby clinics by popular bulletins and by public health nurses were used as evidence of successful methods of accomplishing the objectives. The authorized legislation, which expired in 1929, was extended by the Congress until June 30, 1929, after which it was not renewed. It was the first public health grants-in-aid program enacted in the United States.

In the eight years of its existence, the Sheppard-Towner Act helped to bring about many improvements in health services for mothers and children. Birth registration, one of the Children's Bureau's specific objectives, increased from 30 states in 1920 to 46 states in 1929, representing 95 per cent of the national population. The number of state child hygiene divisions increased from 28 to 47, and the number of permanent maternal and child health centers increased greatly, with 1,594 being established between 1924 and 1929. There was also a widespread increase in public health nursing services. And the Bureau demonstrated the values of a new partnership of federal and state governments in promoting the health of mothers and children, values which contributed to support for the renewal of grants for maternal and child health services under the Social Security Act.

#### *Crippled Children*

Programs of medical care for crippled children developed more slowly and later than those for pregnant women and babies. While most of the major cities had hospitals for orthopedically handicapped children by the end of the 19th century, the first state to undertake such a service was Minnesota in 1897. Various services for the handicapped were a special interest of several voluntary agencies during the early part of the 20th century, including Rotary International, the American Legion, the International Society for Crippled Children, the Elks, the Lions, and the Shriners.

It was also during the first quarter of the 20th century that the Children's Bureau carried out a survey of the provisions for the care of crippled children in 14 states. These studies later became the basis of recommendations by the Children's Bureau to the Committee on Economic Security in its consideration of the proposals for inclusion in the Social Security Act.<sup>5</sup>

The recommendations and reports of the 1930 White House Conference on Child Health and Protection gave considerable impetus to public support for a comprehensive program of medical care and related services for crippled children and for maternal and child health. The conference stated in its report that "Grants-in-aid constitute the most effective basis for national and state cooperation in promoting child welfare and in securing the establishment of that national minimum of care and protection which is the hope of every citizen. . . . Maternity and infancy aid is of fundamental importance in the social welfare field as well as in the health field."<sup>8</sup>

The conference declared that the solution of the problem of the crippled child would be a program in every state, established by law and given sound financial support. The conference delineated that such a program must emphasize prevention and be administered in close association with prenatal, infant and child health, and school health services,

\*\*For a recent study of the early years of the Children's Bureau and its leadership see reference 6.

and require the cooperation of all medical, education, social welfare, and vocational rehabilitation agencies. The conference recommended that federal funds be distributed to a properly constituted state service for crippled children in the several states. The programs were to include early discovery, diagnosis, creative and remedial treatment to enable the handicapped child to function as normally as possible.<sup>8</sup>

#### *The Social Security Act*

A variety of forces led to the enactment of Title V of the Social Security Act with its provisions for three grants-in-aid programs: maternal and child health, crippled children, and child welfare services. Some of these forces, which had been developing gradually since the turn of the century, represented the culmination of federal, state, and local efforts to protect and promote the well-being of children. Other factors were immediately related to the depression of the 1930s and the national desire to take the necessary steps to prevent a recurrence. These forces can be grouped into four closely interrelated themes.

#### **Responsibility of Government**

The first of these was the growing recognition of the responsibility of the federal government for the promotion and protection of the well-being of children. During the 19th century, state and private agencies had assumed responsibility for special groups of children. The establishment of the Children's Bureau meant that the growing concern for children "was translated into a specific public policy to focus attention on the state of well-being of children throughout the country and on their common needs."<sup>4</sup>

The Sheppard-Towner Act was based on the principle that federal assistance to state and local health departments would enable them to extend and improve maternity and infant care and help reduce the high mortality rate. The White House Conference of 1930 provided an excellent assimilation of facts as well as an expression of the climate of opinion that the time had come for action.

#### **Resource Development**

The second force was evidence, brought out during the depression, that far greater needs had existed even in normal times than had been generally realized. The report of the President's Committee on Economic Security summarized some of this evidence, pointing out that resources for the care of handicapped were virtually nonexistent in areas outside of large cities; that the maternal mortality rate in the US was much higher than in other progressive countries; and that from 1922-1929 all but three states participated in the federal-state maternity and infancy programs but, with the loss of federal funds, 23 states appropriated virtually no maternal and child health funds. The report further pointed out that hundreds of thousands of crippled children needed care which they were not receiving.<sup>9</sup>

#### **Economic Security**

The third force was the concept that a program for recovery from the depression should include not only measures to assure adequate income but also measures to prevent destitution and dependency of children as well as adults. The report of the President's Committee on Economic Security recommended that substantial grants-in-aid to state and local health departments be provided to support a nationwide program for the extension of public health services.

In a special message on January 17, 1935, President Franklin D. Roosevelt sent this report<sup>9</sup> to the Congress. He recommended legislation leading to economic security which would include federal aid for services for the protection and care of homeless, neglected, dependent, and crippled children and grants to state and local health agencies.

#### **Special Measures for Child Protection**

The fourth force was the widespread conviction that special measures for the protection of children are an essential part of a program for economic security. The Committee on Economic Security had emphasized that the child must be the core of any social plan.

The creation and enactment of the Social Security Act constitutes one of the greatest social achievements of this country. It was adopted with much enthusiasm and widespread anticipation of a new constructive era. This was characteristically expressed by Representative Thomas A. Jenkins of Ohio, discussing Title V during the floor debate: "This is not legislation that belongs to any party," he said. "This is legislation that has sprung up out of the desire of the people of this country to have the Federal Government participate and help out the states in this great and wonderful work . . ."<sup>10</sup> Unfortunately, this bipartisan support for the children's programs has not been consistently maintained and, particularly in recent years, has been greatly eroded.

Title V of the Social Security Act contained three parts:

*Part 1: Maternal and Child Health Services*—authorized grants to enable states to extend and improve services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress. Funds were used typically for prenatal care, well-



Immunization clinic, Indianapolis, Indiana, 1947. (Photo credit: National Library of Medicine)

baby clinics, school health services, immunization, public health nursing and nutrition services, and health education. One-half of the appropriation, the A fund, had to be matched dollar for dollar, but the other half, the B fund, required no matching. The allotment of the B fund took into account the per capita income of each state so that states with lower per capita incomes received a larger share of non-matching funds than did the richer states. The B fund was the basis of the subsequent development of special project grants of regional or national significance. In later years, special project grants became widespread throughout the government.

*Part 2: Services for Crippled Children*—was an entirely new program. For the first time federal funds would be used with state matching funds to provide comprehensive medical care for certain groups of children. The purpose clause, Sec. 511, reads: "For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress) as far as practicable under the conditions in each state, services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and after care for children who are crippled or who are suffering from conditions which lead to crippling . . ." The statute further states that the state plan must "provide for cooperation with medical, health, nursing and welfare groups, and organizations" and with the state vocational agency.

In contrast to the Sheppard-Towner Act, the Congress set no time limit on the Title V authorizing legislation, taking the position that Title V is continuing legislation and that the federal government has a responsibility to use its taxing power on a continuing basis to assist the states in their programs to extend and improve the health and welfare of mothers and children.

With the Social Security Act, the Children's Bureau entered a new era in which its responsibilities for grants-in-aid administration were paramount; this responsibility was quite different from its continuing responsibilities "to investigate and report" under the Act of 1912. As its staff expanded to administer Title V, the Children's Bureau became increasingly absorbed in grants-in-aid administration. The investigative and study functions decreased, but the reporting functions continued to develop with emphasis on the Title V programs.

Title V, Part 2 of the Social Security Act explicitly requires that state programs must provide services that are comprehensive, including measures for case-finding, diagnosis, treatment including hospitalization, and after care. The concept of comprehensiveness includes prevention and is of the greatest importance in a program that is concerned with long-term illness or handicaps. Prevention in this context includes not only prevention of the onset of illness but also the services needed to mitigate crippling and to minimize emotional and social disability.

The statute left the definition of the crippled child to the states. The predominant crippling conditions during the 1930s and 1940s were orthopedic, accounting for over 80 per cent of the children receiving services. The way was open, however, for broad programs, which, in fact, developed subsequently.

*Part 3: Child Welfare Services*—This part authorized grants to the State Public Welfare Agencies to establish, extend, and strengthen, especially in predominantly rural areas, services for the protection and care of homeless

dependent and neglected children and children in danger of becoming delinquent.

There is no mention of a means test for eligibility in Title V, but following recommendations made by the Children's Bureau the states generally adopted procedures for determining eligibility that differ considerably from those adopted for public assistance. Eligibility for treatment services takes into account not only the family income and size, but also the diagnosis, estimated cost of care including after care, and the continuing added costs required by a handicapped child.

The Act's emphasis on rural areas was due to the inadequacy or lack of resources for the care of crippled children in the rural areas and the greater availability of such resources in the cities. Private groups made significant contributions to the programs by providing related services such as transportation and assisting in organizing the clinics, thereby enabling the state agencies to extend their resources.

In the administration of Part 2, particular attention was given to the quality of care, extension of services to additional diagnostic groups, increased employment of multidisciplinary staff, and focusing attention on the child as a person rather than only on the handicapping condition.

Development by the Children's Bureau of policies and regulations required the states to describe their standards for personnel and facilities, to limit their provision and payment for hospital care and similar services to individuals receiving physicians' services authorized by the state plan, and to make diagnostic services available without charge and without requirement of economic status or legal residence or referral. The point of the latter regulation, of course, is that until a diagnosis is made it is not possible to estimate what treatment is needed and the cost of care.

In paying for hospital care, the Children's Bureau adopted the policy that such payments by a government agency should not exceed the hospital's average daily cost per bed. At the same time, in cooperation with the American Hospital Association, the Bureau developed a uniform system of hospital cost accounting. This system was used by hospitals providing care under the Title V programs as well as those that were not. With the enactment of Medicare in 1965, a different method was included for Medicare and was extended to Title V as well.

When the parents had insurance or could otherwise be considered able to pay a share of the costs, the Bureau required that the state agency that authorized the care determine how much the parents were able to contribute; furthermore, payments to physicians and hospitals were payments in full and additional charges could not be made to the patient.

### *Special Projects*

In 1939, with an increased appropriation, some of the nonmatching B funds were reserved for special projects of regional or national significance to enable states to develop new kinds of programs and to include children with diagnostic problems not hitherto included. Examples include programs for the hospital care of premature infants; for women with complications of pregnancy, which included hospital delivery care; for children with rheumatic fever, epilepsy, hearing impairment, mental retardation, congenital heart disease, etc., as well as grants to institutions of higher learning for the training of nurse-midwives, social workers,

physicians, and others in specialty areas including public health. Special projects are more responsive to application of research fundings than formula grants.

Significant changes took place in the Crippled Children's programs quantitatively as well as in scope and concepts. The number of children receiving medical care in the program in 1958 was 325,000 or 4.8 per cent per 1,000 children under 21 years of age. This is twice the rate in 1937. The proportion of children in the program who received hospital care decreased from 27 per cent in 1937 to 16 per cent in 1958, and the average duration of hospitalization decreased by about one-half.

In part, the decrease in hospital care is attributable to the changes in the diagnostic composition of the programs. Initially they were almost entirely orthopedic programs, but in 1958 orthopedic conditions constituted a little less than 50 per cent of the reported diagnoses. Changes from 1950 to 1958 include:

- Epilepsy—up 596 per cent
- Congenital malformations—up 94 per cent
- Congenital heart disease—up 451 per cent
- Hearing impairment—up 105 per cent
- Mastoiditis—down 43 per cent
- Osteomyelitis—down 47 per cent
- Acute poliomyelitis—down 89 per cent

These changes reflect the response of the Crippled Children's program to the dramatic developments in medicine that research has produced. Those that particularly influenced the Crippled Children's program include:

- Antibiotics for prophylaxis against acute rheumatic fever
- Poliomyelitis vaccine
- Diagnosis and treatment of various types of congenital heart disease, especially through open heart surgery
- Development of the science of audiology and the electronic hearing aid
- Drug treatment of tuberculosis
- Drugs for the control of epilepsy
- Increased understanding of the principles of physical and emotional growth and development
- Care of premature infants, and
- Surgery of the newborn<sup>12</sup>

These were also among the factors producing marked changes in pediatrics generally. Better control of acute illnesses meant that by 1958 a growing proportion of children seem in clinics, hospitals, and private practice had long-term illnesses and handicapping conditions. In teaching hospitals children with medical problems, congenital in origin, constituted between 30 and 50 per cent of the inpatients.

The changes in diagnoses mean that the problems change with time but do not go away. Better neonatal survival rates have also meant increased survival of children with cystic fibrosis, neurological deficits, congenital malformations that may or may not be amenable to surgery, and inborn errors of metabolism such as phenylketonuria. This has its social and psychological counterparts as well. The marked increase in the employment of mothers of preschool children—over 35 per cent of such mothers are employed—is indicative of the extent of the need for adequate child care services. The recently issued report of the House Select Committee on Children, Youth and Families documents the need "for every form of child care"—arguing persuasively that government child care subsidies for low to moderate income families end up costing government less than maintaining the families on welfare.<sup>13</sup>



Nurse examines children (in a segregated school?), 1950. (US Children's Bureau Photo, from the National Library of Medicine)

### *Emergency Maternity and Infant Care Program of World War II*

The Emergency Maternity and Infant Care (EMIC) program began at Fort Lewis, Washington, where the wives of many young men in the armed forces had come to live, as at other camps. The need for maternity care greatly overtaxed the available resources at the base hospital and many of the women were not eligible for other clinical facilities. The state health officer requested a special project grant from the Children's Bureau, which was provided.

When the same situation rapidly developed all over the country, the Bureau of the Budget agreed to include funds for maternity and infant care for the wives and infants of men in the four lower pay grades, without cost to them, including medical, nursing, and hospital care for the prenatal periods; delivery; and six weeks postpartum. Infants were eligible for complete care for the first year of life.

The program ended June 1948; by then 1.5 million maternity and infant patients had received care. This was the largest single public medical care program ever undertaken in the United States. Ahead of its time, it owed its strong support in the Congress and the Executive branch to its close identification with the war effort.

An independent evaluation of the program, made by Nathan Sinai,<sup>14</sup> was the first formal evaluation of a medical care program and was to be followed subsequently by other evaluations of Title V programs.

### *Mental Retardation Amendments*

The positive attitudes toward the handicapped and the development of community programs for them that had emerged in the first half of the century did not generally include the mentally retarded. It was not until 1957 that the Congress, with the sponsorship of Congressman John Fogarty of Rhode Island, increased the appropriation for the Maternal and Child Health programs and earmarked \$1 million for demonstration clinical programs for mentally retarded children. The states and the voluntary organizations of parents of the retarded responded promptly, and new diagnostic, consultation, and education clinics were rapidly established.



But the major developments on a nationwide scale resulted from the leadership of President John F. Kennedy, who appointed a Panel on Mental Retardation to consider better use of existing knowledge. The Panel's recommendations relating to Title V of the Social Security Act were enacted in 1963 in PL 88-156.<sup>15</sup> The authorizations for maternal and child health and for crippled children's services were each increased from \$25 million to \$50 million. In the Appropriations Committee, the Congress earmarked part of the increase for special projects for mentally retarded children. In addition, the statute authorized a new five-year program of Maternity and Infant Care Projects, "in order to help reduce the incidence of mental retardation caused by complications associated with child-bearing." All necessary health care was to be provided to expectant mothers of low income who have or are likely to have conditions associated with child-bearing that increase the hazards to the health of mothers and infants. The authorized appropriation increased from \$5 million the first year to \$30 million each of the last three years. Federal funds were not to exceed 75 per cent of the cost of each project. In addition, PL 88-156 authorized a new Title V program for research projects that were essentially program research and evaluation.

The provision for a new program of Maternity and Infant Care projects enacted into law one of the major recommendations of the President's Panel on Mental Retardation. In view of the limited knowledge regarding the prevention of mental retardation, the Panel was much impressed by recently published studies of the close association between premature birth and brain damage; between low income, poor or no prenatal care and premature birth; and by the large numbers of women of low income living in major cities who received little or no prenatal care.<sup>16</sup>

In his message to the Congress of February 7, 1963, the President had said: "The relationship between improving maternal and child health and preventing mental retardation is clear. But equally clear is the fact that the need for better health services for mothers and children is steadily increasing, in general due to the growing child population, the rising costs of medical care, and changes in the practice of medicine and public health."

The response to the availability, in early 1964, of funds for the Maternity and Infant Care projects was prompt, and by 1969 there were 53 projects in large and middle-sized cities and in rural areas, serving over 100,000 women and their infants annually. A major new and far-reaching policy was the Children's Bureau explicit authorization of the use of the project funds for family planning services. The 1967 amendments to Title V went further and earmarked 6 per cent of the Maternal and Child Health appropriation for family planning services.

The 1963 amendments were instrumental in supporting new mass case-finding techniques for early detection of infants with inborn errors of metabolism starting with phenylketonuria; this helped stimulate widespread interest in metabolic disorders and led to the development and support of cytogenetic and biochemical laboratory services in 21 special projects.

#### *Children and Youth Projects*

A new program of project grants to meet up to 75 per cent of the costs of comprehensive health services for children and youth living in areas with concentrations of low-income families was authorized in 1964 as an amendment to Title V of the Social Security Act, in response to the

same problems that led to the creation of the maternity care programs. In his message to the Congress on Our Nation's Youth, in February 1963, President Kennedy requested "the Secretary of Health, Education, and Welfare to put a high priority on the Department's studies of school health programs and to make recommendations regarding action which may be required."

The Secretary's letter, transmitting a report prepared by the Children's Bureau in response to the President's request, stated: "The material in the enclosed report on 'Health of Children of School Age' emphasizes the gaps in child health supervision in the preschool years with the resultant wide disparity in the readiness of children to begin their education, the great crowding of well-baby clinics and hospital outpatient departments in the cities, the inadequacies in the quantity and quality of medical care received by children in many low-income families, the need for more effective methods of case finding; the special problems of adolescents and the handicapped—all pointing to the need for new approaches and for concentrating our community resources where they are most needed."<sup>17</sup>

The major objective of the legislation was to make possible programs that would provide comprehensive health services through the promotion of health as well as medical care, including case finding, preventive health services, diagnosis, treatment, correction of defects, and after care, both medical and dental. This, in fact, is the definition of "comprehensive" in the statute. The project takes care of the health problems (personal as well as environmental) of a given child population. Thus, the projects are involved not only in direct medical services but also in community health activities such as nutrition education, food demonstrations, working with city authorities to do something about sources of lead poisoning, rat control, etc.

The Children and Youth (C & Y) Projects were enacted in the same year as the Office of Economic Opportunity Neighborhood Health Centers. This came at a time of great interest in community action on behalf of the underprivileged, which pushed colleges and professional schools to become involved in the world beyond the campus. By 1969 there were 58 Children and Youth Projects, some closely allied with the Maternity and Infant Projects or with Neighborhood Health Centers. In 1968, 335,000 children were registered in the C & Y programs. These were children in families in which 37 per cent of family heads were women, one-third of family heads had less than an eighth-grade education, and 40 per cent were unemployed. Early data revealed that about 45 per cent of the registered children required immediate care; the remaining were well and started preventive health services with regular appointments for health supervision.<sup>18</sup>

There are few programs that have borne out their stated programmatic objectives as effectively as the C & Y Projects. The emphasis on prevention and on increasing the availability of care made itself felt; if we compare the diagnoses of children at the initial examination with subsequent examinations, we find that the proportion of children with a diagnosis of "well child" is consistently increased by one-fourth. At recall examinations for dental services, there is a decrease of over 50 per cent in the number of untreated carious teeth. Most important is the fact that since the beginning of the program there has been a marked decrease in the number of children needing hospitalization—from 7.7 per cent of the cases in 1968 to 4.1 per cent in 1970, resulting in a decrease in the annual average per capita costs.



Dentist demonstrates importance of dental care and oral hygiene to interested children in Mississippi, 1941. (Photo credit: National Library of Medicine)

It was no coincidence that the Children and Youth Projects were authorized in 1965, in the same Social Security amendments that authorized Medicaid. The latter is essentially a means of paying for medical care but does not in itself create clinical resources where they are in short supply. The House Ways and Means Committee, in its report on the Social Security Amendments of 1965, pointed out that: "Communities are finding that they do not have adequate resources to which children can be referred for diagnosis and treatment through school health programs, and their resources for the examination, diagnosis, and treatment of preschool children to help them prepare to enter school are also too few and too crowded."

Thus, for the first time, both the Legislative and Executive branches of the federal government made clear the important principle that there are two essential elements in any system of medical care: the financing of medical care, and the availability of clinical resources from which care can be provided and purchased.

#### *The 1967 Amendments*

Three new types of medical care project grants were authorized in 1967: Infant Care (neonatal intensive care), Family Planning, and Dental Care. All five types of projects were extended to June 30, 1972, and the authorization was increased to \$350 million for all the Title V programs. The Amendments specified that 50 per cent of the annual appropriation was to be for the formula grants that have a rural emphasis, 40 per cent for the projects grants, and 10 per cent for research and training. The Amendments further specified that the states were to take over the project grants after June 30, 1972. Each state plan was thereafter to include a program of Maternity and Infant Care Projects, a program of Children and Youth Projects, etc. To support the new state plan requirement, 90 per cent of the annual appropriation would be available for the formula grants (which would also include funds for the projects) and 10 per cent for research and training.

These Amendments, delayed one year and modified, were enacted July 1, 1973. The Congress recognized that putting 90 per cent of the appropriation into the formula with a rural emphasis was in conflict with programs of project

grants that emphasized areas with concentrations of low-income families, such as the major cities. The effect of these amendments greatly increased funds to rural states (with concomitant matching problems) and greatly decreased funds to states with large cities. At the same time, the Congress did not want to drop the rural emphasis. To solve the problem of grants apportionment and to protect the projects already in existence the Congress enacted amendments which: 1) extended the authorization for project grants until June 30, 1974; 2) allocated 90 per cent of the appropriation to the states by formula after that date; 3) provided an additional authorization so that no state would be eligible for less funds after June 30, 1974 than the total amount in formula and project grants in fiscal year 1973, and required the states to make appropriate arrangements for continuation of services to the population in areas previously served under the project grants.

#### *Current Major Policy Issues*

Should federal grants-in-aid be categorical or in a block? Should there be in the federal government a children's agency whose mission is to improve the conditions in which children live so as to foster their healthy growth and development? Should such an agency not only engage in fact-finding but administer grants-in-aid in support of child health and welfare? These interrelated questions are parts of a broader issue: *Should the United States have a national social policy for children that is the basis for the development and continued support of child health and welfare services?*

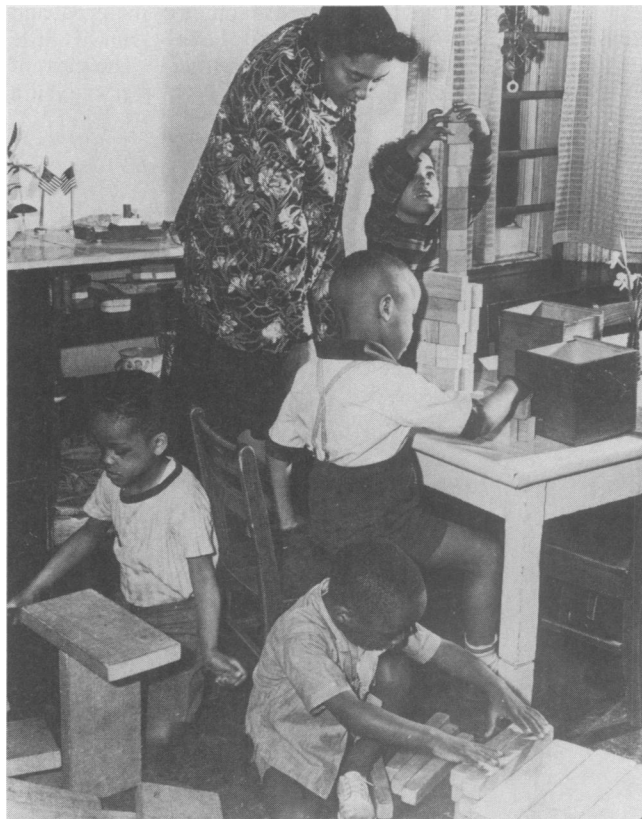
The issue has been debated since the Children's Bureau was established. It is of renewed concern because in 1969 the health grants were transferred by the President to the Public Health Service, and in 1981 the Title V funds were amalgamated with other grants in a block grant for maternal and child health through the Omnibus Budget Reconciliation Act of 1981. It was largely through the efforts of voluntary organizations, in particular the American Academy of Pediatrics, that the Congress enacted a consolidated grant for maternal and child health rather than a broader one as proposed by the President in which such funds would lose their identity. The consolidated grant included eight categorical programs: crippled children's, maternal and child health, lead-based paint poisoning prevention, sudden infant death syndrome, adolescent pregnancy prevention, genetic disease testing and counseling, hemophilia diagnostic and treatment centers, and disabled children receiving supplemental security income benefits.<sup>19</sup>

The appropriations for 1982 and 1983 were \$372 million and \$373 million, respectively, an 18 per cent reduction from the \$455 million appropriations for the eight categorical programs.<sup>19</sup> The statute authorizes that 15 per cent of the appropriation is reserved for special projects of regional or national significance, a provision which is not supported by the Department of Health and Human Services.

Dr. R. Don Blim, speaking for the American Academy of Pediatrics before the Senate Finance Committee, stated that the law establishing the block grant called for an administrative unit within Health and Human Services to coordinate child health programs and provide technical assistance to the states. But thus far nothing has happened. "In fact, the United States is one of the few industrialized nations that does not have a high level policy unit for children's health within its governmental structure," Dr.



**Nursery School**



**Learning to Build**



**MCH Clinic in Jackson, Mississippi**



**Nursery School**



**Child Enrichment**

(Children's Bureau Photographs obtained from the National Library of Medicine)



Blim said. "Instead we have buried an office of maternal and child health deep within HHS and have given it little authority or asked of it little accountability."<sup>20</sup> The current situation stands in sharp contrast to that which prevailed a generation ago.

#### REFERENCES

- Schmidt WM: The Development of Health Services for Mothers and Children in the US. *Am J Public Health* 1973; 63:419-426.
- Bremner RH (ed): Children and Youth in America, Vol. II, pp 813, 870, 876, 601.
- US Statutes, 62 Congress, 2nd Session (1911-1912) Pt 1, Chap. 73 pp 79-80.
- Eliot MM: The Children's Titles in the Social Security Act. *Children* 1960; 7:137-140, 135-136.
- Bradbury D: Five Decades of Action for Children. US Dept HEW, Children's Bureau. Washington, DC: GPO, 1962; pp 17, 15, 39.
- Parker J, Carpenter E: Julia Lathrop and the Children's Bureau: The emergence of an institution. *Soc Serv Rev* 1981; 55:60-77.
- The United States Children's Bureau. *Am J Dis Child* 1967; 114:565-573.
- White House Conference on Child Health and Protection, Organization for the Care of Handicapped Children. New York: Century Co. 1933.
- Committee on Economic Security: Report to the President. Washington DC: Govt Printing Office, 1935; p 37.
- Congressional Record* April 15, 1935; p 5680.
- Ch 531, Statutes at Large XLIX, Part 1, p 641.
- Lesser A: Health Services, Accomplishments and Outlook. *Children* 1960; 7:142-149.
- Mann J: Child Care. *Washington Post*, October 5, 1984.
- Sinai N: EMIC. Ann Arbor: School of Public Health, University of Michigan, 1948.
- Public Law 88-156, Mental Retardation Amendments, Title V, Social Security Act. Washington, DC: GPO, 1963.
- Lesser A: Current Problems of Maternity Care. Children's Bureau, HEW. Washington, DC: Govt Printing Office, 1963.
- US Dept of HEW: Health of Children of School Age. Children's Bureau Pub. No. 427. Washington, DC: Govt Printing Office, 1964.
- Lesser A: The Federal Government in Child Health Care. *Pediatr Clin North America* 1969; 16:897.
- GAO: Report to the Congress by the Comptroller General GAO. HRD 84-35 pp i, ii, May 7, 1984.
- American Academy of Pediatrics: *News and Comments*, September 1984; p 2. P.O. Box 927, Elk Grove Village, IL 60007.

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