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Health Care of Children and Youth in America

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A proposal for a National Health Service for Mothers and Children and other recommendations for reforms in health care for children are presented.

The issue before this National Health Forum is the health care of children and youth in America. The immediate question related to that issue is: "Where do we stand today?" A possible answer to that question might be, "About where we stood in 1915." That was a year of great concern for children around some of the same considerations before us today.

Compulsory health insurance was thought to hold great promise. It was not an especially new consideration even in 1915; other western countries had accumulated ample experience with it, one of them over a period of nearly half a century. Compulsory health insurance at that time was not considered an especially bold or innovative commitment. Few false expectations were attached to it; it was, simply enough, a way of making certain that everyone's medical bills were paid without undue personal hardship—a worthy and modest purpose for a modest public commitment.

The American Medical Association had not yet developed a firm policy in opposition to health insurance; editorials in that Association's Journal in fact seemed supportive. Many states introduced legislation requiring health insurance as easily as they now pass laws requiring automobile insurance. But enabling laws for compulsory health insurance did not enter the statute books although automobile insurance did. High concern for human values in 1915 gave way before even greater concern for property values.

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Concern for people, and especially for children, was manifest in 1915 as a major public issue in other ways. The country was in the midst of great debate on the scope of governmental responsibility to protect the health of children through control of child labor. When the Keating-Owen Act of 1916 was passed in order to prevent interstate commerce of products of child labor, the law was challenged in the courts and declared unconstitutional. Profit incentives of an uncontrolled market system and the God-given rights of parents to determine the fate of their children combined to return small children to the mills and mines of a rapidly expanding industrial economy.

Poor families, whatever their rights, of course had no choice. Economic pressures were so great that child labor was a necessary slow way of death in order to stave off more immediate and certain ways. A bitterly fought amendment to the Constitution would have defined the responsibility of government to protect the health and well-being of children against the crushing abuses of child labor. But the amendment lost—and government's role for the protection of children did not become fixed until enactment of reform measures in the early 1930s. At that time concern for children was considerably abetted by concern for their elders who were competing in a tight job market.

President Theodore Roosevelt, in 1909, called a national conference to review the "circumstances and prospects" for the nation's children. His message to Congress stated: "The interests of the nation are involved in the welfare of this army of children no less than in our great material affairs." The report of his conference reinforced this view by stating: "... it is sound public policy that the State through its duly authorized representative should inspect the work of all agencies which care for

dependent children, whether by institutional or by home-finding methods and whether supported by public or private funds . . . ."

The conference called for establishment of a new bureau of government to institutionalize public responsibility for the protection of children. In 1915 Lillian Wald wrote in behalf of this bureau as follows:

> "Sympathy and support came from every part of the country, from Maine to California and from every section of society. The national sense of humor was aroused by the grim fact that whereas Federal Government concerned itself with the conservation of material wealth, mines and forests, hogs and lobsters, and long since established bureaus that supply information concerning them, citizens who desired instruction and guidance for the conservation and protection of the children of the nation had no responsible governmental body to which to appeal."

Public responsibility for the welfare of children was not easily established. Senators railed against ". . . long haired men and short haired women . . ." snooping around the mills—the owners did not like it. Another Senator asked a colleague how he would ". . . have liked for a government agent to have gone down into his father's humble home or his grandfather's in the days of the Revolution investigating the condition of his sacred home. . . ."

Since 1915 a Children's Bureau has been established and recently disestablished, and each 10 years since 1909 a White House Conference has affirmed but not generally improved upon Theodore Roosevelt's declaration of government's responsibility for the care of children. Herbert Hoover's conference in 1930 raised the sights a little higher with adoption of a Children's Charter of Rights. Government's responsibility was affirmed to obtain and protect those rights on behalf of the nation's children.

The Social Security Act of 1935 and its subsequent amendments took giant steps toward fulfillment of the Children's Charter developed by President Hoover's Conference. The mission was by no means completed. Categorical emphasis under Social Security and uneven implementation through state government deprived many children of the full benefits that might have guaranteed their health and well-being. But these gaps appear as minor inadequacies compared to recent dismemberment of federal agencies, programs, and funding mechanisms that had been built up slowly and painfully over many years in order to improve the health of children. Our nation is turned back to 1915 and to consideration once again of such issues as health insurance that subsidizes private providers and intermediaries; to decentralization of public responsibility to the flimsy and uneven intent of state government; and to reliance on the exploitative potential of profit incentives and market systems for delivery of services that are essential to life. This reliance carries very little in the nature of public guarantee of services or other protection in the consumer's interest.

Concerns about long haired men and short haired women have been resurrected along with ancient rhetoric that extols home and family without helping either of them. Home and family indeed are nearly sacred; they are the best devices we know for raising children, but they are in jeopardy not from public infringement but from public neglect. The veto message of the Economic Opportunity Amendment of 1971, containing the Child Development Programs, raises vintage issues of 1915: ". . . good public policy requires that we enhance rather than diminish both parental authority and parental involvement with children." Implicit in that argument is the thought that to help and support parents who cannot cope is not to strengthen them but somehow to weaken them further. The prototype argument asserted that to take children out of textile mills interfered with their rights to work there!

Lillian Wald could report in 1915 that the national sense of humor was aroused that our government committed itself more fully to hogs and lobsters than to children. She would scarcely be amused that in 1974 our government might very well resolve that inconsistency, not in favor of children, but by withdrawing support from lobsters!

The issue here is not a Children's Bureau, or a Child Advocacy Agency, or the Office of Maternal and Child Health; no single agency ever held the key to good health for all children. The issue is, "Are children important to our national interest?" If the answer be "yes," then we should be alarmed that nearly every focus we know for public responsibility on behalf of children has been downgraded and diffused so that it exists everywhere and nowhere. Nearly every day brings further evidence that government has abrogated its responsibility to protect children. Last week* 59 positions concerned with Child Health were dropped from HEW. In the weeks before that 250 people in the Bureau of Community Health Services were decentralized to Regional Offices, and no personnel in those offices were specifically assigned to Maternal and Child Health Programs. Presumably, the interests of children are to be tended by the same people and the same programs that pertain to the entire population. These circumstances call to mind the wisdom of Grace Abbott, who argued that children deserve special attentions:

> "Children, it should be repeated, are not pocket editions of adults. Because childhood is a period of physical and mental growth and development, a period of preparation for adult responsibility in public and private life, a program for children cannot be merely an adaptation of the program for adults, nor should it be curtailed during the periods of depression or emergency expansion of other programs. Whether children remain in their own homes cared for and supported by their parents or maintained by a public agency, special provision for their needs must be made."

How sobering to realize that the words of social reform tailored for the needs of half a century ago ring out with such poignant appeal today.

How are children faring? What are their circumstances and prospects? Medical care is by no means the greatest

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* Early March, 1974.

determinant of children's health, but it dominates national thinking in matters of health. Abundant data are available concerning medical care and for that reason it is a useful place to begin.

The data chosen for presentation here are selected not because they are different, but because they are characteristic. The data are not complete. A vast literature exists on the subject and bits of it are presented for purposes of illustration, making no pretense to cover the subject exhaustively. Only U.S. data of about the past 5 years are used unless specific notation indicates otherwise.

A popular American aphorism purports that only the middle class suffers from inadequate medical care: the rich provide for themselves and government provides for the poor. A careful review of available data suggests that no part of the aphorism is true; even the rich have difficulty gaining access to medical care. In New York City the care of a group of white infants who were served by private pediatricians met standards set by the American Academy of Pediatrics only half the time.

But the poor suffer *most.* American children who are disadvantaged by poverty or racism or by geographic, cultural, or ethnic isolation receive very inadequate medical care, indeed. Popular supposition to the contrary, there has been no concerted national effort to bring medical relief to disadvantaged people. Small samples of these people have sometimes been involved in projects to demonstrate new patterns of medical care. Many of the demonstrations have been most promising, but the promises have not been extended to reach everyone who would benefit.

What is the record? Who gets medical care?

- Children from high income families were 4-1/2 times more likely than those from low income families to visit a pediatrician;
- In New York City a well-baby check-up in the first 2 months of life was given to 80 per cent of white non-Spanish babies, but only to 56 per cent of the babies of Spanish origin. By 1 year of age, only 0.5 per cent of white non-Spanish babies had received no check-up at all; 7.6 per cent of Spanish origin babies had no check-up;
- Thirty-five per cent of inner city children had not received protective immunizations. Protective immunizations had been given to 74 per cent of white children, but to only 61 per cent of nonwhite children;
- Among mothers who received inadequate prenatal care in New York City, 70 per cent had been classified as threatened by sociomedical risks; among mothers who received adequate prenatal care, only 40 per cent were at risk;
- Preventable disease (rheumatic fever) occurred one-third less among inner city residents who were enrolled in a comprehensive neighborhood health center than among nonenrolled neighbors;
- In Rochester, more than 90 per cent of eligible children were enrolled in Medicaid, but there was no change in the source, frequency, or purpose of their medical visits.

What are the needs for medical care?

- Children under 4 years of age suffer most from acute illness. An average group of 100 young children experienced 375 illnesses per year and the rate fell progressively for older ages to reach 120 illnesses per year for people 65 years of age and older;
- About 30 per cent of 18-year-olds were disqualified for military service because of medical disability;
- About 15 per cent of all children under 16 years of age require medical services because of a handicapping condition. Some 5 million of the nation's estimated 6 million retarded are never reached by any service developed specifically to meet their needs;
- Disability due to illness or accident is 50 per cent higher for the poor than for the nonpoor. Within the lowest income groups "some are poor because they are sick and others are sick because they are poor";
- Some diseases are so prevalent among the poor that they are termed "diseases of poverty." Examples are: tuberculosis, untreated middle ear infections (often leading to deafness and other complications), iron deficiency anemia (about 50 per cent of poor children under 5 years are affected), lead poisoning, malnutrition with attendant increased susceptibility to gastroenteritis, tuberculosis, and respiratory infections and with resultant stunting of growth which in girls perpetuates a cycle of poor pregnancy outcome;
- Among children 6 to 11 years of age, those from families with incomes under $3,000 per year average 3.5 carious teeth each; children from families with incomes over $15,000 average less than one carious tooth per child;
- Prematurely born infants present increased medical requirements in the first weeks of life and they are vulnerable to life-long damage; they are born 3 times more frequently to poor women than to others;
- Three-fourths of the nation's retarded children are found in impoverished, rural, and urban slums. A child from a low income family in these areas is 15 times more likely to be diagnosed as retarded than a child from a high income family;
- It is estimated that 600,000 women in poverty are in need of maternity care; 130,000 of them are reached by a public program, leaving a maternity care deficit of 470,000 women;
- If medical care to all pregnant women in New York City met standards of adequacy, it is estimated that infant mortality could be reduced by 33 per cent;
- About 1.5 million eligible women are reached by family planning services; and 3.5 million others, many of them poor and poorly educated, are not reached;
- Infant mortality for nonwhites is double that for whites. Maternal death among nonwhites is 4 times that for whites;
- Between ages 1 and 4 years a nonwhite child is 3 times more likely than a white child to die of influenza or pneumonia—and twice as likely to die

an accidental death. Home fires from hazardous space heaters are a common cause;

- Infant deaths among Indians and Alaskan natives are nearly twice that for other races;
- Indian children are 3 times more likely to be damaged by accident than other children;
- There are an estimated 1,000,000 migrant workers and family members. Only about one-third of migrant children have an immunization record, and only half of these records indicate adequate immunization. Among migrant children 1 in 10 failed to pass a vision test, and over one-half required dental work. Eighteen per cent of newborns among migrants were delivered by untrained midwives;
- In the South, 15 per cent of young adults 15 to 24 years of age have never seen a dentist;
- About 10 per cent of all emergency room visits on behalf of children 5 years of age or younger are thought to be necessitated by child abuse or neglect; public and professional recognition of child abuse continues to grow.

What does all this mean? It means that health care is rendered most abundantly to population groups whose health is least in jeopardy; and people who are at greatest risk from poor health have the most difficulty in gaining access to health care. Preventive services which should be routine for everyone are maintained at marginal levels at best, and at grossly unsatisfactory levels for disadvantaged people. Deficient immunizations, inadequate prenatal care, and missing well-baby health checks are conspicuous examples of neglect.

If a person in this country is poor, black, poorly educated, employed in a hazardous occupation, part of a large family, or lives in a disadvantaged area his chance of a disability is exceedingly great and his chance of getting help for it is exceedingly small. If a preschool child is black, Chicano, poor, migrant, or living in a rural or urban slum the likelihood of malnutrition and growth failure with all their attendant disabilities is exceedingly great; the likelihood that health can be restored in later years under even the most favorable medical circumstances is quite remote.

America's children need better nurture and improved medical care. What is being done for them?

Prevailing public policy to expand and improve medical care for everyone, including children, provides a three-legged stool. One leg is a funding mechanism called health insurance; another leg formalizes a middle class model of prepaid services for delivery of care, called an HMO (health maintenance organization); and the third leg seeks to improve the quality of care by means of a PSRO (professional standards review organization). That three-legged stool promises to be a useful piece of furniture; but is it really sufficient for starting light housekeeping? The people who will sit most securely on that stool are those with ample bottoms and many supplementary resources. People deprived of personal resources and drained of initiative because of poverty, racism, or other handicaps will not sit very securely. Children, especially, will not be well served. They require some direct initiatives, some guarantees, and some interventions which programs designed to stimulate and protect profit incentives—our three-legged stool stands on that platform—can never provide.

America's children require a National Health Service for Mothers and Children. Such a program would operate not as a token or demonstration health service; it would not depend on local organizational initiatives; and it would extend appropriate health services to every child and expectant mother in America. Such a program would guarantee not just payment for medical services some of which may not even be available, but direct provision of services themselves, by government agencies as necessary, on behalf of all children.

Private and voluntary medical mechanisms perhaps can be made increasingly responsive to the demands that are associated with acute illness and disease. But there is no reason to believe that preventive services, so essential to the health of children, can be entrusted to private incentives. Insofar as these incentives can function, they should of course be invoked, consistent with valued American economic traditions. But insofar as these incentives fail, government must assume a responsibility directly to provide medical care—from local government if possible, and from federal government as necessary. In matters of children's health government must become the residual guarantor for services.

Government need not be seen as an alien force interfering with our lives. Government *is* ourselves organized, and it must be made to respond positively for guarantee of those services which cannot be assured in individual ways.

A National Health Service for Mothers and Children should include:

- Prenatal care;
- Obstetric and midwifery services;
- Homemaking assistance and mother-craft;
- Postnatal care for mother and infant;
- Family planning services;
- Well-child and developmental check-ups;
- Routine immunizations and anticipatory guidance;
- Preschool screening and school health services, including a mandate to treat and correct identified defects;
- Sickness care to treat children not reached by private medical care programs even when they are subsidized.

A National Health Service for Mothers and Children will be an economical measure. It will save our society, not only the anguish of raising damaged children, but the enormous private and public financial burden of caring for diseased, defective, apathetic, and stunted children who become inadequate and unfulfilled adults.

When Americans speak of health they speak first of medical care. This is a distorted priority, reflective of our national eagerness to solve social problems by technological means rather than by more painful and difficult social reforms. Good medical care for children carries abundant justifications and they should not be minimized. But the

substantial benefits of improved medical care can be realized only in a population that enjoys certain other benefits. The health of children and youth is overwhelmingly jeopardized, not from deficient medical care, but from social pathology.

One of the important indicators is malnutrition. No further evidence is required to affirm that many children in America are diseased and stunted from malnutrition. In one southern state for which data are available—and certainly in many others—the normal growth curves for children do not pertain. Preschool children fall off the bottom of the growth curves and disproportionate numbers are packed into the lowest percentiles. Very young children suffer most; it is not a rare problem. Seventy-one per cent of 1-year-olds were found to consume an inadequate diet.

Government must implement a national program to feed children. It must be administered by agencies that have, as a first priority, the interests of children and not those of agri-business. How long can we pretend that we do not know how to do it? We feed armies, we can feed children. The Special Supplemental Food Program for Pregnant, Lactating Women, and Infants and Children 0 to 59 months—known as WIC—affirms that government acknowledges its responsibilities to improve nutrition of children. Initiation of this program only after court order raises doubt that it will be implemented with the full administrative enthusiasm it deserves. The court order suggests to us, however, that government can be helped to do its duty.

One school of thought advises that the public should be better instructed on what to eat. This is not a sufficient response. Many people already know what they should feed their children, only they cannot do it. One of the strongest correlates of inadequate diet in one survey was inadequate housing. A mother living without stove, refrigerator, or indoor running water will be hard pressed to provide her children an adequate diet no matter how much she knows about nutrition.

Housing is a special problem for children. Reference has already been made to the prevalence of burns from hazardous space heaters. Other observers have commented that we use children in this country as biological indicators for inadequate housing, not just by malnutrition and home accidents but by poisoning from lead paints. One critic emphasized that in effect we strive to solve our problem of home-based lead poisoning by using children to leach the lead off tenement walls. A few health departments strive to enforce acceptable housing codes; it should become a matter of top national priority invoking the full force of public authority. Real estate interests will not voluntarily undertake a program to save children from bad housing.

About 40 per cent of all preschool children have parents both of whom work outside the home. Who cares for the children?—not very often the extended family of grandmother or elderly aunts. Our mobile society has nearly eliminated that important and valuable family support. Most mothers who work outside the home do so because of economic necessity, and their children are cared for in a horror of makeshift random ways that range from sterile, impersonal commercialism to quiet and hidden neglect in the crowded quarters of neighbors' homes. America's families need help to care for their children. That help need not be disruptive of family life—it can be supportive.

Some of the most persuasive findings on the need for family supports are derived from a longitudinal study that followed a large group of children from conception to 10 years of age. These findings were reported in *The Children of Kauai*, published in 1971. Children who were born with a handicap tended to lose that handicap if they lived in stable families with emotional supports and educational stimulation. On the other hand, many children who appeared normal at birth acquired a handicap by age 2, especially if they lived in families that lacked advantages. By age 10 nearly 40 per cent of all children had acquired problems requiring special educational or emotional supports; only about one-fifth as many children required special medical care. The key to preventing the vast majority of the health problems was stronger families. That strength must come increasingly from community-based supports.

A national program of community support for families, including day care, could be a family- and life-saving mechanism for improved nutrition, for health education, and for medical care and health maintenance of many kinds. The country came close to such an enactment in 1971; renewed efforts should be made. Failure to do so will bring further deterioration of the American home and family as the best ways we know for rearing children. The great national concern over child abuse is a potent indicator that families need better community supports. The isolated, uninvolved family presents grave dangers to children.

An effort to supplement American families gives important recognition to a new revolution in the world of children. The revolution has to do with change in the role of women. That change can only benefit our society by opening new talent to new opportunity, to new creative endeavors, and to broader social responsibility. The world is full of evidence that children, far from being deprived by this revolution, will be stimulated and enriched by it. One study on working mothers reported that these mothers spent less time with their children—but spent more time talking to them. Day care is here: the public has a responsibility to make it healthful and supportive of children and their parents.

Four public commitments are recommended—National Health Service for Mothers and Children, a public feeding program, national housing reform, and publicly sponsored community-based family support centers including day care. A fifth public commitment deserves careful consideration. It involves establishment of performance standards for local and state health departments and quality review to assure their compliance with standards in order to qualify for shared revenue. Federal government has accepted the obligation for review of standards among private providers who receive public payment for services. No less an obligation attaches to expenditure of public funds through public providers. So many corrective and preventive

measures concerning the health of children relate to community rather than to individual endeavors that new strength needs to be given to a local agency that can serve as a focus of community action for health as defined by its broadest determinants. Such agencies are properly called health departments, and they need to be strengthened in order to fulfill their firmly legislated fiduciary role.

These five public endeavors all require public money and public administrative authority. Some will say we cannot afford them. The response is "poppycock." We cannot afford the awful cost of a nation of neglected children.

Others will say that government is administratively inept and cannot cope with such ambitious undertakings. Again, "poppycock." Government administers well those programs for which we have a strong commitment, and we must make a strong commitment to children. Government is administratively inept only when ineptitude serves a purpose. Somehow all the pensions get paid without confusion to the myriad former government workers, retired military personnel, and Social Security beneficiaries. But we do not like to give money to poor people, and because of that, their welfare programs all seem to be screwed up.

One expert on children, Dr. Bronfenbrenner, has reported:

> "If the children and youth of a nation are afforded opportunity to develop their capacities to the fullest, if they are given the knowledge to understand the work and the wisdom to change it, then the prospects of the future are bright. In contrast, a society which neglects its children, however well it may function in other respects, risks eventual disorganization and demise."

Many years ago, in the midst of our cold war and before travel to the Soviet Union had become commonplace, one of this world's great experts on children, Dr. Jessie Bierman, visited Russia and returned to report her observations on child care. The following quotation is faithful in part to her phrasing and entirely to her spirit: "The Russians will lick us; they will lick us because they take care of their children and we do not. They are assuring their future. We pretend to be a child-oriented society but we neglect, abuse and exploit our children. The strongest possible public leadership needs to reverse this solemn circumstance."

Dr. Bierman will be the first to protest that cold war is sorry justification for protecting children. There are many other justifications that are much more ennobling. Why do we ignore them and deprive ourselves as well as our children? Many cultures rejoice in their children. Among the many recent visitors to China, who has not returned showing slides and enthusiasms for well fed and much loved Chinese children? True enough those children live in a society with repressions and regimentations that are not acceptable to us. Recent political developments in our own country affirm that we must cherish and tend our freedoms. But is that effort not compatible with also cherishing and tending our children? I must believe that it is.

No matter whether our mechanisms for protecting children be public or private, and they surely must be both, they need to function with the forceful mandate that children are important to us. Let us take up that cause.

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