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Commentary

CHILDREN IN HEAVY TRAFFIC: HEALTH STATUS, HEALTH POLICY, AND PROSPECTS FOR REFORM

Sara Rosenbaum†

INTRODUCTION

A COMPARISON OF THE articles in this volume delivered by Abraham Bergman¹ and Dr. Ragnar Berfenstam² speaks volumes about the place which the health care of children occupies in the American social justice fabric. In his article, Dr. Berfenstam, an authority on childhood injury, traces the history of Sweden's remarkable effort to reduce childhood death and injury resulting from preventable accidents.³ Dr. Berfenstam describes a national movement which began in 1954 as a community effort among several collaborating private organizations and that grew into a universal governmental program twenty-five years later. The mission of the initial effort was to overhaul the country's child safety laws and practices and it succeeded in doing so. The role of individual families in protecting their children from dangerous environmental hazards is addressed through parental education activities; but these activities are part of a far broader set of government child safety standards. The Swedish initiative is grounded in the notion that society as a whole has a direct interest in the well-being of children and, therefore, should bear responsibility for their safety,

† The George Washington University Center for Health Policy Research.
3. Id.
even if the prescribed interventions heighten regulation or increase the cost of goods and services.

Dr. Bergman, who is also an authority on child health and injury, explores his lengthy career as a community physician and children's advocate. He writes about numerous policy efforts undertaken on children's behalf, both in the state of Washington and in Washington, D.C. After reflecting on the difficulty of achieving even a minimum level of consensus around social investment in children, he describes his latest mission to secure a single safe playground for children in one of Seattle's poorest neighborhoods. Dr. Bergman's quest to secure one safe playground in one poor neighborhood of one American city stands in stark contrast to the national child safety movement described by Dr. Berfenstam.

One can sense the magnitude of the policy crisis facing American children today, in the contrasting images of child safety in Sweden and America. Children in the U.S. are unprotected by any formal body of social legislation comparable to that enacted for the elderly over the past half century. The basic premise in this country is that parents can and should supply virtually all that children need. As a result, almost all federal and state child health programs are designed to compensate only for the "failings" of the poorest families living at the margins of society. These programs are inadequate to the task of compensating for the widespread failures brought on by a health care system which, left to its own devices, operates to exclude and deny health services rather than to ensure their availability.

Individuals, families and even local communities are incapable of solving the problems created by the American health system. The system is far too complex for the responsibility for children's health to fall to individual families or groups of local volunteers. This is not to suggest that children do not need strong families and strong communities to survive and thrive. Yet, at the heart of the failed child health system lie patterns and trends vastly beyond the grasp of any single family or community.

5. Id. at 32.
It is a tenet of American life that the proper role of government in social policy affecting families with children is as a “last resort” intercessor, not as a creator of just baselines for all individuals. But children’s advocates cannot compensate for a nation that fails to embrace every child as its own through formal, universal, social policies to ensure their welfare. In all Western democracies except the U.S. and South Africa, children are enriched by, but are not dependent upon, the kindness and commitment of individuals to ensure their well-being. Policies and programs to promote the optimal growth and development of children simply are part of the social compact drawn between nations and their current and future citizens.

The need for comprehensive federal intervention in complex areas of social policy is particularly strong in the area of health care. The causes underlying the American health care crisis are so complex and intertwined, and their resolution requires a realignment of one-seventh of the U.S. economy. What makes this period so unique in American history is that it represents one of the few times that Americans may be on the brink of conceding a significant role for government in meeting a basic human need, regardless of any particular individual’s social status. It is an opportunity for children that must not be lost. The health reform debate has produced countless opponents who argue that most Americans need no intervention and that only minor tinkering around the edges is necessary, along with a little expanded relief for the poor. But the health improvements for poor children that were secured during the 1980s, and the erosion of support for these improvements emerged in the 1990s, are a testament to the frailty of policy reform when only the poor are aided and when government seeks to find the narrowest possible gaps to fill rather than the broadest social good to advance.

Part I of this commentary explores the health status of American children and reviews the chief causes underlying poor economic and health indicators for so many children. Part II discusses the experience of federal policy advocacy on behalf of children in the U.S., using the Medicaid reforms enacted during the 1980s as a case study. Part III examines the oppor-

6. See infra Part II.
tunities for child health policy created by the national health reform movement.

PART I: THE HEALTH AND SOCIAL STATUS OF AMERICAN CHILDREN

It is difficult to appreciate the difficulties created by attempting to tailor social policy reforms only to poor children without understanding the size of the health crisis facing all children. A number of the articles in this volume, particularly that of James Strain, do an excellent job of reviewing the condition of children in the U.S. They underscore that it is no longer a handful of families living at the margin whose access to comprehensive health care is compromised. Indeed, today nearly half of all American children live in families with incomes at or below twice the Federal poverty level — an amount of resources insufficient to ensure access to adequate health care.

A. Poverty

In 1992, despite a 2.6% gross domestic product ("GDP") growth rate, 14.6 million American children (21.9% of all children under age eighteen) were poor. Among children younger than age six, the proportion in poverty stood at a remarkable 25.0%. Over the twenty-three-year period between 1969 and 1993, the proportion of children under eighteen living in poverty grew by 56.4%, while for children under age six, the proportion swelled by 63.4%.

These overall statistics mask even graver problems for distinct sub-populations of children. For example, in 1992, 46.6% of African-American children and 39.9% of Latino children were impoverished. That year, a record high forty-six percent of poor children lived in families with incomes below one-half...
the poverty rate, up from thirty-one percent in 1975, when extreme poverty rates first began to be recorded.12

The growth in childhood poverty has occurred mainly among young families who account for most American births. Between 1973 and 1990, the median income of young families with children (family head under age thirty) fell by thirty-two percent in inflation-adjusted dollars, while families without children achieved a five percent gain in median real income over the same time period.13 Particularly hard hit among young families were those headed by a high school graduate. In 1990, poverty affected children in one-third of all such families, who traditionally have comprised the backbone of American society.14

There are several major causes of childhood poverty, many of which have their roots in governmental policies:

1) Falling Wages and Insufficient Tax Relief

In 1967, a family of three earning the minimum wage could maintain a standard of living at 120% of the federal poverty level; however, because of federal and state failure to adjust official minimum wage levels to account for inflation, the minimum wage for a family of three stood at 79.1% of the federal poverty level in 1990.15

The Earned Income Tax Credit ("EITC"), originally enacted in 1975, was designed to help low-income wage earners with children.16 The credit has been of major significance in reducing childhood poverty because of both the tax relief it provides and the work incentives it creates.17 Historically the EITC has enjoyed bipartisan support and was once again expanded in 1993 as part of the Omnibus Budget Reconciliation Act.18 However, the credit provides relatively modest relief; at

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12. Id. at 1.
14. Id.
15. Id. at 27 tbl. 3.2.
17. Id. at 1052.
its maximum level the 1993 EITC still left working families with incomes below the federal poverty level. ¹⁹

2) Declining levels of government cash assistance

The largest need-based cash assistance program for families with children is Aid to Families with Dependent Children ("AFDC"). In 1992 an average of 13.4 million persons, two-thirds of whom were children, received assistance each month. ²⁰ AFDC benefits are confined for the most part to households with only one caretaker relative, and benefit levels are extremely low. Moreover, benefits are virtually unavailable to families that work. As a result, millions of low-income children cannot qualify for aid at all. ²¹ In 1992 only sixty percent of all poor children received AFDC assistance. ²²

Moreover, unlike the major public assistance program for the low-income elderly, which is known as Supplemental Security Income, AFDC benefits are not indexed to inflation. Thus, while nominal state AFDC grants rose from $184.00 to $367.00 between 1973 and 1990, in constant dollars median grants declined over this time period by forty-five percent. ²³

3) The Lack of Assured Child Support

The large number of children living in female-headed families makes child support enforcement extremely important. Yet in 1990, two-thirds of all female-headed families had no child support award at all; half the families with support awards received either less than the full award or else none at all. ²⁴

¹⁹. In constant dollars, the maximum credit a family with $7,765 in earnings could receive in 1994 was $1,941. This would bring a family's total income to $9,706, well below the federal poverty level for a family of three that year. GREEN BOOK, supra note 9 at 1055.

²⁰. Id. at tbl. 27.

²¹. The Family Support Act of 1988, Pub. L. No. 100-485, § 202 mandated part year coverage of certain unemployed families. Additionally, two-parent families with one incapacitated parent may qualify for AFDC benefits, however, of the nation's 4,375 million AFDC family recipient units in 1991, only 223 had two adults in the household. GREEN BOOK, supra note 16, at tbl. 35.

²². Id. at 688 tbl. 26.

²³. Id.

With low family income comes reduced child health status. Even a cursory review of child health indicators reveals the toll that childhood poverty takes on the health of children.

B. Infant death and low birth weight

High levels of childhood poverty are closely associated with elevated infant mortality. In 1989 the U.S. infant mortality rate, considered one of the bellwether indicators of overall national health, stood at 9.8 deaths per one thousand live births. This aggregate number masks elevated death rates for African-American infants. In 1989, African-American infants died at a rate more than twice as high as White infants. Between 1970 and 1989 the Black/White infant death rate "gap" widened, as progress in improving the health of Black infants slowed significantly, mirroring the deepening childhood poverty rate. African-American infant death rates are important not only as a sentinel measure of Black children’s health but as a proxy for low-income infant death rates as well, because of the lack of socio-economic data in the nation’s vital statistics system and the pervasive poverty among Black children.

A principal cause of infant death is low birth weight. While infant low birth weight is only partially understood, many causes are known. These are pre-maturity, poor maternal health and extreme immaturity of the mother (under age fifteen). Infants born at low birth weight, which is a weight of less than 2500 grams, are forty times more likely to die in the first month of life. Low birth weight infants are also at

26. Id. at 20.
27. Deaths before age one per 1000 live births.
29. Id.
30. Id. at 20.
31. See INSTITUTE OF MEDICINE, PREVENTING LOW BIRTH WEIGHT 27 (1985)
32. See id. at 26, 30. It is important to note that the excessive rate of unmarried childbearing in the U.S. is an important factor in childhood poverty; unmarried young mothers are far more likely to have only limited education, thereby further diminishing their chances for overcoming poverty. See Lisa Egibuono & Barbara Starfield, Child Health and Social Status, 69 PEDIATRICS 550 (1982); James Fossett & Janet Perloff, Medicaid in the Inner City: The Case of Maternity Care in Chicago, 68 MILBANK Q 111 (1990).
33. INSTITUTE OF MEDICINE, supra note 31, at 27.
greater risk of death from a variety of conditions such as cerebral palsy and retardation and other lifelong disabilities.\textsuperscript{34} Between 1980 and 1990 there was a nearly six percent increase in the proportion of African-American infants born at low birth weight.\textsuperscript{36}

Infant death rates by cause illustrate the effects of poverty. Death rates from congenital anomalies (unpreventable birth defects) are virtually identical for Black and White infants.\textsuperscript{36} In the case of preventable deaths however, Black infants die at rates far higher than those experienced by White infants. In 1986 Black infants were four times more likely to die from prematurity and low birth weight, two-and-a-half times more likely to die from pneumonia and influenza and two times more likely to die from newborn and maternal complications, newborn infections and accidents.\textsuperscript{37} All of these causes of death are considered either preventable or potentially preventable through health care and other interventions.

C. Childhood mortality and morbidity

Throughout childhood, low-income children are at elevated risk of death from a variety of causes including injury and preventable illness.\textsuperscript{38} America’s recent history with measles stands as a paradigm of the nation’s child health problem. Between 1989 and 1992 a major measles epidemic swept the U.S. affecting more than 60,000 persons and killing scores of children.\textsuperscript{39} The Centers for Disease Prevention and Control ("CDC") found that, despite the fact that ninety percent of children should be fully immunized by age two, in some U.S. cities as few as ten percent of all preschool children were adequately immunized against vaccine.\textsuperscript{40} While the initial reaction was to blame parents, more recent studies carried out for the CDC indicate that extreme poverty, the high cost of immunizations

\textsuperscript{34} \textit{Id.} at 31-33.
\textsuperscript{35} \textit{The State of America's Children, supra} note 13, at 6 tbl. 1.5.
\textsuperscript{36} \textsc{Dana Hughes et al., The Health of America’s Children} 9 (Children's Defense Fund, Washington, D.C., 1989).
\textsuperscript{37} \textit{Id.}
\textsuperscript{38} \textsc{Egbuguonu & Starfield, supra} note 32, at 550; \textsc{Fossett & Perloff, supra} note 32, at 83-86.
\textsuperscript{39} \textit{The State of America's Children, supra} note 13, at 3.
\textsuperscript{40} \textit{Id.}
in pediatricians' offices and overcrowded public clinics are also the problem.\textsuperscript{41}

D. America's standing in the world

The prevalence of infant and child mortality and morbidity among American children are evident when compared to other countries. In 1990 the U.S. stood thirty-first among all nations in the proportion of infants born at low birth weight in 1990; twentieth in the proportion of infants who died; twentieth in mortality among children younger than age five; seventeenth in the proportion of infants fully immunized against polio; and seventeenth in child immunization status, which is behind Nicaragua and Cuba and tied with Botswana, when immunization of only U.S. non-White infants is considered.\textsuperscript{42}

Childhood poverty and children's diminished health status are further exacerbated by the fact that millions of children are uninsured and thus at risk for medical under-service. In 1990, 15.3\% of all children under eighteen (9.8 million children) were completely uninsured. Of the nation's 13.6 million poor children, 3.4 million (twenty-five percent) were uninsured.\textsuperscript{43}

\begin{footnotesize}
\footnotesize
\begin{enumerate}
\item See D. Wood et al., Increasing Immunization Rates in the Public Sector; the Contribution of Missed Opportunities and Other Factors, \textit{5 J MEDICALLY UNDERSERVED} 2, 12 (1994).
\item \textit{The State of America's Children}, supra note 13, at 2-5.
\end{enumerate}
\end{footnotesize}
Table 1: Employment Related Insurance by Race/Ethnicity and Income, 1977 and 1987

<table>
<thead>
<tr>
<th></th>
<th>1977</th>
<th>1987</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>72.8</td>
<td>62.9</td>
</tr>
<tr>
<td>White</td>
<td>78.2</td>
<td>71.3</td>
</tr>
<tr>
<td>Black</td>
<td>52.5</td>
<td>38.1</td>
</tr>
<tr>
<td>Latino</td>
<td>50.7</td>
<td>39.4</td>
</tr>
<tr>
<td><strong>Poor Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>27.5</td>
<td>23.0</td>
</tr>
<tr>
<td>White</td>
<td>40.0</td>
<td>31.5</td>
</tr>
<tr>
<td>Black</td>
<td>11.0</td>
<td>15.9</td>
</tr>
<tr>
<td>Latino</td>
<td>12.5</td>
<td>16.1</td>
</tr>
<tr>
<td><strong>Low Income Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>63.4</td>
<td>47.0</td>
</tr>
<tr>
<td>White</td>
<td>69.0</td>
<td>52.1</td>
</tr>
<tr>
<td>Black</td>
<td>50.5</td>
<td>34.2</td>
</tr>
<tr>
<td>Latino</td>
<td>49.6</td>
<td>38.3</td>
</tr>
<tr>
<td><strong>Middle Income Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>83.6</td>
<td>79.0</td>
</tr>
<tr>
<td>White</td>
<td>84.2</td>
<td>81.3</td>
</tr>
<tr>
<td>Black</td>
<td>83.7</td>
<td>69.5</td>
</tr>
<tr>
<td>Latino</td>
<td>71.7</td>
<td>64.5</td>
</tr>
<tr>
<td><strong>Upper Income Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>85.4</td>
<td>86.9</td>
</tr>
<tr>
<td>White</td>
<td>86.9</td>
<td>87.3</td>
</tr>
<tr>
<td>Black</td>
<td>76.8</td>
<td>83.4</td>
</tr>
<tr>
<td>Latino</td>
<td>69.0</td>
<td>77.5</td>
</tr>
</tbody>
</table>

The statistics on children's lack of health insurance in any single year mask long-term trends in the insurance coverage of children. These trends show the combined effects of a major

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45. Incomes below the federal poverty level.
46. Standard error is greater than 30% of the estimate.
47. Incomes between 100 to 199% of federal poverty.
48. Incomes between 200 to 399% of federal poverty.
49. Incomes at 400% and above of federal poverty level.
erosion in employer-based coverage and an increase in children's dependence on Medicaid, the nation's largest public assistance program. Table 1 shows that between 1977 and 1987 the proportion of children covered by employer insurance dropped from 72.8% to 62.9%. Coverage rates dropped for children of all races with particularly steep declines for African-American and Latino children. Coverage rates declined from 52.5% to 38.1% among African-American children; among Latino children, employer-based coverage declined from 50.7% to 39.1%.

The drop in employer coverage appears to be occurring not because fewer children live in working families, but because those who do are less likely to be insured. In the U.S., access to private health insurance among workers and families depends on their connection to a voluntary system of employer-based health insurance. As the cost of health insurance has skyrocketed, employers have reduced or refrained from contributing to the insurance coverage of family dependents. Declining real-dollar wages among young working families have left millions without the ability either to replace declining employer contributions or to compensate for their absence.

Table 2 shows significant declines in health insurance coverage among children living in employed households, regardless of whether one or both parents works. These statistics are probably the result of several trends that surfaced during the 1980s: the greater proportion of employers that do not offer subsidized group health coverage for both workers and their dependents, a higher concentration of young families with children in low-wage jobs with no fringe benefits and the declining number of employers that offer premium subsidies for their employees' families. Table 3 shows that if these trends are allowed to continue unabated, then by the year 2000, only 19.4% of Black

51. Based on Rosenbaum et al., supra note 44, at tbl. 4 (NMCES and NMES, calculations by Children's Defense Fund).
children, and 25.7% of low-income children will have employer coverage.

Table 3: Proportion of Children with Employer Insurance, 1977-2000

<table>
<thead>
<tr>
<th></th>
<th>1977</th>
<th>1987</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Children</td>
<td>72.8%</td>
<td>62.9%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Black Children</td>
<td>52.5%</td>
<td>38.1%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Children in Two-Parent,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One-Wage-Earner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Families</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-Income Children</td>
<td>63.4%</td>
<td>47.0%</td>
<td>25.7%</td>
</tr>
<tr>
<td>Middle-Income Children</td>
<td>83.6%</td>
<td>79.0%</td>
<td>73.0%</td>
</tr>
</tbody>
</table>

Table 4: Health Insurance Coverage Status of All Children Younger than Eighteen, by Race/Ethnicity, 1990

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Covered by Public or Private Insurance</th>
<th>Covered by Any Private Insurance</th>
<th>Covered by Employer-Based Insurance</th>
<th>Covered by Medicaid</th>
<th>Uninsured Throughout the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Races</td>
<td>65,049</td>
<td>56,634</td>
<td>46,369</td>
<td>39,964</td>
<td>11,993</td>
<td>8,414</td>
</tr>
<tr>
<td>Number</td>
<td>51,929</td>
<td>45,444</td>
<td>39,484</td>
<td>34,356</td>
<td>7,132</td>
<td>6,486</td>
</tr>
<tr>
<td>Percentage</td>
<td>85.6%</td>
<td>87.1%</td>
<td>71.3%</td>
<td>61.4%</td>
<td>18.4%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Black</td>
<td>10,162</td>
<td>8,695</td>
<td>4,954</td>
<td>4,084</td>
<td>4,201</td>
<td>1,467</td>
</tr>
<tr>
<td>Number</td>
<td>7,457</td>
<td>5,344</td>
<td>3,356</td>
<td>2,892</td>
<td>2,237</td>
<td>2,113</td>
</tr>
<tr>
<td>Percentage</td>
<td>85.6%</td>
<td>87.1%</td>
<td>71.7%</td>
<td>38.8%</td>
<td>30.0%</td>
<td>28.3%</td>
</tr>
</tbody>
</table>

Taking the place of employer coverage is Medicaid. As Table 4 indicates, in 1990 on an aggregate basis, there was virtually no difference in insurance coverage rates for African-American and White children. However the underlying poverty

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53. Based on ROSENBAUM ET AL., supra note 44, at tbl. 3A (HIES and NMES, Calculations by the Children's Defense Fund). This table is based on average annual rate of change, 1977-1987, but it does not take into account possible accelerated loss of employer coverage resulting from the current recession.

rate of Black children is mirrored in their Medicaid dependence. Table 4 shows that in 1990, African-American children were more likely to have Medicaid coverage than employer insurance. As Table 4 illustrates, without Medicaid over thirty percent of American children would have been completely uninsured that year.55

The health care barriers facing children extend beyond the simple lack of health insurance. For millions of children who are low-income and who reside in isolated inner-city or rural communities, there are simply no accessible services. An estimated 43.3 million Americans live in areas that can be considered medically under-served because of physician shortages, or high rates of preventable illness and disease, or both.56 Although children under age eighteen comprise only twenty-five percent of the U.S. population as a whole, they constitute one-third of all medically under-served Americans.57

Many factors account for health service shortages. Principal among these are poverty and its depressing effect on physicians' willingness to locate and practice in under-served areas, and the greater dependence by low-income persons on Medicaid, whose payment levels historically have been too low to assure participation by even those providers that do practice within a reasonable distance of poor communities.58 Health services offered by public health agencies, programs such as federally funded community health centers and the National Health Service Corps could considerably ameliorate the shortage of primary health care services in under-served communities. They are severely under-funded, however. For example, in 1990, funding for the community health centers program was sufficient to reach only fourteen percent of the under-served.59

The economic and health-related problems that confront so many American children require a systematic examination of government policies relating to families. The data presented here underscore the fact that the causes of childhood poverty and ill health extend well beyond lifestyle choices or the behavior of individual families. When government wage and income

55. Id. at 11.
56. DANIEL HAWKINS & SARA ROSENBAUM. LIVES IN THE BALANCE 7 (1993).
57. Id. at 8.
58. Fossett & Perloff, supra note 32, at 141.
59. HAWKINS & ROSENBAUM, supra note 56, at 45.
supplementation policies are insufficient to assure full-time workers and their families a decent standard of living, clearly there are bureaucratic problems. When full-time workers cannot afford health coverage for their families, a pervasive problem exists. When millions of children are left to rely on public insurance programs whose rates of provider payment are too low to attract sufficient numbers of private physicians, there is something wrong. When programs essential to the creation of sources of decent health services (such as the Title V Maternal and Child Health Block Grant; the Supplemental Food Program for Women, Infants and Children (“WIC”); childhood immunizations; and National Health Service Corps community health centers) in under-served communities are radically under-financed, it is yet another testament to government and social, rather than family, problems.

PART II: FEDERAL HEALTH POLICY AND CHILDREN: THE CASE OF MEDICAID

The Medicaid maternal and child health legislative reforms enacted during the 1980s exemplify the problems that can arise when health reform efforts are targeted only to poor children. The reforms have made an enormous difference in children’s insurance coverage. However, because the reforms affect only low-income children and involve only the restructuring of a program designed for low-income families, gaining acceptance of the changes is taking a great deal of time. Moreover, preserving the gains against subsequent erosion has proven difficult. The lesson of the Medicaid reforms for children is that, while it is always difficult to expand the reach of social policies and programs, the task is particularly hard when the only beneficiaries of the reforms are poor.

A. Medicaid and Children

Despite its deficiencies, Medicaid has been an extremely important health program for children. Medicaid is closely associated with improved access to both maternity and primary

pediatric health care\textsuperscript{61} and is responsible for reducing the inequity in health care access between poor and non-poor children.

In the mid-1970s Congress twice considered and rejected proposed amendments to expand the number and categories of children eligible for Medicaid.\textsuperscript{62} In both cases the legislation, which grew out of a Carter administration initiative was rejected for a variety of reasons. In the first Congress of the Carter presidency, the bill competed for attention against a far broader national health reform initiative which failed. In the second Congress, the President was much weakened politically and was unable to stave off limitations on Medicaid funding for abortion services which were attached to the House-passed version of the bill. These limitations made further consideration of the matter in the Senate all but impossible, particularly in light of the 1980 presidential election. Finally, and in some ways most important, was the fact that there was relatively little interest in the measure itself. The health problems of poor children simply were not perceived as severe enough to warrant an increase in entitlement spending on a welfare program.

Conditions changed considerably in the 1980s. The largest recession since the Great Depression swept the nation in the early 1980s and raised policy makers' concern over the loss of health coverage. Major reductions in AFDC and Medicaid benefits by the Reagan administration and its supporters were aimed primarily at the working poor and caused Congress to focus increased attention to the problems of children in low-income families. By the mid-1980s numerous reports on the deteriorating health status of low-income children had begun to appear.\textsuperscript{63}

\textsuperscript{61} See Karen Davis \& Cathy Schoen, Health and the War on Poverty 21 (1977).


B. The Reforms of the 1980s

By the mid-1980s, members of Congress and the public were poised to act on health reform. Several years of reductions in government programs for the poor had whetted policy makers' appetites for some type of "forward" social movement. They recognized the plight of lower-income children whose working parents could not secure adequate health care, and who were denied public insurance for their children simply because they worked, and were enormously sympathetic. The reforms themselves were relatively inexpensive because relative to other sub-populations children use very few health services. The issue had undeniable policy merit. Finally, and perhaps most importantly, there was absolutely no interest in the early to mid-1980s in national health reform and no grand scheme against which the expansions competed.

Against relatively improbable legislative odds, but with political and social conditions in their favor, several members of Congress were able to move Medicaid reform legislation for children, ironically as part of large, must-pass budget reduction legislation. They were aided in their efforts by a large constituency of children's advocates, state- and local-elected public officials and the religious movement, in particular the Catholic church, which took up the cause of child health and loaned its assistance in warding off restrictive abortion funding amendments.

The Medicaid child health expansions that took place over a six-year period spanning 1984 to 1990 succeeded in adding coverage for several million children and pregnant women. The reforms for children enacted during the 1980s dwarfed those initially proposed by the Carter administration a decade earlier. They included expanded coverage, the addition of a highly enriched benefit package, complete protection against patient cost sharing, streamlined eligibility determination and enrollment procedures and improvements in provider reimbursement levels. Children's coverage for Medicaid was effec-

64. For a general review of the history of the child health expansions, see Rosenbaum, supra note 62.
65. Id. at 50 & n.13.
66. Id. at 47.
67. See id. at 47.
68. See id. at 46-47, 49-50 tbl. 1, 58 tbl. 5.
tively severed from AFDC eligibility. Had these reforms not been enacted, several million additional children — chiefly those in the working poor families most affected by the loss of employer coverage — would be uninsured today.

The Medicaid reforms represent an enormous and sustained burst of policy-making around the needs of poor families. They stand as an unusual example of success in getting the needs of poor children heard over the din of Washington, D.C. policies and politics. They also demonstrate the lengthy time period needed to achieve important policy reforms for the poor. Reform efforts aimed at poor children are the norm in the U.S. because so many policy-makers are averse to programs that create universal guarantees for children. But achieving even the most deserving reforms are a slow process in this country.

The deficiencies in Medicaid coverage for children had been understood virtually since the time of its enactment in 1965. Yet it took twelve years for a president to propose steps to rectify the problems. From the time that the Carter administration initially proposed Medicaid child health expansions in 1977, it took seven years to pass the first set of reforms and another six years to complete the cycle of coverage expansions for poor children and pregnant women. There were many reasons for the lengthy delay:

1. Politics: Despite the need for expanded coverage for poor pregnant women and children, it took a major recession to draw attention to the plight of poorer workers and their families for Congress to take legislative notice of poor children. It also took extreme measures by the Reagan administration and its supporters to reduce spending on poor

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69. Indeed, recent efforts by the Clinton administration to enact a universal governmental program of free vaccine for all American children regardless of social class and the ensuing backlash against such reforms by some policy-makers and by enormous private business interests that profit from retail vaccine sales demonstrate how unreceptive lawmakers often are when social legislation is used to confer benefits on all children rather than address the needs of a few. See Robert Pear, Clinton Criticized as Too Ambitious with Vaccine Plan: Government Distribution Plan Alarms Drug Makers and Members of Congress, N.Y. TIMES, May 30, 1994, at A1.

70. See ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA (1974).

71. Poor children ineligible for cash welfare already were at high risk for little or no insurance by 1978, and policy-makers already understood that poor uninsured women were far less likely to obtain prenatal care.
children in 1981,72 including reductions in such non-welfare programs as childhood immunizations, WIC and maternal and child health funding, to gain Congressional attention during the "mid-course correction" period of 1982.73

2. Budget Act: Even following agreement by Congress that children's health and insurance problems were serious, a single set of reforms had to be subdivided into small, annual bites because of constraints under the Congressional Budget Act.74 The law, first enacted in 1974 and amended several times subsequently, makes consideration of entitlement legislation such as the Medicaid expansions for children exceedingly difficult.75 Welfare entitlement laws cannot be considered unless there are either offsetting revenues or spending reductions available to finance the legislation during the same fiscal year and in the immediately ensuing fiscal out-years.76 On the other hand, much important maternal and child health legislation, such as programs creating better prenatal, pediatric, nutritional and social care and services for poor families as well as other investments in low-income children, may not achieve their highest payoffs until several decades following enactment, and then only in ways that inure to the national budget but not to the federal budget. Thus, the federal budget process is inherently flawed in how it measures the value of investments in children.

The Budget Act does not permit offsetting long-term costs to be taken into account in determining if a new investment is affordable. Nor does the cost estimation process necessarily give credence to the possibility of more immediate favorable outcomes resulting from changing child health policies, such as improved infant birth weight levels arising from expanded access to maternity care. Such savings are considered speculative. Indeed, there is evidence

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73. Rosenbaum, supra note 62 at 47-49.
75. It is easier under the Budget Act to consider legislation calling for discretionary spending only, in fact the value of proceeding with discretionary measures is very low. The Budget Act severely limits funding available for spending on discretionary programs. 2 U.S.C. § 900, et seq. As a result, even the most laudable federal initiatives may end up only as abstract principles on the books without any funding to make implementation real.
that the immediate impact of improved access to maternity care might be an increase in low birth weight infants since women who otherwise would have lost pregnancies will instead give birth to babies who survive. The long-term value of this greater survival rate falls outside the federal budget consideration process, and the process used to consider state budgets.

Patterns of Congressional Committee jurisdiction over children's spending and the lack of a unified children's account in the budget also act to stand in the way of health policy reform. Even assuming that one could identify something known as a "children's account" and place within it the value of all federal direct outlay and tax investments in children (a highly unlikely and not necessarily constructive activity), the fact is that the Budget Act creates numerous federal spending accounts by government function rather than by population. If savings from health reform accrue in one or more federal spending accounts other than the health account — such as decreased expenditures on child welfare services or special education services as a result of child health improvements — the Congressional health committees do not necessarily get such savings allocated back to them to spend on child health. Even though their legislation may be essential to achieving the cost savings to begin with, Congressional committees concerned with child welfare or special education may be unwilling to have some or all savings in their programs effectively transferred to another committee.

3. The Incremental Nature of Federal Social Policy: The legal and procedural barriers to enactment of sweeping or even relatively sweeping reforms did not evolve out of thin air. They are a reflection of the zeitgeist of Washington, D.C., where only rarely do policies change quickly or significantly. Most laws take a great deal of time to evolve and are enacted only in small bites, because of the effort involved in persuading Americans and their lawmakers that government intervention on a social problem is part of a solution.

In the case of the Medicaid reforms, each legislative "bite" between 1984, which is the year of the enactment of the first reforms, and 1990, when this particular cycle of

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child health coverage restructuring was essentially completed politically if not in actuality, had a separate budget and a separate policy justification. Persuading Congress to authorize sufficient expenditures to cover poor and near-poor pregnant women and children all at once was impossible. Therefore, each year for seven years, beginning in 1983, supporters developed new ways to argue for adding yet another layer of women and children to the covered population. As a result, at least six separate pieces of legislation dealt with maternity and pediatric coverage. In the end the policy reforms were achieved; however, they helped fuel widespread confusion among welfare agencies implementing the changes over which children had to be covered by which date. They also fed the anger of governors that federal law makers were forcing states to deal with problems through the Medicaid federal/state program that the federal government refused to address.

4. Poison pills: Without consensus of organizations along the full political spectrum, the Medicaid reforms never could have passed. During periods when conservative lawmakers opposed expansions for poor women and children, Medicaid legislation was used as a vehicle for abortion restriction amendments. When organizations concerned with abortion but equally concerned with the health of children stepped in to champion the Medicaid expansion measures, anti-abortion riders stopped. That those offering the amendments knew what the immediate impact these amendments would have on further consideration of the legislation and offered the provisions to stop the bill is evident by the fact that such amendments were not offered when legislation to reduce Medicaid spending or other laws viewed as "must-pass," was considered, even though such amendments technically are germane.

Despite the fact that policy-makers, both public and private, resist universal guarantees, the ensuing history of Medi-

78. I do not mean to suggest that there was nothing left to do. Indeed, there was a tremendous amount left to do. The recession of 1990, a major backlash against Medicaid costs and the growing concern over entitlement spending generally brought the small era of Medicaid improvements to a grinding halt.  
79. ROSENBAUM, supra note 72.  
80. Recent studies show that the cost of the maternity and pediatric expansions in fact accounted for only a small fraction of the Medicaid cost explosion during the 1980s. See, e.g., KAISER COMM'N ON THE FUTURE OF MEDICAID, THE MEDICAID COST EXPLOSION (1992).
caid following the reform period illustrates the problems inherent in confining health policy restructuring to the poor. Since 1990 Medicaid has come under sustained attack for both its size and the rate of its growth. Despite the fact that, as a need-based program, Medicaid spending is spurred by high poverty levels, illness and disability and by the generally high cost of providing health care, Medicaid spending growth has repeatedly been attacked in recent years as unaffordable, excessive and overly generous. The expansions for children have not been spared from these attacks. The National Governors Association called for the repeal of some of the child health expansions, and several states have taken steps to eliminate from their program some of the near-poor women and children which were added only several years earlier.  

PART III: CHILD HEALTH POLICY AND NATIONAL HEALTH REFORM

The history of Medicaid improvements for children demonstrates that when reforms are considered for poor children only, the path is long and torturous. It is nearly impossible to achieve major changes in the way in which poor children are insured and obtain health care when their needs are considered alone. It is the legislative equivalent to improving the safety of children a few playgrounds at a time.

The Medicaid reforms of the 1980s were of enormous importance both for their own value and for the symbolic impact of attaining forward movement for poor families on a major social policy issue. However, it is also clear that, even if Medicaid was an adequate substitute for private insurance, the reduction in private insurance is occurring too rapidly to be offset by modest reforms in Medicaid. Thus, achieving health reform through Medicaid reform is at best an essential stop-gap, but does nothing to stem wide-spread and systemic hemorrhaging.

Congress is now on the brink of acting on sweeping health policy reforms. The true momentousness of this debate is that for the first time since the federal government began shaping health policy, the nation appears at least tentatively willing to concede that the federal government has a vital role to play in

81. Rosenbaum, supra note 62.
assuring the overall proper functioning of the health care system, not just its deficiencies for certain populations.

How sweeping Congress is willing to be in this overhaul is currently the central question in the entire debate. Major interest groups which perceive that they have more to lose than gain from broad reforms have mounted an unprecedented political effort to convince Congress that only incremental changes are needed and that the hard choices necessary for the achievement universal guaranteed coverage for all Americans are not necessary at this point in U.S. history. They warrant that “market” reforms coupled with some improvements in Medicaid for the poor will suffice.82 The Medicaid reform efforts for children during the 1980s show the frailty of this approach. Despite the importance of incremental gains, the net result is an improved poor person’s program that remains forever vulnerable to the charge of excessive and unwarranted spending on a certain subset of Americans. Severing off the poor for separate legislative consideration absolutely ensures that they will remain outside the health care financing system that is generally accepted by private health providers. Segregation also ensures that funding is insufficient to either cover an adequate level of benefits or develop the needed resources to ensure adequate access to care. And segregation reduces the debate to a small enough level for opponents to pick on the measure in ways that would be more controllable in a “must pass” bill.

The health plight of the poorest children is indeed the most serious aspect of the overall child health dilemma. But the way to most effectively address the situation is not to enact programs for poor children. Such an approach only threatens to cause them to fall further and further behind, trapped in an insufficiently financed world of their own.

The far preferable approach is to reach an understanding that the future of poor children in America lies in the future of

82. The most representative legislative approach embodying this philosophy is Michel’s H.R. 3080, The Affordable Health Care Now Act, 103d Cong., 1st Sess. (1993). Legislation introduced by Congressman James Cooper (H.R. 3222, The Managed Competition Act, 103d Cong., 1st Sess. (1993)) similarly makes improvements in the private insurance market while giving low-income families some additional funds to purchase coverage. No benefits would be guaranteed, and those that could not afford coverage would be left uninsured. For a comprehensive analysis of the major legislation now pending in Congress, see The Kaiser Commission on the Future of Medicaid, Health Reform Legislation A Comparison of Major Proposals (1994).
us all. We cannot fix children or playgrounds one at a time if the nation is to hold together in the century to come. Each of us has a stake in the life of each American child. As so many of this volume's authors so eloquently underscore, we must never give up on insisting on federal policies that reflect the importance of all children.