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# TRACING THE HISTORICAL FOUNDATIONS OF MATERNAL AND CHILD HEALTH TO CONTEMPORARY TIMES

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*These questions of child health and protection are a complicated problem requiring much learning and action. And we need have great concern over this matter. Let no one believe that these are questions which should not stir a nation; that they are below the dignity of statesman or governments. If we could have but one generation of properly born, trained, educated, and healthy children, a thousand other problems of government would vanish.*

(Herbert Hoover, 1931)

## INTRODUCTION

Policy development to address the needs of mothers and children has played out in the unique political and social context of the United States. Three attributes in particular have influenced and continue to influence the development of maternal and child health (MCH) policies. One attribute is federalism, that is, the fact that there are two major governmental entities—federal and state—that vie for influence within the structure outlined in the U.S. Constitution. This federal–state relationship is further complicated by the fact that there are thousands of county and city jurisdictions, each of which relates to both the federal government and its own state. The relative influence of these partners has waxed and waned since the onset of local and state government interest in the population of mothers and children at the close of the 19th century.

A second attribute is the independent judiciary that has served as the interpreter and

upholder of the basic values infused in the Constitution. Although the interpretation of certain constitutional limits has varied over the years, any given legislative action must pass judicial muster. The third attribute of the U.S. political and social scene is the high value placed on individualism, the free enterprise economic system, and the dominant role of the private sector. Governmental influence in many spheres of life in the United States is generally justified in response to market failures rather than as a fundamental aspect of the social framework (Epstein, 2003; Gostin & Blocke, 2003).

This chapter characterizes three phases in the development of U.S. health policy for mothers and children. First, the chapter reviews the origins of local, state, and federal participation in health care for mothers and children. Next, the discussion focuses on the emergence of the federal government as a major force in public MCH program development, with particular attention to the federal role in addressing equity.

The chapter then concludes with consideration of the current political tensions and efforts to return power and responsibility for MCH policies, once again, to the states. Table 2–1 presents a chronology of the development of selected MCH services in the United States.

### **ORIGINS OF GOVERNMENTAL PARTICIPATION IN THE CARE OF MOTHERS AND CHILDREN**

The three attributes of social policy began to interact in prominent ways with regard to mothers and children after the Civil War.

**Table 2–1** Chronology of MCH Services in the United States

1855	Founding of the Children’s Hospital of Philadelphia
1869	State board of health established in Massachusetts
1879	Formation of a Section on Diseases of Children of the American Medical Association
1888	The American Pediatric Society founded to promote scientific inquiry into children’s diseases
1893	First milk station established in New York City
1904	National Child Labor Committee organized to monitor effects of child labor on health and development
1907	First Bureau of Child Hygiene established in New York City
1909	First White House Conference on Children called by President Theodore Roosevelt
1912	Congress established the Children’s Bureau
1921	First Maternity and Infancy Act (Sheppard-Towner)
1930	American Academy of Pediatrics founded
1935	Social Security Act, including grants to states for aid for dependent children and maternal and child welfare (Titles IV and V, respectively), enacted
1943	Emergency Maternity and Infant Care Act
1944	Association of Maternal and Child Health Programs founded as the Association of Directors of State and Territorial Maternal and Child Health and Crippled Children’s Services
1951	American College of Obstetricians and Gynecologists founded
1954	Special appropriation to MCH programs for community services for children with mental retardation
1963	Special project grants for Maternity and Infant Care
1965	Title XVIII (Medicare) and Title XIX (Medicaid) added to the Social Security Act; amendments to Title V establish maternity care and children’s projects; first Neighborhood Health Center grant awarded
1967	Office of Child Development created as a home for Head Start; functions of the Children’s Bureau distributed among four federal agencies
1968	Amendments to Title V and Title XIX authorizing the creation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
1972	Special Supplemental Food Program for Women, Infants, and Children (WIC) established

*(continues)*

**Table 2-1** (Continued)

1974	Child Abuse Prevention and Treatment Act enacted
1981	Maternal and Child Health Services Block Grant amendments to Title V enacted
1984	Beginning of a series of amendments to expand access to Medicaid
1989	Title V amended to increase accountability
1991	Healthy Start funded in 15 communities
1996	The Personal Responsibility and Work Opportunity Reconciliation Act
1997	Title XXI (State Child Health Insurance Program) added to the Social Security Act
2010	Patient Protection and Affordable Care Act (P.L. 111-148) to expand health insurance coverage is signed into law

A series of developments prompted increased attention to the particular needs of children. In the field of medicine, Dr. Abraham Jacobi and others began to articulate that the therapeutic needs of children differed from those of adults. Developments in the field of sanitation provided new understanding of determinants of infant mortality (Meckel, 1990). Fundamental discoveries in bacteriology and the prevention and control of infectious diseases provided a dramatic opportunity to demonstrate the possibilities of preventing infant deaths (Lesser, 1985). Although the discovery of the germ theory of disease gave public health a technological base, it became clear that prevention was not simply a medical research issue. Effective health promotion also demanded social mechanisms, the most important of which was public health education (Tratner, 1974).

In 1874, Henry Bergh, founder of the New York Society for the Prevention of Cruelty to Animals, personally intervened on behalf of a child who had been physically abused, bringing her situation to the attention of local authorities in New York City. Outrage over the absence of laws to protect children from such treatment prompted New York and other cities to enact laws prohibiting child cruelty and giving private agencies police authority to intervene in abusive situations (Williams, 1983). In New York, the new

Society for the Prevention of Cruelty to Children assumed this responsibility.

Throughout history, children have been expected to provide menial or hazardous labor for their parents. The intense industrialization of the late 19th century drew many children into factories and mines, raising the concerns of child advocates and social reformers about the effects of working conditions on the health and education of children. Industrialization led to the creation of labor-intensive, low-paid jobs in mills, mines, and factories. Coupled with the high Civil War mortality experienced by working-aged males, especially in the South, this situation resulted in the widespread employment of children in a number of out-of-home occupations (Schmidt & Wallace, 1988). By 1900, one in six 10- to 15-year-olds was employed, 40% in industry, 60% in agriculture, and children as young as 7 years were employed in poor or hazardous work environments (Schmidt & Wallace, 1988).

In 1916 the Keating-Owen Act prohibited interstate commerce of goods produced by children. This legislation was controversial because of the necessity for children from poor families to work, and it was overturned by the Supreme Court in a 1918 case, *Hammer v. Dagenhart*, from textile-producing North Carolina (Berger & Johansson, 1980). It was not until the Depression forced unemployed

adults to take jobs previously reserved for children that child labor was permanently constrained (Miller, 1988).

As immigrants poured into cities seeking new opportunities, the unmet health and educational needs of their children, as well as the potential threat to public health through the transmission of infectious diseases, became the subject of concern for reformers and politicians. The institutionalization of vital records keeping provided the first real evidence of the social impact of infant mortality. Infant death records revealed that in the United States in 1900, infant mortality averaged 150 per 1,000 births and was as high as 180/1,000 in some industrial cities. Death claimed as many as 50% of the infants that had been abandoned or orphaned to the foundling hospitals that proliferated as a result of urbanization and immigration (Schmidt & Wallace, 1988). In this context, late 19th- and early 20th-century social workers and public health officials joined forces. As social workers recognized that poverty and social dislocation engendered ill health and that ill health caused poverty by creating economic burdens, they used their particular skills to combat poverty by promoting good health. They mobilized the lay leaders and residents of the community for the control of disease (Tratner, 1974). For example, recognizing the risk to infants of consuming spoiled milk, and the heightened risk for poor infants because of the lack of adequate storage facilities, public health advocates urged municipalities and private individuals to fund milk stations where poor families could collect fresh milk (Grotberg, 1977).

The evolving concept of childhood as a “special” period of growth, socialization, and development provided a rational context for advocacy, whereas child labor, infant mortality, and child maltreatment provided highly visible targets for reform. A coalition of female reformers, the driving force behind the women’s suffrage movement, lent energy, motivation, and critical mass to the ranks of settlement house workers, social

workers, and public health nurses engaged in child advocacy. The first Bureau of Child Hygiene was established in 1907 in New York City under the leadership of Dr. S. Josephine Baker. She had entered the New York City Health Department after prejudice against female physicians had limited her ability to advance in academic medicine and private practice (Baker, 1994). One of the main strategies undertaken by Baker was to send public health nurses to visit the tenement homes of newborn babies in order to educate mothers about how to care for their new infants. The bureau became involved in the health care of school children, the supervision of midwives, and the regulation of children’s institutions.

The convergence of social, economic, and political forces at the turn of the century resulted in the call for a federal role in promoting, if not ensuring, the well-being of children. In 1909, President Theodore Roosevelt convened the first White House Conference on Children. Emerging from the conference were calls for service programs and financial aid to protect the home environment and recommendations that the federal government take responsibility for gathering information on problems of infant and child health and welfare (Lesser, 1985; Schmidt & Wallace, 1988; Skocpol, 1992; Tratner, 1974). These recommendations gave rise to the Mother’s Aid Movement and the American Association for the Study and Prevention of Infant Mortality. The former group drew attention to the benefits of keeping children in the family while pointing out the detrimental effects of dehumanizing institutions. The latter group drew attention to the unacceptably high rate of infant deaths (Lesser, 1985; Schmidt & Wallace, 1988; Tratner, 1974).

With advocacy from education, psychology, medicine, public health, labor, and social work, and over the opposition of groups opposing federal meddling in the private domain of parents, Congress followed another of the conference’s recommendations and enacted legislation establishing the Children’s Bureau. Legislation for such an agency had

been first introduced in 1906, but intense debate centering on the question of whether child welfare was a federal or state responsibility stalled its passage until 1912. Assigned to the Department of Commerce and Labor, reflecting the roots of the bureau in concern over labor conditions for children, the act charged 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 . . . especially investigate the questions of infant mortality, the birth rate, orphanages, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment, and legislation affecting children in the several States and Territories" (U.S. Congress, 1912). The tension between public and private responsibility for children was reflected in the legislation that stated, "No official, or agent, or representative of said bureau shall, over the objection of the head of the family, enter any house used exclusively as a family residence."

Under the leadership of its first chief, Julia Lathrop, the Children's Bureau embarked on an active portfolio of investigations into the conditions of children. For example, the bureau conducted a longitudinal study of the relationship between income and infant mortality (Lathrop, 1919). Other studies addressed child labor, working mothers, children's nutrition, services for crippled children, and juvenile delinquency. In 1915, as the result of bureau studies that concluded that birth registration is "the starting point for the reduction of infant mortality by identifying infants at risk for health problems, or dying," the National Birth Registry was established.

Although the mandate of the bureau was to investigate and report, its leaders began to develop a legislative agenda to address identified problems. In 1918, Representative Jeanette Rankin of Montana introduced legislation to provide federal funds to the states to establish preventive health programs for mothers and infants (Wilson, 1989). This legislation was strongly supported by the suffragettes, but was opposed by the medical

community because it would place responsibility for a healthcare program under the "nonmedical" Children's Bureau (Lesser, 1985). In the midst of the debate over the legislation, the Second White House Conference on Children in 1919 issued recommendations for minimum standards of MCH care.

By 1920, sponsorship of the bill was assumed by Senator Morris Sheppard of Texas and Representative Horace Towner of Iowa. Partially in recognition that the United States was not doing particularly well in responding to problems of maternal and infant health, Congress passed the Maternity and Infancy Act (also known as the Sheppard-Towner Act) in November 1921 (Schmidt & Wallace, 1988).

The Sheppard-Towner Act authorized grants paid "to the several States for the purpose of cooperating with them in promotion the welfare and hygiene of maternity and infancy as hereinafter provided" (Bremner, 1970). Under the act, each state that elected to receive these funds was required to establish a child welfare or child hygiene agency, representing the first federal effort to develop an MCH infrastructure within the states. The monies were allocated as a grant in two parts. Under the first part, each state received an equal share of a \$480,000 appropriation. Under the second part, totaling \$1,000,000, each state received \$5,000, plus an amount proportionate to that state's population in the census of 1920. States were required to match the funds provided under the second part of the act. Funds were distributed in response "to detailed plans for carrying out the provisions of this Act within such State." Although the Sheppard-Towner Act did not regulate the content of these plans beyond "promoting the welfare and hygiene of maternity and infancy," the legislation was quite explicit in what states were not permitted to do. Continuing the attention to individual liberty instilled in the Children's Bureau authorization, the act asserted the following:

*No official, agent, or representative of the Children's Bureau shall by virtue of this*

*Act have any right to enter any home over the objection of the owner thereof, or to take charge of any children over the objection of the parents, or either of them, or of the person standing in loco parentis or having custody of such child. Nothing in this Act shall be construed as limiting the power of a parent or guardian or person standing in loco parentis to determine what treatment or correction shall be provided for a child or the agency or agencies to be employed for such purpose. Second, states were not permitted to spend monies on buildings or payment of any maternity or infancy pension, stipend, or gratuity.*

The Congressional debate over the Sheppard-Towner Act replicated the heated encounters that occurred over the establishment of the Children's Bureau. On one side were those who argued for a federal role in promoting the welfare of mothers and children. This argument was presented in economic terms, that is, that the federal government plays a role in agricultural and commercial activities in order to promote economic development and that children represent no less valuable a resource. The opposition to Sheppard-Towner was argued on several grounds. Some were opposed to any governmental role, that is, interference, in the relationship between children and their parents. In this view, the family was a private domain, and the responsibility for children resided with their parents or local family members or charities. Another source of opposition was organized medicine through the American Medical Association (AMA). Exploiting the uncertainty and fear stemming from the Communist revolution in Russia in 1917, the AMA decried the law as an "imported socialistic scheme unsuited to our form of government." Furthermore, the AMA sought to protect practitioners from what was perceived as the potential for governmental interference or control over the practice of medicine, despite the fact that Sheppard-Towner support for primary care (as opposed

to preventive care) was expressly forbidden. The bill was also assailed by conservatives as "a move toward eliminating racial discrimination" because it required services to be available to all citizens.

The debate within the AMA over Sheppard-Towner spawned the birth of the American Academy of Pediatrics (Hughes, 1980). During the 1922 meeting of the AMA, the Pediatric Section debated and endorsed Sheppard-Towner, concluding that it was in the best interests of mothers and children. The AMA House of Delegates, however, not only condemned the act, but also repudiated the Pediatric Section for its endorsement without the approval of the governing House. Recognizing that the AMA was not prepared to speak for the welfare of children, pediatricians met over the next 8 years and finally convened the first meeting of the American Academy of Pediatrics in Detroit in 1930, becoming a powerful and consistent supporter of MCH policies and programs (Lesser, 1985; Schmidt & Wallace, 1988).

The Sheppard-Towner Act ended up passing handily in 1921, in part because of uncertainty over how newly enfranchised women would vote, coming as it did shortly after the incorporation the previous year of the 19th amendment, granting women the right to vote (Lemons, 1969). Another factor that facilitated its passage was the effort to assuage organized medicine by emphasizing the preventive nature of this legislation in an attempt to avoid a conflict with the private practice of medicine. Whereas physicians were viewed as the appropriate source of care for sick infants and parturient women, the educational and screening activities envisioned in the bill were presented as complements and enhancements of traditional medical care. Nevertheless, opposition intensified throughout the 1920s. Physicians began to recognize the competitive potential that the provision of preventive services had for the development of their practices. Opposition also grew within the Catholic Church, fearful of a governmental role in the provision

of historically church-based charitable services. A third source of protest came from within the Public Health Service, annoyed at the dissemination of health services through this program of the Department of Commerce and Labor. As a result, the act was not renewed after 1929. In succumbing, the Maternity and Infancy Act established the hegemony of both the medical community and the medical model in MCH policy development and established the publicly funded use of private providers as the preferred method of healthcare delivery.

The accomplishments of the Sheppard-Towner Act were reviewed in the Eighteenth Annual Report of the Children's Bureau. Birth registration increased from 30 states, covering 72% of the births in 1922, to 46 states, representing 95% of the population. By 1920, child hygiene bureaus had been established in 28 states, 16 of them in 1919 alone, as a result of Children's Bureau leadership. After the implementation of the act, another 19 states established such bureaus. Hundreds of maternal and/or child health consultation centers were established, often in conjunction with local health agencies. Even after expiration of the appropriation, 19 states continued to fund the efforts implemented under the act.

### **THE EMERGENCE OF THE FEDERAL GOVERNMENT IN COMMUNITY ASSESSMENT, POLICY DEVELOPMENT, AND ASSURANCE FOR MOTHERS AND CHILDREN**

With the descent into the Great Depression in 1929, many states and local communities were confronted by the challenge of rising health needs in the face of catastrophic levels of unemployment and devastated budgets as state and local governments witnessed the decimation of their tax bases. State programs for indigent parents and children existed, but without Maternity and Infancy Act funds, health services for mothers and infants were drastically reduced. By 1934, "23 states appropriated virtually no MCH funds" for such

services (Lesser, 1985, p. 592). The Depression impoverished 40% of the population, including a good number of citizens of good moral credentials. Therefore, the link between indigency and immorality was weakened.

After his election in 1932, President Franklin D. Roosevelt recommended legislation designed to provide temporary assistance to the "deserving" poor and ongoing economic insurance to those who were making it but might need help in the future (Guyer, 1987). He charged the Economic Security Committee to address "security for men, women and children . . . against several of the great disturbing factors of life—especially those which relate to unemployment and old age" (Grotberg, 1977, p. 87). Consultation with Grace Abbott and other representatives of the Children's Bureau resulted in the incorporation of bureau plans into the Social Security Act of 1935. The bureau proposed three major sets of activities: (1) aid to dependent children, (2) welfare services for children needing special care, and (3) MCH services including services for crippled children. These were incorporated into the Social Security Act, enacted on August 14, 1935 (Hutchins, 1994). Title IV provided cash payments to mothers who had lost fathers' support for their children. Responsibility for this title was given to the newly created Social Security Board, rather than the Children's Bureau. Title V consisted of four parts. Part 1, Maternal and Child Health Services, represented an expansion of the programs established under the Sheppard-Towner Act. Part 2, Services for Crippled Children, enabled states to improve services for locating crippled children and "for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling" (U.S. Congress, 1935, p. 631). Part 3, Child-Welfare Services, enabled states to provide services for "the protection and care of homeless, dependent, and neglected children, and children in danger of becoming

delinquent” (U.S. Congress, 1935, p. 633). Part 4, Vocational Rehabilitation, enabled states to strengthen programs of vocational rehabilitation of people with physical disabilities, although the administration of this part was not under the Children’s Bureau.

A broad base of public support existed for the child health, welfare, and economic security components of the Social Security Act. Support for Titles IV and V was especially strong, with leading women’s organizations of the country present at the Congressional hearings to express their support. Opposition to Titles IV and V, which might have been expected given the history of the Maternity and Infancy Act, did not materialize. The AMA was preoccupied with the broader issue of blocking any possibility of national health insurance (Witte, 1963).

Unlike Title IV, which was an entitlement, funding for Title V was discretionary and had several components. One set of funds sent an equal share to each state. A second set was distributed on the basis of live births and required a dollar for dollar match. A third set of funds was allocated based on financial need and the number of live births, without a required match. Finally, Crippled Children’s funds provided an equal share as well as an allotment based on the number of children served, building an incentive to locate and treat children. The Secretary of Labor (as the original home department for the Children’s Bureau and Title V) retained up to 15% of the appropriation for training, research, and demonstrations, including Special Projects of Regional and National Significance (SPRANS).

The onset of World War II created a new challenge in addressing the health needs of mothers and children. With the mobilization of millions of soldiers, many military wives who relocated from their homes were in need of maternity care. Although the bureau attempted to provide support for medical care and hospitalization of these women through Title V funds, the amounts were inadequate. In 1943, Congress appropriated additional funds for the Emergency Maternity and Infant Care Program. These funds, allocated from

general revenues and distributed through the states with no required match, paid for medical care for the wives of servicemen in the lowest four pay grades. By the time the program was phased out in 1949, it had provided care in 1.5 million maternity cases, approximately one of every seven births in the United States at its peak (Grotberg, 1977).

Federal initiatives after World War II were rather limited. Although Title V secured and encouraged the development of MCH agencies within state health departments, the federal government directed its efforts mainly at the support of research and services for particular diseases. For example, the Crippled Children’s Program adopted many conditions beyond the orthopedic problems that were its first targets. Epilepsy, congenital and rheumatic heart disease, hearing impairments, premature newborn care, and other conditions were incorporated into state programs (Lesser, 1985).

After the Second World War, the Children’s Bureau began a slow but steady decline from its position of prominence in the national health and welfare arena. At its founding in 1912, the director of the bureau reported directly to the Secretary of Commerce and Labor and then, after the department split in 1913, to the Secretary of Labor. Although arguments were raised about the appropriateness of the bureau within Labor as opposed to the Public Health Service, the early leaders of the bureau maintained its leadership role in a wide range of maternal and child interests. During the 1930s, consideration was given to dividing the health, education, and welfare activities of the bureau among various agencies, but the political pressure both within and outside the federal bureaucracy was not sufficient to effect this change until the late 1940s. The bureau was moved to the newly created Federal Security Administration in 1945. Although it did retain control, temporarily, of the various grant-in-aid programs that it had developed and administered, this move marked the beginning of the decline of the influence of the Children’s Bureau.



## **SOCIAL ACTIVISM, EQUITY, AND THE DEVELOPMENT OF MATERNAL AND CHILD HEALTH POLICY IN THE 1960S**

### **Special Projects under Title V of the Social Security Act**

President Kennedy's interest in mental retardation, stirred in part by the efforts of his parents to provide for their mentally retarded daughter, provided the bureau with the opportunity to launch new initiatives. Arguing that mental retardation could be prevented, in part, by adequate prenatal care, the administration developed a program of special grants through Title V. Different from the traditional Bureau focus on preventive services, these maternity and infant care (M & I) projects, authorized by PL 88-156 in 1963, were designed to provide comprehensive medical services including prenatal, intrapartum, and postpartum care and hospitalization. By 1969, 53 projects had served 100,000 impoverished women and their infants nationwide (Lesser, 1985). Not only did the scope of supported activities change with the introduction of these projects, but also the administration of bureau activities changed. Rather than allocating funds through state health agencies, the bureau distributed M & I funds directly to the service agencies. Furthermore, funds for these demonstration projects could be allocated to private, nonprofit institutions. Comparable projects for children and youth (C & Y) were inaugurated in 1965. By 1969, 58 C & Y projects had provided preventive and primary medical care to 335,000 children (Lesser, 1985). Funded as "demonstration" projects, the M & I projects in particular reported notable improvements in infant health (Sokol, Woolf, Rosen, & Weingarden, 1980). Special projects for neonatal intensive care, family planning, and dental care followed. The M & I and C & Y projects expanded in number during the 1960s and early 1970s but were never extended beyond their demonstration status to become the general policy.

### **Public Health and Child Protection**

The period from 1960 to 1974 was much like the earlier era of social reform in its public expression of social malcontent and institutional mistrust. Civil rights advocates established that otherwise disenfranchised adults and children had rights that could be enforced by legal and administrative means. Furthermore, by gaining legal access to bureaucratic decision making, those same advocates challenged the complacency of professionals who purportedly "served" disenfranchised adults and children.

At the same time, medical and public health professionals were challenged to reconsider the relationship of child health and social phenomena. In 1946, John Caffey, a pediatric radiologist, published an article describing traumatic long bone fractures in infants. In 1953, an article by Silverman, also a radiologist, discussed the possibility that such fractures might be induced by "parental carelessness." In 1955, Wooley and Evans concluded that infants suffering from repeated fractures often come from homes with aggressive, immature, or emotionally ill adults. In 1957, Caffey recapitulated his earlier findings, adding a commission to physicians to consider parental abuse when diagnosing injured infants (Pfohl, 1976).

However, it was not until 1962, with the publication of Henry Kempe's article, "The Battered Child Syndrome," that the phenomenon of physically abused children seen in the nation's hospitals caught the attention of child health professionals and the public everywhere. "The Battered Child Syndrome" challenged the belief that parental abuse "was a deplorable fact of antiquity." It also documented the medical community's unwillingness to implicate parents in diagnosing abuse (Pfohl, 1976; Williams, 1983).

The public health community's response to the "discovery" of child abuse was immediate and dramatic, and within a decade, child protection had become a national priority. In 1962, the Children's Bureau prepared and

disseminated a model child abuse reporting law, and the Social Security Amendments of 1962 required each state to make child welfare services available to all children, including the abused child. In 1963, 18 bills to protect abused children were introduced in Congress, 11 of which passed, and “throughout the 1960s and into the early 1970s, states developed or expanded their capacities to investigate and treat reports of child abuse.” By 1967, all states had child abuse reporting laws (Pfohl, 1976; Williams, 1983).

In 1973, widely publicized hearings were chaired by Senator Walter Mondale (Democrat from Minnesota) on proposed legislation to establish federal leadership in child protection. In 1974, with the support of virtually every children’s advocacy group and the AMA, the Child Abuse Prevention and Treatment Act was passed, creating a structure for responding to the problem of child maltreatment much like the original Children’s Bureau had been a structure for responding to MCH needs (Williams, 1983).

### **Title XVIII (Medicare) and Title XIX (Medicaid)**

Culminating 3 decades of debate over the nature of the federal role in providing health insurance, Congress enacted Medicare, Title XVIII of the Social Security Act, in 1965. Unique among industrialized nations with national health insurance, the United States limits its coverage to the older population. Medicare provides coverage for short-term hospitalization and medical services. Hospitalization is financed through employment taxes, and physician services are financed jointly through premiums (approximately 25% of the actuarial cost) and general federal revenues (the remaining cost). Unlike Title V, states play no role in the financing, administering, or standard setting for this program.

Because the political struggle over the federal role in health care was waged in the arena of Medicare, the accompanying legislation

to establish Medicaid, a program of health insurance assistance for the poor, was shielded from controversy. Enacted as Title XIX of the Social Security Act, the structure of the Medicaid program built on earlier federal support to the states for low-income older persons. Although an entitlement like Medicare, the Medicaid program involves joint federal–state financing and state development of standards within guidelines established by the federal government. A third characteristic of Medicaid (a characteristic that has gradually changed through a series of alterations during the 1980s) was the linkage of eligibility for Medicaid to eligibility for Aid for Families with Dependent Children (AFDC). Consistent with the state–federal partnership, criteria for welfare eligibility are established by the states so that state welfare regulations had a direct effect on eligibility for the federal Medicaid program. The welfare eligibility requirement severely limited eligibility for Medicaid. As Davis and Schoen (1978) noted in *Health and the War on Poverty*, a majority of states limited AFDC to families without a father in the home. The income and assets requirements further limited access to the program. For example, in 1985, the cutoff for eligibility for Medicaid ranged among states from a low of only 16% of the federal poverty income guidelines to 97% (Rosenbaum & Johnson, 1986).

Soon after the implementation of Medicaid, it became apparent that its focus on acute medical care rather than preventive services impeded its effectiveness for children. Social Security amendments submitted by President Lyndon Johnson in 1967 modified Medicaid and the Title V Crippled Children’s Programs to include a new benefit, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Building on language in the original Crippled Children’s legislation of 1935, the EPSDT program has been described as “potentially the most comprehensive child health care program the government had ever undertaken” (Foltz, 1975, p. 35). The program called for specific

services such as physical and developmental exams, vision and hearing screening, appropriate laboratory tests, dental referral, immunizations, and payment for other services covered by each state's Medicaid program. Furthermore, the services had to be provided according to a periodicity schedule consistent with reasonable standards of care. Finally, states were expected actively to enroll Medicaid-eligible children into their programs.

Unfortunately, the implementation of EPSDT was slowed by several issues. First, the program was cobbled together through changes in programs (Medicaid and Title V) with different missions and different bureaucracies. In particular, the Medicaid program was anchored in the welfare system with its restrictive eligibility criteria, impairing the ability of this bold screening, referral, and treatment program to reach broad groups of children in need. Second, the costs of such an ambitious screening and treatment program were daunting to the states that were required to pay for these new services under the shared financing structure of Medicaid. As Rosenbaum and Johnson (1986) have emphasized, however, the main obstacle to the successful implementation of EPSDT as a program to address the preventive health needs of poor children was the fact that the proportion of poor children who were Medicaid eligible remained low.

In spite of the limitations of the Medicaid program, it did increase access to medical care for poor children. According to a review conducted by the Office of Technology Assessment (U.S. Congress, 1988) and published in *Healthy Children: Investing in the Future*, children with Medicaid were similar to middle-income insured children with regard to general check-ups and immunizations. Furthermore, Medicaid recipients with health problems were more likely to have seen a physician than were uninsured children. Although use of services increased for Medicaid recipients, the sites of care tended to be public health clinics, emergency rooms, and

hospital outpatient departments rather than private physician offices (Orr & Miller, 1981), resulting in the further evolution of a dual system of health care. Studies of the effectiveness of EPSDT in particular suggest that participation in the program decreased the likelihood of referral for specialized care over time (Irwin & Conroy-Hughes, 1982; Keller, 1983). Other studies confirm that this screening and prevention program has not achieved the goals originally envisioned. For example, a review of California's screening program indicated that 30% of the children under age 1 enrolled in Medicaid reported a preventive service, and only 65% of children aged 1 to 4 years were up to date on their immunizations (Yudkowsky & Fleming, 1990).

### **Neighborhood/Community Health Centers**

Although Medicaid quickly became the financial underpinning of medical services for poor mothers and children, several additional health programs arose out of the political and social activism of the early 1960s. The Economic Opportunity Act of 1964 established the Office of Economic Opportunity (OEO). Recognizing medical care as only one of many determinants of health, the OEO funded a series of Neighborhood Health Centers. Although these centers provided comprehensive medical services, including prevention and treatment of physical and mental conditions, their mission was much broader. The Neighborhood Health Centers provided employment opportunities in their low-income catchment areas and served as the focus for other community and economic development activities. In addition to the broad service mandate, several other characteristics made these centers a unique approach to health services for the poor. For example, independent of state and local governments, the centers were supposed to be governed by boards of community members. Furthermore, services were supposed to be without cost to the users.

A key administrative and political aspect of these centers was that their federal support came directly to the local community organizations that had solicited the funds. Unlike the Title V program and Medicaid that allocated funds to states and required a state match, the establishment of Neighborhood Health Centers enabled federal policy makers to leap over potential state-level bureaucratic impediments to addressing local conditions as well as social and political attitudes and prejudices that had disenfranchised the poor people who needed the services provided by these health centers (Sardell, 1988).

As political support for the War on Poverty declined with the election of Richard Nixon in 1968, the legislative base for Neighborhood Health Centers changed. As Sardell (1988) noted, the centers achieved their own authorization under PL 94-63 and were renamed Community Health Centers. Unfortunately, attempts to rationalize the administration and oversight of the centers through the delineation of two types of financial support for (1) required and (2) supplemental services resulted in disproportionate emphasis on required, traditional medical services in contrast to the supplemental services such as health education, social services, and outreach. The appeal of the infrastructure established by the centers was strong, however, and Congress has occasionally appropriated funds for special infant mortality initiatives by them.

### **Special Supplemental Food Program for Women, Infants, and Children**

Created in 1972, the Special Supplemental Food Program for Women, Infants, and Children (WIC) has become a fundamental component of government support for mothers and children. This discretionary program provides supplemental food, nutrition education, and access to medical care. Under eligibility guidelines established by the federal government and through federally appropriated funds, states distribute food (or coupons for

selected, nutritious foods) to low-income pregnant women, nursing mothers, and infants and children considered at nutritional risk. The key economic risk factor is family income under 185% of the federal poverty level. WIC has been associated with health improvements reflected in decreased rates of low birth weight (Rush et al., 1988) and anemia (Yip, Bintin, Fleshood, & Trowbridge, 1987). From a services perspective, however, there has been difficulty in incorporating WIC into other MCH programs. As indicated later in the discussion of major policy changes in the 1980s, administrative efforts are underway to make the supplemental food program a more cohesive part of services for mothers and children. For example, studies of the linkage of the provision of WIC services with immunization have, not surprisingly, shown marked improvement in immunization rates (Kotch & Whiteman, 1982) and use of dental services (Lee, Rozier, Kotch, Norton, & Vann, 2004).

### **Head Start**

Just as Community Health Centers provided sites around which to organize efforts to address the more far-reaching determinants, the period of early childhood offered a time during which key social and economic influences might be altered to promote the later well-being of children. Project Head Start was launched as a summer program in 1965 to provide an intellectually stimulating and healthful environment for preschool children in centers established for that purpose. Proposed for 100,000 children, the popularity was such that over 560,000 children enrolled during that first summer. In spite of controversy over the intellectual benefits of Head Start, this federal effort has grown steadily since its inception. An often overlooked impact of Head Start has been its effect on health. In a review of Head Start studies, Ron Haskins (1989), then a staff analyst with the Committee on Ways and Means of the House of Representatives, noted that children attending Head Start were “more likely

to get medical and dental exams, speech and developmental assessments, nutrition evaluations, and vision and hearing screenings.” Furthermore, Head Start programs are well targeted toward poor children and provide many jobs as teachers and staff for low-income community members.

With the implementation of Head Start, the Children’s Bureau met its functional, if not legislative, demise. The focus of bureau responsibilities had become increasingly in the area of welfare, even though the actual administration of AFDC fell within the purview of another agency. As reviewed by Steiner (1976), there was reluctance to assign a prominent and potentially substantial initiative such as Head Start to the Children’s Bureau. Secretary of Health, Education, and Welfare Robert Finch, lacking strong political support for the Children’s Bureau, delegated Head Start to a newly created Office of Child Development, also assigning the Children’s Bureau, a shell of its former self, to this newly created office. The Title V Maternal and Child Health and Crippled Children’s programs were assigned to the Health Services and Mental Health Administration of the Public Health Service. Child Welfare Services and the Juvenile Delinquency Service were assigned to the Social and Rehabilitation Service (Hutchins, 1994). What remained of the Children’s Bureau was left with its responsibilities limited to that of a clearinghouse for agency information about children’s health and welfare.

## **REDEFINING THE ROLES OF STATES**

The election of Ronald Reagan as President in 1980 was followed by changes in Title V and Medicaid. As part of the Reagan effort to decrease the size of the federal government, reduce federal spending for social programs, and return power to the states, many categorical grants were combined into a series of block grants. The initial proposal by the president was to create two health block grants, converting 11 health services grants and 15

preventive health programs, respectively. Negotiations with Congress resulted in the consolidation of 21 programs into 4 health block grants: (1) alcohol, drug abuse, and mental health; (2) primary care; (3) preventive health; and (4) MCH.

The Maternal and Child Health Services Block Grant consolidated seven programs: Maternal and Child Health Services and Crippled Children’s Services under Title V, Supplemental Security Income Disabled Children’s Services, Hemophilia, Sudden Infant Death Syndrome, Prevention of Lead-Based Paint Poisoning, Genetic Disease, and Adolescent Health Services. Federal regulations covering the content of the programs in this block grant were minimal, permitting states to establish their own priorities. Funding for the block grant was reduced from \$454.9 million in fiscal year 1981 to \$373.7 million in fiscal year 1982, under the rationale that reduced federal regulation would enable states to undertake these activities more efficiently (Peterson, Bovbjerg, Davis, Davis, & Durman, 1986). States were permitted, however, to transfer other block grant funds into the MCH block grant, although transfers of funds from MCH were prohibited. As the decade progressed, Congress increased MCH Block Grant funding to a high of \$527 million by 1986 (Guyer, 1987). Political forces in the 104th Congress threatened to cut the 1997 appropriation for Title V by 50%, but MCH advocates succeeded in reducing the proposed reduction to 1%.

The allocation formula for Title V funds with the Maternal and Child Health Services Block Grant as their current incarnation has undergone several revisions. The initial formula described previously here was altered in 1963 when Congress authorized that project grants could be distributed directly to local health agencies and various public and nonprofit organizations, providing the funding base for the M & I Projects and the C & Y Projects mentioned previously. As described by Klerman (1981) in her lucid review of the development of Title V, Congress decided in

1967 to reallocate these special project funds back into the basic formula grant. States were required to have a “Program of Projects” in M & I care, neonatal intensive care, family planning, health of C & Y, and dental health of children, although by no means was the intent or expectation that these were to extend statewide, beyond the “demonstration” mode. Funds were provided to ensure that each state undertook these required programs, but states with large urban populations were at risk of receiving smaller allocations than they had received under the previous scheme. The section 516 allotment was added to ensure that no state received less through the formula grants than it had received through its previous formula and project grants.

With the creation of the Maternal and Child Health Services Block Grant in 1981, the allocation formula was again based on previous allocations under the categorical programs. States were held “harmless” in that they would receive the same proportion of funds as under the prior legislation. As excess funds became available, they were to be distributed on the basis of the low-income population, but as the General Accounting Office (GAO) noted in 1990, 90% of the MCH block grants were allocated on the basis of their previous allocations, rather than adjustments for the low-income population. In a provocative study of allocation, the U.S. GAO (1992) examined what allocations would look like if done on the basis of three simple “at-risk” indicators—proportion of low birthweight children, proportion of children living in poverty, and proportion of the state’s population under the age of 21 years (compared with the U.S. population). The GAO determined that 14% of the block grant funds would shift from lower risk to higher risk states, with decreases in 37 states and increases in 14.

The Medicaid program also was the object of major change in 1981. Mothers and children were directly affected by adverse changes in the eligibility requirements for

AFDC. Because eligibility for AFDC was the major criterion for participation in Medicaid, a loss of AFDC meant a loss of Medicaid coverage, resulting in a decline in the proportion of poor people covered by Medicaid early in the 1980s.

Changes in Title V and Medicaid during the 1980s reflected the ongoing tension between the White House, controlled by Republicans, and the Congress, controlled by Democrats. The back-to-back economic recessions of 1979 through 1982 were accompanied by deterioration in several fundamental MCH indicators. For example, although the national infant mortality rate continued to decline, several states experienced increases or plateauing rates. The proportion of children covered by health insurance declined. Pressured by governors and advocates for mothers and children, Congress turned to the Medicaid program as the structure on which to address some of the glaring gaps in health services for mothers and children. The budget reconciliation process produced the changes shown in Table 2–2. In 1986, Congress severed the link between AFDC and Medicaid by permitting states to enroll pregnant women in Medicaid whose incomes were up to 100% of the federal poverty level even if their incomes were greater than the state income limit. The 1989 Omnibus Budget Reconciliation Act (OBRA) was noteworthy in that it set a national floor for Medicaid eligibility. By April, 1990, states were required to extend Medicaid coverage to all pregnant women and children up to the age of 6 years with family incomes below 133% of the federal poverty level.

The Medicaid expansions of the 1980s were effective in increasing access to care for poor pregnant women and children. As Cartland, McManus, and Flint (1993) have reported, Medicaid added 5 million recipients, half of whom were children. In 1990, 7% of the children enrolled in Medicaid were recipients as a result of the expansions of the 1980s. The proportion of recipients as a result of AFDC eligibility decreased from

**Table 2–2** Changes in Medicaid Eligibility Beginning in the 1980s

1984	Required states to provide Medicaid coverage to single pregnant women, women in two-parent unemployed families, and all children born after September 30, 1983, if their incomes would have made them eligible for AFDC, according to each state’s income guidelines.
1985	Required states to provide Medicaid coverage to all remaining pregnant women with family incomes below each state’s AFDC eligibility levels and immediate coverage of all children under the age of 5 years with AFDC-level income or below.
1986	Allowed states to cover pregnant women, infants up to 1 year old, and, on an incremental basis, children up to 5 years old living in families with incomes above the state’s AFDC income levels, but below 100% of the federal poverty level, effectively severing the link between AFDC eligibility and Medicaid eligibility. Also, permitted states to make pregnant women presumptively eligible for prenatal care after application and permitted states to eliminate the assets tests for poverty-related eligible pregnant women and children, allowing shortened application forms.
1987	Permitted states to increase the upper limit on income for pregnant women and infants up to 1 year old from 100 to 185% of the FPL.
1989	Required states to provide Medicaid coverage to all pregnant women and children up to the age of 6 years with family incomes below 133% of the FPL by April 1990.
1990	Increase eligibility level for pregnant women and infants to 185% of the FPL for children ages 1 to 6 years to 133% of the FPL.
2010	Patient Protection and Affordable Care Act expands eligibility to a national floor of 133% of the FPL.

90% in 1979 to 72% in 1990, although this population accounted for 29.8% of the increased costs in contrast to 26.8% by the expansion children. The remaining increased costs were accounted for by children not receiving cash assistance (19.4%) and medically needy (24.0%).

The OBRA of 1989 also mandated changes in the design and implementation of the Maternal and Child Health Services Block Grant. States were required to allocate 30% of their funds to children’s preventive/primary care services and 30% to children with special healthcare needs.<sup>1</sup> For appropriations greater than \$600 million, 12.75% was set aside for four targeted initiatives. One set of initiatives expanded maternal

and infant home visiting programs as well as enhanced the abilities of states to provide a range of health and social services using the “one-stop shopping” model. A second set of initiatives was aimed at increasing the participation of obstetricians and pediatricians in Medicaid. Third, monies were directed at the enhancement of rural projects for the care of pregnant women and infants and at the development of MCH centers at non-profit hospitals. The fourth targeted area was to expand outpatient and community-based services (including child care) for children with special health needs. Furthermore, the act required states to undertake a statewide needs assessment and formulate a plan for the use of Title V funds that was based on

<sup>1</sup>During the 1980s, the name of the Crippled Children’s Program was changed to Children With Special Health Care Needs to reflect the multifaceted aspects of care for these children.

the identified needs. In addition to these specific MCH mandates to improve access to care, OBRA 1989 directed the Secretary of Health and Human Services to develop a uniform, simple application for use by Medicaid, Maternal and Child Health, WIC, Head Start, Migrant and Community Health Centers, and Health Care Programs for the Homeless. A final initiative to promote accessibility required state Title V agencies to coordinate their activities with Medicaid. For example, state Title V agencies were expected to work with Medicaid agencies to achieve specified enrollment goals for the EPSDT program.

OBRA 1989 mandated changes to hold states and the Maternal and Child Health Bureau more accountable for the Block Grant expenditures. Annual reports were required to address progress toward their state goals, particularly as linked to the goals articulated in Healthy People 2000 (U.S. Department of Health and Human Services, 1991). Required reporting elements included a variety of MCH health status indicators by class of individuals (pregnant women, infants up to 1 year old, children with special healthcare needs, and other children less than 22 years of age), provider information, and the numbers served as well as health insurance status, including enrollment to Medicaid. The secretary is also required to provide the House Energy and Commerce and Senate Finance Committees with detailed summaries of states' annual reports, a compilation of national MCH data by health status indicators (including an assessment of progress toward Healthy People 2000 goals), and detailed results of each Special Projects of Regional and National Significance project.

Concern over infant mortality, particularly the persistence of areas of strikingly high rates, prompted President George H. W. Bush to launch a targeted infant mortality initiative of substantial size. The Healthy Start program, administered by the Maternal and Child Health Bureau, selected 15 communities (13 urban and 2 rural) and provided

over \$200 million dollars annually to facilitate community-driven approaches to infant mortality reduction. Building on the lessons of Sheppard-Towner and M & I projects, Healthy Start has provided social and educational interventions as well as medical services. Employment of community members as outreach workers reflects economic development as yet another component of this substantial initiative. Beginning in 1998, the initiative was expanded so that by 2002, 96 federally funded Healthy Start projects were addressing infant mortality through perinatal health, border health, interconceptional care, perinatal depression, and family violence services with a budget reduced in scale to approximately \$97 million. In 2000, Mathematica Policy Research, Inc., completed its evaluation of the first 15 Healthy Start projects, noting associations with improved adequacy of prenatal care, lower preterm birth rates, decreased low and very low birth-weight rates only in selected sites, and infant mortality rates that declined significantly, but of the same magnitude as comparable communities (Devaney, Howell, McCormick, & Moreno, 2000).

Since the inception of Title V in 1935, there have been three major motivations behind federal involvement in health services for children. Arising out of the Great Depression, Title V was the first in a series of federal initiatives that attempted to address disparities in health outcomes and services. With the globalization of the economy in the 1970s and 1980s, the motivation shifted to a recognition that a healthy workforce was needed in order to remain competitive. Although Medicaid expansions certainly addressed inequities, the broadening of eligibility represented a strategy to invest in the health of the potential workforce. As health-care costs continued to grow at an alarming rate, with Medicaid and Medicare in particular escalating at annual rates of 21% and 10%, respectively, the motivating force behind health care reform became cost control. Bill Clinton's election to the presidency



in 1992 was motivated, in part, by a growing concern over access to health care, particularly as escalating costs impeded the abilities of employers to offer health care as a benefit, state governments to finance Medicaid and other state healthcare programs, and individuals to purchase needed care.

Soon after his election, President Clinton proposed the Health Security Act, a sweeping reorganization of the healthcare system. The primary goal was to ensure that every citizen would have access to health insurance. Stemming from the work of Enthoven and Kronick (1989), the proposal promoted the concept of managed competition, with a substantial federal role. Large “accountable health partnerships,” consisting of providers of health services (physicians, hospitals, etc.) and managers of payment systems (insurance companies, large health maintenance organizations), would compete with one another to offer packages of services to those who pay for services (employers, governments, and individuals). The “managed” part reflects the imposition of standardized packages of services and in some models the requirement that all populations be served. The “competition” takes place among the partnerships, as they would adjust their prices (and to some degree their packages of services within the established guidelines) in order to attract those who pay for services. As Iglehart (1993, p. 1220) explained, “Managed competition is price competition, but the price it focuses on is the annual premium for comprehensive health care services, not the price for each service.” Each partnership was required to provide several “packages” from which consumers might choose on the basis of price. The packages were required to include one choice that was without cost to the consumer, for example, a health maintenance organization (HMO) in which costs could be strictly controlled. Other packages could include the equivalent of fee-for-service options in which consumers could choose among physicians, but they would bear the additional cost through premiums.

The complexity of the Health Security Act and the timing of its consideration leading up to the 1994 midterm Congressional elections resulted in the defeat of this initiative. The 1994 elections were a watershed in national and local politics in that the Republicans gained the majority in the House of Representatives for the first time in 50 years and regained the majority in the Senate, which they had maintained from 1981–1986. No Republican incumbent governors lost reelection bids, and Republicans ended up controlling 31 states. Acting on the belief that the role of the federal government must be reduced and that responsibility for health and welfare should return to states and even local communities, the Republicans proposed an end to the entitlement status for AFDC and Medicaid, creating instead block grants to the states to address these issues as they deemed appropriate.

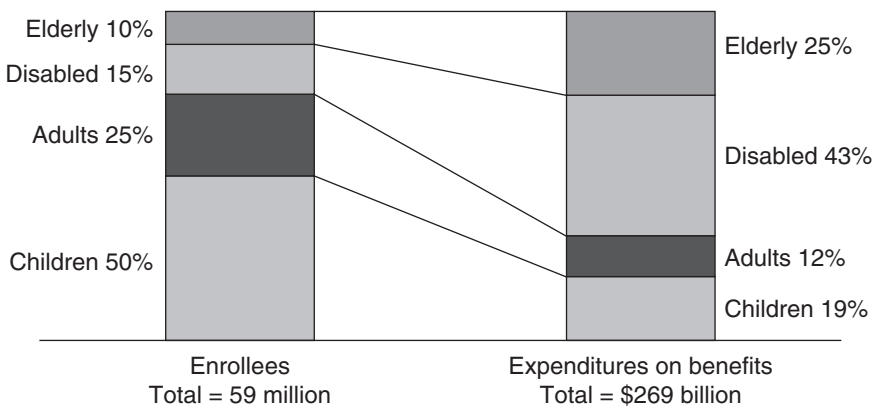
In August 1996, after 2 years of raucous debate, President Clinton signed into law The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (P.L. 104-193). This comprehensive reform made welfare a transition to work, enhanced child support enforcement programs, required unmarried teen mothers to live with parent(s) and remain in school, and limited eligibility for noncitizens (Blank & Haskins, 2001). AFDC, the individual cash entitlement, was repealed and replaced with a block grant, Temporary Assistance to Needy Families (TANF), allowing states the flexibility to convert welfare from a cash assistance program to a jobs program. The block grant also provided an incentive to states to assist individuals in the transition from dependence on a government subsidy to reliance on work, because unlike previous policy efforts to encourage work, work requirements were imposed on the state programs. For example, most participants were limited to 2 consecutive years of assistance and 5 years of lifetime assistance, although 20% of the caseload (e.g., people with disabilities) was exempt from this requirement.

The legislation also incorporated sanctions, particularly financial penalties, for states that failed to meet the work requirements. Although the number of families in receipt of AFDC and then TANF benefits has declined from 4,415,000 at the signing of the law in August 1996, to 2,032,157 in June 2003 (Administration for Children and Families, 2004), the scholarly and policy debates about how to measure the effects of this fundamental change in welfare policy continue (Blank & Haskins, 2001). TANF was reauthorized under the Deficit Reduction Act (DRA) of 2005, and required states to increase the work activities of those receiving TANF funds. Congress failed to reauthorize TANF as scheduled in 2010, extending the program through inclusion in the Claims Resolution Act (P.L. 111-291) to await debate in 2011.

In contrast to the successful effort to convert welfare to a block grant, removing the entitlement to cash welfare, parallel proposals to change the entitlement to Medicaid continue to be debated. Overall, the states are responsible for 43% of Medicaid costs, with state contributions ranging from 50% for the wealthier states to 23% for the poorer states (U.S. GAO, 2003). Annual growth of

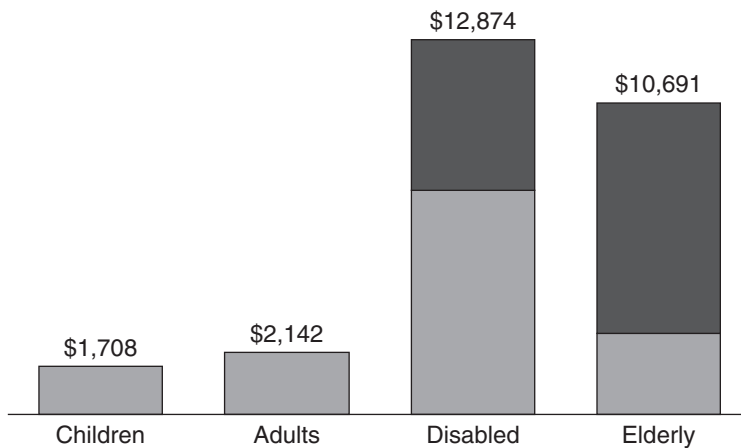
total Medicaid spending reached 27.1% in 1990–1992, subsided to a more modest 3.2% rate of growth in 1995–1997, gradually accelerated to 12.8% in 2002 (Smith, Ellis, Gifford, & Ramesh, 2002), declined to 4.9% in 2008 and then doubled to 9.0% in 2009, as Medicaid programs increased their expenditures as safety nets in response to rising eligibility from the recession of 2007–2009. By 2009, Medicaid expenditures totaled \$373.9 billion (Centers for Medicare and Medicaid Services, n.d.). As an entitlement, Medicaid requires states to generate the funds to cover eligible individuals, thus potentially impinging on discretionary expenditures in state budgets. From the perspective of mothers and children, however, it is important to examine Medicaid expenditures through the lens of Figure 2–1 and Figure 2–2: children comprise approximately 50% of the population of Medicaid recipients but consume only 18% of the expenditures. Coverage of children and pregnant women accounts for a small component of Medicaid’s financial demands on state budgets.

Given the large and growing impact of Medicaid on state budgets, governors and state legislatures vigorously have opposed



\*Expenditure distribution based on CBO data that includes only spending on services and excludes Disproportionate Share Hospitals (DSH), supplemental provider payments, vaccines for children, and administration.

**Figure 2–1** Medicaid Enrollees and Expenditures by Enrollment Group, 2006  
*Source:* Kaiser Commission estimates based on CBO and OMB data, 2003.



**Figure 2–2** Medicaid Expenditures per Enrollee by Acute and Long-Term Care, 2006  
*Source:* Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2006 MSIS data.

the reform of Medicaid from an entitlement to a discretionary block grant, with the likely limitation on federal funds inherent in a discretionary grant (Iglehart, 2003). Medicaid has become the infrastructure for many components of the health system—health care for poor, medically needy, and other vulnerable individuals; long-term care for the older population; and maintenance of hospitals and other organizations that serve the population of those eligible for Medicaid—so that even in the face of the fiscal pressures created by the entitlement, states are reluctant to accept the managerial freedom that would be associated with a block grant.

In spite of the ascendancy of the Republicans in the House and the Senate after the 1994 election and their assertion of a political view that would limit the implementation of new major federal expenditures, there was a growing consensus on the appropriateness of providing health insurance to low-income children who were not eligible for Medicaid, even after the expansions that had taken place beginning in the 1980s. As part of the Balanced Budget Act of 1997, Congress created the State Children’s Health Insurance Program (SCHIP) to provide \$40 billion

in additional federal funds over a 10-year period, with a match that is 30% more generous than the Medicaid match. Established as Title XXI of the Social Security Act, SCHIP reflected the prevailing view that responsibility for design and implementation of programs should rest with the states by allowing states to pursue one of three basic options: (1) create a separate child health program, (2) expand Medicaid eligibility, or (3) develop a combination of new insurance and Medicaid expansion. Of the estimated 11 million children without health insurance in 1998, approximately 39.5% were eligible for Medicaid but had not been enrolled; 25.3% had incomes above that required for Medicaid or the new SCHIP insurance, and the remaining 35.2% became the focus of a new health insurance effort. As of July 2002, 16 states had developed separate SCHIP programs, 15 expanded Medicaid, and 19 adopted a combination (Mann, Rowland, & Garfield, 2003). By 2002, the number of uninsured children had declined to approximately 9.2 million (approximately 12% of children under the age of 19 years), with approximately 23.5% covered by Medicaid or SCHIP (Kaiser Commission on Medicaid and the Uninsured,

2003a). For low-income children, however, 25% of children in families with incomes less than 100% of the poverty level and 17% with incomes less than 199% of the poverty level remained without insurance (Kaiser Commission on Medicaid and the Uninsured, 2003b).

The election of George W. Bush in 2000 aligned both the presidency and Congress under the Republicans for the first time in nearly 50 years. Ironically, this alignment resulted in the largest expansion of federal entitlements since the passage of Medicare and Medicaid in 1965, with the creation of the Medicare drug benefit under the Medicare Prescription Drug Improvement and Modernization Act (P.L. 108-173). Originally budgeted at \$409.8 billion for the 10-year period from 2004 to 2013, estimates from the Medicare actuaries and the Office of Management and Budget subsequent to the bill's passage and signature in December 2003 were as high as \$534 billion (Pear & Andrews, 2004). As an entitlement, the fiscal effects created by the demand for drugs will likely create extraordinary pressure on the entire federal budget in general, especially the discretionary health and social service programs that affect so many families (Iglehart, 2004).

In December 2007, the most severe economic downturn since the Great Depression began, triggered by the bursting of a housing bubble and the collapse of major banks and other financial institutions involved in housing and real estate. Although the National Bureau of Economic Research, using its standard metrics, declared the recession over in June 2009, the unemployment rate of 5% in December 2007 had risen to 9.8% in November of 2010, with a record 30.9% unemployed for 52 weeks or more (U.S. Department of Labor, 2010). According to the Pew Research Center's report *How the Great Recession Has Changed Life in America* (Taylor et al., 2010), in May of 2010, 48% of survey respondents said they were in worse financial shape than before the recession and that household wealth had declined by about

20% from 2007 to 2009. As reported by the U.S. Census Bureau (DeNavas-Walt, Proctor, & Smith, 2010), the official poverty rate in 2009 was 14.3%, up from 13.2% in 2008, and the poverty rate for children under 18 years of age increased from 19.0% in 2008, to 20.7% in 2009.

The election of Barack Obama to the presidency in 2008 was accompanied by the election of substantial Democrat majorities in both houses of Congress. An ambitious political agenda was at first driven by the need for leadership to address the severe recession, reflected in a substantial increase in federal expenditures and authority as a response to the economic crisis. By one estimate, the \$787 billion American Recovery and Reinvestment Act of 2009 (ARRA) directed approximately 20% of the total to children's programs (Aber & Chaudry, 2010). According to Aber and Chaudry, ARRA funds supported children through education and early education (\$86.3 billion); tax programs (\$28.7 billion), including expansion of the Earned Income Tax Credit (EITC); health and nutrition (\$4.8 billion) such as Medicaid and Supplemental Nutrition Assistance Program (SNAP) funding; and others totaling \$153 billion. To put the magnitude of these expenditures in some perspective, recall that the MCH Services Block Grant in 2010 was \$662 million.

The return of Democrat control of the presidency and Congress prompted a renewed effort to establish national health insurance. The first immediate step was to reauthorize the SCHIP (now called CHIP) which had been held up by the Bush administration in a dispute over proper mechanisms to reallocate funds from some states to others when funds were not expended as expected. The Congressional Budget Office (CBO) estimates that the renewed program will cover an additional 6.5 million children in CHIP and Medicaid by 2013. Interestingly, funding is provided by a 62 cent per pack increase in the federal cigarette tax. Thanks to this and other public health insurance programs, insurance

coverage for children actually went up from 2007 to 2008, even though the economy was in a serious recession (childstats.gov, 2010).

In March 2010, after 14 months of highly partisan debate and an eventual vote along strict party lines, President Obama signed the Patient Protection and Affordable Care Act (PPACA). As noted by John Iglehart, “On a scale of significant social legislation, the reform bill ranks with Medicare and Medicaid as a fundamental change in federal policy. The Congressional Budget Office has estimated that 95% of legal U.S. residents would have health insurance by 2019, up from 83% today, with about half carrying employer-based coverage and the other half entitled to publicly sponsored insurance through Medicare, Medicaid, the new state-based exchanges, or other government programs. Employer-sponsored insurance would be subject to new federal regulations, such as a ban on denying coverage to workers with a preexisting condition” (Iglehart, 2010, p. e48[3]). Provisions of the PPACA that specifically target mothers and children include home visiting programs, mandatory break time for nursing mothers, expansion of Medicaid, prohibition of preexisting conditions exclusions from health insurance eligibility, elimination of co-pays for prevention and screening services (including immunizations), dependent coverage up to age 26, and grants for school-based health centers, to name a few.

As this textbook goes to press, the implementation of this historic legislation is in active play, because the 2010 midterm elections produced yet another realignment of political power. The Republican Party picked up 63 seats in the House of Representatives for a 242 to 193 majority, added 5 seats in the Senate, reducing the Democrat majority to 51 seats, and added 6 governorships to total 29, results that will slow the momentum toward an increasing federal role in health care. In addition, legal challenges that reflect the attributes described at the beginning of this chapter are proceeding. For example,

while the overall political forces were aligned to enact this particular legislation, it was not politically feasible to pass a single-payer plan or even a tax analogous to the 2.9% payroll tax for Medicare. In order for this private insurance-driven plan to work, it is essential that all eligible participants purchase health insurance, so that the pool of insured is not limited to those in need of health care, but to the entire population as is the case with conventional health insurance. Challenges to the Affordable Care Act’s requirement that individuals purchase insurance or face a penalty are working their way through the court system (Hall, 2010).

Readers are encouraged to follow the eventual implementation through very informative websites such as the Kaiser Family Foundation (KFF.org) and the journal *Health Affairs* (healthaffairs.org), and specifically for developments that apply to children and families, the Association of Maternal and Child Health Programs (amchp.org) and the American Academy of Pediatrics (aap.org).

## CONCLUSION

Now well into the 21st century, the population of U.S. mothers and children remains at the center of the same debate that raged over the establishment of the Children’s Bureau at the beginning of the 20th century. On one side are those that argue that children represent a community resource, a type of public good, the support of which is a responsibility of all citizens. On the other side are those who assert that the care and nurturance of children, although a community resource, are most effectively undertaken by families and their immediate communities. Interestingly, the same debate with regard to the other large dependent population—older persons—seems to have been answered in 1935, again in 1965, and once again in 2003. Namely, it is the federal government, rather than the states, to which we assign responsibility for the older population. Furthermore, benefits for older persons—Social Security

Old Age and Survivors Benefits, Medicare (and the new drug benefit)—are entitlements and are not subject to the same uncertainty of discretionary programs such as Title V, TANF, and CHIP.

With the implementation of TANF as block grants, particularly the elimination of the categorical entitlements to income support for poor, dependent children, states have assumed more responsibility for ensuring minimum health and welfare services for children. Although state and local governments are indeed “closer” to the people whom they serve, it is the federal government through the Congress and the Supreme Court that has traditionally articulated and enforced children’s rights to the special services and protections

that are the prerequisites of their healthy growth and development. With the devolution of responsibility to the states, it remains to be seen who will ensure, and to what degree, that all children, the most vulnerable and innocent among us, receive the social and health benefits that they need to become productive members of society (Nathan, 1996). Acknowledging and understanding this tension over responsibility for children is especially relevant for the field of maternal and child health as the crisis builds over the ultimate capacity of developed countries to finance the health and welfare benefits that they envision and promise to their citizens, as discussed in the previous chapter on children’s rights and distributive justice.

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