



Child Health Policies

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lation and agency interplay. Issues are presented indicating the need for improved approaches to child health policies, as well as outlining policy factors and guidelines, and clinical impacts. A conclusion is offered that calls for a systemized child health policy translating policy into practice.

Overview

The Children's Bureau

Muhajarine, Vu, and Labonte (2006) indicate that children's well-being should be an issue that bridges political, cultural and disciplinary agendas. Historically, "parents, educators, health and social service providers, and child health researchers, community activists, policy-makers, business people and religious leaders have shared a desire to give children the best start in life" (p. 216). In the past, children were the centerpiece of U.S. domestic policy, with the founding of the Children's Bureau in 1912. In 1909, President Theodore Roosevelt called the first White House Conference on Children. The conference brought together 200 experts and made 15 recommendations which became the stimulus for the Children's Bureau (Harvey, 1991).

According to Golden and Markel (2007), the Children's Bureau was "the world's first governmental agency to consider the problems of children, and once served as a model that inspired the creation of similar agencies in other countries" (p. 446). Given the combined efforts of grassroots women's organizations, as well as Progressive social reformers, "momentum to establish the new agency in the United States grew in the first decade of the twentieth century. Support from the General Federation of Women's Clubs and the National Congress of Mothers and the endorsement at the 1909 White House Conference on the Care of Dependent Children led to legislative initiatives. These initiatives succeeded in 1912, overcoming opposition from those who feared that the Children's Bureau would focus its work on child labor protection" as opposed to improving infant mortality, maternal health, and other areas (Golden & Markel, 2007, p. 446).

The premier achievement of the Children's Bureau was the Sheppard Towner Infancy and Maternity Protection Act of 1921, which became responsible for directing federal funds to the states. As a result as the legislation, "infant mortality rates fell

Abstract

This article provides an overview of child health policies in the United States including historical factors and an overview of the Children's Bureau formed in 1912. It discusses the rationale for child health policies, and examples of progress in the design process, as well as current practice and impacting legis-

Keywords

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State Children's Health Insurance Program

Title V Programs

from 95.7 per 1,000 live births in 1915 – 1919 to 53.2 in 1935 – 1939.” Through these state programs, “more than four million infants and preschool children and approximately 700,000 pregnant women were served (Golden & Markel, 2007, p. 447).

However, despite advancing many compromises and conducting aggressive public relations campaigns and garnishing wide ranging community support, the Children's Bureau and particularly the Sheppard-Towner Act provoked opposition from the American Medical Association. In 1929, funds ceased, and the bureau was “excluded from the planning of the 1930 White House Conference on Child Health and Protection, and subsequent New Deal programs moved away from the “whole child” approach once advocated by the bureau's founders and leaders” (Golden & Markel, 2007, p. 447). Due to these circumstances, mother and infant programs received only limited amounts of funding (Golden & Markel, 2007). From a research perspective, it would be interesting to better understand the effects of the economy of the Great Depression and their impact on policies affecting children.

Other Legislation

The Franklin Roosevelt Administration's first and only New Deal program for young children was the Child Health Recovery Program. It was managed together by the Federal Emergency Relief Administration and the Children's Bureau. “It provided emergency medical care and food to needy children, and directed resources from public and private health care and relief organizations in each state, with physician consultants and part-time health nurses were paid by the Civil Works Administration for performing their work” (Markel & Golden, 2005, p. 1132). The Social Security Administration included several methods of funding for children. According to Markel and Golden (2005),

Title IV provided funds to states for the Aid to Dependent Children program. Title V echoed the programs of the Sheppard-Towner Act, giving federal funds to states that passed enabling legislation for maternal and infant health care or services to “crippled” children and to expand existing child health programs. Although the Social Security Administration (SSA) was the first step in a rapid growth of programs for the elderly, eventu-

ally leading to the Medicare legislation of 1965, similar gains were not made for children, although the Social Security Board, the body charged with implementing the SSA, noted as early as the 1930s that the number of economically disadvantaged children was as much as sevenfold that of the elderly. . . . Children were, and remain, a social group without political muscle (Markel & Golden, 2005, p. 1132).

Over 70 years after its inception, recent attention is once again being given to the plight of policies impacting children. “The creation of the National Center on Minority Health and Health Disparities is one sign of renewed interest. Congressional recognition of child health problems and their need for remediation, as evidenced by the funding of the National Children's Health Act, the monitoring of National Institutes of Health (NIH) funding in pediatric health, and funding for the State Children's Health Insurance Program (SCHIP),” further indicates a revitalized interest in children (Golden & Markel, 2007, p. 447). Moreover, the problem of

. . . racial and income disparities in health care, which is the result of both epidemiological investigations and a growing concern to evaluate the outcomes of federally supported programs once again suggests the need to view health status as a social indicator . . . The critical question, then, is whether or not there exists the political, social, and economic motivation needed to persuade a plurality of voters and their representatives to legislate a plan that would enable the United States to fully embrace the idea it developed nearly a century ago, a federal agency devoted to children (Golden & Markel, 2007, p. 447).

Reasons for Child Health Policies

Much recent research has contributed to a new focus on children's health and development. A new contributing discipline, “population health,” focuses attention on early childhood experiences, beginning during gestation, as contributing factors to health that continue decades later (Muhajarine, Vu, & Labonte, 2006, p. 206). Arguments for investing in early childhood take several forms. One of the most common arguments is that children are the ‘future.’ “If we want to have a healthy, prosperous society in years to come, we must give our children the best possible start in life” (Muhajarine, Vu, and Labonte, 2006, p. 206). The argument can be made that children also have an inherent right to health-promoting conditions, and their health status can be seen both as an investment in long-term societal health as well as “a reflection of its current functioning” (p. 206).

Infant Mortality & Low Birth Weight

Globally, infant mortality and low birth weight (LBW) rates have closely paralleled race and class divisions within society. Babies born to mothers of minority and socially disadvantaged groups “have consistently lagged behind the predominant or wealthier groups.” Statistically, the low birth weight rate is twice as high among African-American children as white children, even though

advances have been made in access to prenatal care and high risk health behaviors such as smoking. Researchers suggest that complicated birth outcomes in the United States indicate pervasive and ongoing social disparities “between women of different classes and ethno-cultural identities rather than a lack of access to quality healthcare or high-risk health behaviors” (Muhajarine, Vu, & Labonte, 2006, p. 207). Deprivation at individual and family levels combined with difficulties at the community level seems to interact resulting in health inequalities, which is an observation producing increased international research attention. Conclusively, “any meaningful effort to enhance children’s health must go beyond a focus on biomedical and behavioral influences and seek to understand the economic conditions and social milieu in which families live and raise their children” (Muhajarine, Vu, & Labonte, 2006, p. 207).

Poverty

Another reason for creating a child health policy is the impact of poverty. Regular, long term income assistance is more beneficial to a child’s health than is irregular, intermittent income assistance. This is illustrative to key decision-makers that in order for impoverished families to be supported and have some sense of stability, regular social assistance provisions are necessary. Additionally, support for the most vulnerable children should be given a high priority. While children as a whole are among the most highly fragile groups within society, illness is of utmost concern to those children in lower socioeconomic levels or of different race or ethnicity. Statistically, 20 percent of children account for 80 percent of all health care moneys spent on children. In addition, the color of a child’s skin may be the best predictor of a given child’s life expectancy. Excellent health care has the potential to change that. For the most vulnerable, specific additional services and interventions may be needed to achieve outcomes equivalent to those for low-risk, upper-income white children. Data from the recently released National Healthcare Disparities Report as well as the just-published Commonwealth Fund’s Chartbook on Children’s Healthcare Quality serve as good starting points for setting priorities for translation (Young, Flores, & Berman, 2004, p. 1316).

Children of Undocumented Immigrants

Further substantiating the need for an improved Child health policy, it has been estimated that 4.8 million undocumented immigrants from Mexico were living in the United States as indicated in 2000. According to Young, Flores, and Berman (2004),

Almost every community in the United States faces the challenge of providing medical care to this group, because the federal government has left much of the funding of health care for uninsured undocumented persons to individual states, local governments, hospitals, and clinics. In 1986, Emergency Medicaid was established by the federal government to subsidize health care expenses for certain defined groups of persons, including any uninsured documented and undocumented children, who were sick enough to be

hospitalized with a specifically defined “emergency medical condition” (p. 1316).

Individual states administer the Medicaid program and are allowed to loosely interpret eligibility requirements and benefits established by the federal government. Moreover, the states are reimbursed for part of the costs of the emergency (Young, Flores, & Berman, 2004, p. 1316).

Applications

Current Child Health Policies

State Title V Programs

State maternal and child health (MCH) programs were charged with improving and assuring the health of all mothers and children under Title V of the 1935 Social Security Act. Title V programs focus on preventing death, disease, and disability, and assuring access to quality health care for the state’s women and children. According to Grason, Silver, and State Title V Program Representatives (2004), as a result of Title V, two developments occurred which have significant impact on state Title V programs and their involvement with Fetal and Infant Mortality Review (FIMR). First, beginning in the 1970s, state Title V programs

assumed leadership roles in forming, maintaining, and monitoring regionalized perinatal services systems. Second . . . state health departments started the transition from the provision of direct services to a broader implementation of the essential maternal and child health services, derived from the three core public health functions of assessment, policy development, and assurance. As a result, state Title V programs redirected their energies toward accountability for population health (p. 252).

State Title V involvement in FIMRs was also supported by Maternal and Child Health Bureau (MCHB)’s financial and technical support to “further develop and encourage state roles with regard to FIMR and other similar case-based mortality reviews, such as child fatality reviews (CFR) and maternal mortality reviews (MMR). State MCH programs used federal grant funds to stimulate the development of new FIMRs in communities, support ongoing efforts, and capitalize on the outputs of the local programs. The MCHB initiated two sets of projects related to state involvement in FIMR programs in the mid- and late 1990s” (Grason, Silver, & State Title V Program Representatives, 2004, p. 251).

FIMR’s

State Title V programs communicate with key policy players such as governors’ staff and state legislatures regarding FIMR findings. They can serve as advocates for FIMR programs to promote greater public or policymaker attention (Grason, Silver, & State Title V Program Representatives, 2004). Further, state Title V programs play an important role in determining whether and how other mortality and morbidity assessment processes should be integrated with the FIMR.

Grason, Silver, & State Title V Program Representatives (2004) conclude that,

State Title V and FIMR program interaction can be mutually beneficial. State Title V programs directly perform public MCH program functions, including data collection, system development and analysis, investigation of health problems, informing the public about MCH, policy leadership, quality assurance and improvement, and developing workforce capacity, especially when they take an active role in their state's local FIMR programs. Moreover, FIMR is an important public health tool that can provide qualitative information missing from vital statistics and other population data routinely collected by states. By supporting FIMR, states obtain data that can inform programs and policy efforts. FIMR programs receive state infrastructure support and buy-in, and state Title V programs obtain a closer link with their constituencies concerned with maternal and infant health (Grason, Silver, & State Title V Program Representatives, 2004, p. 257).

In addition to child health policies and their impact in the United States, other countries, like Canada, are similarly faced with child health issues and policies.

Issues

Research, Policy & Practice

According to Simpson (2004), one of the main issues regarding child health policies is that “evidence alone rarely leads to improvements in practice or changes in policy” (p. 126). Many barriers to effective diffusion exist, because medical advances and policy innovations are adopted at varying rates. On average fewer than 60 percent of children with persistent asthma are receiving care today that follows the guidelines despite the fact that the National Heart, Lung, and Blood Institute (NHLBI) first published a comprehensive guideline on asthma management in children in 1991. Too often, dramatic distinctions are drawn between what it takes to translate research into clinical practice versus policy. However, potential similarities could lead to more fruitful interactions between these two communities (Simpson, 2004). “Each of these two worlds should strive to at least begin decision-making processes with what evidence is available” (p. 126). In the policy world factors that interplay include values, politics, cost, feasibility, and windows of opportunity. In the clinical world, the counterpart is consideration of patients' values, preferences, and risk tolerance; feasibility of implementation; cost, for example, insurance factors; and the patients' readiness for change (Simpson, 2004, p. 126).

According to Simpson (2004), an extensive international literature has emerged over the past twenty years examining reasons for the translational gap between policy and practice and the speed with which, research is adopted into practice or used to inform policy. However, most of the present literature has not

focused on the needs of children. The literature regarding child health policy has only looked primarily either at adults or at the role of research in policymakers' decision making, which again is aimed at the needs of adults. In order to improve children's health, evidence is needed to determine needs and available providers. Additionally, balanced funding is needed by federal research agencies focused on translating clinical evidence into best practice. Research should also be aimed at examining the role of organizational and financing strategies on child health outcomes and quality. While, research has suggested that computerized applications can promote evidence-based practices for children in some areas, this evidence is not translated to a systemized approach (Simpson, 2004, pp. 126 – 127).

Federal support for balanced research between policy and practice in terms of children's health care should dramatically increase. While the establishment of the National Institutes of Health (NIH) roadmap initiative may be helpful in promoting much-needed work to translate advances for specific conditions, populations, and settings into practice, it will be necessary to recognize that it is not just what is studied that needs to change, but research methodologies must also change. Modifying the research process to engage users intentionally requires both resources and time, and these factors must be engaged in this type of research. Lastly, accountability is necessary in order to support the process in order to maintain a child-centered focus (Simpson, 2004). As Simpson concludes, “The NIH policy on including children in research needs to be strengthened by external accountability for progress that is detailed enough to demonstrate whether appropriate inclusion is occurring in discovery and translational research” (Simpson, 2004, p. 128). Not only should additional research increase in regard to a systemized Child health policy, but funding should include research based modalities for translating research into practice.

Terms & Concepts

Child Health Policies: Child health policies can be described as different practices focused on preventing death, disease, and disability, and assuring access to quality health care for a state's mothers and children.

Children's Bureau: The Children's Bureau was the world's first governmental agency to consider the problems of children, and once served as a model that inspired the creation of similar agencies in other countries.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity which would include extreme pain resulting in extraordinary consequences if immediate medical attention is not given.

National Institutes of Health (NIH): The National Institutes of Health is a national organization dedicated to creating a roadmap initiative for promoting much-needed work to translate advances for specific conditions, populations, and settings into practice to benefit children.

Title V Programs: Title V programs focus on preventing death, disease, and disability, and assuring access to quality health care for women and children.

Bibliography

- Barker, D. J. P. (1998). *Mothers, babies, and health in later life*. Edinburgh: Churchill Livingstone.
- Ben-Shlomo, Y., & Kuh, D. (2002). A life course approach to chronic disease epidemiology: Conceptual models, empirical challenges and interdisciplinary perspectives. *International Journal of Epidemiology*, 31, 285–293.
- Benderly, B. L. (1997). *In her own right: Institute of medicine's guide to women's health issues*. Washington, DC: National Academy Press.
- Elo, I. T., & Preston, S. H. (1992). Effects of early-life conditions on adult mortality: A review. *Population Index*, 58, 186–212.
- Geronimus, A. T. (1992). Weathering hypothesis and the health of African American women and infants: Evidence and speculation. *Ethnicity and Disease*, 2, 207–221.
- Golden, J. & Markel, H. (2007). A historically based thought experiment: Meeting new challenges for children's health and well-being. *Health Affairs*, 26(2), 445 – 449. Retrieved August 13, 2008 from EBSCO online database Academic Search Premier: <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=24357038&site=ehost-live>
- Grason, H., Hutchins, J. & Silver, G. (Eds) (1999). *Charting a course for the future of women's and perinatal health*. Rockville, MD: Maternal and Child Health Bureau, US Department of Health and Human Services.
- Grason, H., Silver, G. B. & State Title V Program Representatives. (2004). Perspectives on state Title V Programs' involvement in FIMR Programs. *Maternal & Child Health Journal*, 8(4), 251 – 257. Retrieved August 13, 2008 from EBSCO online database Academic Search Premier: <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=14990500&site=ehost-live>
- Harvey, B. (1991). Why we need a national child health policy. *Pediatrics*, 87(1), 1 – 6. Retrieved August 13, 2008 from EBSCO online database Academic Search Premier: <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=4739656&site=ehost-live>
- Institute of Medicine (1985). *The best intentions: Unintended pregnancy and the well-being of children and families*. Washington, DC: National Academy Press.
- Keating, D. P. & Hertzman, C. (Eds) (1999). *Developmental health and the wealth of nations*. New York: Guilford Press.
- Korenbrot, C. C., & Moss, N. E. (2000). Preconception, prenatal, perinatal and postnatal influences on health. In B. D. Smedley & S. L. Syme (Eds), *Promoting health: Intervention strategies from social and behavioural research* (pp. 149–156). Washington, DC: National Academy Press.
- McCain, M., & Mustard, F. (1999). *Early years study: Reversing the real brain drain*. Ottawa: Children's Secretariat, Ontario Government.
- Markel, H. & Golden, J. (2005). Successes and missed opportunities in protecting our children's health: Critical junctures in the history of children's health policy in the United States. *Pediatrics*, 115, 1129 – 1133. Retrieved August 13, 2008 from EBSCO online database Academic Search Premier: <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=16479073&site=ehost-live>
- Minkovitz, C., & Baldwin, K. (1999). Social context of women. In H. Grason, J. Hutchins & G. Silver (Eds), *Charting a course for the future of women's and perinatal health* (pp. 5–24). Rockville, MD: Maternal and Child Health Bureau, US Department of Health and Human Services.
- Muhajarine, N., Vu, L. & Labonte, R. (2006). Social contexts and children's health outcomes: Researching across the boundaries. *Critical Public Health*, 16(3), 205 – 218. Retrieved August 13, 2008 from EBSCO online database Academic Search Premier: <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=24904417&site=ehost-live>
- Pamuk, E., Makuc, D., Heck, K., Reuben, C., & Lochner, K. (1998). *Socioeconomic status and health chartbook: Health, United States, 1998*. Hyattsville, MD: National Center for Health Statistics, US Department of Health and Human Services.
- Petrini, J., Foti, H., & Damus, K. (1997). *March of dimes statbook: Statistics for monitoring maternal and infant health, 1997*. Wilkes-Barre, PA: March of Dimes Birth Defects Foundation.
- Simpson, L. (2004). Lost in translation? Reflections on the role of research in improving health care for children. *Health Affairs*, 23(5), 125 – 130. Retrieved August 13, 2008 from EBSCO online database Academic Search Premier: <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=14400696&site=ehost-live>
- Williams, D.R. (1996). Racism and health: A research agenda. *Ethnicity and Disease*, 6, 1–6.

Young, J., Flores, G., & Berman, S. (2004). Providing life-saving health care to undocumented children: Controversies and ethical issues. *Pediatrics*, *114*(5), 1316 – 1320. Retrieved August 13, 2008 from EBSCO online database Academic Search Premier: <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=14786870&site=ehost-live>

Zambrana, R.E., Scrimshaw, S., Collins, N., & Dunkel-Schetter, C. (1997). Prenatal health behaviors and psychosocial risk factors in pregnant women of Mexican origin: Role of acculturation. *American Journal of Public Health*, *87*, 1022–1026. Retrieved August 13, 2008 from EBSCO online database Academic Search Premier: <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=9708191871&site=ehost-live>

Suggested Reading

Cone, T. E. (1979). *History of American pediatrics*. Boston, MA: Little Brown & Co.

Dye T. (1998). *Understanding public policy* (9th ed.). Englewood Cliffs, NJ: Prentice Hall.

Gordon, L. (1994). *Pitied but not entitled: Single mothers and the history of welfare*. New York, NY: Free Press.

Institute of Medicine (2000). *Promoting health: Intervention strategies from social and behavioral research*. Washington, DC: National Academy Press.

Keating, D. P. & Hertzman, C. (Eds) (1999). *Developmental health and the wealth of nations*. New York: Guilford Press.

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