HEALTH POLICY AND EARLY CHILD DEVELOPMENT: AN OVERVIEW

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> *Every child we save is not only an economic asset to the nation but we conserve the highest purposes of humanity and protecting and promoting the welfare of the child. The child is her mother's most sublime experience, the father's greatest inspiration, and ultimately the source of the nation's renewal....*
>
> Representative Clarence Lea of California, in support of enactment of the Sheppard-Towner Act of 1921[1]

INTRODUCTION

In recent years, health policymakers, health professionals, and parents have come to understand the enormous significance of the first three years of life. A growing body of scientific literature, most recently presented in an important study from the Institute of Medicine, points to the long-term influence on children of certain key interventions in the early years of life.[2] These interventions entail comprehensive preventive health care, family interaction and support, and activities designed to promote cognitive and sensory stimulation. Professional guidelines related to health care for young children emphasize the importance of ensuring that pediatric practice is grounded in an understanding of early childhood development.[3]

The professional literature suggests that early childhood development interventions take on particular importance in the case of children with lower family incomes. Thus, it is important for policymakers and health care professionals to understand clearly the role of federal public policy in supporting and fostering optimal child development interventions.[4]

For nearly 100 years, the federal government has played an active role in shaping the American health care system to better promote early child development-related health

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[1] Congressional Record, House of Representatives, November 19, 1921 (p. 7988); cited in Ann L. Wilson, "Development of the U.S. Federal Role in Children's Health Care: A Critical Appraisal," *Children and Health Care: Moral and Social Issues* (Loretta Kopelman and John Moskop, eds.) (Kluwer Academic Publishers: Dordrecht, Boston, 1989).

[2] Jack P. Shonkoff and Deborah A. Phillips, eds., *From Neurons to Neighborhoods* (Washington D.C.: National Academy Press, 2000).

[3] See, e.g., Morris Green and Judith S. Palfrey, eds., *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents,* 2nd edition (Arlington, Va.: National Center for Education in Maternal and Child Health, 2000), www.brightfutures.org.

[4] Peter Budetti et al., *Assuring the Healthy Development of Young Children: Opportunities for States,* The Commonwealth Fund, February 2000.

care. This report is the first in a series of analyses exploring federal and state health policy in the area of early childhood development and provides an overview of the evolution of federal health policy related to the financing and provision of preventive health services for young children. Later reports will offer in-depth explorations of certain key programs, including Medicaid, the State Children's Health Insurance Program, community health center programs, and the Title V Maternal and Child Health Services Block Grant.[5]

This report reviews the historical roots of federal involvement in preventive health care in early childhood and presents a brief overview of the key federal programs that are the pillars of modern federal preventive child health policy. The report is designed to provide readers with an introduction to federal health policy related to early childhood development, as well as an overview of statistics on health insurance coverage for young children and certain program-specific data.

A complete overview of the federal government's role in child development policy would cover numerous matters not addressed in this report and would span federal policies and programs in all areas related to child development, such as early childhood education, family social supports, family income assistance, housing, community development, and child nutrition. This report focuses on those programs that have as a major policy objective, and offer significant financial support for, the financing and provision of preventive health care for infants and young children.[6]

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[5] For the next report, see Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, *Room to Grow: Promoting Child Development Through Medicaid and CHIP,* The Commonwealth Fund, July 2001.

[6] For more information on the full range of early childhood development and federal policy, readers may wish to read Lisbeth Bamberger Schorr's book, *Within Our Reach* (New York: Doubleday, Anchor Books, 1989).

I. EVOLUTION OF FEDERAL HEALTH POLICY ON EARLY CHILD DEVELOPMENT

The federal government's involvement in child development as a national policy concern is nearly a century old. The roots of this federal role can be found in programs enacted in the early twentieth century that were designed to investigate the need for, and document the value of, early investment in children. By midcentury, public support for direct federal intervention in public health and social welfare matters grew dramatically; federal initiatives to expand access to preventive health services in early childhood also grew, reaching their apex in the final third of the twentieth century.

The Children's Bureau

The Children's Bureau, whose 1912 enactment was spurred by growing national concern about children, represented the first major federal policy commitment on behalf of child health and development. The Children's Bureau can be understood as a response to a series of social, economic, medical, and scientific developments that had emerged on the national scene by the turn of the century.

The first such development was the urbanization and industrialization of the American economy, an achievement made possible in great part by the labor of millions of immigrants—including immigrant children—whose horrific working and social conditions were documented by reporters, social workers, and others. Entrepreneurs built their fortunes on cheap child labor: statistical reports from 1900 show 1.75 million children employed, 40 percent in industrial settings and 60 percent in rural locations.[7] Children emerged as a leading symbol underscoring the urgency of reform. Terming the situation "child slavery," J. S. Sprago's seminal book, *The Bitter Cry of Children,* documented child labor conditions and shocked the nation.[8]

The second major development was the emergence of pediatrics as a medical specialty.[9] By the beginning of the twentieth century, medical and other health professionals had come to understand the period of infancy and childhood as one of unique importance to proper human growth and development. Professionals gained a deeper understanding of the developmental importance of childhood and intensified public outcry over the conditions in which millions of children lived.

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[7] Wilson, "Development of the U.S. Federal Role," 1989, p. 7.
[8] J. S. Sprago, *The Bitter Cry of Children* (New York: MacMillan, 1906), p. 149.
[9] Wilson, "Development of the U.S. Federal Role," 1989, p. 31.

The final development was the growing importance of scientific and statistical studies in understanding health status and health care needs. Recognition of the role of bacteria in causing illness and death led not only to the food safety movement, but also to the establishment of milk stations for urban infants in New York City and elsewhere. Milk stations provided sanitary food as well as education about infant health, safety, and development, thereby forming a major initial step in health education.[10] Similarly, studies of infant and maternal mortality translated into public health nursing and social work initiatives to educate families about child health and development. As scientific studies of health status grew, so did efforts aimed at improving the health of children. The notion of preventive intervention took hold.

President Theodore Roosevelt introduced legislation in 1906 in both Houses of Congress to establish a Children's Bureau. The legislation was enacted six years later, and the Bureau was established as a formal part of the Department of Labor in 1912.[11] In his history of the Children's Bureau and its evolution into the modern Maternal and Child Health Bureau, Dr. Vincent Hutchins, who for many years directed the Maternal and Child Health Bureau within the U.S. Department of Health and Human Services, wrote that

> the Act of 1912 gave a very broad grant of power to the Bureau. The whole child was made the subject of its investigations. The interrelated problems of child health, dependency, delinquency, and child labor were to be considered and interpreted in relation to the community program for all children.[12]

The Bureau's initial work focused on infant mortality and included a national drive for birth registration and support for early studies of infant and maternal death. Of particular significance was a study of infant and maternal mortality rates in Manchester, New Hampshire. There, nearly all fathers were employed by textile mills and the infant mortality rate was shown to stand at 165 deaths per 1,000 live births.[13] Similar Bureau studies, showing a fourfold difference in death rates among poor and non-poor infants, also helped generate ongoing support for the investigative work of the Bureau. These studies were viewed as particularly important because they discussed how child deaths

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[10] Wilson, "Development of the U.S. Federal Role," 1989, p. 32.

[11] Vincent Hutchins, "Maternal and Child Health Bureau: Roots" *Pediatrics* 94, no. 5 (1994): 695–699.

[12] Ibid., p. 695.

[13] Wilson, "Development of the U.S. Federal Role," 1989, p. 36.

were often caused by conditions that could have been alleviated.[14] From these efforts came support for more research, as well as a series of health education pamphlets on infant and child health. An early pamphlet, published in 1913 and entitled *Prenatal Care,* garnered great public interest.[15]

In the modern era, to the casual observer, the work of the Bureau appears almost quaint and its contributions modest. The Bureau conducted investigations; it did not provide services. The Bureau suffered from minimal staff, inadequate budgets, and "ill-defined" relationships with other parts of the federal government.[16] It had no authority to administer programs or regulate the conditions in which children lived. Housed in the Department of Labor, the Bureau in fact struggled against its opponents to hold onto maternal and child health as part of its mission.[17]

It is not possible, however, to overstate the Bureau's importance as the first major national organization concerned with the connection between child health and the future of the nation. The Bureau's studies were of seminal importance to society's understanding of how to improve the health of children through health care and health education interventions. The very placement of the Bureau in the Department of Labor served to underscore the vital role of child health not only in the area of human growth and development but with respect to the national economy as well.

The Sheppard-Towner Act and the Title V Maternal and Child Health Programs

By the end of World War I, the research and documentary efforts of the Children's Bureau had helped forge a consensus that improving the health of children entailed more than studying problems and issuing reports. In 1918, legislation was introduced in Congress to create what ultimately became the first federal/state grant-in-aid program to improve child health and health care for mothers and children. In 1921, the Sheppard-Towner Act became law, and its administration was assigned to the Children's Bureau. In his history of the Act, Hutchins discusses the writings of Martha May Eliot, who served in the Children's Bureau for many years and was its chief from 1951 to 1956. He quotes Eliot as she defines the significance of the Sheppard-Towner Act:

> The Sheppard-Towner Act established the national policy that the people of the United States, through their federal government, share with the

[14] Karen Davis and Cathy Schoen, *Health and the War on Poverty* (Washington, D.C.: Brookings Institution Press, 1977), p. 122.
[15] Ibid.
[16] Hutchins, "Maternal and Child Health," 1994, p. 696.
[17] Ibid.

states and localities the responsibility for helping to provide community services that children need for a good start in life.[18]

The Act, which was the first federal grant-in-aid program, was not without controversy. It came under repeated legal challenges from organized medicine, which viewed the law as the nationalization of health care and an effort to undermine state sovereignty.[19] Despite the fact that litigation aimed at overturning the law failed,[20] the Act ultimately was permitted to lapse in 1929 in the face of significant political opposition from the American Medical Association and others to federal policy interventions aimed at health care and health care quality improvement.[21] During its eight years of existence, the program had distributed millions of dollars in aid to states and localities for the establishment of preventive programs and services for mothers, infants, and children.

Six years after the demise of the Sheppard-Towner Act, Congress initiated the modern maternal and child health reform movement in the United States by enacting Title V of the Social Security Act of 1935. Whereas Sheppard-Towner had been grounded in concepts of public health, the original Title V programs for mothers, infants, and children were conceived as part of a national social security system. Thus, despite its modest size, Title V and the preventive and treatment services it embodied amounted to a basic statement regarding the national social welfare policy interest in the health and healthy development of children.[22] Indeed, the legislative basis for Title V was the

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[18] Ibid.

[19] *Massachusetts v Mellon,* 262 U.S. 447 (1923); *Frothingham v Mellon,* 262 U.S. 447 (1923). It is interesting to note that the Commonwealth of Massachusetts, considered one of the nation's leaders in both heath care and public health, never participated in Sheppard-Towner as a result of the extraordinary influence of the Massachusetts Medical Society, which presumably led the legal challenge of the Act.

[20] Every law student reads *Frothingham v Mellon,* which, in addition to involving the first legal challenge to modern Congressional health and welfare spending, represents a seminal constitutional law case concerning the ability of taxpayers to challenge the constitutionality of Congressional spending practices. In *Frothingham,* a taxpayer, aided by the American Medical Association, sued to have the Sheppard-Towner Act declared an unconstitutional exercise of Congressional spending authority. Her suit was dismissed on the grounds that she did not have the right to protest her unhappiness over this form of Congressional expenditure because its impact on her was too tenuous to allow her to claim the type of legal injury that is a prerequisite to a lawsuit.

[21] The role of the American Medical Association in causing the lapse of the Sheppard-Towner Act ultimately led to the secession of its Section on Pediatrics and the establishment of the American Academy of Pediatrics. See Hutchins, "Maternal and Child Health," 1994, p. 696.

[22] President Franklin Roosevelt considered and rejected national health reform efforts as part of the Social Security Act of 1935. Title V and Aid to Dependent Children (later renamed Aid to Families with Dependent Children and repealed in 1996), represented the Roosevelt Administration's two health initiatives within the Social Security Act of 1935. The original Aid to Dependent Children program, which provided grants to families with dependent children, required state agencies to include the cost of medical care and other elements in calculating the "standard of need" and payment levels for families.

assumption that "it is the dependence of children and mothers, rather than different diseases or health conditions, that prompts special attention to them."[23]

The Title V programs expanded concepts originally embodied in the Sheppard-Towner Act. Designed as a federal/state grant-in-aid program, Title V allocated funds to states to improve preventive health services for pregnant women, infants, and children. A companion Crippled Children's Program, also part of the original Social Security Act of 1935, was the first federal program to underwrite the costs of medical care, case-finding, and aftercare for children with chronic illnesses and conditions.[24]

The Title V programs expanded during the Second World War with the enactment of the Emergency Maternity and Infant Care Act of 1943 to provide maternity care for the wives of servicemen in the lowest pay grades. Later developments expanded the reach of the Title V programs into areas of child development and the prevention of developmental, behavioral, and psychosocial problems.[25] In 2000, Congress enacted Healthy Start—previously a federal demonstration—that now authorizes the expenditure of funds for the purpose of developing maternal and infant health initiatives in communities with high infant mortality rates.[26]

Medicaid and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The single most significant health insurance program in the United States for children, Medicaid, was enacted in 1965 as a companion to Medicare. The largest of all federal grant-in-aid programs, Medicaid is a means-tested entitlement: all persons who meet program eligibility requirements are legally entitled to coverage for the benefits the program furnishes. All states participate in Medicaid and retain considerable discretion over eligibility and benefits; they also retain a great deal of flexibility over coverage and service delivery design. Federal law, however, establishes certain minimum standards that are particularly strong for children.

Virtually all low-income children under age 19 and born after September 30, 1983, are entitled to Medicaid as a matter of federal policy; in the case of children under age 3, coverage is mandatory up to 133 percent of the federal poverty level. (See Figure 1.) States have the option of adopting more liberal financial eligibility standards, and as of 1999, all states maintained eligibility standards that exceeded this federal minimum

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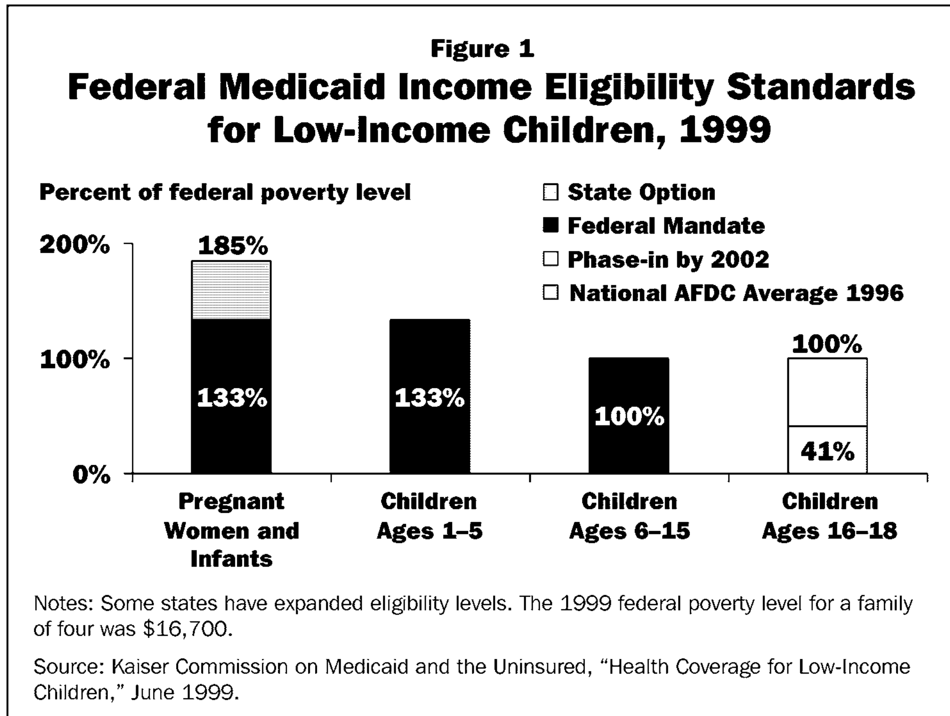
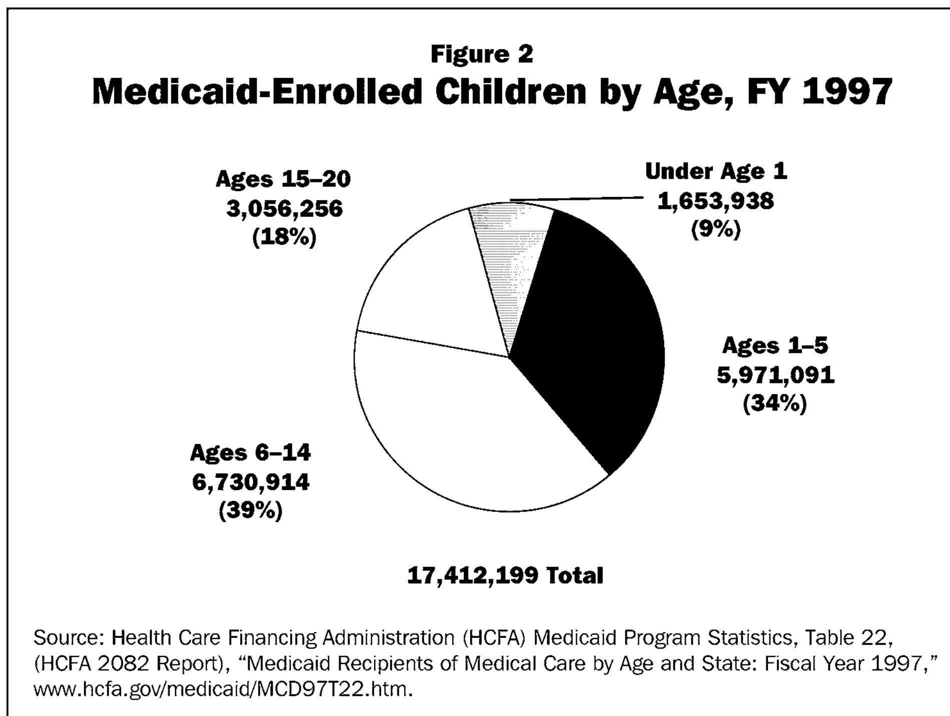
[23] Hutchins, "Maternal and Child Health," 1994, p. 696.
[24] Hutchins, "Maternal and Child Health," 1994, p. 697.
[25] Ibid.
[26] Title XV, P.L. 106-310, *The Children's Health Act of 2000.*

coverage level. Very young children comprise more than 40 percent of all children who receive Medicaid, as Figure 2 illustrates.



Notes: Some states have expanded eligibility levels. The 1999 federal poverty level for a family of four was $16,700.

Source: Kaiser Commission on Medicaid and the Uninsured, "Health Coverage for Low-Income Children," June 1999.



Source: Health Care Financing Administration (HCFA) Medicaid Program Statistics, Table 22, (HCFA 2082 Report), "Medicaid Recipients of Medical Care by Age and State: Fiscal Year 1997," www.hcfa.gov/medicaid/MCD97T22.htm.

Medicaid is singular not only in its entitlement structure but also in the scope of the entitlement it creates for children. In 1967, in the face of overwhelming evidence from state Title V programs, the Head Start program, and the Defense Department regarding the diminished health status of low-income children and youth,[27] Congress amended Medicaid to add a special set of pediatric health benefits known as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Aimed at furnishing comprehensive preventive care and identifying as early as possible low-income children with physical and mental health conditions requiring additional treatment, EPSDT offers unparalleled coverage for preventive health care. This coverage includes periodic and as-needed health examinations, developmental assessments, and other preventive and health education interventions; vision, dental, and hearing care; and diagnostic and treatment services for both acute and chronic physical and mental health problems.

Unlike conventional private insurance, the Medicaid EPSDT program uses a preventive standard to measure the medical necessity of care for children. Under this standard, treatment is considered to be necessary not only once a child is seriously ill but also at the earliest possible time that an intervention is deemed to be medically beneficial to prevent the onset or worsening of a disabling condition. Furthermore, services remain available in the case of children with chronic conditions for as long as they are needed to treat a health problem, promote proper growth and development, and maintain appropriate functioning.

All children and adolescents under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits. In addition to providing states with open-ended federal matching payments to help meet the cost of medical care, the EPSDT program provides states with administrative funding on an open-ended, matching basis to meet the cost of informing families about EPSDT and arranging for screening, diagnostic, and treatment services.

Community Health Centers

Established in 1965 as a federally administered demonstration, the community health centers program was designed to promote access to primary health care for residents of medically underserved communities.[28] As with Medicaid, the health centers program was

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[27] Children's Defense Fund, *EPSDT: Does It Spell Health Care for Poor Children?* (Washington, D.C.: Children's Defense Fund, 1977).

[28] The Neighborhood Health Centers Program (as it was then known) was envisioned as a complement to the newly enacted Medicaid program. Daniel R. Hawkins Jr. and Sara Rosenbaum, "The Challenges Facing Health Centers in a Changing Healthcare System," in *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?,* eds. Stuart H. Altman, Uwe E. Reinhardt, and Alexandra E. Shields (Chicago: Health Administration Press, 1998), p. 100.

in part a response to the overwhelming evidence, particularly from the Head Start program, of poor health among young children. Children comprised the single largest group of patients served by health centers, and their dominance in the centers remains today.

The State Children's Health Insurance Program

The most recent of all major children's health initiatives, the State Children's Health Insurance Program (CHIP), enacted in 1997, complements and builds on Medicaid. CHIP provides states with federal funds to extend comprehensive child health assistance to children with low family incomes who are ineligible for Medicaid or other health insurance. The CHIP program is more loosely structured than Medicaid and does not entitle children to assistance as a matter of federal policy. In addition to reaching those ineligible for Medicaid, CHIP gives states the flexibility to finance the same comprehensive range of preventive and other health services for young children that are available through the EPSDT program.

Figure 3 presents a federal policy timeline in the area of preventive health services for young children. Table 1 presents the budget of selected federal programs for children over the last three years.

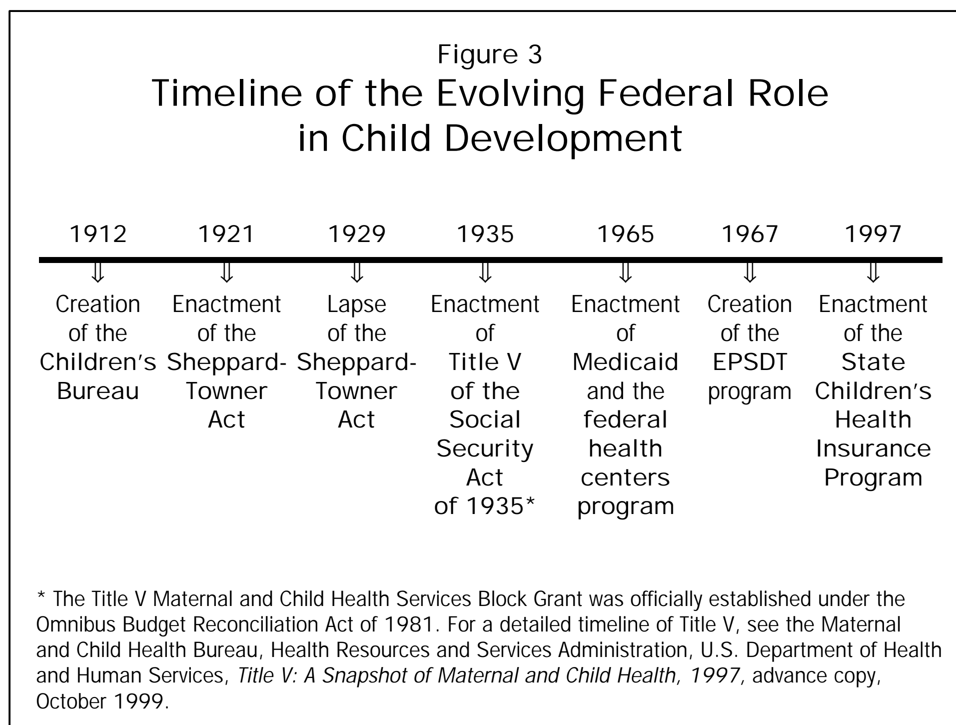


Figure 3
Timeline of the Evolving Federal Role in Child Development

* The Title V Maternal and Child Health Services Block Grant was officially established under the Omnibus Budget Reconciliation Act of 1981. For a detailed timeline of Title V, see the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services, *Title V: A Snapshot of Maternal and Child Health, 1997,* advance copy, October 1999.

Table 1
Budget of Selected Federal Programs for Children, Fiscal Years 1999–2001
(in millions of dollars)

Program	FY 1999 Enacted	FY 2000 Enacted	FY 2001 Enacted*
Medicaid	$23,613	$25,027	$26,070
CHIP	$4,247	$4,259	$4,249
Immunization Programs**	$1,041	$1,097	$1,024
MCH Block Grant	$695	$709	$709
Community/Migrant Health Centers	$390	$430	$493
Children's Mental Health and Substance Abuse	$136	$131	$159
Children's Mental Health Services Program	$78	$83	$92

* Appropriated or estimated budget.

** Includes the Centers for Disease Control and Prevention's Immunization and Vaccine for Children programs and the Food and Drug Administration's Immunization Program.

Source: Office of Budget, U.S. Department of Health and Human Services, "Children and Youth Budget," 2001.

II. HEALTH INSURANCE FOR YOUNG CHILDREN: THE ROLE OF FEDERAL PROGRAMS

Health Insurance Coverage

Unlike other industrialized nations, the United States does not have a single national policy ensuring health coverage for all children. Instead, children (like adults) derive health insurance through a voluntary system comprising both public and private sources—typically employer-sponsored coverage and Medicaid. The key difference between child and adult sources of care, however, is the magnitude of children's reliance on public sources of health insurance, particularly in the case of lower-income children. More than 40 percent of all insured children and more than 60 percent of all low-income children with any insurance derive their coverage from public insurance.

Figures 4a and 4b show the insurance status of young children (infants and children under age 6) by source of coverage. In 1998, 57.9 percent of all young children under age 6 had employer-sponsored health insurance coverage. Not surprisingly, as the poverty level rose, the percentage of young children with employer-sponsored coverage also rose.

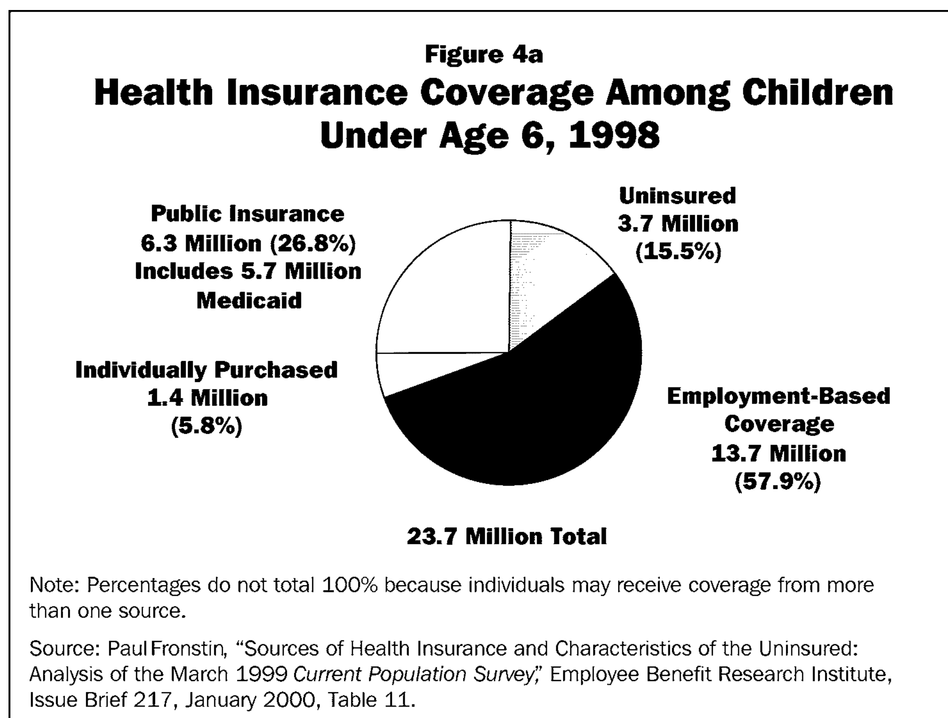


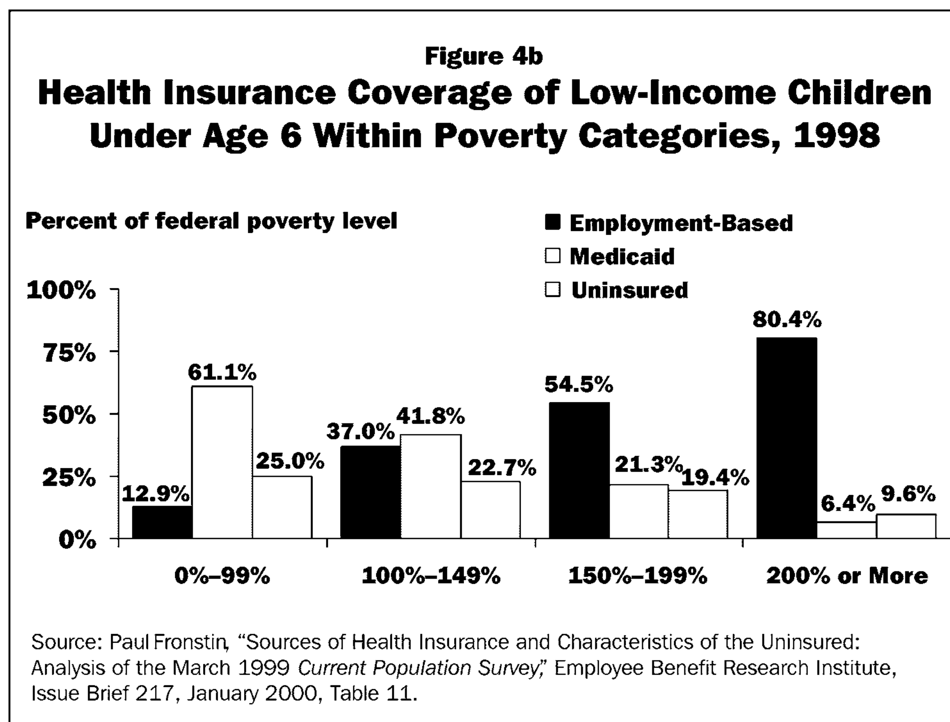
Figure 4a
Health Insurance Coverage Among Children Under Age 6, 1998

Note: Percentages do not total 100% because individuals may receive coverage from more than one source.

Source: Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 *Current Population Survey*," Employee Benefit Research Institute, Issue Brief 217, January 2000, Table 11.

Figure 4b shows by federal poverty level the percentage of young children with employer-sponsored health insurance coverage. Of young children living under 100 percent of the federal poverty level, 12.9 percent were covered by employer-sponsored

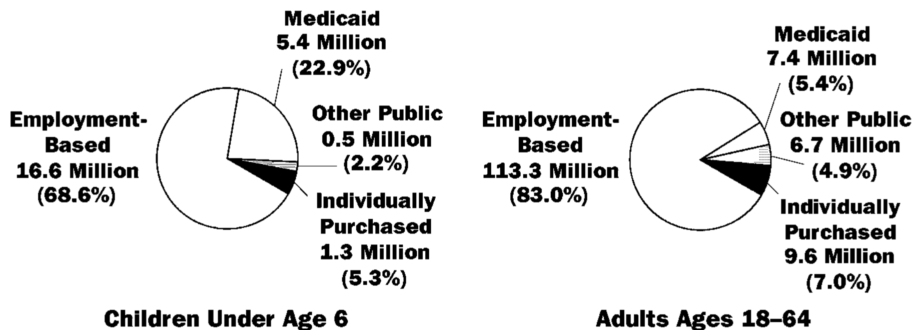
coverage. This percentage rose dramatically to 80.4 percent of young children living at 200 percent of the federal poverty level. Medicaid covered 23.9 percent of all young children, 61.1 percent of young children under 100 percent of poverty, 41.8 percent of young children from 100 to 149 percent of poverty, 21.3 percent of young children from 150 to 199 percent of poverty, and 6.4 percent of young children living at 200 percent of poverty and above. Some 15.5 percent (3.7 million) of all young children and approximately 20 percent or higher of all young children under 200 percent of poverty remained uninsured in 1998.



While these figures illustrate the importance of public insurance, Figures 5a and 5b underscore the unique role that public insurance plays for children compared to adults. Figure 5a compares insurance patterns for insured young children and insured nonelderly adults. Among all young children with any insurance, 22.9 percent derived their coverage from Medicaid, compared with 5.4 percent of adults. Among young children under 200 percent of poverty, the proportional reliance on public coverage is even greater. Figure 5b shows that 49.1 percent of low-income young children derived their coverage from Medicaid, compared with 21.9 percent of adults.

Figure 5a

Sources of Health Insurance Coverage Among Insured Young Children and Nonelderly Adults, FY 1999

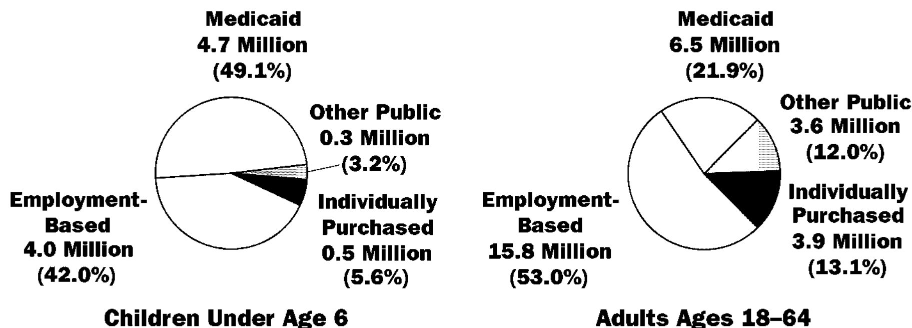


Note: Among children under age 6, an additional 1.2 million (4.7%) were covered by Medicaid but were also included in employment-based coverage. Among adults ages 18–64, an additional 3.1 million (2.3%) were covered by Medicaid but were also included in employment-based coverage.

Source: Columbia University School of Public Health analysis of March 2000 *Current Population Survey*.

Figure 5b

Sources of Health Insurance Coverage Among Insured Young Children and Nonelderly Adults Under 200 Percent of Poverty, FY 1999



Note: Among children under age 6 under 200% of FPL, an additional 0.8 million (8.1%) were covered by Medicaid but were also included in employment-based coverage. Among adults ages 18–64 under 200% of FPL, an additional 2.1 million (6.8%) were covered by Medicaid but were also included in employment-based coverage.

Source: Columbia University School of Public Health analysis of March 2000 *Current Population Survey*.

The reliance on public coverage among young children, especially low-income young children, is likely to grow. Employment-based health insurance coverage rates for children have remained essentially stagnant for years, as Figure 6 illustrates. Until 1999, Medicaid coverage rates declined as employment-based coverage rates rose, and vice versa. It is important to note that the Medicaid coverage rate for 1999 (20%) was still below the 1991 rate (20.4%). Until 1999, employment-based coverage rates had been lower than the

1987 rate of 63.9 percent; the 1999 employment-based coverage rate (64.4%) is only slightly higher than the 1987 rate.

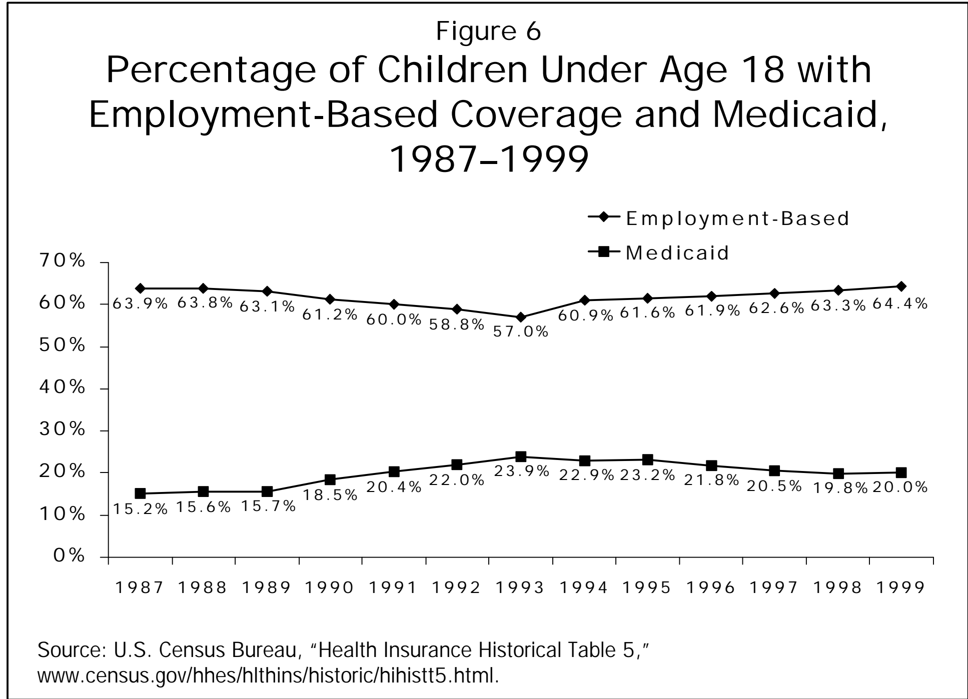


Figure 6
Percentage of Children Under Age 18 with Employment-Based Coverage and Medicaid, 1987–1999

Source: U.S. Census Bureau, "Health Insurance Historical Table 5," www.census.gov/hhes/hlthins/historic/hihistt5.html.

Because access to private health coverage among children is highly sensitive to family income, it is the youngest children—the nation's poorest children—who are least likely to have employer-sponsored coverage and are most likely to rely on public insurance (see Figure 7). As CHIP is phased in and the enrollment process uncovers additional children who are poor enough to qualify for Medicaid, this reliance on public insurance may continue to increase.

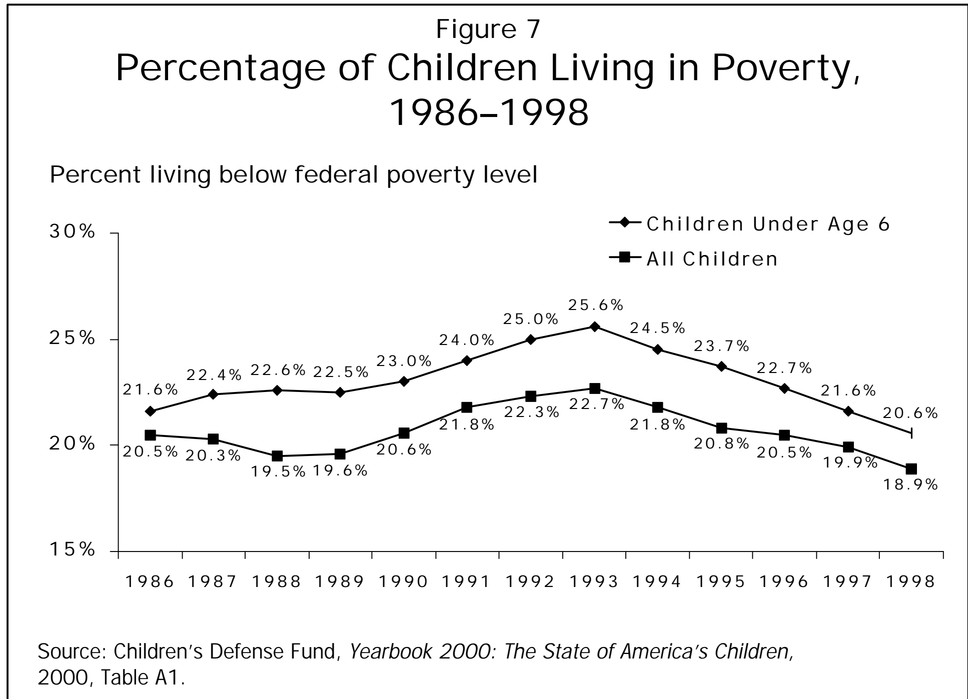


Figure 7
Percentage of Children Living in Poverty, 1986–1998

Source: Children's Defense Fund, *Yearbook 2000: The State of America's Children*, 2000, Table A1.

The Performance of Federally Assisted Public Insurance Programs

Medicaid's impact on children's access to health services is profound. As Figure 8 illustrates, Medicaid eliminates the disparity in use of health care between poor and non-poor children. Figure 8 shows that poor children with Medicaid are as likely as non-poor children to have seen a physician at least once within a year.

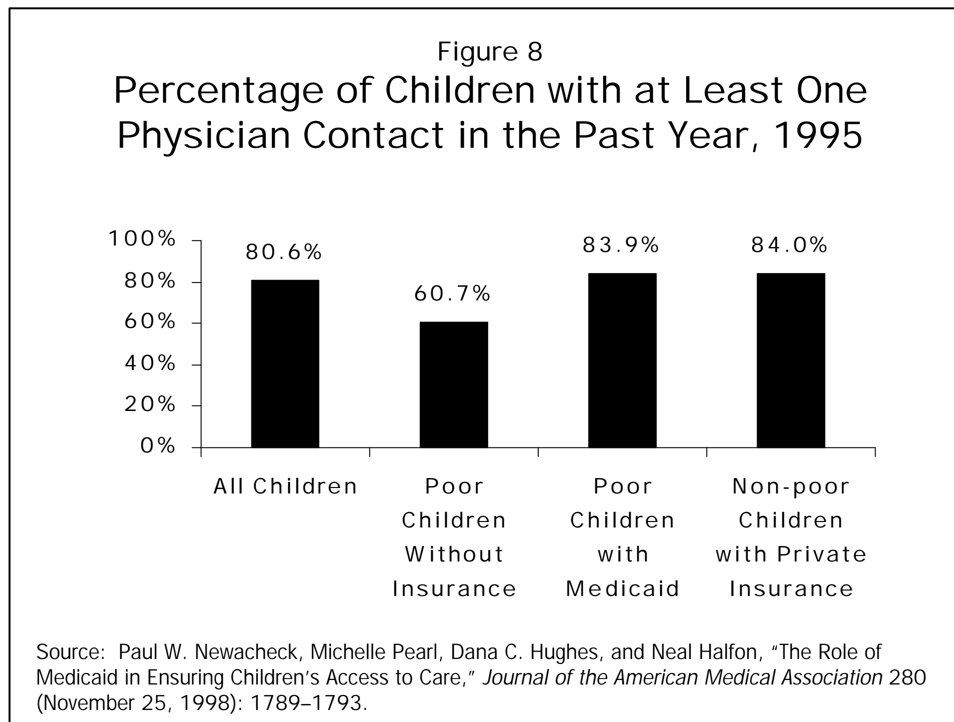


Figure 8
Percentage of Children with at Least One Physician Contact in the Past Year, 1995

Source: Paul W. Newacheck, Michelle Pearl, Dana C. Hughes, and Neal Halfon, "The Role of Medicaid in Ensuring Children's Access to Care," *Journal of the American Medical Association* 280 (November 25, 1998): 1789–1793.

One can assume that as the CHIP program evolves, and as data on health care utilization are collected on behalf of CHIP-eligible children, similar results will emerge. One study of young children enrolled in New York's CHIP program, Child Health Plus (CHPlus), found that enrollment in CHPlus was associated with a significant increase in utilization of access to preventive care. The study also found that continuity of care and many quality of care measures improved among enrolled children.[29]

[29] Jane Holl et al., "Evaluation of New York State's Child Health Plus: Access, Utilization, Quality of Health Care, and Health Status," *Pediatrics* 105(3 Supplement E):711–718 (March 2000).

III. THE FEDERAL ROLE IN PROMOTING ACCESS TO HEALTH CARE FOR MEDICALLY UNDERSERVED YOUNG CHILDREN

Regardless of family income, evidence from national studies of access and to utilization of health services indicate that families appreciate the importance of preventive care. Data from the Urban Institute's Assessing the New Federalism Project indicate that low-income publicly insured children are only slightly more likely than all children (2.7% vs. 1.5%) to use emergency rooms for routine health care. Nonetheless, studies have also found distinct differences in the site in which care is received between privately and publicly insured children. In 1995, 86 percent of all privately insured children, vs. 58 percent of publicly insured low-income children, received care in physicians' offices.[30]

Studies have also found many reasons why publicly insured children may use care in different sites even though they receive a comparable amount of care. A relatively high proportion of low-income children tend to reside in communities with low incomes (20% of poverty or more) as a whole. These low-income communities suffer from a shortage of private physicians in office-based practice.[31] The facilities they use instead include community health centers, hospital-based clinics, and local health department clinics. Because these facilities serve poorer populations, they may be more likely to adapt their services in special ways. Examples include employing multilingual staff; co-locating health services with other programs, such as nutrition, in schools and child care centers; and offering special services for parents.

Furthermore, people tend to be covered by public insurance in short periods: the average length of enrollment is around nine months, although recent improvements in Medicaid and CHIP policy[32] may begin to alter this on-again off-again pattern of coverage.[33] During periods without coverage, low-income children would naturally tend to rely particularly heavily on clinics that receive federally assisted operating subsidies and provide services free of charge or at a highly reduced cost.

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[30] Paul W. Newacheck, Michelle Pearl, Dana C. Hughes, and Neal Halfon, "The Role of Medicaid in Ensuring Children's Access to Care," *Journal of the American Medical Association* 280(20): 1789–1793 (November 25, 1998).

[31] Shonkoff and Phillips, *From Neurons to Neighborhoods*, 2000, p. 329.

[32] See Sara Rosenbaum et al., *The Role of Medicaid*, June 2001.

[33] Federal regulations require that states redetermine Medicaid beneficiary eligibility at least once every 12 months. Some states use one-month, three-month, or six-month redetermination levels. *The Balanced Budget Act of 1997* gave states the option to extend coverage to children up to 12 months after the initial determination of eligibility regardless of any change in financial or non-financial circumstances that would otherwise make them ineligible. See Andy Schneider, Kristen Fennel, and Peter Long, "Medicaid Eligibility for Families and Children," The Kaiser Commission on Medicaid and the Uninsured, September 1998, www.kff.org.

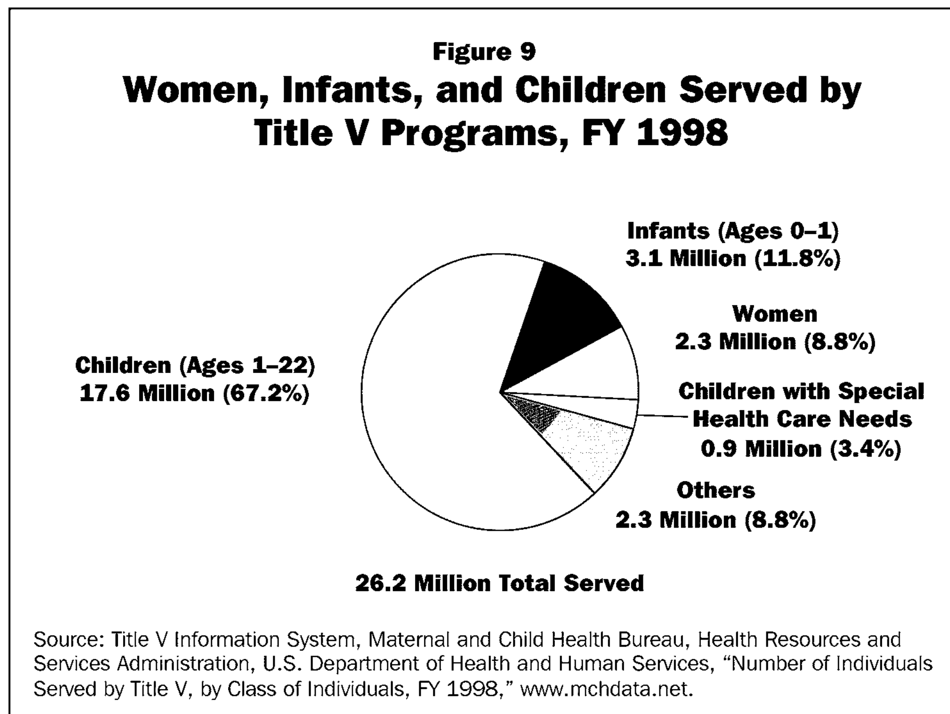
Regardless of the reason, federal policies related to the direct support of health services for medically underserved communities and populations represent a critical component of an overall federal health policy for young children. The importance of these programs to young children is made evident by statistics.

The Title V Maternal and Child Health Services Block Grant Program

As of fiscal year 2000, state Title V programs operated with a combined state and federal budget of more than $4 billion[34] and served more than 26 million women, infants, and children.[35] Figure 9 presents additional data on children served by Title V programs by age. It shows that approximately 12 percent, or 3.1 million, of all those served by Title V programs were infants.

Figure 9

Women, Infants, and Children Served by Title V Programs, FY 1998



Source: Title V Information System, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services, "Number of Individuals Served by Title V, by Class of Individuals, FY 1998," www.mchdata.net.

Community Health Centers

In fiscal year 2000, health centers served more than 9 million patients living in medically underserved urban and rural communities.[36] As of 1999, an additional 1.8 million patients

[34] U.S. Department of Health and Human Services, Title V Information System, Maternal and Child Health Bureau, Health Resources and Services Administration, "Federal-State Title V Block Grant Partnership Budget, FY 2000." www.mchdata.net.

[35] Maternal and Child Health Bureau, HRSA, USDHHS, *Title V: A Snapshot of Maternal and Child Health, 1997,* advance copy, October 1999, p. 11.

[36] Barbara E. Bailey et al., *Experts with Experience: Community and Migrant Health Centers Highlight a Decade of Service (1990–2000).* BPHC, HRSA, USDHHJ (2001). Web site: bphc.hrsa.gov/CHC/CHCDocuments/pdf/tenyear_report.pdf.

were served by clinics designated by the federal government as meeting all standards applicable to federal health centers grantees.[37] These clinics are known as look-alikes.

Figure 10 shows that in 1998, young children under age 5 comprised 14 percent of all federally funded health center patients. That year all health centers (both federal grantees and look-alike centers) served an estimated 4.5 million children, or one of every six low-income children nationally (children with family incomes at or below 200 percent of the federal poverty level). Births to federally funded and look-alike health center patients accounted for one of five low-income births nationally.[38]

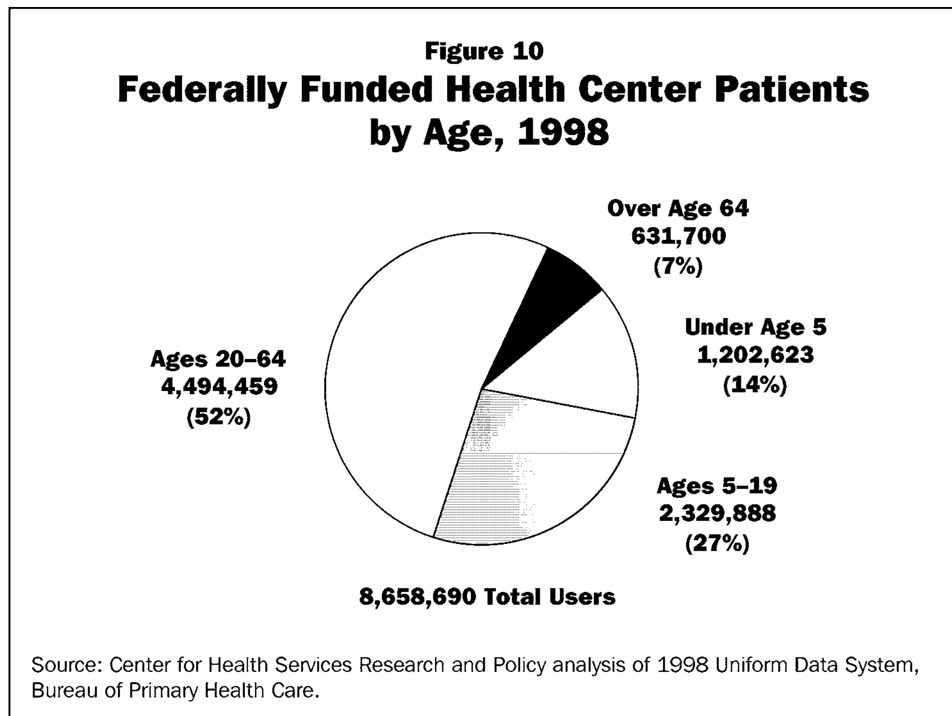


Figure 11 shows selected pediatric encounters at health centers. In 1998, federally funded health centers reported more than 3.3 million pediatrician encounters, and nearly 1.8 million additional encounters were related to child health supervision. Health centers thus represent a major source of primary and preventive health services for low-income infants and young children.

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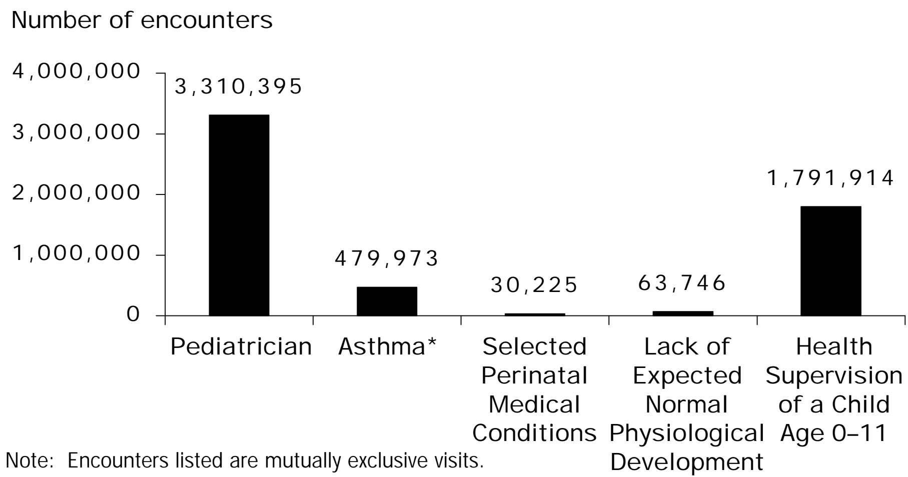
[37] Martha P. King and Stephen M. Christian, "Health Centers and Other Community-Based Providers," *Medicaid Survival Kit,* National Conference of State Legislators, February 2000 Update, p. 6-4.

[38] National Association of Community Health Centers, Inc., *Access to Community Health Care: A National and State Data Book, 1998* (Washington, D.C., 1998) (United States Table), page 1.

Figure 11

Health Care Encounters at Health Centers, 1998



Note: Encounters listed are mutually exclusive visits.

* Most asthma encounters were children.

Source: Center for Health Services Research and Policy analysis of 1998 Uniform Data System, Bureau of Primary Health Care.

IV. CONCLUSION

For nearly a century, the federal government has played a major role in shaping national health policy related to early childhood development. In the beginning, federal policies were aimed at promoting an understanding of the importance of childhood development as a national priority and in documenting the need for services. By the middle of the century, the federal government played an increasing role through Title V programs in support of early childhood development activities carried out through state health agencies. The federal role in early childhood development health policy culminated with the enactment of Medicaid and the EPSDT program; the establishment of health centers for medically underserved children and adults; and finally, creation of the State Children's Health Insurance Program.

These programs all play a vital role today, both as insurers of children and as sources of accessible health services in underserved communities. More than any other age subgroup within the nonelderly population, low-income children depend on these federal programs for the preventive health services that are essential to growth and development.

The major federal policy challenges that lie ahead involve building on the successes of these programs to broaden their reach and strengthen their capacity to provide early childhood preventive health services of the highest quality. In the case of Medicaid and CHIP, these improvements take the form of eligibility and coverage design interventions aimed at ensuring that the maximum number of eligible children are identified and enrolled, and that coverage standards are in accordance with emerging evidence regarding preventive pediatric practice. Strategies also involve ensuring that provider participation standards for both health professionals and managed care entities are of adequate strength to assure quality and that compensation rates are sufficient to attract and support high-quality providers.

In the case of health centers and other federally assisted preventive health providers, quality improvement efforts include support for professional development activities. The activities should be designed to develop skills and clinical competency in preventive pediatrics among the health professionals who deliver early childhood preventive health care on a daily basis.

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#451 *Room to Grow: Promoting Child Development Through Medicaid and CHIP* (July 2001). Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, George Washington University. This report, the second in a series of analyses exploring federal and state health policy in the area of early childhood development, examines how public insurance programs covering low-income children—namely, Medicaid and the State Children's Health Insurance Program (CHIP)—can be used to support and foster optimal child development interventions.

#452 *No Place Like Home: State Home Visiting Policies and Programs* (May 2001). Kay A. Johnson, Johnson Group Consulting, Inc. This report summarizes the results of a survey of states regarding home visiting activities, assessing the direction of state policies and programs through a nationwide examination of state-based home visiting programs targeting low-income families with young children.

#448 *Child Development and Medicaid: Attitudes of Mothers with Young Children Enrolled in Medicaid* (March 2001). Susan Kannel and Michael J. Perry, Lake Snell Perry & Associates. This report on mothers with young children enrolled in Medicaid finds that while generally pleased with the overall care their sons and daughters receive, many mothers feel that the program—as well as pediatricians—could do a better job of providing guidance on early development.

#404 *Appraisals of Parenting, Parent–Child Interactions, Parenting Styles, and Children: An Annotated Bibliography* (September 2000). The Commonwealth Fund Pediatric Parenting Project. Few measures of parenting skills offer an appraisal that is brief, comprehensive, parent-sensitive, psychometrically sound, nonintrusive, and appropriate to child development. This annotated bibliography provides clinicians, clinical researchers, and researchers interested in applied issues with information about those parenting skills measures that are available.

#367 *Assuring the Healthy Development of Young Children: Opportunities for States* (February 2000). Peter Budetti, Carolyn Berry, Pamela Butler, Karen Scott Collins, and Melinda Abrams. This issue brief examines opportunities for states to enhance the provision of health-related developmental services to children in low-income families, particularly by emphasizing the importance of preventive developmental services in primary, pediatric practices.

#304 *Improving the Delivery and Financing of Developmental Services for Low-Income Young Children* (November 1998). Karen Scott Collins, Kathryn Taaffe McLearn, Melinda Abrams, and Brian Biles. This issue brief examines the effects of inadequate health care services on the development of young children, and discusses efforts at the federal and state level to improve access and developmental outcomes for young children in low-income families. It also introduces the Fund's new Assuring Better Child Health and Development Program.