Child Health in America: Is This the Best We Can Do?

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I. INTRODUCTION

Much progress has been made in child health over the past three decades. Contagious diseases such as polio which frightened communities, closed swimming pools, and crippled a president are now routinely prevented. In the past ten years, with one new vaccine, we have eradicated the most common cause of bacterial meningitis among children under the age of six. For many children, the specter of infectious diseases which crippled, debilitated, or killed is now a thing of the past. Although the threat to living beyond childhood is no longer measles, diphtheria, or pertussis—diseases which are now vaccine preventable—the path to adulthood is still treacherous for many low-income children and their families who find that health care is often sporadic, expensive and even unavailable. The new morbidities of childhood are not transmissible diseases but rather poverty, violence, and the hazardous minefield of adolescence.

According to the Children's Defense Fund, every day in America:

3 children die from child abuse.
15 children die from guns.
27 children—a classroom full—die from poverty.
95 babies die before their first birthday.
564 babies are born to women who had late or no prenatal care.
788 babies are born at less than five and a half pounds.
1,340 teenagers give birth.
2,699 infants are born into poverty.
3,356 babies are born to unmarried women.
8,189 children are reported abused or neglected.
135,000 children bring guns to school.[1]

Children are not "little adults," and health care for children encompasses more than just doctor visits. The chronic conditions of childhood are very different from those of adults. Learning and developmental disabilities, as well

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[1] THE CHILDREN'S DEFENSE FUND, THE STATE OF AMERICA'S CHILDREN YEARBOOK (1995).

as behavior problems, are the chronic conditions seen in childhood. This is very different from the chronic conditions seen in adults: heart disease, hypertension, and diabetes. Adults die of disease; however, the leading cause of death for children at all ages, with the exception of infancy, is injury, either unintentional or inflicted.[2] Adolescents are often left out of the equation all together when child health needs and costs are calculated.

We must view children's health needs as different from those of adults. As a country, we would rather spend our dollars on fighting disease than on problems that may be a function of behavior such as injuries, school performance, and violence.

II. POVERTY: THE NUMBER ONE RISK FACTOR FOR LOW IMMUNIZATION RATES

Family income is directly proportional to poor health in children. Low-income children are twice as likely to be born at low birth weight, three times more likely to have delayed immunizations, three times more likely to suffer from lead poisoning, and three to four times more likely to die from disease than children who do not live below the poverty level.[3] If a child is born too soon or too small or to a teenage mother without a functional education or a job, that child is more likely to be under-immunized.

Children are not immunized for a variety of reasons: parents' lack of awareness of the importance of immunizations, "missed opportunities" to vaccinate children who seek care at emergency rooms or those who present to clinics for episodic or sick care, and medical providers who refuse to immunize sick children who have no contraindication for vaccination. In some inner-city communities, fewer than fifty percent of two-year olds are appropriately immunized. It is estimated that "missed opportunities" contribute up to forty percent of the under-vaccination rates.[4] Therefore, immunizations should be seen as a marker, rather than an outcome, for child health. In spite of free vaccines, poor children are still more likely to be under-immunized, and infants whose health care is covered by Medicaid or other government assistance are less likely to be current with well-child health visits.[5]

Youth, poverty, and the lack of any health insurance are intertwined.

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[2] *U.S. Health Care for Children*, THE FUTURE OF CHILDREN, (Summer 1992).

[3] THE CHILDREN'S DEFENSE FUND, *supra* note 1.

[4] Rodewald et al., *Is an Emergency Department Visit a Marker for Undervaccination and Missed Vaccination Opportunities Among Children Who Have Access to Primary Care?*, 91 PEDIATRICS 605 (1993).

[5] Henry D. Mustin et al., *Adequacy of Well-Child Care and Immunizations in U.S. Infants Born in 1988*, 272 JAMA 1111-1115 (1994).

Children and young families represent the majority of those either without health insurance or underinsured. Approximately twelve million children are uninsured.[6] Over twelve percent of all children under the age of eighteen had no health insurance throughout the year in 1992. Poor children are less likely to have a regular source of medical care and twice as likely as nonpoor children to be hospitalized because the admitting diagnosis was not treated in an early stage.[7] Even with the expansion of Medicaid eligibility, twenty percent of poor children remain without health insurance.

In Ohio, over one third of all children under the age of eleven have their health care paid for by Medicaid. In Cuyahoga and Perry counties, representative of large urban and small rural populations respectively, half of all children under the age of eleven receive Medicaid as their "health insurance."[8] For many of Ohio's children, the change in the Medicaid program from an entitlement to a block grant will have consequences that cannot yet be imagined. *Entitlement* means just that. If a family meets income and other criteria, they are *entitled* to participate in the program. With block grants, a set amount of money will be designated for the program and when that money is spent, there will be no more funds until the next fiscal year. Families who are thrown out of work and lose their health coverage may not be able to access Medicaid as a health "safety net" as they can currently.

We are witnessing an increasing demand for placement of children outside their immediate families, families who disproportionately depend on Medicaid to pay for their health care. On any given day in America, almost a half million children are in foster care, group homes or residential treatment centers.[9] Children in foster care have been shown to have a high prevalence and exceptional range of health needs including hearing and vision deficiencies, poor dental hygiene, chronic illness, delayed immunizations, and positive family histories of mental illness and alcohol and/or substance abuse.[10] The most vulnerable children, those in troubled families who need intervention, will certainly feel the brunt of these changes in the financing of Medicaid.

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[6] Jennifer D.C. Cartland & Beth K. Yudkowsky, *State Estimates of Uninsured Children*, HEALTH AFFAIRS 144–151 (Spring 1993).

[7] Robert G. Hughes et al., *Assuring Children's Health as the Basis for Health Care Reform*, HEALTH AFFAIRS 158 (Summer 1995).

[8] CHILDREN'S DEFENSE FUND–OHIO, HELPING FAMILIES WORK:A 1995–96 FACTBOOK.

[9] THE CHILDREN'S DEFENSE FUND, *supra* note 1.

[10] Robin Chernoff et al., *Assessing the Health Status of Children Entering Foster Care*, 93 PEDIATRICS 594–601 (1994).

III. ADOLESCENTS: A DIFFERENT KIND OF ANIMAL

Adolescents fall into a gray area. Indeed, adolescent medicine has only been an acknowledged subspecialty for the last twenty years. Not children and not yet adults, they represent a particular complexity to health care providers. For example, adolescence is where pregnant teens are. Are they still children because of their age or adults because of their condition? How we approach the problems of adolescence presents a particular challenge.

Adolescents are the only age group whose mortality rates have not declined rapidly in the past two decades. Homicide, suicide, and accidental death are the cause of three-quarters of all adolescent deaths.[11] Adolescents represent eighty percent of all firearm-related deaths for children ages one to nineteen years.[12].

In addition to being a minefield, adolescence is also a time of experimentation. In one study of 563 adolescents, over half of those surveyed had tried alcohol and tobacco and a third of those sampled had used marijuana. The connection between risk taking and violence also carries over into sexual behaviors. Ten percent of the sixth-graders in the same sample reported being sexually active, with percentages increasing with age. Over half of all those in the sample who were sexually active admitted to unprotected sex.[13] It has been documented that adolescents who participate in risky sexual behaviors have themselves disproportionately been the victims of sexual abuse.[14] Adolescents who participate in one risk behavior are more likely to participate in other risk behaviors, i.e., those who are sexually active are more likely to use alcohol and tobacco, to use illicit substances and to drive under the influence of intoxicants.[15]

Poverty, the thread that ties together all aspects of poor outcomes in child health, is also directly connected to teenage parenthood. Eighty-three percent of teens who give birth are from economically disadvantaged families.[16] Pregnant teens are less likely to receive early prenatal care and more likely to give birth to low birth weight babies who are at greater risk to die before their first birthday. Babies born to teen moms and women who had their first child as a teenager are more likely to live in poverty and remain poor all their lives.

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[11] Susan G. Milstein et al., *Health-Risk Behaviors and Health Concerns Among Young Adolescents*, 3 PEDIATRICS 422–428 (1992).

[12] James A. Mercy et al., *Public Health Policy for Preventing Violence*, HEALTH AFFAIRS 7–29 (Winter 1993).

[13] Milstein, *supra* note 11.

[14] Steven Nagy et al., *A Comparison of Risky Health Behaviors of Sexually Active, Sexually Abused and Abstaining Adolescents*, 93 PEDIATRICS, 570–575 (1994).

[15] Milstein, *supra* note 11.

[16] THE CHILDREN'S DEFENSE FUND, *supra* note 1.

IV. VIOLENCE: A PUBLIC HEALTH EMERGENCY

1,000 to 2,000 children die from abuse and neglect every year in the United States. It is estimated that 1.4 million children, between two and three percent of the population under the age of eighteen in the United States, suffer maltreatment each year.[17] Though most states mandate the reporting of suspected abuse and neglect by professionals including teachers and the clergy, many children are never protected by "the system." While the scars associated with psychological abuse and neglect are less visible than physical abuse, they are no less permanent. It is reasonable to say that any condition which affected two to three percent of the adult population in any given year, had long term consequences, and was preventable would attract more public attention. It may even be deemed deserving of a colored ribbon on many lapels.

V. MEETING THE BASIC NEEDS

We can no longer afford to look at the issues of child poverty, poor health outcomes, violence, and the unique concerns of adolescence as unrelated. Mercy and colleagues set forth strategies for preventing violence and its consequences that can be applied to all aspects of improving child health. While Mercy was referring to public information campaigns, job training and skills, parenting education, less crowded living conditions, and heightened awareness of unsafe surroundings as they relate to violence prevention, it applies to all aspects of child well-being. If this can be achieved, we will see not only violence reduction, but also improved health outcomes. Following their recommendations, it is imperative that we: (1) Change/increase individual knowledge and skills or attitudes by assisting those parents with few or poor parenting skills to become better parents; (2) change the social environment by improving social and economic circumstances through improved educational retention and graduation rates, job skills, and jobs with benefits that pay a living wage; and (3) change the physical environment by providing families with safe and supportive communities in which to live.[18]

None of these circumstances—child poverty, poor health outcomes, or violence—exist in a vacuum. Low-income families are more likely to live in communities with higher crime rates than those found in middle class or affluent neighborhoods. Children born to low-income mothers are more likely

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[17] Bernard Guyer, *An Epidemiologic Overview of Violence Among Children*, *in* CHILDREN AND VIOLENCE: TWENTY-THIRD ROSS ROUNDTABLE ON CRITICAL APPROACHES TO COMMON PEDIATRIC PROBLEMS 3–11 (1992).

[18] Mercy, *supra* note 12.

to be born at low birth weight and with late or no prenatal care. Premature babies are at greater risk of neglect and abuse. Children who are at risk of abuse, especially sexual abuse, are more likely to exhibit risky sexual behaviors as adolescents. Abused children are at greater risk for alcohol and substance abuse as well as aggressive behavior. The problems that are more prevalent for poor children are interrelated.

What children need to be healthy are not more or better screening mechanisms. With few exceptions, hypertension, diabetes, and cancer are not visited on the young. Usually, they must survive childhood before they must worry about these diseases. Poverty, teenage parenthood, violence, and diminished access to health care have a greater impact on children's health status. For these conditions, there is no vaccine on the horizon.