DOCUMENT RESUME

ED 369 476 PS 021 442

TITLE	Improving Health (Majority Recommendations.) Next Steps for Children and Families. Implementation Guide Series.
INSTITUTION	National Commission on Children, Washington, DC.
SPONS AGENCY	Annie E. Casey Foundation, Greenwich, CT.; Carnegie Corp. of New York, N.Y.; Ford Foundation, New York, N.Y.; Foundation for Child Development, New York, N.Y.; Grant (W.T.) Foundation, New York, N.Y.; Kellogg Foundation, Battle Creek, Mich.; Pew Charitable Trusts, Philadelphia, PA.; Robert Wood Johnson Foundation, New Brunswick, N.J.
PUB DATE	93
NOTE	85p.; For a related guide, see PS 021 441.
AVAILABLE FROM	The Coalition for America's Children, 1710 Rhode Island Avenue, N.W., Washington, DC 20036.
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	*Child Health; Community Involvement; *Family Involvement; Federal Programs; *Government Role; Health Education; *Health Insurance; *Health Services; Medical Services; Parent Responsibility; *Prenatal Care; State Programs
IDENTIFIERS	Health Delivery Systems; *National Commission on Children

ABSTRACT

Based on the assumption that all American children deserve an opportunity to be born healthy and to grow up healthy, this guide presents the recommendations approved by the majority of the National Commission on Children for improving the health of the nation's pregnant women and children. The Commission's five recommendations are: (1) provide universal health insurance coverage for pregnant women and children through age 18 through a public-private system that includes a basic level of care and provisions to contain costs and improve care quality; (2) expand effective health care programs for underserved populations; (3) improve the delivery of health care through joint efforts by health care professionals and professionals from other disciplines to ensure the quality and comprehensiveness of health and social services, participate in publicly funded programs, and serve their communities as volunteers; (4) reinforce parental responsibility to protect their children's health by protecting their own health, modeling healthful behavior, providing a safe home environment, and seeking essential health services for their children; and (5) increase community responsibility for creating safe neighborhoods, supporting the development of community-based health education and health care programs, and sponsoring activities and special projects to help families gain access to needed services. This guide outlines steps to implement these recommendations. (AC)

Implementation Guide Series

Improving Health

Majority Recommendations

NATIONAL COMMISSION ON CHILDREN

2

Improving Health

Majority Recommendations

The National Commission on Children was established by Public Law 100-203 "to serve as a forum on behalf of the children of the nation." It is a bipartisan body whose 34 members were appointed by the President, the President Pro Tempore of the U.S. Senate, and the Speaker of the U.S. House of Representatives. As required by law, the Commission reports to the President; to the Committees on Finance and on Labor and Human Resources of the Senate; and to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives.

NATIONAL COMMISSION ON CHILDREN

Library of Congress Cataloging-in-Publication Data

United States. National Commission on Children.

Next steps for children and families. Improving health (majority recommendations) / National Commission on Children.

p. cm.

Includes bibliographical references.

1. Child health services—United States—Planning. 2. Maternal health services—United States—Planning. 3. Health promotion—United States—Planning. 4. Family—Health and hygiene—United States. I. Title.

RJ102.U56 1993

362.1'9892'000973—dc20 93-35

CIP

Additional copies available from the National Commission on Children, 1111 18th Street, NW, Suite 810, Washington, DC 20036; and (after March 31, 1993) the Coalition for America's Children, 1710 Rhode Island Avenue, NW, Washington, DC 20036.

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Foundation for Child Development
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Senior Policy Analyst

Kirsten Monihan
Administrative Assistant

Denise Smith
Policy Analyst
(Presidential Management Intern)

Linda J. Wells
Executive Assistant

Thomas E. Woods
Research Assistant

Table of Contents

Acknowledgements

The National Commission on Children gratefully acknowledges the extraordinary efforts of all those on the staff who helped prepare this series of implementation guides. Cheryl D. Hayes, the Commission's executive director, has directed all aspects of the Commission's work over the past three-and-one-half years. She supervised the development and preparation of these monographs and contributed to the drafting. Carol A. Emig, the Commission's deputy director, and Jason N. Juffras, senior policy analyst, organized the working group meetings, and Jason assumed major responsibility for drafting several of the guides. Denise Smith, policy analyst, and Thomas E. Woods, research assistant, also contributed to the drafting. Administrative staff members Linda J. Wells, Kirsten Monihan, Bertha A. Gaymon, and John P. Johnson managed all the logistical arrangements for the working group meetings and prepared the manuscripts for publication. Polly Dement, the Commission's communications director, and Chase Haddix, research assistant, organized the public release and distribution.

Others outside the Commission staff also deserve thanks. We are grateful to all those individuals who gave generously of their time to participate in the working groups and to review and comment on drafts of the implementation guides. Their insights and perspectives significantly

enriched the final documents. Sally Stanfield edited the guides, and Francesca Moghari and Linda Humphrey are responsible for the design and layout.

Finally, we acknowledge the generous contributions of our foundation sponsors whose support made this project possible: the W. T. Grant Foundation, Carnegie Corporation of New York, Robert Wood Johnson Foundation, W. G. Kellogg Foundation, Pew Charitable Trusts, Foundation for Child Development, Annie E. Casey Foundation, and Ford Foundation.

Letter from the Chairman

Dear Friends and Colleagues,

The bipartisan National Commission on Children was established by the President and the Congress "to serve as a forum on behalf of the children of the Nation." The Commission's 34 members come from many walks of life and represent an array of viewpoints, professional affiliations, and political perspectives.

The Commission has approached its work with a sense of great urgency. All of us believe strongly that the nation cannot sit idly by while many children move toward adulthood without the support they need to become skilled workers, responsible citizens, and caring members of their families and communities.

In June 1991 the Commission presented its final report, *Beyond Rhetoric: A New American Agenda for Children and Families*, to the President and congressional leaders. The report presented the bold outline of a new national policy in which children and their families are a top priority. To ensure that all children have an opportunity to become healthy, literate, and productive adults, we urged the nation to take decisive steps to ensure income security, improve children's health and educational achievement, support and strengthen families, and create a culture of individual and collective responsibility for the well-being of America's youngest citizens.

In every area but health, the Commission was unanimous in its recommendations. Nine of the 34 commissioners dissented from the recommendations to improve the health of the nation's children and pregnant women that are the subject of this report. These recommendations were originally presented in the chapter entitled "Improving Health" in the final report.

The Commission's recommendations have generated strong interest and support from many quarters. Yet time and again, public officials, private citizens, and members of advocacy, business, professional, and community groups have asked for more specific guidance on how they can help turn the Commission's proposals into action.

Accordingly, the Commission convened a series of working groups in 1992 to identify implementation strategies and to assign responsibility to individuals and organizations within and outside of government who must help get the job done.

These working groups were chaired by Commission members and included an array of scholars, practitioners, state and local elected officials, congressional and executive branch staff, and representatives of advocacy, business, and community groups. Separate groups identified strategies to implement the Commission's recommendations on ensuring income security, improving health, increasing educational achievement, protecting vulnerable children and their families, strengthening and supporting families, and making programs and policies work. The Commission created separate working groups to consider how to implement the majority and minority recommendations on health.

Drawing on the working group discussions, we developed a series of implementation guides that offer practical advice to policymakers, program directors, community activists, corporate leaders, and private citizens. This monograph, *Next Steps for Children and Families: Improving Health (Majority Recommendations)*, is a part of that series. Barry S. Zuckerman, Reed V. Tuckson, and James D. Northway, members of the Commission, ably and graciously served as cochairs of the working group on the majority recommendations for improving health. A list of the working group members appears in the Appendix.

Although members of the Commission who support the majority health recommendations and the working group members had a significant hand in shaping this document, they have not been asked to vote on specific language. The views presented here do not represent nor should they be attributed to the nine members of the National Commission on Children who declined to approve the majority health recommendations.

In my own view, this nation faces a health care crisis of unparalleled proportions. Despite a generation of outstanding medical advances, almost 40,000 babies die each year before their first birthday. More than 8 million children and nearly 500,000 pregnant women have no access to health care because they have no way to pay for it. Many more young people engage in destructive behaviors that risk their own health and well-being and that of their families and communities. It is time for our nation's public and private sector leaders to recognize the pressing need to ensure accessible and affordable health care for all children and pregnant women and to take the necessary steps to enable children to grow up healthy and prepared to meet the challenges of adult life.

The political will to set a new course for solving the nation's health care crisis will grow out of a continuing process of honest, vigorous debate. I sincerely hope that the work of the National Commission on Children will inform these discussions and help shape sound policy in the years ahead.

John D. Rockefeller IV
Chairman

Introduction

All American children deserve an opportunity to be born healthy and to grow up healthy. If this nation is to remain strong and competitive, attending to the health of its children is fundamental. On many important measures of maternal and child health, however, America ranks well behind other less wealthy and less developed countries. After steady improvement in the 1970s, progress on most key child health indicators slowed or declined in the 1980s. Every year preventable disease, disability, and death claim many of the nation's youngest citizens.

The United States has the most advanced medical technology and the highest per capita spending on health care in the world. Yet the guarantee of basic health care for all children and pregnant women remains an unrealized goal. With each passing day, the news about America's failure to come to grips with the crisis in its health care system seems to get worse. Many Americans are effectively denied access to services because they have no way to pay for them. The ranks of the uninsured and the underinsured have grown steadily since 1980, and today more than 8 million children and nearly 500,000 pregnant women are without health care coverage.[1] Others lack access because health providers and facilities are beyond their reach. This is especially true for low-

income and minority families and for those who live in isolated rural areas and in inner cities.

Yet in 1991 this nation spent an estimated $736 billion or 13 percent of its gross national product (GNP) on health care, more than any other Western industrialized nation.[2] In short, Americans are paying more and getting less for their health care dollars. Increasingly, consumers, providers, advocates, and voters have declared this trend unacceptable.

Medicine and medical services are only two factors that contribute to good health, however. Parents play a critical role in protecting their children's health by protecting their own health, creating a safe home environment, promoting healthful behavior, and obtaining health care for themselves and their children. Communities also bear responsibility for keeping neighborhoods safe for children, educating parents and children about health risks, and promoting positive attitudes about health, as well as supporting the development of community-based health care programs to help families gain access to services. Therefore, in addition to health insurance reform, America's policies and programs must also support and encourage families and communities in their roles as guardians of children's health.

In June 1991 the bipartisan National Commission on Children presented to the President, Congress, and the American people a bold blueprint for strengthening America's families and enhancing children's health and well-being. The Commission's proposals, which are outlined in its report *Beyond Rhetoric: A New American Agenda for Children and Families*, embrace public and private sector initiatives to improve income security, health, education, and social supports for families with children. In every area but one

the commissioners were unanimous. All but nine of the Commission's 34 members approved the majority recommendations for improving the health of the nation's pregnant women and children that are discussed in this report. These recommendations include

- **Provide universal health insurance coverage for pregnant women and for children through age 18 through a public-private system that includes a basic level of care and provisions to contain costs and improve the quality of care.**

- **Expand effective health care programs for underserved populations.**

- **Improve the delivery of health care through joint efforts by health care professionals and professionals from other disciplines to ensure the quality and comprehensiveness of health and social services, participate in publicly funded programs, and serve their communities as volunteers.**

- **Reinforce parental responsibility to protect their children's health by protecting their own health and being role models for healthful behavior, by doing everything in their power to provide a safe home environment, and by seeking essential health services for their children.**

- **Increase community responsibility for creating safe neighborhoods, for supporting the development of community-based health education and health care programs, and for sponsoring activities and special projects to help families gain access to needed services.**

This guide outlines steps to implement these recommendations. In the months and years ahead, Congress and the new President are going to be forced to make some

extremely difficult decisions. Employers and public and private sector leaders at the state and local level will also be called on to make choices that will significantly affect the health of America's children and families and the viability of our nation's health care system. It is our sincere hope that this document will provide a framework and guidance for action.

Provide Universal Health Insurance for Pregnant Women and Children

Recommendation

The National Commission on Children recommends that government and employers together develop a universal system of health insurance coverage for pregnant women and for children through age 18 that includes a basic level of care and provisions to contain costs and improve the quality of care.

Implementation Steps

- Congress and the President must work together to establish broad-based health insurance reform that begins with a system of universal coverage for pregnant women and children.

- Employers must provide as a benefit of employment health insurance for pregnant employees or the pregnant spouses of employees and for their children through age 18. Coverage that provides a basic level of care could be purchased either in the private health insurance market or through a new public plan.

- Physicians, hospitals, and the health insurance industry must work together with government to establish measures to control the costs and improve the quality of health care for pregnant women and children.

Discussion

Without access to health care, many pregnant women will be at risk for poor birth outcomes, and their children will experience problems that can severely compromise long-term health and development. America's health care system is in crisis, and it puts the nation's most vulnerable population—pregnant women and children—at greatest risk of failing to receive needed care. In 1991 more than 8 million children and nearly 500,000 pregnant women were effectively denied access to basic health care because they had no way to pay their medical bills.[3] Many more were underinsured or had inadequate coverage to meet their health care needs. Although poor Americans face the greatest barriers to insurance coverage, the specter of inadequate protection and catastrophic medical expenses threatens middle-class families as well.[4] As the U.S. health care system is increasingly strained by rising costs, those who depend on employment-based coverage face the growing risk of joining the ranks of the uninsured.

Not since the 1970s has there been such intense interest in restructuring the nation's health care system. As the new President and Congress begin work, taking steps to solve the health care financing crisis should be among their highest priorities. Indeed, failure to tackle this issue will significantly constrain their ability to address other pressing national problems. In doing so, they must deal with issues both of cost and access. And they must recognize that children and pregnant women require special attention and priority in decisions about health care financing policy.

In the past three years several important national organizations, governmental commissions, and public policy leaders have offered plans for reform. Some have called for a radical realignment of the public/private system now in place; others have called for more marginal, incremental changes. Among these alternatives, however, there has been little consensus. The National Commission on Children joined this rising chorus of voices calling for broad-based reform. Within the Commission, however, there were similar differences concerning approach. Ultimately, the majority of commissioners recommended a public/private, employment-based system that builds on the current system.

Since the release of the Commission's recommendations in 1991, continuing discussion has focused on ways to expand coverage for uninsured and underinsured Americans and at the same time contain spiraling health care costs through private market approaches, such as managed competition, and a global health care budget. These proposals for restructuring are based on several fundamental principles that are widely agreed on, even among those who express differences concerning the specific policy mechanisms for achieving them. These

principles were set forth in a recent Institute of Medicine monograph comparing alternative proposals for health insurance reform.[5]

All pregnant women and children must have continuous access to health insurance coverage. Parents must have a way to pay for health care for their dependent children and for themselves or their spouses during pregnancy and for a reasonable period after delivery, regardless of their employment, family income, family composition, geographic location, or health status. Coverage should be continuous even when there are changes in any one or more of these factors. In particular, when parents change jobs or move to a new community their health insurance coverage should not be interrupted.

Unfortunately, however, this basic goal has yet to be achieved. Many pregnant women and children have no health insurance and many others are underinsured. Because the costs of health care have exploded in recent years, employers have struggled to control the amount they pay for coverage, and many employees have seen their benefits erode while their share of premium costs has increased. For most large employers, the problem of providing health insurance coverage for employees has escalated; for many small employers it has become insurmountable. Although most employed parents still get health insurance for themselves and their children through their jobs, many employers have become less willing to contribute to dependent coverage in recent years. Part-time and seasonal employees, as well as those who work for small firms, are often excluded altogether. Individually purchased coverage, when it is available, is generally very expensive and often beyond the means of low- and moderate-income working families.

In addition, in an effort to contain the costs of coverage, many health insurance plans exclude families that do not meet stringent eligibility requirements related to length of employment, good health status, U.S. residence, age of children, and custodial arrangements for children when parents are separated or divorced. If they fail to satisfy one or more of these requirements, many families are deemed ineligible for coverage altogether or ineligible for coverage for a period of time or for certain health conditions. For families with children who suffer chronic illnesses or disabilities, health insurance coverage may not be available at any cost.

To achieve full and continuous health insurance coverage for pregnant women and children, all these excluded groups must have access to insurance and barriers to coverage must be eliminated. The majority of members of the National Commission on Children recommends doing this by requiring all employers to provide a basic level of coverage that they can purchase in the private health insurance market or through a new public plan. The cost to employers of the publicly provided coverage would be a set percentage of payroll, thus capping the total amount that employers would be required to pay and avoiding excessive costs for covering part-time employees. Because employer contributions would not cover the full costs of coverage, the federal government would have to subsidize the shortfall. For those pregnant women and children not covered by employer-based health insurance, the majority commissioners recommend that coverage be available through the new public plan. The plan would not be means-tested or linked to the present welfare system as Medicaid is. Instead, it would cover all pregnant women and children who do not otherwise receive private health insurance. Alternatively, all employer-based premiums could be

paid into the private market. Low-income pregnant women and children who are not covered by employer-based policies could receive government subsidized coverage purchased in the private market.

The cost of purchasing health care, including health insurance premiums, deductibles, and copayments, must be affordable. Even if other barriers to health insurance coverage are eliminated, many families will continue to be excluded if the cost of purchasing health insurance and the share of health care costs that are not covered are too high. Cost sharing is an important mechanism for distributing the financial burden and encouraging individuals to use health care services appropriately. However, if the share of premium costs, the deductible levels, and copayments are too high, many families will be effectively denied coverage.

To ensure that pregnant women and children have access to health insurance, therefore, families' personal expenditures for health care must be affordable. To achieve this, the majority of members of the National Commission on Children recommends that the amount a family pays for premiums, deductibles, and copayments should be determined on a sliding scale according to income. For low-income families, these fees should be fully federally subsidized.

All health insurance coverage for pregnant women and children must provide a standard level of care that emphasizes primary and preventive care and includes the diagnosis and treatment of diseases and health-impairing conditions as well as specialized care for complex health problems. To ensure that pregnant women and children have access to essential health services, health insurance must cover basic preventive services including:

- comprehensive prenatal, delivery, and postpartum care, with continuous risk assessment during pregnancy and appropriate education and intervention when problems are detected;

- scheduled well-child visits from birth through adolescence, including immunizations;

- family planning services and supplies; and

- preventive dental care.

It also must cover necessary treatment for acute and chronic conditions, including:

- inpatient and outpatient services;

- diagnostic tests;

- prescription drugs, hearing aids and corrective lenses;

- acute dental care; and

- mental health and substance abuse treatment services.

The National Commission on Children recommends that all health insurance plans, both private and public, be required to offer the same basic standard of coverage for pregnant women and children. The federal government, in consultation with representatives of the health care provider industries and representatives of consumer groups, would define standards for covered services. Insurance plans offered by employers would be required to provide at least this basic standard of care (although employers would have the option of offering and individuals would have the option of purchasing more generous coverage). To ensure that poor children and pregnant women would not be worse off than they are now, the

majority of commissioners recommends that the public program, or private coverage purchased for them through government subsidy, should also cover services currently required under Medicaid, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); home health services; hospice care; and skilled nursing facility services. Keeping these services would also ensure that children with chronic and disabling conditions would continue to receive the care they need. Families who have private insurance plans that do not include these services would be able to purchase this coverage at additional expense. To encourage families to use preventive care for pregnant women and children, the majority commissioners recommend that these services be exempt from cost sharing requirements under both the public plan and private health insurance packages.

Universal health insurance coverage for pregnant women and children should be accompanied by tough measures to contain health care costs and promote quality care. The dramatic and unrelenting rise in the cost of health care has forced decision makers to focus on cost containment as a central issue in health insurance reform. Specific approaches to keep national health expenditures (public and private) at an acceptable level relative to national income are essential. There is widespread agreement that coverage of unnecessary, inappropriate, or poor-quality care, care that fails to foster efficient delivery of services, or care that shifts costs from some consumers to others wastes precious health care resources. Moreover, unless costs can be brought under control, many observers project that the entire health care system will collapse, jeopardizing access to care for all Americans. The majority of members of the National Commission on Children urges consideration of several cost containment measures:

• **Adjusting payment rates so that health care providers who make children a priority are not adversely affected.** The payment system for fees to doctors and hospitals should be based on the relative value of services rather than simply on historical charges. In this way, fee schedules could be structured to encourage more widespread provision of primary and preventive care, and to reduce the likelihood of hospitalization and more expensive crisis care. When public and private insurers do not adequately cover primary and preventive care, physicians and other health care providers may be encouraged to prescribe more aggressive forms of care than are necessary. Pediatricians and family physicians who provide basic preventive and primary care for families with children have been especially affected by insufficient Medicaid and private coverage payment rates.

• **Malpractice reform.** To reduce the rising costs of care that are attributable to the increasing volume of malpractice cases brought before the courts and the amounts of damages paid, the Commission urges the federal government to explore steps for reforming malpractice insurance and the judicial processes governing malpractice cases. In particular, the Commission urges the federal government to consider providing malpractice insurance subsidies to obstetricians and other physicians who serve high-risk pregnant women and children in inner cities and isolated rural communities.

• **Establishment of a national system of quality assurance.** To improve and extend health professionals' knowledge of appropriate and accepted diagnostic and treatment practices and help them use these practices more efficiently and effectively, the Commission recommends the establishment of a national quality assurance system. In the current health care system, physicians and other health care providers are

rewarded for the quantity of services they provide, not for the quality of care or the health outcomes of their patients. A national system of quality assurance would help ensure that patients, including children and pregnant women, get services they need and that are appropriate to their conditions. It would also help reduce the number of unnecessary tests, procedures, prescriptions, and surgeries that add to the spiraling cost of health care. Accordingly, a national effort to promote quality health care should include training for experts in quality measurement and enhancement; establishment of a national clearinghouse for information on quality improvement techniques (e.g., techniques for detecting and managing patterns of preventable complications); data collection and research to support the formulation and revision of clinical guidelines; and dissemination and technical assistance mechanisms to inform health care providers and help them incorporate emerging knowledge into accepted practice.

• **Expansion of managed care networks.** Managed care has different meanings to different people. Typically, these programs include payment and provider networks that are designed to contain costs by negotiating reduced fees with providers enrolled in their systems, linking consumers to specific groups of physicians, other health care providers, and hospitals; improving care by increasing families' access to health care providers; and monitoring providers more closely. High quality managed care systems select providers based on the quality and cost effectiveness of the care they provide. They combine efforts to efficiently diagnose health problems and treat them with incentives to provide only appropriate and necessary care. High quality managed care networks are organized to facilitate more patient-condition specific decision making, more effective coordination of health services, and compliance monitoring.

Many child health scholars and advocates are critics of managed care plans on the grounds that they can deny access to needed care as a cost saving measure. This is a special concern for low-income populations. These critics argue there is no data to show that managed care is effective or saves money for pregnant women and children. In light of these concerns, it is important that in structuring managed care systems for pregnant women and children the goal of cost containment is balanced with the goal of providing high quality care and access to a range of related services, especially for children with disabilities or other special health care problems.

A promising new concept for controlling health care costs is **managed competition.** Managed competition is an amalgamation of government regulation and free-market competition. The basic idea is to band employers and individuals into large health-insurance purchasing cooperatives and require health care providers—doctors, hospitals, insurance companies, and health maintenance organizations—to compete on price and quality to win their business. These purchasing cooperatives and corporations would act as benefits managers and administrators. Insurance companies, health maintenance organizations, and other health care provider networks would bid for their business. The cooperatives would have the leverage to negotiate favorable rates for their customers. The plan would require all employers to provide a standard package of benefits. Unemployed people could also buy insurance through their networks, and their coverage would be financed by general tax revenues. To bring further market pressures to keep health care costs down, managed competition would limit the tax deduction employers can take for employee benefits, thus encouraging employers to pay attention to price. It would also modify rules governing the exclusion of employer-paid

health benefits from personal income, thus encouraging employees to pay attention to the costs of care. Finally, a managed competition strategy would use the health insurance purchasing cooperatives and various other regulatory boards to monitor patient satisfaction, health care outcomes, and other measures of quality and efficiency in participating plans. This information would be made available to consumers to assist them in their selection of insurance coverage as well as to health plans and their providers to support their internal efforts to improve the quality of care.

The concept of managed competition has not been implemented nationwide in any country. In the United States there are only a few small-scale plans and none of these serves rural communities. Yet because it is expected to preserve quality and control costs without bureaucratic price controls, managed competition has sparked significant interest across the political spectrum and deserves serious consideration. As with other strategies for containing the rising costs of health care, however, managed competition must consciously recognize the special health care needs of pregnant women and children and ensure that they are not sacrificed or overlooked in efforts to achieve economies in health insurance coverage.

Some proponents of managed competition also advocate a **national limit on health care spending**. This approach in essence requires that a single sum of money (public and private) be allocated for all health expenditures nationally and that most providers function within prearranged fixed budgets. To be established by a national health care board made up of consumers and providers, global budgeting would impose a fundamental discipline on managed competition. As with other cost contain-

ment approaches, the health care needs of pregnant women and children must be given special consideration in the design of a managed competition system, especially in setting benefit, eligibility, and administrative requirements.

Expand Effective Health Care Programs for Underserved Populations

Recommendation

The National Commission on Children recommends that federal and state governments expand effective health care programs that provide services for underserved populations.

Implementation Steps

- Federal and state governments should increase funding for proven programs to improve health care for underserved areas and populations, including the National Health Service Corps, Community and Migrant Health Centers, the Maternal and Child Health Block Grant, and the Special Supplemental Food Program for Women, Infants, and Children (WIC).

- Federal and state governments should address the administrative complexity and reimbursement problems

that make it difficult for consumers and providers to coordinate needed health care for medically underserved pregnant women and children.

Discussion

Paying for health care is critical but not the only essential ingredient in health care reform. Unless services for pregnant women and children are available in their communities, health care will continue to be beyond their reach. In particular, minority children, low-income children, geographically isolated children, and children with poorly educated parents often have difficulty getting the health care they need. Their communities have too few physicians, clinics, and hospitals to meet their needs.

Expand Proven Programs

Several federal programs were established to extend health care services to those who are medically underserved. Despite a record of proven effectiveness, these programs are still not sufficiently funded to reach all the pregnant women and children who would significantly benefit from them. The federal government should support training programs and institutions that train health care professionals who will practice in medically underserved areas so that practitioners are located in geographic areas where they are badly needed.

The National Commission on Children recommends expanding four important programs that bring essential health and nutrition services and resources to underserved areas and populations:

• **The National Health Service Corps** is a federal scholarship and loan repayment program designed to help urban and rural communities with shortages of physicians, nurses, and other health professionals recruit and retain providers. In exchange for financial aid for their medical educations, health care professionals serve in underserved communities for a specified time following their training. The National Health Service Corps has been especially important in bringing obstetricians to many rural and inner-city communities. **Congressional efforts to revitalize the program should continue, and its funding should be incrementally increased annually by approximately $80 million to provide scholarships and loan repayments for approximately 1,100 additional physicians, dentists, nurses, and other health professionals.** If this happens, all medically underserved areas in the country will have an adequate pool of providers by the year 2000.

• **Community and Migrant Health Centers**, with support from the federal and state governments and third-party payers, have for 25 years provided preventive and primary care to people in medically underserved areas, especially areas with high rates of infant mortality. The 600 centers now operating do not begin to match the number of underserved areas, and in many cases the centers that do exist are too small and insufficiently funded to meet the needs of poor children with multiple health problems. **Over the next five years, Congress should appropriate sufficient funds to double the number of centers and substantially increase the capacity of existing facilities. This is estimated to require an additional $150 million annually.**

• **The Maternal and Child Health (MCH) Block Grant** supports thousands of local health departments and

other programs across the nation that provide basic and specialized health care to low-income pregnant women and children, including children who are severely ill and have special health needs. Congress authorized $686 million for the MCH Block Grant in 1989. **Congress should follow through and fund the program at its authorized level (approximately an additional $100 million annually). In addition, the states should direct a portion of additional new funding to supplement federal support.**

- **The Special Supplemental Food Program for Women, Infants, and Children (WIC)** provides highly nutritious food and nutrition education to low-income women who are pregnant or breast-feeding and to their children up to age five. Pregnant women who participate in the program are more likely to receive early regular prenatal care and their children are more likely to get regular pediatric care and immunizations. Despite its demonstrated success, the WIC program has never been fully funded. It currently serves an estimated 4 million pregnant women and young children of an eligible population of 7 million.[6] **Congress should sufficiently fund the WIC program to provide nutritional support to all poor and nutritionally at-risk families who are eligible. This is estimated to require an additional $1 billion annually.**

Coordinate and Integrate Health Care Programs and Financing

Additional funding is critically important but not all that is necessary. The administrative tangle of multiple programs and sources of funding creates its own barrier to care and contributes to costly inefficiencies. Better coordination and integration of these programs are needed to provide health care to underserved populations effectively. Several steps are required:

Federal and state governments should work together to simplify the administrative procedures and requirements associated with enrollment and participation in health care programs for underserved populations. The goal of drawing more pregnant women and children into the health care system is often thwarted by complex and bureaucratic application and eligibility processes. **To the extent possible, eligibility criteria across federal means-tested health and welfare programs should be uniform, and application processes should be streamlined.** Enrollment forms should be brief. They should be written in several languages, require minimum documentation, and be available in a wide variety of accessible locations—such as private physicians' offices, WIC clinics, hospital outpatient clinics, and Head Start programs—to enable families to get the services they need with a minimum hassle. Uniform eligibility and a consolidated application process could significantly reduce the time, expense, and paperwork associated with repeated determinations of the same family's eligibility for several programs.

Congress and the executive branch have already taken a first step in consolidating applications for some of the major means-tested federal programs. As required by Congress, the Departments of Agriculture and of Health and Human Services issued a four-page model application for Medicaid, WIC, Head Start, MCH Block Grant programs, Community and Migrant Health Centers, and health care programs for the homeless. This application covers the major health and social service programs for pregnant women and children under age six.

States should use the model consolidated application for maternal and child health services as a tool for streamlining applications for health services and other forms of public assistance. Several states have already taken deci-

sive steps to simplify procedures for Medicaid eligibility determination, most notably South Carolina, which reduced its form from 45 to 4 pages; Mississippi, which reduced its from 17 to 2 pages; and Louisiana and North Carolina, which reduced theirs from 16 to 4 pages. Other states are working to develop a single form that can accommodate the eligibility requirements of several programs. Texas, for example, developed a screening tool for caseworkers and a shortened bilingual eligibility form for their clients that covers eight programs. Fourteen other states are in the process of creating joint eligibility forms for Medicaid, WIC, and MCH Block Grant programs.

Several other specific steps should be taken to streamline administrative processes and ensure that low-income Medicaid-eligible pregnant women and children receive health care[7]:

- **Establish a single point of entry and eligibility determination for all publicly funded programs.**

- **Implement an integrated computer system to provide easy access and information and to prevent duplicate services.**

- **Provide presumptive eligibility for 45 days until eligibility determination is completed.**

- **Extend eligibility to infants through congressional approval of infant coverage on the mother's Medicaid card.**

- **Station eligibility workers in community institutions outside the public health and welfare departments to make benefits more accessible to patients.**

In addition, **connections between the WIC program and other components of the health care system need strengthening.** Where WIC clinics are not located in community or migrant health centers or other local public health facilities, efforts should be made to link these facilities more closely. For example, low-income pregnant women, infants, and children visiting public health clinics who are not enrolled in the WIC program could be scheduled for WIC appointments. Similarly, those attending WIC clinics who have no source of prenatal care or pediatric care could be given appointments at local health care centers.[8] Extending and strengthening these kinds of ties between programs and providers are essential for improving health care for underserved populations.

Federal and state governments should take steps to be certain that services provided through health care programs aimed at underserved populations are fully integrated with new and existing public and private health care financing systems. The complexity and administrative burdens related to reimbursements (especially for Medicaid) have discouraged many health care providers from accepting low-income patients and have diluted the effectiveness and reach of other programs for the medically underserved. Among the most common problems are difficulty in determining whether a patient is eligible for coverage, restrictions on the types of services covered, extensive delays in paying claims, delays in receiving precertification approvals, and unwieldy claims processing.[9] Several states are beginning to develop mechanisms for addressing these problems, including training programs for administrative staff concerning policies and procedures, hotlines to resolve reimbursement problems, and visits to providers by representatives

of various payment plans to explain procedures and provide technical assistance. **Nationwide, states should establish a continuing administrative body to review, assess, and improve administrative and reimbursement problems experienced by providers under both public and private plans.**

Medicaid presents a special challenge because increasingly it is a program with double roles. Traditionally, it has been an insurance-like program with all the natural tendencies of any third-party payor to strive for efficiency and economically administered services. However, the program is currently also the central financial underpinning of the public health system. Indeed, it is the only publicly financed health program for the poor whose funding is structured as a mandated entitlement. Over the past decade, millions of previously uninsured pregnant women and children served by grant-supported public health providers have gained Medicaid coverage. Therefore, Medicaid should be increasingly available to these providers as a source of financing for their services. Yet these providers face numerous constraints in adapting to this new third-party financing system. As Medicaid moves in the direction of becoming a closed system of managed-care arrangements, public providers who are not part of such systems will be excluded. And even those who do join managed-care networks may suffer from more stringent funding limitations as Medicaid programs further limit their reimbursement levels and provisions.[10]

In the continuing debate over comprehensive health care reform, special attention to the needs of poor, underserved pregnant women and children is critically important. **Health care providers who serve Medicaid-eli-**

gible populations should be encouraged to become part of managed-care networks. However, reimbursement rates need to be sufficient to cover the costs of providing services to this population regardless of whether they are provided through managed-care networks or unmanaged arrangements.

Improve the Delivery of Health Care

Recommendation

The National Commission on Children recommends that health care professionals work with professionals from other disciplines to improve the quality and comprehensiveness of health and social services, participate in publicly funded programs, and serve their communities as volunteers and resource persons.

Implementation Steps

- Federal and state governments, in partnership with local health care providers, should take steps to reduce barriers in the service delivery system that often prevent or discourage pregnant women and children from receiving essential health care.

- Communities should support special projects to provide access to health care for families and children who lack a regular and continuing relationship with health care providers.

- Community-based health care providers and programs should work to develop a comprehensive approach to health care delivery for pregnant women and children.

- Federal and state governments should support demonstrations and provide financial incentives for innovative comprehensive health care service delivery at the local level.

Discussion

Even when health care is available and families have a way to pay for it, services that are fragmented, difficult to reach, impersonally provided, or poorly explained will often not be used. They may need to be offered repeatedly before they are accepted. When this happens, providers are spread too thin, recipients are often discouraged and disillusioned, and society bears the double burden of lost human resources and expensive care. Therefore, establishing services or funding programs is not enough. It is necessary to design them so that services and programs are attractive and useful to the parents and children they are intended to help.[11]

Overcome Barriers to Service Delivery

Numerous barriers stand between some families—especially minorities, low-income and homeless families, migrants, geographically isolated families, and families in which parents are poorly educated or non-English speak-

ing—and the health care they need. If families lack transportation to get to a health clinic, they may not go for routine care. If clinic hours conflict with work schedules, parents cannot take advantage of services that are available to them and their children. If language barriers prevent them from communicating with health care providers or the clinic setting seems unfriendly and intimidating, or if a comprehensive physical examination is required before "free" services can be provided, many parents and children will forego services. When stressed and drained by the pressures of managing daily life in a hostile and disadvantaged environment, getting to a doctor or other health care provider may not seem a high priority for pregnant women who are not experiencing any immediate problems or for parents whose children are not noticeably ill. **Making health care available is not enough for many families, if the service delivery system does not accommodate their needs and circumstances.**

Building bridges between families and services and between programs themselves can be done in several ways:

• **Provide transportation to and from health care providers and facilities.** Offering transportation to and from clinics and doctors' offices is one of the most important ways of encouraging high-risk pregnant women to obtain prenatal care and encouraging parents to seek regular preventive care for their children. Many jurisdictions provide transportation through public and private partnerships. Approaches include seeking donations for purchasing vans and paying drivers, developing a volunteer corps of drivers, protecting volunteers from liability, and encouraging community groups, including religious institutions, to enlist and organize ride-giving services. Other jurisdictions distribute bus tokens or reimburse mileage for bus and taxi travel.[12]

• **Offer expanded or flex-time hours of operation at publicly funded health clinics.** Extending the hours of operation and enabling health care providers to see patients in the evening and on weekends at publicly funded health clinics can make health care much more accessible to low-income families with working parents. Several states, including Florida, have mandated evening and weekend services for primary care programs. Others are conducting pilot projects using extended hours for specific services including family planning and immunizations.[13]

• **Locate outreach programs and services at schools, churches, and other sites easily accessible to families with children.** In an effort to put health care services within easy reach of women and children and thereby increase their use of basic care, jurisdictions are beginning to locate outreach programs and clinics at schools, churches, and other sites that are familiar and easily accessible to families with children. In rural West Virginia, for example, EPSDT screening, as well as the WIC program and Medicaid visits to children are done by outreach workers in the community rather than in urban hospitals and public health clinics.[14]

• **Offer child care services at clinics and other health care facilities.** Parents may have difficulty keeping clinic appointments for themselves or their children when they have no one to care for their other children. In response, some clinics are beginning to offer on-site child care services during health care visits. In Alabama, for example, new county health clinics include space designed as a play area. Some hospital-based clinics and older facilities have converted a room for child care with staff available.[15]

• **Provide specialized assistance to parents who have low-literacy skills or for whom English is a second language.** For parents who have difficulty reading or communicating in English, dealing with clinic staff and filling out the required paperwork is daunting. Recognizing that these are significant barriers to obtaining necessary health care, some jurisdictions are staffing clinics with personnel who are multilingual and are providing literature and forms translated into other languages. In addition, several states are beginning to provide printed materials in low-literacy English and Spanish. Delaware, for example, furnishes "pictorial materials" with "easy reading" text.[16]

Implement Projects to Provide Access to Health Care

Ensuring that all pregnant women and children have access to health care services is essential. Unless the services they need are available in their communities, health care will continue to be beyond the reach of many. Prevention services as well as management of acute health problems and chronic conditions are more likely to occur when families have an ongoing and continuous source of medical care. However, **many families who lack a regular source of health care do not receive essential services unless their communities establish special outreach projects, and help them navigate the complicated health care bureaucracy.**

Home visiting is one community-oriented strategy that links families, especially those who are stressed and isolated, to needed health care services; and states and communities should mobilize the necessary resources to expand these programs. These programs send trained lay workers and professionals, including nurses, social

workers, and therapists, into homes to support, assist, counsel, and educate families concerning the care of their children. Although home visiting is not a cure-all for helping mothers and children become and remain healthy, it can be effective when part of a comprehensive effort to link parents and children to health care and related supports and services. These programs work best in areas where health and social service agencies communicate with one another; where services exist to care for pregnant women and children; where parents and children, as well as extended family members, are encouraged to seek care; and where there is a concentrated effort to attend to the multiple needs of vulnerable families.[17]

To be successful, home visiting programs need to

- Define goals, objectives, and target populations clearly;

- Select workers carefully and emphasize ongoing training, supervision, and support of home visitors;

- Have a strong community focus and legitimacy so that goals match the community needs, and they can be active partners with other community-based programs and health care providers;

- Address the needs of families on a case-by-case basis in ways that are culturally sensitive and appropriately responsive; and

- Have sufficient time and financial resources to establish trusting relationships with the families they serve and to maintain those relationships over a period of years.[18]

One successful home visiting program that has been implemented statewide is Hawaii's Healthy Start program aimed at preventing child abuse and neglect. More than half of parents of newborns in the state receive services. Families are voluntarily screened to identify factors associated with child abuse. Those considered at risk can receive the services of a home visitor who helps the family gain access to regular health care, offers information on child development, conducts developmental assessments of the child, and links the family to other social services. Although the program is universally available, it primarily serves a high-risk population that includes low-income families receiving welfare and those with a history of substance abuse or family violence.[19]

Communities with large populations of high-risk pregnant women and new mothers should develop and support resource mother programs to link vulnerable families to essential health and social services. Related to home visiting programs, resource mother programs pair women experienced and trained in pregnancy care and parenting skills with young pregnant women and young mothers to provide support, information, links to prenatal care, parenting education, and other health and social services. The goal of these programs is to improve birth outcomes among high-risk pregnant women and to help them finish school and become responsible, caring parents. Resource mothers are typically lay health workers living in communities with high rates of low birthweight and infant mortality. They reflect the ethnic, cultural, linguistic, and socioeconomic backgrounds of the families they serve. Resource mothers serve as counselors, case managers, and mentors to pregnant teens, teenage mothers, and other high-risk pregnant women and mothers with infants. Many successful resource mother programs have been launched in communities

nationwide. Typically these programs depend on funds available through the MCH Block Grant, local public health social service funds, private grants, and donated professional services.[20]

Public health agencies, in partnership with private health care providers and philanthropic groups, should expand mobile health care programs to reach pregnant women and children who have no other regular source of health care. Mobile health care facilities have begun to be used across the country to take health care to low-income and homeless families in inner-city neighborhoods and isolated rural communities. The Children's Health Fund, for example, operates mobile clinics for homeless and medically underserved children in New York City and several rural communities in Appalachia and the South in an effort to promote full access to needed care. Vans take comprehensive health care services to children in welfare hotels and poor neighborhoods as well as rural communities. They operate as outreach projects of major hospital pediatric departments. Their services include preventive care, childhood immunizations, care or coordination of care for chronic and acute health problems, anticipatory guidance, screening procedures, hospitalization, and specialty referral as necessary. The vans are scheduled so that parents and children can depend on having ready access to the clinic services at regularly appointed times. All medical data and case information are managed and coordinated on a computer-based system. Special outreach and follow-up teams coordinate appointments for children who need specialty care and provide transportation to doctors and hospitals for families who need it. Launched with the generous support of private donations, these mobile health care projects are funded by a combination of federal grants and Medicaid fee reimbursements as well as private sector support.

Integrate Health Care Delivery Systems

Many high-risk pregnant women and children need an array of health and social services—including mental health, counseling, substance abuse treatment, family planning, and legal services. Their multiple needs can rarely be addressed by a single health care provider or form of treatment. This is especially true of children with chronic and disabling conditions, who often require multiple services from different providers working in different locations and facilities.[21] When poor, socially isolated families have children with special needs, the prospect of arranging the care and services those children require can be overwhelming. Their problems are compounded because medical and social services are generally fragmented and poorly coordinated. The system of public health care often resembles an obstacle course rather than a safety net. It is not unusual for parents to be required to make appointments and take their children to see providers in different clinics and agencies that are located miles apart. It is also not unusual for these professionals to give conflicting advice, since they rarely communicate with one another about their diagnoses and treatment plans.

A comprehensive approach to the delivery of health services can improve coordination among providers, expand social support (through case management), and increase the likelihood that families will get the services they need. When high-risk families can go to one site or receive guidance from a single case manager, pregnant women and children are more likely to receive the support and services they need. One of the most important characteristics of many models of effective comprehensive care programs is that they seek simultaneously to meet the immediate health needs of the mothers and children they serve and to alleviate the stress and other

problems in their home environments that adversely affect health. Services for community outreach, for clinic transportation, and for connecting people with social services are not traditionally part of medical care, but they can make the difference between whether high-risk families and children have minimal care and whether they have the resources to improve unhealthy behavior. Therefore, "one-stop shopping" centers for health care represent promising models.[22] Typically, they provide basic maternal and child health services, outreach, a Medicaid-eligibility worker on site, dietary counseling, special food vouchers, a high-risk pregnancy management team (consisting of a social worker, a nutritionist, and a health educator), home safety assessments, and links to other health and social services in the community. Different program models work better in different places, yet services should be structured and delivered so that they effectively meet the multiple needs of the families they serve. Among those programs that have been especially effective are:

- The Jackson-Hinds Comprehensive Health Center in Hinds County, Mississippi, provides a full range of services, including preventive maternal and child health care, acute medical and dental care, health education, family planning, and counseling. Services are available on a sliding fee basis. Funded as a facility under the federal Community and Migrant Health Centers program, the center began in the Sunday school classrooms of a Jackson, Mississippi, church. The center's top priorities are reducing infant mortality and teen pregnancy, and it serves patients at the main center and through satellite health centers located in high schools, junior high schools, and an elementary school in other parts of the county. Transportation services are provided to enable rural residents to use the clinic services.

• South Cove Community Health Center in Boston, Massachusetts, provides a comprehensive array of multilingual health education and health services for pregnant women and children, as well as life skills education for clients who are unfamiliar with American society and the community. The center serves many first generation Asian families whose culture and customs are very different, especially those related to pregnancy, prenatal care, labor and delivery, and family planning. Multilingual staff reach out to families in the community through home visits and offer assistance in linking families to other community-based sources of social support and services.[23]

Encourage Local Innovation in Service Delivery

Communities are better suited than states or the federal government to develop and implement effective programs to meet the health needs of their children and families. But communities—especially poor communities—cannot do the job alone. The federal government and the states need to contribute at least some of the necessary financial resources, provide technical assistance, disseminate information about promising approaches, and hold communities accountable for their investment of public funds.

In an effort to expand, develop, and adapt potentially effective models for serving high-risk pregnant women and children, the federal and state governments need to support demonstrations and provide financial incentives for innovative comprehensive service delivery at the community level. Essential elements of these demonstrations should be reducing or eliminating bureaucratic hurdles and overcoming organizational and professional barriers that prevent a comprehensive approach to

health care delivery. Equally important is working closely with parents in designing and implementing strategies to improve children's health and to meet their health care needs. In addition, funding for demonstrations should be accompanied by other measures to facilitate administrative innovation, in particular waivers of burdensome program regulations. For example, to test innovative service delivery strategies in several communities as a basis for deciding whether to implement them statewide, several states have requested that the Department of Health and Human Services waive Medicaid funding requirements that states provide all optional services statewide. Such waivers enhance flexibility and provide opportunities for testing new concepts and assessing their effectiveness at a relatively low cost.

Reinforce Parental Responsibility

Recommendation

The National Commission on Children recommends that parents protect their children's health by protecting their own health and being role models for healthful behavior, by doing everything in their power to provide a safe home environment, and by seeking essential health services for their children.

Implementation Steps

- Pregnant women need to protect their own health during pregnancy to reduce the risk of poor birth outcomes and enhance the likelihood that their children will have a healthy start in life.

- Parents need to understand how children grow and develop and how to foster healthy physical, social, and emotional development throughout childhood.

- Parents need to foster attitudes and behaviors that are consistent with good health and serve as role models for healthful life-styles.

- Parents need to protect their children from environmental hazards and physical abuse in their homes.

- Parents need to seek necessary preventive and acute health care services for their children.

Discussion

Parents play a critical role in protecting their children and promoting healthful development from before birth through adolescence. Parents' choices have a significant impact on whether their children get a healthful start in life, whether their youngsters' basic health needs are met, and whether children will adopt attitudes and behaviors that promote good health and prevent the risk of disease throughout life.

Pregnant women need to recognize the importance of maintaining healthful life-styles, getting proper nutrition, and avoiding harmful substances (including alcohol, tobacco, and legal and illegal drugs). In addition, they must obtain adequate prenatal care, beginning early and continuing throughout pregnancy, to monitor their health and help avoid complications that lead to poor birth outcomes, including low birthweight and infant mortality. A mother's responsibility begins before her child's birth, because her own health and behavior during pregnancy are fundamental to the health of her unborn child. Information on how to foster a healthful pregnancy and

prepare for childbirth is available in many communities from physicians and other prenatal health care providers, public health departments, private clinics, and employers, as well as public and private agencies and organizations that serve families. Some communities even provide toll-free numbers that pregnant women can call for information and to schedule appointments for prenatal care. To make wise decisions about life-style and prenatal health care, prospective parents—both mothers and fathers—need to know what to expect during pregnancy and how to do everything possible to have a healthy baby.

Parents need to understand how children grow and develop and how to foster good health and development. Throughout childhood parents are responsible for ensuring that youngsters have an adequate healthful diet, that they get enough sleep and exercise, and that they are protected from disease and health problems that result from poor hygiene and unsafe health practices.

There are many ways in which parents can actively promote their children's good health—physical, social and emotional—beginning at birth. Yet unless they understand how children grow and develop and how to foster good health and development, many parents will find it difficult to meet their children's basic needs effectively. Healthy child development depends to a great extent on whether parents and children have supportive, loving, and stimulating relationships. To develop such relationships, parents need unhurried time with their children and support that enhances their own feelings of competence and confidence.

All parents need social networks of family, friends, and community that provide the concrete emotional assistance essential to family well-being. Some need more

outside help than others. Many young parents of first children, who have had no previous experience caring for an infant or young child, are uncertain how to respond to normal as well as more difficult situations. Parenting education is one important way for young people to acquire basic knowledge and skills. Family resource programs in many communities also assist parents in understanding their children's needs and the responsibilities of child-rearing. Where these supports and services are available, parents should take advantage of them.

The National Health/Education Consortium has developed educational materials for parents-to-be and parents of preschool and school-age children. Called "Help Me Learn, Help Me Grow," the project informs parents about the relationship between children's health and their learning potential. Materials available through the program present suggestions and specific actions for parents and prospective parents to improve their children's learning potential by improving their health. Video "infomercials," posters, pamphlets, and other materials are available in both English and Spanish to address the needs of parents from diverse cultural and language groups, as well as those in different socioeconomic circumstances and at different educational levels.[24]

Parents have a responsibility to help children learn about good health practices and make choices that promote good health and reduce the risks of accidents and disease from the time their children are very young. Children form attitudes about health and behavior based on their parents' behavior. There are many ways in which parents' behavior directly and indirectly affects children's attitudes and behavior—what and how much they eat, their activity levels and choices about physical exercise,

their sleep patterns, and their use of tobacco, alcohol, and other substances. For example, parents who smoke at home not only expose their children to the hazards of passive smoking, but their children are more likely to view smoking as an acceptable behavior and to experiment with tobacco use at young ages. Reducing the initiation of cigarette smoking by children and youth is an important health priority identified by the Surgeon General and the American Medical Association. One of the most important strategies for achieving this goal is for parents to be good role models and encourage their children to avoid smoking.

During adolescence, young people become increasingly responsible for their own behavior. Yet parents continue to have an important role in guiding their children toward wise choices and monitoring their actions to help avoid problems that can have devastating short- and long-term health consequences, including premature and unprotected sexual activity, smoking, alcohol and drug use, and violent or delinquent behavior.

Parents need to protect their children from environmental hazards and from physical abuse in their own homes, as well as from accidents and injuries outside their homes. Parents should not leave their young children unattended. They should provide safe toys, use car seats, and install smoke detectors and other safety precautions (including cabinet locks, electrical outlet covers, and physical barriers to stairways and unsafe areas). To the best of their ability, they should also ensure that their homes are free of lead and other toxic substances and that hazardous materials are kept out of the reach of young children.

Information about how to create safe environments for children is available from a variety of national sources, including the Consumer Product Safety Commission, the National Highway Traffic Safety Administration, and the Centers for Disease Control, as well as community groups. The National Safe Kids Campaign was established in 1987 to build a nationwide coalition of community groups to disseminate information to parents and others about preventable injury and to raise awareness of how best to protect children. Through the campaign, local community groups distribute a variety of booklets and pamphlets and launch public advertising campaigns, seminars, and toll-free numbers to present information on selecting appropriate toys, the proper use of child safety seats in automobiles, burn prevention and fire safety, drowning prevention, bike helmets and bike safety, and protecting young children from injuries at home. Parents need to take advantage of environmental health and safety information that is readily available to them and use it in their daily lives.

Finally, parents must ensure that their children receive adequate health care throughout childhood and adolescence, including regular medical and dental checkups; appropriate health screening, immunizations, and health risk counseling; as well as timely treatment for acute health problems. The American College of Obstetricians and Gynecologists has developed guidelines for activities during pregnancy; prenatal health care and monitoring, including diet, exercise, sleep, work, and travel; and a schedule for prenatal visits and screenings. Similarly, the American Academy of Pediatrics has developed basic guidelines for well-child care, health screening, and immunizations. Parents need to be informed about these guidelines for preventive and acute care, and they need to feel empowered to take advantage of services that are available to them in their communities.

Increase Community Support

Recommendation

The National Commission on Children recommends that communities take responsibility for creating safe neighborhoods, for supporting the development of community-based health education and health care programs, and for sponsoring activities and special projects to help families gain access to needed services.

Implementation Steps

- Communities should provide safe neighborhood environments for families with children and promote an atmosphere that does not tolerate violence.

- Communities should sponsor health education and community-based health services for parents and children to foster healthful behavior and ensure that basic health care is available to all families.

- The media should play an active and constructive role in communicating health promotion messages, both in regular programming and in special media campaigns aimed at influencing health behavior.

Discussion

The choices that individuals make have a significant influence on health status and outcomes. However, individuals do not make choices in a vacuum. The social context in which parents and children live significantly affects their ability to make wise decisions and protect the health of all family members. Parents need to be motivated to promote good health at home, but motivation is not just a matter of convenience. It is shaped by their living conditions—for example, exposure to environmental hazards, violence, and crime—as well as by dominant cultural attitudes, values, and expectations. **To live up to their responsibilities for promoting and protecting children's health, parents need support from their communities.**

Create Safe Neighborhoods

In recent years, crime and violence have become epidemic in most inner-city neighborhoods. Injuries and deaths resulting from violence have become enormous public health problems nationwide. Stories of young

children who are the unintended victims of random shootings on playgrounds, on their neighborhood streets, and even in their homes are common fare on the evening news. So are incidents of older children, especially poor, inner-city teenage boys, who are the victims and the perpetrators of vicious assaults and killings. In a recent opinion survey, parents, especially minority parents, indicated that they "worry a lot" about their children being shot, being harmed by someone on drugs, being beaten up, and being raped or sexually molested.[25] Most violence occurs between people who know one another. Indeed, a disproportionate number of assaults and murders occur between family members. However, a substantial portion of violent attacks are between strangers in situations where the perpetrator has a weapon and is willing to harass or even kill a defenseless victim. This is especially true in low-income urban communities.[26]

Communities have a basic responsibility to protect all their residents and to create and maintain safe neighborhood environments. Across the country, public officials, professionals who work with children, and parents are searching for new approaches to make their streets and playgrounds safer places and to reduce the rapidly rising number of young people who are arrested and jailed for committing violent crimes.

Communities should combine law enforcement efforts to apprehend and punish those who commit crimes with sensitive aftercare and rehabilitation programs for youthful offenders. In recent years many states and communities have adopted stiffer penalties for violence involving handguns or other firearms. These policies have been shown to have a small but positive effect on gun-related homicide rates. However, their potential effectiveness

has sometimes been diluted by judicial policies and practices that result in conviction on reduced charges or reduced sentences.[27]

The Justice Department's "Weed and Seed" program was initiated recently to prevent delinquency and to reduce juvenile involvement in chronic, serious, and violent crime. It is intended as a comprehensive, multiagency approach to local law enforcement and community revitalization that first weeds out violent criminals and drug traffickers from targeted high-crime neighborhoods and housing developments and then seeds the community by providing prevention, intervention, and treatment services along with broad economic opportunities. An underlying premise of the program is that juvenile offenders must be held accountable for their actions, that the sanctions must fit the offense, and that as the severity of sanctions increases so must the intensity of treatment and rehabilitation efforts. **Aftercare that provides intensive supervision to ensure public safety and services that develop individual competence and help prepare young people for reintegration into their communities should be critical components of incarceration and all residential placements.** To receive support through the program, communities must

- Assess criminal activity, including juvenile criminal activity, within the community and identify target areas of high juvenile crime;

- Assess the adequacy of youth activities, education opportunities, and prevention and intervention services;

- Establish a multiagency youth services subcommittee as a part of an overall community "seed" steering committee;

- Sign a memorandum of agreement between appropriate agencies and organizations to contribute resources and to work together with juvenile justice agencies, social service agencies, and community groups; and

- Develop a community implementation plan.

To be effective, law enforcement efforts must be balanced with community revitalization and investment. In its early phases, much of the emphasis of the Weed and Seed program has been on law enforcement. Over the coming several years, communities need to give equal emphasis to rebuilding their economic and human services infrastructures and providing meaningful supports for reintegrating youthful offenders into the social and economic mainstream.

Communities should regulate the use of firearms. Many cities and states restrict the presence or use of guns. Some prohibit carrying concealed weapons within city limits, for example, or brandishing firearms in a threatening manner, or firing a gun in public places. Studies of these kinds of restrictions show they have led to modest reductions in gun-related homicides and assaults. Their effect is significantly influenced by the strength of enforcement efforts. In addition, both federal law and laws in many states prohibit some high-risk groups from owning guns or other specified types of weapons—among them youth, convicted felons, alcoholics, drug abusers, or individuals adjudicated to be mentally ill. At present, however, the determination whether a prospective buyer is a member of one of these high-risk groups depends entirely on information provided by the person buying the gun. There is no external verification requirement or procedural check. Also, federal law applies only to sales by federally licensed firearm dealers,

and as many as two thirds of all gun sales are by nonfederally licensed dealers.[28] Communities should examine their policies governing the use and licensing of firearms to reduce the epidemic of gun-related crimes that result in serious injury and death.

Although regulating the manufacture and sale of guns has met with great resistance in the United States, **the federal and state governments should examine the feasibility of limiting the availability of some classes of weapons**. Machine guns and criminal-use weapons cannot be manufactured for sale to the public. However, with these exceptions, there are no mandatory standards addressing the design, quality, type, or number of guns manufactured in this country for civilian use. In addition, no federal agency with a mandate to protect the public's health has jurisdiction over firearms.[29] The federal and state governments should reexamine their policies concerning the manufacture and sale of guns for civilian use.

Communities should launch efforts to discourage violence as joint initiatives of citizens' groups, public agencies, and private community institutions. As crime has risen in recent years, especially among youth, many communities have begun to initiate efforts to unite citizens groups, community institutions, and public agencies to prevent crime and violence. These activities vary widely from one community to another, depending on the problems and needs of neighborhood residents. They include well-lit streets, neighborhood patrols, adults who monitor the behavior of young people in their neighborhoods, and a shared willingness to expose and condemn peers who break the code of peace. Community service and recreational activities, such as midnight basketball, that offer young people appealing alternative activities

have also begun to develop and should be expanded. Such strategies have shown promise in reducing violent crime in some communities.

One approach that has gained popularity in recent years is **community policing,** which involves the police in proactive crime prevention rather than simply responding to calls after crimes have been committed. Community policing is anchored in the concept of shared responsibility for community safety and security between residents and the police. Programs take different forms in different communities, depending on the needs of the community, the political power of citizens' groups, and the extent of police resources. In general, however, community policing encourages police officers to be more directly engaged with their communities so that they can be more responsive to problems, and it decentralizes police operations to give officers greater familiarity with the specific needs and workings of a neighborhood and its residents. Model community policing programs have been launched in Seattle, Washington; Madison, Wisconsin; Houston, Texas; and New York City. Significant elements of these programs include

- Increasing foot patrols;
- Creating a visible police presence at community meetings;
- Opening storefront police offices; and
- Developing youth intervention programs jointly with the Department of Human Resources, the schools, and community voluntary agencies.[30]

Community-based public health agencies and private groups (including schools, churches, police departments,

and public health departments) should implement violence prevention education to complement more traditional crime reduction approaches. For many young people violence is a learned response to the stressful and often dangerous conditions of their lives. Therefore, violence prevention programs can help individual young people develop attitudes and patterns of behavior that enable them to modify their responses to anger and resolve conflicts without resorting to violence. At the community level such education must be combined with outreach and public education to change community attitudes and beliefs about violent behavior and its roots. Some effective programs already in place include

- Boston's Violence Prevention Project, a community-based primary prevention effort to change individual behavior and community attitudes about violence, has developed a curriculum that is being taught throughout the Boston public schools;[31]

- The Kansas City Project, which provides training in conflict resolution and anger control skills to violent young people;[32]

- The Coalition for Alternatives to Violence and Abuse in Contra Costa County, California, a coalition of community agencies, coordinates a community-wide violence prevention campaign, including a media campaign, violence prevention education, and alternative activities for young people at risk of becoming involved in crime;[33] and

- The Paramount Plan, in Paramount, California, combines a gang prevention curriculum, a school follow-up program, and parent community awareness meetings.[34]

Increase Community-Based Health Education and Health Services

The ability to make informed decisions plays a significant role in personal health behavior. To make wise choices, children and their parents need information on health risks, their consequences, and how to avoid them, as well as on ways to promote good health. Several factors are of overarching importance in the success of community-based health programs:

The first is the ability of programs to use marketing strategies to "target" messages to specific audiences. To effectively reach parents and children in different socioeconomic and cultural groups, especially minorities, requires that the messages and the messengers take account of the attitudes, values, and experiences of the people they are seeking to convince. In many cases minority communities are exposed to the same general health information that is aimed at the rest of the population—for example, antismoking messages, emphasis on diet and fitness, and concerns about substance abuse. However, the effect of these generic messages on minority populations is likely to be minimal unless they are reinforced by more specific ones that are perceived to be personally relevant to minority parents and children.[35] Just as the advertising industry has understood the importance of segmenting markets and tailoring product messages and their formats, the health community should pay attention to socioeconomic and cultural variations in their audiences when delivering health promotion messages.

In trying to reach some populations, particularly low-income urban communities, it is important to craft health promotion messages in ways that are pragmatic rather than morally judgmental. Most Americans value

self-reliance and place substantial responsibility for life choices on individuals. Nevertheless, messages aimed at preventing the destructive behaviors that are prevalent in poor inner-city populations—such as teenage pregnancy, drug use during pregnancy, interpersonal violence, and poor compliance with preventive health regimens—are likely to be more effective if they emphasize practical health benefits and social acceptability rather than moral condemnation.[36] Abstinence, for example, is the most effective strategy for avoiding an untimely or unintended pregnancy and for preventing the spread of sexually transmitted diseases, including HIV infection. Emphasizing the health benefits of abstinence, especially if the message is delivered by a credible source—such as basketball star Magic Johnson—is more convincing to some young people than highlighting moral concerns about sexual activity outside marriage.

Another critical factor in the success of community-based health education and health care programs is achieving community legitimacy. Incorporating mechanisms that enable adults and children to accept the goals and content of a program help alleviate the alienation and mistrust that often greet new government-sponsored or majority-controlled initiatives. To be most effective and influential, health programs need to build "empowerment" into their designs. Among the best ways to do this are

- Using minority professionals in the planning and implementation of programs;

- Establishing program governing boards with memberships that represent the communities to be served; and

- Fully involving community representatives from the beginning of the program.

Health education programs are sponsored by many public and private agencies and organizations, and often are linked to community-based health services.

Comprehensive health education programs in schools (grades kindergarten through 12) provide an important avenue for helping children learn how to develop healthful behaviors and how to avoid the risks and consequences of unhealthful behaviors such as smoking, alcohol and drug use, early unprotected sexual activity, and violence. These programs should begin in the early grades to help children understand how to promote their own health through proper diet, hygiene, and physical fitness. In the middle and high school grades, they should target messages about the risks and consequences of unhealthful behaviors, including smoking, alcohol and drug use, early unprotected sexual activity, and violence, and how to avoid them. Prevention programs should reach children before they begin experimenting with dangerous risk-taking behaviors and when they are receptive to learning resistance skills. They should also be aimed at creating a healthful environment in the school, for example, by banning smoking for students and adults, promoting physical fitness, serving nutritious food, and eliminating hazards to physical safety. In every community, parents should be involved in shaping these programs and should work together with school officials to implement them.

Among those specialized health education programs aimed at preventing risk taking among youth that have been particularly effective are

- Students Taught Awareness and Resistance (STAR), which was developed at the University of Southern California's Institute for Health Promotion and Disease Pre-

vention Research, combines classroom teaching with a larger strategy involving families, the media, and other community institutions and groups.[37]

• Teen Outreach Program (TOP), sponsored by the Association of Junior Leagues International, is a school-based life skills management and community service program for middle and high school students.[38]

A growing number of schools across the country are initiating comprehensive school health programs that combine health education with health services designed to prevent or identify and treat students' physical and mental health problems. **School-based health care facilities are a way of offering basic preventive and acute care to students (and in some cases their families) who otherwise lack access to services.** School-based clinics provide an array of services including health screenings and athletic physicals, preventive care such as immunizations, diagnosis and treatment of minor illnesses and injuries, nutrition and weight reduction counseling, drug and alcohol abuse education and counseling, family planning counseling and referral, prenatal and post-partum care, individual and family mental health counseling, and information and referral for specialized care. School-based clinics vary in the range of services they offer, in some cases because of the differing needs of their students and families and in other cases because of the availability of funding or state and local restrictions.[39]

Examples of effective school-based centers are to be found in communities across the country. Despite positive outcomes, particularly in serving young people who lack health insurance, these programs face serious obstacles: funding is scarce and often seems to fall between

education and health budgets. Rigorous evaluations of the costs and effectiveness of these programs are still in process. Perhaps most significantly, however, opponents who believe school-based health clinics encourage early sexual activity have been vocal, and as a result many centers refer students for contraceptive services rather than providing them on site. Nevertheless, these programs can be a very useful link between their own medically oriented purposes and the new educational mission of schools to help young people understand the elements of healthful lifestyles and how to make positive decisions that affect their health.[40]

Community-based health promotion programs should play a significant role in educating the public about health behavior risks and providing special health services. Community-based health programs sponsored by state and local public health departments, by business and labor groups, and by voluntary and religious organizations can also promote the health of children and their families. Community programs offer supports and services through both informal social groups and formal organized programs. Management, unions, and employee associations in many communities are sponsoring antismoking programs, prenatal care education, and other projects to improve the health of employees and their children. An increasing number of firms also offer wellness and employee assistance programs and host health promotion activities for their communities.

Breastfeeding is one important way to give children a healthy start, and community-based health education programs should play a significant role in educating parents about its benefits. Babies who are breast fed during the early months of life are usually healthier that those who are fed formula. They are more likely to receive

adequate nutrition and develop immunities to illnesses and allergies. Equally important, breastfeeding is a way to foster secure emotional attachments between mothers and their babies. Despite its clear health and cost benefits, however, breastfeeding is not widely practiced among some groups of mothers, especially poor and minority mothers, who are at greatest risk of having frail, undernourished, or unhealthy babies. Often hospital practices and health and nutrition programs do not encourage these mothers to breast feed their babies nor do they support them in their decision to do so. For example, hospitals are more likely to discharge mothers with complementary packages of infant formula provided by manufacturers, than to counsel mothers about the benefits of breastfeeding and help them get started.

Similarly, the WIC program distributes directly or provides vouchers for infant formula to low-income mothers. This is an extremely important aspect of the program, which is aimed at improving the nutritional status of pregnant and post-partum women, infants, and children up to age five who are at nutritional risk. But many observers worry that unless the distribution of formula is balanced with efforts to promote breastfeeding, low-income and minority mothers will be dissuaded from this practice, which has clear health benefits. Recently, the Food and Nutrition Service in the Department of Agriculture, the agency that administers the WIC program, has made breastfeeding a priority. It is now providing training and technical assistance to local programs to help them educate expectant mothers about the benefits of breastfeeding. In addition, community institutions that offer prenatal care and parenting education and those that house WIC programs should also devote more time and attention to promoting breastfeeding.

Voluntary organizations, including those that offer programs for youth, should expand their missions to include community health education. Many organizations serving young people are continuing or beginning to work closely with health professionals and organizations to discourage risk-taking behaviors common in adolescence and to promote healthful life-styles. Mentoring programs and efforts to build strong one-to-one relationships between responsible adults and young people can be especially effective for helping youth develop positive attitudes and healthful behaviors. Among high-risk youth, the most important message is one of hope—helping them understand that preserving their future is worth the immediate sacrifice of avoiding behaviors that compromise their health and safety. Effective community programs for youth must see themselves as partners with families, schools, and other community institutions that serve young people and their families. Among those programs that have developed promising models are

- The Boys and Girls Clubs of America's Smart Moves initiative is a substance abuse prevention curriculum designed specifically for very high-risk children. The comprehensive program works at the individual, family, and community level to change attitudes about alcohol and drugs through prevention classes as well as recreational, educational, and vocational activities.[41]

- The federal Office of Juvenile Justice and Delinquency Prevention sponsors a Gang/Drug Intervention Counseling service offered by the Nuestro Centro (Our Center) community-based service organization in Dallas, Texas. The project staff recruits at least 60 gang members to participate in an after-school counseling program focusing on personal development such as maintaining self-

control, setting personal goals, communicating without violence, building self-esteem, pursuing educational and career goals, and understanding the importance of healthful behaviors.[42]

Religious institutions should be actively involved in health education and health promotion efforts in their communities. Because of their visibility, credibility, and accessibility to the families they serve, these institutions are often in a unique position to deliver preventive health education and services to children and families in their communities who otherwise lack them. Many churches and synagogues make valuable contributions by sponsoring health fairs, establishing health-screening programs, offering individual and family counseling, and supporting adolescent substance abuse and pregnancy prevention efforts. In addition, religious institutions in some communities organize volunteers to provide transportation to help parents and children get to essential health services.

Use the Media to Promote Child Health

Every day children and their parents are exposed to countless media messages that affect their choices about health. Direct messages come from the news and documentary and public affairs programs. Indirect but no less powerful messages are communicated in advertising and network programming. These messages are not always benign. The National Commission on Children concluded that **communities should work to change the way in which national and local media portray violence, irresponsible sexual activity, and other behaviors that adversely affect health and safety.** Although the media are not the only or even the major cause of violence and risk taking among youth, they have a unique opportunity

and responsibility to help create a climate that values healthful behaviors.

In addition, **media campaigns can be effective long-term strategies for influencing attitudes and positively changing health-related behaviors. Broadcasters, producers, and television writers, as well as public health departments and health educators, should work together to use the mass media as effective vehicles for communicating health promotion messages.** In most cases, however, changes in attitudes and behavior do not occur overnight simply because health educators and advocates use the public airwaves to share information on the risks and consequences of unhealthful behaviors. To be successful, a media campaign must be targeted to a well-defined audience, and messages must build from the audience's preexisting needs and motives. Campaign messages aimed at preteens and adolescents, for example, should capitalize on important themes in the development of adolescent identity, including freedom, autonomy, and peer group acceptance. Organizers need to develop a long-term strategic plan that incorporates a series of clearly defined phases, including:

- Identify the health problem and establish it as a priority concern;
- Increase knowledge and change beliefs that impede the adoption of health-promoting attitudes and behaviors;
- Motivate change by demonstrating the personal and social benefits of the desired behavior;
- Teach new behavioral skills;
- Demonstrate how barriers to behavior change can be overcome;

- Sustain change by teaching self-management techniques; and

- Maintain change by providing support from opinion leaders, family members, or peers and by altering perceived social norms.[43]

The Harvard Alcohol Project, a research-based media campaign conducted in collaboration with the television industry, illustrates what a public health campaign can accomplish through a mix of advertising and public relations strategies.[44] The project's goal is to encourage the use of designated drivers and to promote a fundamental shift in U.S. social norms related to drinking and driving. Fifteen Hollywood studios are participating along with the three major commercial networks and leading advertising agencies. The project sought successfully to have television writers introduce dialogue into scripts of top-rated television shows to reinforce an emerging social norm that a driver does not drink. It coupled this approach with network-sponsored public service announcements promoting the designated driver concept. This multiyear project provides a model for developing a sophisticated mass media campaign that draws on knowledge from child health and development, advertising, and public relations to convince adults and young people to change their behavior. Its lessons can and should be applied to health problems and behaviors other than substance abuse.

Conclusion

The National Commission on Children was dismayed that in the United States so many pregnant women are at risk of poor birth outcomes, so many babies are born unhealthy, and so many children continue to suffer health problems that lead to unnecessary disease, disability, and even death. The majority commissioners made a series of recommendations to address the ills that plague the U.S. health care system and threaten the health of adults and children. These proposals are part of a unified plan. Each is important; none alone will be sufficient. In this monograph we have presented a series of concrete steps for implementing these recommendations.

To be effective, however, there must be a combined commitment from families, communities, employers, health care providers, and government. Children's health must first be protected at home. Adequate nutrition, healthful behavior, and a safe environment are essential. In addition, all children and all pregnant women must have access to health care. Universal access to health care and mechanisms to ensure that the appropriate services reach those who are at high risk for health problems and poor outcomes represent a sound social investment.

Appendix

Members of the National Commission on Children's Implementation Working Group on Improving Health (Majority Recommendations)

James D. Northway, President and CEO, Valley Children's Hospital, Fresno, California, and member, National Commission on Children

Reed V. Tuckson, President, Charles R Drew University of Medicine and Science, Los Angeles, California, and member, National Commission on Children

Barry S. Zuckerman, Director, Division of Development and Behavioral Pediatrics, Boston City Hospital, Boston, Massachusetts, and member, National Commission on Children

Marvin Bostin, President, M. Bostin Associates, Inc., Elmsford, New York

Sarah Brown, Study Director, Maternal and Child Health Perspectives on Health Care Reform, National Academy of Sciences, Washington, DC

Neil Halfon, Associate Professor of Pediatrics, School of Public Health, University of California at Los Angeles, Los Angeles, California

Jackie Jenkins-Scott, President, Dimock Community Health Center, Roxbury, Massachusetts

Kay Johnson, Director, Policy and Government Affairs, March of Dimes Birth Defects Foundation, Washington, DC

Jill Kagan, Deputy Staff Director, Select Committee on Children, Youth, and Families, United States House of Representatives, Washington, DC

Toni Kelly-Campbell, Director, Resource Mothers Program, South Carolina Division of Maternal and Child Health, Columbia, South Carolina

Robert McRae, Director, Division of Primary Care, State Health and Human Services Finance Commission, Columbia, South Carolina

Jackie Noyes, Director, Government Liaison, American Academy of Pediatrics, Washington, DC

Mary Ella Payne, Legislative Assistant, Office of Honorable John D. Rockefeller IV, Washington, DC

Amon Rashidi, Program Director, Journey: The Gang Alternative, Dallas, Texas

Irwin Redlener, Director, Children's Health Fund, New York, New York

Richard Smith, Director of Public Policy, Washington Business Group on Health, Washington, DC

Robert Sweeney, President, National Association of Children's Hospitals and Related Institutions, Alexandria, Virginia

Karen Troccoli, Staff Associate, National Commission to Prevent Infant Mortality, Washington, DC

Notes

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NATIONAL COMMISSION ON CHILDREN

1111 Eighteenth Street, N.W.
Washington, D.C. 20036