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ABSTRACT

This report, prepared by the National Commission on Children, discusses six main recommendations for improving children's health and health care. The recommendations discussed in separate chapters are: (1) Reform the Health Care System; (2) Monitor and Evaluate Efforts to Expand Health Care for the Underserved; (3) Address the Climate of Violence, Drugs, and Promiscuous Sexual Activity; (4) Involve Parents and Respect Their Values; (5) Increase Support for Abstinence Education; and (6) Promote Media and Community Responsibility. The report offers a general background on each of these recommendations as well as steps for their implementation. (An appendix with names and contact information for members of the Commission and 20 notes are attached.) (JW)

Implementation
Guide
Series

Improving Health

Minority Recommendations

NATIONAL COMMISSION ON CHILDREN

NEXT STEPS FOR CHILDREN AND FAMILIES

Improving Health

Minority 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

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Acknowledgements

The nine members of the National Commission on Children who prepared the minority recommendations on health gratefully acknowledge the efforts of Susan Dale, consultant, in organizing the working group and drafting this guide.

We are also grateful to all those individuals who gave generously of their time to participate in the working group and to review and comment on drafts of the implementation guide. Their insights and perspectives significantly enriched the final document. Sally Stanfield edited the guide, and Francesca Moghari and Linda Humphrey are responsible for the design and layout.

Finally, we acknowledge the generous contributions of the foundation sponsors who support the Commission's dissemination, education, and outreach activities: 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 leadership. 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 fundamentally disagreed with the key provisions of the majority's proposals for improving the health of the nation's children and pregnant women. These nine commissioners prepared and submitted a minority chapter on health care that appears in the Commission's 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, community, and professional groups have asked for more specific guidance on how they can help turn these 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.

The working groups were chaired by Commission members and included an array of federal, state, and local officials; scholars; practitioners; 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, strengthening and supporting families, protecting vulnerable children and their 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 practi-

cal advice to policymakers, program directors, community activists, corporate leaders, and private citizens. This monograph, *Next Steps for Children and Families: Improving Health (Minority Recommendations)*, is part of that series. Wade F. Horn, Kay C. James, A. Louise Oliver, Nancy Risque Rohrbach, and Josephine (Josey) M. Velazquez, members of the National Commission on Children, ably and graciously served as cochairs of the working group on the minority recommendations for improving health. A list of the working group members appears in the Appendix.

This guide was prepared by the commissioners who endorsed the minority health recommendations with the assistance of a consultant, Susan Dale. It is based on their working group discussions and reflects the views of the participants. It does not represent nor should it be attributed to the majority of members of the National Commission on Children, the chairman, or the staff.

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 their communities. It is time for our nation's public and private sector leaders to recognize the pressing need to ensure accessible, affordable health care to 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

Most American children today grow up healthy, happy, and safe. But some children are at risk, some even at substantial risk. As a nation, we must make every effort to protect every child's health and well-being. There is no time to wait. With each passing day, millions of our children confront disease, disability, violence, malnutrition, and poverty. We must offer their parents real answers, including affordable, accessible quality health care—and we must ensure that every child who needs assistance is reached by public and private efforts. Such initiatives must be genuinely accessible, structurally flexible to meet the varied needs of our children, culturally sensitive to address the rich diversity of our society, and vigorously inclusive to involve parents, families, and children. We need nothing less than a total commitment from all Americans: health care professionals, educators, government officials, clergy, neighbors, and all members of the community must join to protect children's health and well-being.

The nine members of the Commission who endorsed the minority recommendations on health seek to meet those goals by preserving the best parts of the American health care system—its outstanding quality, innovation, and service—while extending access to those currently outside the health care system. We believe in the impor-

tance of choice and highlight the need to improve the health status of children and, indeed, of all Americans. The minority commissioners who prepared this report were guided by the principle that all people should be able to obtain necessary health care through a partnership between the public and private sector, thereby preserving options, choice, and opportunity for consumers.

In the area of structural reform, it is the view of the authors that health care delivery and financing schemes should constrain the rate of growth in health care expenditures. Escalating costs remove real opportunity and access for consumers. Reform without cost containment measures would be negligible, because so many people are simply priced out of the market, regardless of other problems of access.

In addition, health care reform should promote innovation. Moreover, reform should not adversely affect economic growth and stability. Too many suggested reforms would undermine our economy and cost Americans jobs. Reform should also promote the delivery of high quality, cost-effective care. Without preserving the quality of care that we have now, we would offer a false promise to American consumers: access without quality or service.

The minority commissioners who prepared this report also place great emphasis on individual responsibility. Therefore, reform must have prevention as a key goal because without individual efforts to improve diet and behavior, any public or private actions to improve health care are doomed to fail.

Finally, in developing these recommendations, the authors of this report were constantly guided by the principle that the family unit is the principal health educator.

We also recognized that single parenthood is correlated with significantly poorer indices of children's health. Consequently, we emphasized the importance of the two parent family structure in securing a healthy childhood for every child.

With these principles in mind, the minority chapter on health care reform offered the following vital recommendations:

- Any plan for reforming the current health care system must contain the following three elements:

  - Empower consumers, including low-income individuals and families, by giving them direct control over the funds used to purchase their medical care and health insurance and, thus, the incentives to seek the best value for money when buying these services;

  - Eliminate government-induced distortions in the health care delivery and financing system in order to generate greater efficiency by stimulating enhanced competition among providers and insurers and, thus, give them incentives to offer better value for money to consumers; and

  - Restructure tax subsidies and government programs to achieve social equity by targeting the benefits of those subsidies and programs to the individuals and families who need them most.

- Recent efforts to expand health care to the underserved must be carefully monitored and evaluated in order to determine more precisely the best ways of enhancing access for the underserved.

• Problems resulting from malnutrition must be addressed by combating the climate of violence, drugs, and promiscuous sexual activity, instead of simply increasing funding for the Special Supplemental Food Program for Women, Infants and Children (WIC).

• All programs and services for children and youth must ensure that they involve parents and respect their values, taking care not to undermine parents' authority or to diminish their important role and influence in adolescent decision making.

• There must be increased support for abstinence education as the primary means of reducing the spread of sexually transmitted diseases (STDs) and Acquired Immune Deficiency Syndrome (AIDS), as well as the rate of unwed teenage pregnancies.

• The media and other community organizations must take their role seriously in promoting healthy behaviors on the part of parents and children and do nothing to either glamorize or reinforce unhealthy lifestyles, such as the use of drugs, sexual promiscuity, smoking, or unhealthy dietary habits.

To spell out the actions necessary to realize their recommendations, these nine commissioners invited approximately 30 experts on children's health needs and the American health care system to suggest implementation steps. Those steps are outlined in this guide.

Reform the Health Care System

Recommendation

We recommend that any health care reform must empower consumers, eliminate government-induced distortions in the health care delivery and financing system, and restructure tax subsidies and government programs by targeting benefits to the individuals and families who need them most.

Implementation Steps

- We should resist reform efforts that take the power of choice out of the hands of consumers. In reforming the present health care system, choice over health care coverage must remain in the hands of those best able to decide their own needs, rather than be given to bureaucracies.

- Plans that promote "play or pay" schemes or expenditure caps should be resisted because they are not in the best interest of the American people, particularly children.

- An acceptable comprehensive plan for health care reform must include the following elements:

  - Preservation of the role of private insurance companies as the major means of providing access to health care;

  - Malpractice insurance reform;

  - Emphasis on prevention;

  - Major market reforms so that small businesses and individuals can be pooled into larger groups to enable them to receive the same favorable health coverage enjoyed by large employers; and

  - Real cost containment measures, such as continued encouragement of the growth of coordinated care in private plans, Medicare and Medicaid; regulatory reforms that will streamline the current paperwork maze; and the provision of better information to consumers along with the resources to choose the coverage that best meets their needs.

Discussion

Health care costs are escalating out of control. According to the U.S. Department of Health and Human Services, Americans currently spend more than any other

country on health care—$736 billion in 1991—13 percent of the gross national product.[1] Americans are spending too much on health care and we must act to contain the growth of these costs.

But what steps should we take? How can these costs be contained without severely damaging the health care system or removing the incentives for choice, quality, innovation, and service? Several promising reforms have been offered by the President, members of Congress, private associations, and research centers. We advocate only those reforms that preserve the best of the present health care system and contain costs and increase access.

First, and most importantly, we advocate a system of consumer choice in health care. Currently, most Americans are insured through their employers as a tax-free benefit. As a result, too many are overinsured. Because employees do not pay for this benefit themselves, there is little incentive to economize when it comes to medical expenses. For example, doctors sometimes order unnecessary and costly tests knowing that their patients' insurance covers the expense. In addition, patients sometimes make unnecessary trips to the doctor. These unnecessary expenditures drive up insurance premiums. But if patients were consumers, it would be in their best interest to use their insurance sparingly, as well as to make sure that they were not overcovered. Giving individuals the responsibility allows them the freedom to choose which type of insurance best suits their needs.[2]

Second, we believe that tax credits and vouchers must be important components of any health care reform. The Heritage Foundation and the American Enterprise Institute have suggested measures that would provide reimbursable tax credits and vouchers, giving individuals the

power to purchase their own health care directly, thereby preserving choice and providing powerful incentives for quality.[3]

A third component must be liability reform. Legal liability is one of the major contributors to rising health care costs. Malpractice laws exist to protect patients who might otherwise contract away their rights to obtain lower-cost and poor quality services. Yet it may have destroyed access to low-cost health care. Consequently, any comprehensive plan for reforming our nation's health care system must include a discussion of malpractice insurance reform. Possibilities include damage award ceilings, limited tort immunities, time limits on law suits, and the English rule of attorney's fees (where the loser in the suit pays the winner's legal fees to discourage frivolous lawsuits).

Also, because individual behavior is so important to health care reform, we believe that more insurance companies should provide policies that reward healthful behavior with lower costs. For example, an insurance program could offer policies that would enable an individual with five children to be covered with a $500 deductible, for $115 a month, if no one in the family drinks or smokes. The same policy, without the behavioral modifiers, would cost that family $300-$400 per month. Rewarding those who take care of their health and putting disincentives in place for people who abuse their health are good preventive medicine.

Some have advocated a play or pay scheme for reforming the health care system. The play or pay approach mandates that all businesses choose either to play by providing every employee with health coverage or pay by being assessed higher payroll taxes. However, such a

plan would not address the needs of the small market, preserve choice, or provide liability reform. Indeed, play or pay, under the camouflage of providing health insurance, is really a payroll tax. Employers may find it more cost-effective to pay the payroll tax than to shoulder the burden of putting employees and their families in a private health insurance plan. Indeed, when the payroll tax is set too high, it creates incentives for businesses to drop coverage for some or all of their workers and then dump them onto the public plan. When employers dump workers who are costly to insure on to the public plan, it increases the tax burden for all Americans.

In addition, a play or pay approach would cost Americans jobs. By one estimate, if the play or pay plan were put into effect, between 500,000 and 1.4 million workers could lose their jobs.[4]

Increasingly, Americans are realizing that play or pay is just a "pay and pay" plan, with a negligible net effect for those who need it the most. That is why some have turned to a plan for expenditure limits or caps. The idea behind the expenditure cap approach is that the average annual rate of increase in health care expenses should be "capped" at a certain rate of growth. But it is very unclear how such a plan would work. Would there be exceptions? What services would be rationed or eliminated? How would the limits be enforced? How much more bureaucracy would be layered on top of the already overburdened and costly governmental administration of health care?

One likely result of such a plan would be a limitation on or rationing of services, categorically eliminating certain costly or inconvenient procedures. Institutions, such as hospitals, might meet their annual limits too quickly and

force large portions of a hospital to close down or entire categories of services to be eliminated. In addition, such an expenditure cap approach would discourage innovation and cause expensive new technology to be ignored. Indeed, this has been the experience in Canada, which has a form of expenditure caps. For example, in Quebec some institutions have been forced to close down for weeks when the expenditure limits have been reached. In addition, some provinces have limited services, with no access to things such as computed tomography or gallbladder surgery, and there are often long waiting lines for costly procedures, such as bypass surgery. Service in many areas is poor, with widespread complaints of insensitivity and inaccessibility.[5] Many Canadian citizens, in frustration, cross the border and seek medical care in the United States.

And what about the children? How will they fare under such a system? Rationing of care or elimination of services will eventually touch all members of society. But rationing is especially pernicious for children. When money is allocated for competing programs, children's initiatives often lose out. This is because services for older citizens, who may be at more immediate risk of a life-threatening illness, are usually given priority over long-term, good health building services for children. In addition, children are not mobile. They cannot seek services eliminated in one place but still available in another. This problem is compounded by the fact that children and their parents are often not in a position to shop around. They are constrained by the accessibility, affordability, and opportunity offered in their own neighborhoods.

When all these potential problems are added up, children may be most at risk under an expenditure cap

approach. Indeed, putting a system of expenditure caps in place may produce a singular setback to the health of our nation's children.

We believe that any form of national health insurance would be a mistake. Yet, some people have come to believe that national health insurance is an end in itself, rather than a means to finance health care. But the clear, undeniable experience of other countries has been that when choice is removed from the marketplace, quality is reduced and some essential services denied. National health insurance offers access in place of quality, whereas our plan would offer both, as well as cost incentives that would maintain and improve access to care.

Monitor and Evaluate Efforts to Expand Health Care for the Underserved

Recommendation

We recommend that recent efforts to expand health care to the underserved must be carefully monitored and evaluated in order to determine more precisely the best ways of enhancing access for the underserved.

Implementation Steps

- A thorough evaluation of all existing federal programs dealing with the health of America's children must be undertaken.

- Medical individual retirement accounts (IRAs) and vouchers should be examined to ensure that the underserved, as well as all Americans, are able to afford health care.

Discussion

Many Americans are not fully served by the health care system. There are many complex reasons that limit access to care—reasons as individual as each person who is excluded from the system, whether in urban or in rural areas. These Americans need and should have direct access to care. The actions that must be taken should address each individual context and situation and should not merely assume that each person is denied access for the same reason, or even for the same set of reasons. Instead, we must evaluate the actual impact of our efforts, targeting those in need with the solutions that will make a dramatic difference.

We need real solutions that provide real choice to meet the singular and complex needs of our citizens. We need efforts that go directly to the heart of the problem, such as the recent changes in Medicaid eligibility that have expanded services to pregnant women and children. Changes made in 1990 to the Medicaid program also included a provision to phase in coverage of children through age 18 in families below 100 percent of the poverty level. Consequently, by the year 2002, there will be no children living in poverty who do not have access to health care through Medicaid.

Two other examples of beneficial action by the federal government are the Healthy Start initiative and the Centers for Disease Control and Prevention initiative to expand outreach for childhood immunization programs. The Healthy Start initiative is designed to reduce infant mortality by 50 percent in approximately 10 high risk communities. Under Healthy Start, communities will direct the resources themselves to create the services

they need. The immunization initiative will help identify and eliminate barriers to immunization and help purchase 21 million doses of routine childhood vaccines.

In addition to governmental efforts, families must be empowered to make their own decisions. The focus must not be to turn to the government as the only solution or even the solution of first resort. Rather, families are in the best position to consult with their own physicians and other health care professionals to determine their needs and the best ways to prevent or address illness.

Of particular interest is the notion of tax incentives for Individual Medical Accounts. The average cost per family each year for health insurance is $4,500. If an employer would be allowed to take that money, purchase a catastrophic policy that pays for all health costs over $3,000, which would cost between $1,500 and $2,000, the rest could then go into an individual medical IRA account, which the employee could use or not according to need. Each year the remainder would accumulate with interest in a tax-free account. The employee's account would also transfer from job to job. And, in the event of a period of unemployment, that money could be used to purchase insurance. Again, with a medical IRA, choice and flexibility are placed in the hands of the individual.

Voucher systems should also be thoroughly explored. For example, President Bush advanced a plan to guarantee access to health insurance for all poor families through a transferable health insurance tax credit—available even to those too poor to file taxes—that is large enough to purchase a basic health care package. The President's plan also offered new help to the middle class to pay for health care by allowing up to $3,750 in health insurance costs to be deducted from income tax

liability by families with incomes less than $80,000. More than 90 million Americans would have received new assistance under the Bush plan. Others, such as the Heritage Foundation, have offered variations on the voucher idea but share the conviction that the consumer should be empowered with choice as the major tool for health care reform.

Address the Climate of Violence, Drugs, and Promiscuous Sexual Activity

Recommendation

We recommend that problems resulting from malnutrition be addressed by combating the climate of violence, drugs, and promiscuous sexual activity, instead of simply increasing funding for the Special Supplemental Food Program for Women, Infants and Children (WIC).

Implementation Steps

- Public policy regarding low infant birth weight and infant mortality must address behavioral factors. Public programs that aggressively address these behavioral factors should be promoted and implemented.

- Solutions other than nutritional must become part of public policy relating to those problems dealt with by WIC.

Discussion

It is true that millions of children suffer needlessly. For example, each year, according to the U.S. Department of Health and Human Services, 250,000 low birth weight infants start life at a disadvantage, suffering from neurodevelopmental conditions, learning disorders, behavior problems, respiratory tract infections, congenital anomalies, cerebral palsy, autism, mental retardation, and vision and hearing impairments. Each year, 40,000 infants die, often of causes related to low birth weight. Low birth weight (less than 2,500 grams or 5.5 pounds) occurs in about 7 percent of live births and is the greatest single hazard to infant health. Of all infants who die, approximately 60 percent are of low birth weight; of these, about 40 percent are of very low birth weight (less than 1,500 grams).[6]

Why do so many children suffer from low birth weight and other health problems? Although there are many complex causal factors for low birth weight, including malnutrition, the roles of drug abuse, smoking, and stress have too often been ignored.[7] It has been estimated, for example, that up to 375,000 babies are born each year having been exposed to illegal substances prenatally.[8] In addition, the abuse of alcohol produces tens of thousands of babies each year suffering from fetal alcohol syndrome and fetal alcohol effects; smoking by parents retards the growth and development of millions of children. Increasing funding for the WIC program and for other such programs will be woefully ineffective unless other actions are taken to educate parents, address problems of access and poverty, and combat the climate of violence, drugs, and promiscuity that leads to poor infant health.

Involve Parents and Respect Their Values

Recommendation

We recommend that all programs and services for children and youth ensure that they involve parents and respect their values, taking care not to undermine parents' authority or to diminish their important role and influence in adolescent decision making.

Implementation Steps

- Government programs should maintain and foster strong families. We must resist governmental efforts that intervene in adolescent health care by substituting governmental decisions for those of parents or that undermine parental prerogative.

- Primary responsibility for health care such as immunization of children must be restored to parents.

- Additional efforts must be made to create health policy that is "family friendly," in which voluntary associations and mediating institutions are involved to ensure creative and effective responses to a variety of family health issues.

Discussion

Despite the vitriolic denials in some quarters of a relationship between family structure and child health, there is an emerging consensus among researchers and policymakers that family health is the key to child health. Generally, children living with married parents are healthier, both physically and mentally, than children in single-parent homes.[9] For example, studies have shown that children in single-parent families are more likely to endanger their health through the use of tobacco, alcohol, and other drugs.[10] In addition, once they reach adulthood, children who grow up with only one parent are also more likely to divorce and live as a single parent themselves, perpetuating a clear cycle of behavior that increases unwed teenage birthrates, adolescent drug and alcohol use, poor health, and poverty.[11]

Public policies that ignore the role of family structure will not successfully address these problems. For instance, although it is true that children in single-parent homes are less likely to be covered by private health insurance than children in married-couple families, enhanced medical care would not eliminate all the

health risks to which children in single-parent homes are especially vulnerable.

We must also resist federal policies and programs that weaken parental authority and replace it with uniform and ineffective national standards, such as inflexible federal standards for child care, denial of educational choice for parents, expenditure caps that keep children from receiving vital services, and elimination of parental consent or notification laws. Indeed, plans that reduce parental responsibility or place the onus solely on the government discourage parents from taking the initiative or assuming the responsibility to take care of their own children.

Increase Support for Abstinence Education

Recommendation

We recommend increased support for abstinence education as a means of reducing the spread of sexually transmitted diseases (STDs) and Acquired Immune Deficiency Syndrome (AIDS), as well as the rate of unwed teenage pregnancies.

Implementation Steps

- Public policy efforts should recognize that abstinence is the best solution for reducing the health problems caused by teenage sexual activity.

- Abstinence education should be offered to parents as part of a wide range of options that are currently made available for their children's sex education. Contraceptive education must not be viewed as the only or even the principal option for parents and their children.

- Paternalistic government policies that assume that minority and inner-city youth are incapable of controlling themselves and that sexually self-destructive behavior is part of the culture must be condemned and removed.

- Efforts to eliminate Title XX, the Adolescent Family Life Act (AFLA), must be resisted because AFLA is the only federal program that encourages abstinence education and adoption for the babies of unmarried teenagers.

- Implications of the correlation between alcohol and drug use and sexual promiscuity must be recognized and acted on by relevant government programs.

- Funding for AFLA should be increased to $40 million, which is comparable with the level of funding for Title X family planning services for teenagers. There should be continued evaluation of innovative programs to identify effective models and determine the most appropriate directions for subsequent expansions.

Discussion

If our nation is to be successful in addressing children's health needs, we have to discuss unwed teenage sexual activity and pregnancy. Unwed teens are twice as likely to have low birth weight babies. The death rate for babies born to unwed teenage mothers is 1.5 times the rate for babies born to women over age 20.[12]

It is also true that adolescents and young adults have the highest risk of contracting an STD, with 63 percent of

STDs occurring in the under-25 age bracket.[13] It has been medically established that teenagers are much more susceptible to STDs than are adults. For example, a 15-year-old girl has a 1 in 8 chance of contracting an STD if she has sex; a 24-year-old woman has a 1 in 80 chance under the same circumstances.[14] Annually, 2.5 million teenagers contract an STD.[15] Up to 35 percent of all sexually active teenagers have evidence of at least one STD, namely, genital warts caused by the human papilloma virus.[16] In 1991, there were 170,000 reported cases of gonorrhea in the adolescent population.[17]

There is also a growing body of data to indicate that adolescents are an at-risk group for the transmission of the human immunodeficiency virus—with many Americans who are diagnosed with AIDS in their mid-to-late twenties discovering that they originally were infected as adolescents. In fact, one recent study reported that 1 in 500 college students tested positive for HIV, the virus that causes AIDS.[18]

Here is an instance where public health and morality coincide: it is good public health policy to encourage increased sexual abstinence among adolescents and teenagers. Some believe that increased funding for contraceptive education is the solution. But it is not a viable or an effective answer. For example, one study has shown that, among teenagers, increased contraceptive knowledge does not necessarily result in increased contraceptive usage.[19] Even when used, contraception has a high failure rate, especially among unmarried teenagers: 26% of teenage pregnancies occur when a contraceptive is being used.[20] The best birth control, from a public health standpoint, is self control. Self control is also the only 100% effective method of disease prevention. We should empower our youth, increasing support for absti-

nence education as a means of reducing the spread of STDs, as well as the rate of unwed teenage pregnancies. Abstinence is the ultimate precaution against STDs and teenage pregnancy.

Of course, some critics throw up their hands and plead that nothing can be done—that the only possible answer is greater awareness of and availability of contraception. Sadly, this argument has been made about many of our inner city and minority communities—a racist and paternalistic view that defies rationality and responsibility. But such pessimistic beliefs can only become self fulfilling: if we don't try to educate adolescents about abstinence, we cannot expect them to understand why abstinence can be a wise and healthy choice. We must give abstinence efforts a much higher priority and presumption and the community must be urged to join forces to dispense the message of abstinence through credible, persuasive campaigns. Parents should be offered a wide range of educational options for their children, such as abstinence-based sex education.

Promote Media and Community Responsibility

Recommendation

We recommend that the media and other community organizations take seriously their role in promoting healthy behaviors on the part of parents and children, and do nothing to either glamorize or reinforce unhealthy lifestyles, such as the use of drugs, sexual promiscuity, smoking, and unhealthy dietary habits.

Implementation Steps

- National campaigns should be mounted against the destructive issues of teenage pregnancy, sexual promiscuity, and adolescent drug and alcohol use.

- The role of individual responsibility in determining good health must be reinforced in current government policy.

- The media must assume greater responsibility for its programming, with a sensitive appreciation for the effects on children. Parents must strongly urge the media to present less violent, less promiscuous messages. Media messages that promote unhealthful behavior, such as the "safe" use of illegal drugs, should be discouraged. If some members of the media prove unresponsive, parents should exercise their constitutional right to protest such irresponsibility, and boycotts should be organized against the sponsors of such irresponsible media messages.

Discussion

Parents and children receive health care information in a variety of ways—sometimes from the media, sometimes from friends, neighbors, clergy or teachers. However, at best, the messages that are received are mixed—data about good health one moment, messages advocating poor diet or violence the next. At worst, and most often, good health messages are missing.

Such misinformation in the media is unfortunate. It is easier to reduce the incidence of certain unhealthful behaviors, including smoking and alcohol and drug abuse, through prevention rather than through intervention once the behavior has started. The media and community organizations have a tremendous opportunity to advocate good health through positive health messages—for both children and adults—if only the effort is made.

Media efforts must underline the doable—to demonstrate that good health is desirable, possible, and practical. Creative media campaigns can impart vital health care information and can show people how to seize opportunities for good health.

Conclusion

A one-size-fits-all, dogmatic approach to the health needs of children will not serve them well. Effective solutions do not have to be radical, costly, or bureaucratic. Rather, they have to be direct, affordable, and successful. We must use the strengths of our people and our health care system to attack disease, disability, and death vigorously. Children deserve the best we have. They must receive our wisdom, our courage, and our commitment. The recommendations discussed above and the implementation steps generated through an active exchange of views with health care experts are indispensable actions if we are to give children health, happiness, and hope. Reform must provide opportunity and access to solutions. This document offers workable, affordable solutions that would dramatically and directly help children.

Appendix

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Notes

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