

The Impact of Federal Legislation on Maternal and Child Health Services in the United States

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The reciprocal relationships between developments in maternal and child health legislation at the federal level and those at state and local levels are examined critically. The paper traces the sources of preventive health services in maternity and infant care, school health services, and sick-child care in France, Germany, and England, respectively, and suggests that these three streams have remained largely independent of each other over the years in the United States. It examines the historical backgrounds and significance for the future of recent changes in the organizational structure of maternal and child health services within the federal government. The current scene in maternal and child health is assessed. Recommendations are made to help insure (1) that the developmental needs of children are met within the evolving forms of comprehensive health services for all ages; (2) that the health needs of children are not overlooked as part of early childhood care or ancillary to education at all levels; and (3) that health concerns receive adequate consideration in social measures for mothers and children.

Maternal and child health services in the United States are at a critical stage in their history. New systems of personal health services are being developed to serve entire populations regardless of age or categorical needs. Expanding special-purpose programs in early childhood and in adolescence tend to include their own independent health services. These have called into question the more traditional types of health services for mothers and children, which have tended to be separate and clearly identifiable programs in maternity and newborn care, in health supervisory services for infants and for preschool and schoolage children, and in rehabilitative services for handicapped children.

At the same time, further expansion of maternal and child health services can no longer be justified solely by a continuing increase in the number of mothers and children to be served. Both the crude birth rate and the fertility rate in the United States are now well below the lowest levels experienced in the depths of the Great Depression of the 1930s. The total number of births in 1973

was smaller than in any year since 1945 (National Center for Health Statistics, 1974). Indeed, the number of persons under 21 years of age, the age group eligible for federally funded Maternal and Child Health and Crippled Children's Services, declined by nearly 800,000 between 1971 and 1973.

Furthermore, the infant mortality rate in the United States has been dropping rapidly since the mid-1960s. In 1973 the infant mortality rate was 17.6 per 1,000 live births (National Center for Health Statistics, 1974). This represents an unprecedented decline of nearly 30 percent in the short space of eight years. While the United States still has a relatively poor standing in infant mortality among the industrialized nations of the world, arguments for broadened health services based on this point alone are no longer as compelling as they were. The argument must now shift to the need to provide adequate services in order to maintain and expand the gains of recent years, especially for those segments of the population that have not shared equally in these gains.

Within the federal government, child development and child health services have been badly fragmented. The Children's Bureau has become a vestigial appendage of the Office of Child Development, identifiable only in name as required by its original enabling legislation. The administration of Maternal and Child Health and Crippled Children's Services and related formula, project, and research grants is only one of many responsibilities in a new unit in the recently established Health Services Administration (Federal Register, 1973). However efficient the new organizational pattern may prove to be, and this has yet to be demonstrated, the effect will be a further decline in visibility of the health needs of mothers and children within the federal government. The result is that citizens and agencies concerned with the health of mothers and children no longer have a single clear focus for expression of their concerns. All these developments suggest that the field of maternal and child health is undergoing a profound identity crisis.

This is not the first time such a crisis has been faced. Perhaps even more critical conditions prevailed in 1929 and the early 1930s. In 1929, following a period of rapid expansion in state and local maternal and child health services, stimulated and supported by precedent-setting grants under the Sheppard-Towner Act, the act was allowed to lapse just as the devastating effects of the Depression were being felt throughout the nation. Public health ser-

VICES were curtailed when large segments of the population could no longer afford to obtain health care from their own resources. For a time the Children's Bureau lost its influential role within the federal government, to the point of its not being represented on the United States delegation to the International Conference on Maternity and Child Welfare in 1929 (Schlesinger, 1967:1038). The American Child Health Association, the leading unifying force for voluntary child health concerns, was dissolved during this period.

Yet this nadir in maternal and child health services was shortly to be followed by enactment of the Social Security Act in 1935. This event heralded a 35-year period of new directions in health services for mothers and children, a period whose end we may have only recently witnessed. Is this the permanent end of an era, to be recorded only in the historical archives, or is it only a brief interlude preceding the attainment of a new stage in development? The second hypothesis is more consonant with the cyclical nature of previous experience and with germinal developments already evident on the national scene.

Historical Backgrounds

A brief overview of the origins and early development of maternal and child health services in the United States should aid in understanding the forces that have influenced the subsequent course of these services to the present time.

Until the twentieth century, the vaunted American genius for innovation failed to manifest itself, at any level of government, in attacking the myriad health problems facing the country. On the contrary, the sources and much of the content of maternal and child health services in the United States can be traced to three European sources.

Health services related to the reduction of infant mortality were inspired by earlier developments in France. The infant welfare movement in France sprang from the unlikely convergence of two conflicting forces—the growth of the humanitarian spirit after the French Enlightenment, as exemplified by Jean Jacques Rousseau, and military need to replenish the population after its decimation in the Napoleonic Wars. From the first crèche in 1844, through a series of national laws for the protection of pregnant women and in-

fants, French concern led, late in the nineteenth century, to the development of free-standing milk depots and precursors of the well-child conferences (Garrison, 1965). Corresponding developments in the United States did not occur until the late 1890s.

Germany provided the impetus to the development of school health services. German interest in scholarship led to emphasis on the health of schoolchildren as basic to education. Concern for the school environment was manifest in the 1860s (Garrison, 1965). Medical inspection was introduced as early as 1882. The convening of the First Congress on School Hygiene in Germany in 1904 indicated the extent of the interest by the early years of this century. In the United States health services in the schools began in the large cities of the United States between 1900 and 1910.

In England regulation and upgrading of midwife care for uncomplicated deliveries had been far advanced for more than a century (Forbes, 1966). Not until the 1920s were untrained midwives supervised and licensed in the United States, and only in the past few years have qualified nurse-midwives been accepted as members of the obstetrical team. The separation between preventive and treatment services and between ambulatory care and hospital services was also well established in England in the nineteenth century (Brotherston, 1965), but the impact of these English examples in this country is more difficult to determine.

These three distinct sources of maternal and child health services emanated from countries having different national objectives derived from indigenous national traditions, interests, and needs. When the three sources reached the United States they remained separate, almost as if they were immiscible fluids, flowing in parallel streams, sometimes in the same channels, but rarely mixing. These divergent origins have not been fully reconciled, and they still impede the development of services to meet today's needs.

Developments in the United States

Most of the early maternal and child health services in the United States developed in large cities, that is, at the local level. The first governmental unit of any kind devoted solely to maternal and child health services, the Bureau of Child Hygiene in the New York City Department of Health, was organized in 1908. Not until 1912 were counterpart units established in the federal government and as the

Bureau of Child Hygiene in Louisiana. Growth in maternal and child health services continued to be more rapid at the local than at the state level for some years, with fiscal support for local services coming almost exclusively from local tax funds.

During its early years the federal Children's Bureau could affect state and local health services only by exhortation and stimulation. The Sheppard-Towner Act in 1921 drastically enlarged the federal role to include financial support for state and local health services during maternity and infancy. The organization of state maternal and child health units throughout the United States followed. The Sheppard-Towner Act stimulated states to provide additional financial support to local health units. The bulk of the Sheppard-Towner funds had to be matched by an equal amount of state funds, and many states appropriated funds in excess of the matching requirements. The Children's Bureau also strongly encouraged the use of county health units for administration of the program. The big cities, however, continued largely on their own.

With the end of Sheppard-Towner grants in 1929, followed by the onslaught of the Depression, many of the gains in services were lost, but the pattern of reciprocal relationships among the federal government, the states, and the localities was firmly established. The same basic pattern was followed later with the formula grants to the states under Title V of the Social Security Act. While these grants were categorical, in the sense that they were restricted to services during the maternity cycle and to the group up to 21 years of age, they nevertheless permitted wide latitude to the states in the choice of services to be provided. The Social Security Act went beyond Sheppard-Towner in one significant respect. Title V permitted the allocation of up to one-eighth of the Maternal and Child Health grant funds directly to institutions of higher learning, as well as to state health agencies, for special projects of regional or national significance. The emphasis in both the formula grants and these special projects continued to be on direct and supporting services in smaller communities and rural areas.

Direct federal-local relationships were greatly expanded between 1963 and 1970 through the provision of project grants for specific purposes in geographic areas of special need, now primarily the inner-city neighborhoods. A series of Social Security Act amendments and other legislation during these years made possible the support of projects for comprehensive services in family plan-

ning, maternity and infant care, the care of children and youth, children's dental health, and, by extension of maternity and infant care, neonatal intensive care. These special projects redressed much of the imbalance in funds previously available to metropolitan and to non-metropolitan areas. The projects became models for services in other areas. They stimulated changes in patterns of services by university-related obstetrical and pediatric units as well as in professional education in the health care of mothers and children.

While these trends toward direct federal-local relationships were still evident, the Social Security Amendments of 1967 introduced a concept that would radically reverse these trends. These amendments required that, on July 1, 1972, funds for the special project grants were to be incorporated in the formula grants to the states. At the same time, each state would be required to provide "a program (carried out either directly or through grants or contracts) or projects" in each of the five areas mentioned previously. Implementation of this changeover from project to formula grants has since been deferred twice. Unless it is deferred once again the changeover is to take place on July 1, 1974. At the same time the 1973 legislation extending the project grants authorized additional funds in future years (1) to insure that no state would receive less than its current total of formula and project grant funds, and (2) that states which would have received more funds as a result of the shift to formula grants would still receive the greater amount of funds.

This change, if fully implemented, should exert a significant impact on federal-state-local relationships. It would increase the state's responsibility in allocating funds for support of maternal and child health services. Concurrently it would greatly reduce direct federal involvement in local maternal and child health services. Nevertheless it should enhance the need to maintain minimum standards for federally financed services. This calls for expansion rather than curtailment of consultative and administrative staff in the central office and regional office of the federal agency responsible for the broadened formula grants. Inherent in the changeover to formula grants is the hazard that the health needs of inner-city populations will receive less emphasis. This hazard is most acute in states in which project funds have been concentrated in one or two big cities.

Current Needs

What then are current needs in maternal and child health, and what must be done to meet these needs? These are some of the major areas of concern as I see them.

1. *The integration of high-quality maternal and child health services within evolving comprehensive systems of prepaid group health care for enrolled populations.* We must insure that health promotion, preventive and early detection services, and adequate follow-through for evaluation and care of any suspected abnormalities, receive proper emphasis within the full range of personal health services during infancy and childhood, in preparation for pregnancy, and during the maternity cycle. These comprehensive systems of health care, whatever their names, have an opportunity to utilize newer types of health personnel to full advantage. They are in a position to provide developmentally oriented services which many practitioners are hard put to provide alone.

2. *The inclusion of adequate funding of preventive services and ambulatory care services in general, as well as care during the newborn period, in all mechanisms for financing health services for mothers and children.* This applies with equal force to currently available voluntary health insurance plans as to plans for national health insurance.

3. *Extension of our present services and special projects to meet the needs of specific population groups.* Many years may elapse before the bulk of the American population is covered by prepaid group practice plans, and it is quite possible that the groups with the greatest health needs will be among the last to be brought into the fold. The present Maternity and Infant Care and Comprehensive Children and Youth Projects were an emergency answer to urgent needs. They are effective mechanisms for meeting these needs, and they should be protected and supported for the foreseeable future. National health insurance can pay for services but cannot assure that adequate services are actually available. Until adequate services are available to the entire population through comprehensive systems of health care, any method of financing health services should somehow cover payment for services provided by the special projects.

Maternity and newborn care has been transformed during the

past few years. Antenatal screening and diagnosis, fetal monitoring during labor, and intensive care immediately after birth and during the newborn period are being widely applied in the management of pregnant women and infants at higher risk of unfavorable outcomes. Recent evidence points to a greatly improved survival rate among the high-risk infants receiving intensive care and a sharply reduced incidence of serious handicapping conditions among the survivors (Schlesinger, 1973). Every effort must be made to insure the availability of maternal, fetal, and neonatal intensive-care services through organized community and regional programs throughout the country.

4. *Resolution of the long-standing dilemma of providing health services in settings in which the focus is other than health.* Much of the discussion of health services for school children over more than half a century has centered about the non-issue of responsibility for administration of health services within the schools. It should be clear that whatever goes on within the confines of the schools must be the ultimate responsibility of the school authorities, whether or not certain functions are delegated to others. It must also be conceded that school systems, in years past, often had no alternative but to provide many health services themselves in the absence of other community resources.

The real issue today is the promotion of adequate preventive and early detection services for children within evolving systems of health care, and encouraging the schools to utilize these new systems of care as the source of all personal health services. In some localities schools have developed close working relationships with children and youth projects, neighborhood health centers, and other types of ambulatory health care services. This type of arrangement should be actively sought as comprehensive prepaid group health care plans spread across the country.

5. *The need for a focus of concern for maternal and child health within the federal government and for mechanisms for child advocacy both within and outside the federal government.* The recent dissolution of the Maternal and Child Health Service, following so soon after the fragmentation of the Children's Bureau, has left the federal government without a clear point of entry for those interested in maternal and child health services.

The original mandate of the Children's Bureau was to "investigate and report. . . upon all matters pertaining to the welfare of children and child life among all classes of our people." Julia Lath-

rop interpreted this mandate broadly to include an active advocacy role regarding children (Bierman, 1966). When she reached the conviction, in 1916, that a nationwide program of maternity and infancy care was needed, she began an active promotional campaign for legislation to provide federal grants for this purpose to be administered by the Children's Bureau. She was, as she said, "well aware of the fact that it is not popular for bureaus to create new activities for themselves, or ask for measures increasing their own powers." Nevertheless, she fought vigorously and successfully the efforts of the Public Health Service, supported by the American Medical Association, to have the Sheppard-Towner program administered by the Public Health Service.

Over the next half century the Children's Bureau carried out its dual role of children's advocate and program administrator in a remarkably effective manner (Eliot, 1962), especially so in consideration of the meager resources at its command. Throughout this period it successfully resisted repeated efforts aimed at its dismemberment. Implicit in these efforts was the feeling that advocacy and administration were incompatible bedfellows. As the administrative responsibilities of the Children's Bureau burgeoned over the years, the duality of roles made the Bureau increasingly vulnerable to attack. This may well have been a major factor in the final fragmentation of the Bureau, an action that evoked surprisingly little organized opposition when the ax finally fell.

What lessons does this series of events hold for today? There is little likelihood that the Children's Bureau will, or should, ever be reconstituted in its previous form. What seems to be needed are two strong, separate, clearly visible units, one for administrative purposes and one for advocacy. The former was well served by the Maternal and Child Health Service, which combined policy and advisory responsibilities with the administration of grant programs. The advocacy role can be met without new legislation on the foundation of the original mandate of the Children's Bureau, building on the general recommendations of the 1970 White House Conference on Children and Youth and the promising beginnings of the National Center for Child Advocacy in the Office of Child Development in 1971. A reversion to the original concept of the Children's Bureau, with dynamic new leadership and adequate resources, can effectively serve the interests of mothers and children—a group of consumers now lacking a full-time champion in the federal government. After all, most special-interest groups have their avowed advocates

within the federal government; even the hitherto overlooked consumers have voices to speak for them. Mothers and children, who have been well served in the past, deserve no less now and in the future.

At the same time child advocates should have an independent, non-governmental channel for their efforts on a national scale. The advocates of children have been organizing effectively at the local and state levels (Kahn et al., 1973). A number of specialized national organizations have been functioning in their limited areas at the national level. The time is ripe for the rebirth of a vigorous equivalent of the American Child Health Association, after a lapse of nearly forty years, to bring together the mounting concerns for children's health.

In all these areas of concern the nature and extent of future federal legislation will exert a major influence. If past experience is any guide, the long-term trend should continue in the direction of increased federal responsibilities, but with periods of recession in federal involvement in health and social concerns temporarily slowing or even reversing the trend.

Outlook for the Future

What are the chances of establishing the policies and providing the services to attack current and emerging problems in maternal and child health? The long-range prospects appear to be excellent, even from a purely economic standpoint. The United States is approaching a stable population in the presence of continued, although possibly slower, economic growth. In a post-industrial society a large work force will still be required, especially in the service occupations. It is highly unlikely that the United States will resort to the importation of large numbers of workers from less developed countries. Under such circumstances, as French experience in the post-Napoleonic era strongly suggests, each child becomes a unique economic resource to be safeguarded. Health services are a vital element in this endeavor. The provision of intensive-care services for those at higher risk within the sharply reduced overall number of pregnancies and births suggests that this process is already under way.

Prospects for the shorter range over the next decade are less certain. The Sheppard-Towner Act was the result of a fortuitous

convergence of otherwise conflicting political and social forces, combined with strong leadership. Will a similar phenomenon occur during the 1970s, leading to new and dramatic support for health services for mothers and children? We can tentatively identify several forces as already here or on the horizon.

1. *The women's rights movement is reaching a new crescendo.* While the movement is sharply focused on equal rights for women, it also has major implications for children. It undoubtedly is a factor in the present low level of the nation's fertility rate. It should be a factor in continued support of family-planning services and, indirectly, in support of broad maternal health services. Its impact on support of developmentally oriented day-care services for young children should continue to increase as equal opportunities in employment become available to women. The movement has largely been responsible for increasing acceptance of maternity leave as a legitimate use of accrued sick-leave benefits.

2. *The new constituency among the health providers is becoming stronger.* The health professionals and the related educational institutions, as well as the newer types of health workers, are becoming convinced of the need to continue and expand comprehensive health care systems. They are looking to the federal government and other sources for adequate support. This new constituency may well have other sources for adequate support. This new constituency may well have been a major factor in securing extension of the federal project grants under Title V of the Social Security Act and for the commitment to increased support of the projects themselves in succeeding years.

3. *The focus of family planning in the United States is shifting from concern for population growth to emphasis on the health and social benefits.* The movement to bring family-planning services under the umbrella of maternal health services is already well advanced. It is likely that the present constituency for family-planning services in this country will be an important force for the support of broader maternal health services.

4. *Community mental health services for children are receiving greater emphasis with each passing year.* These are an integral part of the total range of health services for children. What the impact of rapid development of mental health services will be on other community child health services is problematical.

5. *The expectations of localities and the states for federal sup-*

port for local health services have been whetted by the provision of project grant funds and by the promise of special revenue sharing for health purposes. In view of the present very unfavorable outlook for the concept of special revenue sharing, the states and the localities may well look to other types of federal support for maternal and child health services within their respective jurisdictions.

6. *Child-advocacy groups are growing in numbers and strength at the local and state levels and are beginning to coalesce nationally.* The other forces already mentioned have given impetus to the child-advocacy movement, but the child-advocacy groups will undoubtedly constitute a major force in their own right.

It is quite possible that these often conflicting forces may reach their maximum strength and converge at a time when the general political climate will once again be favorable to new health and welfare initiatives. The unknown factor in this appraisal of the near future is the source of the strong leadership needed to guide and focus these heterogeneous forces.

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