Rethinking the Organization of Children's Programs: Lessons from the Elderly

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PRESIDENT CLINTON BEGAN THE NATIONAL DEBATE on health care reform by declaring that the "system" is broken and needs to be fixed (Clymer 1993). Nowhere is his statement more relevant than when it is applied to the network of services designed to serve the needs of America's children.

Simply put, the United States does not have a system of care for our children and families. Rather, we have a collection of activities and funding mechanisms that create a complex, fragmented patchwork of services and programs. Such fragmentation was not always the case. The nation's initial response to the plight of children in the first half of this century resulted in a unified approach, administered by the Children's Bureau, to address "all matters pertaining to the welfare of children and child life among all classes."[1] Since then, however, more than 300 separate programs have been established and implemented categorically to address the health, social, and educational needs of children and families (National Commission on Children 1991). And, although they were developed with the best motivations, the expansion of these services, unfortunately, has served at times more to complicate and fragment care

[1] U.S. Stat., 62d Cong., 2d sess., pt. 1, chap. 73.

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than to improve its quality and facilitate access to providers. With few exceptions, these programmatic services are not universally available, regardless of how significant a family's functional needs might be. Excepting educational programs, services to children and families have not been developed as true entitlements, with the result that they are subject to the vicissitudes of economic and political trends, suffering most significantly in times of fiscal constraint (Benjamin, Newacheck, and Wolfe 1991).

Programmatic fragmentation, in and of itself, would not be a serious national policy issue if America's children were doing well. Unfortunately, this is not the case; many of our nation's children continue to suffer the most devastating consequences of social disadvantage. In 1992, nearly one in five children lived in poverty (U.S. Bureau of the Census 1994), and approximately 8.3 million (12.4 percent) children were without insurance (U.S. Bureau of the Census 1994). Children also are increasingly likely to be the victims and/or the perpetrators of violence (Children's Safety Network 1991). And nearly one-third of American children were living with one or neither of their biological parents in 1990 (Annie E. Casey Foundation 1993). Disabling health conditions, substance abuse, teenage pregnancy, poor academic performance, and high dropout rates from school threaten this country's global competitiveness. Despite the fact that the United States expends more than any other industrialized country on health care, our children are far worse off, as measured by simple indicators like the infant mortality rate or the level of full immunization coverage (U.S. General Accounting Office 1993; *Pediatrics* 1990; Starfield 1992; Williams and Miller 1991).

The national debate on health care reform during 1993 and 1994 did not fully explore the system of public and private programs that address the health status and the academic and social functioning of children and their families. Rather, the debate focused narrowly on financing medical care. Although children and their mothers have not been well served by this country's health insurance industry, nearly all the proposals relied on an indemnity insurance structure. Even highly touted reforms in health care delivery, like managed health care, may not necessarily improve the health of children (Arnold and Schlenker 1992; Cartland and Yudkowsky 1992; Fox, Wicks, and Newacheck 1993). Therefore, we believe that although insurance is necessary, it is not sufficient to assure the health of a population; a reformed health care system based on universal insurance coverage and managed care delivery alone is unlikely to adequately solve the service system needs of children. Assuring improvements in children's

health status may require complementary reforms in the statutory protections, organizational structures, and fiscal resources that link health programs, income security programs, and education entitlements. Our purpose here is to examine elements of a model for such a system.

In contrast to children, the elderly in this country enjoy universal entitlement to national health insurance through Medicare, a uniform level of income security, and an organized system of community-based health, nutritional, and social support services. Other authors have compared the ways in which the United States treats its elderly versus its children, pointing out inequities in both investment and outcome (Axinn and Stern 1985; Benjamin, Newacheck, and Wolfe 1991; Cook 1979; Hudson 1978; Preston 1984). We advance a step further by examining the organizational structures of the service system for the elderly in order to propose a model for reforms that may better meet the needs of children and families.

We will analyze the national program of services for the elderly under the provisions of the Older Americans Act (OAA) of 1965, comparing it with the program of maternal and child health services. The analysis includes reviews of the legislative and organizational histories of both maternal and child health services and the Older Americans Act; key informant interviews; and a comparison of two statutes: the OAA and Title V of the Social Security Act (Grason and Guyer 1995). Despite its documented shortcomings, the Title V/MCH program is used to illustrate the child aspect of our analysis because a number of features incorporated in this legislation make it an appropriate starting point for systems reform. Specifically, we argue that basic features of the national policy, and the core program and administrative infrastructure embodied in the OAA, may provide a framework for developing a model to meet the special challenges of child and family services. Thus, we propose that the system which seems to work for the nation's grandparents ought to be available to its grandchildren.

Societal Views of Children and the Elderly

There are a number of fundamental similarities between the elderly and children:

1. Each is an easily identifiable population based on age criterion alone.

2. Both children and the elderly exhibit particular developmental vulnerabilities.
3. As individuals at the ends of the age spectrum, both populations are characterized by a certain level of dependency, requiring service responses that involve families and/or community caretakers.
4. The vulnerabilities and dependency needs of both populations have traditionally prompted varying degrees of special societal protections.

A major difference, of course, between children and the elderly is that the elderly have become a powerful political force that votes in its united interest, unlike children who, without representation, must rely almost singularly on parental advocacy to look after their needs and best interests (Preston 1984).

As a constituency, the elderly are considered to hold both political legitimacy and utility, whereas children often hold neither. This disparity stems from complex factors embedded in American culture, demographics, and political and economic history. Perhaps the most obvious is the documented growth of the elderly population over the last several decades—largely due to advances in medicine—in contrast to a decrease in the birth rate, and thus in the proportionate size of the child population, which can be traced to the availability of contraceptive technologies and economic pressures on the American nuclear family. In 1991, U.S. Bureau of the Census projections suggested that, by the year 2000, the population of Americans over 65 years of age would increase by nearly 17 percent, while the population of children under 18 years would grow at one fifth that rate (Benjamin, Newacheck, and Wolfe 1991). Further, support for strong policies and programs for the aging is derived not only from the elderly themselves, but also from their children, who eventually might be responsible for their care, and from voting-age adults, who will themselves ultimately benefit from such political action (Preston 1984). Moreover, while the legitimacy of children's concerns has frequently been tainted by public attitudes regarding unwed mothers and lack of parental responsibility, the elderly are regarded as a "deserving" disadvantaged population based on their prior contributions to the economy and to the defense of the country (Axinn and Stern 1985; Hudson 1978). Recently, children's advocates have attempted to garner political support from labor and the corporate sector, appealing on the basis of children's future contributions to the country's share of the global econ-

omy; however, these efforts have not been entirely successful. As a nation, we thus appear to have accepted a central role for government in the social welfare of the elderly, while remaining ambivalent about its position in assuring children's well-being.

We describe some of the forces operating to promote societal concerns of the elderly over those of children, but it is not entirely clear why the momentum for children's reform, which began with the Children's Bureau at the beginning of the century, was gradually lost. Exploring the social history in detail is beyond the scope of this article. Rather, we seek to focus our inquiry on a set of concepts that may serve to re-establish a national strategy for children and thereby to refocus their constituency.

Evolution of the Current Public Programs for Women and Children

The special needs of women, children, and families were addressed at the beginning of the twentieth century by a single federal agency, the Children's Bureau, and later incorporated into a single piece of federal legislation, Title V of the Social Security Act. Title V originally provided a national focal point to study health and welfare concerns, to disseminate public information, to create advocates, to build prevention services, to develop a cadre of specially trained professionals who would pioneer and promote high-quality care for children and families at the state and national levels, and to attend promptly to emerging health needs and challenges. Title V also provided the foundation for a system of state-based health services for mothers and children.

Today, however, health and related care for children is provided through multiple and uncoordinated service delivery structures, evolving from 30 years of separately enacted pieces of federal legislation. Federally legislated child health programs represent a mix of income-based entitlement programs, such as the public insurance program—Medicaid—and the Early and Periodic, Screening, Diagnostic, and Treatment program (EPSDT); age-specific entitlement programs, such as early intervention services for infants and toddlers with actual or potential disabilities; quasi-entitlement programs, such as the WIC (the Special Supplemental Food Program for Women, Infants and Children) nutrition program; categorical population or disease-specific programs for immunization, pediatric AIDS, lead poisoning, and family planning; and "gap-filling"

formula grant programs such as Title V prenatal and child health services. Health services are also embedded in education and social services programs. Table 1 displays a sample of the major public benefit programs for children and families.

Families must sort through these options to find their way to those several, frequently overlapping, public programs that might assist them. Within communities, child health services are found in public health departments, private physicians' offices, community health centers, and other nonprofit community agencies, schools, and hospitals, but there is no centralized source of information, intake, or services coordination. All too often, inconsistent and/or rigid eligibility requirements confound or preclude access and care. Efforts of policy-making bodies, public program administrators, and the public to address children's needs are similarly thwarted by the sheer numbers of programs, by the absence of links among them, and by the complexity of the interconnecting pathways.

The authority for establishing, funding, and administering domestic policies and programs is widely distributed across congressional committees and executive branch agencies at the federal level (Institute for Educational Leadership 1993; National Commission on Children 1991). This piecemeal, largely categorical, and often incremental approach to addressing child health needs leads to uneven implementation at the state and local levels and to gross inequities in the eligibility requirements for both individual and subgroups of children and their families (Association of Maternal and Child Health Programs 1991; Guyer 1990). Federal research, demonstration, and training initiatives related to children's services are similarly independently authorized, funded, and developed.

Despite ardent appeals to modify the nation's policies and programs affecting child health and welfare, children continue to fall prey to our basic cultural ambivalence about public responsibility for their well-being, and the system (or nonsystem) of services for children remains in disarray (Institute for Educational Leadership 1993; National Commission on Children 1991; Select Panel for the Promotion of Child Health 1981a).

Evolution of Services for the Elderly

The national program of services for the elderly was established in 1965 through a single piece of legislation, the Older Americans Act (OAA),

designed to address in a consolidated fashion multiple aspects of the lives of the elderly. Concurrent with the enactment of the Medicare program, passage of the OAA represented a symbolic affirmation of the deserving status of the nation's aging population, and perhaps a less overt but equally key acknowledgment of its increasing political utility as its members came to constitute growing numbers of voting citizens who are serviced by a burgeoning provider constituency.

The overarching purpose of the act was to establish a framework for a comprehensive system designed to assist older individuals in maintaining and maximizing independence by removing barriers to access and by providing for a continuum of care at the community level. Although it was never intended to meet all needs, the OAA represents the major legislative infrastructure for "planning of, and advocacy for, services and activities to benefit older persons" (O'Shaughnessy 1992).

The objectives of the OAA to be achieved on behalf of older persons are an adequate income in retirement; the best possible physical and mental health; suitable housing designed and located to meet special needs; full restorative services for those who require institutional care and a comprehensive array of community-based, long-term-care services that includes support to family members and other persons who voluntarily care for older individuals; opportunity for employment without being subjected to age discrimination; retirement in health, honor, and dignity; pursuit of civic, cultural, educational, training, and recreational opportunities; efficient community services that emphasize maintaining a continuum of care for the vulnerable elderly; benefits from research designed to sustain and improve health and happiness; and freedom to plan and manage their lives, participate in the planning and operation of services designed for their benefit, and protection against abuse, neglect, and exploitation.[2]

In signing the legislation, President Johnson declared that the Older Americans Act was "an orderly, intelligent and constructive program. . . under [which] every state and every community can now move toward a coordinated program of services and opportunities for our older citizens" (O'Shaughnessy 1992, 2). Propelled by this vision, the legislation has evolved over the past 28 years to provide the foundation for a "network on aging," linking a federal Administration on Aging (AoA), state units on aging (SUA), area agencies on aging (AAA), citizen advisory com-

[2] P.L. 102-375.

TABLE 1
Selected Prominent Federal Programs for Children and Families

Program	Statute	Administering agency
Health		
Medicaid/EPSDT	Title XIX, SSA	HCFA, DHHS
MCH Services Block Grant	Title V, SSA	MCHB, HRSA, DHHS
Community/Migrant Health Center	Sections 329 and 330, PHSA	BPHC, HRSA, DHHS
Nutrition		
Special Supplemental Food Program for Women, Infants, and Children (WIC)	CNA	FNS, USDA
School Lunch and Breakfast	NSLA, CNA	FNS, USDA
Immunization	Sec. 317j(1), PHSA	CDC, DHHS
Family Planning	Title X, PHSA	OPA, DHHS
Comprehensive Alcohol and Drug Prevention	Title XIXB, PHSA	CSAP, SAMHSA, DHHS
Drug-Free Schools	Title V, ESEA	OESE, ED
Education		
Elementary and Secondary Education	Title I, Chapter 2, ESEA	OESE, ED
Chapter 1	Title I, Chapter 1, Part A, ESEA	OESE, ED
Head Start	HSA	ACF, DHHS
Special Education/Early Intervention	Parts B and H, IDEA	OSERS, ED

Income security		
Aid to Families with Dependent Children	Title IVA, SSA	OFA, FSA, DHHS
Supplemental Security Income for Disabled Children	Title XVI, SSA	SSA, DHHS
Family support		
Child Care Block Grant	Sec. 5081, OBRA 1990	ACF, DHHS
Child Welfare	Title IVB, SSA	ACYF, ACF, DHHS
Family Preservation	Title IVB, SSA	ACF, DHHS
Foster Care	Title IVE, SSA	ACYF, ACF, DHHS
Developmental Disabilities Program	DDABRA	ADD, ACF, DHHS
Juvenile justice	JJDPA	OJJDP, DOJ

Abbreviations: Statutes—SSA, Social Security Act; PHSA, Public Health Services Act; CNA, Child Nutrition Act; NSLA, National School Lunch Act; ESEA, Elementary and Secondary Education Act; HSA, Head Start Act; IDEA, Individuals with Disabilities Education Act; OBRA, Omnibus Budget Reconciliation Act; DDABRA, Developmental Disabilities Assistance and Bill of Rights Act; JJDPA, Juvenile Justice and Delinquency Prevention Act. Agencies—HCFA, Health Care Financing Administration; DHHS, Department of Health and Human Services; MCHB, Maternal and Child Health Bureau; HRSA, Health Resources and Services Administration; BPHC, Bureau of Primary Health Care; FNS, Food and Nutrition Service; USDA, U.S. Department of Agriculture; CDC, Centers for Disease Control and Prevention; OPA, Office of Population Affairs; CSAP, Center for Substance Abuse Prevention; SAMHSA, Substance Abuse and Mental Health Services Administration; OESE, Office of Elementary and Secondary Education; ED, Education Department; ACF, Administration for Children and Families; ACYF, Administration on Children, Youth and Families; OSERS, Office of Special Education and Rehabilitation Services; OFA, Office of Family Assistance; FSA, Family Support Administration; SSA, Social Security Administration; ADD, Administration on Developmental Disabilities; OJJDP, Office of Juvenile Justice and Delinquency Prevention; DOJ, Department of Justice. Program—EPSDT, Early and Periodic, Screening, Diagnostic, and Treatment.

mittees, and local public and private agencies in efforts to expand and improve services and care for older persons. Although funding does not represent a significant portion of federal expenditures on the elderly, the OAA's emphasis on planning and coordination is recognized for its capacity to attract other resources, thereby promoting service system improvements beyond the resources found in the act (O'Shaughnessy 1992).

Currently, the OAA comprises seven titles that form the legislative framework for a uniform, but flexible, consolidated national program of comprehensive, community-based planning and preventive and social services that complement the medical care and income support received by the elderly population through Medicare and Social Security. Approximately 30 categorical services for the elderly are incorporated. A uniform set of core services is required for all communities; however, flexibility is permitted in the array of optional services a locality supports with program funds. Prohibitions against means testing establish services as universally available; contributions, however, are accepted, and targeted planning is encouraged to assure that resources are directed to the most vulnerable within the population. Table 2 outlines the prominent service categories authorized and administered under the act. The OAA established a Federal Council on the Aging, reporting to the President, with the assignment of reviewing and evaluating federal policies, publicly highlighting the needs of the elderly, and sponsoring public forums on issues of concern to the population. OAA program links have been forged with federal programs for the elderly that do not operate under its authority.

The legislation also provides a federal program of training, research, and discretionary demonstration projects. Funds are to be used to expand knowledge about aging and programs for older persons. Specialized training or career preparation for employment in the field of the aging has traditionally been emphasized: multidisciplinary centers of gerontology act as both consultants and educators.

Framework for Comparison of the Older Americans Act of 1965 and Title V of the Social Security Act[3]

Our analysis of the legislative bases for community services for the elderly and for children compares the best features of the OAA with those

[3] P.L. 101-239.

TABLE 2
Community Services for the Elderly under the Older Americans Act

Supportive services	*Nutrition services*
Access[a]	Home-delivered nutrition[a]
Transportation	Congregate nutrition (in multipurpose centers and schools)[a]
Outreach	
Information and assistance	*Community service employment*[a]
Case management	
In-home services[a]	*Elder rights protection*[a]
Homemaker and home health aide	Ombudsman
Home visiting and telephone support	Elder abuse prevention
Legal assistance[a]	Elder rights and legal assistance
Other services permissible[b]	Outreach, counseling, and assistance (for access to insurance and public benefit programs)
Senior centers	
Health education and training, counseling, and referral	
Housing services, including home adaptations	
Health screening	
Employment services, including counseling, referral, and placement	
Crime prevention and victim assistance	
Supportive services for caretakers	

[a] Required service.
[b] This listing provides only a sampling of the 15 identified in the statute.

of Title V of the Social Security Act—the Maternal and Child Health Services Block Grant.

Several policy and organizational principles applicable for meeting children's needs are woven through the provisions of the Older Americans Act:

- A single, highly visible, national locus is assured for developing and coordinating policy, for providing public advocacy, and for supplying information on the population.
- An administrative infrastructure exists at the national, state, and local levels to conduct consolidated planning for all issues of concern to the population.
- Program services are universally available to the population, which is defined by age, irrespective of income status.

- Funded community-based services complement and facilitate access to major income and health entitlements.
- A broad and flexible scope of community-based services is administratively consolidated at the state and local levels, with a uniform set of core services that are protected federally through line-item funding and statutory and regulatory assurances.
- Community-level information and referral resources are centralized, and multiple services are provided (conveniently) at a single site to the extent possible.
- Advocacy for the population and participation by consumers and the public in program planning and oversight are legitimized.
- Research, training, and service demonstrations specific to population issues and needs are used to improve the quality of care and services.

The Title V/MCH program, used here to illustrate the child aspect of this analysis, incorporates a number of features that establish it as a suitable starting point for systems reform:

- Permanent authorization under the Social Security Act, providing stability for administration of the policy and program infrastructure and indicating a priority for child health as part of a larger national commitment to the well-being of its citizens.
- Specified responsibility for planning and reporting related to national objectives, including recognition of a broad responsibility for *all* children that extends beyond a narrowly defined programmatic focus.
- Requirements for substantive state matching funds that promote development of constituencies within communities and state legislatures and that leverage funds well beyond those allocated federally.
- Support for a structure of population-based, universally oriented preventive and support services, and for specialized services that target particularly vulnerable subpopulations.
- Specified requirements for coordination with Medicaid, especially to ensure access and guarantee the quality of care provided to low-income children through the federal insurance program.
- Promotion of a family orientation that would influence the structure of service delivery so that children's care delivered by a broad

spectrum of health and related service providers is developmentally appropriate and responsively planned.
- Inclusion of a component for research, training, and demonstrations to assure quality throughout and to promote system improvements.

Although Title V and the OAA exhibit certain commonalities—long-standing emphases on a national locus for study and reporting on population issues and needs; a universal approach to addressing concerns; planning within states; support for state and local flexibility in configuring the service infrastructure; and resources for research, training of professionals, and service demonstrations—the service system for children and families lacks a core structure and uniform services, resulting in great variability and inequities.

To strengthen the power of what federal and state governments can do for children and families, we next report on a structured and detailed analysis of OAA features—at the federal, state, and local levels—that are missing from, but crucial to, community-based services for children and families. These include:

1. assurances that the concerns of this population will have high-level national visibility
2. specification of organizational structures and functions at the national, state, and local levels that include the horizontal and vertical coordination of all policy development, planning, and service delivery by the multiple public programs that address the concerns of this population
3. definition of a national core uniform set of community-level services and activities
4. legitimized population advocacy and participation by consumers and the community in policy development and program implementation

The Federal Level: Comparison of Program Structure and Functions of the OAA and Title V/MCH

National policy for the elderly at the federal level is guided by highly visible structures that have been delegated and authorized to coordinate federal efforts and to oversee the implementation of programs at the

state and local level. We explore four central aspects of the OAA federal organization, programs, and policy principles.

Visible Single Authority for Population Concerns

The concerns of the elder population achieve high visibility through a single federal administrative entity, the Administration on Aging (AoA) in the Department of Health and Human Services (DHHS). The OAA legislation mandates that the agency head report directly to the secretary of DHHS. Testimony presented on behalf of legislative provisions assuring prominent organizational status in the federal bureaucracy noted, "Thus, the older population would be meaningfully represented in the upper echelons of the Federal government . . . with power and responsibility to take action" (U.S. House of Representatives 1964). The statutory establishment of a complementary organization independent of the bureaucracy, the Federal Council on Aging, whose responsibilities are to articulate population needs to the President and Congress and to provide forums for public policy debate, further strengthens the potential for national attention and action. Together, these agencies serve as focal points for public accountability in addressing the needs of this population, including some that extend beyond the program services administered in the act. Although these agencies need to strengthen their roles in monitoring and influencing policy and practice in other sectors of the services system, the federal AoA and state counterparts are deeply involved, for example, in the analysis and design of the long-term-care system (U.S. General Accounting Office 1991; Justice 1988; U.S. Senate 1993).

In contrast, the organizational status and authority for child health has diminished over the years (Guyer 1990; Select Panel for the Promotion of Child Health 1981b). The federal MCH unit continues to operate as a bureau under several administrative layers significantly removed from the top levels of decision making. Furthermore, while numerous independent commissions have studied the status and needs of children (National Commission on Children; National Commission to Prevent Infant Mortality; Select Panel for the Promotion of Child Health), these initiatives did not have continuing authorization, and so ultimately were unable to fulfill the potential offered by a permanent body like the Federal Council on Aging.

Comprehensive Policy Development and Coordination

Assignment to AoA and the Federal Council on Aging of the responsibility and authority to address *all matters* related to the elderly outlined in the act greatly facilitates the ability of a national constituency to present its issues and concerns to government. Not only does the OAA provide a clearly labeled "front door" to key decision makers (the secretary, the President, and Congress) for constituency groups, but the legislation also further squarely places responsibility for coordinating all federal programs and activities impacting on the population not otherwise consolidated under the act with the assistant secretary for aging.[4] Section 203 of the OAA directs heads of other agencies and departments proposing policies, programs, or services affecting the elderly population to consult and coordinate with the AoA head and to collaborate with activities initiated within the AoA.

These statutory provisions were enacted in response to an awareness that "the Federal programs affecting older persons cut across the responsibilities of many departments and agencies, yet at the present time [1964] these programs are without a central core of direction and coordination" (U.S. House of Representatives 1964). By legislative design, therefore, information and reporting on the elderly population is consolidated, a structure exists to promote comprehensive federal policy and program development, cross-cutting issues are jointly deliberated, and service system responses are coordinated. No such consolidated locus exists to consider the multiple and related health and social welfare needs of children and families. The essential disappearance of the Children's Bureau's charge for addressing the broad range of issues related to children, coupled with the independent development of several hundred categorical federal programs for children and families scattered administratively throughout both the DHHS organization and 10 additional cabinet agencies, defuses public debate and constituency advocacy and promotes fractured policy development on behalf of families with children (Select Panel for the Promotion of Child Health 1981b).

Designation of authority for national policy development for children and families at disparate and frequently lower levels within the federal agency is problematic in several ways. First, no single "rallying" or access

[4] P.L. 102-375, § 202, 1965.

point for the voice of the constituency exists. Second, when there is an entrée, the issues must find their way up through any number of subagency administrators who are also contending with the competing interest of adult populations; attention and/or action may be halted or significantly delayed at any bureaucratic level. Finally, because child health/human service needs in any one domain are often related to, or dependent on, interventions in other domains, intraagency/program communication can be cumbersome and protracted. Coordinated policy and program initiatives occur inconsistently, as they depend primarily on the current political environment and the strength of the good will and leadership skills of agency administrators (Guyer 1990; National Commission on Children 1991; Select Panel for the Promotion of Child Health 1981b). As a result, the government response to the urgent health and social needs of children and their families is inordinately slow.

Identification of a Nationally Uniform Core of Services

Yet another strength found in national-level programming for the elderly can be found in the mandates for a uniform set of core services and service-administering agencies that extend to every community in the country. Although this feature of the OAA program has beneficial aspects at the state administrative and service delivery levels, positive attributes are noteworthy also from the national perspective. Detailing several universally available categories of service programs—supportive services, nutrition services, in-home services, community service employment, and elder rights protection activities—makes them more understandable to policy makers, the constituent population, and the voting/taxpaying public. Further, the administrative and organizational structure specified for both the state and local levels permits federal oversight, through AoA development and monitoring of regulations, to assure that the core program remains protected. Although community-level providers and area agencies on aging at times have expressed frustration over certain limitations in program service and funding flexibility, the categorical protections are largely valued (Binstock 1990; Hudson 1990, in press). Funds and mandates for the nutrition components in particular are regarded as an organizing force for community-level planning and advocacy, as well as for other required and optional services.

Whereas, again, there are remarkable similarities in MCH and OAA

services, the Title V MCH program, under the stigma of the block grant label, is poorly understood. The absence of a uniform core of services makes it difficult to justify requests for additional federal resources and/or to garner constituent advocacy, largely because of the extreme variation in service provision nationally, both within and among states.

Advocacy and Citizen Participation

Finally, there are noteworthy comparisons between the OAA and MCH at the federal level, particularly in the authorities and resources for advocacy roles and activities and the vehicles for public participation in policy formation. From the outset, Congressmen, acting as agents for their constituents, placed a high value on advocacy for the elderly population by mandating a national ombudsman program office, the White House Conference on Aging, and by requiring that older individuals constitute a majority on the Federal Council on Aging. The duty to "serve as an effective and visible advocate for older individuals" is first among the many functions of the AoA commissioner specified in statute. Such government and citizen advocacy partnerships have been deployed to protect Social Security and Medicare entitlement benefits.

Despite the even greater political vulnerability of children as a disenfranchised class of citizens, responsibility for child advocacy remains voluntary and outside the scope of any federal agency. Because advocacy roles are not specified in statute, and because federal children's programs are scattered and administratively buried, children do not have a strong voice in the federal bureaucracy. Outside organizations and coalitions have evolved, but without the ability to enter into sanctioned partnerships with federal programs for children.

The State Level: Comparison of Program Structure and Functions of the OAA and Title V/MCH

At the state level, features of the OAA include a visible and high-level agency within state government; program structures and authorities that support comprehensive planning and development of policy that leads to a coordinated continuum of services; and an emphasis on population

advocacy and citizen participation. These characteristics would benefit a refashioned child and family service system.

Visible Single Authority for Population Concerns

The organizational placement of state units on aging (SUAs) and state MCH agencies mirrors their placement at the federal level. Although no level is identified in either statute, approximately one-half of the SUAs nationally are free-standing, cabinet-level agencies, and others exist as major, high-level administrative units of umbrella human services agencies. The OAA extends protections through categorical design for core services and location of accountability in a state agency whose single purpose is to address the needs of the population. These administrative arrangements and the mandated core program promote equity across states.

Great variability exists with respect to MCH: in a number of states, Title V is administered in conjunction with state health agency management of other MCH and related programs like WIC/nutrition, family planning, early intervention, and others. Most frequently, however, even when there is oversight responsibility for multiple programs, the units assigned to do so are located two or more levels below the state health agency (SHA) director. Thus, health care providers, community-based programs, and advocates for children and families in the state face the same bureaucratic obstacles to obtaining information and contacting key political decision-makers as advocates at the national level.

Comprehensive Planning, Policy Development, and Coordination

The OAA outlines state agency functions to include primary responsibility for planning, policy, administration, coordination, priority setting, and evaluation of *all* state activities related to the objectives of the act. Statutory authorities review and comment on all state plans, budgets, and policies affecting the population. Excepting standards development for Medicaid EPSDT services, the Title V legislation is essentially silent on state agency functions related to MCH policy development across other child-serving programs. Even where several MCH and related programs are administered within a single SHA unit, child health activities administered by the Centers for Disease Control and Prevention (i.e.,

immunization, lead poisoning, school health) frequently are not included in these units, and key financing (i.e., Medicaid), social service, developmental (i.e., Head Start), and mental health programs most often are implemented by separate government agencies. MCH coordination agreements with Medicaid are required, and the Title V statute directs SHAs to "participate in coordination activities with related federal grant programs"; however, without clear reciprocal statutory requirements in related MCH programs, these provisions are inadequate (Association of Maternal and Child Health Programs 1991).

A single state plan addressing needs and services for older individuals is mandated through the OAA. In contrast, multiple annual state plans for MCH, family planning, early intervention, child welfare, child care, child development, Medicaid, immunization (and others) required by categorical federal programs are in most instances developed independently of one another, despite the fact that the children and families served by each are often the same. A major appeal of the OAA as a model is the broad, cross-cutting scope of social and other human service activities organizationally consolidated in both the state and federal government under an omnibus authority and public agency that is singularly focused on population services and advocacy. In contrast, the absence of an identifiable service core and of uniformly identifiable service planning, administration, and coordination structures for MCH services at the state level compromises both political clout and service delivery. Clearly, while the scope of services provided under Title V can translate in the states into a broad range of care for women and children, the MCH program is primarily a health program, and therefore without authority or resources to coordinate or to address in an integrated fashion the interrelated social and educational service and support needs.

Advocacy and Citizen Participation

The OAA mandates that SUAs provide "effective and visible advocacy" for the elder population in various ways: reviewing and commenting on state plans, budgets, and policies that affect the elderly; evaluating needs; and administrating a four-part, comprehensive program of elder rights protection activities (see table 2). This OAA feature is further strengthened by statutory requirements for public hearings and for the establishment of citizen advisory boards.

Title V is silent with respect to a government role in child advocacy at

the state level. Voluntary groups, largely state chapters of national advocacy organizations, "carry the water" alone in this regard in many states; the existence and strength of such organizations vary widely both geographically and over time.

The Community Level: Comparison of Program Structure, Content, and Service Delivery Mechanisms of OAA and MCH Services

The best features of the OAA at the federal and state levels carry through to the community level, where implementation follows consistent principles. Again, the features provide lessons for the MCH population.

Single Authority for Population Concerns

The organizational structure for the OAA program extends vertically to the local level through federal mandates requiring states to establish substate units, called area agencies on aging (AAA). These units are to provide a "focal point" in each community for information, planning, and services. Approximately 670 such units operate in the 57 U.S. jurisdictions. Their organizational location, structure, and functions are outlined in statute and provide the third element of the "national network on aging," whereby the authority and accountability for advocacy, policy development and coordination, planning, and services administration is identified for a selected population at all three levels of government. AAA functions parallel those of the federal and state agencies on aging, and additionally include service delivery and/or administration roles. No such organizational visibility or accountability for children as a class is established at the local level in a national manner by Title V.

Comprehensive Service Planning and Coordination

Each AAA is required to work with service provider organizations and citizen advisory boards to develop plans for comprehensive services for the elderly specific to that geographically defined community. These AAA plans are combined at the state level to develop the required state

annual plan. Requirements for public hearings and local citizen advisory boards also legitimize and promote constituent participation.

Federal MCH legislation does not require processes for local-level planning, nor do service providers or consumers and constituents have to be involved in it. Without such provisions, community-level involvement may be circumvented and opportunities to develop a constituency are missed unless state MCH programs, by their own design, establish procedures for involving service providers and community organizations.

Uniform Core of Services and Flexibility for Delivery Mechanisms

Flexibility is provided at the community level for determining the appropriate scope, mix, and priorities of supportive elder services (transportation, information and referral, outreach, case management, housing assistance). In recent years, area agencies have been able to capitalize on this flexibility to configure supportive services around community access points for the broad array of social and related health and human services for older individuals. Many communities utilize the OAA-funded, multipurpose senior centers as the local "hub" for recreation and volunteer opportunities, and for information and ombudsman services pertaining to age-related entitlements like Medicare and Social Security. In many areas of the country, AAA roles are evolving as intake centers where older persons and their families go to obtain needed services like long-term care, community-based home care, emergency response to abuse or unanticipated shelter needs, and/or case management (Binstock 1987, 1990; U.S. Senate 1993; Hudson, in press; Justice 1988; Quirk 1991).

Community-level MCH services differ significantly from elder services in their lack of either a national definition or a nationally identifiable organizational structure. The expansion of Medicaid has diminished the need in some geographic areas for direct delivery and payment by Title V programs for medical services like prenatal and well-child care, or specialized habilitation, which allows these agencies to expand their outreach roles, and to devote more time to linking families with private sector service providers and finding resources for financing their care. The critical importance of this role for MCH and other child/family-serving public programs has increased with the growing complexity of entitlement programs for low-income families (e.g., Medicaid, AFDC),

insurance plans for higher income families, and specialized care programs (e.g., special education, home and community care for chronically ill or disabled children).

Advocacy and Citizen Participation

The ombudsman program required by the OAA assumes an active constituent role in services planning and oversight and in devising strong consumer protections. The citizen advisory boards for each area agency also require an active constituency. Local citizen boards, composed of consumers as well as civic, religious, and business leaders, decide how to channel public and private fiscal resources, in addition to organizing volunteer initiatives that benefit the elderly and expand the capacity of the area agency staff. Mandated ombudsman programming applies to both protection and advocacy services for neglected and abused individuals as well as to consolidated outreach and counseling programs that assist individuals in linking up with appropriate insurance or public benefit programs. These boards and ombudsman services promote contributions of local financial and human resources and facilitate citizen access to the appropriate public leaders, thereby assuring both local ownership and accountability.

No clearly delineated citizens' organization exists to promote this sort of advocacy and consumer orientation for children's services. Where children's programs do sponsor advisory committees and/or ombudsman activities, resources for their support are usually meager or nonexistent, and because the span of interest and/or authority is narrowly defined to categorical program concerns, the needs of the population are not fully addressed. Citizen power for this constituency is thus fragmented and weak.

Therefore, although OAA and Title V/MCH programs share the advantage of flexibility in configuring services at the local level, legislation for the elderly provides a protected and visible core around which to build comprehensive, cross-cutting health, social, and other service planning and advocacy. Required AAA citizen advisory boards and constituent advocacy can coalesce around core service and planning mandates, providing a base of political support nationally that does not exist for children and families.

Conclusions and Options for Public Organizational Structures to Complement System Reforms in Health, Social Welfare, and Education

Analysis of the design of services for the elderly in the United States reveals apt lessons for child and family health services. The Older Americans Act establishes a high-level, visible national locus for information, policy development and coordination, advocacy, research, demonstration, and professional training. The OAA also provides the legislative structure for a uniform, consolidated program of comprehensive, community-based planning and preventive and social services that complement the medical care financing and income support provided by Medicare and Social Security entitlement.

Constituent and congressional support for this approach has been ongoing and substantive, with reported achievements in the continual identification of needs and construction of exemplary strategies, programs, and services; direct and indirect assistance to "innumerable" older Americans; development of a nationwide infrastructure and focus on the elderly; and recruitment of professionals into the field of the aging (Binstock 1987). Through this federal legislation, the nation has committed to a rationally organized service structure for a population it believes deserving of special protection. Consumer participation is legitimized; infrastructure development and maintenance is articulated and supported; structures for coordinated policy development at all levels are outlined; information resources and access to services are streamlined; and a broad and uniform core of community-based enabling and support services that complement health and income entitlements is assured in all states and localities through mandates and ombudsman services.

The OAA provides a starting point, or framework, for reorganizing health, welfare, and education services for children and families in order to create structures that are linked horizontally and vertically to produce consolidated policy development, planning, and accountability. Such an organizational scheme for child and family services would open up avenues for population advocacy equipped to protect the rights of both individual children and families (i.e., through a cross-cutting ombudsman program addressing health, social, and educational concerns) and to address the concerns of children as a class. Assurance of discipline-specific

expertise (i.e., for MCH, social services, education, mental health) to address service needs through national legislation and resources for federal and state programs, coupled with community-level organizational structures to consolidate all plans and activities for the population, may create a more promising environment for children their families.

The first and most fundamental step to achieving parity between children and the elderly is to rewrite current federal legislation that authorizes key health, social services, and educational programs in order to eliminate conflicts, overlap, gaps, and fragmentation and to maximize coordination within and among systems. Although we concur that progress in achieving consolidation and coordination objectives is possible at the local, and even state, levels, we are convinced that federal legislation will continue to drive the system, and that significant change based on principles of equity cannot occur without this step.

Further, we believe that revisions to national legislation must contain the following elements:

1. a national policy focus and vision for healthy children and strong families that is reinforced by governmental accountability for outcomes consistent with that vision
2. structures and authorities to address both the complexities of service access and coordination and the obstacles of fragmentation, overlap, and barriers at all levels and to streamline and improve the planning, data, and resource allocation functions of government
3. a universally available uniform core of preventive and support services that allows localities the flexibility to use the services appropriately and in line with their own needs so that *all* communities can benefit
4. child advocacy and consumer participation in the design of services and systems and in oversight at all levels of government

Implementation of these principles would move the system of services for children and families in a direction more directly parallel to the infrastructure design for the elderly. However, we make a central assumption that the OAA's effectiveness relates partly to the fact that the basic health and income needs of the elderly are universally met through Medicare and Social Security. Were the system to continue to allow the currently high numbers of children to remain uninsured and/or in poverty, the potential for impact would be diminished. The organizational

changes we recommend cannot replace these critical aspects of ensuring the well-being of children. Rather, they should be seen as part of a framework for a comprehensive reform initiative for children and families.

While we argue for strong leadership roles and authorities at the state level, our proposals recognize that an entirely state-based program cannot overcome the variability and the instability of state capabilities (Benjamin, Newacheck, and Wolfe 1991; Guyer 1990). Our recommendations therefore rely on federal mandates and resources to assure a uniform structure at state and local levels and a uniform core of prevention, support, and access-enhancing services, as well as a system for monitoring, reporting, and advocating. Federal legislation should be used to clarify the complementary roles of public agencies at federal, state, and local levels, and to promote local effectiveness and efficiencies in the private sector.

1. At the federal level, we specifically recommend:

- *Creation of a free-standing National Council on Children and Families* to consolidate (1) information collection and dissemination for the public, the President, and Congress; (2) advocacy for public response to population needs; (3) policy development, review, and oversight for all matters related to the health and well-being of children and their families; and (4) to counsel the President and Congress on policies that affect children and families.
- *Reorganization within DHHS to consolidate major health/human services programs for children and families under the (assistant secretary for) administration for children and families.* This administration would (1) serve as secretariat for the National Council on Children and Families; (2) include social services, a unit of consolidated child/family health programs (i.e., Title V, immunization, family planning, school health, injury prevention, Emergency Medical Services for Children (EMSC), lead poisoning prevention, and others), developmental, and child/adolescent mental health programs; (3) be a liaison member of the Domestic Policy Council; and (4) be responsible for consolidating data, collecting information, and reporting to Congress on population needs and services.
- *Legislation that coordinates federal agencies and guides state and local efforts* by (1) requiring state organizational structures and designation of substate/community authorities for consolidated advo-

cacy, policy, planning, and reporting on the health and well-being of children and their families; (2) creating statewide programs incorporating a uniform core of community-based child and family services; and (3) enacting parallel reciprocal legislative provisions requiring the reconfigured DHHS Administration for Children and Families (ACF) and the Departments of Education, Agriculture, Housing and Urban Development, Labor, and Justice (and others) to coordinate their policies and programs that affect child and family health.

2. At the state level, we specifically recommend creation of:

- *An independent single state agency for child and family policy* in each state that addresses (minimally) child and family health, developmental, social services, and education issues and programs, with advocacy and policy functions and authorities that are parallel to those established for the federal ACF, which means centralized state administration of the core community services program and a comprehensive, consolidated state plan for child and family services.

3. At the regional/community level, we propose:

- *Substate children and families authorities* with appropriate expertise, who are assigned the responsibility for policy development and coordination of all child/family-serving public agencies and programs. Statutorily defined responsibilities of the children and families authority would include: (1) community needs assessment and planning; (2) centralized information and referral services; (3) community-based prevention programs; (4) contracting for the provision of community-based outreach, home-visiting, enabling, social, and other family support services defined in the core program; (5) developing links between the medical care system and social, educational, and other relevant services; (6) administering a consolidated program of ombudsman services for children and families; and (7) as appropriate, creating multipurpose family service centers to implement co-location of services.
- *Family advisory councils*, established to (1) provide for consumer participation in state and regional/community level agencies and entities with public responsibility for services to children and fami-

lies; and to (2) provide ongoing consumer advocacy on behalf of children and their families.

We acknowledge that these recommendations are not a panacea. Implementation of the OAA has been characterized by many of the weaknesses that plague government administration of other programs (U.S. General Accounting Office 1991; Hudson 1992); these deficiencies must be approached in a reasonable manner. Nor can legislative structures remedy the lack of resources. However, our proposals are intended to represent modest, but important, steps for consolidating and coordinating the system.

Our recommendations for a consolidated national program for children and families, based on the model of the national program for the elderly created under the OAA, are intended to promote access to a system that coordinates a broad spectrum of health, social, and educational services at the federal, state, and local levels. In many ways, these recommendations reflect a return to the national principles first enunciated by the Children's Bureau, but lost through the evolution of health and social service programs during the last three decades. This approach, however, moves beyond the tenets of the past by promoting bureaucratic efficiencies consistent with contemporary management practices that would eliminate overlap and duplication in planning, data, and programming of prevention and support services. These recommendations would allow for consolidating funds at the local level, as well as for consumer-directed flexible service design and resource allocation within communities. It should be clear, however, that we are not recommending what is generally called a block grant, or complete devolution of government roles in caring for the child population. Our recommendations will only be successful if federal legislation is accompanied by federal oversight, accountability at all levels, and adequate funding to achieve the national objectives for the health and welfare of children and families.

Prospects for Implementation

How could we reasonably expect reform, reorganization, and strengthening of children's programs in the current political climate? The nation is currently in a period of political retrenchment and economic conserva-

tism. Powerful political forces are focused on reducing the magnitude of the federal budget and deficit, shrinking the size and role of the federal bureaucracy, and shifting governmental authority from Washington to the states.

What makes reform possible at this time, however, is the public demand for change in the current system. Public opinion calls for more efficiency, more local control and flexibility, and greater governmental accountability. There is reluctance, however, simply to tear down those programs perceived of as effective and necessary like Medicare and Social Security (Blendon et al. 1995). Were the public to have as much confidence in the fundamental system of supports for children, it might demand protection for these services as well.

There is obvious unhappiness with the system as it exists. Testimony in the nation's and state capitols is recorded annually from consumers, physicians, community groups, and public agencies documenting the complexity and barriers to efficient use of federal resources for supporting individuals and families. Bandaid policies and programs developed over the past 15 years, creating a profession of case managers, have served, in the end, to exacerbate inefficiencies; stories abound of multiple case managers responsible for organizing services for the same family.

A key thinker on corporate restructuring, Peter Drucker, calls for reexamining government roles to promote greater efficiency. He warns against misguided downsizing or wholesale organizational dismantling before the nation clearly frames the goals of government (Drucker 1995). Salamon urges policy makers to look beyond privatization and utilize all of the tools of government to create a system that balances the functions of the public and private sectors (Salamon 1989). An evolving constituency for efficient administration can be found among the nation's largest foundations, including the Robert Wood Johnson Foundation and Pew Charitable Trusts, which have created programs of integrated children's services at the state and local levels (Robert Wood Johnson Foundation Child Health Initiative: Removing Categorical Barriers to Care; Pew Charitable Trusts' Children's Initiative). These foundation-funded experiments indicate that local and state efficiencies cannot be achieved, however, without the support of vertically integrated structures. We believe the impetus embodied in these forces for more efficiency and effectiveness in government will persist and form the basis for reform. For these and other reasons, it is apparent that federal legislation for children's programs will

inevitably be rewritten, resulting in reductions and restructuring. Might not this environment provide the opportunity to envision how public funds can be better overseen and how the threads of governmental structures can be woven more elegantly to fashion a strong fabric of effective public policy?

Notwithstanding the convincing rationale and potential for an agenda to reorganize and refocus national policies and programs for children and families, countervailing forces and opposition to reform will surface. For example, some governors have adopted the notion of block grants as the singular strategy to achieve local control and efficiencies in service delivery. What goes unrecognized, however, is that the history of the last 20 years of block grants shows the need for specific requirements to ensure accountability, federal protection in cases where states do not assure local involvement, and federal provisions to maximize the benefits of flexibility for the populations served. Similarly, professional constituencies may oppose the restructuring of children's programs because they fear that any change in the entitlement legislation and established programs will result in weaker governmental efforts and less professional authority. These constituencies frequently defend even the most inefficient and poorly implemented programs.

To alleviate such potential opposition, and to address legitimate concerns about maintaining a base of support while change occurs, we call for a strategy that begins with a comprehensive plan, identifying what needs changing in existing legislation, and following that plan incrementally as legislation is opened up. What we propose is a process of reweaving, rather than a wholesale recycling process. Some, perhaps much, of what exists is effective, and/or otherwise very much worth preserving: we must apply our knowledge in a disciplined and directed way.

Conclusion

In the current national debate over the role of the federal government, critics often choose to ignore the positive aspects of federal programs. Pejorative terms like "welfare" or stigmatized concepts like "block grants" are rarely applied to services for powerful constituencies like the elderly. Few tenable proposals are being made to cut their benefits substantially.

The tools of government that have been used in building this system of services for the elderly are available to us for use in improving the lives of a politically weak population: women and children. This article demonstrates how effective legislative, structural, and programmatic elements can be borrowed from one population to serve the needs of the other. As a nation, we need to have the political courage to extend the attributes of a system that works for grandparents to their grandchildren.

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