CHILDREN'S HEALTH: A TIME FOR OPTIMISM?

Seth J. Chandler* and Mary Anne Bobinski**

FOREWORD

As the articles in this inaugural symposium issue of this journal suggest, children are targeted by the customary modern predators of humanity—unthinking viruses, bacteria, and anonymous or hostile other humans armed with fearsome weaponry or poisons peculiarly known as “drugs.” More insidiously, however, children are also attacked by those we rightly think of as usually being their allies—their parents and, sometimes, their healers. Yet, law is an unwieldy instrument for improving the medical condition of children in the United States. Diverting scarce resources so that the clumsy, erring fist of government can interpose between children and their cloaked foes is, as at least some of the articles suggest, a hazardous and sometimes unpopular effort. And so this symposium is a snapshot of the modern dilemma, filled with optimism that “no child be left behind,” and yet containing sobering evidence as to really how difficult it will be to use law as the instrument of elevation.

The most optimistic of our five symposium authors is Marian Wright Edelman, Founder and President of the Children’s Defense Fund, who has the courage to proclaim that we can use government policy to cure not all, but at least many of the medical woes suffered by children in modern America.† It is an argument with a heavy burden: that the United States has attained the resources, knowledge, and wisdom to use law and its instrument, the state, to protect its young in ways that few other societies throughout the history of the species have been able to attain.

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At the heart of Edelman's argument, literally and figuratively, is the assumption that it is right and just to reallocate wealth for the benefit of children within the United States. And a redistributive solution has considerable merit. It is deeply troubling that our medical fortunes are determined not by our own industry but are influenced significantly by that over which we have no control: the family into which we are born. It thus makes particular sense to use government as an instrument to give all children a far more equal opportunity to succeed until such time as we hold them responsible for their own fate, leaving only a modest safety net between misfortunes.

1 Sometimes Edelman couches his argument in terms of providing "insurance." Given the prevalence of third party payment for medical care in modern America, the rhetoric of insurance makes sense. But one must not fall into the trap of thinking that, because the mechanism of payment is insurance, the element of wealth redistribution is missing. Insurance that is not paid for in one way or another by the insured is essentially a program like food stamps, a government welfare program paternally restricted to a particular use, itself regulated by government.

2 Neither her address nor this forward is in the forum for broadly considering critiques of the redistributive ideal. Suffice it to say that redistriuction of wealth requires a second way or another, taxation on productivity that can reduce the size of the pie. See Herbert Hoovershamp, The Limits of Preference-Based Legal Policy, 89 N.Y. U. L. Rev. 4, 66-68 (1994).

3 Cf. Dan Fullenweider, On the Possibility of an Inverse Relationship Between Tax Rates and Government Revenue, 19 J. POL. Econ. 3 (1983) (tracing this notion back to Adam Smith's The Wealth of Nations). In so doing, it threatens actuality to decrase the health of society and the broader the domain of what we call health care—giving free air conditioners to people with asthma, for example—the greater the tax will need to be. Also, redistribution to children based on fruitlessness while confining the scope of redistribution to persons with certain stances in the United States is intellectually troubling. Children in Mexico, Afghanistan, and China are equally qualified and often have greater need. Finally, as a practical matter, statutory redistributions of financial wealth of the sort that are essential for modern governments to compel may accomplish little where the distribution of human capital is growing somewhat intractably unequal. Cf. New MacCormick, Legal Right and Social Democracy 4 (1982) (arguing that attempts to prevent unequal outcomes after an original scheme of equal distribution must involve a systematic form of governance to maintain a "perpetual litigation into every possible cause of supervening inequality and a perpetual redistribution of the fruits thereof.").

4 The influence works in two ways. The genes our forbears provide influence our medical futures, though they often do not control it. And the nomes and economic environment of those to whom we are likewise steer the way in which we are likely to develop. See generally Richard Dawkins, The Selphish Gene (1976).

5 This assertion raises the issue of what we mean by childhood. A binary approach that divides human life between child and adult stages based on chronological time is underinclusive and overinclusive in getting at characteristics such as "innocence" or "helplessness" that partly characterize what we often mean by childhood. See Elizabeth H. Scott, The Legal Construction of Adulthood, 29 HOWARD L. REV. 547 (2000); Joseph Hoffman, On the Parity of Line-Drawing: Juvenile and the Death Penalty, 40 HASTINGS L.J. 225, 274-77 (1989) (noting problems with using chronological age as a basis for determining eligibility for death penalty). Moreover, such an approach draws a line that varies significantly across time and culture. See generally Philip Arms, Captures of Childhood: A Social His-

6 Edelman proposes to accomplish this goal in part through what is called a refundable tax credit focused on the poor. Edelman supra note 1, at text accompanying notes 76-79. This scheme would redistribute wealth from those without legal responsibility for children to those with such responsibilities. Middle income people would see their taxes reduced in proportion to the number of children for which they are responsible. Poor people responsible for children might actually receive cash from the federal government. The hope is that the resulting increase in disposable income among the favored will be used for the benefit of their children and that it would not encourage the creation of children for whom parents were formally responsible but who actually received little benefit from the federal government.

7 Indeed, if one pushes the logic of Edelman's argument, it might make sense to force women to obtain socially accepted levels and types of prenatal care. Such compulsion breaches heavily, however, on the civil rights of women, particularly in a society that is not willing to accord fetuses full legal rights. Cf. Ferguson v. City of Charleston, 552 U.S. 67, 121 S. Ct. 1281 (2001) (warrant required before state can be involved in testing tissues of pregnant women to confirm suspicions of cocaine abuse); In re Baby Boy Doe, 632 N.E.2d 326, 328-31 (N.Y. 1994); 922 IL. App. Ct. 1990 (comitant woman's choice to refuse medical advice to obtain center section during pregnancy must be honored, even though substances which choice may be harmful to her fetus). As Professor Bozang notes in her article in this symposium, it is hardly fanciful to think that either because of denial, manipulation, or because they are actually correct, many parents will not without legal compulsion give birth children the sort of medical care the majority think appropriate. See Kathleen M. Bozang, CAS for Kids, 1 HOUS. J. HEALTH L. & POL'Y 109 (2001).

8 The Gini coefficient is a standard measure of inequality. It ranges from zero for perfect equality to one when all income is earned by one household. According to research from Professor A.B. Atkinson, the Gini coefficient for the United States is approximately 0.34. For the United Kingdom the coefficient is approximately 0.33, and for France it is 0.31. A.B. Atkinson, The Distribution of Income in Industrial Countries, in Procedings of Federal Reserve Bank of Kansas City, available at http://www.kfc.frb.org/PUBLICATION/ SYMPOS/1998/98atkinson.pdf (last visited Sept. 24, 2001).
raised the immunization rate amongst its children substantially during the late 1990s. Research funded partly by government has helped to reduce both the incidence and mortality associated with childhood cancer. Thus, at least some times and in some places, government intervention does seem to help children’s health. The debate in which the remaining authors of the symposium participate is whether Edelman’s optimism is based on more than limited evidence in more than limited situations.

The article of Sara Rosenbaum and an interdisciplinary team of experts enters this debate, skillfully blending close statutory analysis with modern empiricism. It examines the latest major American program designed to protect children, the State Children’s Health Insurance Program (SCHIP). Professor Rosenbaum’s team takes a close look at how states, when given the choice from the federal government, have actually implemented the SCHIP program. The focus is not on the common law, which has come to play but an increasingly interstitial role in the development of health policy, but rather on the main tools of the modern state—the nitty-gritty of statute and regulation.

Rosenbaum finds that in implementing their SCHIP programs, most states have chosen not to give children an entitlement to medical treatment limited only by vague “medical necessity” concepts or by identification of sets of pre-approved treatments. Instead, most of the states have sought to balance the medical desires of those purporting to act for children against the pressing needs of society: police, education, or transportation. Moreover, the study finds that most states have made future funding of the entitlement-based Medicaid program and the balancing approach of the SCHIP program more difficult by using different contracts with incongruent sets of providers to implement the two programs.

The Rosenbaum article suggests the importance of looking at the politics behind law. States, when acting indirectly through their elected federal representatives, have failed for thirty-six years to overthrow a Medicaid regime that has made health, at least for certain children, a nominal “entitlement.” Yet, when given the ability to act on their own with a new program, unburdened by either inertia or the possible political unseemliness of cutting something called “Medicaid,” most states have rejected the redistributionist agenda of advocates such as Edelman. While those of limited resources will temporarily be given the opportunity to avail themselves of the solid safety net of SCHIP coverage, it will be as a matter of federal and state grace in times of wealth, subject to retrenchment or even revocation as the state and nation adjust their priorities to meet other exigencies. While the seeming paradox might be resolved by hard looks at the extent to which Medicaid, as it really operates, constitutes an “entitlement” or the extent to which SCHIP programs, as they have so far evolved, really fail to grant the sort of full medical treatment favored by many, Rosenbaum rightly points out that there must be some reason for states to reject the option simply to expand the Medicaid program.

Abigail English and Madlyn Morreale focus the debate about how to better the health of children by presenting what they assert are the often neglected needs of adolescents. They argue that adolescents need access to knowledgeable health care providers, protection of confidentiality, and funding for comprehensive care. The authors suggest that governments must play a key, though not sole, role in meeting these needs. The article is a comprehensive assessment of the medical, legal, and policy response to adolescence from its earliest recognition as a distinct life period to the present day.

English and Morreale follow Edelman and Rosenbaum’s team in arguing for the importance of government in either encouraging or funding programs that will give adolescents the financial ability to obtain health care. The percentage of adolescents without health insurance has remained relatively stable over the past fifteen years within a range of a little over fourteen percent to a little under eighteen percent. English and Morreale argue, however, that this ap-

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11 It is probably better to think of a Medicaid “entitlement” as belonging to the legal guardians of the children, because it is unlikely that children, acting apart from their parents, will as a practical matter be able to raise a claim for additional medical services.
12 Sometimes this identification of treatment is done through “vouchering,” which is listing a set of treatments that must be provided. See, e.g., 42 U.S.C. § 1396d(a)(3) (Supp. IV 1998) (establishing pediatric vaccination program under Medicaid). Other times the identification is more conceptual. See, e.g., 42 U.S.C. § 1396d(b)(2) (Supp. IV 1998) (Medicaid plan must provide for “inpatient hospital services”).
13 Rosenbaum, supra note 9, at 49.
15 It is interesting to note, in this age of youth-centered advertising and culture, that adolescent medicine began to develop only fifty years ago. See Scott, supra note 5, at 567.
16 English, supra note 14, at 67 nn.19, 21.
parent stability masks a trend in which adolescents are increasingly
covered by public, rather than private, insurance programs. They
also note the importance of some of the less well publicized govern-
ment-funded health care programs, including school-based health
centers, Title X, Title V, and the Ryan White Care Act. The article
reveals some of the limitations of government financing, including
the risk of state or federal funding cutbacks and the sobering ob-
servation that a significant percentage of adolescents who go with-
out insurance actually are eligible for public insurance programs.

English and Morreale argue that government plays another
important role in creating a zone of autonomy within which adoles-
cents are empowered to make their own health care decisions free
from parental knowledge or intrusion. State governments began to
construct the zone of adolescent autonomy nearly fifty years ago
with the enactment of a variety of rules permitting some minors to
consent to health care in certain circumstances. Previously, their
parents or guardians would have had to consent. The zone of auton-
omy has been bolstered by Supreme Court decisions that supple-
ment, and in some cases supplant, the framework supplied by state
law. As the authors note, one result is that the dimensions of
the zone of autonomy change when moving from state to state.
Further, political support for adolescent autonomy—which necessi-

27 Id. at 67 n.22. The recent economic boom may have tempered this trend somewhat, with a
slight increase in the percentage of children covered by private health insurance. See U.S.
Census Bureau, Dept of Commerce, Current Population Reports: Health Insurance Cover-
age, 1999 ( tbl. 6), at http://www.census.gov/hhes/hlthins/bhlht99/hlb99.html (last
28 English, supra note 14, at text accompanying notes 90-148.
29 Id. at 107 n.23. See also American Academy of Pediatrics, Improving Access to Children’s
facts06.htm (last visited Sept. 24, 2003) (providing fact sheets for the United States and
stating, “Over two-thirds of the total number of uninsured children ... are eligible for
Medicaid or separate state programs but are not enrolled”). While English and Morreale
do not assign responsibility for this failure to government or to the parents of adolescents,
they do note the importance of parental involvement. English, supra note 14, at text accom-
panying notes 154-58. Edelman and others implicitly argue that government must address
the issue of eligible yet uninsured children through the simplification of Medicaid enroll-
ment. See Edelman, supra note 1, at 26.
30 English, supra note 14, at text accompanying notes 44-45.
31 Id. at text accompanying notes 81-93.
32 Id. at text accompanying note 97.

rily limits parental authority—is waning at both the state and fed-
eral levels. Significantly, English and Morreale also note the importance of
non-governmental actors in promoting children’s health. The au-
tors trace the beginnings of adolescent medicine in the 1950s
through the first steps of creating an “adolescent-friendly” system of
health care providers. They argue that the health care needs of ado-
lescents cannot be met unless health care providers themselves in-
vest in relevant education and research. While government funding
has encouraged the development of some adolescent service provid-
ers, the authors argue that more action is needed by the private sec-
tor and government to ensure that the system of adolescent care
remains intact during the conversion to a managed care market.

Professor Kathleen Boozang focuses on the risks parents create
by employing complementary and alternative medicine (CAM) to
treat their children. Between one-third and one-half of American
adults use CAM for themselves; the percentage of parents employ-
ing CAM for their children is unknown but thought to be signifi-
cant. Parents of children with chronic or serious illnesses may be
particularly prone to explore CAM. CAM therapies include chiro-
practic, homeopathy, acupuncture, and the use of herbal or nutri-
tional supplements. Children participating in CAM can be at risk
for negative health outcomes because of the possibility that CAM
delays more effective traditional care, because CAM actually
presents a risk of harm, or because of negative interactions between
traditional medical treatment and undisclosed CAM therapies.

While Boozang effectively argues that parental CAM use can
injure children, she does not reflexively advocate increased govern-
mental regulation as a necessary shield between parent and child.
Instead, Boozang carefully analyzes the legal limits on parental au-
thority, noting that our society tends to value parental autonomy
over government interference in many situations. She considers
four different interventions, ranging from outright prohibition by
government to greater education about CAM for private
physicians.30

Boozang contends that governments cannot use outright statu-
tory prohibitions to effectively protect children from the risk of
CAM, in part because of the absence of consensus about which
CAM procedures create sufficiently grave risks to justify such a
ban.31 She argues that less restrictive forms of CAM regulation
might be more effective, such as rules requiring CAM providers
wishing to treat children to coordinate their care with traditional
physicians.32 Professor Boozang gives equal weight, however, to
other strategies that do not rely as heavily on direct governmental
prohibition. She discusses the promise and problems associated
with increasing parental knowledge about the risks and benefits of
CAM.33 Finally, Boozang acknowledges that physician concerns are
most often the stimulant for governmental intervention into paren-
tal treatment choices.34 She provides guidelines for mainstream phy-
sicians, who might be tempted by their training to view all forms of
CAM as "unreasonable" parental decisions about care. Primary reli-
ance on physicians as a vehicle for policing CAM is problematic,
however, as parents interested in CAM may simply bypass conven-
tional medicine altogether.35 For Boozang, there are no sure cures
for the risks CAM creates for children, but private physicians are an
important adjunct to governmental intervention.

Dr. Ellen Wright Clayton also focuses on the problems of gov-
ernment intervention when parents prey upon their children and

(A) state limits on children’s behavior, such as state limits on driving or the use
of alcoholic beverages;
(B) state public health and safety statutes which compel certain types of parental
behavior, such as state laws requiring parents to use child safety seats;
(C) state laws limiting parental choices, such as federal rules limiting parental
authority to authorize a child’s participation in research;
(D) state laws mandating particular medical procedures, such as vaccination; and
(E) state laws permitting governmental intervention to protect children from the
consequences of “unreasonable” health care decisions (noting cases in which
parental religious beliefs regarding traditional medical care place child at
risk). Id. at 120-26.

30 Id. at 126-31.
31 Id. at 127.
32 Id. at 127-31.
33 Id.
34 Boozang, supra note 7, at 129.
35 Id. at 128-31.

the role of private physicians in initiating government action.38 The
conflict that troubles Clayton is not the result of parental ignorance
or healer manipulation, but rather the brutal force sometime directed
by parents at their young. Clayton notes that government has
attempted to control this abuse by creating a legal duty on the part
of physicians to report suspected child abuse. Although, as she
notes, these new laws often divert the proper energies of physicians
and disrupt the physician-family relationship, these consequences
are not her major concern. Instead, it is that government has chosen
to make physicians agents, who are thrown into the frontlines of
this battle and who are extraordinarily vulnerable to attack, while
denying them the resources needed either to conduct full investiga-
tions of suspected abuse or to defend themselves from retaliation
by reported parents. The result of what some would call another un-
funded mandate is expensive and demoralizing for a profession that
has seen its independence and income challenged in recent
decades.39

Clayton’s particular focus is on the scope of immunity statutes.
State employees who work in the field often fall under the protect-
tive umbrella of sovereign or executive immunity. Private phy-
sicians (who often have personal and insurance assets) currently do
not. Her solution is thus to extend to physicians reporting child
abuse the same immunity accorded those we now accept as state
actors.40 Like Edelman, Clayton appears optimistic that this fine tun-
ing of the prior government intervention would improve children’s
health without significant adverse side effects.41

36 Ellen Wright Clayton, To Protect Children From Abuse and Neglect, Protect Physician Report-
37 In reaching these conclusions, Clayton relies significantly on personal experience and
ecdote. She also relies on case reports involving suits against physicians as well as medical
studies showing that many childhood trauasms are indeed most likely caused by abuse.
38 Clayton, supra note 37, at 134-35. Alabama, California, Ohio and possibly New Jersey
already have done this. See Caroline T. Trest, Chilling Child Abuse Reporting: Rethinking the

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The authors in this symposium issue offer many reasons to hope that the future of children’s health care is full of promise. They have identified many of the social and legal impediments to improved health status for children. They also have suggested strategies for overcoming these barriers. For Edelman, Rosenbaum, and English, optimism about the future depends at least in part on whether federal and state governments maintain the will to intervene and whether the tools of intervention are proven to be effective. As we go to press, recent world events have made increased federal funding for children’s health care issues somewhat less likely. Further, funding for health care is no guarantee that parents will take actions necessary to protect their children from harm. Less redistributive and more regulatory approaches may be adopted over the near term. But, as Boozang and Clayton note, even direct regulation to reduce the risk of harm to children can be controversial or ineffective. As a whole, then, the authors of this symposium leave the reader with a sense of guarded optimism. We are grateful that researchers and advocates for children have done so much to illuminate the problems and potential solutions.

CHILDREN’S HEALTH NEEDS FOR THE COMING YEARS

Marian Wright Edelman*

SYMPOSIUM ADDRESS

I am very honored to be here, and to have a chance to thank all of you who pulled all the pieces together to make this a collaborative symposium to talk about our children’s health. It is going to take all of us coming together to do what we have to do for our children and to make sure that no child is left behind.

I want to thank the Health Law and Policy Institute (HLPI) for sharing with the Children’s Defense Fund (CDF) one of your advisors, Michael Solar, who is a very valued member of the Board of the Children’s Defense Fund. I know he is a very valued member of the HLPI Board. I am delighted to be here and I want to thank you for what you are doing and for holding this symposium, because I think this is a very magical time when we have enormous opportunity to do what we all have to do for all of our children.

I think it is a moment of opportunity because you have sent us a President of the United States who has “adopted” the trademarked mission of the Children’s Defense Fund, which is to Leave No Child Behind.® We are going to work as closely as possible with him to define what that means and to make sure, at this moment of great prosperity, that we take the needed steps to achieve our national policy mission and that we take the steps, with your help in Texas, to see that no Texas child is left behind.

This really is a magical moment in history with a new millennium, a new century, a new year, a new President, and a new

*J.D., Yale University; B.A., Spelman College. Marian Wright Edelman is the Founder and President of the Children’s Defense Fund in Washington, D.C. The “Children’s Health Needs for the Coming Years Symposium” was held on the morning of Tuesday, February 21, 2001 at the Fair Park Warlick Hotel in Houston, Texas. The lecture was co-sponsored by Landers & Gilchrist, P.C., the University of Houston Law Center’s Health Law and Policy Institute, and assisted by Texas Children’s Hospital and The Children’s Museum of Houston. Marian Wright Edelman’s keynote address was professionally transcribed and then formatted into this article through the combined efforts of the Houston Journal of Health Law & Policy editors and the Children’s Defense Fund.