

Lecture October 17, 1988
16/20

Keynote Address: Child Health Care in the 90s

By
C. Everett Koop, MD, ScD
Surgeon General
Of the
U.S. Public Health Service
U.S. Department of Health and Human Services

Presented to the American Academy of Pediatrics
San Francisco, California
October 17, 1988

This is not only the occasion of the Academy's Annual Meeting but it was the 40th Anniversary of the founding of the Surgical Section of the American Academy of Pediatrics. I happen to be the only living member of the group of eight who founded that organization in 1948. I was at that time a young man of 31, clean shaven and unbelieving of the fact that I was one of such a small number that are the real beginnings of organized pediatric surgery which has distinguished itself so well in this country over the past five decades.

Pediatric surgeons were persona non grata among surgeons and I have always been grateful that the Academy of Pediatrics provided the fledgling specialty with its first resting place and gave it its cache of authenticity. The Academy made room for us and collegially supported us in our struggle to understand and define what we wanted to do for children and how we ought to go about doing it. That considerable pat on the back for the Academy of Pediatrics and the specialty of pediatrics was a suitable preamble to the thoughts I wanted to share with the Academy that morning. It was also perhaps the last chance I would have to do something like that because my term of office ended at the end of October in 1989. I began then by reviewing some of the things we had done together – the Academy and I, the Surgeon General. I reviewed a very early entrée into the problems of child abuse and family violence in general, moving up to the first Surgeon General's Workshop of Violence and Public Health three years later. And then just in the current month the release of a document entitled: "The Surgeon General's Letter on Child Sexual Abuse" and designed for use by the practitioner.

I then moved on to the "Baby Doe" issue where the Academy and I appeared to be on different sides of the issue but were not. Although I was probably the person in the country that who had more experienced with actual "Baby Does" than any other, the regulations that followed Baby Doe's death were put together without any consultation or any acknowledgement of my expertise. So it is to be expected under those circumstances that when the government was sued over those regulations, I was the government's expert witness defending something that I thought was handled rather poorly. That whole situation was repeated again and finally when the third occasion came, I refused to

represent the government as a defendant if I didn't have some input into the regulations. Secretary Heckler gave me that authority. Even though we were sued again, it was an amicable arrangement and before things were over those who were displeased with the first two sets of regulations had put together with me a rather remarkable document, which was essentially a bill of rights for neonatal care. I did make it clear however, when one talks about who won in that episode it was the children of America.

I then moved on to the cooperative work we had done on many fronts with handicapped or as we grew to call them, special needs children and their families. I announced the planning for a Surgeon General's workshop on the subject for the spring of 1989, where a unique focus was to be on the problems the handicapped child that his or her family has in the transition from child to adult. That is when the child outgrows the kind of care provided by the pediatrician and needs to be handed on to the waiting and capable hands of a practitioner of adult or family medicine. Another great complication in that time of such a child's life is the fact that the parent's insurance for health is no longer valid for the child.

AIDS was the next milestone I talked about and said it in the context of sexually transmitted disease, and then moved on to Otis Bowen's department wide initiative on alcoholism and alcohol abuse.

But what about tomorrow? What about the child health needs of the 90s and even beyond? The President of the Academy had asked me to include this in my remarks. I issued a Surgeon General's warning right then and stated that what I was about to say reflected my own thinking and my own perceptions. They are not necessarily the positions of any administration present or future. I started by taking a look at the group we call children that goes from neonates through the age of 18. The major thrust of my remarks was that what had existed for 200 years is changing because children will no longer be dominant. Five years ago 28% of the American population were children under the age of 18. But by the year 2000, eleven years from the time I was speaking, those two populations would be in balance and then by the year 2010 the balance would go the other way. At that time 24% of all Americans will be under the age of 18 but 26% will be over the age of 55. If our American demographics are in transition so must be our health planning and resource allocation.

Our strategy for tomorrow has to be a little different than it has been in the past. We have to fight for more support for children. But we can't fight for the support at the expense of other population groups especially the elderly. I then moved on to something sometimes difficult to understand. The largest single group of poor people in the United States is children—12 million—or about 1 out of every 4 Americans under the age of 18. But this is misleading. Misleading, because all children have no real economic assets of their own and therefore they're all "poor". Hence, what we really mean is that the single largest population of poor people in the United State is made up of children of poor families. These are two powerful and negative influences on child health in this country: the fact that children will no longer dominate our demographically based health planning and the

fact that a significant number of all children may not have the strong health advocacy they require.

So what should we be doing in that context? I chose to focus on the overriding issue in pediatric medicine and health care: infant mortality. I went into the subject in some detail suggesting we take a second and much closer look at our infant mortality. It must go well beyond the bio medical laboratory. I quoted the statistics from a national study undertaken by the National Center for Health Statistics which looked retrospectively at 10,000 infant deaths – about 25% of the national total—in the 1982 birth cohort from 9 Midwestern and New England states. Some interesting things turned up. The mothers of all 10,000 infants who died were all 20 years of age or older. The researchers then looked at educational attainment and race, and did some cross-tabulation and came up with these new facts: first, the mortality rate among infants born to white women with less than a high school education was 12 per 10000 but among black women was 28. When they looked at those women in the sample who had college degrees or better they found the mortality rate born to white was down to 7.9 but those born to black college educated women was 20.6. Why? Culture, race, genetic predisposition, access, cost? Unfortunately we don't know. Things we have done to improve the lot of white women have not brought comparable benefits for black women right across the socio-economic scale.

Much of our thinking at that time was still in flux. We certainly knew we had to provide universal access to early maternity and pediatric care for all mothers and infants. In our country that translates to: “employers must make available health insurance coverage that includes maternity and well-baby care.” There were more than 56 million women at the time of this lecture, of childbearing age (16-44); almost 28 million of them employed full-time in the American work force. That's 50 percent. If you consider kids 3 years old or younger, half of all their mothers are working full-time.

So with due respect of the Academy and it's members, it is now clearly the managements of business and industry who exercise the most critical influence upon the health of America's mothers and children. So our understanding of the private sector perhaps has to change and shift from the Academy, the San Francisco March of Dimes, and the Y.W.C.A., to companies like Transamerica and United Airlines, AT&T, Marriott, etcetera. They all must collaborate if we are to reduce the infant mortality in the 90s.

In closing I suggested that first we had to strengthen our role as child advocates, we must go back to our data and try to understand them in the context of diversity and heterogeneity of our national life, and we need to expand our community of maternity and child health advocates to include the for-profit as well as the not-for-profit wing of the private sector.

I thanked the Academy for being active members of a courageous, generous and dedicated profession and after my uniform is cleaned, pressed, and hung in the closet I'd like to look back with them on a job well done.