

The 2007 Fedele F. and Iris M. Fauri
Memorial Lecture

*A Historically Based Thought Experiment:
Meeting New Challenges for Children's Health and Well-Being
in the 21st Century*



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The Fedele F. and Iris M. Fauri Memorial Lecture in Child Welfare is presented annually in recognition of former University of Michigan Dean and Vice President Fedele F. Fauri and his wife. Dean Fauri's leadership and accomplishments in the field of child welfare spanned nearly 50 years. Much of the current social welfare legislation at both the state and federal levels is the product of Dean Fauri's activities, first as Director of the Michigan Department of Social Services, and then through his years in Washington, DC, where he held numerous leadership positions including Senior Specialist in Social Security for the U.S. Senate, Social Security Advisor for both the U.S. House of Representatives and the U.S. Senate, Social Security Advisor to President Kennedy, and Chair of the Advisory Council on Public Welfare for the U.S. Department of Health, Education, and Welfare. His accomplishments in the field of child welfare and social work education brought national and international acclaim to Dean Fauri, the School of Social Work, and the University of Michigan. This lecture series is made possible by gifts from alumni, faculty, and friends, and is intended to serve as a forum for the discussion of ideas and proposals to enhance further the well-being of young people.

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In the fall of 2004 and again in spring of 2007, the journal *Health Affairs* asked my colleague, Professor Janet Golden of Rutgers University, and me to write some historical perspectives on children's health policy in the United States and how that history had shaped our present. It was, to put it crudely, an intriguing gig because *Health Affairs* is not only the leading journal of health policy wonks across the nation, it is also read by every Congressperson—or his or her staff members—who is concerned with health issues. So here was a chance, we thought, to, at least, speak truth to power. Many of the historically informed and entirely impassioned conclusions we made would not be a surprise to an audience comprised of the University of Michigan's School of Social Work. They were:

1. Focus on the environment that makes children sick rather than on sick children.
2. Attack the biggest health problems, not just the most interesting ones.
3. Children's health and welfare professionals need to go where the children are!
4. We do not exactly repeat the past, but that doesn't give us permission to ignore it either.

In all candor, we hardly expected many to pay all that much attention to our cliometric analysis; as a historian I am used to being ignored or, at best, tolerated as a literary form of window dressing when major events come up that need a "bit of historical context" or, in the case of anniversaries and celebrations, some background to demonstrate how far we have progressed.

In some sense, however, the Fauri Lecture is a much better bully pulpit not only because it is delivered to a body of distinguished social workers and social theorists who are "on the ground," so to speak, in our struggle for social justice for all Americans, regardless of race, creed, or age, but also because it affords me the opportunity to try to convince you about the remarkable value of historical insight. I may be called biased, but I believe that historians have a great deal to offer to those struggling with policy dilemmas—not only because they have a nuanced and contextualized view of how the dilemmas began and evolved, but also because a study of the past reveals many useful models and good ideas that still deserve to be acted upon. Or as the late President Harry Truman once opined, "There is nothing new in the world, except the history you don't know." This is particularly true in the case of U.S. child health and welfare policy.

I take as part of my lecture's title, "a historical thought experiment," from the school of Aristotle, where, it will be recalled, the ancient philosopher encouraged his students to think out the potential ramifications and results of whatever social quandary they were trying to tackle. In terms of children's health and well-being policy, I suggest we begin such a thought experiment by looking back to the early 20th century, when it appeared for the briefest of moments that children would be the centerpiece of our federal domestic policy, with the founding of the Children's Bureau in 1912 and subsequent children's well-being and health policies. From there, I want to ask the question: *Where would we be today if the vision that propelled the founders of this first federal agency devoted exclusively to child welfare had been realized? Or, what if the United States now created a cabinet-level agency dedicated to children?* In other words, what if we developed a comprehensive, functional, and effective U.S. Department of Children (DOC) that would unite the many disparate federal departments all contributing to the well-being of children, but currently working without coordination and in agencies with other primary agendas?

But first, let's look at some history.

Rise and Fall of the Children's Bureau

Pediatrics is a relatively new development in the history of medicine, not having taken root until the late 19th century. Although the American Medical Association (AMA) established a Section on Diseases of Children in 1880 (which became the Section on Pediatrics in 1933) and the independent American Pediatric Society (APS) was founded by 43 nascent pediatricians in 1888, the profession of pediatrics remained a limited medical enterprise, at best, for much of

this time. Beginning in the mid-1800s, a handful of the largest U.S. cities established freestanding hospitals devoted almost exclusively to childhood surgical conditions such as orthopedic anomalies. Although at the close of the 19th century, 50 physicians established practices with a focus on children, none practiced pediatrics exclusively. Indeed, the leading U.S. pediatrician, Abraham Jacobi, admitted in 1880 that if he restricted his practice solely to the diseases of infancy and childhood, he “would make himself ridiculous.”

During the early decades of the 20th century, the field expanded, as did the places in which pediatricians plied their trade. Children’s hospitals, orphan asylums, specialized clinics, and dispensaries sprang up; at special “milk stations,” clean milk was provided to poor children in concert with what most pediatricians would recognize today as the well-child examination. However, a critical and more universal theme running through this focused work for child health had to do with social factors. In an era in which child labor was still all too common and many young people grew up in slum housing or impoverished rural communities, activists were inspired to attack the causes and consequences of child poverty and ill health. Among their goals were increasing the income of the workingman or breadwinner so that he could better accommodate the needs of his family, providing widows with aid so that they could rear their children at home rather than placing them in institutions, improving institutional care for orphaned or abandoned children, and cleaning up neighborhoods and improving tenement housing. These income- and environment-focused measures typically overshadowed those aimed specifically at the medical needs of children, but they were seen as ultimately providing for a healthier childhood.

The nascent infant and child health movement that united public health officials, philanthropists, health care professionals, and social workers in a crusade to lower the infant mortality rates during the late 1890s and progressing into the early 20th century quickly matured into an effective political organization. A major victory came in 1912 when the U.S. Congress enacted and President William Howard Taft signed into law the Children’s Bureau, an agency within the Department of Labor, and gave it a mandate to “investigate and report on all matters pertaining to the welfare of children.” The Children’s Bureau had long been a dream of groups such as the National Consumers’ League, the General Federation of Women’s Clubs, and the National Congress of Mothers. It was directed by the brilliant Julia Lathrop, a distinguished “graduate” of Jane Addams’ Hull-House in Chicago. Among the Bureau’s early efforts were programs to help communities improve sanitation and milk supplies; the creation of child hygiene divisions in state-run public health agencies; the production and distribution of two influential, instructional pamphlets (“Prenatal Care” and “Infant Care”); and campaigns involving free diagnostic evaluations by health care professionals.

These efforts helped to decrease infant mortality in large urban centers in the United States during the opening decades of the 20th century. Nevertheless, infant mortality remained high at 131 deaths per 1,000 live births, prompting the Children’s Bureau leaders to make combating infant mortality a top priority. Early investigative reports documented the effects of poverty on child health and pointed particularly to the problem of maternal employment. The findings led reformers to propose maternity benefits in the form of medical services to pregnant women and compensation for lost wages that would permit them to stay home and breastfeed their infants. Modeled on similar programs in other industrialized nations, the proposals met with vehement opposition from the AMA (which objected to federal intervention in the distribution of medical care) and others who feared that cash payments to low-income households might limit the supply of workers and cause wages to rise. Forced to find another solution, reformers turned to a more constrained program of maternal education and infant child care carefully designed to avoid antagonizing private physicians; the Sheppard-Towner Maternity and Infancy Act, first proposed in 1918, was signed into law in 1921. The act authorized the federal government to grant funds for maternal and infant welfare to each state, provided the individual states passed their own “enabling legislation.” The federal government supplied approximately \$1.25 million a year to the states, which used the funds for child health and prenatal centers, instructional home visits by nurses, and distribution of educational materials. The funds went only to education and child care; infants and children needing medical care were referred to private physicians or, if unable to afford such services, municipally supported providers.

Congressional debate over the Sheppard-Towner Act was shaped in part by recent wartime experiences. The poor health of many World War I draftees, with 29.1% judged unfit for service, surprised many who were unfamiliar with the health problems of younger, poorer U.S. citizens. In Michigan alone, over 30% of all registrants for the draft in 1918 were rejected because of thyroid enlargements that were the direct result of iodine-poor diets, an indication of the types (and variety) of health challenges facing the nation's youngest citizens. One result was that office-based pediatricians increased their attention to weight, growth, and overall preventive health measures.

Reform organizations used the findings about draftees to press for programs that would facilitate the health of the nation's poor in general and their children in particular. In 1919, the American Association for the Study and Prevention of Infant Mortality became the American Child Hygiene Association, demonstrating its expanded commitment and mission. Under the leadership of Herbert Hoover, the organization merged with the Child Health Organization to become the American Child Health Association. Hoover served as its president for most of the 1920s while he was secretary of commerce in the Harding Administration until his election to the presidency in 1928. During this period, the Sheppard-Towner Act was passed and implemented.

Efforts to pass federal legislation for maternal and child health, however, divided the medical profession, putting pediatricians at odds with other physicians and the leadership of the AMA. During the 1920s, as pediatrics became one of the fastest growing specialties, anxieties about the relationship between pediatricians and social reformers eased somewhat, but in their place new conflicts emerged. The Sheppard-Towner Act provoked the biggest fight of all. The majority of pediatricians supported the act, as did a number of influential women's groups, social workers, politicians, and social-activist societies. Still, although the Sheppard-Towner Act explicitly avoided the free dispensation of clinical care, it sparked the ire of many in the medical establishment. Many opponents invoked the specter of the recent Bolshevik revolution, suggesting it was "inspired by foreign experiments in Communism and backed by the radical forces of this country." Today that trope is typically cloaked in the ominous phrase *socialized medicine*.

Most vociferous in its condemnation was the AMA, which claimed that the law would harm the public and mark an unprecedented intrusion onto states' rights. While the AMA governing House of Delegates was busy condemning the Sheppard-Towner Act, its Section on Diseases of Children voiced its support. The resulting schism, which culminated with the AMA formally chastising the members of the Section on Diseases of Children, motivated many pediatricians, already estranged from the more elite and research-driven APS, to form a new professional group, the American Academy of Pediatrics, in 1930. Devoted principally to advocacy, education, and primary care, its motto was "For the Welfare of Children."

The Sheppard-Towner Act proved to be short-lived. The political clout and antipathy of the AMA and conservative women's groups such as the Daughters of the American Revolution brought a swift end to the legislation. The law was not renewed by Congress in 1927 and was virtually defunded by 1929. In its absence, a system emerged that decidedly separated the provision of medical care for needy children from children whose parents were working or had financial resources; the former provision was labeled "welfare," and the latter was called "fee-for-service" or private medicine.

The rapid demise of the Sheppard-Towner Act should not be read as a sign of failure. But as I just intimated, the seven years that the act was in force saw a significant decline in maternal and infant mortality in regions where it concentrated its efforts. The Sheppard-Towner Act also facilitated the routine practice of U.S. mothers bringing their infants to pediatricians for regular checkups. Finally, the act established an important precedent: it was the first time that the federal government provided funds earmarked for children's health needs.

In the wake of growing support for children's health needs and the long shadow cast by the termination of Sheppard-Towner, President Herbert Hoover convened the 1930 White House Conference on Child Health and Protection. From this summit came a seminal document, the Children's Charter, which spelled out the rights of children.

Among them were: “For every child full preparation for his birth; his mother receiving prenatal, natal, and post natal care” and “For every child health protection from birth through adolescence.” Sadly, these noble goals would not be met. Faced with unprecedented fiscal demands during the Great Depression, President Hoover proved unable to marshal the aggressive measures needed to respond to the growing medical and social needs of children or adults. His successor, President Franklin Roosevelt, had far greater success in acting on these pressing needs; it is ironic that his most important effort on behalf of child health, Title V of the Social Security Act (SSA), ultimately would set in stone the divisions between medical care and social welfare and between social insurance entitlements managed by the federal government and public assistance entitlements managed by the states.

Franklin Roosevelt’s first presidential efforts on behalf of child health was the Child Health Recovery Program, which was overseen by the Federal Emergency Relief Administration and the Children’s Bureau. It provided emergency food and medical care to needy children, channeling the resources of public and private health care and relief organizations in each state, with physician-consultants and part-time public health nurses paid by the Civil Works Administration for performing the work. It was the first and only New Deal program for young children until the SSA of 1935.

The SSA contained several streams of funding for children. Title IV provided funds to states for the Aid to Dependent Children program. Title V echoed the programs of the Sheppard-Towner Act, giving federal funds to states that passed enabling legislation for maternal and infant health care or services to “crippled” children and to expand existing child health programs. Although the SSA was the seminal first step in a rapid growth of programs for the elderly, culminating in the Medicare legislation of 1965, it did not lead to similar gains for children, although the Social Security Board, the body charged with implementing the SSA, was well aware as early as the 1930s that the number of economically disadvantaged children was as much as sevenfold that of the elderly. Data from the U.S. Public Health Service showed that the number of children receiving relief was seven times the number of persons aged 65 and older.

Children were, and remain, a social group without political muscle. The Franklin Roosevelt Administration was facing formidable pressure from advocates of flat pensions for all retirees. These advocates helped to ensure the passage of the SSA and sustain its expansion after World War II. Thus, Social Security was born, a program that redistributes income from working families with children to the elderly.

In the 1960s, this pattern was repeated with Medicare, a health insurance program for all elderly Americans that remains an extraordinarily popular social insurance program. On the other hand, social assistance programs for children (welfare) and medical insurance for children (Medicaid) are limited to needy children. They are defined by income limits and other qualifications that result in varying levels of eligibility and services from state to state. Because these programs are not guaranteed to all children in the U.S. population, they are politically unpopular and often threatened. Thus, the greatest pieces of social welfare legislation of the 20th century aided millions of elderly Americans but did so by drawing sharp divisions that would ultimately undermine the provision of medical care and social well-being for children.

It is ironic that World War II made clear to American political leaders, as World War I had done a generation earlier, that children’s medical needs were not being met. The pregnant wives of servicemen were unable to obtain care from base hospitals that were busy providing services to soldiers, lacked the funds to purchase health care, and failed to qualify for local programs because of residency requirements. These families had an effective group of lobbyists on their side; the American Legion and the Veterans of Foreign Wars convinced members of Congress to pass the Emergency Medical and Infant Care Program in 1943. The Emergency Medical and Infant Care Program provided maternity and pediatric care for the wives and children of servicemen in the four lowest pay grades, paying for the births of one of every seven infants born in the United States. Despite having aided many women and children, the program was seen not as providing medical services but as a means of boosting the morale of the patriotic men serving their country in a time of war. After hostilities ceased, the program lost support and ended in 1949.

Even as the federal government hesitated at establishing laws that directly met the health care needs of its most vulnerable citizens, children, it embraced the promise and possibilities of “scientific” medicine. Perhaps no event symbolized this trend more clearly than the announcement, made from the stage of Rackham Auditorium at the University of Michigan in 1955, that Jonas Salk’s polio vaccine was safe and effective. Between that era to the present, funds from private philanthropies and government research agencies such as the NIH flowed into laboratory research and hospital construction. A booming economy and active labor movement ensured that sick- and well-child care became available to growing numbers of families as private health insurance, obtained as an employment benefit, helped pay the costs of hospitalization, including maternity care.

Several programs designed to serve the nation’s neediest children followed: Medicaid (Title XIX of the SSA), including the comprehensive Medicaid preventive child health program known as Early and Periodic Screening, Diagnosis, and Treatment, which is intended to serve needy children under 21 years old; the Special Supplemental Nutrition Program for Women, Infants, and Children; and, most recently, the State Children’s Health Insurance Program. The history of each program, their achievements, and the ongoing challenges they face have been well chronicled. What must be noted is that these programs were built on a foundation erected earlier that continues to leave children more vulnerable than other age groups, including the elderly. For example, in 2002, 9.2 million children under 19 years old (12% of children) in the United States were uninsured. In addition, the United States has one of the highest infant mortality rates in the industrialized world.

In short, today—and for the time being—we are failing our youngest citizens and creating enormous health care costs and burdens in the years to come. Nowhere is this more obvious than the recent debate on Capitol Hill, and thence to the White House, over renewing the S-CHIP program.

The impulses that led to the creation of the Children’s Bureau in 1912 and the passage of the Sheppard-Towner Act in 1921 may have lost their clout, but the *raison d’être* they articulated remains critically important, particularly as our Congresspersons and the President wrangle over the politics of vital children’s health legislation like S-CHIP programs rather than act in statesman-like fashion and take this issue head-on in a definitive, comprehensive, equitable, and efficacious manner. What has been particularly lost in the brouhaha over S-CHIP in recent weeks is a broad consideration of the national mood suggesting that the time is ripe to return to a federal government’s focus on the whole child and improving child health, at least in part, by focusing on family income and community well-being.

Recent attention to the problem of racial and income disparities in health care, the result of both epidemiological investigations and a growing concern to evaluate the outcomes of federally supported programs, has once again suggested the need to view health status as a social indicator. The creation of the National Center on Minority Health and Health Disparities is one signal of this renewed interest. Congressional recognition of child health problems and their need for remediation—as evidenced by the funding of the National Children’s Health Act, the monitoring of NIH funding in pediatric health, earlier funding for S-CHIP, and other initiatives—also suggests a revitalized interest in children as a whole.

On October 18, after the House failed to override President Bush’s S-CHIP veto by only 13 votes, a CBS poll revealed that 81% of all Americans—Republican, Democrat, and Independent—were in favor of S-CHIP’s passage as written; 74% of all Americans were willing to pay more taxes to fund S-CHIP. The critical question to ask, then, is how can we better communicate that political, social, and economic will—what I define as the social decency and moral imperative—in order to persuade elected representatives to legislate a plan that enables the United States to fully embrace the idea it developed nearly a century ago: a federal agency devoted to children? And if so, how do we harness that energy, feeling, and commitment in order to actually make some history?

The Future: Envisioning the Department of Children

Let's pretend it is 2012 and we find ourselves watching the president's State of the Union address to Congress. In commemoration of the successfully inaugurated and running DOC, he—or she—recalls how, exactly one hundred years after the founding of the United States Children's Bureau, the department began its work and notes its success. He describes the effects of universal health coverage for all citizens under 21, the rising standard of health for children, and the overwhelming American pride that this new agency plays in our national life. And since this is our thought experiment, forgive me the liberty of writing—and delivering—the rest of his imaginary speech. Here's what I envision the president saying:

In the health field we see that the funding of infant, child, and adolescent health research, while still divided among multiple NIH agencies, is now fully coordinated with the DOC, establishing priorities for research based on sound epidemiological principles.

In mandating that priority for health care research be given to illnesses causing days lost from work or school before age sixty, we have redirected funding streams. More children are included in clinical trials; more clinical trials involve treatment for common ailments such as asthma, diabetes, psychological disorders, and substance abuse. The rebalancing of medical research has, in turn, renewed and strengthened medical education. Increasing numbers of physicians and nurses now elect to enter primary-care fields—with an important spillover effect that has meant a growth in geriatric medicine. The decision to reimburse preventive primary care at a high rate has also played a significant role in reshaping hospitals and health centers. Not long ago, the secretary of the DOC observed while lecturing to the American Public Health Association “that the physician running the community asthma clinic was less likely to receive federal grants and tenure in a medical school than someone unraveling the genetics of a rare disease who rarely, if ever, saw a patient, let alone taught a student!” Imagine pursuing such expensive and not necessarily healthy policies.

Today, it should be noted, my administration has facilitated and funded major investigations of the environmental causes of disease being conducted at our nation's finest medical schools and hospitals. They are building on research concepts we began to appreciate in 2007, with the inauguration of the still ongoing National Children's Study. This body of knowledge, in turn, has led to new laws protecting our nation's air, water, land, and food sources.

Fantasies aside, how might we ever get to the point where a future president of the United States might actually deliver such a State of the Union? Here the recent rapid creation of the Department of Homeland Security might serve as a potential model, as well as suggest many explicit warnings on potential—and alas real—pitfalls of how to organize a new cabinet department de novo, within a short period of time.

The Present: Let's Imagine Creating a Department of Children

In the wake of 9/11, both citizens and elected officials recognized the need to act quickly to reorganize the federal government and coordinate what had been disparate and sometimes-feuding organizations, all seemingly dedicated to the nation's preparedness and security. The imperative to act in the form of a Homeland Security Department finally trumped self-serving institutional cultures, national lethargy, interest group politics, and political intransigence. Certainly the end result has proven far from perfect—skirmishes between agencies continue, and a continuing process of evaluation and reorganization will be needed if this agency is to be effective—but few would argue that we ought to go back to the old system.

What if the president declared children's needs a national emergency? Sadly, the data about the numbers of children living in poverty, the infant mortality rate, the lack of medical services for our neediest kids, the troubles with our educational system, and the ongoing abuses of child labor have failed to entirely capture the American imagination strong enough to provoke a lasting social response. Nor has the astounding epidemic of childhood obesity—and the resultant surge of juvenile and type-II diabetes, hypertension, and heart disease—or the alarming abuse of alcohol, tobacco, and illicit substances by American youths. What about the rise in childhood asthma or low immunization rates that still exist in the 21st century in parts of the United States? And what about the remarkably petty debate over the so-called “worthy poor” deserving of S-CHIP, one that harkens 19th century moralism.

In my judgment, all of us who care for children—social workers, pediatricians, public health professionals, and university professors—are simply not doing enough to educate and convince as many people as we can about the dire needs of children today. Instead of the many acute infectious threats that killed 100 out of every 1,000 children born in the United States one hundred years ago, most childhood threats today represent chronic and mental health problems that cost a lot, require long-term management, and, if poorly managed, cost even more. Make no mistake, we live in a world of newly emerging and re-emerging infectious threats, but for today, the major health issues surrounding America's kids are chronic, socially and biologically complex, not always immediately intellectually exciting or gratifying, nor always evocative of definitive action. These relapsing, remitting, and long-term threats are, nevertheless, deadly influences that cut millions of lives short annually. That's precisely why we need to be more active in sounding this alarm without sounding alarmist.

Moreover, a cabinet-level department devoted to children begins to make more sense when one considers the long history of constituent politics in the United States. If, indeed, we could create and pass a bill to create a DOC, we would need to begin by appointing a commission to identify all federal government agencies dealing with children and identify those to be reorganized under the new department. Clearly this would mean shifting the Department of Education from a cabinet-level agency to a division within the new DOC, a politically challenging but, I think, necessary task. We would also have to figure out what to do with agencies or departments with missions or divisions that effect the well-being of children such as the Environmental Protection Agency and the Department of Housing and Urban Development. In other cases, divisions could report to the DOC while remaining under a different agency. Thus the National Institutes of Health would report on their pediatric research programs, and the institutes would receive direction from a joint DOC and DHHS leadership working group, but the NIH as a whole would remain under the DHHS. The much-diminished Children's Bureau, now housed within the Administration for Children and Families, would shift to the DOC along with other DHHS agencies serving children.

Second, the new department would receive an expanded budget, not simply the combined budgets of the agencies it would be absorbing. The new funds would support the inauguration of universal child health insurance and expanded services to the disabled, among other things. Support could come initially from federal revenue resulting from increased federal excise taxes on alcohol, tobacco, firearms, and ammunition. But again, let's not be disingenuous and hide behind regressive taxes such as the one that will support the proposed S-CHIP funding being discussed in Congress by raising a pack of cigarettes by 75 cents to a dollar. The very people—or perhaps their parents—that you are trying to help have healthier lives should not be paying for that program by purchasing and puffing addictive, carcinogenic, and cardiovascular- and pulmonary-damaging products. That's bad health care, bad health policy, and disastrous economic planning of limited resources. In short, it is in our individual, national, and long-term interest to accept that the responsibility of the uninsured and underinsured children of our nation rests on all our shoulders. Every taxpayer must be prepared to kick in what amounts to about 80 bucks a year to fund the current S-CHIP bill that President Bush vetoed this past week. Eighty bucks—the cost of two tickets to the Michigan Theater, a bag of popcorn, and dinner on State Street. And it is up to our legislators to be responsible enough to educate all voters that it is a relatively small cost per taxpayer, and that the mantra of “no new taxes” is no longer a political or social shirt that fits all sizes and situations. All told, not so incidentally, the expenses accrued from halting the Iraq War for forty days—all generated by taxpayers' dollars—would fund S-CHIP for ten million children for an entire year.

Third, following the confirmation of a secretary for the DOC, a transition timetable and budget for expanded children's services would need to be developed, along with appropriate evaluation and reporting systems. We would need the expert advice of academics; the skilled management of professional administrators; an army of social workers, pediatricians, nurses, and other health and welfare professionals, along with the zeal of young students and junior partners who want to make a difference in our society; the give and take of the political process so compromises can be made and promises kept; and the courage to change aspects of the program that do not work well and enhance those that do. That will be the real experiment here—and one I think well worth funding and pursuing.

Alas, my suggestion of a DOC remains only a “thought experiment.” Whether it will ever be proposed, passed, fully funded, and implemented is subject to vigorous speculation, if not outright sneers. Indeed, one of the great things about being a historian is that you get paid to make these types of pronouncements—very nice work if you can get it. Yet, with the centennial anniversary of the Children's Bureau looming, we might recall that the agency was once merely the vision of few progressive reformers—many of them prominent social workers who pioneered your field such as Jane Addams, Florence Kelly, Lillian Wald, Julia Lathrop, and others who, building on the momentum of urban reformers, social welfare activists, and concerned medical leaders, made children the centerpiece of America's federal domestic policy. Its mission of saving infant lives, improving child health, collecting vital statistics, and conducting vital research propelled important social programs and vastly improved the situation of millions of the nation's most vulnerable citizens: from the development of well-baby examinations and free milk depots that provided clean, fresh formula to impoverished babies, to school examinations, dental and eye care, and a revolution wrought by vaccines, not to mention our growing knowledge on children's development, family dynamics, and so many other factors related to a child's well-being. And so, I conclude, to you—social workers, social activists and theorists, children's health professionals, and all of us who care deeply about our great nation and its future: Having made great strides in the 20th century through the efforts of a broad-based, constituent-based federal agency, despite the political obstacles preventing it from confronting issues of poverty and professional self-interest, the question remains, why not do even more and do it even better in the 21st century?

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