

**RETHINKING THE ORGANIZATION OF CHILDREN'S  
PROGRAMS: LESSONS FROM THE ELDERLY**

**EXECUTIVE SUMMARY**

**March 1995**

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## **Basis for the Study**

Despite alarming statistics regarding the health, economic and psychosocial status and academic achievement of children and youth, the United States does not have a "system" of care for our youngest citizens. Rather, there are more than 300 separate programs that have been categorically established and implemented over the last three decades to address the health, social and education needs of children and families, creating a complex, fragmented patchwork of services and programs. 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.

In contrast to children, the elderly in this country enjoy universal entitlement to national health insurance through Medicare, a uniform base level of income security, and an organized system of community-based health, nutritional and social services. Therefore, in this paper, we argue that the system which seems to work for grandparents ought to be available for grandchildren. We apply the models from services for the elderly to inform the national debate on health, education, and welfare reform for young people and their families.

Legislation for the elderly was chosen as a model because there are a number of fundamental similarities between the elderly and children: each is an easily identifiable population based on age criteria alone; both children and the elderly exhibit particular developmental vulnerabilities; as individuals at the ends of the age spectrum, both populations are characterized by a certain level of dependency, requiring that service responses involve families and/or community caretakers; and both populations have traditionally been considered deserving of special societal protections.

This monograph analyzes the organizational structures and functions of the Older Americans Act (OAA) of 1965 to propose a model for reforms to meet the needs of children and families. The analysis includes reviews of the legislative and organizational histories of both maternal and child health services and the Older Americans Act; information gathered in key informant interviews; and a side-by-side comparison of two statutes -- the OAA and Title V of the Social Security Act.

## **History and Current Context**

The Nation's initial response to the plight of children in the first half of this century resulted in a unified approach through the Children's Bureau to address "all matters pertaining to the welfare of children and child life among all classes." However, federally legislated child-oriented programs implemented today represent a mix of income-based entitlement programs; quasi-entitlement programs; categorical population or disease-specific programs; age-specific entitlement programs; as well as "gap filling" formula grant funded programs. As such, this current body of federal authorizing legislation for children and their implementing regulations are not coordinated. Despite ardent calls for major modifications of the Nation's policies and programs affecting child health and welfare, the "system" (or non-system) of services for children remains in disarray.

In contrast, the national program established through the Older Americans Act (OAA) legislation was designed to address in a consolidated fashion multiple aspects of the lives of the elderly. 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. While

never intended to meet all needs, the OAA has provided the major legislative infrastructure for "planning of, and advocacy for, services and activities to benefit older persons."

The OAA establishes a high level, visible national locus for information, policy development and coordination, advocacy, research, demonstration and professional training. Legislation provides the foundation for a "network on aging," linking a federal Administration on Aging, State Units on Aging, Area Agencies on Aging, citizen advisory committees, and local public and private agencies. The OAA also provides the legislative structure for a uniform consolidated program of comprehensive, community-based planning, and preventive and social services which complement the medical care financing and income support provided the elder population through Medicare and Social Security. Approximately thirty 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 supportive services a locality supports with program funds. The OAA establishes a Federal Council on the Aging, and specifies program linkages and roles with respect to federal programs serving the elderly that are not implemented under its authority.

### **Framework for Comparison**

The side-by-side analysis of the legislative bases for community-based services for the elderly, and for children compares the best features of the OAA, and 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 threaded throughout the provisions of the Older Americans Act's seven titles, including:

- a single, highly visible, national locus is assured for policy development and coordination, and for providing public advocacy for and information on the population;
- an administrative infrastructure at the national, state, and local levels wherein consolidated planning with respect to all issues of concern to the population is conducted;
- program services are universally available to the population, which is defined by age, irrespective of income status;
- community-based services funded are those which complement and enhance 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 (eg., nutrition, supportive services and multipurpose centers, elder rights protection programs) protected federally through line item funding and statutory and regulatory assurances;
- community level information and referral resources are centralized, and services co-location is maximized;
- advocacy, and consumer/public participation in program planning and oversight is legitimized; and
- research, training and service demonstrations specific to population issues and needs are used to promote improvements in quality of care and services.

Title V of the Social Security Act is used to provide the child focus of the analysis because the legislation incorporates a number of features which we believe allow it to serve as a vehicle, or starting point, for systems reform. These include:

- 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 which promote development of constituencies within communities and state legislatures and which leverage funds well beyond those allocated federally;
- support for a structure of population-based, universally-oriented preventive and support services, and for highly specialized services which are targeted to particularly vulnerable subpopulations;
- specified requirements for coordination with Medicaid, especially, to ensure access, and quality of care provided through the federal insurance program for low-income children;
- promotion of a family orientation, influencing the structure of service delivery such that care for children is developmentally appropriate and responsively planned; and
- inclusion of a component for research, training and demonstrations to assure quality throughout, and to promote system improvements.

Comparison of the Older Americans Act and the national program for Maternal and Child Health Services reveals a number of important parallels in underlying policy principles and legislative intent. However, key differences between the two pieces of legislation point to at least four central aspects of the OAA federal organization, programs, and policy principles that may apply to a new maternal and child health organization at the federal, state, and community levels.

### **Analysis: Implementation of the OAA and Title V MCH at Federal, State and Community Levels**

The report includes a structured and detailed analysis of those features found in the OAA that are missing from, but highly important for, community-based services for children and families. The OAA exhibits significant advantages with respect to meaningful representation of population concerns in the upper echelons of government, constituent access to policy-making, centralized, clearly identifiable government accountability and increased access to services at the local level. Functions of and relationships among public programs, agencies, private sector providers and consumers are outlined in statute. These provisions establish the foundation for a systems approach to planning at all levels, and providing vehicles for supporting community programming which relates the multiple domains of health, social services, education, and family support, which allow holistic interventions for individuals and families in need. Universally available core services facilitate understanding of the system among legislators and other policymakers, as well as taxpayers. While a uniform core of services is mandated, the OAA promotes local flexibility in how services are delivered, and in constituting the array of ancillary preventive and support services that wrap around the core. Legislated mechanisms for consumer protection and advocacy, and a prominent consumer role in local, state and federal policy formulation assure protections for the elderly not enjoyed by children in this country.

### **Conclusions and Recommendations**

We thus find the OAA instructive as to how health, welfare and education reform initiatives might be envisioned to create structures nationally that are linked horizontally and vertically requiring consolidated policy development, planning and accountability addressing the full scope of issues and public programs key to child and family health and well-being. Based on the analysis, we propose that the first and most fundamental step to achieving parity between children and the elderly is a major rewrite of federal legislation authorizing key health, social services, and education programs. Revisions are needed to eliminate conflicts, overlap, gaps and fragmentation, and to maximize coordination within and among systems. While 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 occur consistent with the following principles:

- 1.a national policy focus and vision for healthy children and strong families, as well as governmental accountability for outcomes consistent with that vision, through creation of a free-standing statutorily authorized National Council on Children and Families;
- 2.structures and authorities necessary to address service access and coordination complexities, fragmentation, overlap, and barriers at all levels, and to increase efficiencies and effectiveness of the planning, data, resource allocation functions of government, implemented through federal legislation, reorganization within DHHS, and creation, in each State, of a mandated independent Single State Authority for Child and Family Policy and sub-state Children and Families Authorities;
- 3.a universally available uniform core of preventive and support services established through federal legislation which can be configured with local flexibility to promote service availability and access in **all** communities; and
- 4.child advocacy, and consumer participation in services and system design and oversight at all levels of government, implemented through ombudsman services, and mandated Family Advisory Councils.

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 program development of the last three decades. This approach, however, moves beyond the tenants of the past by promoting bureaucratic efficiencies consistent with contemporary management practices which would eliminate overlap and duplication in planning, data, and prevention and support services programming. Implementation of 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.

This paper 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.

*This report was prepared by Holly Grason, MA and Bernard Guyer, MD, MPH, Child and Adolescent Health Policy Center, The Johns Hopkins University School of Hygiene and Public Health. Development of this document was supported in part by a Cooperative Agreement (MCU 243A19) from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services. To request a copy of the full report, **Rethinking the Organization of Children's Programs: Lessons from the Elderly. Study Report**, contact the Child and Adolescent Health Policy Center, The Johns Hopkins University, Department of Maternal and Child Health, 624 North Broadway, Room 192, Baltimore MD 21205. (410)550-5443, FAX: (410)955-2303.*