U.S. infant mortality reveals gravity of economic crisis

by Marcia Merry Baker and Linda Everett

World headlines last month were grabbed by the story of the Littleton, Colorado high school shootings, along with continuing reports of other violence among youth across the United States and Canada. Falsely portrayed as a "gun" issue, the real point of alarm is how many children are growing up with a penchant for extreme cruelty. Every aspect of the condition of children in the United States reflects the overall crisis of the nation in fundamental ways—economic breakdown, social demoralization, and cultural pessimism. In particular, what happens to children reflects the fact that citizens no longer *know how to think* about these conditions, or what to do to change things. This week, we look at a revealing aspect of the crisis of infants and children, namely, the impoverished physical circumstances of millions in the United States today, and the policy disaster behind it.

The U.S. population is over 270 millions. For each of the standard demographic age brackets (birth to 1 year, 1 to 4 years, 5 to 14, and so on, through 65 years and older), the data measuring the state of health and the "social geography" of the nation reveal that for each of these strata, there are problems so extensive, that the patterns themselves are refutations of the popular lie that the U.S. economy is "booming."

For example, since the middle of this decade, the leading cause of death in black males, ages 15-24, has become "homicide and legal intervention."

Take infant mortality, where infants are defined as children under age 1. The United States has ranked no higher than 20th among industrialized nations in infant deaths per 1,000 live births. Moreover, certain localities have infant mortality rates characteristic of 50 years ago, or of a poor nation.

Also, take child poverty: What happens after a child manages to survive the first year of life? Nearly one in four of U.S. children under the age of 6, or 5.5 million (23% of all children in the age group), lived in poverty as of 1996.

Figure 1 and **Table 1** show the patterns of infant mortality as of the mid-1990s. But before looking at the details, consider once again the problem in *how to think* about what these patterns mean. Even agencies monitoring child poverty buy into the lie of the boom economy. A year ago, the National Center for Children in Poverty, based at the Columbia University School of Public Health, released a study, documenting that millions, or 23% of the U.S. population under 6, live in poverty. Yet their press release (March 12, 1998) began: "The American economy is booming, but millions of America's youngest children aren't reaping the benefits."

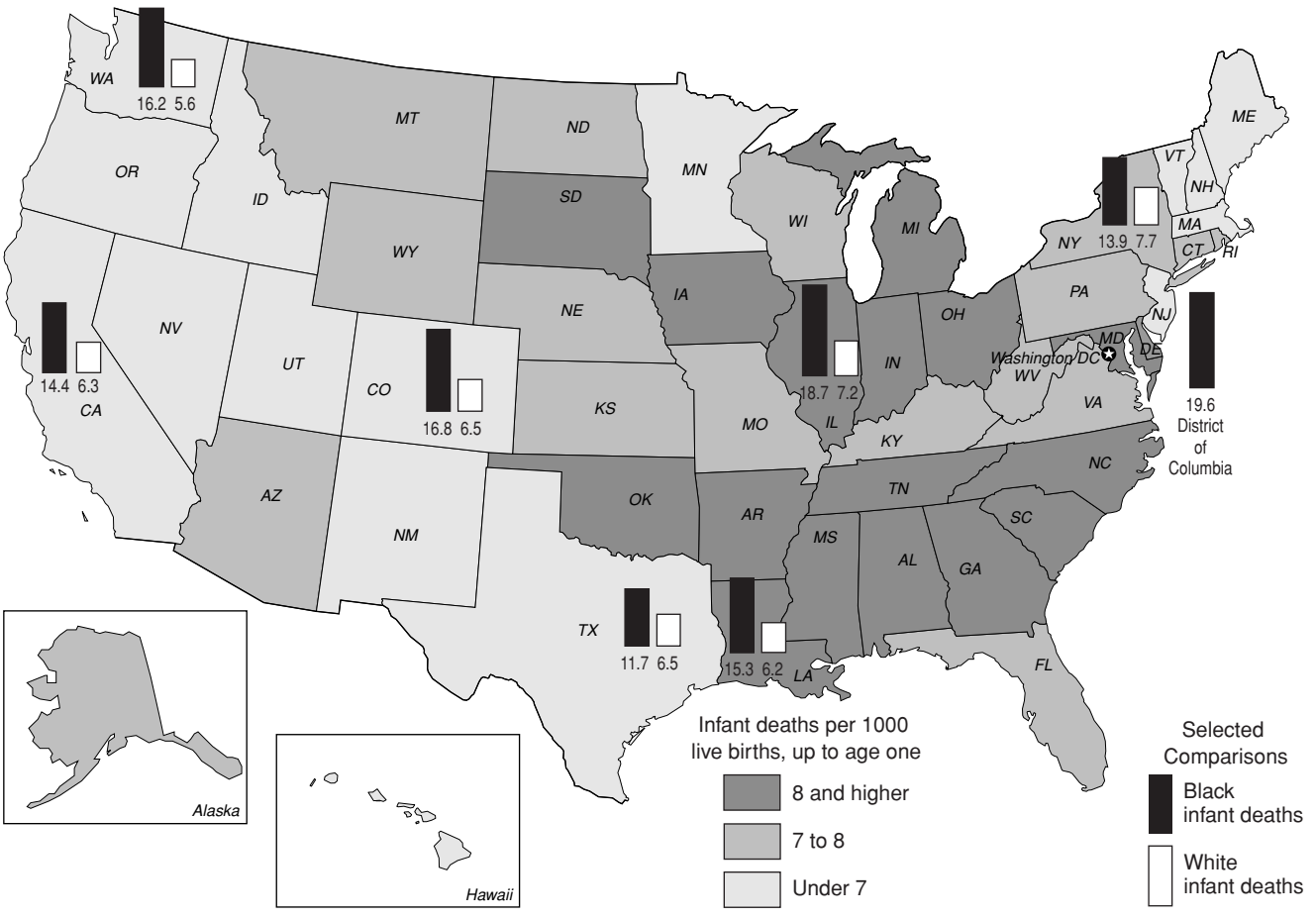
The national infant morality rate as of 1998, was 6.4 per 1,000 live births. Among the countries with a lower infant mortality rates are: Australia, 5.3; Austria, 5.2; Canada, 5.6; France, 5.7; Germany, 5.2; and Japan, 4.1.

Premature birth is the leading cause of infant mortality in certain U.S. locations and groups, accounting for three-quarters of all perinatal mortality and morbidity. Usually, neonatal mortality (death within 28 days of birth) accounts for about 70% of infant mortality. In turn, the high death rates for these pre-term infants are associated with a breakdown in medical infrastructure and living standards, including poor maternal health, prevalence of communicable diseases, growing drug and alcohol abuse, absence of prenatal care, and lack of medical treatment for infants.

Thus, infant mortality is a useful statistic for comparing health indicators among localities, to see where the priority problems are. Our map differentiates three groupings among states, according to their rate of infant mortality. The highest rates, with over 8 deaths per 1,000 live births, are shown in the 16 states with the darkest shading. In addition, the District of Columbia has one of the highest rates of infant deaths in the nation—19.6 per 1,000. Eighteen other states are shown in light shading, which have between 7 and 8 deaths per 1,000

FIGURE 1

Where infant mortality is highest in the United States, 1995



Source: Statistical Abstract of the United States: 1998.

live births. The remaining 16 states have fewer than 7 infant deaths per 1,000 live births.

Black Americans suffer the highest rates of infant mortality in some locations, such as the District of Columbia, where urban poverty is high. Table 1 shows the separate listing for each state's infant mortality rates for blacks and white infants, as well the overall rate for each state. What stands out is that mortality among black infants is more than twice as high as for white infants. In Colorado, infant mortality is 6.5. But, the rate for black infants, 16.8, is nearly three times the rate for white infants, which is 6.0. In Denver, where one-quarter of the population is Hispanic, infant mortality is high.

Bad policies, worsening conditions

Overall, the rate of infant mortality over this century improved markedly with advances in medicine and in living conditions. In 1915, the rate was 10%, with 100 infants dying for every 1,000 live births. As of 1960, the U.S. rate was down to 26, with rates of 22.9 for white infants and 44.3 for black infants. The intention was to lower the rate and close the gap quickly. These rates continued to decline for a while, for both black and white infants, until the 1980s, when factors, especially the invasion of crack cocaine, sparked a rise in infant mortality in many cities, such as Los Angeles (where crack was first introduced into the black community), New York City, Baltimore, Washington, and Chicago. At the same time, over the 1990s, the contributing factors of poverty and despair set in. Therefore, the "statistical" improvements in infant mortality started to slow, and the gap between black and white infant death rates has been widening in recent years.

In reaction to this, a National Commission to Prevent Infant Mortality was established in July 1987. The 15-member panel, chaired by then-Sen. Lawton Chiles (D-Fla.), included the Secretary for Health and Human Services, representatives of Federal and state agencies, and health experts. Another group was the Committee to Study Outreach for Prenatal Care, attached to the Institute of Medicine.

Arguments of all kinds were made to mobilize public

TABLE 1

States ranked by overall rate of infant mortality, 1995; black infant mortality rates are twice white infant rates

State	Deaths per 1000 live births, up to age one			State	Deaths per 1000 live births, up to age one			State	Deaths per 1000 live births, up to age one		
	Total	Black	White		Total	Black	White		Total	Black	White
1. Higher than 8 deaths				**2. Between 7 and 8 deaths**				**3. Under 7 deaths**			
Dist.of Columbia	16.2	19.6	*	West Virginia	7.9	*	7.6	Minnesota	6.7	17.6	6.0
Mississippi	10.5	14.7	7.0	Pennsylvania	7.8	17.6	6.2	New Jersey	6.6	13.3	5.3
Alabama	9.8	15.2	7.1	Virginia	7.8	15.3	5.7	Texas	6.5	11.7	5.9
Louisiana	9.8	15.3	6.2	New York	7.7	13.9	6.2	Colorado	6.5	16.8	6.0
South Carolina	9.6	14.6	6.7	Wyoming	7.7	*	6.8	Maine	6.5	*	6.3
South Dakota	9.5	*	7.9	Alaska	7.7	*	6.1	California	6.3	14.4	5.8
Georgia	9.4	15.1	6.5	Kentucky	7.6	10.7	7.4	New Mexico	6.2	*	6.1
Illinois	9.4	18.7	7.2	Florida	7.5	13.0	6.0	Oregon	6.1	*	5.9
Tennessee	9.3	17.9	6.8	Arizona	7.5	17.0	7.2	Idaho	6.1	*	5.8
North Carolina	9.2	15.9	6.7	Delaware	7.5	13.1	6.0	Vermont	6.0	*	6.2
Maryland	8.9	15.3	6.0	Missouri	7.4	13.8	6.4	Washington	5.9	16.2	5.6
Arkansas	8.8	14.3	7.2	Nebraska	7.4	*	7.3	Hawaii	5.8	*	*
Ohio	8.7	17.5	7.3	Wisconsin	7.3	18.6	6.3	Nevada	5.7	*	5.5
Indiana	8.4	17.5	7.3	Connecticut	7.2	12.6	6.5	New Hampshire	5.5	*	5.5
Oklahoma	8.3	15.1	8.0	Rhode Island	7.2	*	7.0	Utah	5.4	*	5.3
Michigan	8.3	17.3	6.2	North Dakota	7.2	*	6.7	Massaschusetts	5.2	9.0	4.7
Iowa	8.2	21.2	7.8	Kansas	7.0	17.6	6.2				
				Montana	7.0	*	7.0	United States	7.6	15.1	6.3

* Base figure too small for a reliable statistic.
Source: U.S. National Center for Health Statistics, *Vital Statistics of the United States,* from the Statistical Abstract of the United States: 1998.

action to reverse the conditions in which infants were lost. As of 1985, the Institute of Medicine demonstrated the "cost-effectiveness" of prenatal care, showing that for every $1 spent for women lacking the means, another $3 would be saved in medical expenses for low-birth-weight infants in their first year.

In October 1988, the National Commission to Prevent Infant Mortality released recommendations for *universal access to care*. Though not made explicit, this approach implied expanding medical care delivery in order to make it available to all. Doing this, would have diminished rising infant mortality and closed the gap in mortality rates among different groups in the population. The Commission stated, "First, we must provide universal access to early maternity and pediatric care for all mothers and infants. . . . Second, we must initiate immediately a sustained, broad-based effort to make the health and well-being of mothers and infants a national priority and give them the public attention and resources they deserve." Various steps were specified. In 1989, medical experts produced draft Federal legislation called the "Healthy Birth Act."

The act was not passed. And in the mania of the "Contract on America," the Commission was disbanded in 1994. The 1996 welfare "reform" act (Personal Responsibility and Work Opportunity Reconciliation Act) was passed, adding further to the process of deliberately creating conditions that contribute to death and illness, in particular for infants and children. In the absence of decent jobs and income, the Welfare Reform Act has increased poverty.

In the 1998 report from Columbia University showing 5.5 million children in poverty, one of the most striking trends was the "dramatic increase in percentage of poor young children with working parents." The report described the plight of "traditional" families: "The poverty rate of young children living in families with a father employed full time and a mother who was not employed more than doubled between 1975 and 1996, rising from 6% to 14%." (All the poverty estimates in that report were derived from the Census Bureau's Current Population Survey. In 1996, the official poverty line was $16,036 for a family for four and $12,516 for a family of three.)

One consequence of the 1996 Welfare Act was to strip millions of children of their access to medical care. According to the George Washington Center for Health Policy Research, more children than ever now lack medical insurance. Under the "booming" economy, more employers are dropping health coverage altogether, or dropping it for employees' dependents. Of the estimated 11.5 million children who lack coverage, over 4 million are eligible for Medicaid, but were deliber-

ately or unintentionally removed from the rolls by the states when welfare reform was enacted in 1996! The 1996 welfare reform law *de-linked* Medicaid—the health insurance program for the poor funded by Federal and state governments—from entitlement of welfare or cash assistance. However, under Federal law, when states "diverted" families from welfare to work, they were still eligible for Medicaid. But, too often, when people were thrown off welfare, they also lost Medicaid health insurance, because state agencies supposedly didn't understand the Federal regulations. Some states just never enrolled many families who were eligible. California required the needy to fill out a 38-page form.

Even Temporary Assistance for Needy Families (TANF), the program for minimal assistance established by the 1996 law, is now targetted for elimination. TANF designated Federal money to support the poorest American households, mainly single mothers. The funds are channeled through states in the form of a block grant. Now, there is a proposal in the House of Representatives to let states shift TANF funds to general education costs, such as school construction. A Senate proposal would divert TANF funds to international disaster assistance and military aid!

In October 1997, the Clinton administration enacted the Children Health Insurance Program (CHIP), to provide health insurance coverage for children of working parents who were too poor to purchase health insurance, but not poor enough to be eligible for Medicaid. The administration estimated that of the 11.5 million uninsured children, about 3 million were eligible for CHIP. The program provided $24 billion in Federal matching funds to the states, which could use them to expand Medicaid, to create a separate CHIP program, or an alternative arrangement to cover children. After one year of operation, only about 1 million children are insured under CHIP. The National Governors Association has joined with the administration to publicize the program in order to expand enrollment.

The problem is that, as with the Medicaid program, states can employ the most restrictive eligibility requirements they want, based on some percentage of the Federal poverty level (see box). Moreover, the Welfare Reform Act mandated that legal immigrants must *wait* five years before they can apply for Medicaid coverage for their children. This adds up to unnecessary death, disease, and disability in cities with large immigrant populations. Lack of vaccination among these populations increases contagion of childhood killers, such as measles virus and whooping cough.

To prevent such occurrences, the 1960s Medicaid legislation mandated states to provide children with Early and Periodic Screening, Diagnosis, and Treatment, to prevent disabilities (something as simple as untreated ear infections has led to permanent hearing loss), and control disease transmission. But, the 1996 Welfare Reform law contravened this mandate.

High child poverty in George Bush's Texas

Texas, the gateway to the North American Free Trade Agreement and the *maquiladoras* across the border, ranks among the highest in U.S. child poverty. Although not the highest in infant mortality, the disparity between the infant death rates for black and white infants is very high.

Of all the children and youth up to age 18 in the state, 26.9% (1,502,000) are poor, placing Texas 45th out of 50 states. As of 1994-97, fully 24.5% or 1,497,000 of all the children and youth in Texas under age 19, lacked any medical insurance, which places Texas on the bottom rung.

The rate of poverty of children under 6 years old underwent a radical jump, from 24.4% in 1979-83, to 30.3% as of 1992-96, according to the National Center for Children in Poverty—i.e., in 1996, there were over 572,000 children under the age of 6, who were in poverty.

Worse, look at the way Gov. George W. Bush's administration manages to deny medical and other assistance to the state's children. Under the state-administered Federal CHIP program, Texas requires that the older the child applying for Medicaid, the more impoverished the family must be to get coverage. According the Federal Health Care Financing Administration which oversees Medicaid, Texas provides coverage to infants up to age 1 in families with incomes up to 185% of Federal poverty level; for children ages 1-5 in families with incomes up to 133% of FPL; children ages 6-14 in families with up to 100% of FPL; and children ages 15-19 in families with incomes up to 49% of FPL.

Texas then mandated changes whereby, under the new CHIP program, the state will expand Medicaid for children ages 15-18 whose families have incomes up to 100% of FPL. Big deal! Texas has a greater than average number of low-income children in fair or poor health. Low-income children in Texas are almost twice as likely as low-income children nationally to lack reliable access to medical care.

In January, The Urban Institute released a survey showing that Texas families report significantly greater problems obtaining daily necessities, ranging from adequate housing to affordable food, than the rest of the nation; and 17% of low-income parents lack confidence in their ability to get medical care for their children.

According to 1998 data from the Children's Defense Fund, every 23 minutes a baby is born in Texas with low birth weight; every four hours, a baby dies during the first year of life.—*Linda Everett*