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Seriously, What Is a Child?

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An intriguing question to which I have sought the answer ever since coming to these shores is what Americans think of children. Do they view children as the human analogs of pets? Or do they view them, as do most Europeans and Asians, as precious national treasures? Perhaps a mixture of both?

This is not meant to be a frivolous question. Its answer informs the nation's health policy.

If one views children primarily as the human analog of their parents' pets, then it follows that children's health care is primarily the parents' financial responsibility, although one might extend public subsidies to very poor parents to help them care for their children adequately. On this view it is just and proper that, of two households with identical incomes, the one with children will have substantially less discretionary income after necessities than does the childless household.

On the other hand, if one views children as national treasures — and the nation's economic future — then it makes sense to make the health care of children the financial responsibility of society as a whole, just as is the financing of public elementary and secondary education. Why treat children's education as a social good, but their health care as a private consumption good?

I developed renewed interest in this question after observing the tortuous debate in Congress during the last two years over S-chip, the State Children's Health Insurance Program. The debate was over how high up the income scale the public subsidies inherent in S-chip should be extended to American families.

At the time, about nine million American children remained uninsured, most of them in low-income or poor households. Of these, however, close to seven million children actually were entitled to S-chip, but not enrolled. Parental ignorance about this program and the often vexing bureaucratic hurdles that must be scaled to enter S-chip have been the main barriers of entry.

Worse still, unlike Canadians, Europeans, Taiwanese and Japanese, Americans seem to impute

different social values to the health care of children, depending on their socioeconomic status, even if they have insurance. In New Jersey, for example, Medicaid pays a pediatrician about $30 or so for a pediatric office visit. The comparable fee for commercially insured children is somewhere between $100 to $120 a visit.

Evidently, through their legislative representatives the good burghers of New Jersey tell pediatricians that their professional work has only about a third or a quarter of the social value that New Jersey citizens impute to an office visit by a child from a middle- or upper-income family. This differential valuation is uncommon in other industrialized nations, where physicians typically are paid the same fee for a given service, regardless of the patient's socioeconomic status.

Physicians in New Jersey, and in analogous situations in other sates, have perceived this differential-value signal only too clearly. So informed by the citizenry, many of them refuse to treat children on Medicaid altogether. Blame not the physicians, however. The Hippocratic Oath does not mandate ignoring such powerful economic signals. If Americans want to blame anyone for this circumstance, they'll find the culprit in the mirror.

As an American who grew up in Europe and lived for years in Canada, I still have the habit of regarding children as national treasures. In that frame of mind, I recommend to the president and to Congress an alternative approach to health insurance for children.

Just as merely being born on American soil entitles even the child of illegal immigrants to American citizenship and with it a whole battery of publicly financed services — notably elementary and secondary education — so should any child in this country be entitled to tax-financed public health insurance until age 22. Parents who wish to opt out of this public program would receive a risk-adjusted, actuarially equivalent voucher to procure at least equally good coverage from a private insurer. But coverage of children would be mandatory.

The purchasing function under this public program, that is organizing and managing care, could be delegated to private for-profit or nonprofit insurers, as in Medicaid Managed Care. Private insurers would then compete over the quality of their disease-management programs, not through judicious risk selection.

Finally, the fees paid providers under the public program would be set equal to the average of fees paid by the largest two or three private insurers in the state, lest the professional work of physicians caring for poor children continue to be relatively undervalued.

Gone would be the presence of uninsured children in our midst. Gone would be the haggling over how high up the income scale S-chip eligibility should go. Gone would be the relative undervaluation of professional work for poor children. School-based programs for primary health care, staffed by local, self-employed physicians and nurses under contract, would be

financially feasible. And American health-services researchers would no longer have to blush over this country's spotty health insurance for children when attending health care conferences abroad.

We have about 3.3 working-age Americans per elderly American in this country now. According to the Social Security Trustees, that ratio will decline to close to about 2 by the 2030. In light of this trend alone, can anyone doubt that children really are precious? We should give medals to parents who have them, not penalize them financially.

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