Commentary: Successes and Missed Opportunities

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In their historical review of child health in the early 20th century, Markel and Golden help us understand current child health policy in the United States. Their essay describes the path not taken in 2 related areas: the professional development of pediatricians and our broader policy choices for child health. In the first path not taken, pediatrics followed the field of medicine more generally, with its emphasis on technologically sophisticated treatment for acute illnesses. In the second, our policy toward child health in the United States has focused on science and technology while generally ignoring the underlying social determinants of health.

For the casual observer of history, these seem to have been wise choices. In the last 100 years, the infant mortality rate has dropped from >100 deaths per 1000 live births to <8 per 1000, and the average life expectancy has nearly doubled. The polio vaccines of the 1950s were particularly salient proof of the value of our focus on laboratory science. It is difficult for many of us to understand the fear associated with polio. Each summer, families and health care professionals wondered whether polio would appear in their town, bringing paralysis or death to previously healthy children. As the polio epidemics disappeared shortly after the introduction of the Salk and Sabin vaccines, it seemed that miracles were possible when science, government funding, and community effort joined forces against disease.

Antibiotics and immunizations are among the undeniable benefits of our collective focus on scientific advancement, yet they do not account for the remarkable improvement in our collective health over the last 100 years. Research by McKeown and others has demonstrated that specific medical interventions contributed little to our decreased infant mortality rate or increased longevity. Indeed, there is ample evidence that the “mortality decline” that characterizes 20th century Europe and North America was well underway before the introduction of vaccines or antibiotics. Most scholars credit our longer life spans in developed nations to improved nutrition, clean water, adequate sanitation, and other broad public health improvements. The social and political determinants of health still trump specific medical therapies in many developing nations, in which nearly 1 million children a year die from measles despite the existence of an effective vaccine. Likewise, the greatest threats to child health in the United States lie beyond the easy reach of pediatricians working only in private offices or hospital wards.

So what does the history presented by Markel and Golden have to teach us? One key point is that in the early 20th century, pediatric health care professionals were much more closely aligned with child welfare reformers. Child health was defined broadly to include issues of child labor laws and family financial security. A vocal group of physicians, many of whom were women, argued that pediatricians could best serve children by advocating for social and political change. In Europe, such advocates noted, maternal health programs guaranteed every family financial and medical benefits. Yet the field of pediatrics drifted more along the lines prescribed by medicine. The greatest prestige (and highest financial rewards) belong to those who perform technologically sophisticated procedures on critically ill children.

In the last few decades, Haggerty’s call for community pediatrics has found a foothold, thereby reclaiming a rich history of advocacy on behalf of children. As Markel and Golden suggest, however, child health policy remains locked in decisions made in the early to mid-20th century. Over the last 100 years, European nations have viewed the health and well-being of all children as crucial to economic and political strength; today, children in these nations are guaranteed health care and few grow up in poverty. In the United States, meanwhile, we chose the path that supports science and technology as the key to improving child health. The dissenting voice of community pediatrics in the United States, advocating for broader social and political change, has focused on the needs of children at greatest risk, such as recent immigrants and families living in poverty. One unfortunate consequence of child advocacy in the United States is that government support for children is characterized by unpopular poverty programs (Medicaid and Temporary Assistance for Needy Families), while support for elder Americans is viewed as a just reward for a life of hard labor (Medicare and Social Security).

Decisions made a century ago continue to influence policy today; indeed, it is the role of historians to help us understand the origins of our deepest assumptions. However, Markel and Golden also re-
mind us of the highly contingent nature of our past; previous policy choices could have been decided differently. Perhaps history also suggests that it is time for child health advocates to reconsider their strategy and focus on programs that benefit all children.

REFERENCES
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