

Child survival and health care among low-income African-American families in the United States*



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Abstract

This paper provides an assessment and analysis of the increasing rates of mortality among the children of low-income African-American families in the United States and the intensifying problem of improper health care that seems to have given rise to it. The paper first documents the nature and determinants of the problem and then addresses the issue of policy prescriptions for eradicating the dilemma. The primary problem underlying the health-care access of low-income African-Americans is that there is neither a system of universal entitlement that ties their health care in with the rest of the population nor an explicit and comprehensive strategy for care outside the dominant private system.

Introduction

Child survival rates are considered the most sensitive indicator of a nation's health status. The health of infants and their mothers is of critical concern to any nation. Yet, while the United States can boast of having one of the world's most advanced medical systems, it also leads the Western nations in the percentage of infants born too soon or too small and who are, therefore, at far greater risk of death (Hughes et al. 1986).

These days a baby born in Cuba faces better odds of reaching the age of one than a black newborn in Washington, D.C. The life expectancy of American blacks is not only shorter than that of whites but shorter than the average life span in dozens of developed countries (Monmaney et al. 1987:53).

In such nations as Jamaica, Australia, South Korea, Japan, Canada, and several others in Europe, the reported infant mortality rates are lower than they are for African-Americans in the United States (Farley and Allen 1987:47; National Commission to Prevent Infant Mortality 1988:8-9). Why is this so? What are the underlying factors that have contributed and continue to contribute to this disparity in child survival rates? What policy instruments are required to reverse this trend?

This paper provides an assessment and analysis of the increasing rates of mortality among the children of low-income African-American families in the United States and the intensifying problem of improper health care that seems to have given rise to it. It is intended first to document the nature and determinants of the problem and then to address the issue of policy prescriptions for eradicating the

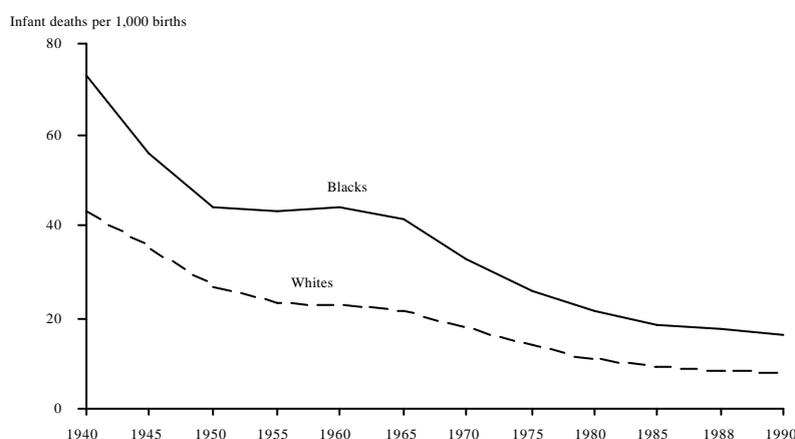
*The views expressed in this paper are entirely those of the author and not those of the United Nations or any other institution to which the author is affiliated. The terms 'African-American' and 'Black' are used interchangeably in this paper. 'Black' will be used to maintain the accuracy of quotations, statistics, and references only.

dilemma. The paper draws considerably from the eight volume *Report of the Secretary's Task Force on Black and Minority Health* that was published in 1986 by the United States Department of Health and Human Services as well as on the *Maternal and Child Health Data Book* published annually by the Children's Defense Fund, and on the annual reports on the health status of the United States submitted to the President and Congress of the United States by the National Center for Health Statistics under the title *Health, United States*.

Child survival and health-care inequities and their determinants

Although health in the United States as a whole has improved, and continues to improve over time, there still exist persistent and significant health inequities for African-Americans and particularly those in the low-income group. Since 1940, infant mortality rates have declined or, put another way, the child survival rates have improved. Throughout this period, however, African-American rates have remained about twice those of whites as seen in Table 1 and Figure 1. In 1988, the white infant mortality rate was 8.5 per 1,000 live births while for African-Americans it was 17.6. More recent data, as reported by Hacker (1992) and Mosley and Cowley (1991), indicate that the ratio remains the same. The infant mortality rate for African-Americans today is about the same as it was for whites 20 years ago. No statistic arouses more pity and frustration than the African-American infant mortality rate. Consequently, for millions of African-American children born today, the future does not seem to hold the promise of success.

Figure 1
Infant mortality rates by race, 1940–1990



Source: National Center for Health Statistics, *Monthly Vital Statistics Report* 39, no. 7, supplement (1990) table 13.

Table 1
Infant mortality rates, foetal-death rates, and perinatal-mortality rates by race, 1950–1984
(number of deaths per 1,000 live births).

Race and year	Infant mortality rate ¹				Foetal death rate ²	Late foetal death rate ³	Perinatal mortality rate ⁴
	Total	Neonatal		Post-neonatal			
		Under 28 days	Under 7 days				

White							
1950	26.8	19.4	17.1	7.4	16.6	13.3	30.1
1960	22.9	17.2	15.6	5.7	13.9	10.8	26.2
1970	17.8	13.8	12.5	4.0	12.3	8.6	21.1
1975	14.2	10.4	9.0	3.8	9.4	7.1	16.0
1976	13.3	9.7	8.2	3.6	9.3	6.9	15.1
1977	12.3	8.7	7.4	3.6	8.7	6.5	13.9
1978	12.0	8.4	7.0	3.6	8.4	6.0	13.0
1979	11.4	7.9	6.6	3.5	8.3	5.9	12.5
1980	11.0	7.5	6.2	3.5	8.1	5.7	11.9
1981	10.5	7.1	5.9	3.4	8.0	5.5	11.3
1982	10.1	6.8	5.6	3.3	7.9	5.4	11.0
1983	9.7	6.4	5.4	3.3	7.4	5.0	10.3
1984	9.4	6.2	5.1	3.3	7.3	4.8	9.9
Black							
1950	43.9	27.8	23.0	16.1	32.1	–	–
1960	44.3	27.8	23.7	16.5	–	–	–
1970	32.6	22.8	20.3	9.9	23.2	–	–
1975	26.2	18.3	15.7	7.9	16.8	11.4	26.9
1976	25.5	17.9	15.3	7.6	16.0	10.7	25.8
1977	23.6	16.1	13.5	7.6	15.6	10.1	23.5
1978	23.1	15.5	13.2	7.6	15.6	9.7	22.7
1979	21.8	14.3	12.1	7.5	14.8	9.0	21.1
1980	21.4	14.1	11.9	7.3	14.4	8.9	20.7
1981	20.0	13.4	11.4	6.6	13.8	8.2	19.4
1982	19.6	13.1	11.1	6.6	13.8	8.1	19.1
1983	19.2	12.4	10.6	6.8	13.5	7.7	18.2
1984	18.4	11.8	10.2	6.5	12.7	7.3	17.4

Source: National Center for Health Statistics, *Health, United States* (several issues). Washington, DC: Government Printing Office.

¹Infant mortality rate is number of deaths of infants under one year per 1,000 live births. Neonatal deaths occur within 28 days of birth; postneonatal deaths occur 28–365 days after birth. Deaths within seven days are early neonatal deaths.

²Number of deaths of foetuses of 20 weeks or more gestation per 1,000 live births plus foetal deaths.

³Number of foetal deaths of 28 weeks or more gestation per 1,000 live births plus late foetal deaths.

⁴Number of late foetal deaths plus infant deaths within seven days of birth per 1,000 live births plus late foetal deaths.

According to Marian Wright Edelman (1986), President of the Children's Defense Fund, when compared to white children, African-American children are twice as likely to be born prematurely, die during the first year of life, suffer low birthweight, have mothers who receive late or no prenatal care, be born to a teenage or unmarried parent, be unemployed as teenagers, have unemployed parents, and live in substandard housing. Furthermore, African-American children are three times more likely than whites to be poor, have their mothers die in childbirth, live in a female-headed family, be in foster care, and be placed in an educable mentally-retarded class. They are four times as likely to live with neither parent and be supervised by a child-welfare agency, five times as likely to be dependent on welfare, and eleven times as likely to live with a parent who never married (Edelman 1987).

Poverty is now inextricably associated with family structure (Hope 1981). During the 1970s, female-headed families became the majority of poor families with children. By 1980 the proportion was 56 per cent and the term 'feminization of poverty' began to appear in the literature. All other things being equal, if the proportion of the poor who are in female-headed families were to increase at the same rate as it did from 1967 to 1977, the in-poverty population would be composed solely of women and their children by about the year 2000 (Moynihan 1986:51). More than 25 per cent of

families with children in the United States were headed by a single parent in 1990. However, among African-American families, 56.2 per cent were headed by single parents compared to only 17.3 per cent for white families (Hacker 1992). To further illustrate this point, on the overrepresentation of female-headed families among the poor in the United States, it can be observed that 15 per cent of African-American male-headed families fell below federally established poverty levels in 1988 compared with 56 per cent of African-American female-headed families. For whites, the comparable figures were seven and 30 per cent. So, while poverty rates are very high among African-American families with an adult male present, African-American families headed by a woman are almost four times as likely to be poor than the African-American male-headed family.

Pearce and McAdoo (1981) have listed all of the possible personal and social sources of poverty, and point out that of these, about half – such as lack of education, inadequate skills, poor health, low work commitment, racism, lack of job opportunities – can apply equally to men and women. The other half apply to women only. Men generally do not become poor because of high rates of divorce and separation, increases in single-parenting, numerical imbalances between the sexes, sex-role socialization, or sexism (Pearce and McAdoo 1981:17; Rodgers 1987:407–411). The poverty of African-American women therefore has a distinct character.

One direct consequence of the feminization of poverty among African-American families has been an increase in the number of poor African-American children. As the percentage of African-American families headed by a woman has increased, poverty among African-American children has also worsened. The reason is that the rate of poverty for children in a family headed by an African-American woman is extremely high. It is much higher than for children in other families (Rodgers 1987:405). Children are the poorest group in the United States society. In 1988, more than one child out of five was poor and more than two-thirds (68.5%) of the children in African-American female-headed families were poor. A child in a female-headed family is four times more likely to be poor than a child in a male-headed or two-parent family (Children's Defense Fund 1985).

The increasing proportion of African-American families headed by women has aroused a great deal of concern in recent years. This concern has been aroused because of the social and behavioural factors contributing to such a phenomenon and the social and other consequences, resulting from such a phenomenon, that go well beyond the statistics already provided here. Those statistics merely underscore a complex social crisis that is shaking the African-American population in the United States.

During the past 30 years, female-headed households became increasingly common in the United States. Among African-American families, two factors seem to have been the primary contributors to such a situation (O'Hare et al. 1991; Hacker 1992). The first can be regarded as a sort of 'men's liberation'. More and more married African-American men now feel much freer to leave their families and start again. This can now be accomplished without negative social consequences and at very little economic cost. In the past, legal divorces were more difficult to obtain and both the African-American Churches and general community frowned on such family break-ups. The second factor, a woman's right and freedom to bear children, whether married or not, applies equally to African-American and white women. However, African-American women outnumber African-American men, at ages 20 to 49, ages when most people marry and start families. Consequently, fewer African-American women are getting married because there are not sufficient eligible men. Although there are, on average, 103 African-American males born for every 100 African-American females, the African-American male mortality rate is higher than that of females at every age. For the 20 to 49 age group, there are only 89 African-American men for every 100 African-American women in the United States (O'Hare et al. 1991).

Female-headed families generally have fewer economic resources than other families. The loss or lack of a male breadwinner creates or perpetuates poverty. In addition, parental control over children, once maintained by the presence of fathers, seems to have been eroded with the result being higher teenage pregnancy, crime, and school dropout rates (Hacker 1992). Being a school dropout, in turn imposes social disadvantages and maintains the vicious circle in which such people either were born or later found themselves.

No other absolute statistic expresses so eloquently the difference between an environment of sufficiency and an environment of deprivation as the difference between the infant mortality rate of African-Americans and whites. During the 1980s, the postneonatal mortality rates (deaths among infants aged 28 days to one year) averaged 3.3 per 1,000 live births of white babies. However, for African-American infants, the babies most likely to be born into poverty, the postneonatal rate averaged 6.6 per 1,000 live births for the same period. This was double the national rate.

On the basis of current trends, African-American infants are at a higher risk of death than white infants for all leading causes of death, including those causes that are unrelated to birthweight. African-American infants are twice as likely as white infants to die as a result of maternal complications of pregnancy and accidents. Their risk of death from pneumonia and influenza is three times as high. However, the most disturbing fact about the disparity of causes between African-American and white infant deaths is that most of the causes of death, for which African-American infants are at a higher risk, are considered preventable: preventable, that is, with proper and timely health care.

In privileged environments, most children who die before they are a year old are born with the condition that kills them: physical immaturity, a congenital deformity, a genetic disease, or a birth injury. The children of the poor have a large share of these problems too, but the impact of these handicaps is swamped by a tidal wave of malnutrition and infection. Malnutrition in the very young does not usually kill outright; rather it is an accessory to the crime, lowering resistance to infections and parasitic diseases that would not be life-threatening to a well-nourished child.

Just as undernutrition prepares the way for infection, disease undermines the nutritional status of the child. Sick babies often lose their appetite, so that food intake is reduced just when they need more nutrients than usual to fight off illness. Gastrointestinal diseases, among the most common afflictions of infancy, interfere with the absorption of nutrients from food. Children who are poorly fed to begin with may not have the chance to recover their nutritional losses from one bout of disease before they are struck with another. As mentioned before, the most tragic aspects of these deaths is that they are demonstrably preventable.

There is undoubtedly a direct relationship between rising poverty rates and rising infant mortality rates. Women and children at greatest risk of poverty seem to be the least likely to receive needed health care. During the 1980s, one in every ten infants born to African-American mothers was born to a woman who received either no prenatal care or none until the last three months of pregnancy. Among white babies, for the same period, four out of five were born to women who received early prenatal care and only one in 20 was born to a woman who had received late or no care (Hughes et al. 1986:5-6).

Prenatal care beginning early in pregnancy and continuing on a regular basis is important to the health of both mother and infant. Early prenatal care provides an opportunity to detect and treat medical and obstetric problems and to advise the mother regarding nutrition and hygiene, and against the use of hazardous products such as recreational drugs, cigarettes, and alcohol. Prenatal care can help prevent complications during pregnancy and labour. Also, there is a negative association between timing of prenatal care and low birthweight. Racial groups with higher frequencies of prenatal care visits tend to have lower incidences of low birthweight and vice versa (O'Hare et al. 1991:12-13).

The lower the birthweight, the greater the chances of death, serious congenital anomalies, or other severe impairments. Here again, African-Americans are disproportionately affected. That is, African-Americans are more than twice as likely as whites to have low birthweight (less than 2,500 grams) infants (Howze 1985-86:21; Manton, Patrick and Johnson 1987:185-187). In the 1980s, the proportion of infants born to African-American mothers and weighing less than 2,500 grams averaged 12.5 per cent compared to 5.6 per cent for infants born to white mothers (Hughes et al. 1989).

African-American infants in the United States die from preventable or curable conditions because they and their mothers get little or no medical care before, during, or after birth. Research has found that the outcome of pregnancy is directly related to the quantity and quality of prenatal care. By monitoring the condition of the mother and the developing foetus, trained observers can identify high-risk pregnancies and recommend appropriate interventions when necessary. For poor African-American women, prenatal care tends to be virtually nonexistent. Pregnant African-American women are less likely to receive prenatal care or more likely to receive it later in pregnancy than white women (Hacker 1992).

As mentioned before, child survival rates are considered to be the most sensitive indicator of a nation's health status. A high child survival rate would indicate a highly developed health-care system. Given that, it is difficult to understand why the African-American infant mortality rate is tolerated at a higher level than that of the white population in a highly developed country such as the United States (Rice and Jones 1982:198).

Undoubtedly, a reduction in the African-American child mortality rates is closely tied to health-care utilization. However, health-care utilization by children and pregnant women is closely tied to health insurance, without which they are less likely to receive needed health care. Some national studies have indicated that, despite their greater need for health services, poor African-American mothers and children actually receive less care. The lack of health insurance, in turn, is directly related to the circumstance of poverty and, hence, the inability to afford such insurance (Trevino and Moss 1983; O'Hare et al. 1991).

For poor African-American families, the lack of proper health care is a function of low income. A prerequisite for access to medical care is the ability to pay for such services. The median income for all African-American families is substantially lower than for white families resulting in less disposable income being available for the direct and indirect purchase of health care. The African-American family median income in the 1980s was 58 per cent of white family income. A 1982 survey conducted by the Robert Wood Johnson Foundation found that only about nine per cent of the United States' adult population under age 65 had no health insurance coverage of any kind. This percentage had held relatively constant since 1976 (Aday, Fleming and Anderson 1984). However, by the end of the 1980s, the proportion had almost doubled, increasing to 16 per cent (Ries 1991).

The predominant source of funding for health care for those under 65 years of age in the United States is employment-based third-party health insurance. However, because African-American groups tend to experience higher unemployment rates, fewer minorities have access to this kind of health insurance (US Department of Health and Human Services 1986, Vol. 2:295). In 1983, the Census Bureau, looking at all ages of the population of the United States, found 15.2 per cent of all persons not covered by either private or public health insurance. Fourteen per cent of whites lacked health insurance and 21.8 per cent of African-Americans. Inability to pay is the most commonly cited reason for not having health insurance (Trevino and Moss 1983; Craig 1991). More recently published data indicate no appreciable change from the 1983 estimates. This was also reported by Andersen et al. (1987) and Ries (1991).

Medicaid¹ has therefore emerged as an important source of health insurance for many African-Americans. The 1982 Robert Wood Johnson survey found that 20 per cent of African-Americans used Medicaid as their only source of health insurance (US Department of Health and Human Services 1986, Vol. I:190). In the late 1980s, four per cent of whites and 17.3 per cent of African-Americans were covered by Medicaid (National Center for Health Statistics 1986:202). This especially high Medicaid coverage rate for African-Americans can probably be attributed to two factors, the first being poverty, and the second being a greater percentage of these families headed by single women than other population groups, thereby increasing the likelihood of categorical Medicaid coverage through Aid to Families with Dependent Children (AFDC). However, although Medicaid has enabled many African-American families to have access to medical care, reimbursement schedules limit the range of available health services and frequent changes in program eligibility tend to disrupt the continuity of health care.

Having some form of health insurance is related to utilization of health services and to whether people report having a usual source of medical care. Twenty-five per cent of the medically uninsured report having no usual source of care compared to only 13 per cent of those covered by private insurance, 11 per cent of those covered by Medicare, and 15 per cent of those enrolled in Medicaid (US Department of Health and Human Services 1986, Vol. I:190).

The continuity of health insurance, generally defined as the proportion of the year a person is covered by health insurance, is related to employment status and to changes in Medicaid eligibility, and therefore has an impact upon health-care utilization. Greater proportions of African-American families are without insurance for some portion of the year than are the white population. Those with less continuity of health insurance use health services less frequently than those who are insured all year round (US Department of Health and Human Services 1986, Vol. I:190; Freeman et al. 1987).

Policy issues

Because child mortality is so closely linked and tied to broad economic and social conditions and to the complex interactions among them, specific interventions designed to improve a child's chances of survival may have a limited effect if they are pursued in isolation. The most decisive gains to be made in moving from high to moderate African-American child mortality rates involve improvements in the direct causes of death of African-American children. Clearly, policies that accomplish these goals will confer great benefits on the United States society as a whole. A reduction in the African-American infant mortality rates would not only further reduce the national infant mortality rates but would also result in the realization of a major humanitarian goal.

Some analysts, for example Rice and Jones (1985), have argued that to improve African-American health and eliminate or at least reduce health-care inequities, it is necessary to view health care as a civil-rights issue. They claim that the cumulative effect of racism over the years has produced significant socioeconomic differences between African-Americans and whites in, for example, income, education, housing, occupational status, and class. These factors, in turn, have a direct relationship to health care and health status. Furthermore, socioeconomic differences between African-Americans and

¹ Medicaid was launched in 1965 to replace a fragmented and grossly inadequate system of medical assistance to recipients of separate public assistance programs. It offers reimbursements to states for a portion of the medical costs of low-income persons. Each state administers and operates its own program, establishing its own rules consistent with federal guidelines. During the past decade, and particularly during the Reagan administration, Medicaid expenditures were scaled back by restricting coverage and benefits for working families near the poverty line. In recent years, however, the United States Congress has restored some of the federal funding to the Medicaid program but not to the levels that existed before 1980. Consequently, the working poor have fallen through the cracks in the system. They are not poor enough to qualify for Medicaid yet they lack sufficient funds to pay for the high costs of private health insurance coverage (Craig 1991).

whites have led to distinctions in perceptions of the importance of health care and use of health-care services. The significant disparity in overall income between African-Americans and whites is, perhaps, the most important variable responsible for the dual system of health care and the resultant African-American health-care inequities (Rice and Jones 1985:208).

The policy options for improving child survival rates and reducing inequities in health care among low-income African-American families seem to be clear-cut. However, the manner of implementation of these policy options is still being debated (Murray 1984; Moynihan 1986; Edelman 1987; Goggin 1987). Basically, the policy options revolve around the need to improve the utilization of and access to health-care services, reduce the disparity in health insurance coverage, and increase the availability of appropriate health-education materials and information.

It is essential to improve access to, and use of, health-care services. Federal, state, and local governments must, individually and collectively, provide for the health care of all United States' citizens, more particularly for the low-income African-Americans and especially for pregnant low-income women and their children. Such an advocacy does not preclude the role of African-American individuals to act on their own behalf and in their best interest in these matters. I somewhat agree with Loury (1984) that

It is now virtually beyond dispute that many of the problems of contemporary Afro-Americans lie beyond the reach of effective government action and require, for their successful resolution, actions that can only be undertaken by the black community (pp.6-7).

However, as Moynihan (1986) has pointed out, this is an elementary fact that applies to all ethnic groups at all times. The problem here is that we are discussing a historically disadvantaged group that will remain historically disadvantaged if policies do nothing more than promote private initiative and private consumption, despite their merits in other circumstances, and as Murray (1984) would prefer to have it. Policies must instead be concentrated on the removal of the root conditions that create and maintain socio-economic inequities among ethnic groups in the United States (Hope 1983:32-33). Consequently, it is both banal and erroneous to charge that those who advocate a role for government in social policy are 'bleeding-heart liberals' who ignore the responsibility of the individual.

Getting back to the central issue, improving health-care access and utilization will improve prenatal care which in turn will save the lives of thousands of African-American infants and prevent low birthweight and needless birth defects. It was estimated that if current trends were permitted to continue, between now and the mid-1990s, 16,500 babies would die in the United States, primarily because they were born too small to survive (Hughes et al. 1986). At least one in nine or 1,800 infant deaths could be prevented simply by ensuring that their mothers received early and comprehensive prenatal care (Hughes et al. 1986). Moreover, prenatal care while saving lives will also save money. For every dollar spent on prenatal care, three dollars are saved in hospitalization costs (McManus 1984:47). The average estimated cost for required medical services, in the 1980s, for each low birthweight infant was \$15,000 (US Department of Health and Human Services 1986, Vol. I:14). This means that the total cost for medical services for low birthweight African-American infants averaged \$192,000 per 100 total live births while for white infants it was \$85,500 per 100 total live births. Finally, with respect to access to prenatal care, it will certainly be a way of reaching pregnant teenagers and teenage mothers. Teenage pregnancy has important implications for both the mother and the infant. Teenage mothers are more likely to be unmarried, have less prenatal care, and have a larger percentage of low birthweight infants than older mothers. In the 1980s, the percentage of live births to teenage mothers averaged 12 per cent for white mothers and 25 per cent for African-American teenage mothers.

The next policy issue has to do with reducing the disparity in health insurance coverage. The United States continues to be the only major industrial nation without a comprehensive national health-insurance plan. This probably explains, to some significant degree, the problem with respect to access and utilization of health care among the poor and particularly the African-American poor. The consequence of that situation is, of course, lower child survival rates and larger percentages of babies born with low birthweight and other health problems. Many of the African-American families tend to rely on Medicaid and charity for their health-care needs because they have no other source of care or ways to finance it. However, there are also limitations with respect to the range of coverage in the Medicaid program. Given these Medicaid limitations and the probability that Congress is not likely to enact legislation for a comprehensive national health-insurance plan in the very near future, then the only other alternative is to provide for income support for the poor to enable them to acquire either private insurance or the ability to pay for their health-care services.

On another level, and over the long term, there is some agreement with the suggestion of Rosenbaum and Johnson (1986) that the state governments might consider establishing a program to provide publicly-subsidized insurance coverage for poor working families. Such programs would allow poor families to buy insurance coverage on an income-adjusted, sliding premium basis (Lewin and Lewin 1987:51). This strategy would provide health insurance to workers while reducing the disincentives whereby workers earning too much lose all Medicaid support (Wilensky 1987:43). It is recognized, however, that both the political support and the fiscal wherewithal may be unobtainable, in the near future, for such a policy reform, given the current fiscal crisis affecting the state governments.

Finally, let us consider the policy issue of health information and education. Health education is an effective means of increasing public awareness about actions which individuals and communities can take to improve personal health. Since many of the factors associated with African-American infant mortality can be controlled, then much more work is needed to educate African-American populations on the health risks and hazards associated with childbirth and teenage pregnancy. Additionally, health education and information let individuals and families become aware of the existence of health services so they can increase their use of those services and educate themselves on the proper use of medication and the significance of continued health care both before and after childbirth. In this regard, there is a pressing need for greater outreach programs conducted primarily in low-income neighbourhoods in familiar surroundings such as community centres or the local health clinic or even in the churches or schools (Edelman 1987).

Health-education campaigns provide needed information and thus enhance personal autonomy in the face of health risks. They seek to reduce or eliminate behaviour that produces health-related burdens for individuals, families, and society. Therefore, these campaigns have the capacity to limit the extent to which the community as a whole may be compelled to accept the negative externalities generated by those individuals and families who, knowingly or unknowingly, contribute to infant mortality. Moreover, as suggested by Bayer and Moreno (1986), health-education campaigns would represent a public expression and demonstration, at both the official and non-official levels, of the concern for the health and well-being of members of the society.

Conclusions

Differing patterns of health services utilization, health-insurance coverage, access to health providers, and the availability of appropriate health-education materials and programs contribute to the disparity in health status between African-American and white populations in the United States. However, it seems that the most significant variable limiting access to proper health care, among African-American populations, is low income. If poverty results in the lack of health care then children will die in the shadow of the most modern hospitals.

The United States, if only both to insure and ensure its economic future, must accept that the children of the poor are as important economically as the children of the non-poor. If for no other reason, the United States should invest in social programs for children because such programs produce long-term savings that more than offset short-term costs. The destiny of any nation is tied to the destiny of its children; all of them. Investing money in health care improves the rates of child survival and decreases the rates of low birthweight. There are huge savings in the cost of medical care after birth, and of institutional care for some of the babies who would otherwise have been born handicapped.

The primary problem underlying the health-care access of the African-American poor is that there is neither a system of universal entitlement that ties their health care in with the rest of the population nor an explicit and comprehensive strategy for care of poor African-Americans outside of the dominant private system. Research has shown that the uninsured systematically use less medical care than the insured population, and that they are less likely to seek care when sick. This means that more African-American children than white children will continue to die because of lack of access to prenatal and postnatal health care. Broadening the reach of health insurance is therefore regarded by many as one way to improve access to health care by the poor (Reinhardt 1987). However, much needs to be done in terms of who pays and the method for determining how much is paid. Over the short run, significant initiatives will probably have to originate at the state and local government levels. In the longer run, there would need to be some direct federal involvement in the provision of national health insurance that either automatically covers every citizen of the United States or covers those United States citizens without adequate private health insurance.

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