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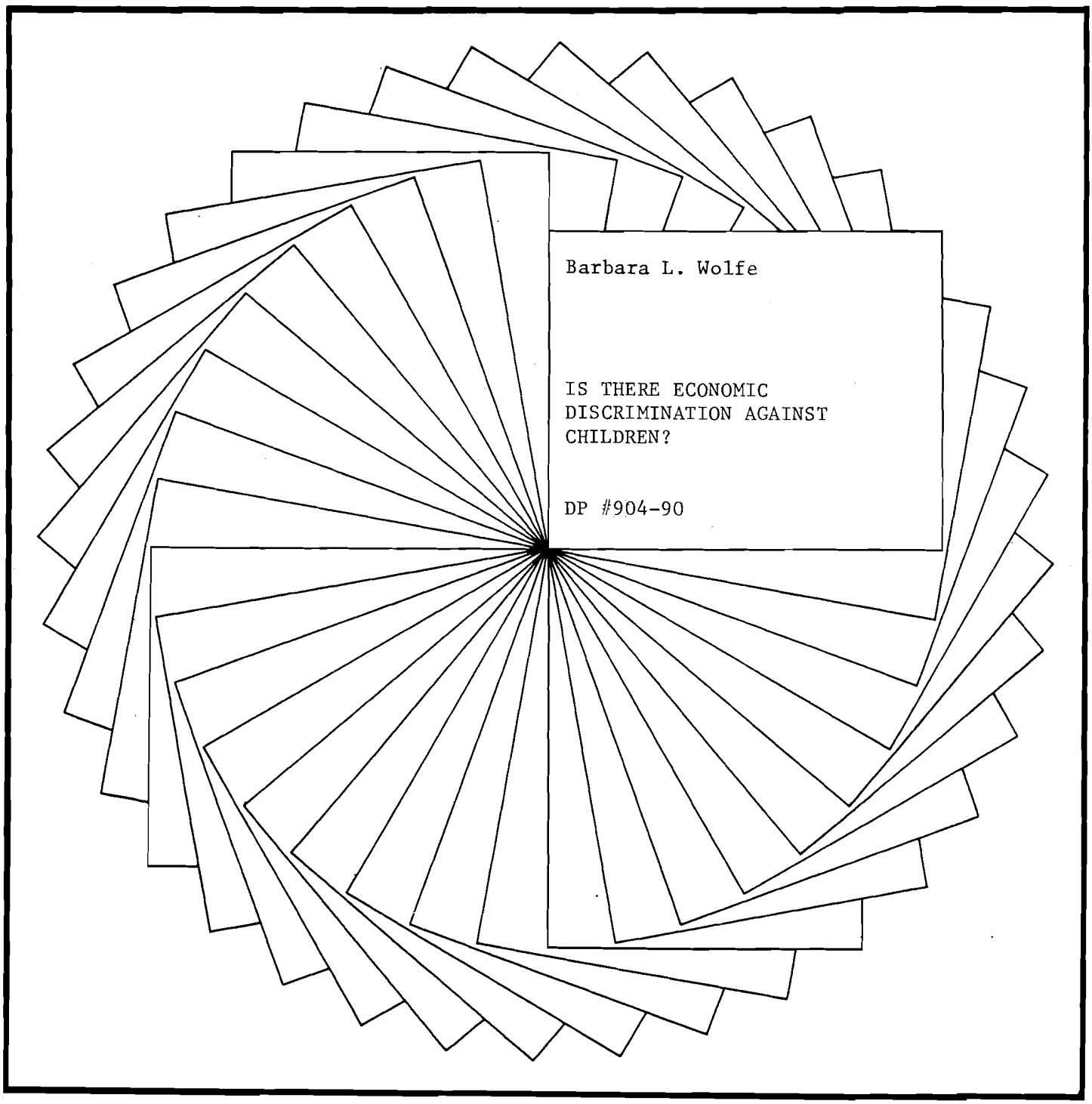

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Is There Economic Discrimination against Children?

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Abstract

The economic circumstances of most of the elderly in our society have improved greatly in the past thirty years, owing largely to government programs such as Social Security, Medicare, and Supplemental Security Income. At the same time, the circumstances of many children have worsened for a number of reasons. Children are more likely than they were in the past to live in single-parent homes. Child poverty has risen because children depend on the earnings of their parents for support, and real median earnings have declined. Furthermore social programs for children, from education to Aid to Families with Dependent Children, are increasingly inadequate to serve the young.

Because the failure to invest sufficient resources in the human capital of our children will have grave repercussions for both individuals and society, two ideas are advanced that, along with innovations in education and child care, should improve the life chances of future generations. These are a health insurance program to provide specific needed services to all children and a program to enable youth to borrow from the Social Security Trust Funds to finance their education and training.

Is There Economic Discrimination against Children?

Since Samuel Preston raised the issue in his 1984 presidential address to the Population Association of America (Preston, 1984), there has been heated debate over whether children are receiving less than their share of public resources. Preston argued that more and more of our public resources are being directed toward the elderly while a smaller and smaller share is going to children. He pointed to public spending on Social Security and Medicare, which has risen rapidly, in contrast to spending on welfare and education, which has stagnated or fallen. More recently, we have again focused on the plight of children, particularly those in single-parent households. To some, the current plight of many of our children is a time bomb; we are seen as leaving to the next generation a legacy of unproductive, poorly educated children, ill equipped to function in an increasingly demanding labor market.

In this paper, I contribute some facts and draw some conclusions from this debate. I look at the economic situation of children and the elderly and how they have changed over time. Next I describe how public resources have been allocated to these two groups. Then I explore the likely effects of insufficient resources for children, and why there is such disparity between our treatment of the young and our treatment of the old. Finally, I present two proposals for increasing our investment in children.

I. FACTS ABOUT CHILDREN AND THE ELDERLY

First, let me describe these two populations:

Children: Children 18 and under in the United States are increasingly nonwhite and increasingly likely to live in single-parent families or in families in which both parents work. In 1987 a quarter of all children were nonwhite and nearly a quarter--over 23 percent--lived in single-parent families. The picture is starker for nonwhites: nearly 50 percent live in families headed by a woman. These proportions have doubled in twenty years and are likely to continue to grow. Because almost two of three new marriages dissolve and a quarter of all births are out of wedlock, it is estimated that almost 60 percent of all children and 90 percent of black children will spend some time in a single-parent household (Levitan, Garth, and Pines, 1989, p. 6). For children born in 1980, the predictions are even worse. Seventy percent of white children and 94 percent of black children can expect to spend some time in a single parent household--31 percent of their childhood for whites but nearly 60 percent for blacks (U.S. House of Representatives, 1989, pp. 832-833).

Two-parent families in which there are two earners are also a growing trend. In 1983 only 41 percent of two-parent families had a mother who stayed at home, compared to 62 percent twenty years earlier. The increase is greatest among women with preschool-age children (Haveman et al., 1988).

The elderly: The elderly are surviving longer. As a result, the proportion of our population that is elderly has been growing, especially the proportion aged 75 or older. And, they are less likely to be widowed than in 1970. And, like children, the elderly have changed their living arrangements over time. They used to live in other people's households, especially those of their children. Now they are

much more likely to be living alone or with a spouse (U.S. Bureau of the Census, 1989). In 1987 12 percent of the population were aged 65 or older. Of these, 16 percent of the men and 41 percent of the women were living alone. Most, 53 percent, were living in married-couple households, but this is more true for men than for women.

To compare the economic status of these two groups, we look at poverty rates (see Table 1 and Figure 1). Poverty rates tell us the proportion of a population that falls below an arbitrary income level defined by the Census Bureau as the poverty line. This poverty line varies by household size; it is based on income, which includes cash transfers but not in-kind transfers such as food stamps, subsidized housing, or medical assistance.

The poverty rate for the elderly has fallen substantially in the last five decades, especially in the last two. In 1969 26 percent of the elderly were poor. In 1987 12 percent of the elderly were poor, compared to a poverty rate of 13.5 percent for the population as a whole.

The poverty rate among children declined for most of this time but started to rise twenty years ago, and since 1974 it has exceeded that of the elderly. In fact, as can be seen in Figure 1, during the Reagan years the child poverty rate fluctuated around 20 percent, compared to about 16 percent in the eight preceding years. This means that one in every five children was poor. In recent years, children have been the largest group in the poverty population; about 40 percent of all the poor are children (Danziger, 1989a, p. 6).

We must remember, however, that although the elderly as a group are doing well, and children as a group are falling behind, there remain

Table 1

The Trends in Poverty: Among Children by Family Type and Race and Among the Elderly, by Race

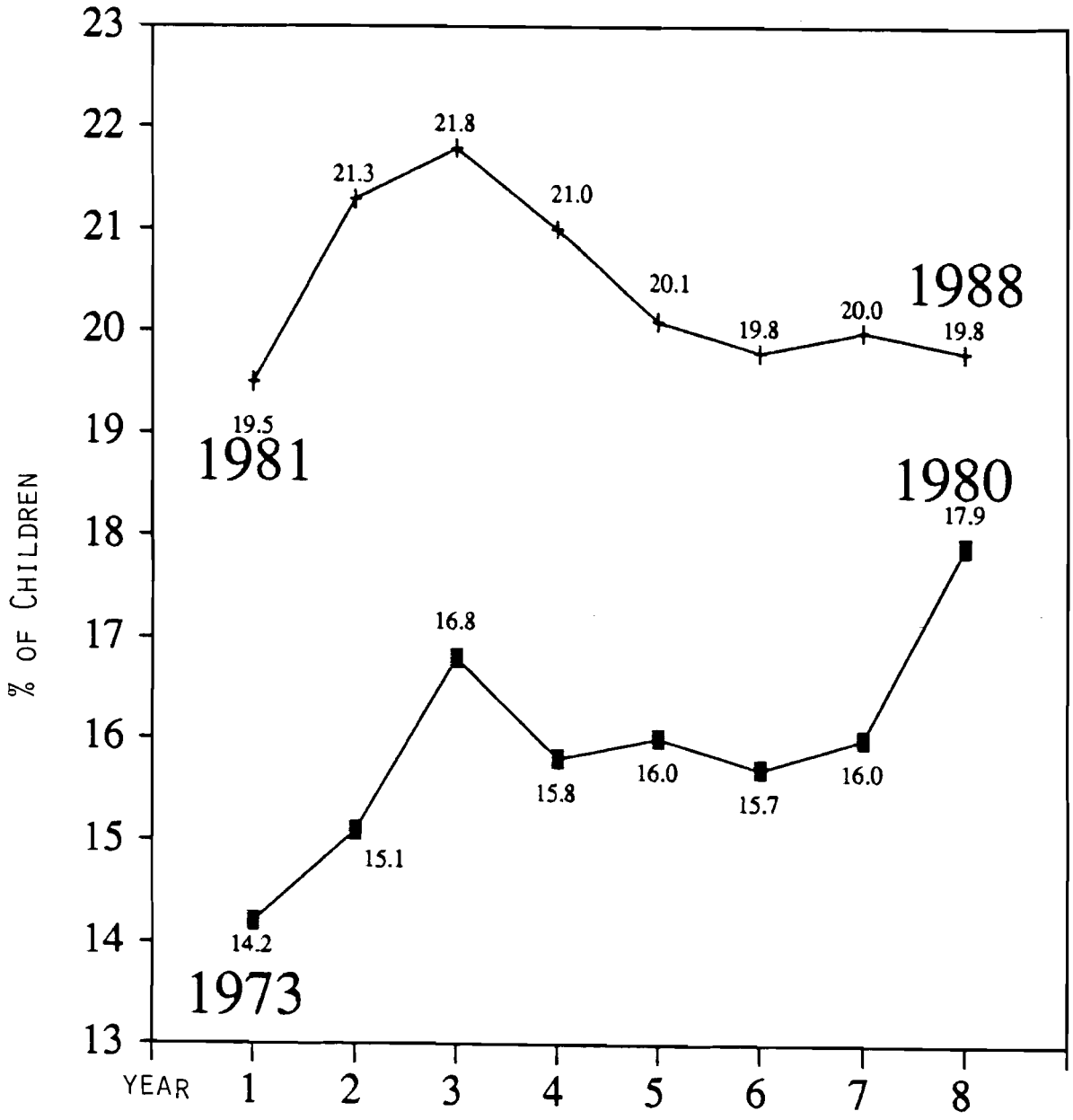
	Percentages in Poverty				
	1949	1959	1969	1979	1987
All persons		22.4%	12.1%	11.7%	13.5%
All children	47.6%	26.1	15.6	17.1	20.6
All elderly	60.2	35.2	26.0	15.2	12.2
Children					
In white, non-Hispanic families	41.2	18.8	10.4	11.7	15.0
Husband-wife families	39.3	16.9	7.7	7.8	9.1
Female-headed families	73.1	57.7	44.0	41.3	44.8
In black, non-Hispanic families	87.0	63.3	41.1	36.1	45.1
Husband-wife families	85.7	57.9	29.0	19.7	16.7
Female-headed families	93.4	84.4	67.9	61.2	66.8
In Hispanic families	73.0	53.3	33.3	28.3	39.3
Husband-wife families	71.6	51.3	28.8	22.5	
Female-headed families	92.4	74.3	64.3	62.0	
Elderly	60.2	35.2	26.0	15.2	12.2
White					
Men	52.8	30.1	20.1	8.6	6.8
Women	67.3	36.4	30.4	15.8	12.5
Black				36.3	33.9
Men	86.4	65.2	43.7	26.5	24.6
Women	92.3	64.9	50.0	35.3	40.2

Source: Danziger (1989b). Computations for 1949-1979 by Sheldon Danziger from computer tapes of the 1950, 1960, 1970, and 1980 Censuses of Population, 1987 data from U.S. Bureau of the Census, Current Population Reports, Poverty in the United States, Series P-60, No. 163 (Washington, D.C.: U.S. Government Printing Office, 1987).

Note: For 1949-1979, children 0-14 years of age; for 1987, children 0-18.

FIGURE 1

CHILD POVERTY RATE



- REAGAN YEARS, 1981-1988, 20.41% AVG.
- PRE-REAGAN YEARS, 1973-1980, 15.94% AVG.

Source: Danziger (1989a)

many among the elderly who are very hard up (for example, single elderly black women). Moreover, among children, some groups have far more poverty than others. In 1985, for example, nearly 65 percent of children who lived in Hispanic and black families headed by a single parent were poor, while only 8.3 percent of white children in two-parent families could be classified as poor (Smolensky, Danziger, and Gottschalk, 1988, p. 40).

Having established that children as a group are more likely to be poor than the old, let us look at the sources of support for the two groups. First we look at those aspects of the economy and government spending that are designed to benefit all children, such as the earnings of family heads and education, and then those designed to reach all of the elderly; such as social security. Then we examine those programs that help the needy: For children, Aid to Families with Dependent Children, Medicaid, and food stamps; for the elderly, Supplemental Security Income, Medicaid, and food stamps.

II. COMPARING SOURCES OF SUPPORT FOR THE TWO GROUPS

A. Earnings vs. Social Security

The real earnings of the median worker declined between 1970 and 1989 (Smolensky, Danziger, and Gottschalk, 1988, pp. 42-44). In fact the exact year the decline began was 1973, the year of the first OPEC oil crisis, which set off lines at gas stations, inflation, and a major recession. Grown-up children from the baby boom entered the labor force largely during this period and were particularly hard hit by the poor economic conditions. At the same time mean social security benefits

continually increased relative to the median earnings of males. These benefits are available to retired members of the workforce 62 and over and their families. Some economists attribute the decline in poverty among the elderly and its increase among children to this pattern of mean earnings of prime-age males and social security.[1] The 1972 Social Security Amendments increased benefits by 20 percent and introduced an automatic indexing of benefits to "keep pace with inflation," at a time when wages of men were not keeping up with inflation. Earnings of women increased but were still lower than men's and, as mentioned earlier, the number of children living with only one parent has been rising. Average benefits per retired worker increased by 46 percent between 1973 and 1984. Total federal expenditures per elderly person in 1985 or real dollars went from $5,500 in 1971 to more than $9,000 in 1985, an increase of 65 percent in 14 years. Added to this is the increase in the standard deduction for the elderly as well. Real earnings dropped by 12 percent for men 35-44 from 1973 to 1986; by half that for men 45-55 and by more than 20 percent for men 25-34 who are high school grads. Low wage jobs have grown while middle wage ones declined.

B. Education

Public education is our major public investment in children. The percentage of federal budget outlays spent on education decreased from 5.9 percent in 1980 to 4.1 percent in 1985 (U.S. Bureau of the Census, 1989). Enrollments stayed at roughly the same level over this period. The federal share of expenditures on public primary and secondary education declined from 9 to 6 percent or by one-third, while real expenditures per pupil increased slightly--by 2.5 percent per year from

1980 to 1985. This is an improvement over the 1970s, when per pupil expenditures increased by 2.2 percent per annum even though enrollments in public school declined by five million, or by more than 10 percent. Over the last three decades the proportion of classroom teachers to all staff declined from 65 percent to 54 percent. Thus more educational dollars now go to noninstructional personnel (bus drivers, security officers) who only indirectly influence our children's education.

Another indication of the lessening commitment to invest in children's education is the pay scale for primary and secondary teachers. The ratio of average starting salaries of teachers relative to liberal arts graduates declined about 3 percent from 1975 to 1987, when it stood at 85 percent (U.S. Bureau of the Census, 1989). The ratio of the average salary of teachers to net earnings of physicians stayed about the same over this period--at about 22 percent, or $25,200 versus $112,800 in 1986. The status of physicians is also much higher than that of teachers. (By the prestige scale of the National Opinion Research Center [NORC], a high school teacher's rank is 63, a physician's, 82 [and a university professor's, 78].) It should come as little surprise that there is a big difference in the college-entrance-examination scores of pre-med students and education majors. The achievement test scores of students planning on teaching are relatively low and have dropped more rapidly than among the overall population of entering students. And the best students--in terms of entrance-exam scores--are less likely to become teachers (Vance and Schlechty, 1982).

We turn now to the relationship between education and poverty. Level of education and poverty are closely related. Children in poor families are three times more likely to drop out of high school than are

children in more prosperous families. Each year a child lives in poverty reduces his or her probability of graduation by nearly 1 percent (Haveman et al., 1989). The high school dropout rate is higher today than it was 20 years ago. About 750,000 students per year drop out (Congressional Research Service, 1988b). The high school graduation rate differs by race and income. As of 1986, 83 percent of whites aged 18-24, 76 percent of blacks, but only 60 percent of Hispanics had graduated from high school. Enrollment in college among this age group follows a similar pattern--it is highest for whites, next highest for blacks, and lowest for Hispanics (18 percent). In general, rates of college enrollment are down, at least for nonwhites, since 1976.

According to a report of the Congressional Research Service (1988a), children in single-parent families and those living in poverty have on average, some degree of "depressed educational attainment." School policies (or the absence of special policies) evidently play a role in influencing this outcome. Children living in single-parent households, especially those headed by mothers, have lower educational attainment, whether measured by years completed, grades, test scores, or behavior in school. The educational difference on average between those who ever lived in a single-parent household and those who had never lived in a single-parent household is 1.1 years. This may not just reflect family structure: single parents tend to have lower education levels and lower financial resources than parents in two-parent families. As noted previously, over half of children in one-parent families live in poverty.

In an ongoing study that I am conducting with Robert Haveman at the University of Wisconsin, we are looking at factors that influence the

probability of high school completion, using data from the Michigan Panel Study of Income Dynamics. We are following children who were between the ages of zero and 6 in 1968 to the present. Early findings are the following: that (1) children who grow up in a single-parent family headed by a woman who has not graduated from college have only a 69 percent probability of graduating from high school; (2) If the single parent graduated from high school, the probability of the child graduating from high school increases by 9 percent. (And, as expected, if either parent attended college the probability of graduation is further increased.) (3) Children whose parents separate have lower school attainment than children whose family structure does not change.

There is evidence that schools play a role in determining these relatively poor educational outcomes. One study has noted that when families are going through a transition, children tend to be absent, late, truant, and aggressive. They are also likely to change schools. Evidence suggests that schools and teachers respond to these problems in ways that "are more negative than warranted" (Hammond, 1979). According to a study by Hetherington, Camera, and Featherman (1983), schools do not give children in such families the benefit of the doubt. One piece of evidence consistent with this conclusion is that living in single-parent families causes children to get lower grades than their achievement test scores warrant (Hetherington, Camera, and Featherman, 1983, p. 283). Schools and teachers also tend not to schedule conferences, assemblies, and other social activities when working parents can attend; nor do they provide transportation so that children whose parents cannot chauffeur them can attend various extracurricular events. There is also evidence that school staffs have negative

expectations of children of single parents and of these parents (Clay, 1981, 29-32, 49-55). There is a tendency to place children from low-income families in nonacademic tracks. This both limits their options to future education and concentrates such children together.

C. Health Care

Another area of public investment is health care, particularly financing in the form of public insurance. Most health insurance for children is private and most is based on parent's insurance at his or her place of employment. The percentage of children without health insurance has been going up: from 13 percent in 1980 to 16 percent in 1986 (U.S. Bureau of the Census, 1989). Children make up about a third of the uninsured.

In 1978, per capita spending by government on health care was 15.6 times as high for the elderly as for children (Meyer and Moon, 1988). And in 1986, about 75 percent of the federal government expenditures on health care went to the elderly, compared to 5 percent to children. Big differences in utilization would occur even without public spending--but they increased with the introduction of Medicare and Medicaid in 1966. Medicare is a federal program that provides health insurance or financing of medical care for those aged 65+, some disabled persons, and those with end-stage renal disease. Medicaid is a joint federal/state health insurance program for certain categories of low-income persons. Over 11 million children had no health insurance in 1987 (Short, Monheit, and Beauregard, 1989). Nearly all the elderly are covered by health insurance. Medicare, which is tied to social security, covers virtually all the elderly, although there are gaps in coverage.

Medicaid, which was designed to provide health protection for specified groups of the poor, should cover the elderly poor. Only about one-third of the elderly poor are beneficiaries of Medicaid, however.

Children's health coverage primarily depends on whether they have a parent who works in a job that offers health insurance coverage or whether their family is eligible for AFDC and hence Medicaid. This eligibility varies from state to state, although since 1986 all children younger than age 7 who live in families with incomes below the poverty line may be covered at the state's option. Many children who live in families with incomes as low as 30 to 50 percent of the poverty line do not have any coverage for medical care.

As a result, many do not obtain even minimal health services. It is generally assumed that children receive free vaccinations. Yet fewer children 1-4 are vaccinated against measles, rubella, DPT (diphtheria-tetanus-pertussis), polio, or mumps today than in the period 1976-1983 (see Table 2). White children are more likely to be vaccinated for each of these diseases than are nonwhites. In fact, according to the Division of Immunization of the Center of Disease Control, less than half of nonwhite children ages 1-4 are vaccinated against any of these diseases (National Center for Health Statistics, 1988, p. 80).

Discrimination or inequities toward children begins early--with inadequate prenatal care of mothers. According to a study by the U.S. General Accounting Office (1987), nearly two-thirds of Medicaid recipients and uninsured women reported insufficient prenatal care. Nearly all (84 percent) uninsured women who received insufficient care cited not enough money as the most important barrier to receipt of care; among the Medicaid group, one third cited no transportation as the most

Table 2

Changes in Health Status As Measured by Immunizations and Life Expectancy

	1970	1974	1979	1985	% Change 74-85
Percentage of Immunized Children Ages 1-4					
Measles					
All	57.2	64.5	63.5	60.8	-6
White	60.4	66.8	66.2	63.6	-5
Nonwhite	41.9	53.1	51.2	48.8	-8
Rubella					
All	37.2	59.8	62.7	58.9	-1.5
White	38.3	61.0	64.7	61.6	+.1
Nonwhite	31.8	53.6	53.7	47.7	-11
DPT					
All	76.1	73.9	65.4	64.9	-12
White	79.7	76.8	69.0	68.7	-10.5
Nonwhite	58.8	59.6	49.2	48.7	-18
Polio					
All	77.5	63.1	59.1	55.3	-12.4
White	80.5	66.7	63.6	58.9	-12
Nonwhite	62.7	45.0	38.9	40.1	+11
Life Expectancy (in years)					
Birth					
All		72.0	73.9	74.7	+3.7
Male		68.2	70.0	71.2	+4.4
Female		75.9	77.8	78.2	+3.0
65+					
All		15.6	16.7	16.8	+7.7
Male		13.4	14.3	14.6	+9.0
Female		17.5	18.7	18.6	+6.3

Source: National Center for Health Statistics, various years.

important barrier. Among women who applied for eligibility when pregnant, about a fifth had difficulties that kept them from receiving sufficient care. Difficulties included long delays in receiving notification of eligibility and being unable to get a provider to see them. Physician participation rates in Medicaid vary from 60 percent in the South to 69 percent in the North Central region (Mitchell and Schurman, 1984, pp. 1026-1037). (These low rates reflect relatively low rates of Medicaid reimbursement.)

One more contrast should be made in the role of the public sector in subsidizing health insurance. The purchase of private health insurance is heavily subsidized because the employer contribution to the premium is excluded from the worker's taxable income. This subsidy is greater, the greater one's marginal tax bracket. Furthermore, not all jobs offer health insurance. Low-paying, part-time, and retail and service jobs are less likely to be covered than well-paying jobs. Full-time workers in firms with 100 or more employees are almost always covered. The value of the tax exclusions has been estimated to be about $50 billion in foregone revenue (as of 1986), which is about twice the federal outlays for Medicaid. The tax exclusions may well have increased the coverage of employees, leading to increased demand, higher prices, and distortion of the location of medical care facilities to higher-income areas. All of these changes have negative consequences for access of the poor, including children.

D. Aid to the Needy

A number of government programs are designed specifically to provide for the needy. How are they distributed between children and

the elderly? Is the beneficent hand of government more open to the old? That appears to be the case (see Table 3 and Figure 2).

All of the poor can participate in the food stamp program, a program that enables them to purchase food at very low cost. The old and young are served equally by this program, although some studies have shown that the old are less likely to make use of it. In addition, the principal benefit for poor children is Aid to Families with Dependent Children (AFDC), commonly known as welfare. This program is directed at children in single-parent families and, since 1988, at children in two-parent families if the breadwinner is unemployed. In 1986 the average AFDC payment was only 40 percent of the poverty line, and only 59 percent of poor children received the benefit (U.S. House of Representatives, 1989).

Compare this with the principal benefit for the low income elderly, Supplemental Security Income (SSI). In 1974 Supplemental Security Income was implemented on a federal level. Both cash assistance and eligibility for Medicaid were determined by national standards to cover the elderly and disabled. In 1986 an elderly couple receiving SSI and food stamps had an income that was greater than 80 percent of the poverty line, and almost all of the elderly poor received some cash benefits (Smolensky et al., 1988).

Most of the elderly also receive Social Security benefits. As I mentioned earlier, these payments have continued to increase relative to the median earnings of men, the poverty line, and AFDC payments. According to recent data (U.S. House of Representatives, 1989), our transfer policies including both welfare (cash and noncash) and social insurance remove from poverty 21.2 percent of two-parent families with

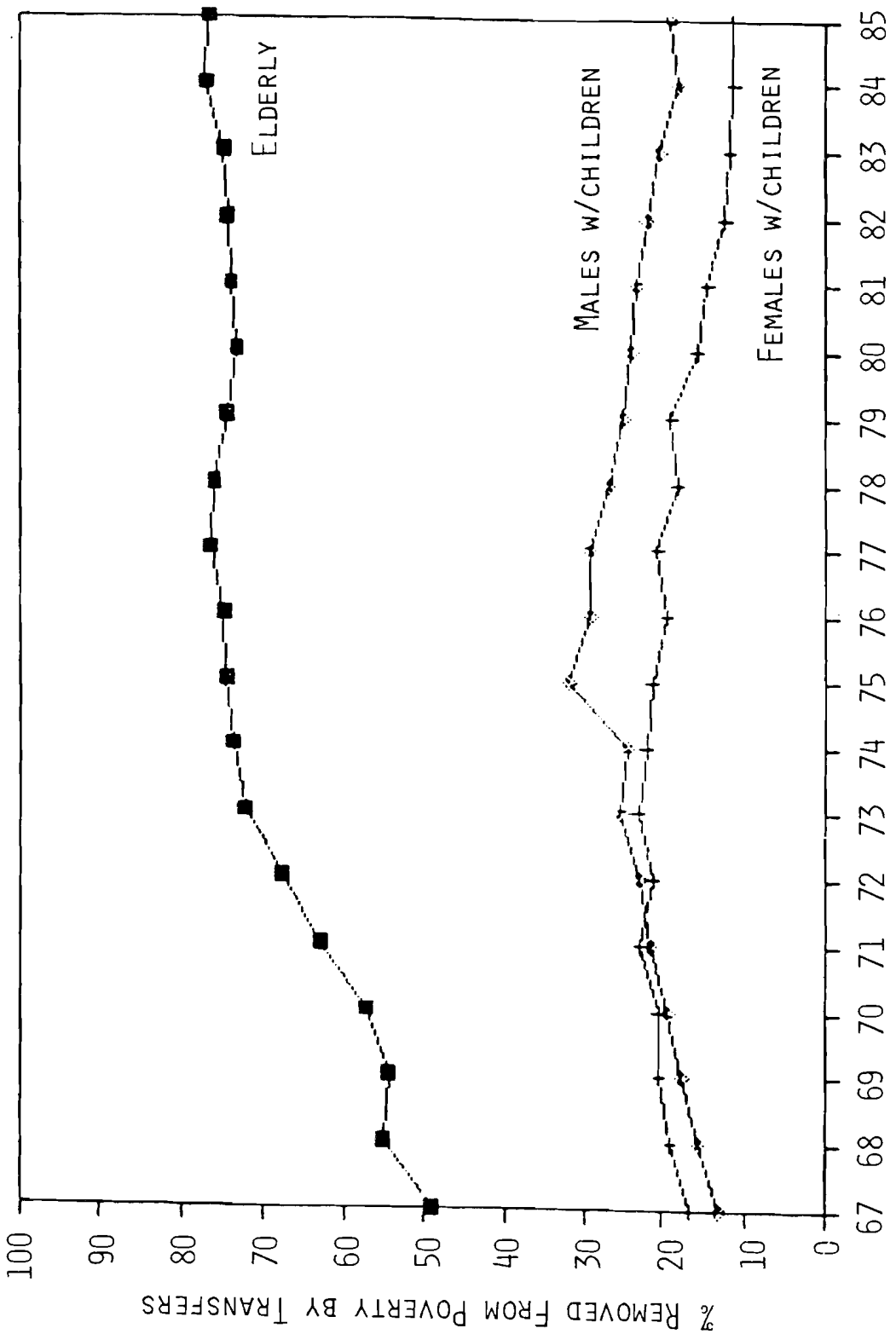
Table 3

Trends in Federal Spending for Social Programs
(Millions of 1985 Dollars)

	1967	1973	1979	1985	% Change 73-85
AFDC	$8,103	$13,706	$9,233	$8,625	-37
Medicaid	11,783	28,964	36,132	41,719	+44
Medicare	9,448	20,924	40,894	69,649	+233
Social Security	63,420	111,507	148,988	186,432	+67
Education Grants for Disadvantaged		5,497	5,768	5,641	+2.6

Source: Haveman (1988, Table A.26).

FIGURE 2
ANTIPOVERTY EFFECTS OF CASH TRANSFERS
1965-1985



Source: Danziger (1989a)

children, 23 percent of poor sole-parent families with children, and 80 percent of poor elderly families.

Average cash transfers to families with children who are poor before receiving any assistance from government declined from 1973 to 1984, whereas average cash transfers to the elderly poor increased and came to more than double the average payments to families with children ($7322 to the elderly poor versus $2946 for two-parent families and $3276 for female-headed families, in 1984). The result, according to Danziger (1989a), is that 13 percent of white, 41 percent of black, and 37 percent of Hispanic children remained poor in 1985, either because they and their families received no transfers or because the transfers were not large enough to enable them to escape poverty. The small sizes of transfers to families with children reflect in part the significant changes made during the Reagan era to reduce eligibility for AFDC. These changes were targeted on the working poor, making it extremely difficult for them to supplement earnings with welfare. Cash benefits also declined in that they failed to keep up with inflation. Among the elderly, 13 percent remained poor after receiving transfers. Many of these are widows. One reason for their low incomes is that social security benefits fall by one-third when a husband dies. The size of the reported increase in poverty, however, is somewhat arbitrary, since the poverty line falls by 20 percent as family size shrinks from two persons to one, whereas benefits are cut 33 percent. If the poverty-line adjustment was consistent with the social security adjustment, 14 percent of white elderly widows and 36 percent of black elderly widows would have incomes below the poverty line (Smolensky et al., 1988, p. 36). Both couples and widows who have private pensions are far less

likely to become poor than those without pensions. Poverty is not necessarily a permanent state, however, even for widows. A recent study by Burkhauser and Duncan using the Retirement History Survey found that on average most recently retired persons in poverty in any year were not in poverty the year before or the year after (1988, p. 75).

III. EFFECTS OF UNDERINVESTMENT IN CHILDREN

Perhaps the most crucial implication of the reduced commitment to children is the reduction in human capital. Not only will the life chances of children be lowered, so will our national income. Employers look at human capital--both educational attainment and health--in making employment decisions. Years of schooling is the single most important factor. (Differences in formal education account for 38 percent of the wage gap between black men and white men [Corcoran and Duncan, 1979].) Simple tabulations from the Census suggest that male high school dropouts earn on average about 78 percent as much as those who graduate from high school but don't continue with their schooling. Male dropouts earn 56 percent as much as those who go to college. Women who drop out of high school earn 75 percent and 52 percent as much as women who graduate high school and women who attend college. High school dropouts are also less likely to be employed than graduates. In 1985 for example, 76 percent of men of prime working ages who did not graduate from high school were in the labor force, compared to 90 percent of those who graduated from high school but had no additional education. Among those in the labor force, dropouts are also more likely to be unemployed (U.S. Department of Labor, 1986).

The effects of lack of investment in medical care and health insurance are profound. Health influences productivity, first in the school and later at home and/or in the workplace. Poor health limits activities, cuts back days of productive activity at school or work, and lowers energy and concentration. Health is determined by a variety of factors including sanitation, shelter, and nutritious food. It is also influenced by hereditary factors, life style, and medical care. Health is difficult to measure accurately. One commonly used indicator is life expectancy. If we use it to compare the elderly versus children, we find the elderly have been doing better in recent years. Between 1974 and 1985, life expectancy at age 65 increased by 8 percent compared to life expectancy at birth, which increased by only 4 percent (see Table 2). Large strides have been made in controlling at least two of the diseases that smite the elderly: heart disease and cerebrovascular disease. The death rate from these two illnesses was cut in half between 1970 and 1984 (National Center for Health Statistics, 1988). At the same time, death rates for homicide and heart disease increased for children under 15. Infant mortality rates, another commonly used measure of health, have been stagnant in the 1980s after a period of substantial decline in the 1970s. Early and adequate prenatal care prevents stillbirths, miscarriages, as well as low birth weight among babies which is a signal of poor health and sometimes lifetime physical and mental disabilities. According to a GAO report (1987) babies born to mothers who receive no prenatal care are three times more likely to be of low birth weight. The report cites an Oregon study which found that insufficient care was associated with a 2 to 5 times greater probability of low birth weight and infant mortality.

In a study published in 1982, van der Gaag and I looked at determinants of child health. We found that if the mother in a household is employed, a child's health tends to be poorer. The negative association was higher for part-time work than for full-time work, perhaps reflecting different (better) child-care arrangements for full-time workers. We found that mother's schooling is positively associated with health. So is parents' marital status. Children of never-married women had significantly poorer health and children of divorced mothers somewhat worse health than children of married parents. Being nonwhite was also negatively associated with health.

Medical care can intervene in some cases of ill health, both as a preventive and as a curative factor. Access to and use of medical care can therefore be an important determinant of health. The use of medical care is determined by the usual factors that apply to demand, but in the case of medical care there is an important intervening factor--namely, health insurance. Health insurance lowers the price of medical care and hence increases utilization.

Poor children who do not have health insurance use less medical care than poor children with coverage or children of higher-income families. Having a comprehensive and generous health insurance plan has a greater effect on the use of medical care by poor children than by other children. Children with Medicaid tend to have as many general check-ups and immunizations as other insured children, though among children with health problems, use of health services is still somewhat below that of children in higher-income families (U.S. Congress, 1988, pp. 17-18).

The failure to invest adequately in the human capital of all of our children will mean that the United States will have lower productivity, be less competitive in the international market, and have a lower national income. Recall that more and more of our children are growing up with fewer parental resources--less time, only one parent, stress due to separations, etc. Instead of compensating for this loss, we seem to be making matters worse. Schools have too few resources. We don't attract enough bright students to teaching. Teachers have little or no training on how to deal with children who are facing the stresses of separation, moves, and low income. Seventeen-year-olds in 1986 scored lower (5 percent) on science proficiency tests than their counterparts 20 years ago. And 13-year-old children in the United States score below children in other developed countries in math and science (National Center for Education Statistics, 1989). Many children have no health insurance and do not receive the medical care than they need. Many children who are born with low birth weight never fully recover. Many children do not receive services to prevent problems that lower their productivity at school and at work. Lack of preventive services and lower nutrition result in less productive workers. Additional social problems may develop--especially if income inequality increases as a result of the lack of investment in some of our children. Not only are individuals less able to compete, there are ramifications for the entire economy. Lower levels of human capital for some are likely to increase inequality, with its demoralizing and destabilizing effects on a racially diverse society.

IV. HOW DID WE GET HERE?

Why has this disparity between our treatment of the young and our treatment of the old developed? One explanation is that somehow the U.S. public believes that social insurance--social security for example--has been earned and paid for by contributions made while working, and thus it is deserved. Because benefits to single parents--welfare--are not based on earnings but rather are based on "need," they are thought by many to be payments that support lazy people who choose not to work. Children are heavily dependent on the earnings and health insurance of their parents. As earnings growth declines, as more and more babies are born to parents who belong to minority groups, and as children spend more and more time in single-parent rather than two-parent households, the well-being of children declines.

Children and their parents are also losing political power. The elderly have increased in number and will continue to increase as a proportion of our population. They vote more than other age groups and belong to well organized lobbying groups such as the AARP. They have therefore become a powerful political force, or at least are perceived as a potentially major force. In addition, some of the middle-aged population support policies for the elderly both because it is a way to shift part of the burden of caring for their parents away from themselves and onto the public sector, and because they expect to share in the benefits when they retire. During this century the proportion of U.S. citizens who agreed that children should accept financial responsibility for their old parents dropped from 50 percent in the 1950s to 10 percent in the 1970s (Crystal, 1982). A similar change in

view is taking place concerning who should take care of the elderly. It is no longer viewed as the responsibility of the children (usually daughters), since most women work (Crystal, 1982).

At the other end of the age spectrum, children can't vote and are a declining percentage of the population. The middle-aged population will never again be children, and fewer older adults are grandparents, who may feel a greater stake in the future of the young. An increasing percentage of adults are childless, which decreases the bloc of voters who would naturally support policies toward children. And children are more likely to belong to minority groups, toward whom some of the majority population may feel less commitment. Parents are still expected to take financial responsibility for their children, and policies to require that they do so are being pursued with increased vigor (enforcement of the laws obligating absent parents to pay child support, for example). These factors plus the stagnation in real earnings, which has led to a real decline in living standards of children, particularly those who do not live with parents who are both earners, are putting our future generations at risk.

V. WHAT MIGHT BE DONE?

It is clear that we are investing less in our nation's children and that these children have, on average, fewer private resources than was the case in the past. We have been allocating more resources to the elderly as a group, although the rate of increase in social security benefits should be curbed by changes made in this decade. All of this

argues for some fundamental changes in public investments or allocation of resources.

In terms of investment, the nation seems to have put our troubled education system and child care on its agenda. We regularly read of the need to attract brighter students to education,[2] and there are several bills in Congress to support child care so I mention here two ideas which focus on other aspects of the problem--one for health insurance coverage, the other for providing resources to children so they can invest in themselves.

Numerous bills are being considered to extend Medicaid to children not otherwise covered.[3] The 1988 Family Support Act extended Medicaid coverage for 12 months to all who lose eligibility because of increased income or work. But Medicaid reimbursement is low compared to the amount paid by private coverage. This discourages medical practitioners from providing services, forcing Medicaid recipients to use emergency rooms, which are more expensive and do not have the benefit of medical records.

A more comprehensive approach is clearly needed. In order to target children, we should introduce what I like to call Healthy-kid, a program that is federally operated and covers all children below a specified age, say 18. This plan would provide coverage for a specific set of services. For children living in families with income below 1.75 times the poverty line, these services would be provided without cost. For children in higher-income families, there would be income-based copayments; that is, the percentage of each charge paid by families would be higher among higher-income families. Coverage of other services beyond this specific package of services would require cost

sharing by the poor and private insurance or direct payments by the better off. In other words, the federal government would provide a federal minimum of health insurance coverage for all children. This plan would also cover pregnant women--again with copayments tied to income. The plan would be operated through the Health Care Financing Administration (HCFA), which now runs Medicare. Children could obtain their coverage by signing up with an HMO that has a contract with the HCFA, or they could use services on a fee-for-service basis. The payments to providers would not depend on the child's household income but only on the child's location (and perhaps his or her underlying health status for HMO's). This program should avoid the current disincentives to serve the poor compared to middle- and upper-income families. This insurance or financing may save some money in the long run by decreasing the need for high-cost care such as intensive care for infants who have low birth weights. Some of the costs of the program could be financed by taxing the value of health insurance premiums paid by the employer beyond a maximum amount (or cap). The cap could be set at 80 percent of the actuarial value of basic benefits, or the entire value of employer-based premiums could be taxed at 50 percent of the full value.

Alternatively, we could move to provide basic coverage for all citizens. Again, it is only basic services that would be provided, and again, copayments would be tied to income. However, I think we should start with Healthy-kid. By doing so, we will gain some knowledge of the costs of running a nationwide program that covers basic services only, for everyone, regardless of income.

My second proposal is to use the Social Security Trust Fund as a way to increase an individual's capacities. The social security system could serve as collateral for loans to young people to enable them to increase their productivity. Thus one young adult might take a loan from the Social Security System to finance a college education or a graduate degree. Another might finance an apprenticeship. These loans would be available to individuals 18 or over only for approved investments. A new office in the local Social Security office would review the application. Payment of the proceeds of the loan would be made directly to a college, apprenticeship program, etc. Defaulting the loan would reduce the defaulter's future social security pension benefits, but at a rate that would not reduce a person's income below 85 percent of the poverty line.

This approach would provide equality of opportunity, making youth less dependent upon the fortunes of their parents. It would improve the productivity of young adults and add to their income, the national income, and the Social Security Trust Fund. It also carries some risk for the individual who borrows, since nonrepayment hurts his/her own economic condition in retirement.

Finally, let me just briefly state how we might change things at the other end of the age spectrum. We can turn Social Security into a minimum standard benefit sufficient to keep the elderly out of poverty. We would expect those who want larger incomes in their old age to save during their working years, perhaps by putting their money in special accounts that provide tax advantages. Of course, such a change would have to be phased in gradually over time.

I am not advocating depriving the old of their hard-won security. There are numerous other ways to finance increased resources to the young. What I am proposing is that we reallocate our spending so that those who are most needy and who are needed by all of us--our children--have the opportunity to become productive citizens.

Notes

[1]According to a report of the U.S. House of Representatives (1989) over the years 1979-1987, 28 percent of the increase in poverty among families with children was due to declines in real market income, 46 percent to declines in means-tested programs, 14 percent to changes in social insurance programs, and 3 percent to federal tax changes (p. 977).

[2]For education, one of the prevailing views is that we need to find a way to create incentives for bright promising teachers to enter the profession, for them to be appropriately rewarded, and for information to be communicated on programs and approaches that are successful. Some resources for experimental schools would also be useful. Privatization and/or allowing parents freedom of choice in selecting schools is another current popular option.

[3]For example, Lloyd Bentsen, chair of the Senate Finance Committee, has introduced a bill to provide Medicaid coverage to all pregnant women and children up to age 6 in families with incomes up to 1.8 times the poverty line. President Bush has suggested extending coverage to women and infants living in families with incomes up to 1.3 times the poverty line and to finance immunizations for all children receiving food stamps.

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