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REMARKS

ASSOCIATION OF THE CARE OF CHILD HEALTH

WASHINGTON, D.C.

MAY 30, 1990

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EVEN THOUGH I AM PREACHING TO THE CHOIR -

AND EVEN THOUGH YOU HAVE HEARD ALL I WILL SAY EXPRESSED BY OTHERS MORE ELOQUENTLY IN THE PAST FEW DAYS →

I AM DELIGHTED TO HAVE BEEN CHOSEN TO SPEAK TO YOU AT THIS CLOSING PLENARY SESSION OF THE 25TH ANNIVERSARY MEETING OF THE ASSOCIATION FOR THE CARE OF CHILDREN'S HEALTH.

THE SIGNIFICANCE OF ACCH IN THE HEALTH CARE SYSTEM LIES IN ITS MULTI-DISCIPLINARY NATURE WHICH ENCOURAGES A TEAM APPROACH IN SOLVING THE PROBLEMS CHILDREN FACE IN A WORLD THAT SEEMS TO ME TO GROW EVER MORE HOSTILE.

IT IS SIGNIFICANT, AND AUGERS WELL FOR THE FUTURE THAT SO MANY PARENTS ARE PARTICIPANTS IN THIS MEETING.

THE INTERNATIONAL FLAVOR OF THE MEETING HAS PROVIDED AN OPPORTUNITY FOR THE UNITED STATES AND CANADA TO LEARN FROM EACH OTHER:

OUR GOALS ARE COMMON; THE MEANS TO THEM ARE DIFFERENT; BUT WE EACH HAVE STRENGTHS AND WEAKNESSES. GOOD HEALTH CARE IS OBVIOUSLY NOT NECESSARILY A MATTER OF WHO HAS MOST DOLLARS, IMPORTANT THOUGH MONEY CAN BE. OUR CURRENT CHALLENGE IS TO INVEST LIMITED DOLLARS MOST WISELY, ANOTHER AREA WHERE WE HAVE MUCH TO LEARN FROM OTHER SYSTEMS.

WHAT IS OUR COMMON CHARGE?

CHILDREN ARE THE FUTURE OF OUR NATIONS -- A VERY SPECIAL RESOURCE. IN THIS COMPETITIVE WORLD CHILDREN ARE TOO SMALL, TOO WEAK, TOO POOR – TO LOBBY FOR THEMSELVES. WE MUST ASSURE THAT ALL CHILDREN HAVE THE FULLEST OPPORTUNITY TO PARTICIPATE IN ALL ASPECTS OF LIFE.

CHILDREN DESERVE TO GROW UP RECEIVING QUALITY HEALTH CARE, EDUCATION, AND NECESSARY SOCIAL SUPPORT SERVICES. THEY DESERVE TO HAVE A HOME WITH A FAMILY AND LIVE IN A COMMUNITY THAT CAN MEET THEIR NEEDS. INVESTMENT IN CHILDREN AND FAMILIES IS THE CORNERSTONE OF PUBLIC HEALTH AND SHOULD BE THE FOUNDATION OF EVERY NATION'S POLITICAL AGENDA.

WE MUST MOVE TO CONSENSUS AND THEN TO ACTION TO MEET CHILDREN'S NEEDS AND TO SUPPORT THEIR FAMILIES APPROPRIATELY.

AS WE MOVE INTO THE LAST DECADE OF THE TWENTIETH CENTURY, NEITHER THE U.S. NOR CANADA HAS YET ENACTED A NATIONAL YOUTH AGENDA THAT ADDRESSES THE NEEDS OF CHILDREN COMPREHENSIVELY. EXISTING SERVICE DELIVERY SYSTEMS DO NOT FUNCTION IN WAYS THAT CHERISH AND PROVIDE FOR CHILDREN AND THEIR FAMILIES. CHILDREN SEEM TO COME LAST, NOT FIRST. IT SHOULD BE THE OTHER WAY AROUND.

IT IS TIME TO RE-EXAMINE THE WAYS IN WHICH WE LOOK AT CHILDREN AND FAMILIES -- TO REALLOCATE RESOURCES AND TO REDESIGN SERVICE DELIVERY SYSTEMS IN WAYS THAT HELP ALL OF OUR YOUNG PEOPLE AND THEIR FAMILIES, OVERCOME THE BARRIERS THAT KEEP THEM FROM BECOMING HEALTHY, WELL-EDUCATED, PRODUCTIVE CITIZENS.

THIS IS OUR TASK! THIS IS OUR CHARGE!

THE COUNTENANCE OF HEALTH CARE HAS CHANGED. IT IS NOW INEXTRICABLY TIED IN WITH THE SOCIO-ECONOMIC STATUS OF CHILDREN AND THEIR FAMILIES.

POVERTY, GHETTO LIFE, ILLITERACY, POOR NUTRITION NOT ONLY CONTRIBUTE TO DISEASE AND DIMINISHED HEALTH; THEY ALSO IMPEDE ACCESS TO CARE, AND IF THAT IS ACHIEVED, TREATMENT THEREAFTER.

WHILE THERE HAVE ALWAYS BEEN POPULATIONS WITHIN OUR COUNTRIES THAT DO NOT HAVE EQUAL OPPORTUNITY OR EQUAL ACCESS TO SERVICES, IN RECENT DECADES THERE HAVE BEEN MAJOR CHANGES IN THE FABRIC OF THE SOCIETY THAT SIGNAL THE NEED FOR CHANGES IN OUR SOCIAL INSTITUTIONS AND IN OUR PROFESSIONAL PRACTICES.

FAMILIES NEED NEW KINDS OF SUPPORT IF THEY ARE TO SURVIVE AND FLOURISH IN AN ENVIRONMENT THAT IS CHARACTERIZED BY THE FOLLOWING KINDS OF ISSUES:

* **COMMUNITIES AND NEIGHBORHOODS NO LONGER FUNCTION AS SYSTEMS OF SUPPORT WITHIN WHICH CHILDREN CAN SAFELY GROW INTO ADULTHOOD AND BECOME SELF-SUFFICIENT. VIOLENCE AND SUBSTANCE ABUSE HAVE THREATENED THE STABILITY OF FAMILIES AT ALL SOCIOECONOMIC LEVELS.**

* DESPITE THE FACT THAT OUR COMMUNITIES ARE MORE CULTURALLY DIVERSE, SOCIAL INSTITUTIONS HAVE NOT ADAPTED TO THESE CHANGES. PROFESSIONAL INSENSITIVITY TO CULTURAL DIFFERENCES AND LANGUAGE BARRIERS IMPEDE ACCESSIBILITY TO SERVICES FOR CULTURALLY DIFFERENT FAMILIES AND CHILDREN.

* POVERTY IS EVER-PRESENT. 21% OF CHILDREN (12.9M) ARE POOR; MOREOVER, IN THE LAST FIVE YEARS, THE NUMBER OF FAMILIES IN POVERTY HAS GROWN BY FORTY PERCENT.

HALF OF AFRICAN-AMERICAN AND LATIN CHILDREN UNDER 6 LIVE IN POVERTY. HALF OF POOR CHILDREN ARE IN RURAL OR SUBURBAN AREAS; IT IS NOT AN URBAN PROBLEM ONLY. ONLY 40% OF ALL POOR CHILDREN ARE FROM HOMES IN WHICH BOTH PARENTS RESIDE.

* THERE ARE SIGNIFICANT CHANGES IN TRADITIONAL FAMILY STRUCTURES AND ROLES. OUR SERVICE DELIVERY SYSTEMS ARE NOT ORGANIZED IN WAYS THAT ARE RESPONSIVE TO THE NEEDS OF SINGLE PARENT FAMILIES, AGGREGATE FAMILIES AND FAMILIES WITH TWO WORKING PARENTS.

NOR ARE THEY TO ADOPTIVE AND FOSTER PARENTS, NOR HOUSEHOLDS WHERE THE GENERATIONAL LINES ARE BLURRED BECAUSE GRANDMOTHER, MOTHER AND GRANDCHILD ALL HAVE CHILDREN BEING RAISED TOGETHER.

THERE ARE FEW SUPPORTIVE SERVICES AVAILABLE TO FAMILIES IN THEIR COMMUNITIES, SUCH AS CHILD CARE, THAT ENABLE FAMILIES TO MEET THEIR RESPONSIBILITIES.

* HOMELESSNESS IS REACHING EPIDEMIC PROPORTIONS IN THE U.S. FAMILIES ARE THE FASTEST GROWING SEGMENT OF THE HOMELESS POPULATION. MOREOVER, ONE OUT OF EVERY FIVE HOMELESS CHILDREN IS SCHOOL-AGE.

* 42 MILLION CHILDREN AGED 10 - 19 IN THE UNITED STATES EXPERIENCE SERIOUS PROBLEMS. SUBSTANCE ABUSE IS INCREASING AND CREATES SERIOUS DISRUPTIONS IN THE LIVES OF CHILDREN AND FAMILIES AS WELL AS THREATS TO THEIR HEALTH AND SAFETY.

THE NATIONAL ADOLESCENT STUDENT HEALTH SURVEY INDICATED THAT 77% OF EIGHTH GRADERS AND 89% OF TENTH GRADERS HAVE USED ALCOHOL; 15% OF EIGHTH GRADERS AND 35% OF TENTH GRADERS HAVE USED MARIJUANA; AND AMONG THE CLASS OF 1987, 5.6% HAD USED CRACK-COCAINE.

TEENAGE SUICIDES AND VIOLENT DEATHS HAVE BEEN INCREASING AT AN ALARMING RATE. SUICIDE AND HOMICIDE ARE STILL THE NUMBER ONE CAUSE OF DEATH FOR THIS AGE GROUP.

* VALUE SYSTEMS ARE BEING TRANSFORMED AS CHILDREN SEE MATERIALISTIC REWARDS COMING FROM DEALING IN DRUGS AND FROM OTHER ILLICIT ACTIVITIES RATHER THAN FROM THE KINDS OF JOBS THAT THEY CAN OBTAIN AS A RESULT OF THEIR SCHOOLING.

* SCHOOLS AND MEDICAL FACILITIES ARE FACED WITH SERVING CHILDREN THEY NEVER HAD TO DEAL WITH BEFORE. CHILDREN WITH HANDICAPPING CONDITIONS ARE BEING DE-INSTITUTIONALIZED AND "MAINSTREAMED" INTO EDUCATIONAL PROGRAMS IN THE PUBLIC SCHOOLS.

AS APPROVING AS I AM OF MAINSTREAMING, I DEPLORE THE LACK OF COORDINATION BETWEEN THOSE WHO PLAN EDUCATION AND HEALTH CARE FOR OUR CHILDREN.

AIDS HAS BECOME A SERIOUS THREAT TO OUR CHILDREN. AS OF 1990, THERE HAVE BEEN 2116 CASES OF AIDS FROM BIRTH TO 13 YEARS OF AGE. THERE HAVE BEEN 406 CASES IN TEENAGERS 13 TO 19 YEARS OF AGE. BOTH ARE MISLEADING FIGURES.

WITH THE LONG INCUBATION PERIOD FOR HIV INFECTION, LOOK TO THE PREVALENCE OF AIDS IN THE 20 – 30 YEAR GROUP TO GET AN IDEA OF HOW MUCH HIV INFECTION TAKES PLACE IN THE TEEN YEARS.

* THE NUMBER OF TEENAGE PREGNANCIES IS ESCALATING AND THE CONSEQUENCES OF INAPPROPRIATE CARE ARE BEING FELT IN THE RISE OF INFANT MORTALITY AND MORBIDITY RATES.

ALL OF THESE ISSUES CONSTITUTE THE SOCIAL CONTEXT WITHIN WHICH SERVICES WILL NEED TO BE OFFERED. WE LIVE IN A SOCIETY IN WHICH CHANGE IS A CONSTANT. RECOGNIZING THIS ONGOING SOCIAL CHANGE AND ITS EFFECTS ON FAMILIES AND CHILDREN, IS NOT ENOUGH.

MUST

ABOVE ALL WE MUST BE FLEXIBLE, WE ORGANIZE HEALTH, EDUCATION, AND SOCIAL SUPPORT SERVICES IN WAYS THAT ACKNOWLEDGE THE COMPLEXITY OF SOCIAL ENVIRONMENTS AND ADDRESS CONCERNS AS THEY EMERGE.

OBVIOUSLY WE NEED A COMPREHENSIVE POLICY.

NEGATIVE SPIRALLING EFFECTS OF POOR HEALTH IN CHILDHOOD ARE DEVASTATING BECAUSE THEIR IMPACT LASTS A LIFETIME AND THERE IS A CONTINUING LINK BETWEEN GENERATIONS. UNHEALTHY MOTHERS GIVING BIRTH TO UNHEALTHY BABIES WHO GROW UP UNHEALTHY . . . THE CYCLE BECOMES MORE POWERFUL WITH EACH GENERATION.

FORTUNATELY INDIVIDUAL CITIZENS FROM THROUGHOUT NORTH AMERICA, CORPORATIONS, AND GOVERNMENTS, NOT JUST OUR HUMAN SERVICE SYSTEMS, ARE BEGINNING TO RECOGNIZE THAT WE MUST INVEST IN THE HEALTH OF OUR CHILDREN . . . AN INVESTMENT IN HEALTH, NOT JUST AN INVESTMENT IN THE TREATMENT OF DISEASE.

THE SOLUTIONS ARE NOT SIMPLE, QUICK FIXES. RATHER,

<u>COMPLEX SYSTEMS CHANGE</u> IS REQUIRED. CLEARLY, AS WE

HAVE JUST SEEN, POVERTY IS THE SINGLE CONDITION THAT IS

HAVING THE MOST DRAMATIC IMPACT ON THE HEALTH STATUS

OF CHILDREN IN THE U.S. AND TO A SLIGHTLY LESSER DEGREE,

ON CANADA'S CHILDREN.

THE HEALTH CARE SYSTEM ALONE CAN NOT SOLVE POVERTY, BUT IT DOES NEED TO ADDRESS ISSUES OF POVERTY.

OUR SYSTEMS OF EDUCATION AND CHILD WELFARE OR SOCIAL SERVICES ARE ALSO VITALLY IMPORTANT PARTNERS IN ADDRESSING ISSUES OF POVERTY AND BUILDING A COMPREHENSIVE, COORDINATED SYSTEMS OF HEALTH, EDUCATION, AND SOCIAL SUPPORT FOR CHILDREN AND THEIR FAMILIES.

WE MUST PUT THESE SERVICES PERMANENTLY IN PLACE AT THE FAMILY AND COMMUNITY LEVEL. SURELY, OUR NATIONS WITH THEIR POWER, DOLLARS, AND "KNOW-HOW," CAN ACCOMPLISH THIS TASK.

CHILDREN SHOULD HAVE THE RIGHT TO QUALITY HEALTH CARE AND EDUCATION. IT IS TIME THAT OUR COUNTRIES DEVELOPED NATIONAL COMPREHENSIVE POLICIES FOR CHILDREN AND FAMILIES.

WHAT WOULD THE IDEAL COMPREHENSIVE HEALTH-CARE SYSTEM BE LIKE?

IT WILL BE:

1. **FAMILY-CENTERED, AND IT WILL BE**
2. **COMMUNITY-BASED; AND IT WILL BE**
3. **ACCESSIBLE TO ALL; AND IT WILL BE**
4. **COORDINATED - NOT A "PIECEMEAL APPROACH - BUT FAMILY NEEDS ADDRESSED HOLISTICALLY.**

IT WILL ALSO BE BASED ON THE ACKNOWLEDGEMENT OF:

THE CENTRAL AND CONSTANT ROLE OF THE FAMILY (DEFINED IN ITS BROADEST SENSE) IN THE CHILD'S LIFE ("UNITED BY CHOICE NOT BIRTH"), BUT BASED ALSO ON THE RECOGNITION OF THE IMPORTANCE OF THE CULTURAL SENSITIVITY, THE NEED TO SUPPORT, NOT SUPPLANT THE FAMILY'S ROLE, AND THE NEED TO FOSTER INDEPENDENCE; NOT DEPENDENCE.

WE DO HAVE THE EXPERIENCE WITH A FAMILY-CENTERED PROGRAM FOR CHILDREN WITH SPECIAL NEEDS, IN 1987, – THAT SHOWED HOW THE APPROACH COULD AND SHOULD WORK; IT DID NOT HAVE AS A GOAL THE SYSTEMIC CHANGE THAT IS NEEDED.

NOW WE HAVE TITLE V LEGISLATION.

EFFORTS TO ACHIEVE BROADER SYSTEMIC CHANGE IN THE NATURE OF SERVICE DELIVERY SYSTEMS HAVE EMERGED IN THE MOST RECENT TITLE V LEGISLATION, THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROGRAM AND IN THE INITIATIVES SPONSORED BY THE SURGEON GENERAL'S OFFICE DURING MY TERM OF OFFICE.

THE PURPOSES OF TITLE V INCLUDE THE IMPROVEMENT OF THE HEALTH OF ALL MOTHERS AND CHILDREN AND FACILITATING THE DEVELOPMENT OF COMMUNITY-BASED SYSTEMS OF SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS AND THEIR FAMILIES.

IT WAS RECOGNIZED THAT THESE EFFORTS NEED TO BE ACCOMPLISHED BY THE DEVELOPMENT OF FAMILY CENTERED, COORDINATED SYSTEMS OF CARE WITH THE INVOLVEMENT OF ALL RELEVANT SECTORS OF THE SERVICE COMMUNITY.

THE MCH PROGRAM FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS IS AN INNOVATIVE EFFORT TO CHANGE THE WAY THAT HEALTH SERVICES ARE ORGANIZED FOR THESE CHILDREN AND THEIR FAMILIES.

THE FOCUS FOR THIS INITIATIVE WAS DEFINED AFTER EXTENSIVE INVOLVEMENT WITH PROFESSIONALS OF ALL DISCIPLINES AND WITH PARENTS AND FAMILIES IN NEED OF THESE SERVICES.

THESE SERVICE RECIPIENTS HAD HIGH PRAISE FOR TECHNOLOGICAL ADVANCES AND THE TECHNICAL ASPECTS OF CARE. HOWEVER, THEY EXPERIENCED SOME OF THE FOLLOWING DIFFICULTIES WITH THE SERVICE SYSTEM:

* PROFESSIONALS IN HOSPITALS AND IN COMMUNITY PROGRAMS DID NOT VIEW PARENTS AS PRIMARY CARE PROVIDERS FOR THEIR CHILDREN. AS A RESULT, FAMILIES WERE NOT RECEIVING ADEQUATE INFORMATION AND SUPPORT. THEREFORE, SERVICES SHOULD BE RE-FOCUSED TO BE <u>FAMILY-CENTERED</u>.

* **SERVICES WERE SOMETIMES INADEQUATE WHEN CHILDREN LEFT HOSPITALS AND RETURNED TO THEIR HOME COMMUNITIES; SO, THE SERVICE DELIVERY SYSTEM SHOULD BE RESHAPED TO BE COMMUNITY-BASED.**

* **FAMILIES OFTEN HAD TO APPROACH MULTIPLE AGENCIES AND PROFESSIONALS (OFTEN AS MANY AS 20 – 30) IN ORDER TO GET ALL NEEDED SERVICES; THUS, SERVICE SYSTEMS SHOULD BE COORDINATED TO FACILITATE ACCESS TO SERVICES.**

IN ORDER TO RESPOND APPROPRIATELY TO CONCERNS OF CHILDREN WITH SPECIAL NEEDS AND THEIR FAMILIES, SERVICE PROFESSIONALS NEEDED TO RECONCEPTUALIZE THE SERVICE DELIVERY SYSTEM THEREBY CALLING FOR BROAD SYSTEMIC CHANGE. THESE ISSUES REPRESENT THE CURRENT FOCUS OF THE TITLE V LEGISLATION.

THREE KEY ISSUES IN A COMPREHENSIVE SYSTEM OF CHILD HEALTH CARE

FIRST, CARE MUST BE ACCESSIBLE. WHAT DOES THIS ENTAIL? ADEQUATE FINANCING, FOR ONE THING. BUT THAT IS NOT ALL.

OUR CANADIAN COLLEAGUES HAVE DEALT WITH THIS ISSUE MORE SUCCESSFULLY THAN WE HAVE IN THE U.S. FOR EXAMPLE, THERE IS UNIVERSAL ACCESS TO PRENATAL CARE IN CANADA, WHICH CONTRIBUTES TO CANADIAN RATES OF INFANT MORTALITY AND LOW BIRTH WEIGHT BABIES BEING LOWER THAN THE U.S.

BUT CANADA DOES NOT HAVE THE NUMBERS WE DO, NOR THE ETHNIC, RACIAL AND ILLITERACY BARRIERS THAT ARE OURS.

WE HAVE THE PARADOX OF WOMEN WANTING PRENATAL CARE AND NOT GETTING IT WHILE AT THE SAME TIME WE HAVE FAILING CAMPAIGNS TO GET UNWILLING WOMEN TO AVAILABLE CARE.

* ALL CHILDREN AND THEIR FAMILIES SHOULD HAVE ACCESS TO ADEQUATE HEALTH CARE INSURANCE. IT MUST COVER CHRONIC CARE AND CARE IN THE COMMUNITY.

IT MUST RECOGNIZE THE COMPREHENSIVE NEEDS OF CHILDREN AND THEIR FAMILIES. IT MUST ASSURE EQUAL ACCESS TO CARE FOR ALL CHILDREN ACROSS GEOGRAPHIC BOUNDARIES.

MANY OPTIONS ARE BEING CONSIDERED TO IMPROVE PUBLIC AND PRIVATE INSURANCE. AS SYSTEMS AND SERVICES ARE DEVELOPED, PUBLIC, PRIVATE AND VOLUNTARY RESOURCES MUST BE REDIRECTED IN WAYS THAT SUPPORT FAMILIES.

THIS WILL VARY BY STATE AND LOCALITY AND YOU MUST BE FLEXIBLE AS WELL AS INNOVATIVE IN BRINGING THIS ABOUT IN YOUR OWN COMMUNITIES.

SECOND, CARE MUST BE GEOGRAPHICALLY ACCESSIBLE, THAT IS, -- COMMUNITY-BASED.

* **THE UNITED STATES IS RECOGNIZED INTERNATIONALLY FOR SOPHISTICATED TERTIARY CARE AND TECHNOLOGICAL ADVANCES; YET WE LACK ACCESS AND EQUITY FOR BASIC SERVICES AT THE FAMILY AND COMMUNITY LEVEL.**

WE ARE THE ONLY DEVELOPED NATION THAT DOES NOT GUARANTEE HEALTH CARE TO EVERY CITIZEN. SERVICES NEED TO BE PROVIDED IN OR NEAR THE HOME COMMUNITIES OR NEIGHBORHOODS OF CHILDREN AND THEIR FAMILIES.

FAMILIES SHOULD NOT HAVE TO TRAVEL LONG DISTANCES FOR SERVICES. WHENEVER POSSIBLE, CHILDREN SHOULD BE CARED FOR AT HOME RATHER THAN IN A HOSPITAL.

THIRD, THERE IS THE PART OF ACCESSIBILITY THAT INVOLVES SERVICE COORDINATION, THE -- ELIMINATION OF GAPS AND OVERLAPS.

SERVICES MUST BE COORDINATED TO BE RESPONSIVE TO CHILDREN AND FAMILIES, TO PREVENT GAPS IN SERVICE, AND TO KEEP SERVICES FROM BEING PROVIDED SEPARATELY FROM EACH OTHER. STRONG LEADERSHIP AND COMMITMENT ARE NEEDED AS PEOPLE AND GROUPS WORK TOGETHER TO IMPROVE DELIVERY OF SERVICES.

INCREASED FORMAL COLLABORATION BETWEEN HEALTH, EDUCATION, AND SOCIAL SERVICE PROFESSIONALS IS AN IMPORTANT BUILDING BLOCK IN THE DEVELOPMENT OF THESE NEW SYSTEMS OF CARE.

AS THE NEEDS OF CHILDREN AND FAMILIES EXPAND AND BECOME MORE COMPLEX, IT IS MORE AND MORE APPARENT THAT BOUNDARIES OF PROFESSIONAL RESPONSIBILITY, AS REFLECTED IN OUR EXISTING SERVICE DELIVERY SYSTEM, ARE OFTEN DYSFUNCTIONAL.

THERE ARE SEVERAL POPULATIONS OF CHILDREN CURRENTLY BEING SERVED INDEPENDENTLY BY HEALTH, MENTAL HEALTH, EDUCATION, AND SOCIAL SERVICE CARE GIVERS.

INSTEAD, WE MUST MAKE CHANGES IN THE SERVICE SYSTEM THAT ALLOW, INDEED FORCE, PROFESSIONALS TO PROVIDE SERVICES TO CHILDREN AND FAMILIES COLLABORATIVELY.

FOURTH, THERE MUST BE ACCESS TO INFORMATION.

KNOWLEDGE IS POWER; FAMILIES MUST BE GIVEN ACCESS TO CULTURALLY APPROPRIATE RESOURCES -- THERE IS A MAJOR NEED FOR COMPREHENSIVE AND UNDERSTANDABLE HEALTH EDUCATION.

FINALLY, ACCESS INVOLVES TIME AND SCHEDULES - ADJUSTING OUR PROFESSIONAL HOURS TO FIT THOSE OF WORKING FAMILIES.

AS HEALTH CARE COSTS SOAR, WE ARE BEGINNING TO REALIZE THERE IS A BETTER WAY THAN REPARATIVE AND REHABILITATIVE MEDICINE.

CARE MUST FOCUS ON PREVENTION.

PREVENTION MUST BE THE NORM -- IT NOT ONLY SAVES LIVES BUT IS ULTIMATELY COST-EFFECTIVE.

WE KNOW WHAT WE CAN DO WITH SMOKING, FOR EXAMPLE.

DURING MY EIGHT YEARS AS SURGEON GENERAL, SMOKING AS A PERCENTAGE OF THE POPULATION, FELL FROM 33 TO 24%

AND WE NEED MORE SOPHISTICATED APPLICATION OF TECHNIQUES OF BEHAVIOR MODIFICATION FOR DRUG ABUSE, TEEN AGE PREGNANCY, STD, ACCIDENT PREVENTION, CONTROL OF INTERPERSONAL VIOLENCE.

IT IS IMPERATIVE THAT THERE BE A CHANGE IN PRIORITIES BOTH FOR INDIVIDUALS, THOSE WHO PROVIDE HEALTH CARE, POLICY MAKERS, AND IN THE U.S., THE PAYORS.

PREVENTION AND HEALTH PROMOTION ACTIVITIES MUST BECOME A SIGNIFICANT PRIORITY. WE MUST BE WILLING TO ALLOCATE RESOURCES TO PREVENTION, NOT JUST TO THE TREATMENT OF DISEASE.

LACK OF RESOURCES FOR IMMUNIZATIONS, AT THE RIGHT TIME LEADS TO COSTLY TREATMENT OF PREVENTABLE DISEASES.

LACK OF EDUCATION FOR HEALTHY BEHAVIORS AND LIFESTYLES AGAIN LEADS TO EXPENSIVE TREATMENT OF PREVENTABLE DISEASES.

THE TERRIBLE PLIGHT OF BABIES BORN TO COCAINE, PARTICULARLY CRACK, ADDICTED MOTHERS IS STRAINING HOSPITAL PEDIATRIC SERVICES.

TO BACK THIS UP, WE HAVE A STRONG PUBLIC HEALTH SYSTEM. MORE PUBLIC HEALTH ACTIVITIES MUST TAKE PLACE IN COMMUNITIES, HOMES AND ESPECIALLY SCHOOLS WHICH ARE A VASTLY UNDERUSED RESOURCE.

PROMOTING OPTIMAL PHYSICAL DEVELOPMENT AND MENTAL HEALTH ARE CRITICALLY IMPORTANT ASPECTS OF PREVENTION.

IT SHOULD GO WITHOUT SAYING THAT CARE MUST BE PROVIDED BY PROFESSIONALS AND PARAPROFESSIONALS WHO RESPECT AND VALUE THE FAMILY, WHICH MEANS WE MUST RECRUIT AND ADEQUATELY PREPARE PROFESSIONALS AND PARAPROFESSIONALS IN SUFFICIENT NUMBERS TO DO THE JOB.

* FAMILIES SHOULD PARTICIPATE IN THE DEVELOPMENT OF CURRICULA AND PREPARATION OF THESE PROVIDERS AT THE PRE-SERVICE AND IN-SERVICE LEVELS.

* **PROFESSIONAL ORGANIZATION MEETINGS AND TRAINING PROGRAMS SHOULD BE MODELS OF PARENT/PROFESSIONAL COLLABORATION.**

* **AN INTERDISCIPLINARY APPROACH TO HEALTH CARE SHOULD BE EMPLOYED WITH A BALANCE OF PROFESSIONALS AND PARAPROFESSIONALS.**

* MORE EMPHASIS SHOULD BE PLACED ON THE TEAM APPROACH TO HEALTH CARE DELIVERY IN ALL SETTINGS.

* EDUCATION OF THOSE WHO GIVE CARE SHOULD INVOLVE MORE COURSE WORK AND PRACTICAL EXPERIENCE IN THE DEVELOPMENTAL NEEDS OF CHILDREN. TRAINING PROGRAMS SHOULD EMPHASIZE THE INFLUENCES OF FAMILY, PSYCHOSOCIAL, AND ENVIRONMENTAL FACTORS ON HEALTH STATUS.

* HEALTH PERSONNEL TRAINING SHOULD INCLUDE PROGRAMS THAT PROVIDE CONTACT OVER TIME WITH CHILDREN WITH SPECIAL HEALTH CARE NEEDS AND THEIR FAMILIES, PARTICULARLY IN HOME AND COMMUNITY SETTINGS.

* INCENTIVES TO SERVE UNDERSERVED POPULATIONS, MUST BE DEVISED,PARTICULARLY FOR THOSE IN REMOTE RURAL AREAS AND IN OUR INNER CITIES.

I KNOW THAT MANY OF YOU ARE HOSPITAL-BASED PERSONNEL. AS WE WORK TOGETHER TO DEVELOP COMPREHENSIVE SYSTEMS OF CARE, HOSPITALS HAVE A KEY ROLE. MAJOR CHANGES ARE NEEDED IN OUR HOSPITALS, AS WELL. THESE INCLUDE:

–MORE MUST SHOW BETTER LEADERSHIP IN HEALTH PROMOTION.

–BETTER INTERFACE, MORE EFFECTIVELY WITH COMMUNITY CARE GIVERS.

–ENHANCEMENT OF SYSTEMS OF COORDINATION – THE EVER INCREASING SPECIALIZATION CREATES HAVOC FOR FAMILIES.

–GREATER RESPONSIVENESS TO CHILDREN AND THEIR FAMILIES.

A REEXAMINATION OF METHODS OF TRAINING HEALTH PROFESSIONALS.

THE NEXT FEW YEARS PROVIDE A SPLENDID OPPORTUNITY TO BUILD A STRONGER HEALTH AND EDUCATION FOUNDATION FOR CHILDREN. WE HAVE SUFFICIENT RESEARCH THAT TELLS US WHAT WORKS. NOW IS THE TIME TO APPLY THAT KNOWLEDGE TO ALL CHILDREN AND THEIR FAMILIES.

I THINK IT IS POSSIBLE IN SPITE OF FISCAL CONSTRAINTS. THE CHALLENGE IS TO WORK TOGETHER COLLABORATIVELY TO PUT PERMANENT SYSTEMS OF SERVICES IN PLACE IN OUR COMMUNITIES.

I THINK THAT WE HAVE IDENTIFIED THE KEY ELEMENTS OF EFFECTIVE SERVICE DELIVERY. WE KNOW THAT SUCCESSFUL PROGRAMS ARE COMPREHENSIVE, FLEXIBLE, AND ACCESSIBLE. WE KNOW THAT SKILLED, DEDICATED PROFESSIONALS FOCUS ON THE NEEDS OF THE FAMILY, NOT THE AGENCY.

WE KNOW THAT MOVING FROM CATEGORICAL TO GENERIC SERVICE APPROACHES AND MOVING FAMILY-CENTERED SERVICES ARE CHALLENGING AND TIME-CONSUMING TASKS THAT REQUIRE STRONG COMMITMENT, SKILLS, AND TALENT.

WE MUST TAKE ACTION THAT RESPONDS TO OUR COMMON CONCERNS AND RESULTS IN COLLABORATIVE PROVISION OF SERVICES TO CHILDREN AND FAMILIES IN THEIR COMMUNITIES.

EACH OF YOU MUST FIND WAYS TO COLLABORATE IN THE DEVELOPMENT OF COMPREHENSIVE SERVICE DELIVERY SYSTEMS AT THE COMMUNITY LEVEL.

TO ACCOMPLISH THIS, WE MUST SHARE INFORMATION ABOUT INNOVATIVE EFFORTS TO MODIFY SERVICE DELIVERY IN ALL PROFESSIONS AND IDENTIFY AREAS WHERE WE CAN WORK TOGETHER AND ASSUME MUTUAL RESPONSIBILITY.

MANY OF YOU ON THE WORK ON THE FRONT LINE WITH CHILDREN AND FAMILIES. YOU SHOULD VIEW EVERY HEALTH ENCOUNTER AS AN OPPORTUNITY TO ENHANCE THE CONFIDENCE AND COMPETENCE OF THE CHILD AND FAMILY . . . AN OPPORTUNITY TO PROMOTE HEALTH

YOU SHOULD THINK BIGGER THAN JUST A HOSPITAL STAY . . . TO THE DAY-TO-DAY EXPERIENCE, OVER TIME, OF THE CHILD AND FAMILY.

NO MATTER WHAT YOUR HEALTH DISCIPLINE, CONSIDER LISTENING, TEACHING AND THE EFFECTIVE PROVISION OF INFORMATION TO FAMILIES AND TO OTHER PROFESSIONALS AS MAJOR ROLES FOR YOU.

BECOME INVOLVED IN SHAPING HEALTH CARE SYSTEMS IN YOUR COMMUNITY. VOLUNTEER TO SERVE ON LOCAL COMMITTEES IN THE HEALTH COMMUNITY OR THE BUSINESS COMMUNITY THAT IS BECOMING CONCERNED ABOUT HEALTH.

CALL YOUR HEALTH DEPARTMENT. WRITE YOUR LOCAL AND NATIONAL LEGISLATORS AND THEIR HEALTH STAFF. WORK WITH PARENT ORGANIZATIONS AND VICE VERSA.

YOU CAN LEARN FROM EACH OTHER. THERE IS POWER IN NUMBERS AND IN BRINGING MULTIPLE PERSPECTIVES TOGETHER.

MANY OF YOU ARE INVOLVED IN TEACHING FUTURE HEALTH PROFESSIONALS GIVE GREATER PRIORITY TO BUILDING KNOWLEDGE AND SKILLS IN HEALTH PROMOTION AND IN RESPECTING AND ENABLING FAMILIES.

BE MORE CREATIVE IN HELPING INDIVIDUAL CARE GIVERS UNDERSTAND AND RELATE TO COMMUNITY ORGANIZATIONS AND AGENCIES.

MANY OF YOU ARE FAMILIES CARING FOR CHILDREN WITH SPECIAL NEEDS. WE NEED YOUR VOICES, YOUR IDEAS, YOUR PARTNERSHIP TO REDESIGN THE SYSTEMS OF CARE TO BE MORE RESPONSIVE TO YOUR NEEDS AND STRENGTHS.

THE TASK BEFORE US IS DIFFICULT. I BELIEVE, HOWEVER, THAT WE CAN TAKE IMPORTANT STEPS TO ENHANCE COLLABORATION BETWEEN HEALTH, EDUCATION, AND SOCIAL SERVICE PROFESSIONALS WHICH WILL MOVE BEYOND SINGLE ISSUES TO A DEVELOPING STRUCTURE WITHIN WHICH ONGOING COLLABORATION IS SUPPORTED AND SUSTAINED.

THEREFORE, LET US WORK TOGETHER TO ENABLE ALL CHILDREN TO RECEIVE THE KIND OF SERVICES THEY NEED AND DESERVE. WE HAVE MANY STRENGTHS TO BUILD UPON. USING OUR KNOWLEDGE AND SKILLS, AND BY COLLABORATING, I KNOW THAT COMPREHENSIVE, **WE CAN MAKE IT HAPPEN -- COORDINATED, FAMILY-CENTERED SERVICES FOR CHILDREN IN THEIR COMMUNITIES.**

THESE ARE EXCITING TIMES. I DO NOT SHARE THE GLOOM AND DOOM MENTALITY. IF I WERE YOUNG ENOUGH TO MAKE A CAREER DECISION, I WOULD DO THE SAME THING ALL OVER – ONLY TRY HARDER. THERE IS NO GREATER SATISFACTION THAN HELPING A CHILD.