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THE OREGON MEDICAID PRIORITY-SETTING PROJECT: THE IMPACT ON POOR CHILDREN

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INTRODUCTION

OREGON'S MEDICAID PRIORITY Setting Project ("Oregon Proposal") is an understandable attempt to cope with inadequate state resources for providing health care. But it is a misguided and inequitable approach that should not be followed. One of its most serious flaws is its disproportionate impact on poor children.

Children are disproportionately affected by Oregon's Proposal in part because they are disproportionately represented among the poor whose care is targeted by Oregon's priority setting and who would bear the brunt of any reductions in service. But Oregon's Proposal exacerbates the problem by specifically excluding all health services provided to the elderly from the priority setting. In fiscal year 1989, services for persons 65 and over accounted for 30.4% of Oregon's Medicaid budget. This system, therefore, exempts those who use disproportionate amounts of health care and leaves little for the children. A system such as this which makes children more vulnerable to health care cuts than others is unfair and unwise.

Some proponents of the Oregon Proposal contend that the priority setting will not lead to cuts in services for poor children because increased attention to the health sector will generate public support for adequate funding. This contention, however, is naive, given the context. It was Oregon's inability or unwillingness to pay for current levels of service that led to the priority setting scheme in the first place. Priority setting is not likely to generate the political

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will necessary to expand funding to cover not only current levels of service, but also the thousands of new eligibles.

Indeed, Oregon's purpose in setting priorities is to assist in deciding what to cut when the budget falls short. If the purpose was merely to identify which services are necessary to provide and which services are not, Oregon could have included all groups of Medicaid eligibles in the priority setting and used these priorities to determine and guarantee for each group a minimum level of health service. But, nowhere does the Oregon proposal provide for setting a minimum benefit package which will not be subject to cuts.

It may be that some type of priority setting is appropriate for defining a basic benefit package. In designing this package, however, the costs and benefits of health services should be evaluated not only in relation to each other, but also to other public expenditures. Furthermore, if budget shortages lead to benefit cuts, these cuts should not disproportionately impact children. If especially vulnerable groups like the elderly are excluded, children should be among them. Oregon's Proposal does not meet these guidelines and introduces several other administrative and policy problems.

I. THE CONTEXT: HEALTH CARE FOR POOR CHILDREN

A. Poverty

The Oregon Proposal is directed at health care for those currently covered by Medicaid, the uninsured or inadequately insured, and those who are uninsurable due to pre-existing medical conditions. For all these groups, poverty and medical indigency are significant factors even though many of these people do not meet the federal standard for poverty.

Poverty is central to the health care crisis and affects children disproportionately. Slightly over a quarter of the population in the United States is under 18 years of age; poverty and medical indigency is increasingly concentrated in this population. Of that part of the total population in the United States falling within the federal standard for poverty, about 42% are children. In contrast, 12% of the poor are over 65 years of age.

Approximately 13 million children, or about 20% of all children, live in poverty. As Victor Fuchs has noted, "by the mid-1980s the poverty rate among children (21%) was almost double the rate among adults (11%), a situation without precedent in American history." Among children, poverty tends to be inversely

related to age, with greater numbers of younger children living in poverty than older children. The percentage of children under six years of age living below the poverty level in 1968 was 17%. It grew to 23% by 1987.

Slightly over half of these poor children under age six do not live in our central cities; 28% live in suburban areas and 26% in rural areas. Almost half of all African-American children and more than one-third of all Hispanic children live in families with incomes below the poverty line. (For all age groups, these minority populations are also increasingly represented among the ranks of the poor.)

B. Family Structure

It is important to look beyond these poverty statistics and also consider the family, social, and economic factors that contribute to child poverty, and that can further impede access to health care for children. More children grow up in poverty today in large part because of changes in the composition of their families. At present over 15 million children live with only one parent, usually the mother. Almost two million children live with neither parent, and this group is expanding rapidly. Of children living with one parent, 50% of white children are with a divorced mother; 54% of African-American children and 33% of Hispanic children are with mothers who have not married. One-third of unwed African-American mothers are teenagers.

Contrary to the welfare stereotype, the majority of poor children live in families where the sole parent or parents work. While some may lament that by the year 2000 four out of five infants under one year of age in this country will have mothers in the workforce outside the home, it also must be acknowledged that America depends increasingly on working women. Businesses need their labor. Families need their second or primary income. The Social Security and Medicare systems need their taxes. Systems to improve child health care must accept that parents increasingly must be working parents.

The poverty of children is only partly related to the fact that female heads of households have an average income of less than one-third that of married couples. Recent statistics show that more than 70% of the increase in the number of poor children that occurred in the early 1980s was due to rising poverty in families with a man present.

These dramatic increases in single parent and working parent households in poverty have changed not only the economic status of children, but also intrafamilial dynamics and behaviors. The basic values that children acquire, their motivation, their sense of self-esteem and identity, and their personalities will, in large part, be determined by what goes on in these changed family units. And, of course, their capacity to function later as healthy, productive adults will depend in large measure on the way in which their physical, mental, and developmental health needs were met during childhood.

C. Health Insurance for Children and Pregnant Women

Given the disproportionate poverty among children, it is not surprising that they are also disproportionately represented among the uninsured. In 1985 about 17% of the national population, or 35-38 million people, were uninsured by public (Medicaid and Medicare) or private insurance. Slightly over one-third of the uninsured are children; in 1986 this accounted for about 20% of all children. It is also estimated that an additional 3-4 million children are inadequately covered under existing health insurance.

The number of uninsured children has been increasing annually at the rate of about 1-2%. About 40% of the uninsured children live below the poverty level; another 30% live within 200% of the poverty level. (In 1986 the federal poverty level for a family of three in the continental United States was \$9,120.) Two-thirds of these uninsured children live in families headed by a worker; about half of these families are single-parent households. Employment, however, is no guarantee of insurance. In 1985 about 20% of uninsured children lived with a working, insured parent whose employer-based health insurance did not extend to their children. Coverage of children by employer-based plans generally has been decreasing.

Thus, the increase in the number and proportion of uninsured children is due to many factors: the increasing rate of poverty among children, the increasing cost of health insurance, and the decreasing coverage of the poor and of children by employer insurance and by Medicaid. The younger the child, the more likely it is that he or she lacks full coverage and lives in poverty. Unfortunately, these young children with the greatest need are also the most vulnerable to long-term disabilities if they do not receive early medical attention. A number of early interventions have been demonstrated to be cost effective for children.

Insurance coverage of women of child-bearing age presents a similarly bleak picture. Nine and one-half million women ages 15-44 have no health insurance, public or private. A total of 14 million women in 1985 were uninsured against the costs of maternity care. Women's ability to obtain prenatal and reproductive care from obstetrician-gynecologists is directly related to whether or not they are insured. Even when prenatal care can be obtained, it is delayed for three times more uninsured than insured women.

D. Variations in Medicaid Coverage Among States

These problems in insurance coverage are compounded in the public sector by how states administer the Medicaid program. States vary enormously in eligibility policies, scope of services covered, availability of providers, quality of services, and reimbursement levels and systems. For example, the ratios of the number of Medicaid beneficiaries to total poor population in each state range from 0.31 to 1.57. The annual income threshold for Aid to Families with Dependent Children (AFDC) in 1986 varied from \$1,416 to \$8,880; for the medically needy, from \$0 to \$9,900. Reimbursed hospital inpatient days varied from 12 to unlimited days. The number of well-child visits covered ranged from four to 25. Average payments had similar broad ranges: \$178 to \$602 for inpatient hospital care per day; \$6.64 to \$21.61 for a physician's office visit; and \$233 to \$1,038 for complete obstetrical care.

The federal matching formula has obviously failed to achieve an equitable provision of health care across all states. Poor states with the largest needy populations tend to spend less than rich states. In addition, lack of administrative commitment to the Medicaid program and its beneficiaries is also a major problem in many states.

Access to health care for pregnant women and children is not only hampered by these variations in eligibility standards, scope of service, and reimbursement systems, but also limited by inadequate financing and outreach to those eligible. For example, it is estimated that the Special Supplemental Food Program for Women, Infants, and Children (WIC) reaches only 44% of those eligible. Similarly, the Early Periodic Screening Diagnosis and Treatment Program as administered in many states serves fewer than half of the children eligible.

II. THE OREGON PLAN

A. Parameter Problems

Given this dire situation in availability of health insurance and health care for children, as well as increasing numbers of poverty-level children, Oregon's desire to improve overall health services is laudable. The parameters that the state has drawn, however, need to be reviewed.

There can be no dispute that any health service system must include cost containment and budget control mechanisms that will involve judgments about medically necessary or useful services. The Oregon Proposal goes further, however. Oregon defines which services are most necessary and beneficial, but then fails to guarantee any of them as a basic benefit package. The priority list becomes a guide for the order of cuts in health services according to vacillating state budgets.

1. The Role of State Government

The 50 state legislatures are not the proper forums for defining which health services children and adults shall receive. The need for a patient with end-stage renal disease for a kidney transplant is the same whether he or she lives in California or Iowa, and a federal law recognizes this basic equity. Shouldn't the same criteria apply in treating a child with clubbed feet? Unequal access based on income and geography already exists under the current system; the Oregon approach that increases control and decision making at the state level will only aggravate this inequality. The story of the Medicaid family who left Oregon for another state to get a bone marrow transplant for their child could be repeated a hundredfold.

There are a myriad of federal proposals to define a basic benefit package for children and adults at the federal level and to make health insurance universal. Those concerned about health care should focus on forcing the federal and state governments to define a basic health care package and to establish a stable funding mechanism to support that package. Oregon's proposal does not define a basic package, but establishes a bureaucratic mechanism to vary services according to priorities and changes in funding.

For many reasons, it is important that decision making about basic health benefits rest with the federal government. These include: the taxing and coordinating powers of the federal government; the widely varying resources among states that create inequities in the health services they can afford; the fact that the

cost and quality of medical care are influenced by national factors rather than by state factors; the fact that many companies conduct their business in more than one state; the effects of international competition on what employers can afford to pay for their employees' insurance; and the mobility of our working population.

To say that health service benefits should be set at the federal level does not mean that state and local government should not be involved. Many national proposals for a basic package of health services recognize the need for region administrative control and for some discretion among states and communities in directing service dollars.

States are understandably impatient for action at the federal level. Clearly, the federal government's actions of the past decade—decreasing funding for states while increasing mandatory services—created the crisis in Oregon and other states. Thus, the best approach is to increase pressure at the federal level, rather than to relieve it by seeking reduced benefit entitlements at the state level, a tactic that will further institutionalize inequities across the country.

Many proponents of the Oregon Proposal agree that it is most appropriate for health care planning to occur at the federal level. They contend that the situation is so dire and the leadership at the federal level so lacking that states must proceed on their own. If they are correct, however, there are better ways to proceed. For one, Oregon could examine its health care funding across the board, define a basic set of services and then make a commitment to funding them. In times of budget shortfall, instead of automatically cutting what was once part of the minimum package, reductions in other state funding programs would have to be considered or even mandated. Oregon has not done this, but rather has singled out Medicaid eligible children and their parents for priority setting and, in all likelihood, reductions in the current Medicaid services.

2. Targeting Children

Although refusing to admit that priority setting will lead to service cuts, Oregon nevertheless excludes from that process health services for the elderly, blind, and disabled and further exempts all age groups for certain services primarily utilized by the elderly. This leaves AFDC linked eligibles—families with dependent children—to bear the brunt of priority setting. This priority setting in turn makes cuts in services to this group politically easier. When the Medicaid budget falls short, policymakers and health care prov-

iders can follow this road map for cuts in beneficial services rather than go through the difficult process of finding funding to treat an individual child or advocating for a shift or increase in funding at the state level. Claiming justification from the priority setting process, physicians, hospitals and administrators will be further relieved from responsibility for providing necessary basic health services to those who cannot pay for them.

Children are disproportionately represented in the group of Medicaid eligibles not excluded from priority setting for two reasons: Medicaid focuses on families with dependent children, and children are disproportionately represented among the poor. This approach only widens the existing gap between funding of services for children and for the elderly.

In the 1970s and early 1980s, the number of children decreased while the number of elderly increased. As this occurred, government funding for children's programs was also cut back. These curtailments, coupled with the dramatic changes in family structure discussed above, plunged more and more children into poverty. As many have noted, the public policy response during most of the 1980s, while children's poverty was on the rise, was increasing reliance on the weakened family unit and decreasing support from the government. Just the opposite occurred for the elderly. Government attention and programs for them increased, and their relative income status improved.

The increased support for the elderly was and continues to be appropriate. But so is increased support for children. Both are especially vulnerable groups and, if special protection is appropriate for the elderly, it also is for children. Nevertheless, the gap between the two is already considerable. In 1960 the ratio of federal government spending for the elderly to that for children was three to one. It is now ten to one. The state trends are similar. This gap should not be widened by making a disproportionate number of children subject to cost cutting mechanisms while exempting the elderly.

Of course, even if all Medicaid eligibles were included in priority setting, children would still be especially affected since children are disproportionately represented among this population (17% of Oregon's children were on Medicaid in 1989 compared to 7% of its elderly). Whether or not children covered by Medicaid would be better or worse off by virtue of being in this group would depend on what level of benefits they receive. Oregon's priority setting scheme, which does not guarantee services at any level, would be very risky for anyone included in priority setting, children or old-

erly. At a minimum, however, this risk should not be increased for children by excluding most other Medicaid recipients from the priority setting proposal.

Making children the primary targets of priority setting and any reductions in service may have some short term benefits such as ameliorating budget problems at the expense of fewer non-voting, poor people. It is also an understandable approach for a state given that under current policy the federal government bears much more of the burden for medical care for the elderly through Medicare than it does for children and nonelderly adults.

Proponents of the Oregon Proposal counter criticism by pointing to the increased numbers of children who will be eligible for some Medicaid services. The critical question is, which services? Oregon's lack of commitment to a basic set of health services opens the door for budget problems to whittle away at the package so severely that this large group of children will be left with many basic health needs unmet.

Indeed, the stranglehold of budget problems is probable for several reasons. First, Oregon has a poorer than average record in raising revenues through taxation or otherwise to cover Medicaid services. Second, the Oregon Proposal is structured to levy cuts on the least politically powerful population group—poor children and their families. Third, because such a significant segment of the Medicaid group will be exempt from the priority setting, their care costs will likely rise as will those for the insured population. This will contribute to health care inflation that will further reduce the buying power of funds appropriated for children.

Proposals that target children for health care cuts should not be supported. On moral grounds, all children, as well as the elderly, are entitled to adequate health care. On economic grounds, the arguments for caring for the health of children are equally strong.

Our future productivity and competitiveness as a nation, and Oregon's as a state, depend upon the healthy development of children. Demographic changes in our population indicate that children of poverty will make up a substantial and increasing proportion of the workforce in the United States in the next century. Under the Social Security systems in the late 1940s, 17 workers contributed to the benefits of each retiree. By 1992 the ratio will be three to four workers per retiree. At least one of these workers will come from the group of children who are now living in poverty. The capacity of these children to contribute as productive citizens

will, in part, result from the priorities we set now for their health care and education.

Human capital must be conserved and cultivated, both directly and indirectly. We will need every child to join our work force with as few disabilities as possible. Further, because health, human development, and educational achievement are all closely related, the effects of limiting health resources for children will surely hasten the erosion of the effectiveness of our educational systems. Learning is a difficult endeavor for a child with a toothache or with a hearing defect resulting from delayed treatment of otitis or meningitis. The Oregon proposal has significant implications for the continued economic success of our society, as well as for justice and equity across generations.

3. Health and Other Public Funding Priorities

Oregon's system for setting priorities draws the lines of competition for public funds too narrowly. Health care for poor women and children should not be the only publicly funded program examined when budgets fall short. Shouldn't the "public" set priorities in funding schools, roads, and legislative salaries in addition to health care? For example, shouldn't the debate weigh highways against prenatal care, rather than deciding between prenatal care and providing an operation for scoliosis? Given the choice between a bone marrow transplant to cure leukemia in a five-year old and fewer trash collection days, how would the Oregon "public" choose? The public may view transplants as less important than immunizations, but they may value transplants more than keeping a state university Ph.D. program in Archaeology or renovating a prison. Why single out those covered by Medicaid and the uninsured in applying cost-effectiveness criteria? Why not apply the same criteria to the education system or the prison system, whose costs have similarly escalated?

Of course, the Oregon legislature, when confronting a health care funding crisis could still expand its inquiry and consider nonhealth services for budget cuts. But the mechanism established by the Oregon Proposal greases the wheel for cuts within health care. The areas for cutting have been identified and ranked in advance under the cloak of an ostensibly representative process, and the cuts will primarily affect those who are weakest politically. One can ask whether the Oregon approach represents a health system innovation, the failure of political and medical leadership, the self interests of the business or hospital communities, or all of these. A

different political context would result if Oregon set priorities for health services, identified a basic set of these services, and then guaranteed funding for them. If appropriations fell short, the state would have to look across state programs and to its general revenues for funding.

B. Practical Problems: Providing Health Services on the Shifting Sands of Budgets and Priorities

Oregon is proposing a system that can shift basic health care entitlements from one year to the next, and even within the year. A person requiring a bypass or heart valve may get it this year, but not the next. Indeed, the changes can occur within a year; the legislation requires only a 60 day wait to implement reductions in a needed health service after legislative action.

For example, in the 11th month of a state budget cycle when there is no more money to pay for care, decisions could be made not to treat eclampsia in the 25-year-old pregnant wife of a migrant farm worker receiving a minimum wage, or this couple's asthmatic child, or the child's 63-year-old diabetic grandmother when she breaks her hip in a fall. These reductions would occur while privately insured and Medicare eligible Oregonians continue to receive the same medical services.

Unquestionably, great inequities exist today as to who receives which medical services. Proponents of the Oregon Proposal argue that, under the new approach, these inequities will follow from a more public and presumably representative decision-making process.

There is, however, another consequence of the Oregon Proposal. In effect, it creates a direct line between the budget cutters' office in the State Capitol and the doctor's treatment room. As a result, pressure is taken off the hospital and clinic administrators to balance services and fundraising so as to correct deficit situations in a way that maintains a fair allocation of care. A hypothetical example helps to illustrate this point.

Consider the case of a doctor at an HMO (or hospital or clinic, etc.) that also contracts with the state for Medicaid patients. She has two ten-year-olds in her office, each needing corrective surgery for a club foot. One is privately insured; the other is on Medicaid. As it happens, the Oregon medical system is underfunded in this legislative year, and all clinics have been notified that club foot surgery, which was previously covered, is no longer covered. One

child can be referred to an orthopedist for treatment and not the other.

Is it likely that this doctor will provide service to the one child and not to the other? If she chooses between the two patients, how would such a decision be justified given the physician-patient relationship and the ethical responsibilities it entails? Is the child from the poor family to have the surgery deferred until next year, adding another obstacle to achieving normal development?

In most states today, even those with severely under-funded health care systems, both children would likely be treated (assuming the medically indigent child gets into the health care system). If reimbursement for the Medicaid patient were insufficient or unreasonably delayed, this would become a "loss" for the HMO or hospital, perhaps offset by a profit-making program or a reduction in operating costs. The organization might cut back on some educational or support services. Or, if these cases resulted in losses over an extended period of time, the viability of this and many other HMOs or hospitals would be threatened, generating public attention and lobbying to acquire more public and private resources. As it stands, the current system spreads the risk of an inadequate state and federal budget year among many more participants in the state's health care system.

In contrast, Oregon's budget-sensitive approach would allow the HMO, hospital or clinic to prohibit the physician from providing care, with the full backing of the state. This approach can add new stress to the doctor-patient relationship and undermine the doctor's ethical obligations to the patient. The Oregon Proposal and the dilemma it poses for the doctor-patient relationship could well decrease the attractiveness of the medical profession. What will be the implications for recruiting people into the health profession? Will health professionals migrate into or out of the state? Will a separate group of providers have to be employed to provide the rationed care to Medicaid patients? Will some HMOs or clinics decide not to participate so as to avoid putting their physicians in such a dilemma?

C. The Limits of Research

Oregon's Proposal attempts to set priorities in health services with significant reliance on cost-effectiveness and/or cost-benefit information. Yet, few such studies are available relative to the great variety of health services to be prioritized and, in particular, relative

to health services for children and pregnant women. These badly needed assessments of health care technology are costly and time consuming to perform. (We are using health care technology in its broadest sense, including diagnostic and treatment protocols.) Even with the recent increase in federal funding for this purpose, the resources available are fairly limited and will be focused primarily on Medicare related issues. There is also a shortage of qualified researchers to carry out data collection and analysis.

Is Oregon willing to spend significant amounts of money for such evaluations? Considering that states have rarely committed much to evaluation of their programs in the past, it is very unlikely that funding for cost-effectiveness or for the necessary reassessments will be adequate.

Further, what will be done in the absence of studies that establish or refute the cost-effectiveness or cost-benefit of a specific prevention, diagnosis, or treatment item? Will health care based only on experience and incomplete information that is judged to be appropriate for the privately insured be withheld from or provided to Medicaid patients? Should care based on a large amount of such evidence be given a higher or lower priority than an item supported by one cost-effectiveness study that is statistically significant at the 5% level? These are often matters of clinical or policy judgment in its best sense. Legislators and the public may be unduly influenced by statistical observations that are not clinically significant.

There may also be long-term implications for the public's definition of what are necessary or even beneficial medical services. As lower-priority services are discontinued, there is the danger that in the minds of the public and the legislature, these services will become "unnecessary." In fact, given that most accepted treatments in medicine are based on empirical experience and incomplete information rather than cost-effectiveness studies, the basis for assigning a service a low priority may be suspect from the beginning. Legislators looking to avoid taxes may find it attractive to take the position that care which is too low on the priority list to be funded out of available money is really unnecessary. Once so defined, increased funding in future years to provide this care is less likely.

III. CONCLUSION

Oregon is addressing the basic way the health care system is organized, legally and administratively, as well as fundamental economic, social, and ethical issues that extend beyond their state bor-

ders and budget. Although Oregon has engaged in a very complex political process, aided by a sophisticated computer program, the proposed solution to take more control at the state level will not solve the health care crisis that requires federal planning and attention to ensure equity among states and for children.

The debate has been opened. Oregon's proposal has focused attention on providing health care for all, including children. Alternative proposals must continue to be debated; children's health needs should be central to those debates. We would do well to remember the words of Abraham Lincoln:

A child is a person who is going to carry on what you have started. He is going to sit where you are sitting, and when you are gone, attend to those things which you think are important. You may adopt all the policies you please, but how they are carried out depends on him. He will assume control of your cities, states and nations. He is going to move in and take over your churches, schools, universities and businesses. All your books are going to be judged, praised or condemned by him. The fate of humanity is in his hands.

REFERENCES

- ALAN GUTTMACHER INSTITUTE, FINANCING MATERNITY CARE IN THE UNITED STATES (1987).
- Behrman, *The Vulnerable Child*. 6 CALIFORNIA PEDIATRICIAN 27 (1990).
- Brock, *Paying Physicians*, 36 CASE W. RES. L. REV. 760 (1986).
- Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Physicians*, 36 CASE W. RES. L. REV. 708 (1986).
- CHILDREN'S DEFENSE FUND, THE HEALTH OF AMERICA'S CHILDREN. MATERNAL AND CHILD HEALTH DATA BOOK (1989).
- D. ELLWOOD, POOR SUPPORT, POVERTY IN THE AMERICAN FAMILY (1988).
- PUBLIC CITIZEN HEALTH RESEARCH GROUP, POOR HEALTH CARE FOR POOR AMERICANS: A RANKING OF STATE MEDICAID PROGRAMS.
- FORD FOUNDATION, EARLY CHILDHOOD SERVICES: A NATIONAL CHALLENGE. (1989).
- V. Fuchs, *Are Americans Underinvesting in Children?* (unpublished manuscript prepared for Stanford University's "What Do Families Do?" Conference (Nov. 9-12, 1989)).
- INSTITUTE OF MED., NAT'L. RES. COUNCIL, SOCIAL POLICY FOR

- CHILDREN AND FAMILIES, (D. Garduque & L. Garduque eds. 1989).
- J. Golenski, *A Report on the Oregon Medicaid Priority Setting Project* (Mar. 1990) (unpublished paper).
- GOLENSKI & BLUM, THE OREGON PRIORITY SETTING PROJECT (Mar. 30, 1989) (unpublished paper).
- H. HODGKINSON, ALL ONE SYSTEM: DEMOGRAPHICS OF EDUCATION, KINDERGARTEN THROUGH GRADUATE SCHOOL (1985). INSTITUTE OF MED. NAT'L RES. COUNCIL, SOCIAL POLICY FOR CHILDREN AND FAMILIES (1989).
- NATIONAL CENTER FOR CHILDREN IN POVERTY, FIVE MILLION CHILDREN. A STATISTICAL PROFILE OF OUR POOREST YOUNG CITIZENS (1990).
- NATIONAL COMM'N. ON CHILDREN, REFERENCE BOOK (1989).
- S. Bill 27, (codified within OR. REV. STAT. §§ 414.025, 414.036, 414.042 (1989)).
- S. Bill 534, (codified within OR. REV. STAT. §§ 735.605 - 735.650 (1989)).
- S. Bill 935, (codified within OR. REV. STAT. §§ 316.096, 317.113, 353.725, 353.765, 353.775 (1989)).
- POLICY ANALYSIS FOR CA. EDUC., CONDITIONS OF CHILDREN (1989).
- Preston, *Children and the Elderly*, 21 DEMOGRAPHY 435 (1984).
- Wise & Meyers, *Poverty and Child Health*, 35 THE PEDIATRIC CLINICS OF NORTH AMERICA 1169 (1988).

