Special Communication

Children and US Federal Policy on Health and Health Care
Seen but Not Heard

Glenn Flores, MD; Bruce Lesley, BA

Children account for 73.5 million Americans (24%), but 8% of federal expenditures. Data on health and health care indicate that child well-being in the United States has been in decline since the most recent recession. Childhood poverty has reached its highest level in 20 years, 1 in 4 children lives in a food-insecure household, 7 million children lack health insurance, a child is abused or neglected every 47 seconds, and 1 in 3 children is overweight or obese. Five children are killed daily by firearms, 1 in 5 experiences a mental disorder, racial/ethnic disparities continue to be extensive and pervasive, and major sequester cuts and underfunding of pediatric research have damaged our global leadership in biomedical research and hobbled economic growth. In this analysis, we identify 10 urgent priorities for the health and health care of US children, including poverty, food insufficiency, lack of health insurance, child abuse and neglect, overweight and obesity, firearm deaths and injuries, mental health, racial/ethnic disparities, immigration, and research. Overwhelming, bipartisan support by voters exists for enhancing our nation's investments in children's health and well-being. Federal policy action steps are proposed to successfully address these priorities and ensure a healthy, productive future for US children and the nation.

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Children younger than 18 years old comprise 24% of the US population, equivalent to 73.5 million Americans,[1] but children account for 8% of federal expenditures,[2] and federal spending on children in 2014 fell by more than $20 billion (14%) since 2010, including declines in 4 of the past 5 years.[2] It is estimated that by 2017, the federal government will spend more on interest payments than on children.[3] Most US voters believe that the lives of children have deteriorated during the past decade (57%) and that this generation will fare far worse than their parents (67%).[2]

The President and Congress confront a critical juncture in the health and health care of US children. Their decisions (or inaction) have the potential to profoundly impact the health, well-being, and productivity of current and future generations of Americans. More than 1 in 5 US children lives in poverty,[4] a risk factor for childhood developmental and behavioral disorders, hospitalizations, and death. One in 11 US children lacks health insurance coverage,[4] although two-thirds are eligible for but not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).[5] Millions of US children experience child abuse and neglect, hunger, obesity, violence, mental health disorders, teen pregnancy, and racial/ethnic disparities in health and health care.[6]

The aims of this article are to identify 10 urgent priorities for the health and health care of US children, and to propose federal policy action steps to successfully address these priorities and ensure a healthy, productive future for US children and the nation. Urgent policy priorities were identified using the following criteria: (1) the prevalence of a condition or issue, (2) the potential for a major impact on reducing morbidity or mortality or advancing child health and health care, and (3) the feasibility and potential for amelioration by federal legislation.

Poverty

In 2012, 16.1 million children (22%) lived in poverty (**Table**), a number and proportion not statistically different from in 2010, when childhood poverty reached its highest level in 20 years.[7] A child is born into poverty in America every 29 seconds.[8]

Poverty is associated with major adverse health outcomes for children, including significantly higher risks of low birth weight, injuries, lower IQ, intensive care unit admissions, and infant, condition-specific, and overall mortality.[9,10] Childhood poverty is associated with substantially higher mortality rates in adults, regardless of adult socioeconomic status (ie, even affluent adults who were poor as children have elevated death rates), and this increased mortality risk extends across 2 generations.[11,12]

What federal policy action steps can be taken to reduce childhood poverty and its impact on US children's health? The United States should prioritize reducing childhood poverty. Britain's 1999 campaign to reduce childhood poverty offers a highly successful model. This initiative included measures to increase employment, income for families with children, and investments in children.[13] Although not eliminating poverty in the United Kingdom (UK), the ini-

Table. Priorities in the Health and Health Care of US Children and Suggested Policy Action Steps to Address These Priorities

Priority	Scope of Problem in the United States	Suggested Policy Action Steps
Poverty	16.1 Million children (22%) live in poverty	Prioritize reducing and eliminating childhood poverty
		Enact measures to increase employment, income for families with children, and investments in children
		Extend Child Tax Credit and Earned Income Tax Credit
Food insufficiency	>16 Million children (22%) live in food-insecure households	Eliminate childhood hunger by investing in rather than cutting children's nutrition programs
		Fully fund and maintain current structure of SNAP and WIC, so that all children needing nutritional assistance receives it until their families' income rises
		Fully fund and maintain the national school meals program and implement new healthier standards
Lack of health insurance	7 Million children (9%) have no health insurance	Fully fund CHIP and Medicaid and ensure 12-mo continuous enrollment in both
		Make CHIP permanent and extend CHIP coverage to 300% of poverty for all children
		Eliminate CHIP financial cliff in 2016 (planned 73% funding cut)
		Abolish ACA family glitch and subsidize affordable coverage for workers' family members
		Improve Medicaid and CHIP outreach and enrollment using community health workers and parent mentors
Child abuse and neglect	A child is abused or neglected every 47 s and dies from abuse or neglect every 7 h	Prioritize reducing and eliminating child abuse and neglect
		Reduce by half rates of maltreatment and maltreatment deaths by 2018
		Fund screening and prevention research
		Determine whether domestic-violence prevention and treatment result in reductions in child maltreatment
		Provide needed services to all families with maltreated children
Overweight and obesity	32% Of children are overweight, and 17% are obese	Pass the bipartisan FIT Kids Act (HR 2178)
		Maximize funding for the USDA's Farmers' Market Promotion Program and Fresh Fruit and Vegetable Program
Firearm deaths and injuries	5 Children die daily by firearms; a child is killed every 4 h by firearms	Enforce a mandatory criminal background check system and background check for every firearm sale
		Establish regulations requiring safe storage of firearms and ammunition
		Ban assault weapons and high-capacity ammunition magazines (S 150)
		Set up mandatory firearm safety classes and licensing
		Tax firearms and ammunition to better represent societal costs, and fund programs and research on prevention, gun safety, and mental-health services
		Increase NIH and CDC funding of research on firearm safety and prevention of associated injuries and deaths
Mental health	Up to 1 in 5 children experiences a mental disorder annually, at a cost of $247 billion	Ensure that all children with mental disorders have timely access to needed mental-health care
		Provide adequate funding of mental-health services and restore funding cuts
		Increase the number of mental health-care providers accepting Medicaid by enhancing reimbursement rates
		Eliminate shortages in mental health-care providers
Racial/ethnic disparities	Minority children will outnumber children of white race/ethnicity by 2020, but racial/ethnic disparities are extensive and pervasive and occur across the spectrum of health and health care	Collect data on race/ethnicity, primary language spoken at home, and parental English proficiency on every pediatric patient
		Monitor and publicly disclose disparities annually at federal, state, local, health-plan, and institutional levels
		Ensure that all children have medical and dental homes and access to needed specialty care and mental-health care
		Enhance the diversity of the health-care workforce
		Fund research on innovative solutions to eliminate disparities, such as health-care empowerment zones and community-based interventions

(continued)

tiative sliced poverty rates by more than half from 1999 to 2009, from 26% to 12%, removing 1.8 million children from poverty.[13] In contrast, between 1999 and 2009, US childhood poverty decreased during welfare reform, plateaued, and climbed during the recession to 21%. Although progress in UK child-poverty rates lately has stalled, over the last 15 years, the UK has gone from one of the highest child-poverty rates in the developed world to the European Union average.[14] Because poverty can be associated with other outcomes addressed later in this article, reducing childhood poverty potentially can have a wide-ranging impact on improving child health.

Voters overwhelmingly support the federal government addressing childhood poverty, regardless of party lines[15]: 82% of voters (89% of Democrats, 81% of independents, and 76% of Republicans) want Congress and the White House to cut child poverty in half within 10 years.[15] Eighty-one percent of US voters (90% of

Table. Priorities in the Health and Health Care of US Children and Suggested Policy Action Steps to Address These Priorities (continued)

Priority	Scope of Problem in the United States	Suggested Policy Action Steps
Immigration	Children living in immigrant families are the fastest growing group of US children, and 1 in 3 US children (18.7 million) is a first-generation or second-generation immigrant	Obtain health insurance for all children, including immigrants
		Require third-party reimbursement by all payers for trained medical interpreter services, so that no child is ever denied health care or experiences injury or death because of language barriers
		Protect immigrant children by ensuring that immigration enforcement does not needlessly separate children from their parent
		Provide immigrant children with pathways to citizenship
Research	2013 Sequester resulted in budget cuts of $1.57 billion to NIH, $75 million to NICHD, and $289 million to CDC; in FY 2013, only 12% of the NIH budget was devoted to pediatric research, and only 4% was devoted to NICHD, although children comprise 24% of the US population	Reverse sequester cuts and increase annual funding for NIH and CDC to ensure medical advances, protect the public's health, train future generations of researchers, create jobs, and maintain America's standing as the world's leader in biomedical research
		Increase NICHD funding (4% of the total NIH budget) and overall NIH pediatric funding (12% of the total NIH budget), so that they are more commensurate with the proportion of children in the US population (24%)
Enhance investments in and focus on children's health and well-being	Overwhelmingly, bipartisan support by American voters exists for measures that would enhance our nation's investments in and focus on children's health and well-being	Initiate an annual children's budget that details federal spending on children and provides an official accounting of federal investments in childre
		Create a bipartisan children's commission to recommend solutions to problems facing children[a]

Abbreviations: ACA, Patient Protection and Affordable Care Act; CDC, Centers for Disease Control and Prevention; CHIP, Children's Health Insurance Program; FY, fiscal year; HR, House of Representatives; NICHD, Eunice Kennedy Shriver National Institute of Child Health and Human Development; NIH, National Institutes of Health; S, Senate; SNAP, Supplemental Nutrition Assistance Program; USDA, US Department of Agriculture; WIC, Special Supplemental Nutrition Program for Women, Infants, and Children.

[a] Modeled after the bipartisan children's commission convened in the early 1990s, whose resulting policies have been credited with lifting millions of children out of poverty and with reducing the rate of uninsured children to record lows.

Democrats, 82% of independents, and 74% of Republicans) want Congress to extend the Earned Income Tax Credit and Child Tax Credit, which help keep children out of poverty.[15]

Food Insufficiency

More than 16 million US children (22%) live in food-insecure households.[16] One in 3 American children receives Supplemental Nutrition Assistance Program (SNAP) benefits, 47% of SNAP recipients are children, and half of all US children will receive SNAP benefits.[17,18] Food insecurity is associated with deleterious consequences for children's health, including elevated risks of suboptimal health and hospitalizations.[19]

No child should go hungry in the United States. A national goal should be to eliminate childhood hunger, a stated aim of the Administration.[20] Two crucial steps are needed to achieve this goal. First, Congress should fully fund and maintain SNAP and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), so that all children needing nutritional assistance receive it until their families' income rises. SNAP provides nutritional assistance to more than 22 million children, and WIC serves 7 million. Under sequestration, however, WIC was severely threatened, and more than $354 million was cut from child nutrition programs.[21] WIC is now funded at postsequester levels and is plagued with uncertainty as Congress continues to grapple with final federal funding decisions. Some in Congress are proposing SNAP cuts at a time when SNAP participants already experienced benefit cuts in November 2013. Second, the National School Lunch Program (NSLP) and the School Breakfast Program (SBP), providing free lunch and breakfast in schools to low-income children, should continue fully funded by Congress, with new healthier standards implemented. The NSLP and SBP provide meals in schools to more than 30 million low-income children in 99% of public schools, and low-income children receiving free NSLP and SBP meals perform better in school.[22]

Lack of Health Insurance

Seven million US children (9%) have no health insurance.[4] Every 42 seconds, an American child is born uninsured.[8] Uninsured children are significantly more likely than insured children to have worse health, no regular physician, delayed immunizations, unmet medical or prescription needs, impaired specialty access,[23] and higher odds of emergency department visits,[24] avoidable hospitalizations,[25] injury hospitalizations,[26] adverse newborn outcomes,[27] and death in hospitals and intensive care units and after trauma.[28]

What federal policy steps will reduce the number of uninsured children? First, full, uninterrupted federal funding should be secured for Medicaid and CHIP. Since the inception of CHIP in 1997, Medicaid and CHIP together resulted in a 47% reduction in the proportion of uninsured US children, now at 9%.[29] In contrast, 20% of adults are uninsured.[29] Recent federal proposals to reconstitute Medicaid and CHIP as block grants or impose per capita caps would devastatingly restrict or eliminate benefits, underfund Medicaid, disadvantage children with even lower caps, and ration care.[30] In addition, requiring Medicaid and CHIP renewal every 6 months results in higher administrative costs and burdens for states, inefficiencies and hassles for families, and an increased likelihood of children losing coverage. Unfortunately, only 23 states have 12-month continuous eligibility for both Medicaid and CHIP, so the time has come to require at least 12-month continuous enrollment in Medicaid and CHIP in all states, as proposed in the bipartisan Stabilize Medicaid and CHIP Coverage Act.

Second, critical threats to insuring uninsured children should be eliminated. CHIP should be made permanent and CHIP coverage ex-

tended to 300% of the poverty threshold for all US children, as Massachusetts did, cutting childhood uninsurance to less than 3%.[31] We recommend eradicating the 2016 financial cliff, when CHIP funding will drop by 73%, from $21.1 billion to $5.7 billion.[32] We should abolish the Patient Protection and Affordable Care Act family glitch, in which insurance exchanges provide no subsidies for spouses and children of workers who can afford individual employer-based insurance, even if these workers cannot afford dependent coverage, because affordability determinations are based on costs of the individual worker's policy—not the family policy. The family glitch will cause 460 000 low-income children (7% of uninsured children) to remain uninsured.[33]

Third, federal and state funding should be committed to implementing evidence-based programs—including community health workers (CHWs) and parent mentors—highly effective in Medicaid and CHIP enrollment of uninsured children, given that two-thirds of uninsured children (almost 5 million) are eligible for but not covered by Medicaid and CHIP.[5] Randomized clinical trials document that CHWs and parent mentors are substantially more effective than traditional Medicaid and CHIP outreach and enrollment in insuring uninsured children, and result in faster, more continuous coverage, with high parent satisfaction.[34,35]

Child Abuse and Neglect

A child is abused or neglected every 47 seconds and dies from abuse or neglect every 7 hours in the United States.[8] In 2011, 681 000 children experienced abuse or neglect (hereafter referred to as maltreatment), and 1570 died from it.[36] Maltreated children have higher likelihoods of lower cognitive capacity, language disorders, poor academic performance, and teen pregnancy.[37] One-third of maltreated children will abuse or neglect their own children.[37] Up to 80% of young adults maltreated as children have psychiatric disorders, and up to two-thirds of people in drug treatment programs were abused as children.[37] Maltreated children have much higher odds of arrests for juvenile criminal behavior and for violent or criminal behavior as adults.[37] Annual costs of child maltreatment in the United States are $124 billion.[38]

Because no child should be maltreated, we recommend that a national goal should be a reduction by at least half of the rates of maltreatment and maltreatment deaths by 2018. Federal funding urgently is needed for studies on effective maltreatment screening and prevention interventions because little is known about what are the best methods for identifying children at risk of or now experiencing maltreatment, and how to prevent child maltreatment. A pressing need exists to determine whether domestic-violence screening, prevention, and treatment reduce child maltreatment, given that domestic violence is the most potent maltreatment risk factor.[39] Federal legislation is needed to ensure needed support services—including family preservation services, substance-abuse counseling, housing, and education and employment services—for all families with maltreated children, because most families with substantiated physical abuse are not provided support services.[39]

Overweight and Obesity

Overweight among US children is pandemic: 32% of US children are overweight, and 17% are obese.[40] Childhood overweight (including obesity) is associated with many complications, including hyperlipidemia, hypertension, sleep apnea, orthopedic disorders, and discrimination.[41] Childhood overweight is a known risk factor for adult overweight. An overweight 10-year-old child has a 40% to 80% probability of overweight at 35 years old.[42] All severely obese children became obese adults in one study,[43] and adolescent overweight is associated with double the risk of adult mortality.[44]

The proposed bipartisan FIT Kids Act (HR 2178) would combat childhood obesity by promoting healthy nutrition, physical activity, physical education, and school wellness programs. Key provisions of this legislation include (1) collecting school-level data on physical education; (2) grants promoting physical activity, physical education, fitness, and nutrition in schools; (3) assisting low-performing schools; (4) prioritizing schools with greatest needs; (5) ensuring equal physical activity opportunities for disabled students; and (6) monitoring outcomes.

Another top childhood obesity priority is maximizing federal funding for the Farmers' Market Promotion Program (FMPP) and the Fresh Fruit and Vegetable Program (FFVP). The FMPP funds improving and expanding farmers' markets and community-supported agriculture programs. The FMPP is a powerful tool in reducing childhood obesity because it increases access to fresh fruits and vegetables, facilitates the use of SNAP and WIC benefits at farmers' markets, and prioritizes funding outlets selling healthy foods in low-income neighborhoods and food deserts.[45] The FFVP provides all students in selected low-income elementary schools with free fresh fruits and vegetables.[46]

Firearm Deaths and Injuries

In 2010, 1970 US children were killed by firearms,[47] equivalent to 5 children dying daily and one killed every 4 hours by firearms. In 2010, 12 593 US children suffered nonfatal gunshot injuries, equivalent to 525 gunshot injuries daily and one every 42 minutes.[47] Among children 10 to 14 and 15 to 24 years old, firearms are the second leading cause of injury deaths, behind only motor vehicle accidents.[48] Among those 1 to 24 years old, firearms cause twice as many deaths as cancer, 5 times as many as heart disease, and 15 times as many as infections.[49] America has substantially higher rates of childhood firearm deaths than other high-income countries, with firearm death rates 7 times higher for 0 to 4 year olds, 11 times higher for 5 to 14 year olds, and 43 times higher for 15 to 24 year olds.[50]

Substantial reductions in childhood firearm deaths and injuries might be accomplished through multidimensional strategies informed by other public-health successes, including reductions in poisonings, tobacco use, and motor vehicle deaths.[51] These strategies include safety measures limiting access to appropriate users, product changes reducing lethality and injury potential, routine education and licensing, and taxation representing societal costs.[51] One key policy step limiting firearm access to appropriate users would be mandatory criminal background checks for every firearm sale, as proposed in the Fix Gun Checks Act of 2013 (S 374). Another key step would be federal regulations requiring safe storage of firearms and ammunition, which is associated with fewer unintentional childhood firearm injuries, including a 73% reduction in firearm injuries simply by storing guns locked.[52]

Product changes reducing lethality and injury potential have been successful in public-health campaigns to reduce childhood poisonings and motor vehicle accident deaths and injuries. Because recent mass shootings such as in Newtown, Connecticut, and Aurora, Colorado, demonstrate the lethality and destructive toll of military-style assault weapons and high-capacity ammunition magazines, banning assault weapons and high-capacity ammunition magazines would seem reasonable steps, as proposed in the Assault Weapons Ban of 2013 (S 150). Driver education and licensing are key safety standards that reduce motor vehicle accidents; analogously, firearm safety classes and licensing should be mandatory.

Firearm-related assaults, homicides, and self-inflicted injuries and deaths cost America $33.8 billion per year, including $900 million in medical costs and $32.9 billion in lost productivity.[53] Taxation of tobacco products significantly reduces their consumption.[54] Therefore, a commonsense policy step would be to tax firearm and ammunition sales to better represent their substantial societal costs and fund programs and research on related prevention, gun safety, and mental health services.

A recent report by the Institute of Medicine[55] called for more research on firearm violence, risk and protective factors, interventions, gun-safety technology, and influences of video games and other media. We propose that the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), and other relevant federal agencies should specifically fund research in these areas.

Mental Health

Up to 1 in 5 children experiences a mental disorder.[56] For the first time in 50 years, the top 5 chronic conditions are all mental rather than physical disorders.[57] Half of all mental and substance-use disorders start by 14 years old.[58] Pediatric mental-health and substance-abuse hospitalizations increased by 24% between 2007 and 2010, and hospitalizations for mood disorders increased by 80% between 1997 and 2010. Suicide is the leading cause of death among youth 12 to 17 years old.[56] Mental disorders in children and youth cost $247 billion annually.[56] Nevertheless, only half of US children with mental disorders receive mental-health services.[59] Only 63% of US counties have at least 1 mental-health facility treating children and adolescents, and more than four-fifths of US counties are partial or whole Mental Health Professional Shortage Areas.[59] Although Medicaid is the single largest mental health-care payer, 35% of US counties have no outpatient mental-health treatment facility accepting Medicaid, even though Medicaid enrollees are more likely than the general population to be more disabled and have more severe mental disorders.[60] Whereas 51% of psychiatrists practice in solo and group practices, only 3% and 8% of patients in these settings, respectively, have Medicaid coverage.[60] States cut more than $1.6 billion for mental health services between 2009 and 2012, and they eliminated 4000 psychiatric hospital beds since 2010.[61]

Four policy steps are proposed to improve children's mental health care. These include (1) ensure that all children with mental disorders have timely access to mental health care, including inpatient, outpatient, crisis, and school care; (2) adequately fund mental-health services and restore funding cuts; (3) increase the number of mental health-care providers accepting Medicaid by enhancing reimbursement rates; and (4) eliminate shortages in mental health-care providers by adding more training programs and expanding loan repayment and forgiveness.

Racial/Ethnic Disparities

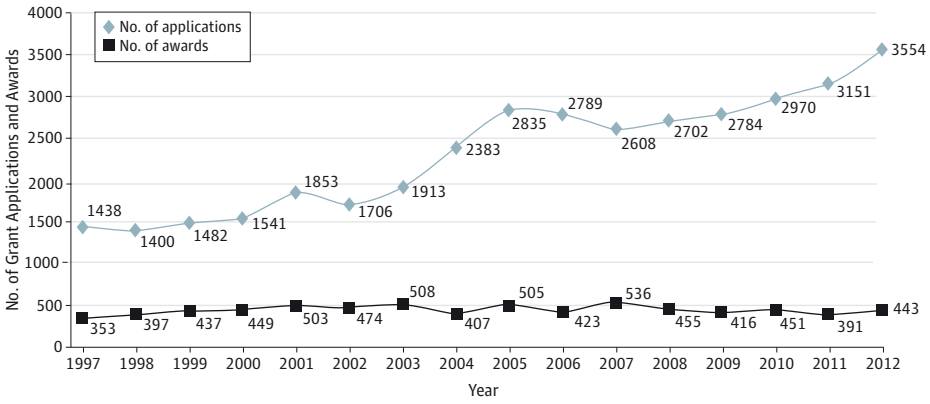
Racial/ethnic minority children comprise 47% of US children (34.8 million),[1] and minority children will outnumber children of white race/ethnicity by 2020.[62] Nevertheless, racial/ethnic disparities are extensive and pervasive, and occur across the spectrum of health and health care.[63] Compared with children of white race/ethnicity, African American children have higher overall death rates; substantially higher rates of asthma deaths, hospitalizations, and emergency department visits; the largest percentages and numbers of new human immunodeficiency virus and AIDS diagnoses in every age group and via perinatal transmission; autism diagnosed an average of 1.4 years later; and a lower likelihood of kidney transplantation.[63] Compared with children of white race/ethnicity, American Indian/Alaskan Native children have a higher death rate, more than 7 times the firearm injury rate, and lower odds of mental-health visits or antidepressant prescriptions after depression diagnoses.[63] Asian/Pacific Islander children are more likely than those of white race/ethnicity to have no usual source of health care, the worst access to specialty care, and increased injuries and lead intoxication.[63] Latino children are more likely than those of white race/ethnicity to have no health insurance; unmet specialty-care needs; higher mortality rates from leukemia and after congenital heart surgery; higher rates of tooth decay, injuries, obesity, exposure to violence, and impaired access to mental health care; and the highest rates of teen births, feeling sad or hopeless, and attempting suicide.[63]

Several policy steps are needed to eliminate these disparities. Data on race/ethnicity, primary language spoken at home, and parental English proficiency should be collected on every pediatric patient, so that disparities can be identified, monitored, and targeted as part of quality improvement efforts, consistent with recent Institute of Medicine reports, guidelines by disparities experts, and the Patient Protection and Affordable Care Act.[62] Children's disparities should be monitored and publicly disclosed annually at the federal, state, health-plan, and institutional levels. All children should have medical and dental homes and access to needed specialty care and mental health care. Workforce diversity needs to be enhanced, given that communities with high proportions of minorities are 4 times more likely than other communities to have physician shortages, but underrepresented minority (URM) physicians are more likely than non-URM physicians to care for minority, publicly insured, and uninsured patients.[62] To eliminate disparities, more federal funding is needed for research on and implementation of innovative solutions, such as health-care empowerment zones, and known efficacious and cost-effective interventions, such as parent mentors and CHWs.[62,64]

Immigrant Children

Increasing by 66% from 1995 to 2012, immigrant children are the fastest-growing group of children in the United States.[65] One in 4

Figure 1. Numbers of Grant Applications and Awards From 1997 to 2012 at NICHD



From an analysis of data from the National Institutes of Health.[75] NICHD indicates Eunice Kennedy Shriver National Institute of Child Health and Human Development.

US children (18.7 million) is a first- or second-generation immigrant.[65] Approximately 62 million Americans (21%) speak a language other than English at home, and 25.1 million (9%) have limited English proficiency (LEP).[66]

Immigrant children experience major disparities, including a substantially greater risk of being uninsured than citizen children, with 45% of undocumented children uninsured (vs 9% of US children), and 25% of citizen children in mixed immigrant families (with one immigrant parent) uninsured (vs 8% of citizen children of US-born parents).[67] Despite large numbers of LEP Americans and federal policy (Title VI) requiring the provision of adequate language assistance to LEP patients, many LEP children and families do not receive professional medical interpretation, but rather must resort to ad hoc interpreters (family members, friends, or strangers from waiting rooms) or having no interpreter. One landmark study[68] revealed no interpreter use for 46% of LEP patients, and 39% of interpreters used had no training. Language barriers can profoundly negatively impact access to care, health, use of services, communication, satisfaction, and patient safety, and can cause serious injuries or death,[69] but only 13 states provide reimbursement (through Medicaid and CHIP) for interpreter services.

Between July 2010 and September 2012, 204 810 parents of US citizen children were deported[70]; 5100 children languish in foster care nationwide because their undocumented immigrant parents were detained or deported.[70] These children can spend years in foster homes, with some put up for adoption after termination of parents' custody rights. In addition to this being morally difficult, increased costs of separating children from parents directly impact US taxpayers. Separation from parents due to detention or deportation harms children's mental and physical health, academic performance, and economic security.[70]

Several policy steps are needed to ensure the health of immigrant children. Health insurance should be provided to all US children, including immigrants, especially given that uninsured children are significantly more likely than insured children to have worse health, no regular physician, delayed immunizations, and preventable hospitalizations, and to die.[23-28] Third-party reimbursement by all payers for trained interpreters should be mandatory, so that no child is ever denied health care or experiences injury or death because of language barriers. Legislation is needed to ensure that immigration enforcement does not needlessly separate children from their parents, which harms children's health and increases risks of entering foster care.[70] In addition, immigrant children should be provided pathways to citizenship.

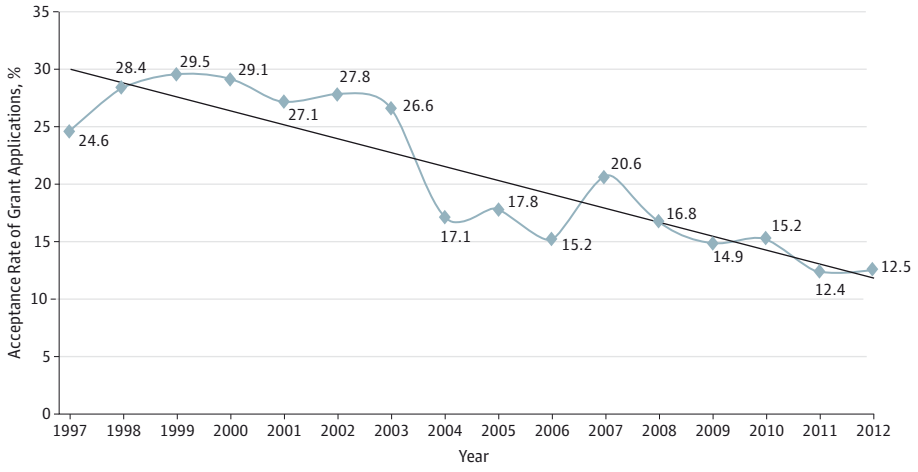
Research

The NIH is the largest funding source of medical research in the world, creating hundreds of thousands of jobs by funding thousands of scientists in every state, and more than 130 Nobel Prize winners have received NIH support. Every $1 invested in NIH research generates $2.60 in economic activity, and 2011 NIH investments yielded 432 000 jobs and $62.1 billion.[71] The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the largest federal funding source for pediatric research, has sponsored research resulting in dramatic reductions in infant mortality, deaths due to neonatal respiratory distress syndrome and sudden infant death syndrome, maternal-fetal human immunodeficiency virus transmission, serious infections due to *Haemophilus influenzae* type B, and adverse consequences of phenylketonuria and congenital hypothyroidism, and 29 NICHD grantees have won a Nobel Prize.

The 2013 sequester cut $1.57 billion to NIH, $75 million to NICHD, and $289 million to CDC.[72] These cuts were characterized by the former NIH director as a "disaster" that will "set medical science back a generation," given that these cuts follow years of flat budgets and will damage research and innovation, including 12 000 researchers and scientists losing jobs.[72] Although 2012 marked the greatest number of applications ever submitted to NIH, the 2012 funding success rate of 17.6% was the lowest ever, almost half the 1999 peak success rate of 32.4%.[73]

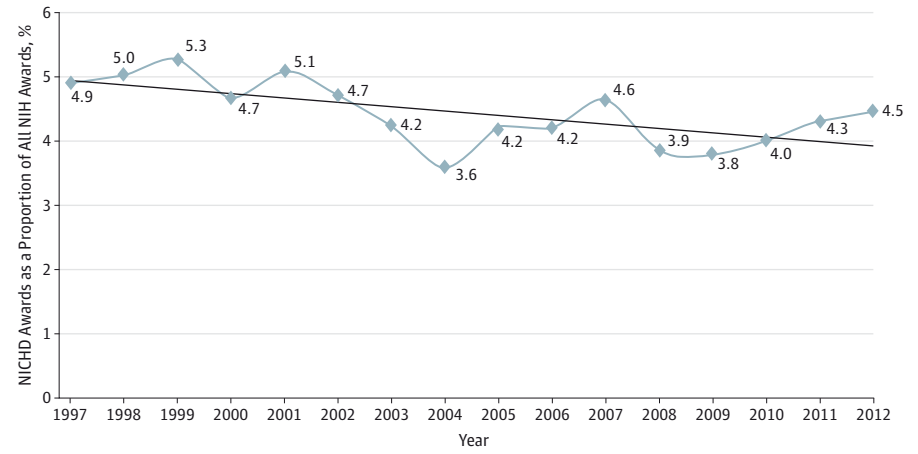
In 2013, only 11.8% of the NIH budget was devoted to pediatric research,[74] and only 4.3% to NICHD,[75] although children comprise 24% of Americans.[1] Fiscal year 2012 marked the highest number of NICHD applications ever, but NICHD acceptance rates in 2012 (12.5%) and 2011 (12.4%) were the lowest ever, and among the lowest of any NIH institute.[73] Between 1997 and 2012, the number of NICHD applications rose dramatically, while the number of awards remained flat, acceptance rates dropped substan-

Figure 2. Acceptance Rate of Grant Applications From 1997 to 2012 at NICHD



From an analysis of data from the National Institutes of Health.[75] NICHD indicates Eunice Kennedy Shriver National Institute of Child Health and Human Development.

Figure 3. NICHD Extramural Grants as a Proportion of All NIH Extramural Awards From 1997 to 2012



From an analysis of data from the National Institutes of Health (NIH).[74] NICHD indicates Eunice Kennedy Shriver National Institute of Child Health and Human Development.

tially, and the proportion of NIH dollars devoted to NICHD slightly declined (**Figures 1**, **2**, and **3**). Anecdotally across the country, many promising young investigators are choosing or are forced to forgo pediatric research careers because of the rapidly dwindling prospects of procuring career-development and independent-investigator funding.

Federal policy action urgently is needed to ensure ongoing cutting-edge medical advances, protect the public's health, train future generations of researchers, create jobs, and maintain America's standing as the world's biomedical research leader. Not only should damaging NIH and CDC sequester cuts be reversed, but annual NIH and CDC funding should be increased to leverage the substantial documented major return on investment in terms of biomedical discovery, economic growth, and jobs creation. Annual NICHD funding (4% of the total NIH budget) and overall NIH pediatric funding (12% of the total NIH budget) also should be increased, to be commensurate with children in the US population (24%).

Conclusions

Data indicate that child well-being in the United States has declined since the most recent recession. Childhood poverty rates are at their highest in 20 years, 1 in 4 children lives in a food-insecure household, 7 million children lack health insurance, a child is abused or neglected every 47 seconds, and 1 in 3 children is overweight or obese. Five children are killed daily by firearms, 1 in 5 experiences a mental disorder, racial/ethnic disparities continue to be extensive and pervasive, immigrant children are our nation's fastest growing group of children but experience suboptimal access to health care, and major NIH and NICHD sequester cuts and underfunding of pediatric research have damaged our global leadership in biomedical research and hobbled economic growth and jobs creation.

Practical, data-driven federal policy solutions are available to successfully address each of these 10 urgent priorities, thereby ensuring a healthy, productive future for American children and our nation

(Table). In addition, overwhelming, bipartisan support by US voters exists for measures that would enhance our nation's investments in and focus on children's health and well-being. In our nation, we need a new commitment to making necessary investments to improve child well-being across several domains. With respect to investments, 66% of US voters (76% of Democrats, 63% of independents, and 56% of Republicans) want the President to establish a children's budget, providing an official accounting of federal investments in children.[15] Overall, 78% of US voters (89% of Democrats, 76% of independents, and 68% of Republicans) support the creation of a bipartisan children's commission to recommend solutions to the problems facing children.[15] Because the needs of our nation's children have never been greater, an extraordinary opportunity exists for federal policy to profoundly improve the health, well-being, and productivity of our current and future generations, an investment strongly supported by Americans across the political spectrum.

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