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Fighting for Their Lives: Women, Poverty, and the Historical Role of United States Law in Shaping Access to Women's Health Care

Susan L. Waysdorf
University of the District of Columbia
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BY SUSAN L. WAYSDFOR*  

INTRODUCTION

Perhaps in no other context of American life is the relationship
between poverty, racial discrimination, and gender discrimination
more stark and historically consistent than in the area of health care
delivery and medicine. Today, women’s daily relationship to securing and
maintaining health care for themselves and their children remains a major
factor in keeping women and their families locked in poverty. Yet, women
are the primary consumers of health care, both for themselves and as the
primary caregivers of their children and their parents.

In the United States, access to health care, and the scope and quality of
one’s health care needs directly correlate to one’s power, privilege, wealth,
and status. In this context, poverty has always been a key factor in determin-
ing a person’s prospects for health. For women the cycle has for the most
part remained unbroken. As a group women have been oppressed on the basis
of race, gender, sexuality, and the caregiver-homemaker-childrearer
designation. Women’s oppression has led to poverty, poverty to poor health,
and poor health back to poverty. In fact, the term “feminization of poverty”¹

* Associate Professor of Law, and Director, HIV/AIDS Legal Clinic,
District of Columbia School of Law. A.B. 1972, University of Chicago; J.D.
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women with AIDS and their children whom the author has met and has had the
privilege of assisting, and from whom she has learned the true meaning of
struggle, dignity, and hope.

¹ The term was put forward by Diane Pearce a feminist researcher in her
CHANGE REV. 28 (1978). The “feminization of poverty” describes the important
aptly paints the picture that depicts the connection between women, health care, and poverty.

Indeed, little has changed for poor women and their children in the delivery of health care in the United States over the last seventy-five years. In general, women still lack any meaningful level of participation, control, or decision-making over the processes, financing, rationing, and development of modern health care delivery systems. For poor women, this reality is even more starkly outlined and clearly finds its roots in historical developments. With regard to health care, a key sphere of life, women continue to constitute an oppressed group, disempowered legally, politically, and as consumers in the health care system.\(^2\)

This Article explores the connection between women’s health needs and women’s poverty from an historical and comparative law perspective.\(^3\) The Article analyzes the law’s impact on how poor health and correlation between gender and poverty and in particular the increase of poverty among women-headed households. See also Evelyn N. Glenn, Cleaning Up/Kept Down: A Historical Perspective on Racial Inequality in “Women’s Work”, 43 STAN. L. REV. 1333 (1991) (connecting female poverty and race to the historical discriminatory role of women in the work force); Audrey Rowe, The Feminization of Poverty: An Issue for the 90’s, 4 YALE J.L. & FEMINISM 73 (1991) (addressing the increased number of women and, in particular, woman-maintained households, living in poverty in this decade and the reasons for this growth); see generally LINDA GORDON, PITIED BUT NOT ENTITLED 6-7 (1994) (providing a comprehensive history of women and welfare, noting that “[p]overty has long been ‘feminized,’ particularly because women alone with children have been exceptionally poor. . . . As a result single motherhood has been a central concern for welfare designers since the 1880s.”).

\(^2\) See SUSAN SHERWIN, NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE 222-23 (1992); see generally Patricia Peppin, Power and Disadvantage in Medical Relationships, 3 TEX. J. WOMEN & L. 221 (1994).

\(^3\) While this Article focuses on women’s health care needs and the lack of a coherent health care policy in the United States and programs affecting women, the health care needs of children are a central, underlying, and parallel issue. A full or serious treatment of the health care needs of children and status of children’s health care in this country at each relevant point in this Article would make the discussion unwieldy and therefore beyond the scope of this Article. However, it is this Article’s contention that one cannot truly address the issues of women’s health without also simultaneously dealing with the parallel needs of children.

For detailed and insightful critiques of our nation’s lack of health care coverage or public policy towards children, see, e.g., SARA ROSENBAUM ET AL., CHILDREN’S DEFENSE FUND, THE HEALTH OF AMERICA’S CHILDREN (1991);
inadequate health care affect women, in particular, by increasing their impoverishment, maintaining welfare dependency, and of course by exacerbating ill health. In general, women have continued to be impoverished by bad health and bad health care, despite many advances by women in almost every other sphere of American life. Notably, these advances have occurred over the last seventy-five years since women’s potential for forging change through the electoral system became a reality with the right to vote.

Yet in actuality, women’s empowerment in relation to health care as a “legal rights” issue for all women has made, at best, spotty progress over the course of this century. Among women, most health care advances predominately remain accessible to those who are white and middle class, and have scarcely affected poor women’s access to health care. This is a reflection of the fact that federal public policy decisions and legislation over the last eight decades have resulted in a form of medical apartheid for men, women, and children in this country. This is a system which is overtly based on economic status, and covertly based on race and gender. In other words, this is a two-tiered, health care


In the areas of health law and ethics, the focus of feminist scholarship and research has traditionally been on abortion, reproductive rights, surrogacy rights, and new reproductive medical technologies. By contrast, comparatively little has been written about women and health care as a “legal rights” issue, public policy issue, or the relationship between women’s health care and the continued impoverishment of women. In addition, historians traditionally have given short shrift to the role women have played in the development of medicine and the United States public health system, or to the role of women’s legislative efforts to provide for women’s health needs.

In recent years, the focus on women, health care and the law has begun to change. This is reflected in recent works and studies on women and AIDS, women and aging issues, women and disabilities, a feminist view of medical ethics, and the particularized health needs of women of color and poor women.

The United States caste or apartheid system of medical care links one’s economic status to the kind and quality of medical care that one can receive. This is a direct result of the specific eligibility requirements set out by federal law under the Aid to Families with Dependent Children (“AFDC”), see infra notes 189-210 and accompanying text, Supplemental Security Income (“SSI”), see infra notes 160-88 and accompanying text, and Medicaid welfare programs, see infra notes 189-210 and accompanying text, as discussed in greater detail
caste system, built for the benefit and profit of the privatized medical profession and health care industry, and resulting in particular detriment to poor women and their children.

Under this system, those who can afford private health insurance, or those who are in the labor market and receive health insurance as a benefit of employment, have access to a world-renowned health care system. Most other Americans are medically disenfranchised. The unemployed, the working poor, the impoverished — who are increasingly women and their children — people of color, the homeless, immigrants, the institutionalized, are locked out of the top tier of health care. This apartheid system of “welfare medicine,” which bases one's access to quality health care on one’s economic status, finds its roots in the legal and policy decisions of the last seventy-five years.

To this day, the United States stands virtually alone among developed or industrialized nations in lacking universal health coverage for all people, and universal prenatal care and maternity care for all women, regardless of their

throughout this Article. A key premise of this Article is therefore the following: although it would be a gross violation of federal law to base eligibility for welfare medicine on race, gender, or ethnicity, or to exclude people from accessing health insurance or top quality medical care on those grounds, due to the demographics of who is poor in this country, our nation’s medical care system is in actuality a caste system based on racial and gender discrimination, as well as economic status.

6 ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974). Throughout this Article, the term “welfare medicine” is used to refer to the system of government health benefits and care — today manifested by the Medicaid system — which bases eligibility on economic status, that is, on one’s poverty. Welfare medicine compromises the bottom tier of the United States system of apartheid medicine and health care. The term “welfare medicine” was coined by Stevens and Stevens, id., and figures prominently in their analysis of the historic tensions which led to this two-tiered health care system.

By 1950 the proponents of comprehensive national health insurance and those in favor of providing medical care only to those in proven need formed two distinct political camps. The two philosophies were once again in conflict. . .

. . . It was in this context that “welfare medicine” was defined. Medical services to the poor were viewed as a reflection of unavoidable — but peripheral — breakdowns in the economic system, rather than as a pointer toward national health service benefits.

Id. at 21.
economic status. In other words, the United States fails to assure at least a floor of health care, a minimum set of services for all pregnant women and children. There simply are no statutory entitlements, no recognized guarantees under the United States Constitution, and no body of case law that assures access to comprehensive, basic health care to all women and children, regardless of their ability to pay or their social status.

This Article argues that historically there have been at least two primary models for health care delivery and care: first, universal health care coverage to all, regardless of ability to pay; and second, the welfare medicine-medical apartheid model, a policy-law paradigm linking government provision of health care to economic status and to poverty. This Article shows that in the early part of this century, federal programs and laws which exemplified the former model—universal care—were in fact fought for, legislated, and, at least briefly, carried out. If those programs and policies had been followed and developed, rather than derailed, they would have led to a radically different scenario for health care in the United States today. The clearest examples of these early universal care models were marked by the efforts of Progressive Era reformers, led by women Suffragists and the “social feminists” of the women’s rights movement, and resulted in the federal programs enacted under the Sheppard-Towner Act.

By contrast, public policy and legislative choices over time have resulted in the medical apartheid model for the United States. This policy of welfare medicine links government provision of medical care to “means-testing”

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7 See Strain, supra note 3; see also C. Arden Miller, M.D., Summation & Commentary, 86 PEDIATRICS 1124, 1124-26 (Supp. 1990) (comparing the health of children in the United States to that of children in Canada, England, Wales, France, the Netherlands, and Norway).
8 Rosenbaum, Rationing Without Justice, supra note 3.
9 See id. “Instead, children who today are the poorest Americans are also among the most likely to be medically underserved.” Id. Rosenbaum makes this point in relation to children in the United States, but its extension to the plight of the nation’s women is applicable here.
10 See GORDON, supra note 1, at 31. As social historian Gordon, in her exhaustive study of the women’s rights movement and the history of women’s welfare in this country, notes: the term “social feminists” was first coined in WILLIAM L. O’NEILL, EVERYONE WAS BRAVE: THE RISE AND FALL OF FEMINISM IN AMERICA (1969). Generally, the term refers to the women’s social reform network active in women’s rights, and women and children’s health and welfare during the Progressive Era of the first two decades of the twentieth century.
based on economic status, and today is most clearly represented by Medicaid, the federal government’s medical entitlement program. While a significant portion of the nation’s poor are in fact entitled to Medicaid, and in some cases, other “medical charities,” many others have absolutely no means of accessing health care other than through public hospital emergency rooms in times of medical crisis. Medicaid recipients are also relegated to relying on a predominately different and lower quality medical system for their health care needs. In being denied equal access to quality health care, the poor in this country are thus set apart from the poor of most other industrialized nations.

The inequities brought on by the United States system of medical apartheid have affected poor women and their children in very particular ways. It is therefore a central contention of this Article that the cyclical dyad of women’s poor health and women’s poverty is a direct result of our government’s historical approach to linking health care needs to economic status. Concretely, eligibility for cash welfare programs, most particularly, Aid to Families with Dependent Children (“AFDC”) and Supplemental Security Income (“SSI”), has been the key to health care entitlements under Medicaid, since the program’s creation in 1965.


13 Aid to Families with Dependent Children (“AFDC”), 42 U.S.C. §§ 601-617 (1994). Created as part of the Social Security Act of 1935, and originally called Aid to Dependent Children (“ADC”), today AFDC is the nation’s largest welfare program, providing monthly cash payments to the relative caregivers (primarily single mothers) of impoverished dependent children. Under federal Medicaid law, eligibility for AFDC guarantees eligibility for Medicaid benefits. The number of AFDC-recipient families increased from 1.9 million in 1970 with expenditures of $15.5 billion, to 5.0 million families in 1993, with expenditures of $22.3 billion. The average monthly AFDC benefit per family was $676 in 1970, and $373 in 1993, a 45% reduction. COMM. ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, 103D CONG., 2D SESS., OVERVIEW OF ENTITLEMENT PROGRAMS 393 (Comm. Print 1994) [hereinafter GREEN BOOK].

This Article argues that the programmatic linkage between AFDC/SSI and Medicaid, cemented in 1965, was the direct result and resolution of earlier historical developments in, and decisions concerning, United States health care policy and social welfare programs. From an historical perspective, the Article proposes that had the federal government, earlier in this century, instead stayed the course of the Sheppard-Towner Act and established universal health care coverage, including universal maternity coverage for all women, our nation would be in a dramatically different situation today, in terms of the nation's health and the distribution of poverty.

The following sections address several key issues and inquiries concerning the historic relation between women's health and women's poverty. First, what has been the historical relationship between women's health and women's poverty? What has been the role of federal law in providing for women's health and in resolving the multi-faceted social issues regarding women's health? Why has the federal government's provision of women's health care historically been linked to women's poverty and to women's fertility role as childbearer and as mother? Why has government, through its cash benefit and medical welfare programs, conditioned women's health entitlements on poverty, at least since 1935? Should women (and men and children) have a government-protected right to health care?

A central aspect of this discussion's historical framework is women's winning the right to vote, and the role, if any, that women's suffrage and women's political empowerment has had in shaping women's access to health care. Women's efforts to obtain political and social equality date back much earlier, however. This symposium marks the anniversary of one of the most important points in those efforts: the one hundred fiftieth anniversary of the Seneca Falls Declaration of Sentiments. Today the need to analyze and evaluate women's health care rights from both a historical and a legal perspective is especially pressing and timely. This

15 While the multi-faceted issues of women's health, human reproduction, and the medical profession provide the context and background for the legal issues discussed in this Article, the purpose here is not to survey the whole range of these complex issues. Those subjects are beyond the scope of this Article. Rather, the purpose here is to focus on the roles that the law and legal public policy have played in empowering, entitling, and regulating women's access to health care. For more extensive materials on the issues affecting women's health in this country (in addition to those relied on in this Article), see the inclusive bibliography on women's health by Edward T. Mormon et al., *Bibliography, in Women, Health, and Medicine in America* 517 (Rima D. Apple ed., 1990).
is particularly true because in 1996 the nation is at a crossroads in resolving the futures of both its welfare and health care systems.

Today the provision and quality of health care generally, the issue of universal health care, and government’s responsibility to provide health care to the poor have become issues of national concern and debate. Recent Congressional proposals have the potential of dramatically affecting millions of poor women and families who receive AFDC, as well as Medicaid. For despite these programs’ shortcomings, and their contributions to marginalizing the poor, the proposed demise of AFDC and Medicaid would clearly devastate the millions of poor families who have benefited from these “safety nets,” unless universal health care and other social programs are adopted to immediately replace them.

Part I of this Article sets the context for understanding the historical tension between the universal care and the welfare medicine-medical apartheid models. Part I frames the discussion in a description of the conditions of women’s health, health care, and poverty. The connections between women, health, and poverty will be drawn by focusing on the inter-relationships between women’s legal status in our society, women’s health, and the feminization of poverty. This section will also discuss how poor women experience health care in this country, from the lack of insurance, barriers to access, and policies of discouragement, to legal and medical inequities.

Part II of this Article analyzes the historical role of federal law and policy in regulating, empowering, and resolving the multi-faceted issues concerning women’s health care and women’s impoverishment. Focusing on the first half of the twentieth century, the discussion will track the key historical developments which connect women’s legal and political empowerment, particularly from the perspective of federal law and public policy. These include women’s winning the right to vote and women’s advances in health care. This historical overview will show that

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16 On the one hand, this is an era of legislative efforts at serious health care reform geared to opening up access to the health care system, represented by the now-defunct National Health Care reform measures initiated by the Clinton Administration in 1993. See American Health Security Act of 1993, H.R. 1200, 103d Cong., 1st Sess. (1993), the central legislative piece behind President Clinton’s health care reform plan. On the other hand, we are faced with the Republican Party’s promotion in Congress of the Personal Responsibility Act, 142 Cong. Rec. H344-02 (1996), and other Congressional “welfare reform” initiatives which would effectively dismantle both Medicaid and AFDC.

17 See infra notes 24-65 and accompanying text.

18 See infra notes 66-210 and accompanying text.
initial federal efforts to legislate health care needs for all women and children, at least in the area of maternal and infant care, were a direct result of women's suffrage. Moreover, these early twentieth century federal programs and policies were universal in nature, intended for the benefit of all women and children, regardless of their economic or social status.

These efforts were most clearly represented by the Sheppard-Towner Act of 1921, a visionary piece of federal legislation. While relatively limited programmatically, the Sheppard-Towner Act was this country's first attempt at providing a universal approach to women's and children's health care needs.19 After the repeal of the Act, the federal government's entitlement of and interest in women's health needs increasingly became associated with women's economic status, that is, with women's impoverishment. By the 1970s, several years after the establishment of the Medicaid-AFDC bond, striking racial and class differentiations in women's health care, illness, and mortality were fixed in place nationwide.

Part III posits that our nation's future potential for achieving quality and equality in health care for all will be informed by the lessons of the past.20 Only by enacting and securing universal health care will the United States be armed both to successfully wage war on the poverty of women and children, and to effectively address their health care needs. This discussion will provide a view, based on the author's own practice, of the current reality of women with AIDS.21 It is a central premise of this Article that the degree of devastation, trauma, and challenge that women with AIDS are experiencing today is a direct result of the United States government's historic failure to provide universal health care coverage for women and children.22

19 Sheppard-Towner Maternity & Infancy Act, ch. 135, 42 Stat. 224 (1921), repealed by Act of Jan. 22, 1927, ch. 53, § 2, 4 Stat. 1024, 1024. The Sheppard-Towner Act also was the first federal health care plan and public policy to raise the ire and active opposition of the emerging American medical profession and other conservative forces. This opposition resulted in the legislation's repeal by Congress six years later.

20 See infra notes 212-35 and accompanying text.

21 This approach is utilized because women with AIDS represent in the sharpest relief both the historical culmination and the current reality of the nexus between poverty, the oppressions of race and gender, and health care.

For this reason, Part III of this Article will illustrate through the story of Anita how women with AIDS struggle to gain access to health care and to defy the epidemic from defining their social status, their personal worth, and their sense of dignity for themselves and their families. Anita's story will also show how the federal law and public policy paradigm of welfare medicine-medical apartheid not only has contributed to stigmatizing and impoverishing women, but has also failed to serve their health care needs, especially in times of crisis.

I. PRELUDE: WOMEN'S HEALTH — WOMEN'S POVERTY

For most poor women, poverty is caused, exacerbated, or prolonged by poor health, chronic illness, lack of access to health care, and overall inability to pay for medical treatment, drugs, and care. In other words, in the United States, poor health and inadequate health services are key factors which contribute to the "feminization of poverty." In a great proportion of poor families, women are likely to be the single parent caregivers of their children. Together, mother and children, whose

also mothers and living in poverty, are in large part suffering today precisely because the United States government historically has rejected universal health care coverage and instead linked health entitlements to welfare. Their children, many of whom themselves are born with AIDS, are suffering because maternity, prenatal, and infant care coverage are not provided routinely to all women.

"Anita" was a former client in my AIDS law practice. The name is a pseudonym to protect the confidentiality of the real client. Some of the facts of her situation have also been slightly altered. In essence then, Anita represents a composite sketch of the several hundred women with AIDS whom I have met, spoken with and/or assisted since 1990, years in which the AIDS epidemic increasingly targeted women and children.

Similar connections between other spheres of women's lives and the "feminization of poverty" recently have been drawn by scholars and researchers. For example, these theories have linked women's poverty to divorce, see LENORE J. WEITZMAN, THE DIVORCE REVOLUTION (1985); and to domestic violence, see Martha F. Davis & Susan J. Kraham, Protecting Women's Welfare in the Face of Violence, 22 FORDHAM URB. L.J. 1141 (1995).

Peter B. Edelman, Towards a Comprehensive Antipoverty Strategy: Getting Beyond The Silver Bullet, 81 GEO. L.J. 1697, 1706 (1993) (noting that based on 1991 U.S. Census Bureau figures, 47.1% of female-headed households with children under 18 lived in poverty). See also GREEN BOOK, supra note 13, at 1153, 1156 (noting that of all demographic groups, poverty was highest among female-headed families with children, at 48.3% in 1992; in general, African Americans, individuals in women-headed households, and Hispanics had poverty
lives are defined by spheres of disempowerment, are increasingly drawn to, then locked into poverty. What are the problems and barriers women in general face, and more particularly, poor women and poor women of color face in accessing health care in the United States? Why and to what degree do these factors help to impoverish women and contribute to keeping poor women poor?

First, it is helpful to identify the contextual web of the United States health care system prior to examining the particular obstacles poor women and women of color face in accessing health care, and the ways in which this situation leads to poverty. Sociologists, health care analysts, and historians have recognized that there is a direct relationship between the socioeconomic structure of society, the organization of the medical profession, the ways in which medical care is delivered, and the types and distribution of illness and disease.

Fundamental inequities in the United States continue to support the structures, obstacles, and attitudes which grossly disadvantage women in the health care system. For example, until a decade ago, most of what was thought to be known about women's health problems had been learned from studies of men and then applied to women. In many rates that greatly exceeded the average.


27 Id. at 144.

28 Id. at 174. "If, as I argue, health problems are at least partially rooted in the larger society, then strategies for change should, of necessity, address the contradictions inherent in such a system." Id. at 144.


At the end of the 1980s, national data on women's health issues became available. Until 1990, the National Institutes of Health (NIH), the world's premier health facility, paid scant attention to women. NIH began its major initiatives for women only after the General Accounting Office (GAO) reported that merely 13% of the NIH budget was allocated for women's research. NIH also realized that insufficient scientific knowledge existed about the unique issues concerning effective diagnosis, treatment, and management of women's health problems.

Id. See also Vanessa Merton, The Exclusion of Pregnant, Pregnable, and Once-Pregnable People (a.k.a. Women) From Biomedical Research, 3 TEX. J. WOMEN & L. 307, 312 (1994) (analyzing the historical exclusion of women from medical research and the developments beginning in 1990 which began to break these
ways, the health care industry and medical profession in the United States have been historically based in patriarchy and a demeaning view of women. Together, these paternalistic forces have led to a volatile relationship between women and the medical profession in the United States, a relationship which has resulted in harm to women.\textsuperscript{30}

As groups, poor women and women of color face profound inequities and disadvantages in accessing health care.\textsuperscript{31} Many factors contribute to women’s lack of access to health care. These include lack of transportation, inability to pay for services, lack of health insurance, lack of information, geographic availability of specific services, perception of need, risk for specific health conditions, and acceptability of the services, particularly in terms of language barriers and cultural sensitivities.\textsuperscript{32}

Recent debates concerning our nation’s responsibility to ensure health care access, and the critiques of our health care system have placed little focus on this central reality. Poor women, particularly poor women of color in this country, are impoverished and also experience poor health, as a direct result of the inequities inherent in both the United States generally, and more specifically the health care delivery systems. These inequities and disadvantages have resulted in lack of access, dependence on hospital emergency rooms for primary care, bars to participation in clinical drug protocols and programs, paternalistic and often racist attitudes and treatment from health care professionals, and dependence on the largely inadequate Medicaid system of welfare medicine. As noted earlier, despite its inadequacies, the Medicaid system has, nonetheless, provided a critically important “safety net” for those women — particularly the unemployed, impoverished women and women of color — who

\textsuperscript{30} FISHER, \textit{supra} note 26, at 144. Fisher argues that the practice of medicine in the United States, and the patient-physician relationship, is the embodiment of patriarchal culture. Male dominance is meshed with professional dominance to produce the practice of medicine as a basic distortion. \textit{See also} Peppin, \textit{supra} note 2, at 225-28.

\textsuperscript{31} Many of the same factors which disadvantage poor women in accessing health care also affect poor men in our society. However this Article focuses on poor women and their health, rather than, for example, the effects of poor health and of poverty on all homeless people, the critically important subject of another article. In addition, as will be shown throughout this Article, poverty and health inequities affect women differently, and in some ways with greater intensity and impact, than those same factors affect poor and otherwise disadvantaged men.

\textsuperscript{32} Gonzalez-Pardo, \textit{supra} note 29, at 58.
lack access to private health insurance, which is the key to accessing quality health care in the United States.

In the United States, health insurance status is, in fact, the main determinant in whether, and how, one can access health care. Whether or not one has health insurance is linked to one’s employment status. Due to women’s role in the home and in the labor market, women are less likely to have employment-related health insurance coverage, especially if they are the primary caregivers of the children in their family. Thus, in general, women are less likely to have private insurance and are more likely to have public assistance coverage. Furthermore, for those who are covered, many private insurance policies as well as public coverage programs, most notably Medicaid, do not cover many important services for women.

Generally speaking, women experience worse health problems than men in the United States; women have more acute symptoms, chronic conditions, and short and long-term disabilities arising from various health problems. In addition, gender and racial biases, as well as

33 Id. at 59. Working women and mothers, and more specifically, the working poor, suffer when they are ineligible for both employer-provided health insurance and Medicaid.

Type of employment influences health coverage as well. . .

The escalating cost of private health insurance contributes to the percentage of uninsured Americans. Employers may drop insurance coverage, exclude certain employees, or shift premium costs to employees who may not be able to pay for them. Part-time workers, self-employed workers, seasonal workers, and their families are more likely to be uninsured. Women are more likely than men to be in these part-time jobs, temporary jobs, and lower-paying jobs with lower rates of insurance coverage. . . In addition, many individuals in lower paying jobs may not qualify for Medicaid assistance.

Id.

34 Id.

35 Id. Often, women’s health insurance does not cover critical services such as cancer screening, family planning, or abortion. “There are many ways that insurers may exclude coverage for pregnancy-related services. . . Insurers may also have high deductibles or co-payments for some services, making them less accessible to women.” Id. For more on the shortfalls and inadequacies of Medicaid coverage, see infra notes 189-210 and accompanying text.

36 Gonzalez-Pardo, supra note 29, at 57. This is true, even when the calculation between the prevalence and degree of women’s health problems as compared with those of men excludes reproductive health problems. Gonzalez-Pardo further notes:
economic status, combine with age discrimination to affect older women disproportionately. \textsuperscript{37} With the graying of America, the older population has become overwhelmingly female. \textsuperscript{38} Generally, as women age, the

Certain health problems are more prevalent in women than in men. Heart disease, cancer, and strokes are the major killers of both men and women. Cardiovascular disease, however, accounts for a higher percentage of deaths among women than men at all stages of life. Yet the myth persists that heart disease is unique to men. NIH Director Bernadine Healy referred to this myth as the “Yentl Syndrome.” . . .

Each year, 6 million women in the United States, half of whom are teenagers, acquire a sexually transmitted disease (STD). . . .

Women are the fastest growing population with acquired immune deficiency syndrome (AIDS), despite public perception that AIDS is a man’s disease. . . . As a result of perinatal transmission, AIDS is the leading cause of death among Hispanic children and the second leading cause of death among African-American children. Furthermore, women with AIDS die more rapidly than men with AIDS because they are not adequately tested, monitored, diagnosed or treated. . . .

Domestic violence is a serious health threat to women. Battery is the single largest cause of injury to women. . . . Yet, many women fall through the cracks because of inadequate care or a lack of money.

\textit{Id.} at 58 (citations omitted).

\textsuperscript{37} \textit{See} Lois Grau, R.N., Ph.D., \textit{Illness-Engendered Poverty Among the Elderly, in Too Little, Too Late: Dealing with the Health Needs of Women in Poverty} 103 (Cesar Perales & Lauren S. Young eds., 1988). Currently 13 percent of the elderly live below the poverty line. . . .

Moreover, poverty among the elderly is not a random event — its most likely victims are women. . . . Women comprise 60 percent of the elderly but make up 72 percent of the aged poor. Older women as a whole have lower average incomes than older men.

\textit{Id.} at 105. Furthermore, notes Dr. Grau, race further exacerbates the poverty status of the elderly in this country.

Minority membership increases the risk of poverty in old age. Blacks and Hispanics represent the poorest groups of aged Americans. . . .

Those who are poor and old are also more likely to suffer from ill health. Women and minorities with low incomes and low educational levels have a higher incidence of disease than their economically more affluent counterparts.

\textit{Id.} at 106.

\textsuperscript{38} Because women outlive men by an average of 6.8 years, they are disproportionately represented among older age groups. Population data also show that the poverty rate is higher for women than for men,
inequities and disadvantages experienced by women in medical care also increase. In other words, while longer life expectancy sounds like good news for women, disease trends indicate that in actuality women will face greater health problems in their old age, such as osteoporosis and Alzheimer’s Disease.

Furthermore, poverty is a dispositive factor in a person’s prospects for health. Being poor usually means living without access to adequate nutrition, housing, heat, clean water, clothing, and sanitation, each of which has a negative impact on a person’s health. Furthermore, the poor are more likely to work in dangerous, unregulated industries which

especially for Hispanic and African-American families headed by women. The feminization of the poor and the elderly is a real phenomenon that impacts health care access and other related issues. Gonzalez-Pardo, supra note 29, at 57 (citations omitted). See also Carol J. Bess, Gender Bias in Health Care: A Life or Death Issue for Women with Coronary Heart Disease, 6 Hastings Women’s L.J. 41 (1995). Bess notes that while women are outliving men by over seven years, living longer does not mean living well, especially for older women. Older women are not only poorer than older men, but are less likely to have private health insurance or other assets and financial resources for health care than older men. Id. at 47.

Nancy S. Jecker, Ph.D., Age-Based Rationing and Women, 266 JAMA 3012 (1991). See also Grau, supra note 37, at 107-10 (“Of particular interest here is illness-engendered poverty, which occurs when health-care costs exceed an individual’s ability to pay. . . . As might be expected, single elderly women are particularly vulnerable.”). Id. at 107-08.

Gonzalez-Pardo, supra note 29, at 57. Furthermore, notes Gonzalez-Pardo, “Although women live longer than men, they spend their later years in greater discomfort and with more disability. Women who require care in nursing homes and personal care facilities already outnumber men three to one.” Id. at 58. See also Grau, supra note 37, at 106 (“Older women live longer than older men, and they are more likely than men to experience multiple, chronic, and increasingly debilitating diseases prior to death. Men are more likely to die of shorter-term fatal illnesses.”).

Sherwin, supra note 2, at 222. Sherwin also argues:

[T]he poor are more likely than others to work in industries that pose serious health risks and to do without adequate health insurance. And the poor suffer higher rates of mental illness and addiction than do other segments of the population. Financial barriers also often force the poor to let diseases reach an advanced state before they seek professional help; by the time these individuals do receive care, recovery may be compromised.

Id. (citations omitted).
pose health risks. Workers in marginal, high-risk workplace environments are subject to increased disease-inducing stress. These workers also are more likely not to have health insurance and not to seek medical care until diseases have reached an advanced state. They are also more likely to suffer from multiple health-compromising addictions than other segments of the population. In general then, poverty contributes to poor health; and viewed from a demographic perspective, the lower the economic status, the “poorer” one’s health is likely to be.

In addition, economic well-being has consistently had significant, adverse effects on women and their children. Research has found that living in poverty has contributed to more serious health problems among women, and has led to increased behavioral problems, higher high school dropout rates, lower job skills, more violence, and more homelessness for their families. Women’s health is further complicated by the fact that many women living in poverty are mothers, often single mothers, responsible for the rearing of the children, including meeting their daily health care needs. Since the coupling of AFDC and Medicaid entitlements in 1965, the level of poverty and the number of single mother households has increased, as has the disproportionate share of these households among African Americans and Hispanics. On the brink of

42 Id. at 222-23.
43 Id.
45 Julie B. Wilson, Ph.D., Women and Poverty: A Demographic Overview, in Too Little, Too Late: Dealing with the Health Needs of Women in Poverty 21 (Cesar A. Perales & Lauren S. Young eds., 1988). Dr. Wilson notes:

Women are more likely than men to be poor, more likely to remain poor once they enter poverty, and increasingly likely to be left with the responsibility for children without access to the resources of the other parent.

. . . The major determinant of women’s higher poverty rates appears to be household status. Women who head their own households are nearly five times as likely to be poor as men who head their own households.

Id. at 21, 23 (emphasis omitted).
46 Id. at 25. Writing in 1987, Dr. Wilson noted: “Over the past two-and-a-half decades the share of poor people living in female-headed households has doubled, rising from 18 to 35 percent.” Id. See supra notes 13, 25. Moreover, among African Americans and Latinos, women-headed households with children
the twenty-first century, single mothers and their children face especially difficult financial, social, and political obstacles as a result of the combined impact of the economic hurdles facing all female-headed households, along with the pressures of accessing health care.

In fact, the economic strangle-hold on female-headed households has pushed more families into poverty, both "graying" and also "feminizing" the poverty line. A significant result is that many families who several decades ago would have been categorized as working class are now the "working poor," and are in actuality "semi-welfare" families. Moreover, poor women of color have the sole responsibility for the basic primary and preventive health care needs for themselves and their families at an even higher proportion than in white families.

are even more likely to be living in poverty. Edelman, supra note 25, at 1706 (citing to 1991 U.S. Census Bureau figures, the author notes that the poverty rate of single parent, female-headed households for African Americans is 60.5%, for Latinos, 60.1%, and for whites, 39.6%).

Insurance coverage is another major barrier to accessing health care, particularly for poor women of color. See Ruth E. Zambrana, Ph.D., A Research Agenda on Issues Affecting Poor and Minority Women: A Model for Understanding Their Health Needs, in TOO LITTLE TOO LATE: DEALING WITH THE HEALTH NEEDS OF WOMEN IN POVERTY 137 (Cesar A. Perales & Lauren S. Young eds., 1988). In 1985, African-American and Puerto Rican women were twice as likely as whites not to have health insurance. Individuals with low family income were found to be less likely to have health insurance. See id. at 149. In addition, because health insurance coverage in the United States is directly linked to employment status, and due to the high unemployment rates of single mothers, women who are single mothers are far less likely to have health insurance for themselves and their families.

She [the low-income woman] must address these needs using a male-dominated, affluent health care delivery system oriented toward tertiary care. At each step of the way the woman is faced with complex responsibilities and encounters multiple barriers, while being responsible for maintaining wellness and preventing illness for her family under socioeconomic conditions that promote mental and physical illness. . . . She must learn how the health care system is organized, where to seek appropriate care, and how to linguistically and culturally translate their concerns into information that will be meaningful to health professionals. . . . At the same time, poor and racial/ethnic women are most likely to be heads of households, to have larger families, to bear the heaviest burden of caring for the health and well-being of all family members,
A woman's quality of life and her health is further compromised when she, or one or more of her children, is living with a chronically debilitating or terminal illness. Such a condition likely requires medical expertise, expensive drugs and treatments, and routine medical visits which put the illness at the center of the family's life. While accessing health care for one's children is a key aspect of parenting, and of mothering generally, for women living in poverty it is a cornerstone of life's daily duties, responsibilities, time expenditures, and overall planning.

Furthermore, the combined disadvantages of gender, class, and racial status clearly increase the likelihood that poor women of color will have to be in the poorest health themselves, to experience the greatest psychologically induced symptoms or illnesses, and to be at highest medical risk, particularly during pregnancy and childbirth.

\[\text{Id.}\]

50 See, e.g., id. at 149. Dr. Zambrana notes:
[a] study of single parents found that poor health, personal illness or the illness of a child or relative prevented a number of respondents from entering the labor market. . . . [She] also found that poor health, particularly after childbirth, was a major factor in accounting for the discontinuous work histories among Puerto Rican women in New York.

\[\text{Id.}\]

51 See generally Waysdorf, supra note 22 (noting the situation of women with AIDS, and their struggles to access health care for themselves and their children).

52 Poor women's daily lives are largely defined by waiting in interminable lines to access medical welfare systems, traveling to and from welfare-supported medical providers, seeking answers and attention, participation in and control over their own and their children's medical care, all within an essentially alienating, discouraging and paternalistic system. See Susan D. Bennett, "No Relief but upon the Terms of Coming into the House" — Controlled Spaces, Invisible Disentitlements, and Homelessness in an Urban Shelter System, 104 YALE L.J. 2157, 2159 (1995) (describing the process of alienation and discouragement that welfare recipients, predominately mothers, go through in order to access benefits and care).

The term discouragement refers specifically to those practices implemented by public assistance offices that make the process of applying for benefits so wearisome and unpleasant that the applicant simply gives up and goes away.

Discouragement practices can take many forms. . . .

Most of these practices are invented and implemented by front-line welfare workers.

\[\text{Id.}\]
serious health care needs, as well as the likelihood that those needs will not be adequately met, if they are met at all. Yet, relatively few studies have attempted to identify the special health needs of African-American and Latina women, nor to explore the history of the struggles by women of color to access health care. However, it is clear that the socio-economic dimensions of women's lives, including multiple work and family roles, low wages, unemployment, psychosocial factors, such as chronic life stress, and the pressures and direct impact of racism and misogyny, all are critical to an understanding of the health status of poor and minority women.

Indeed, women of color are at a basic disadvantage in terms of their health status, due to a variety of factors. In general, women of color

53 Zambrana, supra note 48, at 142-43. See also Sidney D. Watson, Health Care in the Inner City: Asking the Right Question, 71 N.C. L. REV. 1647 (1993). “Race, poverty and geographic inaccessibility to health care interact. As a result, an urban Black typically is sicker and in greater need of health care than a suburban white, but is less likely to be able to afford or obtain health care.” Id. at 1647-48.


56 See Zambrana, supra note 48, at 138.

57 Id. at 142. Dr. Zambrana points to three major groups of factors which define the poorer health status of women of color: (1) higher infant mortality rates, higher neonatal death rates, and higher post-neonatal death rates; (2) greater prevalence of some chronic diseases, such as diabetes, hypertension,
in the United States experience poor health. Women of color have AIDS, hypertension, stroke, heart disease, uterine cancer, breast cancer, respiratory disease, alcohol-related diseases and conditions, lupus, and pregnancy-related mortality at consistently higher rates than white women. In addition, given the generally disadvantaged status of women of color, they have been a low research priority as well. Only in the last several years have the government and the medical research establishment begun to focus on how much needs to be done concerning women’s health, and more particularly, the health of poor women and women of color.

Due to the particularly devastating and unprecedented effect which AIDS has had on poor women, and poor women of color in this country, the epidemic has contributed to sharpening the focus on these issues. In cardiovascular diseases, and certain types of cancer, such as cervical cancer; (3) a lower life expectancy of five to seven years than among their white counterparts, attributable to higher rates of chronic disease and less access to medical care systems, particularly for early detection and prevention of disease. Id.

Nearly a decade after she described these factors, the veracity of Dr. Zambrana’s analysis is reflected by the impact of the AIDS epidemic and its demographics. By the 1990s, African-American women were nearly nine times more likely than white women to die from HIV infection and AIDS. Waysdorf, supra note 22, at 161 (citing to NATIONAL COMMISSION ON AIDS, THE CHALLENGE OF HIV/AIDS IN COMMUNITIES OF COLOR 4 (1992)).

58 Scales-Trent, supra note 54, at 1362 (“AIDS, hypertension, cancer, alcoholism, respiratory disease, diabetes, lupus: This is a litany of deadly names and chilling numbers.”); see also SHERWIN, supra note 2, at 225-26.

59 Scales-Trent, supra note 54, at 1362. Writing in 1991, Scales-Trent noted the creation in 1990 by the National Institutes of Health (“NIH”), the Office of Research on Women’s Health. This office was created in response to pressure from the Congressional Caucus for Women’s Issues. Its task was to ensure that research on women’s health is conducted by the NIH and that there is appropriate participation by women in clinical trials. The creation of the NIH women’s research office was then codified under the National Institute of Health Revitalization Act of 1993. 42 U.S.C. § 287d (Supp. 1993). See Merton, supra note 29, at 312 (analyzing the historical developments which led to the creation of the NIH Office of Research on Women’s Health, with the mandate to promote research on women’s health). In addition, in July 1990, United States Representatives Patricia Schroeder (D-CO) and Olympia Snowe (R-ME), then the co-chairs of the Congressional Caucus for Women’s Issues, introduced the Women’s Health Equity Act of 1990, an omnibus package of federal legislative proposals which addressed a variety of women’s health research and delivery issues. See also Rutherford, supra note 55.
general, the government’s response to the AIDS epidemic represents the culmination of this nation’s attitudes and discriminations within the health care delivery system and society at large. Moreover, the distinct lack of recognition of; and response to; women with AIDS, at least until the 1990s, has been a direct result of the forces which have historically disadvantaged and harmed women in the provision of health care. Yet, since the mid to late 1980s, women and children, overwhelmingly from communities of color, have been the hardest hit by AIDS; and the fastest growing numbers of new cases are in these demographic groups.

As a result, the AIDS epidemic has placed the issues concerning health care for women, and more particularly, poor women of color, in sharper focus. Indeed, the AIDS epidemic has in many ways become a paradigm for the medicine of our times. The epidemic has progressively targeted the poorest of the poor, those with the fewest resources to

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60 In my practice as a legal aid attorney and clinical law professor, working with women with AIDS, I have seen firsthand the ravages this epidemic has wrought over half a decade on a population defined by racial, class, gender, and other socio-economic parameters. Along with others, I have borne witness to hundreds of women and their children in this epidemic, knowing that for each poor woman with AIDS that I have met, thousands others like her throughout this country are struggling through life’s challenges. They are each, in their own way, facing this crisis for which few systems — medical, legal, social, or economic — are in place to deal with an epidemic of this proportion and intensity.

I have seen terminally and chronically-ill women organizing and then continually reorganizing their lives: their time, efforts, support networks, and bare financial resources, attempting to seek out and to secure health care. Also, the struggle for women’s rights to health care has been a cross-generational one and one nothing short of a struggle for the survival of the family. Women with AIDS have been fighting together, across generations, for their lives and against this epidemic of unprecedented and immense proportions.

61 See Waysdorf, supra note 22, at 159-72.

62 For these reasons, in this Article, I approach the question of women and health care rights in a voice spirited by women, their caregivers, and their children in the AIDS epidemic. I have found this voice through my legal work with them over the course of the years in which the epidemic has affected women and children more severely than any other groups. With this voice, I ask why so few adequate health care systems and resources were in place to serve women and their children as they became the primary target of AIDS; and how has the AIDS epidemic been able to so swiftly devastate significant numbers of poor women, particularly poor women of color, after so many years of struggle for women’s rights to health care?
fight the illness and all of its ramifications. As a result, AIDS highlights the ways in which lack of medical care and low quality health conditions contribute to the poor getting poorer, the poor getting sicker, and entire communities becoming devastated. Moreover, this has been the case, in large part, because this nation’s health care system has been built on welfare paternalism towards the poor, and has been re-enforced by discriminations based on race, gender, and class, factors which have played a significant role in the AIDS epidemic as well.

As AIDS has increasingly targeted women and children, the epidemic has exacerbated already existing gaps and deficiencies in the welfare medicine system, poverty-induced chronic health problems, and other obstacles women face in accessing health care in the United States. In sum, federal governmental choices in health care law and policy over the last century have paved the way for the devastating impact which AIDS has had on all infected people, and on poor women of color with the virus in particular.

A review of the legal and social history of women’s health care, discussed in the following section, will provide the context for the story of Anita, a mother with AIDS, as told in Part III of this Article. Her story is in many ways typical of poor women’s struggle for health care in the 1990s. While Anita’s personal choices are clearly her own, the social context for her illness, her inability to access health care without becoming impoverished, and the impact of welfare medicine-medical apartheid policy on her and her children are all products of the failures of public health policy and law of the last century.

63 See Waysdorf, supra note 22, at 159-72.
64 See Watson, supra note 53, noting:

The problem is exacerbated by the dual epidemics of AIDS and tuberculosis. Both diseases disproportionately affect Blacks and Hispanics, particularly those in the inner city. . . A primary reason for the high rate of AIDS is that minority life in the inner city is identified with poverty, massive unemployment, and rampant intravenous drug use.

Id. at 1649 (citations omitted).

In addition, for the great majority of women with AIDS, women of color, and women who live in poverty, the only health care option which they have had access to is Medicaid. As welfare medicine, Medicaid has been only partially capable of dealing with the intensity and deadliness of AIDS, especially as it has affected women and the children who have contracted the disease perinatally. See generally Waysdorf, supra note 22.

65 See infra notes 212-35 and accompanying text.
II. HISTORY OF WOMEN’S HEALTH LAW AND POLICY

A. Law’s Legacy to Women’s Health

Several basic themes have been recurrent throughout the history of women’s health care law and public policy. Social historian Molly Ladd-Taylor has posed several theorems in her important study of women’s health and public policy.66 These foundational themes are useful to this Article’s discussion of the law’s relationship to women’s health and poverty. First, women have always played a key role in the creation of the American public health system, as activists, as health professionals, and as the primary consumers of health care.67 Yet, established schools of American history, political science, and sociology have consistently given short shrift to women’s role in the development of the public health system.

Second, most laws regarding women’s health have focused on women’s reproductive role as mothers or as potential mothers.68 As a result, a review of major federal legislation related to women’s health shows that virtually all of women’s health entitlements and rights have revolved around women’s roles as bearers and caregivers of children. For example, at different historical points, the federal government has promulgated laws which provide for limited entitlements for women’s prenatal care, for neonatal care and for the care of young children. Yet, virtually no federal legislation has ever been enacted which ad-

67 Id.; see also Gonzalez-Pardo, supra note 29, at 60.
68 Ladd-Taylor, Women’s Health, supra note 66, at 392 (“Because women bear children and have been chiefly responsible for raising them, policymakers have tended to see women as family members, rather than as individuals, and to equate women’s concerns with those of their children.”).
69 For example, see the discussion of the United States Children’s Bureau, see infra notes 80-159 and accompanying text; the Sheppard-Towner Act of 1921, see infra notes 80-159 and accompanying text; Title V of the Social Security Act of 1935, see infra notes 160-88 and accompanying text; the Medicaid program initiated in 1965, see infra notes 189-210 and accompanying text; and the enhancements to Medicaid in the 1980s aimed at assisting pregnant women and young children, see infra notes 189-210 and accompanying text.
dressed provision or protection of women’s health needs unrelated to woman as childbearer and childrearer.\textsuperscript{70}

Another recurrent theme in women’s health law and policy in the United States concerns the limited nature of the nation’s health insurance and medical welfare systems.\textsuperscript{71} As noted earlier, unlike other industrialized nations and even some developing nations, the United States has no national health care system nor universal health or maternity insurance, and no family health allowance, other than for the poorest of the non-working poor.\textsuperscript{72} Despite government awareness of the relationship between poverty and illness, it has rarely provided direct aid to the needy without severe constraints, social controls, obligations, and conditions.\textsuperscript{73} Moreover, most of the aid that the federal government has provided has been widely differentiated at the state level, and has been oriented toward education rather than direct material assistance.

In other words, the federal government has for the most part not viewed health care for women, including reproductive health and prenatal and neonatal health of children, as an unencumbered public right or universal entitlement for all women as a group. Rather, government policy has viewed the question of women’s health needs, at best, as a matter of family welfare for the very poor. A final and consistent theme in women’s health history has been the persistent opposition of organized medicine, most notably the American Medical Association, to publicly

\textsuperscript{70} At the same time, federal rules and regulations have traditionally excluded women from participating in potentially beneficial clinical research and drug trials precisely because of women’s reproductive role. See generally Merton, supra note 29.

\textsuperscript{71} Ladd-Taylor, Women’s Health, supra note 66, at 392.

\textsuperscript{72} See supra notes 7-9; see also GEORGE J. ANNAS ET AL., AMERICAN HEALTH LAW 44 (1990). Until recently, South Africa and the United States were the only industrialized countries that did not have a national system to finance and provide for a level of health care for all citizens. Since the destruction of South Africa’s white apartheid system, the new government is committed to meeting the health care needs of all its people, leaving the United States as the only industrialized nation without a system of universal health care.

\textsuperscript{73} Ladd-Taylor, Women’s Health, supra note 66, at 392. Furthermore, Ladd-Taylor notes: “The American ‘semiwelfare’ state is constrained by the ideologies of self-help and states’ rights, by racial and ethnic diversity, and by the traditional distrust of a strong federal government.” Id.
funded health-entitlement programs. Together, these themes provide the contextual background and the normative framework for understanding the historical development of women's legal rights, access and entitlement to health care in this country.

Before the beginning of this century, women possessed no legal protections, rights nor entitlement to health care. The twentieth century has been marked by at least four great upheavals in social welfare, health law, and public policy concerning women and children. At various points in this cycle of developments federal legislation was drafted and passed, some of which was later repealed, and which specifically addressed the rights of mothers and their children to health care.

The first developments occurred in the century's early decades in response to industrialization. Historically important strides in meeting women's health needs, albeit primarily maternal health, were largely a result of women's winning the right to vote. The success of the Woman Suffrage Movement in 1920 brought into existence the women's "body politic" as a contender and a force in the development of public policy affecting women's lives. The second wave was triggered by the Great Depression, a period which saw the creation of New Deal governmental

Id. at 393.

Indeed, the American Medical Association's hostility to "state medicine" is arguably the principal reason for the limited nature of the U.S. public health system. . . . Dominated by male specialists engaged in private practice, the AMA viewed preventive health services for women and children as a threat to doctors' incomes and control over the health-care system. Today, women's health policy continues to show the influence of the medical lobby. Most public health services reinforce the authority of physicians, provide treatment based on high technology rather than basic preventive care, and are available only to those who cannot afford private medical care.

Id. (citations omitted). See also PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 266-89 (1982) (providing an historical analysis of the AMA's relationship to government health insurance programs).

In actuality, a review of federal legislation which addresses women's health shows that these laws primarily were aimed at the health needs of infants and children, and then by connection, the maternal health care of women as reproducers, childrearers, and caregivers. Again, this reality reinforces the theme, discussed earlier in this Section, which ties federal health policy for women to women's fertility, and role as mothers.
social programs, including job and other national rehabilitative programs, social security,76 and AFDC.78

The third health and social welfare transformative period occurred during the Kennedy-Johnson Administrations, with the emergence of Medicare and Medicaid in 1965. These two critically important public health programs represent the temper of the Great Society, the War on Poverty, and the massive social programs these historic federal policy campaigns produced.79

Finally, the late 1960s and early 1970s saw the rise of social movements for African Americans’ civil rights and for women’s empowerment. These movements, which sought to reallocate power relationships, also fueled the rise of community and “people’s” health centers. Community based health care became a core component of the organized women’s health and abortion rights movement. Yet throughout, as a result of class and race biases within the ranks of the predominately white and middle class health-care reform movement, as well as within the medical profession, the needs of poor women and women of color received minimal attention. Moreover, the health entitlements and other social services which poor women and women of color did receive, for example under the AFDC and Medicaid programs, served to further marginalize them. On the other hand, these programs also served to provide them with a critically important entitlement “safety-net.”

Today, the nation has entered a new stage regarding federally mandated entitlements, with the Republic Congressional majority challenging the health and cash welfare guarantees which, despite their shortcomings, have provided a minimal level of care to millions of poor people. Together then,


78 Aid to Families with Dependent Children (“AFDC”), 42 U.S.C. §§ 601-617 (1988) (originally entitled Aid to Dependent Children (“ADC”)).

79 These social welfare programs led to the creation in 1972 of the SSI welfare cash assistance entitlement program for the impoverished elderly and disabled. See generally Gay Gellhorn, Disability and Welfare Reform: Keep the Supplemental Security Income Program but Reengineer the Disability Determination Process, 23 Fordham Urb. L.J. 961 (1995), for a detailed and informative
these historical developments and trends reflect the dynamics among women's legal empowerment and suffrage, women's health, and women's impoverishment. While the following sections in no way are a comprehensive history of women's health law and public policy, they do focus attention on the key legal developments in women's health, as well as the historical tension between the universal health care, and the welfare medicine-medical apartheid models.

B. Women's Suffrage and the Sheppard-Towner Act: Pioneer Legislation for Women's Health

Before the first decade of the twentieth century, the law in this country did not provide in any way for the health care or general welfare of either women or children, despite their special needs. Relief for the poor and needy in America was based on the Elizabethan poor laws whose premise was that pauperism was a form of social disease to be deplored.80 This view began to shift when the welfare of children, particularly poor children, became a core issue for the social reformers of the Progressive Era during the first two decades of the twentieth century. Industrialization, urbanization, and immigration produced higher rates of infectious diseases, infant mortality, and death in young children.81 Children worked in factories, lived in inadequate housing, and suffered from malnutrition.82 To Progressive Era reformers, these needy children, the impoverished, the poor disabled, and the blind could not be blamed for their situation. Increasingly these groups were viewed as the "deserving poor,"83 for whom government had a responsibility to provide.

80 STEVENS & STEVENS, supra note 6, at 5.
82 Id.
83 STEVENS & STEVENS, supra note 6, at 6.

Nevertheless, born of the recognition that there were identifiable groups of persons who could not be labeled social deviates or paupers by choice, a number of special assistance programs slowly grew up during the early twentieth century, geared to provide help to "deserving" individuals. Impoverished old people, underfed children, and the unemployable blind could scarcely be blamed for their condition nor envied for being the recipient of relief.

These early categorical programs are important because the divisions were carried over into the Social Security Act of 1935, to become — with the addition of a further category for the totally and permanently disabled in 1950 — the framework on which Medicaid was
In general, the period was defined by an awakening in the United States to the health care needs and general plight of its children. At the national level, the first White House conference on children was convened in 1908, followed by the formation of the National Child Labor Committee in 1909. In 1912, the Child Saving Movement, a product of the Progressive Era, led to the creation of the Children’s Bureau. Established within the United States Labor Department, the Children’s Bureau was first headed by reformer Julia C. Lathrop, former director of Chicago’s Hull House and the first woman to head a federal government agency.

A focus of the federal Children’s Bureau was the development of “mothers’ pension” laws designed to keep children on relief and in their own families rather than to send them to institutions. Because the Bureau found a definite correlation between poverty and infant mortality, it also focused many of its efforts on lowering the mortality rate. The

Id. at 6-7.
84 Strain, supra note 3.
85 Sardell, supra note 81, at 274.
87 Ladd-Taylor, Women’s Health, supra note 66, at 399. See STEVENS & STEVENS, supra note 6, at 6 (providing an insightful history of the Children’s Bureau and this country’s earliest welfare institutions and programs). The Children’s Bureau was the first federal office concerned with a specific age group and it became the model for the later development of welfare and social security programs. The bureau was also the basis for the Federal Security Administration which ultimately became the Department of Health, Education and Welfare. See also Barbara B. Woodhouse, “Who Owns the Child?: Meyer and Pierce and the Child as Property, 33 WM. & MARY L. REV. 995 (1992) (discussing the patriarchal ownership model of the family and the emerging rights of children).
88 STEVENS & STEVENS, supra note 6, at 6. These statewide pension laws formed the basis of this Child Saving Movement and were geared to the needs of widows and their children rather than the needs of deserted wives or unmarried mothers and their children.
89 J. Stanley Lemons, The Sheppard-Towner Act: Progressivism in the 1920s, 55 J. AM. HIST. 776 (1968). In addition, social historian Molly Ladd-Taylor has suggested that the early twentieth century view that the health needs of women and children were identical marked the period’s legislation and programs to combat infant mortality and prohibit child labor. As noted earlier, this view of women’s health needs has continued to underlie contemporary health
Children's Bureau was the first federal agency to be headed and staffed primarily by women, eight years before women won the right to vote. It was the first recognized, organized, and officially authorized federal agency concerned with women's and children's distinct legal entitlements. In effect, the Children's Bureau served as the "women's branch" of the federal government during the first two decades of this century and later served that role in conjunction with the Women's Bureau, created in 1918.

The movement propelling the Children's Bureau and its enabling legislation cut across economic groups and geographic regions. It...
included women physicians and nurses, farm mothers, settlement residents, women volunteers, and social workers. Unique to social reform movements of that period, especially those authorized and funded by the federal government, the Children's Bureau movement involved reformers working hand-in-hand with the recipients or beneficiaries of the reform measures. Together, they established infant and prenatal clinics, distributed milk to the needy, and ran educational programs for mothers through state-run agencies.

By 1923, forty-eight states had child hygiene bureaus, all but three run by women. These state efforts and agencies worked under the direction of and in coordination with the federal Children's Bureau. The Children's Bureau did not have appropriated funds to distribute direct federal financial aid to the needy. Instead, the Bureau, on an initial appropriation of only $25,640, distributed child rearing advice and led national campaigns, including programs to register births, to pasteurize milk, and to investigate and stem the causes of infant mortality.

The force and momentum of these women-led, women-run legal and social reform efforts united with the momentum of the Woman Suffrage Movement to create the historically significant Sheppard-Towner Act, enacted in 1921. The Sheppard-Towner Act specifically addressed the maternal health needs of women, and the health of children, across all economic and social lines. Indeed, the Act was not only the high point

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93 Id. at 399.
94 Id. at 400; see also U.S. DEP’T OF LABOR, PUB. No. 4, PRENATAL CARE (1913).
95 Sheppard-Towner Maternity & Infancy Act, ch. 135, 42 Stat. 224 (1921), repealed by Act of Jan. 22, 1927, ch. 53, § 2, 4 Stat. 1024, 1024. Sponsored by Julia Lathrop, chief of the Children's Bureau, the bill was originally introduced into Congress in 1918 by Jeannette Rankin, the first woman to serve in Congress. Little progress was made toward its passage until the full enfranchisement of women was won in 1920, when the bill was re-introduced by Democratic Senator Morris Sheppard of Texas and Republican Congressman Horace Towner of Iowa. See Lemons, supra note 89, at 777.

The National League of Women Voters and the National Consumer League, direct offsprings of the Woman Suffrage Movement, lobbied the national political parties to approve the maternity bill in their 1920 platforms. The Democratic, Socialist, Prohibition, and farmer-labor parties all endorsed the bill; the Republican platform ignored it. The bill passed Congress in 1921 and was signed into law by President Harding on November 23, 1921.

96 Social historians Molly Ladd-Taylor, J. Stanley Lemons, and Linda Gordon have provided broad studies of the Sheppard-Towner Act (and the
of the Children's Bureau's activities, but was also the culmination of the entire women's social reform, welfare, and health movement of the first part of this century, which was led by the social feminists of that time.\footnote{7}

While not widely known, studied, or recognized, the Sheppard-Towner Act\footnote{8} should take its place in history as the first concrete and
material product of the newly created women’s national electorate — a
direct result of women’s winning the right to vote in 1920.99 The Act
is also historically significant for being the first piece of federal
legislation addressing the health needs of women and children. The
Sheppard-Towner Act authorized appropriations to those states which
accepted and agreed to comply with its provisions, for the purpose of
implementing state-run, federally-monitored, and federally-coordinated
programs to reduce maternal and infant mortality, and to protect the
health of mothers and infants.100 Responsibility for administration of the

see also CHILDREN AND YOUTH IN AMERICA (Robert H. Bremner et al. eds., 
1974) (three volume history); Sardell, supra note 81. More recently, and of
particular note, historians Molly Ladd-Taylor and Linda Gordon have written
extensively about Sheppard-Towner and the women social activists who created
the law and its programs.

99 See Sardell, supra note 81, at 281. Molly Ladd-Taylor also analyzes the
legislation as the direct result of both the women-led Child Saving movement of
the Progressive Era, as well as the Woman Suffrage Movement.

Lathrop designed the bill, which was sponsored by Texas Senator
Morris Sheppard and Iowa Congressman Horace Towner, and endorsed
by every major women’s organization. The first “women’s” bill to pass
after suffrage and the first federal social welfare measure, Sheppard-
Towner passed Congress by a wide margin and was signed into law by
President Harding on November 23, 1921.

Ladd-Taylor, Women’s Health, supra note 66, at 400-01.

The historian J. Stanley Lemons, who has also focused much of his work
concerning the Progressive Era and women’s rights on the Sheppard-Towner Act,
see Lemons, supra note 89, called the Act “the first major dividend of the full
enfranchisement of women.” Id. at 776. He wrote that “[w]omen’s organizations
helped to force the enactment of the bill and later fought to preserve it from
repeal.” Id.; see also GORDON, supra note 1, at 93-94 (noting that “[a]ttacks on
the Children’s Bureau escalated because it won a significant victory — the first
federal welfare program — the Sheppard-Towner Act of 1921. Fearing the power
of newly enfranchised white women, Congress authorized a program of matching
funds to the states for programs in maternal and child hygiene.”).

100 Sheppard-Towner Maternity & Infancy Act, ch. 135, 42 Stat. 224 (1921),

An Act [f]or the promotion of the welfare and hygiene of maternity and
infancy, and for other purposes.

Be it enacted by the Senate and House of Representatives of the
United States of America in Congress assembled, That there is hereby
authorized to be appropriated annually, out of any money in the
Treasury not otherwise appropriated, the sums specified . . . to be paid
to the several States for the purpose of cooperating with them in
law was placed with the Children's Bureau, within the United States Department of Labor, in cooperation with state agencies active since the establishment of the Children's Bureau in 1912.101

The Sheppard-Towner Act authorized the appropriation of federal dollars, distributed as matching funds to the states, to be used for information and instruction on nutrition and hygiene, for prenatal and child-health, and for "well-baby" conferences. Funds under the law also supported visiting nurses for pregnant women and new mothers,102 as well as midwife training programs.103 Sheppard-Towner funds were used to establish some 3000 clinics where women physicians and public

promoting the welfare and hygiene of maternity and infancy as hereinafter provided.

Id. (emphasis omitted). For the first fiscal year $480,000 was appropriated to be "equally apportioned among the several States, and for each subsequent year, for the period of five years, $240,000, to be equally apportioned among the several States . . . ." Id. § 2, with an additional $1,000,000 appropriated for each fiscal year from the federal Treasury. Of the $1,000,000 additional appropriations, a minimum of $5,000 was to go to each state, as long as each State provided matching funds from its own Treasury. Id.

101 Id. § 3.

The Children's Bureau of the Department of Labor shall be charged with the administration of this Act, except as herein otherwise provided, and the Chief of the Children's Bureau shall be the executive officer. It shall be the duty of the Children's Bureau to make or cause to be made such studies, investigations, and reports as will promote the efficient administration of this Act.

Id.

102 Lemons, supra note 89, at 782. "It provided for instruction in hygiene of maternity and infancy through public health nurses, visiting nurses, consultation centers, child care conferences, and literature distribution." Id.

103 See Molly Ladd-Taylor, "Grannies" and "Spinsters": Midwife Education Under the Sheppard-Towner Act, 22 J. SOC. HIST. 255 (1988) [hereinafter Ladd-Taylor, "Grannies" and "Spinsters"] . In this important piece, Ladd-Taylor provides a critical analysis of Sheppard-Towner's programs to regulate midwives, primarily African-American midwives in the South. According to Ladd-Taylor, the Sheppard-Towner nurses and health educators served a culturally interventionist role, despite their "good" intentions to improve women's health. Ironically, the Sheppard-Towner midwife training programs contributed to the medicalization of childbirth and the decline of midwifery. Id. at 270. For more on the relationship of the predominately white women's health reformers who administered the Sheppard-Towner Act and their ambivalent relationship to black women, both at the grassroots and the leadership levels, see supra notes 97-98.
health nurses examined children and taught mothers about infant care, nutrition, and illnesses.\textsuperscript{104}

The emphasis was on mothers’ education, preventive education and care, such as immunization, as well as counseling and community outreach. The women health activists who carried out the Sheppard-Towner programs avoided competition with general practitioners of private medicine by not directly providing treatment for illness.\textsuperscript{105} Provision of direct financial aid and medical care to the needy was explicitly forbidden under the law, a result of a political compromise in the legislative drafting process.\textsuperscript{106} Furthermore, while the visiting nurses

\textsuperscript{104} Sardell, \textit{supra} note 81, at 275. In reviewing the seven year effort from 1921 to 1928 of the Sheppard-Towner programs, the Children’s Bureau reported that it conducted 183,252 health conferences, established 2978 centers of prenatal care, visiting nurses under the program made 3,131,996 home visits, and 22,020,489 pieces of preventive health education literature had been distributed. In the final four years of the Sheppard-Towner Act, more than 4,000,000 infants and 700,000,000 expectant mothers had been reached. Forty-five states had actively participated in the Sheppard-Towner federal-state partnership. \textit{Id.}

By 1927, the infant death rate as well as the maternal death rate had been dramatically reduced, despite the fact that the general death rate of all people in the United States rose slightly for the same period (1921-1927). However, much more needed to be done; in many ways, the cumulative effect and longer-term impact of the Sheppard-Towner programs were just seriously being felt at the time of the law’s repeal. \textit{Id.}

For more on the concrete accomplishments of the programs under the Sheppard-Towner Act, see United States Children’s Bureau, \textit{Eighteenth Annual Report, 1930} 1-3 (1930), \textit{reprinted in} 2 CHILDREN AND YOUTH IN AMERICA, \textit{supra} note 98, at 1008-10. The areas of evaluation included (1) expansion of the birth and death registration areas; (2) creation of state child-hygiene bureaus or divisions; (3) establishment of permanent health centers for women and children, and increases in staffing of the clinics by nurses and doctors; (4) increases in state appropriations under the Act.

\textsuperscript{105} Sardell, \textit{supra} note 81, at 275. The fact that the Sheppard-Towner programs did not provide for direct provision of medical assistance was a result of a Congressional compromise during the passage of the bill. This political compromise was made in response to the vehement and persistent opposition of the American Medical Association to what it viewed as “socialist medicine” under the proposed law. \textit{See infra} notes 114-16 on AMA opposition to Sheppard-Towner; \textit{see also} Gordon, \textit{supra} note 1, at 94 (“But the AMA did not capitulate entirely, and the Children’s Bureau was forced to give up direct provision of medical care under the program.”).

\textsuperscript{106} Sheppard-Towner Maternity & Infancy Act, ch. 135, § 12, 42 Stat. 224
authorized and funded under the law traveled widely, had significant influence, and provided able assistance, their role was also somewhat constrained. The law prohibited them, as government agents, from entering homes to investigate or to seize children.\(^\text{107}\)

In addition, Sheppard-Towner's federal-state partnership format established the precedent for contemporary maternal, child health, and welfare programs, including the Medicaid and AFDC programs. This format incorporates the "block-grant" or federal grants-in-aid arrangement, popular in federal legislation today, and which authorizes the matching of federal and state appropriated funding for specific services and programs.\(^\text{108}\)

In hindsight, Sheppard-Towner's programmatic scope and level of federal appropriations were relatively very small under modern standards.

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No portion of any moneys apportioned under this Act for the benefit of the States shall be applied, directly or indirectly, to the purchase . . . of any building . . . nor shall any such moneys or moneys required to be appropriated by any State for the purposes and in accordance with the provisions of this Act be used for the payment of any maternity or infancy pension, stipend, or gratuity.

\textit{Id.} Molly Ladd-Taylor has noted the impact of the law's prohibition on direct financial or medical assistance.

Although the ultimate goal of the bill's female supporters was publicly-funded medical and nursing care for every woman, the Sheppard-Towner Act was a political compromise which forbade outright financial aid and medical care, and required each state to pass special legislation and provide a plan for implementation before it could receive federal funds.

Ladd-Taylor, "\textit{Grannies}" and "\textit{Spinsters}", \textit{supra} note 103, at 258.

\(^\text{108}\) Gonzalez-Pardo, \textit{supra} note 29, at 60; \textit{see also infra} note 122.
For example, the legislation was significantly limited by the prohibition on provision of direct financial aid or medical treatment.\(^9\) Yet, Sheppard-Towner is historically significant in normative terms for its core elements of equality, universal coverage, education, and preventive care, as well as for its underlying policy that children's health is a foundation of the nation's future. In addition, the law's programs were for the most part successful in lowering infant and mother's childbirth mortality, and in improving the health and welfare of children and their mothers.\(^10\) As important perhaps, the law finds its place in history for the vehement political opposition which it engendered.

From the beginning, the Act was actively and intensely opposed by the growing and consolidating medical profession, led by the American Medical Association ("AMA").\(^11\) The Catholic Church, the Woman Patriot organization, and other conservative forces also vigorously opposed the federal program.\(^12\) While these forces failed to prevent the bill's passage in 1921, they were ultimately successful in their campaign against the legislation when it was repealed six years later.\(^13\)

The campaign to defeat Sheppard-Towner and the work of the Children's Bureau was philosophically intensive, with attacks ranging from claims that the law's programs were "socialist medicine," and a part

\(^9\) See supra note 106 on the prohibition of direct assistance under the law. Furthermore, under the terms of the act, from its adoption in November 1921 to its termination in June 1929, approximately seven million dollars were provided by the federal government for grants-in-aid to the states for the promotion of maternal and infant health and welfare. See also 2 CHILDREN AND YOUTH IN AMERICA, supra note 98, at 1003.

\(^10\) See supra notes 103-04 for the accomplishments of Sheppard-Towner programs. While under Sheppard-Towner, the states had the option of enacting enabling legislation which allowed them to participate in the federal program. By 1927 forty-five of the then forty-eight states, and the territory of Hawaii, had accepted the provisions of the Sheppard-Towner Act. Only Massachusetts, Connecticut, and Illinois refused to join the program.

\(^11\) Sardell, supra note 81, at 275.

\(^12\) Id. See also CHILDREN AND YOUTH IN AMERICA, supra note 98. Several reactionary women's organizations, including the National Society of the Daughters of the American Revolution and the Woman Patriot Publishing Company actively campaigned against Sheppard-Towner. Their activities included intensive lobbying in Congress during both the period of initial passage of the bill in 1921, and also the years after 1925 with efforts to repeal the law. 68 Cong. Rec. 1280-81 (1927).

\(^13\) Lemons, supra note 89, at 779.
of an "imported socialistic scheme,"\textsuperscript{114} to a "bolshevik conspiracy."\textsuperscript{115}

\textsuperscript{114} See \textit{id.} at 780-81 in which the historian notes, "The \textit{Journal of the American Medical Association} launched its campaign against Sheppard-Towner on February 5, 1921, and it continued to oppose the act until it was repealed. The 1922 AMA house of delegates condemned Sheppard-Towner as an 'imported socialistic scheme.'" \textit{Id.} at 781 (citation omitted). The following is the actual resolution presented at the AMA's seventy-third annual meeting, held May 22-26, 1922 in St. Louis:

\begin{quote}
WHEREAS, The Sheppard-Towner law is a product of political expediency and is not in the interest of the public welfare, and
WHEREAS, The Sheppard-Towner law is an imported socialistic scheme unsuited to our form of government, and
WHEREAS, The Sheppard-Towner law unjustly and inequitably taxes the people of some of the states for the benefit of the people of other states for purposes which are lawful charges only upon the people of the said other states, and
WHEREAS, The Sheppard-Towner law does not become operative in the various states until the states themselves have passed enabling legislation, therefore be it
RESOLVED, That the American Medical Association disapprove the Sheppard-Towner law as a type of undesirable legislation which should be discouraged.
\end{quote}

\textit{Proceedings of the St. Louis Session}, 78 JAMA 1613, 1709 (1922).

\textsuperscript{115} 67 CONG. REC. 12,918-52 (1926) (quoting a testimonial letter from the Woman Patriot presented to the Senate during the debates to reauthorize, extend and renew the Sheppard-Towner Act). A classic example of "red-baiting," the Woman Patriot attacked the Sheppard-Towner Act and the Children's Bureau as a "Bolshevik conspiracy," and claimed that Florence Kelley, a leader of the Childrens Bureau movement, was a "Marxian socialist . . . pupil and translator of Friederich Engels (coauthor with Karl Marx of the \textit{Communist Manifesto}) and Engels's chosen lieutenant for introducing communism into 'the flesh and blood of Americans' as he instructed her." \textit{Id.} at 12,919. Furthermore, as reported in the Congressional Record of July 3, 1926, the Woman Patriot claimed:

1. The Congress and public tricked: These bills [to renew Sheppard-Towner] are dishonestly presented to hide their true scope and purpose. They are counterfeit legislation, organized schemes to trick the Congress and the country by pretended humanitarian, beneficent-appearing bills, masked as "welfare" and "women's" measures, and intrusted to certain women's organizations to engineer, the better to allay public suspicion, but are none the less straight imported communism. The Bolshevik wolf rarely gets to the doors of Congress except as a little Red Riding-hood. . . .
Strategies to defeat the law were multi-leveled, coordinated, and far-reaching, with campaigns carried out in the halls of Congress, the ranks of the medical profession, and in grassroots and reactionary women's patriotic groups.\textsuperscript{116}

The battle to defeat Sheppard-Towner was carried out in the federal courts as well. In \textit{Frothingham v. Mellon},\textsuperscript{117} the Supreme Court heard a challenge to the law brought in 1922 by one of the Woman Patriot organization's leaders, Mrs. Randolph Frothingham of Boston, Massachusetts.\textsuperscript{118} The suit challenged the federal government's use of federal and state taxes for Sheppard-Towner's programmatic appropriations.\textsuperscript{119}

3. Revolutionary conspiracy: The Federal maternity bill [Sheppard-Towner] inextricably interlocks with the child labor amendment and the Federal Children's Bureau. They constitute, with the Federal Education Department bill, a unified agency and program of revolution by legislation. They are as deliberate a conspiracy to destroy this Republic as any plot ever hatched to overthrow a government by force and violence.

\textit{Id.} \textsuperscript{116} Lemons, \textit{supra} note 89, at 779. The historian notes:

[D]espite the modest character of the Sheppard-Towner bill, the measure was assailed as a threat to the very institutions of the nation. Because suffragists favored the bill, anti-suffragists opposed it. Extreme conservatives condemned the plan as a part of a Bolshevist conspiracy against America. States rights advocates alleged that it threatened the integrity of the states. Finally, the bill was caught in the cross fire between the American Medical Association and a collection of quack medical cultists.

The principal advocates of the theory that the Sheppard-Towner bill was a communist invention were the National Association Opposed to Woman Suffrage and its legacy, the Woman Patriots. For years, they had maintained that feminism and woman suffrage were the same as socialism and communism.\ldots\textsuperscript{118} The Woman's Municipal League of Boston, the American Constitutional League, the Constitutional Liberty League of Massachusetts, and the Massachusetts Public Interests League agreed.

\textit{Id.} at 779-80 (citations omitted).

\textsuperscript{117} 262 U.S. 447 (1923).

\textsuperscript{118} See 67 CONG. REC. 12,918, 12,918-19 (1926) (documenting Senate hearings on extension and renewal of the Sheppard Towner Act).

\textsuperscript{119} As reported in the Court's opinion, plaintiff's brief noted on behalf of Mrs. Frothingham:

The appellant maintains that the so-called Sheppard-Towner Act is null and void because it is in violation of the Constitution of the United
Frothingham’s claim was joined with the claims of several other parties, including the state of Massachusetts, which challenged the federal grants-in-aid format of the Sheppard-Towner Act. The United States Supreme Court dismissed the plaintiff-appellants’ claims against Sheppard-Towner for lack of jurisdiction. An effect of the Court’s holding was the establishment of a strong precedent for the use of federal grants to the states, as modeled by the Sheppard-Towner Act.

It is also historically significant that in arguing that the Court should uphold Sheppard-Towner in *Frothingham*, the United States set forth, perhaps for the first time, public policy that affirmed the federal government’s interest in women’s and children’s health and welfare. Arguing on behalf of the Secretary of the Treasury, the Children’s

120 The state of Massachusetts claimed that the law was unconstitutional because the state’s rights and powers as a sovereignty and the rights of its citizens were invaded by the law’s authorization of expenditures. *See id.* at 459-70.

121 The Court did not reach the merits of the Act itself, in essence dismissing the constitutional challenge on the basis that there existed no justiciable controversy, finding that the plaintiffs lacked standing and that therefore the federal grants-in-aid format of Sheppard-Towner was in effect constitutionally valid on the challenged grounds. *Id.* at 480. Justice Sutherland, writing for the majority held: “We have reached the conclusion that the cases must be disposed of for want of jurisdiction without considering the merits of the constitutional questions.” *Id.*

122 *Id.* at 447. *See* Cohen, *supra* note 77, at 954-55. In discussing the legal impact of *Frothingham v. Mellon*, Cohen noted: “Not only were [federal grants to the states] deemed a sound political and administrative way to build and support state agencies, but such grants apparently would pass constitutional muster.” In actuality, a legacy of the Sheppard-Towner Act is that the law did become a policy model for future grant-in-aid federal laws, for example, the AFDC and Medicaid programs, which were based on the federal-state appropriations partnership model. *See also* Ryan White CARE Act, 42 U.S.C. § 300ee-7 to § 300ee-12 (1991) (distributing federal appropriations through state AIDS agencies for the care and assistance of people living with AIDS in the designated states; states then match the federal appropriations for distributions to service providers).
Bureau, the Department of Labor, the United States Commissioner of Education, and the United States Public Health Service's Surgeon General, the United States clearly advocated federal support and funding for women's and children's health needs. Moreover, in *Frothingham*, the United States argued that health care should be treated like public education by according it the same level of public and governmental support and recognition. The United States argued that this was necessary due to the compelling interest which the government has in supporting and promoting the health and longevity of its citizens. In its brief for the Court, the United States argued that the health of its people should be a manifest concern of government, and that, in essence, health care was a question of a public right.

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123 *Frothingham*, 262 U.S. at 458-59. United States Solicitor General Beck, with Robert Reeder, Special Assistant to the United States Attorney General, on the brief for Mellon et al., argued:

Ours is a dual form of government and thus involves a dual citizenship. Therefore both the Nation and the States have an equal interest in providing that the citizen shall be well born as well as well educated. If the new-born child is a citizen of the State in which he is born, he is equally a citizen of the United States, in which he is also born. Both governmental entities have a direct and practical interest in the new citizen. . . . Both the Nation and the States, therefore, have a direct and practical interest that the citizen shall not only have a "mens sana" but that it shall also be "in corpore sano," and the latter consideration of a healthy, vigorous life not infrequently depends upon the conditions of birth. Moreover, the mothers of America give to both State and Nation their future citizens, and it seems a strange doctrine to contend that while the State has a legitimate interest in the preservation of women from the perils of maternity, the United States has not an equal interest.

*Id.*

124 *Frothingham*, 262 U.S. at 459.

125 *Id.* In the *Frothingham* argument for the United States, the Attorney General's office and the Solicitor General further contended:

I have already quoted from the wise words of Washington in his final message to Congress, in recommending the establishment of a national university for the wise education of the American youth. He recognized the direct interest that the United States has in the intellectual welfare of its citizens; and, if it has such interest, why has it not an equal interest in the physical welfare of its future citizens?

*Id.*
Once the constitutional court challenge was dismissed, the Sheppard-Towner Act's administrators, organizers, and supporters remained embattled, particularly with the American Medical Association, but also, with the United States Public Health Service. The AMA perceived the Sheppard-Towner Act to be an unacceptable threat to the medical profession's then consolidating system of privatized medicine. Additionally, the AMA and its state affiliate medical organizations viewed Sheppard-Towner to be the politically expedient result of Congress' fear of the new women's electorate and, more specifically, of an opportunistic response by Congress to Sheppard-Towner's feminist administrators and supporters. These perceptions became the basis for

126 The United States Public Health Service, more acceptable to the AMA than the Children's Bureau, was in conflict with the Children's Bureau, and actively vied with the Bureau for control of the Sheppard-Towner appropriations. See Gordon, supra note 1, at 95 (concerning opposition of the United States Public Health Service ("PHS") to Sheppard-Towner). Of interest here, Gordon has described the PHS's conflict with the Children's Bureau as both a territorial and a philosophical struggle.

More ominous for the Children's Bureau, however, was the attempt of the PHS to swallow some or all of its work. Sheppard-Towner — a step toward publicly funded medical care — had antagonized not only the conservative medical leadership represented by the AMA, but even the more progressive PHS. . . . But the PHS offensive against the Children's Bureau had layered motives: It represented both a fundamental conflict of political values, and a jurisdictional power struggle imbued with hostility to the women's reform community. The PHS wanted to control all health-related activities and to cut down the Children's Bureau. The AMA and the PHS labeled the Children's Bureau women as a bunch of radicals, even Reds; as unnatural, nosy women; and as simultaneously dangerous and incompetent.

These attacks crested at the 1930 White House Conference on Child Health and Protection.

Id. at 200.

127 Starr, supra note 74, at 260-61; Ladd-Taylor, Women's Health, supra note 66, at 393; Lemons, supra note 89, at 779; Sardell, supra note 81, at 275.

128 See Proceedings of the St. Louis Session, supra note 114, at 1709 ("WHEREAS, The Sheppard-Towner law is a product of political expediency and is not in the interest of the public welfare.").

129 See, e.g., 32 Ill. Med. J. 143- (1923), reprinted in 2 Children and Youth in America, supra note 98, parts 7 & 8, at 1020, in which the journal editors wrote:
all future AMA opposition to women’s efforts to organize for their health rights and needs. In these ways, the Sheppard-Towner Act was the first major piece of federal legislation to catch the brunt of the AMA’s developing fear of state medicine.130

After failure to prevent initial passage of the legislation in 1921, the AMA and other conservative forces escalated the battle against the law, conducting vigorous lobbying to defeat reappropriation of the legislation in 1926. While a compromise extended the appropriation until 1928, Congress repealed the law on June 30, 1929.131

Among other long-term implications and effects, the defeat of the Sheppard-Towner Act marked the move toward privatization of women’s health care, the growth and consolidation of the medical profession, and within the profession, the growth of the obstetrical and gynecological specialties. The law’s demise also signaled the decline of women’s expertise and leadership in the field of maternal and child health care, at least until the last several decades of the twentieth century.132 The AMA-led campaign to defeat the law also reflected the AMA’s growing

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At a recent meeting of a medical society, a member asked, “Why didn’t the A.M.A. prevent the passage of the Sheppard-Towner bill?” The same question has been asked many times by others. The Sheppard-Towner bill was passed, not for the public health reasons but on account of political exigencies. Women had just been given the vote. No one knew how they would use it. Nearly every congressman had a distinct sense of faintness at the thought of having all the women in his district against him. Male opposition he was used to. But the women’s vote! Awful thought! Suppose all the women voted against him! Shrewdly and persistently, the idea was impressed on the minds of the women of the country that the Sheppard-Towner bill was a wonderful measure; that in some miraculous fashion it would save thousands of lives of mothers and babies now being lost; that it was the one bill all women must support. At the same time, all members of Congress were told again and again that the women of the country demanded the measure and that each congressman’s future depended on his vote on this bill.

Id. 130

Lemons, supra note 89, at 779. The AMA would play a similar role in lobbying against national health insurance during the drafting of the 1935 Social Security Act and then again in the 1960s during the drafting of Medicaid and Medicare. See STARR, supra note 74, at 266-89; Cohen, supra note 77, at 935-36.


132 ANNAS ET AL., supra note 72, at 938.
advocacy of private, profit-driven medicine, in partnership with the then-developing private health insurance industry.\textsuperscript{133}

In these ways, in the period after World War I, the AMA consolidated its opposition to what it perceived to be "socialized medicine,"\textsuperscript{134} largely through its campaign against the Sheppard-Towner Act and the Children's Bureau. The AMA's antagonism was actually aimed at any system that led to some controls over the way private medical practitioners practiced medicine, even if only in the form of supervision of fees or additional paperwork. The powerful organization in actuality opposed any type of governmental monitoring or intervention.\textsuperscript{135} Therefore, the successful campaign to defeat Sheppard-Towner was a critical turning point for the AMA and the catalyst that finally turned it away from progressivism.\textsuperscript{136}

Yet importantly, in the 1920s the AMA did not speak for the entire medical profession; some prominent physicians and medical schools strongly supported Sheppard-Towner.\textsuperscript{137} Moreover, the hundreds of women physicians across the country who staffed the Sheppard-Towner clinics and administered its programs were steadfast proponents of the programs, as was their organization, the Medical Woman's National Association.\textsuperscript{138} Furthermore, the AMA's campaign to defeat the Act's

\textsuperscript{133} STARR, supra note 74, at 260-61.
\textsuperscript{134} Id.
\textsuperscript{135} STEVENS & STEVENS, supra note 6, at 10.
\textsuperscript{136} Lemons, supra note 89, at 780. The demise of Sheppard-Towner is closely tied to the AMA's break from progressive ideals.

The AMA had marched within the broad ranks of progressivism from 1900 to World War I and vigorously campaigned for pure food and drugs, protection of the public from medical quackery, a federal department of health, and the elevation of standards in medical practice and education. Nevertheless, the AMA had always been silent on other great health problems: slums and tenements, factory hazards, child labor, and the exploitation of women in sweatshops and dangerous trades.

The AMA first broke away from progressivism over the issue of compulsory health insurance; and after its house of delegates condemned health insurance in 1920, the association came to see the Sheppard-Towner Act as only another form of the same thing.

\textit{Id.} (citation omitted).
\textsuperscript{137} Id. at 781.
\textsuperscript{138} Id. The organization's own journal, the \textit{Medical Woman's Journal}, hailed as one of the world's greatest citizens Dr. Josephine Baker, a leading advocate and administrator of Sheppard-Towner programs in New York, who was later to
passage in 1921, and later its campaign for the Act’s repeal, led to the formation of the American Academy of Pediatrics. Pediatricians who supported Sheppard-Towner broke their ties with the American Medical Association over the Act and formed their own association. In short, the Sheppard-Towner Act became a lightning rod, as medical organizations and individual medical providers took philosophical and political stances about the law and concerning government’s relationship to health care.

In actuality, therefore, Sheppard-Towner’s defeat was no doubt a result of several factors. Perhaps most significantly, the law’s demise signaled a downward shift in women’s political and legal empowerment, a shift from which it would take women decades to recover. What had appeared to many Congressmen in 1921, the “morning after” women won the right to vote, as a massive “women’s bloc” to be contended with, was no longer such a daunting political influence five relatively short years later. Women clearly did not vote as a bloc. As historian Molly became president of the organization in the early 1930s. Id.

139 Strain, supra note 3. The American Academy of Pediatricians was established by twenty-four pediatricians after the American Medical Association condemned the Sheppard-Towner Act. Id.

140 As discussed earlier in this Article, historian J. Stanley Lemons has suggested that at the time of the legislation’s passage, the Congress was heavily influenced by the new women’s electorate and fear of the “women’s vote.” A principal force moving Congress was fear of being punished at the polls. The women’s vote was an unknown quantity at the time. For years, the suffragists had promised to clean house when they got the vote, and they claimed that women would be issue oriented rather than party oriented. Politicians feared that women voters would cast a bloc vote or remain aloof from the regular parties. The leaders of the major women’s organizations hoped to mobilize the female vote for reform. Passage of the maternity bill was the first goal of the newly enfranchised women, and it took precedence over all other efforts. In 1920, the League of Women Voters helped to create the Women’s Joint Congressional Committee (WJCC), which coordinated lobbying activities in Washington for nearly two dozen national women’s organizations and claimed to speak for 20,000,000 members. The WJCC lobbied vigorously, while the constituent organizations drummed up grass roots support and deluged Congress with a torrent of letters, telegrams, and personal delegations. If a woman read any of the mass circulation women’s magazines — Good Housekeeping, Pictorial Review, McCall’s, Woman’s Home Companion, or Delineator — she was exposed to many articles which favored the Sheppard-Towner bill.
Ladd-Taylor has noted, this was a fact which, "combined with the conservative political climate and the disarray of the post-suffrage women's movement, reduced the effectiveness of the maternal and child health lobby."¹⁴¹ In addition, at that point Congress was desperately moving through a series of dramatic cost-cutting measures which affected the future of federal appropriations under the Sheppard-Towner Act.¹⁴² A combination of these and other historical factors resulted in the law's ultimate demise on the eve of the Great Depression.

Despite its relatively short life-span, its internal limitations, and its resounding defeat, the Sheppard-Towner Act nevertheless must also be

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Lemons, supra note 89, at 778.

¹⁴¹ Ladd-Taylor, Women's Health, supra note 66, at 402. Many historical factors weigh into the defeat and the repeal of the Sheppard-Towner Act. Full discussion of these factors goes beyond the scope of this Article. However, factors included co-opting of the Act's programs by the male medical establishment, replacement of women state directors of child-welfare programs by men, and the inability of the Sheppard-Towner supporters to sustain a grassroots women's health movement in the states. Although some states continued their own maternal and child health programs after the repeal of Sheppard-Towner and the withdrawal of its federal funds, the programs received little public attention. Clearly, more research and scholarly attention has to be given to this period. As Ladd-Taylor has written:

Among the questions to consider are the impact of the Depression on the political priorities of women activists; the role women in government played in the development of public policy; the growing influence of the medical profession; and the political impact of declining infant and maternal mortality rates among the middle class.

Id. at 403.

¹⁴² 3 CHILDREN AND YOUTH IN AMERICA, supra note 98, at 1220 (quoting EDWIN E. WITTE, THE DEVELOPMENT OF THE SOCIAL SECURITY ACT 165-71 (1963)).

[Title V of the Social Security Act of 1935], in effect, was a revival, increase, and extension of the aid given to the states under the Sheppard-Towner Act, from 1922 to 1929. This aid under the Sheppard-Towner Act was discontinued, partly in an economy streak of Congress and partly because its administration had aroused the opposition of some influential people in the Catholic Church, the United States Public Health Service, and the doctors generally. On the other hand, it was very popular with the women's organizations, which ceaselessly agitated for the renewal of the Sheppard-Towner Act, after discontinuance of the aid in 1929.

Id.
recognized for its accomplishments. A fair historical treatment must acknowledge the law’s vision, and its political and social-economic legacy, as well as the opposition it engendered. Of great historical significance, for example, the Sheppard-Towner Act provided the overwhelmingly white and middle-class welfare reform, suffragist, and social-feminists networks (which coalesced under the activities of the Children’s Bureau and Women’s Bureau), their first meaningful involvement with communities of color, particularly with African-American women health care organizers and providers in the South.¹⁴³

During this same period, African-American women activists were leading a parallel and pioneering advocacy movement for the improvement of the health and welfare of African Americans.¹⁴⁴ In this post-Reconstruction period, the combined forces of economic, social and racial discrimination, as well as Jim Crow segregation, had a particularly egregious impact on the health of African Americans.¹⁴⁵ Moreover, in

¹⁴³ GORDON, supra note 1, at 88 (“The first significant involvement of this white welfare network with racial minorities was through the Sheppard-Towner Act, because it was their first national program and therefore the first to reach the South and the West.”).

¹⁴⁴ For more on the history of African-American women’s health care and reform movements, see Beardsley, supra note 55; Bernier, supra note 55; Lado, supra note 55; and Randall, supra note 55; see also GORDON, supra note 1, ch. 5, for an in-depth analysis of the African-American women welfare and health care movements during the early decades of the twentieth century. This history is particularly important because of the devastating post-Reconstruction period in which these activities occurred for African Americans.

Black women’s activism was born in an era of radically worsening conditions for most African Americans, in contrast to the improving conditions for white women. The National Association of Colored Women (NACW) formed when segregation was intensifying and blacks were being stripped of the modest political gains facilitated by Reconstruction. As white women got the vote most blacks remained disfranchised. In the South the sharecropping system deepened poverty. By 1924 the second Ku Klux Klan claimed 4.5 million members... Black women had no reason to identify with the exclusively white definitions of women’s “interests” that dominated in the white women’s welfare network.

Id. at 112-13.

¹⁴⁵ See supra notes 24-65 and accompanying text for a discussion of the particular health problems of women of color. For a critically important historical perspective on African-American women’s health, see Beardsley, supra note 55, who wrote:
comparison to white women, African-American women experienced even more serious health problems. For African Americans, lack of care and enormous barriers to accessing medical treatment, factors which generally continue to have an impact to this day, were the predominant realities. Maternal deaths during childbirth, venereal disease, particularly syphilis and gonorrhea, tuberculosis ("TB"), diabetes mellitus, cardiovascular and renal diseases, cancer, and death by "unknown causes," or "ill-

But to explain ill health of black women merely on the basis of economic and social deficits would be to miss its underlying cause. That cause was racism — and the segregation and discrimination that it invoked, not just in the South but wherever blacks took up substantial residence.

Although black women's health problems had some ties to their status as females (and bearers of children), in matters of health their racial status was a far greater determinant than their gender. In racist America, their blackness was their primary identification, subjecting them, the same as their men, to all the beliefs and practices of white supremacy. The consequences for health were as corrosive as they were inevitable. . . .

. . . .

. . . First came the "era of denial," spanning the years 1900-1930. Those were the decades when racism had its harshest impact, not just in denying black women health care but also in locking a great proportion of them in positions of permanent disadvantage, long after the burden of racism had eased.

Id. at 122-23.

146 See Beardsley, supra note 55, at 125-26, who evaluated the conditions and quality of African Americans' health during the first half of the twentieth century with a focus on African-American women's health:

In consequence, the great majority of black women in the North and in the South endured serious and multiple problems, many of them related to maternity. To begin with, black women got little care, professional or otherwise, during pregnancy. That was partly because care was largely unavailable. . . .

. . . . Following a long tradition reinforced by poverty, Southern black women commonly used midwives as birth-attendants, and the dangers were often great. . . .

. . . . If blacks had to endure primitive conditions, it was not because better facilities did not exist. They did at many white hospitals, but segregation dictated that blacks could not use them.

Id.
defined conditions,” were epidemic in proportion for African Americans through the first half of the twentieth century.147

African-American women’s activism, beginning with the formation in 1896 of the National Association of Colored Women (“NACW”), focused on the ill health of African-American women and children. The work of the NACW closely paralleled the efforts of the white women reformers of the Children’s Bureau in the first part of the twentieth century.148 The broad-reaching work of African-American women health reformers had a major impact on the health of African Americans, on the grassroots and local levels, despite the numerous obstacles they faced.149 Due to segregation and racism, African-American women health and welfare activists for the most part worked independently of the

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147 Id. at 126-29.
148 Id. at 130.

But black women were not just objects of benevolent white attention, nor just victims of an unjust social order. They were also actors in the struggle for health improvement. Beginning with the formation in 1896 of the National Association of Colored Women (NACW) and continuing with a myriad of local efforts, black women-most of them middle class-showed a talent for organization and an eagerness to uplift their race, along a broad front. . . . In many ways black volunteer work paralleled that of white women (who had started a half-century or so earlier): it involved primarily the middle class, and it was concerned chiefly with preserving the values of home and family. But in key respects it was different. Whereas white women were responding primarily to problems of their own gender and class, black women were filled with a mission to better their whole race.

Id.

149 GORDON, supra note 1, at 124. Writing on the history of African-American women’s welfare reform efforts during this period, Linda Gordon noted:

Between 1890 and 1930, African Americans created approximately two hundred hospitals and nurse-training schools, and women often took charge of the community organizing and fund-raising labor. Over time black women’s health work changed its emphasis, from providing for the sick in the 1890s to preventive health projects after about 1910. Already in the last century, most locations with a considerable black population had mutual benefit societies that paid sickness as well as burial insurance. In several cities the societies also paid for medicines and actually created their own HMOs.

Id.
Children’s Bureau administrators and staff, whose focus remained on federal legislation, policy, and programs.

Of great historical significance, during this period of racial segregation, when white supremacy reigned throughout the nation, a fledgling and tentative, but nonetheless self-conscious, relationship did exist between the Children’s Bureau reformers and African-American women health providers. Evaluation of this relationship, including the degree to which the Sheppard-Towner programs were made accessible to and were supportive of African-American women, as well as the cultural and religious attitudes of the social feminists, must be evaluated in the normative terms of that era, as well as by contemporary standards.150

150 Notably, research has shown that Sheppard-Towner programs and Children’s Bureau staff were to some degree—at least in principle—supportive of and worked with African-American midwives and social activists who were the mainstay of the African-American women’s health networks, and were a parallel development to the white women’s health reform movement. Yet, the Sheppard-Towner workers also served a culturally interventionist role, which ironically contributed to the demise of the African-American midwifery movement, and the medicalization of childbirth in America. See Ladd-Taylor, “Grannies” and “Spinsters”, supra note 103, at 255-75.

In contrast to conservatives and some physicians who cared little about high mortality rates among blacks (a few even saw “some virtue, some real reason in nature’s law — the survival of the fittest”), the Children’s Bureau tried to provide adequate services for all racial and ethnic groups throughout the country. Convinced that education and research would lead to action, the Bureau staff expected the instructional programs of the Sheppard-Towner Act to convince midwives and mothers to reject the “superstitious” practices of the past in favor of new procedures approved by the medical establishment. Well-intentioned but culturally insensitive, most Sheppard-Towner nurses had little respect for rural black culture or traditional healing. Although they believed that they were helping rural mothers and protecting midwives, their attempts to make midwifery scientific and professional denied the value of traditional skills and folk healing, thus furthering the medicalization of birth.

Id. at 259 (citations omitted).

Moreover, while it is well recognized that the leadership and administrators of the Children’s Bureau were white and primarily middle-class, little study beyond Molly Ladd-Taylor’s work on African-American midwives has been done in this critical area. More research is needed on the degree to which the Children’s Bureau and Sheppard-Towner programs actually benefitted and served African-American women and children, as well as other people of color. This is
While documentation of collaboration between African-American women health providers and activists, and the Children's Bureau staff is sparse, some evidence does exist of a political and social alliance between the two forces, which was also, to a degree, contentious and ambiguous. Equally important are the signs of collaboration on the grassroots level between Children's Bureau staff and African-American women health reformers, activists and providers, particularly African-American "granny" midwives in the South.

particularly important because of the equality, universalist, and social justice themes advocated by the white women social feminists and reformers.

As shown by Ladd-Taylor's critical analysis of Sheppard-Towner's midwife training programs, historical evidence indicates that despite their goals and stated social justice philosophies, the white social feminists also manifested racial tensions and prejudices, typical of their cultural, religious, and ethnic backgrounds.

\[151\] See also GORDON, supra note 1, at 88 noting the impact of this ambiguous relationship:

The Children's Bureau insisted on serving minority women, to their credit, but their insistence on state autonomy in developing local programs allowed great discrimination against African Americans and Mexican Americans. The program's agents were often disdainful and racist (refusing, for example, to recognize any value in traditional healing practices).

\[152\] See supra notes 143-51; see also Ladd-Taylor, "Grannies" and "Spinsters", supra note 103; Judy B. Litoff, Midwives and History, in WOMEN, HEALTH, AND MEDICINE IN AMERICA 443 (Rima D. Apple ed., 1990) (writing extensively on the role and history of midwifery).

Molly Ladd-Taylor uncovered much useful information about the responses of southern "granny" midwives to midwifery training programs established under the Sheppard-Towner Maternity and Infancy Protection Act of the 1920s by analyzing the progress reports which the state boards of health sent to the federal Children's
Of further historical significance, while the Sheppard-Towner Act did not provide direct financial assistance or medical care to women and, by contemporary standards, was very humble, it was the closest this nation has come to a federally-mandated universal health program. As noted earlier, the Sheppard-Towner programs were in fact tremendously successful in improving infant, child and women's maternal health. Moreover, in contrast to virtually all subsequent federal social welfare and health legislation, Sheppard-Towner was a pioneer law because eligibility for its benefits and entitlements did not require means-testing. The law was therefore intended to benefit all women and children, not just the needy or "deserving" poor.

In addition, it is significant that the social feminist reformers who propelled the Sheppard-Towner programs continued to rely on an ideology of maternalism which linked women's rights to women's

Bureau. Although these reports were written by white physicians and nurses who shared many of the racist assumptions of the era, Ladd-Taylor found that the picture of the midwives which emerged was that of assertive women who both welcomed the help and challenged the authority of Sheppard-Towner workers.

See supra note 100 (discussing the size of the Sheppard-Towner Act's appropriations); see also Lemons, supra note 89, at 781 ("In retrospect, this pioneering bill seems pitifully small.").

See supra note 104, for concrete accomplishments of the Sheppard-Towner Act; GORDON, supra note 1, at 94 ("Sheppard-Towner had a significant impact on women's and children's health, lowering infant and maternal mortality rates in the areas where it concentrated despite its brief period of work."); see also U.S. CHILDREN'S BUREAU PUBLICATION NO. 203 THE SEVEN YEARS OF THE MATERNITY AND INFANCY ACT (1931) (Washington, D.C.).

"Means-tested" is a legal term of art, meaning that eligibility for certain welfare programs is based on one's economic status, including income, assets, and receipt of other public entitlements.

GORDON, supra note 1, at 94-95, noting:

The Children's Bureau intended Sheppard-Towner as a first step in federal welfare, not as an isolated experiment. It represented a cautious and partial break with the mothers' aid legacy, in that it provided non-means-tested assistance. . . . In continuing the casework approach, Sheppard-Towner did continue the dangers of cultural domination and privacy invasion, but because means-testing was not required, the program did not seem to be stigmatizing its beneficiaries.
Yet, they clearly understood the central role of health care in combatting poverty and in advancing women's and children's quality of life. The Sheppard-Towner Act was based on a view that women and children deserved unique attention and care, as well as the accountability and the interest of the government and nation. This perspective was in sharp contrast to the traditional, paternalistic, and stigmatizing view of women as weak and powerless victims. Moreover, the traditional, paternalistic view has become an underlying tenet of modern welfare policy in the United States, and has served to marginalize poor women and their families.

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157 See id. at 103 (discussing the ideological force of progressive maternalism among the women reformers of the era).

The force behind progressive maternalism—the maternalism of arguments for protective legislation, mothers' pensions, and the Sheppard-Towner Act—was a women's movement, a vibrant, decentralized, mass social movement. Behind that movement and contributing to its vigor were a variety of other more radical activistisms, notably the intense labor struggles and the growth of the Socialist party in the pre-World War I era, which contributed to a general sense of the necessity and urgency of public action to ameliorate economic suffering and inequality.

Id. This ideology of maternalism also has had its socially regressive tenets; in another context, for example, a maternalist view sees women's place as in the home, rather than in the workplace or government.

158 See id. at 105 (discussing the central role which health issues played in the women reformers' overall ideology of, as well as strategy for, social change).

It was this health emphasis, of course, which created the Children's Bureau's worst enemies—the PHS and the AMA. Social work leaders were well aware of this, but health seemed to them so fundamental that it could not be given up. They assumed that a program of public medical care was inevitable in the United States and viewed their own work as pioneering something that would later be organized on a mass scale. Above all, their health emphasis grew from their woman-centered approach to welfare. They understood that health issues, particularly those surrounding reproduction and child development, were central to women's unique problems of poverty.

Id.

159 See id. at 6.

The perverse tendency of our welfare system to deepen inequality has been particularly pronounced in the case of AFDC. The stigmas of "welfare" and of single motherhood intersect; hostility to the poor and hostility to deviant family forms reinforce each other... The resulting immiseration makes poor single mothers even more needy and less politically attractive. The economic downturn of the last decade has
The Sheppard-Towner Act — in program, policy, and practice — spoke to the significance of women’s special role in society. The Act gave women reformers their voice. Sheppard-Towner, in its time, articulated women’s power, contributions, and role, not only as caregivers and reproducers, but as equal, invaluable, and productive members of society. With the Act’s repeal, these values and principles would cease to be the basis for the federal government’s health or welfare programs. From that point forward, women’s and children’s poverty would be the basis for, and their link to, legal entitlements to basic health and social needs.

C. Title V of the 1935 Social Security Act: A New Deal For Whom?

It is perhaps ironic that less than seven years after the repeal of the Sheppard-Towner Act, its supporters, administrators, and staff were able to achieve restoration and even expansion of some of its key provisions with the passage of the Social Security Act of 1935. Like the Sheppard-Towner Act, Title V of the new Social Security Act offered federal block grants to states for the provision of maternal and child health services. Social historians have noted the longer-term impact deepened both the poverty and the resentment, and created the impression that we are experiencing a new, unprecedented, and primarily minority social problem.

Id.


Id. §§ 501-505, 49 Stat. at 629-31 (Title V, Part I — maternal and child health services). See also id. §§ 511-515, 49 Stat. at 631-33 (Title V, Part II — services for crippled children); id. § 531, 49 Stat. at 633-34 (Title V, Part IV — authorizing grants to states for vocational rehabilitation). A related health program was authorized under id. §§ 601-603, 49 Stat. at 634-35 (Title VI — authorizing Public Health Work program).

Part III of Title V, entitled “Child-Welfare Services,” “provided for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent,” id. § 521, 49 Stat. at 633. This program, also administered by the Children’s Bureau, was the first national social welfare services program of a non-health nature. It was subsequently incorporated into Title IV. See Cohen, supra note 77, at 936.

The federal-state partnership and grants-in-aid format of the Sheppard-Towner Act was carried forward into the welfare programs of the New Deal and beyond. GORDON, supra note 1, at 96 ("The 1920s developments confirmed what was to become, in the New Deal, the fixed design for U.S. welfare programs —
of Sheppard-Towner in light of its brief tenure and its demise, particularly with the subsequent passage of Title V. Historians have questioned and analyzed the multiple historical factors which allowed many of Sheppard-Towner's programs to re-emerge, some even in enhanced form, and essentially unopposed, under Title V.

Historians have questioned and analyzed the multiple historical factors which allowed many of Sheppard-Towner's programs to re-emerge, some even in enhanced form, and essentially unopposed, under Title V.

For example, historian J. Stanley Lemons has suggested that the values and programs of Sheppard-Towner, while defeated under the law itself, re-emerged and triumphed with the passage of the New Deal's Title V. Lemons, supra note 89, at 786. Lemons wrote:

Consideration of maternity and infancy protection was merged with the broader development of social security legislation within the New Deal. Restoration came with the Social Security Act of 1935. Protection of maternity and infancy was embodied in Title V of the comprehensive measure. . . .

The Sheppard-Towner Act was both an example of the persistence of progressivism in the 1920s and a link between the progressive period and the New Deal. . . . Even though conservative forces were able to eliminate it on the eve of the depression, advocates of the idea finally triumphed during the New Deal.

Other historians have argued that "The end of the Sheppard-Towner Act and the beginning of the great depression eroded the States' abilities to continue useful child health work." 3 CHILDREN AND YOUTH IN AMERICA, supra note 98, at 1207. Yet, historians appear to concur on the historical significance of Title V as the re-embodiment of Sheppard-Towner, perhaps in a stronger and even more effective form.

New developments, however, were not long in coming. Drawing upon the experience of the Sheppard-Towner Act, the leadership of the Children's Bureau designed a new and stronger plan which the first woman Cabinet member, Secretary of Labor Frances Perkins, presented in her Annual Report of 1934. It was enacted in 1935 as Title V of the Social Security Act. In the next 40 years Title V was the foundation upon which notable advances were made under the leadership of the Children's Bureau. More extensive programs for maternity care and care of infants and children were created and, for the first time, federal funds were used to assure a full range of medical care for handicapped children.

Social historian Molly Ladd-Taylor has questioned how Progressive Era reformers such as Grace Abbott, the Children's Bureau chief during Sheppard-Towner, was able in 1935 to win "a great victory, when some provisions of the Sheppard-Towner Act were restored and expanded in Title V of the Social
For in fact, in many ways, Part I of Title V in particular was very similar to the Sheppard-Towner Act, most notably in its focus on maternal and infant health; yet, in other ways, it was significantly different. In actuality, federal monies allocated to maternity care and education were substantially increased under Title V, as compared to allocations under Sheppard-Towner. Perhaps most importantly, for the first time, under Title V, governmental response to health needs became closely linked with welfare, the disadvantaged, and poverty.

Security Act," despite the absence of a strong women's health movement. See Ladd-Taylor, Women's Health, supra note 66, at 403-04. Ladd-Taylor also noted:

Ironically, federally funded maternal and child-health services expanded in the 1930s and 1940s, just as grassroots interest in maternal health policy declined. . . .

Sadly, women's success at getting the government to fund and administer the child-health services they initiated seems to have led to their loss of control over the services.

Id. at 404.

For an additional perspective on this transformative period from Sheppard-Towner to Title V, see Gordon, supra note 1, at 98.

The pioneers had worked in grassroots organizations trying to lobby from outside political structures; the new leaders were much closer to political power.

The 1920s offered this women's network a unique conjuncture—a waning women's movement and a waxing female bureaucracy. Women had previously become prominent in welfare activity largely because it was not governmental. Their own victories in winning recognition of state responsibility threatened to deprive them of a place in the welfare establishment. Adapting to these new conditions in the 1920s, they were learning a new language, a language of politics rather than morality. . . . They created the Women's Joint Congressional Committee [WJCC] in 1920, which four years later included twenty-one organizational members and orchestrated joint campaigns.

Id. at 98. The work of the WJCC included support of a federal department of education, Sheppard-Towner, defending the Women's and Children's Bureau appropriations, enforcement of Prohibition, pasteurization laws, rights for Native Americans, prison reform, and regulation of the coal industry, among other issues. Id.

165 Ladd-Taylor, Women's Health, supra note 66, at 403-04. See also Lemons, supra note 89, at 786 (noting that Title V expended significantly higher annual appropriations towards maternal and child health and welfare).

166 Social Security Act, § 501, 49 Stat. at 629, codified as Part I of Title V, the legislation states: "For the Purpose of enabling each State to extend and improve, as far as practicable under the conditions in such State, services for
Notably, at the same time that Title V was enacted, the Social Security Act also authorized Title IV, which provided grants to states for Aid to Dependent Children ("ADC"), the precursor to today's largest welfare program, now titled Aid to Families of Dependent Children ("AFDC").

Like Sheppard-Towner, Title V was not a direct entitlement or financial assistance program. Instead, Title V gave the states discretion to make grants directly to public and private health care providers, including for subsidized prenatal care, health education, and outreach to pregnant women, and transportation to clinics. Moreover, Title V reduced state autonomy in implementing these programs, and increased federal control and appropriations. As a result, programs under Title V generally had a broader reach, and a more positive impact on African Americans in the South than the Sheppard-Towner programs had been able to accomplish. The maternity and infant care projects ("MIC")

promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $3,800,000." Id. (emphasis added).

The establishment of the ADC program would provide the critical link thirty years later to the nation's medical program for the poor, Medicaid, enacted in 1965.

The historian Beardsley noted the significance of Title V on the health of African-American women, particularly in the South: Among them the most far-reaching was the Social Security Act of 1935 (SS). Remembered chiefly for its aid to the elderly and unemployed, SS — with its shower of federal funds — also laid the foundation for the first truly national health program. But it did something else, particularly important to black women. It shifted health leadership from the states to Washington. For poor blacks and whites, that would prove crucial: there would now be an alternative (and augmented) source of health funding for such needs as nutrition and maternal and infant care, not
authorized under Title V of the Social Security Act have been recognized for their quality and comprehensiveness, as well as for the impact they have had in reducing infant mortality.\footnote{171}

Programs under Title V were different from programs under Sheppard-Towner in other ways as well. For example, as a part of this country’s first great social welfare program, Title V generally limited provision of its programs and services to the poor.\footnote{172} Unlike the non-means-tested, “open door” policy of the Sheppard-Towner Act, Title V of the Social Security Act was primarily directed at poor or otherwise disadvantaged women and their children.\footnote{173} In contrast to Sheppard-Towner, Title V directed attention and benefits to poor, at risk families, signifying a dramatic shift in United States public policy towards health care. In the 1960s and 1970s, this shift would coalesce into contemporary health and welfare policy. Specifically, this change in the course of public policy was concretized with the 1965 enactment of Medicaid, the coupling of Medicaid to AFDC, and subsequently Medicaid’s coupling to SSI, created in 1972 as a unified federal program for the poor, disabled, and elderly. Thereafter, applicants for basic health entitlements tied to the race and class mentality of Southern state legislators, welfare directors, and even public health officers, who had often made race and social conformity preconditions for receiving health services.

What SS meant for black women was best seen in the initiation of maternal and child-health services, provided by the thousands of prenatal, infant, and well-baby clinics set up after 1935-permanent clinics for urban areas and two-to-three day travelling clinics for rural populations. \footnote{171} Beardsley, \textit{supra} note 55, at 134 (citation omitted).

\footnote{172} ANNAS ET AL., \textit{supra} note 72, at 932.

\footnote{173} GORDON, \textit{supra} note 1, at 257 (“Title V was actually less far-reaching than Sheppard-Towner had been, because it restricted services to the needy by requiring means-testing, which was certain to be stigmatizing and to drive many away.”). It is noteworthy therefore that while Title V programs may have increased access to prenatal health care for African-American women, at the same time, Title V restricted access to government programs for the (white) middle and working classes. \textit{See supra} note 170.

\footnote{174} \textit{See} Social Security Act, § 501, 49 Stat. at 629. Ladd-Taylor, \textit{Women’s Health, supra} note 66, at 404, also notes this fundamental difference between Sheppard-Towner and Title V (“Yet in contrast to the Sheppard-Towner Act, which distributed literature and opened clinic doors to middle-class as well as poor women, the Social Security Act was directed only to the needy who could not afford private medical care.”).
would be strictly means-tested as a central condition of eligibility for federal assistance under the Medicaid program.

While the means-testing process of economic eligibility for benefits under Title V was not clearly outlined in the law itself, what was certain was that Title V was not intended to be universal health coverage for all women and infants. Nor was any part of the Social Security Act intended to provide universal health coverage for all Americans.174

The 1935 Act, it is true, did provide for federal grants to states for maternal and child health services and for crippled children, under Title V of the Act; but this program, too, emphasized the prevailing philosophy toward health-care provision. When health services were necessary as an essential part of income protection or national security, they were to be provided under government subsidy and supervision. Health protection thus continued to be subsidiary to income maintenance. . . .

. . . The basic question of welfare medicine was already evident. Could health services for the poor continue to be left to the whims of local government . . . Or should health services be organized in their own right, as a separate social goal, parallel to old-age insurance or education?

. . . Competing social philosophies were coming face-to-face with the economics of modern medicine.

Id.175

Universal health care coverage for all Americans was explicitly not intended to be a component of the Social Security Act of 1935. See id. at 13 (arguing that with the passage of the 1935 legislation, "the provision of health services remained in limbo, both for the poor and for the working population."). It was increasingly clear that a causal link existed between health needs and economic status. For example, Stevens and Stevens note that a 1943 Social Security Board found that about one-third of the ADC children were in need because of the physical or mental incapacity or illness of the parent. Id.

Yet, the bottom line was that President Roosevelt took the position that the public and the medical profession were not yet ready for a major federal incursion into medical care. As a result, the 1935 patchwork of the Social Security Act was created. See also GORDON, supra note 1, at 255 ("In [President Franklin D. Roosevelt's] earlier compromises with antiwelfare forces, including prominently organized physicians and big business, the president eliminated two programs that had been an integral part of most welfare planners' vision: public works and medical insurance.").

For additional materials on the complex history of the Social Security Act of 1935 and the defeat of national health insurance as a part of the law, see STARR, supra note 74, at 266-89, 280 ("Compulsory health insurance had stood

174 See STEVENS & STEVENS, supra note 6, at 14.

175 Universal health care coverage for all Americans was explicitly not intended to be a component of the Social Security Act of 1935. See id. at 13 (arguing that with the passage of the 1935 legislation, "the provision of health services remained in limbo, both for the poor and for the working population.").
Indeed, Title V has been interpreted to mean that its purpose was, and continues to be, primarily to serve the health care needs of economically disadvantaged women and children who are on welfare.

To some degree, this explains then why the American Medical Association did little to oppose the passage of Title V, an essentially poverty-based health program, less than half a decade after the AMA’s intensive campaign against the Sheppard-Towner Act. First, the influences and realities of women’s empowerment, organization, and leadership, so central to the Sheppard-Towner Act, were simply not a significant part of the Social Security Act’s design, drafting, passage or administration. Second, the medical establishment was so concerned about the possible drafting of national health insurance, unemployment compensation, and old-age pensions into the Social Security Act, that Title V seemed like the lesser of the “socialized” evils. Perhaps, it can fairly

on the periphery of national politics throughout the New Deal — omitted from Social Security, never fully backed by the president, subordinated to other programs even by many reformers.”).

176 Ladd-Taylor, Women’s Health, supra note 66, at 404.
Conservatives and the medical establishment who defeated Sheppard-Towner were too alarmed about the prospect of national health insurance, unemployment compensation, and old-age pensions to actively oppose the children’s sections of the Social Security Act. Moreover, women’s organizations, which played such an important role in Sheppard-Towner, had only an auxiliary role in the design and administration of the Social Security Act.

Id.

177 Cohen, supra note 77, at 935-36.
The health and medical care programs were included in the law without any political controversy, largely due to the American Medical Association’s (AMA) great sense of relief that the Social Security Act did not include a provision for state or national health insurance. In order to avoid the “terrible calamity” of compulsory or voluntary state or national health insurance, the AMA readily accepted for the first time a measure of federal financial intervention into other aspects of state health and medical care policy that it had opposed during the 1920s.

Id. (citation omitted).
Compared to the specter of national health insurance, Title V’s programs, directed to maternal and child health and limited to the poor, yet administered by the Children’s Bureau, just as under the Sheppard-Towner Act, brought on considerably less cause for alarm.

At the same time, the AMA was successful in keeping early versions of Medicare and Medicaid from being incorporated into the 1935 Social Security
be argued, that this was the view, precisely because entitlements under Title V were limited to needy groups.

Furthermore, while the goals of the Progressive Era leaders, the Woman Suffrage Movement and the social feminist reformers generally had been based in equality and social justice ideologies, the movements and their leadership still reflected many of the racial and class tensions and biases prevalent in the nation, both then and now. Middle-class, white women had to a large degree provided the organizational fuel and political power for the women’s health care reforms of the Progressive Era, most notably within the Children’s Bureau and under the Sheppard-Towner Act, but within the Woman Suffrage Movement, as well.

Following the Progressive Era, and by the mid-1930s, those groups were themselves in economic and political transformation. Increasingly, those that followed in the steps of the Progressive Era social feminists would be covered by private health insurance, would have access to prenatal care, and would not share the infant mortality or other health problems of their poorer sisters. Historical trends confirmed the fact that the primarily white, middle-class social reform leaders of the 1920s would no longer consider federal funding for maternal and infant care to be a priority “women’s issue.” From here on, including among the

Act. As a result, these landmark national health programs did not achieve realization until fully three decades later. See STARR, supra note 74, at 260-80.

178 See supra note 141.

179 See, e.g., Ladd-Taylor, “Grannies” and “Spinsters”, supra note 103, at 269.

Brought into existence by the Progressive Era women’s movement for child welfare, the Sheppard-Towner Act could not survive the absence of a well-organized women’s movement in the 1920s. Despite the hopes of the bill’s supporters, the Maternity and Infancy Act did not lead to universally available maternity care. Prosperity, the conservative political climate of the 1920s, and the decline in mortality among white infants — from 72 to 64 per 1,000 live births between 1921 and 1928 — made federal funds for maternity and infancy care appear less urgent to middle-class women than it had in the past.

Id.

180 Ladd-Taylor, Women’s Health, supra note 66, at 408. Federally funded programs for women and children’s health would increasingly become an aspect of poverty and welfare programs, rather than women’s health programs.

The inadequate maternal and child health-care system in the United States today is the product of the medical opposition to “state medicine,” the unwillingness of politicians and voters to spend federal dollars on public health programs, and the absence of a strong women’s lobby
reformers themselves, health care for women and their children would gradually, but finally, be relegated to the realm of poverty and welfare. With the passage of Title V, the imprint was cast: hereinafter, one’s poverty or economic status would define eligibility for health care services, as well as government’s responsibility to provide care.

Thus, with the emergence of these New Deal programs, the “double-edged sword” or dichotomous nature of the social welfare perspective was becoming clear for the first time in United States history. On the one hand, the importance of the federal government’s recognition and provision for the nation’s poor can not be overstated from a humanitarian perspective and as a matter of public policy. On the other hand, with the linking of health care to poverty, the poor increasingly became marginalized and stigmatized. Government’s responsibility for health care became increasingly framed as an entitlement for the poor and the disadvantaged, rather than as an issue of public right and universal coverage for all women, for all children, or for all Americans. Therefore, a woman with health care needs for herself and her family would now have a government established incentive to be poor and to remain poor, in order to receive health care entitlements.

Indeed, to understand this shift in focus to the maternal health care needs of exclusively the economically disadvantaged, and Title V’s departure from the more universal perspective of its predecessor, the Sheppard-Towner Act, Title V must be analyzed within the broader context of the Social Security Act of 1935, of which it was a part. From an historical perspective, the Social Security Act of 1935 was a massive, omnibus, New Deal legislative vehicle which was the first manifestation of the expanding federal role in social welfare.\footnote{181} As a result, the Social Security Act of 1935 would become the basis for what some critics call the “welfare state,”\footnote{182} what other social historians have termed the system of “welfare medicine,”\footnote{183} and what also has been referred to in this Article as the medical apartheid model of U.S. health care.

Importantly, under the Social Security Act of 1935, poor families not only received income and services (under Titles IV and V), but, for the for prenatal and infant care. Because federally funded maternal and infant care is directed toward the poor (in contrast to programs, like Social Security, which benefit middle-class voters), it is often stigmatized as charity and cut off from mainstream political support.

\textit{Id.}

\footnote{181}{See Cohen, \textit{supra} note 77, at 936.}

\footnote{182}{See \textit{id}.}

\footnote{183}{See generally Stevens & Stevens, \textit{supra} note 6.}
first time, they were also recognized by the federal government for their existence, their plight, and their struggles for survival. Yet, the Social Security legislation — by not including and embracing universal, national health care and insurance — locked in the welfare medicine model of health care. In this way, it can fairly be argued, the Social Security Act of 1935 was a compromise which preserved the basic social, political, and economic structure of the nation at a time when it was struggling out of the most severe economic depression in its history.

Robert and Rosemary Stevens, social historians of the medical welfare system in the United States, have suggested that when the Social Security Act was passed in 1935, the public's political attitudes, as well as the government's public policy concerning social welfare were evolving and inchoate. However, with the Act's passage, program-
matically patchwork and philosophically disparate as it was, the die for the medical apartheid paradigm of health care in the United States was cast.\textsuperscript{188}

D. Medicaid and AFDC: Concretizing the Poverty-Health Care Link

While the 1935 Social Security Act was able to "sidestep" national health insurance and universal coverage, the issue did not disappear.\textsuperscript{189}

The Social Security Act of 1935 was to include programs encompassing both philosophies. Indeed, through its various titles, it provided an umbrella for divergent views. . . .

This dichotomy was also reflected in other parts of the legislation. . . . Over-all it set up a tripartite system of income security — social security, public assistance, and unemployment compensation — which has been the basis of American social-welfare programs from that day to this. And apart from the fragmentary children's services, the issue of health care was not faced.

\textit{Id.} at 11-12.

\textsuperscript{188} \textit{Id.} at 16 (explaining that Title V's "separatist pattern for health services paralleled the pattern of income protection which that Act emphasized"). While no doubt many middle-class families benefitted from the medical services of some of the New Deal programs, it was but a "temporary merger of the poor and the middle class which did not survive the 1935 Social Security Act." \textit{Id.} Lacking a system of national health insurance, there was no overriding philosophy of medical care which would encompass the poor with all other social groups. . . .

The philosophy of containment of the poor that led to early attitudes toward welfare assistance had its effect, too, on health care for dependent groups. . . . Where they existed, there was thus a two-class system of medical care, a system of private hospitals and physicians for those able to afford them, and a public system — if system is the right word — for the indigent. . . .

. . . With respect to that, there was one system for the poor (public assistance) and another for the working population (Social Security). Lacking a national health insurance system for both groups, government responsibility for the poor continued to be accepted, while government responsibility for the middle class was avoided or — as in the case of services for veterans — was not regarded as welfare medicine.

\textit{Id.} at 16-17.

\textsuperscript{189} For example, receiving little public and scholarly attention, the Emergency Maternity and Infant-Care ("EMIC") program, established during World War II, was the largest public health-care program until that time. During the war, the
The earlier interest in federal provision of health care for specially designated, needy groups was carried forward through implementation of an increasing array of publicly-subsidized programs for certain sectors.\textsuperscript{190} At the conclusion of World War II, the Congress passed a series

EMIC program provided maternity care to the wives of enlisted men in the non-commissioned ranks of the armed forces, and also provided hospital care to their infants up to one year of age. See 3 CHILDREN AND YOUTH IN AMERICA, \textit{supra} note 98, at 1257. By the fall of 1942, it was apparent that funds available under Title V of the Social Security Act would not meet the dramatically increased needs of army wives and their infants. Approved in 1943, EMIC arose from the tragic conditions observed by physicians, public health workers, social workers, and officers of the armed services, on army bases and posts. These reports reached Congress and governmental agencies; then legislative action was taken under existing laws, rather than through the enactment of new legislation. Responsibility for the administration of EMIC was carried out by the Children's Bureau. \textit{Id.} at 1261.

While EMIC recipients were not means-tested, "the program was based on the assumption that men financially supported the family while women cared for the children." Ladd-Taylor, \textit{Women's Health, supra} note 66, at 405. In fact, notes the historian, "women serving in the military were excluded from the program." \textit{Id.} The Children's Bureau viewed and "justified EMIC more as a way to maintain military morale than as a necessary health service." \textit{Id.}

Over one and a half million women received maternity care under EMIC during the years of World War II. After the war, maternal and child health programs were once again limited to preventive health services. Yet there remained precedent for federal funding of prenatal, obstetrical, and postpartum care. See Sardell, \textit{supra} note 81, at 276. This direct medical care contrasted with the planning, training, and preventive health projects, funded by Sheppard-Towner and Title V of the Social Security Act.

\textsuperscript{190} STEVENS & STEVENS, \textit{supra} note 6, at 42-43. For example, health services programs were enacted for Cuban refugees, and for migrant farm workers in 1962, and for participants in Head Start programs and residents of Appalachia in 1965. In addition, public health services were provided through the initial development of neighborhood health centers under the Office of Economic Opportunity ("OEO") "War on Poverty" legislation (1964). However these programs generally provided health services as a secondary aspect of some other social goal. \textit{Id.} at 43.

From about 1946 to 1963, however, the major thrust of federal involvement in health was not the provision or subsidy of services but the less direct function of long-term investment in hospital construction, biomedical research, and funding of health manpower programs. The Hill-Burton Act of 1946 provided for a major impetus for hospital construction in the years following World War II, initially and
of amendments to the Social Security Act which expanded federal appropriations and programs for maternal and infant care.\textsuperscript{191} Then in 1965, Congress further amended the Social Security Act, by establishing the Medicare\textsuperscript{192} and Medicaid\textsuperscript{193} programs. Medicaid is a comprehensive federal-state partnership providing health and long-term care for some sectors of the nation’s poor. Medicaid recipients are predominately poor families with dependent children and the poor elderly, blind, and disabled. Eligibility is determined by strictly regulated, complex, means-tested requirements.\textsuperscript{194}

In general, the Medicaid program provides federal matching funds to the states, to be administered by the states for medical services to the poor. Persons covered by Medicaid are then entitled to a basic set of

\begin{itemize}
  \item particularly in rural areas.
\end{itemize}

\textit{Id.} (citation omitted).

The Kerr-Mills Act of 1960, P.L. 86-778, 74 Stat. 924, 987, \textit{repealed by} P.L. 92-603, 86 Stat. 1329, 1484, was the first extension during this period of welfare medicine to a new category, the elderly poor. The Kerr-Mills program would later become incorporated into Medicaid. \textit{See generally} STEVENS \& STEVENS, \textit{supra} note 6, at 26-36 (analyzing the Kerr-Mills program, as a forerunner of Medicaid. “In large part, however, the problems of Kerr-Mills reflected not so much the failings of welfare administration but the lack of alternative channels of medical care.” \textit{Id.} at 36.).

\textsuperscript{191} Ladd-Taylor, \textit{Women’s Health, supra} note 66, at 406. Subsequently, in 1963, the Maternal-Child Health Amendments were made to the Social Security Act. These amendments allocated funds for maternity care in order to prevent mental retardation. \textit{See generally} 3 \textit{CHILDREN AND YOUTH IN AMERICA, supra} note 98, part VI, \S \textit{II}.


\textsuperscript{193} Medicaid, 42 U.S.C. §§ 1396-1396u (1994). A full discussion of the factors which led to the enactment of Medicaid and Medicare, as well as the vast complexities of these programs is beyond the scope of this Article. Readers will find the following sources on these programs useful: STARR, \textit{supra} note 74; STEVENS \& STEVENS, \textit{supra} note 6; Eleanor D. Kinney, \textit{Rule and Policy Making for the Medicaid Program: A Challenge to Federalism}, 51 OHIO ST. L.J. 835 (1990).

\textsuperscript{194} For a breakdown of who is eligible for Medicaid under the original 1965 legislation, \textit{see generally} STEVENS \& STEVENS, \textit{supra} note 6, at 61-65; GREEN BOOK, \textit{supra} note 13, at 783-88.
health benefits to be provided and administered by the states. States can also provide additional benefits to their recipients from an “optional” list.\textsuperscript{195}

Most important to the central premises of this Article, Congress predicated Medicaid eligibility on eligibility for AFDC,\textsuperscript{196} and the predecessor programs to SSI programs.\textsuperscript{197} These programmatic linkages resulted in mandatory guarantees of public health entitlements under the Medicaid law. Therefore, those groups who traditionally have been eligible for Medicaid — the “categorically needy” — have been the very poor, and increasingly, high proportions of woman-headed households with dependent children.\textsuperscript{198} Finally, the coupling of AFDC and SSI with Medicaid represents the resolution of decades of debate concerning the scope of federal government health and welfare policy and programs.\textsuperscript{199}

\textsuperscript{195} See Sara Rosenbaum, Mothers and Children Last: The Oregon Medicaid Experiment, 18 AM. J.L. & MED. 97, 100 (1992) [hereinafter Rosenbaum, Mothers and Children Last]; see also STEVENS & STEVENS, supra note 6, at 65-68 (providing a detailed discussion of the care provisions and benefit structure of the Medicaid program).

\textsuperscript{196} 42 U.S.C. §§ 601-687 (1994). Medicaid legislation identifies AFDC recipients as the one mandatorily designated “categorically needy” group to automatically qualify in every state for Medicaid benefits. See also GREEN BOOK, supra note 13, at 783 (describing the AFDC/SSI-Medicaid link).

\textsuperscript{197} Id. §§ 1381-85 (1994). For a detailed discussion of the SSI program, and the link between poverty and health care for impoverished disabled children, adults, and for the impoverished elderly, see Gellhorn, supra note 79; see also 42 U.S.C. § 1396a(a)(10)(a)(i) (1988) (provision linking Medicaid eligibility to AFDC and SSI).

\textsuperscript{198} States must provide Medicaid to all persons receiving cash assistance under AFDC. GREEN BOOK, supra note 13, at 784. The number of AFDC-Medicaid recipients (adults and children) increased from 10,978,000 in 1972 to 14,919,000 in 1982, to 22,058,000 in 1992. Id. at 798.

\textsuperscript{199} STEVENS & STEVENS, supra note 6, at 51-52.

Compared with Medicare, which had cut-and-dried provisions for eligibility and benefits, Medicaid (Title XIX of the Social Security Act) was relatively ill-designed, its future vague. Medicaid was, in fact, Kerr-Mills applied to a wider constituency: an extension of medical payments under state welfare provisions rather than a new health service program. . . .

By providing more generous federal matching funds to the states and by extending the principle of “medical indigency” to all welfare categories, Medicaid offered to the states the opportunity not only for vast expansion in public assistance medical services but also for a
Furthermore, the Medicaid program has been characterized by inadequacies, inequities, and shortcomings in its provision of care and its funding levels.\textsuperscript{200} As one of the nation's most complex social welfare programs, and its most comprehensive public health program, Medicaid has been the subject of very mixed reviews. On the one hand, Medicaid has been called "the only government program that even remotely compensates for the absence of a national health policy, which would aspire to assure at least basic health care for all United States citizens."\textsuperscript{201} For example, in the first decade of Medicaid funding, the program clearly and dramatically increased access to care for poor pregnant women, mothers, and their children.\textsuperscript{202}

On the other hand, as important as Medicaid clearly has been as a "safety net," providing desperately needed health care for poor mothers and their children, it has been an inadequate substitute for private insurance,\textsuperscript{203} or certainly, for federally-sponsored universal health care rethinking of their goals and philosophy.

\textit{Id.} at 51.

\textsuperscript{200} Volumes have been written on the failures and inadequacies of the Medicaid program. \textit{See id.}; James Strain, of the American Academy of Pediatricians, has noted:

Currently, the program [Medicaid] is fraught with problems and inequities, especially for children. Reduced payment for services, restrictions on the number of services covered and excessive paper work are among the factors that limit pediatrician participation in the program. Lack of pediatrician participation in Medicaid has led to a two-class system of child health care.


\textsuperscript{201} Rosenbaum, \textit{Mothers and Children Last, supra} note 195, at 99.

\textsuperscript{202} Sardell, \textit{supra} note 81, at 278. "The proportion of women seeking care in their first trimester of pregnancy increased during the period 1969-1980. This was especially true for black women. . . . There is also evidence that publicly funded reproductive, maternal and child health services have helped to reduce mortality and morbidity among children."

\textsuperscript{203} \textit{See} Rosenbaum, \textit{Rationing Without Justice, supra} note 3, at 1874. Had it not been for Medicaid, millions of poor children and their mothers would have gone without any medical care at all under the current two-caste system of health delivery in the United States. However, as important as Medicaid has been, health law policy analyst Rosenbaum notes that it has been severely restricted and inadequate. "There is no public insurance safety net for children like the
coverage. Also, Medicaid covers only a portion of the poor and, because of its traditional link to AFDC, is basically unavailable to many needy groups, such as adults in poor working families who lack employment-based health insurance. The Medicaid expansions of the mid-1980s addressed these serious enrollment issues and expanded eligibility to some sectors of the poor previously excluded, particularly to additional groups of poor children. However, these changes generally did not address health care benefits, resources, and delivery issues, which have been major faults with health policy in the United States generally and the Medicaid program specifically.

Some aspects of the Medicaid program were culled from past efforts and experiments in government sponsored health and welfare pro-

Medicare program for the elderly. Children without private coverage either obtain limited relief through Medicaid or go without." Id. at 1875.

204 See Rosenbaum, Mothers and Children Last, supra note 195, at 101. See also Green Book, supra note 13, at 787. In 1992, while Medicaid covered 11.2% of the total U.S. population (excluding institutionalized persons who are not eligible), this included only 47% of those with incomes below the federal poverty level. Id.

205 Beginning in 1984, Congress enacted a long series of Medicaid reforms in response to the growing numbers of poor and uninsured children, and poor women of childbearing age who were not yet mothers, and who did not meet the poverty means-test for eligibility or, who were not AFDC recipients. These reforms included the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494 (requiring some Medicaid coverage of all economically-eligible children under age five, all single pregnant women and women in two-parent unemployed families with family incomes below AFDC levels) and the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, 100 Stat. 82 (requiring coverage of all pregnant women with family incomes below AFDC levels). Rosenbaum, Mothers and Children Last, supra note 195, at 101-02 n.30. It took almost 15 years, starting with attempts by the Carter Administration, to revise Medicaid, first to permit, and then to require, coverage of low-income pregnant women and children who are not otherwise AFDC recipients. Id. at 102; Green Book, supra note 13, at 784-85.

See also Rosemary Barber-Madden & Jonathan B. Kotch, Maternity Care Financing: Universal Access or Universal Care?, 15 J. HEALTH POL., POL’Y & L. 797, 803 (1990). "This legislation eliminated Medicaid’s traditional categorical exclusion from mandatory coverage of very low-income pregnant women who do not receive cash assistance. These changes did not, however, remedy the financial barriers to Medicaid faced by pregnant women and children whose family incomes exceed AFDC levels . . . ." Id.

206 Sardell, supra note 81, at 283.
grams. For example, as under both the Sheppard-Towner Act and Title V of the 1935 Social Security Act, a major focus of Medicaid has been the provision of infant, prenatal, and maternal health care benefits. In this way, Medicaid has maintained the historic link between public health care entitlement and women’s fertility role. Furthermore, as under Title V, which, as previously noted, was the first medical entitlement program to tie health care eligibility to economic need, under Medicaid, for the most part, only those mothers receiving AFDC would be eligible for health benefits. A product of this legacy is this: a powerful government incentive has been created for a woman to become poor and to remain poor in order to receive government sponsored health care and medical assistance for herself and for her family. Therefore, for all of Medicaid’s strengths and weaknesses, its role as a “safety net” founded on a social welfare vision on the one hand, and its vagueness, internal limitations, and massive welfare bureaucracy on the other, with the creation of Medicaid the nation now firmly had in place its full-blown system of welfare medicine-medical apartheid health care.

III. Epilogue: AIDS and Universal Health Care — Health Paradigms of the 1990s

A. Anita’s Story: Women and AIDS

Finally, we come to Anita, whose story is a product of this legacy of federal public policy and legislative choices concerning women’s health and welfare. Sadly, her story highlights the link between the struggle for health care and a family’s plunge into welfare and poverty. Anita’s path to illness and poverty is a case study which demonstrates the ways in which the dynamics involved in a mother’s seeking health care for herself and her children, in the majority of cases, leads to and exacerbates her family’s poverty. Anita is a twenty-five year-old African-American

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207 Stevens & Stevens, supra note 6, at 76 (“In some respects Medicaid was a new program, but in others, it was merely an extension of what was going on before.”).

208 Medicaid is also available to women who are not mothers but who are impoverished and disabled, under the SSI program.

209 See supra notes 172-75 and accompanying text.

210 In addition, the disabled and aged poor who are SSI recipients would also be eligible for Medicaid health benefits.
mother with AIDS.\textsuperscript{211} Her parents were both public school teachers, and the family lived in northeast Washington, D.C. Anita had her first child just after graduation from high school in 1986. She put aside her plans to attend the local public university in order to care for her baby, despite her long-held goals to become an elementary school teacher. Determined, however, to remain off welfare and to be a self-sufficient mother, Anita held down a minimum-wage job as a clerk-typist. She continued to live with her parents, and her mother cared for the baby while Anita worked during the day. Her child’s father stopped by to visit occasionally but provided no financial support. Anita suspected him of having relations with other women, and of using drugs, but he became violent whenever she questioned him.

In the spring of 1991, Anita became pregnant with her second child. Without private health insurance or Medicaid, Anita did not have the means to pay for, and therefore access, prenatal care. With her parent’s financial assistance, Anita had her baby in the public hospital’s maternity ward. At that time, Anita was diagnosed as HIV positive; the HIV test had been administered because she was considered to be “at risk” for the infection.\textsuperscript{212} With Anita’s consent, her newborn was also tested for the HIV infection and received a positive diagnosis. At the age of 25, Anita was devastated by this double diagnosis at the birth of her second child. She suspected her infection was the result of her sexual relations with her child’s father, due to his drug problem and relations with other women.\textsuperscript{213} However, Anita feared raising the subject with him out of fear that he would become violent.

With her young child at home, and now her newborn infant who had special health care needs, Anita knew she had to stay at home to care for her children, and to forego further employment. Her HIV diagnosis helped to explain why she always seemed to be tired, and coming down with one cold or flu after another. She worried ceaselessly about her infant’s health and whether he would convert to a negative HIV diagnosis.\textsuperscript{214} With no health insurance, no other means to pay for

\textsuperscript{211} See supra note 23.
\textsuperscript{212} See Waysdorf, supra note 22, at 147 n.3 (explaining the term “at-risk”).
\textsuperscript{213} Id. at 149 n.6 (explaining trends in modes of transmission, and noting that since July 1993 more U.S. women were infected through heterosexual contact than through intravenous drug use).
\textsuperscript{214} See generally id. at 148 n.5 (citing to statistics which explain the seroconversion process of approximately two-thirds of infants born to HIV-infected mothers). All children born to HIV-infected mothers have HIV antibodies carried from their mother’s womb. As a result, all such newborns will
medical care, and no means of support for herself and her children, Anita began to feel desperate. With the worry, stress, and the physical challenges of caring for her newborn and of monitoring her own HIV-infection, Anita was constantly exhausted.

Unemployed and faced with the reality that her parents could no longer support her young family, nor provide for their health needs, Anita applied for AFDC. "Going on the welfare rolls" was quite literally the last thing in the world Anita wanted to do. However, she had heard that she would automatically get a Medicaid card for herself and the children, if she received AFDC. While she probably could have handled keeping a low paying job with her relatives providing child care, the health needs of her children were not negotiable. If going on AFDC was the route to Medicaid, then Anita would reluctantly take that route. Certainly, she self-justified, this would be a temporary situation. But for now her family's survival was unequivocally up to her alone and how well she could "work the system."

Anita soon began receiving $331 per month in AFDC direct payments. She received the Medicaid card and soon she was enrolled in a pilot health care project at Howard University Hospital, which provides comprehensive care to HIV-infected pregnant women and their children. With her health deteriorating, and the final HIV-diagnosis of her infant still uncertain, Anita came to fully depend on the Medicaid-sponsored health care she received at the hospital. Her health care case manager

test positive for the virus because the HIV test identifies the antibodies to the virus rather than the actual presence of the virus itself. By the age of 15 to 18 months, two-thirds of the infants born to HIV-positive mothers will "seroconvert" to a negative diagnosis, as they gradually lose their antibodies. The other third will continue to test positive for HIV infection, will in actuality maintain the infection, and will develop AIDS. Id. Recent research developments indicate that administration of AZT to the mother during her pregnancy may significantly reduce the incidence of actual positive perinatal transmission. See AZT Reduces HIV Transmission from Infected Moms to Their Newborns, J. OKLA. STATE MED. ASSOC., June 1995, at 88(6), 270-1; P.B. Matheson et al., Efficacy of Antenatal Zidovudine in Reducing Perinatal Transmission of Human Immunodeficiency Virus Type 1, J. INFEC. DIS., Aug. 1995, at 172, 353-58.

215 See supra notes 189-210 and accompanying text.

216 Subsequently, Anita would learn that she (and her infant son) could be eligible for SSI, the nation's welfare program for the disabled and elderly poor, due to her HIV disabilities. As would AFDC, SSI would also make Anita eligible for Medicaid. See supra notes 193-99 and accompanying text (discussing Medicaid eligibility requirements).
became her lifeline — her financial planner, her partner in decision-making, the basis of her support and care network. To Anita, being a "good mother" meant struggling to access quality, HIV-related health care for herself and her newborn, and keeping her older child healthy.

Living on welfare, Anita was now deeply trapped in poverty. For a number of reasons, she and the children had to move out of her parent's home and into subsidized public housing. Each month, after paying her rent and other incidentals, she had $25 dollars left to buy her children clothes and to pay for public transportation. Anita's dream of being a teacher like her parents had to be put aside. The lives of Anita and her children were now intricately tied to public welfare assistance: AFDC cash payments, food stamps, public housing, and Medicaid-sponsored health care. Anita's illness exacerbated her poverty, and now it would keep her and her children poor.

Unfortunately, the story of Anita is typical of the great majority of women, and particularly mothers, living with chronic or terminal illness in the United States today. In fact, Anita was more fortunate than most others on several counts. While her family could not continue to support her financially, they continued to provide her with emotional and other personal support. In this way, her family helped to keep Anita from becoming stigmatized and socially isolated due to her AIDS. Also, once she received Medicaid, she gained access to a health care provider which not only accepted Medicaid, but which was an experimental model in providing family-centered comprehensive care for mothers with AIDS.

Still, for Anita, a set of dynamics fell into place which brought together her own personal and financial choices, and her health care needs, with the already existing inequities of health care delivery, access, and quality in the United States. These dynamics created a context of poverty and public welfare entitlements from which Anita could not and would not escape. Anita's story clearly shows the impact of legal, economic, political, and psycho-social tensions, as they affect poor women who face a range of health needs, from serious and chronic health problems to simple pregnancy.

Simply put, Anita's story highlights the failures of our nation's apartheid system of welfare medicine which links health care to poverty. As noted throughout this Article, this is a system which provides Medicaid entitlements for certain categories of the needy poor, rather than universal coverage for all regardless of social and economic status. On the one hand, at least Anita had the option of accessing Medicaid, which became her health care "safety net" as she faced her AIDS diagnosis. This was the case, despite the longer-term economic and social consequences for herself and her family. But on the other hand, the lessons of
history, as discussed throughout this Article, demonstrate that it did not have to be this way.

Under contemporary federal health care policy, Anita had to give up working, even though she was still physically able to be employed, in order to qualify for government health benefits. She had to quite literally choose poverty, unemployment, and social and economic marginalization in order to access even a minimal level of health entitlements available under Medicaid. Even with the support of her parents, Anita was stigmatized and marginalized by the process. Earlier on, she had not been able to access prenatal health care nor treatment for her HIV infection. As a member of the "working poor," she had not had access to private, employer-provided health insurance. At the same time, Anita had "too many" assets to qualify for welfare medicine as long as she was employed or living with her parents.

Had federal policy and health law concerning women and children taken a different course over the last eight decades, the result would have been dramatically different for Anita and for the millions of other poor women like her. For example, from a hypothetical perspective, one might ask what might have been the consequences for Anita if she had lived during the era of the Sheppard-Towner Act. Indeed, it can fairly be argued that despite the defunct law's shortcomings, its prohibition on direct provision of medical treatment, and its relatively minimal apportionments in contemporary standards, Anita still would have fared considerably better if Sheppard-Towner's universally accessible, maternal and infant health programs had been available to her.

Under Sheppard-Towner, Anita could have accessed preventive care and education for her HIV infection, allowing her to be diagnosed and to begin treatment earlier in the course of her illness. With health education on the risks of HIV transmission, perhaps she would have avoided infection altogether. In addition, Anita could have accessed prenatal care and education during her pregnancies. Therefore, she would have learned of her newborn's diagnosis and health problems earlier in her pregnancy, thereby minimizing the medical risks to herself and to her baby. Moreover, hypothetically speaking, under an extended, contemporary, universal care model of Sheppard-Towner — one which would provide direct assistance and medical care — Anita would not have been forced to stay unemployed and to become an AFDC or SSI welfare recipient in order to receive government health benefits.

For despite the law's shortcomings and weaknesses, Sheppard-Towner's programs and policies were driven by principles that placed it miles ahead of what is currently available to women in terms of public health entitlements, education, and preventive care. In fact, Sheppard-
Towner was universal in nature, eligibility for its programs was not means-based, and the law emphasized preventive care and education, diagnostic services and general health education. By contrast, contemporary reality has dictated that generally, women with AIDS, like Anita, do not get diagnosed in the course of prenatal care, the potential risk of the infection’s transmission to the infant is not identified, and neither mother nor baby are given the chance of preventing transmission. Without health insurance, without access to health care generally, and prenatal care specifically, Anita and millions of women like her and their newborns continue to face tremendous risks. Furthermore, as for most women with AIDS, Anita’s deepening poverty became a dispositive factor in her prospects for maintaining her health, especially in the face of her HIV infection.

Anita’s story teaches that it is not enough just to recognize the effects of poverty on health, although the direct impact of poverty on health is clearly significant. It is also necessary to look at who is at risk of becoming the victim of poverty. Therefore, in a hierarchical, status-based society such as ours, members of groups that are oppressed on the basis of gender, race, sexuality, and class, like Anita, are the people who are most likely to be poor, to remain poor, and to experience a disproportional share of illness.

Moreover, terminal or chronic illness like AIDS or cancer may further precipitate an individual’s or family’s slide into poverty, due to the sudden need for expensive medical treatments and drugs. This process of impoverishment is exacerbated if the family lacks health insurance. Furthermore, when it is the mother who is terminally ill, the whole family is dramatically affected. In addition, social factors such as isolation, fear, hostility, and stigma, which typically accompany serious, transmittable diseases such as AIDS and TB can further contribute to and hasten one’s impoverishment.

In this way, the plight of women with AIDS and their children is the modern-day legacy of the health care choices our government has made over the course of this century. Their dilemma is largely the result of the legislative and the policy choices to replace pioneering, early twentieth

\[217\] See generally Waysdorf, supra note 22.

\[218\] SHERWIN, supra note 2, at 221-22. Moreover, notes the author, “not only does being oppressed lead to poverty and poverty to poor health but being oppressed is itself also a significant determining factor in the areas of health and health care. Those who are most oppressed in society at large are likely to experience the most severe and frequent health problems and have the least access to adequate medical treatment.” *Id.*
century universal maternal and infant health coverage programs, as exemplified by the Sheppard-Towner Act, with welfare medicine. This legacy has contributed to keeping poor women and their children poor, particularly those with special health care needs. These historical developments have resulted in a further feminization of welfare medicine, and of the poverty paradigm which has evolved over the last eight decades.

Finally, Anita’s story of lost opportunities, of illness and poverty is not unique. For as noted throughout this Article, the institutional responses of the medical establishment and the welfare state to Anita’s health needs find their roots in the developments of the early part of this century. This history consists of broken promises, of systemic gender, race and class discriminations, of paternalistic and patriarchal laws and public policies affecting women, and of the power of the medical establishment to defeat women’s struggles for health care, both for themselves and for their families.

B. Universal Health Care: A New Deal for All

This Article’s broad review of historical developments in women’s health policy and law over this century, and Anita’s individual story, illustrate that universal prenatal and primary health care is as much a prerequisite for a healthy, just, and economically sound society, as are other public rights and entitlements. The intersections of race, gender, and poverty in the provision and quality of women’s health care, and particularly the impact of these factors on women of color, indicate that the question of our health needs must be broadly redefined as an issue of civil rights and of human rights.

219 See Sardell, supra note 81, at 302. Children live in families and in communities. To become a society that produces healthy infants and children, we must deal with adult employment and family income, education, drug use, and housing issues. A universal prenatal and primary health care system providing transmedical services to pregnant women and children must be part of a comprehensive set of employment, wage, child care, and housing policies that support both the adults and children in families.

Id.

220 See Scales-Trent, supra note 54, at 1368 ("It is also immediately clear that our health needs must be defined very broadly. They must also be redefined as civil rights, in order to reinforce the sense of urgency and entitlement.").

221 Taunya Banks, for example, has addressed the question whether the
The concept of universal coverage has been well-recognized for its potential social benefits. As this Article has shown, at times in this country, universal care has served as an alternative model to poverty-based health entitlement programs. The medical apartheid system has contributed to stigmatizing the poor and to impoverishing those who are uninsured and in need of health care. Moreover, a continuing criticism of the U.S. health care system has been the lack of universal coverage, particularly in light of its economic feasibility and its resulting, myriad benefits.

The notion that all Americans should have access to a basic AIDS epidemic may force United States society, the courts, and the medical profession to "rethink the issue of a right to health care." Taunya Banks, AIDS and the Right to Health Care, 4 Issues in L. & Med. 151, 173 (1988). Banks notes that there is no single agreed upon concept in United States public policy or legal authority concerning whether health care is a civil, constitutional, human, or ethical right. Moreover, while the United Nations General Assembly recognized health care as a human right in the 1948 issuance of the Universal Declaration of Human Rights, the document does not reflect current rights or health policy in the United States. While there is no constitutional right to medical care, no legal obstacle exists to prevent the creation of that right legislatively. Id. at 159-61. Writing in 1988, Banks noted:

In 1970, Senator Edward Kennedy introduced the Health Security Act. Although the measure was never enacted into law, it is the closest Congress has come to recognizing health care as a right. The federal government provides some limited health insurance benefits under Medicare and Medicaid, but neither program can be considered comparable to a right to medical care.

Id. at 161 (citation omitted).

The most basic strategy to improve the health of poor, urban minorities requires universal health care financing for all Americans—Black and white, young and old, urban and rural, sick and well...

Our present system of health care financing disproportionately excludes minority, inner-city residents from the primary source of coverage—employer-provided health insurance.

See, e.g., Watson, supra note 53, at 1656.

See, e.g., Rosenbaum, Rationing Without Justice, supra note 3, at 1879 (arguing in favor of universal health care for all children). National health expert Rosenbaum notes:

There is no better example of health resource misallocation than the lack of a basic health system for all American children. Millions of children are uninsured, underinsured and underserved. By the end of the
package of quality health care services, regardless of ability to pay, was, for example, expressed by some proponents and drafters of the Clinton Administration's plan for health care reform.\(^{224}\) In fact, support for universal coverage continues to grow among some sectors in this country. For despite the fact that the availability and quality of medical care for much of the nation's population has dramatically improved over the last thirty years,\(^{225}\) great disparity in health care

decade, if something is not done, half of all American children and eighty percent of all black children will lack private health insurance. . . .

For approximately ten billion in 1992 dollars, all pregnant women and children could be given comprehensive health insurance coverage, neighborhood health centers could be developed in all medically underserved areas, and a basic public health infrastructure for children and families could be revived. This investment represents an approximate 1.5% increase in the national health budget. . . .

An investment in child health is one that no nation can afford not to make and that virtually all civilized nations except the United States have chosen to pursue.

_Id._ (citations omitted).

\(^{224}\) Louise G. Trubek & Elizabeth A. Hoffmann, _Searching for a Balance in Universal Health Care Reform: Protection for the Disenfranchised Consumer_, 43 DEPAUL L. REV. 1081 (1994). Trubek and Hoffmann have written:

Universal coverage is essential for a number of reasons. The two most commonly cited reasons are the high number of uninsured citizens and the escalating cost of health care. There are, however, other significant reasons. In order to have universal coverage, there must be a coordinated system to allocate the resources and ensure that everyone is part of the system. . . .

Such a comprehensive system also possesses another advantage: the reduction of stigma attached to groups considered to be undesirable.


still exists based on poverty, gender, access, health insurance status, and race.

Moreover, as discussed throughout this Article, past efforts at universal health programs for women have focused on women’s reproductive health needs, particularly maternal and infant care programs. This perspective is based on a view which links women’s health needs to women’s fertility role. While women’s health care in fact is not limited to reproductive health, maternity care remains a major factor in the health of women and infants, and has triggered more recent proposals for universal maternity and infant care coverage.

226 See generally Gonzalez-Pardo, supra note 29.
227 See Barber-Madden & Kotch, supra note 205.

Access to care continues to be a major national problem affecting women insured by both private and public insurers as well as women who are neither insured nor Medicaid eligible. At the same time, infant mortality rates and/or low birthweight rates have not been reduced to any significant degree during this period, and significant disparities continue to exist between those who receive care and those who do not, and between those who get care early and those who do not.

Id. at 807-08.
228 Blendon et al., supra note 225, at 280-81.

As a generalization, it appears that not only are there differences in access, but the care provided differs for blacks and whites along a number of dimensions . . . . This study reports disturbing trends. There continues to be a lack of parity in access to health care, and a consequent excess of unmet medical needs for blacks compared with whites. . . . Despite progress during the past two decades, the nation still has a long way to go in achieving equitable access to health care for all its citizens.

Id.
229 See generally Barber-Madden & Kotch, supra note 205.
230 For example, Barber-Madden and Kotch have suggested the necessity of a universal maternity care program, noting that “data from national studies show that comprehensive maternity care can improve pregnancy outcome and, at the same time, contain costs.” Id. at 808. In their article, Barber-Madden and Kotch endorse and elaborate on the Universal Maternity Care Plan, proposed in 1985 by the Council on Maternal and Child Health of the National Association for Public Health Policy. This plan for universal maternity care would have only one eligibility criterion — pregnancy. Id. They have estimated that comprehensive maternity care coverage could be provided for the nation’s 3.7 million women who give birth annually at a cost of $18.4 billion (based on 1987 figures), assuming that women in America are eligible and would participate. Id. at 809-
Today, however, women's health activists are demanding that other health concerns of women — breast cancer, AIDS, heart disease, menopause, and domestic violence — also be addressed by government funds and programs. Other legal experts reason that in order for government health programs to be effective in their provision of care, as well as to be equitable and long-lasting, they must be universal in nature — available to all regardless of ability to pay.

10. See Trubeck & Hoffmann, supra note 224, at 1090. They [women's health activists] believe that unique female health issues must also be recognized in areas of health care that are often thought of as gender-neutral, such as mental health, cardiovascular health, and AIDS care.

Women's health care activists believe that quality health care must also include preventive care, and they emphasize the necessity of free access to tests and screenings, such as pap smears and mammographies. They stress the importance of education regarding the prevention of disease, self-detection of warning signs, potential health risks with treatments and behaviors, and strategies to live with various health conditions. Women's health activists argue that for education to be available to all women, information must be dispensed in a way that all women can understand.

Id. (citations omitted).

232 See, e.g., Law, supra note 224, at 773. Law has argued:

LESSON NO. 1: PROGRAMS THAT SERVE ONLY THE POOR TEND TO BE POOR PROGRAMS.

We see this phenomenon quite dramatically in the contrast between Social Security on the one hand, and welfare programs for poor women and children on the other. As a program that serves people of all economic classes, Social Security is politically strong, provides for regular benefit increases to match increases in living costs, and generally avoids demeaning intrusion into people's private lives. By contrast, Aid to Families with Dependent Children (AFDC), a program exclusively for the poor, is politically vulnerable, has been subject to drastic reductions in the real value of benefits during the Reagan-Bush years, and is characterized by abusive denials of dignity and privacy. Therefore, as programs exclusively for the poor are weak, advocates should seek to represent constituencies that encompass working class and lower middle class people, as well as the poor.

Some Medicaid programs demonstrate that poor people's programs tend to be poor programs. Because Medicaid is a means-tested program, it is often politically vulnerable and ungenerous.

Id.
Legislative initiatives addressing the need for universal health care coverage and for redressing gender and racial disparities within the U.S. health care system have been sparse. However, the Women’s Health Equity Act of 1991, proposed by Senator Barbara Mikulski and Representatives Patricia Schroeder and Olympia Snowe, was a significant attempt to redress the gender gap in U.S. health care. As proposed, the Act was a broad-reaching omnibus package of legislation designed to address research, services, and prevention gaps in women’s health. While seeking to close the gender gap in U.S. health care, the

233 The legislation was first introduced in July 1990 as the Women’s Health Equity Act of 1990, was later amended, reintroduced in February 1991 and renamed the Women’s Health Equity Act of 1991. See Rutherford, supra note 55, at 283 n.150 (citing CONGRESSIONAL CAUCUS FOR WOMEN’S ISSUES, THE WOMEN’S HEALTH EQUITY ACT OF 1990 (1990)). The legislation was again introduced, but as a whole defeated, as the 1993 Women’s Health Equity Act. One component of the omnibus legislation which targeted the inclusion of women in clinical research protocols, in essence by codifying NIH policy, was actually passed as the NIH Revitalization Act of 1993, Pub. L. No. 103-43, 107 Stat. 122. See Merton, supra note 29, at 379.

234 H.R. 1161, introduced by Representatives Patricia Schroeder and Olympia Snowe, S. 514, introduced by Senator Barbara Mikulski, in February 1991. See also Gonzalez-Pardo, supra note 29, at 60.

235 See Gonzalez-Pardo, supra note 29, at 60. Title I — Research sections of the Women’s Health Equity Act of 1991 included programs to permanently authorize the Office of Research on Women’s Health, established by the National Institute of Health in September 1990, legislation to codify NIH’s policy regarding the inclusion of women and minorities in drug and scientific research, and several programs to fund (or to dramatically increase funding where programs already existed) in research and early detection programs for breast cancer, women’s mental health, drug and alcohol abuse, ovarian cancer, osteoporosis, contraceptive and infertility research, and women and AIDS. Title II — Services section included programs relating to breast cancer, teenage pregnancy, and expansion of health programs under Medicaid. Title III — Prevention sections of the legislation included programs further expanding Medicaid coverage for pregnant women and children under six, expanding Medicaid coverage to include routine mammography and pap smear screening, preventive care programs for women at high risk for AIDS, and the regulation and monitoring of mammography screening facilities. Rutherford, supra note 55, at app. (referencing Congressional Caucus for Women’s Issues — The Women’s Health Equity Act of 1991).

236 Gonzalez-Pardo, supra note 29, at 60; see also Rutherford, supra note 55, at 283 (for more information on the Women’s Health Equity Act of 1991 (“This omnibus package of legislation focuses on women’s health and seeks to guarantee
legislation does not go as far as calling for universal health coverage, that is, government-funded health care services, treatment and education for all women.

The failure of the Women's Health Equity Act of 1991 and the Clinton Administration's Health Security Act of 1992 to be adopted by Congress, clearly illustrates the lack of public awareness and, increasingly, with the new Republican majority in Congress, government's opposition to this life and death issue for all Americans. The failures of these legislative initiatives also show how far the nation still has to go towards providing quality health care for all, regardless of economic or social status.

CONCLUSION

The history of women's rights to health care, and the laws that have addressed women's health care needs teaches that only universal health care for all will ensure that poor women's (and children's) health care entitlements will be protected and sustained. Indeed, the legal and policy developments of the last eight decades demonstrate that women's access to health care (and by extension, to children's health care) must share the status of other civil rights and universal public rights. That will not be possible unless and until laws are in place which will provide for and protect the right to health care, for everyone.

The lessons of history, as discussed throughout this Article, teach that the same kind and quality of health care must be made available to all regardless of economic status. Welfare health care for the poorest has not been the answer and cannot remain marginalized as a minimal entitlement for poor women and their families. The medical apartheid system of welfare medicine, linking need to poverty, has in many ways served to provide a subsistence level of care to millions of poor families. But in fact, what has been called a "safety net" and a product of a progressive legacy has also served to maintain the status quo of this health care caste system, to stigmatize, and to further impoverish poor women and their children.

women greater equity in medical research and the delivery of health care services. It includes twenty individual bills divided into three separate titles — research, services and prevention.

Merton, supra note 29, at 379; see generally Keelyn Friesen, Non-Passage of the Women's Health Equity Act: Inaction May Lead to Cancerous Results, 14 HAMLINE J. PUB. L. & POL'Y 243 (1993) (advocating the passage of the legislation, focusing specifically on its necessity in view of women afflicted with breast cancer).
Only universal health care will begin to break the vicious cycle of women, poverty and poor health. Universal health care will be a giant step towards releasing poor women from the social, economic, and legally sanctioned trap of welfare lives and welfare medicine.