9

Child Health and Well-Being

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Welfare Reform Academy

Committee to Review Welfare Reform Research

www.welfareacademy.org

Part of a forthcoming volume

Family Well-Being After Welfare Reform

Edited by Douglas J. Besharov

9

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Lorraine V. Klerman[*]

Welfare reform may affect the health of children positively or negatively through several pathways. This chapter will first examine those pathways. Then it will consider whether existing federal data sets can be used to measure the changes that might occur and what alternative sources are needed.

Pathways Through Which Welfare Reform Might Affect Child Health

Welfare reform might affect child health by making medical care less available to children through creating or worsening financial or other barriers. It also might affect health in more subtle ways through its effect on other benefit programs, on child care, on children with special health care needs, and on poverty generally.

Medical care. Welfare could make medical care less available if families lose their access to Medicaid, the major federal program for poor children. But Congress was aware of this danger and included in the welfare reform legislation a provision that families who would have been eligible for Medicaid under Aid to Families with Dependent Children (AFDC) would remain eligible for Medicaid. Moreover, the welfare reform law did not alter eligibility for Medicaid under the several expansions developed under the Omnibus Budget Reconciliation Acts. In addition, a year after the welfare reform law was passed, the State Children's Health Insurance Program (SCHIP) was passed, increasing the number of children who are eligible for federal-state programs of health insurance.

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But eligibility alone does not guarantee that children will be insured. Prior to welfare reform, women and children enrolled in AFDC were automatically eligible for Medicaid (that is, no additional application was needed). As a result of welfare reform, women must apply for Medicaid directly. Many reports suggest that this process has led to many Medicaid-eligible children not being enrolled either because mothers did not realize that separate enrollment now was necessary, because mothers lacked the time to engage in this process, or because welfare workers incorrectly interpreted the new law.[1] The federal government is urging the states to take aggressive action to ensure that all Medicaid-eligible children are enrolled. The latest figures suggest that the decline in Medicaid enrollment between 1995 and 1997 has been reversed and that enrollment is beginning to increase, suggesting that federal and state efforts to increase the percentage of enrolled children are succeeding.[2] Few women leaving welfare for work are likely to find employment that offers private health insurance, but public health insurance will still be available for their children if they take appropriate action.

But insurance is not the only resource necessary to obtain medical care. The mother or some other family member must have the time to take the child to a provider. The various activities associated with seeking employment or with employment itself might make it difficult to find time to apply for Medicaid. Having a job, looking for a job, or engaging in job training may also mean that the mother is not available to take a child for health supervision examinations or care for acute or chronic conditions.

Other benefit programs. Similar problems arise in relation to other benefit programs, especially food stamps. Welfare workers are not aggressively linking families to all the services to which they may be entitled. Enrollment in the food stamp program has declined markedly since the implementation of welfare reform, despite the fact that few former welfare recipients have earnings that place them over the food stamp eligibility cutoff (130 percent of the federal poverty level).[3] In fact, a 1999 General Accounting Office report detailed cases in which states were making it difficult to apply for food stamps, not informing families that they were still eligible for food stamps even if they left the welfare rolls, or even taking illegal actions regarding

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[1]Bowen Garrett and John Holahan, "Health Insurance After Welfare," *Health Affairs* 19 (2000),175–184.

[2]Eileen R. Ellis and Vernon K. Smith, *Medicaid Enrollment in 21 States, June 1997 to June 1999* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2000).

[3]Shelia R. Zedlewski and Sarah Brauner, *Are the Steep Declines in Food Stamp Participation Linked to Falling Welfare Caseloads?* Assessing the New Federalism Project, Series B, No. B-3, (Washington, D.C.: Urban Institute, 1999).

food stamp eligibility.[4] Welfare reform could have an adverse impact on children's health if it makes it more difficult to provide them with the nourishment they need.

Child care. Welfare reform requires states to make child care available to working mothers. High-quality child care might have a positive effect on child health by detecting health problems early and helping families obtain care, as Head Start does by providing healthy foods and teaching mothers about health-promoting activities for themselves and their children. Child care of poor quality can lead to illness and injury, as well as deprive children of the emotional support and intellectual stimulation that they need. Welfare reform is challenging states and local communities to develop and fund child care that meets high standards or the federal government to fund a universal preschool program, perhaps by expanding Head Start.

Children with special health care needs. Some women have been on the welfare rolls because they were caring for children with special health care needs, such as asthma or cerebral palsy, or who were in wheelchairs or dependent on a ventilator. Preschool children with such conditions may need round-the-clock care, and their school-age counterparts who are integrated into regular or special classes might still need after-school supervision. Women with little or no income have often sought help from welfare to enable them to stay at home and care for such children. Although such women should be exempt from the requirements of the welfare reform act, apparently some are being pressured to seek employment. It will be important to determine whether the health of children with special needs is affected by welfare reform.

Poverty-related conditions. Welfare reform may affect child health by improving or worsening the conditions associated with poverty. The data overwhelmingly indicate that children whose families fall below or close to the federal poverty line have poorer health than do more well-to-do children, even when both have health insurance. Granted, access to medical care may be more difficult to obtain for the poorer child with Medicaid than for the more well-to-do child with private health insurance, but the differences appear to be the result of other factors as well: less adequate housing, more dangerous and unhealthy neighborhoods, inadequate child care facilities, and behaviors and practices by children and parents that are less conducive to health promotion. For example, poor mothers—because of inadequate information, time pressures, or insufficient funds—may select less healthy foods for their children, allow them to be sedentary, not use child restraints in automobiles, or not provide helmets for bicycles. Their homes may lack working smoke detectors or have peeling lead paint or molds and other airborne particles that cause asthma attacks. Food may not be stored safely if refrigeration is inadequate or absent.

If obtaining employment allowed mothers to move their children to safer and healthier housing and environments and put the mothers and children in contact with others who might

[4]U.S. General Accounting Office, *Food Stamp Program—Various Factors Have Led to Declining Participation*, No. RCED-99-185 (Washington, D.C.: U.S. General Accounting Office, 1999).

model healthier behaviors—welfare reform might have a positive effect on child health. If, as seems likely, mothers make little money from their jobs, or if they are forced off welfare and have no new source of income, poverty will continue to take its toll on the health of children through limited access to high quality health care, inadequate housing, poor food, and health-compromising behaviors.

Monitoring Through Federal Data Sets

The information required to measure the impact of welfare reform would need to have several features:

- Measures that are sensitive to the aspects of children's physical and emotional health that might be affected by welfare reform.

- Ability to determine present and past economic status, including welfare receipt and, possibly, the reasons that the mother left the welfare rolls.

- A sample that includes enough poor children to permit valid conclusions to be reached.

- Inclusion of a sample of children with similar characteristics who were not affected by welfare reform to serve as a comparison group (enabling the researches to avoid the error of attributing to welfare reform changes that were already occurring, such as the decline in teenage births).

- Inclusion of measures during a period before implementation of welfare reform (or early in that process) in order to provide before-and-after data.

- Periodic data collection in order to trace trends over time.

- Aggregation of data by state (if state comparisons are wanted).

- Ability to provide information within a year of its collection.

Child health measures. The effects of welfare reform on child health could be measured by health status, health-related behaviors, or medical care access or utilization. The traditional measures of health status are deaths, illnesses, and injuries. These measures are probably too crude to be able to detect welfare reform's effects. Mortality is declining for children of all ages, although injuries and violence among adolescents still cause many deaths. With the exception of asthma and diabetes, illnesses also are also declining, although sexually transmitted infections remain a problem among adolescents. Non-fatal injuries also are declining. It is unlikely that welfare reform will have any effect on these traditional measures or, if it did, that the effect could

be determined given the strong time trends. A reversal in the generally favorable trends coinciding with the implementation of welfare reform, however, would be worrisome.

Experts agree on few measures of children's emotional health. Many of these measures cannot be administered using survey methods.

Another health status measure is the parent's perception of the child's health. The National Center for Health Statistics' ongoing National Health Interview Survey (NHIS) asks parents whether they think the health of a child is, in general, excellent, very good, good, fair, or poor. Welfare reform probably would not affect this measure.

An alternative way to measure health status is by examining physical and mental functioning. For many years, the health of the elderly has been measured by their ability to perform the activities of daily living, that is, can they do the things that one ordinarily does on a daily basis without assistance? The NHIS asks a representative sample of the population whether they are unable to carry on their *usual* activity. The usual activity of school-age children is attending school; for preschool children, it is play. The 1994 National Health Interview Survey on Disability included a question for children on difficulty preforming *everyday* activities in the area of learning, communication, mobility, and self-care. But even these measures may not be sensitive to welfare reform; moreover, the questions on everyday activities have not been incorporated into the ongoing NHIS.

Welfare reform might affect health-related behaviors related to safety, nutrition, or sexual behavior. Because they have more money, employed mothers might provide their children with booster seats, bicycle helmets, or more nutritious foods (for example, they might meet the "five a day" standard for fruits and vegetables). Or, on the negative side, the absence of the mother from the home because of employment might provide more opportunities for adolescent sexual activity.

Welfare reform might affect access to and use of medical care, as described earlier in this chapter. Some of the traditional measures of medical care are usual source of care and frequency of physician visits during a defined period. The latter is a poor measure of medical care adequacy because children with a chronic condition, such as asthma, may need to see a physician often, while children who are healthy may not.

The problem of how to measure child health and child well-being is being pursued in many quarters, not just by those interested in welfare reform. The Federal Interagency Forum on Child and Family Statistics issues an annual report entitled, *America's Children: Key National Indicators of Well-Being*, which includes measures of economic security, behavioral and social environment, and education, in addition to health. The Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services also issues a report,

Trends in the Well-Being of America's Children & Youth, which uses a larger set of indicators, including mortality, health conditions, health care, social development, behavioral health, and teen fertility. The Annie E. Casey Foundation's annual *Kids Count Data Book* presents state profiles of child well-being and is one of the few publications that provide state-level data. In addition, several groups—such as the Children and Adolescent Health Measurement Initiative, a collaborative effort of the Foundation for accountability and the National Committee for Quality Assurance—are now working to develop new measures of child health.

Federal data sets. The federal government operates several data collection systems that contain information about children's health status, health-related behaviors, and medical care access and utilization. Health status can be measured using the Vital Statistics system (characteristics of births and deaths), NHIS, National Health and Nutrition Examination Survey, and the National Hospital Discharge Survey. (All these surveys are the responsibility of the National Center for Health Statistics.) The Centers for Disease Control and Prevention (CDC) publishes data on communicable diseases, including those diagnosed in children and youth.

Health-related behaviors can be studied using data from NHIS, the Youth Risk Behavior Surveillance System (a CDC survey), the National Household Survey on Drug Abuse (sponsored by the Substance Abuse and Mental Health Administration), and Monitoring the Future (a survey of youth substance abuse). Information on adult behaviors that might influence child health are collected in the Behavior Risk Factor Surveillance System, a CDC survey.

Medical care access and utilization can be measured by examining data from the NHIS, the Medical Expenditure Panel Survey (an Agency for Healthcare Research and Quality survey), the National Immunization Survey (an NCHS survey), the State and Local Area Integrated Telephone Survey (SLAITS, an NCHS survey), the March supplement to the Current Population Survey, and the Survey of Income and Program Participation (the latter two are Census Bureau surveys). Administrative data, such as Medicaid files from the Health Care Financing Administration, also are useful. This list is not exhaustive.

Although all these federal data sets contain measures of child health and are either ongoing or collect information periodically and have been doing so since before welfare reform was implemented, none are totally adequate to the task of assessing the impact of welfare reform. Few ask about welfare status and some have no indicator of economic status. In most of the studies, the sample of poor children is not large enough to reach valid conclusions. Moreover, the poor, who are most likely to be affected by welfare reform, are more likely to be among those whom federal studies are unable to contact or to convince to cooperate, leading to low response rates in this group. Few federal data sets can be disaggregated to the state level or to smaller geographical areas. Because of variations in state welfare policies, policymakers may want to obtain data at the state or county level. Also, policymakers may want a quicker turnaround time than is now available from many of the federal data systems.

The NHIS is the most likely to show changes in children's health *after* welfare reform, because it collects information on a large enough sample of poor children (usually defined as family income below the federal poverty level). But having a poverty level income does not mean the family is on welfare. In 1990, only 66.7 percent of children whose family money income for the previous year fell below the poverty threshold received AFDC and, in 1997, the median state AFDC benefit was 34 percent of the 1997 poverty guidelines.[5] NHIS sampling methods, moreover, provide data only for the nation as a whole and for a few large states. The CPS can provide information on changes in health insurance status by state and relatively quickly, but its estimates have been questioned, especially for the smallest states. SIPP is another possibility.

Federal data collection efforts would need to be modified to make them more responsive to monitoring the effects of welfare reform. Surveys samples would have to be enlarged, oversample the poor, and selected to permit disaggregation of results to at least the state level. Reports would have to be generated more expeditiously and questions added on the aspects of child health most likely to be affected by welfare reform. These modifications seem unlikely, however, because of their costs. And even if Congress approved additional funds, the magnitude of the changes would probably mean that the revised surveys would not be fielded for several years, so that baseline data would not be available.

Similar suggestions for modifying or expanding the federal statistics systems were made by the Committee on National Statistics of the National Research Council as a result of a 1996 workshop. The report noted, "The changes that are occurring in heath and social welfare programs require new or modified survey questions on a wide range of topics."[6] Other themes, still relevant today, were:

- Modifying the sampling schemes of existing surveys is important to meet data needs for program analysis and monitoring. The workshop noted that devolution of responsibility for social welfare programs to state governments increased the need for state-level estimates and that none of the national surveys provided complete and reliable estimates at the state level.

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[5]U.S. House of Representatives, Committee on Ways and Means, *1998 Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means,* (Washington, D.C.: U.S. Government Printing Office, 1998).

[6]Constance F. Citro, Charles F. Manski, and John Pepper, eds, *Providing National Statistics on Health and Social Welfare Programs in an Era of Change, Summary of a Workshop* (Washington, D.C.: National Academy Press, 1998).

- Creating a comprehensive, regularly updated, accessible database that provides detailed information about program features for states (and localities, where applicable) is essential.

Another possibility would be a federally sponsored survey specifically designed to examine the effects of welfare reform on the entire country as well by state. Such a survey could be built on SLAITS, which already calls many households to request information about children. But even SLAITS would need to be modified to oversample those most likely to be affected by welfare reform and, because it is a telephone survey, it may miss the poorest families who are most likely to lack phone service. (SLAITS attempts to compensate for this problem by weighting.) Again, this approach would be expensive, but it probably could begin relatively soon following an authorization. Again, baseline data would not be available.

Non-Federal Approaches to Monitoring

A group of largely independent studies of welfare families is being used to determine the effects of welfare reform on child health. Some of the studies are funded by the federal government, and others by states and foundations. Several started early enough so that baseline data are available and some have comparison groups. Fortunately, the directors of these studies realized the advantages that might accrue from using the same set of child health and well-being measures. With support from the John D. and Catherine T. MacArthur Foundation and the Department of Health and Human Services, they worked with Child Trends to develop measures of child well-being that include: health and safety, social and emotional adjustment, use of health and human services, child care, and home environment and parenting practices. The Urban Institute's National Survey of America's Families will also will be able to provide relevant data, but only for thirteen states.

Conclusion

Measuring the effect of welfare reform on the health and well-being of children will be difficult, but not impossible. Some federal data sets will provide trends on a limited group of indicators for poor children nationally and for the largest states, but most federal data collection efforts are not adequate to the task. Their indicators of child health are not sensitive enough to detect the types of changes in child well-being that welfare reform might produce; they do not have a large enough sample of welfare families; they ask too few questions about welfare status; and they can not provide state-level data, which might provide insights into whether different welfare reform policies had different effects.

The problem of detecting changes resulting from a 1996 law that is still being implemented is compounded by the 1997 passage of SCHIP legislation. Its effects, particularly on insurance coverage and use of medical care, will probably be greater than any caused by

welfare reform.[7] Distinguishing between the effects of SCHIP and welfare reform will be almost impossible using federal data sets.

The country, however, will have the results of several well-designed individual studies, mostly at the state level. If the studies are well executed, they will provide the necessary information for selected areas and it should be possible to extrapolate, cautiously, from these studies to the entire country. (The 1998 *Green Book*, issued by the Committee on Ways and Means of the U.S. House of Representatives, includes an appendix listing the studies that are monitoring the effects of welfare reform.)

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[7]Peter G. Szilagyi, Jack Zwanziger, Lance E. Rodewald, Jane L. Holl, Dana B. Mukamel, Sarah Trafton, Laura P. Shone, Andrew W. Dick, Lynne Jarrell, and Richard F. Raubertas, "Evaluation of a State Health Insurance Program for Low-Income Children: Implications for State Child Health Insurance Programs," *Pediatrics* 105 (2000), 363–371.

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Comments

Kristin Moore[*]

The first question we need to consider is this: Why should welfare reform be expected to affect children's health, health care, or health-related behavior? What is the theory underlying this expectation? Welfare reform is a pretty distal influence on children's health. Multiple determinants of health exist, including genetic factors and the social and physical environment. In addition, most children are pretty healthy. If rates of child health problems are low and welfare reform is no more than a distal influence on children's health, why would we expect to find any effects of welfare reform that are big enough to be measurable?

There are good reasons to hypothesize that welfare reform focused on adults might affect children's health outcomes, but as with the housing, we need to think through that story line. Health *services* are not a child outcome. We need to be careful not to track services and call them child outcomes. They are pathways that affect child outcomes and are important—but they are just not child outcomes. We need to examine child health and safety; those are child outcomes.

To examine child health and safety, one needs to assess it. Assessments may be done through the parents' report, the child's report, a doctor's report, or a direct health assessment. Child-related health services also should be measured—again, as a pathway, not as an outcome. Such services include the State Children's Health Insurance Program (SCHIP), Medicaid, and employer-provided health insurance as well as family health practices.

Because measurements should be guided by theory, we need to think through which measures are needed. This task is hard because the research community has been addressing this question only for the past decade or so. It takes some time to develop clear directional hypotheses. We are dealing with social behavior in many of these instances. Patterns of behavior can change; behavior is not driven by immutable physical laws. At this point in time, hypotheses need to be bidirectional because we do not have a good sense as to whether the effects of welfare reform on children's health or other outcomes will be positive, negative, or neutral. We need to look for positive as well as negative effects.

Because health conditions are infrequent among children and take time to develop, researchers should identify "crocuses" and "miners' canaries" that might serve as harbingers of good or poor child health outcomes. Possible outcomes include health status, infectious diseases,

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accidents, injuries, or poisonings. Such problems could result from poor supervision, monitoring, or care on the part of parents or child care workers. Child health outcomes also could improve if family income, parent education, or household organization improve in ways that enhance children's health and safety.

Adolescent risk-taking behavior, such as precocious sexual activity or substance abuse, also could result from too little supervision. Health problems could go untreated because of parental time pressure or a lack of health insurance coverage for preventive health care.

We need to think through how welfare reform, both specifically and in interaction with other concurrent changes, might affect adult and family outcomes. Then we need to think through how those variables would, in turn, affect children's outcomes.

Table 1 shows the results of ten months of working with twelve states to compile the theories of governors, legislatures, and welfare administrators about how welfare reform might affect the children in their state.[1] No one who participated in those discussions, was ready to suggest causal influences at this point in time. But, as the figure shows, it was hypothesized that state policies would affect all of the targets of welfare policy—specifically, income and employment, family formation, marriage and nonmarital childbearing, teen childbearing, and attitudes.

Adult areas that are not specifically targeted by welfare reform but which research and program experience suggest might affect children's health include the parents' psychological well-being and stability in various aspects of the child's life, including child care, income, residence, household structure, and family composition. Involvement of the absent parent, the use of services, and patterns of alcohol and other drug consumption also play a role. Even those constructs often do not affect children directly but do so through the home environment, parenting practices, or child care—those are environments that directly affect children. Table 1 shows the process by which one would expect that the outcomes of child health, safety, and social or emotional adjustment might be affected.

[1]Child Trends, *Children and Welfare Reform: A Guide to Evaluating the Effects of State Welfare Policies on Children* (Washington D.C.: Child Trends, 1999).

CORE CONSTRUCTS FOR THE PROJECT ON STATE-LEVEL CHILD OUTCOMES

TARGET OF WELFARE POLICIES	OTHER VARIABLES LIKELY TO BE AFFECTED BY STATE POLICIES	ASPECT OF CHILD'S ENVIRONMENT LIKELY TO BE AFFECTED BY PREVIOUS COLUMNS	CHILD OUTCOMES
INCOME: Total income Sources of income (mother's earnings, father's earnings, child support, AFDC, food stamps, SSI, Foster Care/Adoption) Stability of income Financial strain/Material hardship ***EMPLOYMENT:*** Any vs. None Health benefits through employment Wages (hourly) Hours of employment Stability of employment Education/Licenses Hard job skills Multiple jobs concurrently *Barriers to employment* ***FAMILY FORMATION***: Nonmarital birth/Marital birth Child/Family living arrangements Marital status, whether married to biological or non-biological father	***PSYCHOLOGICAL WELL-BEING:*** Maternal depression ***STABILITY AND TURBULENCE:*** Foster care Stability in child care Stability in income # of moves of residence Change in marital status or cohabitation Reason child not living with family ***ABSENT PARENT INVOLVEMENT:*** Whether child support provided Paternity establishment Frequency of contact with child ***USE OF HEALTH & HUMAN SERVICES:*** Food stamps Medicaid (awareness, use, eligibility) Child care subsidy (awareness, use, eligibility) Access to medical care ***CONSUMPTION:*** % of income spent on child care and rent	***CHILD CARE:*** Type Extent Quality (group size, ratio, licensing, parent perception) Stability *Child care history for last several years* ***HOME ENVIRONMENT AND PARENTING PRACTICES:*** Child abuse/neglect (Admin.Data) Domestic violence/abusive relationships Family routines Aggravation/stress in parenting *Emotional support and cognitive stimulation provided to child*	***EDUCATION:*** Engagement in school (Focal Child) School attendance (All Child) School performance (All Child) Suspended/expelled (All Child) Grades (All Child) ***HEALTH AND SAFETY:*** Hunger/nutrition (Focal Child) Child health status (Focal Child) Regular source of care (Focal Child) Teen childbearing (All Child) Accidents and injuries (All Child) ***SOCIAL & EMOTIONAL ADJUSTMENT:*** Behavior problems (Focal Child) Arrests (All Child) Social competence (Focal Child)

Constructs in italics—Only for those states fielding an in-home survey All Child—All children of the respondent Focal Child—One child aged 5-12.
Source: Reprinted by permission from Child Trends, *Children and Welfare Reform: A Guide to Evaluating the Effects of State Welfare Policies on Children* (Washington D.C.: Child Trends, 1999), figure 3.2.

Schooling or engagement in education and cognitive development have not been discussed in this conference so far, yet education was certainly one of the areas that the states and the research community would want to examine as an outcome. We need to think about children's development within a conceptual model like that indicated by the figure and base that model on the research literature as well as experience in the community.

The way in which health outcomes vary for children of different ages is an important issue. The health problems and issues that adolescents face are different from those of younger children. Boys and girls have different needs. The subgroup of children with existing health conditions should be examined to see how they prosper after welfare reform. Other important subgroups, such as immigrants, also should be considered.

Because health outcomes are more likely to be measured fully and carefully in health studies than in economic or sociological studies, it would be valuable to examine the health databases for the outcome measures and make sure that social and economic variables are added to those databases. What missing constructs are there, and could they be added to those databases? The expensive dependent variables are in those databases. For example, in the forthcoming Early Childhood Longitudinal Study, the birth cohort is important because National Institutes of Health has invested considerable funds in adding assessments of children as they are followed over time.

Assessments should cover mental as well as physical health. Again, the hypotheses support an indirect effect, in which the stress of welfare reform has either negative or positive effects that are transmitted to the children (for example, parental mental health). To assess the entire process, we need all the constructs measured in one database. We can track indicators, but if we truly want to develop an understanding of how this conceptual model works, we need all the information in one longitudinal or experimental study.

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Child Trends. 1999. *Children and Welfare Reform: A Guide to Evaluating the Effects of State Welfare Policies on Children.* Washington D.C.: Child Trends.

Comments

Jerry Wiener[*]

As a clinician, I have always been more interested in individuals than in populations. I also am interested in the process of human development and what affects or influences normal and adverse developmental outcomes.

Why would welfare reform affect the health of children, and in what ways?

One area is the homeless population. When most people think of the homeless, they do not think of children, but children constitute a larger number than people realize. Homeless children have severe health problems of all kinds. Their health status is terrible.

Most of that information comes from a pediatrician, Ethan Wiener, who is working with the Children's Health Fund in the New York Health Project. His paper (unpublished manuscript) documents the extent and the degree of difficulties in homeless children, who are affected by the most adverse circumstances imaginable. In every area of physical, mental, and behavioral health, they are at great risk and experience great morbidity.

In assessing the impact of welfare reform on children's physical health versus their behavioral and mental health, we have two related but different universes of observation and measurement. Physical health is measured most often at points in time, and mental and behavioral health are measured by issues over time, so that adverse outcomes in these latter domains may not become apparent for several years.

This perspective is somewhat different from that of the other authors in this volume. We are moving rapidly away now, particularly because of the expanding understanding of the role of genes, from what has been a focus on the dominance of the environment and its effects on development. Throughout the twentieth century, social science research focused on the dominance of the environment in the nature-nurture controversy in explaining the developmental process. But researchers are beginning to examine the developmental process in a more sophisticated way by looking at gene-environment relationships, interactions, and codependencies.

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What welfare reform changes are likely to affect these gene-environment interactions and codependencies? This perspective assumes that the child's genetic endowment, for better or for worse, from early on influences the behavior of the immediate environment—in other words, the behavior of the parents, caretakers, and siblings. It proposes that certain kinds of environmental conditions are required to translate genetic endowments or predispositions into developmental and behavioral realities. These behaviors further organize new environmental realities and so on, almost like a double helix itself in terms of codependencies and interactions.

The environment acts as a switch for genetically predisposed developments. If the environment does not provide for the type of switches, then important adaptive capacities and behaviors may be adversely affected, compromising adaptation to the larger society. That may be where investigation needs to focus.

Not to exclude the genetic contribution, but among the problem environments one might examine are the effects of single parenting, poverty, unstable parenting, abuse, parental mental illness, and homelessness. More important are various combinations of the above factors together with other circumstances that I have not included, because the complexity occurs in those combinations and the difficulty lies in teasing out cause from correlations.

Homelessness is correlated with terrible nutrition and a decrease in the level of immunization. Immunization is probably the single most important cause of improvement in child health, certainly in the past century. In addition, mental illness is a characteristic of the homeless adult population; about 50 percent are found to have a serious diagnosable mental disorder. So homelessness brings together many issues.

For example, the high rate of asthma is increasingly recognized in the homeless population as well as in low-income and poverty populations. The incidence of asthma has increased dramatically over the past few years in this population and in low-income and poverty populations for unknown reasons. Obesity, together with terrible nutrition, is a major health problem in low-income populations. So are delayed development; learning disabilities; physical abuse; and a much higher incidence of serious behavioral problems and psychiatric disorders, displayed in part in a high level of violence and aggression.

Those who study resilience, or survival, attempt to determine why children under similar or identical circumstances succeed or fail. I would hope that the social sciences might have something to offer us in that regard.

Discussion

Health Indicators

Ron Haskins: Is there any evidence of negative effects on children's health since the beginning of welfare reform?

Douglas J. Besharov: Let me amend that question. Has there been any effect on poor children?

Lorraine V. Klerman: Asthma is the only condition that I know to be on the increase among poor children, and that increase started before welfare reform.

Douglas J. Besharov: You reported that children's health was generally improving. Would currently collected data allow us to determine if the health of middle-income children was improving tremendously and the health of low-income children was getting worse?

Lorraine V. Klerman: The National Health Interview Survey is an ongoing survey that collects data on many health conditions and on economic status. So it is possible to compare trends in those conditions across economic groups. But fortunately most children are not poor, so there are fewer data on them, and many of the conditions about which data are collected are either not very common in children or are not very sensitive to children's health. To answer your question, NHIS would reveal these differences if they were major but, if they were marginal (which is likely), NHIS would need to interview a greater number of poor families and have a greater number of child health-sensitive questions to detect them.

Douglas J. Besharov: This is a theme in a number of the areas we are talking about.

Kristin Moore: An illustration of why it is important to have a conceptual model and look at pathways is infant mortality. We are saving a lot of babies that are born at very low birth weights because of medical technology in the delivery room, but many of those children are impaired. They have more cognitive and neural problems. In other words, it is a good thing that they are being saved, but they have problems that go on. You have to separate out those effects of medical care on these children.

Robert Rector: When I speak of the long-term outcomes and whether a variable affects them, let me clarify. I am usually talking about such things as future drug use; success in work, school, and marriage; criminal behavior; and emotional stability.

A generic point that I have made before needs to be made again. My wife and I used to live near Dupont Circle about fifteen years ago. It is an interesting neighborhood in the sense that it is yuppie and expensive, but if you go three blocks in one direction, you are basically in an inner-city neighborhood. One of the things we used to find when we lived there was that when we came back from the movies or wherever, no matter what time it was, there were always people out in the neighborhood, out on the street. Even at 1:00 or 1:30 a.m., we always found a number of two- and three-year-old children running around on the street corner, with the adults out front drinking.

If you go to that neighborhood at 1:30 a.m. in good weather, another set of children will be out there toddling around. Some of them can barely walk.

Now, my image of what welfare reform is about is those little children. A tremendous, almost infinite number of bad things are going on in their lives. In almost every meeting I attend, however, I am continually struck with, first, the complete irrelevance of the discussion to what is actually happening in the life of those children. Second, I am amazed at the almost total irrelevance of most of our databases to measuring what is going on in the life of those children; the irrelevance of most of our evaluations; and the irrelevance of most of our public policy, including conservative work-oriented policies.

It seems that our policymakers and researchers are not focused on what is actually going to control the life outcomes of children. Most of the variables that we want to adjust are irrelevant, and most of the discussion is irrelevant. I happen to think that there are policies that might actually help those children, but they are almost never discussed, and we continue to be preoccupied with things that are marginal to the underclass, which should be the central focus of welfare reform.

Lorraine V. Klerman: Somebody asked whether welfare reform might have an impact on infant mortality. You need to understand that most children who are going to die in the first year of life die in the first week. Most of these children die because of congenital anomalies incompatible with life or from extreme prematurity, that is, being born too soon. Our knowledge of how to prevent these two conditions is very weak. Urging women to take folic acid supplements before they become pregnant could reduce some congenital defects. How would welfare reform encourage that? Convincing women to stop smoking during pregnancy would impact low birth weights but, again, how would welfare reform encourage that? Some believe that reducing stress might improve pregnancy outcomes. Does welfare reform increase or decrease stress? The few

infants who die between one month and one year of life usually die of SIDS or injuries. Will welfare reform affect these?

Irv Garfinkel: If there are almost 40,000 households in the NHIS annually and 20 percent are below the federal poverty level, then there should be almost 8,000 children in the sample. You do not need to oversample poor children. There are enough.

Lorraine V. Klerman: There are several problems here. First, not all households include young children, who are probably most likely to be affected by welfare reform. Second, we will be looking for conditions that occur infrequently in children. For these reasons oversampling of poor families with young children might be necessary.

Irv Garfinkel: But you can also pool across years.

Lorraine V. Klerman: Yes, but if you pool data across years you will be less likely to see year-to-year trends.

Medicaid Coverage

Ron Haskins: Isn't it clear that Medicaid coverage is declining?

Lorraine V. Klerman: Medicaid coverage increased with the Medicaid expansions of the 1980s and early 1990s. It declined in the years immediately following the implementation of welfare reform, probably as a result of de-linking it from AFDC, as I mentioned in my paper. There are signs that the rate of Medicaid coverage is now on the rise and, of course, many children are now being covered by SCHIP, so the percentage of uninsured children should be declining overall.

Ron Haskins: According to administrative data, Medicaid coverage decreased in 1995 and 1996, undoubtedly due to welfare reform. If Medicaid coverage declined and there is no evidence that children are less healthy, why are we spending billions of dollars on Medicaid?

Lorraine V. Klerman: First, it is too early to tell if the decline in Medicaid in 1995 and 1996 had any affect on children's health. The lag in obtaining data, at least from the NHIS, is too long. Second, if children only lost coverage for a year or two, most would not be affected, at least the relatively healthy ones. Third, many, if not most, of the children who lost Medicaid coverage probably still received care from the "safety net" providers who care for the uninsured. (However, those safety net providers might be less "financially healthy" as a result of the children being uninsured.) Finally, the absence of Medicaid coverage is unlikely to affect mortality, with the possible exception of women being unable to obtain prenatal care or pre-term infants not being accepted by neonatal intensive care units, neither of which appears to have

happened. And lack of Medicaid coverage probably will not affect the number of illnesses children experience, although it may impact how long they are sick and whether they suffer any long-term effects.

Lack of Medicaid coverage will affect how often children are seen by a physician, especially for preventive care, and it may affect immunization rates (but again, the safety net providers may pick up the slack). So the impact will be felt in the short run on utilization measures rather than on mortality and morbidity. A reduction in Medicaid coverage or an increase in the percentage of uninsured children would probably increase the pain and suffering experienced by children. Children who do not see a physician when they need care and children who do not go to a dentist for preventive care will probably suffer more than children with easier access because they are insured.

Robert Greenstein: I wanted to get back to Ron Haskins' point, which seems hard to answer. My understanding is that if you compare having Medicaid to having no Medicaid at all, before there was any program, you can find some effects. But if you have a three-, four-, or five-percentage-point reduction in the proportion of poor children on Medicaid, I do not know whether it will show up in the kind of data that we now have, and it seems to me that it is confounded by two points, one of which Lorraine raised. There are data problems here. If you use the CPS data, which are fraught with problems in terms of Medicaid, you find that between 1996 and 1998, the percentage of poor children with Medicaid coverage dropped from 63 to 58 percent, not just welfare leavers, but the whole universe of poor children.

We have data instruments that could look at low-income children as a whole; if there is a health effect, I do not know that they could pick it up. As Lorraine mentioned, at the same time that we have this shrinkage in Medicaid coverage, there is an expansion in SCHIP coverage to an only modestly higher-income group.

As many people have said, the CPS data are not good at assessing Medicaid or food stamp enrollment. The administrative data for the number of families and people getting food stamps are good. The administrative data on Medicaid are not good, and no reliable source exists of the number of people getting Medicaid, which further confounds the problem of trying to figure out what is going on.

It would be interesting to have some research on the health effects, if any, among citizen children in families with at least one immigrant parent. An Urban Institute study has found that 21 percent of all uninsured children in the country are citizen children in a family with at least one immigrant parent, which accounts for 50 percent of the uninsured children in California. Maybe someone can study that as an identifiable population. I do not know what it would show, but it might be useful to study.

Douglas J. Besharov: I will tell you what it will show. It will show that those children are healthier without medical coverage because they start off healthier. It is cultural—David Hayes Batista and other people have found that those immigrant children are in healthier physical condition on many dimensions—lower infant mortality, higher birth weight.

Robert Greenstein: You would ideally want to see what changes occurred over time in that population.

David Murray: I believe that our effort to discover what may be going on in lower-income circumstances also is obscured by immigration effects. That is, as a larger number of first-generation immigrants arrive in low-income circumstances but experience dramatic improvement in terms of their children's well-being and status, their success may occlude our ability to see what would happen if we kept constant the U.S. population.

It is valuable to redirect our notion toward health outcomes and socioeconomic status, as you recommended, but race is not irrelevant in some dimensions. It shows up in a variety of areas in which there is a continuing biological contribution (for example, differences in kidney and high blood pressure problems for black and white males and different cardiovascular outcomes for Mexican-American women compared with non-Hispanic white women). If you control for SES, race actually is a contributor at some significant level to different health outcomes, particularly when you turn to something like low birth weight and infant mortality rates, where race also plays a factor.

But that is my segue into the next component. If we are looking for any kind of theoretical link between welfare reform and potential direct measures of well-being in children, the hinge from my perspective would be just that arena—low birth weight and infant mortality.

If you look at family structure, the evidence is quite striking that it is probably the single most consequential variable, even though a variety of other factors contribute to the likelihood of an infant not being low birth weight, not expiring in the first twelve months, and having a relatively good start at well-being. If welfare reform can somehow be leveraged to alter family structure in the direction of something like marriage or two-parent stability, my impression is that we will see the beneficial effects in low birth weight occur there first.