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# Caring for Families: Sharing the Burden Through Federal Policy Intervention

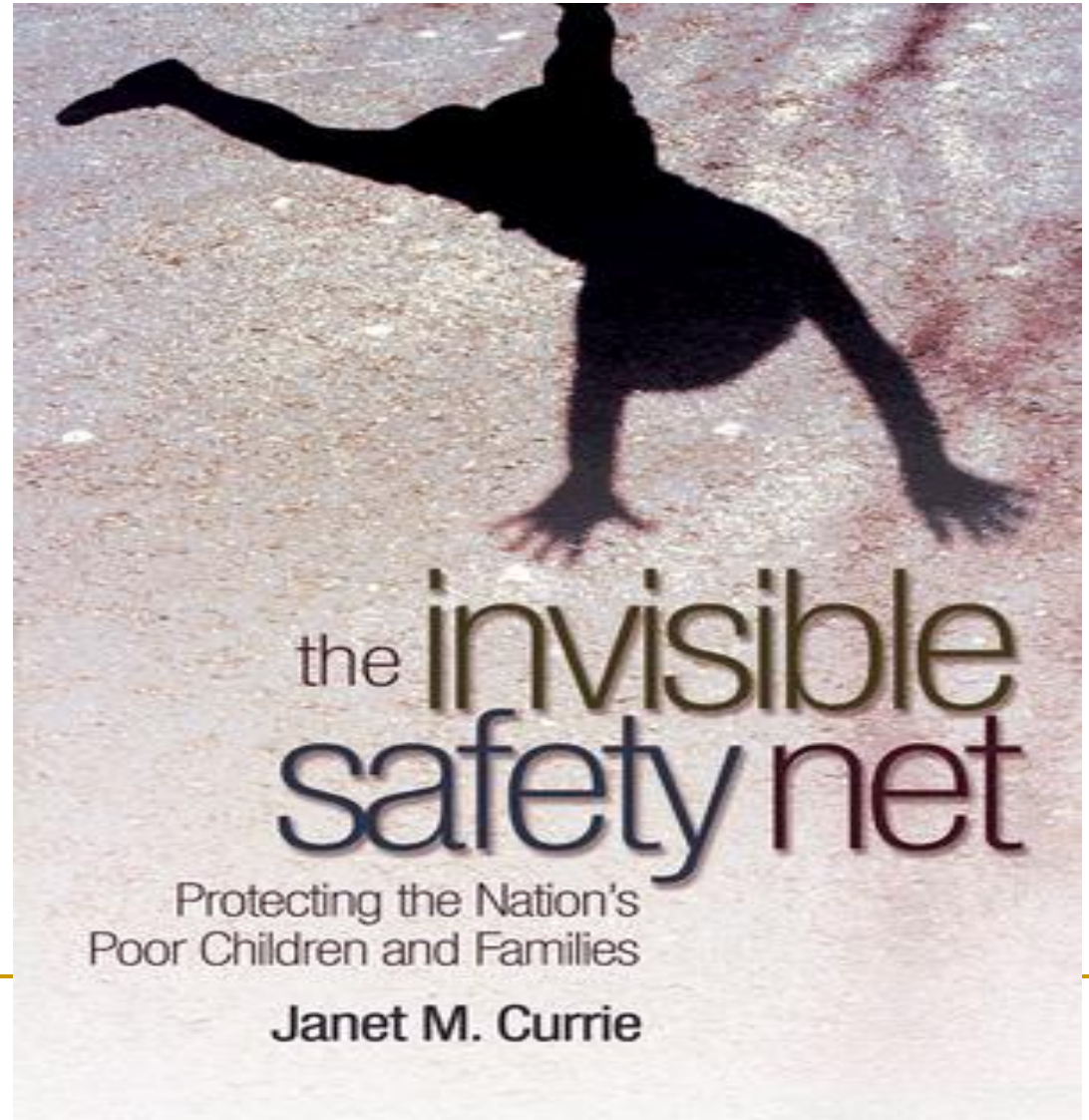
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Janet Currie

Columbia University and

National Bureau of Economic Research

My book discusses key components of the federal safety net and argues that they are effective



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These components can be thought of as policies to:

- Extend health insurance coverage
  - Reduce poverty through cash transfers to parents
  - Directly target child outcomes
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Overwhelming evidence that health insurance improves children's access to health care, and health.

- Increases in well child care (Currie and Gruber), decreases in preventable hospitalizations (Aizer; Dafny and Gruber), decreases in infant mortality.
  - Currie, Decker, and Lin suggest that poor adolescents in states that had generous public insurance programs from the time of their birth are in better health than those who were not.
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While expanding health insurance eligibility is important, it is not sufficient to improve health:

- Need to increase “take up” by eligible uninsureds. Mandates?
  - Or, follow example of Medicare Part B – make kids automatically eligible for Medicaid unless parents opt out by selecting insurance coverage of equivalent value.  
i.e. have people opt out rather than opt in.
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## Other measures that might improve take up:

- Streamline eligibility and application process
  - Extend eligibility periods (e.g. from 6 months to one year)
  - Harmonize eligibility requirements across programs
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But insurance coverage cannot eliminate disparities due to differences in incidence of conditions.

Low SES children have more of most conditions.

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**Health of Poor vs. Non-Poor Children, 2001-2005 NHIS**

	<b>Poor</b>	<b>Non-Poor</b>
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**Maternal Assessment of Child Health**

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health is excellent/very good	0.700	0.869
AGE 2~3	0.746	0.901
AGE 4~8	0.725	0.873
AGE 9~12	0.682	0.870
AGE 13~17	0.661	0.853

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**Health at Birth**

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Birth weight (grams)	3221	3348
Birth weight < 2500 grams	0.112	0.078

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**Ever Chronic Conditions**

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Ever told Asthma	0.159	0.131
Ever mental problem <sup>a</sup>	0.119	0.079
Ever told ADHD, 2-17	0.071	0.060
Trouble hearing or seeing	0.076	0.053
Stuttering or stammering-past 12 mo.	0.026	0.012
Ever told heart problems	0.018	0.014
Ever told diabetes	0.002	0.002
Ever told had arthritis	0.002	0.001
- Any of the above	0.324	0.265



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# What about Income Transfers to Parents?

- Bringing all families with children up to the poverty line would be surprisingly inexpensive given programs already in place (EITC, SSI, TANF etc.)
  - Documented effects of income transfers are positive but small (Mayer, Brooks-Gunn and Duncan, Dahl and Lochner).
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We need programs that prevent disparities before they start. There are many candidates:

I will focus here on three types of programs with proven results:

- ❑ Head Start/Early Intervention Programs
  - ❑ WIC
  - ❑ Nurse Home Visiting
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# Head Start

- Is a preschool program for poor 3-5 year old children.
  - Serves 800,000 children per year at a cost of \$6.2 billion.
  - Local grantees must follow detailed performance guidelines.
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# Head Start Regulations Cover:

- Education
  - Nutrition
  - Health Services
  - Selection into the program
  - Facilities
  - Training and staffing
  - Family and community partnerships
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## But Inputs are not the same as Outputs: Does Head Start Work?

- The Head Start Impact Study, a randomized trial of early Head Start shows improvements in test scores after one year relative to controls.
  - But if Head Start is an “investment,” then we need to know the longer-run return.
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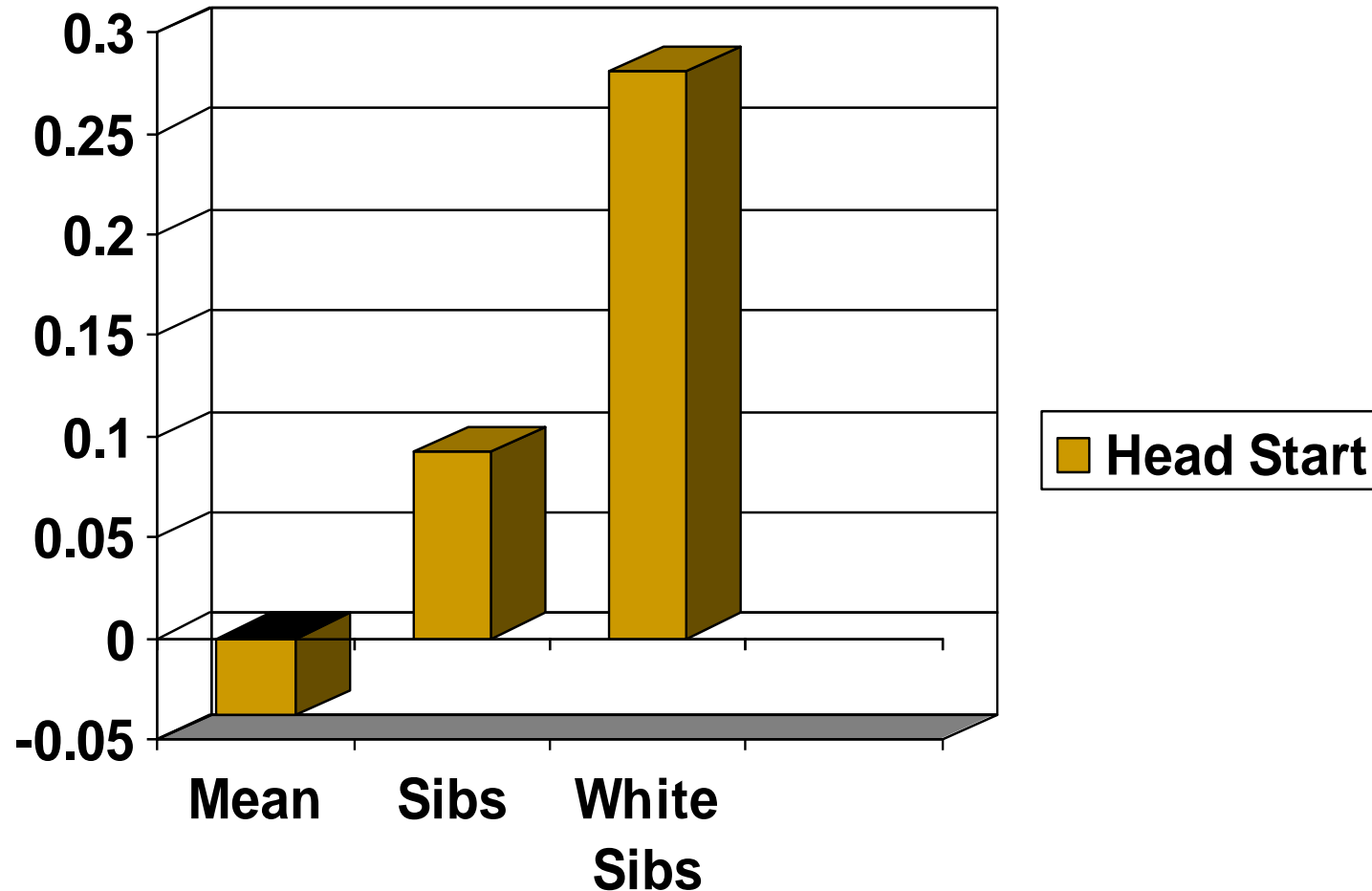
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# Currie and Thomas studies

- Use existing national data sets.
  - Compare children who attended Head Start to their own siblings who did not.
  - This design controls for the fact that Head Start children are worse off than other children. In fact, Head Start centers are *required* to select the neediest children.
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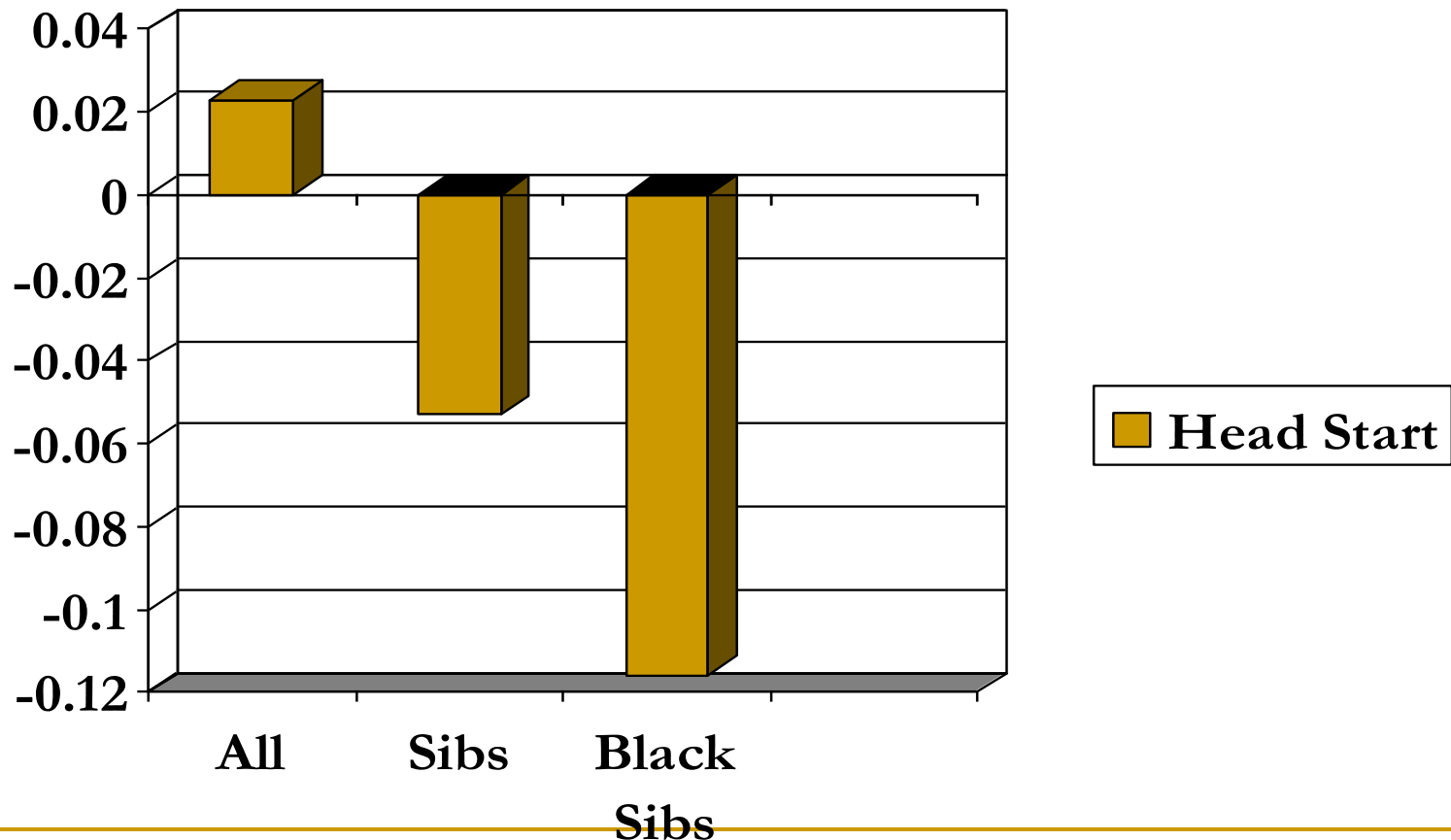
# Effect of Head Start on probability of attending college, adults 18-30:

Source=Garces, Thomas, and Currie using data from the PSID.



# Effect of Head Start on probability of being booked or charged with a crime among 18-30 year old adults.

Source=Garces, Thomas, and Currie using data from the PSID.





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# New research supports long-term effects of Head Start

- Deming uses NLSY children and looks at longer-term outcomes. Finds HS closes 1/3 of gap between poor and non-poor children on an index of a range of outcomes. (Effects 80% the size of Perry Preschool).
  - Carniero and Ginja use discontinuous eligibility criteria to identify effects in NLSY data. Finds reductions in behavior problems, crime, depression, obesity in adolescents.
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## Other evaluations of health benefits to attendees show:

- Introduction of Head Start was associated with large reductions in the mortality (Ludwig and Miller).
  - Attendees more likely to be insured, receive dental care, and are in better overall health (as reported by parents). Benefits larger for children of non-native speakers, children with special needs, and children whose mother's were depressed at baseline (Head Start Impact Study).
  - Reduction in overweight among children who were able to move from a part-day to a full-day program due to changes in program availability (Frisvold).
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# The cup is either

- **1/2 Empty** – Head Start does not bring attendees up to the level of the average child.
  - **1/2 Full** – Head Start has long lasting positive effects on schooling attainment and other outcomes. Benefits exceed costs.
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## Are state “universal pre-K” programs better?

- There are as many children in state programs as in Head Start.
  - There have been few high quality evaluations.
  - There are no standard reporting systems across states.
  - Are “universal” programs serving the neediest students?
  - Do they offer programming of sufficiently high quality to improve the outcomes of disadvantaged students?
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## Oklahoma's program shows high quality programs can be effective

- is run through the public schools and emphasizes high quality.
  - Gormley, Gayer, Phillips, and Dawson show that compared children whose birthdays fell just before cutoffs for enrollment to those whose birthdays fell just after found a 52% gain in pre-reading skills, 27% gain in pre-writing skills & a 21% gain in pre-math skills.
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# WIC

- Provides nutrition supplements, nutrition education, and facilitated access to medical care to infants, children up to 4 and pregnant and lactating women.
  - WIC already serves much of the target population of (up to 54% of pregnant women are eligible and 67% of eligibles participate).
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Increasing evidence that maternal health before birth may be particularly important (see evidence from flu epidemic of 1918:)

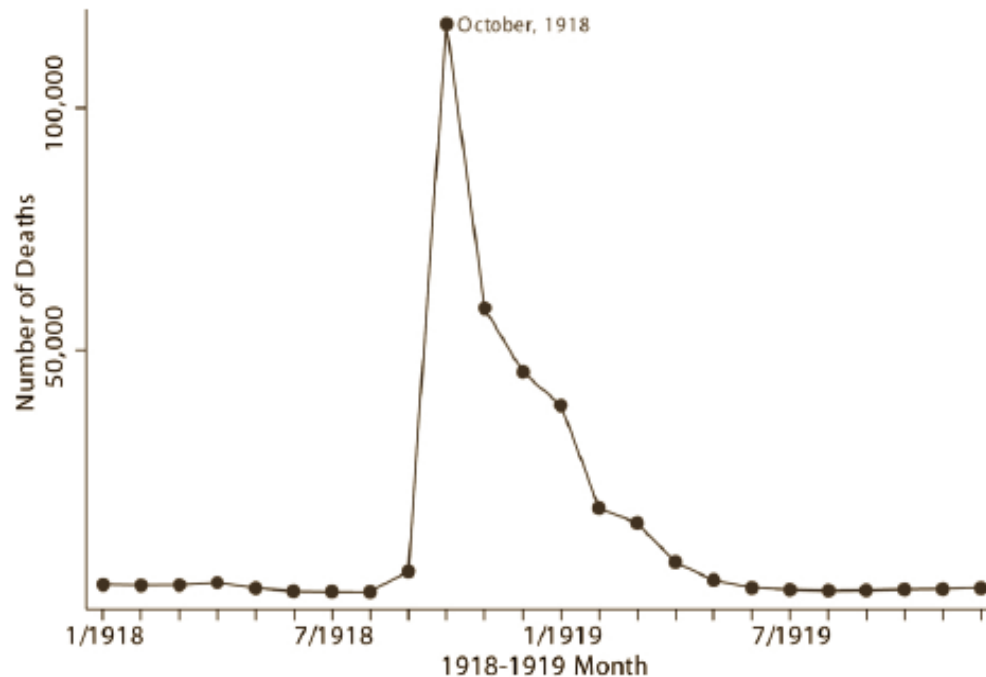


FIG. 1.—U.S. influenza deaths: *a*, by year; *b*, by month

# Birth cohorts with higher deaths had lower schooling attainment (Source: Almond)

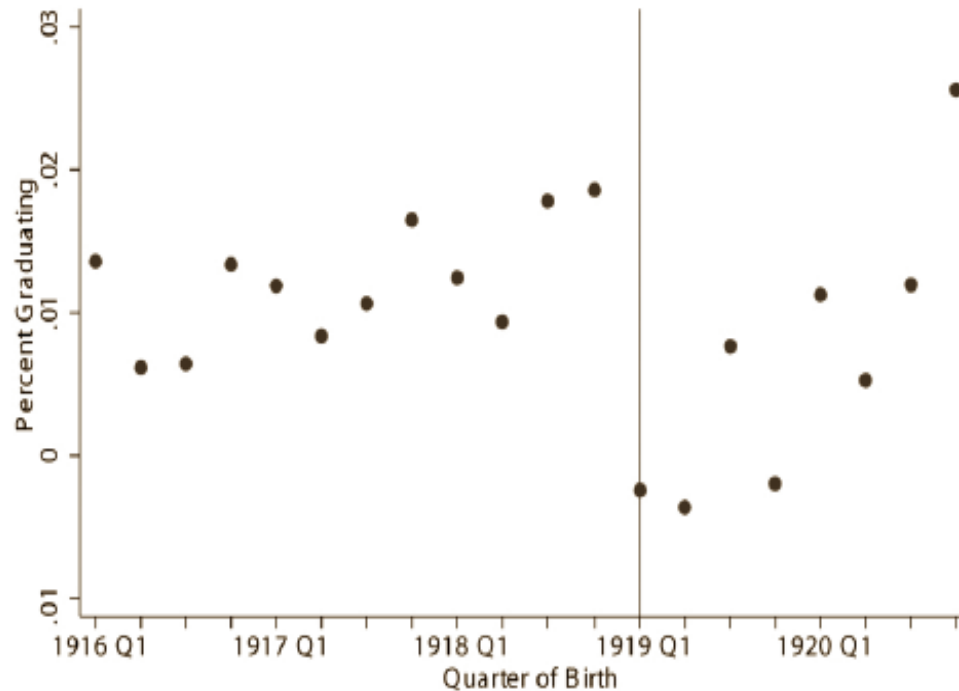


FIG. 5.—*a*, 1980 high school graduation rate by quarter of birth. *b*, Regression-adjusted 1980 high school graduation rate by quarter of birth.



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# WIC Works! (But Why?)

- Reduces the incidence of low birth weight especially among black mothers.
  - Reduced anemia among young children between 1975 and 1985 (Yip et al.).
  - Sibling studies show gains in cognitive functioning among children who got WIC in utero (Kowaleski-Jones and Duncan).
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# Nurse-Family Partnership Home Visiting

- This is a specific model of home visiting conceived by David Olds
    - Targets “at risk” mothers of first borns
    - Visits begin in pregnancy and continue at least two years post-natally
    - Visitors are nurses (not para-professionals)
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Currently operates in 20 states with 20,000 mothers

- CO, LA, OK, PA, WA have state-wide programs
  - Other states (CA, NJ) have significant participation.
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# Randomized Evaluations Indicate Improvements in:

- Prenatal health
- Birth spacing
- School readiness
- Child injuries
- Maternal employment

Benefits exceed costs.

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# An Important Limitation of the Safety Net is that it is Fragmented

- Many programs – some very effective
- Most with different eligibility criterion
- Application processes are burdensome

Result is that eligible needy children may fall through the holes

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# Giving all children:

- Health insurance
- Transfers to bring family incomes up to poverty
- An early intervention program like Head Start
- WIC
- Nurse home visiting

Would solve this problem.

Would cost ~200 billion (vs. ~120 billion currently spent)

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# Compare to:

- Costs of Medicare: \$380 billion
  - Costs of Medicaid: \$258 billion
  - Costs of Social Security: \$480 billion
  - Costs of “bailout”: One trillion and rising!
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# Key Directions for Future Research

1. We need data that will allow us to follow children's health over the life course to look at long term consequences of health conditions, insurance, and interventions. The National Children's Study will allow us to do this from the prenatal period to age 21 for a cohort of 100,000 children.
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## In the mean time...

Linkage of existing data sets could help to fill in the blanks – e.g. linking vital statistics records and/or hospital discharge records with administrative records.

Adding questions to existing data sets such as Census, NHIS and NHANES about where people were born and where they lived to age 5 could help.

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## 2. We Need Investigations of the Determinants of:

- Take up of insurance
  - Take up of care
  - Disparities in the incidence of conditions (due to environmental toxins, parenting, heredity...?)
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### 3. We Need to Open the Black Box of Program Design:

- Why do successful early intervention programs work? What are the key components?
  - Which state-sponsored early intervention programs are effective?
  - Why does WIC work, given that research into prevention of preterm birth and the effectiveness of prenatal care has produced disappointing results?
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