Testimony of Dr. Deborah A. Frank

Before the
Subcommittee on Human Resources
Committee on Ways and Means
U.S. House of Representatives

Hearing on Welfare Reauthorization Proposals
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Distinguished chairman and members of the committee, I am here today on behalf of my young patients and my colleagues. I am one of many pediatric clinicians who daily treat sick and hungry children in America. I am also one of the Principal Investigators with other pediatric researchers in the Children's Sentinel Nutrition Assessment Program (C-SNAP) initially funded by a grant from the W.K. Kellogg Foundation and other private donors. Since 1998 we have monitored the impact of current public policies and economic conditions on the nutritional and health status of low income children less than 3 years old in six medical institutions serving Baltimore, Boston, Little Rock, Los Angeles, Minneapolis and Washington DC. As busy policy makers you probably do not have time to peruse the pediatric and nutrition journals, but before you vote on H.R. 240, the Personal Responsibility, Work, and Family Promotion Act of 2005, you need to know that the medical evidence suggests that this measure entails unintended but grave risks to the health of your youngest constituents. The special needs of infants, toddlers, and chronically ill children are not, as far as I know, reflected in any of the non-medical evaluations of welfare reform to which the committee website refers. I would like to dedicate this testimony to the children I treat for malnutrition at Boston Medical Center, many of whom are from families who have experienced welfare sanctions.

We and researchers in other disciplines have found that, except for white, non-Hispanics, the number of American children who experience food insecurity has increased since the start of the 21st century. As you know, food insecurity is defined by the federal government as limited or uncertain availability of nutritionally adequate safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. While we have found that little children in working poor families and those with stable TANF benefits experience unacceptable levels of food insecurity, it is particularly concerning that this health risk is increased a further 50% for young children in families who experienced welfare sanctions, whether full family or partial, including simply having a child subject to the child exclusion (family cap) provision. Even without sanctions, the risk of food insecurity is increased 37% for families whose benefits are reduced for purely administrative reasons. Dr. John Cook and the rest of our C-SNAP team initially published this finding in an article in the 2002 *Archives of Pediatric and Adolescent Medicine* (information on accessing this article appears at the end of this testimony). These data were based on results from 2,718 children evaluated from August 1998-December 2000. We more recently reassessed these findings among 4,430 infants and toddlers seen through mid-2004 and the magnitude of increased risk was identical.

Why are we as pediatricians so deeply concerned about increasing "food insecurity" among these families whose welfare benefits are sanctioned or reduced? Because food insecurity is a serious health problem! Food insecure children are prone to the infection-malnutrition cycle increasing their risk of severe illness and hospitalization. A lack of essential nutrients impairs the body's ability to heal and decreases immune function causing a child to be more susceptible to illness. With any acute illness, most children lose weight and need, after recovery, to eat more than usual to regain lost weight and resume normal weight gain. Because food insecure families cannot provide the extra food children require to regain weight after an illness, the child becomes more malnourished and more susceptible to the next infection. It is this infection-malnutrition cycle which in settings without adequate medical care leads to the death of malnourished children. In this country the cycle often manifests in preventable recurrent illness and a need for costly therapeutic health resources.

It is important to note that food insecurity even in the absence of outright hunger injures children's health. C-SNAP data show that young children in food insecure households *with hunger* are 2.3 times more likely to be in fair or poor health than children in food secure households. Children in food insecure households *without hunger* are still 1.7 times more likely to be in fair or poor health than children in food secure households. We have consistently found that after considering background family characteristics, young children in food insecure families (whether or not they have a history of TANF participation) are 30% more likely than their peers in food secure families to be hospitalized before the age of 3 years. As would be expected from the physiology of food insecurity that I just outlined, these children from food insecure families are more likely than their peers to be hospitalized for severe respiratory and gastrointestinal infections. Those of you who as parents or grandparents have sat long hours by the bed of a hospitalized baby or child can readily imagine the suffering this entails for parents and their children. What you may not realize is how very expensive such excess hospitalizations are for us all as taxpayers -- the average cost of a brief 3-4 day pediatric hospitalization is more than $11,000.

Food insecurity during the period of most rapid growth of body and brain in early life can also have lasting effects, even if the families' economic situation eventually improves to the point where they are no longer food insecure. Children in food insecure households are at increased risk not only for short term infections but for persistent deficits in cognitive development, and behavioral and emotional problems that can impede their future success in school and their later productivity as adults in the workforce.

Paradoxically, food insecurity may also place older children at risk for being overweight or obese. In order to prevent hunger, food insecure families often sacrifice the quality of the food they eat to get enough quantity to prevent the sensation of hunger, particularly in their children. Low nutrient quality cheap foods with high calories and fat content will prevent a child from experiencing painful pangs of hunger, but they do not protect the child from nutrient deficiencies that put the child at risk for being overweight.

While I reflect pediatricians' special concerns about infants and toddlers, other colleagues have reported deeply troubling data about the potential impact of increased work requirements on caregivers of chronically ill children of any age. Families on welfare are more likely than other

poor families to have children with chronic illness. These children miss more days of school and have more scheduled and urgent doctor visits, emergency department visits and hospitalizations than other children. Their home medical regimens require substantial parental involvement to keep them healthy. When chronically ill children get sick, their primary caregivers have the experience and expertise to care for them. The primary caregivers know their complete medical histories, are able to recognize subtle early signs of illness, know how their illness episode should be managed at home and when to seek urgent medical care. Substitute caregivers will likely not have the necessary experience, expertise or inclination to care for these children when they are ill.

Low-income families whose children are chronically ill face substantial challenges in finding appropriate day care for their children. In a study of current and former welfare recipients with chronically ill children, my colleague Dr. Lauren Smith found that 40% of current welfare recipients had difficulty finding appropriate child care because of their child's condition and 34% indicate that difficulty in finding adequate day care for their children is a substantial barrier to employment. She and her co-authors have also found that 60% of current recipients and 80% of former recipients have missed work due to their child's illness, and 75% of these parents report that their child's illness is a substantial barrier to finding and keeping a job. Her team also found that over time, chronically ill children experiencing household hardships, such as food insecurity, utility disconnections and housing problems were found to have increases in subsequent emergency department visits and hospitalizations.

I am aware of a distressing case from Boston Medical Center where I work of a chronically ill little girl who died while in the care of an adolescent sibling while her mother was out of the home trying to work to avoid welfare sanctions. I anticipate that the proposed increased work requirements in bill H.R. 240 will lead to other similar preventable tragedies as well as less obvious but serious deterioration in the well-being of infants, toddlers, and chronically ill children. These particularly vulnerable children would then consume even more medical resources, experience further preventable disability, and experience more difficulties functioning in school and in the workplace.

Knowing this medical information, you can understand why pediatricians around the country are so gravely concerned about the prospect of inflicting food insecurity upon more families with young and chronically ill children via mandated full-family sanctions if parents cannot meet the more stringent work requirements outlined in H.R. 240.

To use a medical analogy, H.R. 240 proposes a "treatment" for America's most impoverished families that has an unacceptable risk benefit profile. Requiring more families to participate in work activities and imposing longer work hours may result in mitigating deprivation for a few children whose parents are lucky enough to succeed in finding and keeping adequately paid work. However, many more families, particularly those with young or chronically ill children, or with parents burdened with poor mental and physical health, cognitive impairments, or sequelae of physical and sexual abuse will lose all income for their survival needs. The side effects of H.R. 240's increased and unrealistic work requirements are predictably the exposure of more families and children to mandated full family sanctions and thus to food insecurity, ill health, and excess hospitalizations.

If there was a medical treatment, which possibly helped some patients and predictably and possibly irreversibly injured others, we as physicians would be bound to do an extremely careful and individualized assessment of each patient before applying the treatment. If the treatment were to be applied, we would use the lowest possible dose, and closely follow up and monitor those who received the treatment to try to reverse it if harm emerged. I would urge you to take a similarly thoughtful approach to issues of welfare reform, with avoidance of unrealistic work requirements on families suffering barriers to meaningful employment, particularly those with young or chronically ill children. Clearly full family sanctions should be avoided, since our data show even partial sanctions, like the family cap, have adverse effects on young children. Just as a hazardous cancer treatment must first be reviewed by a tumor board before being undertaken, any proposed sanctions could be reviewed by a third party and a sanction avoidance plan devised to help families to overcome barriers to compliance. If a family does experience sanctions, repeated follow-up and assessment of the safety and well being of affected families and their children should be mandatory.

In closing, I cannot imagine that the distinguished members of this committee really intend to make America's babies hungrier and sicker. You now know the medical data that demonstrate declining welfare caseloads do not automatically indicate an improvement in the well-being of American children. On the contrary, families who leave welfare because of sanctions or who have their benefits reduced before they have reached family stability are more likely to have hungry, sick children.

H.R. 240 will inevitably increase the number of children exposed to sanctions. If you pass a bill that triggers a "sanctions epidemic," hungrier and sicker children will incur more health care costs in the short term and be less likely in the long term to succeed in school and participate productively in the future work force. The lives of these children are in your hands as much as if you stood over them with a surgical scalpel, and I urge you, as we always urge new doctors, "primo no nocere!" (First do no harm!).

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Welfare Reform and the Health of Young Children:
A Sentinel Survey in Six United States Cities

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ABSTRACT:

Context
Welfare reform under the 1996 Personal Responsibility and Work Opportunity Reconciliation Act replaced entitlement to cash assistance for low-income families with Temporary Assistance to Needy Families, terminating or decreasing cash support for many participants. Proponents anticipated continued receipt of food stamps would offset effects of cash benefit losses, though access to food stamps was also restricted.
Objective
Examine associations of loss or reduction of welfare with food security and health outcomes among children age ≤ 36 months at six urban hospitals and clinics.
Design and Setting
A multi-site retrospective cohort study with cross-sectional surveys at urban medical centers in five states and Washington, DC, August 1998-December 2000.
Participants
Caregivers of 2,718 children ages ≤ 36 months whose households received welfare, or had lost welfare through sanctions were interviewed at hospital clinics and emergency departments.
Main Outcome Measures
Household food security status, history of hospitalization, and (for a sub-sample interviewed in emergency departments) whether the child was admitted to hospital the day of the visit.
Results
After controlling for potential confounding factors, children in families whose welfare was terminated or reduced by sanctions had greater odds of being food insecure (Adjusted Odds Ratio: 1.5, 95% CI: 1.1, 1.9), of having been hospitalized since birth (AOR: 1.3, CI: 1.0, 1.7) and (for the emergency department sub-sample) of being admitted the day of an emergency department visit (AOR: 1.9, CI: 1.2, 3.0), compared to those without decreased benefits. Children in families whose welfare benefits were decreased administratively due to changes in income or expenses had greater odds of being food insecure (AOR: 1.5, CI: 1.1, 2.2), and of being admitted the day of an emergency department visit (AOR: 2.8, CI: 1.4, 5.6). Currently receiving food stamps did not mitigate the effects of loss or reduction of welfare benefits on food security or hospitalizations.
Conclusions
Terminating or reducing welfare benefits by sanctions, or decreasing benefits because of changes in income or expenses is associated with greater odds of young children experiencing food insecurity and hospitalizations.