



# THE KIDS ARE ALL RIGHT

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**Bill Clinton ran on a promise to “end welfare as we know it.” He vetoed the first two welfare reform bills passed by Congress, but in August 1996, Congress sent him a third version. He signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), fulfilling his campaign pledge and transforming the social safety net for millions of Americans.**

PRWORA was a sweeping piece of legislation—it ended cash entitlements to welfare recipients, imposed work requirements, created tough child support enforcement mechanisms, and much more.

Twenty years later, we know that welfare rolls shrunk and employment rates of single mothers rose after PRWORA went into effect in July 1997, and we also know that many parents lost their only source of cash income and now struggle to survive on less than \$2 per person per day.<sup>1</sup>

But welfare reform involved more than just PRWORA. Indeed, there have been many changes to safety net programs since PRWORA, including expansions of Medicaid and the Earned Income Tax Credit (EITC). In this article, we pose the following question: Has the overall set of changes to the safety net since PRWORA improved outcomes for children?

To answer that question, we look at several measures of child well-being—mortality rates, teen pregnancy, drug use, and high school graduation rates—and find that across all these measures, poor children are much better off today.

### Mortality Rates

We start with mortality rates because they offer an unambiguous, though admittedly blunt, measure of how children's fortunes have changed over time. Happily, mortality rates have fallen dramatically for all children since 1990.<sup>2</sup>

When we examine trends for children in poor U.S. counties,

we find that mortality rates have declined even more sharply. As shown in Figure 1, child mortality rates are higher in poorer places, but the poorest places have experienced the greatest declines in mortality.<sup>3</sup> Deaths for boys ages 0–4 in the wealthiest counties dropped by 4.2 per 1,000 births between 1990 and 2010, compared with a decline of 8.5 per 1,000 in the poorest counties.<sup>4</sup>

Perhaps even more striking is the reduction in mortality rates among black children. In 1990, black mortality rates were much higher than white mortality rates, even when comparing black children in the richest places with white children in the poorest (6.2 deaths per 1,000 births for black male children in the richest counties; 4 per 1,000 for white male children in the poorest counties).<sup>5</sup> Thus, on the eve of welfare reform, racial disparities trumped geographic disparities.

In 2010, the mortality rate for black male children in the richest counties was still higher than the mortality rate for white male children in the poorest counties, but the gap had narrowed considerably. When children with multiple races (a growing category) are included in the analysis, black-white child mortality gaps have closed even further.

Overall, we've seen a significant decline in mortality and racial inequality in mortality for children.

This rosy outlook may appear at odds with much of the recent mortality research showing a large mortality gap between the rich and poor in the United States. But these studies focus

on Americans in middle age, and thus the gap largely reflects past health history and other factors such as drug and alcohol use.<sup>6</sup> As Figure 1 shows, the income mortality gradient now is relatively shallow among young children.

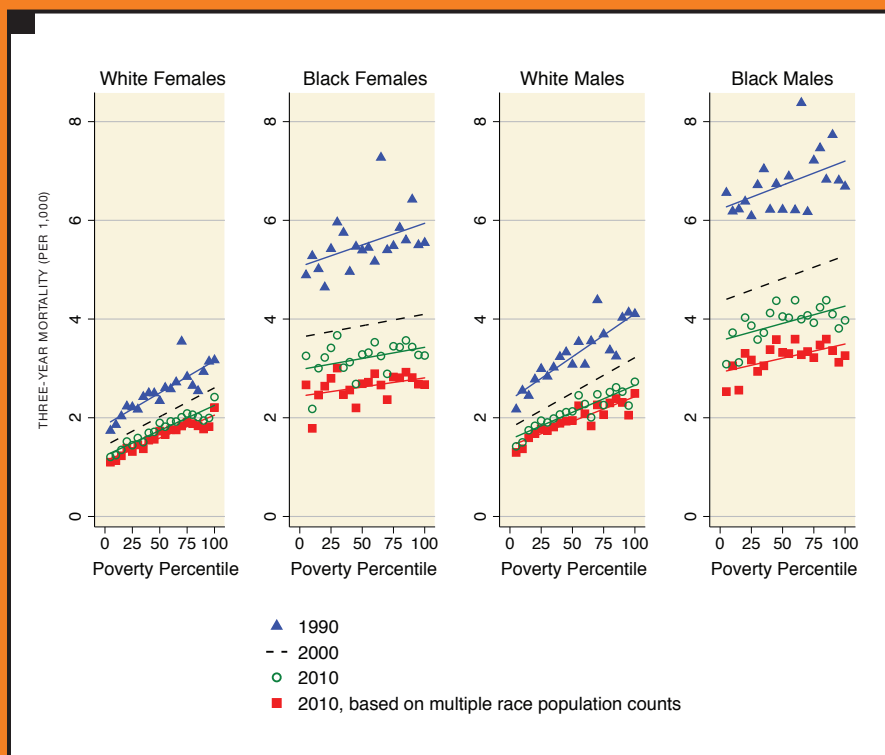
### Other Health-Related Metrics

It's not enough to say that children are simply surviving at higher rates than they were prior to welfare reform. We must also examine quality-of-life metrics to determine whether children are living healthier, more promising lives.

Research shows that healthier children grow up to be healthier adults, and improvements in children's health today would suggest that mortality inequality in old age is likely to decline in the future (though it may be higher among those who are currently middle-aged).<sup>7</sup>

In 1996, more than 40 percent of eighth graders reported using alcohol. By 2015, that statistic had fallen by half.<sup>8</sup> Similarly, the fraction of teenagers who smoke has declined significantly. Lifetime usage fell 32.4 percentage points for 12th graders from 1996 to 2015, while daily use fell 16.7 percentage points.<sup>9</sup>

FIGURE 1. Three-Year Mortality Rates Across County Groups Ranked by Poverty Rates, Aged 0–4



Source: Data from Vital Statistics, U.S. Census, and American Community Survey. Published in Currie and Schwandt, 2016b.

Smoking is a leading cause of poor health in the United States, and many of its ill effects are irreversible even after smokers have quit. The significant drop in lifetime smoking rates for 12th graders—from 63.5 percent to 31.1 percent—should translate into a much healthier population in the future.

Finally, in one of the biggest public health successes of the past few decades, the teen pregnancy rate has declined precipitously. In 1990, the teen pregnancy rate for African-Americans was 116 births per 1,000 women, and by 2014, it had fallen to 35.<sup>10</sup> Declines are also evident for Hispanics and whites. Though teen births still occur disproportionately to blacks and Hispanics compared to whites, racial and ethnic gaps in teen pregnancy have narrowed appreciably.

Rising obesity rates among children are one caveat to this positive picture. However, the most recent national surveys suggest the trend has reversed among children 11 and younger, suggesting that heightened awareness of the dangers of obesity and policy responses are having an effect.<sup>11</sup>

### Educational Attainment

Moving beyond health-related metrics, we turn now to educational attainment, because it's such an important factor in determining children's future prospects.

High school graduation rates have risen across the board, as shown in Figure 2. Yet echoing the pattern seen for child mortality and teen pregnancy, blacks and Hispanics have made large gains relative to whites, narrowing ethnic and racial gaps in educational attainment.

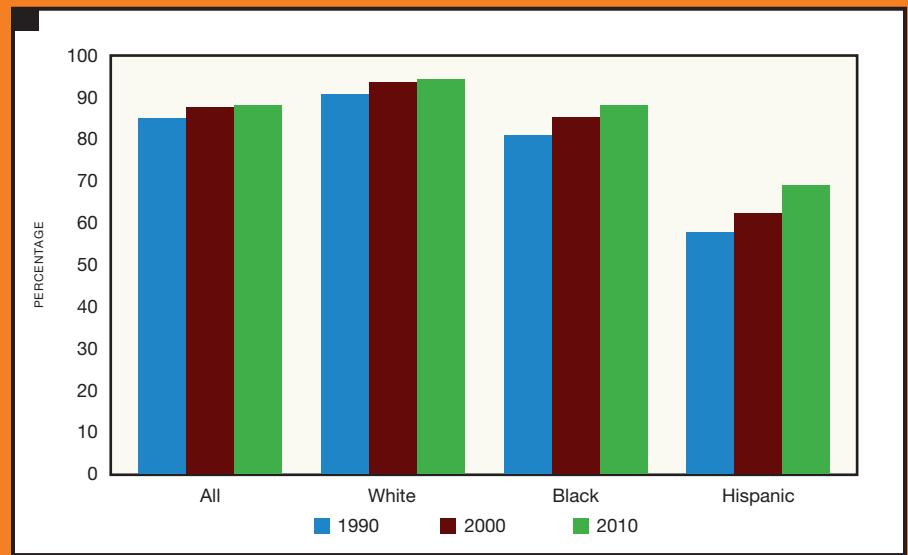
The overall increase in high school graduation rates helps to explain the results of a recent study showing dramatic increases in mortality rates among white females who drop out of high school.<sup>12</sup> Because there were 66 percent fewer white female high school dropouts in 2010 than in 1990, the recent mortality statistics are drawn from a different—and far more disadvantaged—group of people.<sup>13</sup>

### The Role of Policy

If we accept that children are better off today in many tangible respects than they were in the 1990s, we still have to ask: What role did welfare reform play? What other factors may have contributed to the improvement in children's fortunes?

It is difficult to disentangle the effects of welfare reform from the economic and other changes that have occurred since the 1990s, and we will not endeavor to do so here. However, we will provide a brief overview of some of the most significant policy changes that were intended to address children's well-being.

FIGURE 2. Percentage of 24- to 29-Year-Olds with Four Years of High School or More



Source: Current Population Survey.

First, starting in the late 1980s and continuing through the 1990s, Medicaid was expanded to cover all poor children and many children in lower-income working families, rather than only covering the children of welfare recipients. In addition, the creation of the State Children's Health Insurance Program (SCHIP) in 1997 expanded public health insurance for poor pregnant women and children. Today, 48 percent of all births are paid for by Medicaid.<sup>14</sup> Several recent papers compare the first cohorts to have access to expanded public health insurance with older cohorts born just before the expansion of coverage. This research shows clear improvements in health for children who became eligible for public health insurance.<sup>15</sup> Because these children have benefitted from health insurance their entire lives, they are in better health now, and we should expect continued health benefits as they enter adulthood.

Second, Congress expanded the EITC in 1993, with the goal of eliminating poverty for those who work full-time. In the same year, Congress added more money for the Food Stamp Program (now called the Supplemental Nutrition Assistance Program), which has continued to expand over time. Both reforms provided additional resources to children who lived in qualifying households. Studies show that these changes have had positive impacts, especially for the most vulnerable children.<sup>16</sup>

Finally, in response to growing evidence about the importance of preschool environments, many states developed or expanded their public child care and preschool programs, and such programs now serve more children than Head Start. Of course, many of these programs are effectively modeled on Head Start, and both Head Start and state preschool programs have been shown to improve the short- and long-term outcomes of poor children.<sup>17</sup>

## Conclusion

On many indicators, children are much better off today than they were before PRWORA, especially poor children and African-American children. Indeed, the improvement in children's fortunes suggests that policy may be able to buffer the health effects of economic inequality.

While these trends likely reflect, at least in part, other PRWORA-era developments (e.g., economic expansion and other policy and cultural changes), improvements in child well-being over the past 20 years are clear. Despite the strong

evidence that outcomes for children have improved dramatically, these trends have been almost entirely ignored in public discourse. We should endeavor to preserve policies that have benefitted children and facilitated these improvements. If we don't, we risk losing the sizable gains that children have made.

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## Notes

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