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THE STATE OF THE AMERICAN CHILD: THE IMPACT OF FEDERAL POLICIES ON CHILDREN

HEARING

BEFORE THE

SUBCOMMITTEE ON CHILDREN AND FAMILIES

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

ON

EXAMINING THE STATE OF THE AMERICAN CHILD, FOCUSING ON THE IMPACT OF FEDERAL POLICIES ON CHILDREN

JULY 29, 2010

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C O N T E N T S

STATEMENTS

THURSDAY, JULY 29, 2010

ADDITIONAL MATERIAL

THE STATE OF THE AMERICAN CHILD: THE IMPACT OF FEDERAL POLICIES ON CHILDREN

THURSDAY, JULY 29, 2010

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN AND FAMILIES,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:04 a.m. in Room SD–430, Dirksen Senate Office Building, Hon. Christopher J. Dodd, chairman of the subcommittee, presiding.

Present: Senators Dodd, Casey, and Merkley.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The committee will come to order.

Let me welcome all of you here this morning. I will give you a minute here to get settled. I thank our witnesses. I thank our guests in the audience. And I see my colleague from Oregon here as well. Senator Merkley, thank you for joining us here this morning.

I have been told, before beginning with my opening comments, that we will have a vote somewhere around 10:40–10:45 this morning. I believe there are several other members who will be coming by this morning to participate in the hearing, and so we will try and keep a continuum going and try and stagger. So as soon as that vote occurs, Senator Merkley, I might skip right out myself and make the vote and hand the gavel to you for a few minutes and come right back and try to work it in a way so we allow our witnesses to continue and the questions to proceed.

What I will do this morning is make a few minutes of opening remarks myself and then I will ask my colleague from Oregon if he has any opening comments he would care to make. Then we will turn to our very distinguished panel of witnesses who are here this morning and we are very grateful to them and their Departments for their willingness to participate in this, the third, of our hearings on The State of the American Child: The Impact of Federal Policies on Children. So again, brief opening comments and then colleague comments and then turn to our witnesses.

First of all, let me welcome everyone here this morning, including our very distinguished panel, as I have said, to this, the third, in a series of hearings on the State of the American Child.

This subcommittee, Children and Families, is, I believe, the Senate's only body specifically focused on addressing the needs of chil-

dren and their families in our Nation. This series of hearings is historic in both its scope and its purpose. In fact, I am not aware of any recent efforts in Congress to explore so deeply the factors that underlie the well-being of America's children.

As the parent of two young daughters, I understand the weight of wanting to see your child reach his or her full potential. Sometimes this weight is too heavy for a single parent, as we all have learned, trying to maintain a job while caring for an ill child. Sometimes the weight is too heavy for a family, making the very difficult decision as to whether or not to send that child who has done everything right over the years off to college or to maintain those mortgage payments on the house that you have lived in for a long time. And sometimes this weight is far too heavy even for a school district, striving to provide nutritious meals for children, but lacking the resources because of the conditions economically in the county or community in which they reside. Without support, these weighty challenges, of course, I think as all of us appreciate, in very many instances become absolutely insurmountable both for children, for families, and for communities.

Parents do the best they can. In fact, they want the very best for their children. Almost without exception in this country, that is a given. But what we have come to realize is that a broad array of support systems at the local, State, and Federal levels do exist to help families and children thrive. And as I have said before, the most rewarding work that I have ever done in my 35 years in the Congress of the United States has been helping shape these family support systems at the Federal level. In many ways, the success of our Nation can be measured by, of course, the success of our own children, and we have fought to improve the quality of life of every child. We have made our society, I think, stronger, more productive, and just.

Too many parents had to chose between the job they need, and the children they love during a child's illness. For this reason, of course, we fought for the Family and Medical Leave Act. Since it was signed into law in February 1993, over 50 million Americans have taken up 12 weeks of job-protected, unpaid leave in order to care for a child or a family member.

We have strengthened and expanded Head Start programs across the Nation, helping some of the most vulnerable children develop the cognitive and social and emotional skills required to launch them on a path to maximizing their potential.

And we have strengthened child care and afterschool programs as well.

We know that a child who lacks health insurance fares far worse than a child who is insured when it comes to a host of crucial medical services, including doctor visits, dental care, vision care, and prescription drugs. And so we expanded health insurance coverage through the CHIP program and Medicaid to millions of uninsured children and passed health reform which extends insurance coverage of proven preventative services like routine immunizations and regular pediatric visits at no cost to millions more.

And yet, our work is far from over, and the results certainly have not demonstrated that we have taken care of every child in this Nation.

This subcommittee held its first hearing in this series in June. Our witnesses highlighted pressing issues affecting kids, including their health, education, and family and community lives. Not surprisingly our conversation turned to the impact of the current economic crisis on our children and their families. As Dr. Harry Holzer, an economist at Georgetown University, outlined, the current economic crisis will have long impacts on children even when the economy improves. Most worrisome, even as unemployment is forecasted to fall over the next several years, child poverty is expected to steadily rise to nearly 25 percent by the year 2012.

But even though the current crisis has heightened our awareness of the problems of children, many of these problems, like poverty, were worsening before 2008, before this economic crisis even hit us. This week, the Annie E. Casey Foundation released their Kids Count Databook which showed—and I quote—"overall improvements in child well-being that began in the late 1990s stalled in the years before the current economic crisis downturn."

Therefore, I think it is imperative that we take a hard look at what we need to do in order to help all American children succeed and maximize their potential.

On Monday, the Subcommittee on Children and Families held its second hearing in this series at the Yale Child Study Center in New Haven, CT where we examined State and local efforts aimed at addressing the changing needs of our families before and during this economic crisis. Fortunately, the individuals and organizations at the State and local level are doing incredibly innovative work at a time when their own organizations are making very difficult budgetary adjustments. Many of these efforts are enhancing the very Federal programs that we have built over the years. We have learned about unique programs aimed at improving the social and health outcomes of children enrolled in Head Start, such as collaboration of dentists, providing oral health services and a training program for fathers.

We learned about a successful pilot program called Help Me Grow that began in Hartford, CT and has been expanded statewide and replicated in seven other cities across the United States to link families to a variety of health, developmental, and community services.

We heard testimony on the successes of an afterschool program in the low-income community in Bridgeport, CT. The success of this program, the Bridgeport Lighthouse program, which I have been involved with for a number of years, is consistent with the studies that have shown that students enrolled in afterschool programs perform better on tests compared to other students in the same district who do not have the advantage of afterschool programs.

The proven benefit to children who participate in afterschool programs is well-studied and tremendously well-documented, and as a result, I was deeply disappointed to see the Senate appropriations bill change the 21st Century Community Learning Center program in such a way that it will split funding for afterschool programs with other costly initiatives. Local and State initiatives can and are having a tremendous impact like the afterschool program in Bridgeport, but they need consistent support at the national level in order to remain effective.

Today we are going to hear from our witnesses about the impact and success of the programs they oversee while looking at opportunities to expand or align them with the tremendous work being done at the State and local level. History has shown us that the Federal Government does play a critical role in improving the lives of children and families. With more than one in five children living in poverty in the early 1990s, various policies enacted under the Clinton administration helped reduce child poverty by a rate of more than 25 percent.

The same was true, I might add, in the 1960s where efforts were made on the anti-poverty programs. We had staggering rates of poverty, and yet, as a result of those efforts in the early 1960s, we reduced those numbers tremendously in those years. And then when we backed away from them, we began to see those numbers climb again.

In the 1980s, we did the studies on the commission looking at the status of children. As a result of those studies, you saw the child care tax credits, a lot of innovative programs, and we reduced the numbers again. Then we backed away from it again. Once again, we see the numbers beginning to rise.

The pattern is as clear as anything you can imagine. So once again, as we enter this phase when I know there is a lot of talk about cutting back on a lot of these programs, understand what the cost will be, understand what the price will be if we make the kind of decisions which deprive these children and their families the support systems that they absolutely must have if they are going to succeed at all.

So with more than one in five children living in poverty in the early 1990s, as I said, various policies enacted under the Clinton administration helped reduce the child poverty rate by more than 25 percent. The rate is still too high, of course, but no one could argue about the difference the child tax credit, work incentives, and expanded health insurance for low-income children made in the lives of millions of children. So we must continue to improve and strengthen existing programs that work and give us the kind of results that we have seen in the past.

Before the committee today is a panel of experts from the Departments of Labor, Health, Education, as well as an economist from the White House. And I look forward to their testimony.

Our work on behalf of children is never done at all, of course. Over 20 years ago, as I mentioned a moment ago, the National Commission on Children was established which laid out a plan to address the needs of children. Out of that effort came many vital programs such as the Earned Income Tax credit and the Children's Health Insurance Program. Much has changed in the field of children in the last 20 or 22 years, and for this reason, I think it is time that we take another look at the status of children and their families in our country and outline promising new directions for policy and programs. More importantly, this is not something we should do every 20 years. It should be done every year, and I plan to introduce legislation in the coming days which will do just that: provide an annual, permanent basis by which we can judge the status and the condition of the American child.

So I look forward to hearing from our witnesses today and taking their lessons and learning from them as we move forward in our fight to improve the condition of one out of four Americans, those children who are under the age of 18 in our country, and to see to it that we leave them in far better shape than the presence circumstances would indicate.

With that, I want to turn to my colleagues briefly to see if they have any opening comments. Senator Merkley arrived here first, so you get the first arrived/first up opportunity, and then I will turn to Senator Casey.

STATEMENT OF SENATOR MERKLEY

Senator MERKLEY. Mr. Chair, thank you very much and thank you for your emphasis on the status of children and programs that will improve their lives. What we all have come to learn time and time again is that the issues faced in childhood very much set a course for a person's life and disproportionately so, so that they deserve a great deal of our attention.

And many of the issues about which you all will be testifying are issues certainly of great concern to me and great concern to my constituents back in Oregon. I look forward to your comments this morning. Thank you.

Senator DODD. Thank you, Senator.

Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. Thanks so much, Mr. Chairman. I want to thank our witnesses who are here. I will have a longer statement for the record.

But I do want to say that often when you have a successful program or public policy, a lot of people can stand up and claim credit, as is often the case. But few, if any, of U.S. Senators in the last 50 years have done more, have labored longer in the vineyard of helping children and standing up for their rights, for their well-being, and for their health and safety and really their future—few have done more, and I cannot think of any who have done more, than Senator Chris Dodd. We are eternally grateful for that kind of leadership and commitment. We need to draw inspiration from his example, all of us, in the wake of his leaving in the early part of January 2011. So we are grateful for that leadership. We are especially grateful he called this series of hearings to examine a set of issues that candidly, even in the party I am a member of, we do not spend enough time on. So I want to thank him for his leadership and for his continuing efforts to put a spotlight on a whole range of important issues as it relates to children.

I want to thank this committee for the work it has done, and also President Obama and his administration, not just because you are here today but because of what has been a really focused and determined effort by President Obama to put dollars and resources and focus and energy behind programs to help our children. We are grateful for that, and I think we are looking forward to this hearing today.

Thank you very much.

[The prepared statement of Senator Casey follows:]

PREPARED STATEMENT OF SENATOR CASEY

Thank you, Chairman Dodd, for calling this third in a series of hearings on the state of the American Child—and thank you for your continued outstanding leadership on children's issues. I would also like to thank the panelists who have taken time out of their busy days to share with us the Administration's activities and programs that are improving the lives of children.

This is a critically important time for us as a committee, as a Congress and as a Nation to be assessing the state of the American child. We've had a rough few years, with economic toil and high levels of unemployment. Families are suffering, and children cannot help but be affected. As we chart our way out of the recession, it is essential that we reassess our priorities as they relate to children.

While we have made many strides in the right direction—the State Children's Health Insurance Program, investments in home visitation and early education—children are still losing out. As an overall share of the budget, our Federal investment in children has been falling steadily. Though children make up a quarter of our population, out of every dollar spent by the Federal Government, less than a dime goes to children, according to a report released earlier this month by First Focus. And because children are also disproportionately helped by programs that rely on Congress to act to fund them year after year, they are more vulnerable to swings in politics, economics, and public opinion.

Congress acted to help children through the American Recovery and Reinvestment Act (ARRA). Federal spending on children hit a record high of 2.3 percent of GDP in 2009, largely as a result of the recession and increased investments under ARRA. The children's share of ARRA was more than twice as large as the children's share of the Federal budget as a whole. But, much of the Recovery Act's spending substituted for or cushioned spending cuts in States and localities, hard-hit by the recession.

We cannot afford to let a generation get swept away in this recession. The economic downturn has raised the child poverty rate in this country to levels not seen in the last 20 years. A new study by the Foundation for Child Development, which was released in June, evaluated the well-being of children in the United States and the impact of the recession. It found that one in five children live in poverty. This rate of nearly 22 percent is up from 17 percent from before the recession began in 2006. This rate places the United States the highest among its peer nations.

We must act to ensure the extensions in early childhood investment included in the Recovery Act are continued—and that this support becomes the new baseline for children. I was gratified by the Labor/Health/Education Subcommittee markup earlier this week, which has set aside funding for critical programs such as Head Start and Child Care Development Block Grant at Recovery Act levels.

In Pennsylvania, the ARRA funding has helped to improve the quality of child care and ensure more children have access to care. Over the past year in the State's quality child care program—a na-

tionally recognized approach known as Keystone STARS—nearly 30 percent of the child care programs in this initiative moved up a STAR level. The child outcome data for this program is showing exceptionally positive results, on par with those obtained for the State's PA Pre–K Counts program as well as its State investment in Head Start. The ARRA funding has also helped to bring the waiting list for child care to zero.

Quality must be a core focus of our investment in early childhood programs. The research is irrefutable—investing in quality programs for our children in their earliest years greatly improves their life outcomes in so many areas. Conservative estimates of early childhood education programs put the savings to our economy at about $7 for every $1 we invest. Analyses of other early childhood programs have produced estimated benefits of up to $13 for every dollar spent. If this were the stock market, we'd all be buying these stocks.

Just in the last few weeks, several articles and reports have appeared that further highlight the importance of investing in children, especially when it comes to early childhood education.

- In May, an article in the journal Child Development found that participating in high-quality child care early in life can give children an academic leg up for years to come. Researchers conducting this longitudinal study found that the positive effects of high-quality child care can have lasting effects on cognitive development and academic success.
- Earlier this week, the College Board recently issued a series of recommendations which they refer to as "10 recommendations so important they cannot be ignored." It's a part of their "College Completion Agenda" to provide a roadmap to ensure that 55 percent of all adults ages 25 to 34 have an associate degree or higher by 2025. The first recommendation: Make voluntary preschool education available to all children in low-income families.
- And only yesterday, the *New York Times* ran an article called "The Case for $320,000 Kindergarten Teachers," which discussed a study that was recently presented at a conference, although it has not yet been reviewed. However, this study found that high-quality kindergarten teachers are worth about $320,000 a year; students who had learned more in kindergarten were, as adults, more likely to go to college, less likely to become single parents, more likely to be saving for retirement, and were earning more than comparable peers.

Such investments speak to a philosophy rooted in the fundamental principle of what it means to be an American—and that is that every person, and every child, has the opportunity to succeed. When America supports high quality child care, we encourage children, families and our Nation to reach their full potential.

I look forward to hearing from the witnesses today about all the Federal programs that are making a difference for children—and how we can strengthen those programs.

Senator DODD. Thank you, Senator Casey. And if you have a longer set of comments about my record, I would be pleased to take it.

[Laughter.]

Thank you very much, Senator Casey.

I have said this before, by the way, and there will be others I hope who will join us today. And as I do get ready to leave after 30 years in the Senate, I cannot begin to tell you what a sense of confidence and comfort it is to know that there are people like Bob Casey and Jeff Merkley who are going to be here, I hope, for a long time, who care deeply about the issues, have brought, just in the short time they have been here, tremendous interest and support for these efforts. So I leave with a great sense of comfort knowing that there are going to be people here who will continue the efforts, as there were before I arrived in the Senate, people like Hubert Humphrey and George McGovern. Bob Dole did a lot of work on nutrition issues with children over the years. So this has been a continuum over the years that people have made an effort. And as I said a little while ago, nothing, no set of issues have given me a greater sense of joy or pleasure to work on over the past 3 decades than this cluster of issues, but I am very comfortable knowing that there are some people sitting at this very dais who are going to carry on the effort. So I thank both of you very much for your efforts.

Let me introduce our witnesses, and then I will ask you to try and keep your remarks, if you can, somewhere—I am not gong to gavel people down. Obviously, this is important. But do not filibuster like Senators are inclined to do, and we may get through the hearing here this morning.

Dr. Cecilia Rouse currently serves as a member of the Council of Economic Advisers, received her doctorate in economics from Harvard, currently on leave from Princeton University where she is a Theodore Wells Class of 1929, I guess it is in the title of this thing, Professor of Economics and Public Affairs. She has been a senior editor of the future of children in the Journal of Labor Economics and served on the National Economic Council under President Clinton from 1998 to 1999, and her research focuses on labor economics and the economics of education. We thank you for being with us.

Seth Harris, whom I have known for a long time, is the Deputy Secretary of Labor, the 11th person to hold this position since it was created in 1986. Mr. Harris served as a professor of law at the New York Law School and director of its labor and employment law programs. During this time, he was the senior fellow at the Life Without Limits Project of the United Cerebral Palsy Association and a member of the National Advisory Commission on Workplace Flexibility. He graduated from NYU where he was editor-in-chief of the Law Review as well.

David Hansell is the Acting Assistant Secretary for the Administration for Children and Families within the Department of Health and Human Services. Prior to his work at HHS, he served as the Principal Deputy Assistant Secretary at the Administration for Children and Families. He also served as commissioner of the New York State Office of Temporary and Disability Assistance and as chief of staff of the New York City Human Resources Administration. He is also a graduate of Yale Law School in my hometown of Connecticut. You are very familiar with Yale Child Study Center, I presume, as well.

Dr. Thelma Meléndez is the Assistant Secretary for Elementary and Secondary Education. In that capacity, she serves as the principal advisor to the U.S. Secretary of Education on all matters related to pre-K, elementary, and secondary education. She earned her doctorate from the University of Southern California where she was in the Rossier School of Education program, specializing in language literacy and learning. Prior to arriving at the Department of Education, Dr. Meléndez served as the superintendent of the Pomona Unified School District in California.

And Dr. Howard Koh is the Assistant Secretary for Health at the Department of Health and Human Services. In that role, Dr. Koh oversees the HHS Office of Public Health and Science, the commissioned corps of the U.S. Public Health Service in the Office of the Surgeon General. He also serves as the senior public health advisor to the Secretary. And in keeping with the great tradition of the panel, Dr. Koh is also a graduate of Yale College and the Yale School of Medicine. You are beginning to think there is some pattern in all of this.

[Laughter.]

And I would be remiss if I did not point out that his brother is a great friend of mine as well and is actively involved with the State Department. So, Dr. Koh, we thank you for joining us as well.

And with that, let me turn to our witnesses. Again, I presume some of you may have supporting data for some of the testimony you are going to provide for us this morning. I will just make the unanimous consent that all supporting data and information and materials that you think would help give us a solid foundation on which to draw some conclusions in this committee will be included in the record as well.

With that, Dr. Rouse, you are on.

STATEMENT OF CECILIA ELENA ROUSE, Ph.D., MEMBER, COUNCIL OF ECONOMIC ADVISERS, WASHINGTON, DC

Ms. ROUSE. Good morning, Chairman Dodd, Senators Merkley and Casey. I am very pleased to represent the Council of Economic Advisers this morning at this important hearing, and I thank you very much for your strong commitment to improving the lives of children and their families.

In my written testimony, I document the status of children in America in three areas: economic status, health, and education. To the extent possible, I assembled data that reflect their status since the beginning of the recession, although at this point such data are often unavailable.

Let me begin with trends in economic status. Between 1990 and 2007, expansions in the economy brought increases in family income and with that decreases in the percentage of children living below the poverty level. Along many dimensions, the biggest gains over the past 20 years occurred during the economic expansion of the 1990s. The bottom line is that a good economy is good for everyone, especially children.

Unfortunately, the recent recession has had a negative impact on this progress. The median income for families with children has decreased, and as a result, the percentage of children living in pov-

erty has also increased. In 2008, the most recent data available, 19 percent of children lived in poverty and 8.5 percent, or over 6 million, lived in extreme poverty.

As far as child health is concerned, there has been progress in some dimensions such as rates of infant mortality, exposure to environmental hazards, and health insurance coverage largely due to the Children's Health Insurance Program.

Unfortunately, trends in the area of childhood diseases offer a more mixed picture. The percentage of children with cavities, the most common chronic disease among children, has declined, but the prevalence of asthma has increased.

Most importantly, the rate of childhood obesity has increased significantly. In the late 1970s, 5.5 percent of children were considered obese. Today that number has increased to 17 percent. And unfortunately, childhood obesity has been associated with a variety of immediate and future health problems. Many of the future health problems stem from the fact that these obese children are more likely to become obese adults. A recent estimate suggests that overall obesity is responsible for almost 10 percent of total annual medical expenditures, or nearly $150 billion per year. The direct medical costs of obesity have been estimated to be similar in magnitude to those associated with smoking.

Finally, I document that along some dimensions, U.S. student educational achievement has improved. However, the level of achievement is not nearly as impressive. Proficiency on national tests is low and our standings in international comparisons have slipped.

So what has been and what will likely be the impact of the recession on well-being of American children? A vast academic literature has generally found that children from wealthier families have higher educational attainment, are healthier, and are more likely to go on to have successful labor market outcomes than their poorer counterparts. Given this relationship, the impact of the current recession on children is of great concern. While it is too early to know for certain, by all expectations it will set us back.

Recognizing that my colleagues will speak about many of the Federal Government's efforts in several initiatives supported by the administration, I would like to briefly underscore four areas that I believe are important for improving the well-being of children.

First, given the importance of family circumstances on child well-being, an important short-run change is a solid and timely economic recovery. This is why the HIRE Act and extension of unemployment benefits were so important.

In addition, the President has continued to call for additional support for small businesses, as well as for funding to help retain teachers.

Second, with the alarming increase in childhood obesity, it is important that we find a way to improve nutrition and healthy lifestyles among American children. A notable step is to expand and improve the Federal nutrition program. In addition, the First Lady's *Let's Move!* campaign calls upon everyone who has an effect on children's health to act together to end the epidemic of childhood obesity within a generation.

Third, the competitiveness of the U.S. economy depends on the productivity of its workers. The Federal Government's investments in education and training have moved in the right direction. Further, reauthorizations of the Elementary and Secondary Education Act and the Workforce Investment Act, as well as making the Early Learning Challenge Fund a reality, will enable the Federal Government to continue these efforts.

Finally, one of the biggest changes that impacts the lives of children is that an increased proportion are raised in households in which all parents work in the labor market. While many employers have adapted to the changing family circumstances of U.S. workers by providing flexibility in the workplace, too many do not. Wider adoption of such practices may well benefit more firms' workers in the U.S. economy as a whole, including children whose parents can more fully attend to their health care, schooling, and other needs.

The Federal Family and Medical Leave Act was a historic first step toward helping workers balance the responsibilities to their families, as well as to their employers. As of 2007, 82 percent of all workers in the private sector had access to unpaid family leave. We very much appreciate your leadership, Senator Dodd, on the FMLA, and the Administration supports further efforts in this area.

In sum, the well-being of children has improved along many dimensions over the past 2 to 3 decades. While it has improved, there is still work to be done especially in light of the recent recession. The Federal Government has played and must continue to play a significant role in maintaining and accelerating progress. Such efforts include sound economic strategies that enable parents to provide for their children, improved access to quality health care, and high quality education from cradle to career. These investments are critical as our future prosperity depends on ensuring that American children from all backgrounds have the opportunity to become productive workers.

Thank you for your dedication to these issues and for holding this important hearing. I would be happy to address any questions that you may have.

[The prepared statement of Ms. Rouse follows:]

PREPARED STATEMENT OF CECILIA ELENA ROUSE, PH.D.

Good afternoon Chairman Dodd, Ranking Member Alexander, and distinguished members of the subcommittee.

I am very pleased to represent the Council of Economic Advisers (CEA) at this important hearing and thank you for your strong commitment to improving the lives of children and their families. I focus my remarks on documenting the status of children in America in three areas: economic status, health, and education. To the extent possible, I have assembled data that reflect their status since the beginning of this recession although at this point such data are often unavailable. I conclude by suggesting four areas in which it is particularly important to bring change in order to improve the well-being of children.

The bottom line is that a good economy is good for the well-being of all, and especially children. Along many dimensions, the biggest gains over the past 20 years occurred during the economic expansion of the 1990s, as poverty rates in families with children dropped dramatically as did some important measures of health, such as rates of infant mortality. Given the link between the economy and child well-being, we must remain vigilant to maintain these gains in the wake of the recent recession, as investments in children are investments in the future prosperity of America.

Trends in Economic Status

Between 1990 and 2007, U.S.-real gross domestic product grew at an average annual rate of 3.0 percent, and unemployment averaged 5.4 percent; growth was particularly strong during the 1990s. Not surprisingly, the resources available to children improved during this time as family incomes also rose. As evidence, the median income of families with children increased by 12 percent during this period fueled by an increase of 16 percent between 1990 and 2000. Consistent with this economic growth, the percentage of children living below the poverty level decreased from 21 percent to 18 percent between 1990 and 2007, as shown in Table 1.[1]

Unfortunately, the recent recession has had a negative impact on this progress. In 2008, the median income for families with children decreased by 2.3 percent from the previous year and the percentage of children living in poverty increased to 19 percent. Moreover, 8.5 percent of children (over 6 million) lived in extreme poverty (defined as having family income less than 50 percent of the poverty threshold). The percentage of children in food-insecure households jumped to 22.5 percent in 2008, up from 16.9 percent in 2007, and is the highest percentage since data collection began in 1995.[2] According to the *2010 KIDS COUNT Data Book* recently released by the Annie E. Casey Foundation, most experts expect the child poverty rate to increase significantly over the next several years.[3]

Trends in Child Health

Before the recession the United States had also witnessed improvements in child health along many dimensions. For example, the rate of infant mortality—which serves as an important indicator of the health of a nation as it reflects a number of other measures, including maternal health, quality of healthcare, and socioeconomic conditions—decreased from 9.2 infant deaths per 1,000 live births in 1990 to 6.7 in 2007. Similarly, the proportion of children covered by health insurance increased from 87 percent in 1990 to 89 percent in 2007 (see Table 1).

Progress has also been made in reducing the impact of environmental hazards, such as lead poisoning and unsafe drinking water, on child health over the past two decades. Lead poisoning can cause a multitude of health problems from learning disabilities and behavioral problems to seizures, coma, and death. Young children and children living below the poverty line in older housing are particularly at risk. Fortunately, blood lead levels have decreased in recent decades; for example, the percentage of young children (ages 1–5) with more than 10 micrograms of lead per deciliter of blood dropped from 8.6 percent between 1988 and 1991 to 1.4 percent between 1999 and 2004.[4] Access to safe drinking water is another important environmental measure of health since children are especially sensitive to certain contaminants in drinking water, which have the potential to cause illness, developmental disorders, and cancer. The positive news is that the percentage of children served by community water systems that did not meet all applicable health-based drinking water standards has dropped from 18 percent in 1993 to 6 percent in 2008, although estimates have fluctuated during that time period.

While there has been some progress in terms of child health over the past 20 years, trends in the area of childhood diseases offer a more mixed picture. The most common chronic disease among children is dental caries (cavities). And, the percentage of children (ages 5–17) with untreated cavities has declined from 24.3 percent in the late 1980s and early 1990s to 16.3 percent in more recent years. In contrast, the prevalence of asthma, another very common chronic childhood disease, increased in past decades (1980s and 1990s). More recent data show that in 2008, 9.5 percent of children (under 18) had asthma, an increase from 8.8 percent in 2001.

Asthma is a major cause of childhood disability and can be very burdensome in terms of both medical and indirect costs. For example, in 2003, 12.8 million school days were missed due to asthma among those who reported at least one asthma at-

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[1] The official poverty measure estimates poverty rates by comparing a household's cash income to a threshold that accounts for family size and inflation. Noncash benefits, such as food stamps, are not included as income.

[2] A household is defined as "food-insecure" if it was unable at times to acquire adequate food for active, healthy living for all household members due to insufficient money or other resources for food.

[3] Annie E. Casey Foundation. *2010 KIDS COUNT Data Book: State Profiles of Child Well-Being.* 2010.

[4] Jones, Robert L., et al. "Trends in Blood Lead Levels and Blood Lead Testing Among U.S. Children Aged 1 to 5 Years, 1988–2004." Pediatrics (March 2009): E376–85.

tack in the previous year.[5] In addition, even after controlling for higher asthma prevalence, minority children have much greater rates of adverse outcomes, which include emergency department visits, hospitalizations, and death.[6]

Depression is another important medical condition with 8.3 percent of youth (ages 12–17) reporting at least one "major depressive episode" in the past year in 2008. Depression negatively impacts development and well-being of adolescents; however, not all youth are affected equally.[7] For example, in 2008, female adolescents were almost three times as likely as males to have had a major depressive episode in the past year. The prevalence of this condition among all youth has not changed in recent years.

Most importantly, the rate of childhood obesity has increased significantly from the past. Child obesity is defined as a body mass index (BMI) at or above the 95th percentile for children of the same age and sex. In the second half of the 1970s, 5.5 percent of children (ages 2–19) were considered obese. This proportion increased to 17 percent of children in the most recent data available (2007–8). When including overweight children (with a BMI between the 85th and 94th percentiles), this number nearly doubles to 32 percent.[8] Childhood obesity has been associated with a variety of immediate and future health problems including high cholesterol and high blood pressure, both risk factors for cardiovascular disease, as well as asthma, diabetes, and psychological stress such as low self-esteem.

Researchers estimate that direct medical costs for children with elevated BMI are estimated to be $3 billion per year.[9] In addition, many of the future health problems stem from the fact that obese children are more likely to become obese adults. And, obesity across all age groups is costly in terms of both direct medical costs and indirect costs that arise from losses in productivity, absenteeism, and premature death. Estimates suggest that obesity is responsible for almost 10 percent of total annual medical expenditures, or about $147 billion per year in 2008.[10] Another study found that between 1987 and 2001, increases in the proportion of, and spending on, obese people relative to people of normal weight account for 27 percent of the rise in inflation-adjusted per capita spending.[11] Conservative estimates find that the direct medical costs of obesity are similar in magnitude to those associated with smoking.[12]

TRENDS IN EDUCATION

Along some dimensions U.S.-student achievement has improved over the past 30 years, particularly as measured by the National Assessment of Education Progress (NAEP), the Nation's Report Card. For example, as shown in Figure 1, the performance of 9-year-olds (who are typically enrolled in 4th grade) and 13-year-olds (typically 8th grade) improved in mathematics between 1978 and 2008. Nearly three-quarters of 13-year-olds in 2008 scored above the 1978 median, with similar gains throughout the distribution. The performance of 17-year-olds (typically 12th graders) has also improved, although the gain was smaller.

Despite this progress, the level of achievement is not nearly as impressive. In the most recent tests, only 32 percent of 8th graders were proficient in reading and only 34 percent in math, where a student is deemed "proficient" if he or she demonstrates age- or grade-appropriate competency over challenging subject matter and shows an ability to apply knowledge to real-world situations.[13]

This low level of attainment, which is observed at both the secondary and post-secondary levels, is underscored in international comparisons. Among the cohort

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[5] Akinbami, Lara J. "The State of Childhood Asthma, United States, 1980–2005." *Advance Data from Vital and Health Statistics*, no. 381 (2006). Hyattsville, MD: National Center for Health Statistics.

[6] Akinbami, Lara J., et al. "Status of Childhood Asthma in the United States, 1980–2007." *Pediatrics*, American Academy of Pediatrics (March 2009): S131–45.

[7] Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being*, 2010. Washington, DC: U.S. Government Printing Office. July 2010.

[8] Ogden, Cynthia L., et al. "Prevalence of High Body Mass Index in U.S. Children and Adolescents, 2007–8." *Journal of American Medical Association* 303, no. 3 (2010): 242–49.

[9] Trasande, Leonardo, and Samprit Chatterjee. "Corrigendum: The Impact of Obesity on Health Service Utilization and Costs in Childhood." *Obesity* 17, no. 9 (2009): 1473.

[10] Finkelstein, Eric A., et al. "Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates." *Health Affairs* (2009): W822–31.

[11] Thorpe, Kenneth E., et al. "Trends: The Impact of Obesity on Rising Medical Spending." *Health Affairs* (2004): W4–480–6.

[12] Stein, Cynthia J., and Graham A. Colditz. "The Epidemic of Obesity." *Journal of Clinical Endocrinology & Metabolism* (2004): 2522–25.

[13] National Assessment of Educational Progress. "The Nation's Report Card: Grade 8 National Math and Reading Achievement Levels." 2009.

born between 1943 and 1952 (that largely completed its education by the late 1970s), the United States has the highest percentage with at least a bachelor's degree (or the equivalent) compared to other developed nations. However, that percentage has not grown in the United States while increasing substantially in other countries. The OECD data suggest that only 40 percent of Americans born between 1973 and 1982 have completed associate's degrees or better which is lower than that in 11 other countries (led by Canada and Korea, where up to 56 percent completed some post-secondary degree or extended certificate program).[14] High school graduation rates show a similar pattern as the United States has slipped from the top to the middle in recent cohorts.

These relatively low rates of educational attainment have costs to both the individual and to society. As one example, individuals who have not graduated from high school earn less than those with a high school degree and are significantly less likely to be employed at a stable full-time job or one that pays benefits much less at all. As a result of their relatively poorer labor market prospects, these workers contribute less in taxes and are more likely to draw on public assistance. By one estimate, high school dropouts earn approximately $300,000 less over their lifetime than high school graduates (with no further education and in present discounted value terms) and contribute about $70,000 less in taxes.[15]

And so there is work to be done to strengthen the education and training of American workers and as we do so, it is important to emphasize that the task of improving later educational outcomes begins before elementary school. School readiness which involves both cognitive skills—as measured by vocabulary size, complexity of spoken language, and basic counting—and social and emotional skills—such as the ability to follow directions and self-regulate—is critical to later educational and labor market success. Children who arrive at kindergarten without these skills lack the foundation on which later learning will build. And yet relatively recent research indicates that as many as 45 percent of entering kindergartners are ill-prepared to succeed in school.[16] Because investments in the youngest members of U.S. society generate better-prepared students and healthier workers that earn higher wages, economists have estimated that the long-run benefits outweigh the costs of a high-quality pre-school. Steven W. Barnett and Leonard N. Masse estimate that a dollar investment in one program produced $2.50 in long-run savings for taxpayers.[17] James Heckman, Nobel Laureate in Economics, and his colleagues estimated even higher savings of $7 from another program.[18]

THE IMPACT OF FAMILY CIRCUMSTANCES ON CHILD WELL-BEING AND IMPLICATIONS FOR THE IMPACT OF THE RECESSION ON CHILDREN

A vast academic literature has attempted to explain the role of family economic resources on child well-being and has generally found that children from more advantaged families have better outcomes than those from less advantaged backgrounds. Children from wealthier families have higher educational attainment, are healthier, and are more likely to go on to have successful labor market outcomes than their poorer counterparts.

More specifically, studies have found that income is associated with a number of education-related outcomes such as a child's cognitive abilities and school achievement. One study found that children in families with incomes below 50 percent of the poverty line scored significantly lower on a set of cognitive tests than children in families with incomes at 150–200 percent of the poverty line.[19] Another study estimated that on average, children who had experienced poverty during some or all

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[14] Organisation for Economic and Co-operation and Development. "Education at a Glance." 2009.

[15] The figures in the text have been inflated to 2009 dollars. Rouse, Cecilia E. "Consequences for the Labor Market." In *The Price We Pay: Economic and Social Consequences of Inadequate Education*, edited by Clive Belfield & Henry M. Levin, pp. 99–124. Washington, DC: Brookings Institution Press, 2007.

[16] Hair, Elizabeth, et al. "Children's School Readiness in the ECLS–K: Predictions to Academic, Health, and Social Outcomes in First Grade." *Early Childhood Research Quarterly* 21, no. 4 (2006): 431–54.

[17] Barnett, W. Steven, and Leonard N. Masse. "Comparative Benefit-Cost Analysis of the Abecedarian Program and Its Policy Implications." *Economics of Education Review* 26, no. 1 (2007): 113–25.

[18] Heckman, James J., et al. "The Rate of Return to the High/Scope Perry Preschool Program." Mimeo, University of Chicago. April 2009.

[19] Smith, Judith R., Jeanne Brooks-Gunn, and Pamela K. Klebanov. "The Consequences of Living in Poverty for Young Children's Cognitive and Verbal Ability and Early School Achievement." In *Consequences of Growing Up Poor*, edited by Greg J. Duncan and Jeanne Brooks-Gunn, pp. 132–39. New York: Russell Sage Foundation, 1997.

of their adolescence completed between 1.0 and 1.75 fewer years of schooling than children who had not.[20] Similarly, proficiency rates on the NAEP assessments are much lower for those whose family incomes make them eligible for a free or reduced-price lunch, as shown in Figure 2. The low achievement in these subgroups is also reflected in low attainment as measured by high school completion, college enrollment, and college completion.

There is a similar relationship between family circumstances and health outcomes. For example, researchers in one study that controlled for maternal education and family structure found that children in families facing long-term poverty had more behavioral problems than children who had never dealt with poverty.[21] In another, average blood lead levels were found to be 60 percent higher for children (ages 1–5) in lower-income families than for those in higher-income families.[22] Similarly, poverty remains a significant factor in the prevalence of cavities with 26 percent of children in poverty having untreated cavities compared to just 11.8 percent of children with family incomes at or above 200 percent of the poverty threshold.

Given the relationship between family circumstances and child well-being, of great concern is the impact of the current recession on children. Since December 2007, total private employment decreased by 7.9 million, and the current unemployment rate remains unacceptably high at 9.5 percent. Children have also been adversely affected as the percentage of children living in a household with at least one unemployed parent more than doubled between 2007 and 2009 such that now 1 in 10 children live in a household with at least one unemployed adult (see Figure 3). Further, over 2 million homes were foreclosed in 2008 and the number of people in families that were homeless rose by 9 percent that year. According to one study, more than 450 school districts had an increase of at least 25 percent in the number of homeless students between the 2006–7 and 2007–8 school year[23] In the 2008–9 school year, the U.S. Department of Education reported a 20 percent increase in the number of homeless students.[24]

While it is too early to know for certain the impact of this recession on children, by all expectations, it will set us back. Homeless children are, generally speaking, more likely to suffer from health and mental health problems and to perform poorly in school, than children in stable housing.[25] Job loss not only affects the workers who lost their jobs, but also has a lasting impact on their children. In one important study, economists followed the lives of children whose fathers lost their jobs due to plant closings and those whose fathers had not been displaced. The researchers found that, as adults, the annual earnings of children whose fathers had been displaced were 9 percent lower than those whose fathers had not been displaced; they were also 3 percentage points more likely to ever receive public assistance.[26]

The recession also has had a negative impact on older youth: the unemployment rate for youth (ages 16–24) was 18.2 percent last month, nearly double the national unemployment rate. This weak labor market will likely adversely impact their future labor market outcomes as well. One study found that students who graduated during a recession experienced persistent lower wages than those who graduated during better times.[27] Specifically, a 1 percentage point increase in the national unemployment rate decreased initial wages by 6 percent. Even 10 years after graduation, the wage loss was still present at 4 percent. I note that this difficulty that young adults are having gaining exposure to the world of work, is one reason that the President has joined with Members of Congress to support funding for summer youth employment.

Given the current length of this recession, it is important to look not only at impacts of transitory poverty but also at the impact of longer-term poverty on child well-being. Persistent poverty status affects a plethora of outcomes, ranging from

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[20] Teachman, J.D., et al. "Poverty during Adolescence and Subsequent Educational Attainment." In *Consequences of Growing Up Poor*, edited by Greg J. Duncan and Jeanne Brooks-Gunn, pp. 382–418. New York: Russell Sage Foundation, 1997.

[21] Duncan, Greg. J., Jeanne Brooks-Gunn, and Pamela K. Klebanov. "Economic Deprivation and Early-Childhood Development." *Child Development* 65 (1994): 296–318.

[22] Jones (2009).

[23] Duffield, Barbara and Phillip Lovell. "The Economic Crisis Hits Home: The Unfolding Increase in Child & Youth Homelessness." National Association for the Education of Homeless Children and Youth (December 2008).

[24] United States Interagency Council on Homelessness. "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness." 2010.

[25] Duffield and Lovell (2008).

[26] Oreopolous, Philip, Marianne Page, and Ann H. Stevens. "The Intergenerational Effects of Worker Displacement." Working Paper 11587. Cambridge, MA: National Bureau of Economic Research (August 2005).

[27] Kahn, Lisa. "The Long-Term Labor Market Consequences of Graduating from College in a Bad Economy." Mimeo, Yale University. August 2009.

adult earnings to criminal behavior to health. Researchers estimate that the total difference in lifetime earnings between children who lived in persistent poverty and children who did not amounts to about 1.3 percent of 2008 GDP.[28] Children living in poverty are more likely to be involved in criminal activity, which will cost society at least $170 billion annually. And due to the incidence of poor health in poorer children, direct expenditures on health care are estimated to cost an additional $22 billion a year.

While family income plays a big role in these adverse outcomes, there are also indirect channels through which the recession will affect children. For example, one study found that job loss is associated with increased divorce rates.[29] Children in unstable families have poorer school performance and increased behavioral problems, and unemployment can also cause stress for parents, which can affect their behavior with their children.[30] This, in turn, can affect children's emotional adjustment.[31]

Finally, it is important to highlight one indicator of child well-being that, thanks to the Federal Government, has not suffered during the recession—health insurance coverage for children. Given that over one-half of Americans obtain their health insurance through their employer, hard economic times can bring increases in the numbers of children without health insurance coverage. Not surprisingly, the proportion of children covered by private health insurance has continued to decrease since the start of the recession. Fortunately, the increase in the proportion of children covered by public health insurance more than compensated for the decline in private insurance. According to the Census Bureau, about 10 percent of children were without health insurance in 2008. A more recent estimate from the *National Health Interview Survey* suggests that in 2009, 8.2 percent of children were without health insurance, the lowest level on record. These positive developments will continue as a result of the historic expansion of the Children's Health Insurance Program, which extended coverage to 2.6 million additional children in fiscal year 2009, and the Patient Protection and Affordable Care Act of 2010, which will end limits on pre-existing conditions, extend the period of time during which children can stay on their parents' health insurance, and make health insurance more affordable for all.

WHAT HAS TO CHANGE FOR CHILDREN TO DO BETTER?

Recognizing that my colleagues will speak about many of the Federal Government's efforts and several initiatives supported by the Administration, I would like to underscore four general areas that I believe are important for improving the well-being of children.

A Speedy Economic Recovery

First, given the importance of family circumstances on child well-being, an important short-run change is a solid and timely economic recovery. The CEA estimates that by the middle of the second quarter of 2010, the American Recovery and Reinvestment Act of 2009 (ARRA) had raised the level of real GDP by 2.7 to 3.2 percent and the level of employment by 2.5 to 3.6 million relative to what they would have been without it.[32] However, unemployment remains at 9.5 percent, and recent economic data indicate that while a recovery is starting to take place, much stronger job gains are needed to put the millions of Americans who have lost their jobs since the start of this recession back to work. This is why the HIRE Act, the jobs tax credit that provides an incentive for small businesses to hire unemployed workers, is so important to this economy, as is extension of unemployment benefits. In addition, the President has continued to call for additional support for small businesses as well as for additional funding to help retain teachers as we head into the next school year. When parents have jobs that provide the resources to put nutritious

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[28] Holzer, Harry J., et al. "The Economic Costs of Childhood Poverty in the United States." *Journal of Children and Poverty* 14, no. 1 (2008): 41–61.

[29] Charles, Kerwin K., and Melvin Stephens, Jr. "Job Displacement, Disability, and Divorce." Working Paper 8578. Cambridge, MA: National Bureau of Economic Research (November 2001).

[30] Cavanagh, Shannon, and Aletha C. Huston. "Family Instability and Children's Early Problem Behavior." *Social Forces* 85, no. 1 (2006): 551–81; Morris, Pamela, Greg J. Duncan, and Christopher Rodrigues."Does Money Really Matter? Estimating Impacts of Family Income on Children's Achievement with Data from Random-Assignment Experiments." Unpublished manuscript, Northwestern University (February 2004).

[31] Kalil, Ariel. "Unemployment and job displacement: The impact on families and children." *Ivey Business Journal* (July/August 2005).

[32] Council of Economic Advisers. "The Economic Impact of the American Recovery and Reinvestment Act of 2009, Fourth Quarterly Report." July 2010.

food on the table and a safe and stable place to live, it is reflected in the well-being of their children.

A Commitment to Healthy Children

Second, with the alarming increase in childhood obesity and the associated health and economic consequences that ensue, it is important that we find a way to improve nutrition and healthy lifestyles among American children. A notable step is to expand and improve the Federal nutrition program. Two bills currently awaiting floor votes—the Healthy, Hunger-Free Kids Act in the Senate and the Improving Nutrition for America's Children Act in the House—aim to increase children's access to healthier meals by providing additional funds to child nutrition programs, including the National School Lunch Program. The improved child nutrition program will not only assist schools in meeting meal requirements and enrolling eligible children but also support nutrition education in schools to promote healthy eating habits. In addition, the First Lady's *Let's Move!* campaign calls upon everyone who has an effect on children's health (from parents to teachers to political leaders) to act together to end the epidemic of childhood obesity within a generation. To assist in achieving this goal, a White House Task Force on Childhood Obesity was established by the President and is implementing a series of 70 recommendations.

A Commitment to a World-Class Education

Third, the competitiveness of the U.S. economy depends on the productivity of its workers. A growing share of jobs requires workers with greater analytical and interactive skills, which are typically acquired with some post-secondary education. And yet students cannot succeed in post-secondary education and training programs if they are ill-prepared. While the current U.S. education and training system has been shown to provide valuable labor market skills to participants, it could be more effective at encouraging completion and responding to the needs of the labor market. As detailed in the CEA report, "Preparing the Workers of Today for the Jobs of Tomorrow," a comprehensive strategy must include a solid early childhood, elementary, and secondary system that ensures students have strong basic skills; institutions and programs that have goals that are aligned and curricula that are cumulative; close collaboration between training providers and employers to ensure that curricula are aligned with workforce needs; flexible scheduling, appropriate curricula, and financial aid designed to meet the needs of students; and incentives for institutions and programs to continually improve and innovate; and accountability for results.[33]

The Federal Government's investments in these areas have moved in the right direction particularly with some of the innovative investments in the ARRA and the Health Care and Education Reconciliation Act of 2010. The Reauthorizations of the Elementary and Secondary Education Act of 1965 and the Workforce Investment Act will enable the Federal Government to continue these efforts so that the U.S. education and training system can once again be first in the world. The Administration also remains committed to working with Congress to make the Early Learning Challenge Fund a reality. This proposal, if enacted, would challenge States to establish model systems of early learning and ensure that more children enter school ready to learn and succeed.

Workplaces That Recognize Changes in Family Economic Structure

Finally, as documented in the CEA report, "Work-Life Balance and the Economics of Workplace Flexibility," one of the biggest changes that impacts the lives of children is the growing participation of women in the labor force. For example, while in 1968, 48 percent of children were raised in households where the father worked full-time, the mother was not in the labor force, and the parents were married; by 2008, only 20 percent of children lived in such households. As a result, an increased proportion of children are raised in households in which all parents work in the labor market (for single-parent households, this means that the one parent works; for two-parent households, both parents work). In 1968, 25 percent of children lived in households in which all parents were working full-time; 40 years later, that percentage had nearly doubled.[34]

In addition, compared with 1965, in 2003 women spent more time on market work and significantly less time on non-market work such as food preparation, kitchen cleanup, and washing clothes. For men, the patterns were reversed as they spent substantially fewer hours on market work and somewhat more hours on non-market

[33] Council of Economic Advisers. "Preparing the Workers of Today for the Jobs of Tomorrow." (July 2009).

[34] Council of Economic Advisers. "Work-Life Balance and the Economics of Workplace Flexibility." (March 2010).

work.[35] With men and women both performing non-market and market work, often one or both of them need the ability to attend to family responsibilities such as taking children to doctors' appointments. And while many employers have adapted to the changing family circumstances of U.S. workers by providing flexibility in the work place (most commonly by allowing workers to periodically change when they work), many do not.

While the costs and benefits of adopting flexible work arrangements vary by employer, the benefits of adopting such management practices can outweigh the costs by reducing absenteeism, lowering turnover, improving the health of workers, and increasing productivity. As such, to the extent employers may not have accurate information about the costs and benefits of these practices and because benefits may extend beyond the individual employer and its workers, wider adoption of such policies and practices may well benefit firms, workers, and the U.S. economy as a whole, including children whose parents can more fully attend to their health care, schooling, and other needs.

CONCLUSION

While the well-being of children has improved along many dimensions over the past two to three decades, there is still work to be done especially in light of the recent economic recession. The Federal Government has played, and must continue to play, a significant role in maintaining and accelerating progress through improved access to sound economic strategies that enable parents to provide for their children, quality health care, and high quality education from cradle to career. These investments are critical as our future prosperity depends on ensuring that American children from all backgrounds have the opportunity to become productive workers.

Thank you for your dedication to these issues and for holding this important hearing. I would be happy to address any questions that you may have.

[35] See Table II in Aguiar, Mark, and Erik Hurst. "Measuring Trends in Leisure: The Allocation of Time Over Five Decades." *Quarterly Journal of Economics* 122, no. 3 (2007): 969–1006.

Table 1. Selected Indicators of Child Well-Being:
Poverty, Infant Mortality, Health Insurance, and Obesity

	1990	2000	2007	2008
	Percent			
Children (Ages 0-17) Living in Poverty[a]				
Below 100% Poverty	20.6	16.2	18.0	19.0
Below 50% Poverty	8.8	6.7	7.8	8.5
	Infant Deaths per 1,000 Live Births			
Infant Mortality[b]	9.2	6.9	6.7	--
	Percent			
Health Insurance Coverage[c] at Some Time During the Year for Children (Ages 0-17)				
Any Health Insurance	87.0	88.4	89.0	90.1
Public Health Insurance	21.9	24.4	31.0	33.2
Private Health Insurance	71.1	70.2	64.2	63.5
	Percent			
Children (Ages 2-19) who are Obese[d]	10.0	13.9	16.9	--

[a] Percentages include children not related to the householder.

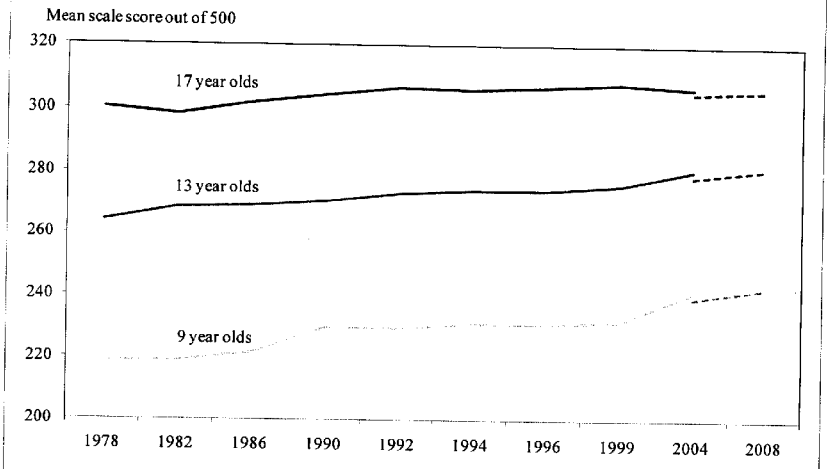
[b] Infant deaths are deaths before an infant's first birthday.

[c] Children are considered to be covered by health insurance if they had public or private coverage at any time during the year. Some children are covered by both types of insurance; hence, the sum of public and private is greater than the total. Public health insurance for children consists mostly of Medicaid, but also includes Medicare, the State Children's Health Insurance Programs (SCHIP), and the Civilian Health and Medical Care Program of the Uniformed Services (CHAMPUS/Tricare).

[d] Obesity defined as body mass index (BMI) greater than or equal to sex- and age-specific 95th percentile from the 2000 CDC Growth Charts. Excludes pregnant females. Obesity data presented are for the selected ranges of years: 1988-1994, 1999-2000, 2007-2008.

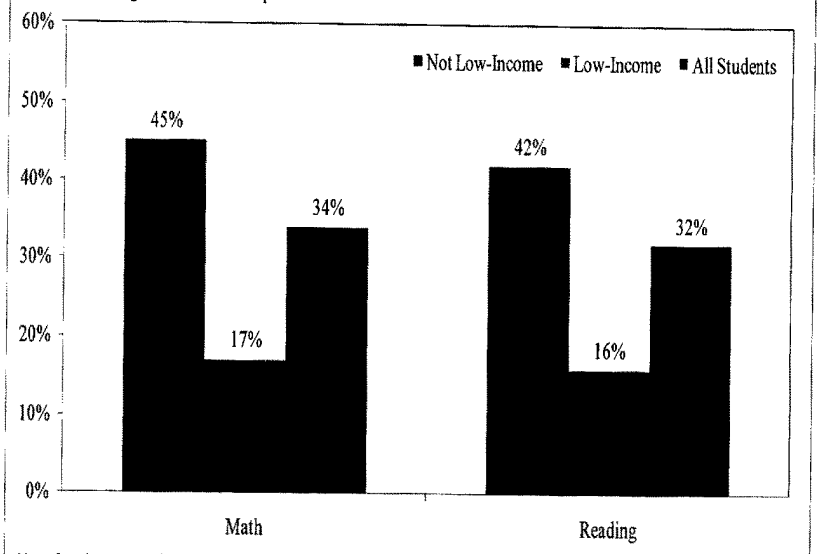
SOURCES: U.S. Bureau of Labor Statistics, Current Population Survey, Annual Social and Economic Supplements; The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org; CDC/National Center for Health Statistics, National Health and Nutrition Examination Survey.

Figure 1. Long-term Trend Math Performance, 1978-2008



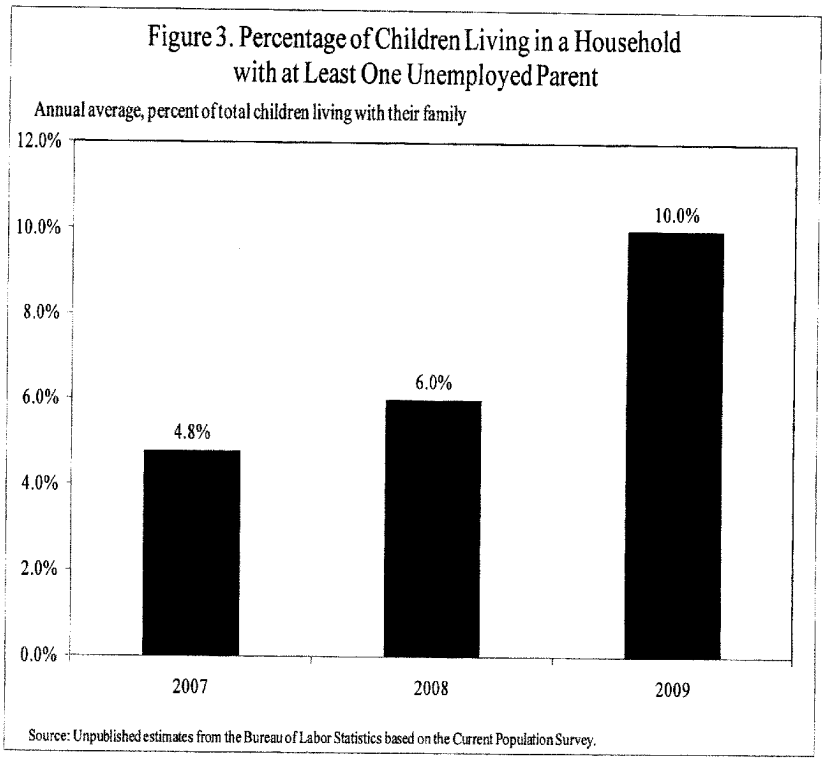
Notes: In 2004 and thereafter, accommodations were made available for students with disabilities and for English language learners, and other changes in test administration conditions were introduced. Dotted lines represent data from tests given under the new conditions.
Sources: Department of Education (Institute of Education Sciences, National Center for Education Statistics). National Assessment of Educational Progress (NAEP), Long-Term Trend Mathematic Assessments.

Figure 2. 8th Grade National Math and Reading Achievement Levels by Low-Income Status, 2009



Notes: Low-income status is determined by eligibility for the National School Lunch Program (NSLP). Eligibility for NSLP is determined by family income: free lunches are offered to those students whose family incomes are at or below 130 percent of the poverty level; reduced-price lunches are offered to those students whose family incomes are between 130 percent and 185 percent of the poverty level. Students are deemed "proficient" if they demonstrate age- or grade-appropriate competency over challenging subject matter and show an ability to apply knowledge to real-world situations.

Sources: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, National Assessment of Educational Progress (NAEP).



Senator DODD. Thank you very much, Dr. Rouse. It was very helpful.

Mr. Harris, welcome.

STATEMENT OF SETH D. HARRIS, DEPUTY SECRETARY, U.S. DEPARTMENT OF LABOR, WASHINGTON, DC

Mr. HARRIS. Mr. Chairman, Senators Casey and Merkley, thank you so much for inviting me to testify about the Labor Department's efforts to improve the lives of children in America.

Mr. Chairman, it is a special honor and a distinct pleasure to reflect on your 30-year career as one of this Nation's leading advocates for America's workers and children. Because of your service, working parents and their children are more prosperous, they are healthier, and they live in a fairer world. You were motivated by a simple but fundamental principle: Workers do not merely work. They are people, whole people. And our workplace policies must value their contributions in the workplace while respecting the realities of their everyday lives. Workers' families need both their economic support and their loving care. Your dedication to this vision has helped to humanize the American workplace so that millions of workers can satisfy both of these needs.

Mr. Chairman, your departure at the end of this Congress will mark the end of an era and a great loss for America. At the Labor

Department, we share your values and we are committed to carrying on your work.

Secretary Solis has laid out a simple and straightforward vision for the Labor Department: good jobs for everyone. Good jobs are found in safe and healthy workplaces. They provide opportunities to acquire the skills workers need for the jobs of the future and to ensure workplace flexibility for family and personal caregiving.

Mr. Chairman, we believe this vision nicely reflects your life's work on behalf of working families. The Family and Medical Leave Act, which the Labor Department administers, has helped more than 50 million Americans balance the demands of work with the needs of their families and their own health. In doing so, the FMLA promoted the economic security of American working families. Mr. Chairman, without your hard work, as Dr. Rouse said, the FMLA would not have become the law of the land.

While the FMLA is essential to workplace flexibility, you know well, Mr. Chairman, that the FMLA provides eligible workers only with unpaid job-protected leave, and many families simply cannot afford to miss a paycheck. The Obama administration has endorsed your Healthy Families Act to assure workers get at least 7 days of paid sick leave. This fundamental workplace standard will assure that workers can stay home if they or their children are sick and do so without fear of losing their job or income.

As important as the rights protected by the FMLA are, they can be frustrated when a family cannot afford good quality health care. The Patient Protection and Affordable Care Act will completely change the quality of life for the millions of American families who live in fear of doctors' bills or a notice from the insurance company canceling their policy. Again, Mr. Chairman, your leadership was essential in getting this landmark health insurance reform law passed.

Again, workers are pillars of our economy and their families. This is especially true for nearly 9 million working women who are also heads of household. Simply the financial health of families increasingly depends upon women. Both women and men must be able to secure their families' places in the middle class and this means that all workers must earn wages that can support a family. However, gender wage inequality stubbornly persists. For this reason, we thank you, Mr. Chairman, for championing the Paycheck Fairness Act.

Good jobs for everyone includes assuring that young people have the skills they need to compete in the rapidly changing global economy. The Department administers several programs that benefit young adults entering the workforce. Under the Workforce Investment Act, the Department administers youth activities funds with our State and local partners that deliver job training, work experience, and job placement services to low-income youth who experience barriers to employment. Many eligible young people do not have basic skills and the population we serve frequently includes homeless youth, runaways, pregnant or parenting teens, ex-offenders, school dropouts, or foster children. These young people are, indeed, fortunate that you and your colleagues in the Senate fought to ensure that the Recovery Act included $1.2 billion or the WIA youth funds. This funding enabled more than 325,000 youth across

the United States to experience employment during the summer of 2009.

The Labor Department also prepares older children and young adults to become productive contributors to our economy through programs like Job Corps and Youth Build. By taking low-income youth and placing them on a career pathway with job training and support, the Department helps them lay the foundation for lifetime income security and, when they start families, a better future for their children.

Mr. Chairman, I have only skated over the surface of the Labor Department's work on behalf of children. We enforce the FLSA's child labor protections. We support transitional jobs as part of the President's Fatherhood Initiative, among many other activities I would be delighted to talk about during Q&A.

Let me close by saying, Mr. Chairman, your absence from the Senate will be a great loss for America's working families and children. In tribute to your legacy and in full recognition of the work yet to be done, we will fight to ensure that your vision of a humanized labor market and compassionate workplaces continues to guide the work of the Department of Labor.

Thank you again for inviting me to testify today, and I look forward to our questions.

[The prepared statement of Mr. Harris follows:]

PREPARED STATEMENT OF SETH D. HARRIS

Good morning Chairman Dodd, Ranking Member Alexander, and members of the subcommittee. Thank you for inviting me to testify about the Labor Department's role in improving the state of America's children.

Mr. Chairman, it is my great honor and distinct pleasure to have this opportunity to reflect on your 30-year career as one of this Nation's leading advocates for America's workers and children. Because of your service, the lives of working parents and their children are more prosperous, healthier, and more fair. You have fought for the rights of women, minorities, children, and those whose voices are not always heard. These Americans may not know your name. But they know the products of your endeavors. And your efforts, very simply, have made their lives immeasurably better.

Your impressive accomplishments in the House of Representatives and in the U.S. Senate were motivated by a simple but fundamental principle: workers don't merely work. They are more than economic inputs into America's economy or costs on an employer's ledger. They are people—whole people—and our workplace policies must value their contributions in the workplace while respecting the realities of their everyday lives. Workers are also parents, spouses, and adult children of aging parents. Their families need both their economic support ***and*** their loving care. Your dedication to this vision has helped to humanize the American labor market and American workplaces so that millions of workers can satisfy both of these needs. As you reminded your colleagues just a few years ago,

> "When we talk about a more compassionate America, nowhere is that more evident than in our caregiving leave policies. No one should have to choose between work and family."

To that, Mr. Chairman, we would add only a resounding "Amen."

Your departure at the end of this Congress will mark the end of an era and a great loss for America, but your work will live on. At the Labor Department, we share your values and we are committed to carrying on your work. We also fully expect that we will hear from you, even after your retirement, if we stray from the path you have laid out.

On behalf of Secretary Solis, the 17,000 men and women of the U.S. Labor Department, and the millions of working Americans whom we serve, thank you for your outstanding leadership and service.

SECRETARY SOLIS' VISION AND GOOD JOBS FOR EVERYONE

Secretary Solis has laid out a simple and straightforward vision for the Labor Department: *Good Jobs for Everyone*. We are the Department of *Good Jobs for Everyone*. Good jobs can be found in safe and healthy workplaces, and in fair and diverse workplaces. Good jobs support a family by increasing incomes and narrowing the wage gap, while providing opportunities to acquire the skills and knowledge that workers will need for the jobs of the future, particularly in high-growth and emerging industry sectors like "green" jobs. Good jobs help middle-class families remain in the middle class. They also provide upward mobility and a pathway to the middle-class for low-wage workers and those disenfranchised from the labor market. Good jobs facilitate the return to work for those individuals who experienced workplace injuries or illnesses and are able to work, while providing sufficient income and medical care for those who are unable to do so. Good jobs ensure that workers have a voice in their workplaces, and provide health care coverage and retirement security. And finally, good jobs provide workplace flexibility for family and personal care-giving. Mr. Chairman, we believe that this vision nicely reflects your life's work on behalf of working families.

In the remainder of my testimony, I will discuss how Secretary Solis' vision of *Good Jobs for Everyone* seeks to address the concerns of working families and children from birth through the beginnings of adulthood. The Labor Department administers programs that help ensure good jobs for parents and, in doing so, provides access to a better childhood for their offspring. Simply put: children have the greatest opportunities when their parents can provide them with economic security and family stability. But the Labor Department also assures that children have the opportunity to acquire the education and develop the skills they need to become productive contributors in the new American economy and, in turn, the economic bulwarks for their families. Just as you have advised, Mr. Chairman, our goal and the goal of our partners in the agencies testifying here today is to help workers succeed as whole people, in the workplace and in the home.

WORKPLACE FLEXIBILITY AND LEAVE: FAMILIES BALANCING LIFE'S DEMANDS

The right to take job-protected leave to care for a child who is sick is absolutely essential to the concept of a "good job." It recognizes the dual role that working parents play. The seemingly never-ending juggling act that parents face in trying to balance work life and family life begins as soon as a baby arrives, continues beyond that first call home a school nurse makes when a child has a fever or a broken bone, and remains when a call comes from a nursing home to resolve a health issue for an ailing parent. That is why one of the tenets of Secretary Solis' definition of *Good Jobs for Everyone* is that a good job "provides workplace flexibility for family and personal care-giving."

You know better than anyone, Mr. Chairman, that the Family and Medical Leave Act (FMLA) provides this necessary flexibility. The passage of the FMLA was the most important legislative event of its time for the lives of working families. This landmark law gave working Americans the right to take unpaid leave to be there for their families when it counts: when a child, parent, or spouse has a serious illness, or when a baby is born or adopted. The FMLA has helped more than 50 million Americans balance the demands of the workplace with the needs of their family and their own health, and in doing so promoted the financial stability and economic security of American working families. As President Clinton noted when he made FMLA the first legislation he signed into law, your bill set a long overdue standard of fairness in the workplace. Mr. Chairman, there can be no doubt that without your hard work and persistence, the FMLA would not have become the law of the land, and countless American workplaces would be void of the basic standard of fairness it mandates.

The impact that the FMLA has on the health and well-being of our Nation's children cannot be overstated. More mothers and fathers have the opportunity to bond with their newborns. Employees recuperate more quickly and completely from illness resulting in greater productivity upon their return. Children are healthier, infection rates in childcare facilities decrease, and parents are less likely to postpone or skip their children's vaccination schedules all because their parents are provided job-protected sick leave.[1]

Guided by Secretary Solis, the Department of Labor has recommitted itself to the enforcement of the FMLA. The Department's Wage and Hour Division (WHD) ensures that workers' FMLA rights are protected. In one instance, WHD was able to

[1] Vicky Lovell, Ph.D., "No Time To Be Sick: Why Everyone Suffers When Workers Don't Have Paid Sick Leave," Institute for Women's Policy Research, 2004.

successfully assist a working mother who was a manager at a Dollar General store near Houston, TX. She needed to leave from work for the birth of her child and notified her employer 2 months before she was to give birth. The employer, however, failed to properly notify the employee of her rights and responsibilities under the FMLA, and subsequently terminated her employment while she was on leave for the birth of her child. Fortunately, a WHD investigator was able to recover several thousand dollars in back wages for this new mother. Such gross violations of the law are inexcusable and will not be tolerated.

As you know, Mr. Chairman, family life is constantly changing, and the rules and regulations that govern workplace flexibility must keep pace. The Department is committed to ensuring that all working parents have the tools they need to balance work and family life—even if their families do not fit the "traditional" definition. The Department recently updated FMLA guidance to respond to the ever-increasing diversity in modern American families. Seventeen years after the enactment of the FMLA, the Wage and Hour Division published a new Administrator's Interpretation clarifying that the definition of a "son or daughter" includes the concept of *in loco parentis*—that is, the person who has day-to-day responsibility for a child is entitled to take job-protected leave to care for that child who is seriously ill. Under this interpretation, the brother who receives a call in the middle of the night that his sister and her infant daughter have been in a serious car wreck; the woman who is awaiting the birth of her same-sex partner's biological child; or the grandmother who is the sole guardian of a grandchild forced to stay home from school because of an asthma attack, are entitled to take the necessary leave because they have assumed the role of a parent.

More than 100,000 children growing up with same-sex parents can benefit from this important interpretation of the FMLA, while countless children being parented by grandparents, domestic partners, and other extended family members will also benefit. The specific make-up of a family should have no effect on the life of a child, nor does it change the pivotal role a caregiver plays in that child's development. The Labor Department's updated FMLA guidance is yet another small step towards ensuring that all children, regardless of the family they come from, are properly cared for.

While the FMLA is essential to the workplace flexibility needed by today's working families, Mr. Chairman, you have acknowledged that it has its limitations. As it stands, the FMLA provides eligible workers only with *unpaid* leave, and many families simply cannot afford to miss a paycheck. In 2008, the Department's Bureau of Labor Statistics (BLS) found that only 61 percent of private-sector employees are offered paid sick leave for their own illness or injury. Only 23 percent of the lowest 10 percent of wage earners had access to paid sick leave, and only 17 percent of that group had access to personal leave. The Administration supports your efforts to secure more access to paid leave for American workers. As you know, the President's budget included an initiative to encourage States to set up paid leave funds.

In addition, at a hearing about the H1N1 flu pandemic you chaired last year, I was proud to announce the Administration's strong endorsement of your Healthy Families Act. Your great friend Senator Edward M. Kennedy introduced this important legislation, and I applaud you for continuing to champion this bill. The Healthy Families Act would provide workers with 7 days of paid sick leave. This fundamental workplace benefit will assure that workers can stay home if they or their children are sick, and do so without fear of losing their job or critical income. We look forward to continuing your fight to get this important legislation enacted.

HEALTH CARE

For decades, as health care costs rose astronomically, insurance companies imposed more and more restrictions on health insurance policies, and fewer employers offered health benefits, American workers found it harder and harder to provide for their families' most basic need for health care. As important as the rights protected by FMLA are, they can be substantially frustrated when a parent who takes FMLA-protected leave to care for a sick child cannot afford to take that child to a doctor. The Patient Protection and Affordable Care Act (Affordable Care Act) will completely change the quality of life for the millions of American families who live in fear of doctors' bills or a notice from the insurance company that their policy had been canceled.

Mr. Chairman, you have been a true leader in the fight for guaranteed health care for children and were instrumental in the passage of health care reform. Throughout your career, you have fought for health care reform based on your deep belief that quality, affordable and accessible health care for every single American should be a right, not a privilege. Passage and enactment of the Affordable Care Act has

secured your place in history as a champion for the ordinary working Americans, all of whom will benefit from this new law.

The benefits this law will provide for working families are immense. Even low-income workers will have the peace of mind that comes with having quality health care coverage for the whole family. Workers will decide what job works best for their families based on relevant factors, like pay, location, career advancement opportunities, and job satisfaction. No longer will workers be held hostage to a job simply because they cannot afford to lose the health care benefits that come with it. Now, all workers will have access to quality affordable coverage. Simply removing the pre-existing condition limitation will have a profound effect on American workers. Workers with chronic medical conditions will not be tied to one job for the rest of their lives. As workers find jobs that better match their skills, employers will benefit as well.

At the Department of Labor, we are proud to be one of the lead agencies implementing the Affordable Care Act. The Department has worked with the Departments of Health and Human Services and Treasury to issue regulations on coverage of preventive services, pre-existing condition exclusions, lifetime and annual limits, rescissions, patient protections, grandfathered health plans, and most relevant to this hearing, the extension of coverage for adult children. I will talk more later about how the Department helps ease young adults' transition into the workplace, but I would like to note that the Affordable Care Act's requirement that health plans and insurance companies extend coverage for adult children up to the age of 26 significantly helps young adults make good decisions about their first jobs, instead of being driven into a job just for health care coverage or risking living without care while they job hunt.

INCOME SECURITY

As I mentioned earlier, the Department of Labor views workers as pillars of the economy ***and*** their families. To support a structure, a pillar must be strong and grounded on a solid foundation. In human terms, workers must earn wages that allow them to support their families and have the necessary skills to keep those jobs. Poverty is antithetical to a safe and secure family. My former colleague Dr. Harry Holzer testified at the first hearing of this series on the "State of the American Child" about how unemployed parents and childhood poverty are linked to negative long-term consequences for the future employment and earnings of children. When parents struggle to provide for their children's needs, children suffer in both the short- and long-term, and recognition of this link magnifies the implications of the current economic crisis. As witnesses at that first hearing discussed, the recent recession and continuing unemployment crisis will have lasting impacts on today's American children.

That is why the Labor Department helps families by fighting for wage earners to get the pay that they are entitled to and providing them with a solid foundation of training so they can secure the jobs that will help them secure or find their place in the middle class.

ENSURING FAIR PAY

The growing number of female breadwinners in this country means that the financial health of families increasingly depends on women. With nearly 9 million working women who are also heads-of-household, the Labor Department is committed to making sure that pathways out of poverty are open to women as much as they are to men. Often, however, the mere opportunity is not enough. As the Chairman knows well, gender wage inequalities stubbornly persist, and women of color often bear a disproportionate share of this burden.

For this reason, Mr. Chairman, thank you for championing the Paycheck Fairness Act for the last seven Congresses. You have been at the very forefront of this fight, and it is a fight this Administration has pledged to continue. Enacting this important legislation would enhance the Equal Pay Act and bring economic justice to America's working women; in doing so, this country would take another step towards ensuring that many fewer mothers would have to choose between paying the bills and caring for their loved ones.

Though President Obama affirmed his commitment to equal pay for women by signing the Lilly Ledbetter Fair Pay Act into law, Secretary Solis, this Administration, and you, Mr. Chairman, all agree that more must be done. As a result, the President established the National Equal Pay Enforcement Task Force. The Department's Office of Federal Contract Compliance Programs is working with other agencies across the government to ensure that the promise of equal pay for women is fulfilled.

FATHERS AND TRANSITIONAL JOBS

Responsible fathers are also crucial to the economic security of families. The President is firmly committed to promoting and supporting responsible fatherhood. As part of this commitment, the Labor Department's Employment and Training Administration (ETA) is working closely with the Department of Health and Human Services' (HHS) Administration for Children and Families (ACF) to launch a new initiative to test and evaluate transitional jobs. Transitional jobs typically provide subsidized employment, supportive services and job placement assistance to participants with little work history. These opportunities help vulnerable workers overcome substantial barriers to work, build a resume, and move into long-term, unsubsidized employment. ACF has provided technical assistance on how child support enforcement would affect program approaches in the Labor Department's Transitional Jobs demonstration projects for low-income non-custodial parents. We believe that stable employment for fathers will have long-term beneficial effects for their children.

JOB TRAINING FOR THE YOUTH OF TODAY, PARENTS OF TOMORROW

The Department of Labor invests in job training for all workers. It is another tenet of *Good Jobs for Everyone* that a good job provides opportunities to acquire the skills and knowledge for the jobs of the future. Secretary Solis and Assistant Secretary for Employment and Training Jane Oates have testified before the HELP Committee numerous times on the Department's full array of job training programs and how they support the economic security of America's families through lifelong job training, knowledge, and skills acquisition. I will not take the committee's time to go over these programs again. As I mentioned earlier, however, these programs are critical to helping families reach and remain in the middle class in a 21st century economy.

Instead, I would like to focus on the Department's job training programs that benefit young adults who are just leaving childhood and entering the world of work. The Secretary's vision of *Good Jobs for Everyone* includes ensuring that young people have access to careers in high-growth industries and the skills they need to compete in the global economy. This vision aligns with your determination, Mr. Chairman, to improve life opportunities for our children and youth. In due time, children become adults and have their own children. Putting these young adults on a track to gainful, skilled employment early in life is the best way to ensure not only their own success, but the future success of their children. Research suggests paid work experience may improve educational and employment outcomes for at-risk youth.[2]

Under the Workforce Investment Act of 1998 (WIA), the Department administers Youth Activities funds allocated to State and local areas to deliver a comprehensive array of youth workforce investment activities. These activities help ensure that youth obtain the skills and knowledge needed to succeed in a knowledge-based economy, and emerging industry sectors such as healthcare and "green" jobs. WIA authorizes services to low-income youth, ages 14 to 21, who experience barriers to employment. Many eligible young people are deficient in basic skills, and are frequently homeless, runaways, pregnant or parenting, criminal offenders, school dropouts, or foster children.

As you know, Mr. Chairman, WIA programs serve both in-school and out-of-school youth, including youth with disabilities and other youth who may require additional assistance to complete an educational program or to secure and hold employment. By providing them with access to tutoring, alternative secondary school services, summer employment, occupational training, work experience, supportive services, leadership development opportunities, mentoring, counseling, and follow-up services, participants are prepared for both post-secondary education and ultimate employment. The WIA Youth program typically serves between 250,000 and 300,000 youth per year.

These young people are indeed fortunate that you and your colleagues in the Senate fought to ensure that the American Recovery and Reinvestment Act (Recovery Act) included increased funding for WIA programs. The Recovery Act provided an additional $1.2 billion in WIA Youth funds, with an emphasis on summer employment. The Recovery Act also allowed the Department to increase the age of eligibility for youth services to 24 years of age. DOL's ETA is encouraging summer youth programs to develop work experiences that would expose young people to jobs in the emerging "green" economy. For example, in Philadelphia, PA, many youth received a combination of post-secondary training with worksite experiences in green jobs.

[2] Edwards, K., and A. Hertel-Fernandez. 2010. "The Kids Aren't Alright: A Labor Market Analysis of Young Workers." *EPI Briefing Paper #258*, Economic Policy Institute.

Some of these youth participated in a partnership with Temple University, which provided them with Environmental Research Internships and experience working with researchers in the field. The summer work experiences described above are especially critical for low-income youth. This Recovery Act funding enabled more than 325,000 diverse youth to experience employment during the summer of 2009. Of these youth, approximately 159,000 were African-American, 7,000 were American Indian or Alaska Native, 6,000 were Asian, and 87,000 were Latino.[3]

Recovery Act funding also enabled ETA and ACF to promote subsidized summer employment opportunities for similar low-income youth. To date, we are aware of at least 15 States that will be using the Temporary Assistance for Needy Families (TANF) Emergency Contingency funding provided in the Recovery Act for summer employment programming, giving youth access to a multitude of support services and occupational skills training.

Unfortunately, the summer youth programs have not yet been funded this summer. Funding these programs is essential, even at this late date. We hope that Congress will still act so we can help students this summer and into the fall.

In addition to the WIA services described above for low-income students enrolled in high school, the Labor Department also provides alternative pathways to successful employment for disconnected youth and those who do not graduate from high school. One such initiative is the Department's YouthBuild program, which provides job training and educational opportunities for low-income or at-risk out-of-school youth ages 16 to 24. By providing these youth with the opportunity to acquire academic and work-related credentials while constructing or rehabilitating affordable housing for low-income or homeless families in poor communities, the YouthBuild program creates opportunities to re-engage out-of-school youth in education, skills training, and leadership development while serving their community. Many YouthBuild program graduates continue on in community or 4-year colleges to gain the education and skills that they need to be productive in the 21st Century economy.

Recently, YouthBuild programs have begun providing training in green construction techniques, which will help youth compete for jobs in a changing construction sector. The Lake County YouthBuild program in northern Chicago trains its young people in green construction and has begun installing solar water heating and solar electricity in the low-income housing that it builds in its community. In addition, the Department has introduced a new Apprenticeship Training Program, designed specifically for YouthBuild, to support the transition of our young people into apprenticeship opportunities in high-growth, emerging sectors of the economy. In Portland, OR, YouthBuild created a registered apprenticeship program with the Laborers Union to train its students in weatherization skills, and created green career tracks in several fields for its YouthBuild graduates in partnership with Portland Community College.

The Labor Department's most intensive program that assists youth with employment is Job Corps. Established 46 years ago to help fight the War on Poverty, Job Corps helps at-risk youth with education and job training in an effort to halt the perpetual cycle of poverty that claims the livelihood and future success of far too many American children. By providing a foothold for graduates to ascend beyond low-wage jobs through training and education, Job Corps gives many of its graduates a pathway to the middle-class. Job Corps students and graduates earn academic credentials, such as a High School Diploma or GED, and industry-recognized certifications, State licensures, or apprenticeships in their career technical training area. These credentials ensure that graduates have attained the skills and knowledge necessary to compete in today's labor market, including emerging industries, like green jobs. By operating 123 centers in 48 States, Puerto Rico, and the District of Columbia, Job Corps provides training and education opportunities to young men and women nationwide. Additionally, on-site daycare services at 28 of these centers, allow students who may be parents to fully participate in the program

We have heard numerous success stories from impressive Job Corps alumni. Some years ago, James Sollome thought he was on the verge of starvation. His father was in prison and he was an unemployed high school dropout who had been living out of his car for 4 months. While job-hunting at a local unemployment office, James was informed of the opportunities available at the Excelsior Springs Job Corps Center. In a little more than a year after joining Job Corps, James graduated with his GED and earned his certificate of completion in painting. He went on to college, and

[3] Mathematica Policy Research, Inc., "Reinvesting in America's Youth: Lessons from the 2009 Recovery Act Summer Youth Employment Initiative." Contract Number DOLU091A20968. February 26, 2010.

in the coming year, he is expecting to graduate with a Ph.D. in pharmacology and toxicology from the University of Arizona.

Another success story comes from a woman in the Chairman's home State of Connecticut. Roccina Blash, a native of Waterbury, graduated at the top of her class in the Emergency Medical Training (EMT) program at New Haven Job Corps Center. In May 2010, Roccina accepted a full-time position with American Medical Response Ambulance Service. She is not alone in her success. There are thousands of Job Corps students who have launched thriving careers with the assistance of the Department of Labor.

It is programs like these that typify the Department of Labor's role in maintaining and promoting the state of the American child. By taking often disenfranchised, low-income youth and placing them on a career pathway with job-training and support, the Department of Labor helps them on the path to lifelong income security and economic stability and a better future for their children.

MAKING SURE FIRST JOBS ARE SAFE AND SUCCESSFUL

While the Department helps youth transition into the working world, it is also part of our mission to ensure that youth are employed only in jobs that are safe and age appropriate. Part of building a long-lasting and productive relationship between young people and work is making sure their early experiences are positive ones. An unsafe or age inappropriate job is unlikely to be a successful job. A good job is a safe job—no matter how old or young you are.

Towards this end, the Department vigorously enforces the child labor provisions of the Fair Labor Standards Act. The Department recently published new child labor rules governing the employment of youth in nonagricultural industries, which became effective on July 19, 2010. These changes, which represent the most sweeping revisions to our child labor rules in over 30 years, are crafted to improve the occupational safety and health of the workplaces of the 21st Century and the realties faced by working youth and their employers. These rules reflect the hard work and commitment of the Labor Department's Wage and Hour Division and Occupational Safety and Health Administration, along with our partners at the Department of Health and Human Services' National Institute for Occupational Safety and Health. The new regulations give employers clear notice that there are certain jobs children are simply not allowed to perform. They also expand opportunities for young workers to gain safe, positive work experience in fields such as advertising, teaching, banking and information technology, as well as through school-supervised work-study programs. With the completion of these rules, DOL staff have turned their attention to strengthening the regulatory protections for children working in agriculture.

These strategies work. Last year, Wage and Hour investigators found children working in the blueberry fields of North Carolina. While we assessed civil money penalties against those farmers and farm labor contractors for the violations, our staff also engaged the local community, local departments of social services, and State migrant education consultants, to provide alternatives to children whose parents are in the fields and to provide education on child safety. This year, when we sent investigators back into the fields unannounced, we found no children working in the blueberry fields of North Carolina. We strongly believe that our efforts to prevent young workers from being employed in unsafe occupations and industries will lead to fewer injuries and fewer deaths.

CONCLUSION

Mr. Chairman, your absence from the Senate will be a great loss for America's working families and children. As President Obama said on the announcement of your retirement, "You have worked tirelessly to improve the lives of children and families, but your work is not done." In tribute to your legacy and in full recognition of the work yet to be done, we will fight to ensure that your vision of a humanized labor market and compassionate workplaces lives on at the Department of Labor.

My testimony illustrates the ways that the Labor Department enables America's children to succeed and thrive across various life-stages. We are hard at work to realize *Good Jobs for Everyone*—for today's workers and their families, as well as the workers of the future. Thank you for inviting me to testify today. I would be happy to answer any questions the committee may have.

Senator DODD. Well, thank you very, very much, Mr. Harris. It is very helpful. I am anxious to ask you some questions about the Department of Labor. So we thank you for being here today.

Yes, Mr. Hansell. How are you?

STATEMENT OF DAVID A. HANSELL, ACTING ASSISTANT SECRETARY, ADMINISTRATION FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. HANSELL. Good morning. Chairman Dodd, Senator Casey, Senator Merkley, I am pleased to appear before you to discuss the state of children in America.

But I would first like to join my administration colleagues in taking this opportunity to express our appreciation to you, Mr. Chairman, for your longstanding commitment to improving the lives of our Nation's children. From expanding child care and strengthening Head Start, to addressing child abuse and domestic violence, this subcommittee, under your leadership has made enormous contributions to children across the country.

While many children in our Nation are thriving, as you indicated, statistics show that far too many children are growing up in poverty without adequate family support and without access to quality care and education. The President and Secretary Sebelius have established a number of priority initiatives to address these challenges.

Recognizing that children's early experiences are critical in shaping the foundation for long-term growth and development, one of the Secretary's highest priorities is early childhood development. The early childhood programs administered by the Administration for Children and Families both provide enriching experiences that promote the long-term success of disadvantaged children and assist low-income working parents with the availability and cost of child care. Child care subsidies are provided to 1.6 million children nationally, and Head Start funds 1,600 grantees in our poorest neighborhoods to serve nearly 1 million children in poverty.

The Recovery Act included a $2 billion increase in child care funding, allowing providers to serve 200,000 more children than would otherwise have been possible and make quality improvements to the program. The President's fiscal year 2011 budget requests another $1.6 billion to sustain this Recovery Act investment and outlines a set of principles for child care reauthorization, focusing on serving more low-income children in safe, healthy, nurturing child care settings that will promote learning, child development, and school readiness.

The Recovery Act also invested $2.1 billion in expansions to Head Start and Early Head Start programs, expansions that the President's budget would sustain in fiscal year 2011.

We also continue to improve Head Start using the tools provided by Head Start reauthorization. We will be significantly increasing the expectations for what Head Start programs should achieve by strengthening Head Start program performance standards. We will be providing the necessary supports to meet those expectations by reinventing the training and technical assistance system, and we will be strengthening accountability by implementing a system that injects competition into the Head Start program for poor performing grantees as envisioned by this subcommittee in the Head Start reauthorization.

The administration is committed to working with States to reduce the incidence of child abuse and neglect and provide safe and

permanent homes for all of America's children. Our efforts to prevent the maltreatment of children, to mediate children's exposure to violence, to find permanent placements for those children who cannot safely return to their homes, and to provide transitional services for older youth are all critical to ensuring that America's children grow into healthy, stable adults.

We have been working closely with the subcommittee on reauthorization of two programs offering critical support for these children and young adults: the Child Abuse Prevention and Treatment Act and the Family Violence Prevention and Services Act.

We are also committed to investing in proven programs and strategies to positively impact children's safety, permanence, and well-being or in programs that show significant promise in that regard. A new $20 million grant program will be funded shortly to support innovative strategies for moving to permanent homes children who have been in foster care the longest.

There is no question that families should be the core support for children. Children's well-being depends on financial and emotional support from both parents, and parental employment is the key to long-term economic security for families. Bolstered by the $5 billion provided in the Recovery Act, our new TANF emergency fund is helping families during the economic downturn, including significant investments in subsidized employment. States have plans to create more than 200,000 jobs for needy adults and youth by September. Given the difficult fiscal choices that States are facing in an economy that still has high unemployment, we strongly urge the Congress to take action now so that all States can continue to access the emergency fund in fiscal year 2011.

Research suggests that the most stable families consist of two parents who are involved and invested in their children's success. The President is committed to promoting responsible fatherhood and helping fathers meet their obligations by ensuring that they have the broad range of services, including job, relationship, and parenting skills training that they need to be successful. The vision of the President's Fatherhood Initiative, in conjunction with services offered through our child support enforcement, child care, and TANF programs, offer an integrated set of strategies to bolster the economic security of especially vulnerable families and their children.

Under your committed leadership, Mr. Chairman, significant strides have been made in understanding where we are most challenged in improving the state of American children and targeting funding and attention to policies that seek to address these challenges. We look forward to continued efforts to ensure that legislative changes and key investments are made to further improve the lives of America's children. I look forward to answering questions after their testimony.

[The prepared statement of Mr. Hansell follows:]

PREPARED STATEMENT OF DAVID A. HANSELL

Chairman Dodd, Ranking Member Alexander, and members of the subcommittee, I am pleased to appear before you today to discuss the state of Children in America. I would first like to take this opportunity to express my thanks to you, Mr. Chairman, for your long-standing commitment to improving the lives of our Nation's children and your tireless efforts on their behalf.

From expanding child care and strengthening Head Start to addressing child abuse and domestic violence, this subcommittee has made enormous contributions to children across the Nation, and we are grateful for your steadfast dedication and efforts. You have been influential in targeting funding for services to improve the lives of children through these and a wide range of other programs in the Administration for Children and Families (ACF), including the Community Services Block Grant, the Low Income Home Energy Assistance Program, the Assets for Independence Program and the Developmental Disabilities Program.

For purposes of today's hearing, I will limit the focus of my testimony to early childhood development; the safety, permanence, and well-being of our most vulnerable children; and, fatherhood and economic security (which play a major role in the lives of children and their families) and how ACF programs are contributing to these efforts.

I would like to begin by sharing some significant statistics regarding the state of many children in this country.

STATE OF CHILDREN IN AMERICA

While in many respects American children are doing well, ACF has particular stewardship of programs for children and families most at risk for negative outcomes. As you are keenly aware, there are far too many in need of our services.

• *Poverty*—Between 1993 and 2000, the child poverty rate declined from 22.7 percent to 16.2 percent due in substantial part to a near full-employment economy and rising employment among single mothers.[1] Unfortunately, since 2000 these positive trends have not been sustained. By 2008, nearly 1 in 5 children lived in poverty and 8 percent of children (5.9 million) lived in extreme poverty, defined as living in a family with income less than one-half of the poverty threshold. These are the highest percentages of children living in poverty since 1998. About 22 percent of children lived in households that were food insecure at times in 2008, an increase from 17 percent in 2007 and the highest percentage recorded since monitoring began in 1995.[2]

• *Family Structure*—In 2008, 67 percent of children ages 0–17 lived with two married parents, down from 77 percent in 1980. Among the 2.8 million children (4 percent) not living with either parent in 2008, 54 percent (1.5 million) lived with grandparents, 25 percent lived with other relatives, and 21 percent lived with non-relatives. Of children in non-relative homes, 38 percent (228,000) lived with foster parents.[3] The percentage of children exiting foster care to a permanent home through adoption or guardianship has been increasing. Over 40 percent of births in the United States were outside marriage in 2008.[4]

• *Child Care*—Many children spend time with a caregiver other than their parents. The majority of children (61 percent) ages 0–6 received some form of non-parental care on a regular basis in 2009.[5] At the same time, the parents of more than 28 million school-age children work outside the home.[6] For both young children and those in school, the cost of care and the lack of support too often do not allow families the ability to access high quality care, particularly for very young children. The average annual price of care for an infant in a center ranged from $4,560 in the least expensive State to $15,895 in the highest. A recent report from the Carsey Institute found that, among working families who made child care payments for their young children, families living in poverty paid 32 percent of their monthly family income for child care—nearly five times more than families at 200 percent of poverty or higher.

• *Child Maltreatment*—In 2008, the rate of substantiated reports of child maltreatment was approximately 10 per 1,000 children ages 0–17. Younger children are more frequently victims of child maltreatment than older children. Neglect is the predominant form of maltreatment for all children and the youngest children are most at risk. In 2008, there were 22 substantiated child maltreatment reports per 1,000 children under age 1, compared with 12 for children ages 1–3, 11 for children

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[1] U.S. Census Bureau, "Table 3. Poverty Status of People, by Age, Race, and Hispanic Origin: 1959 to 2008," available at: *http://www.census.gov/hhes/www/poverty/data/historical/hstpov3.xls*.

[2] Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2010.* Washington, DC: U.S. Government Printing Office.

[3] Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief Key National Indicators of Well-Being, 2010.* Washington, DC: U.S. Government Printing Office.

[4] *Ibid*.

[5] America's Children in Brief: Key National Indicators of Well-Being, 2010 (Childstats.gov).

[6] U.S. Department of Labor, 1998 (*www.afterschoolalliance.org*).

ages 4–7, 9 for children ages 8–11, 8 for children ages 12–15, and 5.5 for adolescents ages 16–17.[7]

ADMINISTRATION PRIORITIES

While many children across the country are thriving, these statistics show that far too many children today are growing up in poverty, without adequate family support, and without access to quality care and education. The President and the Secretary have established a number of priority initiatives to address these challenges. The first I would like to discuss focuses on early learning and school readiness.

EARLY CHILDHOOD DEVELOPMENT

Recognizing that children's early experiences are critical in shaping the foundation for their long-term learning, development and growth, one of the Secretary's highest priorities is early childhood development. We know that with nurturing and responsive relationships with parents and caregivers and with engaging learning environments in early care and education settings, young children are capable of tremendous growth and resilience in the face of adversity. That is why we are focused both on raising the bar on quality in early childhood programs—including child care and Head Start—and on expanding access to high quality programs so more children can participate in them.

Early childhood programs are critical to breaking the cycle of poverty in the United States, and are vital to the country's workforce development, economic security, and global competitiveness. The early childhood programs administered by ACF are designed both to assist low-income working parents with the cost of child care, and to fund programs that provide enriching early childhood experiences that promote the long-term success of disadvantaged children.

Child care subsidies are provided to 1.6 million children nationally through the Child Care and Development Fund to reduce the burden of high child care costs for low-income working families. Additionally, Head Start funds over 1,600 grantees in our poorest neighborhoods to provide enriching early childhood experiences and health services to nearly 1 million children in poverty.

Evidence continues to mount regarding the profound influence children's earliest experiences have on their later success. Because of the strong relationship between early experience and later success, investments in high quality early childhood programs can pay large dividends.

Recognizing this, the Congress significantly increased funding for both the Child Care and Head Start programs through the American Recovery and Reinvestment Act (Recovery Act). The Recovery Act included $2.1 billion to fund expansions in Head Start, Early Head Start, investments in teachers, classroom materials, and services and supports for State Advisory Councils on Early Childhood Development and Education. The program will be serving nearly 50,000 additional children in Early Head Start and over 13,000 additional children in Head Start. Child Care funding increased by $2 billion in the Recovery Act, and the providers will serve an estimated 200,000 more children than would otherwise have been supported by the program.

While this is important progress, far too many children still do not have access to *high quality* early childhood services. Head Start serves just over half of poor children, Early Head Start serves less than 5 percent, and the Child Care and Development Fund serves only one in six eligible children. Further, for those receiving services, the quality of their experiences has not received adequate attention to produce the benefits that all children need and deserve.

As we move forward, we have a number of goals for our early childhood programs including, improving the quality of child care and Head Start programs, fostering the integration of ACF's early childhood programs with other early learning programs and social services, vertically aligning programs with the elementary and secondary education system, and strengthening program integrity.

Using the Child Care and Development Block Grant's (CCDBG) mandatory 4 percent quality set-aside, we are helping States build a systematic framework for quality investments. This effort includes taking actions to strengthen the quality of child care programs by expanding the number of States with Quality Rating and Improvement Systems (QRIS). The QRIS includes a set of standards that define each level of quality, an incentive and support system to help programs meet higher standards, and outreach to inform parents of what the ratings mean.

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[7] Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief Key National Indicators of Well-Being, 2010.* Washington, DC: U.S. Government Printing Office.

There is much more that can and should be done to raise the quality of child care for America's children. We look forward to working with Congress to craft a child care reauthorization framework, including needed reforms to ensure that children receive high quality care that fosters healthy child development and meets the diverse needs of families. The President's fiscal year 2011 budget request proposed an increased investment of $1.6 billion for child care and outlined a set of principles for reauthorization focusing on serving more low-income children in safe, healthy, nurturing child care settings that are optimally effective in promoting learning, child development and school readiness. The Early Learning Challenge Fund (ELCF) also remains a priority of the Administration and we look forward to working with Congress to make the ELCF a reality.

In addition, because high quality early childhood education spans the ages of birth to age 8 and involves the transition of children from early childhood programs into our Nation's schools, continued collaboration between the Department of Health and Human Services and the Department of Education is essential. Secretary Sebelius and Secretary Duncan have been working very closely, and the two Departments have a number of joint efforts currently underway. We have formed working groups consisting of the best minds in both Departments to address the most pressing issues in the early childhood field, including creating a more educated, better trained early childhood workforce; better connecting the early education and health systems; and improving the way data are collected and used to improve early childhood systems at the State level. The two Departments also co-hosted listening sessions across the country to hear from the foremost experts and early childhood practitioners concerning these issues. The Departments consult regularly on the early childhood initiatives underway in each Department and will continue to collaborate on future initiatives and legislation that are vital to the development and education of our Nation's youngest children, especially efforts to improve the quality of these programs and services with the goal of improving child outcomes.

We also continue to improve Head Start using the tools provided to us by the Improving Head Start for School Readiness Act of 2007. As you may recall, in January of this year ACF released the findings of the Head Start Impact Study which showed that at the end of 1 program year, access to Head Start positively influenced children's school readiness. When measured again at the end of kindergarten and first grade, some of these benefits persisted, but the Head Start children and the control group children were at the same level on many of the measures studied. While the Head Start program has significantly changed since the study was conducted in 2002, we are using the findings of the Head Start Impact Study and that of other studies to improve the program.

We have developed a set of initiatives outlined in a planning document entitled, *The Head Start Roadmap to Excellence*. These initiatives will strengthen Head Start programs in preparing poor children for success in school and life. The initiatives in the Roadmap significantly increase the expectations for what Head Start programs should achieve, provide the necessary supports to meet those expectations, and strengthen the accountability provisions for programs that do not meet expectations. Specifically:

- To increase what we expect from Head Start programs, we are strengthening the Head Start Program Performance Standards. These standards provide a standard definition of quality services for all Head Start grantees. The revised program performance standards will institute best practices in the field of early education and child development and ensure that Head Start programs meet the educational, health and nutritional needs of the children and families they serve, along with improving program integrity and fiscal management.
- To provide additional support to programs, we are reinventing the training and technical assistance system. The new system will provide "cascading levels of support" for Head Start programs with National Centers providing information about best practices to State Centers, and mentor coaches helping programs to implement these best practices at the program level.
- Finally, to strengthen accountability, we will implement a system that injects competition into Head Start by requiring low performing programs to compete for continued funding as required by this subcommittee in the Head Start reauthorization. This recompetition process is absolutely central to raising the bar on quality not only by getting rid of poor performers but in providing significant new incentives for programs to improve their performance and offer quality services. We are working hard to craft a system that is fair and transparent and that will result in a significant improvement in program quality. We anticipate publishing the proposed rules later this year.

Program integrity is one of HHS's key priorities and applies to all programs administered by HHS. The President has charged each Federal agency with launching rigorous audits and conducting "annual assessments to determine which of their programs are at risk of making improper payments . . ." In response, Secretary Sebelius recently established the Council on Program Integrity, which will look at all areas within the Department—from Medicare and Medicaid, to Head Start and Child Care, to LIHEAP—to conduct risk assessments of programs or operations most vulnerable to fraud or abuse; enhance existing program integrity initiatives or create new ones; share best practices on program integrity throughout HHS; and measure the results of our efforts.

ACF already has taken steps to enhance program integrity in all of our programs, including our early childhood programs. For example, the Office of Head Start has created a fraud hotline that will allow information on inappropriate behavior to be reported directly to the Assistant Secretary. It also initiated unannounced visits of Head Start programs and is developing new regulations to strengthen program integrity at the grantee level.

I would like to turn now to our priority goals for ensuring the safety, permanence and well-being of children.

SAFETY, PERMANENCY, AND WELL-BEING OF VULNERABLE CHILDREN

The Administration is committed to working with States to reduce the incidence of child abuse and neglect and provide safe and permanent homes for all of America's children. The children facing challenges to safety and permanency are among the most vulnerable children in our country. Our efforts to prevent the maltreatment of children, mediate children's exposure to violence, find permanent placements for those children who cannot safely return to their homes, and provide temporary or transitional placements and services for older youth are critical to ensuring that America's children grow into healthy, stable adults.

The impact of not addressing the needs of these vulnerable children is far-reaching. Maltreatment in general is associated with a number of negative outcomes for children, including lower school achievement, juvenile delinquency, substance abuse, and mental health problems.[8] Certain types of maltreatment can result in long-term physical, social, and emotional problems, and even deaths.[9] Children who witness domestic violence are at a greater risk of developing behavioral and emotional problems, cognitive and attitudinal issues, and long term problems.[10] Children who witness domestic violence in their homes are more likely to justify their own use of violence in their relationships.[11] It is imperative that we seek solutions that build on promising practices to address the needs of these children.

We have been working closely with this subcommittee on reauthorization of two programs offering support for these populations—the Child Abuse Prevention and Treatment Act and the Family Violence Prevention and Services Act. We look forward to continuing these efforts and finalizing enactment of these key pieces of legislation.

At the same time, this Administration has placed a significant priority on the development and implementation of evidence-based and evidence-informed research and practice. We are committed to investing in programs and strategies that have proven effective through rigorous evaluation, building on promising practices, and

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[8] Administration for Children and Families, Office of Planning, Research and Evaluation. (2004b). Children ages 3 to 5 in the child welfare system. NSCAW Research Brief No. 5. Washington, DC: Author.

English, D.J., Widom, C.S., & Brandford, C. (2004). Another look at the effects of child abuse. NU journal, 251,23–24.

[9] Fellit, V.J. (2002). The relationship of adverse childhood experiences to adult health: Turning gold into lead. Zeitschrift fur Psychosomatische Medizin and Psychotherapie 48(4), 359–69. Retrieved June 18, 2007, from *www.acestudy.org/docs/GoldintoLead.pdf*.

Flaherty, E.G., et al. (2006). Effect of early childhood adversity on health. Archives of Pediatrics and Adolescent Medicine, 160, 1232–38.

[10] Stapleton, J.G., Phillips, K.G., Moynihan, M.M., Wiesen-Martin, D.R., Beulieu, A.L. (2010) *New Hampshire endowment for health planning grant final report: The mental health needs of children exposed to violence in their homes.* Retrieved July 26, 2010 from *http://www.nhcadsv.org/Maureen/EFHReportFINAL.pdf*.

[11] Singer, M.L., Miller, D.B., Guo, S., Slovak, K and Frieson, T. (1998) The Mental Health Consequences of Children's Exposure to Violence. Mandel School of Applied Social Sciences, Community Health Research Institute, Case Western Reserve University, Cleveland, OH: Cuyahoga County.

Jaffe, P.G., & Geffner, R. (1998). Child custody disputes and domestic violence: Critical issues for mental health, social service, and legal professionals. In G. Holden, R. Geffner, & E. Jouriles (Eds.), *Children exposed to marital violence: Theory, research, and applied issues* (pp. 371–408). Washington, DC: American Psychological Association.

promoting innovation to expand the body of knowledge all of which increase the portfolio of interventions proven to positively impact children's safety, permanence and well-being. Proven strategies are particularly important in the child welfare and well-being arenas because the stakes for children are so high.

The Administration recently demonstrated its commitment to identifying and replicating best practices for children who stay in foster care the longest by proposing a $20 million grant program to fund innovative strategies for moving these children to permanent homes. The first year of funds for these grants will be awarded in September and the President's Budget proposes continued funding for these grants to identify effective practices for our most vulnerable children. The goals of the innovative approaches to foster care program are to: implement innovative intervention strategies that are informed by the relevant literature; reduce long-term foster care stays and improve child outcomes; and rigorously evaluate these efforts to provide substantial information about the effectiveness of the programs, interventions, and practices in reducing long-term foster care. State projects that meet negotiated targets will be eligible for incentive payments that will be awarded above and beyond the base award amount and will be given flexibility in using the incentive payments to enhance project-related activities. This initiative to reduce long-term foster care is a significant step toward improving services and outcomes for vulnerable children who pass through, and often remain in, the child welfare system.

Another example of the President's commitment to targeting funds towards evidence-based approaches and testing innovation is the new Home Visiting program created in the Affordable Care Act. Just last week, HHS released $88 million for development and implementation of high-quality, evidence-based statewide home visiting programs, to assure effective coordination and delivery of critical health, development, early learning, child abuse and neglect prevention, and family support services to young children and families.

Additionally, the President's fiscal year 2011 budget requests a $10 million increase in child abuse discretionary activities. These funds will be used to establish a new competitive grant program for States to support increased use, and high quality implementation, of evidence-based and evidence-informed child maltreatment prevention programs and activities. The competitive grant program is intended to encourage States to use existing funding streams to support community-based prevention activities rooted in a strong evidence base. Funds also will be used to insure that child maltreatment prevention and family support is integrated with other State systems for children and youth.

With the current condition of the economy putting additional stress on families, States are seeing an increase in child abuse and neglect and domestic violence. At a time of increasing pressure on State budgets it is imperative that funding is targeted to evidence-based and evidence-informed approaches to maximize every dollar spent protecting and supporting children and families. Further, the cost of addressing the consequences of abuse and neglect after maltreatment has happened far exceeds the cost of investing in evidence-based interventions that prevent abuse from occurring or effectively mitigate the consequences of the abuse.[12]

The last priority area impacting the state of our Nation's children that I would like to discuss is advancing economic security and fatherhood.

ECONOMIC SECURITY AND RESPONSIBLE FATHERHOOD

There is no question that families are the core support for children. Children's well-being depends on financial and emotional support from both parents, and parental employment is the key to long-term economic security for families. To help families succeed in the workforce, we seek to connect parents not only with work, but also with educational opportunities and other supports to help them move into better jobs, child care to help meet the costs of work and basic needs, and with services to address the barriers that sometimes make work difficult for some individuals.

The Temporary Assistance for Needy Families Program (TANF) provides assistance and work opportunities to needy families and is one of the Nation's primary safety net programs for low-income families with children. Under this $16.5 billion block grant program, States have broad flexibility to design programs that strengthen families and promote work, personal responsibility, and self-sufficiency. Within certain Federal requirements, States can determine their own eligibility criteria, benefit levels, and the type of services and benefits available to TANF recipients.

[12] Pew/PCA, "Time for Reform: Investing in Prevention, Keeping Children Safe at Home." See *http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Foster__care__reform/time__for__reform.pdf*.

As with child care, Head Start, and Child Support, the Recovery Act included significant investments to bolster the safety net for low-income children and families. This legislation affected the TANF program in several key ways, including the establishment of a new $5 billion Emergency Contingency Fund for States, Territories, and Tribes for fiscal year 2009 and fiscal year 2010. This Emergency Fund was structured with the recognition that there are multiple ways to help families during an economic downturn by expressly providing additional funding for basic assistance, short-term needs, and subsidized employment. To date, ACF has awarded over $4 billion in TANF Emergency Funds to 47 States, 17 Tribes, the District of Columbia, and the Territories of the Virgin Islands and Puerto Rico.

The TANF Emergency Fund has played a crucial role in allowing TANF jurisdictions to respond to the needs of vulnerable children and families during this economic downturn. TANF jurisdictions have taken advantage of the opportunities provided by the Emergency Fund to implement programs and provide benefits that specifically target children. For example, ACF has awarded Emergency Fund dollars for benefits such as back-to-school clothing allowances, scholarships for summer camps, and services provided through partnerships with local agencies that operate Summer Food Service Programs, and community organizations, such as The Boys and Girls Club.

Further, as of July 25, 34 States, the District of Columbia and the Virgin Islands have established subsidized employment programs using $1 billion in Emergency Funds. These States have plans to create nearly 200,000 jobs by September. This is an unprecedented use of funds for subsidized employment programs. In January, the Department of Labor and HHS issued a joint letter encouraging workforce and human services agencies to work together to explore all funds available for the creation and expansion of subsidized summer employment programs for low-income youth. Taking advantage of this opportunity, and in the absence of additional Workforce Investment Act (WIA) funding for this purpose, 21 States and the District of Columbia are using emergency funds to expand and develop programs specifically designed for youth; some have even partnered with their local WIA One Stop Centers in order to maximize recruitment and implement effective practices. Since youth employment is at a 60-year low, this is a crucial investment in supporting a robust economic recovery.

Given the difficult fiscal choices States are facing in an economy that still has high unemployment, and the recent extremely positive activity by States, we strongly urge Congress to take action so that all States can access the Emergency Fund in 2011 when, unfortunately, unemployment and poverty are likely to remain elevated in the aftermath of the recession. By extending the Emergency Fund through fiscal year 2011 and providing additional funding, Congress can help States continue their innovative efforts to expand employment and strengthen the safety net so desperately needed by many low-income children and families. In addition, the Department of Labor's fiscal year 2011 request includes second-year funding for their Transitional Jobs Program to demonstrate and evaluate program models, which combine short-term subsidized or supported employment with a well-designed suite of supportive services and job search assistance during and after the transitional job to help individuals with significant barriers to obtain the skills they need to secure unsubsidized jobs. Fiscal year 2010 funding will be used to support and rigorously test transitional jobs programs targeting non-custodial parents, a group whose employment outcomes are likely to have an important effect on children.

While employment is a key element of providing support to children, research suggests that the most stable families consist of two parents who also are involved and invested in their children's success. Children who have a quality relationship with their father are more likely to stay in school and pursue higher education and are less likely to be sexually active, or give birth out of wedlock at a young age.[13] Unfortunately, too many fathers today are not engaged and participating in their children's lives. They are not making the emotional and financial contributions they could and are, therefore, not having the kind of impact that promotes family and child well-being.

Responsible fatherhood programs can help fathers find work and stay engaged in their children's lives, allowing fathers to provide the emotional and financial support every child needs. The President is committed to promoting responsible fatherhood and helping fathers meet their obligations by ensuring that they have the broad range of services (including job, relationship, and parenting skills training) that they need to be successful. On Father's Day this year President Obama said,

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[13] The Effects of Father Involvement: A Summary of the Research Evidence. Sarah Allen, MSc and Kerry Daly, Ph.D., University of Guelph (2002) (*http://www.ecdtp.org/docs/pdf/IF%20Father%20Res%20Summary%20(KD) pdf.*)

"Now, I can't legislate fatherhood—I can't force anybody to love a child. . . . What we can do is come together and support fathers who are willing to step up and be good partners and parents and providers. . . ."

The vision of the President's fatherhood initiative in conjunction with services offered through Child Support Enforcement, Child Care and TANF offers an integrated set of strategies to bolster the economic security of especially vulnerable families and their children. Our fiscal year 2011 budget request to create a new Fatherhood, Marriage and Family Innovation Fund would build a strong evidence base around what service intervention models work to remove barriers to employment and increase family functioning and parenting capacity, and identify best practices that could be replicated within TANF, Child Support Enforcement, and other State and community-based programs. The Innovation Fund will provide for comprehensive programs that can meet the multiple needs that fathers and their families face.

A guiding premise for us is that children need and deserve the financial and emotional support of both of their parents. Accordingly, we have placed a high priority on the effective operation of the Child Support Enforcement program. Child Support Enforcement is integral to family economic security and, of course, is an important aspect of our responsible fatherhood efforts. This program serves 17 million children overall, and half of all poor children. Most families in the program are low-income working families and the majority of children are born outside of marriage. Forty-five percent of these families formerly received TANF and 13 percent are currently in the TANF program.

In fiscal year 2008, the Child Support Enforcement Program collected $26.6 billion in child support, while the total Federal contribution to costs was $4.1 billion. By securing support from non-custodial parents, the Child Support Enforcement Program lifts a million people out of poverty every year and helps families avoid the need for public assistance. Child support provides about 30 percent of income for the poor families who receive it, and over 90 percent of the child support money collected by the program is distributed directly to children and families. This represents a shift in programmatic mission that began with welfare reform, to move the program from one that sought to reimburse the Federal and State Governments for public assistance paid to families. Distributing more of the support collected to families increases and stabilizes family income and strengthens positive outcomes for families. The emerging mission of the child support program is to improve child well-being by working with both parents to improve parental capacity to support their children.

The Recovery Act temporarily restored Federal matching funds for State expenditures made with child support incentive payments—a long-standing policy that was ended by the Deficit Reduction Act of 2005. In the past, State programs relied heavily on this authority to fund operations, and we estimate that program expenditures would be cut by over 10 percent without the continued matching funds, since it is unlikely that States could afford to make up the reduction in Federal funding. The President's fiscal year 2011 budget requests a total of $4.3 billion for the Child Support Enforcement Program and includes several legislative proposals, the most significant being a 1-year continuation of the Recovery Act provision.

CONCLUSION

With the work of this subcommittee, and under your committed leadership, Mr. Chairman, significant strides have been made in understanding where we are most challenged in improving the state of American children and targeting funding and attention to policies that seek to address these challenges. As I have discussed in my testimony, the Administration has developed an integrated set of strategies to bolster ongoing efforts. Where we can, we are making policy changes and targeting resources to effect the change that is needed, but as I have outlined there are a number of key areas where we need your help. We look forward to working with the Congress to ensure that legislative changes and key investments are made to continue to improve the lives of children in America.

Thank you for the opportunity to address the subcommittee today. I would be happy to answer any questions.

Senator DODD. Thank you very, very much, Mr. Hansell. I appreciate your testimony.

Dr. Meléndez, welcome and welcome to the committee.

STATEMENT OF THELMA MELÉNDEZ DE SANTA ANA, ASSISTANT SECRETARY, OFFICE OF ELEMENTARY AND SECONDARY EDUCATION, U.S. DEPARTMENT OF EDUCATION, WASHINGTON, DC

Ms. MELÉNDEZ DE SANTA ANA. Thank you very much, Chairman Dodd, and thank you, Senator Casey and Senator Merkley. It is a wonderful opportunity, actually my first, to testify on behalf of the U.S. Department of Education. Mr. Chairman, I especially want to thank you, as others have done, for the decades of leadership in Congress as a champion for our country's most vulnerable children and families and the founder of the Senate's first Children's Caucus.

As you know, I am the Assistant Secretary of Elementary and Secondary Education, and I come to this position with experiences as a superintendent, as a principal, and as a classroom teacher, and most recently, as you mentioned, as superintendent of the Pomona Unified School District.

I appreciate your leadership in convening these hearings on the State of the American Child. It is critical that we are all aware of the challenges facing the Nation's children and families, particularly in these tough economic times.

Many of us believe that education is the one true way out of poverty for disadvantaged students. In fact, education is critical, not just for the success of the individual child, but also for the success of this country. There is no doubt that an educated workforce is the key to remaining competitive in a global economy and necessary to ensuring the prosperity of our communities.

While we have made great strides as a Nation, we still have a lot of work to do. The achievement gap between economically disadvantaged students and their more affluent peers is far too wide and it starts before kindergarten. In 2005, only 59 percent of poor 4-year-olds participated in preschool education compared to 72 percent of nonpoor 4-year-olds. This gap continues as children get older.

When we look at NAPE scores of both 4th and 8th graders, we continue to see very significant gaps between low-income students and their more affluent peers, as well as minority and nonminority students.

Additionally, far too many young people fail to graduate from high school on time, especially young African-American, Latino, and Native American students. Nationally about 70 percent of students graduate from high school on time with a regular diploma, but just over half of African-American and Latino and American Indian students earn diplomas within 4 years of entering high school. And only 13 percent of Latinos and 17.5 percent of African-Americans hold a bachelors degree. We must do better.

That is why the President and Secretary Duncan announced the Administration's program to reduce America's high school dropout rate with General Colin Powell and Alma Powell, the chair of the America's Promise Alliance, who testified at your first in this series of hearings. Mr. Chairman, the President has set an ambitious goal that by 2020 we will once again have the highest proportion of college graduates in the world.

This goal is the basis of this Administration's cradle-to-career strategy for education reform. Our plan begins with stronger early learning programs and services and continues with rigor and high expectations to ensure that more students enter high school on the path to graduate, prepared for college and a career. And finally, we must work to make sure that more students earn a college degree that prepares them for a meaningful career.

The reauthorization of the Elementary and Secondary Education Act is an essential means to an end. Our proposal for reauthorization, the Blueprint for Reform, includes a focus on high-quality teaching and learning, improving equity and excellence, and building capacity at the State and local levels. The Blueprint is focused on closing the achievement gap, raising the bar for all students, and as you know, this is a moral and an economic imperative. Early learning from birth through 3rd grade is an essential part of our strategy for meeting the President's 2020 goal. Research demonstrates that learning begins at birth and that high-quality early learning programs help children, especially high-needs children, arrive in kindergarten ready to succeed in school and life, as Mr. Hansell mentioned.

That is why the Administration's fiscal year 2011 budget request included $9.3 billion over 10 years for the Early Learning Challenge Fund to support States in strengthening their early learning settings. We recognize the difficult fiscal challenges and appreciate the work of the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Services for including $300 million for this important priority in the fiscal 2011 mark. We remain committed to working with Congress to advance funding for this initiative and continuing our work on early learning with the Department of Health and Human Services.

We are also setting high expectations and improving teaching and learning in our K–12 schools. Our approach builds on the efforts of the Nation's Governors and the State chief school officers by supporting State-developed college- and career-ready standards. But improving teaching and learning does not end with standards. It only begins there. We have got to support high-quality assessments, State and locally developed curricula, and professional development for teachers and principals that are aligned to these standards.

Research tells us that teachers are the most important in-school factor in student success, but access to effective teachers is not equal. High-poverty, high-minority schools and students get shortchanged. We need to make sure that the best teachers teach where they are needed the most. Our proposal provides funds to spur the creation of more effective teacher preparation pathways, meaningful career ladders, and stronger supports to retain great teachers and programs to reward them for all that they do.

To address the greatest achievement gaps and the lowest graduation rates, our proposal drives resources to our lowest performing schools. We have all set a goal of turning around 5,000 of our lowest performing schools, the bottom 5 percent in each State in the country. There are schools where achievement has been low for years and is not improving. In fact, 2,000 of our high schools

produce a majority of our Nation's dropouts and approximately 75 percent of our Latino and our African-American dropouts.

Thanks to the Recovery Act and annual appropriations, we have already committed $4 billion in school improvement grants to support local turnaround efforts. Through our Blueprint and our annual budget request, we will continue to seek resources and support to turn around these lowest performing schools.

Our plan recognizes that diverse learners, including English learners, migrant, rural, and homeless students and students with disabilities, have specific needs that must be addressed through additional support.

Further, thanks to your efforts, we are increasing college access and opportunities for more students, providing $40 billion in increased Pell Grants to help more students go to college. And the Department has undertaken, over the past 2 years, to simplify the student aid application process so that all students can get the aid for which they are eligible.

And finally, our proposal strives to build capacity at the State and local levels through our initiatives like Race to the Top which includes grants to States for systemic reforms, Investing in Innovation, or i3, which provides grants to districts and nonprofits to develop and scale up promising practices. We need to make great improvements and pioneer new models. Our proposal also supports a comprehensive approach to student needs through Safe and Healthy Students and support for afterschool programs.

We also want to increase support for strong family and community engagement in education. So we propose to double title I funding for family engagement and require districts and schools to implement strong family and community engagement efforts.

Through his fiscal year 2011 budget request, the President has demonstrated that he is absolutely committed to children and to improving their education. He has proposed historic increases for education, the largest increase ever requested for ESEA, to ensure that students can succeed and that our country can maintain its place as a global leader.

I think we can all agree that the current state of education is not good enough, especially when our most vulnerable children and families continue to struggle. We must all do better. We must continue to work together in a bipartisan way to reauthorize and improve ESEA as soon as possible. Our children simply cannot afford to wait.

Once again, thank you, Chairman Dodd. Thanks to the committee for this opportunity to testify, and I look forward to answering any questions that you may have.

[The prepared statement of Ms. Meléndez de Santa Ana follows:]

PREPARED STATEMENT OF THELMA MELÉNDEZ DE SANTA ANA

Thank you, Chairman Dodd, Ranking Member Alexander, and members of the subcommittee for this opportunity to testify on behalf of the U.S. Department of Education. Mr. Chairman, I especially want to thank you for your decades of leadership in Congress, as a champion for our country's most vulnerable children and families, and the founder of the Senate's first Children's Caucus.

My name is Thelma Meléndez de Santa Ana, and I currently serve as the Assistant Secretary for Elementary and Secondary Education. I come to this position with experiences as a superintendent, a principal, and a classroom teacher, most recently as the superintendent of the Pomona School District in California. In each position

I've held, I have been focused on what will improve teaching and learning, to help ensure the success of all of our children.

I appreciate your leadership in convening these hearings on the "State of the American Child." It's critical that we all be aware of the challenges facing the Nation's children and families, particularly in these tough economic times. We have to see the roadblocks in order to overcome them.

Many of us believe that education is the one true way out of poverty for disadvantaged children. In fact, education is critical not just to the success of an individual child, but also to the success of the country. There's no doubt that an educated workforce is the key to remaining competitive in a global economy and that an educated citizenry is necessary to ensure national prosperity and the common good.

While we have made great strides as a nation, we have a lot of work to do. The achievement gap between economically disadvantaged students and their more affluent peers is far too wide. And far too many young people fail to graduate from high school on time—especially young African-American, Latino, and Native American students.

Nationally, about 70 percent of students graduate from high school on time with a regular diploma, but just over half of African-American and Latino and American Indian students earn diplomas within 4 years of entering high school. In many States, the graduation gap between white and minority students is stunning; in several, it is as much as 40 or 50 percentage points. And, only 13 percent of Latinos and 17.5 percent of African-Americans hold a bachelor's degree. We must do better. That is why the President and I announced the Administration's program to reduce America's high school dropout rate, which we announced with General Colin Powell and Alma Powell, the chair of the America's Promise Alliance—who testified at your first in this series of hearings. Our goal is that by 2020, we will once again have the highest proportion of college graduates in the world—and reaching that goal will require focusing attention not only on high school dropouts, but all along the educational continuum.

This goal is the basis of this Administration's cradle-to-college-and-career strategy for education reform. Our plan begins with stronger early learning programs and services, making sure children enter school ready to learn. Further, we must ensure that more students enter high school with strong grounding based on high standards and effective teaching in elementary and middle school, so they are on a path to graduate from high school ready to succeed in college and a career. And, finally, we must work to make sure that more students earn a college degree that prepares them for a meaningful career.

The reauthorization of the Elementary and Secondary Education Act (ESEA) is an essential means to this end. Our reauthorization Blueprint for Reform includes a focus on high-quality teaching and learning, improving equity and excellence, and building capacity at the State and local levels. We've centered the goals of the Blueprint on closing the achievement gap and raising the bar for all students. This is a moral and economic imperative.

The years prior to kindergarten are critical in shaping a child's foundation for later school success. Research demonstrates that learning begins at birth and that high-quality early learning programs help children, especially high-need children, arrive in kindergarten ready to succeed in school and in life. Early learning is an essential part of our strategy for meeting the President's 2020 goal. As the Secretary says, we have to get schools out of the catch-up business.

The Department's early learning agenda focuses on children from birth through third grade, with seamless transitions between preschool and elementary school. Our proposal for reauthorizing ESEA supports a continuum of learning that will help to close the achievement gap and ensure that every student graduates from high school ready to succeed in college and a career.

Our approach builds on the great efforts of the Nation's governors and the chief State school officers by supporting implementation of State-developed college- and career-ready standards. But improving teaching and learning doesn't end with standards—it only begins there. We've got to support high-quality assessments, State and locally developed curricula, and professional development and communities of collaborative support for teachers and principals that are aligned to those standards. And we need to ensure fair and rigorous accountability, measuring every student's growth towards college and career readiness, as growth and progress are critical elements of any picture of how our schools are doing.

In order to close the achievement gap between economically disadvantaged students and their more affluent peers, we must provide better educational opportunities for all students.

High quality early learning programs and services are so important to ensuring equity and excellence for a child's educational future. Studies show that at least half

of the achievement gap between poor and more affluent children already exists when they enter kindergarten. The larger the gap, the harder it is to close later on. That is why the Administration's fiscal year 2011 budget request included $9.3 billion over 10 years for the Early Learning Challenge Fund, to support and encourage States to reform and raise the bar across their early learning settings. Many in Congress worked to include the Early Learning Challenge Fund in the Healthcare and Education Reconciliation Act earlier this year. We remain committed to working with Congress to advance funding for this important initiative in fiscal year 2011.

Research also tells us that teachers are the most important in-school factor in student success, but access to effective teachers is not equal. We all know that high-poverty and high-minority schools are being short-changed—often being taught by less experienced, less well-prepared, and less-effective teachers. We need to make sure that the best teachers teach where they are needed the most. We want to spur the creation of more effective pathways for preparation of teachers, meaningful career ladders and stronger efforts to retain great teachers, and we want to support educators in their instructional practice and reward them for all they do. Our proposal will provide funds to develop and support effective teachers and leaders and make sure that every child has the opportunity to learn from excellent teachers.

In order to address the greatest achievement gaps and the lowest graduation rates, our proposal drives efforts and resources to our lowest performing schools.

We have set a goal of turning around 5,000 of our lowest performing schools—the bottom 5 percent in each State in the country. These are schools where achievement has been low for years and isn't improving. Many of these schools produce a disproportionate percentage of our high school dropouts. In fact, fewer than 15 percent of all high schools, about 2,000 schools, produce a majority of our Nation's dropouts and approximately two-thirds of Latino and African-American dropouts.

Thanks to the Recovery Act and annual appropriations, we have already committed $4 billion to support local efforts to turn around these lowest performing schools through School Improvement Grants—up to $6 million to help each of these schools. Through our Blueprint and our annual budget request, we will continue to seek resources and support to turn around our lowest-performing schools.

Our plan also recognizes that diverse learners, including English Learners, migrant, rural, and homeless students, students with disabilities, and other vulnerable populations have specific needs that must be addressed through additional support. For example, to better support English Learners (EL), we are encouraging states to develop English language proficiency standards and high-quality assessments that prepare EL students to succeed. We also expect schools to understand the diversity of their EL populations and better differentiate their supports for subgroups of EL students.

Further, thanks to SAFRA, we are increasing college access and opportunities for more students, providing $40 billion in increased Pell Grants to help more students go to college. And, the Department has undertaken efforts over the past 2 years to simplify the Federal student aid application process so that all students can get the aid for which they are eligible.

Finally, our proposal strives to help build capacity at the State and local levels for making the reforms necessary to close the achievement gaps. Our plan recognizes that capacity is a critical element as States, districts, non-profit organizations, and communities undertake major changes to improve education for all their students. Through our initiatives, like Race to the Top, which provides grants to States for systemic reforms, and Investing in Innovation, or i3, which provides grants to districts and non-profits to develop and scale up promising instructional practices, strategies and supports, we can make great improvements and pioneer new models. Our proposal supports a comprehensive approach to students' needs, including through Safe and Healthy Students and support for afterschool programs. We maintain important formula funding, and structure competitive programs to target the areas that most need those funds.

We also propose to increase support for strong family and community engagement and efforts to create open, welcoming avenues for parents to engage with teachers, schools, and programs. We believe that family and community engagement should be a requirement for schools and districts, especially as they seek to improve. And that's why we propose to double title I funding for family engagement. In addition, through Promise Neighborhood grants, we will support the development and implementation of a continuum of effective community services, strong family supports, and comprehensive education reforms in high-need communities, to improve children's education and life outcomes.

Through his fiscal year 2011 budget request, the President has demonstrated that he is absolutely committed to children and to improving their education—he has proposed historic increases for education programs—the largest increase ever re-

quested for ESEA—to ensure that students can succeed and that our country can maintain its place as a global power.

I think we can all agree that the current state of education is not good enough, especially when certain segments of our population, our most vulnerable children and families, continue to struggle. We must all do better. And that's why we must continue to work together in a bipartisan way to reauthorize and improve ESEA as soon as possible. Our children simply can't afford to wait.

Once again, thank you Chairman Dodd, and thanks to the committee for this opportunity to testify. I look forward to answering any questions you may have.

Senator DODD. Doctor, thank you very, very much. I appreciate your testimony.

Dr. Koh, welcome.

STATEMENT OF HOWARD K. KOH, M.D., M.P.H., ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. KOH. Thank you very much, Chairman Dodd, Senator Casey, Senator Merkley. It is a great honor to be here today to address the state of children's health and to review the activities of the Department of Health and Human Services to advance the health and well-being of America's children.

The youth of today are tomorrow's workers, parents, and leaders, and we must provide them with every opportunity to reach their full potential for health. So this hearing is of great importance to the Nation and to me personally as the Assistant Secretary for Health, as a physician who has cared for patients for over 30 years, and as a father of three.

First, Mr. Chairman, thank you for your extraordinary service to our Nation's children and families. Over the past 3 decades, you have demonstrated an outstanding commitment to promoting the health of children and guaranteeing essential health services. You have led so many efforts to build a foundation for health for the youngest and most vulnerable in our society. Most importantly perhaps, you have long recognized that children's health is shaped by a constellation of interconnected factors outside of the realm of individual biology of disease, including education, economics, family environment, policy change, and many other dimensions. Our Department views health through the same broad lens, and we share your commitment to a broad societal interconnected approach to health to respond to these needs.

And on a personal note, Mr. Chairman, since I grew up in New Haven, CT, attended college and medical school there, and have felt your personal support of me and my brother, Legal Advisor Harold Koh of the State Department, as we both entered public service on the Federal level, I want to thank you for everything you have done not just for my family but for so many families across this country.

The public health future of our children rests on more culturally competent health care and a major focus on prevention and wellness. And we are very proud to be in an administration where those priorities are upheld by the President and Secretary Sebelius.

We know that there will be major demographic shifts over the coming decades. By 2050, we have projected 107 million will live in the United States, 25 million more than today, and also diversity will expand, as you have heard from my fellow speakers. So in these and many other ways, the population of children will grow

and change and we must be ready to address these challenges with new opportunities.

In that spirit, the definition of children's health has expanded and is now viewed broadly. In fact, in 2004, an Institute of Medicine report proposed a new definition saying,

> "Children's health should be defined as the extent to which an individual child or groups of children are able or enabled to develop and realize their potential, satisfy their needs, and develop the capacities that allow them to interact successfully with their biological, physical, and social environments."

So we embrace this broader definition, and it highlights not just the physical health aspects but also mental health and social well-being dimensions of true health or, as the World Health Organization has stated, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

I am very pleased to tell you, Mr. Chairman and subcommittee members, that the health status of children as a whole has improved in many ways over the last several generations. When we look at Healthy People 2010, the Nation has either progressed toward or met many targets that were set a decade ago. For example, let me cite a few.

For childhood immunizations, we are at near record high levels, including those related to diphtheria, polio, hepatitis, meningitis, pneumococcal infections, and meningococcal disease.

For Sudden Infant Death Syndrome, we have clear reductions in that category.

For perinatally acquired AIDS, we have had a decreasing number of new cases.

Breastfeeding rates have increased.

We have an increase in health insurance coverage rates for children, although we need much more.

We have a decline in adolescent birth rates after a 2-year increase and a decline in percentage of preterm births for the second straight year.

However, we at the Department and so many others across the country are aware of the many, many health challenges that remain. For example, childhood obesity. You have already heard that theme from my fellow speakers. Preterm births, infant mortality with the recent stall in the decline of rates and striking disparities. Injury and violence remain leading causes of death for adolescents. Conditions such as asthma, autism, and other developmental disorders impact quality of life. Tobacco, alcohol, and other drugs remain major challenges for our children. Early sexual activity leads to sexually transmitted disease and unintended pregnancy. And mental health disorders deserve special attention.

So at Health and Human Services, we are committed to working with you and so many others across the country to address these challenges. And there are many, many opportunities and let me just cite a few.

With your great leadership, Mr. Chairman, we have reauthorized the Children's Health Insurance Program and also the Affordable Care Act will have such far-reaching implications for generations to come. And we are delighted that through these two efforts, cov-

erage will be expanded, prevention will be highlighted, and kids will be healthier for the future.

We are particularly pleased that in the Affordable Care Act, there are $15 billion dedicated over the next 10 years in a new Public Health and Prevention Fund and also a dedicated effort for a new public health and prevention strategy that is going to emphasize reaching full potential for adults and children.

Allow me to comment further on three areas: tobacco, obesity, and emotional well-being.

On June 22, 2009, we entered a new era of prevention and tobacco control when the President signed the Family Smoking Prevention and Tobacco Control Act into law. Mr. Chairman, I remember very fondly being in the Rose Garden with you and thanking you for your leadership then, and I want to thank the subcommittee members who have all been so supportive on tobacco control and launching the country to a new era in public health due to the passage of this law.

As you have heard, we are also partnering with the First Lady on the *Let's Move!* campaign to solve childhood obesity in the next generation, and we have many activities in the Department to support that work, new dietary guidelines coming out for Americans in the very near future, and the Affordable Care Act promotes many activities about prevention that will focus on obesity.

And then finally, on emotional and mental health for our kids moving forward, last year a very important Institute of Medicine report entitled, Preventing Mental, Emotional, and Behavioral Disorders in Young People, articulated the issues and offered broad strategies for moving forward with respect to treatment, recovery and prevention, and we are embracing those approaches at the Department.

So in summary, Mr. Chairman and subcommittee members, thank you for the opportunity for this brief presentation. By expanding opportunities for our kids, building the right infrastructure, focusing on prevention and wellness, we have many, many opportunities for the future, and we look forward to broadening and strengthening our partnerships with you and so many others across the country. Thank you very much.

[The prepared statement of Dr. Koh follows:]

PREPARED STATEMENT OF HOWARD K. KOH, M.D., M.P.H.

INTRODUCTION

Good morning Chairman Dodd, Ranking Member Alexander and members of the subcommittee. It is my honor to be here today to review the state of children's health and to present the activities of the Department of Health and Human Services (HHS) to advance the health and well-being of America's 74.5 million children. The young people of today are tomorrow's workers, parents and leaders. We must provide them with every opportunity to reach their full potential, which, in turn, requires good health.

First, Mr. Chairman, thank you for your extraordinary service to our Nation's children and families. Over the last 36 years, you have demonstrated an outstanding commitment to developing policies that promote children's healthy development and guarantee essential health resources. Your leadership has helped millions of poor children receive the care they deserve. You have led so many efforts to build the foundation for health for the youngest and most vulnerable among us. More importantly perhaps, you have long recognized that children's health is shaped by a constellation of interconnected factors outside of the traditional health realm, including education, family environment and community settings. HHS views "health"

through the same broad lens. We share your commitment to ensuring that values of interconnectedness and shared responsibility are part of all of our continuing efforts to respond to the health needs of infants, children, adolescents and their families.

I am pleased to say that the health status of children as a whole has improved significantly over the last few generations. Expanded access to health care and increased commitment to the development of comprehensive and coordinated child health initiatives across life stages have led to this improvement. We at HHS are acutely aware of the many challenges that remain such as childhood obesity prevention, tobacco control and the onset of mental health disorders, and we are working with our Federal, State and local partners to address them. That's why one of the first things President Obama did was sign into law a reauthorization of the Children's Health Insurance Program (CHIP)—a down payment on comprehensive health insurance reform. And in March of this year, the President signed the Affordable Care Act, putting in place comprehensive reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans. These new laws will have far reaching positive impacts on our healthcare system and on children's health and lives for generations to come.

EXPANDING ACCESS AND IMPROVING QUALITY: CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) AND THE AFFORDABLE CARE ACT

Expanding Access to Private and Public Coverage

CHIPRA and the Affordable Care Act greatly expand resources and coverage for CHIP and seek to improve the quality of care, including shifting toward a greater focus on prevention. CHIPRA and the Affordable Care Act combine to provide an additional $69 billion in Federal CHIP allotments through fiscal year 2015. The Centers for Medicare and Medicaid Services (CMS) shows that in fiscal year 2009, 8 million children were enrolled in CHIP, and the funding increases in CHIPRA and the Affordable Care Act will allow States to cover millions more children in both Medicaid and CHIP.

Additionally, Secretary Sebelius has initiated the Secretary's Challenge: Connecting Kids to Coverage, a 5-year campaign that will challenge Federal officials, governors, mayors, community organizations, tribal leaders and faith-based organizations to enroll the nearly 5 million uninsured children who are eligible for Medicaid or CHIP but are not currently enrolled.

The Affordable Care Act builds on these commitments. Children will benefit from new rules of the road that insurance companies have to follow, comprehensive reforms that expand access to health coverage, a new emphasis on the quality of children's care, and important new policies and programs that will put prevention first.

Beginning this year, health insurance companies will be prohibited from excluding children from coverage because of pre-existing conditions. Additionally, insurance companies will no longer be allowed to impose lifetime dollar limits on essential benefits, nor will they be permitted to cancel coverage when an individual gets sick just because of a mistake in her paperwork.

To move toward a system where all children have access to health insurance, the new law not only extends CHIP through Fiscal Year 2015 and provides additional funding, but also strengthens both Medicaid and CHIP by raising Medicaid's Federal income eligibility floor to 133 percent of the Federal poverty level in 2014 and maintaining existing levels of coverage for children in CHIP. Furthermore, in 2014, families who are not eligible for other affordable coverage will be able to use State insurance exchanges to obtain coverage for themselves and their children.

Improving Quality of Health Care

To address quality improvement in children's health care, the Affordable Care Act creates quality priorities and promotes quality measurement for children, as well as reporting requirements for care children receive. The act outlines provisions to ensure there are an adequate number of medical providers to meet increased future needs. And, coverage in the new State-based insurance exchanges will include children's dental and vision coverage—two critical forms of coverage that are often not included in coverage packages for children.

Children will also benefit from unprecedented investments in prevention at both the individual and community levels, as essential prevention services are more fully integrated between the clinic and community. At the individual level, new health plans are required to cover recommended preventive services with no cost-sharing for the enrollee. These recommended services include regular well-baby and well-child visits, routine immunizations, and other screenings that are important to keep

kids healthy. Additionally, the Affordable Care Act makes a major investment—$1.5 billion over 5 years—in evidence-based home visitation programs designed to improve outcomes—including maternal and child health and development outcomes—for pregnant women and families with young children.

To ensure quality and safety of pediatric medications, the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act have stimulated pediatric studies of therapies intended for the pediatric populations. As a result, labeling has been changed for almost 400 medications to include information to guide safe use in children. Before 1997, a majority of medications (approximately 80 percent) that were prescribed to pediatric patients were not studied in children.

At the community level, the Affordable Care Act invests $15 billion over the next 10 years in public health and prevention programs through the creation of the Public Health and Prevention Fund to promote improved health outcomes. Its activities will complement the work of the first-ever National Prevention and Health Promotion Strategy, which will emphasize prevention and well-being—identifying and prioritizing actions across government and between sectors to benefit Americans of all ages.

By expanding and sustaining the necessary infrastructure to prevent disease, detect it early, and manage conditions before they become severe, HHS is working to transform our health care system to keep children healthy and reduce the likelihood that children will develop chronic disease later in life. As part of this historic commitment, the Department has leveraged the Communities Putting Prevention to Work (CPPW) program, funded through the American Recovery and Reinvestment Act (ARRA). This program expands the use of evidence-based strategies and programs, mobilizes local resources at the community-level, and strengthens the capacity of States. Through its four distinct but unified initiatives, CPPW will: increase levels of physical activity; improve nutrition; decrease obesity rates; and decrease smoking prevalence, teen smoking initiation, and exposure to second-hand smoke. The initiative's strong emphasis on policy and environmental change at both the State and local levels supports an expanding definition of "health" for the public.

DEFINING "HEALTH" AND HEALTHY CHILDREN

The definition of "health" in childhood has evolved significantly over time. A century ago, when infectious diseases posed the greatest threat, "health" was viewed as the absence of disease or premature mortality. Today, "health" in general, and children's health in particular, is now viewed in a broader developmental context. A 2004 Institute of Medicine (IOM) report, *Children's Health, The Nation's Wealth*, proposed a new definition to reflect these new realities:

> Children's health should be defined as the extent to which an individual child or groups of children are able or enabled to: (a) develop and realize their potential; (b) satisfy their needs; and (c) develop the capacities that allow them to interact successfully with their biological, physical, and social environments.

This broader definition incorporates not only the physical absence of disease, but also highlights healthy development throughout life stages which recognizes the critical roles of mental and social well-being. As shown in the Centers for Disease Control and Prevention's (CDC) Adverse Childhood Experiences study, psychologically difficult events in childhood are linked with a range of later physical and behavioral health problems, including smoking, suicide, heart and lung disease, physical injury, diabetes, obesity, unintended pregnancy, sexually transmitted diseases, and alcoholism (Felitti, et al. 2002). Indeed, as noted by the World Health Organization (WHO), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

This "social determinants" approach to health is the vision behind the Department's Healthy People initiative—a national health-promotion and disease-prevention agenda that, for the last three decades, has articulated overarching goals, emerging public health priorities and tracked movement toward specific targets. In the coming decade, Healthy People 2020 proposes four overarching goals: (1) achieve health equity, eliminate disparities and improve health for all groups; (2) eliminate preventable disease, disability, injury and premature death; (3) promote healthy development and healthy behaviors across every life stage; and (4) create social and physical environments that promote good health for all. As we prepare for the next decade, implement the Affordable Care Act, and enter a new era of prevention, HHS will continue using the Healthy People framework as a public health roadmap to unify our national dialogue about health, including children's health, motivate action, and encourage new directions in health promotion.

Wrapping up Healthy People 2010 activities permits an assessment of the status of children's health in relation to targets set a decade ago. Preliminary analyses in-

dicate that the Nation has either progressed toward or met the target on a number of objectives for children. These figures, detailed below, reflect movement on a host of diseases, conditions, risk factors, and behaviors for the growing population of U.S. children.

STATE OF CHILDREN'S HEALTH: DATA SNAPSHOT AND PROGRESS TOWARD HEALTHY PEOPLE 2010 TARGETS

The number of children in the United States is increasing. In 2009, there were 74.5 million children in the United States, 2 million more than in 2000. This number is projected to increase to 101.6 million by 2050. In 2009, the population of children was evenly divided over three age groups: 0–5 years (25.5 million), 6–11 years (24.3 million), and 12–17 years (24.8 million). Children's racial and ethnic diversity is projected to grow in the decades to come: by 2023; less than half of all children are projected to be White, non-Hispanic. By 2050, 39 percent of U.S. children are projected to be Hispanic (up from 22 percent in 2009), and 38 percent are projected to be White, non-Hispanic (down from 55 percent in 2009).

Similar to the Healthy People framework which is used to motivate action on children's health activities and improve health outcomes, the Forum on Child and Family Statistics releases an annual report using statistical data from 22 Federal agencies on the well-being of U.S. children and families. This year's report demonstrates a number of key positive trends including: a decline in the percentage of pre-term births (for the second straight year); an increase in health insurance coverage rates for children; a decline in the adolescent birth rate after a 2-year increase; and teen smoking rates at their lowest levels since data collection began for the report.

Maternal, Infant and Child Health and Early and Middle Childhood

Perhaps the most notable development is that following years of increases, the Nation's pre-term birth rate declined for the second straight year, from 12.8 percent in 2006 to 12.7 percent in 2007 to 12.3 percent in 2008. Decreases in pre-term birth rates between 2007 and 2008 were seen for each of the three largest race and ethnicity groups: White, non-Hispanic; Black, non-Hispanic; and Hispanic women. Still, one out of every eight babies in the United States are born pre-term, and the U.S. pre-term birth rate is higher than in most developed countries.

After decades of decline, the recent stagnation in the U.S. infant mortality rate has generated concern among researchers and policymakers. The U.S. infant mortality rate did not decline significantly from 2000 to 2005, showed a slight decline from 2005 to 2006, and a non-significant increase from 2006 to 2007. In 2007, a total of 29,138 infant deaths occurred in the United States, and the U.S. infant mortality rate was 6.75 infant deaths per 1,000 live births, compared with 6.89 in 2000. Furthermore, there persist significant disparities in infant mortality rates among racial and ethnic minorities.

Maintaining and enhancing the success of childhood vaccination is crucial to ensuring children's long-term health and public health. Increased immunization rates over the last century have improved children's health and increased life expectancy. Today, childhood vaccination rates are at near record high levels but they can still improve.

Autism is more prevalent than previously believed, affecting 1 out of every 110 American children.

Chronic diseases continue to affect a large percentage of children. For example, nearly 1 in 10 children (9 percent) have asthma, which includes children with active asthma symptoms and children with well-controlled asthma. The percentage of children with current asthma increased slightly from 2001 to 2008.

Childhood obesity is another major public health challenge: 1 in 3 U.S. children are over-weight or obese. Additionally, a third of children born in 2000 are expected to develop weight-related diabetes in their lifetime. Combined data for the years 2005–8 indicate that Mexican-American and Black, non-Hispanic children were more likely to be obese than White, non-Hispanic children. Obesity impacts children in almost every facet of their life, not just health. According to the White House Task Force on Childhood Obesity's Report to the President, severely obese children have a level of health-related quality of life (a measure of their physical, emotional, educational and social well-being) well below their peers that are not overweight. Obesity rates are related to poor eating patterns: in 2003–4, on average, children's diets were out of balance, with too much added sugar and solid fat and not enough nutrient-dense foods, especially fruits, vegetables, and whole grains. The average diet for all age groups met the standards for total grains, but only children ages 2–5 met the standards for total fruit and milk.

Unintentional injuries—such as those caused by burns, drowning, falls, poisoning and road traffic—also remain the leading cause of morbidity and mortality among

children in the United States. Each year, among those 0 to 19 years of age, more than 12,000 people die from unintentional injuries, and more than 9.2 million are treated in emergency departments for nonfatal injuries.

Adolescent Health

Injury and violence are the leading causes of death for adolescents. For example, motor vehicle crashes are the leading cause of death for U.S. teens, accounting for more than one in three deaths in this age group. In 2008, 9 teens ages 16 to 19 died every day from motor vehicle injuries. Per mile driven, teen drivers ages 16 to 19 are four times more likely than older drivers to crash. Fortunately, teen motor vehicle crashes are preventable, and proven strategies can improve the safety of young drivers on the road. In 2008, about 3,500 teens in the United States aged 15–19 were killed, and more than 350,000 were treated in emergency departments for injuries suffered in motor vehicle crashes. Young people ages 15–24 represent only 14 percent of the U.S. population; however, they account for 30 percent ($19 billion) of the total costs of motor vehicle injuries among males and 28 percent ($7 billion) of the total costs of motor vehicle injuries among females.

Today's adolescents face a variety of challenges and stresses. By far, the largest challenges to this age group are the dangers of drugs and alcohol, and the onset of mental health disorders. Illicit drug use among youth remained unchanged from 2008 to 2009. In 2009, 8 percent of 8th graders, 18 percent of 10th graders, and 23 percent of 12th graders reported illicit drug use in the past 30 days. These statistics represent declines from peaks of 15 percent for 8th graders and 23 percent for 10th graders in 1996 and 26 percent for 12th graders in 1997. However, the proportion of 8th graders who disapprove of trying marijuana or hashish once or twice increased from 69 percent in 1998 to 76 percent in 2004, exceeding the Healthy People target of 72 percent. An emerging substance use issue of concern is the non-medical use of prescription drugs among teens. Past-year nonmedical use of substances such as Vicodin and OxyContin increased during the last 5 years among 10th graders and remained unchanged among 8th and 12th graders. Nearly 1 in 10 high school seniors reported non-medical use of Vicodin; 1 in 20 reported abuse of OxyContin.

Alcohol use is an ongoing public health concern. Between 1999 and 2009, heavy drinking declined from 13 percent to 8 percent among 8th graders, from 24 percent to 18 percent among 10th graders, and from 31 percent to 25 percent among 12th graders. For students in grades 9 through 12, riding with a driver who has been drinking achieved its Healthy People target. In addition, a nationwide legal standard of .08 percent blood alcohol concentration (BAC) maximum levels for driving while intoxicated (DWI) enforcement and prosecution was achieved. This standard represents an effective tool in the effort to combat drunk driving. Research has found that passage of a 0.08 percent BAC *per se* law (which makes it an offense in and of itself to drive with a BAC measured at or above .08, whether or not the driver or operator exhibits visible signs of intoxication), particularly when accompanied by publicity, results in a 6 percent to 8 percent reduction in alcohol-related fatalities. In spite of these gains, underage drinking remains a serious threat to the health and safety of adolescents. On average, 28 percent of youth aged 12 to 20 drank alcohol in the past month. These underage drinkers consumed, on average, more drinks per day (4.9) on the days they drank than persons aged 21 or older (2.8).

Also, despite progress in reducing tobacco use, nearly 3,900 kids try their first cigarette each day, and 1,000 of those children become daily smokers. Tobacco dependence is recognized as a pediatric disease because 90 percent of tobacco users begin using before 18 years of age. Recent Morbidity and Mortality Weekly Report data from CDC on tobacco found that for three measures of cigarette use (ever smoked cigarettes, current cigarette use, and current frequent use), rates among high school students began to decline in the late 1990s, but the rate of decline slowed during 2003–9. However, indicators of exposure to second-hand smoke in children have decreased from 88 percent in the years between 1998 and 1994 to approximately 53 percent in 2007–8. But this still represents a significant risk because routine exposure to second-hand smoke increases the probability of lower respiratory tract infections, asthma, and sudden infant death syndrome.

Mental health disorders also often have their onset during the teen years. In 2008, 8.5 percent of youth aged 12–17 years old had a major depressive episode in the past year. In fact, half of all lifetime cases of mental illness begin by age 14 and by age 24. In this sense, adolescence is a particularly vulnerable period for the onset of mental disorders.

Early sexual activity is also associated with emotional and physical health risks. Youth who engage in sexual activity are at risk of contracting sexually transmitted infections (STIs) and becoming pregnant. In 2007, 48 percent of high school students

reported ever having had sexual intercourse. In the same year, among those reporting having had sexual intercourse during the past 3 months, 16 percent reported the use of birth control pills to prevent pregnancy before the last sexual intercourse, and 62 percent reported use of a condom during the last sexual intercourse.

The Healthy People Midcourse Review

At the Healthy People 2010 midcourse review, progress was made toward achieving or exceeding targets for the Nation's maternal, infant, and child health objectives. We can cite achievements throughout the life course of the young child through to young adulthood, including:

• *Preconception care—Folic acid intake:* The proportion of women of child-bearing age consuming the recommended daily intake of folate increased. Median red blood cell (RBC) folate levels for non-pregnant females aged 15 to 44 years exceeded the Healthy People target of 220ng/ml.

• *Preconception care—Smoking cessation:* The proportion of women who have abstained from smoking during pregnancy increased, moving toward the target of 99 percent.

• *Perinatally acquired HIV:* The target for the number of new cases of perinatally acquired AIDS was exceeded: new cases declined from a baseline of 82 new cases in 2002 to 57 cases in 2003, surpassing the target of 75 cases. Prevention of perinatal HIV transmission requires routine HIV screening of all pregnant women and the use of appropriate antiretroviral and obstetrical interventions that begin during the pregnancy and continue through the first few months of the infant's life. Together, these actions can reduce the rate for mother-to-child HIV transmission to 2 percent or lower.

• *Breastfeeding:* Rates increased for immediate and 6- and 12-months post partum.

• *Immunizations*: A number of Healthy People vaccination objectives reached their targets, including those related to diphtheria, polio, hepatitis, bacterial meningitis, pneumococcal infections, and meningococcal disease (for adolescents). Perinatal hepatitis B prevention programs and the routine hepatitis B vaccination of children have also resulted in a decline of cases of chronic hepatitis B virus infections in infants and children aged 2 years and under—achieving 63 percent of the targeted change. Additionally, just as the objectives related to the vaccinations themselves are important, so are the objectives related to evidence-based strategies for raising vaccination coverage rates. The proportion of public and private health care providers who have measured childhood vaccination coverage levels and the proportion of children participating in population-based immunization registries moved toward their targets.

• *Sudden infant death syndrome (SIDS):* Despite significant declines in rates since 1990, SIDS remains the third leading cause of infant death. Clear reductions occurred in infant deaths and deaths attributed to sudden infant death syndrome. Reported rates for SIDS declined by 15 percent between 1999 and 2002. From its original baseline of 35 percent, the proportion of infants being put to sleep on their backs met the Healthy People target of 70 percent.

HHS ACTIVITIES TO IMPROVE CHILD HEALTH OUTCOMES

Multiple agencies within HHS are working to maximize the impact of available resources to respond to the current and emerging physical, mental and social health needs of children and their families. In the rest of the testimony, we use the lifespan framework to review the current status of these activities:

Maternal, Infant, and Child Health and Early to Middle Childhood

Current Program Activities and Accomplishments

Infant mortality: HHS is analyzing reasons for the recent stagnation in infant mortality rates, possible causes of pre-term birth, issues in the coding and reporting of sudden and unexplained infant deaths, and strategies for preventing maternal illness and death. Given the high pre-term birth rate, and the lack of substantial decline in the infant mortality rate in the United States, a comprehensive public health research agenda that investigates the social, genetic, and biomedical factors contributing to pre-term birth and existing racial and ethnic disparities would inform policies and activities. A National Summit on Preconception Care was convened by CDC and its partners in June 2005, and there have been subsequent conferences focused on preconception care in 2008 and preconception health in 2010. National recommendations to coordinate services are forthcoming and are expected to lead to improved pregnancy outcomes and reduce costs associated with adverse perinatal outcomes.

SIDS: The national "Back to Sleep" campaign is educating physicians and caregivers about the risks associated with prone sleeping (sleeping with stomach facing down). As a result of the campaign and other SIDS prevention education, the proportion of infants being put to sleep on their backs has doubled since the baseline in 1996, but the rate has leveled off in recent years.

Prenatal care: HHS is a partner for Text4Baby, a free mobile information service designed to promote maternal and child health. An educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB), Text4Baby provides pregnant women and new moms with information to help them care for their health and give their babies the best possible start in life. Women who sign up for the service by texting BABY to 511411 (or BEBE in Spanish) will receive free text messages each week, timed to their due date or baby's date of birth. CDC is also promoting the Baby-Friendly Hospital Initiative, a global program sponsored by the WHO and the United Nations Children's Fund (UNICEF), to encourage and recognize hospitals and birthing centers that offer an optimal level of care of lactation according to the WHO/UNICEF Ten Steps to Successful Breastfeeding for Hospitals.

Folic acid intake: Consumption of folic acid by women of childbearing age has been shown to reduce the rate for neural tube defects (NTD). HHS, through the Food and Drug Administration (FDA) and CDC, has emphasized food fortification with folic acid to help prevent NTDs. In addition to food fortification, CDC has several ongoing folic acid education projects designed to reach affected populations.

Smoking cessation: Federal partnership activities aimed at reducing tobacco use among pregnant women are under way, including efforts to strengthen States' capacities to develop, implement, and evaluate tobacco prevention and cessation programs for women of reproductive age.

Perinatally acquired HIV: The Health Resources and Services Administration (HRSA) continually monitors the number and proportion of babies tested who are born to HIV-positive mothers enrolled in programs funded under Title XXVI (HIV Health Care Services Program) of the Public Health Service Act, the number of children receiving care and treatment, the number of pregnant HIV-positive women in care, and the number of pregnant women on prophylaxis. The reduction of babies born infected with HIV is also apparent in programs authorized under title XXVI. This decline is attributable, in part, to the emphasis placed on testing high-risk women of child-bearing age, enrolling those women testing positive into primary care, and ensuring that pregnant women are provided with appropriate primary care for therapy and prenatal care through providers under title XXVI.

Breastfeeding: Multiple initiatives support breastfeeding, from the Federal level down to the community level. Among Federal initiatives that encourage breastfeeding are the "National Breastfeeding Awareness Campaign," the Healthy Start Initiative, and HRSA's Title V Maternal and Child Health Block Grant Program. Additionally, the Affordable Care Act requires employers to provide a reasonable break time and place for breastfeeding mothers to express milk for 1 year after their child's birth. HHS is working with other Federal departments and public and private employers to help mothers receive the support they need to breastfeed in the workplace.

Immunizations: HHS, led by CDC, supports State-based immunization efforts that make vaccines available to financially vulnerable children and adolescents, as well as adults when funds are available. Additionally, a significant investment $300 million was made through ARRA in supporting State- and local-based programs to ensure vaccination efforts reached underserved groups. Funds will also support programs to increase public awareness and knowledge about the benefits of vaccination, as well as the risks of vaccine-preventable diseases. Additional funds were also allocated to assess the impact and effectiveness of newly recommended vaccines and monitor vaccine safety.

HRSA's Title V Block Grants for maternal and child health: HRSA's Maternal and Child Health (MCH) Block Grant program is a key Federal effort that focuses solely on improving the health of all mothers and children. The partnership between the Federal Government and States ensures that the needs of mothers and children, including children with special health care needs, are addressed. Specifically, the program seeks to: (1) assure access to quality care, especially for those with low-incomes or limited availability of care; (2) reduce infant mortality; (3) provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at-risk pregnant women); (4) increase the number of children receiving health assessments and follow-up diagnostic and treatment services; (5) provide and ensure access to preventive and child care services as well as rehabilitative services for certain children; (6) implement family-centered, community-based, systems of coordinated care for children with special healthcare needs; and (7) provide toll-free hotlines and assistance in applying for services to pregnant women with in-

fants and children who are eligible for Medicaid. The program's wide range of activities include support for MCH research, training of MCH providers, genetic services and newborn screening and follow-up, sickle cell disease, hemophilia, universal newborn hearing screening, and early childhood systems of services that bring together health, education and social services.

In working to improve access to healthcare, the MCH Block program has been able to increase both the number of children served by the States under title V (to 35 million in fiscal year 2008) and the number of children receiving services under Title V of the Social Security Act who have Medicaid and CHIP coverage. Increased coverage under Medicaid and CHIP for children receiving title V services better assures access, availability, and continuity of care to a wide range of preventive and acute care services.

Childhood Obesity: HHS is partnering with the First Lady in promoting the "*Let's Move!*" campaign to end the epidemic of childhood obesity in the next generation. Based on four pillars of helping parents make healthy choices, creating healthy schools, providing access to healthy and affordable food, and promoting physical activity, the initiative is helping schools, communities and families address the epidemic.

HHS's early actions to implement elements of the White House Childhood Obesity Task Force Plan include efforts to prevent childhood obesity in child care settings—a pivotal phase in children's lives. While each State creates and enforces its own child care licensing standards, HHS, through the Administration on Children and Families, plans to roll out guidance and suggested standards for physical activity and nutrition for child care later this summer. Also, as part of the Head Start Body program, HHS will provide individual grants to Head Start programs to improve or construct playgrounds and outdoor play spaces under the Head Start Body Start National Center for Physical Development and Outdoor Play. HHS is also empowering parents and caregivers with nutritional knowledge, tools and resources to make healthy choices. Over the next year, HHS will: in partnership with the Department of Agriculture, release the new Dietary Guidelines for Americans that provides science-based advice about making food choices to promote health; develop a new Front of Pack labeling system to make it easier for consumers, with a quick glance, to make healthy and informed food choices; and oversee the implementation of menu labeling provisions authorized by the Affordable Care Act. The Affordable Care Act requires owners of retail chain restaurants and vending machines (with more than 20 locations) to post caloric information, which will empower consumers to make healthier choices.

HHS is also implementing community demonstration projects authorized by CHIPRA; the Department will award $25 million in grants to select communities for health care providers to work with schools, community programs, recreation centers and other groups to build seamless community-clinical systems to reduce and prevent obesity among child residents. Additionally, since the White House Task Force established a goal of 100 percent of primary care physicians assessing body mass index (BMI) at well-child and adolescent visits by 2012, HHS will outreach to State Medicaid Directors to help them better understand the scope of prevention services they should provide to children and encourage BMI assessment and follow-up. Also, HRSA has launched a learning collaborative to significantly increase the health of children and families. Over the next year (through July 2011), faculty experts are helping to design, implement and test information that communities, including grantee community health centers, can use to help children achieve and maintain a healthy weight.

Additionally, HHS is updating the President's Challenge program to ensure consistency with the Physical Activity Guidelines and make it easier for schools to implement the program. The First Lady has set a goal of doubling the number of children in the 2010–11 school year who earn a President's Active Lifestyle Award (PALA). HHS will lead our Nation toward achieving this goal. The modernization of the President's Challenge Youth Fitness Test will begin this year, and HHS will double the number of children in the 2010–11 school year who earn a PALA award.

Obesity research also continues across the Department. For example, the National Institutes of Health's (NIH) National Collaborative of Childhood Obesity Research (NCCOR), launched in 2009 in partnership with the CDC and the Robert Wood Johnson Foundation, is accelerating research progress and translating findings into effective solutions at the societal level. NCCOR is designed to coordinate funding efforts, pooling members' resources for large projects that might not be feasible otherwise. NCCOR recently launched the Envision project ($15 million), which aims to help us understand the complexity of childhood obesity and virtually test environmental and policy interventions through sophisticated computational, systems mod-

els. During Fiscal Year 2010, NCCOR also will begin funding a nationwide study to determine the effectiveness of existing community-based strategies and programs.

Childhood Injury Prevention: Through public health surveillance efforts, research and implementation of effective strategies, CDC is working to protect young Americans from the threat of injury and violence. CDC prioritizes its work for children and adolescents by focusing on: (1) child maltreatment prevention and (2) prevention of child/adolescent motor vehicle related injuries.

Motor Vehicle Injury Prevention: CDC's research and prevention efforts are focused on improving seat belt use and reducing impaired driving, and helping groups at risk: child passengers and teen. Examples include raising parents' awareness about the leading causes of childhood injury in the United States and how they can be prevented. For example, CDC launched the initiative titled, *Protect the Ones You Love: Child Injuries Are Preventable*. CDC is also supporting States in the implementation of optimal graduated licensing laws (GDL). CDC's research and prevention efforts are focused on improving seat belt use and reducing impaired driving, and helping groups at risk: child passengers and teens.

Autism and Developmental Disabilities: Through ARRA, funding for autism research increased from $118 million in Fiscal Year 2008 to $196 million in Fiscal Year 2009. Several HHS agencies and offices are addressing autism spectrum disorders through research, surveillance, public education, and service delivery. HHS and the White House co-hosted a meeting with external stakeholders in recognition of World Autism Awareness Day on April 2, 2010, to learn more about the gaps in addressing the needs of people with autism. The Interagency Autism Coordinating Committee (IACC), a Federal advisory committee established in 2006 through the Combating Autism Act, advises the HHS Secretary and coordinates all efforts within the Department concerning autism. The IACC released the second edition of the Strategic Plan for Autism Spectrum Disorder Research in January 2010. The 2010 Plan adds 32 new research objectives and more fully addresses the needs of people with autism spectrum disorder across the spectrum, from young children to adults, and places new emphasis on both non-verbal and cognitively-impaired people with autism spectrum disorder. On April 30, 2010, Secretary Sebelius announced appointment of five new members to the IACC who add a breadth of expertise and perspectives to the committee.

In an effort to better understand risk factors and potential causes of ASD, CDC is currently conducting one of the largest studies in the United States to help identify factors that may put children at risk for ASD and other developmental disabilities. This study, being conducted across a six site network known as the Centers for Autism and Developmental Disabilities Research and Epidemiology (CADDRE), is called SEED, the Study to Explore Early Development. SEED is now nearing the close of the enrollment phase and first publications will be in Fiscal Year 2011.

Asthma Control Programs: CDC's National Asthma Control Program is reducing the number of deaths, hospitalizations, emergency department visits, school or work days missed, and limitations on activities due to asthma. Funding for health departments in 34 States, the District of Columbia, and Puerto Rico to conduct asthma surveillance, maintain and expand partnerships, implement statewide comprehensive asthma plans with their partners, implement interventions to reduce the burden of asthma, and develop and implement an evaluation plan. CDC also funds the State health departments in California, Michigan, Minnesota, Mississippi, Missouri, New York, Oregon, Rhode Island and Washington to conduct in-depth surveillance projects (three of them using Medicaid data), disparities assessments, and interventions, implementation and evaluation.

Surveillance efforts continue: In 2005, CDC implemented its National Asthma Survey (NAS) data collection effort as a call-back survey subsequent to the Behavioral Risk Factor Surveillance Survey (BRFSS). By 2009, participation in the Asthma Call-back Survey (ACBS) had expanded to 35 States, the District of Columbia and Puerto Rico. In 2010, 40 States will use the ACBS to collect data. Before CDC initiated the NAS and ACBS, none of this information was available at the State level. The ACBS data are used by the States to track *Healthy People* goals, evaluate programs, and plan future activities at the State level.

Early Hearing Detection and Intervention: Prior to the authorization of the Early Hearing Detection and Intervention (EHDI) program in 2000 (under the Children's Health Act), less than half of the infants in the United States were being screened for hearing loss. CDC's EHDI program provides support on the development and implementation of State-level tracking and surveillance systems to ensure that infants and children with hearing loss are identified early and receive services as soon as possible. Collaborative work with State EHDI programs and other partners to ensure infants receive recommended follow-up diagnostic and intervention services in a timely manner to realize the benefits of newborn hearing screening.

Food allergy: Food allergy is an emerging major health problem that affects approximately 4 percent of U.S. adults and 5 percent of children under 5 years old, and its prevalence seems to be increasing. Despite the risk of severe allergic reactions to food, and even death, there is no current treatment other than allergen avoidance and treating the symptoms associated with severe reactions. NIH's National Institute of Allergy and Infectious Diseases (NIAID) remains committed to basic research and clinical studies to advance our understanding of food allergy. NIAID-supported clinical trials continue to demonstrate the potential for immunotherapy to prevent or reverse established food allergies, such as peanut allergy, in children. NIAID also is leading an effort to develop "best practice" clinical guidelines for healthcare professionals for the diagnosis, management, and treatment of food allergies. The guidelines are expected to be published before the end of 2010.

National Children's Study (NCS): Efforts to promote health and prevent disease are predicated on understanding the causes and timing of, and triggers for, events that affect children's health. The NIH, joined by a consortium of Federal partners, has begun to pilot test recruitment strategies for the NCS, a large, multi-year research study with the goal of discovering and exploring the relationships between the environment (broadly defined), genetics, growth, development and health on 100,000 children from before birth through age 21. Complex environmental interactions and their relationships with critical growth and development periods will be studied, and it is expected that the data gathered will be utilized by researchers for many decades to come, providing insight into what constitutes children's health, but also childhood precursors of many adult chronic conditions.

Additional research and healthcare quality improvement projects for children: HHS's Agency for Healthcare Research and Quality (AHRQ) current projects include: testing approaches to deliver effective treatments for children with mental health problems; making medication management child-centered; implementing evidence-based care processes for infants with fever; using computers to automate developmental surveillance and screening; preventing adverse effects of medications during pregnancy; comparative safety and effectiveness of stimulant medication for children with ADHD; and effectiveness of ADHD treatment in at-risk preschoolers. In addition, AHRQ is working collaboratively with CMS to implement CHIPRA through the identification of evidence-based healthcare quality measures for use by public and private programs, and other activities related to improving quality.

Adolescent Health

Current Program Activities and Accomplishments

Tobacco control: On June 22, 2009, the President signed the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) (Public Law 111–31) into law. The Tobacco Control Act grants the FDA important new authority to regulate the manufacture, marketing and distribution of tobacco products to protect the public health generally and to reduce tobacco use by children and adolescents. HHS is directly supporting FDA's regulation of tobacco products and is promulgating regulations that limit the sale, distribution, and marketing of cigarettes and smokeless tobacco to protect the health of children and adolescents. FDA has also implemented provisions that prohibit the use of certain characterizing flavors in cigarettes, and prohibit manufacturing tobacco products with the descriptors "light," "mild," or "low" or similar descriptors.

CDC provides national leadership for a comprehensive, broad-based approach to reducing tobacco use. Essential elements of this approach include State-based, community-based, and health system-based interventions; cessation services; counter-advertising; policy development and implementation; tobacco product research; surveillance; and evaluation. A key goal of CDC's tobacco control program is to reduce the initiation of tobacco use among children, adolescents, and young adults. CDC will continue to encourage effective, evidence-based efforts to reduce youth smoking rates in the United States. These include strategies such as counter-advertising mass media campaigns; higher prices for tobacco products through increases in excise taxes; tobacco-free environments; programs that promote changes in social norms; comprehensive community-wide and school-based tobacco-use prevention policies to help reduce smoking; reductions in tobacco advertising, promotions, and commercial availability of tobacco products through implementation of FDA's regulatory authority; and effectively countering tobacco industry marketing influences.

Division of Adolescent School Health: CDC's Division of Adolescent and School Health addresses six critical types of adolescent health behavior that research shows contribute to the leading causes of death and disability among adults and youth. These behaviors usually are established during childhood, persist into adulthood, are interrelated, and are preventable. The Division focuses on collecting data

to better understand the risks and challenges facing the adolescents of today, as well as develop strategies to prevent disease and promote overall well-being wherever possible.

Office of Adolescent Health: Consistent with the directive contained in the Fiscal Year 2010 Consolidated Appropriations Act (Act), a new Office of Adolescent Health (OAH) has been established within the Office of Public Health and Science of the HHS Office of the Secretary. The President's budget for Fiscal Year 2010 proposed a new Teenage Pregnancy Prevention initiative to address high teen pregnancy rates by replicating evidence-based models and testing innovative strategies. The Act provides $110 million to support the TPP Program with not less than $75 million for funding the replication of programs that have been proven effective through rigorous evaluation and not less than $25 million for funding demonstration programs to develop and test additional models and innovative strategies.

In the short term, OAH will focus primarily on the implementation of the Teen Pregnancy Prevention program. However, HHS envisions that the Office of Adolescent Health will also address many of the interrelated health needs of adolescents such as mental health, injury and violence prevention, substance abuse, sexual behavior, pregnancy prevention, nutrition, physical activity, and tobacco use, as authorized. The OAH is planning to work with other HHS agencies, including the Substance Abuse and Mental Health Services Administration (SAMHSA), to coordinate adolescent activities within the Department and address the recommendations contained in recent IOM reports on the health needs of adolescents.

Addressing onset of mental health problems: A 2009 IOM report *Preventing Mental, Emotional and Behavioral Disorders in Young People*, clearly articulated that we have many programs that can prevent problems including substance use and mental disorders. Current SAMHSA programs focusing on prevention, treatment and recovery for youth include:

• *The Drug-Free Communities Program and Sober Truth on Preventing Underage Drinking (STOP Act):* Fund communities to develop coalitions across different sectors of the community—schools, law enforcement, businesses and merchants, health and behavioral healthcare providers, media, faith-based, community leaders—to prevent and reduce substance abuse among youth using a strategic prevention framework and evidence-based population prevention practices.

• *Safe Schools Healthy Students Program:* Addresses the common risk factors associated with substance use and school violence while strengthening factors that promote good mental health. These grants, jointly funded by the Departments of HHS, Education, and Justice, enable local educational agencies to partner with their local mental health, law enforcement, and juvenile justice agencies to support a comprehensive, coordinated plan of activities, programs, and services. Local comprehensive strategies must address five elements, including early childhood social and emotional learning programs. Results from this program indicate a 15 percent decrease in number of students involved in violent incidents (17,800 in Year 1 of grant to 15,163 in Year 3); decreases in number of students experiencing or witnessing violence, and improved overall sense of safety in the school.

• *Community Mental Health Services for Children and their Families Program (Children's Mental Health Initiative):* This treatment program for youth with serious emotional disorders has had an impact in nearly 22 percent of the 3,177 counties in the United States and has served over 88,000 children with disabling mental health conditions. The program is based on a system of care approach which provides individualized, comprehensive and coordinated, community-based wrap-around services to maintain children in their homes and communities and to prevent more costly and restrictive institutional care. Key outcomes from this program include reductions in negative symptoms, improved functioning in school, less involvement with the juvenile justice system, and reduced family stress.

CLOSING

Thank you Mr. Chairman for the opportunity to present this overview about the state of children's health and well-being in the United States. HHS is committed to expanding access to health care and increasing our coordination of child health initiatives with our Federal, State and local partners to devise, test and implement solutions to the challenges and opportunities ahead. I would be glad to answer any questions you may have.

Senator DODD. Thank you very much, Doctor, and I thank all of you for your work, your dedication to these issues, and the efforts you are making today to improve the quality of life for these kids and their families.

Let me begin. Some of you have suggested this already, but it is something that is so important. It can get dizzying, obviously, when we start listening to all the various programs and ideas at the local level, State level, obviously, the national level as well. And the question that comes to mind, obviously, is the ability to coordinate.

I am particularly grateful to the Administration, as chair of the Banking Committee. Jeff Merkley and I serve together on that committee. Bob Casey, in fact, was on that committee with us. And looking at the issue of how do we bring efforts together on the issue of livable communities. To the Administration's great credit, they have now formed an interagency task force with the Department of Energy, the Department of Housing, and the Department of Transportation. So they begin to coordinate efforts in that regard.

It occurs to me, obviously, this is a similar set of cases we are talking about here, the ability to have some sort of an interagency involvement so that there is the debate about whose jurisdiction. I mean, there has been an age-old debate since 1965. Does Head Start belong in the Department of Education or the Department of Health and Human Services? In fact, we had yesterday a conversation. Bob Casey and I spent an hour or so together talking about these issues with Tom Harkin, the chairman of the committee, and we spent about 20 minutes just talking about that very point, about jurisdiction when it comes to these questions.

So it seems to me it is important, without resolving the issues and getting into the internecine battles that can occur over who has jurisdiction over which programs, if you can sort of leapfrog over all of that and end up with that sort of coordinated effort, then the fact that it exists in one Department or another becomes less significant in my view if, in fact, there is a highly coordinated way of dealing with these questions.

And as you point out, Dr. Koh, there is so much of this, that each of these Departments represented here today—and I will include the Council of Economic Advisers as well. The ability to coordinate those efforts and looking holistically at how this child or the children are developing on a social, on a health, on an educational basis—and I wonder if any of you want to pick up on that point and let me know what is going on in terms of our ability to coordinate these activities.

Who would like to start? We will start with you, Mr. Hansell.

Mr. HANSELL. Well, Mr. Chairman, you are raising a very important issue, and it is one I am happy to say I think has been a hallmark of this Administration. I have to say, having served previously in State and local government, I have never seen a level of interdepartmental collaboration as I have seen in the Obama administration. And it is for exactly the reasons you say, which is that while we have multiple siloed programs and funding streams, the goals, the outcomes we want to achieve are common to them, and we have to make sure that they are working together and not at cross purposes.

Actually I can give two examples that relate to the colleagues on my left and my right which I think are wonderful illustrations of this.

Dr. Meléndez and I both talked in our testimony about how we are working very closely between ACF and the Department of Education to create a real birth to 8 continuum of early childhood programs, and we have a number of initiatives underway to do that. The Early Learning Challenge Fund, which we proposed, we think would be important in bringing States to the table to really partner with us on that, but the work is already going on. We very strongly believe and I know that Dr. Meléndez and her colleagues do as well that all of the programs, those we administer, the child care and Head Start programs, as well as the K–12 programs that the Department of Education administers, must have a common set of outcomes, a common framework, a common set of data elements so that we can make sure that as we achieve gains early on for children, those gains are sustained as they move into the educational system and onward into adulthood. So that is one example.

Another has to do with our work with the Department of Labor and the Employment and Training Administration. We have focused very heavily this year on the summer youth employment program which has traditionally been funded through the Workforce Investment Act funding. But many States were challenged this year because their Recovery Act funding for that purpose had been largely exhausted. So we worked with Assistant Secretary Oates in the Employment and Training Administration to issue guidance to States very early this year on how they could use the new TANF emergency funds to bolster their WIA funding to make sure that they could sustain and, in many cases, even expand their summer youth employment programs because, again, that is a key to helping youth get sort of on the right track so that they can develop the kind of workplace skills that they are going to need as they move into adulthood.

And I am delighted to say that States have taken this up with gusto. We now have 21 States and the District of Columbia that are using the TANF funds to supplement their WIA funds to support summer youth programs this summer. Tens of thousands of slots have been created.

So those are, I think, from our perspective very important but only very early examples of the kinds of collaboration that we hope to accomplish. But I think they are illustrative of the work that is going on in this Administration.

Senator DODD. Do either of you, Mr. Harris or Dr. Meléndez, want to comment on that at all? Do you have any other thoughts you might share?

Mr. HARRIS. I can only agree. What we have found in this Administration is that collaboration rises up organically between the Departments. It is not imposed from above. As a result, I think it is much, much more effective.

We could talk also about a collaboration we have with ACF with respect to transitional jobs. We are in cooperation with the Education Department in creating a K through work data quality initiative that will include job training initiatives and postsecondary education. So I think it has worked very well.

There are areas, I think, where we could do more with respect to, for example, data sharing. When we, for example, regulate in the child labor area, we work very closely with the National Insti-

tute of Occupational Safety and Health, but building a larger database and building integrated databases of information on what is going on in child health both in the workplace and outside I think would be a helpful step. But that is something I think that will grow up organically as we continue to address these issues together. So I agree completely with Assistant Secretary Hansell.

Senator DODD. That is very good.

Yes, Dr. Koh.

Dr. KOH. Mr. Chairman, I can cite another example. We have a health promotion target-setting process, Healthy People that I alluded to, and this is a very important year. Healthy People 2010 is concluding this year, and we are about to launch Healthy People 2020, so targets for the country for the next decade. In that target-setting process, we have a Federal interagency work group that reaches across Government and it sets targets for the whole country to shoot for and involves so many partners across the Federal Government and across every community in the country. So that is one proactive way of aligning a lot of resources and mobilizing resources.

Senator DODD. That is good to hear.

My lead-off witness in Connecticut the other day at the Yale Child Study Center was Ed Zigler. I can see the smiles occurring on all the faces. The audience cannot see it, but for those of you not familiar with the name Ed Zigler, he is sort of the high priest of early childhood development issues, the author and the founder of the Head Start program back in 1965 and has written extensively and been engaged now for so many years in the subject matter.

He cites the four touchstones for him in dealing with these issues. Parental involvement, direct health issues, education issues, and child care are the four touchstones he uses.

I would like to pick up on the parental involvement issue. This to me is one of the more perplexing set of issues. When you look at the children in Head Start programs and even at my State level the amount of afterschool programs, obviously, they do not reach everyone. To a large extent, the parents who are aware of the existence of programs, who make an effort, have a substantial lead on others who are not aware or are so stressed out trying to cope every day just to put food on the table, where they live. It makes it harder and harder to engage these families in providing for the needs of their children. They care no less about their children in my view. They still have the same desires that their children get the best they can possibly give them. But it is overwhelming. It is just overwhelming.

It perplexes me to a great deal on almost every level we talk about of how do we engage parents more. It obviously begins there. From the very moment of conception, obviously at child birth, all of these efforts, if you can just engage at the earliest possible stage of a child's development, then the results just dramatically improve proportionately to the extent you are involved early.

I wonder, Dr. Meléndez—because one of the difficulties is how do we get parents involved—Head Start requires that parents be involved. So that is one of the conditions of the Head Start program. We get participation by parents in Head Start. It drops signifi-

cantly by the 1st grade and beyond—parental involvement—generally speaking. I think it goes back to the point, Dr. Rouse, you made earlier. When you have children who come from affluent or relatively secure economic means, those numbers are vastly better in terms of parental involvement, and as the economics worsen, then the parental involvement, engagement declines substantially.

I wonder what thoughts are being given on how we can do a better job of reaching out to parents of children. Any thoughts you might have on this at all I would be interested in. Let me begin with you, Dr. Meléndez.

Ms. MELÉNDEZ DE SANTA ANA. Absolutely. And if I may say just to add a little bit to a conversation earlier, part of the work that we are engaged in with HHS is to really build on that transition between early learning programs and kindergarten. That is a critical transition period. As it plays out when it comes to parental engagement, that is critical.

Having been in the classroom, having been a principal and worked in different levels, you are absolutely right. At the elementary level, you see the parents around. Having worked in middle school, you see less of them. In high school, you see even less.

What we are trying to do in the Department through our use of title I funds in our proposal is to say, look, let us double the amount of money and put in, in terms of our proposal, opportunities for parents, for schools to take responsibility for being welcoming environments for parents, ensuring that parents are welcomed, ensuring that they have a voice in the decisions that are being made.

We are also asking in our proposal for a set-aside of 1 percent so we can find those innovative programs so that States can compete out funds for nonprofits and school districts to identify them. You know, it is very difficult for school districts to think about ways in which they can do that, but there are many examples across the country where that is happening, where there are ways in which parents are brought in. There are training programs. There are ways in which they can be engaged.

And so we look forward to further conversation in which we can work together across our agencies and work together with Congress to be able to identify because that is critical. If a parent is not there, if a parent is not supportive, it is very, very difficult, yet not impossible.

Senator DODD. Home visiting. I think a lot of times too—particularly in poorer families, it is not uncommon that their parents themselves had their own—the school environment was not the most welcoming. Therefore, to engage them to come to a place which was in some cases seen as almost a hostile environment, it makes it even harder.

Ms. MELÉNDEZ DE SANTA ANA. Absolutely, or language, whether they have access to that.

We had a program in which we asked teachers to go out to the homes of the students, and the teachers were absolutely amazed. They had no idea how they lived, the type of environment they had. And it really helped in terms of understanding the types of strategies and ways in which they can interact with the students and their parents.

Senator DODD. Have there been any national programs you are aware of? I mean, you talked about it with Pomona, I gather, as superintendent.

Ms. MELÉNDEZ DE SANTA ANA. Yes.

Senator DODD. But I wonder if there have been any unique examples where a community or a county has been successful in these home visiting programs because I could not agree more. I think if a teacher can see where a child lives and the circumstances in which they live, that is a very different relationship the following morning in terms of looking at that child and how that child learns and what that child is grappling with. I just think the dynamic is fundamentally different as a result of that experience.

But I am wondering if there has been any examples at a State or local level where this has worked particularly well.

Yes, Doctor.

Dr. KOH. Mr. Chairman, you probably know that in the Affordable Care Act there are new resources for HRSA, the Health Resources and Services Administration, to promote home visiting programs. That just got unveiled in the last several weeks. I think it is $1.5 billion over the next 5 years. So these programs are evidence-based. There is a scientific database to show that they are effective and it is targeted particularly for young parents. So we could not agree with you more that the home visiting theme is effective for education but also for health as well.

Senator DODD. Yes, Dr. Rouse.

Ms. ROUSE. If I may, I would just add that certainly while there is an important role for encouraging parental involvement at the earliest stages and at a fundamental level, I think the lack of workplace flexibility for many workers makes it—even for those workers that want to be able to go to the school and meet with the teacher, but are not able to get time off from work—and that is especially true for low-skilled workers who have the least flexibility.

Senator DODD. Well, we have tried. We have authored some legislation over the years to try and provide leave from work for parents. Everyone sort of gets the notion of FMLA now. It took forever, but on family and medical leave where you have an illness. And everyone bought into the illness ultimately. It took 7 years, but they got to the point where they understood that an illness warranted having a parent be able to spend some time with a child. We have had a much more difficult time convincing my colleagues that the ability to be able to make that school visit, to take that hour or 2 is a harder sell.

I have to ask you too, Dr. Meléndez, because I mentioned in my opening comments about my concerns over what happened in the appropriations committee with afterschool programs. The extended day issue I also like. It is very important. You get 7 hours for that. I get 15 hours with the afterschool programs. And the extended day is a very expensive program. What I do not like is the idea of taking money out of afterschool programs to pay for that. There are other means, and afterschool is just very critical.

Again, you talk about adolescents. The statistics and data of the problems that children get into during that period between 2 p.m. and 6 p.m. in the afternoon is stunning.

Can you share with me any thoughts on whether or not the Administration is going to be supportive of at least trying to maintain some static funding, or are we going to start having competition between extended day and afterschool?

Ms. MELÉNDEZ DE SANTA ANA. Well, first of all, I just want to say thank you because as the superintendent, we had an afterschool program funded by the Federal Government, and it was a wonderful program at a middle school and with a nonprofit. So I know how important it is to have programs that support students especially in impoverished areas and the important role that they play.

We are looking at how we can extend the day and give school districts the opportunity to figure out how they can embed afterschool programs and extend the day as a coherent program. That is part of what we are thinking through and would be more than happy to work with you as we move toward reauthorization and have conversations with you about this topic.

Senator DODD. Well, yesterday the Appropriations Committee cut the funding, and now they are going to go to full committee today. To the extent you can weigh in at all between now and this afternoon—you know, this is not down the road. This is now happening as we are talking here. So to the extent someone can weigh in—again, I do not like to see us competing because I think the extended day idea has a great value. Just at the same time, I am looking at what families struggle with. You go back to that working family and the conditions and having good afterschool programs make a huge difference. And they also support. I mean, it is not just a place for child care, but the idea that it becomes an educational place, all sets of skill sets and so forth are developed during that time. So I just raise the issue. I cannot resist raising the issue since you are here.

Ms. MELÉNDEZ DE SANTA ANA. Of course.

Senator DODD. Dr. Rouse, I want to go back, if I can, because these economic statistics are troubling to me. A recent report issued at the end of June by the Congressional Budget Office highlighted the fact that income inequality has tripled in the last 30 years to levels not seen since 1928 in our country. Given your expertise as an economist, what is the impact of this growing income gap on the well-being of children? And what are the roots of the growing inequality? And have there been economic policies which have increased the inequality in the United States in your view?

The Urban Institute—Brookings Institution Tax Policy Center considers only the impact of tax policy changes and have provided data that indicate that the tax cuts enacted in 2001 and 2003 have widened income inequality in the country.

Ben Bernanke, who appeared before me the other day in his capacity as the Chairman of the Federal Reserve Board in coming before us on their annual report to Congress on the Humphrey-Hawkins issue—and Ben Bernanke is a rather unique and fascinating choice that was made by President Bush I do not think in anticipation of what was going to occur shortly after he gets the job. But he wrote his doctoral dissertation, and his real expertise is the depression era and what happened in it.

I asked him the other day to comment, if he would, based on his expertise and his own doctoral studies, about the impacts of long-term unemployment on people. He was very direct. Once you get people back to work, which obviously we all want to see happen, there are implications beyond that that affect that child, affect those families, and there are long-term effects as well.

I wonder if you might just expand on that a bit in your capacity on the Council of Economic Advisers.

Ms. ROUSE. Sure, I am happy to.

In terms of the impacts of increasing inequality, I certainly know of no studies that suggested increasing inequality is helpful to the well-being of children, and especially when it is that the wealthier families are becoming wealthier and the struggling families are even struggling more, it would be inconceivable really that it is going to be helpful to the well-being of children.

The prospects of long-term unemployment are certainly of concern in terms of the impacts on children. One of the most interesting and compelling studies on this is evidence from Canada, but it is evidence that looks at plant closures. And what the researchers found is that children whose fathers had been displaced earned 9 percent lower earnings as adults—so this is the impact on the children for when they are adults—than the children whose fathers had not been displaced. They were 3 percentage points more likely to ever be on public assistance as well. So we certainly do anticipate that there will be long-term impacts on the children from this recession. So I think it is something to be quite concerned about.

Senator DODD. Senator Merkley, you are back with us and thank you.

Senator MERKLEY. Thank you very much, Mr. Chair.

I appreciate the point that you are making, Dr. Rouse, and the loss of manufacturing jobs may well be one of the most profound impacts upon the well-being of our children.

I was very struck when I went into a food bank a few months ago and the director immediately said to me the biggest positive change we have seen is that we used to have a stream of families coming in who had essentially been driven into desperation or poverty by payday loans, 500 percent interest rates, and that reforming those had ended that. They did not see families coming in in that situation. Then she proceeded to say, however, the unfortunate news is the unemployment now is driving a similar stream of folks to the food banks.

One of the things that I wanted to raise specifically, because it is an issue that came up last year and I want to keep raising it, in relation to children's health is tobacco and specifically the tobacco industry's interest in pursuit of new products to drive addiction. Folks are well aware that when people take up tobacco in their 20's, they rarely become addicted to it. So to continue a customer base, if you will, that you need to drive addiction in children.

So there is a series of new products that have come out. This is one that is being test-marketed in Portland and a couple other cities around the country called Orbs. It is in a little package like this, shaped like a cell phone so that when it is in a child's pocket, it will look like a cell phone rather than look like tobacco. It makes it very hard for teachers to know what is there. It has a very fancy

little dispenser that pops out one tablet at a time kind of like a Pez dispenser. So it is a lot of fun. And they come in two flavors which are mint and caramel. To me this represents a huge threat to the future of our children.

There are also two other similar products being tested. One are dissolvable breath strips. You have seen all these dissolvable breath strips that you put on your tongue. Well, these are finely ground tobacco dissolvable breath strips. And the third are toothpicks. So these are experiments in reaching children.

We were able to get in a 2-year accelerated review by the FDA and the FDA controls tobacco of these products. But particularly for those of you who deal in health, I wanted to make a little of a pitch to focus on trying to stop these types of products because they will lead to a new generation of tobacco addiction and tobacco health issues. And I would just see if anyone has any comments about it.

Dr. KOH. Senator, first of all, I want to thank you for your leadership on this issue, and I have seen many announcements of your passion on this issue and your leadership and press coverage of your attention to this emerging public health challenge. So thank you very, very much.

As I alluded to in my comments, with the leadership of Chairman Dodd and yourself and so many others, we are revitalizing our efforts on tobacco control at the Department and across the country. As you aptly point out, as more and more States go smoke-free in this country—about 24 of the 50 States have gone smoke-free in public places—the tobacco industry is creating more and more new, innovative products to put before adults and also young people. You have placed great attention to that, and we want to thank you for that.

We do have a situation around the world where several dozen countries have completely smoke-free nations, and the tobacco industry is aware of that and they are trying to plan for the future. So these new products have hit the market. So with the new authority granted to the FDA and a new commitment to preventing addiction for kids, we need to track these trends very, very carefully.

So thank you for your leadership on that.

Senator MERKLEY. Thank you and thank you for your efforts, and I hope the Administration will continue to pursue this, especially after we get the results of this study from the FDA of these products.

A second thing I wanted to address in the context of childhood obesity is that clearly children's play habits have changed dramatically. Having a 12-year-old and a 14-year-old, I see this firsthand. Video games have replaced everyone throwing their books in the door and running out to the neighborhood afterschool gathering.

In that sense, a troubling thing to me is that a lot of school athletic extracurricular activities that were free—so whether I played basketball or tennis or ran cross country, it was free. There are now activity fees throughout our Nation, maybe not all schools, but certainly my impression is most schools try to make ends meet. That means children in poverty are less likely to participate. Not only are they less likely to participate in the neighborhood activi-

ties because the neighborhood gathering does not occur anymore, but then they are less likely to participate in organized athletic programs at the school because of the school activity fees.

I wonder if any of you have insights on studies that have been done on this or things that we need to do to try to change that dynamic.

Dr. KOH. I can comment again, Senator, if you wish. You are absolutely right that we need greater attention to policies to help promote exercise and prevent obesity in the next generation. This is a tremendous initiative that has been led by the First Lady, as a number of us have noted.

Recently through the Affordable Care Act, the CDC has funded over 40 communities to look at policy changes in communities called Communities Putting Prevention to Work. It is focused on policy change for adults and kids to prevent tobacco addiction and to prevent obesity. So some of those policy changes that you are alluding to are being addressed by some of the communities being funded by this new initiative and we are eagerly awaiting some of those results in future years.

Ms. MELÉNDEZ DE SANTA ANA. Part of our proposal in the Blueprint is to expand the content areas to include physical education as competitive grants where States and local school districts can request grants around physical education in ways that they can ensure that students have programs that will support them, along with music and arts, environmental literacy, different areas like that, financial literacy.

Mr. HANSELL. And I might add, Senator, relating this to your earlier point, obviously we want to start kids out as early as possible with good health habits and not bad health habits. So we, in both our Head Start and our child care programs, are very involved with the First Lady's *Let's Move!* initiative, are working with providers to integrate both good nutrition and physical activity into those programs, and are working with them providing guidance, and providing technical assistance on how they can get the kids started with those kinds of good health habits as early as possible.

Senator MERKLEY. Thank you very much, Mr. Chair.

Senator DODD. Thank you very much, Senator. I appreciate your emphasis on the tobacco issues. This was a great cause of Senator Kennedy, of course, who chaired the committee here for years, and with his illness, prior to his death, I was acting chairman of the committee with the help of Senator Merkley and others. I do not know, Bob, if you were involved with the committee at that juncture or not. But we went through a rather contentious markup of the bill and it passed overwhelmingly on the floor of the Senate. The House, obviously, had passed the legislation earlier.

But the numbers are just breathtaking. I will turn to Senator Casey in a minute. I think we had 3,000 a day—3,500 children under the age of 18 start smoking for the first time every day. So today before the day ends, keep that number in your mind, if you would. Just before today ends, somewhere between 3,000 and 4,000 children will pick up the habit. And we know, of that number, about 1,000—it is a lifetime habit. The good news is that some of them drop it, obviously, with the tremendous efforts being made today.

Of course, the economic model is perfect because we lose about 3,500 to 4,000 people a day in the country as a result of smoking. So the business model is, as Senator Merkley has pointed out, if you do not get those kids starting every day, obviously if you lose 4,000 smokers a day, you would be out of business pretty quickly if you did not attract a new audience and a new constituency.

I am terribly disappointed, by the way, with the industry because a major part of that bill was designed, obviously, to promote stopping the advertising and putting better labels and so forth. The industry has gone out and hired a bunch of first amendment lawyers to be able to kill all of the provisions of that part of the bill. I will just say editorially that I look at the U.S. Supreme Court and who is on it today, and some of the people in the past who represented other industries in the past when it came on first amendment arguments. I do not minimize first amendment arguments, but when you consider the damage being done.

And if you want to talk to someone, talk to a parent who smokes about whether or not they want their children to smoke.

So I appreciate your raising the issue. It is an important one.

Senator Casey.

Senator CASEY. Thank you, Chairman Dodd. And I want to thank our witnesses. Sorry. After your testimony, I had to run and I did not hear the full measure of Senator Dodd's questions and Senator Merkley's, but I got a brief summary. So I do not want to plow the same ground.

But I did want to say first that the substance of your testimony today individually and cumulatively is very helpful because too often what happens in Washington is that you have a lot of bills, even bills that deal with substantial subject matters, that pass and they fade away before anyone knows they passed, and we do not have a chance to really concentrate on what happened. The Recovery Act was a good example of that. It was so substantial in its impact in a very positive way, and yet, we up here have not done a very good job of telling people that.

The same is true, I think, as it relates to children. When you went through, each of your testimonies pointed out the impact of programs and policies and new strategies employed since the early part of 2009 that are having a positive impact.

One of the challenges we have is figuring out better ways to assemble all of these and put them into one narrative, one set of reporting for the American people, because sometimes they hear about this program or that program, and they are not sure that it is working.

So what Senator Dodd has not only talked about, but worked on for years, is making sure that we are not just cataloging programs, we are trying to put them in an organized fashion. That is why having a report annually is so critical because it is not just the American people who do not get enough exposure to some of the achievements or some of the ways programs are actually working and getting results year after year, but even U.S. Senators do not pay enough attention sometimes to how programs are working or not and the results we are getting.

So that is not a question. That is really a concern that I raise—that we have got to figure out better ways to let people know and to let all of us know the success of some of these programs.

It leads me to a broader question which is very much related to what Senator Dodd started with in his questioning. It is not the same issue but it is related. This question about coordination and, frankly, strategy. I think if there is one thing missing now it is that we do not have nationally enough of a strategy. We have a lot of programs that are working. We are getting good results. But we need to have a strategy that we are all clear about.

Then, of course, what is missing too is the political will. One report recently said that we are spending basically a dime out of a dollar on kids, roughly. That is not nearly good enough.

So I wanted to ask you about whether—and this is really for anyone. I know you have a particular line of responsibility within your Department or within your jurisdiction, but how do we get to the point—and I think the Administration has tried with the Early Learning Challenge Fund to coordinate and have a more systemic approach—but how do we get to the point where we have an actual strategy in place which will dictate what we do, and if we do not have a strategy in place, we cannot really make the kind of progress we need to make? Does anybody have any thoughts on that in terms of the strategy?

Mr. HARRIS. Well, I will begin, Senator. I think that your emphasis on outcomes is absolutely critical. For us to spend less time talking about programs and more time talking about how those programs change and improve people's lives in the way we have with some of the bills that Senator Dodd has driven through Congress, I know that has been a focus both for Secretary Sebelius and for Secretary Duncan. It has also been a focus for Secretary Solis at the Labor Department where we are working very hard to not only do a better job of articulating how our programs improve the lives of working people and their children, but also to use the information about how our programs achieve outcomes to improve the programs themselves. So in the focus that you hear from Secretary Duncan in particular, but also in the Labor Department, on innovation where we are data-driven in our decisionmaking, that is a critical part of assembling any strategy. And understanding how each element of what we do in our Department drives to the ultimate goal of improving the lives of working families, improving the lives of children is critical to that.

I think unique, at least in modern history, among presidential administrations, this administration is deeply committed to social science research and to data-driven decisionmaking. So I have a lot of confidence that the building blocks of a national strategy, not just with respect to children, but with respect to working families—one of the themes I think you have heard today from everybody on the panel is how parents are critical to the stable economic support of their families and how their economic condition is going to drive outcomes for their children for decades to come. So I think as we focus on that more and focus on outcomes more, I think we are going to be more successful in building the kind of strategy that you are articulating.

Senator CASEY. Anybody else on this question? Doctor.

Dr. KOH. First of all, Senator, it is good to see you again. I remember about a year ago joining you in rural Pennsylvania for an event on health reform and the Affordable Care Act.

Senator CASEY. That is right.

Dr. KOH. So it is great to see you again.

Because of your hard work in the passage of the act, there are several deliverables on national strategies that I think you will be very proud of.

First, there is a requirement in the act to create a national prevention strategy to be submitted to you and other Members of Congress by next March. A baseline report on prevention was submitted July 1, but the follow-up report on a national prevention strategy is due next March. After this hearing I will go back and reemphasize to my colleagues that there should be a special part of that dedicated to prevention for kids and well-being for kids.

Also, in the Affordable Care Act, there is the directive for a national health care quality strategy. So again in that report, there should be a dedicated part that is focused on health care in kids and quality.

So I think those are two strategies, Senator, that you might want to track as we move forward with implementing the Affordable Care Act.

Senator CASEY. Well, I know in our discussions yesterday, Senator Dodd and Senator Harkin and I were wrestling with, among others, these kinds of questions. That is why having an annual report is I think vitally important.

The good news is—and this is not recent, but I think the intensity or the commitment by CEOs and business leaders I think has been there, you could argue, for a while. I know in Pennsylvania, for example, in the late 1990s a lot more CEOs, including the State's business roundtables, were talking about early education as being a real focus. So I think there is support there, but I think all the more reason why we need some of those folks to support a strategy, just as they do in any kind of business planning or strategic planning.

I was noting that along this line, we got a report yesterday. I want to talk about results and legislation. Dr. Rouse, you mentioned a couple of them today. You have all referred to the Recovery Act. You talked about the HIRE Act and a whole series of bills that were passed, but we just had a report yesterday from Mark Sandy and Dr. Alan Blinder from Princeton projecting and analyzing economic performance. And it said without any Government action, the downturn would have continued in 2011, and they give a report on what happened with the Government action. Real GDP would have fallen 7.4 percent in 2009 and another 3.7 percent in 2010. Now, it is hard to prove a negative. It is hard to prove that things would have been worse when the economic conditions are bad for a lot of people.

The same is true, I think, when it comes to children. We have to figure out more and better ways to let people know about results, and the only way to get the kind of results we need is to have a strategy. So we did not solve that problem today, but I think we are informed about it more than we were.

I know I am over, but Senator Dodd is willing to give us a lot more time today.

Senator DODD. Thanks, Senator, very, very much.

By the way, let me correct myself. Earlier I mentioned the afterschool programs, and my staff very properly reminded me here that, first of all, they increased the funding for the 21st Century Community Learning Centers. But what they did do—and the point I was trying to make—is they are now allowing some of those resources to fund the extended learning time out of that program, which means you are going to add pressure in terms of the afterschools. So by adding a new program without the kind of increases we would all like to see because of the obvious restraints we are going through, you put pressure on the afterschool programs and therefore reduce it.

So I should express my gratitude. They did increase some funding. By the way, they did it for Head Start as well and the child care development block grants as well, close to $1 billion in either case, and in this environment I appreciate very much Senator Harkin's leadership on that as well.

Let me get into the health issues with you too. I know, Dr. Koh, you talked a lot about this. Oral health is such a critical issue. It just amazed me the other day listening to a doctor in Connecticut. We have now 40 dentists that are beginning to work on oral health in our schools. And I was amazed at how 30 to 35 percent of 3-year-olds have tooth decay. I just found that stunning. I do not know. Maybe I should not be as surprised, given the poverty levels, but the idea that a 3-year-old is already suffering from tooth decay seemed to me just a glaring statistic.

The obesity issue we have talked about and I think properly talking about the First Lady's efforts in that regard are tremendous.

I listened this morning to our colleague, Blanche Lincoln, who chairs the Agriculture Committee of the U.S. Senate, and she has proposed legislation now dealing with better nutrition and the standards being set for these various food programs that children depend upon. So many do.

The exercise issue. Senator Murphy talked about the lack of exercise. We have had hearings on this. I have had hearings on the obesity issue. Senator Harkin has been a champion in talking about the quality of food and nutrition and the importance of those issues.

And health has so much to do—we have talked about the parental issues. We talked about the education issues. But the health aspects, a child that does not get that good, healthy start and then maintain that healthy involvement, obviously you can put all of the other efforts and they begin to stumble if you do not get that kind of an effort.

I mentioned this program in Connecticut called Help Me Grow, which has been replicated now throughout the State of Connecticut, in fact, being used in the southern States as well, where we link a variety of health, developmental, and community services together. You have got a one-stop. This is really the great advantage.

I am going to turn to Dr. Koh because I think he is familiar with this.

But I wonder if there are any other similar efforts at the national level or other States that are doing something like that because it seems so essential to me, given the array of services that are out there and how daunting that can be, going to Senator Casey's point, from a parental standpoint. So having a place where you can go and have the access of that information seems so critically important.

So, Dr. Koh, I wonder if you might share some thoughts on that.

Dr. KOH. Sure, I can start, Mr. Chairman. I am sure my colleagues can add.

I think you have hit a very important theme, and as I mentioned in my remarks, what we value about your vision is taking the broadest possible view of health. And that is what you are alluding, I think, in your question. We need to view health broadly, look at not just causes of death in certain populations, but also impact on quality of life, emphasize prevention, try to eliminate disparities, talk about the emotional aspects of health, as well as the physical aspects of health. So I think your question is alluding to much of that.

Senator DODD. In fact, my staff reminded me that in the Affordable Health Care bill—and Bob Casey was involved in this as well, The National Quality Strategy—we fought very, very hard that children be a part of that.

Dr. KOH. Great. That is wonderful.

Senator DODD. So that is now part of that examination. The good news is most children are doing pretty well. So it is not a huge audience, but it is an important one.

So I apologize for interrupting.

Dr. KOH. I can answer also broadly that the Affordable Care Act really tries to build better systems of care and prevention and link prevention to care and build a way to link clinic and community in many of the ways that you have alluded to.

I will give you one example. For the community health centers, which really serve many of the underserved in this country, there has been tremendous investment in those community health centers, investment in a stronger primary care workforce, more investments in prevention, as I have mentioned before. Some of those will focus on oral health. There is language in the Affordable Care Act for greater emphasis on oral health. I think in general building better systems of prevention and treatment, especially in underserved communities, is a big theme from the Affordable Care Act moving forward.

Senator DODD. Does anybody else want to comment on that issue of the—and Healthy People 2010, by the way, I think is a terrific program. In fact, Lamar Alexander and I wrote the Preemie Act in 2006 to combat the increasing rates of preterm and low-birth weight children. That is up for reauthorization next year, and I will not be here, but I am looking at you, Bob, and others who are not here. I got a bucket list I am putting together here of things you are going to have to keep an eye on as we move along.

Senator CASEY. Can we consult you, though, for free?

Senator DODD. For free, absolutely.

But again, the low-birth rate among nonHispanic African-Americans over the past 15 years has remained about twice that of non-

Hispanic Caucasian women. Again, I wonder if you have any thoughts on this. I do not want to get that specific, but can you share with us any thoughts at all at the Federal level on the premature birth rate issue?

Dr. KOH. Well, as I mentioned, the good news was that the rate has dropped this year, but we still have one out of eight children who are born prematurely. So that number is way too high. So, again, we are going to need more attention to a comprehensive approach for moms even before they become pregnant, making sure that they are getting coverage with health insurance, making sure they have good nutrition, making sure they have a health care provider to consult, and then taking good care of that child from the instant he or she is born, and making sure that wellness and prevention is emphasized from literally the first day of life.

Senator DODD. I am jumping around on you quickly because the vote just started, and I am not going to try and have you hang around for a half an hour or an hour until we come back again. So I will rush along and maybe leave the record open for some additional questions we have.

But on the Family and Medical Leave Act, the Department of Labor—and I had a question in here regarding data. There has not been any updated information about how this is working right, if that is correct, in the last few years. When was the last time—2000? Was it that long ago?

Mr. HARRIS. Yes, that is right, Senator.

Senator DODD. So the question then is I wonder if there is any effort being made here to bring us up to date on how this is going.

Mr. HARRIS. Yes.

Senator DODD. I am trying to make a case, and I am not getting very far with it. But, obviously, look, I would have had a paid program if I could have. You have to stagger it a bit for all the obvious reasons we have thought about. But I cannot really get to that point unless I get more data on how we are doing with the present law.

Mr. HARRIS. And that is precisely what we are intending to do. In 2011, we are going to be doing a study on Family and Medical Leave usage.

But I do not want you to give up hope on paid leave. Let me just say you have been a critical leader on this, and when you talked about learning lessons from the States' experience, you know that before there was a Family and Medical Leave Act, a number of States had State family and medical leave acts that gave us the evidence that showed that not only would it work effectively for families, but it would be very low-cost for employers. The study we did in 2000 ratified that, and my expectation is that the study that we are going to do in 2011 will show that it is a tremendous benefit to families at a fairly low cost to employers.

But we are now seeing States or we have seen States over the last decade developing State-paid leave policies of varying sorts, temporary disability policies. In California, paid leave policies.

So the President in his fiscal 2011 budget proposed a $50 million fund to incentivize States or to pay for States' administrative costs in the creation of paid leave programs in those States. Earlier this week, the subcommittee on appropriations, the Labor Appropria-

tions Subcommittee, included $10 million of those $50 million to get us started in incentivizing States to create State-paid leave programs.

So we agree with you that that is the right direction to go in right now, that there are too many particularly low-wage workers who are unable to take the family and medical leave that they need because they simply cannot afford to go without a paycheck. We think the way to do that is to allow States to innovate in this space and for us to provide them with incentives to do that.

Senator DODD. Let me jump to another issue that I am interested in. While conducting these hearings, we learned a great deal about both State and local groups, and the Federal Government obviously measures. We talked about having this annual report. The National Longitudinal Surveys of Youth run by the Department of Labor Statistics is critical, obviously, for many of us up here. The most recent survey follows a group of children through adulthood to examine critical childhood well-being. The Bureau of Labor Statistics has not started collecting data on a new group of children since 1997. I wonder if you could share with us whether or not you intend to start surveying a new group of children. If so, when? And how would this type of data aid the Department in your view in understanding the efficacy of these programs?

Mr. HARRIS. We do not yet have funding to create a new cohort for the National Longitudinal Survey, and that is part of the discussion for—we are just beginning our discussions about the fiscal 2012 budget, and it is part of that discussion. There will, however, be a new data release on the NLS cohort from 1997 that will come out in June 2011 that will provide us with more information about adolescents, young adults, and slightly older adults that are in that 1997 cohort. So we will have some more information, but we are taking a look at whether or not we can propose a budget that will fund an additional cohort.

Senator DODD. Terrific.

Bob, do you have any additional quick questions? They will hold the vote for us.

[Laughter.]

Senator CASEY. Nice to have a senior member who can hold votes.

I had a couple more. One was one of the ways I try to think about these issues in a broad way—and those who know a lot more would frame this a little differently, but if we do four things well, I think we are getting close to a strategy. One is children's health insurance. Two is early learning. Three is nutrition and anti-hunger strategies, and fourth is just basic safety.

I was reading—and this is in my prepared statement, but the college completion agenda—a recent report came out about 25- to 34-year-olds who have an associates degree or higher. We are not doing so well across the world. But the first recommendation they made to improve the number of 25- to 34-year-olds who have an associates degree or higher—recommendation No. 1 was to make preschool education available to all. So we are finally linking what happens down the road to what happens in the dawn of a child's life.

We have talked a good bit today about children's health, about early education, and Senator Dodd covered a lot of those topics, as well as the nutrition, which is part of what Chairman Lincoln is doing on our committee on the Child Nutrition Act, and we hope to get that done soon.

But let me go to that fourth matter, which a number of you have touched on, which is just the protection element, abuse and all of the horrific stories we hear on a regular basis about children being abused or neglected. Anything that anyone wants to say about that issue, and then I think we have to go.

Mr. HANSELL. Well, that is one of our responsibilities, one we take very seriously, and we work with and fund States to implement programs to reduce child abuse and maltreatment. I guess what I would say in terms of the directions in which we are moving—a couple of comments. Through the formula funding we distribute to States under the CAPTA program, what we are trying to do is to work with States to move in the direction of using those funds—again, it is consistent with some of the things we have talked about this morning—to support evidence-based and evidence-informed interventions. The things that we have documented, is evidence that will really make a difference in ideally, of course, preventing child abuse and maltreatment, by addressing the issues otherwise. And so that is what we are trying to focus States on with their core funding.

But we also have added a discretionary component to the CAPTA program through which we are using $10 million to expand the evidence base, essentially to expand the compendium of interventions that we know will make a difference in preventing child abuse, child neglect, and child maltreatment. As we do that, we can then encourage States to draw from that evidence base in using the base resources, Federal and State, that they have to address these very, very important issues.

Senator CASEY. Thanks. We will submit some more questions for the record, but I do want to thank Chairman Dodd for this opportunity. Thank you.

Senator DODD. Well, thank you.

That is obviously up for reauthorization. We are trying to get that done now in the next few weeks before we adjourn. I appreciate that as well.

I would be remiss if I did not point out, by the way, that you always take great pride in your sort of official family, and Lloyd Horowitz who is sitting right behind you, Dr. Meléndez, used to sit back up here behind me in this committee. It is a pleasure to see you, Lloyd, and thank you for all your service when you were on this side of the dais and now working on that side of the table. So I would be remiss if I did not thank you personally for the tremendous efforts you have made and what a great advocate in the educational field you have been. So thank you very, very much for that.

To all of you, I thank you. I wish we could spend all day with you on these matters. You are so knowledgeable and thoughtful about all of this. We are very blessed to have quality people who care so deeply and bring a wealth of experience to these debates and discussions.

It is a subject matter that historically some of my strongest—when I wrote the first child care development block grant program back in the early 1980s, my cosponsor was Orrin Hatch of Utah. When we did Family and Medical Leave, it was Kit Bond and Dan Coates of Indiana. Senator Alexander and I have done a lot of work on these issues of premature birth and infant screening. A former opponent of Bob Casey, Rick Santorum, and I worked on autism together. He had issues in Pennsylvania.

On these issues we were able to build bipartisan support. I really worry in a way that we are losing that. It worries me. These were not issues that should divide people. We are talking about children in the country and how we do a better job and give them a decent start in life. My hope is again, as I get ready to leave town, that they get back to that spirit again when it comes to these issues. There are a lot of other reasons in which you can have ideological debates. This ought not to be a set of them. We are all aiming for exactly the same thing. We know how difficult it is for parents, for communities today to meet these challenges. We work on the assumption that every parent—every parent—wants to do the very best they can for their child. If you begin with that notion that we ought to be doing everything we can to make that a reality, as close to a reality as possible.

So I am very grateful to all of you for years and years of your involvement in these issues and your knowledge and expertise. It would be tremendously helpful. So we look forward to your continuing work with us up here on this side and with people like Bob Casey who will be carrying on the challenges here and doing a great job at it as well.

So the committee will stand adjourned and I thank you.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR COBURN

Mr. Chairman, I appreciate the subcommittee engaging in a timely discussion on the state of the American child and the impact of Federal policies on children. It is critical that we understand how the decisions we make here in Congress impact the futures of our children and grandchildren.

Regrettably, the outlook of the American child is bleak.

The current state of the American child is a $13.2 trillion national debt that is a direct result of Federal policies. The state of the American child is generational theft perpetrated by the hands of a Federal Government devoid of fiscal discipline. It is a theft carried out by members of both political parties.

The witnesses testifying before the subcommittee offered compelling information and statistics concerning the challenges facing today's youth, but none of the formal testimony raised concerns about the impact that our national debt will have on our Nation's youth. Quite to the contrary, testimony submitted to the subcommittee largely advocated for more and bigger government programs which, of course, require yet more Federal spending.

This is not to discount the real challenges pointed out by those who took the time to testify before the subcommittee, but it is a gross oversight that must be addressed.

A few months ago I met a 3-year-old girl from Maryland named Madeline. I first came to know this precious little girl through a photograph. She was dressed head-to-toe in pink, had a little blond ponytail, a pacifier in her mouth and a sign weighing heavily around her neck that read: "*I'm already $38,000 in debt and I only own a dollhouse*."

When Madeline was photographed, she was already $38,000 in debt. Nearly 7 months later, the national debt is now over $42,000 per man, woman and child in this country.

If one were to extrapolate that rate of increase—from $38,000 to $42,000—to cover every 6-month period for the next 20 years, it becomes clear that the future of today's youth is one saddled by debt. If you include unfunded liabilities—Madeline will owe $1,113,000 when she turns 24.

If you had a 6-percent interest rate on $1,113,000, Madeline is going to have to pay $66,000 a year in interest on the debt. She will pay that before she pays any taxes to run the government, defend the country, and pay for Medicare for my generation. These costs will impact her ability to continue her education, to own a home and to start and provide for her own family.

We should not be proud of Federal policies that steal from our children. There is no more important question before the country today than whether or not we will continue stealing opportunity and freedom from the next generation.

Sadly, Congress has repeatedly demonstrated that it is unwilling to prioritize spending. On multiple occasions this year the U.S. Senate rejected amendments to cut spending. Instead of trimming the fat for the benefit of future generations, Congress chose to raise the debt ceiling by $1.9 trillion to $14.3 trillion. Instead of working to pay for programs by eliminating fractions of the hundreds of bil-

lions this country loses to waste, fraud and abuse in the government, Congress chose to instead violate PAYGO rules and add $266 billion to the deficit this year alone.

These choices have consequences on America's children.

What has made this country great has been the heritage of sacrifice demonstrated by the generations that have come before us. We are now denying that heritage, but it is not too late to reverse course. Congress must reverse course and rein in spending. We must restore a bright and hopeful future for all of the Madeline's of this country.

PREPARED STATEMENT OF KELLYANN DAY, MSW, EXECUTIVE DIRECTOR, NEW HAVEN HOME RECOVERY, INC.

Good morning Senator Dodd and distinguished guests it's an honor to be here. Thank you for inviting me to speak and thank you for great work on family and children's issues.

Contrary to the stereotype of men sleeping in doorways or pushing overloaded shopping carts stuffed with their worldly belongings, families now comprise 40 percent of the homeless population in the United States. The percentage is closer to 50 percent in the State of Connecticut.

Just 30 years ago, child and family homelessness did not exist as it does today. The numbers of homeless families in the United States are increasing at a rapid rate. According to the National Alliance to End Homelessness' Web site, "Approximately 3.5 million individuals experience homelessness each year—about 600,000 families and 1.5 million children. An additional 3.8 million adults and children are residing in doubled-up, overcrowded, or otherwise precarious housing situations."

Connecticut faces a significant and growing challenge of family homelessness, with a steadily increasing number of homeless families with children. We saw a 13 percent increase in homeless families from 2007 vs. 2008 and a 33 percent increase between 2008 and 2009!

Available shelter and housing for homeless families is decreasing. There is a rising demand for shelter and housing at a time when State and local government are unable to support the operations of shelters and are cutting budgets. The development of affordable and supportive housing has slowed significantly. Public housing authority lists are long and rarely open for new names.

In 2007, the nationwide average shelter stay for a homeless family was 5 months. With the economy worsening in 2008 and 2009, the length of stay has been increasing. At NHHR we have seen a 17 percent increase in the number of days a family is living at the shelter.

In a nationwide survey, 87 percent of homeless families cited a lack of affordable housing as the primary cause of their homelessness. Although most homeless families are headed by a single parent, families in 36 of the 50 States must work at least two full-time jobs in order to afford Fair Market Rent for a two-bedroom unit.

- Overcoming homelessness is almost impossible without steady employment.
- Over two-thirds of homeless parents are unemployed.
- 53 percent of homeless mothers do not have a high school diploma.

In 17 of 50 States, households must earn over $16/hour to afford the Fair Market Rent for a two-bedroom unit. According to the National Center on Family Homelessness' Stat Report Card, the minimum wage in Connecticut is $8.25. The average wage for renters is $16.53, but the hourly wage needed to afford a two-bedroom apartment is $21.11. That means someone working full-time at minimum wage earns only 39 percent of what is needed to afford the average two-bedroom apartment.

Homeless children have less of a chance of succeeding in school. This year 35 percent of the 130 children sheltered in NHHR shelters were between 6 and 12 years old and attending school.

- Homeless children are more likely than housed children to be held back a grade.
- Homeless children have higher rates of school mobility and grade retention than low-income housed children.
- Frequent school transfers are the most significant barrier to the academic success of homeless students.

Homeless families are more vulnerable to serious health issues. While homeless, children experience high rates of acute and chronic health problems. The constant

barrage of stressful and traumatic experiences also has profound effects on their development and ability to learn.

Children experiencing homelessness are:

- Four times more likely to show delayed development.
- Twice as likely to have learning disabilities as non-homeless children.
- Sick four times more often than other children.
- Have four times as many respiratory infections.
- Have twice as many ear infections.
- Five times more gastrointestinal problems.
- Four times more likely to have asthma.
- Go hungry at twice the rate of other children.
- Have high rates of obesity due to nutritional deficiencies.
- Have three times the rate of emotional and behavioral problems compared to non-homeless children.

Violence plays a major role in the lives of homeless children.

- By age 12, 83 percent had been exposed to at least one serious violent event.
- Almost 25 percent have witnessed acts of violence within their families.
- Homeless parents and their children are more likely to have experienced violence.
- Domestic violence is the second most frequently stated cause of homelessness for families.
- One out of three homeless teens have witnessed a stabbing, shooting, rape, or murder in their communities.

Among youth aging out of foster care, those who subsequently experience homelessness are more likely to be uninsured and have worse health care access than those who maintain housing.

Over 50 percent of all homeless mothers have a lifelong mental health problem.

Homeless adults in family shelters, when compared to the general adult population, have three times the rate of tuberculosis and eight times more HIV diagnoses.

Homeless parents and their children are more likely to be separated from each other.

Homelessness is the most important predictor of the separation of mothers from their children.

- 34 percent of school-aged homeless children have lived apart from their families.
- 37 percent of children involved with child welfare services have mothers who have been homeless at least once.
- 62 percent of children placed in foster care come from formerly homeless families.

The deck is clearly stacked against homeless and the unstably housed. How do we focus on education when we don't have a stable place to sleep? Forty-five percent of the homeless children sheltered at NHHR shelters were under 6 years old. We have new born babies at the shelter, often!

Of the 15 programs that NHHR operates I'd like to highlight two.

The first is the Family School Connection (FSC) program, funded by the Connecticut Children's Trust Fund. It operates out of the Fair Haven K–8 School, which has the highest number of homeless families in the city. FSC is an intensive home visiting program that provides parent education and student advocacy. Children who are "at risk" of neglect because of excessive tardiness or truancy and/or academic or behavior challenges **are referred to the program**.

Young children who are frequently tardy, absent, and disconnected from school are likely to be living in circumstances where family issues are interfering with their participation and opportunity to learn and achieve.

Outcomes:

- Significant drop in DCF referrals by the School (comparable to last year).
- an increase in parental involvement.
- 15 percent increase in grades for students enrolled in the program.

On a cold morning in March, during the CMT's the FSC staff received a call from the school requesting assistance. When staff arrived, they found that a 3d grade boy was selling his Christmas toys to classmates to help his Dad pay for rent and food. A back pack full of food, a Stop and Shop gift card, toiletry items and warm clothing were provided to the child to bring home that day. Subsequently the family was informed about the program and enrolled. As of today, Dad is employed, engaged with the school and accessing community resources. The child is excelling socially and

academically. This is a highly successful program and we have many families on the wait list.

The Family School Connection program conducts universal screening of all its families. The program is prevention-based, and therefore, screens clients to make sure the State Department of Children and Families (DCF) is not involved with the family. The program also screens children for social and emotional development and refers those at risk for help.

The vision of Family School Connection is that every child will be raised within a nurturing environment that will ensure positive growth and development.

The mission of the Family School Connection (FSC) program is to work in partnership with parents of children ages 5 to 12 years old who are frequently tardy, absent or disconnected from school in order to strengthen the parent-child relationship, home-school relationship and the parent's role in their child's schooling.

GUIDING PRINCIPLES

- Young children who are frequently tardy, absent, and disconnected from school are likely to be living in circumstances where family issues are interfering with the child's participation and opportunity to learn and achieve.
- Developing a trusting and productive relationship between the program staff and the family is the foundation for strengthening a vulnerable family.
- Consistent and reliable contacts are the most effective way of establishing a supportive and helpful relationship between the program staff and the family.

The goals of the Family School Connection program are to:

- Enhance nurturing parenting practices.
- Reduce stress related to parenting.
- Increase parental involvement in the child's education.

The program works to achieve these goals by meeting the following objectives:

- Increase primary caregiver's parenting skills, attitudes, and behavior.
- Increase primary caregiver's ability to use community resources.
- Increase communication between primary caregivers and school personnel.
- Increase primary caregiver's involvement in the child's education and presence in the school.

A growing body of intervention evaluations demonstrates that family involvement can be strengthened with positive results for children and their school success. To achieve these results, it is necessary to match the child's developmental needs, the parent's attitudes and practices, and the school's expectations and support of family involvement. Three family involvement processes for creating this match emerge from the evidence base:

- ***Parenting*** consists of the attitudes, values, and practices of parents in raising young children.
- ***Home-School Relationships*** are the formal and informal connections between the family and educational setting.
- ***Responsibility for Learning Outcomes*** is the aspect of parenting that places emphasis on activities in the home and community that promote learning skills in the young child.

The Family School Connection Program encompasses these processes in the design and structure of the program through three components aimed at reducing the risk of child abuse and neglect and increasing positive results for children and their school success:

HOME VISITATION

Home visiting based on the concept of "family-centered" practice is the foundation of the Family School Connection program. This practice is designed to engage families as partners and is essential to the success of the program. Research has found that parents enrolled in the home visiting component experienced less stress, developed healthier interactions with their children, and became more involved in their children's academic lives during the time they participated. The program results also suggest that this home visiting is a promising way to decrease child abuse and neglect in families with school-aged children.

Program participants are offered weekly home visits for as long as the family feels the visits are beneficial or until the child ages out of the program. At any time the frequency of the visits can be changed based on the family's needs and preferences. The first objective of the home visitor is to establish a relationship with the family. Often this is accomplished by addressing immediate and concrete needs identified by the family such as employment, child care, transportation, basic necessities, and

other issues that might be making it difficult for the parent to attend to the child's need to be in school.

The second objective is to establish a plan for assisting the family. The home visitor works with the family to create and implement a Family Action Plan that draws on the family's strengths, community resources, and the skills of the home visitor to:

- strengthen parent-child relationships;
- create linkages for the family to community resources;
- support the parent in meeting their family's basic needs;
- support the parent in attaining their own aspirations and needs; and
- support the overall social-emotional needs of the parent and child.

The clinical supervisor works with the home visitor to assess the family's needs and support the home visitor and parent in the creation and implementation of the family action plan. The clinical supervisor can also provide clinical intervention for the family if the need arises.

HOME-SCHOOL TEAM

The program supports families by helping both the parent and child make a positive connection with the child's school. Program staff help the family connect with a host of school and community services. Program staff also work with school personnel to help the school better understand and support the needs of the family. Parent school involvement is an essential piece of the program and is encouraged by program staff at every opportunity.

FAMILY LEARNING

Traditionally, school officials have found it challenging to get parents involved, especially in areas that have a large non-English speaking, immigrant population. This has been due, in large part, to language and cultural barriers experienced by non-English speaking parents. In order to accommodate this population, parent engagement strategies are modeled after those used by Brein McMahon High School in Norwalk, CT, where there is also a large immigrant population. Communication is also crucial to getting parents involved. Parents may not get involved because they lack direct and helpful information. Information needs to be provided consistently and in different formats to ensure the information is delivered in a clear and supportive style. Resources should be provided to parents who want to learn more about their children's education and activities. The FSC staff aid school staff trying to increase involvement by implementing these strategies.

Program staff work with families help them understand and take responsibility for their children's learning outcomes. This is the aspect of parenting that places emphasis on activities in the home and community that promote learning skills for children. Responsibility for learning outcomes in the elementary school years falls into four main areas: supporting literacy, helping with homework, managing children's education, and maintaining high expectations.

Program staff work in partnership with the school, community organizations, and arts and cultural institutions to engage families in family learning opportunities. Family learning opportunities can range scope and service but are all intended to extend to help the parent understand and under-take their role as the child's first and most important teacher. The home visitor works with the family to enroll them in family literacy programs, before and afterschool programs, tutoring services or parent workshops on topics that support and extend a child's learning to the home and community.

Highlights this year:

- 316 books were read between Oct 2009 to May 2010 by FSC enrolled students.
- The FSC program was able to purchase school uniforms for children within the FSC program. FSC has become an active investor of Fair Haven School's "uniform is unity" policy.
- FSC families participated in New Haven Home Recovery's holiday program, Adopt a Family, where 32 FSC families were adopted and given Christmas gifts this holiday season.
- The FSC program co-sponsors the RIF program with The Fairhaven School to promote reading as well as connect families with the school. FSC staff and families participate in this school-wide presentation.
- The FSC program participated in the Fair Haven School Advisory Program (Grades 7–8). The advisory program is an arrangement whereby one adult and a small group of students have an opportunity to interact on a scheduled basis in order to provide a caring environment for guidance and support, everyday adminis-

trative details, recognition and activities to promote citizenship. The purposes of advisory are to ensure that each student is known well at school by at least one adult who is that student's advocate (the advisor), to guarantee that every student belongs to a peer group, to help every student find ways to be successful, and promote coordination between home and school.

• The FSC program had six target children graduate from the Fairhaven K–8 and all are registered to attend high school in the fall. In addition, as result of FSC involvement, parents reported school successes with their children.

• All FSC families participated in the Homework Contract campaign. This assists families with becoming involved in their children's academics and build on parent-child school relationships.

• During the fiscal year ending, June 30, 2009, FSC families participated in a series of family field trips with transportation and admission sponsored by NHHR. The field trips include: Duckpin bowling, Movie night Lake Compounce, Roller Magic Rink, Beauty and the Beast at the Chevrolet Theatre, Lighthouse Park, Norwalk Aquarium and Beardsley Zoo.

FSC annual data:

• 107 Families have been referred.
• 53 Families were enrolled.
• 85 Children participated.
• 211 People total.

The Second Program is the The Homeless Prevention and Rapid Re-housing program, funded through the American Recovery and Reinvestment Act provides funding and services to families and individuals. NHHR serves families who are at imminent risk of homelessness, or who are literally homeless. Examples of assistance that may be provided include:

Financial Assistance

• Rental assistance, including back rent.
• Security and utility deposits.
• Assistance with utility payments, including utility arrearages.
• Moving cost assistance (not furnishings).

General Assistance

• Referrals to other agencies/shelters when appropriate.
• Legal services to assist appropriate person's to stay in their housing (not assistance with mortgages)

Populations to be Served

Programs will target people who would be homeless "*but for this assistance.*"

• *Rapid Re-Housing:*

Includes people who are literally homeless (ex: living in a shelter, a motel, a car, etc.) who require more permanent housing.

• *Prevention with Re-location:*

Includes people who are at imminent risk of becoming homeless (ex: notice to quit, in the process of an eviction, institutional discharge, housing has been condemned, etc.), who are unable to repair their current housing situation and will need to relocate.

• *Prevention In Place:*

This includes people who are at risk of becoming homeless (ex: behind on rent, temporary loss of income, etc.), but who intend to stay in their current housing situation.

The following is the program breakdown of those served through HPRP:

HPRP

	Households	Total in Household
Admitted	15	56
Discharged	40	41
In progress	183	569
Total	238	766
Denied	138	438

For example, Jack and Diane were evicted from their home of 5 years. Jack is a self-employed contractor. Diane is a stay at home mother of 6 children. Upon eviction, the family moved into a local homeless shelter, but one of their children's asthma became so severe they were forced to move to a motel. After two apartments fell through, the family finally found a house to rent. Unfortunately the timing was off and they had reached their limit on the credit card at the motel and were being put out on the street. Their only choice was to sleep in their car. HPRP prevented this from happening by providing funding for the motel and ultimately relocating them into a home.

Mike and Gina were being evicted on the day they came to NHHR for help. Gina is pregnant and was recently laid off from her job. The couple has 3 young boys and Gina's elderly, disabled mother living with them. Dad was working and Gina had found an apartment to rent but they did not have the security deposit. The Connecticut Department of Social Services has closed the security deposit guarantee program. NHHR's HPRP program was able to pay the security deposit and part of the first month's rent in order to avoid this family moving into a shelter.

Lastly, Juan and Julia, both college graduates, moved to NH from Puerto Rico in order to seek medication care for their son. Their 1-year-old was ill and had recently undergone open heart surgery at Yale New Haven Hospital. In addition the boy was recovering from liver disease and other infections. The family was living in the Ronald McDonald House during the baby's hospitalization, but had no place to live upon discharge. A stay at a shelter, would have comprised the boy's fragile health. They considered going back to Puerto Rico, but funding was limited and they needed to remain close to necessary medical care. HPRP was able to assist them in finding housing, paying for security deposit and rental assistance. The family is stably housed and Juan and Julia are currently looking for work.

These two programs are examples of excellent programs that need to and should continue.

Please feel free to contact me with any questions or concerns regarding this testimony.

Prepared Statement of Beth Mattingly, Director, Research on Vulnerable Families, The Carsey Institute

Subcommittee Chairman Senator Dodd, Ranking Member Senator Alexander, and all the subcommittee members, thank you for the opportunity to submit testimony on The State of the American Child: The Impact of Federal Policies on Children.

My name is Beth Mattingly and I am the director of research on vulnerable families at the Carsey Institute at the University of New Hampshire. The Carsey Institute examines child poverty, how different family policies influence rural, suburban, and urban families and how families adjust their labor force behavior during times of economic strain.

The Carsey Institute at the University of New Hampshire has conducted extensive policy-relevant research on the differences between rural, suburban, and central city families and children in order to better understand trends in child poverty and the implications of different policies. This document summarizes the findings of the Carsey Institute and some of the Federal policy recommendations that have emerged from this research.

Research shows that poverty has negative impacts on the life outcomes of children through decreased access to quality health care, nutrition, child care, education, and other opportunities.[1] Exposure to poverty in America is not uniform, but rather varies by region, State, and place type. Our research consistently shows that rural places have poverty rates that are about as high as those found in central cities, yet many continue to view poverty as primarily an inner city problem.[2]

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[1] See Bradley, Robert H., Case, Anne, Angela Fertig, and Christina Paxson. 2005. "The lasting impact of childhood health and circumstance." *Journal of Health Economics* 24:365–89, who examined the impact of prenatal conditions and child health at age 7 on various outcomes; Corwyn, Robert F., McAdoo, H. P., & García Coll, C. G. (2001). The home environments of children in the United States part I: Variations by age, ethnicity, and poverty status. *Child Development*, 72, 1844–86; Brooks-Gunn, Jeanne. and Greg. J. Duncan. 1997. "The effects of poverty on children." *The Future Of Children/Center For The Future Of Children, The David And Lucile Packard Foundation* 7:55–71; Korenman, Sanders, Jane E. Miller, and John E. Sjaastad. 1995. "Long-term poverty and child development in the United States: Results from the NLSY." *Children and Youth Services Review* 17:127–55; McLoyd, Vonnie. C. (1998). Socioeconomic disadvantages and child development. *American Psychologist*, 53, 185–204.

[2] See Weber, Bruce, Leif Jensen, Kathleen Miller, Jane Mosley and Monica Fisher. 2005. "A critical Review of Rural Poverty Literature: Is There Truly a Rural Effect?" *International Regional Science Review* 28:381; O'Hare, William P. 2009. "The Forgotten Fifth: Child Poverty in Rural America." The Carsey Institute, Durham, NH.

Recent estimates from the Carsey Institute suggest that more than one in five American children under age of 6 lived in poverty in 2008.[3] According to data from the American Community Survey (ACS), this rate is significantly higher in the rural South, where approximately one-third of children live in poverty.[4] In no region across the United States did child poverty significantly decline from 2007 to 2008, and in some places, including the Midwest, the rates increased.[5] Some factors that increase the risk for poverty are:

• *Education, Wages and Work Hours.* Both parental employment status and parental education influence children's risk of being poor. Non-metropolitan mothers of children under the age of 6 maintain higher rates of employment than their urban counterparts (69 percent and 63 percent, respectively).[6] Yet, despite these higher rates of work, rural mothers earn lower wages, have lower overall family incomes, and experience poverty rates nearly 4 percent higher than their urban counterparts (24 percent vs. 20 percent, respectively).[7] Also, while non-metropolitan mothers appear to have higher rates of employment than urban mothers, on the whole, individuals living in non-metropolitan areas are more likely to be working part-time than those in metropolitan areas (21 percent vs. 18 percent respectively).[8]

• *Fragile Family Structures.* Data show that American family structures have been shifting since the 1990s, particularly in rural America.[9] By 2008, only 68 percent of rural children were living in married couple families, down from the 1990 estimate of 73 percent.[10] This shift has major implications for child poverty, as only 9 percent of married couple families are in poverty, compared with 21 percent of single father homes, and 43 percent of single mother homes.[11] Family structure is part of the story behind extremely high child poverty rates in the rural South: there are high rates of divorce, out-of-wedlock childbirth, and female-headed households,[12] all of which are associated with higher risks of poverty.[13]

• *Racial Composition.* Rural, non-white children lived in low-income families at nearly twice the rate of white children, and nearly 2.5 times the rate of white children in central cities.[14]

CHALLENGES FOR RURAL POVERTY AND FEDERAL POLICY IMPLICATIONS

Tax Credits and Income Needed for Basic Needs

Poverty may be reduced by allowing families better and continued access to tax credits, including the Earned Income Tax Credit (EITC) and the 2009 Recovery Act's Child Tax Credit. The Child Tax Credit in particular is threatened by an approaching expiration date, a change that would have a detrimental effect on working rural families, with the loss of income affecting up to 3.3 million low-income rural children.[15] Similarly important, the EITC is disproportionately accessed by rural families, representing 16 percent of tax filers, but 20 percent of EITC claimants, translating into an average credit of $1,850 per family.[16] These direct infusions of money into rural families can improve child outcomes by allowing parents to afford better quality food, child care, and educational materials.

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[3] Mattingly, Marybeth J. 2009. "Regional Young Child Poverty in 2008: Rural Midwest Sees Increased Poverty, While Urban Northeast Rates Decrease." The Carsey Institute, Durham, NH.
[4] Ibid.
[5] Ibid.
[6] Smith, Kristin. 2007. "Employment Rates Higher Among Rural Mothers Than Urban Mothers." Carsey Institute, Durham, NH.
[7] Ibid.
[8] Shattuck, Anne. 2009. "Rural Workers Would Benefit from Unemployment Insurance Modernization." Carsey Institute, Durham, NH.
[9] O'Hare, William and Allison Churilla. 2008. "Rural Children Now Less Likely to Live in Married-Couple Families." Carsey Institute, Durham, NH.
[10] Ibid.
[11] Ibid.
[12] Mattingly, Marybeth J. and Catherine Turcotte-Seabury. 2010. "Understanding Very High Rates of Young Child Poverty in the South." The Carsey Institute, Durham, NH.
[13] O'Hare, William, Wendy Manning, Meredith Porter, and Heidi Lyons. 2009. "Rural Children Are More Likely to Live in Cohabiting-Couple Households." Carsey Institute, Durham, NH.
[14] Churilla, Allison. 2008. "Urban and Rural Children Experience Similar Rates of Low-Income and Poverty." Carsey Institute, Durham, NH.
[15] Sherman, Arloc and Marybeth J. Mattingly. 2010. "Over 3 Million Low-Income Children in Rural Areas Face Cut in Child Tax Credit if Recovery Act Improvement Expires." Carsey Institute and Center on Budget and Policy Priorities, Durham, NH/Washington, DC.
[16] O'Hare, William and Elizabeth Kneebone. 2007. "EITC is Vital for Working-Poor Families in Rural America." Carsey Institute, Durham, NH.

Research also suggests that the poverty threshold does not adequately reflect the incomes needed to provide for families' basic needs,[17] [18] and that a revision of the threshold would expand the eligibility guidelines for participation in assistance programs, such as supplemental nutrition plans,[19] tax credits, health insurance, and child care subsidies.[20]

Limited Access to Childcare

Higher employment rates among rural mothers means an increased demand for quality child care for the working day hours. Despite demand, however, rural mothers have fewer quality care providers available than their urban counterparts,[21] and more obstacles to accessing it, such as a lack of transportation. Though urban families pay more for child care,[22] perhaps due to the higher quality of available care, in the poorest families across regions, a staggering percentage of yearly income is spent on child care.[23] Families below the poverty line dedicate 32 percent of their monthly income to child care, nearly twice what those just above the poverty line pay, and nearly five times the percentage that families 200 percent above the poverty line pay.[24] As such, rural families tend to turn to informal non-relative care (e.g., a babysitter) at higher rates than their non-rural counterparts (25 percent usage versus 20 percent usage, respectively),[25] which may be of poorer quality, and may result in decreased child development.[26] Far more families are in need of child care assistance than receive it, so additional funding for assistance through the Child Care Development Block Grant would be beneficial.[27]

Poor Educational Outcomes

Research suggests that rural children may have greater difficulty in the school system than urban students, beginning with things like letter and sound recognition in kindergarten.[28] This disadvantage may be rooted in the poorer quality of rural children's pre-school childcare, as discussed above. Older rural students have fewer upper-level mathematics courses available to them, as compared to urban students (one to three classes versus seven classes available, respectively).[29] This limited availability translates into lower scores on standardized exams among rural students, which can limit students' capability and interest in related (and profitable) college majors and careers.[30] In addition, experiencing poverty as a child, as many rural students do, is correlated with completing fewer years of school altogether than a student who hadn't experienced childhood poverty.[31] [32]

Increased Food Insecurity

While food security is defined as regular, dependable access to enough quality food to sustain a healthy lifestyle,[33] food insecurity means that "access to adequate food

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[17] Churilla, Allison. 2008. "Urban and Rural Children Experience Similar Rates of Low-Income and Poverty." Carsey Institute, Durham, NH.

[18] Mattingly, Marybeth J. and Catherine Turcotte-Seabury. 2010. "Understanding Very High Rates of Young Child Poverty in the South." The Carsey Institute, Durham, NH.

[19] Wauchope, Barbara and Nena Stracuzzi. 2010. "Challenges in Serving Rural American Children.

[20] Smith, Kristin and Kristi Gozjolko. 2010. "Low Income and Impoverished Families Pay More Disproportionately for Child Care." The Carsey Institute, Durham, NH.

[21] Smith, Kristin. 2006. "Rural Families Choose Home-Based Child Care for their Preschool-Aged Children." Carsey Institute, Durham, NH.

[22] Ibid.

[23] Smith, Kristin and Kristi Gozjolko. 2010. "Low Income and Impoverished Families Pay More Disproportionately for Child Care." The Carsey Institute, Durham, NH.

[24] Ibid.

[25] Smith, Kristin. 2006. "Rural Families Choose Home-Based Child Care for their Preschool-Aged Children." Carsey Institute, Durham, NH.

[26] Smith, Kristin. 2007. "Employment Rates Higher Among Rural Mothers Than Urban Mothers." Carsey Institute, Durham, NH.

[27] See Smith, Kristin and Kristi Gozjolko. 2010. "Low Income and Impoverished Families Pay More Disproportionately for Child Care." The Carsey Institute, Durham, NH.

[28] Smith, Kristin. 2006. "Rural Families Choose Home-Based Child Care for their Preschool-Aged Children." Carsey Institute, Durham, NH.

[29] Graham, Suzanne E. 2009. "Students in Rural Schools Have Limited Access to Advance Mathematics Courses." Carsey Institute.

[30] Ibid.

[31] Case, Anne, Angela Fertig, and Christina Paxson. 2005. "The lasting impact of childhood health and circumstance" Journal of Health Economics 24:365–89.

[32] McLoyd, Vonnie. C. 1998. Socioeconomic Disadvantages and Child Development. American Psychologist, 53, 185–204.

[33] Stracuzzi, Nena and Sally Ward. 2010. "What's for Dinner? Finding and Affording Healthy Foods in New Hampshire Communities." Carsey Institute, Durham, NH.

is limited by a lack of money and other resources."[34] Nearly 15 percent of American households were food insecure in 2008,[35] with a disproportionate number of these families living in rural America.[36] Many households in rural America are dependent upon Federal nutrition programs to reduce food insecurity,[37] with higher rates of use of programs like food stamps,[38] summer lunch programs,[39] and the Women, Infants, and Children program[40] than among their urban counterparts. Participation in most of these programs is highest in the South, particularly among families who are headed by a single, non-white female.[41] Though these programs are key to maintaining the well-being of many poor families, anywhere from 92 percent to 55 percent of eligible people do not participate depending on the program in question,[42] likely due to a lack of access to information about eligibility or the geographic isolation of their residence.

Many rural families who are eligible to take part in child nutrition programs do not participate (43 percent).[43] Policies wishing to address increased food insecurity should focus on obstacles that keep rural families from participating in governmental nutrition programs. For instance, rural families might have a more difficult time accessing child nutrition programs because of their increased remoteness from and lack of transportation to facilities that are able to help.[44] Governmental programs have attempted to remedy some of the problems with transportation by creating programs where food is delivered to rural children in need. However, many of these programs suffer financially because of the same problem they are meant to alleviate; the remoteness of rural families in need.[45]

Access to Healthcare

Nearly 10 percent of American children are without health insurance, with the highest numbers of uninsured in rural regions and southern cities.[46] Of all children who are covered, 28 percent are covered by a public insurance plan, such as Medicaid or the State Child Health Insurance Plan (SCHIP).[47] In addition to lower rates of insurance holdings among rural children, they are also more likely to be covered by these public plans than their suburban counterparts, highlighting the important role of public health insurance in rural America.[48]

The enactment of health care reform undoubtedly will change the picture of rural access to health care. The implementation should be monitored carefully to ensure that rural health care needs are met.

Risk for Child Maltreatment

Research shows that there were nearly 2 million counts of alleged child maltreatment in the United States in 2007, mostly regarding suspected neglect.[49] The types of maltreatment in rural areas are quite similar to those in urban areas, with families experiencing various stressors, such as alcohol abuse or mental health problems, which exacerbate the circumstances of family violence. However, rural families who have been reported to Child Protective Services are more likely to be facing additional stressors than urban families, including difficulty paying for basic needs, and

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[34] Ibid: 1.
[35] Ibid.
[36] Wauchope, Barbara and Nena Stracuzzi. 2010. "Challenges in Serving Rural American Children through the Summer Food Service Program." Carsey Institute, Durham, NH.
[37] Smith, Kristin and Sarah Savage. 2007. "Food Stamp and School Lunch Programs Alleviate Food Insecurity in Rural America." Carsey Institute, Durham, NH.
[38] Ibid.
[39] Wauchope, Barbara and Nena Stracuzzi. 2010. "Challenges in Serving Rural American Children through the Summer Food Service Program." Carsey Institute, Durham, NH.
[40] Wauchope, Barbara and Anne Shattuck. 2010. "Federal Child Nutrition Programs are Important to Rural Households." Carsey Institute, Durham, NH.
[41] Ibid.
[42] Ibid.
[43] Wauchope, Barbara and Anne Shattuck. 2010. "Federal Child Nutrition Programs are Important to Rural Households." Carsey Institute, Durham, NH.
[44] Ibid.
[45] Wauchope, Barbara and Nena Stracuzzi. 2010. "Challenges in Serving Rural American Children through the Summer Food Service Program." Carsey Institute, Durham, NH.
[46] Mattingly, Marybeth J. and Michelle Stransky. 2009. "Rural and Urban Children Have Lower Rates of Health Insurance Coverage and are More Often Covered by Public Plans." Carsey Institute, Durham, NH.
[47] Ibid.
[48] Ibid.
[49] Mattingly, Marybeth J. and Wendy A. Walsh. 2010. "Rural Families with a Child Abuse Report are More Likely Headed by a Single Parent and Endure Economic and Family Stress." The Carsey Institute.

high levels of family stress.[50] In addition, rural families are more likely to have their children relocated into out-of-home placements than urban families.[51] Higher rates of poverty, less access to additional resources, and higher populations of non-white residents are all common in rural areas, and are all independently related to higher risks of out-of-home placement.[52]

Reducing the risk for child maltreatment is complicated; however, some promising ideas include increasing family supports, particularly for those experiencing financial strains and family stressors that could manifest in poor outcomes like child maltreatment. Additionally, further understanding the stressors for unmarried couples,[53] immigrants,[54] or those experiencing multi-generational poverty could result in more appropriate responses to rural poverty, and help to close the persistent rural-urban gap.

Thank you for the opportunity to identify some of the implications of Federal policy for rural children and families.

[Whereupon, at 11:52 a.m., the hearing was adjourned.]

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[50] Ibid.

[51] Mattingly, Marybeth J., Melissa Wells, and Michael Dineen. 2010. "Out-of-Home Care by State and Place: Higher Placement Rates for Children in Some Remote Rural Places." The Carsey Institute.

[52] Ibid.

[53] O'Hare, William, Wendy Manning, Meredith Porter, and Heidi Lyons. 2009. "Rural Children Are More Likely to Live in Cohabiting-Couple Households." Carsey Institute, Durham, NH.

[54] Johnson, Kenneth. 2006. "Demographic Trends in Rural and Small Town America." Carsey Institute, Durham, NH.