



Focus

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Paternity and public policy

by Daniel R. Meyer

Daniel Meyer is an assistant professor at the School of Social Work, University of Wisconsin–Madison, and an IRP affiliate.

Policy attention is turning with new interest to issues surrounding the legal establishment of paternity for children born out of wedlock. Even five years ago, the possibility of a conference focused solely on such issues would have been questionable, owing to the paucity of information on the topic. Now a body of research has begun to emerge. Its findings were highlighted at a conference jointly sponsored in February 1992 by the Institute for Research on Poverty and the U.S. Department of Health and Human Services. This article provides background information on the topic

of paternity establishment, summarizes the findings reported at the conference, and makes inferences about future policy. The last section points out the gaps in our knowledge.

The reasons for growing interest in establishing paternity

Four factors have contributed to the rise in interest in paternity establishment.

First, the percentage of children born outside marriage has increased dramatically in the last thirty years, from 5 percent in 1960 to 11 percent in 1970, 18 percent in 1980, and 27 percent in 1989.¹ This increase occurred among both whites and blacks. The percentage of births to white unmarried mothers rose from 2.3 percent in 1960 to 19.2 percent

in 1989; for blacks it rose from 21.6 percent to 65.7 percent over the same years (see Figure 1). A number of factors account for the increase, among them a decline in marriage, substantially lowered birth rates among married women, and increased sexual activity among unmarried women.²

Second, many children born out of wedlock are poor and depend on public assistance. The poorest demographic group in the United States consists of children in single-parent families;³ especially poor are those living with never-married mothers: 54 percent of such families had incomes below the poverty line in 1989, compared to 27 percent of divorced families and 15 percent of all families with children.⁴ Many of these poor children receive public assistance. Whereas 28 percent of children receiving Aid to Families with Dependent Children (AFDC) were born out of wedlock in 1969, by 1990 that fraction had increased to 54 percent.⁵ Some research has shown that never-married mothers and their children are significantly more likely to depend on AFDC for longer periods of time. David Ellwood found that the average number of years of AFDC receipt by never-married women was 9.3, compared to 4.9 for divorced women and 6.8 for separated women.⁶

Third, concerns about the poverty and dependency of single-parent families have prompted a review of the child support system to determine whether noncustodial parents provide sufficient amounts of child support. This critique has revealed that the system is weakest for children of

never-married mothers.⁷ These data are disturbing. Fewer never-married women have child support awards—24 percent in 1989, compared to 48 percent of separated women and 77 percent of divorced women. Even among those with awards, more than one-fourth receive no payments. And even when never-married women have an award and obtain some payment, their annual average receipt is \$1888, compared to \$3060 for separated women and \$3322 for divorced women.⁸ The recognition that never-married women receive much less child support than do other single mothers has led to new interest in paternity establishment, since until paternity is established the formal system cannot award or collect child support.

Finally, paternity establishment brings with it a variety of other benefits. Legally acknowledged fathers may provide health insurance and inheritance.⁹ Furthermore, only when paternity has been established can children receive Social Security benefits (should the father die or become disabled) or military benefits that accrue through the father's service. Medical histories and genetic information are available to children whose father is known. And emotional and psychological benefits, including a sense of identity and heritage, can be gained through identification of fathers.

Paternity establishment has thus taken on greater importance because it affects increasing numbers of children, because many of these children are poor and depend on public assistance, because the child support system may not

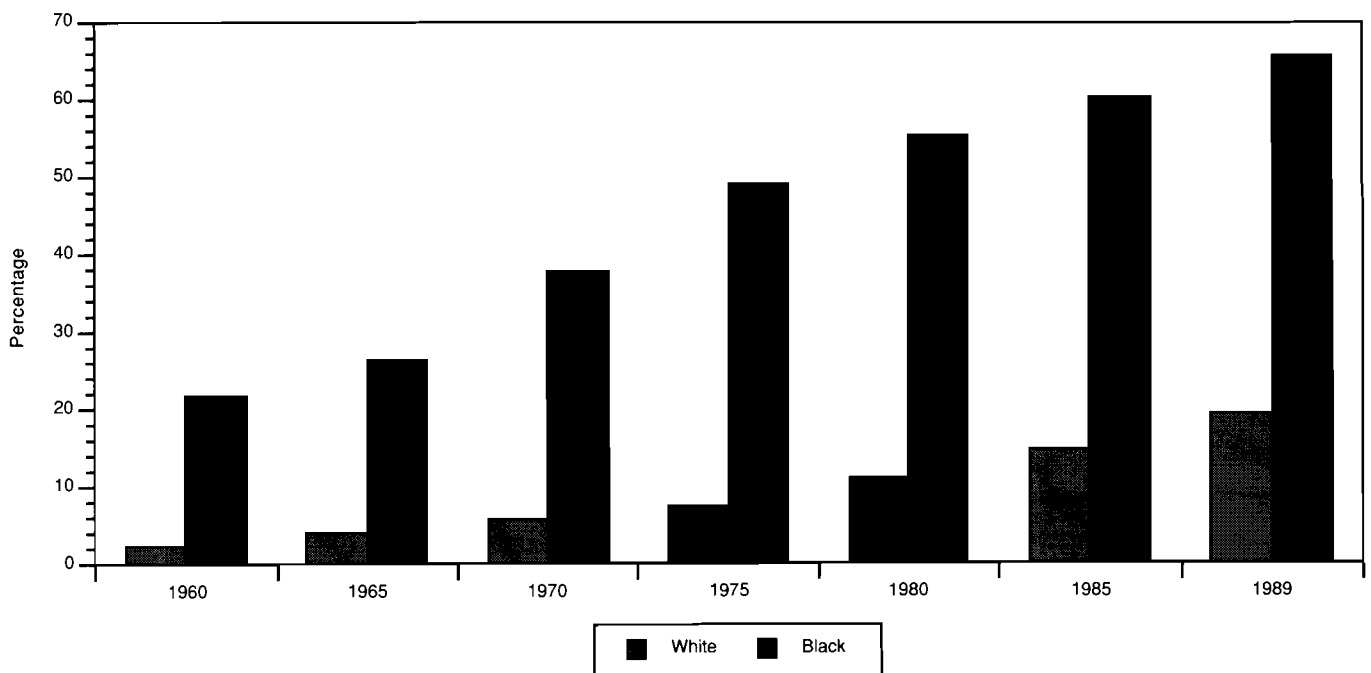


Figure 1. Births to Unmarried Women As a Percentage of All Births, by Race, 1960–1989.

Source: U.S. House of Representatives, Committee on Ways and Means, *1992 Green Book* (Washington, D.C.: GPO, 1992), p. 1074; *Statistical Abstract of the United States, 1991* (Washington, D.C.: GPO, 1991), p. 67, and *1987*, p. 61.

Note: Percentages for blacks prior to 1970 include black and other.

be working well for these families, and because there is increased interest in the nonfinancial benefits of paternity establishment. A variety of issues surrounding the topic were explored by the papers presented at the conference. The following overview describes the legal and historical context of paternity establishment, summarizes the important findings of the conference papers, and assesses the policy implications of the findings.

The legal and historical background of establishing paternity

Because the legal procedures surrounding paternity establishment in the United States lie in the realm of family law, they have been a state rather than a federal responsibility. Until the late twentieth century most states relied on the Elizabethan Poor Laws as precedent for paternity laws and procedures. Because these laws considered nonmarital intercourse to be “both a sin and a crime—both a moral and a government offense,” a paternity suit was a criminal action, and a judicial process was required to establish proof beyond a reasonable doubt. Furthermore, because the usual purpose of a paternity action was to collect support for the child, voluntary acknowledgments of paternity were few. Additionally, until recently it was difficult to prove paternity. Now, however, genetic testing makes it possible to establish paternity by medical tests rather than judicial process.¹⁰

As a result of changes in attitude, technological advances, and the growing importance of establishing paternity, the federal government has taken an increasingly active role in promoting paternity establishment. In 1967 it required states to attempt to establish paternity for children born out of wedlock who were receiving AFDC. In 1975 Congress added Part D to Title IV of the Social Security Act, creating a federal Office of Child Support Enforcement and requiring each state to establish a corresponding office (known as IV-D offices). These offices were given the responsibility of establishing paternities for both AFDC and non-AFDC families. Legislation in 1984 extended the period in which states could take paternity action to a child’s eighteenth birthday. The 1988 Family Support Act set goals for the number of paternities established by the states, with financial penalties to be assessed when states do not meet these goals. That legislation also requires parties in contested cases to take genetic tests if requested by any party, gives greater financial responsibility to the federal government for genetic testing, encourages states to establish civil (rather than criminal) processes for paternity establishment, establishes time limits for processing paternity cases, and requires states to obtain social security numbers from both parents when issuing birth certificates.

Several observers have concluded that the state IV-D offices have typically focused more on enforcing existing child support orders than on establishing paternity.¹¹ This

may be changed by the Family Support Act’s requirement that the number of paternity establishments increase.

In the early years of the child support offices, many workers believed it was not usually cost-effective to establish paternity. In a study funded by the federal Office of Child Support Enforcement to determine if this was true, Edward Young reviewed case files from 1980 to 1983 in three county child support offices that were thought to have effective paternity procedures. He found that in Dane County, Wisconsin, child support collections for AFDC cases with paternity established offset the expenses of the agency on all paternity establishments; the average case broke even within 23 months.¹² A more recent study in Nebraska also found that the benefits of focusing on paternity establishment outweighed the costs.¹³

The low priority for paternity cases has been documented by other research as well.¹⁴ Several papers from a 1986 conference on young unwed fathers demonstrated that few children of these fathers had paternity established, even fewer had child support awards, and still fewer received child support.¹⁵ Observers of the child support system noted that problems in the paternity establishment process seemed the greatest hurdle to receipt of child support.¹⁶

The situation may be improving. The ratio of paternities established by the child support offices to the number of nonmarital births has increased from .19 in 1979 to .22 in 1980 to about .28 in 1983. Both the paternity adjudication rate and the probability of obtaining a child support award increased over the period from 1979 to 1986.¹⁷ However, the vast majority of children from nonmarital relationships still do not have paternity established, and even more do not have child support orders.

Another recent finding is that many fathers informally admit paternity and, once approached by the child support system, voluntarily acknowledge paternity.¹⁸ The likelihood of establishing paternity, however, declines as children age,¹⁹ in part because contact between unmarried fathers and their children tends to decline over time.²⁰

Principal findings from the conference papers

Variation in practices

Until recently, the only descriptions of paternity processes and organizational structures were from local or state studies. To obtain a national picture, the Urban Institute in 1990 conducted a National Survey of Paternity Establishment Practices, covering child support agencies in 249 counties in 42 states and the District of Columbia.²¹ The major conclusion of the study was that great diversity exists around the country both in organizational arrangements and in the process of paternity adjudication. The three basic types of organization appear to be a “human services agency model,” in which paternity is handled by an agency

Paternity Establishment: A Public Policy Conference

These conference papers (IRP Special Reports 56a and 56b) may be obtained from the Institute for Research on Poverty, 1180 Observatory Drive, 3412 Social Science Building, University of Wisconsin, Madison, WI 53706. The price for either SR 56a or SR 56b is \$8.00. The set of two may be purchased for \$15.00.

Special Report 56a: Overview, History, and Current Practices

Conference Overview—Paternity and Public Policy: Findings, Policy Issues, and Future Research Needs
Daniel R. Meyer

A Brief History of the Legal Structure for Paternity Establishment in the United States
Marygold S. Melli

New Data on State Performance in the Establishment of Paternity: Is It Valid and What Use Can Be Made of It?
John K. Maniha

Paternity Establishment in 1990: Organizational Structure, Voluntary Consent, and Administrative Practices
Pamela A. Holcomb, Kristin S. Seefeldt, and Freya L. Sonenstein

Interorganizational Dependencies and Paternity Establishment
Charles F. Adams, Jr., David Landsbergen, and Daniel Hecht

Paternity Establishment in 1990: Performance at the Local Level
Freya L. Sonenstein, Pamela A. Holcomb, and Kristin S. Seefeldt

Innovative State Programs: Washington, Delaware, and Virginia
John Hoover, Barbara Paulin, and Harry Wiggins

Special Report 56b: Studies of the Circumstances of Mothers and Fathers

Paternity Establishment among Never-Married Mothers: Estimates from the 1986 Current Population Survey, Alimony and Child Support Supplement
Burt S. Barnow

Paternity Establishment in Arizona: A Case Study of the Process and Its Outcomes
Ann Nichols-Casebolt

Paternity Establishment for AFDC Mothers: Three Wisconsin Counties
Sara McLanahan, Renee Monson, and Pat Brown

Executive Summary of a Study of Paternity Decisions: Perspectives from Young Mothers and Young Fathers
Esther Wattenberg, Rose Brewer, and Michael Resnick

Teen Fathers and the Child Support Enforcement System
Maureen A. Pirog-Good

Do the Earnings Deficiencies of Unwed Fathers Account for Their Low Child Support Payments?
Robert I. Lerman

Can Fathers Support Children Born outside of Marriage? Data on Fathers' Incomes over Time
Daniel R. Meyer

that is not primarily legal (43 percent of the counties); a "legal agency model," in which the IV-D office contracts with private attorneys or contracts with or operates out of the office of the prosecuting attorney or the attorney general (21 percent); and a "two-agency transfer model," in which a human services agency typically handles voluntary cases but transfers any contested cases to a legal agency (36 percent).

Stages in the process of establishing paternity are also distinguished,²² as are distinctions in the ways that contested and uncontested cases are handled.²³ Although the national trend has been toward encouraging voluntary consent, 20 percent of the counties still do not give fathers an

opportunity to acknowledge paternity outside a court process, and another 20 percent allow only one opportunity.

Additional diversity exists in the way the state offices treat teenage fathers.²⁴ Over three-quarters reported that they attempted to pursue all paternity cases regardless of age; the remainder did not pursue cases in which the father was "too young." The likelihood of a teen father being assigned child support also differs across the states. More than half the states have some minimum support award (ranging from \$10 to \$100 per child per month) that may be applied to a teen father. Even very young fathers may be required to pay child support: in half the states, child support administrators recalled at least one case in which a father under the age of sixteen was assigned child support payments.

Weakness of the data

The key indicator of success in establishing paternity is the ratio of paternities established to the total number of children for whom paternities need to be established. Obtaining accurate numbers for both the numerator and denominator is quite difficult.

The numerator poses particular problems because there are no national data collected on the number of paternities established. Since 1978 state child support offices have reported the number of paternities that are established through the IV-D System; since 1986 they have also reported expenditures on paternity establishment. However, because many states do not have automated systems, it is difficult to assess the accuracy of these numbers.²⁵ In addition, in most states only a limited number of mothers with nonmarital births enter the child support office. Other women establish paternity through a court or administrative process independently of the child support office, and we have no way to estimate their number. Another method of estimating the number of paternities established would be to use national survey data, but the commonly used large surveys have not asked specific questions about paternity establishment. Several researchers try to approximate the numerator using the Current Population Survey's Child Support Supplement, but conclude that this measure is quite imprecise.²⁶

The denominator, the number of children who are eligible to have paternity established, also poses problems. As a part of vital statistics, the number of nonmarital births is collected on an annual basis, but there is no aggregate count of the number of children eligible for paternity establishment at a single point in time. Not all children born from a nonmarital union are potentially eligible for paternity establishment. Children put up for adoption, those whose parents marry, and those who die or whose father has died are not candidates. One estimate is that 10 percent of the nonmarital births in Wisconsin in the 1980s were not eligible for paternity establishment.²⁷

If the paternity ratio is seen as a measure of state or local agency performance, then the denominator could be considered the number of nonmarital births in that jurisdiction in each year. However, the number of children potentially in need of having paternities established includes those aged zero to eighteen, and comparing the number of paternities established in one year to the number of nonmarital births is therefore problematic. In addition, mobility into and out of the jurisdiction can confound the numbers. A measure of IV-D agency performance might compare the number of paternities established to the active paternity caseload, but in one study less than half of the counties sampled could answer the question "How many paternity cases were active in your office in FY 1989?"²⁸ and many states had substantial difficulty in identifying all children in IV-D cases born out of wedlock.²⁹

Uncertainty of success

Given these data problems, success in paternity establishment is difficult to ascertain in the nation as a whole, in states, or in individual child support offices. A simple comparison of the number of paternities established by state IV-D offices in 1987 with the number of out-of-wedlock births in 1985 (assuming it may take two years to establish paternities) reveals an establishment rate of 31.3 percent.³⁰ At the county level, the ratio of paternities established by IV-D offices in FY 1989 to the number of out-of-wedlock births in 1988 yields a weighted mean of .49 for a nationally representative sample of counties. This ratio varied greatly across the counties, however, ranging from .04 to 3.25, and it was greater than 1 in eleven of the 249 counties surveyed.

Another method is to compare the number of children aged zero to eighteen who have had paternity established with the number of children who are eligible for establishment. Burt Barnow thus estimates that 24.5 percent of unmarried women with children had paternity established in 1989, and 4.3 percent did not; for the remaining 71.2 percent of the sample, whether paternity had been established was unknown.³¹

Two conference papers look at individual AFDC cases within a state to compare those having paternities established with those needing but not obtaining paternity establishment. The results from Arizona and Wisconsin are vastly different, suggesting the degree of variation around the country.³² In Arizona only 3.8 percent of AFDC children had paternity established one to two years after their case was opened. In Wisconsin between 42 percent and 69 percent of nonmarital children receiving AFDC in December 1988 had paternity established when the records were reviewed one to two years later.

The Family Support Act sets a standard for the number of paternities to be established by the child support office in relation to the number of out-of-wedlock children in the AFDC caseload. Each state was required to report its base rate as of December 1988. The percentage varied dramatically across the states, from 11 percent in Oklahoma to 84 percent in Maryland, the average being 45 percent.³³ Because of questions regarding the accuracy of these numbers, John Maniha conducted several comparisons to other measures of state performance and found that the ranking of the states on this measure was consistent with other known measures of their performance.³⁴

Correlates of failure and success

Poor connections between the AFDC system and the child support system may be connected to low levels of paternity establishment.³⁵ This appears to be particularly possible in the case of child support offices that follow the "legal agency model." Charles Adams and his colleagues assert that one way to address problems of the interface of the AFDC and child support systems is for the child support

agency to be directly administered by human services departments (the human services agency model). This model may create problems later, however, when interaction with the courts becomes important. Adams believes the most effective strategy is to use a human services model, but to focus on voluntary acknowledgments of paternity to reduce dependence on the legal system.³⁶

Another finding is that counties that initiate the paternity process early are likely to have much higher success rates.³⁷ More than 60 percent of the unmarried fathers in one sample were present at the births of their children, which suggests that starting the paternity establishment process in the hospital (or even before) may lead to higher adjudication rates.³⁸

Counties that can process cases quickly are also likely to have much higher success rates.³⁹ When the system is slowed by time lags, tasks often need to be done more than once. For example, if a mother provides an address for the father during the intake interview, but the case does not proceed for some time after that, then a search for the father's address may be required if he moved during the intervening period.

Finally, effective record-keeping systems are important to success. The technology used in state child support systems is often quite inadequate.⁴⁰ Adams and his colleagues argue that the capacity to share information electronically throughout the paternity establishment process is a necessary ingredient in an effective system.⁴¹

Characteristics of mothers and fathers associated with successful adjudication

Mothers who were white non-Hispanics, aged twenty to twenty-nine, had one or two children, had at least a high school education, lived in the suburbs, or had family incomes between \$5000 and \$15,000 were most likely to have had paternity established.⁴²

We have much more information on mothers than fathers but two conference participants, Maureen Pirog-Good and Robert Lerman, used the National Longitudinal Survey of Youth to obtain data on fathers. Pirog-Good reports that teen fathers are more likely to come from single-parent families and from families of lower socioeconomic status, tend to have been in more trouble with the criminal justice system, to have lower levels of education, and to experience divorce. Teen fathers tend to enter the labor force earlier than men who don't become fathers in their teens and thus have higher incomes through age twenty. However, their average earnings do not rise as fast as those of non-teen fathers, and their mean earnings even decrease by the time they are twenty-nine. Teen fathers are unlikely to pay child support.⁴³

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Institute for Research on Poverty
1180 Observatory Drive
3412 Social Science Building
University of Wisconsin
Madison, Wisconsin 53706
(608) 262-6358
Fax: 608-265-3119

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Lerman examines the relationships among earnings, fatherhood, marriage, and child support behavior among young men. He finds that educational levels, skill levels, and other characteristics of young men have strong impacts on earnings and child support. Unwed fathers earn less, generally, than all others, and they also pay the least child support. The relationship between child support and earnings is complicated, with earnings in one year clearly being linked to higher child support payments in the next year, and child support payments in one year being linked to higher earnings in the next. Lerman concludes that policies should not only provide training to increase earnings, but might also attempt to increase the motivation to pay child support.⁴⁴

Esther Wattenberg and her colleagues and Daniel Meyer focused specifically on fathers in paternity cases. Those that Wattenberg interviewed were a very low income group. Although many were working, their jobs were marginal: unskilled, low-paid, or part-time.⁴⁵ Meyer found that although

many fathers had very low incomes at the time paternity was established, a sizable portion did not, and many increased their incomes significantly over the next three years.⁴⁶

Lack of national consensus

Many would now agree that there are advantages to society and to the children themselves in establishing paternity for almost every child born out of wedlock. Although there is a trend toward establishing the legal right to have a father, the authors of these papers and the participants at the conference noted that there is no agreement on how strong that right should be. Is it stronger, for example, than the right of a mother not to have contact with the father? Is it stronger than the rights of men who are not completely sure that they are the fathers? How strong should be the link between establishing paternity and securing a child support obligation?—weak, so that many paternities are established, or strong, so that children obtain the financial support to which they are entitled? The responses to these questions lead to specific policies.

Some argue that the system is beginning to focus more on efficiency, at the expense of the father's right to due process and his right to representation. Several factors are interrelated: states are moving toward encouraging voluntary consent, and some men who acknowledge paternity may not understand the implications of their statement. Second, many states and counties have moved toward greater use of default judgments (judgments made in the absence of the alleged father), clearly favoring efficiency at the expense of accuracy. In Virginia, blood test results indicating a 98 percent or greater probability of paternity are not rebuttable, raising the possibility that up to 2 percent of the putative fathers may be wrongly assigned paternity and an eighteen-year financial obligation. Finally, in some locations the petition for paternity is made by a branch of the court itself, raising questions about the fairness of the hearing.⁴⁷

Direction for policy

The conference papers have several policy implications. They point to the need for strengthened links between AFDC and child support workers. They indicate the desirability of regular monitoring of the incomes of fathers in paternity cases, since the earnings of many rise substantially over time. They make it clear that we must devise ways to speed the paternity process and to get it started as early as possible.

Many states have already begun to take action along these lines. A number of them are increasingly encouraging voluntary acknowledgment of paternity. In the state of Washington, for example, hospitals are required to give fathers the opportunity to sign an affidavit of paternity. The program appears to be successful in that the state is currently receiving an average of 644 affidavits per month, compared

Recent IRP Publications on Child Support

The following papers are available from the Institute for Research on Poverty, 1180 Observatory Drive, 3412 Social Science Building, University of Wisconsin, Madison, WI 53706.

Discussion Papers

Marieka Klawitter and Irwin Garfinkel, "Child Support, Routine Income Withholding, and Postdivorce Income for Divorced Mothers and Their Children." DP 938–91.

Daniel R. Meyer, "Child Support and Welfare Dynamics: Evidence from Wisconsin." DP 939–91.

Daniel R. Meyer, Irwin Garfinkel, Philip K. Robins, and Donald Oellerich, "The Costs and Effects of a National Child Support Assurance System." DP 940–91.

Irwin Garfinkel, Daniel R. Meyer, and Gary D. Sandefur, "The Effects of Alternative Child Support Systems on Blacks, Hispanics, and Non-Hispanic Whites." DP 946–91.

Marieka Klawitter and Irwin Garfinkel, "The Effects of Routine Income Withholding of Child Support on AFDC Participation and Costs." DP 961–91.

Elizabeth Phillips and Irwin Garfinkel, "Changes over Time in the Incomes of Nonresident Fathers in Wisconsin." DP 967–92.

Yin-Ling Wong, Irwin Garfinkel, and Sara McLanahan, "Single-Mother Families in Eight Countries: Economic Status and Social Policy." DP 970–92.

Daniel R. Meyer, "Data Adjustments in the Child Support Supplement of the Current Population Survey." DP 976–92.

Reprints

Donald T. Oellerich, Irwin Garfinkel, and Philip K. Robins, *Private Child Support: Current and Potential Impacts*. R 650, 1991.

Nora Schaeffer, Judith A. Seltzer, and Marieka Klawitter, *Estimating Nonresponse and Response Bias: Resident and Nonresident Parents' Reports about Child Support*. R 655, 1991.

Irwin Garfinkel, Donald Oellerich, and Philip K. Robins, *Child Support Guidelines: Will They Make a Difference?* R 662, 1991.

to approximately 1550 births to unmarried parents each month.⁴⁸ While this is not required of the hospitals in Virginia, the child support agency has signed agreements with several hospitals to provide a small fee for every voluntary acknowledgment the hospital provides.

Several states are experimenting with techniques to speed the process of establishing paternity. One method is to encourage paternity establishment outside the legal system. In Virginia, a voluntary acknowledgment of paternity has the same force and effect as a court order. Another means of speeding the process is to issue default judgments: in Oregon, one-third of the paternity cases are now decided by default.⁴⁹

States are also attempting to begin paternity establishment at an early stage. For example, Delaware has implemented a new program in which public health nurses contact unmarried women toward the end of their pregnancies and explain the benefits of paternity establishment. A referral is then made to the child support office, which follows up after the birth of the child. The Washington program, mentioned earlier, which offers fathers an opportunity to acknowledge paternity when the baby is born, has shown significant success, as have similar programs in Virginia and in Kent County, Michigan. One conference participant suggested that states should base child support staff in selected hospitals.⁵⁰

Attempts are being made to increase incentives for child support offices to give priority to paternity cases. In Wisconsin, Ohio, and California, payments are provided to counties that have high levels of paternity establishment.⁵¹

It has been suggested that we reexamine the incentives in place for parents to cooperate with the child support office. Currently there is a child support "pass-through," according to which the first \$50 per month paid by the noncustodial parent of a child receiving AFDC goes to the custodial family and the remainder, which goes to the state, serves to offset the costs of AFDC. Prior to 1984, when the pass-through was established, all child support went to offset the costs of AFDC. The intent of the pass-through was to provide a monetary incentive for custodial parents receiving AFDC to cooperate with the child support agency and also to give noncustodial parents some incentive to cooperate, since at least a portion of their payment would go to their children. Yet \$50 per month may not be large enough. According to Wattenberg, some of the young men and women who were interviewed by her project suggested that at least \$100 a month would be more appropriate.⁵² Nichols-Casebolt states that some of the intake workers in Maricopa County, Arizona, believe that AFDC mothers may be unwilling to cooperate with the formal child support system because the potential benefits (\$50 a month) are less than the potential cost involved in jeopardizing their relationship with the child's father.⁵³ If, on the other hand, the father pays informally and the mother reports to the Office of Child Support Enforcement that she does not

know where the father is, both may be better off financially. Adams and his colleagues do not specifically mention the pass-through, but they observe substantial reluctance of clients to cooperate with the child support system. They assert that this indicates "that administrative reforms alone might not be sufficient, and that interventions aimed more directly at influencing client attitudes might be required to achieve the performance standards prescribed in the 1988 legislation."⁵⁴

Nichols-Casebolt and others have suggested that increased education might be an appropriate strategy—that mothers who are made aware of the benefits of paternity establishment will be more likely to desire it, and that fathers may develop stronger relationships with their children if they have been motivated to accept responsibilities.⁵⁵ Several states and localities have developed educational materials on paternity and on child support for use in schools.

An educational strategy alone, however, has serious weaknesses. A study in Nebraska found that paternity establishment rates were not significantly higher for mothers who received "education" concerning the benefits of establishment.⁵⁶ In addition, if education increases the number of clients who expect paternity services and the child support system is not given additional resources, the system will not be able to handle new cases efficiently and may have raised the expectations of mothers to no avail.

Finally, Wattenberg and her colleagues and others have suggested that we completely separate the establishment of paternity from the child support process.⁵⁷ They suggest making a "Declaration of Parentage" form routinely available so that a simple statement before a notary will establish paternity, which would not be connected to the legal issues of child support, visitation rights, or custody.

It is unclear, however, how these processes can be disentangled. When a court reviews a request for child support on behalf of a child born out of wedlock, some determination of parentage must be made. If the Declaration of Parentage form is accepted by the courts, then the processes are linked. If it is not seen as binding, then how can it be used to grant the child eligibility for benefits from the father? Other benefits of paternity, such as medical history, genetic information, and emotional and psychological links are based more on whether the father is known than on whether a form has been signed.

Others advocate decriminalizing the whole paternity adjudication process and streamlining the process for those who voluntarily acknowledge paternity. Many states have moved in this direction, and, indeed, it is strongly encouraged by the Family Support Act.

Future research

The conference papers tell us what gaps in our knowledge remain to be filled. First, we clearly need more accurate

data. No current national data set can help us understand the characteristics of women who have had paternity established as opposed to those who have not. We have even less accurate data on the fathers, and no data that link specific mothers and fathers. We have very little information on individual mothers, fathers, and children over time. On the aggregate level, we now have some data from the states on the percentage of cases in the IV-D system for which paternity has been established. But the accuracy of this information is still open to question, and even after audit the numbers may be subject to error until automated systems are in use in every state. How do we know if new national policies on paternity are needed if we do not have an accurate picture of the current system? In the absence of national data, perhaps data from individual states should be more thoroughly analyzed and disseminated.

We are only beginning to understand the relationship, if any, between the structure of child support agencies, paternity practices, and adjudication rates. We presume a relationship exists between expenditures and effectiveness, but we are not sure what it is. Effectiveness is probably also related to the characteristics of the individuals involved, but we have no theory and little understanding of any links between individual characteristics and effectiveness. Clearly, additional work (perhaps using longitudinal data) on the factors associated with program performance would be helpful. A related set of unanswered questions concerns the paternity practices of the child support offices in regard to teen fathers. For how many of these fathers is a formal declaration of paternity deferred until they are older or gain a reliable income source? How many of these “deferred paternities” are eventually established?

We know little about the child support behavior of men after their paternity is established, other than that they tend to pay less than other noncustodial fathers. Do their awards change as their income changes? Does compliance increase over time? If lack of compliance is found, does it result from changes in income, changes in willingness to pay, or other factors? How much informal support is provided, and does it change over time? Although it appears that a large majority of noncustodial fathers for whom paternity is established cannot initially pay an amount of child support sufficient to raise their children out of poverty, to what extent can child support decrease the poverty of these children in the longer term? Can enough child support be collected to substantially reduce the reliance of mothers and children on AFDC?

We lack knowledge of the relationship between paternity establishment and visitation. Do fathers who have had paternity formally established have more contact with their children? Does this contact continue throughout the child’s life? If there is increased contact, what are its effects?

Little research exists to help us understand the mother’s perspective on paternity establishment. Wattenberg et al. have begun to obtain the views of AFDC mothers and

fathers on the costs and benefits of establishing paternity, but this work needs to be corroborated beyond the Minneapolis–St. Paul area, and broader samples need to be taken. We know little about the effects of and the extent to which sanctions are used when parents do not cooperate in the paternity-establishment process. Policy approaches that increase the incentive to establish paternity, such as a guaranteed amount of child support for custodial parents who have had paternity established, need to be tested and evaluated to see if they are effective.

Perhaps most important, we know little about the longer-term effects of establishing paternity. Most of the work to date has implicitly assumed that establishing paternity would benefit children in the long run, but this assumption is not based on research. The first effect would presumably be increased financial support for the child, but we have few data on the effects of paternity establishment on later child support awards and payments. Are child support awards established? Do fathers pay? Even if we observe that fathers who had paternity established five years ago are paying modest amounts of child support now, a further question remains: What if the fathers, mothers, and children for whom paternity was established five years ago were a fairly select group? Would establishing paternity for all other families now have the same effect?

The relationship between paternity establishment and the well-being of the child is not settled. If paternity is established routinely, what effects would this have? Would it increase contact between fathers who would otherwise not be involved with their children? If so, would increased contact increase conflict between the parents? Some work has been done on this question for children affected by divorces,⁵⁸ but not for children born out of wedlock.

A host of research issues have not yet been addressed. Answers to the questions posed, as well as to others, are critical if our society is to develop effective policies in an area of growing importance. ■

¹U.S. House of Representatives, Committee on Ways and Means, *1992 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means* (Washington, D.C.: GPO, 1992), p. 1074. Hereafter referred to as *1992 Green Book*.

²Sandra Danziger and Ann Nichols-Casebolt, “Teen Parents and Child Support: Eligibility, Participation, and Payment,” *Journal of Social Service Research*, 11 (1988), 1–20.

³Irwin Garfinkel and Sara S. McLanahan, *Single Mothers and Their Children: A New American Dilemma* (Washington, D.C.: Urban Institute Press, 1986).

⁴U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 173, *Child Support and Alimony: 1989* (Washington, D.C.: GPO, 1991), p. 11.

⁵*1992 Green Book*, p. 669.

⁶Ellwood, "Targeting Would-Be Long-Term Recipients of AFDC." Report prepared for the U.S. Department of Health and Human Services by Mathematica Policy Research, Inc., Princeton, N.J., 1986.

⁷Because most national data sets do not permit accurate identification of all children born from nonmarital relationships, researchers usually rely on data on never-married mothers. A nonmarital child who is not legitimated and whose mother eventually marries is also eligible for paternity establishment and child support, but these analysts miss this group. In addition, some divorced, separated, and widowed women have nonmarital children who are eligible for paternity establishment.

⁸The data in this paragraph come from U.S. Bureau of the Census, *Child Support and Alimony: 1989*, p. 5.

⁹Esther Wattenberg, Rose Brewer, and Michael Resnick, "Executive Summary of a Study of Paternity Decisions: Perspectives from Young Mothers and Young Fathers." Summary of a report prepared for the Ford Foundation, February 1991. Conference paper. For information on how to obtain the conference papers, see box, p. 4.

¹⁰See Marygold Melli, "A Brief History of the Legal Structure for Paternity Establishment in the United States." Conference paper.

¹¹See Charles F. Adams, David Landsbergen, and Daniel Hecht, "Interorganizational Dependencies and Paternity Establishment." Conference paper.

¹²Edward M. Young, "Costs and Benefits of Paternity Establishment." Report to the Office of Child Support Enforcement, 18-P-00229-99-01, 1985. Dane County includes Madison, the state capital.

¹³David A. Price and Victoria S. Williams, "Nebraska Paternity Project: Final Report." Submitted to Nebraska Department of Social Services by Policy Studies, Inc., Denver, Colo., 1990.

¹⁴See, for example, Blanche Bernstein, "Shouldn't Low-Income Fathers Support Their Children?" *The Public Interest*, 66 (1982), 55-71; Margaret A. Kohn, "Child Support Enforcement and Young Unwed Fathers," in *Young Unwed Fathers: Research Review, Policy Dilemmas and Options*, ed. Jacqueline Smollar and Theodora Ooms, report to the Assistant Secretary for Planning and Evaluation, U.S. DHHS, under Contract HHS-100-85-0004, 1987; and Esther Wattenberg, "Establishing Paternity for Nonmarital Children," *Public Welfare*, 45 (1987), 9-13, 48.

¹⁵Jacqueline Smollar and Theodora Ooms, eds., *Young Unwed Fathers*.

¹⁶Danziger and Nichols-Casebolt, "Teen Parents and Child Support."

¹⁷Ann Nichols-Casebolt and Irwin Garfinkel, "Trends in Paternity Adjudications and Child Support Awards," *Social Science Quarterly*, 72 (1991), 83-97.

¹⁸Kohn, "Child Support Enforcement and Young Unwed Fathers"; Wattenberg, "Establishing Paternity for Nonmarital Children"; and Sandra Danziger and Ann Nichols-Casebolt, "Child Support in Paternity Cases," *Social Service Review*, 64 (1990), 458-474.

¹⁹Danziger and Nichols-Casebolt, "Teen Parents and Child Support."

²⁰Sandra Danziger, "Father Involvement in Welfare Families Headed by Adolescent Mothers," IRP Discussion Paper no. 856-87, 1987; Wattenberg, "Establishing Paternity for Nonmarital Children."

²¹See Pamela A. Holcomb, Kristin S. Seefeldt, and Freya L. Sonenstein, "Paternity Establishment in 1990: Organizational Structure, Voluntary Consent, and Administrative Practices"; and Sonenstein, Holcomb, and Seefeldt, "Paternity Establishment in 1990: Performance at the Local Level." Conference papers.

²²Ann Nichols-Casebolt, "Paternity Establishment in Arizona: A Case Study of the Process and Its Outcomes." Conference paper.

²³Holcomb et al., "Paternity Establishment in 1990."

²⁴See Maureen P. Pirog-Good, "Teen Fathers and the Child Support Enforcement System." Conference paper.

²⁵John K. Maniha, "New Data on State Performance in the Establishment of Paternity: Is It Valid and What Use Can Be Made of It?" Conference paper.

²⁶See Burt S. Barnow, "Paternity Establishment among Never-Married Mothers: Estimates from the 1986 Current Population Survey, Alimony and Child Support Supplement." Conference paper. See also Laudan Y. Aron, Burt S. Barnow, and William McNaught, "Paternity Establishment among Never-Married Mothers: Estimates from the 1986 Current Population Survey, Alimony and Child Support Supplement." Report by Lewin/ICF to the Assistant Secretary for Planning and Evaluation, U.S. DHHS, 1989.

²⁷Danziger and Nichols-Casebolt, "Child Support in Paternity Cases."

²⁸Sonenstein et al., "Paternity Establishment in 1990."

²⁹Maniha, "New Data on State Performance in the Establishment of Paternity."

³⁰The data in this paragraph are drawn from Sonenstein et al., "Paternity Establishment in 1990."

³¹Barnow, "Paternity Establishment among Never-Married Mothers."

³²Compare the data in Nichols-Casebolt, "Paternity Establishment in Arizona," with those in Sara McLanahan, Renee Monson, and Pat Brown, "Paternity Establishment for AFDC Mothers: Three Wisconsin Counties." Conference papers.

³³Maniha, "New Data on State Performance in the Establishment of Paternity," p. 12. The base rates were needed because one of the state standards was that paternity establishments must have increased by at least six percentage points above that base by September 30, 1992.

³⁴*Ibid.*, p. 11.

³⁵Nichols-Casebolt, "Paternity Establishment in Arizona."

³⁶Adams et al., "Interorganizational Dependencies and Paternity Establishment."

³⁷McLanahan et al., "Paternity Establishment for AFDC Mothers."

³⁸Wattenberg et al., "Executive Summary of a Study of Paternity Decisions."

³⁹Nichols-Casebolt, "Paternity Establishment in Arizona."

⁴⁰Maniha, "New Data on State Performance in the Establishment of Paternity."

⁴¹Adams et al., "Interorganizational Dependencies and Paternity Establishment."

⁴²See Barnow, "Paternity Establishment among Never-Married Mothers," and McLanahan et al., "Paternity Establishment for AFDC Mothers," for discussion of characteristics of mothers who were likely to have paternity established.

⁴³Pirog-Good, "Teen Fathers and the Child Support Enforcement System."

⁴⁴Lerman, "Do the Earnings Deficiencies of Unwed Fathers Account for Their Low Child Support Payments?" Conference paper.

⁴⁵Wattenberg et al., "Executive Summary of a Study of Paternity Decisions."

⁴⁶Meyer, "Can Fathers Support Children Born outside of Marriage? Data on Fathers' Incomes over Time." Conference paper.

⁴⁷Adams et al., "Interorganizational Dependencies and Paternity Establishment."

⁴⁸The discussion of the Washington program is in John Hoover, Barbara Paulin, and Harry Wiggins, "Innovative State Programs: Washington, Delaware, and Virginia." Conference paper.

⁴⁹Adams et al., "Interorganizational Dependencies and Paternity Establishment."

⁵⁰Nichols-Casebolt, "Paternity Establishment in Arizona."

⁵¹U.S. Department of Health and Human Services, *Paternity Establishment*, 3rd edition (Washington, D.C.: National Institute for Child Support Enforcement, 1990).

⁵²Wattenberg et al., "Executive Summary of a Study of Paternity Decisions."

⁵³Nichols-Casebolt, "Paternity Establishment in Arizona."

⁵⁴Adams et al., "Interorganizational Dependencies and Paternity Establishment," p. 2.

⁵⁵Nichols-Casebolt, "Paternity Establishment in Arizona."

⁵⁶Price and Williams, "Nebraska Paternity Project."

⁵⁷Wattenberg et al., "Executive Summary of a Study of Paternity Decisions."

⁵⁸See Sara McLanahan, Judith A. Seltzer, Tom Hanson, and Elizabeth Thomson, "Child Support Enforcement and Child Well-Being: Greater Security or Greater Conflict?" Paper presented at conference, "Child Support and Child Well-Being," Airlie House, Airlie, Va., December 1991.

Research Opportunities

IRP Small Grants and Sabbatical Grants, 1992-1993

The Institute for Research on Poverty at the University of Wisconsin-Madison and the U.S. Department of Health and Human Services will sponsor the twelfth competition under the Small Grants and Sabbatical Grants program for research on poverty-related topics during the period July 1993 through June 1994. Subject to availability of funding, two programs are offered: (1) several grants of up to \$15,000 each (two months salary, plus related research costs) are available and do not require residence in Madison or Washington, D.C.; (2) a smaller number of grants of up to \$35,000 each are available for visitors in residence at either IRP or the Department of Health and Human Services during the 1993-94 academic year. The latter awards may be made for research sabbaticals or postdoctoral research. Researchers must hold the Ph.D. To obtain guidelines (available October 1), write to Small Grants Program, Institute for Research on Poverty, 1180 Observatory Drive, 3412 Social Science Building, University of Wisconsin, Madison, WI 53706. Application deadline: February 5, 1993.

University of Michigan's Research and Training Program on Poverty, the Underclass, and Public Policy

The University of Michigan's Research and Training Program on Poverty, the Underclass, and Public Policy offers one- and two-year postdoctoral fellowships to American minority scholars to expand knowledge in this area in all the social sciences. Fellows will conduct their own research and participate in a year-long seminar on Poverty, the Underclass, and Public Policy under the direction of Sheldon Danziger, Professor of Social Work and Public Policy, and Mary Corcoran, Professor of Political Science, Public Policy, and Social Work. Funds are provided by the Ford and Rockefeller Foundations. Applicants must have completed their Ph.D. by August

1, 1993. The application deadline is January 8, 1993. For an application packet, contact the Program on Poverty, the Underclass, and Public Policy, School of Social Work, 1065 Frieze Building, University of Michigan, Ann Arbor, MI 48109-1285.

Fellowships and Grants from the Social Science Research Council

The Social Science Research Council, through its Committee for Research on the Urban Underclass, is providing fellowships and grants in 1993 with funds from the Rockefeller Foundation. Research topics must be related to the urban underclass. Special emphasis is placed on the recruitment and training of minority students and scholars.

1. Dissertation fellowships are available to provide financial support for full-time research directed toward the completion of the doctoral dissertation. These fellowships offer stipends of up to \$1000 a month for up to 18 months and additional resources of up to \$4000 to cover research expenses incurred during the fellowship period. Applications will be accepted from any doctoral candidate who has completed all the requirements necessary for the Ph.D. except the dissertation, and whose proposal has been approved by the candidate's dissertation committee.

2. Faculty members and university administrators may apply for the support of undergraduate research assistance on topics related to the urban underclass. Stipends of up to \$4000 per student and research-related expenses of up to \$1000 per student are available for undergraduates who are members of minority groups. For group research projects, at least half of the students must belong to minority groups.

Applications must be postmarked by December 10, 1992. For further information and application materials contact Social Science Research Council/Research on the Urban Underclass, 605 Third Avenue, New York, NY 10158.

Myths about custodial fathers

Child support in the United States used to be straightforward: mothers were given custody of the children, and fathers, who normally had higher incomes, were ordered to pay child support. The situation may be growing more and more complex, however, as men increasingly receive custody of their children. Daniel R. Meyer, an IRP affiliate, and Steven Garasky, an economist at Iowa State University, have examined current trends in male custody and find that the reality differs in many respects from the common conceptions about custodial fathers. This article is based on their paper (see box, p. 14) exploring the myths about male custody.

Much has been written about the explosion in the number of single mothers and its detrimental effects on children, on economic security, and, indeed, on society. Very little, however, has been written about single fathers. Much has also been written about child support policies, but almost all discussions assume that it is the mothers who have custody of their children and that it is the fathers who are absent. Indeed, the major data source on child support—the Current Population Survey—Child Support Supplement—will finally include fathers beginning this year. Meyer and Garasky find that whenever the lack of attention on custodial-father families is mentioned, several reasons are given to explain why they do not need to be studied as extensively as female-headed families. These reasons are no longer valid. Among the myths that Meyer and Garasky dispel are the following: (1) custodial fathers always have high incomes; (2) there are not many custodial fathers; (3) most custodial fathers have remarried; (4) most custodial fathers are widowers, and all were married at some time; and (5) custodial fathers primarily receive custody of older boys.

Myth #1: Custodial fathers have high incomes

A significant percentage of father-only families live in poverty. More than 18 percent of all father-only families are poor, and almost half of these have incomes that are less than 50 percent of the poverty line. Another 21 percent have incomes that are no more than twice the poverty line.² Even the poverty rate among fathers who are married but have custody of children from a previous relationship is high. Estimates based on data from the 1985 Survey of Income and Program Participation (SIPP) indicate that nearly 12 percent of the families of these fathers are impoverished, and another 26.6 percent have incomes that are between 101 percent and 200 percent of the poverty line.

Still, as is well known, an extremely high percentage of mother-only families (43 percent) live in poverty,³ and the average income of father-only families is substantially higher than that of mother-only families. According to Meyer and Garasky, data from the Current Population Survey (CPS) indicate that in 1989 single fathers earned on average \$24,178, whereas the average for single mothers was only \$12,959. Never-married fathers earn 2.3 times as much as never-married mothers, and divorced fathers earn 1.5 times as much as divorced mothers.

Myth #2: There are not many custodial fathers

Many people think that the number of custodial fathers is so small that it is insignificant. In fact, some researchers use the terms “single-parent families” and “female-headed families” interchangeably, as if only women head one-parent families.⁴ At one time, female-headed families made up such a large percentage of one-parent families that researchers could safely assume that they were representative of all single-parent families. Today, however, this may no longer be the case. According to data from the CPS, in 1989, there were 1.4 million father-only families, compared with 7.4 million mother-only families and 25.5 million two-parent families.⁵ And although father-only families do constitute the smallest number of families with children in the United States, they have been growing at a faster rate than mother-only families and two-parent families. As indicated in Figure 1, between 1959 and 1989, the number of father-only families increased by almost 300 percent, with most of this increase occurring after 1973. The number of mother-only families increased by almost 200 percent during this same period, while the number of two-parent families remained the same.⁶

Myth #3: Most custodial fathers have remarried

Most custodial fathers are *not* currently married, although the percentage of custodial fathers who have remarried (41) is substantially higher than the percentage of custodial mothers who have done so (23).⁷ What Meyer and Garasky could not determine from the SIPP data, however, was whether remarried custodial fathers obtained custody of their children before or after they married again. It is possible that many fathers wait until they have remarried and have a more “stable” home before they take custody of their children.

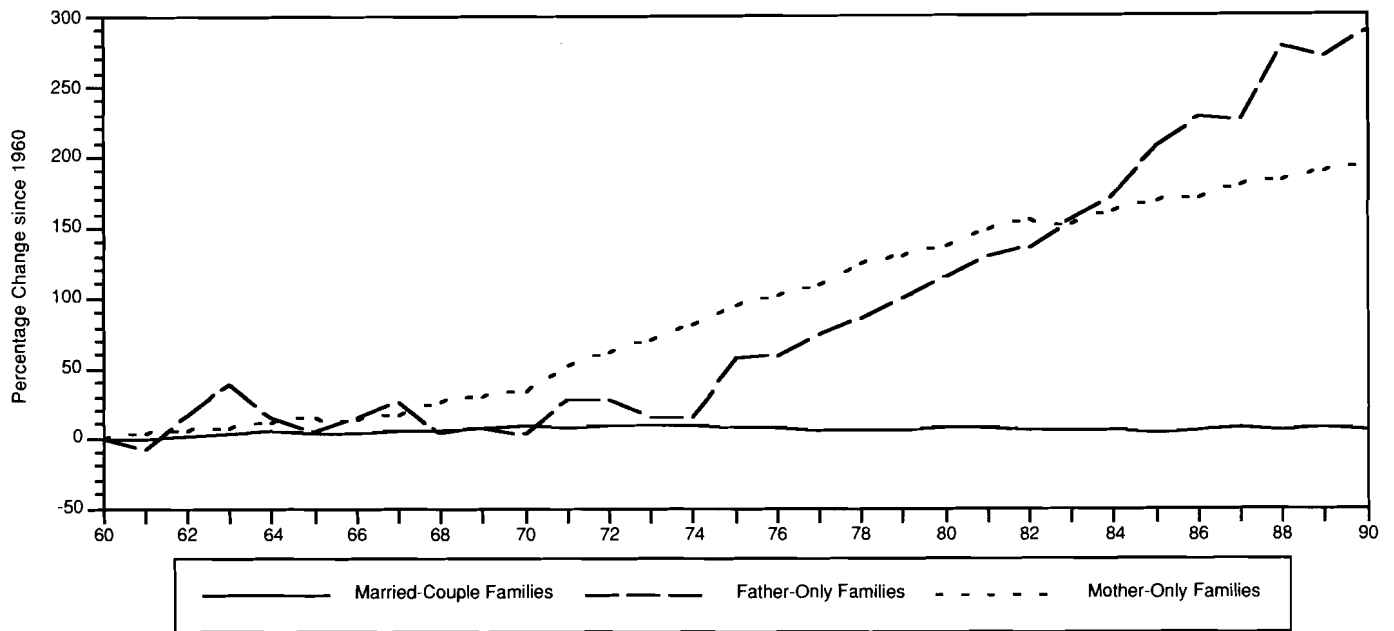


Figure 1. Growth among Family Types: Families with Children under 18.

Note: The figure includes the following: married-couple families with children under age 18; male householder, no wife present, with children under age 18; female householder, no husband present, with children under age 18. Widows and widowers are included. From 1979 on, unrelated subfamilies are not included.

Source: U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 168, *Money Income and Poverty Status in the United States: 1989* (Washington, D.C.: GPO, 1990).

Myth #4: Most custodial fathers are widowers, and all were married at some time

At one time, many custodial fathers were widowers and most had once been married. In 1970, about a third of all children in father-only families lived with widowers, and only a few lived with fathers who had never been married.⁸ But the number of children living with widowers decreased from 262,000 in 1970 to 150,000 in 1990, while the number living with never-married fathers increased dramatically, from 32,000 in 1970 to 488,000 in 1990.⁹ The number of children living with divorced fathers has also risen substantially over this same period, from 168,000 to over 1 million.¹⁰ Currently, of the children living in single-parent families headed by fathers, approximately 7.5 percent are in households headed by widowers, and 24.5 percent live in households headed by never-married fathers.¹¹

Myth #5: Custodial fathers primarily receive custody of older boys

This myth really has two parts: first, that fathers primarily obtain custody of older children and, second, that fathers are more likely to receive custody of boys. It is true that the children living in father-only families are older than those living in mother-only families; still, 17.5 percent of single-father families include children younger than three, and about one-third contain a preschooler.¹² Similarly, although the children in father-only families are somewhat more likely to be boys, 44 percent of all children in such families are girls.¹³

Policy implications

Child support policies are often based on two assumptions: that the mother always receives custody of the children and that the noncustodial parent always has the higher income. While these assumptions are still true for most child support cases, they simply do not hold for a growing number of other cases. In light of the evidence presented here, Meyer and Garasky believe that child support policies should be reexamined to ensure equity when the custodial parent is the father or when the custodial parent has a higher income than the noncustodial parent. Rather than recommend new policies, Meyer and Garasky list the following areas of current policy that may need further scrutiny.

Setting the amount of child support awards

The states establish their own rules for determining the amount of child support awards. Currently, there are two approaches to setting award amounts. One approach maintains that noncustodial parents should share their income with their children; accordingly, states should order noncustodial parents to pay an amount in monthly child support that is equal to what they spent on their children per month when they were living with them. The other approach holds that the amount of a child support award should equal the cost of raising a child, and that if the custodial parent earns enough income to meet that cost, then the noncustodial parent should not be required to pay any child support. These two approaches have different

Custodial Fathers: Myths, Realities, and Child Support Policy

by
Daniel R. Meyer and Steven Garasky

Technical Analysis Paper no. 42, 1991

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Office of the Assistant Secretary for Planning and
Evaluation, U.S. Department of Health and Human
Services, 202-245-1880. Forthcoming as IRP
Discussion Paper no. 982-92, 1992.

implications when the noncustodial parent's income is lower than the custodial parent's: making noncustodial parents share their income with their children would lead to a positive award, even if the income of a noncustodial parent was small; making award amounts equal to the cost of raising a child could lead to no award at all if the custodial parent's income were deemed high enough to meet that cost.

Almost all states use the first approach and order noncustodial parents to share their income, however small, with their children. However, evidence indicates that the application of this approach varies with the gender of the noncustodial parent.¹⁴ Specifically, regardless of how little a noncustodial father earns, he may be expected to provide some minimal amount of support for his children. Not all low-income, noncustodial mothers, however, are required to pay child support. Although at least one group of researchers argues that this is justified to offset the unfair treatment (e.g., lower wages for the same work) women otherwise receive at the hands of society,¹⁵ Meyer and Garasky recommend that the decision concerning the amount of a child support award be made without respect to the gender of the noncustodial parent.

Establishing paternity

Until fairly recently, paternity could only be established through the courts, by legal proceedings. Today, however, in several states paternity can be established without the involvement of the judicial system; in fact, some states only require that a man sign a notarized document acknowledging that he is the father of the children in question; no further "proof" is needed. Because more and more fathers are receiving custody of their children, Meyer and Garasky commend these new policies that make it quick and easy to establish paternity and suggest that *all* states adopt proce-

dures that enable paternity to be established in a simple and straightforward manner.

Future research on child custody issues

Currently, the United States does not have a federal child custody policy, and Meyer and Garasky do not believe one is needed. Most people believe that the courts are predisposed to giving custody to mothers. However, as the data that dispel the myths surrounding custodial fathers suggest, courts no longer automatically award sole physical and legal custody to mothers. Whether this benefits or harms families is under debate. What cannot be debated is the fact that further research is needed on the effects of different custody arrangements on the well-being of children. In particular, researchers should investigate the impact that particular custody arrangements have on the behavior, school performance, and health of children in one-parent families.¹⁶

Conclusion

Many child support policies were established under the assumption that women would always have sole physical and legal custody of their children. This assumption is no longer valid, however. Since 1973, the number of father-only families has increased at a faster rate than has the number of mother-only families, and today 15 percent of all single-parent families are headed by a father. In light of these developments, Meyer and Garasky argue that child support policies must be reexamined to ensure that they are appropriate for *all* the diverse custody arrangements that now exist. ■

¹⁴"Custodial fathers" refers to fathers who are not widowers and who have sole custody of their children; they live with their children, either alone or with a partner who is not the mother of the children. In this article, "father-only families" and "single-father families" are families that include only a father and the children he has custody of; "custodial-father families" are families that include a father, the children he has custody of, and an adult partner who is not the mother of the children. Custodial fathers may be in either type of family.

¹⁵Meyer and Garasky base these percentages on data from the 1990 Current Population Survey, which provides information that was current as of 1989. In 1988, the poverty line for a family of three was \$9435.

¹⁶U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 175, Table 4, *Poverty in the United States: 1990* (Washington, D.C.: U.S. GPO, 1991).

⁴For an example, see David T. Ellwood, *Poor Support: Poverty in the American Family* (New York: Basic Books, 1988). Also, Sara McLanahan and Karen Booth, in "Mother-Only Families: Problems, Prospects, and Politics" (*Journal of Marriage and the Family*, 51 [August 1989], 557–580; available as IRP Reprint no. 611), state that their review of single-parent families focuses only on mother-only families because "the number of [father-only families] is still small—less than 10% of all one-parent families."

⁵U.S. Bureau of the Census, *Poverty in the United States: 1990*. Thus, father-only families make up 15 percent of all one-parent families.

⁶U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 168, *Money Income and Poverty Status in the United States: 1989* (Washington, D.C.: U.S. GPO, 1990).

⁷Meyer and Garasky's tabulations based on SIPP data.

⁸U.S. Bureau of the Census, Current Population Reports, Series P-20, No. 212, *Marital Status and Family Status: March 1970* (Washington, D.C.: U.S. GPO, 1971); and Current Population Reports, Series P-20, Nos. 287, 365, 410, and 450, *Marital Status and Living Arrangements* (Washington, D.C.: U.S. GPO, 1975, 1981, 1986, and 1991).

⁹*Ibid.* In the CPS, the number of father-only families headed by men who have never been married is, surprisingly, much larger than anticipated. The SIPP estimate of the number of never-married fathers who head families is much smaller, about 100,000 in 1986, compared to 350,000 in the CPS in 1990. One reason for this discrepancy is that the number of never-married single fathers has grown rapidly during this time period: from the 1987 to the 1990 CPS the number increased from 209,000 to 345,000, a 65 percent increase in three years. Although some of this increase may be due to the increase in children living with parents who cohabit, even in 1990 only one-third of all never-married fathers had a female partner living with them, and in some of these instances that partner may not have been the children's mother.

¹⁰*Ibid.*

¹¹*Ibid.*

¹²Meyer and Garasky's tabulations based on 1987 CPS data.

¹³Meyer and Garasky's tabulations based on 1990 CPS data.

¹⁴See Donna Hendrickson Christensen, Carla M. Dahl, and Kathryn D. Rettig, "Noncustodial Mothers and Child Support: Examining the Larger Context," *Family Relations*, 39 (1990), 388–394.

¹⁵*Ibid.*

¹⁶Nicholas Zill has begun to study these questions; see Zill, "Behavior, Achievement, and Health Problems among Children in Stepfamilies: Findings from a National Survey of Child Health," in E. M. Hetherington and J. D. Arasteh, eds., *Impact of Divorce, Single Parenting, and Stepparenting on Children* (Hillsdale, N.J.: Lawrence Erlbaum, 1988).

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Changing the U.S. health care system: How difficult will it be?

by Barbara L. Wolfe

Barbara L. Wolfe is Professor of Economics and Preventive Medicine, University of Wisconsin–Madison, and an IRP affiliate.

Issues of health care reform are gaining increasing attention and are now very high on the list of current public policy concerns in the United States. Two central problems face the U.S. health care system. One is the increasing cost of medical care; the other is the lack of health insurance for growing numbers of citizens. Yet major change is unlikely in the near future. Why is this?

Problems of the U.S. health care system

Costs

The United States spends more money per capita on health care than any other country.¹ Furthermore, health care costs continue to increase at a high rate: in the last decade, every 40 months the share of the Gross National Product (GNP) spent on health care went up by 1 percent. It was 12.3 percent in 1990 and, according to some experts, is expected to be 14 percent this fiscal year.² Even if the rate of increase remained constant, by the year 2000 the United States would be spending at least 15 percent of its GNP on health care.

Most of the costs for health care are paid by so-called third parties—private insurers, public insurance, public direct provision. Only about 25 percent of the costs are paid directly by consumers.

The dominant form of health insurance in the United States is private insurance. Approximately three-quarters of U.S. citizens are covered by private plans (two-thirds of these are covered by employer-based plans); 18 percent are covered by public plans (Medicaid and Medicare), and 13.9 percent have no coverage.³ Many people—particularly the elderly—are covered by both private and public plans.

About 9.7 percent of the population, including more than 15 percent of all children, are covered by Medicaid,⁴ a joint federal-state public program that pays for the health care of low-income and disabled citizens. The greatest outlay of Medicaid funds, however, goes to the elderly. In 1990, 27 percent of total Medicaid spending was for nursing home care (excluding care for the mentally retarded).⁵ The largest public program to provide health insurance is Medicare, a federal program providing coverage to those 65 and over and the disabled who qualify to receive Social Security.⁶

For businesses, the cost of health care is escalating rapidly, more rapidly than inflation and their profits from increased productivity combined. This situation limits a firm's ability to shift the increase in premium costs to employees.⁷ Instead, businesses are offering less generous plans: They are increasing deductibles and/or the co-insurance rate and, more important, they are reducing coverage of the dependents of workers. Coverage for part-time employees has been cut, as have benefits for temporary employees.

One aspect of health care costs that has become increasingly important to U.S. firms is the liability to pay for health care benefits promised to retirees. Beginning this year, firms have to report on their financial statements the unfunded liability of health insurance benefits promised—the estimated amount they owe their retirees in health benefits. One early estimate is a \$227 billion liability in 1988 dollars.⁸

Health care expenditures are also an increasing problem for the public sector. Medicaid continues to grow as a share of state budgets, reflecting both price increases and increases in benefits and eligibility mandated by the federal government. Similarly, health care spending is a major problem for the federal government—it is the second fastest growing component of the federal budget (outpaced only by the growth in the public debt). At both levels of government, health care spending accounts for at least 14 percent of total expenditures.⁹ These costs create fiscal pressures on the governments and limit their ability to respond to other needs, including reducing their budget deficits.

The uninsured

The other major aspect of the health care dilemma is the increasing numbers of persons without health insurance. This problem has grown as firms have cut back on private coverage, as persons have become unemployed, as increasing numbers have taken jobs in industries that tend not to provide coverage (such as the service sector), and as states have attempted to reduce their Medicaid expenditures by restricting eligibility for Medicaid (and welfare). Approximately 34.6 million U.S. citizens do not have any health insurance coverage,¹⁰ and millions more have too little health insurance to cover the costs of catastrophic illnesses or serious injuries.

The probability of being uninsured is far greater among persons who live in families with incomes below the poverty line or just above it compared to those who live in families with higher incomes. Young persons are much more likely to be uninsured than older persons, and those living in single-parent households are less likely to be protected than childless couples.

Strong evidence exists of a link between insurance coverage and utilization of medical care.¹¹ Those with insurance use more care, controlling for health, age, and location, than those without coverage; those with more extensive coverage use more care (at least outpatient care) than those with limited coverage. The lack of coverage causes financial insecurity, inequitable burdens across communities, increased costs for businesses (which must pay higher premiums to cover the costs to medical facilities of care for uninsured and underinsured persons), and increased participation in welfare programs such as Aid to Families with Dependent Children, in addition to delayed and forgone medical care.

Proposed alternative health care plans

Many economists, policy analysts, and politicians have proposed alternative health care plans. These plans can be classified into four categories: employer mandates, expansion of current arrangements, tax incentives, and nationalized health insurance. The employer mandate, the so-called pay-or-play plan, requires employers to provide some minimum level of coverage to all employees and their dependents. Employers could either provide insurance to employees directly, following set specifications both on the breadth and depth of insurance coverage and the “proportion of the premium paid for by the employer,”¹² or they could pay a fixed percentage of their payroll (or a fixed percentage up to a maximum per employee) into a pool, the funds from which would cover the cost of insurance for their employees and their dependents. The insurance pool would be organized by (but not necessarily run by) the public sector and would also offer insurance to those not otherwise covered.¹³ Individuals insured through this ar-

angement are likely to pay a significant portion of the cost of coverage. Firms having few workers may be exempted from this mandate. The current plan in Hawaii is an example of pay-or-play. All employees (but not their dependents) who work twenty or more weeks in a year are covered.

The second set of plans—to expand the current public programs—would permit various persons with specific characteristics to “buy into” Medicare or Medicaid, at a cost that is related to their income. For example, all pregnant women, infants, and young children; disabled persons; and/or those who retire before age 65 (the current age for eligibility for Medicare) might be given access to one of these public programs. The current 24-month waiting period for Medicare coverage of the severely disabled is likely to be reduced or eliminated.

A third set of plans would modify the two tax incentives currently in place regarding health insurance. The first is a tax subsidy for the purchase of employer-based coverage. This subsidy, by omitting the employer’s contribution to health insurance from the employee’s reported income, eliminates both payroll and income taxes on this component of compensation.¹⁴ The second tax subsidy is included in the federal income tax: One can claim a tax deduction for medical care expenditures (including privately paid insurance premiums), for amounts greater than 7.5 percent of adjusted gross income.

The current set of incentives is worth more to higher-income persons, since the value of the incentives depends on one’s marginal tax bracket.

Proposed modifications would provide refundable tax credits¹⁵ to low-income families,¹⁶ and/or set a maximum on the amount of the employer-based premium that can be excluded from the employee’s tax base.¹⁷ This maximum could be based on an actuarial cost of a basic insurance plan for families of specified sizes and ages (with an adjustment for disability). A third alternative would combine employer-based insurance incorporating a high deductible (say a family would have to pay \$36,000 per year before receiving reimbursement) with an employer contribution to a tax-free medical savings account to cover deductibles and other health costs. The savings account would work like an Individual Retirement Account (IRA). The employer contribution would be based on the savings from shifting to a new insurance plan with a much higher deductible. The funds could be used for deductibles, for insurance premiums (should the individual not be employed), or for long-term care. The employee would keep any savings amounts not spent, subject to certain limitations on withdrawals.

President Bush’s proposal is an example of a plan that uses tax incentives. His proposed plan would provide a refundable tax credit to those with family incomes below the poverty line; a sliding-scale nonrefundable tax credit to

families with incomes up to \$80,000 (in 1992 dollars) and to single persons with incomes up to \$50,000; and a tax credit to all the self-employed without regard to income. For 1992, the tax credit would be \$3750 for a family or \$1250 for an individual, usable only to purchase health insurance. The value of the credit would increase by the rate of overall price inflation.

The final set of policies being discussed is some form of nationalized health insurance. They range from combining the expansion of public programs with mandated coverage to full-blown single-payer systems (in which the government pays for all medical care) like that of Canada (see below). Providers of care remain private, but the financing is public. One primary focus of these plans is to eliminate the high cost of overhead caused by the duplication of forms, administration, etc., of multiple payers.

The German system of medical care resembles that of the United States in some ways: care outside of hospitals is provided by private practitioners who are paid on a fee-for-service basis and who provide care to patients who choose them; hospital care, however, is provided by doctors who work for the hospital and are paid a salary. (The fees paid to physicians are based on a negotiated fee schedule,¹⁸ whereas the hospital payment is based on a negotiated per diem rate.)¹⁹ Most persons receive insurance through their place of employment (many plans are based on occupation), and health insurance is offered by numerous insurers. Unlike the situation in the United States, 90 percent of these insurers are nonprofit and are known as sickness funds. These sickness funds are more heavily regulated than U.S. insurers: they must offer a minimum plan; employees and the self-employed (except those with high incomes) must enroll in a plan; dependents must be covered; unemployed and retired persons (and their dependents) must be covered by the sickness fund that covered them while employed; no deductibles are permitted; and there is cost-sharing only for hospital care and prescription drugs. Financing is via mandatory payroll contributions of about 13 percent of wages, subject to a ceiling. These payroll taxes cover the costs of the entire system.

The Canadian plan combines private fee-for-service practitioners with hospitals that operate on a budget that is set annually. Long-term care is provided as part of the system. Providers are paid according to a fee schedule and patients cannot be charged directly—there are no co-payments. All citizens of Canada are covered; the central government covers a share of the cost of the plan, the provinces, the rest. Each province has its own plan to provide additional financing, determine fee schedules, regulations, etc. Compared to the United States, fewer practitioners are allowed to practice (in a number of the provinces); there is far less investment in new capital and less diffusion of new technology; there is more queuing and more denial of care. On the plus side, greater contact exists between physicians and patients, and financial insecurity caused by the uncertainty

of the costs of future medical care and insurance coverage has all but been eliminated.

Why is change difficult?

It is unlikely that the United States will change its health care system substantially in the next few years. Minor reforms may occur on the state or local level; tax incentives may well be altered to subsidize the cost of buying insurance for those not insured at their place of employment; but no major national change can be expected. There are several reasons for this:

1. It is generally assumed (and feared) that extending coverage to those who are currently uninsured will substantially increase the costs of medical care. This may not, in fact, be true. About half of those uninsured at any point in time will have coverage within about eight months,²⁰ and their overall utilization of the system is unlikely to increase substantially if they have coverage all of the time rather than intermittently. In addition, most persons without insurance do receive care when they become seriously ill. The cost of this care is already included in medical care expenditures. Some increase in expenditures on medical care can be expected, at least in the initial period in which coverage is extended, but the total cost of such increased coverage will be smaller than is publicly perceived.

2. Entrenched interest groups wish to avoid any change that might penalize them. The private insurance sector, including its employees, for example, is bound to fight against the shift to public provision of health coverage or mandated private coverage of high-risk persons. Private health providers (depending on the proposed plan) may fear reduced compensation and further regulation of their services. Suppliers of medical equipment—a broad spectrum of companies—may fear loss of business. Employees and their dependents who are currently covered by plans provided at their place of employment with little cost-sharing required of them also have an interest in maintaining the status quo, as do employees covered by the policy of other family members. Employers in firms that do not offer insurance or offer only limited coverage may fear the increase in costs. And low-income earners may place a smaller value on health insurance than the cost to them of proposed plans.

Parties who might gain tend to be more diffuse and may not coalesce to lobby for a proposed change. These groups include employers who now provide extensive coverage to their employees and the dependents of their employees; providers who primarily serve low-income people, especially those who are uninsured; individuals who are not covered because they are high risk and/or do not have the option of obtaining coverage at their place of employment; employees who see their cash compensation eroding as the cost of insurance coverage takes a larger and larger share out of their paychecks; and, finally, employees who fear the

loss of coverage either because of anticipated reductions in breadth of coverage or loss of their job.

3. Mandating coverage may increase unemployment, particularly for low-skilled workers, and may force some small businesses into bankruptcy. At this time of relatively high unemployment, this is a serious danger. It is a problem, however, primarily for the employer-provided pay-or-play plans.

4. Many citizens (employers, employees, and others with private income) fear that a number of these plans will lead to higher taxes—and hence reduce their net income. Whether net income is reduced depends on the plan adopted, its financing, and the individual's current situation. Most of the new plans appear more costly to employees than the system in place, because few employees fully understand that they are now paying (albeit with pretax dollars) for most of their health insurance. Furthermore, employees are not likely, at least immediately, to obtain the full value of their current contribution to health insurance (this refers to the component now known as the employer's contribution) in their paychecks if coverage is removed from their place of employment.²¹ Under any scenario, some persons will lose (pay more, get less coverage) and others gain (obtain coverage, pay less). But it is difficult to predict accurately what sort of redistribution of costs and benefits will occur. (We really do not fully understand who actually pays for medical care today.)

5. Although there is little willingness to provide the highest quality care to those publicly insured (for example, to those on Medicaid), there is also an unwillingness to “bite the bullet” and ration health care or to set up clearly defined dual standards of care. Many are also reluctant to hold down the rate of improvement in technology or to move away from the so-called technological imperative (do all that is technologically possible to save a life). But at least some members of the public may no longer hold this position. The rapid spread of living wills demonstrates that individuals sometimes choose to limit major life-saving efforts when there is little chance of long-term survival or for a high-quality life. The state of Oregon has also moved away from the goal of providing all possible health services to a limited number of Medicaid recipients. It is attempting instead to provide coverage to a greater number of persons by establishing a list of medical priorities and allocating a specified level of dollars according to that priority list. Other care will not be provided under the Oregon Medicaid plan.²²

What can be done?

What all of this suggests is that major change is unlikely in the next few years, but that more realistic attitudes toward medical care are likely to increase the probability of change in the more distant future. More accurate information would be a first step in evolving more realistic attitudes. If

people had an accurate picture of how much they are paying—and for what—they could better assess proposed changes. The United States has a good deal to learn about its health care system and a good deal to teach its citizens if productive change in its health care system is to take place.

Absent any major shift, however, steps can be taken to patch the current health care system. One such step would be to provide coverage for a specific set of services to *all* children under the age of nineteen under what I call a Healthy-Kid program. Primary care would be provided in community care centers, where parents and children would go for children's care. Further medical care would be referred to other private providers, but with the community care center as the manager of the care for all children who live in the area.²³ Certain basic care, such as immunizations, would be provided to all children without charge; specific additional care would require co-payments which would be income conditioned. That is, higher-income families would pay higher charges. The plan would also cover pregnant women—again with co-payments tied to income. The plan would be operated through the Health Care Financing Administration (HCFA), which now runs Medicare. The payments to the community providers would be in the form of a prepayment for all specified services (similar to payments to a Health Maintenance Organization), except for required co-payments. The payments to providers would not depend on the income of the child's family but only on geographic location (and, perhaps his or her underlying health status for those with a chronic condition).²⁴ The (group of) community providers would be responsible for paying all of the additional costs of care for children in their jurisdiction; HCFA would provide reinsurance above a set limit (that is, they would cover medical expenses over a very high amount, say \$100,000).

Children are relatively inexpensive to cover. Including all of them in one program would avoid a dual-quality system, ensure access to basic preventive services, and provide access to family planning and prenatal care for teenagers, who would know where to go to receive assistance. Providing coverage for children would reduce the cost of employer-based and other private coverage, increasing thereby the probability of greater private coverage for adults.²⁵ Locating programs in communities would increase the likelihood that residents would use the appropriate clinic rather than emergency rooms and other expensive and inefficient forms of care. Providing coverage for pregnant women in their communities should encourage the early use of prenatal care and hence decrease the need for high-cost care such as intensive care for infants with low birth weights.

A second step that could be taken would be to cap the tax subsidy on employer-based health insurance. If a cap is enacted, it is likely to lead to a redesign of policies to provide protection for major health problems. Insurance companies would have an incentive to design policies to provide full coverage for care that is cost-effective (immu-

nizations, certain screening programs) but would require significant co-payments for other care. Insurers would face a new incentive: to provide coverage such that the premium was not much beyond the cap, thereby reducing the cost of the plan. Employees would become aware of the cost of their insurance, for they would directly pay any amount over the cap with posttax dollars and would have increased co-payments as well.

A cap on the tax subsidy for health insurance and the introduction of Healthy-Kid are useful first steps, therefore, both toward improving the current U.S. health care system and toward forcing us to realize what it costs. ■

¹As of 1990, the United States spent \$2,566 per person, or \$666.2 billion, on health care (U.S. House of Representatives, Committee on Ways and Means, *1992 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means* [Washington, D.C.: GPO, 1992], pp. 288–289).

²The increase has several causes, including the aging of the population (older persons use far more medical care than younger persons); the improvements in technology, which extend life and improve the quality of life but are expensive in terms of real resources; and the third-party payer system (see text), which makes possible the rapid spread of new technology but reduces the incentive of consumers to search for lower-priced care and increases the probability that they will demand care for any given health problem.

³*1992 Green Book*, pp. 312–313.

⁴*Ibid.*, p. 1646.

⁵*Ibid.*, p. 281.

⁶Persons on end-stage renal dialysis are also eligible, regardless of their eligibility for Social Security.

⁷It is difficult for firms to reduce nominal wages. Hence, if there is little growth in productivity or little increase in prices, firms are constrained in their ability to shift to employees the burden of paying for increases in health insurance. Over time, as prices increase and as productivity increases, the increased cost of health insurance can be passed on to employees.

⁸Estimate from the U.S. General Accounting Office, HRD-89-51.

⁹According to K. Levit and C. Cowan, “Business, Households, and Government: Health Care Costs, 1990,” *Health Care Financing Review*, 13 (Winter 1991), 83–93, Table 5, including expenses for employees, 17.2 percent of federal revenue and 16.3 percent of state and local revenue go for health care.

¹⁰*1992 Green Book*, p. 311.

¹¹See for example, K. J. Arrow, “Uncertainty and the Welfare Economics of Medical Care,” *American Economic Review*, 53 (1963), pp. 941–973.

¹²This is in quotes, for most economists believe that, with the exception of workers at a mandated minimum wage, employees bear the bulk of the cost of insurance in terms of forgone earnings. However, if there is a

sudden increase in coverage, it may take time for the full share to be shifted to employees. This occurs because it is difficult to reduce nominal wages.

¹³The public sector would also provide a subsidy toward the purchase of health insurance for those with low incomes. However, if the “pay” part of the pay-or-play plan were large enough, this would not be necessary.

¹⁴Employees of certain types of firms can also set up a special account which allows them to omit their own expenditures for health care from their income for income tax purposes. Once a year, a decision can be made to put an amount they specify into an account set up for the purpose of paying for health care expenditures. If funds remain at the end of the year, they are not returned to the individual.

¹⁵Under a refundable tax credit, the government refunds to the taxpayer any amount of the credit remaining after taxes are paid.

¹⁶The formation of risk pools is another alternative that is sometimes discussed in conjunction with refundable tax credits. Single individuals, families, or small firms generally must pay far more for the same insurance coverage than persons in large groups. Risk pools combine groups of individuals or small groups of employees to reduce the surcharge insurance companies charge small groups or individuals. (The surcharge reflects both higher costs of selling to small groups and the fear of adverse selection—that only those with the greatest expected medical expenditures will purchase individual policies.)

¹⁷A proposal to reduce the tax subsidy to high-income persons is a more limited form of such policies.

¹⁸These fee schedules are based on a relative-value scale similar to that being introduced for Medicare. The actual schedule differs across regions and is the result of negotiations between regional associations of physicians and the nonprofit insurers. They can be lowered toward the end of the year if expenditures on physicians are high relative to a goal or cap.

¹⁹These rates are based on annual global (all-inclusive) budgets set for each hospital, the result of negotiations between each hospital and the regional association of insurers.

²⁰K. Schwartz and T. McBride, “Spells without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured,” *Inquiry*, 27 (1990), 281–288.

²¹Firms are likely to wait to see how much they will have to contribute under any new financing plan, and they may seek to establish alternative fringe benefits to promote employee loyalty. Both of these likelihoods reduce the amount firms are willing to offer employees as cash compensation.

²²The plan must be approved (i.e., granted a waiver) by the federal government before it can be put into effect. In its present form, the waiver has been rejected by the Bush administration.

²³The providers in the community care center would be either private providers who contract to provide care at the center as well as manage all additional care for the children served by the center or, in certain limited cases, publicly employed providers.

²⁴The conditions covered would be limited and might include certain cancers, AIDS, and a few other expensive chronic conditions. The adjustment would be a multiplicative factor such as 1.5 times the basic prepayment.

²⁵For private insurance companies, Healthy-Kid may represent a trade-off: a loss of the market for children and pregnant women but an increase in the market for adults.

IRP summer research workshop: Problems of the Low-Income Population

The third annual summer research workshop focusing on applications of new methods of empirical analysis to poverty research was held June 16–20, 1992. Organized by Robert Moffitt, Brown University, and Charles F. Manski and Robert Mare, University of Wisconsin–Madison, this series of workshops is designed to build a community of research interest around topics concerning the low-income population and to draw junior researchers into the field. The following presentations were made:

Joseph Altonji, Northwestern University, “The Effects of High School Curriculum on Education and Labor Market Outcomes”

Discussant: Eric Hanushek, University of Rochester

David Blau, University of North Carolina, “Labor Force Dynamics of Older Men”

Discussant: Richard Burkhauser, Syracuse University

Aimee Dechter, University of North Carolina, “The Effects of Women’s Economic Independence on Union Dissolution”

Discussant: Pamela Smock, University of Wisconsin–Madison

Thomas Downes, Northwestern University, “On Estimating Individual Demands for Local Public Goods from Aggregate Data”

Discussant: Guido Imbens, Harvard University

Daniel Friedlander, Manpower Demonstration Research Corporation, and Philip Robins, University of Miami, “Estimating the Effect of Employment and Training Programs: An Assessment of Some Nonexperimental Techniques”

Discussant: Joseph Hotz, University of Chicago

Paul Gertler, Rand Corporation, “Family Productivity, Labor Supply, and Welfare in a Low-Income Country” (coauthor, John Newman)

Discussant: Marjorie McElroy, Duke University

Peter Gottschalk, Boston College, and Robert Moffitt, “Earnings Inequality and Earnings Mobility: Evidence from Panel Data”

Discussant: Thomas MaCurdy, Stanford University

Mark Gritz, University of Washington, and Thomas MaCurdy, “Participation in Low-Wage Labor Markets by Young Men”

Discussant: James Walker, University of Wisconsin–Madison

David Grusky, Stanford University, “Modeling Cross-National Variability in Occupational Sex Segregation” (coauthor, Maria Charles)

Discussant: Robert Hauser, University of Wisconsin–Madison

Lingxin Hao, University of Iowa, “Support Systems, Mother’s Time at Home, and Children in Poverty”

Discussant: Judith A. Seltzer, University of Wisconsin–Madison

Kathleen Harris, University of North Carolina, “Work and Welfare among Single Mothers in Poverty”

Discussant: Robert Moffitt

James Heckman, University of Chicago, “Audit Pairs for Racial Discrimination: Methodology and Estimates”

Discussant: Glen Cain, University of Wisconsin–Madison

Guido Imbens, “Average Causal Response with Variable Treatment Intensity” (coauthor, Joshua Angrist)

Discussant: Charles F. Manski

Christopher Jencks, Northwestern University, “Is the Underclass a Useful Analytic Category?”

Discussant: Peter Gottschalk

Alan Krueger, Princeton University, “Estimates of the Economic Return to Schooling from a New Sample of Twins” (coauthor, Orley Ashenfelter)

Discussant: James Heckman

Robert Meyer, University of Wisconsin–Madison, “Performance Indicators in Education”

Discussant: Joseph Altonji

Steve Sandell, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, and Barbara Goldman and Daniel Friedlander, Manpower Demonstration Research Corporation, Roundtable: “Performance Standards in the JOBS Program”

Arthur Sakamoto, University of Texas, “The Effect of Schooling on Earnings in Japan”

Discussant: Thomas DiPrete, Duke University

John Karl Scholz, University of Wisconsin–Madison, “The Relationship between Public and Private Transfers” (coauthors, William Gale and Nancy Maritato)

What we know about the effects of foster care

Social agencies have no more awesome power than the right—with due process of law—to take children from their parents for an indefinite period of time and dispose of them as they see fit. Although no one disputes the need for foster care, no one endorses it as a solution to the problems for which it is invoked. When children are abused or neglected by their parents, or when the parents cannot—for any of a number of reasons—care for their children, someone must intervene to see that the children are adequately looked after. That someone is usually the government, and the intervention is frequently foster care.

“There has always been, and will always be, a tension in the child welfare field between child saving and family preservation.”¹ To the question, “What is best for the child?” no firm answer can be given because the parenting behavior of families in stress is highly unpredictable, and the impact of foster care remains to be measured. In an effort to explore the consequences of foster care, Thomas McDonald, Reva Allen, Alex Westerfelt, and Irving Piliavin, with the support of the Institute for Research on Poverty, have carried out an extensive review of the research that has been done on one aspect—doubtless the most important—of foster care (see box). They focus on “outcomes,” that is, the long-term effects of foster care on the functioning of adolescents and adults.

Foster care is care for children outside the home that substitutes for parental care. The child may be placed with a family, relatives or strangers, in a group home (where up to a dozen foster children live under the continuous supervision of a parental figure), or in an institution. Whatever its form, foster care is an enormous upheaval in the life of a child, who often must adjust not only to a different family, a different location, a different school, and different peers, but to a different culture as well. Important decisions concerning the lives of foster children are in the hands of strangers—courts, social welfare agencies, substitute parents, any one of which may have custody of the child. At the same time the biological parents may maintain their physical and emotional ties with the child. In fact these ties are considered crucial, for the essence of foster care is that it is a temporary expedient, since “it is generally agreed that it is in the best interests of children to live with their families.”² Yet it is argued that this temporary expedient often becomes a permanent state, from which the child escapes only into adulthood and putative independence.³

The adjustment to foster care would be difficult enough for children from stable backgrounds, but the children requiring foster care can seldom be so described. Most—between 75 and 80 percent—are taken from their homes because their parents fail to care for them adequately. The failure may be brought about by a sudden calamity, such as physical or mental illness or imprisonment of the care-giving parent. Or the parents may be drug addicts, oblivious of parental responsibilities. Or they may abuse, neglect, or abandon their children.⁴

Between 15 and 20 percent of foster children enter the system because they have problems with which the parents cannot cope.⁵ The child may, for example, be retarded or have mental or physical handicaps. Less than 5 percent of the cases are caused primarily by environmental factors such as financial need, inadequate housing, or chronic unemployment, but poverty frequently contributes to the crises that require children to be placed in foster care.⁶

History of foster care

Unprotected children have not fared well over the course of history. Children are the quintessential victims: helpless, delicate, and demanding. Infanticide and abandonment are as old as recorded history (witness Oedipus) and are thought to still be commonplace in countries with large poor populations. In many instances such extreme measures were deemed necessary—when, for example, there was insufficient food to go around.

Churches and workhouses gradually lessened the outright murder of infants in Europe after the Middle Ages, although the vast majority of infants placed in foundling homes died in their first year. Because older children had some economic value for the work they could perform, they were indentured. Indeed they were not considered children, but rather small adults as far as work was concerned, except they had none of the rights of adults. In Tudor England, children reached the age of majority at nine. David Copperfield and Oliver Twist bear witness to the life of such children in the nineteenth century. At that time laws pertaining to cruelty to animals were much more stringent than laws dealing with cruelty to children, and in at least one case, a child was removed from abusing parents on the grounds that she was a member of the animal kingdom.⁷

**Assessing the Long-Term Effects
of Foster Care:
A Research Synthesis**

by

Thomas McDonald, Reva Allen, Alex Westerfelt,
and Irving Piliavin

IRP Special Report.
Forthcoming

The rights of children have only gradually been established: Until recently parental rights were considered inviolate. The United Nations Declaration of the Rights of the Child in November 1954 was an important milestone in stating the rights that children should have.⁸ And in the United States a number of legal rights for children have emerged, often in conflict with the rights of parents.⁹

The first well-known foster family care program in the United States was The Placing Out System of the New York Children's Aid Society. This program was established by Charles Loring Brace in 1853, with the goal of disposing of vagrant children. Children were rounded up from the city streets and obtained from institutions and shipped to rural communities in the West or South, where committees of citizens arranged for them to be taken in by families. A description of the procedure makes it sound like a slave auction, and it was generally conceded that the motives of the families with whom the children were placed had more to do with self-interest than Christian charity.¹⁰ Though many of the children were not orphans, they were permanently severed from their biological families.

Despite some opposition, the idea caught on, and by 1923 thirty-four states contained private organizations engaged in shipping children to communities far from their homes, and it is estimated that 100,000 children were placed from New York City alone between 1854 and 1929.¹¹

The evolution of foster family care is closely related to the evolution of substitute care in institutions. At about the same time that The Placing Out system came into use, about twenty states opened public orphanages to provide temporary homes for destitute children. These orphanages were thought to be a great improvement over the almshouses, which housed not only children, but insane, senile, and diseased adults. However, for many years a debate raged over whether an institution or a foster family home was more desirable. As more and more states passed laws prohibiting the placement of children in almshouses, foster family care came into wider use. The concept of foster family care eventually won out and was recommended as the best substitute for a natural home at a White House Conference on Children in 1909.¹²

The rate of children in substitute care of all kinds appears to have peaked in the early 1930s. With the passage of the Social Security Act in 1935, rates declined dramatically. Most of the decline, however, was the result of decreased use of placements in institutions. Foster family care rates remained relatively stable until 1960, when they began to rise significantly.¹³

Although foster family care is still held to be better for children than institutions—except in special cases, as when the child needs special care that a family cannot provide—it is increasingly under attack. For no sooner was it established as a solution to the problem of unprotected children than it began to be seen as a problem itself, standing in the way of reunifying families.

The system is blamed for maintaining children in temporary situations when the best arrangement for them is permanent placement in homes with biological or adopted parents. The longer a child is in foster care, it is argued, the more he or she becomes estranged from his biological parents and the less likely becomes the option of adoption. Nor is there any guarantee that the child will stay in a single foster-care setting. He or she may be moved from temporary setting to temporary setting, each requiring the enormous adjustment discussed earlier. Indeed, caseworkers would sometimes deliberately move a child who was establishing strong bonds with a foster family, if that child was expected eventually to return home. Concern that foster care stands in the way of reunification or adoption has caused the federal government to reassess and alter its arrangements for funding foster care (see below).

Role of government

The individual states bear the principal responsibility for the welfare of children, and each state has its own administrative and legal structures and programs to address the various facets of child welfare: supportive services for families, the provision of financial assistance, and placement of children outside the home.

Federal funding in this area as in many others is designed to encourage the states to operate in a fashion that is assumed by the federal government to be in the best interest of all citizens. In the area of foster care, this approach has entailed first support for and then restrictions on foster care.¹⁴

In 1961 federal matching funds were authorized specifically to pay for the maintenance of poor children who were eligible for Aid to Dependent Children (ADC, now AFDC) when they were placed in foster homes or child care facilities, if it was determined that living at home was counter to the child's best interests. This amendment to the Social Security Act (P.L. 87-31) was a response to the refusal of states to provide ADC payments to otherwise eligible children who were living in "unsuitable" homes. At first tem-

porary, this arrangement (under Title IV-A, the section of the Social Security Act which funds AFDC) was made permanent in the 1960s, after which program expenditures grew rapidly. Foster care appeared to become the treatment of choice for at-risk children covered by AFDC, since little federal money was available to otherwise provide for these children. Some federal funding was available for preventive and permanency services through the Child Welfare Services Program (Title IV-B of the Social Security Act). Although Title IV-B was designed to provide services to families and reduce the need for foster care by addressing problems that could cause neglect, abuse, exploitation, or delinquency of children, the funds in this program were limited, and since they were not restricted to poor children (as stipulated for the Title IV-A funds), states tended to use them to help cover the costs of maintenance in foster care of children not eligible for AFDC—approximately two-thirds of the foster care population.¹⁵

In 1974 the enactment of P.L. 92-672 (Title XX) made a third federal program available for children. Now called the Social Services Block Grant Program, it entitled states to funding to provide social services and to train staff to carry out the work. The Title XX funds became block grants in 1981, to be allocated to states on the basis of their population. However, only a small portion of this money was spent on protective services for children.

During the seventies the number of children in foster care grew rapidly, and it was suggested that the foster care program provided fiscal incentives to the states to place children in foster care and keep them there rather than prevent the need for placement in the first place. Because Title IV-A was an open-ended entitlement, whatever the state paid for AFDC foster care was reimbursed by the federal government at the AFDC reimbursement rate (between 50 and 83 percent of the cost). Title IV-B and Title XX provided only limited federal funds for children; preventive and rehabilitative services were funded primarily at the state and local level.

The concern that government policy was harming children motivated the Congress to pass two laws. The first, the Indian Child Welfare Act of 1978 (P.L. 95-608), gave increased authority to tribal courts to determine where Indian children were placed. The Adoption Assistance and Child Welfare Amendments of 1980 (P.L. 96-272) applied to all foster children and modified the existing programs, putting stress on permanency planning with a hierarchy of goals. The first of these goals was to keep the child in the home, unless it was imperative to remove him/her. The second was timely reunification of the child with his/her family; the third was adoption, the fourth, guardianship, and last on the list was long-term foster care.

The Adoption Assistance and Child Welfare Act of 1980 moved AFDC foster care, which had been part of the general program of Aid to Families with Dependent Children

(Title IV-A), to a newly created Title IV-E. Under this program the federal government provides a match at the state's Medicaid rate for foster care maintenance payments to eligible children. To be eligible for Title IV-E funding, a state must specify that reasonable efforts will be made to prevent the need for foster care and to make it possible for children to eventually return home. For each child placed in foster care, there must be a judicial determination that a reasonable effort was made to prevent the placement. In addition to maintenance, Title IV-E also supplies matching funds for placement and administrative costs and for training programs.

A link was created between Title IV-E and Title IV-B, the Child Welfare Services Program, to cause states to put more stress on the prevention of foster care and reunification of families than on using their IV-B funds for foster care maintenance. Use of IV-B funds for child day care, for maintenance in foster care, and for adoption assistance payments was limited to \$56.6 million—the 1979 Title IV-B appropriation. But under specified conditions states may transfer a portion of their IV-E funding (for AFDC-eligible children) to child welfare services (for all children) under the IV-B program, if their foster care maintenance expenditures (IV-E) are less than expected based on their 1979 expenditures. The transfer is to some extent contingent upon the states carrying out a number of procedures to protect children in foster care—including monitoring, case reviews, and a reunification program.

To encourage adoption in lieu of foster care, Title IV-E contains an adoption assistance program to provide payments to families adopting AFDC-eligible children with special needs, which includes belonging to a minority group. An additional section of Title IV-E, added to the program in 1985, is an entitlement program to help the states smooth the transition of foster children to independence (the Independent Living program).

The number of children in foster care dropped from approximately 302,000 in 1980 to a low of 269,000 in 1983. Since then, the number has climbed steadily, and the number of children in foster care in 1990 was estimated to be over 400,000.¹⁶ The amount the federal government reimbursed to the states for foster care in 1990 was \$1473.2 million.¹⁷ In addition the federal government paid \$252.6 million under Title IV-B for child welfare services and an undetermined amount under Title XX.¹⁸

Given that foster care continues to be the fate of so many children, it is not surprising that researchers should ask how it affects a child's ability to function as an adult. A first step in this direction is the literature review undertaken by McDonald, Allen, Westerfelt, and Piliavin.

Foster care studies

Twenty-seven studies were examined. They are briefly described in Table 1. They had in common that they were carried out in the past thirty years and provided information on outcomes—what happened to the children after foster care.¹⁹ In every other respect there was enormous variation. Some were large, some small; some retrospective, some prospective; some American, others from other nations. Some provided comparison groups; others did not. Some examined children who were self-selected by their behavior into foster care. In other studies the children were removed from their homes for reasons not of their own making: One study, for example, examined children who, for their safety, were transported out of London in World War II; another looked at children removed from their homes in infancy. Some studies measured outcomes for emotionally disturbed children. One measured effects of foster care on children who were removed from homes because they were maltreated. The ages of the children entering foster care and the length of time in care varied from study to study and within studies. So of course did the individual experiences of the children—both at home and in foster care. And the type of foster care also varied—foster families, group homes, or institutions. Some were returned to their homes, others were discharged after reaching majority. Attrition was a significant problem for most of the studies, and nonresponse rates were generally between one-third and one-half. There was no way of ascertaining if those who voluntarily participated in studies differed from those who did not.

The studies were evaluated on the basis of their quality, as judged by the inclusion of data from a comparison group, the size of the sample, the age of the former foster child at follow-up (the older the former foster child, the better), attrition, and the time period during which the study took place (time periods after the passage of P.L. 96–272 in 1980 were preferred, since that was the point that foster care ceased to be seen as a viable solution to the problems necessitating out-of-home care). Results from more methodologically sound studies were given greater weight in the review of outcomes. The inclusion of a comparison group or comparative data was believed to be most critical for judging outcomes. Even so, the synthesis of the work consists for the most part of broad generalizations.

The outcomes identified in the various studies are (1) adult self-sufficiency (including educational attainment and intellectual ability, employment and economic stability, and residential status and housing); (2) behavioral adjustment (criminal behavior and use of alcohol and drugs); (3) family and social support systems (marital stability, parenting capability, friends); and (4) sense of well-being (mental and physical health and satisfaction).

Findings from the studies

Self-sufficiency

Almost all of the studies of former foster children revealed that their level of education is below the average for those of comparable age in their state or country. While in school, foster children functioned at a level that was below average and below their capacity. They were more likely to pursue vocational training than college. Youth discharged from family foster care generally completed more schooling than those from group settings. The younger the child at placement, the fewer years of schooling attained.

Because academic performance is associated with adult employment and socioeconomic status, the poor showing of children who have been in foster care is clearly a matter for concern. Yet the studies indicated that a majority of former foster children (between 64 and 92 percent) are self-supporting adults. Their employment tends to be steady but precarious. About 25 percent of former foster children receive public assistance at some point as adults. Those discharged from foster family homes do better than those from group settings, and adoptees do better than foster children. Foster families, and to a lesser extent, biological families, appear to provide economic support for a significant portion of adult former foster children. This appears to be similar to the situation one would expect to find for young adults in the general population.

The majority of foster care follow-up studies indicate that most (roughly 60 to 70 percent) of the subjects were living independently in adequate housing. Sizable numbers of subjects were found to be still living with their foster parents or friends and relatives. Biological families appear to provide minimal housing support. Studies of homelessness, however, have revealed that a disproportionate number of the homeless have spent time in foster care.²⁰ The number of former foster children among the homeless may suggest that efforts have fallen short to provide some sort of transition to independence for those who age out of foster care. Or it may suggest something else entirely, such as that children sent to foster homes have severe problems that make them vulnerable to homelessness, or that the foster care experience is debilitating in a way that leaves them unable to function independently, or that they lack family support networks to provide them with housing in a crisis. The exact link between foster care and homelessness is not known.

Behavioral adjustment

Arrest rates for male former foster children generally fall between 25 and 35 percent, but have been reported to be over 40 percent. Of those arrested, one-quarter to one-half are subsequently convicted. Arrest rates for women are

Table 1
Studies of Outcomes of Foster Care

Source	Type of Study	Characteristics of Sample	Outcomes Studied	Data Collection	Attrition
J. McCord, W. McCord, & E. Thurber. 1960. "The Effects of Foster Home Placement in the Prevention of Adult Antisocial Behavior." <i>Social Service Review</i> , 34, 415–419.	Prospective, with comparison group	N = 38 (19 in out-of-home) Ages: early 30s Selection criteria: Follow-up of an earlier delinquency prevention study in Massachusetts. Of 24 removed from their homes as young adolescents, data were available on 19, who became subjects. Matched comparison group was drawn from remaining sample (N=236).	Criminal behavior, alcoholism, mental health.	Observation of children and families.	21% dropout
H.S. Maas. 1963. "The Young Adult Adjustment of Twenty Wartime Residential Nursing Children." <i>Child Welfare</i> , 42, 57–72.	Retrospective, no comparison group	N = 20 Ages: 19–26 years Selection criteria: Placed at least 1 year as preschool children for their safety by parents in British wartime residential nurseries; average stay over 3 years.	Living arrangements, employment, leisure-time interests, education, and family life; Thematic Apperception Test.	All subjects interviewed; 14 observed with families; parents of 18 interviewed; records of collateral agencies.	78% dropout (Appears that first 20 successful contacts were used)
E.G. Meier. 1965. "Current Circumstances of Former Foster Children." <i>Child Welfare</i> , 44, 196–206.	Retrospective, no comparison group	N = 66 Ages: 28–32 years Selection criteria: Adults who as children had experienced 5 or more years of foster home care in Minnesota, who had not been returned to their own families during their childhoods, and who were discharged from guardianship between 7/1/48 and 12/31/49. Attempted to use all eligible males and a random sample of eligible females.	Social effectiveness and sense of well-being: includes family life, living arrangements, economic/employment history, community involvement.	Interviews and questionnaires; phone calls or letters from those who refused to participate in full study.	20% dropout

M.E. Allerhand, R.E. Weber, & M. Haug. 1966. <i>Adaptation and Adaptability: The Bellefaire Follow-up Study</i> . New York: Child Welfare League of America.	Retrospective, no comparison group	N = 50 Ages: 18 years average Selection criteria: All boys discharged from Bellefaire between 1/58 and 6/61. Must have been in care at least 6 months.	Adaptability (intrapsychic balance and total role fulfillment) and adaptation (interpersonal and cultural role fulfillment).	Agency records; interviews with subjects, their parents, and psychotherapist if currently in treatment. Interviews held 1–2 years after discharge: 1959–63.	4% dropout
T. Ferguson. 1966. <i>Children in Care—and After</i> . London: Oxford Univ. Press.	Prospective, no comparison group; normative data provided	N = 203 Ages: 18–20 years Selection criteria: Youth in care of the Children's Department of Glasgow, Scotland, until the age of 18; left care between 1961 and 1963.	Educational achievement, health, employment and economic history, criminal behavior, family life and relationships, recreation.	Agency records, school teachers' reports, interviews with subjects every 6 months for 2 years after discharge from care. Data collected 1961–65.	1% dropout
L.L. Heston, D.D. Denney, & I.B. Pauly. 1966. "The Adult Adjustment of Persons Institutionalized as Children." <i>British Journal of Psychiatry</i> , 112, 1103–1110.	Retrospective, with comparison group	N = 97 (47 in placement) Ages: 21–50 years Selection criteria: Subjects placed in foundling homes in Oregon; 25 born to schizophrenic mothers in state psychiatric hospitals; average stay over 2 years.	MMPI scores, socioeconomic status, psychosocial disability, psychiatric diagnosis.	Interviews, record reviews	27% dropout
L.N. Robins. 1966. <i>Deviant Children Grown Up: A Sociological and Psychiatric Study of Sociopathic Personality</i> . Baltimore: Williams and Wilkins.	Retrospective, with comparison group	N = 624 (524 in placement) Ages: 27–53 years Selection criteria: 524 former child guidance clinic patients, 16% of whom had lived in foster homes and 16% in orphanages for 6 months or more prior to their referral to the clinic.	School problems and achievement, marital history, adult relationships, military service, job history, history of arrests and imprisonments, financial dependency, geographic moves, history of deviant behavior, physical and psychiatric diseases, alcohol and drug use, intellectual level, cooperativeness, willingness to talk, frankness and mood.	Interviews	21% dropout
H.S. Maas. 1969. "Children in Long Term Foster Care." <i>Child Welfare</i> , 48, 321–333, 347.	Retrospective, no comparison group	N = 422 Ages = ? Selection criteria: Follow-up of children who had been studied by Maas and Engler in the late 1950s; all had been in foster care for at least 3 months in 1 of 9 counties in the U.S. as of 4/1/57. Eight of the 9 original counties participated in this study.	Disposition from care and length of time in care.	Original study: agency records; collected data in 1957–58. This study: agency staff completed questionnaires in 1967.	23% dropout

(Continued)

Table 1, Continued

Source	Type of Study	Characteristics of Sample	Outcomes Studied	Data Collection	Attrition
E.A. Frommer & G. O'Shea. 1973a. "Antenatal Identification of Women Liable to Have Problems in Managing Their Infants." <i>British Journal of Psychiatry</i> , 123, 149-156. 1973b. "The Importance of Childhood Experience in Relation to Problems of Marriage and Family-Building." <i>British Journal of Psychiatry</i> , 1, 123, 157-160.	Retrospective, with comparison group	N = 116 (58 "separated") Age = N/A Selection criteria: Study of the impact of early separation (before age 11) on women's later experiences with parenting; all married British-born primigravidae women attending antenatal clinics in London.	Feelings toward the child and husband, physical and mental health, expected financial impact of having a baby, behavior of the infant.	Interview and observation	28% dropout at time 1; 32% at time 2
S.E. Palmer. 1976. <i>Children in Long Term Care: Their Experience and Progress</i> . Canada: Family and Children's Services of London and Middlesex.	Retrospective, no comparison	N = 70 Ages: 18-21 years Selection criteria: Children who had been in the care of 2 Children's Aid Society agencies in Toronto, Canada, and the C.A.S. in London, England. They were at least 3 years of age when they left their families; minimum of 5 years in care ending when they reached majority (or up to age 21 if still in school); did not have physical or mental condition severe enough to keep them from leading a normal life; not from a distinct cultural background.	Social progress (improvement in behavior, performance, and emotional problems and academic progress.	Agency records. Date of data collection not given; probably early 1970s.	46% dropout
S.N. Wolkind. 1977a. "A Child's Relationship after Admission to Residential Care." <i>Child Care, Health, and Development</i> , 3, 357-362. 1977b. "Women Who Have Been 'In Care' — Psychological and Social Status during Pregnancy." <i>Journal of Child Psychology and Psychiatry</i> , 18, 179-182.	Retrospective, with comparison	N = 534 (36 placed in care) Age: N/A Selection criteria: Primiparous women attending obstetric clinic in London; study of background factors affecting future maternal role; separated at least 3 months before age of 16.	History of housing or social problems, presence of psychiatric and chronic physical disorders.	Interviews	5% dropout
D. Fanshel & E.B. Shinn. 1978. <i>Children in Foster Care: A Longitudinal Investigation</i> . New York: Columbia University Press.	Retrospective, no comparison group	N = 624 Ages: 5-17 years Selection criteria: Had entered New York City's foster care system during 1966 and were in care at least 90 days; newborn-12 years of age at entry; this was their first entry into care. Used an age and gender quota system.	Status changes experienced by children; changes in their personal and social adjustment.	IQ and projective tests, behavioral ratings and developmental profiles, teacher assessments, and reports from parents, subjects, caseworkers. Data collected 1966-1971. (Not all data were collected for all subjects.)	Potential sample = ? Final sample = 624

T. Harari. 1980. "Teenagers Exiting from Foster Family Care: A Retrospective Look." Ph.D. dissertation, University of California, Berkeley.	Retrospective, no comparison group	N = 85 Age: 17–23 years (19.8 average) Selection criteria: Turned 18 by 2/78, had left care as adolescents between 1/74–6/78, had been in care a minimum of 1 1/2 years, not diagnosed as mentally retarded, still living in northern California.	"Current life experience," interpersonal affect and self-esteem scales from Jackson personality inventory.	Interviews	60% dropout
M. Fox & K. Arcuri. 1980. "Cognitive and Academic Functioning in Foster Children." <i>Child Welfare</i> , 59, 491–496.	Retrospective, no comparison group but standardized tests used	N = 163 Ages: 5–18 years Selection criteria: All children in care of Children's Aid Society of Pennsylvania in 1978.	Cognitive and academic skills; grade level.	Standardized tests including Wechsler Intelligence Tests and Wide Range Achievement Test.	0% for intelligence tests; 14% for WRAT-Reading; 65% for WRAT-Arithmetic
J. Triseliotis. 1980. "Growing Up in Foster Care and After." In J. Triseliotis, ed., <i>New Developments in Foster Care and Adoption</i> . London: Routledge & Kegan Paul.	Retrospective, no comparison group	N = 59 Ages: 20–21 years Selection criteria: Scottish study of subjects born in 1956–57 who had spent 7–15 years in a single foster home before the age of 16.	Educational achievement, employment history, family life, living arrangements, contact with foster family, coping ability, sense of well-being, criminal behavior, and perceptions of social workers.	Interviews with former foster children and their foster parents, 1976–77.	32% dropout
J. Kraus. 1981. "Foster Children Grown Up: Parameters of Care and Adult Delinquency." <i>Children and Youth Services Review</i> , 3, 99–114.	Retrospective, no comparison group	N = 491 Ages: 27–28 years Selection criteria: All former wards of the state of New South Wales, Australia, born 1951–52, and discharged at age 18 into situations other than the care of their family or relatives; averaged 9.3 years in care.	Criminal activity	Criminal and welfare records.	None
R. B. Zimmerman. 1982. <i>Foster Care in Retrospect</i> . New Orleans: Tulane Studies in Social Welfare, Vol. 14.	Retrospective, no comparison group	N = 170 Ages: 19–29 years Selection criteria: Former foster children in New Orleans who entered care between 1951 and 1969, had been in a foster home for at least a year, and had not been adopted; only 1 child from any one family.	Educational achievement, financial status, life satisfaction, family life and relationships, social support, views regarding fostering experience, employment, health, history of mental illness or antisocial behavior.	Interviews. March–April, 1980.	64% dropout

(Continued)

Table 1, Continued

Source	Type of Study	Characteristics of Sample	Outcomes Studied	Data Collection	Attrition
T. Festinger. 1983. <i>No One Ever Asked Us: A Postscript to Foster Care</i> . New York: Columbia University Press.	Retrospective, no comparison group; normative data provided	N = 600 Ages: 22–26 years Selection criteria: Young adults who had been discharged from foster care in the New York metropolitan area in 1975, who had been in care continuously for at least the preceding 5 years, and who were 18–21 years old at discharge.	Well-being, family life and relationships, personal problems, social support, educational achievement, employment, finances, health, drug/alcohol use, criminal behavior, use of formal help-providers, perceptions of fostering experience.	In-person and phone interviews, questionnaires. Data collected 5/79–4/80.	54% dropout
S. Frost & A.P. Jurich. 1983. "Follow-up Study of Children Residing in The Villages." The Villages, Topeka, Kans.	Retrospective, no comparison group	N = 176 Ages: ? Selection criteria: Former foster children who had lived in group care at the Villages in Topeka, Kansas, for at least 6 months.	Educational achievement, employment, social support, legal history, financial status, overall functioning level, satisfaction with care.	Personal and telephone interviews, questionnaires. 1982–83.	46% dropout
M.A. Jones & B. Moses. 1984. <i>West Virginia's Former Foster Children: Their Experiences in Care and Their Lives as Young Adults</i> . New York: Child Welfare League of America.	Retrospective, no comparison group	N = 629 Ages: 19–28 years Selection criteria: Young adults who had received foster care in West Virginia for at least 1 year after 10/1/77 but before 1/1/84, and who were at least 19 years of age on 1/1/84.	Living arrangements, employment/finances, social support, family life and relationships, evaluation of care received, education, health, legal history, alcohol/drug usage, life satisfaction.	Personal and telephone interviews. Questionnaires, data collected in 1984.	48% dropout
E.R. Rest & K.W. Watson. 1984. "Growing Up in Foster Care." <i>Child Welfare</i> , 63, 291–306.	Retrospective, no comparison group	N = 13 Ages: 19–31 Selection criteria: Former foster children who had been in the care of Chicago Child Care Society, who had entered care at the age of 6 or younger and reached maturity within the agency's program, and were discharged as independent functioning adults between 1966 and 1981.	Perceptions of experience of care and the impact of this on current life, employment, family life and relationships, self-concept.	Interviews, 1981	Not reported

J. Triseliotis & J. Russell. 1984. <i>Hard to Place: The Outcome of Adoption and Residential Care</i> . London: Heinemann.	Retrospective, with comparison group	N = 159 (68 in residential care, 91 adoptees)	Employment, living arrangements, mental health problems, educational achievement, financial status, family life and relationships, health, criminal behavior, alcohol use, social support, coping capability, life satisfaction. Contrasts with biological families.	Agency records; interviews and questionnaires, 1978–80.	47% dropout
A. Dumaret. 1985. "IQ, Scholastic Performance, and Behaviors of Sibs Raised in Contrasting Environments." <i>Journal of Child Psychology and Psychiatry and Allied Disciplines</i> , 26, 553–580.	Retrospective, with comparison groups	N = 104 (35 adoptees, 48 own home, 21 foster care)	IQ, school performance and behavior, job history and status (for older subjects).	Tests of subjects (in school), questionnaire to teachers, records. Most of testing done in schools. Neither mothers nor children knew they were being studied. Unclear how the job history data were collected (probably record reviews).	None
D.K. Runyan & C. Gould. 1985. "Foster Care for Child Maltreatment: Impact on Delinquent Behavior." <i>Pediatrics</i> , 75, 562–568.	Retrospective, with comparison group	N = 114 foster children = 106 comparison	Juvenile delinquency	Abstracting of cumulative files maintained by social service agency, juvenile courts, and schools.	?

(Continued)

Table 1, Continued

Source	Type of Study	Characteristics of Sample	Outcomes Studied	Data Collection	Attrition
D. Quinton, M. Rutter, & C. Liddle. 1986. "Institutional Rearing, Parenting Difficulties, and Marital Support." In S. Chess & A. Thomas, eds., <i>Annual Progress in Child Psychiatry and Child Development</i> , 1985. New York: Brunner/Mazel.	Prospective, with comparison group	N = 94 ("ex-care" group) = 51 (control) Ages: 21–27 years Selection criteria: Two groups of British women first studied as children in the mid-1960s. First group were girls who had been residents in 1 of 2 children's homes. Comparison group were same age as ex-care group, never had been in care, lived with families in same geographic area and had had school behavior assessed at same age with same questionnaire.	Overall style of parenting, effectiveness and consistency of control, parental sensitivity to the child's needs, expressed warmth toward and criticism of the child.	Interviews with women and spouses, and direct observation of mother-child interactions.	14% dropout ("ex-care" group) 20% dropout (controls)
D. Fanshel, S.J. Finch, & J.F. Grundy. 1990. <i>Foster Children in Life Course Perspective</i> . New York: Columbia University Press.	Retrospective, no comparison	N = 180 106 were interviewed Ages: Early 20s to mid 30s; Average = 24 years. Selection criteria: All former foster children who had been in placement with the Casey Family Program 1966–1984, and who had been discharged by 12/31/84. Included divisions in Washington, Idaho, Montana, California.	Personal and social functioning as adults.	Agency records. Interviews with 106 subjects living in Washington state.	41% dropout
R. Barth. 1990. "On Their Own: The Experiences of Youth after Foster Care." <i>Child and Adolescent Social Work</i> , 7, 419–440.	Retrospective, no comparison group	N = 55 Ages: 17–26 years Selection criteria: Youth who had left foster care in the San Francisco Bay area more than 1 year but less than 10 years prior to the study and who were at least 16 years old at the time of emancipation. All youth had been on their own for at least 1 year.	Employment, contact with foster parents and birth relatives, education, life skills, health, substance use, criminal activity, housing, income.	Interviews, typically in the youths' homes (24% by phone), lasting 1 to 3 hours.	25% dropout

Source: McDonald et al., *Assessing the Long-Term Effects of Foster Care: A Research Synthesis*, IRP Special Report, forthcoming.

much lower—about 10 percent. Although the arrest records are higher than one would expect in the general population, they may not be different from a comparison group controlled for race and economic status. It is clear, however, that adults who had received foster family care participated in less criminal behavior than those who had been in group care or had been living with relatives. Increased ties with family and community of origin were associated with higher rates of criminal behavior. No consistent relationship was found between reason for placement (neglect, abuse, etc.) and subsequent criminal behavior.

Alcohol and drug use do not appear to be particular problems for former foster children, compared to similar groups in the general population.

Family and social support

Results of two of the better-designed studies (see Quinton, Rutter, and Liddle, and Triseliotis and Russell in Table 1) suggest that problems may exist for former foster children in forming stable cohabiting situations, in parenting, and in establishing integrated social relationships in their community. The risks are heightened if the child enters foster care at an older age, if the child has social or behavioral problems, is placed in a group setting, and has ongoing ambiguous contact with biological parents.

Former foster children are likely to have higher numbers of teen pregnancies, more marriages to spouses who failed to provide emotional support, and greater social isolation than the general population. Further findings suggest that the risks of these outcomes are reduced through a nurturing and stable foster family care experience and adoption.

Personal well-being

Conclusions are difficult to draw from the mixed findings of a limited number of studies on physical health. Several studies suggest that compared to the general population, former foster children have poorer physical health, even when income differences are controlled. They also have poorer mental health, as determined by the fact that psychiatric referral and use were higher for them than for adoptees or persons in the general population. Individuals from group settings—particularly whites—scored lower on measures of life satisfaction. They had less self-esteem, less happiness, and less satisfaction with life as a whole than did former foster-home residents and persons in the general population. Yet, as a whole, former foster children do not see life as any less satisfying than do individuals who were not separated from their families during childhood.

What do the findings mean?

All of the findings are equivocal. Although it appears that children who spent their time in family foster homes are

functioning better as adults than those who spent time in group care or at institutions, the explanation for this could simply be that children with severe problems are not put into family care.

Children who were placed in foster care because their parents neglected, abandoned, or abused them had more negative outcomes than those placed because of mental illness, death, imprisonment, or physical illness of the caretaker. Children with fewer different placements while in care also functioned better as adults. But fewer placements could indicate that the child was stable and adaptable to begin with.

Contrary to current thinking, children in foster care for longer times do better than those returned to their biological homes after a short time. This result clearly depends on the quality of the foster care and whether the needs of the children are met when they return home. On the same note, contact and closeness with his/her biological family while in care may be advantageous to the child, or it may be harmful.

A general conclusion drawn by the authors from such findings is that adoption—when available as an option—is a better alternative than long-term foster care. Theoretically, adoption can provide children with a second chance for a supportive and loving family. In practice, however, the adoption process has its pitfalls. Over half the children waiting for adoption must wait two or more years for placement. This is especially true of older children and black children.²¹ Though estimates of failed adoptions range widely, most researchers find that the overall rate is close to 10 percent, with rates as high as 30 percent for subpopulations such as older children and those with special needs and problems.²²

Where adoption is not feasible, long-term foster care, particularly in a stable family setting, can be a desirable alternative to reunification of a family burdened with problems. Foster care alone does not condemn an individual to an unhappy and unproductive life as an adult. Many, if not the majority, of these subjects do survive as adults, but often precariously. While there is no clear evidence that the foster care experience has detrimental effects, it is also clear that it does not adequately mediate the detrimental effects of earlier childhood experiences. As a result, individuals leave foster care with considerably higher risk for negative outcomes in life.

Where do we go from here?

The review emphasizes the need for more and better studies of foster care. The authors support the use of much more rigorous research designs, which include random assignment of children to a variety of placements, on the ground

that available evidence suggests that the process whereby a placement is determined for an abused or neglected child is all but random anyway. "The idiosyncratic nature of placement decisions and resulting inequalities in treatment of children and families are widely discussed and documented in the literature" (see the forthcoming study).

The authors also raise the question of what we should expect from foster care. Is it sufficient that the care doesn't damage children more than they have already been damaged by the events that led to the breakup of their family? Should we rate the foster care as successful if it produces outcomes equal to those of adults in a comparable group in the general population? Or should we seek to devise a system of caring for these needy children that enhances their future chances? ■

¹Thomas McDonald, Reva Allen, Alex Westerfelt, and Irving Piliavin, "Assessing the Long-Term Effects of Foster Care: A Research Synthesis," Institute for Research on Poverty special report, in press, p. 5.

²U.S. House of Representatives, Committee on Ways and Means, *1992 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means* (Washington, D.C.: GPO, 1992), p. 839.

³Ibid., pp. 842–843. See also Alfred Kadushin and Judith A. Martin, *Child Welfare Services*, fourth edition (New York: Macmillan, 1988), pp. 431–432.

⁴Kadushin and Martin, p. 358.

⁵Ibid.

⁶Ibid., p. 359.

⁷Robert E. Shepherd, Jr., "The Abused Child and the Law," in Albert E. Wilkerson, *The Rights of Children: Emergent Concepts in Law and Society* (Philadelphia: Temple University Press, 1973), pp. 76–77.

⁸The rights in the UN Declaration are aspirations that may be a long time in coming; witness Principle 10: "The child shall be protected from

practices which may foster racial, religious, and any other form of discrimination. He shall be brought up in a spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood and in full consciousness that his energy and talents should be devoted to the service of his fellow men." The entire proclamation is reprinted in Wilkerson, *The Rights of Children*, pp. 3–6.

⁹For example it is now considered the right of the child born out of wedlock to receive support from its father. The federal Office of Child Support Enforcement has been active in assisting states in locating fathers, establishing paternity, and collecting child support. See on this topic, "The Family Support Act of 1988," *Focus*, 11:4 (Winter 1988–89), pp. 15–18; and Irwin Garfinkel, "The Evolution of Child Support Policy," *Focus*, 11:1 (Spring 1988), pp. 11–16; and Daniel R. Meyer, "Paternity and Public Policy," in this issue of *Focus*.

¹⁰Kadushin and Martin, p. 348.

¹¹Ibid., p. 347.

¹²Ibid., pp. 350–351.

¹³McDonald et al., "Assessing the Long-Term Effects of Foster Care."

¹⁴The ensuing description of government programs is taken from U.S. Senate, Committee on Finance, *Foster Care, Adoption Assistance, and Child Welfare Services*, Committee Print 101–118 (Washington, D.C.: GPO, 1990), and *1992 Green Book*.

¹⁵*1992 Green Book*, pp. 841–842. "The entire federal payment for child welfare services represented a relatively small proportion of the amount that state and local governments had to spend just on maintenance costs alone" (p. 842).

¹⁶Ibid., p. 903.

¹⁷This includes \$835 million for maintenance payments and \$638.2 million for administration and training. The federal government spent an estimated \$50 million during this period on the Independent Living program (see *1992 Green Book*, p. 847).

¹⁸Ibid.

¹⁹The individual studies and their results are described in detail in the McDonald et al. paper. A brief summary table, taken from the paper, accompanies this article.

²⁰See, for example, Irving Piliavin, Michael Sosin, and Herb Westerfelt, "Conditions Contributing to Long-Term Homelessness: An Exploratory Study," IRP Discussion Paper no. 853–87, 1987.

²¹*1992 Green Book*, pp. 875–876.

²² See, for example, Thomas McDonald, Alice Lieberman, John Poertner, and Helene Hornby, "Child Welfare Standards for Success," *Children and Youth Services Review*, 11 (1989), 319–330, especially Table 1, p. 324; and Richard P. Barth and Marianne Berry, *Adoption and Disruption: Rates, Risks, and Responses* (New York: Aldine de Gruyter, 1988), p. 96.

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