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Sent via email: healthsurveys@cdc.gov

RE: Proposed questionnaire redesign: Comment request: The National Health Interview Survey/February 22, 2016

To Whom It May Concern:

We are writing to respond to the request for comments about the proposed questionnaire redesign of the National Health Interview Survey (NHIS). The great effort undertaken by the National Center for Health Statistics to keep the NHIS a timely and relevant survey, with content to meet the needs of data users, is laudable. We are alarmed, however, that the changes to the NHIS announced on February 22, 2016 will discontinue the family questionnaire that collects basic demographic, socioeconomic, health status, disability, and health insurance information about everyone in the sampled household. Instead, the revised survey will only collect this information for one sampled adult and one sampled child per household. Further, in the description of the questionnaire changes, it is unclear whether the collection of *family* income and poverty information will also be discontinued.

The proposed termination of the family survey signals a dramatic departure from the previous fifty years of NHIS data collection and greatly reduces the utility of the NHIS to answer today's pressing health questions, in two ways. First, **we will no longer be able to use the NHIS to study the effects of family context on health**. Second, **the use of the NHIS to study health disparities will be severely curtailed** because the new design will be less likely to capture large enough samples of special populations like immigrant families and children, people with disabilities, or persons in same-sex relationships.

Household-based surveys like the NHIS form the backbone of U.S. population data infrastructure. While other U.S. household surveys focus on measuring labor market outcomes, the NHIS is exceptional in collecting household information alongside a wealth of health and health care outcomes. The unique co-occurrence of this information in a single data set has contributed to our knowledge that family context is incredibly important for child health. Poverty holds severe consequences for child development and health; maternal

education and employment greatly influence child health outcomes; children in single-parent families have markedly different health outcomes than children in nuclear families.

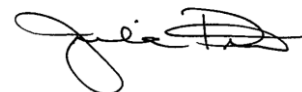
Researchers recognize the importance of family context to child health: Google Scholar citations of studies using the NHIS to examine the effect of parent characteristics on child health number over 22,000, with more than half published in the last 5 years.

The relevance of family context is not limited to its effects on child health. It is impossible to evaluate some of the recent health care reforms enacted under the Affordable Care Act without information about relationships between co-resident family members because health insurance coverage, whether through an employer or a public program, is often based on family relationships. Family and household arrangements impact the risk of suicide for American adults. The living arrangements of older adults significantly influence their self-rated quality of life, psychological distress, disability onset, and mortality outcomes.

Equally alarming, the proposed changes will undermine our ability to use the NHIS to monitor health disparities. Some special populations, such as people in same-sex unions, in mixed race unions, or in blended and extended families, and the U.S.-born children of immigrants, are identified using information on all household members. Limiting the sample to one selected adult and child greatly reduces the number of cases of interest for key health topics. To illustrate how these changes will harm studies of health disparities, we need only highlight that membership in a special population affects whether a person is selected as the sample adult or sample child. For example, sample adults are significantly more likely to be born in the U.S. than adult household members not selected to be the sample adult (82% vs. 77% over the 1997-2014 period). Using the projected sample sizes announced at the 2015 PAA meetings, limiting the NHIS only to the sample adult translates into an estimated NHIS sample size reduction of 5,473 immigrant adults *per year*, or a 37% annual cut.

The importance of maintaining data collection about all members of the household is clear. The current system of collecting individual information for the entire household works because it is flexible, allowing researchers to select the family characteristics most relevant to their studies. Removing the measurement of family characteristics from the most important national survey of U.S. health will leave a disturbing gap in public health surveillance and population data infrastructure and will harm the state of health knowledge for years to come. We urge you to reconsider the decision to eliminate the collection of vital demographic, socioeconomic, and health information about all members of sampled NHIS households.

Sincerely,



Steven Ruggles

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