

**The Health of Poor Urban Women:
Findings from the
Project on Devolution and
Urban Change**

**Denise F. Polit
Andrew S. London
John M. Martinez**



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overView

The Health of Poor Urban Women: Findings from the Project on Devolution and Urban Change

To what extent might the health of welfare recipients and their children play a role in the new welfare environment? In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), creating a five-year lifetime limit on the receipt of federal cash welfare benefits for most families. PRWORA dropped the language from prior legislation that excused welfare recipients from mandatory participation in welfare-to-work activities for health reasons. The new policy considers all recipients subject to participation requirements and time limits, except for an undefined 20 percent of each state's caseload who may be excused for "good cause." There is little information about whether the 20 percent figure is sufficient to encompass all recipients with health problems — or whether women leaving welfare will be able to secure the health care they need for themselves and their children.

This report describes the health and health care needs of welfare recipients (and former recipients) living in large urban areas, where a substantial percentage of the national welfare caseload lives. The report is based on 1998-1999 survey and ethnographic data from the Project on Devolution and Urban Change, a multi-component study designed to examine the implementation and effects of PRWORA in four urban counties: Cuyahoga (Cleveland), Los Angeles, Miami-Dade, and Philadelphia. Survey respondents were selected randomly from among the May 1995 public assistance recipients residing in high-poverty neighborhoods in each county. The report compares the health of four groups of women based on their statuses at the time of the survey: women who had left welfare and were working, women who combined welfare and work, women who received welfare and did not work, and women who neither worked nor received welfare. Ethnographic interview data, collected from welfare recipients living in selected neighborhoods in each site, complement and augment the survey findings.

Among the key findings:

- The women (and their children) had substantially higher rates of physical and mental health problems than did national samples of women and children — and their health problems were often multiple and severe.
- Women who worked (especially if they had left welfare) were in much better physical and mental health than those who did not work.
- Nevertheless, working women who had left welfare often lacked health insurance and still experienced substantial physical and mental health problems, as did their children.
- The high prevalence of health problems among women who were still receiving welfare suggests that there will be major challenges to welfare agencies as a growing number of recipients face time-limit pressures.
- Women with multiple health problems (and women who had been physically abused) were more likely than other women to have been sanctioned by the welfare agency in the previous year.
- Welfare leavers who were not employed had the most compromised health situations: They tended to have high rates of health problems, lack insurance, and experience high levels of unmet need for health care.

Women's health problems and those of their children likely constrain women's entry into the workforce and their ability to remain there. Additionally, health problems compromise women's ability to comply with participation requirements, which raises questions about current sanctioning policies. Given the health care needs identified in this study, an especially critical policy challenge is to develop mechanisms to ensure that women who leave welfare maintain health insurance.

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Preface

The Project on Devolution and Urban Change is a multidisciplinary, longitudinal study of the aftermath of the landmark 1996 federal welfare law in four large urban counties and their major cities — Cleveland, Los Angeles, Miami, and Philadelphia. This report focuses on issues critical to the long-term success of welfare reform: the physical and mental health and health care needs of welfare recipients and their children. Health concerns, which are broadly defined in this report to include health-relevant hardships such as hunger and unsafe housing, are examined in relation to people's welfare and employment status.

Prior to passage of the 1996 law, welfare recipients who had health problems or who were caring for children with health problems were not required to participate in welfare-to-work activities. Under the law, which includes a five-year limit on most families' receipt of federal cash welfare assistance, all recipients are required to participate except for an undefined 20 percent of each state's caseload.

Although it is not known how many women might warrant such exemptions on health grounds, the report's findings, which are based on a survey of nearly 4,000 women in these four large cities and in-depth ethnographic interviews with about 170 women, suggest that health problems are quite prevalent and often severe. Among the women remaining on welfare at the time of the survey in 1998-1999, nearly 80 percent had at least one health problem that could pose a challenge to employment, and about 50 percent had multiple health barriers. These health problems — which were typically accompanied by other barriers such as lack of education credentials and limited prior work experience — appeared also to affect the women's ability to comply with participation requirements. The greater the number of health problems, the greater the likelihood a woman had been sanctioned by the welfare agency for noncompliance.

Although the women who had left welfare and were working had far fewer health problems than those remaining on the rolls, they were substantially more likely to have health problems than same-age women nationally. Most were in low-wage jobs without fringe benefits, and a sizable percentage were uninsured and had children who lacked health insurance.

When policymakers debate reauthorization of key provisions of the 1996 law, we hope that the information presented in this report proves useful in deliberations over health status, in relation especially to time limits, and that these officials consider policies to ensure that women who leave welfare for work do not lose ground by losing their highly valued health benefits.

Judith M. Gueron
President

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The Authors

Executive Summary

I. Introduction

This report addresses a timely and important question in this era of unprecedented change for poor mother-headed families:

What are the health situations of welfare recipients and former recipients living in large urban areas during this era of welfare reform?

Prior studies have shown that poor people in general and welfare recipients in particular are less healthy than people who are not poor. However, *current* information is needed about the scope and intensity of health problems of welfare recipients — and recent welfare leavers — because of dramatic changes in the policies affecting them as a result of the passage in August 1996 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). One of the key features of this act is that it places a five-year lifetime limit on federally funded cash benefits for the majority of recipient families. Another important feature of PRWORA is that states now must either engage most of their caseloads in work-related activity or face financial penalties. As a result, welfare agencies must now work programmatically with women who had previously been exempted from any welfare-to-work participation requirements — including women with health problems. Thus, there is considerable interest in understanding how health and health-related issues such as domestic violence constrain recipients' ability to comply with welfare requirements and to secure stable jobs before they reach the time limit for cash assistance.

Using unusually rich and extensive data from multiple sources, this report describes the health and well-being of urban women who either had been welfare recipients or were still recipients and who, therefore, were at especially high risk of being affected by welfare reform policies. As a cautionary note, it is important to recognize that the data for this report were collected before time limits were imposed. Thus, the findings do not offer evidence on how welfare reform might affect health outcomes or on how health factors might influence the success of welfare reform. Rather, the findings provide an early snapshot of a vulnerable group of families potentially facing time-limit pressures and the loss of benefits that can affect their health and well-being.

This report is based on data from the Project on Devolution and Urban Change (Urban Change, for short), which is being undertaken by the Manpower Demonstration Research Corporation (MDRC), a nonprofit, nonpartisan organization that develops and evaluates interventions designed to improve the well-being and self-sufficiency of economically disadvantaged populations. The Urban Change project, a multicomponent study designed to examine the implementation and effects of PRWORA, is being conducted in four large urban counties: Cuyahoga, Ohio (Cleveland); Los Angeles, California; Miami-Dade, Florida; and Philadelphia, Pennsylvania.¹

Information in this report about broadly defined health and health-care outcomes of cur-

¹For brevity's sake, the sites (that is, the counties) are often referred to in this report by the names of their principal cities: Cleveland, Los Angeles, Miami, and Philadelphia. Only in the case of Philadelphia, however, are the city and county identical in their boundaries.

rent or former welfare recipients came from in-home survey interviews with 3,771 women and in-depth ethnographic interviews with 171 women. The ethnographic interviews were conducted in 1998 with a sample of about 30 to 40 recipients living in three high-poverty neighborhoods in each city. The survey interviews were conducted in 1998-1999 with a sample of women who, in May 1995, had been single mothers receiving benefits and living in neighborhoods of concentrated poverty; this sample was randomly selected from administrative welfare agency records. Thus, the survey findings are not based on a representative sample of all recipients but, rather, on a representative sample from very poor urban neighborhoods in four major cities with large welfare caseloads.

In addition to providing an overall description of health outcomes in these poor, mother-headed urban families, this report for the first time examines health in four important subgroups defined on the basis of the women's employment and welfare status at the time of the survey interview. The four work/welfare subgroups are

- women who had left welfare and were working (the work-only group)
- women who were combining work with welfare (the work-and-welfare group)
- women who were receiving welfare and did not work (the welfare-only group)
- women who had left welfare and were not working (the no-work, no-welfare group)

Each of these groups poses distinct challenges to policymakers and welfare staff in relation to both safety net services and strategies for leaving and remaining off welfare in a time-limited environment. Recipients' health concerns need to be taken into consideration with regard to both policy areas.

II. The Findings in Brief

- **Compared with national samples, women in the Urban Change survey sample had *substantially* higher rates of personal health and mental health problems and children's health problems.** Women in the survey sample were more likely than women in national samples to be food insecure and hungry, to be in poor physical and emotional health, to be overweight, to have had numerous doctor visits in the prior year, and to have children in fair or poor health. On a scale indicating the number of potential health barriers to employment (out of eight specific health problems), three out of four women in the survey sample had at least one such barrier, and 40 percent had two or more health problems.
- **The ethnographic data suggest that the survey data do not fully capture the *severity* of the health-related hardships the families faced.** While the survey data provide information about the prevalence and breadth of health problems among urban welfare recipients, they do not fully capture the gravity of the women's health-related problems, or those of their children. For example, about 20 percent of the current welfare recipients in the survey sample indicated that they had one or more child

with a health problem, while the ethnographic interviews provide rich, detailed accounts of the types and severity of problems the children faced, including cancer, HIV infection, cardiac problems, and mental illness.

- **Health problems were strongly related to the women's employment status.** Overall, women who were working — especially if they had already left welfare — were in substantially better physical and mental health than women who did not work, and they were also less likely to have children with health problems. Nonworking women were also much more likely than working women to have *multiple* health problems. The evidence suggests that the relationship between health and employment primarily reflects the effect that health problems had on the women's work status, and not vice versa.
- **Health care access, however, was strongly related to the women's welfare status.** Women who had left welfare — whether they were working or not — were significantly more likely than women still on welfare to have health care access problems, including not having health insurance, not having a regular health care provider, and having had a need for health or dental care that had gone unmet because of financial constraints. Women who had left welfare were also less likely to be getting food stamps, despite the fact that the large majority appeared to still be eligible for food stamp benefits.
- **The four work/welfare groups, then, had appreciably different health profiles — and all four groups had distinct health-related vulnerabilities.** Women who had exited welfare and were not working had the most compromised health situations: They had a very high rate of health problems *and* the worst health care access circumstances. Women who had left welfare and were employed were the healthiest group, but they also had health care access problems; moreover, despite their *relative* good health in comparison with women in the other three groups, many employed welfare leavers also experienced personal and children's health problems that could affect their ability to remain self-sufficient.
- **Both groups of women still on welfare, especially those without paid employment, had a high prevalence of health problems that pose challenges to welfare agencies.** The Urban Change survey data indicate that most welfare recipients — the majority of whom were subject to the welfare agency's participation requirements and the time limits for cash receipt — experienced one health problem or more. Among women in the sample who in 1998-1999 were still welfare recipients, the percentage with health problems appears to far exceed the 20 percent who might be eligible for an exemption from the federal time limits. For example, nearly 30 percent said they had a health condition that limited their ability to work; about 50 percent had two or more health barriers to employment. Yet only 14 percent of current recipients indicated that they were exempt from participation requirements because of a health problem.

- **Negative experiences with the welfare agency were more prevalent among women with health problems.** Welfare recipients with multiple health problems and with certain health problems (notably, physical abuse, risk of depression, having a chronically ill or disabled child) were more likely than other recipients to have been sanctioned in the prior year. Welfare leavers with multiple health problems were more likely than other women who had left welfare to say that they had been terminated by the welfare agency rather than that they left of their own accord.

III. The Welfare Policy Context

In the long-standing welfare policy debate about who is or is not deserving of public support, health status has always been one consideration. Reflecting this, the Social Security Act of 1935 provided federal funds for state welfare programs covering two groups of people who were not expected to work: first, the aged, blind, and disabled (who received Supplemental Security Income, or SSI benefits); and second, single mothers, who became eligible for public welfare assistance because society saw an explicit value in providing for the care of needy children in their own homes, by their mothers. In the subsequent 65 years, however, the growth of the welfare rolls, changes in the demography of the welfare population, and the increasing movement of women (including mothers with very young children) into the labor force have eroded the legitimacy of defining welfare as an alternative to work. Accordingly, starting with the Work Incentive Program (WIN) in 1971, Congress has defined an ever-expanding group of single mothers on welfare as employable and subject to participation and work requirements, with the key exceptions being tied, until recently, to the age of the youngest child and the health of the mother or her children. For example, prior to the passage of PRWORA in 1996, women with children under age 3 (or under age 1, at the option of the state), or who were *ill or incapacitated or taking care of a household member who was ill or incapacitated*, could not be required to participate in welfare-to-work programs.

The 1996 PRWORA legislation took one further step in this evolution by dropping the language that excuses people from mandatory participation for health reasons. Participation requirements and time limits now extend to the full welfare caseload. Excluding those who meet the stringent SSI disability definition, the new policy defines all welfare recipients as employable, with the exception of an undefined 20 percent who may be excused from the federal time limits for “good cause.”

PRWORA introduced a number of other changes as well. It replaced the previous cash welfare program (Aid to Families with Dependent Children, or AFDC) with a new form of aid called Temporary Assistance for Needy Families (TANF). The act provides lump-sum block grants to states and gives them unprecedented discretion and responsibility for developing welfare programs. However, PRWORA involves certain federal mandates, notably, a five-year lifetime limit on federally assisted cash benefits for most families. States may grant exemptions from the federal time limit, but the number of exempted families may not exceed 20 percent of the average monthly caseload in the state (although states can use their own funds to support families after the five-year limit). PRWORA also imposes more stringent work and participation requirements than had previously existed, requiring most recipients to go to work no later than

two years after becoming eligible for TANF benefits. Thus, an implicit assumption of PRWORA is that the great majority of recipients are sufficiently healthy and employment-ready to participate in mandated work-related activities and, eventually, to become self-sufficient through employment.

Under PRWORA, states have great latitude in designing their own welfare policies and programs, as well as certain policies relating to food stamps and medical assistance — benefits that have clear health implications. For example, states make decisions regarding the criteria for exemptions from or extensions of the time limits; receipt of transitional services such as child care and medical assistance after welfare exit; and eligibility criteria for Medicaid. In addition, states can place even more stringent time limits on clients' receipt of cash aid than the five-year limit mandated by the federal legislation. As a consequence, each state now runs its own individualized welfare program. Recipients in the four sites selected for the Urban Change project are subject to substantially different rules, procedures, and programs.² All the states, however, face one new challenge in common: They are now required under the PRWORA provisions to work with many recipients who previously would have been granted exemptions — including those with health, mental health, domestic violence, and substance abuse problems.

Thus far, there have been some encouraging early signs about certain aspects of welfare reform. In particular, despite the fact that the five-year federal time limit has not yet been reached by those who were receiving benefits when the legislation was enacted in 1996, the welfare rolls have dropped sharply, both nationally and in all four states involved in the Urban Change study. While time-limit terminations have not yet directly reduced the caseloads in most states, the current emphases on work and time limits have apparently led many to leave (or not apply for) welfare. However, many factors besides welfare reform have undoubtedly contributed to caseload declines, including the strong economy and greater availability of jobs and the expansion of the Earned Income Tax Credit (EITC), which is a special tax credit primarily benefiting low-income working parents.

Whatever the underlying causes, the rapidly declining welfare caseloads have prompted considerable concern about recipients who have remained on the rolls during this era of economic prosperity — in particular, about the barriers they face to employment and about possible strategies for moving them into the labor force. At the same time, there is interest in the fate of recipients who have left welfare — how well they are managing, how stable their employment situations are, and how successful they have been in accessing services that support their transition to employment. Of particular interest is access to two key safety net programs that are relevant to the health of poor families: food stamps and medical assistance.

Despite the fact that the Food Stamp Program was scaled back through several PRWORA provisions, food stamp benefits have continued as one of the few federal entitlement programs and are considered a cornerstone of aid to the working poor. During the 1994-1999 period, however, participation in the Food Stamp Program declined by 33 percent, a larger reduction than can be attributed to the improved economy or welfare reform. There is emerging evidence that grow-

²The early implementation experiences of welfare agencies in the four Urban Change sites are described in an earlier report. See Janet Quint, Kathryn Edin, Maria Buck, Barbara Fink, Yolanda Padilla, Ollis Simmons-Hewitt, and Mary Valmont, *Big Cities and Welfare Reform: Early Implementation and Ethnographic Findings from the Project on Devolution and Urban Change* (New York: MDRC, 1999).

ing numbers of eligible families are no longer receiving food stamps, giving rise to some apprehension about the nutritional status of poor families leaving welfare.

Similar concerns exist with regard to health insurance. Until the passage of PRWORA, cash assistance and Medicaid (the federal program providing health insurance to the poor) were linked. However, in recognition of the fact that most women who leave welfare for low-wage jobs do not get employer-provided health insurance, Congress tried to minimize adverse effects of welfare reform on health care coverage by severing the ties between Medicaid eligibility and eligibility for TANF. States are now required to provide Medicaid coverage to families who meet income and family structure guidelines that applied to the AFDC program on July 16, 1996, even if those families do not meet their state's new cash assistance criteria. Thus, there is no time limit for Medicaid benefits, but wage-earners qualify only if their incomes are very low. (States also offer transitional Medicaid benefits to workers leaving welfare, regardless of their earnings, for periods of 6 to 12 months, depending on the state.) Additionally, in 1997 Congress passed a major health care expansion, the Children's Health Insurance Program (CHIP), a voluntary matching program that allows states to expand health insurance for uninsured children in low-income families. However, as is the case with food stamps, many children and their parents who are eligible for Medicaid and CHIP coverage appear not to have enrolled. In 1996, for the first time in about a decade, the number of people insured by Medicaid declined, while the rate of uninsured people nationally increased, leading to speculation that an unintended consequence of welfare reform is the loss of health care insurance for many low-income families.³

Thus, a number of recent policy changes that have the potential to affect poor families' access to food stamps, Medicaid, and cash assistance could, in turn, have implications for their health and health care access. At the same time, health-related issues have implications for the success of the new policies.

IV. The Urban Change Project

The Urban Change project is one of several studies that are examining the implementation and effects of PRWORA. The Urban Change project is distinctive in a number of respects and is expected to yield data of unparalleled breadth and depth that can be used to address many questions of relevance to policymakers and practitioners.

One distinctive aspect of the Urban Change project is its urban focus, which was based on the assumption that the effects of welfare reform — favorable or unfavorable — will be most evident in urban areas, where poverty and welfare receipt (and public health problems) are concentrated. Indeed, the majority of welfare recipients in the United States live in urban areas; nearly one-third (32.7 percent) of all welfare recipients in 1999 lived in 10 of the largest urban counties — three of which are Urban Change sites: Cuyahoga (Cleveland), Los Angeles, and Philadelphia. In fact, some 14 percent of all welfare recipients in the United States lived in the four Urban Change counties in 1999, and that percentage has been growing.

³There is some very recent evidence that this situation is improving, as described in Janet Quint and Rebecca Widom, *Post-TANF Food Stamp and Medicaid Benefits: Factors That Aid or Impede Their Receipt* (New York: MDRC, 2000). However, initiatives to prevent eligible families from losing Medicaid benefits upon welfare exit were not in place when the 1998-1999 survey data for the present report were collected.

A second noteworthy aspect of the Urban Change project is its multidisciplinary nature. The study involves five distinctive components that are designed to complement each other. Data from these components will be carefully integrated to provide rich, comprehensive descriptions of the welfare reform stories that are unfolding in the four Urban Change sites. Table 1 summarizes the major features of the five Urban Change study components. A third unique characteristic of Urban Change can be seen in this table: The study has the potential to answer questions about welfare reform at different levels of aggregation, and from different perspectives. The project will analyze and integrate multicomponent data to answer questions about PRWORA in relation to individual recipients, their children, the neighborhoods in which they live, and the welfare agencies and other providers that serve them.

The current report uses first-round data from the survey and ethnographic components of the Urban Change project, collected in 1998-1999 — after PRWORA was implemented but before any time limits were imposed. The report focuses on describing the health-related living conditions, physical and mental health statuses, and health care access of women who were at different points in the hoped-for trajectory between welfare receipt and self-sufficiency, and it addresses questions about the extent to which that expected trajectory is consistent with the life circumstances of the recipients.

V. The Prevalence and Complexity of Health Problems in the Urban Change Population

The women in the Urban Change samples, as a whole, had a large number of health problems — problems that have implications for the women's employability and for their ability to comply with welfare participation requirements.

- **Women in both the survey and the ethnographic samples were substantially less healthy and had greater health care access problems than national samples of adults.**

Consistent with the fact that women in Urban Change samples were economically disadvantaged, health problems and health-relevant hardships abounded. As shown in Table 2, the women in the Urban Change survey sample were more likely than national samples of adults to be food insecure, to have severe housing problems, to be in fair or poor health, to have unfavorable scores on a widely used measure of physical and mental health, to be overweight, to smoke, and to have had numerous doctor visits in the prior year. Moreover, despite the fact that more than half these women were still on welfare, the sample as a whole had higher rates of being uninsured than national samples. Finally, the women were more likely to have children who had experienced hunger and who were in fair or poor health. For several health measures, the Urban Change sample had even worse outcomes than national samples of disadvantaged groups, such as people who had incomes below poverty or who had not completed high school (not shown in table).

The Project on Devolution and Urban Change

Table 1

Key Features of the Urban Change Project

Goal

To understand how state and local welfare agencies, poor neighborhoods, and low-income families are affected by the changes to the income support system in response to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.

Locations (sites)

Four large urban counties: Cuyahoga (Cleveland, Ohio), Los Angeles, Miami-Dade, and Philadelphia

Time frame

1997–2002

Project components

The *Ethnographic Study* illuminates the effects of the changes by chronicling, in depth and over time, how approximately 40 welfare-reliant families in each site cope with the new rules and policies.

The *Implementation Study* describes both the new welfare initiatives — rules, messages, benefits, and services — that are developed at the state and local levels and the experiences of the local welfare agencies in putting these new initiatives into practice.

The *Individual-Level Impact Study* measures the impact of the new policies on welfare, employment, earnings, and other indicators of individual and family well-being, via two components:

1. an *administrative records component*, for countywide samples of welfare recipients and other poor people
2. a *survey component* involving two waves of in-person interviews with a sample of residents of high-poverty neighborhoods

The *Institutional Study* examines how the new policies and funding mechanisms affect nonprofit institutions and neighborhood businesses.

The *Neighborhood Indicators Study* assesses changes in statistical indicators that reflect the social and economic vitality of urban counties and of neighborhoods within them where poverty and welfare receipt are concentrated.

Distinctive features

Its urban focus. The project examines the impacts of welfare reform in America's big cities.

Its neighborhood focus. All five components of the project will focus especially on residents of high-poverty neighborhoods, the public and nonprofit agencies that assist them, and the effects of welfare reform on the stability and vitality of their communities. Findings will also be reported at the county level.

Its effort to integrate findings across the components. The goal of the project is to bring multiple data sources and methodologies to bear in answering the questions of interest. The results of the separate studies are intended to illuminate, clarify, reinforce, and otherwise complement each other, as exemplified in this report.

The Project on Devolution and Urban Change

Table 2

Comparison of Outcomes on Selected Indicators for Urban Change Respondent Survey Sample and National Samples

<u>Outcome</u>	<u>Urban Change Sample</u>	<u>National Sample</u>	<u>National Comparison Group</u>
Food insecure ^a (%)	49	10 36	All families ^b All families below poverty
Childhood hunger (%)	5	1	All families with children
Worst-case housing needs ^c (%)	34	7	All families
Reports fair to poor health (%)	25	8 12	Women age 25-44 ^d Black women age 25-44
Low score on a standardized physical health scale (SF-12) ^e (%)	31	10	Adults age 18-44
Low score on a standardized mental health scale (SF-12) ^e (%)	26	16	Adults age 18-44
Currently smokes cigarettes (%)	40	23	Women over 18 ^d
Overweight (BMI greater than 25) ^f (%)	66	37 50	Women age 20-34 ^d Women age 35-44
Average number of doctor visits, past 12 months	6.0	5.4	Women age 18-44
Preschool-age child in fair to poor health (%)	8	3	Children under age 6
Adolescent child in fair to poor health (%)	12	3	Children age 5-17

(continued)

Table 2 (continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES:

^aThis measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

^b1998 Current Population Survey; in G. Bickel, S. Carlson, and M. Nord, Household food security in the United States, 1995-1998 (Washington, DC: U.S. Department of Agriculture, Food and Nutrition Service, 1999).

^cFamilies have worst-case housing needs if they have no rental assistance and pay more than 50 percent of their income (not including food stamps) for rent and utilities.

^d1996 National Health Interview Survey, National Center for Health Statistics, Current estimates from the National Health Interview Survey, 1996, *Vital and Health Statistics*, Series 10, No. 200 (Washington, DC: U.S. Department of Health and Human Services, 1999).

^eThe Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

^fThe ranges for weight were calculated utilizing the body mass index (BMI), which references the risk of morbidity and mortality associated with weight. A person whose BMI is 30 or higher is classified as obese.

- **For the Urban Change sample as a whole, *multiple* health problems were the rule, not the exception.**

On a scale indicating the number of potential health barriers to employment, only 26 percent of the survey sample had none of the eight health problems included,⁴ whereas *more than 40 percent had multiple health problems*. Moreover, the health problems of these women were typically compounded by other constraints that would presumably pose additional challenges to finding and keeping a job — constraints that have traditionally been the focus of discussions about welfare recipients' employability: having no work experience, not having a high school diploma, not speaking English, and having many or very young children. When these five non-health-related constraints to employment were added to the multiple health barrier scale, *less than 10 percent of the sample faced none of the 13 constraints*, as shown in Figure 1. Fully three times as many women had four barriers or more as had none (29.6 percent versus 9.1 percent, respectively), and roughly half the sample had at least three barriers.

- **The survey provides descriptions of the prevalence and scope of health problems among women in Urban Change, but the ethnographic data more fully capture the *severity* and complexity of the health-related hardships the families faced.**

The ethnographic interviews yield rich, in-depth, and dynamic glimpses into the lives of women living in selected neighborhoods in the Urban Change sites. Their stories provide insights into the gravity of health problems in this population of poor urban women and reveal that chronic illness, disability, injury, and health risks among families still receiving welfare created burdens from which few were totally exempt. The ethnographic interviews not only confirm the prevalence and salience of health problems reported in the survey but also suggest that the survey findings may to some extent lead to *underestimates* of their health problems. For example, about half the women in the ethnographic sample, as in the survey sample, were food insecure. However, the ethnographic data reveal that *even women who were rated as food secure* needed to piece together a complex array of tactics (eating day-old bread, using food pantries, getting food donations from family members) to ensure that their food needs were satisfied. As another example, women in the ethnographic sample often responded to direct questions about their physical health by saying it was “good,” while in the context of other discussions they volunteered information about serious and sometimes multiple health problems. Additionally, the ethnography reveals that when mothers indicated that their children had health problems, these problems were often quite severe. The ethnographic sample was not specifically selected because of health concerns, and yet it includes women whose children had such extreme problems as cancer, cardiac ailments, HIV infection, seizure disorders, severe retardation, and mental illness — not to mention the health problems typically associated with poor urban children, such as asthma and lead poisoning.

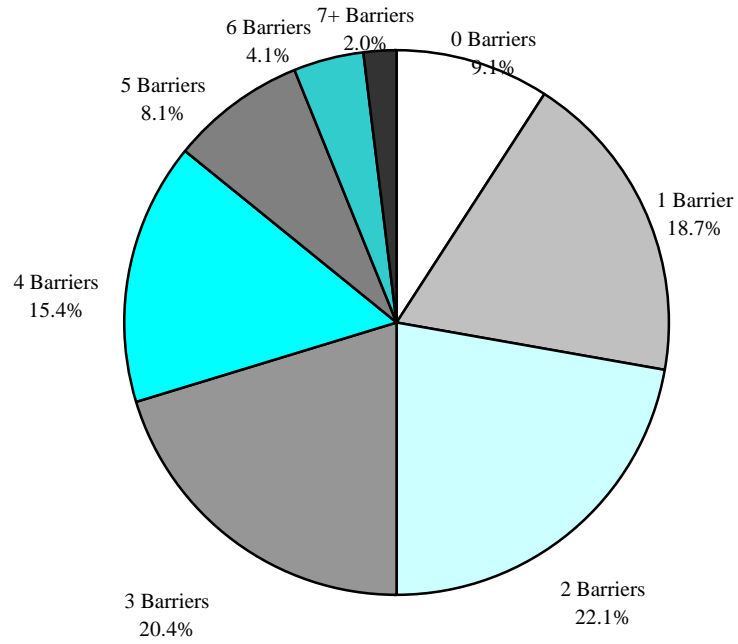
⁴The eight health problems in the health barrier scale include the following: being in poor physical health, as indicated by a low score on a health status scale; being at moderate or high risk of depression; having more than five doctor visits in the prior year; being morbidly obese; having been homeless or sheltered in the prior year; having used a hard drug (cocaine, heroin) in the prior month; having been physically abused in the prior year; and caring for a child with an illness or disability that constrained the mother's ability to work.

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Figure 1

Health and Nonhealth Barriers to Employment

Most women faced multiple health and nonhealth barriers to employment.



- **Women who were working — especially if they had left welfare — had better health and mental health outcomes than women who did not work, and they were less likely to have children with health problems.**

Table 3 summarizes key health outcomes for the four research groups. Across all outcomes considered in this table — and across many others discussed in the full report — women who had left welfare and were working had fewer health-related material hardships and were also healthier than women in the other three groups. Specifically, women in the work-only group were less likely than other women to be food insecure, to have housing problems, to have multiple material hardships, to be in fair or poor health, to have a work-limiting physical problem, to smoke, to be at risk of depression, to have been physically abused, and to have a child with an illness or health problem. Women in the two nonworking groups — whether they were still on welfare or had left — had similarly high rates of health problems. For example, about one out of three women in the two nonworking groups described themselves as being in fair or poor health. Women who combined work and welfare were in the middle of these two extremes with regard to virtually all indicators of health.

On the multiple health barrier index, women in the work-only group were least likely to have any of the eight health barriers — although, notably, 62.4 percent did have one or more (see Figure 2). Women who were working and still receiving welfare were somewhat better off than women in the two nonworking groups, but they nevertheless had more health problems than working welfare leavers. Women still on welfare and not working had the highest prevalence of multiple health problems.

It is important to note that the group differences in health outcomes do not merely reflect differences in the women’s background characteristics. Health differences in the four work/welfare groups persisted even when such factors as age, education, number of children, citizenship status, and race/ethnicity were controlled.

- **The relationship between the women’s employment status and their health most likely reflects the constraints that health problems pose for labor force participation.**

In a cross-sectional study with only one point of data collection, it is impossible to conclusively determine whether health problems affected women’s employment, or vice versa. It seems plausible that employment itself could confer some health benefits on poor women — for example, by improving their financial situation and thus their access to material resources that can benefit health. However, there is substantial evidence in both the survey and the ethnographic data that the strong and consistent relationship between women’s health and their employment status primarily reflects the effects of health problems on their decision or ability to work. For example, women in the two working groups were healthier than nonemployed women *even when total family income and health-related material hardships were statistically controlled* — which indicates that the women’s financial resources do not account for the association between employment and health.

- **Among women still on welfare, the prevalence of health problems that could undermine employment consistently exceeded 20 percent.**

The prevalence of individual health problems among current welfare recipients was consistently in the 25 percent to 40 percent range. For example, 29 percent had a health condition

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Table 3

Selected Health Status Outcomes, by Mother's Work and Welfare Status^a

Outcome (%)	Full Sample	Working, Not on Welfare	Working, Not on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Food insecure ^b	48.8 ***	41.8	49.5	52.5	55.4
Has 2 or more housing problems ^c	25.5 ***	19.9	28.4	28.9	26.2
Has 3 or more material hardships ^d	28.1 ***	19.3	26.4	35.6	30.6
Reports fair to poor health	25.5 ***	17.2	20.0	32.1	35.0
Physical problem limits work or type of work	24.0 ***	11.6	15.7	34.1	37.9
Currently smokes cigarettes	39.8 ***	32.2	39.9	44.9	44.1
At moderate or high risk of depression ^e	27.2 ***	19.9	23.6	32.7	34.8
Physically abused in past 12 months	8.8 **	6.6	7.6	10.4	11.1
Has an illness/disability that limits mother's work or school participation	19.8 ***	13.0	18.6	25.0	23.1
Sample size	3,765	1,240	626	1,468	431

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

^aWomen in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

^bThis measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

^cRespondents indicated whether they had any of the following housing problems: broken windows, leaky ceilings, roaches/vermin, and problems with wiring, plumbing, heating, and appliances.

^dThe eight material hardships used in this index include: food insecurity, receipt of emergency food in prior month, spends more than 50 percent of income (including food stamps) on housing, has two or more housing problems, had utilities turned off in past 12 months, has 2 or more neighborhood problems, witnessed a violent crime in the neighborhood, and homeless or sheltered in past 12 months.

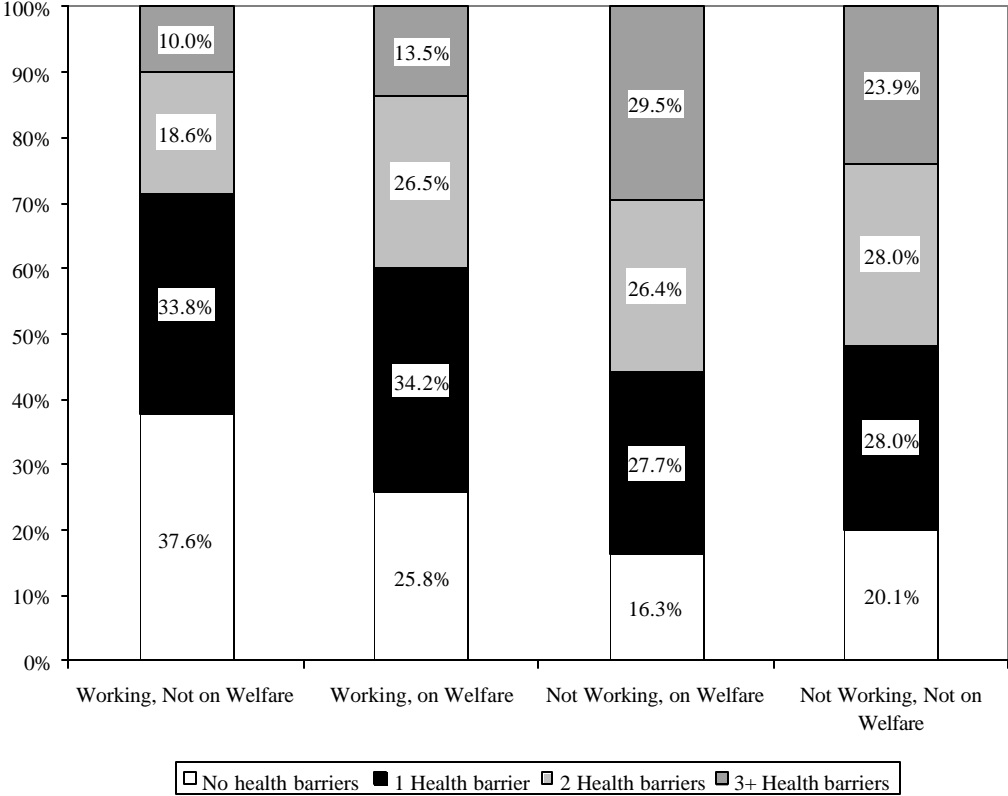
^eRisk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

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Figure 2

Health Barriers to Employment

Health barriers were most common among nonworking women.



that limited their ability to work, 30 percent were at high risk of depression, 41 percent had a health limitation that constrained moderate activities (for example, pushing a vacuum cleaner), and 23 percent had a child with a disability or illness that affected their employment. Since women having one such problem are not necessarily the same as those having another, the prevalence of *any* problem is substantially higher. Thus, on the multiple health barrier scale, nearly 80 percent of current recipients in the survey sample had at least one potential health barrier, and half had two or more. These rates are even higher among the welfare recipients who were not working, and so as the women who are able to work leave welfare, the percentage of the caseload with health problems will presumably increase.

- **The majority of women still on welfare said that they were subject to work or participation requirements. Only 14 percent said that they were exempt due to health reasons.**

About 40 percent of the women who were receiving welfare at the time of the 1998-1999 survey said that they were not required to engage in a work-related activity. The most commonly reported reason for an exemption was for a physical health problem of the woman herself (11.7 percent of recipients), and an additional 2.7 percent said that they were exempt because of the poor health of their child or some other family member. (The second most prevalent reason for an exemption was the age of the women's youngest child, reported by 7.7 percent of current recipients.) As a consequence, many women who reported health problems in the survey said that they were not exempt from participation. For example, nearly half (47.4 percent) of the women with three health barriers or more said that they were subject to the welfare agency's participation requirements.

- **Multiple health problems were related not only to employment and welfare status but also to the employment and welfare experiences of women.**

Among the women who were working, those with multiple health problems were less likely than those without such problems to be working full time, and they also worked in jobs with lower hourly wages. Moreover, even among those working full time, women with multiple health problems were less likely than other full-time workers to be working in jobs with fringe benefits, *including health insurance*. Health problems were also related to the timing of exits from welfare: Welfare leavers with health barriers were more likely than those without barriers to have left welfare recently (within the prior 12 months) and to say that they had been terminated by the welfare agency rather than that they had left of their own accord. Substantial percentages of women with multiple health problems who had left welfare had reapplied for welfare in the preceding year but had been denied. Among the women still on welfare, the greater the number of health barriers, the greater the likelihood that the woman had been sanctioned in the prior year.⁵ Overall, nearly one-third of current recipients had been sanctioned; but women who reported being highly depressed, having been physically abused, or having a child with a serious health problem were significantly more likely to have been sanctioned than women without these

⁵A penalty involving loss of part or all of the cash assistance grant (and sometimes of other benefits as well) for a period of time because of noncompliance with welfare rules. A full-family sanction is a penalty for noncompliance with welfare requirements under which all members of a household receiving welfare have their cash grants (and sometimes other benefits) eliminated.

problems. Among both welfare leavers and current recipients, women with health barriers were substantially less likely than other women to think that time-limited welfare is fair.

- **Health outcomes varied across the four sites, but not in a consistent fashion, and the same pattern of health-related differences among the four work/welfare groups was observed in all four sites.**

For most of the health outcomes included in the Urban Change study, there were significant site differences. However, the pattern of differences did not consistently point to one site's having better or worse health outcomes than others. For example, food insecurity was highest in Los Angeles; cigarette smoking was highest in Cleveland; and depression and physical abuse were highest in Philadelphia. Thus, despite significant site differences on individual health outcomes, women in the four sites did not differ on the multiple health barrier scale. Moreover, all four sites exhibited a comparable pattern in terms of work/welfare group differences. In every site, working women, especially those who had already exited welfare, had better health outcomes than nonworking women.

VI. Health Care Access and the Safety Net

Although health status was strongly linked to employment, health care access — and the use of other safety net programs — was associated with welfare receipt, which is consistent with the fact that welfare recipients are automatically eligible for Medicaid.

- **Women who had left welfare — whether they were working or not — were substantially less likely than women still on welfare to have health insurance.**

Women in the two groups of welfare leavers were more than *five times* as likely as the two groups of current welfare recipients to be uninsured in the month before the interview. As shown in Table 4, one-third of the women in the work-only group and about 45 percent of those in the no-work, no-welfare group did not have insurance in the month prior to the interview, compared with 6 percent among welfare recipients. Welfare leavers were also substantially more likely than current recipients to have had a spell without health insurance in the prior year. Figure 3 shows that substantial minorities (about one in four) of the women who had exited welfare had been *uninsured for the entire previous year*. Other family members, including children, were also affected by welfare exits. For example, as shown in Table 4, about 30 percent of the women who had left welfare had a child who was not insured in the prior month, compared with about 7 percent of the women still on welfare. Women who had left welfare were also substantially more likely to have had no insurance for the entire family in the prior month.

- **With respect to all other indicators of health care access, women who had left welfare had more problems than current recipients.**

Table 4 also shows that about twice as many welfare leavers as current recipients did not have a usual source of health care at the time of the interview. Moreover, welfare leavers were substantially more likely to say that someone in their family had needed medical or dental care in

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Table 4

**Selected Outcomes Relating to Health Care Access
and Food Stamp Benefits,
by Mother's Work and Welfare Status^a**

Outcome (%)	Full Sample	Working, Not on Welfare	Working, Not on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Uninsured, prior month	19.5 ***	33.7	6.1	6.2	44.5
Ever uninsured, past 12 months	30.4 ***	45.7	15.7	15.6	56.0
Everyone in family uninsured, prior month	11.2 ***	20.9	1.8	2.6	26.5
Any uninsured child, prior month	16.5 ***	27.8	6.8	6.7	34.5
Has no usual source of care	11.2 ***	14.7	8.7	7.1	18.3
Anyone in family needed doctor but couldn't afford it	23.4 ***	32.4	13.9	15.1	39.5
Anyone in family needed dentist but couldn't afford it	25.0 ***	35.0	15.0	15.9	41.8
Did not receive food stamps, prior month	30.9 ***	68.0	7.0	3.4	51.2
Food insecure with no food stamps, prior month ^b	13.0 ***	26.0	3.4	1.8	27.5
Sample size	3,764	1,239	626	1,468	431

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

^aWomen in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

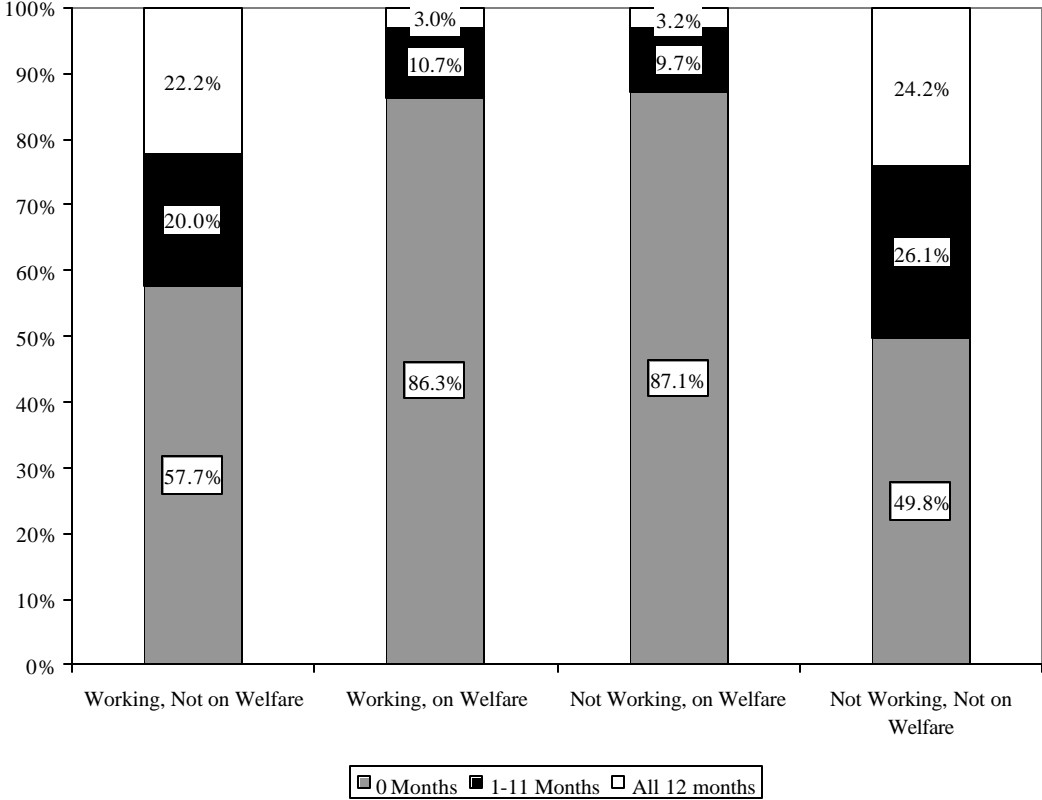
^bThis measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

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Figure 3

Health Insurance Coverage

Many welfare leavers had spells without health insurance.



the prior year but had been unable to obtain it because of financial constraints. Some 40 percent of those who had left welfare and were not working and 32 percent of those who were working reported an unmet need for medical care in their families, compared with about 15 percent of those still receiving welfare. Across all the indicators of access, then — whether pertaining to the women, their children, or other family members — current recipients fared better than former recipients, and they fared especially better than those who were not working.

- **The majority of women who had left welfare were not getting food stamps at the time of the interview.**

Among former welfare recipients, some 68 percent of those who worked and 51 percent of those who did not work no longer received food stamps. Yet, on the basis on their self-reported income, the majority of welfare leavers who were not receiving food stamps appeared to be eligible for this benefit (although information on the women's assets, which is also used in eligibility determination, was not available in the survey). As shown in Table 4, about one of every four former welfare recipients was food insecure but did not receive food stamps in the prior month. By contrast, only a handful of recipients had not gotten food stamps in the prior month and were food insecure.

- **There were significant site differences in safety net coverage.**

Miami was the only site where the majority of women (55 percent) in the survey sample had left welfare, in line with the fact that Florida had the sixth-highest rate of welfare caseload decline in the country for the 1996-1998 period. (By contrast, only 31 percent of the Los Angeles survey respondents had exited welfare.) Consistent with the fact that welfare exits were related to health care access problems, women in Miami had the highest rate of being uninsured in the prior month, of having a spell without insurance in the prior year, and of having an unmet need for medical or dental care in the prior year. For example, 30 percent of Miami respondents were uninsured in the month prior to the interview, compared with 13 percent of respondents from Philadelphia. However, it is important to note that all sites have taken steps since the 1998-1999 interviews to address problems with Medicaid coverage for welfare leavers. It should also be noted that, among the women who had left welfare, those in Miami were most likely to still be receiving food stamps (45.9 percent), while former recipients in Los Angeles (15.7 percent) were least likely to still be food stamp recipients.

VII. Health Patterns in the Four Work/Welfare Groups

The findings of the Urban Change health study indicate that the health situations of highly disadvantaged urban women cannot be adequately characterized by comparing welfare leavers with ongoing recipients or by comparing employed women with nonemployed women. *All four research groups had appreciably different health profiles* — profiles that were similar across the four Urban Change sites. The work/welfare groups are all of public policy interest because they pose distinct challenges — and also because the groups are undergoing changes in size and composition as a result of welfare reform. This section summarizes the characteristics and health circumstances of the women in the four work/welfare groups.

- **Compared with women in other groups, women who had left welfare and**

were working (the *work-only group*) were advantaged in terms of health status and most other indicators of emotional, financial, and social well-being — except for access to health care.

One-third of the women in the Urban Change sample were former recipients who were working. Most were high school graduates with one or two children (typically, school-aged). The majority worked full time (30 hours or more per week) in jobs that paid above the minimum wage and that offered at least one fringe benefit; about half had employer-provided health insurance for themselves. Women in this group typically had been working in their current jobs for more than one year, and three out of four had left welfare more than one year before the interview. Their total family income in the prior month (including food stamps, child support, and all family members' earnings but not including the Earned Income Tax Credit, housing subsidies, or the cash value of medical insurance) averaged just under \$1,750, which would translate to about \$21,000 annually.

For virtually every indicator in the survey, women who had left welfare for employment prior to reaching the time limits were the least disadvantaged group. They were better off financially and had fewer health-related material hardships than other women in the Urban Change sample: They were more likely to be food secure, had better-quality and safer housing, lived in less dangerous neighborhoods, and were less likely to have been homeless in the prior year. They were the healthiest group and were least likely to be at risk of depression or to report high levels of stress. They were also least likely to have been victims of domestic violence. Their children were healthier than children of other women, and their children also appeared to have other advantages, such as higher levels of contact with their fathers.

However, the work-only group was not fully protected by the safety net designed to safeguard the working poor. Nearly half these women had had a spell without health insurance in the prior year, and nearly a quarter had been uninsured the entire year. Even among those with stable, full-time employment (that is, working in the same job for at least one year), over one-third did not have health insurance as a fringe benefit. Some 40 percent of the women in the work-only group said that they or someone in their family had foregone medical or dental care in the prior year because they could not afford it. Fewer than one-third were receiving food stamps, despite the fact that more than half of those not receiving them appeared to be income-eligible.

Even though women in the work-only group were the healthiest and had the best material resources of any group, they were nevertheless mostly single mothers juggling jobs and parenting responsibilities while living in stressful and disadvantaged situations. Employed welfare leavers were more likely to be food insecure than those living below poverty nationally. And, *although healthier than women in the other groups, they were less healthy than same-aged women nationally*. Thus, it appears that many of those who had been able to leave welfare for employment still had health-related problems that might undermine permanent self-sufficiency, especially in light of health care access problems for themselves and their children.

- **Women in the *work-and-welfare group* were healthier and had more human capital resources than women in the two nonworking groups; additionally, by virtue of their Medicaid benefits, they had good access to health care.**

Women who combined work and welfare made up a relatively small proportion of the

overall Urban Change survey sample (17 percent) but a noteworthy percentage of all current welfare recipients in the two welfare groups (30 percent). Until recently, relatively few recipients combined welfare and work; the growth of this group presumably reflects the more generous financial incentives that most states now offer recipients, allowing them to have more of their earnings disregarded for the purpose of computing welfare benefits.

Women in the work-and-welfare group, about half of whom had a high school diploma, were predominantly single mothers caring for two or more children, and most had a preschool-age child. The majority of women had held their current jobs for more than six months. Only about half had full-time jobs, and most had no fringe benefits. Fewer than one out of four had jobs with wages that would raise them above poverty if they worked full time. Their total family income in the month prior to the interview, including welfare and food stamp benefits but not the EITC, averaged about \$1,400, which would translate to an annual income of under \$17,000 per year.

Current recipients who worked had less favorable health outcomes than welfare leavers who worked, but they had consistently better outcomes than women in the two nonworking groups. For example, working welfare recipients were about half as likely as nonworking women to say that they had a physical problem or other health condition that limited the kind or amount of work they could do. In light of the fact that these women were already working, it seems likely that many of them will exit welfare before they reach the time limits. However, because of their more limited human capital resources than women in the work-only group, those in the work-and-welfare group appear even less likely to secure jobs with health benefits, even though their health problems suggest an even stronger need for health care access. These women may experience severe hardships in their transition off welfare without new policies that can guarantee them access to health care — and to food stamps, for which most will likely continue to be eligible.

- **Compared with women who worked, women in the *welfare-only* group had worse circumstances with regard to their material resources, their health status, and their children's health; but they had good health care access to address their health problems.**

Women who continued to receive cash welfare benefits and were not working composed 39 percent of the Urban Change sample — the largest of the four work/welfare groups. The majority of these women were not high school graduates, and about half had three or more children, at least one of whom was a preschooler. Typically, these women had not worked for pay at all in the prior year, and nearly one out of five had never worked for pay. This was the poorest of the four groups, with total family income from all sources in the prior month averaging \$935, which would be an average annual income of about \$11,000.

Women in the welfare-only group were living in the least healthful circumstances by virtue of having multiple, and severe, material hardships. The majority were food insecure, and yet they spent, on average, over one-third of their total family income (including food stamps) on food. These women tended to live in poorer-quality housing and resided in more violent, more dangerous neighborhoods than women in the other groups. Many women in the ethnographic sample — the vast majority of whom were nonworking welfare recipients — described extensive crime, drug use, and gang activities in their neighborhoods, and they discussed how fears about personal safety for themselves and their children kept them hostages in their own homes.

Women in the welfare-only group were also the least healthy of women in the Urban Change sample, with about one out of three reporting a health condition that limited the amount or type of work they could perform. The majority were at risk of depression and reported high levels of stress. One out of four had a child with a physical problem that constrained employment options. Welfare recipients in the ethnographic sample provided powerful stories about how their children's health problems — often quite serious ones — hampered their ability to work and to comply with the welfare agency's participation requirements. Overall, three times as many of these women had multiple health barriers as had none (56 percent versus 16 percent). However, these women had good access to health care to address their various health problems through Medicaid. As has been found in other studies, they worried substantially more about losing medical benefits than about losing cash assistance — and they had tremendous anxiety about how they would care for their sick children when they were working.

Many women in the welfare-only group could be characterized as “hard to employ” and may well not be able to secure paid employment before they reach their time limit. The majority not only had multiple health barriers but also were handicapped by poor education credentials and limited work experience. Health problems may have also interfered with their ability to comply with the welfare agency's participation requirements. Most of these women will likely have difficulty making a transition off welfare.

- **Women in the *no-work, no-welfare* group had the most compromised health situations, including the most unfavorable health profiles and the most severe health care access problems of any group.**

Women who had left welfare and were not working composed 11 percent of the survey sample. These women were more likely to be married than those in other groups. Additionally, their children (and they themselves) tended to be older. About half did not have a high school diploma, and one out of ten said that they could not converse in English. The majority had not worked for pay at all in the prior year, and most had not collected any welfare benefits in that period — although only a small minority reported no source of income in the prior month. The most important income source was from the paid employment of another household member. This group was nearly as disadvantaged financially as the welfare-only group, with an average total family income from all sources of just over \$1,000 in the prior month, or roughly \$12,000 annually.

For many health outcomes, this group had the highest prevalence of problems. For example, women who neither worked nor received welfare were most likely to be food insecure, to say that they were in fair or poor health, to have unfavorable scores on a standardized measure of physical health status, to be at high risk of depression, and to have been physically abused in the prior year. Overall, their health situations looked similar to those of women in the welfare-only group, with one critical exception: Nearly half were uninsured, and over one-third had a child who lacked health insurance. Two out of five of these women had unmet medical and dental needs in their families. Fewer than half of the women in this group lived in households that received food stamps, and yet over 80 percent of the nonrecipients appeared eligible on the basis of their income.

Some of the women in this group appeared to be no longer eligible for TANF assistance, because they no longer had an age-eligible child, or because of their marital status, or because they had already moved into a disability assistance program. Others, however, seemed at high

risk of returning to welfare in light of health-related and other constraints to employment and given their need for health insurance.

VIII. Implications of the Findings

Welfare reform is being widely hailed as a success because of declining welfare caseloads. In fact, the Urban Change survey data indicate that *substantial numbers of welfare recipients from even the most disadvantaged urban neighborhoods have been able to secure fairly stable employment* — notwithstanding the fact that most of them have at least one health-related or human capital barrier to employment. However, both the women who have left welfare and those who remain on the rolls face issues that merit the scrutiny of policymakers, welfare staff, and service providers.

- **The women who have remained on welfare despite encouragement to find a job, impending time limits, and the strong economy have multiple health and other impediments that pose powerful challenges to welfare agencies.**

Although most women who had left welfare and were working had potential barriers to employment, these women nevertheless had better education credentials, more prior work experience, fewer children, and far fewer health problems than women who continued to receive cash assistance. In particular, current recipients who were not combining work and welfare despite current financial incentives to do so appear to include women who may not be immediately employable. With the time limits approaching for many of them, welfare agencies face unprecedented pressures to prevent current recipients from losing their benefits without having a job — as well as pressures resulting from the fact that caseloads increasingly comprise women with complex health-related problems.

- **Effective strategies to address the needs of the hard-to-employ need to be identified and replicated.**

Some of the barriers of welfare recipients — such as having chronic health problems or several children with illnesses — may be too intractable to remedy to the point where the women could become totally self-sufficient. Other health barriers identified in this study, however, could be diagnosed and possibly improved through interventions. In particular, substance abuse and mental health services may prove to be critical to certain segments of the welfare caseload — as well as to women who leave welfare for work and find it difficult to sustain employment. Substantial percentages of women in all four work/welfare groups were at high risk of depression, and major depression is the leading cause of disability in the United States. It seems possible that aggressive mental health and related services could have favorable effects on the ability of these women to enter — and remain in — the labor force. It is also possible that a combination of services and temporary extensions of the time limit will be required to address some of the complex psychosocial issues confronting many welfare recipients remaining on the caseloads. Many welfare agencies are taking advantage of the exceptional opportunities they have now to experiment with alternative service packages and intervention strategies as a result of the programmatic (and fiscal) flexibility they now enjoy under PRWORA. In many cases, strategies to work with the hard-to-employ involve collaborations with other service providers, which seems essential, given

the complexity of these women's problems. With the federal time limits looming large, reliable information on the effectiveness of these strategies is becoming crucial.

- **As more and more women reach the time limits, it may prove necessary to reassess the policy of restricting exemptions from the five-year limit to 20 percent of the caseload — or the policy of having a two-tiered system of exempt and nonexempt recipients.**

PRWORA's 20 percent exemption policy was based on a preliminary estimate of the proportion of recipients who would face insurmountable barriers to employment and thus would require ongoing cash assistance. Based on the data from the Urban Change survey, it seems possible that more than 20 percent of these women may need an exemption from — or an extension of — the time limit. It is, of course, important to remember that the sample is not representative of all welfare recipients and that the Urban Change data are nonclinical and therefore have limitations as formal measures of health status. Nevertheless, among the women most at risk of reaching their time limit without a job — that is, among women in the welfare-only group — the great majority appear to have serious and multiple impediments to employment. And as the number of recipients continues to decline by virtue of exits due to employment, recipients with multiple barriers will dominate the remaining caseload, and there will be fewer and fewer women in the "base" for calculating the exemption rate.

A related issue is that current policy establishes a two-tiered system (a three-tiered system, if SSI is included) to characterize the employability of welfare recipients: In the first tier, a minimum of 80 percent are presumed employable and capable of becoming self-sufficient; and, in the second tier, up to 20 percent are presumed to have a more permanent need for cash assistance without being required to work. In fact, as this report describes, there are varying degrees of employability that are tied to recipients' human capital resources, their life experiences and circumstances, their health and mental health conditions, and their children's health. The degree to which a person is healthy enough to work is more on a continuum than a yes-or-no issue; more dynamic than static; and also depends on what supports (for example, health insurance) are available. Thus, there could be inherent problems in having such sharp cutoff points that, on the one hand, *require* 80 percent to leave welfare within five years without further cash assistance and, on the other hand, do *not* require the remaining 20 percent to participate in services that could benefit them and their families. It may be appropriate to consider alternative policies that give states greater flexibility (or financial incentives) to develop the most suitable plan for recipients at all points along the employability continuum. And states might wish to explore alternative kinds of work activities for some cases — such as supported work, which entails closely supervised job training for small groups of people facing similar barriers to employment.

- **In a time-limited welfare environment, appropriate screening procedures appear essential for policy planning purposes and for a fair and effective programmatic response to women with health-related barriers.**

Without time limits, states might be justified in simply identifying hard-to-employ cases by seeing who on the caseload cannot find a job. However, intervention strategies for recipients with a severe health-related problem or multiple barriers to employment will likely take time to succeed, suggesting the need for early identification — not when recipients are within months of hitting the time limit. Although welfare agencies may be reluctant to slow down the process of moving recipi-

ents into jobs quickly by instituting universal, in-depth assessments, there may be a benefit in instituting simple, low-cost screening procedures, either at intake or after a brief job search period. For example, Los Angeles County's welfare-to-work program has begun using a short, self-administered questionnaire during the intake process that asks about substance abuse, mental health problems, and domestic violence. Clients who indicate that they may have a problem are referred immediately to a social worker for a clinical assessment. Although such screening will not identify all women with problems, it will likely provide data for improving large-scale planning (about sanctioning policies, for example, or resource allocation) and for developing a course of action for many women who require substantial assistance in leaving the welfare rolls.

- **Health problems not only constrain employment but also appear to constrain recipients' ability to comply with participation requirements, raising questions about current sanctioning policies.**

Sanctioning is increasingly viewed as an important tool for encouraging compliance with mandated welfare-to-work activities and work requirements. A number of states — including three of the four involved in this study — have instituted full-family sanctions (that is, a total cutoff of all TANF benefits) as a penalty for noncompliance, and sizable percentages of recipients in the survey sample (nearly one-third) reported having been sanctioned in the prior year. The findings from both the ethnographic study and the survey suggest, however, that noncompliance may in some cases reflect genuine health-related obstacles that recipients face. A particular concern is that more than 40 percent of the women who had been physically abused in the prior year, compared with 29 percent of nonabused women, reported having been sanctioned. These findings suggest that states should reevaluate their sanctioning policies and explore and evaluate mechanisms for special outreach (such as home visits and in-depth assessments) to families in sanction status. For example, in Cleveland the welfare agency has contracted with nonprofit social service agencies to make home visits to every family who is sanctioned for noncompliance with welfare-to-work requirements. The home visitors are trained to identify barriers and to arrange for services that could help the family regain compliance.

- **Given the health care needs identified in this study, an especially critical policy challenge is the development of mechanisms to ensure that women who leave welfare maintain their health insurance coverage.**

It is laudable that recent initiatives have made an increasingly large number of low-income children eligible for health insurance through Medicaid expansions and the Children's Health Insurance Program (CHIP). However, the disparity in policies for low-income women and low-income children merits scrutiny. The women in the Urban Change population were less healthy than their children, yet they were less likely to have insurance and less likely to have access to health care — even though *they* were the ones who shouldered the responsibility for raising and financially supporting their children. Maintaining health insurance coverage among those who leave welfare is a two-pronged issue. First, it is important to put into place strategies to ensure that eligible women receive the health insurance benefits to which they are entitled when their TANF benefits are terminated. All four Urban Change sites have taken steps since the survey data were collected to improve the delivery of transitional Medicaid benefits. Second, consideration needs to be given to mechanisms for making health insurance available to women who are not currently eligible. Some employed welfare leavers would not qualify for Medicaid on the basis of their earnings, yet they are clearly in need of insurance. There are several ways by which

better access to insurance could be achieved, including incentives to employers, further expansions of Medicaid eligibility, Medicaid buy-in plans, and state-funded insurance programs.

- **Closely behind the need for improved policies and procedures relating to Medicaid is the need for closer examination of food stamp benefits for transitioning welfare recipients.**

Adequate nutrition is a prerequisite for health and well-being, and food stamps are the central policy tool for providing nutritional assistance to low-income families. Most welfare recipients who leave welfare continue to be income-eligible for food stamps, but there is increasing evidence — including findings in the current study — that many eligible families do not receive food stamp benefits. In the work-only group, only about one-third of the women were food stamp recipients, despite the apparent eligibility of most nonrecipients. And in the no-work, no-welfare group, over 80 percent of those not receiving food stamps appeared eligible. Data from this study as well as other studies of welfare leavers suggest that steps need to be taken to ensure that women who leave welfare for work obtain food benefits for which they are eligible. The steps could include (1) better training of caseworkers so that they fully understand new eligibility rules and are aware of the importance of consistently and regularly communicating this information to clients; (2) better use of technology to identify qualified welfare leavers who are eligible for food stamps; (3) outreach to welfare leavers to notify them of eligibility; (4) more convenient office hours and mechanisms for employed people to apply for benefits or get recertified (such as mail-in recertification and “one-stop” locations for various services and benefits); and (5) outreach at food pantries or other community locations that serve the needs of the poor.

- **In all policies arenas relating to public assistance, it is critical to anticipate the inevitability of an economic downturn and to take employment barriers into account in planning for such a downturn.**

In a strong economy such as the current one, a single barrier might have minimal effects on women’s employment. As the impediments mount up, the obstacles presumably become increasingly difficult to overcome — both because the women themselves have to cope with the barriers and also because they become less attractive to prospective employers. In a less favorable economy, however, employers can be more selective in hiring — and less cautious about firing. Women with even one health-related or other employment barrier may find it substantially more difficult to transition from welfare to work, and to sustain jobs, in a different economic climate. Anticipating such change could lead, for example, to the development of formulas tying the unemployment rate to exemption criteria, rates of exemptions, and extensions of the time limits.

In conclusion, it is clear that, as public policymakers head toward decisions about the reauthorization of PRWORA (scheduled to occur by 2002) and about features that can improve the success of this legislation, the health and health care needs of welfare recipients in urban areas warrant special consideration.