

# Welfare to Work?

## Impact of Maternal Health on Employment

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The landmark welfare reform legislation passed by Congress in 1996—the Personal Responsibility and Work Opportunity Reconciliation Act—revealed politicians’ beliefs that the primary solutions to poverty reside in stringent work and personal behavior requirements on individuals.<sup>1</sup> The law posited that requiring poor women with children to work and restricting their sexual and reproductive behaviors would lift poor families out of poverty within the federally mandated 5-year time limit and make them self-sufficient.

Many have debated the ethical and causal assumptions of this approach. We highlight another component not considered in the legislation: the health status of poor women and children. The Personal Responsibility and Work Opportunity Reconciliation Act ended the entitlement to a basic level of subsistence that President Roosevelt’s New Deal established with the Social Security Act of 1935; it also abdicated the long-standing guarantee to protect the “health and well-being” of the poor.<sup>2</sup> This was unfortunate, given the indisputable evidence that the poor bear a disproportionate share of the disease burden in this country.<sup>3</sup>

Beyond basic data on caseload statistics, numbers of sanctions, and employment trends, the Personal Responsibility and Work Opportunity Reconciliation Act did not require states to report a great deal of information to the federal government. Thus, few national data are available with which to assess any association between the new welfare policies and the health of the target population.<sup>4</sup>

One research project that examined health issues among women who had received public assistance in 4 urban areas (Cleveland, Los Angeles, Miami, and Philadelphia) revealed that these women (and their children) had higher rates of physical and mental health problems in comparison with US women overall.<sup>5</sup> Furthermore, working women who had left welfare (“leavers”) continued to experience

**Objectives.** This study investigated whether health problems among poor mothers of chronically ill children affect their ability to obtain and maintain employment.

**Methods.** Mothers of children with chronic illnesses were surveyed at clinical and welfare agency sites in San Antonio, Tex.

**Results.** There were distinct health differences according to mothers’ TANF and employment status. Mothers without TANF experience reported better physical and mental health and less domestic violence and substance use than did those who had TANF experience. Those not currently working had higher rates of physical and mental health problems.

**Conclusions.** Poor maternal health is associated with need for cash assistance and health insurance. Policymakers must recognize that social policies promoting employment will fail if they do not address the health needs of poor women and children. (*Am J Public Health.* 2002;92:1462–1468)

these health problems and often lacked health insurance. Leavers who were not working had the worst health situations: increased health problems, no health insurance, and unmet health care needs.

Another city-level study (conducted in Boston, Chicago, and San Antonio) that collected health-related data showed that a quarter of women remaining on welfare reported health conditions that prevented them from working (as compared with 11% of former recipients and 8% of nonrecipients); also, these women experienced higher levels of depression and domestic violence compared with nonrecipients.<sup>6</sup> Other reports of health-related problems among individuals who have had contact with the welfare system support these findings, although the primary foci of these research efforts have often been economic and, therefore, limited in their health content.<sup>7–9</sup>

In the present study, we examined whether health problems among mothers of chronically ill children affect their ability to comply with the increased emphasis on employment. Data were derived from a study conducted in San Antonio, Tex, a city with a population of just over 1 million people of primarily Hispanic (59%), non-Hispanic White (32%), and African American (7%) ethnicity.<sup>10</sup> Nationally, Texas ranks poorly on many social and health

indicators, including overall population living in poverty (10th), school-aged children living in poverty (13th), recipients of Temporary Assistance for Needy Families (TANF) (36th) and food stamps (31st) per 100 people in poverty, number of uninsured children (2nd), and per capita spending on public health (44th).<sup>11</sup> In 1999, Texas had the highest proportion of low-income families in the country.<sup>12</sup> Given these data, it is important to determine whether poor families that have children with chronic illnesses are experiencing other problems as well.

## METHODS

### Study Design

The research findings reported here were derived from the baseline round of a longitudinal study of 504 low-income mothers in San Antonio, Tex, who had children with specific chronic illnesses. A closed-ended survey instrument was administered in person by trained bilingual (English and Spanish) interviewers who recruited women at 1 of 8 clinical sites or 1 of 2 welfare agency sites. The survey required approximately 40 minutes to administer.

We undertook special efforts to recruit participants from diverse sites (e.g., walk-in clinics, inpatient wards, a private pediatric office,

a public hospital, and TANF job centers) and thus minimize bias in the sample. Eligible participants were the parents (usually the mothers) or primary caretakers of children aged 2 to 12 years with 1 of 7 diagnoses: asthma, diabetes, hemophilia, sickle-cell anemia, cystic fibrosis, seizure disorder, or cerebral palsy (or other serious neurological impairment).

### Survey Instrument

The primary purpose of the survey instrument was to elicit information on the health status of the child and the child's mother (or primary caretaker), health insurance, and TANF status. The survey also collected information on employment, child care, mental health, domestic violence, substance use, and demographics. Although we were able to include previously validated items in some survey sections (e.g., mental health [SF-36 Health Survey<sup>13,14</sup>], domestic violence [Partner Violence Screen<sup>15</sup>], and substance abuse [CAGE<sup>16,17</sup>]), our unique focus required us to develop many measures specifically for this study (e.g., different categories of welfare status, association between health and compliance with welfare and work requirements). We hoped that including questions about depression, domestic violence, and substance use would help us augment findings from previous work on the prevalence of these problems among the poor.<sup>18</sup>

The principal researchers, clinicians, and San Antonio health department personnel extensively reviewed and revised the survey. It was translated into Spanish as part of a multi-step process involving native speakers from the area. The survey was pretested in a clinical setting and further revised to clarify areas of misunderstanding and to incorporate potential responses to field-coded questions not previously considered by the researchers.

### Data Collection

Informed consent was obtained from study participants, who were interviewed while waiting for their children's medical appointments (at the clinical sites) or their own case-worker appointments (at the TANF sites). All of the recruitment sites provided a special location in which to conduct the interviews (e.g., an empty examination room or office) so as to ensure privacy. Participants received a \$10

gift card to the local grocery store as thanks for their time and participation. The study coordinator conducted standard validation analyses of 10% of the completed surveys.

### Measures and Data Analysis

The findings presented here focus on prevalence of maternal health problems according to welfare status. Welfare status was defined as follows: no contact with the welfare system (had never applied for or received benefits), denied (had applied for but been denied benefits), pending (had pending applications), former (had received benefits in the past), or current (receiving benefits at the time of enrollment in the study). We present bivariate associations between maternal health and welfare status and employment and examine important employment issues such as availability of child care and ability to keep medical appointments. We conducted multivariate analyses of predictors of welfare status and employment barriers related to health using binary and multinomial logistic regression.

## RESULTS

### Sample Description

Most (91%) of the survey respondents were mothers of children with chronic illnesses, and the remainder consisted of other female relatives, legal guardians, or fathers. (Because the overwhelming majority of respondents were either mothers or other female caretakers, the analyses described subsequently collectively refer to *mothers*, *maternal* health, and so forth.) The mean age was 31 years. This was a low-income sample, with more than half of the respondents reporting a monthly income of less than \$1000 for a mean household of 4.7 people.

Fewer than half of the respondents had health insurance, and about one third (35%) did not have high school diplomas. The majority of the sample reported Hispanic ethnicity, being born in the United States, and English as their primary language. About half of the respondents were married or cohabiting, and half were single or separated. Although fewer than half were employed at the time of enrollment in the study, two thirds of those not working had been employed in the previous 3 years.

As can be seen in Table 1, distinct profiles were revealed among those who had never been welfare recipients, those currently receiving TANF, those who had left TANF (or were denied benefits), and those applying for TANF. Respondents with any TANF experience (i.e., applicants, current or former recipients) were more likely than nonrecipients to have monthly incomes below \$1000. Similarly, those with any TANF experience had significantly fewer years of schooling than did nonrecipients. Compared with TANF nonrecipients, more of the women with any TANF experience were single or separated. The proportions of Spanish speakers among TANF nonrecipients and recipients did not differ, although former recipients were less likely to be Spanish speakers.

About half of nonrecipients, former recipients, and denied applicants were currently employed, as compared with fewer than one fifth of current recipients and pending applicants. Notably, those with any experience with the welfare system reported higher levels of previous employment than did nonrecipients. Current TANF recipients had approximately double the rate of health insurance coverage of the total sample and of most of the other comparison groups; only about one third of former TANF recipients had health insurance. There were significantly higher rates of food insecurity and telephone disconnection among those with any TANF experience than among nonrecipients.

### Maternal Health According to Welfare and Employment Status

Maternal health measures included specific health problems, limitations in activity due to health, depression, domestic violence, substance use, and emergency department visits (although also considered a measure of health care use, emergency department visits were used here as a marker of poor health). Mothers without TANF experience reported significantly better physical and mental health and lower rates of domestic violence and substance use than did those with any TANF experience (Table 2). Although current and former TANF recipients had substantially higher rates of these health problems, the highest rates were seen among those who had applied for TANF and been denied benefits or

**TABLE 1—Sociodemographic Characteristics of Mothers of Chronically Ill Children, by Welfare Status (n = 504)**

	Total	Nonrecipients	Current	Former	Denied	Pending
Age, y, mean	31.0	30.6	31.8	30.3	32.3	32.0
Income less than \$1000/mo, %***	53.6	36.2	79.0	64.7	52.8	80.0
Highest grade, y, mean**	11.3	11.6	10.1	11.5	10.9	10.5
No high school diploma, %	35.2	32.9	54.0	26.7	37.7	40.5
Marital status, %***						
Single/separated	49.1	30.7	68.3	64.2	54.7	69.0
Cohabiting/married	35.6	54.7	17.5	20.0	28.3	35.6
Cohabiting/not married	15.3	14.7	14.3	15.8	17.0	15.3
Ethnicity, %***						
Mexican American/Hispanic	62.2	69.2	62.3	45.0	78.8	53.7
Black/African American	22.0	12.2	23.0	39.2	17.3	29.3
White/Anglo	10.5	14.9	4.9	7.5	3.8	12.2
Other	5.3	3.6	9.8	8.3	0	29.3
Born in US, %	87.9	84.1	87.3	93.3	86.8	95.2
Primary language Spanish, %*	11.5	15.1	15.9	3.3	13.2	7.1
Household size, mean No.	4.7	4.7	4.8	4.5	5.1	5.0
Employment, %						
Currently employed***	42.3	48.2	17.5	47.5	52.8	19.0
Worked in past 3 years**	63.2	53.8	51.9	81.0	68.0	76.5
Tried or wanted to work in past 3 years	40.2	31.5	52.0	58.3	50.0	25.0
Has health insurance, %***	45.7	40.3	85.7	34.5	47.2	45.2
Hardship in past 6 months						
Hardship scale, mean score**	1.2	1.0	1.3	1.4	1.3	1.7
Any hardship, %***	60.8	47.1	69.4	71.7	71.7	76.2
Housing, %	32.1	28.8	27.0	36.7	32.1	45.2
Food, %***	40.3	29.6	44.4	50.8	45.3	54.8
Telephone service cut off, %*	25.6	19.9	27.0	27.5	34.0	38.1
Utility service cut off, %	14.7	12.4	17.5	15.8	18.9	14.3

\* $P < .05$ ; \*\* $P < .01$ ; \*\*\* $P < .001$  (across-group trends).

for whom decisions were pending. The pending group had the lowest mental health scores (i.e., highest levels of depression) and the highest rates of domestic violence and emergency department visits.

Similarly, there were significant differences on most health measures between respondents who were and were not employed at the time of enrollment in the study. Those who were not working reported more health problems, limitations due to health, emergency department visits, depression, and domestic violence than did those who were employed (Table 2).

Respondents were asked if they were currently employed, if they had been employed

within the past 3 years, or if they wanted or tried to work during this time. When factors related to finding employment, work absenteeism, and job loss were assessed, significantly higher rates of health-related (own, child's, and other family member) and child-care-related barriers were reported for most measures among those not currently working. Specifically, compared with employed women, significantly more women not currently employed reported that they experienced difficulty finding work owing to their own health (36% vs. 64%), their child's health (44% vs. 56%), and lack of child care (38% vs. 62%). Similarly, greater job loss among currently unemployed women was as-

sociated with their own health (34% vs. 70%), their child's health (43% vs. 57%), the health of another family member (38% vs. 62%), and lack of child care (41% vs. 59%). Moreover, examination of the effect of these barriers to finding work showed that rates of barriers regarding child health (72% vs. 34%), mother's own health (42% vs. 20%), the health of other family members (30% vs. 15%), and child care (58% vs. 40%) were twice as high among those who had wanted or tried to work in the previous 3 years but had not been able to do so as among those who were currently employed or who had been employed within the past 3 years (data not shown).

**TABLE 2—Health-Related Characteristics of Mothers of Chronically Ill Children, by Welfare and Employment Status (n = 504)**

Variable	Total	TANF Status					Currently Working	
		Nonrecipients	Current	Former	Denied	Pending	No	Yes
<b>General health</b>								
Routinely suffer from any of 9 chronic health conditions, %	70.5	60.8**	82.0	76.1	78.4	77.5	71.9	68.4
Health problems, mean No.	1.7	1.2***	2.4	1.9	2.3	2.1	1.9**	1.5
Health problems make activities of daily living difficult, %	63.6	56.3†	72.0	63.7	63.4	81.3	68.3*	56.7
One or more visits to emergency department in past 6 months, %	33.7	26.1**	42.9	35.0	39.6	50.0	37.5*	28.6
<b>Depression</b>								
Depression, mean score	61.6	67.6***	57.0	58.7	56.5	51.3	59.4*	64.8
Routinely suffer from depression, %	26.5	16.4***	42.9	28.6	32.1	42.9	33.0***	17.5
Experienced domestic violence, %	23.8	16.4*	31.7	29.5	28.6	40.0	27.4††	18.7
Any negative mention of alcohol/drug use, %	14.7	9.4*	17.5	20.0	20.8	16.7	16.2	12.8

\*P<.05; \*\*P<.01; \*\*\*P<.001; †P<.06; ††P=.052 (across-group trends).

### Child Care and Ability to Keep Medical Appointments According to Welfare Status

We examined the often conflicting relationships of employment responsibilities with child care responsibilities and medical appointment attendance for children with chronic illnesses (data not shown). Those with current (40%), former (33%), denied (49%), and pending (40%) TANF status reported significantly more difficulty obtaining child care because of their child’s health problems in comparison with nonrecipients (23%;  $P<.01$ ). Similarly, nonrecipients were significantly less likely to miss children’s medical appointments because of work or school (19%) than were those in the current (25%), former (35%), denied (55%), and pending (23%) groups ( $P<.01$ ).

### Predictors of Health-Related Employment Barriers

We conducted multivariate analyses assessing maternal health barriers to employment. Three binary logistic regression models examined whether mothers’ health status (1) made it difficult to find a job, (2) caused missed work days, or (3) caused loss of a job. Variables included measures of maternal health and child health, maternal and child health insurance status, and relevant demographic factors (Table 3). In the first model, worse maternal mental health (i.e., depression), more other maternal health problems, and more maternal

visits to the emergency department were significantly associated with difficulty finding a job. Specifically, increased maternal health problems and emergency department visits were associated with a 50% increase in emergency department visits and with a fivefold increase, respectively, in difficulty finding work. Mothers who had less education, were older, and were members of households with fewer people also had more difficulty finding work. Maternal health problems and visits to the emergency department were 2 and 4 times more likely, respectively, to be associated with job absenteeism (model 2). Depression, maternal health problems, and lack of maternal health insurance all were associated with a greater likelihood of job loss (model 3).

### Predictors of Welfare Status

Multinomial logistic regression was used to test correlates of TANF status, categorized as current/former recipients vs nonrecipients (model 1) and denied/pending applicants vs nonrecipients (model 2) (Table 4). In model 1, having maternal health insurance, being single or separated, and having a monthly income of less than \$1000 were associated with current or former TANF status. In model 2, maternal health problems, child health-related limitations in daily activities, lack of child health insurance, and being single or separated were associated with having applied for TANF. Specifically, women with more health problems were 25% more

likely to apply for TANF, women without health insurance for their children were more than 2.5 times more likely to apply, and women with children whose activities were limited were 60% more likely to apply.

### DISCUSSION

To examine the potential association between health and welfare in the context of recent welfare policy changes, we studied women who had children with chronic illnesses. We found that women who had had any contact with the TANF system (i.e., the current, former, denied, and pending groups) were significantly more likely to report health problems and recent visits to the emergency department in comparison with nonrecipients. In addition, 2 separate mental health measures revealed worse depression scores and increased prevalence of depression in this group overall (and, most saliently, among the pending group). The same pattern was seen in reports of domestic violence, with 40% of the pending group affected. This group also reported the greatest material hardship, particularly insufficient amounts of food and loss of telephone service.

Although it is not surprising that health problems and barriers to work associated with health and child care were reported more frequently among those not currently employed, the higher prevalence of jobs lost because of health problems and lack of child care should

**TABLE 3—Binary Logistic Regression Models Predicting Maternal Health Barriers to Employment Among Mothers of Chronically Ill Children**

	Health Made It Hard to Find a Job, OR (95% CI)	Health Caused Missed Work Days, OR (95% CI)	Health Caused Loss of Job, OR (95% CI)
Maternal mental health	0.97** (0.95, 0.99)	0.99 (0.97, 1.0)	0.97* (0.95, 0.99)
Domestic violence experienced	0.83 (0.3, 2.1)	0.77 (0.3, 1.7)	1.91 (0.8, 4.6)
Substance use reported	0.67 (0.2, 2.1)	1.35 (0.6, 3.1)	0.70 (0.2, 2.1)
Maternal health problems	1.47** (1.1, 1.9)	2.09*** (1.6, 2.7)	1.44** (1.1, 1.9)
Mother visited emergency department (past 6 mo)	4.99*** (2.1, 11.7)	4.31*** (2.2, 8.4)	1.61 (0.7, 3.8)
Child activities limited	1.35 (0.5, 3.4)	0.74 (0.4, 1.5)	0.98 (0.4, 2.4)
Child visited emergency department (past 6 mo)	1.12 (0.4, 2.9)	1.01 (0.5, 2.1)	1.60 (0.6, 4.3)
Child visited hospital (past 6 mo)	0.91 (0.3, 2.7)	0.67 (0.3, 1.6)	1.75 (0.7, 4.6)
Child has health insurance	0.99 (0.3, 3.0)	0.85 (0.3, 2.1)	1.63 (0.5, 5.0)
Mother has health insurance	0.70 (0.3, 1.7)	0.78 (0.4, 1.6)	0.39* (0.15, 0.98)
Harder to find child care	1.08 (0.4, 2.6)	1.37 (0.7, 2.8)	1.15 (0.5, 2.8)
Years of education	0.76* (0.6, 0.9)	1.17 (1.0, 1.4)	0.94 (0.8, 1.2)
Married (vs single)	0.93 (0.5, 1.6)	0.77 (0.5, 1.1)	1.19 (0.7, 2.0)
Born in US	0.77 (0.1, 4.7)	1.18 (0.3, 5.2)	2.87 (0.4, 21.6)
Age (of mother)	1.08* (1.01, 1.15)	1.03 (1.0, 1.1)	1.05 (1.0, 1.1)
Speak English/both most comfortably	2.01 (0.3, 13.3)	3.75 (0.8, 18.4)	0.42 (0.1, 2.5)
No. of household members	0.76* (0.6, 0.99)	1.05 (0.9, 1.3)	0.84 (0.7, 1.1)
Income (>\$1000 mo)	0.86 (0.3, 2.3)	0.91 (0.4, 1.9)	0.57 (0.2, 1.5)
Model $\chi^2$ (df)	79.86*** (18)	102.99*** (18)	46.82*** (18)

Note. OR = odds ratio; CI = confidence interval.  
\* $P < .05$ ; \*\* $P < .01$ ; \*\*\* $P < .001$ .

be cause for alarm. Conversely, the increased difficulty in keeping children’s medical appointments, particularly among the former recipient and denied applicant groups, may indicate that health needs are not being adequately addressed in these families. Their health appears to hamper their ability to obtain and maintain employment, and their employment appears to hamper their ability to adequately address their health needs. This predicament was most apparent among those who had not worked in the past 3 years but had wanted or tried to work. Their reports of having twice as many health and child care barriers to employment as do those currently or previously employed indicate that health problems are serious impediments to employment.

Maternal health problems (including depression) were clearly associated with difficulty finding work after adjustment for child health status, child health insurance, child care, and demographic variables. Maternal health variables were also associated with missed work and job loss. The association of

lack of maternal health insurance with lost employment is dramatic, especially because findings from state welfare “leaver studies” have indicated that need for health insurance is a top reason for TANF recidivism.<sup>19</sup>

The persistence of maternal health insurance status as a predictor of current or former TANF status provides additional evidence that need for health insurance is an important factor in TANF application. That low income is associated with TANF status is logical; similarly, the association between being single or separated and TANF status probably represents the long-standing prohibition against providing benefits to married women. Health is a factor in applying for assistance, because maternal health problems, children’s health-related limitations in daily activities, and lack of child health insurance are all associated with having applied for TANF. In the multivariate analysis, low income was not a significant factor for applicants, which suggests that there may be a group that does not meet the income eligibil-

ity requirements, yet still has special health needs and may therefore apply for TANF because of the need for health insurance.

Our findings have limited generalizability in that they are based on a sample of mothers of chronically ill children from 1 urban center. However, the finding of increased rates of health problems among families receiving welfare is consistent with other reports.<sup>20,21</sup> The cross-sectional nature of these data does not permit conclusions concerning causality; however, the follow-up round of data collection is under way. Information on maternal and child health was based on the mother’s self-report; thus, validity may be an issue owing to imperfect recall (e.g., estimates of medical visits, missed school days). Respondents were recruited at both clinical and TANF centers, and thus the study participants differed in that half were seeking care for their child at the time of the interview and half were not (although the latter were required to have a child with 1 of the same 7 diagnoses). However, this sampling approach

**TABLE 4—Multinomial Logistic Regression Model Predicting Temporary Assistance for Needy Families Status Among Mothers of Chronically Ill Children**

	Current/Former vs Nonrecipients, OR (95% CI)	Denied/Pending vs Nonrecipients, OR (95% CI)
Maternal mental health		
Less depressed	1.59 (0.7, 3.3)	1.50 (0.6, 3.7)
More depressed (reference)	0.00	0.00
Domestic violence		
No experience	0.53 (0.2, 1.2)	0.42 (0.2, 1.1)
Experience (reference)	0.00	0.00
Substance use		
No report	0.50 (0.2, 1.1)	0.49 (0.2, 1.3)
Experience with substance use (reference)	0.00	0.00
Maternal health problem scale score	1.16 (1.0, 1.4)	1.27* (1.02, 1.59)
Maternal visits to emergency department (past 6 mo)		
None	1.21 (0.7, 2.2)	0.83 (0.4, 1.8)
One or more (reference)	0.00	0.00
Child health affects activities		
No	0.75 (0.4, 1.4)	0.38* (0.2, 0.9)
Yes (reference)	0.00	0.00
Child visits to emergency department (past 6 mo)		
None	0.86 (0.5, 1.6)	0.90 (0.4, 2.0)
One or more (reference)	0.00	0.00
Child hospitalizations (past 6 mo)		
None	0.90 (0.5, 1.8)	2.30 (0.9, 5.9)
One or more (reference)	0.00	0.00
Child health insurance		
No	1.39 (0.6, 3.1)	2.62* (1.02, 6.72)
Yes (reference)	0.00	0.00
Maternal health insurance		
No	0.44** (0.2, 0.8)	0.59 (0.3, 1.3)
Yes (reference)	0.00	0.00
Impact of child's health on child care		
None	0.65 (0.3, 1.3)	0.51 (0.2, 1.1)
Made it harder to find (reference)	0.00	0.00
Years of education	0.97 (0.9, 1.1)	0.91 (0.8, 1.1)
Marital status		
Single/separated	4.39*** (2.2, 8.8)	3.00* (1.2, 7.2)
Married (reference)	0.00	0.00
Born in US		
No	1.03 (0.3, 3.2)	0.77 (0.1, 3.9)
Yes (reference)	0.00	0.00
Age (mother)	1.02 (1.0, 1.1)	1.05 (1.0, 1.1)
Language spoken most comfortably		
Spanish	0.64 (0.2, 2.1)	0.53 (0.1, 2.9)
English or both (reference)	0.00	0.00
No. of household members	1.09 (0.9, 1.3)	1.18 (1.0, 1.4)
Income		
<\$1000/mo	2.66** (1.5, 4.9)	1.74 (0.8, 3.8)
≥\$1000/mo (reference)	0.00	0.00
Model $\chi^2$ (df)		124.49*** (40)

Note. OR = odds ratio; CI = confidence interval.  
\* $P < .05$ ; \*\* $P < .01$ ; \*\*\* $P < .001$ .

minimized sample bias by allowing for the inclusion of a broad group of individuals who might have contact with the welfare system.

## CONCLUSIONS

When the Personal Responsibility and Work Opportunity Reconciliation Act was passed in 1996, the major goal of policymakers was to move the poor “from welfare to work.” Almost immediately, the TANF caseload began to drop; it is currently less than half of what it was in 1996.<sup>22</sup> This decline was accompanied by a drop in Medicaid caseloads, which has left many without health insurance.<sup>23</sup> Although many did leave for employment,<sup>19</sup> others left as a result of sanctions,<sup>24</sup> confusion about the new policies, time limits, or diversion policies.<sup>25</sup> Proponents have interpreted the absolute drop in welfare caseloads as a de facto success,<sup>26,27</sup> but others have asked the following obvious questions: Are the leavers really working? Have their incomes improved? Are they still living in poverty? Are they able to care for their children? Are their children faring better economically and socially? Do women and children have health insurance? Do women have health or social problems that may interfere with their ability to obtain employment and become self-sufficient?<sup>28,29</sup>

Despite the “creaming” that occurred shortly after the law passed in 1996—with the most employable leaving TANF for work first—various studies have reported adverse outcomes among leavers, such as lack of employment, incomes at or below the poverty level, lack of work-related benefits, reductions in child supervision, poor educational outcomes among adolescents,<sup>30</sup> and return to TANF.<sup>31</sup> Our report clearly documents (1) the increased prevalence of health problems among the poor, (2) the association between poor maternal health and need for cash assistance and health insurance, and (3) maternal health barriers to employment and job retention (for details on the impact of poor child health on maternal employment, see the Smith et al.<sup>32</sup> and Wood et al.<sup>33</sup> articles elsewhere in this issue).

Few require convincing of the correlation between health and work. Unfortunately, in their zeal to promote the spirit of the Personal Responsibility and Work Opportunity Reconciliation Act and get the poor to work, many states

have overlooked 2 related barriers to employment: health problems and lack of health insurance. Our data from San Antonio suggest that women who have sick children (but who have relatively higher incomes) may apply for TANF partly because they need health insurance. Our findings clearly indicate that being poor is associated with health problems and that health problems, in turn, are associated with difficulty in finding employment. Policymakers should recognize that social policies that narrowly promote employment are destined to fail if they do not take into account the close association between health and work. ■

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### Contributors

D. Romero, W. Chavkin, P.H. Wise, L.A. Smith, and P.R. Wood contributed to the development of the hypotheses, to the planning of the study, and to the preparation of the article. D. Romero analyzed the data and wrote the article.

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