Impoverished Women With Children and No Welfare Benefits: The Urgency of Researching Failures of the Temporary Assistance for Needy Families Program

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In the United States, the numbers of impoverished women with children and no cash safety net are increasing and constitute an emerging population. Many have exhausted cash benefits from Temporary Assistance for Needy Families, the work-based welfare program that replaced Aid to Families With Dependent Children in 1996. We examine empirical evidence about poverty and use of welfare programs in the United States, jobs for women on welfare, the consequences of leaving welfare, health disparities disproportionate to those of the general population, and outcomes for children of needy families. It is important that public health researchers investigate the experiences of the families for whom Temporary Assistance for Needy Families has failed. (*Am J Public Health.* 2009;99:793–801. doi:10.2105/AJPH.2006.106211)

Temporary Assistance for Needy Families (TANF) was structured to move parents off welfare and into the workforce with basic work-related skills.[1,2] There have been more than 8 million TANF recipients since the program was created in 1996,[3] and the monthly caseload is about 2 000 000.[4] At least 250 000 cases have been closed because of state or federal time limits rather than because recipients had achieved work readiness and financial independence within the program's federally mandated 5-year lifetime limit.[5] The recipients were dropped, and we do not know what has happened to them.

The federal legislation that created TANF in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA),[1] did not require data to be gathered about parents who were unsuccessful in TANF and were terminated from the program.[6–8] Administration of the reformed welfare program was devolved to the states, as was its evaluation. States were required to report only caseload numbers, percentages of persons with basic education and job skills, employment statistics, and changes in absolute poverty. Perhaps the most far-reaching federal mandate about outcomes, however, was that if states did not reduce their welfare caseloads by at least 50%, they risked losing their TANF block grants. TANF reauthorization legislation in 2006 was even more stringent in how this was to be calculated.[2]

TANF represents a sweeping redesign of supports and services for poor women who need assistance to meet basic needs for themselves and their children.[9–15] We know that social policies have an impact on the health of individuals and are expressed in patterns of health in populations; thus, such a sweeping change in social policy can have a considerable effect on population health. Yet outcome measures have narrowly focused on shrinking welfare rolls and readying women for entry-level jobs.[14,16–20] The health consequences of welfare reform, a major policy change in the United States, have not been considered to be of critical importance.[7] This narrow outcome focus must not be allowed to exclude consideration of the public health issues involved.

Historically, when social or economic policies have impinged on health and the determinants of health, the public health system has held the public trust for protecting the health of the nation and addressing broad health issues, with particular concern for the vulnerable.[21] Families on TANF are a highly vulnerable population, many of them prevented by health barriers from meeting program expectations of self-support within 5 years. The lack of national-level data about this extremely vulnerable population is a major public health concern. To move toward more appropriate interventions, consistent, comparable data about the emerging population that has used up the legislated 60-month maximum period for the TANF welfare safety net are needed.

THE EARLY YEARS OF TANF

Welfare reform has generated a considerable amount of research. Panel studies done by 3 research teams—the Women's Employment Study, the Three City Study, and the Fragile Families and Child Wellbeing Study—have produced TANF data from specific geographic areas. Participants of the Three City Study and the Fragile Families and Child Wellbeing Study also include low-income women who were not on TANF. Research groups using national databases and administrative data sets include the Urban Institute, Mathematica Policy Research Inc, and the Manpower Demonstration Research Corporation Project.

Fifteen state and county studies of people who left the welfare system (so-called *leavers*) were funded in 1998 by the Office of the Assistant Secretary for Planning and Evaluation (ASPE)[22] of the US Department of Health and Human Services, and ASPE grants in successive years extended these studies and data sets. The studies, which focused on the early reform years and on women on TANF before they used up their 5-year TANF support, concentrated on common administrative data elements across states and jurisdictions such as the size of caseloads, rates of exit from TANF, and child welfare. Their findings have been synthesized by Acs et al.[4,23]

In comparing early exit data from the many TANF programs, we can identify common elements, including geographic areas, definitions of populations studied, policies for supports and services across states, study samples, data collected, and methodology.[22] Few studies have used national or recent data; as Acs and Loprest stated, "Indeed, most available studies use data that predate 2000, and it is still rare to find studies using data any later than 2002."[4(p17)]

Thus, even recent updates and evaluations of the early exit data sets demonstrate considerable variability and make it difficult to discern trends over time. Recent updates of such surveys as the National Survey of America's Families, Survey of Income and Program Participation, and Current Population Survey somewhat mitigate this variability and difficulty in discerning trends by adding additional years of interview or survey data.

Despite these issues, the existing studies do help us understand people who left TANF but have the option of returning because they have not used up their allotted 5 years in the program. Findings from these studies indicate that compared with TANF recipients not yet close to their time limit, those nearing their time limit suffer more from problems related to health, functional ability, social support, transportation, education, substance abuse, and domestic violence.[6,24–28]

By 2005, at least 250 000 recipients had reached state or federal time limits,[5] but little is known about the fate of families who reached the limit and were terminated from the program. These families are the least studied, and their number is growing. The need for more study of this marginalized population is urgent. Barriers to their securing adequate, sustainable employment are similar to those of other poor people, but parents who had no options other than enrolling in TANF often differ in the degree and number of resources, access to resources, personal deficits, and especially health status.

It is apparent that TANF services are not intensive or flexible enough to meet the needs of families with multiple barriers as they try to get and keep adequate employment. Different or enhanced strategies are needed to address the barriers of some TANF recipients if they are to move into the workforce before they are terminated from TANF cash support.[23,29,30] Increasing the likelihood of success will require new research so that the new strategies will be based on evidence.

The public health system is well suited to oversee the data collection and analysis of the effects of TANF on the health outcomes of vulnerable people.[31] A population health perspective is needed that can link determinants of health and health outcomes to interventions and policies. Such population health research can further identify the health needs and assets of this population, uncover policy and program factors that may have impeded self-sufficiency, and document the economic, social, and health consequences of losing lifetime access to the safety net that welfare was always meant to provide.

Despite calls for accountability, the 2006 TANF reauthorization omitted requirements for follow-up.[25] As with PRWORA, states are not required to follow recipients who were terminated after using up their 5 years of TANF.[1,32] These women and their children have essentially become invisible, and if they encounter economic adversity in the future, federal legislation does not provide them the option of returning to TANF for cash support. Without an account of what has happened to these families, we cannot comprehend the full impact of US welfare reform, particularly its public health implications.

US POVERTY AND WELFARE USE

Federal poverty guidelines for 2009 state that a family of 4 earning $22 050 is at 100% of the poverty level.[33] In 2006, 38.7 million people in the United States lived at or below the federal poverty level, among them 13.28 million children.[34] Households headed by single women had the highest poverty rate in the United States; fully 31% were poor. Compared with White Americans, racial/ethnic minorities bore a disproportionate burden; 39% of both Black and Hispanic female-headed households were poor.[35,36] This level of poverty among women and children in the world's richest industrialized nation defies simple explanation.[37,38]

Government Assistance to the Poor

Government assistance to the poor is based on a society's ethical principles and enlightened self-interest. When impoverished subgroups get too large, harm to the larger society is inevitable. Harm from unrestrained poverty includes an undereducated and underskilled workforce, a reduced market for goods and services to fuel the economy, increases in illness, violence, and crime, and devaluation of life.[39] When children grow up in families that are poor, basic health and normative development are put at risk.[40]

Implementation of TANF in the strong economy of the late 1990s resulted in a rise in employment and a fall in welfare caseloads.[41,42] Between 2000 and 2002, a weaker labor market was less able to absorb entry-level job seekers, and the unemployment rate of low-income single mothers increased from 9.8% to 12.3%. Poverty rates and use of food stamps rose, and receipt of unemployment insurance increased. During this period, some of those women who lost their jobs were eligible for unemployment insurance, and this partial safety net may have helped them stay off TANF.[43–45] The current economic downturn and weakened labor market, with rising food and energy costs, may again have serious consequences for vulnerable post-TANF families trying to get and keep entry-level jobs. This makes it even more pressing to look at the effects of TANF policy and collect data on this disadvantaged group.

Effects of TANF on Immigrant Families

Immigrant families fare poorly in post-PRWORA America because the legislation bars them from receiving federally funded assistance until they have been in the country for 5 years.[1,2,46] The 1996 legislation denied federally means-tested benefits to recent immigrants, denied some benefits to all immigrants, and gave states authority to set their own eligibility rules. Legal immigrants who have been in the United States for more than 5 years can access cash welfare in all states except Alabama, but fewer than half the states finance substitute TANF programs for newly arrived immigrants.[47,48] In 2006, when TANF was reauthorized, a distinction between qualified (legal) and unqualified (illegal) immigrants was added. The public health implications of TANF policy for low-income immigrant families have a place on the public health research agenda.

JOBS AND WOMEN ON WELFARE

Social policy analysts differ on whether the primary goal of welfare policy should be reducing poverty or reducing dependency by putting people to work.[49] A major fiscal goal of TANF policy is to reduce recipients' dependence on government assistance by requiring self-sufficiency through work; however, the low-wage jobs for which most TANF recipients are prepared do not pull their families out of poverty. Officially, the TANF approaches for moving individuals to work are (1) "human capital

development" (i.e., individuals receive more education and less occupational training) and (2) "labor force attachment" (i.e., individuals are encouraged to enter the labor market quickly, even at low wages).[50] In response to PRWORA, states focused on labor force attachment because it was expected to be faster and cost less. Human capital development was essentially limited to helping low-income women get a general equivalency diploma and learn basic work skills for entry-level jobs.[41]

The expectation was that if given TANF assistance, women would work their way out of poverty by getting low-wage jobs quickly and then would move to better-paying jobs and, within 5 years, become financially independent. Pavetti and Acs[51] used National Longitudinal Survey of Youth data and a simulation model to illustrate that this trajectory toward better-paying, more stable jobs would be common for young women but far less common for women with children or women who have not completed high school—common characteristics of women who have ever used the welfare system for support.

A 5-year, 11-program comparison study, the National Evaluation of Welfare to Work Strategies, indicated that labor force attachment programs cost less than human capital development programs, and in the short term move more people to work. Differences in employment and earnings between the 2 approaches were statistically insignificant at 5 years, and in half the programs, gains in earnings were less than reductions in welfare payments and food stamps.[52] Because these current approaches have been shown to be short-term fixes and not effective enough for moving many people on welfare to adequate, sustainable employment, research is needed to improve strategies and outcomes.

Low-Wage Jobs

For a single mother in a low-paying job, a conflict can occur between her imperative to keep a job so she can pay for food and shelter and her responsibility to see to the health, safety, and education of her children. The needs of children create a crisis when family needs overlap with demands of employers.

In a Manpower Demonstration Research Corporation Project study in Philadelphia, PA, of low-income current and former welfare participants, Michalopoulos et al.[53] reported in 2003 that just 40% of them had jobs that paid at least $7.50 per hour and had health insurance benefits. Much of the employment was in unstable jobs, and recidivism to welfare was slightly higher than during the years preceding welfare reform. Most women did not work steadily, and 40% were employed in part-time jobs. Barriers to work included physical health problems, clinical depression, and not having a driver's license. Problems at work included poor working conditions, low pay, and job location.

In a related ethnographic study,[54] which used a subset of the participants in the study by Michalopoulos et al., 75 former and current welfare recipients were interviewed in-depth; nearly all identified barriers to getting and keeping jobs that could sustain their families, including limited time with their children, child care problems, and decreases in children's school performance. (Although these are issues for many working mothers, for women on TANF they are often exacerbated by disparities in heath status, the need to work 2 jobs to make ends meet, or weak network supports.) In this subset, 44% of the women worked in spite of these constraints, but they cycled on and off jobs, which left them with interrupted benefits, unstable income, and the appearance of a poor employment record. One third did not work at all in the formal labor sector.

Fraker et al.[55] evaluated welfare-to-work programs and also found barriers to employment and self-sufficiency, such as limited education, limited work experience, issues related to single parenting of young children, and work-limiting health problems that contributed to lower than expected levels of employment and self-sufficiency after 2 years in the program. More recent analysis of earlier data sets has indicated that women generally show modest economic progress in the short term, but considerable employment instability and cycling in and out of poverty is common.[26,56]

Essentially, low-paying jobs can leave female-headed households chronically on the brink of crisis, especially when women hold jobs that offer little flexibility and few benefits. With few options and without a margin of reserve resources, family capacity to weather difficulties and maintain health and well-being is tenuous at best.[57–61] Courtney and Dworsky[62] followed TANF applicants and found that after 4 years most of them were no better off than when they had applied. Farrell et al.[5] suggest that we do not know enough about how post-TANF participants are doing, and Blank writes that "It is essential to know more about who these women are and how they and their children are coping and surviving."[24(p195)]

Staying on TANF for Multiple Years

Women who stay on welfare for 2 years or more have been identified as particularly disadvantaged. These so-called *stayers* are less successful at preparing themselves for employment and maintaining the necessary stability in their lives for reliable workplace performance.[25,63,64]

In a study using 1999–2001 data from the Three Cities Study, 44% of TANF stayers had not completed high school, 62% reported functional disability, and 22% reported clinical depression.[65] Pavetti and Kauf[26] reported on an intensive intervention implemented shortly before TANF participants used up their 60 months of TANF benefits. They identified low cognitive functioning, limited education and language skills, and physical health problems as barriers to independence and self-sufficient employment. These are barriers that restrict the pool of jobs for which long-term welfare recipients can qualify and make it more difficult to keep the jobs they get. These barriers resist simple solutions and have public health implications; the public health system has an important place in developing the broad, research-based evidence to find more effective interventions.

Former TANF Recipients Still Living in Poverty

Early US Department of Health and Human Services data were frequently used to suggest that individuals who left or were dropped from welfare were actually working, and that at the time they left welfare or shortly thereafter, the women would be economically better off than when they were on welfare. This optimism has been tempered by data from other sources.

Data from the National Survey of America's Families, collected by the Urban Institute, indicated that most people who left welfare in the first years of TANF were working, usually at low-wage jobs that required little training and provided no benefits.[66,67] Average earnings

were below the poverty line, and at least one third relied on extended families for support, had difficulty providing enough food for their children, and often could not pay utility bills and rent. Also, more than a quarter of the nonworking former TANF recipients were ill or disabled and unable to work.

Eleven of the more than 30 studies funded by ASPE showed that many recipients cycled on and off TANF, with approximately 20% of leavers returning to TANF within a year of leaving.[23] The synthesis report by Acs and Loprest,[4] which used data from the National Survey of America's Families, Survey of Income and Program Participation, and Current Population Survey to update earlier research, concluded that, on average, incomes remained flat among leavers between 2001 and 2005; their analysis of Current Population Survey data indicated a significant increase in severe poverty in that group.

Sanctioning, Disconnection, and Termination

Once women are enrolled in TANF, they must adhere to the work-readiness rules or be *sanctioned*, which can result in termination of benefits. In many states, sanctioning is a temporary measure; after sitting out a penalty period, individuals can reapply for support. There is no provision in the TANF legislation that requires sanctioned individuals to be permanently barred from TANF, but 17 states have used sanctioning in that way. States are not required to follow up with recipients who have been sanctioned, so there is not enough reliable information about their employment or the impact that sanctions have on their families.[26,68–71]

Becoming *disconnected*—without work and without welfare support—is a phenomenon of considerable concern and consequence.[24] Turner et al.[28] followed a Women's Employment Study panel of single mothers in an urban Michigan county who had started receiving TANF in 1997. Over a 5-year period, about 9% of the women displayed a pattern in which they left TANF for jobs, became unable to keep those jobs, and then had difficulty coming back to TANF. Their chronic disconnection from work and cash welfare was related to a combination of factors, including physical limitation, learning disability, drug or alcohol misuse, and lack of a driver's license.

Several other studies have shown that about 20% of leavers were disconnected and more disadvantaged than other leavers.[28,72–74] Barriers to staying connected included limited education, poor health, lack of transportation, learning disabilities, substance misuse, domestic violence, and risk of economic hardship. Loprest et al.[75] reviewed initial approaches taken by 11 states in the ASPE studies and suggested strategies for early assessment and services to eliminate work-related barriers for people on TANF. Baider and Frank[76] described transitional jobs programs and suggested that they are an effective approach for TANF participants with barriers to employment success.

Acs and Loprest[4] called for efforts to reduce the number of cycling or disconnected people TANF has failed and for research on this group as more recipients reach their time limits and are unable to return to welfare. Golden et al.[77] suggested a framework for TANF revisions based on the context of low-income working families—those with job instability, limited earnings, limited opportunities for advancement, and jobs that make parenting difficult, and whose children often have unmet health and developmental needs.

Women who have been *terminated* from the program because they have reached the federal time limit no longer have the option of assessment and additional barrier reduction. The federal lifetime limit for TANF cash assistance is 5 years, and states must use their own funds to continue support after that time. Nineteen states have shorter time limits, and just 8 states have either no time limit or continue benefits only for children. When women leave TANF—not voluntarily and not when they are ready for work but because they have reached their maximum lifetime cash eligibility—they are at a marked disadvantage in the workplace. This group includes individuals with health problems and multiple barriers to work that cannot be adequately addressed within the narrow get-a-job scope of much current TANF programming.[78]

There is a dearth of information about what happens to people who have used up their 60 months of TANF cash support. As far as we know, only 2 studies have assessed people terminated at 60 months. Hetling et al.[79] reported administrative data gathered in Maryland where people could stay on or come back on TANF even after 60 months. They found a 43% recidivism rate after 1 year after 60-month exits. Crichton[64] found that "timed off" Michigan families had unmet health needs and extremely low levels of self-sufficiency; half the mothers were not working, 72% had incomes below the federal poverty guideline, and almost half were rated as having unstable lives.

The usual TANF protocol does not appear to provide enough intervention to overcome the health and social obstacles faced by hard-to-serve individuals, many of whom desire to work. They appear to need ongoing support and more and different preparation than they are receiving.[24,66,73,80–82] Additional assessment and case management could be tested as strategies for improving outcomes for women who have used up their 60 months on TANF without achieving basic work skills or self-sufficiency. For example, Blank[24] suggested creating a temporary and partial work waiver program and other functional outreach and policy changes to provide more effective employment assistance.

Given the prevalence and effects of health problems reported by TANF participants and the importance of improving the program, the public health system must be involved in the redesign of policy and strategies that will succeed with hard-to-serve individuals. Yet much of the data, and most of the researchers, TANF personnel, and legislators are focused on the socioeconomic and political aspects of TANF rather than on the health concerns of this vulnerable population. When members of other disciplines attempt to identify people with health barriers or disabilities and refer them to the health care system or to Supplemental Security Income (SSI) and Social Security Disability Income (SSDI), they will identify only the more obvious health issues. The public health system must accept responsibility for research and intervention.

Effects of Termination on Other Benefits

During their enrollment in TANF, women and their children usually have Medicaid health coverage, and when they leave they are eligible for a transitional period of Medicaid, called Transitional Medicaid Assistance. These programs have time limits, which vary by state.[83,84] Currently, State Children's Health Insurance Program (SCHIP)

programs have made insurance available for nearly all children whose families are below 200% of the federal poverty level.[85,86]

ASPE state studies indicated that between 10% and 34% of TANF leavers were uninsured,[23] and that fewer than half of those who had jobs had access to job-related health benefits or health benefits with affordable employee copayments. A significant number did not enroll in Medicaid after they left TANF, even though they were still eligible by income.[6,87,88] Polit et al.[89] also identified this phenomenon in a Manpower Demonstration Research Corporation Project study of urban women who had left Aid to Families With Dependent Children or TANF. More recently, Cheng,[90] in analyzing Survey of Income and Program Participation data from 623 recipients of TANF and Medicaid, found that 48.8% left TANF and then had no insurance and 14.3% left and then received private insurance. Data on why these Medicaid-eligible families lost their coverage are limited, although it is possible that leavers did not know they might still be eligible for such support. The issue of health insurance is of great concern, because lack of access to health care influences the health status and unmet health needs of families.[64,89,91,92] There is a pressing need for research to gain understanding of this phenomenon.

HEALTH DISPARITIES

Healthy People 2010 (the 10-year public health plan for the United States developed by the US Department of Health and Human Services) provides indisputable evidence that the poor and undereducated in the United States bear a disproportionate share of the nation's disease burden.[93] As a response to this fact, a central goal of *Healthy People 2010* is to reduce this burden in vulnerable social groups.[93,94] Poor Americans, particularly those in low-income racial/ethnic minority groups, have higher death rates from coronary heart disease, cancer, diabetes, and injury, and these rates have been linked to gender, access to care, and health insurance coverage.[20,59,93,95–98] TANF has not had a notable impact on reducing this disparity, and it continues to be a public health issue.

In the general population, depression and physical health problems have been linked to each other and to unemployment, job loss, and low job performance. Results of study after study suggest that the low-income population served by TANF is less educated and poorer than the low-income population not enrolled in TANF and has a high prevalence of mental and physical health problems that persist over time and limit the ability to work.[4,11,58,59,63,78,96,99–106] Most studies cited here used self-report data from the Current Population Survey, National Survey of America's Families, Survey of Income and Program Participation, and other surveys and interviews. The research in the Three Cities Study and Women's Employment Study used self-report and diagnoses or diagnostic criteria. Synthesis and review studies used data from the early TANF years and drew further conclusions from them. Similar findings from such a variety of research approaches and study samples lends credibility to the results.

Mental health problems have been a particular barrier to employment for low-income women. Loprest et al.,[107] using National Survey of America's Families data from 2002, found one quarter of low-income mothers to be in poor or very poor mental health. Burton et al.,[99] using clinical diagnoses and longitudinal ethnographic data gathered between 1999 and 2003, found a high incidence of mental health problems in poor women, including those on TANF; more than half the participants (63%) reported concurrent mental and physical health problems in themselves as well as in at least 1 of their children, whereas only 36% of employed women reported these problems. Danziger et al.,[63] who screened for 5 psychiatric disorders as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition* (*DSM-III-R*),[108] found that 35% of Women's Employment Study respondents met the criteria for at least 1 of the 5 diagnoses. These reports drew on data from the earlier years of the TANF program.

These studies are part of the mounting data on the barriers to economic self-sufficiency experienced by people in the TANF program. They illustrate the urgent need to improve the program and process. Doing this requires evidence-based research about what would have helped those for whom TANF failed. But without a mandate to gather postexit data, there are few data about those who were terminated at the 5-year lifetime limit.

Because the SSI and SSDI programs exist for people with disabilities, people on welfare who did not receive SSI or SSDI were presumed physically and mentally fit to be successfully employed within the TANF time limits.[109] This assumption largely ignored the health disparities present in this country, the narrow SSI definitions of child disability, the cumbersome eligibility process, and SSI restrictions that exclude entire categories of people such as those with certain substance misuse problems. It points out a lack of an evidence base for the TANF program.

Substance Misuse

Substance misuse is one of the more intractable, disabling barriers to work success.[109–112] In a multisite national study of women on TANF who had substance misuse problems (n=673),[113] 68% reported lifetime periods of significant depression, 56% reported lifetime anxiety, 40% had serious difficulty controlling violent tendencies, 40% had given serious thought to suicide, 31% had made a suicide attempt, and 33% reported chronic medical problems. The researchers recommended that, in addition to job training, these welfare recipients needed drug and alcohol treatment services and greater support and intervention regarding personal problems and obstacles to employment.

Government Acknowledgment of Health Problems

As far back as 2000 and 2001, federal agencies identified the struggles TANF recipients had with the burden of disease. US General Accounting Office (now Government Accountability Office)[114,115] reports indicated that 44% of TANF recipients had physical or mental impairments, whereas only 15% of the non-TANF population did. Consequently, the GAO called for a more coordinated federal effort toward TANF recipients who had impairments; this call was not heeded when PRWORA was reauthorized in 2006. Nevertheless, extant evidence suggests that mothers with multiple impairments are more likely to stay on TANF for extended periods of time and are less likely to become ready for work or reach financial independence. They cycle in and out of work as dictated by their own or their children's chronic illness or disability.[116] When women are terminated from TANF, these

problems follow them. Post-TANF data are needed to support policy changes for increasing the self-sufficiency of women after they leave TANF.

CHILDREN'S HEALTH

US census data indicate that families receiving welfare benefits are almost twice as likely to have a child who is disabled (16%) or severely disabled (9%) than nonwelfare families. In the Three City Study, the most common mental health conditions reported for children were attention deficit hyperactivity disorder, autism, anxiety, and depression; common physical problems were severe asthma, seizures, diabetes, and lead poisoning.[99] National Health Interview Study data indicated that more than 25% of children in TANF families, compared with 21.5% of children in low-income, non-TANF families, had at least 1 chronic health problem or disability such as asthma, mental retardation, cerebral palsy, autism, attention deficit disorder, muscular dystrophy, cystic fibrosis, sickle-cell anemia, diabetes, arthritis, or congenital heart disease.[58]

In a study of more than 500 low-income mothers of chronically ill children who were former TANF recipients, Romero et al.[59] found that 64% were not employed because of their own health problems and 56% were not employed because of their child's health. These health issues of mothers and children contribute to women's need for welfare assistance. For women on TANF, the barriers decrease the ability to move off TANF to a self-sustaining job, or to move off before they are terminated from TANF after 60 months.

Outcomes for Children in the Welfare-to-Work World

Study findings on child outcomes have been mixed. An early Women's Employment Study report suggested that when mothers repeatedly moved between working and being on welfare, or were in unstable jobs with irregular schedules, their children were more likely to be anxious and depressed. Working itself had little effect, and combining work and welfare supports was beneficial.[117] Subsequent research identified more behavior problems in the children of low-income working mothers, suggesting that mothers' employment may impose risks on development.[118]

Children of mothers who have moved from TANF to work have been found to be no better or worse off than before their mothers enrolled in TANF. In addition, when women leave welfare for work, it can have positive outcomes for their children, but only if mothers are provided tangible welfare support, such as earned income tax credits, child care supplements, food stamps, Medicaid, and transportation assistance.[9] Additional observational studies of the adolescent children of TANF recipients suggest that welfare reform has not changed teenage fertility and school dropout rates.[119–121]

In random-assignment studies, parents were assigned either to programs with combinations of mandatory employment activities, earnings supplement, and time limits, or to a control group. A synthesis of these studies suggests that these programs had a weak negative effect on adolescent education.[122,123] There are very limited data about how children and families manage when mothers are terminated from TANF cash support at 60 months without adequate work skills.

Child Care and TANF

Lack of child care is an important factor in employment instability for low-income mothers with young children. Because the cost of care for more than one child exceeds the earnings of most low-income mothers, these women must earn well above the minimum wage.[8,124] Women who are poor are also more likely to use home-based child care, which is not well regulated and can be of lower quality.[125]

Child care subsidies are a limited TANF mandate and may or may not continue for a period after women exhaust their 5-year lifetime eligibility for TANF cash benefits. Whether or not women have left TANF, however, subsidies end when they reach an earning level that is still well below the poverty line. For those who continue to receive TANF-supported child care after they no longer receive cash payments, the child care copayments may become unaffordable. Loprest[126] found that within 3 months of exiting TANF, 27.7% of leavers who did not receive child care subsidies returned to TANF, whereas 19.5% who did receive child care subsidies returned.

THE PUBLIC HEALTH CHALLENGE

The depth and breadth of barriers that hold back women on TANF from becoming employed and self-sufficient are profound and deeply disturbing. Researchers in most studies of TANF are in resounding agreement that further investigation is needed to determine how effective welfare reform has been.

The public health system has held the public trust of protecting the health of the nation, with particular concern for the vulnerable. TANF families are a vulnerable population, many with health barriers that prevent parents from meeting TANF expectations for self-support. TANF policy focuses on social and economic welfare reform, and in so doing has not emphasized the health care needs of these families. Our lack of national-level data about this population is a major public health concern, because without it we cannot help create more appropriate TANF strategies and interventions that include a public health perspective.

Reversing the health disparities experienced by women who use or have used TANF support will require extending the public health functions that create the conditions necessary for health. Crafting of a more effective welfare policy will require attention to broad public health issues, a public health perspective, and a significant number of public health professionals.

Our call for a public health research agenda on TANF includes the following recommendations:

- A national database that provides comprehensive information about the women who have left TANF after exhausting their 5-year lifetime limit of subsistence support; this could also facilitate improved enrollment of TANF leavers in Medicaid, food stamps, and other non-TANF programs;
- Ongoing, systematic follow-up of health outcomes using a core set of common measures for women and their children who have been terminated from TANF cash support, not because they were ready for work or self-sufficient but because they had exhausted their eligibility;
- Identification of the full range of barriers—including socioeconomic, cultural, educational, and health-related barriers—that confront women who are poor and have used up their 5-year limit on TANF cash payments,

identification of prevention components for those barriers, and testing of new public health strategies to bring appropriate resources to the health barriers confronting this hard-to-serve population;
- Full participation of public health officials and scholars in bringing a public health focus to the planning, implementation, and evaluation of TANF policy and programming. Given their body of knowledge of complex community settings and multiple causation models, public health professionals are best equipped to assess multiple, interacting, interdependent barriers to health;
- Full involvement of TANF recipients in the planning, implementation, and evaluation of TANF policy and programming; and
- Effective problem solving on the challenges of doing comprehensive, long-term public health evaluation of TANF, including (1) the cost of follow-up, (2) agreement among the states on a comparable data set to be evaluated, and (3) common data collection tools.

CONCLUSIONS

It is apparent that TANF is failing some of the families it was supposed to move toward self-sufficiency. Leaving these families behind without a subsistence safety net creates an urgent need for new ways to support their health. But new ideas require new data. At this point, we do not have an adequate evidence base to create interventions that give appropriate support to the health of the target population affected by TANF.

The current situation is unacceptable. We do not know how well those who exhaust their TANF benefits will survive, and with what outcomes and at what price to lifetime physical and emotional health and well-being. We do not know which interventions do the most good in achieving self-sufficiency over time, nor do we know or measure the "optimum dose" of TANF interventions such as job skills training, interpersonal skills building, human capital development, drug and alcohol treatment, chronic illness management, and domestic violence prevention.

We do not know whether TANF programs focus on the factors most critical to the TANF population. For example, TANF may be teaching work readiness for entry-level jobs to women who will quit or be fired because work readiness is not their primary problem—their real problem is that they cannot meet the special needs of children who are ill or disabled without missing too many days of work to retain their low-status jobs.

Given the time limits on TANF cash benefits, it is imperative that program implementation be more effective at fostering sustainable welfare exits after which women can maintain socioeconomic stability with the hope of improving their own and their families' lives. This level of effectiveness requires new knowledge quite different from the knowledge that brought the TANF program this far. Growing numbers of individuals exiting TANF because they have exceeded its time limit, rather than because they are ready for work, attest to the importance of research that can be used to revise the program and shape a policy that better supports the public health agenda of the nation.

The women who are unsuccessful at securing sustainable employment through TANF within 5 years are among the most vulnerable persons in the United States today. Women who are excluded from TANF by sanctioning or immigrant status are also at grave risk. Unless we attend to their experiences and document their needs and capacities, and unless we use this information to provide authentic support and remove barriers from their lives, we may be relegating them and their children to a hazardous future that can only undermine personal and public health. ■

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Contributors

E. Hildebrandt conceptualized the article, researched the literature, and drafted the content. P. Stevens contributed substantially to the conceptualization, organization, and final content of the article.

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