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Health-related effects of welfare-to-work policies

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ABSTRACT

Non-health related policies may have consequences for health that are more important than the outcomes they were originally designed to produce. In this paper we evaluate the effects of welfare-to-work programs (WTW) on physical and mental health status and a variety of health behaviors. The paper is based on data from the minimum income program of Madrid's Government (IMI). We match the program's administrative records (39,200 households) – covering the whole history of the program from the second half of 1990 to 2001 – with a specific survey of former recipients who took part in different work-related activities conducted in 2001 (2300 households). We perform propensity score matching to find that both health status – including physical and mental health problems – and behaviors outcomes were modestly better for those individuals who had taken part in work-related activities. These results offer support for the contention that welfare-to-work policies may have positive unintended health effects.

Introduction

Non-health related policies may have consequences for health that are equally or more important than the outcomes they were originally designed to produce. This impact may be especially important in the case of income support policies. Health outcomes and health behaviors have become important themes in the broader public discourse about welfare reform. In most OECD countries, antipoverty programs have been redesigned with the aim of achieving better results in terms of work, personal responsibility, and economic self-sufficiency. As a result, raising the employability of recipients has become a key issue. This strategy faces major challenges, as poor physical or mental health may interfere with work goals in these programs (Bjorklund, 1985; Coiro, 2008; Danziger et al., 2000; Kovess, Gysens, Poinsard, Chanoit, & Labarte, 1999; Meara & Frank, 2006).

The evidence on the other side of the issue is much more limited. Welfare-to-work programs may impact households' economic resources, time constraints, and levels of stress. By fostering transitions from welfare to work these policies may affect both lifestyles and health status although it is not clear in which direction. This impact is an open question that has fueled some recent research but results are still inconclusive. There are primarily two domains of literature in this area. The first concerns the impact of welfare programs on health insurance (Bitler, Gelbach, & Hoynes, 2005; Borjas, 2003; DeLeire, 2006; Kaestner & Kaushal, 2003). The second area explores the relationship between welfare-to-work programs and a variety of health outcomes with a dominant role of assessment related to psychological distress. Evidence on this issue is beginning to emerge, and the results of different studies suggest that welfare-to-work programs can have significant effects on health outcomes (See Bitler & Hoynes, 2008, and Blank, 2009, for a review).

Our paper focuses on the second strand of this literature. There are still some key issues that remain open questions which the paper attempts to address. First, very few studies provide information on the effects of welfare-to-work programs both on health status and health behaviors. In this paper we evaluate the effects of a specific program on physical and mental health status and a variety of lifestyles. Second, few papers have specifically focused on work-related program participation. The mere fact of participation in work-related activities – even if recipients do not successfully find a job – may have positive benefits. Third, although previous work has provided evidence on European countries (Huber, Lechner, & Wunsch, 2009), to date the bulk of the research literature on health effects of welfare-to-work participation has almost exclusively focused on North America. This paper is based on data from the minimum income program of Madrid's Government (IMI). The Spanish model is an interesting case of welfare reform and universal health systems in the comparative context. A pioneering

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model of welfare-to-work was put into action some years before employment-targeted reforms were implemented in most OECD countries and transitions from employment to unemployment are rather larger than in other countries.

The main goal is testing whether participation in work-related activities yields positive results in terms of health outcomes and lifestyles. We match the program's administrative records – covering the whole history of the program – with a specific survey of former recipients who took part in different activities (2300 households). We perform propensity score matching to find that both health status – including physical and mental health problems – and behaviors outcomes are modestly better for those individuals who had taken part in work-related activities.

The structure of the paper is as follows. The following section reviews some of the pathways trough which welfare-to-work programs may affect health status and behaviors. The third section introduces the program and the data used in the empirical part. The fourth section presents the estimation strategy. Empirical results are discussed in the fifth section. The paper ends with a brief list of conclusions.

Health effects of welfare-to-work policies: a review

Background

There are likely many pathways through which welfare-to-work programs can affect health. However, theory is ambiguous on the potential effects of participation on health status and behaviors. Some of the most common approaches on the determinants of health provide very general guidelines for the setting of hypotheses and their testing. Nevertheless, it is not easy to draw from these approaches any very detailed hypothesis to be tested. In keeping with standard theories, possible income and employment effects anticipate that taking part in these programs might yield positive effects in terms of health outcomes. We might also expect behavioral changes in participants in these programs that reduce the risk of physical and mental health problems. These positive effects will largely depend however on the kind of activities they engage in. Employment improvements will also be limited by the type of jobs these individuals have access to.

Why welfare-to-work policies might have positive health effects is still a relatively open research question. Very general approaches, like the health production function may help to identify some of the general avenues through which these programs may affect health. Kenkel (1995) used the health production function framework to analyze the importance of lifestyles on health. The stock of health is produced as a function of the production technology given by the various lifestyles, the stock of human capital and different socioeconomic variables that can have an influence on the productivity of gross investment, the stock of pre-existing health or the determining factors of the rate of depreciation. The inclusion of these factors responds to the fact that health is considered an essential resource including aspects of both consumption and capital. Bitler and Hoynes (2008) used this differentiation to anticipate the effects of welfare reform on health. Since health is a durable capital stock that will change slowly with investment and health services are investment goods consumed each period, it can be expected that a somewhat immediate impact of reform on health insurance could take place, while it may take months or years for welfare reform to impact on health status. A key issue, therefore, is the extent to which welfare-to-work participation can produce substantial changes in lifestyles.

Besides lifestyles, investment decisions can be largely affected by changes in income. Insofar as welfare-to-work programs aim at alleviating recipients' financial problems, these policies should improve health. An enormous literature has grown about the positive gradient between socioeconomic status (SES) and health (See Cutler, Lleras-Muney, & Vogl, 2008, and Currie, 2009, for recent reviews). Living in low-income households leads to psycho-social stress, which compromises bodily functions, including the immune system. Participation, therefore, in welfare-to-work programs – by raising recipients' income – may cause better access to care, a greater ability to afford a healthy lifestyle, less risk from the environment and better nutrition.

A possible direct link between changes in SES and health induced by work-related activities is the impact of transitions from welfare to paid job. While the effect from more income is clear that of employment is more controversial. Clark and Oswald (1994) found that jobless people had approximately twice the mean mental distress of those with jobs. Theodossiou (1998) also found that unemployed individuals have significantly higher odds of experiencing a marked rise in anxiety, depression and loss of confidence and a reduction in self-esteem and the level of general happiness. Focusing only on mental health, Bjorklund (1985) and Mayer and Roy (1991) reached a similar conclusion.

A key question may be the role of occupations in this relationship. Llena-Nozal, Lindebooma, and Portraita (2004) found that the higher the skill level of the occupation, the better the mental health. Morefield, Ribar, and Ruhm (2011) suggest that blue-collar employees have a greater likelihood of transitioning from very good to bad health but with no difference in the relative probability that they move from bad to very good health. Reform-induced increases in employment may lead to changes in a parent's time endowment which in turn can affect choices about health care utilization, diet, and health (Haider, Jacknowitz, & Schoeni, 2003). Paid employment also increases an individual's ability to contribute to the household's financial well-being, enhancing sense of accomplishment and self-esteem. Depression, high stress levels, low self-esteem and lack of motivation have been found to be associated with less participation in job activities (Montoya, Bell, Atkinson, Nagy, & Whitsett, 2002). Insofar as work-related activities can remove some of these barriers, positive psychological effects from these activities could be expected (Gottschalk, 2005).

There is no guarantee, however, that moving from welfare to work might always yield positive benefits. Previous work has provided evidence that regular health-promoting behaviors may work better in low-income households than low-wage jobs (Cheng, 2007; Yoo, Slack, & Holl, 2010). Empirical work with panel data for some countries has shown that the event of unemployment might not matter as such for health status (Böckerman & Ilmakunnas, 2009). Recipients who move to jobs characterized by low wages, low substantive complexity or routinization may have poorer psychological health (Elliot, 1996). There is also evidence suggesting that access to paid jobs is not enough to overcome structural problems related to welfare participation. Recipients may continue to experience high levels of psychological distress even after securing employment (Kulis, 1988). Evidence also suggests that adverse health effects accumulate over children's lives (Case, Lubotsky, & Paxson, 2002). Moreover, welfare-to-work programs will only produce positive health effects under substantial reductions of material hardship. While some authors have found that ex-recipients experience higher levels of hardship than welfare recipients (Danziger, Heflin, Corcoran, Oltmans, & Wang, 2002; Edin & Lein, 1997), others conclude that material circumstances of single mother families improved modestly after welfare reform in the U.S. (Meyer & Sullivan, 2008).

In short, while general approaches like the health production function or the SES gradient anticipate positive health effects of welfare-to-work programs there are some factors that can limit these relationships. This is the case of the characteristics of the