Social Science & Medicine 80 (2013) 141–146

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Commentary

A commentary on "A randomized controlled trial to improve health among women receiving welfare in the US: The relationship between employment outcomes and the economic recession"

Heather Scott-Marshall [a,b,*]

[a] Institute for Work & Health, Toronto, Ontario, Canada
[b] Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada

ARTICLE INFO

Article history:
Available online 3 January 2013

Keywords:
Public health interventions
Social patterning of health
Life course
Work disability
Labour-market outcomes

The research paper by Kneipp, Kairalla, & Sheeley, (2013) examines the impact of a public health nursing (PHN) intervention designed to improve the employment outcomes of women receiving Temporary Assistance for Needy Families (TANF). The goal of the intervention is to improve the rate at which TANF recipients move from "welfare-to-work" by ameliorating the high rate of chronic health conditions observed in this group. A secondary objective examines the effect of the most recent recession on the employment outcomes of TANF recipients, particularly whether exposure to the recession modifies the efficacy of the intervention. Some exploratory analyses also investigate relationships between select socio-demographic and health characteristics.

My commentary on this work is less a critique than it is a rendering of the issue within a sociological framework. It proceeds as follows: first, I briefly consider the impact of TANF and its contribution to the long-term economic self-sufficiency of needy families. I then comment on the article's focus on health barriers to employment in TANF recipients by foregrounding two underlying complexities: 1) there is a lack of consensus in the literature regarding the prevalence of different types of health conditions in the TANF population and little is known about how these conditions contribute to work disability; and, 2) a micro-level focus on health as a barrier to labour-market engagement in TANF women obfuscates the more basic determinants of adult life course circumstances, namely a history of disadvantage in exposure to risks and access to rewards that arises from social position. In the closing section, I recommend that policy-makers take a life course approach to mitigating social disadvantage by investing early and deeply in human capital.

Temporary Assistance for Needy Families (TANF)

On July 1st 1997, a new US federal assistance program entitled Temporary Assistance for Needy Families (TANF) succeeded the Aid to Families with Dependent Children (AFDC) which had been in effect since 1935. The program was developed under the auspices of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) instituted under Bill Clinton. The major thrust of TANF was to incentivize employment among the poor by adding a "workfare" dimension to welfare legislation. Benefits became subject to strict term-limits to a maximum of five years (Peterson, 2000). The bill emerged from the pervasive ideology that the poor had become too dependent on public financial assistance since generous benefits discouraged employment (Acs & Loprest, 2007; Blank, 2002). Unfortunately, despite stringent work requirements instituted by the bill, there is not an easy relationship between employment and economic sustainability.

Comparisons of the pre- and post-TANF environment show a large decline in welfare caseloads (e.g., Kneipp et al. (2013) cite

* Institute for Work & Health, 481 University Avenue, Suite 800, Toronto, Ontario, Canada M5G 2E9. Tel.: +1 416 927 2027x2177; fax: +1 416 927 4167.
E-mail address: hscott-marshall@iwh.on.ca.

0277-9536/$ – see front matter
http://dx.doi.org/10.1016/j.socscimed.2012.12.019

a 50% drop in the number of TANF recipients between 1996 and 2000). It is estimated that work participation rates rose 9% among welfare recipients with the proportion of income derived from employment increasing nearly fourfold between 1990 and 1999 (Blank, 2002). However, other indicators paint a darker picture of welfare reform. Studies comparing national labour-market data have found that the average income of former TANF recipients remained unchanged or even declined in the years following program reform (Loprest & Zedlewski, 2006; Acs & Loprest, 2007). In their analysis of data from the Survey of Income and Program Participation (SIPP), Acs and Loprest (2007) found that between 1996 and 2001 the average median annual income of former welfare recipients was reduced by nearly $5000. The study also found that the proportion of former welfare recipients falling into "deep poverty" (i.e., <50% of the poverty threshold) during this period had increased significantly from 24.4% to 33.3% (Acs & Loprest, 2007).

The dismal economic outcomes of former welfare recipients can largely be attributed to the fact that employment in this group is concentrated in the low-wage labour-market. In particular, the employment of single mothers (who comprise the majority of the TANF population) is concentrated in gender-segregated occupations and industries characterized by low wages and few benefits (Blank, 2002; Jones-DeWeever, Peterson, & Song, 2003). Research also shows that working welfare recipients have a very low rate of coverage from employer-sponsored health insurance plans (Acs & Loprest, 2007; Jones-DeWeever et al., 2003).

At the aggregate-level, the tendency for most former welfare recipients to be employed in low-wage work means that TANF has had little impact on the national poverty rate. In 1996 just prior to the introduction of welfare reform the national poverty rate was 12.0%. By 2007 (just prior to the global recession) the rate was 11.1%. For women aged 18 to 64 the poverty rate remained virtually unchanged during this period: from 13.2% in 1996 to 12.6% in 2007 (United States Census Bureau, 2012). In view of these statistics we can conclude that the increasing number of individuals who exit TANF because they are no longer eligible for benefits has not been associated with real economic gains for former welfare recipients and their families, but instead has contributed substantially to the share of the labour-force that qualifies as the "working poor" (Acs & Loprest, 2007; Blank, 2002; Jones-DeWeever et al., 2003).

Health barriers to employment

Several observers (including Kniepp et al., 2013) have credited the high prevalence of chronic health conditions in female TANF recipients with imposing a significant barrier to employment on this group (Danziger et al., 2000; Hauan & Douglas, 2004; Loprest & Zedlewski, 2006). While this observation is likely for the most part correct, a full analysis of the problem requires that we unpack the evidence in two respects: first, by acknowledging the lack of consensus in the literature as to the prevalence of specific health conditions in the TANF population and furthermore that little is known about the extent to which these conditions contribute work disability; and second, a focus on health as an individual-level barrier to employment obfuscates the structural mechanisms ultimately responsible for the social patterning of disadvantage in the labour-market.

Studies examining the health barriers to employment in welfare recipients have typically been concentrated in a handful of geographic areas with a relatively short period of follow-up – i.e., about five years post-welfare reform (Acs & Loprest, 2007; Dasinger, Speiglman, & Norris, 2002; Hauan & Douglas, 2004; Loprest & Maag, 2009; Michigan Program on Poverty and Social Welfare Policy, 2004; Rangarajan & Wood, 1999). There has also been a high degree of cross-regional variation in the instruments used to evaluate health outcomes in TANF recipients (Acs & Loprest, 2007; Loprest & Maag, 2009). Kneipp et al. (2013) cite a study by Corcoran & Chen (2004) which draws on data from the Women's Employment Survey (WES). The WES is a five-year panel study that began in 1997 and comprises a sample of female TANF recipients residing in one urban Michigan County. Data from WES show that about one in three (31%) women in the sample reported a health condition in at least one wave of the study (Michigan Program on Poverty and Social Welfare Policy, 2004). However, reports of health problems were less consistent over time with less than one-fifth (17.9%) of women reporting health problems in more than two years of study. According to Kneipp et al. (2013), "70% [of TANF recipients] report some limitation in physical functioning" a figure that I have been unable to corroborate in the WES data. Mental health disorders were more common in the WES with over two-thirds (67.9%) of the sample meeting diagnostic criteria for at least one of six disorders studied in at least one wave of study, though there is no information on how persistent mental health conditions were over time. Kneipp et al. (2013) state that "up to 60% [of TANF recipients] meet diagnostic criteria for Major Depressive Disorder, Post-Traumatic Stress Disorder, and/or social phobia" though this statistic is somewhat misleading since it applies to only a single wave of WES (with the actual figure at 67.9% as indicated above). Furthermore, I have difficulty understanding the authors' choice to cite Corcoran & Chen (2004) since this study examines differences between female welfare recipients exposed to temporary employment to those who have not been exposed, and does not provide estimates of characteristics (i.e., socio-demographic, health and other barriers) for the overall sample. Where health statistics are reported the highest estimate for "physical limitations" is 57.1% for women in the non-working group.

Acs and Loprest (2007) summarize the wide variation in estimates of the prevalence of health conditions in the TANF population due to differences in both geography and measurement. For physical health problems estimates range between 17% and 41%; for mental health disorders the range is between 12% and 36%. Kneipp et al. (2013) draw on a relatively small sample of female TANF recipients with specific socio-demographic characteristics (e.g., mostly African-American, residents of two counties in North Central Florida) for which the population prevalence of chronic health conditions is not known.

A more precise estimate of health-related barriers to employment in the TANF population is important since this establishes the size and characteristics of the caseload that may require specialized resources like the public health nursing intervention used in the Kneipp et al. study (2013). Also key to managing health barriers to employment is understanding the link between specific health conditions and work disability. A recent study using national-level data found that over one in four (26.8%) TANF recipients report a physical, mental or emotional problem that either prevents them from working or limits work. The percentage was similar for food stamp recipients (24.2%), though it was much higher than the estimate for low-income single mothers (6.2%) and adults in the general population (4.9%). Prior research shows that TANF recipients who report a work-limiting condition are significantly less likely to be employed (Loprest & Maag, 2009; Loprest & Zedlewski, 2006). There is also evidence that the prevalence of health-related work limitations in the TANF population have increased over time (Acs & Loprest, 2007; Bavier, 2001).

Despite evidence of work-limiting conditions in the TANF population, Kneipp et al. (2013) do not explicitly link the "chronic health conditions" observed in their sample with work disability. This omission is particularly stark in view of the types of disorders observed in their sample – i.e., seasonal allergies, back pain, headaches and depression. I am not aware of any research that