

Welfare Reform and Women's Health: Review of the Literature and Implications for State Policy

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INTRODUCTION

DISCUSSIONS of welfare have focused almost exclusively on the economic well-being of low-income families or demographic predictors of welfare participation, while the role of health of women, a potentially important factor in welfare participation, has been a minor consideration in research studies. Summarized here are the findings of studies examining the relationship between welfare participation and physical and mental well-being of women and what is known about (1) the effects of poverty on health; (2) the patterns of employment among welfare participants and the health consequences of low-wage work on women; (3) domestic violence among welfare recipients; (4) the potential health consequences of the provisions of the new Temporary Assistance to Needy Families (TANF) program for women's and adolescent health; and (5) the consequences of the new TANF provisions for the health and well-being of immigrant women.

We discuss, as well, the policy implications of welfare reform including monitoring and assurance issues confronting States. The implementation of TANF and other welfare reform initiatives poses great challenges for States as they integrate programs, reduce inefficiencies, and develop coordinated systems. The issues raised here are intended to guide State policymakers in creating systems that will protect and support women. Welfare reforms have the potential to significantly impact the health and well-being of participating families. It will be imperative to create and/or bolster mechanisms to monitor the social, economic and health effects of welfare reform. Most importantly, through prudent and compassionate policymaking, States can protect women and their families from the potentially damaging conse-

quences of welfare reform and genuinely promote their journey toward self-sufficiency.

BACKGROUND

The Aid to Families with Dependent Children (AFDC) program, known originally as Aid to Dependent Children (ADC), was established by the Social Security Act of 1935. It was designed as a federally mandated entitlement that guaranteed case assistance to all needy, eligible families with children who were “deprived of parental support or care because a father or mother is absent from the home continuously, is incapacitated, is deceased or is unemployed (1).” Most States set income eligibility guidelines well below the federal poverty level to control costs and reduce the appeal of welfare. As a result, approximately 60% of children living in poverty received AFDC benefits in the early 1990s. Moreover, the case assistance from AFDC alone left families well below the poverty level; even supplementation with food stamps and Medicaid rarely brought families above the poverty line. As a result, the majority of families on AFDC had to supplement case assistance with income from part-time employment, families, and friends.

The Personal Responsibility Work Opportunity Reconciliation Act

In August 1996, President Clinton signed into law the Personal Responsibility Work Opportunity Reconciliation Act (P.L. 104-193), ending a 60-year federal commitment to provide families some basic level of assistance during periods of economic hardship. The legislation replaces the AFDC program with the Temporary Assistance to Needy Families (TANF), and differs from its predecessor in five important ways:

- TANF replaces the federal AFDC entitlement program with a block grant to individual States;
- there is no longer a guarantee of cash assistance to all eligible individuals;
- recipients may receive benefits for no more than five years over a lifetime;
- recipients must adhere to work requirements to receive benefits; and

– current and future legal immigrants are denied certain benefits until citizenship.

Moreover, P.L. 104-193 targets a number of provisions directly at adolescents by requiring them to live in an adult-supervised setting and attend school or employment training as conditions for receipt of TANF assistance. The legislation also sets aside a pool of funds to reward the five States that can most markedly reduce out-of-wedlock births. States also have the option to institute a family cap on benefits.

Under the TANF program, States receive an annual block grant based on their prior AFDC spending level. Thus, funding formulas favor those States which historically have provided more generous welfare benefits. While the block grant gives States greater fiscal flexibility, downturns in the economy may leave some States severely strapped for resources to cover increased caseloads.

Twenty percent of a State's caseload may be excluded from the five-year limit for hardship reasons. However, beyond that exemption, a State may not use block grant funds to aid children once their parent has reached the time limit. For low-income families, the loss of the welfare entitlement coupled with the five-year lifetime cap represents the elimination of an important albeit meager refuge from the volatility of the low-wage labor market, which is typically insufficient to meet a family's economic needs and has few if any benefits.

The TANF work requirements are much more exacting and encompassing than those contained in previous legislation. States must demonstrate an increasing rate of work participation for all recipients. By 2002, 50% of the TANF caseload must be participating in at least 30 hours of paid work per week. States that fail to meet the annual work participation targets are subject to substantial fiscal penalties. The type of individual who can be exempted is likewise restricted. Women with pre-school age children must work, although States have the option of excluding women with children under the age of one (2,3).

Finally, States have the option of denying or limiting TANF and Medicaid benefits to non-citizen immigrants. New immigrants (those arriving after August 1, 1996) are barred for the first five years from these services. After five years, states have the option of extending these restrictions until citizenship.

POVERTY AND HEALTH

The U.S. has one of the highest rates of poverty among adults and children among all industrialized countries. Almost one-third of U.S. workers do not earn enough to keep a family of four above the poverty line, and half of all working women earn less than subsistence levels (4-6). With implementation of welfare reforms, many advocates and researchers are predicting a substantial increase in poverty in the U.S. The debilitating effects on health of short and long term poverty have been demonstrated by hundreds of past research studies (7-9).

Poverty is not only a marker for a lack of access to basic necessities due to family economic deprivation, but also serves as a proxy for the presence of other adverse social conditions. Health problems, once acquired, are more severe in families living in poverty compared to non-poor families. Long-term poverty, in particular, can have even greater devastating consequences on health. Studies have demonstrated large effects of long-term poverty (i.e., poverty that spans several years) on stunting and wasting of children and IQ scores (10).

Many welfare recipients, because of the low levels of cash assistance and the employment opportunities available to them, are at risk of long-term poverty. Women coming off the welfare rolls are likely to get low-wage jobs that keep them at or below the poverty line. Furthermore, longer stays in paid employment among low-wage workers do not lead to substantial gains in hourly wages. Rather, having a college degree is one of the few strong predictors of subsequent employment and means to escape poverty (4,6). Yet welfare reforms, with their shortened time limits, will allow few women to pursue higher education. Job training is not likely to usher women out of poverty, as recent evaluations have demonstrated that women may gain only \$500 additional dollars per year as a result of such programs (11). Low-wage work with little or no benefits and few opportunities for advancement are the more likely outcomes facing women coming off the welfare roles. This is likely to keep welfare recipients from escaping poverty and to increase the numbers of families living in poverty in the coming years. Recent studies estimate welfare reform provisions are likely to increase the number of persons in poverty by 2.6 million including 1.1 million children—an increase in

child poverty of 12%. Moreover, of those families who would be affected by the provisions, more than half are working families (12).

Implications for Policy

A key challenge for States is to assure that women and their families are not further impoverished by welfare reform initiatives. States might develop systems that:

- monitor poverty trends of women as they leave welfare to work; and
- evaluate the types of activities and support services necessary not only to prepare women for work but also to permanently move them out of poverty.

Long-term poverty is likely to remain a problem for those who cannot work or those who cannot move out of low-wage work due to physical and mental disabilities or lack of jobs. States should aim to assure women and their families a minimum safety net that will keep them from becoming further impoverished. Assurances States might consider include:

- a minimum living wage that allows families to escape poverty;
- food and housing subsidies for families whose low-wage earnings do not enable them to move out of poverty;
- enhanced support to women seeking to complete their education;
- a wholly state-funded rainy-day fund, free from the time limitations of TANF, available to families during economic downturns.

WELFARE PARTICIPATION AND WOMEN'S HEALTH

While there is extensive evidence linking poverty to poor health status, the literature examining the effects of welfare participation on the physical and mental well-being of women is limited. Few studies, to date, have attempted to assess the effects of welfare participation on health. Nor is there much literature examining the health status of women on welfare, their health services needs, and their utilization of health care services. There are primarily two domains of literature in this area. The first concerns the impact of welfare on mental health outcomes such as psychological distress, self-esteem, and personal

competence. The second area explores the relationships between welfare participation and access to health insurance.

Welfare and Psychological Well-Being

The limited evidence to date suggests there are psychological effects due to welfare participation, but these effects are not uniform for all aspects of psychological well-being (13–15). Lower levels of personal competence have been reported among welfare recipients compared to non-recipients, but no welfare effects on self-satisfaction have been found. Moreover, no clear effects on personal competence and self-satisfaction have been associated with entering or exiting welfare. The effects, while generally in the expected direction, could be attributed to either AFDC or an event triggering the need for AFDC such as divorce, separation, or loss of employment. Most recent research on homeless women receiving AFDC report high levels of poor mental health and posttraumatic stress disorder—two to three times that of the general female population. Over 25% of AFDC recipients report having attempted suicide. Mental health hospitalization and other disabling health conditions such as asthma and anemia are also high (16).

Evidence from the one longitudinal study of welfare and mental health suggests that psychological distress is both a risk factor and an outcome of AFDC participation, but again it is unclear whether the psychological distress experienced upon entry into welfare is due to welfare or a precipitating event (15). Persistent welfare is strongly associated with poor health, which in turn is associated with higher levels of psychological distress. Moreover, welfare heritage (having been dependent upon welfare in childhood) is associated with higher levels of psychological distress and poor self-esteem.

While there is research examining the psychological impact of entering and leaving welfare, only one study to date has examined the psychological impact of total or partial cutbacks in AFDC benefits—an area of research particularly relevant to the potential mental health consequences of welfare-to-work initiatives currently underway (14). Not surprisingly, the psychological impact of AFDC cutbacks is most deleterious for those women who are highly dependent upon AFDC. Furthermore, this impact is neither transitory nor mitigated by current employment status. These women may continue to experience high levels of psychological distress even after securing employment.

Welfare and Access to Health Insurance

The second domain of literature examining the relationship between welfare and health focuses on the need for Medicaid and its effect on decisions to enter or stay on AFDC (17-19). Greater AFDC participation has been consistently reported among women with poorer health. There is less consistent though generally solid evidence showing a strong correlation between a high need for Medicaid and greater AFDC participation. It has been estimated that the expected coverage available through Medicaid is considerably greater than that of private insurance. These findings suggest that private health insurance may not be adequate to meet the greater health needs of women and children served by AFDC (18). Taken together these data indicate that access to health insurance is a compelling incentive to enter or stay on AFDC, and a woman's need for health insurance is determined by her own or her child's health status.

At any given time, it has been estimated that a third of poor women (below 200% of poverty) will be uninsured, and only about one in five poor women is covered by the Medicaid program (20). Medicaid coverage is typically transient because eligibility is largely contingent on either AFDC participation or pregnancy. Women leaving AFDC face particularly bleak prospects for health insurance coverage. It has been reported that nearly half of former AFDC participants became uninsured within three years of leaving welfare. Of the 38% of women who were able to acquire private insurance, approximately half did so through their spouse (21). These findings, which were based on the work experiences of the most educated and able-bodied women on AFDC, may actually underestimate the potential severity of uninsurance. Welfare policy initiatives intended to move the most chronically dependent into work are likely to result in higher levels of uninsurance than those reported in the literature. These women are likely to have more health problems and fewer skills to acquire and maintain a job with benefits (21).

The provisions of P.L. 104-193 stipulate that States must continue to provide Medicaid to those participants who meet the State's AFDC income eligibility criteria as of July 1996, regardless of their eligibility for TANF (22). Hence, women could continue to receive Medicaid indefinitely so long as they meet the income eligibility criteria.

However, these income eligibility criteria are typically set at very low levels and even a moderately paying full-time job is likely to push women above the eligibility standard. In 1995, the maximum income allowed before families became ineligible for AFDC averaged 67% of the poverty level. Women who lose cash benefits due to increased earnings may receive transitional benefits for a period of 12 months following termination of cash assistance.

Implications for Policy

Being on welfare and leaving welfare can both be psychologically distressing. Leaving welfare may lead to the loss of health insurance and the ability to pay for critical health care needs. The optimal solution to this situation would be a universal system of health insurance. States, however, can institute a number of policies short of this universal option that could ease the transition out of welfare and increase the likelihood that women will attain a level of health and well-being that will allow them to be productive members of their communities. Monitoring the health of women and their access to care as they move out of welfare will be an important function for States to undertake. At a minimum States should consider monitoring:

- the physical and mental health of low income women;
- physical and mental health problems related to the stress or occupational hazards of low-wage employment; and
- long-term health insurance status of poor women leaving and entering the workforce.

States can assure that poor women have access to health care through a number of different mechanisms, but most notably through the option to expand Medicaid. States might consider any of the following:

- Medicaid coverage for chronically ill, low-income women who do not meet SSI eligibility;
- low cost buy-in to Medicaid;
- Medicaid expansions to cover all low-income women beyond the prenatal and post-partum period; or
- tax incentives to businesses to provide health insurance for low-wage workers and their dependents.

EMPLOYMENT AND THE WELL-BEING OF WOMEN

Patterns of Employment of Women Receiving AFDC

Contrary to the popular view that all women on welfare are economically dependent on the State to provide for their families, a large proportion of women combine paid employment with receipt of AFDC (6,23). The volatility and insecurity of low-wage employment makes cycling back and forth between welfare and work a necessity for women with few long-term job possibilities. It is worthwhile to note that the literature contains widely divergent estimates of labor market and AFDC participation depending on whether estimates are based on cross-sectional or longitudinal analysis. Since long-term recipients with the least amount of employment experience are most likely to be represented on the welfare rolls at any given time, cross-sectional studies tend to underestimate employment rates. Likewise, welfare duration is likely to be overestimated in cross-sectional studies since they do not capture the paid-work participation of the cyclers (women who cycle between employment and welfare) (24).

A review of data derived from the Panel Index Study of Income Dynamics 1974-1987, showed that 63% of non-black mothers receiving AFDC had initial welfare spells lasting one to two years. Only 12% of these mothers had spells lasting seven or more years. The corresponding figures for blacks were 48% and 21% (25). The proportion of long-term dependence increased when multiple periods of welfare participation over a ten-year period were included. Nevertheless, 82% of white mothers and 66% of black mothers receiving AFDC did not become "trapped" into long-term dependence. Those mothers who did become chronic dependents are a unique subset of the AFDC population. Poor health, low education, having preschool-aged children, and low pre-welfare wage rates, are all significantly associated with a lower probability of welfare exit and thus longer duration of welfare spells (26).

The events precipitating entry into welfare are highly correlated to duration of AFDC spells. Changes in the family structure via divorce, separation, or non-marital birth, account for 75% of all welfare entries. Women entering the welfare system due to a divorce or separation have shorter spells of participation than those entering due to an out-of-wedlock birth. A little less than half (45%) of welfare entries are due to divorce and separation, a third are due to out-of-

wedlock births, 16% are due to a fall in income. Changes in family structure are important to welfare exit, but to a lesser extent than changes in income. A third of the exits from welfare are due to marriage, while 40% are due to increases in income (27).

In between or during welfare spells, women rely on employment (either in the legitimate or underground economy), and/or contributions from partners, friends and family to secure the economic well-being of their families. Spalter-Roth et al. (6), in examining data from the Survey of Income and Program Participation (SIPP) for the period 1986-1987, found that approximately 40% of women receiving AFDC were also employed during the two-year period. Among this group of AFDC recipients, 17% simultaneously combined work and welfare, and 22% cycled between paid jobs and receiving AFDC (6). Other studies also support the finding that a substantial proportion of AFDC recipients combine benefits with employment (28,29).

In summary, contrary to public perception, employment is an important strategy for allowing AFDC recipients to meet economic obligations. The majority of AFDC spells are of short duration and most spells end as a result of gaining employment (24,26). A substantial proportion of AFDC recipients also have years of prior employment experience before entering the welfare system.

Employment and Women's Health

Given that a substantial proportion of welfare recipients participate in the paid workforce and that an even larger number of recipients will be forced into relying solely on employment to meet their economic needs, a review of the literature on employment and health might shed light on the impact of welfare reform on the well-being of women. Although employment and health have been studied extensively, there are a number of limitations in our ability to generalize those findings to women receiving welfare. First, most studies of women's health and work focus on married women, white women, and middle class women. For example, many studies have examined the differences between married women who stay at home versus married women who work. Thus, it is difficult to generalize this literature to single mothers in low-wage jobs. Further, middle-income married women will differ from single low-income mothers in their relative home and work demands. These relative demands have been shown to affect health (30). With these caveats in mind we summa-

alize the relevant literature on employment and the well-being of women and children.

Research has demonstrated that there are a number of positive benefits for women in being employed full-time outside the home that can lead to or maintain good health (31). For example, paid employment increases a woman's ability to provide for or contribute to her family's financial well-being, enhancing her sense of accomplishment and self-esteem (32,33). Women not employed outside the home perform work tasks within the home, but research has shown that these tasks, compared to tasks performed in the workplace, may be less rewarding and are associated with lower levels of psychological well-being (31,34). Being employed outside the home can also increase supportive social networks and rewards for work, and in some cases can yield positions with high levels of control over work tasks. These characteristics of work are all associated with high levels of psychological health and have been used to demonstrate that women who are employed tend to report better health compared to women who stay at home. These studies, however, have been primarily with middle-income married women. Women receiving welfare are likely to have less human capital—education and job experience—than middle-class women, and are more likely to procure jobs with lower pay and lower job complexity than women in these studies. Women with jobs characterized by low wages, low substantive complexity, routinization, repetitiveness and low occupational control—the type of jobs that women on AFDC are likely to have access to—have poorer psychological health than women with jobs without these characteristics (28,35–38).

Furthermore, there is tentative evidence to suggest that the combination of AFDC participation and employment might be especially harmful. Psychological distress has been estimated to be higher among all poor women working full-time compared to part-time, irrespective of AFDC status, and is highest among women working full-time and also receiving AFDC benefits. The lowest levels of psychological distress are reportedly experienced by women receiving AFDC and working part-time. These findings provide further evidence that for poor women the stressors associated with low-wage employment may outweigh any potential benefits (14). It has been proposed, in fact, that the most optimal work situation for poor

mothers is a combination of part-time work and welfare. Poor mothers, it is argued, require more time with their children because their harsh neighborhood conditions make parenting more difficult (39). Poor mothers lack the options available to middle class mothers to stay at home full-time, caring for their children if they choose.

An examination of the relationship between employment and health should extend as well to the health barriers women face in finding or keeping employment. Evidence suggests that failure to account for health barriers may overestimate the effects of employment incentives in work-to-welfare programs by as much as 50%. This methodological oversight reinforces the misconception that single mothers would work if given the appropriate incentives (19). A woman's or her child's disability markedly reduces the capacity of women to respond to employment incentives and is one reason for longer-term welfare participation (6,17-19). A recent study found that nearly 30% of families receiving AFDC include either a disabled mother or child. Moreover, of those mothers who were disabled, more than half had a serious disability.

These findings were consistent across three national data sets: the 1990 Survey of Income and Program Participation, the 1990 National Health Interview Survey, and the 1992 National Longitudinal Survey of Youth (40). A greater need for Medicaid has been associated with a reduced likelihood of working (18,19). With or without welfare reform, women receiving AFDC and TANF have difficulty finding permanent jobs, jobs with living wages, and jobs with benefits. Recent data suggest that finding any job might be difficult for a large proportion of TANF recipients (41). A recent study by Regional Financial Associates estimates that only 13 States will be able to absorb all of the TANF recipients coming off the rolls in the near future. Recipients in northeastern States will have a particularly difficult time finding jobs. Exits from welfare are also associated with diminished access to other health and social programs—e.g., health insurance, subsidized childcare, food and housing subsidies—leading to increased economic strain and stress placed on families (24). This increased economic strain has the potential to directly contribute to declines in the physical health and psychological well-being of mothers trying to make ends meet.

Implications for Policy

In general, because of the types of jobs welfare recipients have access to, it is not likely that they will experience the demonstrated benefits of employment on health. Moreover, with the increase in contingent work in the U.S., women going from welfare to work may obtain jobs with no or few health, retirement or vacation benefits, further eroding any positive effects of employment on health (6). Since it is clear that long-term employment in the low-wage sector is neither conducive to poverty reduction nor to health, States should endeavor to move women out of low-wage work as expeditiously as possible. With this aim in mind, States will need to carry out the following functions:

- monitor how quickly women are moving out of minimum-wage employment; and
- monitor potential mental health problems that may keep women from moving into higher paid work.

Within the parameters of the TANF program, States can exercise a great deal of flexibility in developing policies and creating systems that will allow women to move into sustainable employment. States might consider options such as:

- inducements to industry and business to train and promote low-wage workers to higher wage positions;
- social supports and networks to help women deal with the multiple demands of home and work;
- flexible work plans that allow mothers of small children to combine part-time work, school, and child rearing.
- inducements to industries and businesses that employ large numbers of minimum wage workers to provide flexible work hours, child care, insurance, and transportation assistance.

WELFARE AND DOMESTIC VIOLENCE

Studies have shown that women receiving AFDC compared to other women suffer higher rates of lifetime and current violence. There have been several explanations for this observation. First, rates of domestic violence are higher among poor compared to non-poor women. Second, low-income women involved in abusive relationships have historically used AFDC as a means to gain economic independence from a violent partner (42). Finally, recent reports have

noted that a high proportion of women on AFDC seeking employment or taking part in job training programs have partners who actively prevent their participation through the use of violence (43,44). Data drawn from surveys of AFDC participants since 1992 estimate that between 11.8% and 30% are currently experiencing physical abuse from a partner, and 57% to 64% have experienced such violence during adulthood (44,45). Recognition by legislators of the relevance of violence in the lives of women on welfare has led to the Family Violence Option (FVO) of the TANF legislation. The FVO allows programs in some States to exempt TANF recipients from the usual time limits if they experience domestic violence. Not all States, however, have adopted the FVO option. As of March 1997, 14 States had adopted all or part of the FVO option as part of their welfare plan and seven were considering an FVO option (46).

A number of recent studies have reported that child support and child visitation are the topics of many disputes between couples receiving AFDC. It has been noted that the new reforms that aggressively pursue child support for AFDC recipients may place some women at greater risk of violence from partners. Implementation of greater security and support measures within TANF programs will be necessary if women are to escape abuse in their relationships. Not only is violence itself a serious health problem but the health consequences of physical and psychological violence are severe and often long-term. Examples of these problems include mortality, physical and psychological morbidity, and lost productivity and income. Long-term consequences include chronic headaches, bowel disorders, and death. Psychological consequences include acute stress disorder, depression, anxiety, attempts of suicide, substance abuse, post-traumatic stress disorder, stormy interpersonal relationships, and revictimization (47). Thus, although the new welfare reform program has recognized the relevance of implementing some provisions for women who experience violence, some specific components of the reforms may increase the risk of violence in women's lives.

Implications for Policy

States can play an important role in both monitoring the effects of domestic violence and protecting women from undue risk of death and disability. States might consider implementing the following activities for monitoring purposes:

- instituting a domestic violence surveillance system in partnership with hospitals, public health agencies, law enforcement and social service agencies; and
- instituting policies and programs that may increase reporting of domestic violence incidents

States can also address the issue of domestic violence by:

- adopting the FVO option;
- routinely screening for domestic violence in job training and General Equivalency Diploma (GED) programs;
- integrating domestic violence services with other welfare-to-work support programs;
- enhancing security and confidentiality protocols of TANF and related programs; and
- ensuring there are sufficient numbers of safe havens to house women and children fleeing dangerous situations.

ADOLESCENT PREGNANCY AND NON-MARITAL BIRTHS

A major goal of P.L. 104-193 is to reduce adolescent pregnancy and non-marital births. Three provisions of P.L. 104-193, the out-of-wedlock bonus, the high performance bonus, and the creation of a new capped entitlement for abstinence education, are aimed specifically at reducing adolescent pregnancy and non-marital births. An additional \$20 million is available to five States that are able to demonstrate a net decrease in all non-marital births without increasing the rate of abortions. The bonus to high performing States is available to any and all States that demonstrate fulfillment of the goals and purposes of TANF—reducing non-marital births, formation of two-parent families, and promotion of marriage. It is not clear to what extent States will go to attain these monetary bonuses.

Under P.L. 104-193, the strategy for reducing adolescent pregnancy with respect to sexual behavior focuses solely on abstinence education. Over five years, \$250 million in grant monies have been set aside to fund these programs. Abstinence-only education has several components as defined by the Personal Responsibility and Work Opportunity Reconciliation Act (Title IX, Section 912, subset 510(b)(2)(A-H)). Abstinence education teaches the social, psychological and

health benefits of abstaining from sexual activity, and the belief that the expected "standard" for human sexual activity is a mutually faithful monogamous relationship in the context of marriage. Some of the less substantiated elements of abstinence-only education are those teaching that sexual activity outside of heterosexual marriage is likely to have harmful psychological and physical effects, and that non-marital births are likely to have harmful consequences to the child, family and society. Funds for abstinence-only education are to be distributed to States that apply for the monies and federal funds must be matched by non-federal monies.

Researchers and policy makers have expressed concern over abstinence-only education in that there is little or no scientific evidence demonstrating its effectiveness. Almost no adolescent pregnancy prevention programs report success in reducing sexual activity, although some programs have demonstrated modest success in increasing contraceptive use and reducing pregnancy (48,49). Moreover, findings from evaluations of adolescent pregnancy prevention programs suggest that the most effective strategy is one that targets a wide range of high-risk behaviors, incorporates developmentally appropriate instruction, and is initiated prior to commencing intercourse (48-50).

While nothing in P.L. 104-193 precludes States from implementing abstinence-only education alongside more comprehensive programs, funds appropriated for abstinence-only education cannot be used to provide information about contraceptive options. Abstinence-only curricula are designed to confine information available to students about sex to abstinence alone. Since nearly half (42%) of sixteen year olds report being sexually active, many adolescents would benefit from more comprehensive education on sexual practices (51). Moreover, given the recent increases in STDs in the US, increased access to information about condom use as a means of STD and HIV prevention is indicated. Abstinence-only curricula, if widely implemented in place of more comprehensive programs, could facilitate increases in the future morbidity and infertility of the youth in the U.S.

This focus on adolescent childbearing may be overzealous, given recent trends in adolescent sexual and reproductive behavior. The rate of adolescent pregnancy is much lower today than in decades past, and adolescents represent a minority of women (5% in 1993) on the welfare rolls. Non-marital births among both adult women

and adolescents, on the other hand, have increased sharply. The greatest increase has been among adult women: adolescents currently account for a smaller proportion of out-of-wedlock births than they did in the 1970s. The increase in non-marital births reflects broad changes in sexual activity and reproductive behavior among women of all ages, races, and socioeconomic backgrounds. Currently, it is estimated that 8 in 10 teenagers are sexually experienced by age 20, and historic differences by race, income and religion have narrowed over the years: 60% of poor adolescents aged 15-19 are sexually experienced compared to 50% of higher income adolescents (52). While adolescent child-bearers are more likely to become dependent on welfare at some point in their lives, it is important to note that for many poor adolescents, delayed childbearing does not markedly improve their economic status (53).

Living in Adult-Supervised Setting

P.L. 104-193 prohibits States from providing federally funded TANF assistance to unmarried adolescent parents unless they are living in an adult-supervised setting, namely their parents' home. The legislation stipulates that in cases where the parent is unavailable or may cause harm to the adolescent, the State "shall provide or assist the individual in locating a second chance home, maternity home, or other appropriate adult-supervised supportive living arrangement." States are provided a great deal of latitude in determining the nature of this "assistance." It could conceivably range from the establishment of maternity homes to referring adolescent mothers to a bulletin board or phone book. Furthermore, since the legislation does not provide additional monies for alternative housing, States may be tempted to comply in the most minimal manner possible or circumvent the mandate altogether. Arizona, for example, has argued that its preexisting waiver exempts it from the housing assistance mandate (54). If other States adopt similar positions, adolescents who cannot live with their parents may find little help in finding a suitable alternative, placing them and their children at increased risk for homelessness.

Consideration should also be given to the incentives built into the TANF program that may indirectly encourage adolescents to remain or return to an abusive home. For example, adolescents who are living with their parents or in other adult-supervised settings are not

subject to the five-year lifetime cap on benefits. In other words, while they are living with an adult they can “bank” their TANF time. If an adolescent mother establishes an independent household or marries, her time on TANF is subject to the lifetime cap. Hence, in situations where there are few alternatives, there may be an incentive for adolescent mothers to remain in an abusive home in order to save their TANF time.

Food Stamps

Perversely, while P.L. 104-193 mandates adolescents to live at home, it penalizes them for doing so by reducing their food stamp allotments. Adolescents living with a parent cannot establish a separate food stamp household, which typically results in a larger food stamp allotment. Thus, adolescents living with their parents are likely to have smaller food stamp allotments and consequently fewer resources to purchase basic foodstuffs. In addition, the new legislation changes the age at which earnings of students can be disregarded, from 22 to 17 years (54). Thus, the earnings of working students aged 18 and older can be used in calculation of the food stamp allotment. Adolescent mothers wishing to pursue both school and work are faced with a set of difficult choices which potentially make them vulnerable to further impoverishment and hunger. Mothers who forego either school or work to maintain their allotment or make-up for shortages miss out on opportunities to gain important employment experiences and acquire new skills. Those who choose to pursue both school and work face the prospect of increased hunger for themselves and their children as they struggle to make ends meet on reduced food stamp allotments.

Implications for Policy

States can significantly contribute to the development and well-being of poor adolescents by monitoring closely the effects of welfare reform, and by judiciously using incentives and supports to allow adolescents to complete their schooling and raise their children without undue hardship. Monitoring functions necessary to achieve this end would include:

- tracking high-school and college completion rates for adolescent mothers;

- tracking repeat pregnancies and barriers to effective contraceptive use;
- tracking the long-term social and economic outcomes of adolescent mothers involved in welfare-to-work programs;
- evaluating rigorously the effects of abstinence-only curricula, both positive and negative; and
- tracking and evaluating state policies intended to reduce adolescent pregnancies and non-marital births

Evaluations of a number of adolescent parent welfare demonstration projects have yielded a wealth of information about the features of welfare-to-work programs most likely to produce successful outcomes. By incorporating these features into policies and programs, States can improve adolescents' chances of escaping poverty and becoming economically self-sufficient adults (55). These features include:

- incorporating flexibility into work and school mandates;
- individualizing approaches to handling emergencies and family crisis with an aim towards teaching effective problem-solving skills;
- adequate supports for child care and transportation; and
- specialized training for staff who work with adolescents.

To further ensure the well-being of adolescents, States will want to insure that adolescents have full access to the following:

- low-cost, confidential family planning, abortion, and STD prevention and treatment services;
- comprehensive sexuality education;
- adequate housing if the adolescent mother cannot live at home;
- routine screening and assistance for adolescents experiencing violence either in the home or from a partner; and
- food subsidies to assist mothers who are working and going to school.

WELFARE REFORM AND IMMIGRANT WOMEN

Under P.L. 104-193, States currently have the option to deny or limit legal immigrants, residing in the U.S. prior to August 22, 1996, access

to a host of federal means-tested programs including TANF, non-emergency Medicaid, and Title XX social services block grant. Furthermore, current legal immigrants are barred from receiving food stamps. Legal immigrants arriving in the U.S. after August 22, 1996 are barred for five years from receiving assistance from these programs as well as Social Security income (SSI). The only category of immigrants exempted from these provisions are U.S. armed service members and veterans, their spouses and dependents, refugees and immigrants who had been granted asylum, and legal immigrants who have worked a minimum of 40 quarters, their spouses and dependents. Non-legal immigrants, the undocumented, and various categories of lawfully present non-citizens (i.e., persons fleeing persecution but not designated as refugees, and temporary agricultural workers) are barred from receiving any "federal public benefit." States wishing to provide assistance to these groups of immigrants must first enact a State law making them explicitly eligible for State-funded assistance. Emergency medical care and public health services, such as immunization, testing, and treatment of communicable diseases, are still available to all classes of immigrants.

The impetus for this harsh and potentially health-endangering legislation was born out of the misperception that welfare use among immigrants was widespread and growing. According to 1993 Current Population Survey Estimates, only 6% of immigrants receive any type of cash welfare benefit (AFDC, SSI, or General Assistance). Though immigrants use welfare at slightly higher rates than natives, most welfare use is concentrated among refugees and elderly immigrants who have significant social, physical, and mental health needs. Poor immigrants as compared to poor natives are less likely to use welfare (16% vs 25%) (56).

P.L. 104-193 has alarming implications for the health of undocumented immigrant women. No State may deny emergency medical care to any immigrant regardless of legal status. Under the provisions of P.L. 104-193, undocumented women are barred from receiving Medicaid-funded prenatal services but may receive Medicaid-funded emergency labor and delivery services. Legal immigrant women who entered the U.S. after July 1996 face similar restrictions for at least five years. States that wish to fund prenatal benefits for these women must pass special legislation to do so (57).

While most States have opted to maintain Medicaid coverage for

legal immigrants who lived in the U.S. prior to enactment of P.L. 104-193, there is less support for extending pregnancy-related benefits to new and/or undocumented women. Legislative initiatives in California and Texas have been proposed that would deny prenatal care benefits to undocumented and new legal immigrants. In New York, the federal government has sought to vacate the ruling in *Lewis vs Grinker* that had allowed the State to provide Medicaid-funded prenatal care to all pregnant women regardless of their legal status (58).

Policies to limit poor immigrant women's access to prenatal care are both inhumane and costly to society. States and localities will be burdened with the increased costs of paying for pregnancy-related illnesses and conditions which might have been prevented. The consequences to poor immigrant women may be borne out in untreated complications of pregnancy, resulting in adverse infant outcomes, impaired fertility, and maternal mortality.

Implications for Policy

P.L. 104-193 is a landmark piece of legislation in many respects, not the least of which is the new role it has carved out for States in setting immigrant policy. States are now responsible for making major decisions about which immigrants are eligible to receive public benefits. This new role will require States to develop mechanisms to certify legal status, enforcing restrictions and deeming requirements, and financing benefits for those losing or excluded from services. P.L. 104-193 has created myriad new classes of immigrants whose eligibility is determined by date of arrival, length of residency, and progress toward naturalization—criteria which in no way are related to the immigrant's indigence or need (59). While there are now two distinct classes of qualified and unqualified immigrants, States have a major stake in assuring that the "unqualified" do not become a marginalized underclass. Monitoring will be of critical importance to States in this respect. Information regarding the health and well-being of immigrants is scant, and for the undocumented even more so. Undocumented women are a class of immigrants likely to be impacted by benefit exclusions most immediately, and States should make concerted efforts to monitor them closely. Indicators that should be monitored include:

- trimester of entry into prenatal care;

- adverse perinatal outcomes such as pregnancy complications, low birth weight, infant mortality, maternal mortality; and
- access to reproductive health services.

States must ensure that all women regardless of legal status have access to high quality and timely maternity care and reproductive health services. Policies States may want to consider include:

- drafting special legislation to allow undocumented women to receive publicly funded prenatal care services;
- providing low-cost or subsidized reproductive health services to all poor immigrant women of childbearing age;
- promoting outreach efforts to communities to encourage poor immigrant women to seek prenatal care early; and
- avoiding coercive mandates that require health providers to assess the legal status of their patients prior to rendering services: such mandates create a climate of fear and mistrust.

SUMMARY AND CONCLUSIONS

Welfare reform has the potential to diminish the health and well-being of poor women on many fronts. While the provisions of P.L. 104-193 markedly reduce the size and scope of the safety net currently available to impoverished families, States also wield a significant amount of latitude in determining the implementation of reforms. By streamlining inefficiencies, targeting resources appropriately, and appreciating the realities facing the working poor, States can craft policies and programs that will protect and empower women to overcome a lifetime of social and economic disadvantage.

States will want to monitor the social, economic and health effects of reforms and ensure that these reforms do not further impoverish women and their families. Reforms should be developed and implemented with the ultimate goal of moving poor women out of low-wage work and into work that will allow them to become economically self-sufficient over the long term. In order to achieve this goal, providing all those employed with a living wage, post-secondary education, and job training should remain top priorities. Reforms should also aim to assist women to balance the demands of child rearing, work, and school. Paid “work” is but one of many demands in the complex lives of women, and family and school responsibilities must

be considered as well. Work and health are intimately connected and efforts should be made to ensure that the move into the workforce does not further diminish the physical and mental well-being of women (especially women with chronic conditions), and/or reduce their access to health care. Since the road to poverty can start with adolescent childbearing, States must ensure that reforms allow adolescents to finish their education and develop the skills necessary to make a successful transition to work and adulthood. While P.L. 104-193 severely restricts access to health care for particular classes of immigrants such as undocumented women, states should use their discretionary authority to ensure that these women are not jeopardized by lack of pregnancy-related care or other vital health care.

Poverty is not an intractable feature of the human condition. Many of the decisions made by our leaders at all levels of government and community life can profoundly impact the lives of the poor. States can, through the creative, compassionate and prudent use of resources, make a significant contribution to ending "welfare as we know it."

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ABSTRACT

In August 1996, the Personal Responsibility Work Opportunity Reconciliation Act (P.L. 104-193) was signed into law, ending a 60-year federal entitlement guaranteeing families some basic level of assistance during periods of economic hardship. Several components of this new legislation have the potential to impact upon the health and well-being of women and children. We summarize studies examining the relationship between welfare participation and physical and mental well-being of women and what is known about the effects of poverty on health; the patterns of employment among welfare participants and the health consequences of low-wage work on women; domestic violence among welfare recipients; the potential health consequences of the provisions of the new Temporary Assistance to Needy Families (TANF) program for women's and adolescent health; and the consequences of the new TANF provisions for the health and well-being of immigrant women. We discuss the implications for policy makers in monitoring and minimizing the negative impact of welfare reforms on women's health and well-being.