Employment Barriers Among Welfare Recipients and Applicants With Chronically Ill Children

Lauren A. Smith, MD, MPH, Diana Romero, PhD, MA, Pamela R. Wood, MD, Nina S. Wampler, DSc, MPH, Wendy Chavkin, MD, MPH, and Paul H. Wise, MD, MPH

Objectives. This study evaluated the association of chronic child illness with parental employment among individuals who have had contact with the welfare system.

Methods. Parents of children with chronic illnesses were interviewed.

Results. Current and former welfare recipients and welfare applicants were more likely than those with no contact with the welfare system to report that their children's illnesses adversely affected their employment. Logistic regression analyses showed that current and former receipt of welfare, pending welfare application, and high rates of child health care use were predictors of unemployment.

Conclusions. Welfare recipients and applicants with chronically ill children face substantial barriers to employment, including high child health care use rates and missed work. The welfare reform reauthorization scheduled to occur later in 2002 should address the implications of chronic child illness for parental employment. (*Am J Public Health.* 2002;92:1453–1457)

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act significantly changed welfare policy in the United States. The stated intent of the legislation, commonly referred to as welfare reform, was to decrease reliance on welfare and increase the economic independence of poor families. The legislation replaced the Aid to Families with Dependent Children (AFDC) program with the Temporary Assistance for Needy Families (TANF) program, eliminated entitlements to cash benefits, and imposed a 5-year time limit for benefits, work requirements, and benefit reductions or terminations for noncompliance with program provisions.[1]

Parents of children with chronic conditions are likely to experience difficulties complying with these new requirements because their children's health needs require them to take so much time away from work. Low-income parents in general, and current and former welfare recipients in particular, are more likely to have low-wage jobs that do not provide vacation or sick leave that would allow them to care for sick children.[2–5] Welfare recipients have been shown to cite child illness as a barrier to employment.[1,6–9]

Anything that poses a barrier to sustained parental employment, such as chronic child illness, will undermine the intent of the welfare legislation. The law has incompletely addressed the needs of families with chronically ill children, however. Welfare agency screening for health barriers to employment is often inadequate.[10] In addition, welfare recipients with chronically ill children are often unaware that work exemptions and time limit extensions based on child illness are available.[11] Because those targeted by the legislation are parents, understanding the implications of chronic child illness for parental employment will be important when the legislation is reauthorized later in 2002, especially given current proposals to increase the work requirement.[12]

There has been no research since the implementation of the welfare reform legislation that has specifically considered the association of clinically significant rates of chronic child illness with particular employment outcomes among parents who have had contact with the welfare system. In the present study, we sought to fill this gap by exploring the prevalence of employment barriers among a cohort of families with chronically ill children.

METHODS

Study Sample

A detailed description of the study sample and recruitment methods can be found in the Romero et al. article elsewhere in this issue.[13] In brief, the study involved an initial cross-sectional investigation of 504 predominantly low-income English- or Spanish-speaking parents or primary caretakers of children aged 2 to 12 years with one of 7 chronic illnesses (asthma, diabetes, sickle-cell anemia, epilepsy, hemophilia, cerebral palsy, or cystic fibrosis). Respondents were identified during 2001 at clinical sites and welfare offices in San Antonio, Tex.

Trained interviewers approached all families, determined eligibility, and administered a structured survey in respondents' preferred language. The survey included original and previously validated questions.[14] Data were collected on child health care use, illness severity (including asthma severity as assessed with the Rosier Asthma Functional Severity Scale, described in detail elsewhere in this issue[15]), welfare status, current and recent employment, employment barriers, receipt of Supplemental Security Income, and demographic characteristics.

High child health care use was defined as 3 or more emergency department visits or 2 or more hospitalizations in the previous 6 months. Welfare status was defined as current (receiving TANF benefits at the time of enrollment in the study), former (had received TANF/AFDC benefits in the past), denied (had applied for TANF/AFDC and been denied benefits), pending (had pending applications), or no contact with the welfare system (had never received TANF/AFDC).

Statistical Analysis

Bivariate analyses and multivariable logistic regression analyses were performed to examine the association of welfare status with child health status, health care use, employ-

TABLE 1—Demographic Characteristics of Mothers of Chronically Ill Children, by Family Welfare Status

Characteristic	Total (n = 504)	Current (n = 63; 12.5%)	Former (n = 120; 23.8%)	Denied (n = 53; 10.5%)	Pending (n = 42; 8.3%)	Nonrecipient (n = 226; 44.8%)	*P*
Race/ethnicity, %							< .001
Latino	62.2	62.3	45.0	78.8	53.7	69.2	
Black, non-Hispanic	22.0	23.0	39.2	17.3	29.3	12.2	
White, non-Hispanic	10.5	4.9	7.5	3.8	12.2	14.9	
Other	5.3	9.8	8.3	0.0	4.9	3.6	
Birthplace US, %	87.9	87.3	93.3	86.8	95.2	84.1	.07
English speaking, %	88.3	84.1	96.7	86.8	92.9	84.5	< .01
Married, %	35.6	17.5	20.0	28.3	14.3	54.7	< .001
Education < 12 y, %	35.2	54.0	26.7	37.7	40.5	32.9	< .01

Note. Current = currently receiving TANF; Former = received TANF/AFDC in the past; Denied = application for TANF/AFDC denied; Pending = TANF application pending; Nonrecipient = never received TANF/AFDC. TANF = Temporary Assistance for Needy Families; AFDC = Aid to Families with Dependent Children.

ment status, and employment issues. SAS (version 8.02, SAS Institute Inc, Cary, NC) and Epi Info (version 6.04, Centers for Disease Control and Prevention, Atlanta, Ga) were used in conducting data analyses.

The primary outcome variables included in the multivariate logistic regression models were current parental unemployment (yes, no) and work absence(s) in the previous 6 months because of child illness (yes, no). The models controlled for race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, other) and parental age, educational level (less than high school, high school or greater), marital status (married, unmarried), and birthplace (United States, other). Multivariate analyses were performed to examine the association of welfare status, child health status, child health care use, and demographic variables with these 2 parental employment outcomes.

RESULTS

Demographic Characteristics

The majority of parents were Latino or Black, reported that they had been born in the United States, and were comfortable speaking English (Table 1). Approximately half of the respondents (55.2 %) had some previous contact with the welfare system, and 23.8% were former welfare recipients. Race/ethnicity, educational level, and marital status differed significantly among the 5 welfare groups. The majority of respondents (91.3%) were mothers; 4.2% were fathers, and 3.4% were grandparents.

Child Health Status and Health Care Use

As can be seen in Table 2, the most common chronic illness among this group of children was asthma (a frequency of 78.4%). Sixty-two percent of respondents reported that their children's health problems limited their ability to take part in normal childhood

TABLE 2—Limitations in Activity and High Health Care Use Among Chronically Ill Children, by Family Welfare Status

Characteristic	Total (n = 504)	Current (n = 63; 12.5%)	Former (n = 120; 23.8%)	Denied (n = 53; 10.5%)	Pending (n = 42; 8.3%)	Nonrecipient (n = 226; 44.8%)	*P*
Diagnosis, %							.001
Asthma	78.4	87.3	80.8	66.0	88.1	75.7	
Diabetes	7.1	0.0	3.3	7.5	0.0	12.4	
Seizure	6.3	4.8	7.5	7.5	9.5	5.3	
Other[a]	8.1	7.9	8.3	18.9	2.4	6.6	
Limitation in activity, %	62.5	71.4	65.0	75.5	69.0	54.4	.01
Emergency department visit within 6 mo, %	58.7	68.3	60.0	66.0	57.1	54.0	.22
High health care use,[b] %	21.8	31.7	27.5	17.0	19.0	17.7	.06
Missed school days, mean No.	7.7	13.7	6.1	9.2	8.5	6.6	.08

Note. Current = currently receiving TANF; Former = received TANF/AFDC in the past; Denied = application for TANF/AFDC denied; Pending = TANF application pending; Nonrecipient = never received TANF/AFDC. TANF = Temporary Assistance for Needy Families; AFDC = Aid to Families with Dependent Children.
[a]Sickle cell anemia, hemophilia, cerebral palsy, and cystic fibrosis.
[b]3 or more emergency department visits or 2 or more hospitalizations.

TABLE 3—Employment Difficulties Among Parents of Chronically Ill Children, by Family Welfare Status

Characteristic	Total (n = 504)	Current (n = 63; 12.5%)	Former (n = 120; 23.8%)	Denied (n = 53; 10.5%)	Pending (n = 42; 8.3%)	Nonrecipient (n = 226; 44.8%)	*P*
Currently employed, %	42.3	17.5	47.5	52.8	19.0	48.2	<.001
Recently employed, %	36.5	42.9	42.5	32.1	61.9	27.9	<.001
Child health barrier,[a] %	74.3	70.6	81.7	87.8	80.6	66.1	<.01
Own health barrier,[a] %	43.9	51.0	47.0	51.0	61.1	34.9	<.01
Other family health barrier,[a] %	32.3	29.4	31.3	38.0	36.1	31.2	NS
Missed work because of child illness,[b] %	69.3	60.5	79.6	80.0	73.5	61.0	<.01
Missed child medical visit because of work inflexibility,[b] %	27.8	25.0	35.0	54.5	23.5	18.9	<.001

Note. Current = currently receiving TANF; Former = received TANF/AFDC in the past; Denied = application for TANF/AFDC denied; Pending = TANF application pending; Nonrecipient = never received TANF/AFDC. TANF = Temporary Assistance for Needy Families; AFDC = Aid to Families with Dependent Children; NS = not significant.
[a]Health problem made it difficult to find a job or caused job loss.
[b]Includes only those with current or recent employment (total n = 397, current n = 38, former n = 108, denied n = 45, pending n = 34, nonrecipient n = 172).

physical activities such as sports, gym class, and outside play. Current welfare recipients and denied applicants were more likely than those with no contact with the welfare system to report that their children's activities were limited.

Almost 60% of children had been to the emergency department, and the average number of days of school or day care missed because of illness in the past 6 months was 7.7. The children of current recipients and applicants had missed significantly more school than had the children of those with no contact with the welfare system. The children of current and former recipients exhibited the greatest proportions of high health care use.

Employment Issues

Rates of current and recent employment varied significantly among the 5 welfare groups (Table 3). Although the majority of respondents (74.3 %) indicated that their children's health problems had made it difficult to find or keep a job, the degree to which the 5 groups identified this barrier differed significantly, with former recipients and denied applicants having the highest rates. Respondents also identified their own health and the health of other family members as barriers, but less frequently than they identified child health barriers.

More than two thirds of respondents who had worked in the previous 3 years (n=397) indicated that they had missed days from work because of their children's illnesses (Table 3). Former recipients and denied and pending applicants had the highest rates of work absences. More than 25% of respondents reported that their children had missed medical appointments because they were unable to arrange time away from work; the rate for denied applicants was twice as high as the overall rate.

Table 4 presents the results of regression analyses examining the association of welfare status and high rates of child health care use with unemployment and missed work after parental education, race/ethnicity, age, birthplace, marital status, and receipt of Supplemental Security Income had been controlled. Parents of children with high health care use rates were more likely to be unemployed (odds ratio [OR]=1.7; 95% confidence interval [CI]=1.001, 2.9). High rates of child

TABLE 4—Association of Welfare Status and High Child Health Care Use With Parent Unemployment and Missed Work

	Adjusted Odds Ratio (95% Confidence Interval) for Current Unemployment[a]	Adjusted Odds Ratio (95% Confidence Interval) for Missed Work in Previous 6 months[a,b]
All children		
Family welfare status		
Nonrecipient (reference)	1.0	1.0
Current	4.3 (1.9, 9.7)	0.8 (0.4, 1.9)
Former	1.7 (0.96, 2.9)	2.3 (1.2, 4.2)
Denied	1.2 (0.6, 2.4)	2.7 (1.2, 6.4)
Pending	6.6 (2.6, 16.7)	1.6 (0.7, 3.9)
High child health care use	1.7 (1.001, 2.9)	1.0 (0.6, 1.8)
Children with asthma		
Family welfare status		
Nonrecipient (reference)	1.0	1.0
Current	5.5 (2.0, 15.0)	0.9 (0.4, 2.2)
Former	1.7 (0.9, 3.2)	3.6 (1.7, 7.5)
Denied	0.7 (0.3, 1.6)	3.6 (1.1, 12.1)
Pending	4.1 (1.5, 10.7)	2.5 (0.9, 7.3)
Rosier functional severity scale score	1.5 (0.8, 2.8)	4.6 (2.0, 10.3)

[a]Adjusted for parental education, race, parental age, country of birth, marital status, and receipt of Supplemental Security Income.
[b]Respondents who had not worked in the previous 6 months were excluded from the analysis.

health care use were not associated with parents missing work, however.

Among the subgroup of parents of children with asthma (n=367), former recipients (OR=3.6; 95% CI=1.7, 7.5) and denied applicants (OR=3.6; 95% CI=1.1, 12.1) were significantly more likely to have missed work because of child illness. A high asthma severity score in children, as measured by the Rosier Asthma Functional Severity Scale, was strongly associated with work absences in parents (OR=4.6; 95% CI=2.0, 10.3).

DISCUSSION

Welfare recipients and applicants with chronically ill children face substantial barriers to employment related to their children's illnesses. These barriers include high rates of child health care use and missed work. Denied applicants had the highest rates of child health barriers and work absences. We do not know why these families were denied welfare, so we cannot determine whether the rejections were related to the employment difficulties described. Because most studies of welfare recipients do not include separate data on denied applicants, the experiences of this group have rarely been explored.[16–19] The association of child illness with parental work absences and unemployment seen in this study is consistent with the findings of other studies involving large national data sets.[20,21] However, ours is the first study to link specific chronic childhood illnesses with parental employment outcomes.

The present findings are particularly relevant because parents receiving welfare are more likely to have chronically ill children than are other poor families.[4,22,23] Because it may be difficult for mothers of chronically ill children to meet the current work requirements, not to mention the proposed increased requirements, these women will be more vulnerable to benefit terminations for noncompliance.

Some states offer work exemptions and time limit extensions on the basis of parental or family member disability,[24] but recent research has shown that parental knowledge and use of such provisions are limited.[11] These exemptions are often based on such strict criteria (e.g., Supplemental Security Income disability determination) that they would not be available for many chronically ill children. Nevertheless, these children often have significant health needs requiring parental participation in their medical care. Such families may also have difficulty completing the transition from welfare to stable employment, which was the major goal of the welfare reform legislation.

There are likely to be economic and health consequences of the choices that parents of chronically ill children make when they must choose whether to miss work or miss their children's medical appointments, and a substantial proportion of our respondents indicated that their children had missed medical appointments because they were unable to take time away from work. This finding is consistent with national data suggesting that low-income mothers in general, and former welfare recipients in particular, lack sick or vacation leave.[2–4]

The economic consequences of work absences could include lost wages or, if absences occur frequently, even a lost job. On the other hand, when parents miss their children's medical appointments, continuity and quality of care are undermined. For example, children with asthma who miss their flu shot, do not receive a peak flow meter or an asthma care plan, or do not obtain a refill for their inhaled steroids are at higher risk of increased and preventable morbidity. Missed appointments are likely to result in more reliance on emergency departments, which are not usually organized to provide the multidisciplinary approach that benefits chronically ill children.

This study also highlights the importance of child care for chronically ill children. Although we did not collect data on the availability or cost of child care, the inadequate supply of child care for current and former TANF recipients has been well documented.[25–27] The 1996 welfare legislation provided additional funding for child care subsidies, but many states have been unable to provide these subsidies to all eligible families.[27,28] If the overall supply of child care is inadequate, it is not likely that there will be a sufficient supply of specialized child care settings that can accommodate chronically ill children by providing their medications and monitoring their symptoms.

This study involved important methodological limitations. First, the sample was recruited in San Antonio, Tex, and so the findings are not necessarily generalizable to other states. Second, we relied on parental reports of child health status and employment status. However, self-reports of such information are considered valid and are collected in numerous national surveys.[14]

Finally, because of the cross-sectional design of the study, we cannot conclude that there is a causal relationship between chronic child illness and parental employment problems. Although we postulate that chronic child illness adversely affects parental employment, it is possible that the association we found resulted from some other cause. It is also possible that illness severity is exacerbated by parents' employment. Inflexible work conditions can make it difficult for parents to take their children for care, and many parents have jobs that do not provide health insurance. These factors, in combination, could lead to an increase in illness severity because children are not receiving the health care they need.

Policymakers focusing on the 2002 reauthorization of the welfare legislation need to consider that welfare recipients with chronically ill children will face challenges in complying with work requirements and may need additional assistance such as subsidized child care in settings that accept chronically ill children. Efforts should be made to ensure that family resources are not further strained by the unnecessary loss of Medicaid and Food Stamp benefits, because data suggest that many eligible children and families lose these benefits when they leave welfare.[16,29–31] State and federal policymakers need to create reasonable employment and welfare policies for low-income families with chronically ill children that will help them achieve sustained employment and improved family well-being without jeopardizing their children's health. ■

About the Authors

Lauren A. Smith and Paul H. Wise are with the Department of Pediatrics, Boston University School of Medicine,

Boston, Mass. Diana Romero and Wendy Chavkin are with the Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, New York City. Pamela R. Wood is with the Department of Pediatrics, University of Texas Health Science Center, San Antonio. Nina S. Wampler is with the Division of American Indian and Alaska Native Programs, University of Colorado Health Science Center, Denver.

Requests for reprints should be sent to Lauren A. Smith, MD, MPH, Boston Medical Center, Department of Pediatrics, Dowling 3 South, One Boston Medical Center Pl, Boston, MA 02118 (e-mail: lauren.smith@bmc.org).

This article was accepted May 15, 2002.

Contributors

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

Acknowledgments

This work was supported by funding from the National Institute of Allergy and Infectious Diseases, National Institutes of Health (grant UOI AI39769-03S1); the Robert Wood Johnson Foundation; the Maternal and Child Health Bureau, Health Resources and Services Administration; the Open Society Institute; the Ford Foundation; the Moriah Fund; the General Service Foundation; and the Office of Population Affairs, US Department of Health and Human Services.

We wish to thank Fernando Guerra, MD, MPH, William Parry, MD, James Alexander, MD, Steven Enders, and the administrators at the San Antonio Texas Works offices, without whose assistance we would not have been able to conduct this research. We would also like to thank Monica Trevino, MSW, for her coordination of the project, along with all of the dedicated interviewers, the many clinical and agency site personnel, and the children and families who participated. We offer many thanks to Heather Smith, MPH, for her assistance with data management and in preparation of the article.

Human Participant Protection

This work was approved by the institutional review boards at Boston University Medical Center, the Columbia University School of Public Health, the University of Texas Health Science Center, and CHRISTUS Santa Rosa Hospital. All participants consented to be interviewed.

References

1. *Temporary Assistance for Needy Families Program (TANF); Final Rule.* Washington, DC: US Dept of Health and Human Services, Administration for Children and Families; 1999.

2. Heymann SJ, Earle A, Egleston B. Parental availability for the care of sick children. *Pediatrics.* 1996; 98:226–230.

3. Parrott S. Welfare recipients who find jobs: what do we know about their employment and earnings? Available at: http://www.cbpp.org/11-16-98wel.htm. Accessed August 5, 1999.

4. Heymann SJ, Earle A. The impact of welfare reform on parents' ability to care for their children's health. *Am J Public Health.* 1999;89:502–505.

5. Cancian M, Haveman R, Kaplan T, Meyer D, Wolfe B. Work, earnings, and well-being after welfare: what do we know? *Focus.* 1999;20(2):22–25.

6. Tweedie J, Reichert D, O'Connor M. Tracking recipients after they leave welfare. Available at: http://204.131.235.67/statefed/welfare/leavers.html. Accessed April 14, 2000.

7. Olson K, Pavetti L. *Personal and Family Challenges to the Successful Transition From Welfare to Work.* Washington, DC: Urban Institute; 1997.

8. Danziger S, Corcoran M, Danziger S, et al. Barriers to work among welfare recipients. *Focus.* 1999;20: 31–35.

9. Earle A, Heymann SJ. What causes job loss among former welfare recipients: the role of family health problems. *J Am Med Womens Assoc.* 2002;57: 5–10.

10. Danziger S, Corcoran M, Danziger S, et al. *Barriers to the Employment of Welfare Recipients.* Ann Arbor, Mich: University of Michigan Poverty Research and Training Center; 2000.

11. Smith LA, Wise PH, Wampler N. Knowledge of welfare reform program provisions among families with chronic conditions. *Am J Public Health.* 2002;92: 228–230.

12. *Working Toward Independence.* Washington, DC: US Dept of Health and Human Services, Administration for Children and Families; 2002.

13. Romero D, Chavkin W, Wise PH, Smith LA, Wood PR. Welfare to work? Impact of maternal health on employment. *Am J Public Health.* 2002;92: 1462–1468.

14. National Center for Health Statistics. Current estimates from the National Health Interview Survey, 1994. *Vital Health Stat 10.* 1995;No. 193.

15. Wood PR, Smith LA, Romero D, Bradshaw P, Wise PH, Chavkin W. Relationships between welfare status, health insurance status, and health and medical care among children with asthma. *Am J Public Health.* 2002;92:1446–1452.

16. *Welfare Reform: Information on Former Recipients' Status.* Washington, DC: US General Accounting Office; 1999. GAO/HEHS publication 99-48.

17. *Data Available to Assess TANF's Progress.* Washington, DC: US General Accounting Office; 2001. GAO publication 01-298.

18. Loprest P. *How Are Families That Left Welfare Doing? A Comparison of Early and Recent Welfare Leavers.* Washington, DC: Urban Institute; 2001.

19. Prendergast M, Nagle G, Goodro B. *How Are They Doing?: A Longitudinal Study of Households Leaving Welfare Under Massachusetts Reform.* Boston, Mass: Massachusetts Dept of Transitional Assistance; 1999.

20. Smith LA, Hatcher JL, Wertheimer R. The association of childhood asthma with parental employment and welfare receipt. *J Am Med Womens Assoc.* 2002; 57:11–15.

21. Kuhlthau KA, Perrin JM. Child health status and parental employment. *Arch Pediatr Adolesc Med.* 2001; 155:1346–1350.

22. Urban Institute. Profile of disability among AFDC families. Available at: http://www.urban.org/periodc/26_2/prr26_2d.htm. Accessed July 15, 1997.

23. Newacheck PW, Halfon N. Prevalence and impact of disabling chronic conditions in childhood. *Am J Public Health.* 1998;88:610–617.

24. US Dept of Health and Human Services, Administration for Children and Families. TANF: selected provisions of state plans. Available at: http://www.acf.dhhs.gov/programs/ofa. Accessed April 14, 2000.

25. *Welfare to Work: Child Care Assistance Limited; Welfare Reform May Expand Needs.* Washington, DC: US General Accounting Office; 1995.

26. *Welfare Reform: Implications of Increased Work Participation for Child Care.* Washington, DC: US General Accounting Office; 1997. GAO/HEHS publication 97-75.

27. *Child Care: States' Efforts to Expand Programs Under Welfare Reform.* Washington, DC: US General Accounting Office; 1998. GAO/T-HEHS publication 98-148.

28. Piecyk JB, Collins A, Kreader JL. *A Report of the NCCP Child Care Research Partnership: Patterns and Growth of Child Care Voucher Use by Families Connected to Cash Assistance in Illinois and Maryland.* New York, NY: National Center for Children in Poverty, Columbia University; 1999.

29. Loprest P. *Families Who Left Welfare: Who Are They and How Are They Doing?* Washington, DC: Urban Institute; 1999.

30. Garrett B, Holahan J. Health insurance coverage after welfare. *Health Aff.* 2000;19:175–184.

31. Smith LA, Wise PH, Chavkin W, Romero D, Zuckerman B. Implications of welfare reform for child health: emerging challenges for clinical practice and policy. *Pediatrics.* 2000;106:1117–1125.