

SELF-ASSESSMENT OF HEALTH AND BARRIERS TO EMPLOYMENT

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EXECUTIVE SUMMARY

Welfare recipients tend to have poorer health than the general population. Poor health itself can be a barrier to employment among the Temporary Assistance for Needy Families (TANF) caseload, but combined with other barriers, its effect may be compounded. In a 2002 TANF Caseload Survey in Maryland, three in ten (28.4%) caseheads rated their health as poor¹. Self-assessment of health is a valid source of information on an individual's health status. In fact, it has been shown to be as useful as physician-diagnoses in assessing actual health status. Therefore, this report seeks to determine if multiple barriers are more likely among clients who assessed their health as poor, and if so, what type of barriers these clients experience.

We found that clients who rated their health as poor were more likely to have indications of actual poor health. Three-fourths of caseheads with a poor health rating had a chronic health or medical condition (74.8%) and a physical functioning level below the U.S. average (74.7%). More than half (56.4%) of these caseheads reported that their health interfered with their ability to work.

On the other hand, 15.5% of caseheads with an excellent health rating had a chronic health or medical condition and one-quarter (24.9%) had a physical functioning level below the U.S. average. Only 13.4% reported that their health prohibited them from working.

Using client health status, this report examines the demographic profile, the frequency of barriers, cash assistance use, and employment participation and earnings among caseheads completing the 2002 TANF Caseload Survey.

¹ 28.4% rated their health as either fair or poor and are referred to as having a poor health rating; 27.4% rated their health as good; and 44.3% rated their health as either excellent or very good and are referred to as having an excellent health status.

Demographic Profile

Clients with poor health were eight years older, on average, at the time of the survey than those with excellent health (35 years vs. 27 years). They were also older at the birth of their first child (24 years vs. 20 years). Additionally, these clients had older children, on average, at the time of the survey (6.6 years vs. 4.1 years).

Clients with poor health were 10 percentage points less likely to live in Baltimore City (59.2% vs. 70.1%) and 13 percentage points less likely to be African American (77.8% vs. 91.1%) compared to those with excellent health.

Identified Barriers

Eight in ten (84.8%) clients in the sample had multiple barriers. Those with a poor health rating had 4.3 barriers, on average, while those with an excellent health rating had 3.1 barriers, and those with a good health rating had 3.5 barriers.

Human Capital Deficits

Clients had about one human capital deficit, on average. Regardless of health status, two in five caseheads lacked a high school degree. However, those with poor health were about 10 percentage points more likely to lack work experience than those with excellent health (26.3% vs. 17.5%).

Family and Personal Challenges

Caseheads with poor health had 2.3 family or personal challenges, on average, compared to one (0.82) barrier among those with excellent health. Three-quarters (78.5%) of clients with a poor health rating had an identified health issue, and half had a family health problem (47.5%) or a mental health problem (46.4%). One-third or less of clients with an excellent or good health rating experienced any of the nine possible family and personal challenges.

Logistical and Situational Challenges

Clients with excellent health were more likely to experience logistical and situational challenges. Specifically, they were nearly 20 percentage points more likely to have a child care issue (46.8% vs. 29.5%) and 10 percentage points more likely to have unstable housing (24.3% vs. 13.1%) compared to those with poor health.

Welfare Use

Those with poorer health had more months of cash assistance receipt than those with excellent health. In fact, they were 12 percentage points more likely to have received 49 or more months of cash assistance in the five years before the survey than those with excellent health (19.8% vs. 7.4%), and 10 percentage points more likely to have received more than two of the three follow-years (30.1% vs. 20.3%).

Employment & Earnings

Caseheads who assessed their health as poor were less likely to be employed and earned less over time. The gap in employment participation between clients with excellent health (64.2%) and those with poor health (48.7%) was only 15 percentage points in the year before the survey. Yet, by the third follow-up year, this gap had increased to 26 percentage points (88.1% vs. 61.7%). In the two years before the study month, earnings were clustered together for all clients regardless of health status. However, earnings were consistently lower for clients with poor health in the three follow-up years.

Study findings have several important implications for front-line TCA practice and program management. First and foremost and independent of how clients' assess their own health, results show that a non-trivial number of TCA families do have barriers that are not always readily apparent. Such things as domestic violence, criminal records, possible learning disabilities, or a mental health problem were not uncommon.

These may be topics that are not routinely addressed in every welfare-to-work focused interview or readily admitted to by clients, even though these issues can interfere with the clients' abilities to comply with work requirements. Another general implication of this study is that use of the simple inquiry "In general, how would you rate your own health?" with five equally straight-forward response choices (excellent, very good, good, fair, poor) could be of value to clients, case managers, and the general TCA program. Clients' answers to this question are correlated with the number and type of familial, human capital, and logistical problems present in their homes and with welfare use, employment, and earnings.

Of course, the mere presence of a barrier does not mean a client is inappropriate for welfare-to-work activities or that the client has slim odds of a successful welfare exit. On the other hand, the mere absence of an easily-identifiable barrier does not mean that other, less discernible problems are not present. Study findings suggest that use of self-assessed health could be useful as a way for front-line case managers to begin to sort clients into the most appropriate categories for their situations. At minimum, it could help identify clients who could benefit from more in-depth assessment or referral.

Clients' responses could also be indicative of families who may be at high risk of having other, perhaps unrecognized or unacknowledged problems that, if unaddressed, could cause work compliance problems for individual clients and for the state's welfare-to-work program as a whole. Use of this simple health assessment question is not a silver bullet, but, in an era of scarce resources, elevated caseloads, and inflexible federal work rules, it is an easy-to-use screening question that appears to hold promise as another tool that may enhance client and program success and facilitate the most productive allocation of work supports, job slots, and other resources.

INTRODUCTION

The 1996 welfare reform, Temporary Assistance for Needy Families (TANF) champions two key themes. The first is that cash assistance is to be a temporary source of income support. The second is that prompt engagement in activities intended to facilitate swift transitions from welfare to the workplace is generally expected of clients. Those messages have been reinforced by rules that subject most single-parent TANF families to work participation requirements.

Empirical data confirm that both the cash assistance system and client behaviors reflect the program's emphasis on work. For example, welfare spells are significantly shorter now than in the mid-1990s, and, as documented in Maryland's landmark study, *Life after Welfare*, thousands of women have been able to leave welfare for work and they have not returned (Nicoli, Logan, & Born, 2012).

Some clients' paths from welfare to work are obstructed by barriers, however. Impediments vary, but often include limited education, little or no work experience, physical and mental health problems, substance abuse, and child care and transportation issues. Some impediments are time-limited (e.g. recovering from surgery) while other are chronic (e.g., mental illness). Most families face one barrier, but more commonly, two or more are present simultaneously (Bloom, Loprest, & Zedlewski, 2011; Ovwigho, Born, Ferrero, & Palazzo, 2004).

The presence of a work barrier does not mean a client is inappropriate for welfare-to-work activities, or has slim odds of a successful welfare exit. However, the chances of success are much better if barriers and their severity are determined through individualized client assessment. The knowledge generated about unobserved as well as observed barriers makes it more likely that cases get assigned to the most appropriate work-eligible or

work-exempt category for their situations. Data from assessment allows more nuanced, realistic barrier removal plans and self-sufficiency goals to be crafted and serves as a baseline against which progress can be measured.

Assessment benefits the agency too, helping to ensure that scarce work supports, job slots, and other resources are allocated appropriately based on solid understanding of the capabilities and circumstances of clients. It allows better referral information to be given to welfare-to-work vendors, improving referral processes and the TANF agency's ability to track the provision and outcomes of vendors' services. Case sorting errors due to incomplete information can be minimized, reducing a key source of risk related to work participation rate achievement.

Maryland is near implementation of a standardized, online assessment tool—the Online Work Readiness Assessment (OWRA)—statewide. In the interim, resource constraints and elevated caseloads imply that rationing may be necessary: doing full-on assessments with high risk clients and some form of less intensive screening with all others.

This report looks at one specific screening question to see if it correlates with TANF clients' welfare and work patterns and the presence of other barriers. Positive findings would suggest this item (self-rated health status) could be a useful initial case screening device for front-line case managers. Self-rated health status is a reliable, valid measure of both objective and subjective health. As such, it could help front-line staff screen and identify clients in need of more in-depth assessment or referral. It could be generally useful as well by providing additional information to help craft the most appropriate service trajectories and independence plans for clients.

BACKGROUND

The Temporary Cash Assistance (TCA, Maryland's TANF program) population is now more diverse than it was at the beginning of welfare reform in the mid-1990s. Even within the largest client cohort—female-headed, single-parent families with children—service needs, personal resources, and self-sufficiency prospects vary considerably. The large majority of clients do have at least one impediment to employment. In order for families to successfully navigate the path from welfare to work it is essential that barriers be identified and appropriately addressed.

Client Assessment and Screening

A prerequisite to any successful effort to help a client is having sufficient information about their situation. This is essential in case managers' efforts to help TCA clients move from welfare to independence, just as it is in all other types of human services. Client screening and assessment is typically the first step in the welfare-to-work process.

Upfront client screening and assessment has been a feature of Maryland's reformed cash assistance program since its inception in 1996. This is congruent with the Maryland tradition of using data to drive decision-making in public human services programs. This includes decisions about how best to serve individual clients and how to most effectively deploy scarce program resources while achieving federal program performance mandates.

Maryland has also been a national trailblazer in this area. Among other things, the state applied for and was awarded several competitive federal grants on the topic of assessment. Relevant to today's report was a survey-based project to identify employment barriers among active TANF recipients (Ovwigo et al., 2004). The overarching finding of this and subsequent Maryland studies was that standardized,

formal assessments can more accurately and consistently identify barriers to work compared to informal methods (Hetling, Saunders, & Born, 2004; Ovwigo, Saunders, & Born, 2005).

One standardized question in the client survey asked clients to rate their own overall health on a five point scale where response choices ranged from excellent to poor. There are a number of reasons to think that this one straightforward question might have widespread utility on the TCA front-lines. In particular, there is empirical evidence to suggest that it could be a useful client screening query that may help to identify clients for whom more in-depth assessment might be beneficial before assignment to a work activity.

Among other things, the subjective belief that one is in poor health may be at least as important as one's actual health status in predicting behavior. It is probably not mere coincidence that the Urban Institute found that fully half of jobless TANF leavers in the late 1990s rated their health as being very poor (Loprest & Zedlewski, 2002). Similarly, a longitudinal study using multiple national data sources found that single mothers who reported a health problem or disability were less likely to be employed over time and less likely to move up in the earnings distribution (Hauan & Andersson, 2012). There is also considerable evidence that low-income women, and TCA recipients in particular, are more likely to face a variety of health issues than are women in the general population.

Poor Health among TANF Recipients

Poor health is common among welfare recipients. Identified physical or mental health issues occur in 20 percent to 40 percent of clients nationwide (Bloom et al., 2011; Dworsky & Courtney, 2007; Ovwigo et al., 2004). Additionally, Maryland experienced an 80 percent increase in the

number of clients with long-term disabilities in recent years (Nicoli, Passarella, & Born, 2012). Welfare clients may also face health issues that remain unidentified. Among the work-eligible population in Maryland's welfare caseload, for example, only three percent were identified with a long-term disability and yet one quarter had applied for Supplemental Security Income (Saunders, Kolupanowich, & Born, 2012).

Issues with poor health are much more prevalent among women receiving cash assistance than among women in the general population. A Michigan study found that current and recent welfare recipients had higher rates of hypertension and obesity, as well as lower levels of physical functioning in daily activities, compared with a national sample of women (Kaplan et al., 2005). While few of these welfare recipients had diagnosed health issues, they were 2.79 times more likely than woman in the national sample to self-report their health as fair or poor (39% vs. 14%).

Self-Assessment of Health

Research has found that individuals are able to accurately self-assess their general health by simply asking them to rate their overall health as excellent, very good, good, fair, or poor. This has proven to be a valid indicator for subsequent mortality and is an appropriate measure of health status for statistical use (Idler & Benyamini, 1997; McGee, Liao, Cao, & Cooper, 1999). In fact, the statistical significance of self-rated health status was greater than that of physician health ratings in predicting mortality, suggesting that individual ratings capture overall health that may be undiagnosed by physicians (Idler & Benyamini, 1997).

Additionally, responses to this self-assessment question provide a meaningful measure of health for comparison across populations, including gender, age, socio-economic status, and race/ethnicity (McGee et al., 1999; Ware, 1976). Women, African Americans, Native Americans, and those

with lower educational attainment were more likely to rate their health as fair or poor. Regardless of these differences, those who rated their health negatively were also more likely to have indications of poor health. Specifically, they spent more days in bed due to illness and had more physician visits than those who rated their health as excellent, very good, or good (McGee et al., 1999).

This self-assessment question aims to measure more than just physical health. It measures broad perceptions of health, including physical, mental, physiologic, and social health (Idler & Benyamini, 1997; Ware, 1976). When asked to assess one's health, individuals may interpret that question differently. That is, one individual may rate their health based on a traumatic event affecting their mental health, while another may rate their health based on a diabetes diagnosis. Others may rate their health based on family history of illness. Regardless of individual interpretation, its usefulness in predicting subsequent mortality makes it a relevant measure of health status. Hence, the self-assessment question is intended to be a measure of overall general health.

Barriers among the TANF Caseload

In addition to health issues, welfare recipients experience numerous other barriers to employment, such as human capital deficiencies, lack of transportation or child care, criminal histories, and domestic violence, among others. Previous studies have found more than eight in ten caseheads had at least one barrier to employment (Bloom et al., 2011; Dworsky & Courtney, 2007; Ovwigho, et al., 2004; Williamson, Saunders, & Born, 2011). Moreover, families tend to experience multiple barriers at one time. Studies have found that one-third or more of caseheads have two to three barriers, while two-fifths or more have four or more barriers (Dworsky & Courtney, 2007; Ovwigho et al., 2004).

As a requirement of the reformed welfare system, TANF, authorized by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, adult recipients of cash assistance must work or participate in a work-related activity. Lack of participation in these activities may lead to sanctioning of the family's benefits or federal penalties imposed on the state. However, families that face particular barriers may find it difficult to meet these work requirements.

Generally, those who report a barrier are less likely to be working than those who do not report any barriers. This is especially true among those who report having less than a high school education or having a physical or mental health issue. The likelihood of being employed was as much as 30 percentage points lower for caseheads that did not have a high school education and 25 percentage points lower for caseheads with a physical or mental health issue (Danziger et al., 2002; Dworsky & Courtney, 2007).

Employment participation is also diminished as the number of barriers increases. For example, in a Michigan study, 82 percent of caseheads without any barriers were likely to be employed compared to only 62 percent of those with two to three barriers and 40 percent of those with four to six barriers (Danziger et al., 2002). Not only are those with barriers less likely to be working, but they also earn less when working than those without barriers. Not surprisingly, those without a high school education had the greatest earnings deficit, followed by those caring for a disabled household member and those without work experience (Dworsky & Courtney, 2007).

Experiencing a barrier, however, does not necessarily preclude a casehead from working since some barriers—for example, transportation—can often be easily addressed by the agency. Yet, as caseheads experience multiple barriers, their effects may be compounded, making it

substantially more difficult to work, especially if particular barriers occur together. Researchers at the University of Maryland examined whether there were any patterns of co-occurring barriers. Among the most common 15 co-occurring barriers, a mental health issue was present in more than half of these relationships. It most frequently co-occurred with a child care problem, domestic violence, unstable transportation, child disability, general health, criminal history, a child under six, and unstable housing (Williamson et al., 2011). Clients with a mental health issue co-occurring with unstable transportation or a general health issue were nearly 20 percentage points less likely to be working.

Goals of this Project

In this study, we use a sample from a federally-funded Maryland study that focused explicitly on identifying the incidence of a wide range of possible work impediments—from transportation to domestic violence—among single-parent, female-headed TCA families with at least one child. The impetus for our participation in the original federal study was to gather reliable information about the frequency and type of client problems that might need to be addressed in order to facilitate successful welfare to work transitions, while our subsequent report on co-occurring barriers was intended to expand the knowledge base with a new assessment tool—OWRA.

These are also the purposes of described in today's report, albeit with a twist. The twist is that we hope to determine if one straight-forward, validated question about perceived health status is associated with how many and what type of other barriers may be present in clients' homes. The specific questions addressed are:

1. To what extent is clients' self-assessed health status associated with three other health measures from the TANF Caseload Survey?

2. How, if at all, does the demographic profile of clients and their TCA cases differ depending on self-assessed health status?
3. How many human capital, personal and familial, and situational and logistic barriers do our study families have, and do the patterns vary depending on the client's self-assessment of health?
4. Do cash assistance, employment, and earnings patterns vary depending on the self-assessed health status of the adult TCA recipient?

Commonsense suggests, and we expect, that clients who perceive themselves to be in poor health might have more barriers, perhaps more severe ones, and perhaps barriers of a different sort than clients who believe themselves to be in great health. It seems logical to also anticipate that clients

who think their health is not good might have lower rates of employment and earnings. If study results are as expected, local TCA program managers might wish to consider routinely asking the simple, but valid and reliable question: "In general, how would you rate your own health...." as part of all work-readiness assessments for single-parent, female-headed families. Responses could be indicative of clients for whom more in-depth assessment is needed as well as serve as a more general 'red flag' for families likely to have other impediments present. This additional information, in turn, could help to insure that clients are assigned to the most appropriate caseload category (e.g., work-eligible, long-term disabled) and lead to the development of more evidence-based independence plans.

METHODS

Sample

The sample for this study was randomly selected from the universe of active single-adult Temporary Cash Assistance (TCA, Maryland's TANF program) cases in June 2002 (n=15,867). Single-adult cases were defined as those having one adult grantee and at least one child included in the welfare grant. Child-only cases, two-adult households, and cases with no children receiving assistance were excluded. A sample of 1,146 cases was initially selected and 819² completed the TANF Caseload Survey. This yields a valid sample with a 95% confidence level and $\pm 5\%$ margin of error and a 71.5% survey response rate.

To allow examination of differences between Baltimore City and Maryland's 23 counties, we stratified the initial sample of 1,146 on jurisdiction, with half of the cases from Baltimore City (n=573) and half (n=573) from the 23 counties that comprise the balance of the state. In all analyses presented here, the data are weighted so that the proportion of Baltimore City cases in the final sample is equal to the proportion of Baltimore City cases in the Maryland TCA single-adult caseload. The methodology of the weights can be found in Appendix A.

Data Sources

The present study utilizes two types of data. Survey data provide information about family characteristics and barriers to employment. Administrative data are used to describe families' welfare receipt and employment outcomes.

Survey Data

To obtain detailed data on family characteristics and barriers to employment, telephone surveys were conducted using the TANF Caseload Survey instrument,

developed by Mathematica Policy Research, Inc. (MPR) with input from the six ASPE grantees participating in the study. The instrument was designed to assess current TANF families' key barriers to employment, including family composition, employment history, job training, education, earnings, child care, physical and mental health, chemical dependence, domestic violence, transportation, and neighborhood characteristics. The University of Maryland, School of Social Work also contracted with MPR to administer the survey instrument in Maryland. Interviews were conducted by MPR with 819 of the 1,146 sample families between August 19 and October 31, 2002. The survey was completed via computer-assisted telephone interviewing (CATI) and averaged 35 minutes in length. All surveys were conducted in English, and no proxies were used.

To assess if our final surveyed sample of 819 single-adult TANF families was representative of the statewide single-adult caseload, we compared the demographic characteristics and employment and welfare receipt histories of survey respondents and non-respondents utilizing data from our administrative data systems. Details of this analysis are presented in Appendix A and are from our final project report (Ovwigo et al., 2004). In general, respondents and non-respondents were quite similar. However, we did find statistically significant differences on three demographic characteristics—age, race, and marital status. Non-respondents were, on average, one and a half years older than respondents, more likely to be Caucasian and, according to the administrative data, more likely to be married. Readers may wish to keep these differences in mind when considering study findings, but we do not believe they negate or diminish the value or utility of our findings for our state's policy-makers and program managers.

² 817 caseheads responded to the question related to self-assessment of health.

Administrative Data

Findings related to welfare utilization and employment are based on administrative data retrieved and analyzed by the authors from several computerized management information systems maintained by the State. Specifically, demographic and program participation data were extracted from the Client Automated Resource and Eligibility System (CARES) and its predecessor, the Automated Information Management System/Automated Master File (AIMS/AMF). Employment data are drawn from the Maryland Automated Benefits System (MABS) and supplemented with data from the Unemployment Insurance (UI) data systems of the states bordering Maryland.

CARES

CARES became the statewide automated data system for certain DHR programs in March 1998. Similar to its predecessor AIMS/AMF, CARES provides individual and case-level program participation data for cash assistance (AFDC or TCA), Food Supplement (formerly known as Food Stamps), Medical Assistance, and other services. Demographic data are provided, as well as information about the type of program, application and disposition (denial or closure), date for each service episode, and codes indicating the relationship of each individual to the head of the assistance unit.

MABS

MABS includes data from all employers covered by the state's Unemployment Insurance (UI) law (approximately 93% of Maryland jobs). Independent contractors, sales people on commission only, some farm workers, federal government employees (civilian and military), some student interns, most religious organization employees, and self-employed persons who do not employ any paid individuals are not covered. "Off the books" or "under the table"

employment is not included, nor are jobs located in other states.

In Maryland, which shares borders with Delaware, Pennsylvania, Virginia, West Virginia, and the District of Columbia, out-of-state employment is quite common. Overall, the rate of out-of-state employment by Maryland residents (17.4%) is roughly five times greater than the national average (3.6%)³. Out-of-state employment is particularly common among residents of two very populous jurisdictions (Montgomery, 31.3% and Prince George's Counties, 43.8%), which have the 5th and 2nd largest welfare caseloads in the state. One consideration, however, is that we cannot be sure the extent to which these high rates of out-of-state employment also describe welfare recipients or leavers accurately. Also notable is the fact that there are more than 125,000 federal jobs located within Maryland and the majority of state residents live within commuting distance of Washington, D.C.

To supplement the MABS data, we incorporate data on UI-covered employment in the states that border Maryland. These data, obtained through a data sharing agreement among the participating states, did not become available until 2003 and thus, were not available during the original ASPE study, but are available in the three-year follow-up data from the following states: Delaware, New Jersey, Pennsylvania, Virginia, West Virginia, Ohio, and the District of Columbia. While the inclusion of these data provides a more comprehensive picture of leavers' post-exit employment, readers are reminded that our lack of data on federal civilian and military employment continues to depress our employment findings to an unknown extent.

³ Data obtained from U.S. Census Bureau website <http://www.factfinder.census.gov> using the Census 2000 Summary File 3 Sample Data Table QT-P25: Class of Worker by Sex, Place of Work and Veteran Status, 2000.

Finally, because UI earnings data are reported on an aggregated, quarterly basis, we do not know, for any given quarter, how much of that time period the individual was employed (i.e., how many months, weeks or hours). Thus, it is not possible to compute or infer hourly wages or weekly or monthly salary from these data. It is also important to remember that the earnings figures reported do not necessarily equal total household income; we have no information on earnings of other household members, if any, or data about any other income (e.g. Supplemental Security Income) available to the family.

Analyses

Data were analyzed using descriptive statistics. Specifically, frequency tables were created to summarize client information and measures of central tendency were used to describe client characteristics and trends. Chi-square and analysis of variance statistical methods were used to test for differences among these groups of clients based on their response to the question, “In general, would you say your overall health is . . .”. Caseheads were able to choose between five responses—excellent, very good, good, fair, and poor. For purposes of this report, we combine all excellent and very good responses into one category referred to as excellent health status. We also combine all fair and poor responses into one category referred to as poor health status.

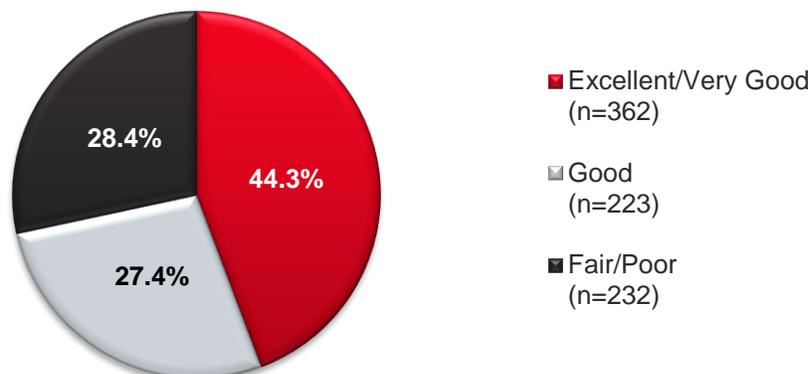
FINDINGS

Self-assessment of overall health has been found to be a valid and reliable source of information on health status, as individuals are able to accurately assess their own health when provided with specific scaled responses (Idler & Benyamini, 1997; McGee et al., 1999; Ware, 1976). This question provides information on overall health rather than focusing simply on physical health. When respondents are asked this question, it is framed broadly so that they provide information on a general concept of their health which can include physical, mental, social, and physiologic health. Figure 1 provides the responses of the 817 single-parent TCA caseheads who rated their own health. More than two in five (44.3%) rated their health as excellent and nearly three in ten rated their health as either good (27.4%) or poor (28.4%).

“Actual” Health Status

Although research has shown that self-assessment of health is a valid measure of health status, we further examine how casehead responses related to their health status as measured via other items included in the survey. We would expect caseheads who assessed their health as excellent to have few health issues while those with self-reported poor health to have other documented health issues.

Figure 1. Self-Assessment of Health



Note: Data have been weighted to be geographically representative of Maryland’s single-adult TANF caseload in June 2002.

There are three health indicators from the TANF Caseload Survey:

1. **Presence of a chronic health or medical condition** is based on self-report of any chronic conditions including, arthritis, asthma, emphysema, back problems, cancer, diabetes, fatigue, learning disability, headaches, heart condition, hepatitis, cirrhosis, high blood pressure, anxiety, obesity, seizures, and ulcers.
2. **Work interference due to own physical health** is based on the self-report of any physical health issues that interfered with the ability to work.
3. **Physical functioning below the average for the U.S. population** is based on methodology of the Physical Functioning Scale of the SF-36 Health Survey, a widely used and well-validated survey measure of general health and physical functioning (Ware, Snow, Kosinski, & Gandek, 2000). One of its advantages is that scores can be compared to age-specific national norms. It is based on the respondents’ answers to questions related to their ability to complete daily physical functions.

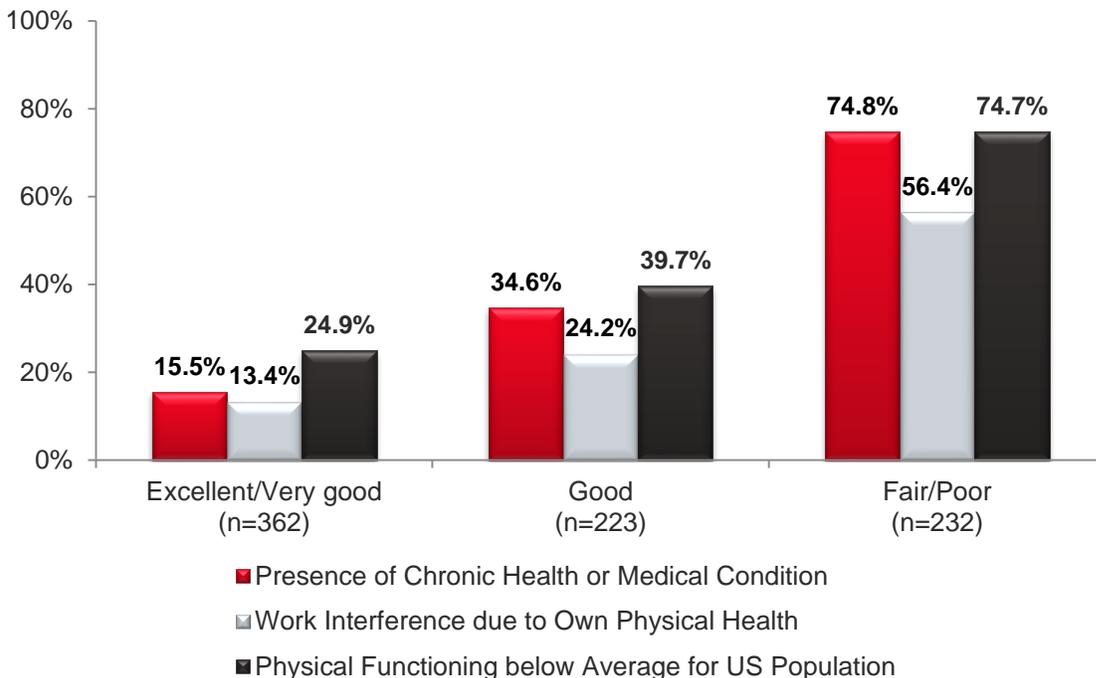
Figure 2 provides the percent of caseheads experiencing any of these health indicators by the rating of their own health. As expected, the percent of caseheads experiencing these health issues increases as the self-ratings move from excellent to poor. Specifically, three-fourths of caseheads who rated their health as poor indicated that they had a chronic health or medical condition (74.8%) and their physical functioning level was assessed below the average for the U.S. population (74.7%). More than half (56.4%) indicated that their health had interfered with their ability to work.

On the other hand, less than a quarter of those rating their health as excellent experienced any of these physical health issues. Results for clients who assessed their own health to be good were between the two extremes. It is worth noting,

however, that on all three of the health indicators, those rating their health as good had results much more in line with the results for clients who rated their health as excellent.

Based on these indicators of health, it appears that clients' assessments of their own health do correspond to their reports of particular health issues. Additionally, self-assessed health status corresponds to an independent assessment of physical functioning levels. This brief review of the relationship between self-assessment of health and indicators of actual health permit the assumption that clients with a poor health self-rating do, in fact, have poor health. Therefore, all analyses of additional barriers to employment, cash assistance receipt, and employment participation and earnings will be examined based on the client's self-assessment of health.

Figure 2. "Actual" Health by Self-Assessment Rating***



Note: Data have been weighted to be geographically representative of Maryland's single-adult TANF caseload in June 2002. Counts may not sum to total sample size due to missing data for some variables.

* p<.05, ** p<.01, ***p<.001

Demographic Profile

The sample for this study is based on the universe of active cases composed of one adult recipient and at least one child recipient, thereby excluding child-only cases, cases with two adults, and cases with no children on the grant. Based on these exclusions, the general profile of the sample casehead and case mirrors that of a single-adult with a child case from the June 2002 active caseload. The demographic information for this sample is displayed in Table 1. The typical case, then, is an African-American (84.6%) woman (96.8%) in her early 30's (mean=30.15) who resides in Baltimore City (64.6%) with her two children (mean=1.85) in which the youngest is about five years old (mean=5.05). There are differences, however, in age, race, residence, and age of the youngest child when comparing caseheads by health status.

Clients that rated their health as poor were older at the time of the survey and at the time of the birth of their first child. On average, those with a poor health rating were 35 years old at the time of the survey and 24 years old when they had their first child, while clients rating their health as excellent were 27 years old during the survey and 20 years old at the birth of their first child. Half (50.8%) of the clients with poor health ratings were 35 or older at the time of the interview compared to only 17.9% of those with an excellent health rating. The average age of clients rating their health as good (mean=29.47) fell between the other two health ratings, but closer to the average among clients who believe their health to be excellent.

Not only were clients with a poor health rating older, but they also had older children at the time of the interview. The youngest

child in these households was over six years old (mean=6.66) compared to four years old (mean=4.13) among clients rating their health as excellent. Again, the clients with a good health rating fell between the other two groups with the age of the youngest child at nearly five years old (mean=4.90). More than half (56.2%) of the children from the clients rating their health as poor were school age while nearly three-fourths (71.0%) of the children of clients rating their health as excellent were under the age of five. This certainly has implications for child care among the healthier clients, potentially affecting their ability to maintain employment.

There were fewer African-American clients and Baltimore City residents among those with poorer health. Clients with a poor health self-rating were 10 percentage points less likely to live in Baltimore City (59.2% vs. 70.1%) and 13 percentage points less likely to be African American (77.8% vs. 91.1%) compared to those with excellent health. These two indicators are likely related because Baltimore City has a larger African American population, so clients are more likely to be Caucasian when residing in one of Maryland's 23 counties.

According to this demographic profile, it appears that poor health may be related to age, which is not surprising. As people age, their health is also likely to diminish. Hence, these ratings may be expected simply based on the fact that those with a poor health rating are older; however, the average age is only 35 (with a range from 15 to 62 years) so poor health should not necessarily be expected at this average age. So, while age and poor health seem to have some connection, other factors are also likely relevant to the health of clients, as they perceive it.

Table 1. Payee & Case Demographic Profile

	Health Status							
	Excellent/Very Good (n=362)		Good (n=223)		Fair/Poor (n=232)		Total (n=817)	
Payee Gender								
Female	97.4%	(352)	96.9%	(217)	95.6%	(222)	96.8%	(791)
Payee Age***								
Younger than 25	44.9%	(163)	36.7%	(82)	19.3%	(45)	35.4%	(289)
25 to 34	37.2%	(134)	33.9%	(76)	29.9%	(69)	34.2%	(279)
35 and Older	17.9%	(65)	29.3%	(66)	50.8%	(117)	30.3%	(248)
Mean [Median]	27.42	25.00	29.47	28.00	35.07	35.00	30.15	28.00
Payee Age at Birth of First Child^{4***}								
Younger than 16	12.0%	(42)	10.7%	(23)	5.4%	(11)	9.8%	(76)
16 to 20	56.5%	(196)	52.2%	(111)	37.0%	(77)	50.0%	(384)
21 and older	31.5%	(109)	37.1%	(79)	57.6%	(120)	40.1%	(308)
Mean [Median]	20.46	19.18	21.02	19.54	24.06	21.74	21.60	19.75
Payee's Race***								
African American	91.1%	(329)	81.3%	(182)	77.8%	(180)	84.6%	(691)
Caucasian	7.8%	(28)	15.4%	(34)	18.2%	(42)	12.8%	(105)
Other	1.1%	(4)	3.3%	(8)	4.0%	(9)	2.6%	(21)
Residence**								
Baltimore City	70.1%	(254)	61.4%	(137)	59.2%	(137)	64.6%	(528)
Assistance Unit (AU) Size								
2	47.2%	(171)	45.7%	(102)	46.7%	(108)	46.6%	(381)
3	32.4%	(117)	30.3%	(68)	34.3%	(80)	32.4%	(264)
4 or more	20.4%	(74)	24.0%	(54)	19.0%	(44)	21.0%	(171)
Mean [Median]	2.89	3.00	2.88	3.00	2.77	3.00	2.85	3.00
Number of Children in AU								
1	47.2%	(171)	45.7%	(102)	46.7%	(108)	46.6%	(381)
2	32.4%	(117)	30.3%	(68)	34.3%	(80)	32.4%	(264)
3 or more	20.4%	(74)	24.0%	(54)	19.0%	(44)	21.0%	(171)
Mean [Median]	1.89	2.00	1.88	2.00	1.77	2.00	1.85	2.00
Age of Youngest Child***								
Under 1	19.3%	(70)	18.8%	(42)	14.0%	(32)	17.7%	(143)
1 to 4	51.7%	(187)	42.5%	(94)	29.9%	(68)	43.1%	(349)
5 to 9	18.1%	(65)	23.2%	(51)	28.2%	(64)	22.3%	(181)
10 to 15	9.4%	(34)	12.4%	(27)	23.0%	(52)	14.1%	(114)
16 to 18	1.4%	(5)	3.0%	(7)	5.0%	(11)	2.9%	(23)
Mean [Median]	4.13	2.51	4.90	3.19	6.66	6.25	5.05	3.48

Note: Data have been weighted to be geographically representative of Maryland's single-adult TANF caseload in June 2002. Counts may not sum to total sample size due to missing data for some variables. Valid percentages are reported. *p<.05 **p<.01 ***p<.001

⁴ Age at the birth of first child is an estimate for female payees calculated by using the payee's date of birth and the date of birth of her oldest child included in the assistance unit. If payees have other, older children who are not included in the assistance unit, our figures will understate the true rate of early child-bearing among the sample.

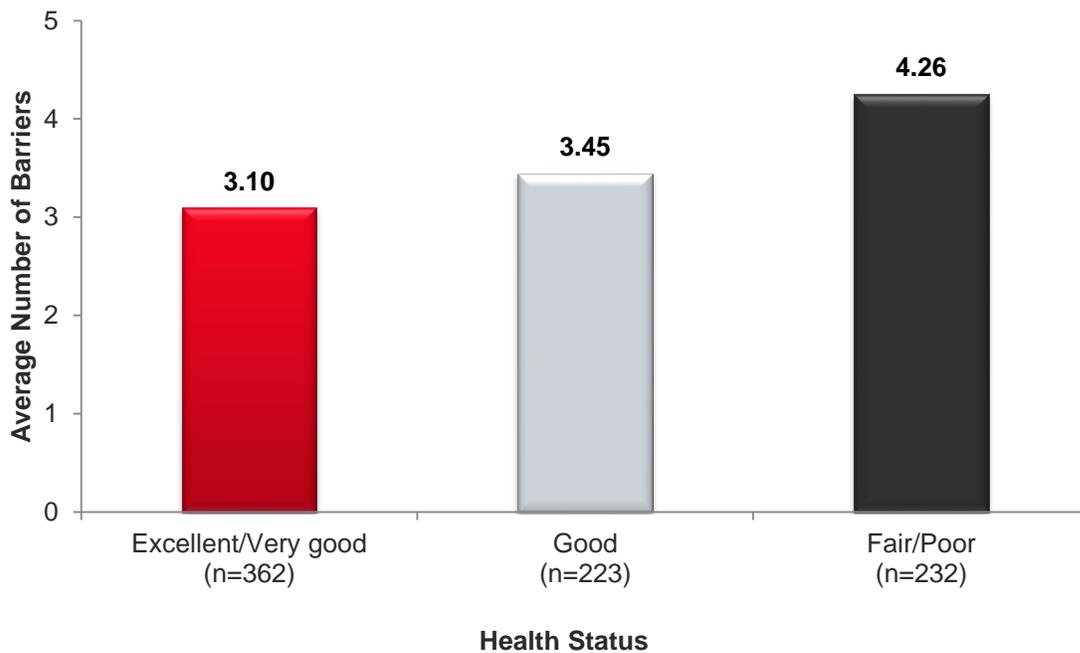
Presence of Identified Barriers by Health Status

As previous research has found, many TANF recipients have multiple barriers to employment. Based on the TANF Caseload Survey implemented in Maryland, recipients had an average of 3.9 barriers (Ovwigbo, et al., 2004). This section will examine how barriers, including multiple barriers, are related to clients' responses to the self-assessment of their general health. Are those with poorer health likely to have more barriers to employment? If so, what types of barriers are most common?

Average Number of Identified Barriers

In the findings from the TANF Caseload Survey, most (84.8%) welfare recipients in Maryland had at least two identified barriers (Ovwigbo, et al., 2004). Figure 3 examines the average number of barriers identified by the clients' health status. Generally, as we move from an excellent health self-rating to a poor rating, the number of barriers increases. Those with excellent health had 3.10 barriers, on average, compared to 4.26 barriers among those with poor health. In the next section of the report, we examine the nature of these barriers in some detail.

Figure 3. Average Number of Identified Barriers***



Note: Data have been weighted to be geographically representative of Maryland's single-adult TANF caseload in June 2002. *p<.05 **p<.01 ***p<.001

Human Capital Deficits

Individuals with limited human capital experience many barriers to employment: higher unemployment, lower earnings, poorer health, inadequate access to health benefits, and more use of the public welfare system (Bloom & Haskins, 2010; BLS, 2011). According to the Bureau of Labor Statistics (2011), the unemployment rate of average high school dropouts was 14.1% with \$451 in weekly earnings compared to an unemployment rate of 9.4% and \$638 in average weekly earnings for those with a high school diploma.

As described in Table 2, nearly three-fifths (56.1%) of all clients completing the TANF Caseload Survey had an identified human capital barrier. Three in ten (29.5%) caseheads had one identified human capital deficit, one in five (20.1%) had two human capital deficits, and less than one in ten (6.5%) had three human capital deficits. The

lack of a high school education (41.8%) was the most common human capital deficit followed by a job skill barrier (26.3%) and no work experience (21.0%).

Regardless of the health self-assessment response, most clients had an average of one human capital barrier. Those with poorer health were slightly more likely to have more human capital barriers, but the differences were not statistically significant. About two-fifths of each group lacked a high school education. A job skill barrier was identified in nearly one quarter (22.8%) of those with an excellent health rating compared to three in ten (30.2%) caseheads with a poor health rating. However, having no work experience was the only barrier that was statistically significant between the groups. One quarter (26.3%) of those with poor health ratings had no work experience compared to less than one in five (17.5%) of those with excellent health ratings.

Table 2. Identified Human Capital Deficits

	Health Status			
	Excellent/ Very Good (n=362)	Good (n=223)	Fair/Poor (n=232)	Total (n=817)
Number of Human Capital Deficits				
0	47.0% (168)	42.2% (94)	41.0% (94)	43.9% (356)
1	30.2% (108)	29.2% (65)	28.6% (66)	29.5% (239)
2	16.7% (60)	23.8% (53)	21.9% (50)	20.1% (163)
3	6.1% (22)	5.0% (11)	8.5% (19)	6.5% (53)
Mean [Median]	0.82 [1]	0.92 [1]	0.97 [1]	0.89 [1]
Type of Human Capital Deficits				
No High School Diploma	41.6% (150)	43.1% (96)	40.8% (94)	41.8% (340)
Job Skill Barrier	22.8% (82)	27.7% (62)	30.2% (70)	26.3% (214)
No Work Experience*	17.5% (63)	21.0% (47)	26.3% (61)	21.0% (171)

Note: Data have been weighted to be geographically representative of Maryland's single-adult TANF caseload in June 2002. If a casehead did not respond to all three questions related to human capital barriers, their responses were coded as missing in the count for number of human capital deficits. Due to missing data, counts may not add up to total. Valid percentages are reported. *p<.05 **p<.01 ***p<.001

Family and Personal Challenges

The stress of family and personal challenges can certainly affect a casehead's ability to work. The number of hours a casehead can work may be limited by the need to care for a child with health issues, or a casehead may not be able to obtain employment if there is a criminal history. In Table 3, we explore the extent to which the following nine personal and familial barriers were present among clients completing the TANF Caseload Survey: health problems, family health problems, mental health problems, drug or alcohol dependency, domestic violence, being pregnant, a potential learning disability, difficulty with English, or a criminal record.

On average, clients completing the survey had 1.31 personal challenges. One-third (32.6%) of clients did not have any of these challenges, yet more than one-third (36.0%) had two or more such challenges. The most common personal challenges were family health problems (33.5%), mental health problems (28.9%), and physical health problems (20.9%). Also, one in seven caseheads had a domestic violence issue (14.3%) or a criminal record (14.1%), and more than one in ten had a possible learning disability (11.0%).

Clients rating their health as excellent or good had about one personal challenge, on average, but clients rating their health as poor had 2.27 personal challenges, on average. Nearly half (46.1%) and one-third (33.5%) of those with an excellent or good health rating, respectively, had no identified personal challenges, compared with only five percent (5.4%) of those with a poor health rating. Two-fifths (40.0%) of those with poorer health had three to eight personal challenges.

Among those with a poor health status, nearly four in five (78.5%) had a health problem and nearly half had a family health problem (47.5%) or a mental health problem

(46.4%). No more than one-third of clients with an excellent or good health rating were identified with any of these three health issues. However, a family health problem and mental health issue were the greatest two identified barriers among these more positive health rating groups. The percent of clients that may have a learning disability is also statistically significant. Less than five percent (4.2%) of healthier clients may have a learning disability, but one in ten (10.3%) of those with a good health rating may have one, and nearly one-quarter (22.3%) of those with a poor health rating may have a learning disability.

These findings may warrant particular attention going forward. They clearly indicate that a non-trivial number of adults in single-parent, generally work-eligible, TCA cases have work impediments that may not be readily apparent or, necessarily, identified in routine assessment interviews. While one in three clients did not report any of these personal or familial challenges at the time of the survey, others were not as fortunate, particularly those who had rated their own health as poor. Two-fifths of this latter group, to illustrate, appeared to have at least three of these nine issues present in their homes. In addition, several of the problems commonly present in sample cases are not easily resolved. Among these is mental health, an issue present in almost three of every ten cases and in nearly one of every two cases in which the client believed herself to be in poor health.

Another less visible and tractable problem affecting study families—especially those with self-assessed poor health—is possible learning disabilities, a potential issue in one in five clients with a poor health self-rating. As Table 3 also makes clear, regardless of how the adult rated her own health, the rates of two other often hidden or imperceptible problems—domestic violence and having a criminal record—are higher than in the general population, affecting one in seven sample families.

Table 3. Identified Personal and Family Challenges

	Health Status			
	Excellent/ Very Good (n=362)	Good (n=223)	Fair/Poor (n=232)	Total (n=817)
Number of Personal & Family Challenges***				
0	46.1% (154)	33.5% (71)	5.4% (9)	32.6% (235)
1	35.0% (117)	34.1% (72)	21.2% (37)	31.4% (227)
2	13.4% (45)	22.2% (47)	33.5% (58)	20.8% (150)
3 to 5	5.4% (18)	10.1% (22)	37.3% (65)	14.5% (105)
6 to 8	0.0% (0)	0.0% (0)	2.7% (5)	0.7% (5)
Mean [Median]	0.82 [1]	1.11 [1]	2.27 [2]	1.31 [1]
Types of Personal & Family Challenges				
Health Problems ^{5***}	0.0% (0)	0.0% (0)	78.5% (166)	20.9% (166)
Family Health Problems***	24.8% (87)	33.3% (74)	47.5% (105)	33.5% (267)
Mental Health Problem***	17.4% (62)	29.2% (64)	46.4% (105)	28.9% (232)
Chemical Dependence	3.7% (13)	5.4% (12)	6.6% (15)	5.0% (41)
Domestic Violence	13.0% (47)	14.4% (32)	16.4% (38)	14.3% (116)
Pregnant	5.8% (21)	5.6% (12)	2.7% (5)	5.0% (38)
Possible Learning Disability***	4.2% (15)	10.3% (23)	22.3% (50)	11.0% (88)
Difficulty with English**	0.4% (1)	0.3% (1)	3.0% (7)	1.1% (9)
Criminal Record	14.1% (51)	13.4% (30)	14.8% (34)	14.1% (115)

Note: Data have been weighted to be geographically representative of Maryland's single-adult TANF caseload in June 2002. If a casehead did not respond to all questions related to personal and family challenges, their responses were coded as missing in the count for number of personal and family challenges. Due to missing data, counts may not add up to total. Valid percentages are reported. *p<.05 **p<.01 ***p<.001

⁵ A casehead was defined to have a physical health problem if self-assessment of health was poor or fair and the physical functioning was in the lowest quartile.

Logistical and Situation Challenges

The final set of barriers reviewed in this report is logistical and situational challenges. While these challenges can certainly impede work, they can be temporary barriers if addressed properly. For example, having an issue with accessing child care can be addressed through a child care subsidy provided via the federal block grant, Child Care and Development Fund (CCDF). An issue with transportation can be resolved with vouchers for clients residing in areas with public transportation, and unstable housing may be addressed through collaborative work with the local housing agency. Knowledge of these challenges will allow caseworkers to either provide the resources necessary to resolve the barrier or provide a referral to another agency that can do so. Table 4 displays the extent to which logistical and situational challenges are a barrier to employment for caseheads completing the TANF Caseload Survey.

Clients were identified with 1.58 logistical challenges, on average, and one-third (32.5%) had only one challenge while half (49.4%) had multiple challenges. More than half (56.4%) of caseheads resided in a bad neighborhood, defined as a casehead perceiving at least one of four neighborhood conditions as a big problem. Issues with child care were identified by two-fifths (41.0%) of caseheads followed by a transportation problem (25.9%) and unstable housing (20.1%).

While not statistically significant, the clients with an excellent health rating had slightly more logistical challenges than those with a poor health rating (1.60 barriers vs. 1.54 barriers). However, they were significantly more likely to have a child care issue, likely related to the younger age of their children. Nearly half (46.8%) of caseheads with an excellent health rating and two-fifths (43.8%) of those with a good health rating had a child care problem, compared to three in ten (29.5%) caseheads with a poor health rating. Furthermore, the caseheads with an excellent health rating were more likely to have unstable housing compared to those with poor health (24.3% vs. 13.1%).

For the most part, Table 4 suggests there are no differences in the number of logistical and situational barriers by the adult's perception of her own health status. Moreover, the main difference across groups—issues with child care—is almost certainly an artifact of age differences among the children in the groups, rather than an issue that is independently associated with the adult's health status. Child care problems were reported significantly more often by women in the excellent and good health status groups, but these women are also significantly younger and have younger children than do the women in the poor health group where child care problems were fewer in number. The general conclusion we draw from these findings is that situational and logistical challenges faced by single-parent TCA families are generally the same and do not appear to be associated with how the adult perceives her own health to be.

Table 4. Identified Logistical and Situational Challenges

	Health Status			
	Excellent/ Very Good (n=362)	Good (n=223)	Fair/Poor (n=232)	Total (n=817)
Number of Logistical & Situational Challenges				
0	15.3% (51)	23.5% (48)	17.7% (38)	18.2% (138)
1	32.9% (109)	25.6% (53)	38.5% (83)	32.5% (245)
2	28.9% (96)	26.6% (55)	20.4% (44)	25.9% (195)
3	16.5% (55)	18.2% (38)	16.9% (37)	17.1% (129)
4 to 5	6.3% (21)	6.1% (13)	6.6% (15)	6.4% (48)
Mean [Median]	1.60 [1]	1.57 [2]	1.54 [1]	1.58 [1]
Type of Logistical & Situational Challenges				
Child Care Problems***	46.8% (168)	43.8% (98)	29.5% (68)	41.0% (333)
Unstable Housing**	24.3% (88)	20.5% (46)	13.1% (30)	20.1% (164)
Transportation Problem	22.6% (81)	28.2% (63)	28.9% (67)	25.9% (210)
Bad Neighborhood Conditions*	53.5% (183)	53.5% (111)	63.5% (139)	56.4% (433)
Any Discrimination	16.7% (59)	15.4% (34)	22.9% (52)	18.1% (146)

Note: Data have been weighted to be geographically representative of Maryland's single-adult TANF caseload in June 2002. If a casehead did not respond to all questions related to logistical and situational challenges, their responses were coded as missing in the count for the number of logistical and situation challenges. Due to missing data, counts may not add up to total. Valid percentages are reported. *p<.05 **p<.01 ***p<.001

Welfare Use

Intuitively, we would expect caseheads with more barriers to have received more months of cash assistance due to potential effects on employment. Receipt of benefits may also be influenced by the type of identified barriers, in that caseheads with child care problems may have less receipt than those with mental health issues. Receipt may also be affected by how cases are designated: caseheads exempted from work due to a barrier such as a long-term disability may have more months of receipt compared to a work-eligible case that will be sanctioned if the casehead is not compliant with work requirements.

In the previous section, we found that clients who self-assessed their health as poor have more barriers and these barriers tend to be personal and family challenges that may be difficult to discern and ameliorate. In contrast, clients who self-assessed their health as excellent have fewer barriers and their barriers are more likely to be logistical challenges that can be resolved at the agency level. With this in mind, the next two figures will examine the receipt of Temporary Cash Assistance (TCA, Maryland's TANF program) by self-assessed health status.

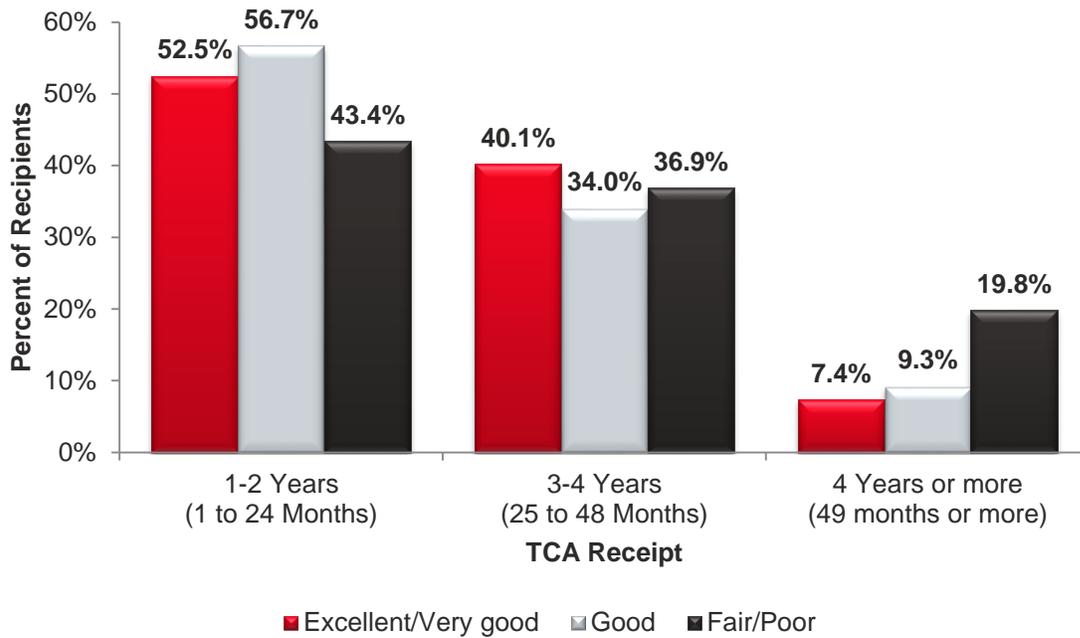
Figure 4 provides the TCA receipt of caseheads in the five years before the TANF Caseload Survey (June 1997 to July 2002). This receipt does not have to occur consecutively; rather, we are examining the total number of months of receipt over this five year period. More than half of those with an excellent (52.5%) and a good (56.7%) health rating had short-term TCA receipt of one to two years. Between one-third and two-fifths of all groups received

three to four years of TCA. However, nearly one-fifth (19.8%) of those with a poor health rating received 49 or more months of TCA compared to less than 10 percent of those with an excellent health rating (7.4%) and those with a good health rating (9.3%).

Figure 5 provides cumulative TCA receipt in the three years after the TANF Caseload Survey (September 2002 to August 2005). Nearly half of the caseheads with an excellent (47.3%) or good (47.4%) health rating received 12 months or less of TCA in the three years after the survey compared to 37.7% of those with a poor health rating. About one-third of all three groups received between 13 and 24 months of TCA. Three in ten (30.1%) caseheads with a poor health rating received TCA for more than two of the three follow-up years compared to two in ten caseheads rating their health as excellent (20.3%) or good (22.6%).

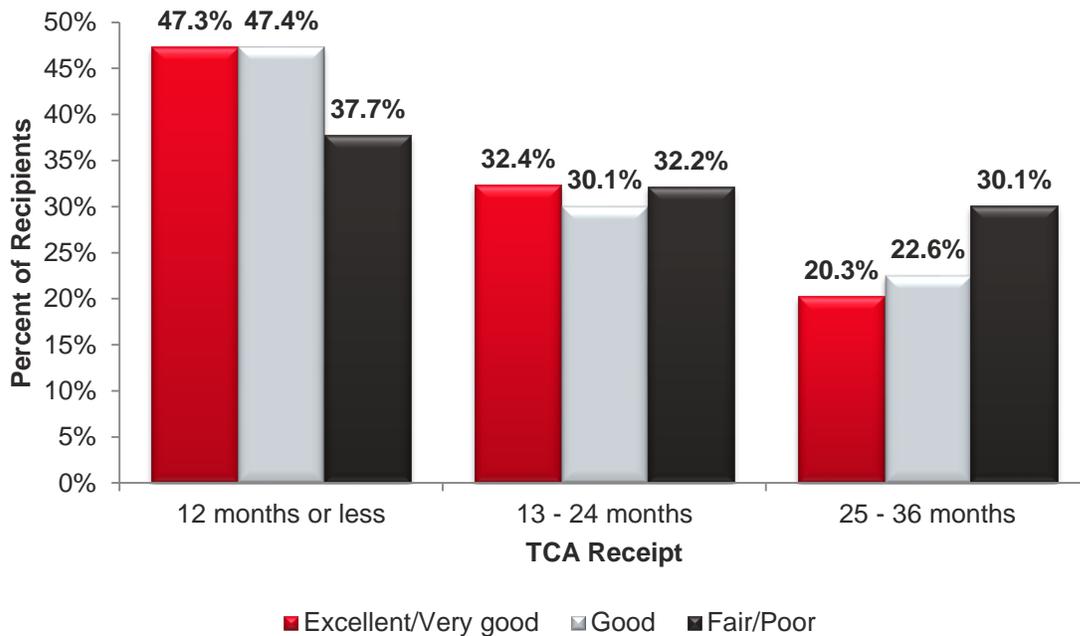
There are many disparate factors that influence or are associated with patterns of welfare receipt. These range from the 'boom or bust' state of employment opportunities available at any given point in time to cash assistance eligibility rules, benefit levels, and program requirements, as well as, personal, child, or family troubles, lack of job skills, and limited education, among others (see, for example, Nicoli et al., 2012). The perceived and actual health status of the mother is also a factor, of course, but as Figures 4 and 5 suggest, poor health appears to primarily matter at the longer-term end of the welfare utilization scale. Women who rated their health as poor are significantly more likely to have more months of welfare receipt in both the four years prior to our survey and in the three years following it.

Figure 4. TCA Receipt in the Previous Five Years by Health Status***



Note: Data have been weighted to be geographically representative of Maryland's single-adult TANF caseload in June 2002. Valid percentages are reported. * $p < .05$ ** $p < .01$ *** $p < .001$

Figure 5. TCA Receipt in the Three Follow-up Years by Health Status*



Note: Data have been weighted to be geographically representative of Maryland's single-adult TANF caseload in June 2002. Valid percentages are reported. * $p < .05$ ** $p < .01$ *** $p < .001$

Employment and Earnings

Thus far, the findings have shown that caseheads with a poor health status are likely to have more barriers and more personal and family challenges while those with an excellent health self-rating have fewer barriers and are more likely to have barriers that can be addressed via agency intervention. Hence, we expect lower employment participation among those with poor health.

Figure 6 provides employment participation from two years before the survey to three years after the survey by health status. Those with a poor health rating had significantly lower employment participation in all time periods. Their employment participation was between 15 percentage points (in the previous year) and 26 percentage points (in the third follow-up year) lower than clients with excellent health.

Nonetheless, all three groups saw a decline in employment participation between the previous two years and the previous year. Eight in ten (81.6%) caseheads with excellent health were working in the previous two years, however employment decreased by nearly 20 percentage points in the previous year to 64.2%. Employment among clients with good health decreased by nearly 20 percentage points as well, from 74.3% to 55.6%. The decline was less severe for caseheads with poor health, from 60.3% to 48.7% (11.6 percentage points), however employment participation continued to decline into the first follow-up year while the other two groups began to see an increase.

Employment participation among those with excellent and good health began to increase in the first follow-up year, and by the second follow-up year, employment participation was on par with participation in the previous two years. Employment continued to increase into the third follow-up year, in which nearly nine in ten (88.1%) caseheads with an excellent health rating and nearly

eight in ten (78.5%) caseheads with a good health rating were employed.

Those with poor health, on the other hand, saw a much slower pace of growth over this period. An increase in employment participation did not begin until the second follow-up year, but this rate was still lower than that from the previous two years (57.6% vs. 60.3%). Employment participation was almost the same as the previous two years in the third follow-up year with employment at 61.7% (compared to 60.3% in the previous two years).

Earnings do not follow the same clear path, but those with poor health generally earn less than the other two groups. Figure 7 provides median quarterly earnings from two years prior to the TANF Caseload Survey to three years after the survey. Since mean, or average, earnings can be affected by very high or low wages, we provide median earnings. The median provides the point at which half of the sample is above a particular earnings amount and half of the sample is below that earnings amount.

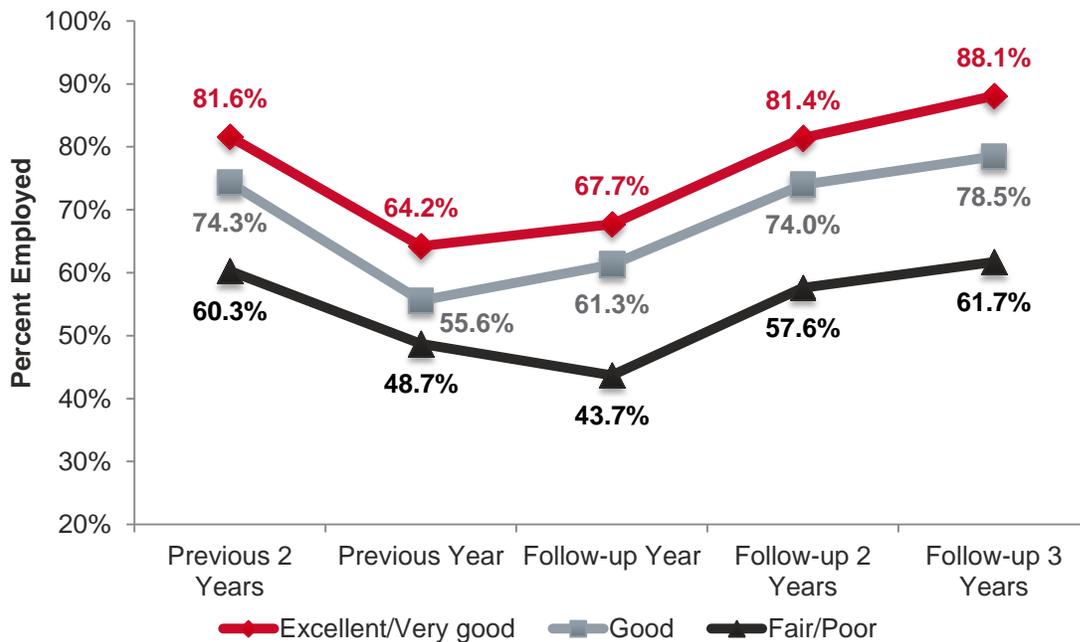
In the first two time periods, all three groups have earnings clustered together. In the previous two years, median quarterly earnings were \$1,044 for those with excellent health and \$1,237 for those with good health; earnings for those with poor health were between the other groups at \$1,141. In the previous year, all three groups experienced a decline in median quarterly earnings and were each around \$900. In the first follow-up year, however, earnings increased for all three groups, and were higher than they were in the previous two years. Each group saw a subsequent decline in earnings in the second follow-up year and an increase in the third follow-up year; nevertheless the pattern remains that those with good health had the highest earnings followed by the caseheads with excellent health. Clients with poor health had the lowest earnings in all three follow-up years.

These employment and earnings show peaks and valleys for all clients, regardless of how well or poorly they perceive their own health to be. Still, the general finding is the same for both variables and at all measuring points: clients who rate their own health as being poor tend to fare less well than other clients. The employment participation data lead to a straightforward, if not terribly surprising finding: the better a client feels about their health status, the more likely she is to work. For the most part,

the quarterly earnings data paint the same picture.⁶

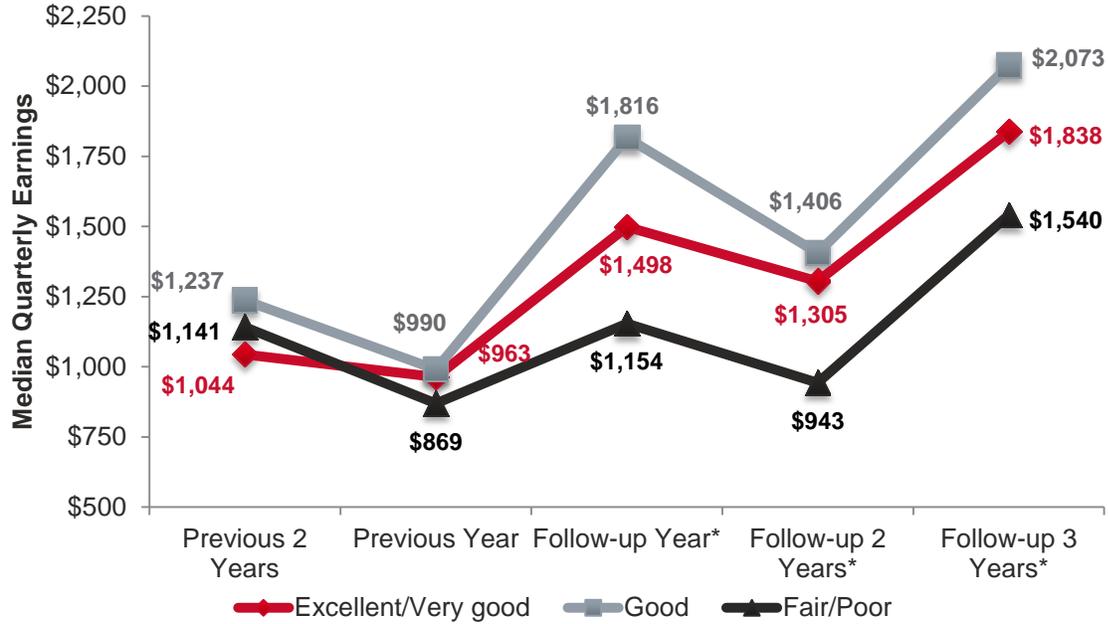
⁶ The pre-survey dips in employment and earnings for all three groups of clients are almost certainly related to the fact that all women in our sample were all on TCA at the time of the survey, and for the most part, had come onto welfare within the past 12-24 months. Regardless of the women's self-health assessment, therefore, the dips are most likely related to the event that precipitated their cash assistance applications, not to their health status per se.

Figure 6. Employment Participation by Health Status***



Note: Data have been weighted to be geographically representative of Maryland's single-adult TANF caseload in June 2002. Valid percentages are reported. *p<.05 **p<.01 ***p<.001

Figure 7. Median Quarterly Earnings by Health Status



Note: Data have been weighted to be geographically representative of Maryland's single-adult TANF caseload in June 2002. Earnings figures include only those working at least one quarter during the time period. Valid percentages are reported. *p<.05 **p<.01 ***p<.001

CONCLUSIONS

This report examined whether the responses to a casehead's self-assessment of health would shed light on additional barriers to employment. We assumed that caseheads who rated their own health as either fair or poor would also have more barriers than those caseheads who rated their health as either excellent, very good, or good. The findings within this report point to the fact that caseheads with poorer health seemed to experience more difficulties. Not only did these caseheads have a health issue, but they had additional barriers which were more likely to require long-term solutions. Caseheads with poor health were more dependent on cash assistance and less likely to be employed. Among those who were employed, earnings were low.

Caseheads with a fair or poor health rating had about four barriers, on average, while those with a more positive self-assessment of health had three barriers. Furthermore, those with lower health ratings were more likely to have a physical or mental health issue and more likely to have a family member with a health issue. On the other hand, caseheads with an excellent or very good health rating were more likely to have a logistical barrier, such as a child care or transportation problem. These logistical barriers have the potential to be quickly resolved via agency intervention, while health issues, if they can be improved, require more time and effort on the part of the agency and the casehead.

Health status was also related to the receipt of cash assistance, employment

participation, and earnings. Clients with a poor or fair health rating were 10 percentage points more likely to have received 49 or more months of TCA in the five years prior to the TANF Caseload Survey and to have received more than two of the three follow-up years than those with an excellent or very good health rating. No more than three in five caseheads with a poor or fair health status were working at any point during the study period, compared to four in five caseheads with an excellent or very good health rating. Furthermore, caseheads with poor health had lower quarterly earnings than caseheads with better health, earning about \$500 less.

Understanding that individuals are able to accurately assess their own health and that this self-assessment also may have a relationship with the number and type of other barriers to employment, can provide caseworkers with a way to determine which clients may need additional support. Clients who self-assess their health as fair or poor should always have further assessment of barriers, as it is likely there will be additional barriers that need to be addressed in an independence plan. This finding does not suggest that those with an excellent, very good, or good health rating do not have barriers or should not receive full assessments. In fact, these clients are likely to have logistical barriers that the agency will need to address. However, this finding does suggest that work is probable among clients with a positive self-assessment of health, while those with poor health may need to have other, significant barriers removed before work is an option.

REFERENCES

- Bloom, D., Loprest, P.J., & Zedlewski, S.R. (2011, August). *TANF recipients with barriers to employment* (Brief No. 01). Washington, DC: Urban Institute and Office of Planning, Research and Evaluation, Administration of Children and Families.
- Bloom, D., & Haskins, R. (2010). "Helping high school dropouts improve their prospects." *The Future of Children*, 20(1), 89-108. Princeton: Princeton-Brookings.
- Bureau of Labor Statistics. (2011). *Current Population Survey*. Washington, D.C.: Author.
- Danziger, S., Corcoran, M., Danziger, S., Heflin, C., Kalil, A., Levine, J., Rosen, D., Seedeltd, K., Siefert, K., & Tolman, R. (2002). *Barriers to the employment of welfare recipients*. Ann Arbor, MI: University of Michigan.
- Dworsky, A. & Courtney, M.E. (2007). Barriers to employment among TANF applicants and their consequences for self-sufficiency. *Families in Society*, 88(2), 379-389.
- Hauan, S. & Andersson, F. (2012). *Work histories and employment outcomes of single mothers*. Washington: D.C.: Office of the Assistant Secretary for Planning and Evaluation, Office of Human Services Policy – U.S. Department of Health and Human Services.
- Hetling, A., Saunders, C., & Born, C.E. (2004). "Missing" domestic violence victims in welfare caseloads: *The discrepancy between survey and administrative disclosure rates*. Baltimore: University of Maryland, School of Social Work.
- Idler, E.L. and Benyamini, Y. (1997). Self-rated health and mortality: A review of twenty-seven community studies. *Journal of Health and Social Behavior*, Vol. 38 (March): 21-37.
- Kaplan, G., Siefert, K., Ranjit, N, Raghunathan, T., Young, E., Tran, D., Danziger, S., Hudson, S., Lynch, J., & Tolman, R. (July 2005). The health of poor women under welfare reform. *American Journal of Health*, Vol. 95: 1252-1257.
- Loprest, P. & Zedlewski, S. (2002). Making TANF work for the hard to serve. *Assessment the New Federalism*, (2). Washington, D.C.: The Urban Institute.
- McGee, D.L., Liao, Y., Cao, G., Cooper, R.S. (1999). Self-reported health status and mortality in a multiethnic US cohort. *American Journal of Epidemiology*, Vol. 149(1): 41-46.
- Nicoli, L.T., Passarella, L.L., & Born, C.E. (2012). *Life on Welfare: Trends in the TCA caseload since the Great Recession*. Baltimore: University of Maryland, School of Social Work.
- Owigho, P.C., Born, C.E., Ferrero, A, & Palazzo, C. (2004). *Life on Welfare: The active TANF caseload in Maryland*. Baltimore: University of Maryland, School of Social Work.
- Owigho, P.C., Saunders, C., & Born, C.E. (2005). *Barriers to independence among TANF recipients: Comparing caseworker records & client surveys*. Baltimore: University of Maryland, School of Social Work.
- Saunders, C., Kolupanowich, N., & Born, C.E. (2012) *Maryland RISE: A first look at participants, activities & outcomes*. Baltimore: University of Maryland, School of Social Work.
- Ware, J. (1976). *The reliability and validity of general health ratings*. Santa Monica, CA: The Rand Corporation.

Ware, J.E., Snow, K., Kosinski, M., & Gandek, B. (2000). *SF-36 health survey manual and interpretation guide*. Boston: New England Medical Center.

Williamson, S., Saunders, C. & Born, C.E. (2011). *Online work readiness assessment: Barriers to work and post-assessment experiences*. Baltimore: University of Maryland, School of Social Work.

APPENDIX A: CALCULATION OF WEIGHTS

To ensure that the reported results accurately reflect the universe of Maryland work-mandatory TANF cases, we base our analyses on weighted data. The original sample was stratified on jurisdiction, with half of the cases originating from Baltimore City and the remaining half from the 23 counties that comprise the balance of the state. The final survey weights correct for this stratification. Specifically, we used normative weighting. Baltimore City cases are weighted by a factor of 1.3069306, and County cases by 0.7012048. These weights ensure that, in the final sample, Baltimore City represents 64.5% of the total, as it does in the June 2002 single-adult TANF caseload.

Although we found some statistically significant differences between survey respondents and non-respondents, we chose not to attempt correcting these

differences through weighting. We based this decision on two factors. First, such weighting assumes that if you correct for known sample differences on factors such as ethnicity and age, you will automatically correct for unknown sample differences on factors not measured by the survey. We did not believe this assumption is justified, and were concerned that, in attempting to correct for some differences, we would create others.

Second, the ultimate test of the representativeness of the survey sample is a comparison with the population of interest, not the sub-group of non-respondents. Our administrative data allow such a comparison. As can be seen in Table A-1, we find little difference between our survey respondents and the universe of Maryland work mandatory TANF cases in June 2002.

Table A1

	Weighted Respondents (N=819)	Universe (N=15,867)	Difference
Payee age			
Under 18	0.0%	0.1%	-0.1
18-20	8.0%	6.8%	1.2
21-25	28.9%	26.7%	2.2
26-30	17.3%	18.7%	-1.4
31-35	15.8%	16.1%	-0.3
36 and older	30.1%	31.6%	-1.5
Mean	30.5	30.9	-0.4
Standard Deviation	9.1	9.0	
Residence			
Baltimore City	64.5%	64.5%	0
County	35.5%	35.5%	0
Race			
African American	86.1%	83.8%	2.3
Caucasian	13.1%	14.8%	-1.7
Other	0.9%	1.4%	-0.5
Marital Status			
Divorced	3.1%	3.4%	-0.3
Married	3.0%	2.7%	0.3
Never Married	84.6%	81.5%	3.1
Separated	8.3%	11.2%	-2.9
Unknown	0.5%	0.7%	-0.2
Widowed	0.3%	0.5%	-0.2
Gender			
Female	96.8%	96.6%	0.2
Male	3.2%	3.4%	-0.2
Age at First Birth			
Under 16	9.8%	8.4%	1.4
16	8.8%	9.3%	-0.5
17	12.0%	11.2%	0.8
18	11.7%	12.6%	-0.9
19	9.6%	10.9%	-1.3
20	8.0%	8.5%	-0.5
21-25	20.7%	20.8%	-0.1
26-30	10.3%	10.1%	0.2
31 and over	9.3%	8.1%	1.2
Mean	21.6	21.5	0.1
Standard Deviation	5.8	5.5	
Size of AU			
2	46.5%	45.2%	1.3
3	32.3%	29.3%	3.0
4 or more	21.2%	25.5%	-4.3
Mean	2.9	3.0	-0.1
Standard Deviation	1.1	1.2	

	Weighted Respondents (N=819)	Universe (N=15,867)	Difference
Number of Children			
1	46.5%	45.2%	1.3
2	32.3%	29.3%	3.0
3	14.1%	15.3%	-1.2
4	4.8%	6.4%	-1.6
5	1.2%	2.3%	-1.1
6 or more	1.2%	1.6%	-0.4
Mean	1.9	2.0	-0.1
Standard Deviation	1.1	1.2	
Age of Youngest Child			
Less than 12 months	17.6%	17.3%	0.3
1 year	16.7%	15.8%	0.9
2 years	12.7%	12.1%	0.6
3 years	7.4%	8.2%	-0.8
4 years	6.3%	6.5%	-0.2
5-9 years	22.4%	21.6%	0.8
10-15 years	14.0%	15.7%	-1.7
16-18 years	2.9%	2.8%	0.1
Mean	5.0	5.2	-0.2
Standard Deviation	4.5	4.6	

APPENDIX B: BARRIER DEFINITIONS

Actual Physical Health	
Presence of Chronic Health or Medical Condition	Self-report of any chronic conditions including, arthritis, asthma, emphysema, back problems, cancer, diabetes, fatigue, learning disability, headaches, heart condition, hepatitis, cirrhosis, high blood pressure, anxiety, obesity, seizures, and ulcers.
Work Interference-Own Physical Health	Self-report of any physical health issues that interfered with the ability to work.
Physical Functioning below US Average	Methodology of the Physical Functioning Scale of the SF-36 Health Survey, incorporating norms based on age and gender.
Human Capital Deficits	
No High School Diploma	Self-report by respondent.
Job Skill Barrier	Respondent has not performed at least four common job skills, such as speaking with customers, reading instructions, writing letters/memos, word process/data entry, filling out form, etc.
No Work Experience	Self-report that respondent has not been employed at all since turning 18.
Personal & Family Challenges	
Presence of Health Problems	Following the methodology of the University of Michigan's Women's Employment Study, a casehead was defined to have a physical health problem if self-assessment of health was poor or fair and physical functioning was in the lowest quartile.
Family/Friend with Health Problems	Self-report that respondent has a child with health, behavioral, or special needs or respondent is caring for an elderly, disabled, or sick family member or friend.
Mental Health Problem	Defined as either having a high level of nonspecific psychological distress based on the K10 psychological distress scale and norm referenced from the Australian Survey of Mental Health and Well Being OR a probable major depression determined following the methodology of the composite International Diagnostic Interview Short Form (CIDI-SF) where individuals with 3 or more of 7 symptoms of major depression are classified as being at risk of major depression.
Chemical Dependence	Determined following the methodology of the Composite International Diagnostic Interview Short Form (CIDI-SF) where individuals with 3 or more of 7 symptoms of alcohol (or drug) dependence are classified as being at risk of alcohol (or drug) dependence.
Domestic Violence	Self-report by respondent that there has been severe physical violence (hitting, beating, choking, using or threatening use of a weapon, or forcing sexual activity) in the past year.
Pregnant	Self-report that respondent is currently pregnant.
Possible Presence of Learning Disability	At risk of having a learning disability based on the Washington State Learning Needs Screening Tool; it is not a diagnostic tool, but rather indicates that the possibility of a learning disability.
Difficulty with English	Self-report that respondent has difficulties speaking, reading, or writing English because English is not the native language.
Criminal Record	Self-report that the respondent has a criminal record.
Logistical & Situational Challenges	
Child Care Problems	Self-reported problems that prevented casehead from participating in work, education, or training during the past year.
Unstable Housing	Self-report of an eviction or moving two more times in the past year.
Transportation Problem	Self-reported problems that prevented casehead from participating in work, education, or training during the past year.
Bad Neighborhood Conditions	At least one neighborhood characteristic is perceived by casehead to be a big problem.
Any Discrimination	Self-report that respondent has experienced any discrimination.