

ILL-PREPARED FOR THE LABOUR MARKET: HEALTH STATUS IN A SAMPLE OF SINGLE MOTHERS ON WELFARE

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Abstract

This paper presents the results of a survey of the health of a group of lone mothers receiving the Domestic Purposes Benefit who were not exempt from work test for any reasons related to their health, to introduce a discussion of the potential ramifications of work activation policy for the health and wellbeing of lone mothers on welfare. The survey data indicate that the self-reported health status of those women who took part in the survey is very low in comparison with national data for New Zealand women. The results not only bring into question the basis on which fitness for work is assessed by welfare agencies, but, perhaps more importantly, necessitate a consideration of the potential of work activation policies to exacerbate the discrepancy in health outcomes between lone mothers and the rest of the population.

INTRODUCTION

An increasing insistence on welfare support being attached to conditions of work training and readiness has been accompanied by a discourse that both emphasises individualised notions of responsibility, and views this responsibility as a marker of a good relationship between all citizens and the state. "Welfare to work" or "activation" policies targeting sole mothers are also promoted on the grounds that the transition from welfare receipt to paid employment will be good for the state as well as good for the women themselves.

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While impediments to sole mothers' participation in the labour market are recognised, the framing of those terms is usually limited to the discussion of financial barriers and lack of child support. The extremely poor health status of sole mothers in particular, and long-term welfare recipients in general, is given inadequate consideration. The most recent discussion of sole-parent employment patterns in New Zealand (Goodger and Larose 1999), for instance, does not mention that health status may be a contributory factor.

The existence of persisting health inequalities in New Zealand has been clearly documented (Pomare 1995, Ministry of Health 1999a, Howden-Chapman and Tobias 2000). Poor health outcomes are not only associated with unemployment, low income, and low levels of education, but the evidence that the health experience of New Zealanders is divided along ethnic lines has been steadily accruing over the past 20 years (Pomare 1995, Howden-Chapman and Tobias 2000, Te Puni Kōkiri 2000). The National Advisory Committee on Health and Disability has concluded that income is the single most important determinant of health in New Zealand (National Health Committee 1998). The current government has provided official recognition that the gap between rich and poor, measured in terms of a variety of economic and social, educational and health indicators, has been steadily widening. Moreover, these disparities are at risk of becoming firmly entrenched.²

While New Zealand women continue to have a higher life expectancy than men, they are more likely than men to experience or report more long-term illness or disability such as depression, arthritis and diabetes, poorer mental health, and higher access to health and disability services. The poorest health is likely to be experienced by women on low incomes and of low socio-economic status, particularly Māori and Pacific women (Ministry of Women's Affairs 1999).

The data gathered by the New Zealand Ministry of Health's *Taking the Pulse: The 1996/7 New Zealand Health Survey* (using the SF-36 health status questionnaire, which is discussed later in this paper) indicate that women scored slightly (but statistically significantly) lower on all scales of self-reported health except general health. The differences were more pronounced for scales more closely associated with mental health. Further analysis of that data (Sarfati and Scott 2001) clearly identifies lone mothers as a vulnerable group in need of special consideration if inequalities in health are to be addressed. The study found that lone mothers had lower physical health scores than partnered mothers, but these differences were largely explained by

² In 2000 the New Zealand Government prioritised the reduction of disparities in social and economic outcomes and put in place an intersectoral work programme called "Closing the Gaps" (Howden-Chapman and Tobias 2000:iv).

differences in socio-economic status. However, lone mothers had significantly worse mental health scores. Lone mothers have a higher risk of social isolation and high demands placed on them as main provider and caregiver, which can adversely affect health, both directly and through higher rates of health risk behaviours.

Other overseas studies also indicate that sole mothers on pensions have poorer health than other groups in the population. In the United States, Edin and Lein (1996) conducted multiple qualitative in-depth interviews with 379 low-income mothers in four cities to investigate the factors affecting their survival on welfare benefits and decisions to enter paid work. One-third of respondents indicated that temporary health problems experienced by themselves or their children were factors in delaying entry into employment. Short and Freedman (1998), analysing nationally representative American panel interview data (n=44,000), also demonstrated that having insufficient funds or insurance for medical problems was a key factor in discouraging single mothers from working, confirming findings from previous economic studies.

In Australia, a group of female sole-parent pensioners who reached the end of their benefit eligibility as a result of their youngest child reaching the age of 16 was studied by Shaver et al. (1994). Reasons cited for not undertaking job training included their own ill health or disability (30%), caring for an elderly, disabled or sick adult (4%), and caring for a sick or disabled child (3%). In another Australian study (Wolcott and Glezer 1995), 10% of a sample of sole mothers indicated in interviews that ill health was a factor in their preference for part-time instead of full-time work, with a further 4% citing care of sick relatives as an impediment.

A longitudinal (1987–94) interview study of 300 single mothers in Ontario, half of whom were on social assistance, also showed the close links between health status perceptions of mothers and their children (Gorlick 1995). More recent Canadian research (reported in Browne 2000) claims to demonstrate that welfare mothers with serious mental health problems are more likely to have children with a behavioural disorder or developmental delay, thereby compounding their difficulties in managing the transition into paid work outside the home.

A major policy assumption embedded within most welfare-to-work programmes is that the health of female beneficiaries could be improved by paid employment. Recent research in the United Kingdom casts doubt on this belief. Through a self-completion questionnaire, Baker et al. (1999) researched lone mothers (n=719) and a comparison group of partnered women (n=8,779). Logistic regression analysis showed no significant independent association between paid work and improvement in health status for lone mothers, especially for mental health. The study also suggested that global indicators of long-term health must be made more precise, as the relationship between paid work and health may be condition-specific. Furthermore, it drew

attention to the need to understand more fully how changes in the family life cycle – such as those related to preschool children – affect the health–employment relationship. Finally, the study suggests that health status will remain a major factor in influencing whether beneficiaries can remain in paid work after gaining employment.

The population targeted by the study reported on in this paper consisted of lone mothers who were welfare beneficiaries and whose welfare support was subject to work “activation” schemes. At the time of this study New Zealand Domestic Purposes Benefit (DPB) regulations required that a “work test” be carried out several times a year after the recipient’s youngest child reached the age of six. Among the exemption criteria were “health reasons”. The data in this paper are derived from a sample of those female DPB recipients *not* exempt from a work test for reasons of their own health, and provides a snapshot of their physical and emotional wellbeing. The sample was taken in November 2000. The analysis indicates that their health status is very low in comparison with national figures, that poor socio-economic circumstances seem to make a greater contribution than ethnicity to the relative health disadvantage of this group, and that emotional and physical role functioning are the areas most affected.

Since this study was completed, the New Zealand Cabinet removed work-test obligations for DPB recipients. While the reforms are to be welcomed because they acknowledged that work testing was not flexible enough to take into account the complex and individual circumstances of sole parents’ lives, they still have a particular focus on supporting clients into sustainable paid employment. The replacement for the work test (implemented in October 2002) was enhanced case management, which included a mandatory planning-for-work process carrying sanctions for non-compliance.

METHOD

The study population for this survey was defined as female DPB recipients registered at Department of Work and Income (DWI) offices in Browns Bay, Otara and Kaitiaia as at 30 September 2000, whose youngest child was six years or older and who were not exempt from the work test for reasons of their own health. The particular DWI sites were chosen to give us a purposive and stratified sample of women on the DPB. Browns Bay, situated on Auckland’s North Shore, is an area of relatively high socio-economic status, and its rating on the New Zealand Deprivation Index (NZDep)³ is 3 (Crampton et al. 2000). The ethnicity of most DPB recipients served by the Browns Bay office is Pākehā and the general population in that area would be expected to enjoy comparatively good health. Otara, in South Auckland (NZDep 10), is an area of low

³ NZDep uses a scale of 1–10, where 10 represents the most deprived areas.

socio-economic status, of comparatively poor health, and of high Māori and Pacific Island ethnicity. Kaitaia (NZDep 10) is a small town in a more isolated, rural district and is an area of low socio-economic status and high Māori population.

The DWI database and a health questionnaire were used to create a socio-demographic and health profile of the DPB recipients in the study. The DWI database was accessed under conditions protecting the privacy of its clients. In order to assess the functional status and wellbeing of our sample of women on the DPB, a questionnaire was aggregated from a number of overseas welfare-to-work research questionnaires, New Zealand research surveys on the socio-economic determinants of health, and the SF-36 questionnaire, which is a widely used instrument of measurement of self-reported health (Ware et al. 1994).

This paper focuses on the SF-36 data. The administration of the SF-36 creates scores for both physical and mental health components. It incorporates reports of behavioural function – which focus on observable and tangible standards external to the individual, such as walking a specific distance or performing customary self-care activities, as well as more subjective measures of wellbeing – described in terms of the frequency and intensity of feeling states.

The SF-36 questions are designed to measure physical and mental health in relation to the following eight health concepts:

- physical functioning
- limitations of daily role performance due to physical health
- bodily pain
- general health perceptions
- vitality (energy levels)
- social functioning
- limitations of daily role performance due to emotional health
- general mental wellbeing.

Higher scores (maximum 100) represent better self-reported health. Population mean scores (norms) for the New Zealand population have been calculated by the Ministry of Health and Statistics New Zealand national survey, *Taking the Pulse: The 1996/7 New Zealand Health Survey* (Ministry of Health 1999b). This paper incorporates the SF-36 comparisons with the national data on women of similar age groups.

As well as the eight scales, two summary scales have been calculated: Physical Component and Mental Component summary scores. These component summary

scores are standardised and norm based.⁴ The SF-36 does not indicate specific illnesses such as diabetes, obesity or heart disease, or particular pathologies such as clinical depression. Rather, it is a holistic overview of women's health or lack of it.

The questionnaire was self-administered and returned by post, although a small number of respondents took the option of completing the questionnaire by using a free-phone number. The response rate was 25.9%.

LIMITATIONS

Eliciting voluntary information from welfare beneficiaries about details related to their welfare support is a notoriously, and understandably, difficult task, as beneficiaries are likely to feel vulnerable in regard to a scrutiny of their personal circumstances and distrustful of the reasons for the gathering of information. Despite being referred to as customers and clients, the beneficiaries in the study were not only financially dependent on their relationship with the state agency under whose auspices the questionnaire was sent out, but they did not have the option of taking their custom elsewhere. When required to fill out forms on a regular basis and have one's every request documented, even the least suspicious of people may simply tire of questions. In addition to this, as our results show, being "down and worn out" was a description that characterised more than a third of those in our sample population who found the time, energy and motivation to respond to our very long questionnaire.

With a response rate of 25.9%, some non-response bias is likely to exist. We believe this bias related to the degree to which the subject matter – health – was perceived to be an issue, to differing perceptions of the usefulness or risk associated with such data gathering, and to levels of time, energy and household organisation.⁵ The size and format of the questionnaire probably introduced some degree of bias with respect to education levels and confidence with questionnaires and written English.

⁴ The Physical and Mental Component summary scales are scored using norm-based methods. The means, standard deviations and factor score co-efficients used in scoring come from the general New Zealand population (in this case these figures were taken from the *Taking the Pulse* data). A linear T-score transformation method is used so that both the Physical and Mental Component summary scores have a mean of 50 and a standard deviation of 10 in the general New Zealand population. This transformation is in contrast to the 0–100 scores used for the eight separate SF-36 scales. Those eight scales have means ranging from 65 to 86 and standard deviations ranging from 15 to 35 in the general New Zealand population.

⁵ After we sent out a reminder about the questionnaire with a prize draw of six large Christmas hampers, considerable numbers of respondents used the freephone number to get a second form sent out, having misplaced the original. In most cases we were told that the respondent had opened the original letter but read only far enough to know that the survey was voluntary, "filed" it for later and forgot about it.

To mitigate some of the limitations arising from predicted ethnic differentials in response rate, and to allow for different geographic features of benefit office service areas, a stratified sample was employed. While the total number of respondents (244) was relatively small, the stratified sample ensured an adequate representation of major ethnic groups and responses from rural, urban, and upper and lower decile areas. The results from this study are consistent with those recently published results from a much larger national sample of lone mothers taken in 1996/97. Not only does this study target a more specific population and provide more descriptive detail about what the health status figures mean, but the protocol employed also provides us with the ability to follow up the same respondents for interview. It is these planned interviews that will ultimately facilitate a richer understanding of the specificities and particular mechanisms by which factors associated with DPB status are transformed into vulnerable health status.

A PICTURE OF HEALTH: THE RESULTS

The analysis of the SF-36 data indicates that:

- The health status of women who took part in our survey was low in comparison with national data of women of similar age.
- Poor socio-economic circumstances seem to make a greater contribution than ethnicity to the relative health disadvantage of this group.
- The area most affected by physical and emotional limitations was the ability to carry out everyday activities.

Characteristics of our Respondent Sample

Two hundred and forty-four women completed the questionnaire. Overall, the response rate was highest for Pākehā and lowest for Pacific women. It was highest in Browns Bay, the least deprived of the areas, and lowest in Otara, where the sample was predominantly Pacific. The median age of our respondents fell in the 40–44 years age group, which is slightly older than the 35–39 years median for the whole sample.

Respondents' Health and Comparisons with National Data

The SF-36 comprises 36 specific questions, which are weighted and aggregated to construct eight component scales and two summary scores. While no major assertions can be made on the basis of the answers to the individual questions in isolation, the answers offer a picture of what the respondents were reporting, and add descriptive substance to the states to which the various scales refer. The results for some individual questions are shown in Tables 1, 4 and 5.

Respondents were asked, “In general would you say your health is: Excellent / Very Good / Good / Fair / Poor?” Table 1 shows that 31.5% of respondents rated their health, in general, as “fair” or “poor”.

Table 1 DPB Beneficiaries’ Ratings of Their General Health (n=243)

Rating	%
Excellent	13.2
Very Good	27.7
Good	27.7
Fair	23.6
Poor	7.9

Self-reported general health of the sample as a whole is reflected in the General Health scale score (GH), and compared to the GH for the wider population in Table 2. The mean GH for our respondent group was 62.0, compared to 76.06 for women 25–64 years in the general population. Thus, the self-reported general health of the sample of women on the DPB was lower than that of women in the general population.

The SF-36 is designed to offer a concurrent measurement of both physical and mental health status. Table 2 compares the eight scale results for our sample of women on the DPB with those of women aged 25–64 in the general population. The respondents’ mean is significantly lower than the general population’s mean on every scale.⁶

Table 2 A Comparison of Mean (SF-36) Scale Scores for Beneficiary Respondents and New Zealand Women

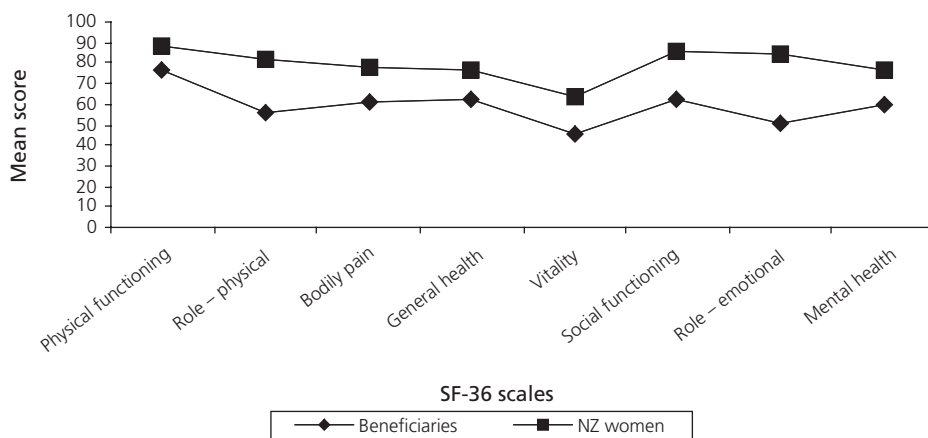
Scale	Beneficiary respondents (n=243)	NZ women aged 25–64 (n=2,960)
Physical functioning	76.19	88.20
Role – physical	56.17	81.72
Bodily pain	60.90	78.40
General health	62.00	76.06
Vitality score	45.66	63.69
Social functioning	62.48	85.76
Role – emotional	51.10	83.81
Mental health	60.08	76.64

⁶ The estimates of sample sizes necessary to detect differences between two groups are based on published formulas (Cohen 1988). They assume a non-directional hypothesis (two-tailed test) with a false rejection rate of 5% and a statistical power of 80%. That is to say, a real difference, in either direction, would be detected 80% of the time.

The eight scales for the sample and for the general population of women aged 24–64 are graphed (Figure 1) to create a profile that illustrates the sites of greatest difference (or disadvantage). The line representing the DPB sample has a similar pattern to that representing women in the general population, but the scores are lower by at least 12 points.

The components evidencing the greatest divergence in scores are those of “social functioning” (23.28 points difference); “role – physical” (25.55), which represents the impact of physical health on performance of everyday activities; and “role – emotional”, which represents the impact of emotional health on daily role performance and shows an enormous 32.71 point difference, indicating that it is inordinately affected by DPB status.

Figure 1 Comparison of SF-36 Scores of Beneficiaries and New Zealand Women



The eight scales are weighted and aggregated to compute Physical and Mental Component summary scores.⁷ Table 3 compares the Physical and Mental Component summary scores of the beneficiary sample and New Zealand women aged 25–64.

Table 3 Comparison of Mean Physical and Mental Component Scores

Component score	Beneficiary respondents	New Zealand women aged 25–64
Physical	46.09	51.17
Mental	36.93	48.97

⁷ The Physical and Mental Component summary scales are scored using norm-based methods. Specifically, this means that all scores above and below 50 are, respectively, above and below the average in the New Zealand population.

While New Zealand women in the 25–64 age group reported physical health status slightly above the general population norm (of 50), the physical health score of women on the DPB was more than three points lower than the norm. Mental health scores for women on the DPB were even lower (13 points below the norm and 12 points below New Zealand women of a similar age group).

In order to provide qualitative detail and tangible description of the sorts of states that these figures represent, Tables 4 and 5 summarise responses to specific questions asked about wellbeing and physical function. Respondents were asked a series of questions of the form, “How much of the time during the past 4 weeks ...?” Table 4 shows that 34.6% of our sample reported feeling worn out “all” or “most of the time” during the previous four weeks, and 16.5% reported feeling down “all” or “most” of the time during the past four weeks. Thus many of our respondents could be characterised as tired and miserable.

Table 4 Beneficiary Respondents Reporting Specific States of Wellbeing

	% (n=243)					
	All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
Did you feel full of life?	5.3	21.0	16.0	34.2	16.0	7.4
Have you felt down?	3.7	12.8	13.2	38.7	25.5	6.2
Did you feel worn out?	10.7	23.9	17.3	32.1	12.8	3.3
Have you felt calm and peaceful?	5.8	18.5	13.6	36.2	18.1	7.8

Table 5 summarises figures for more observable categories of physical function, such as bending and carrying. Respondents were asked a series of questions of the form, “Does your health now limit you ...?”

Table 5 Beneficiary Respondents Reporting Limited Ability to Perform Daily Activities

	% (n=240)		
Activities	Yes, limited a lot	Yes, limited a little	No, not limited at all
Lifting or carrying groceries	7.9	31.5	60.6
Bending, kneeling or stooping	10.4	36.3	53.3
Climbing one flight of stairs	4.2	22.1	73.8
Walking 100 metres	5.4	19.1	75.5
Bathing or dressing yourself	3.7	11.2	85.1

Table 5 shows that 46.7% of our respondents reported that their ability to bend, kneel or stoop was to some degree limited; 39.4% said that their ability to lift or carry groceries was to some degree limited; 26.3% reported limited ability to climb one flight of stairs, and 24.5% to walk 100 metres; and 14.9% of our respondents reported limited ability to bathe or dress.

When the SF-36 data were analysed by area office, and by ethnicity, no significant differences appeared.

DISCUSSION

Our results show that women in our sample had a self-reported health measure lower on every SF-36 scale than women of comparable age in the general population. The greatest difference between the two groups is apparent in those scales that measure the impact of health on the performance of everyday activities. With a Physical Component summary score of 46.09, physical health for these women on the DPB was closest to that of women aged 65–74 in the general population (whose score was 45.3).

Over 30% of our sample of beneficiaries rated their health as “fair” or “poor”. This figure, along with the proportion of respondents reporting limited ability to perform simple daily activities, is consistent with Australian findings that 30% of female Sole Parent Pensioners reported that poor health prevented their uptake of training or work at the end of their pension eligibility (Shaver et al. 1994).

The magnitude of the difference between the mean mental health score of the beneficiary sample and that of women of the same age in the general population (12 points) signals a serious disparity. These results, however, concur with a large body of international research that has consistently found high rates of depression, anxiety and mental distress affecting sole mothers (e.g. Brown and Morgan 1997, Macran et al. 1994, Walters 1993, Aneshensal et al. 1981, Hunt et al. 1973, Moss and Plewis 1977, Berkman 1969).

While our sample was stratified for ethnicity and areas of socio-economic deprivation, the results do not reveal any differences in health status by either ethnicity or area. This is in contrast to data from the general population (*Taking the Pulse*) which, overall, correlates ethnicity with poorer health. We cannot (and certainly would not) conclude from our data that there are no ethnic differences in the health status of DPB mothers, but we can conclude that any differences there might be are not large enough to be detected in this sample and with this tool. Our data do strongly imply that poor socio-economic circumstances make a greater contribution than ethnicity alone to the relative health disadvantage of this group. Our results also indicate that residing in a more privileged neighbourhood does not protect sole mothers from the health disadvantages associated with DPB receipt.

Further, more qualitative interviews with this group might help us understand whether the poor health of female DPB beneficiaries is primarily a result of a general income disadvantage or whether there are other particular features of being on the DPB that affect women's health. Attention to the complex of factors related to DPB receipt, rather than low income alone, may prove more useful in revealing the mechanisms by which DPB receipt is transformed into poor health.

DPB receipt is clearly associated with low income, with lack of control over life circumstances and, anecdotally, with social isolation. It is generally assumed that full participation in the labour market will improve the quality of welfare mother's lives not only because their income will be increased but, in accordance with theories of social cohesion, because labour market attachment will constitute an increased level of integration into (those ill-defined entities) communities. However, there are distinct problems with both these assumptions when they are applied to sole mothers.

Not only is the financial advantage of employment often dubious for sole mothers, as the demands of their primary responsibility (children) and the necessity for flexible leave provision tend to restrict them to the low pay of serial, casual work, but the costs of increased responsibilities and the instability and insecurity of their labour market attachment may outweigh what advantage there is. Being forced into taking up employment under conditions that may be difficult to comply with will not necessarily offer a heightened sense of control over life circumstances. Increased involvement in wider networks can be a source in itself of increased stress. Ultimately, social capital and related social cohesion measures may well prove to be concepts that are as incapable of capturing the situation for women (particularly women with sole-parenting and financial responsibilities) as traditional socio-economic status measures have been. This may be for similar reasons if we recognise the manner in which the state has (quite explicitly in New Zealand, anyway) assigned itself the absent husband's role.

If income is indeed the major predictor of health status, then an increased income should improve health outcomes. However, there is increasing evidence that for sole mothers not only are the overall financial advantages of the transition from welfare to work doubtful (Short and Freedman 1998, Olikier 1995), but also that the extra stresses involved and the juggling of excess paid and unpaid responsibilities are burdens likely to contribute to negative health outcomes, particularly in the area of mental and emotional wellbeing (Olikier 1995, Arber et al. 1985). Baker et al. (1999) argue that the assumption that paid work improves women's health is derived from the experiences of partnered mothers, and that the circumstances of the two populations differ too greatly to make inferences from one to the other. It would also be prudent to stay mindful of the inadequacy of socio-economic status measures to date in capturing the class experience of women in general. This inadequacy has usually been attributed to

the fact of many women's differential relation to employment and income – often dependent, for both social status and cash, on the benevolence of another party.

The vulnerability of sole mothers on welfare – in terms of health outcomes in particular – is likely to be a combined result of the extra stresses of sole parenthood, welfare recipient status, socio-economic disadvantage, and poverty in general. Clearly there are particular stresses associated with unplanned, unsupported or unaccompanied pregnancy as well as with widowhood, divorce and partner loss. On the other hand, it has also been pointed out that poor health may increase the likelihood of remaining single and of partnership dissolution (Benzeval 1998), as well as decreasing employment opportunities. Thus the possibility of health selection into DPB receipt deserves some consideration.

Whatever the line of transmission, these data paint a bleak picture of the health and wellbeing of these women on the DPB who are not exempt from work or training obligations for reasons of their own health or disability. The enormous discrepancy in health scale scores between this group and women of the same age in the general population suggests, at the least, a need to examine the criteria by which health is assessed by welfare agencies. Health, in general, is an important factor determining the extent and type of labour force participation feasible, and is one that has been shown to figure in sole mothers' decisions about paid work (Edin and Lein 1996, Wolcott and Glezer 1995, Shaver et al. 1994). Given the comparatively poor health status of these female DPB recipients, health will remain a major factor in influencing whether – even if they are successful in attaining a job – these mothers can remain in paid work.

Policies that would require all these women to undertake paid work may satisfy an ideology of reciprocal responsibility, whereby civic obligations are reduced to labour market participation. However, our data identify the health of many DPB mothers as a considerable barrier to employment, which gives rise to the possibility that employment may further undermine health outcomes for some. While most welfare-to-work initiatives are based on the assumption that women's health will be improved by employment, caution must be taken that such interventions, aimed at heightening social cohesion, do not simply displace other measures that would improve access to routine health care services.

This assessment of the health and wellbeing of this group of women (who had been targeted for work test) brings into question the basis on which fitness for work is assessed by welfare agencies, and necessitates a consideration of the potential of work-oriented programmes to exacerbate an already enormous discrepancy in health outcomes between these women and the rest of the population. It remains to be seen whether the less draconian policies of enhanced case management, which has replaced

work tests, will take into account the health discrepancies of women on the DPB when planning for them to move into paid employment.

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