MORE THAN JUST ANOTHER OBSTACLE: HEALTH, DOMESTIC PURPOSES BENEFICIARIES, AND THE TRANSITION TO PAID WORK

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Abstract

The difficulties faced by sole mothers in the welfare-to-work transition are well documented, but policy researchers tend to focus on "employability" issues rather than the known relationship between poverty and poor health. This paper explores the impact of self-reported poor health on the ability of beneficiaries to seek and retain paid work. The research material is derived from a two-year study funded by the Health Research Council. In this paper we focus on the results from qualitative interviews with 120 sole mothers receiving the New Zealand Domestic Purposes Benefit. Two major findings are presented. First, poor health presents a substantial and under-appreciated barrier to a transition into sustainable paid employment for some sole mothers. Second, health is more than just another obstacle to employment when it is understood within the social context of their lived experiences and identities. The implications of these findings for policy and programme delivery, which we outline in the final section, are significant both for New Zealand and for other countries with similar social programmes.

INTRODUCTION

International research has documented numerous difficulties faced by sole mothers in making the transition from "welfare" to work. For many, the successful passage into employment is strewn with such obstacles as unaffordable or unreliable childcare, inflexible workplace practices, high work-related costs, insufficient job skills or confidence, and few employment contacts. While New Zealand and other OECD countries have emphasised the "employability" of beneficiaries, the well-documented interrelationships among poverty, sole parenthood and poor health have not featured prominently in policy discussions.

This paper is based on qualitative interviews with sole mothers receiving New Zealand's Domestic Purposes Benefit[1] (DPB), and focuses on their perceptions of the impact of poor health on seeking and retaining paid work. Health-related concerns are perceived to create significant and under-appreciated barriers to a sustainable transition into paid employment by many sole mothers. In the context of their socio-economic circumstances, poor physical and mental health appears to be widespread, and is more than just another obstacle to paid work. Poor health actually compounds their other problems. The final section of our paper presents the policy implications of these findings.

EMPLOYMENT, POOR HEALTH AND LONE MOTHERS

Numerous studies suggest that the impact of motherhood on employment and income differs from that of fatherhood in industrialised countries. Women's job opportunities and wages relative to men's are most likely to decline after they become mothers, as mothers are more likely than fathers to disrupt paid work for family responsibilities (O'Connor et al. 1999, Baker 2001). The probability of earning low wages and living in poverty is further augmented if mothers are members of certain cultural groups, lack job experience, or live without a male breadwinner (Vosko 2000). Considerable research also suggests that neither state benefits nor employment earnings allow many sole mothers to escape from poverty (Edin and Lein 1997, Hunsley 1997, Baker and Tippin 1999).

Compared to partnered mothers and fathers, sole mothers typically have lower levels of education and job skills, and are seldom able to find well-paid jobs with flexible hours and job security (Goodger and Larose 1999, Millar and Rowlingson 2001). Fewer have worked long enough with the same employer to be entitled to employment-related benefits, such as sick leave. Fewer are able to share childcare with a family member. Many sole mothers also experience emotional problems arising from marriage breakdown, continuing disputes with former partners, and children's behavioural problems that interfere with finding and keeping paid work (Pryor and Rodgers 2001).

Sole mothers usually view their children as their major priority, and some perceive the opportunity to care for young children at home on social benefits as more viable than earning low wages and worrying about children's supervision (Edin and Lein 1997, Curtis 2001, Millar and Rowlingson 2001). However, an increasing number of mothers are attracted to paid work by the opportunity to meet new people, to use their skills

1 This benefit has been provided since 1973, mainly to sole mothers caring for children at home.

and earn some money, and the desire to be a "role model" for their children. In addition, the stigma of social assistance, the constant scrutiny by case managers and neighbours, and low benefit levels motivate others to seek employment. In New Zealand, employment rates for sole mothers increased before new employment requirements were enforced for beneficiaries in the 1990s (Goodger and Larose 1999, Goodger 2001). This confirms that factors other than policy requirements encourage sole mothers into paid work. However, many mothers with young children feel that part-time work is more manageable than full-time work because it allows them to improve their incomes while retaining their caring responsibilities.

In the United States, with its punitive welfare-to-work policies,[2] "welfare mothers" who move into paid work are most likely to remain employed and less likely to return to social benefits if they have more than 12 years of schooling, previous employment experience, and fewer than three children (Harris 1996, Cancian et al. 1999, Corcoran et al. 2000). Job instability is also related to family stresses, domestic violence, physical and mental health problems, substance abuse, inappropriate work behaviours, and employer discrimination (Riccio and Freedman 1995).

Dorsett and Marsh (1998) reported that British sole mothers have high rates of cigarette smoking, augmenting financial problems and poor health. Low income, poor health and low morale all interfere with returning to paid work and improving their circumstances. Curtis (2001) found that Canadian sole mothers typically report poorer health than married mothers, but when they controlled for age, income, education, lifestyle factors, family size, and other recognised determinants of health, the differences diminished. Sarfati and Scott (2001) found that New Zealand sole mothers were more likely to be Māori, to have lower family incomes, lower educational qualifications, and to live in more deprived areas. They also found both poorer physical and mental health among lone mothers, but the physical health differences disappeared after controlling for socio-economic variables. Whitehead et al. (2000) concluded that the Swedish social security system is better at keeping sole mothers healthier and out of poverty than the British system, but that Swedish sole mothers still report poorer health than partnered mothers.

New Zealand governments made a number of policy changes affecting women on the DPB throughout the 1990s (Wilson 2000). At the time of this study, Work and Income[3]

2 In 1996 a federal law was passed to mandate the states to limit social assistance to no more than two years at a time and five years over a lifetime (Ellwood 2001). This law was strengthened in February 2003 (*New York Times* 13 Feb 2003).

3 The former Department of Work and Income was reorganised into the Ministry of Social Development during our study, but the service we were dealing with continues to be called Work and Income.

required beneficiaries to seek paid work, organised community work, or education/job training if their youngest child was at least six years old and they were not deemed ineligible for health-related or other reasons. However, in April 2003 the Government removed the "work test". DPB mothers are still encouraged to seek employment or skills training but paid work is no longer mandatory. Because our study was done under the former work-testing regime, some of the difficulties reported by mothers may no longer apply. However, the relationship between poverty and poor health continues, affecting the transition from welfare to work for beneficiaries. Therefore, the insights into the health–work nexus offered by this research are still relevant to social policy in New Zealand as well as overseas.

RESEARCH DESIGN

The larger study, funded by the New Zealand Health Research Council[4] and facilitated by the (former) Department of Work and Income, involved three aspects. First, the SF-36 health questionnaire was mailed to sole mothers receiving the DPB in the spring of 2000, with results reported by McMillan and Worth (2001) and Baker (2002). Second, Work and Income gave us access to internal documents and manuals, which complemented interviews/focus groups with national staff and case managers, previously discussed by Tippin and Baker (2002). This paper deals with the project's third aspect: qualitative interviews with DPB sole mothers with children over six years old and who, at the time of the interviews, were expected to seek paid work or job training.

The sample was drawn from sole mothers from three Work and Income offices in the North Island: Otara (South Auckland), Brown's Bay (Auckland's North Shore) and Kaitaia (Northland). These offices were selected to provide diversity in terms of socio-economic status, ethnicity and urban–rural experiences. In September 2001 Work and Income selected prospective interviewees from its database, but all respondents were asked to contact the research team directly to ensure their anonymity. As an incentive, beneficiaries who agreed to participate had their names entered into draws for food hampers.[5] Between September and December 2001 we talked to 120 sole mothers for about an hour each, typically in their homes, and the interviews were tape-recorded and later transcribed.

The findings presented below represent the experiences and views of the sole mothers we interviewed and cannot be taken to represent the entire beneficiary population. In

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4 The grant was made to Maureen Baker, Heather Worth, David Tippin and Tracey McIntosh at the University of Auckland, and was administered through the Centre for Research on Gender from 2000 to 2002.

5 This was done both for respondents to the mail survey and those who participated in interviews, and involved six hampers valued at $300 each.

the previous mailed survey, one-third of the mothers reported physical or mental health problems that interfered with daily life. However, in reporting results from the interview survey we have not quantified responses to questions about health. The paper tends to focus more on sole mothers who reported health problems, and the entire sample may also over-represent those with grievances against Work and Income. Nevertheless, the data provide a contribution to the project's main objective: to understand and elaborate the dimensions that health-related factors play in the lives of sole mothers attempting to move into paid work.

THE HEALTH OF BENEFICIARIES AND THEIR DEPENDANTS

> **"There's some weeks when I feel like I can't even get out of my bed, but there's other weeks where I feel like I could run a thousand miles."**

Our mailed survey found that sole mothers reported much poorer physical and mental health than New Zealand women of comparable age, a finding that is consistent with previous research. Over one-third of the respondents reported that poor physical and mental health affected the performance of daily activities and "social functioning". Divergences with comparable national data were particularly apparent in mental health, with beneficiaries more likely to report feelings of depression and a general absence of emotional wellbeing (Baker 2002).

In our qualitative interviews, many sole mothers reported good health and expected few problems in the foreseeable future. Others noted past health concerns but said that they now enjoyed a period of remission. However, some mentioned acute or chronic conditions of varying seriousness. Problems with physical movement (such as bending, lifting, walking distances) were attributable to arthritis, past injuries or obesity. Respiratory problems, gynaecological ailments, substance abuse, gastro-intestinal problems, neurological disorders, heart and circulatory disease, and cancer were also cited as current or recurring health issues.

Some beneficiaries also spoke at length about their emotional health, including post-natal and chronic depression, panic attacks, insomnia, stress from relationship breakdowns and continuing abuse from ex-partners, and chronic fatigue. Some reported a general undiagnosed sense of poor health and prevailing anxiety, and mentioned that they were on antidepressants. Others reported multiple health problems, both physical and emotional, which they linked to their stressful lives.

Chronic and periodic problems with their children's health were also discussed. These included asthma, bronchial infections, influenza, ear infections, epilepsy, rheumatic fever and other heart problems, meningitis, fractured limbs, and a range of psychological and behavioural problems. Some mothers mentioned that their

children's immune systems were weak and their health was poor as a result of malnourishment and substandard housing (especially dampness and cold in winter). Some mothers reported that their relationship breakdown and financial uncertainties negatively affected their children's health. Several spoke of the "huge emotional turmoil" that their children had experienced, of unpredictable behaviour that occurred in consequence, and of difficulties finding counselling for them.

Some mothers were very conscious – almost preoccupied – with the ups and downs of their own health and their children's wellbeing. We heard stories of sudden flare-ups of chronic conditions. A few observed that their physical and mental health deteriorated with alarming regularity at stressful times of the year, such as the approach of school holidays. Many remarked on the unpredictability of their children's health and the constraints this placed on their own activities.

Health and Living on the DPB

> **"If I go down, the whole ship goes down."**

The women we interviewed varied in the picture they painted of their health when they applied for the DPB. Some said it was fine and that any stress and uncertainty was reasonably manageable. For others, the trauma and stress of the circumstances giving rise to their benefit application were profound. Recalling this period was difficult for some women, who cried during the interview and spoke of their depression and inability to cope. One woman characterised her mental state as:

> **"… really low, very low, very ill and in fact I was very emotionally, probably to a certain extent mentally, destabilised by what I'd been through and I didn't actually want to go on the DPB… it was mentally battering."**

Beneficiaries spoke of both positive and negative aspects of living on the DPB, and how these relate to their family's health. They noted that the DPB makes it possible to manage illness by remaining at home with a sick child or recovering from their own illnesses with no income loss. The DPB also helped some to leave abusive relationships. Some women commented that their own health improved when they went on the DPB, relieving their stress by providing the security of a regular but low income.

Despite these positive aspects, a substantial majority made it clear that they do not like living on the benefit and want to become self-supporting. They worry about becoming poor role models for their children because they are unable to demonstrate a work ethic. They want a better way of life with fewer financial concerns and more adult contact, but feel trapped in poverty. They resent the discrimination and stigmatisation encountered in the community, and the sense of victimisation they feel. One mother said:

"Initially it was really a lifesaver because when you're in a relationship and you just want to get out and it's semi-kind of violent and stuff, it's… sometimes the only thing you can do, and… then you get thinking, I just don't want to carry on like this, I want to go and get some stimulation and get a job and meet people and stuff."

Sole mothers cited many disadvantages of living on the DPB, most often the financial pressures of managing on a low income, coupled with the fear of unanticipated expenditures such as visits to the doctor or prescription drugs. Living on the DPB was referred to as "survival", "a real struggle" and "totally impossible". As one woman said:

"You feel like a second-class citizen basically and a lot of energy goes into just surviving. You spend more time because of your really tight financial situation running around trying to get assistance to help you keep going all the time... it's a real catch-22. It's a really vicious cycle."

For some, the tiredness and fatigue of juggling paid work, caring responsibilities and managing a tight budget caused extreme stress with physical symptoms.

Some women saw clear links between poverty and health problems for themselves and their children, and felt they were on a downward spiral:

"It becomes so stressful when you have a pile of bills and people are ringing you for money. The only other place to get the money from is what you spend on food, so you stop buying food and that creates poor health problems and it goes on and on."

The longer-term health consequences of living on the DPB were also a concern:

"What worries me more is not now, what our health is like now, it is what the five-year impact will be... will I be more prone to osteoarthritis, heart attacks and cancer?"

Social Isolation and its Impact on Health

"There's no back-up, no nothing."

Some beneficiaries maintained close ties to their families, whānau and communities, which provided them with essential physical, financial and moral supports. Some moved closer to parents or siblings after marriage breakdown because they knew they could not cope alone. Other beneficiaries were more socially isolated and less integrated into their communities. Some deliberately moved away from their community to avoid family conflict or abusive ex-partners and restricted their social

contacts, speaking of their desire to keep to themselves. But others noted that they are not asked out socially because friends think they cannot afford the cost. Those mothers living in rural areas and spending most of their time with their children (or other beneficiaries) felt particularly isolated:

> **"[I'm] definitely isolated… Just alone and nothing to look forward to in the future… [I] live from day to day on my own, parenting all the time and not seeing anyone, not being able to have any dream, or any sort of future sort of plans, and just having to survive from day to day, especially financially."**

This woman went on to speak of the sense of hopelessness and depression at not seeing any way out of her current situation. Another mother characterised life on the DPB as "never feeling as if you're actually in mainstream society".

Social isolation was also apparent among first-generation immigrants who moved to New Zealand with their partners and were left with no family in this country when relationships foundered. Others spoke of the difficulties of being a DPB mother in a new city, where support systems have yet to be built but poor health inhibits this process. Some articulated the links they perceived between lack of social support, poor health and unexpected illnesses, and the difficulties this poses for paid work. The lack of "back up" support was especially profound for employed mothers:

> **"I don't have any family. I have… just only me. I have to stay with [my son] when he's sick."**

These comments suggest that the lack of social contacts, coupled with poverty and unanticipated illness, can give rise to stress, which may lead to mental health problems that limit the family's horizons and lead to poor mothering. The socio-economic circumstances of sole mothers, combined with poor health, can restrict both their community and work activities. In the next section we focus on health and paid work.

THE HEALTH–WORK NEXUS

> **"There's no carrots there dangling at us that make it worthwhile for us to be in the workforce."**

Health concerns pose little or no obstacle to employment for some sole mothers, but others reported a more complex relationship between health and paid work. Four major themes emerged from the interviews:

- Children's poor health impedes maternal employment.
- Sole mothers' own health makes work difficult.
- Employers and co-workers have no time for health problems.
- Health affects work preferences.

Below, we deal with each separately.

Children's Poor Health Impedes Mothers' Employment

Children's physical and emotional health clearly affects the ability of some sole mothers to find paid work, but beneficiaries with disabled or very sick children were usually exempted from work requirements under the former regime. Children's periodic illness makes it difficult to *retain* paid work. Normal childcare that is reliable and affordable is difficult enough to locate, but trying to find someone to care for a sick child is even more challenging. Flexible work hours or working from home are helpful in this respect. Some sole mothers are ineligible for sick leave because they have not worked for the same employer for long enough, but even those who are eligible report that sick leave is inadequate to accommodate both their own illnesses and their children's. Taking unpaid leave has an obvious financial impact on low-income mothers but also makes them less valued employees.

Employed mothers adopt various strategies when they need to take time off for children's diagnostic tests or illness. Several women quit jobs when they were refused sick leave for children: "I just left". Other mothers reported that they reluctantly send their sick children to school:

> **"If they're not very well, you sort of say to them, well, sorry you've got to go to school… but I know that when they're not very well, it's actually better to have them in bed for a day to recover."**

Some mothers took the child to work with them if he/she was mildly ill, but they also did this reluctantly:

> **"I want to work and I don't take the time off when they're sick… I feel that's quite bad having to take my sick children to work, but in saying that, I do get sick leave but I'm saving those sick leave days for when I really need to take them off, for when they're *really* sick."**

Part-time work was no assured solution, as illness could coincide with workdays. With two or more children the problems became more acute.

Mothers of children with a more serious health problem usually felt they could not work outside the home at all. This was especially the case for children with serious asthma, disabilities, or high susceptibility to infections.[6] However, mothers also talked about children's emotional problems and "acting out" behaviour as another barrier to paid work, as one distressed mother reported:

> **"My son burnt the house down… he ended up trying to stab his sister in the head – all sorts of things were happening… I just had to give up work."**

"Difficult to handle" children, especially adolescents, are thought by some mothers to be so demanding, unpredictable and emotionally draining that they leave them with little energy to work on a regular basis. One mother commented: "[I] seem to be burnt out, worn out, tired all the time… they wear me out… 'cause I never have a break from them". A "settled" child, as one mother phrased it, is the basis for a successful attempt at working, as it permits the mother to devote herself wholeheartedly to employment.

Women's Ability and Motivation to Sustain Work

> **"I have had sick days... when my whole body whizzes and I just can't function at all, I can't even get out the door."**

> **"I kept saying that I had to go to work, had to have the money… I just kept trying to push myself to keep going because I couldn't afford not to go to work."**

Some DPB mothers mentioned that they had to leave previous jobs or could not perform certain kinds of work for reasons of poor health. Chronic physical problems, such as back pain, could affect their ability to work at a job that required standing up most of the time or periodic lifting. Maintaining physical stamina was a major concern for some, who said they had to "be careful" in what they did.

One mother related how a chronic gynaecological problem meant that she was bedridden and in pain for several days each month. To cope:

> **"I just doped myself up on painkillers because I didn't want to lose my job... and most of the time you have to talk to male managers and stuff… I don't really want to go into it".**

6 Case managers exempted DPB mothers only if their children's illness was deemed to be severe.

Other women reporting physical problems said the issue really boiled down to one's "emotional state": "I believe in myself and I believe I can work around it". Some women said they were unsure about how well they could cope with a regular work regimen, especially being on medication, which sometimes had debilitating side-effects on their energy levels and ability to manage. Others reported that depression had caused them to leave previous jobs: "I actually walked out of work one day and said I just couldn't handle it anymore".

For some sole mothers, the ability to cope with mental and physical health problems was dependent on the right combination of boss, co-workers and work environment. They understood that seeking a job that met all these conditions reduced their job prospects but argued that their children's health and their own wellbeing were more important than any requirement to find a paid job. As one woman who reported major health problems succinctly put it: "I am not going to die for the sake of going to work".

Employer and Co-Worker Responses to Health Problems

Requests for employment leave received mixed reactions from employers. Some were supportive – one woman's employer held her job open long after her sick leave had expired. Others permitted mothers to adjust their hours or move to more suitable jobs within the firm. One mother said that her employer's reaction to her child's illness was "not too bad because I was a good worker", but when requests for leave became more frequent "they started getting a bit angry". Negative reactions from employers included refusing to grant sick leave but also asking probing questions about reasons for leave.

Co-workers could also react negatively: one mother with physical health problems observed that "the workers don't like you if you don't carry your weight". Other women reported employers and co-workers expressing frustration with their perceived unreliability because co-workers had to pick up the slack. As a result, some mothers felt reluctant to request time off. Matters were even worse if the job was new, they were ineligible for sick leave, or had insufficient time to prove their worth to co-workers or the boss.

Some women didn't know how much to reveal about health limitations in job situations. During job interviews, some employers probed for information about childcare arrangements, especially in times of child sickness, and mothers were generally upset by these questions. They felt that telling the truth could restrict job possibilities and that "keeping quiet" was the best strategy. They also reported discrimination and differential treatment in the workplace because they were beneficiaries and therefore were assumed to be under extra stress and to experience problems with children's illness. Some mothers reported that they do not take leave when they are unwell because they need to "bank" their own sick leave to stay home

with their children. Sick leave entitlements that do not clearly cover child illness force sole mothers to make difficult decisions about how to handle paid work and family health problems.

Health and Work Preferences

Some sole mothers firmly believed that poor health limited their labour market participation. Physical impairments such as arthritis, back pain or previous injuries meant that some sought part-time jobs that did not require physical stamina. As one woman said: "when you're in low-paid jobs, they're physical jobs, which is exactly what I really can't do anymore". Another related that daily coping with pain in order to be able to work "leaves me exhausted. So I'm not actually a very nice mother, which has really affected things around here." Other women were concerned about their ability to sustain employment over a longer time, especially those who previously had given up a job for health reasons or who had a chronic/unpredictable health problem. One mother who spoke in this vein said: "I need to give myself time to get my health right, get everything right, so that when I do get out there again, hopefully I can maintain it long term." Those with chronic health concerns were especially likely to report that they were unable to cope with full-time work. Most mothers wanted a job with limited demands that would allow them to manage their family responsibilities and to take time off for child sickness or health emergencies without job loss.

Work location was also a health-related issue for some. Working close to home could limit the amount of pain-inducing time on public transport. Working at home or "teleworking" was seen as a way to manage illness and disability, as well as the childcare and employment costs: "If I were told to go and work 9 to 5, it would probably be more difficult because some days I am definitely lower peak than others." Some mothers preferred to take a job close to home so they could be there for their children immediately before and after school hours and thus were able to deal with health and behavioural problems.

Low-stress jobs were also preferred. As one woman said, "I love the fact that I can walk in there, do my job, walk out and there is no stress. When I collect the children from school, I don't have my mind on the job, I don't have sleepless nights". Another mother described her feelings when she became eligible for work testing:

> **"It got hard for me when the youngest turned six and I knew I had to go out and get work… you see, I thought my health wouldn't be up to it… I thought that I didn't have much stamina. I thought I'd had so much stress that I thought that I'd actually damaged myself, you know, just through stress."**

The worry about being "pushed" into full-time work and consequently being unable to cope was also expressed. One sole mother commented that "I can take short bursts of high stress but not constant". Others noted that there were additional stresses associated with the transitional period into paid work that they found "nerve-wracking" and "hard to keep yourself going". Managing sole motherhood with adolescents was the most stressful period of all, according to many women. As one mother explained:

> **"… at the moment I have the teenage stresses which are horrendous – I thought the little kids stuff was pretty bad… I can't phone [their father] and ask him what he thinks so I just have to work it out myself. I feel until the children have left home, I don't feel my health will allow me to go full time but I would love to be full time [and] off the benefit totally."**

Depression and its effects on employment prospects were major concerns for some women. "I have popped in and out of depression and when I get it, I can't concentrate". Daily uncertainties damage self-confidence:

> **"At the moment I go up and down with my mental health and if I am pushed too far, if I have too much pressure on me, I can quite easily get depression again. I don't think I can cope with every day working at the moment. I don't want to cope with that stress. I like being in my home. It is a safe environment."**

The types of work these sole mothers felt able to cope with were intimately entwined with broader perceptions of "good mothering" and general family responsibilities. One mother observed:

> **"It wasn't really the health, I suppose, although that contributed to me not really getting a job – it was more: what do I do with the kids in the holidays and what about before and after school?… it just seemed life was kind of a bit tricky enough and what I'm going to do now is going to make it even more complicated."**

Another mother, describing how she was attempting to balance working, poor health and childcare responsibilities, said, "I just cracked up". Another woman said her children became frustrated and angry with her lack of energy: "I'm too exhausted to go anywhere, I'm too exhausted to do anything and I literally just collapse on the couch or collapse in bed and stay there." Thus, as health and other worries are compounded, some mothers feel powerless, out of control and unable to cope.

TALKING ABOUT HEALTH TO CASE MANAGERS

Some sole mothers reported favourable encounters with the welfare system concerning health-related issues, especially those with a positive and trusting relationship with their case manager. They valued a case manager with a non-threatening and supportive attitude, an ability to listen, who treated clients as "individuals and not numbers", made full disclosure of health-related benefits and entitlements, and had a holistic understanding of how health problems might affect work capacity. These comments illustrate these points:

> **"My case manager was wonderful, she knew I was sick and didn't put pressure on."**

> **"She has been fantastic, absolutely wonderful… understanding, empathetic, knows that you are not trying to rip off the system."**

Clients also appreciated the use of discretionary powers to adjust work hours, arrange courses or exempt them from work testing for health-related reasons. Some sole mothers, however, reported difficult interactions with case managers concerning health and paid work. The balance of this section explores factors affecting their perceptions.

The Initial Encounter with the Case Manager

Sole mothers typically arrive at the welfare office in some state of distress relating to marital separation, financial difficulties or family problems. Almost without exception, the women we interviewed recalled that case managers never asked questions about their health or how they were coping. One sole mother vividly recalled her initial encounter:

> **"When I first went on the benefit I was so run down, stressed out, damn near suicide because I didn't know what to do or where to go and, like I say, it depends on who you come across at WINZ… they weren't really worried about where my head was at … They only looked at all the material things that I had."**

Some were aware that their own state of mind and reluctance to volunteer information influenced the lack of health-related discussion:

> **"No, she didn't [ask about my health]. Mind you, I was a mess. I just sat there and bawled all the way through. I was a write-off… I was so embarrassed having to go and ask for the DPB, never thinking I'd ever be on it again, and I just cried my eyes out. I was just a mess…"**

Other clients regarded their case managers' attitudes with indignation:

> **"When I was pregnant with my daughter… I couldn't fill out a form… I think it was a special benefit form or something and there was a whole lot of figures to do… So I took [my receipts] along there, and this woman just started screaming at me… to add it up and I said, well have you got a calculator 'cause brain of mush being eight and a half months pregnant and she just stood there and screamed and screamed at me and told me I was this and I was that. The whole room was looking – they were just aghast and that's the sort of thing that happens. I mean, it was never a case of, are you coping? do you need counselling? Do you think maybe you should go get some?"**

Failing to ask about health concerns left some feeling that they had been short-changed, especially sole mothers emerging from physically or emotionally abusive relationships. One woman whose partner had died reported that no counselling was offered, nor did the case manager ask how her children were coping with their father's death. A few mothers claimed they were not told that disability benefits could help pay for counselling.

The value of counselling, when it was offered, was much appreciated. For example:

> **"I got sent to a guidance counsellor, which was great. She was really good and got me thinking, and motivated me, which I needed… especially when you've got an illness or a disability… there's so many doors closed to you."**

Counselling was perceived to increase the chances of finding a suitable job:

> **"It would be so neat if you had someone who really knew what they were doing, who could see your circumstances, you know, with my arthritis and other health problems I've had along the way, and look at that and look at the needs of my children and say, okay, you could cope with this direction."**

Women generally reported a "hit and miss" approach, with counselling or referral services offered by those case managers with knowledge of community resources. In response, some clients arranged counselling at their own expense.

General Interest in Client's Health

Health was consistently discussed with case managers during an application for sickness or disability benefits, before surgery, or when a client was "sickly looking". Other women reported being asked about their general wellbeing by "caring" case managers. Otherwise, sole mothers repeatedly said that they thought Work and Income had insufficient interest in how health affects their capacity to find or keep paid

work. From an initial benefit application to locating employment, sole mothers perceived that case managers were more concerned about getting money for them or getting them off the DPB. One mother said, "it's only the money and all they're there for… to double check that their paper work is in order and the information received from me is done".

While some clients appreciated the chance to "talk things over" with their case managers, these discussions seldom extended into the health–work nexus. One client with both physical and mental health problems claimed, "I can't recall a single conversation or a single form asking about health". Another said to our interviewer, "This is the first time I've actually talked about health… they've never brought it up. You're the first one". Other clients were not aware that health concerns could be raised with their case manager.

Some sole mothers reported that their case managers ignored or dismissed health concerns as unrelated to the capacity to seek paid work:

> **"They basically ignore you. If you go in and say that you need to go back on the benefit because whatever or the doctor has a sick note, they tend to be doing their work while you are telling them the story… You feel like you are telling them things and they are not really interested."**

This client went on to say that she is now reluctant to mention health problems: "I will just apply for whatever I need and if they ask a question I will respond but if they don't then I won't even bother commenting". Other women reported that when they raised health issues, the discussion could founder on the demand to provide convincing proof, such as a medical certificate. Not all women could produce such evidence, and some chose not to because they felt they couldn't afford the cost and/or the "bother" of a doctor's visit.

This perceived lack of interest in health by case managers was attributed variously to insufficient training, time pressures, excessive concentration on bureaucratic processing instead of treating clients as individuals, and an inability or unwillingness to understand clients' circumstances. As one woman put it, "I don't really believe they know what it's like to be there". Another who had a "good" relationship with her case manager claimed that:

> **"I have never come across one [case manager] that is in tune with the person sitting opposite them and that person's emotional stress at the time. I think that they are just there to do their job and make sure they get through before the next appointment comes along so that they are running on schedule".**

Other clients felt the non-interest in health was for more tangible reasons:

> **"They don't ask about your health… [or] your children's health. They don't want to know… because they're scared that you might go and ask for more money."**

Knowledge and Skills Concerning Health Issues

Sole mothers reported considerable variation in case managers' understanding of health issues, and in particular how these relate to employment capacity. Some were aware of the challenges that case managers face: "They're not nurses so you could say something medical and they're wondering what the hell you're talking about". Another said:

> **"I don't believe the people in the offices would have the experience or the expertise or whatever it takes to even think about things like that. Because I would say probably a lot of those people are just surviving themselves."**

Some commented on their case manager's lack of understanding or skills to handle these discussions. One mother spoke of her case manager's "lack of life experience" and characterised her as "young and very unskilled to handle distressed people". Several others commented that their case managers did not have children of their own and therefore could not understand their problems with sick children.

Some clients were aware of the complications that case managers might encounter when dealing with clients who were under "stress":

> **"I don't think that they would consider if you had something stress-related that you were in fact sick… Stress means, to them, just getting on and doing something about it – bucking up. I have had to plead stress to them but when I look at some of them, they are probably more stressed than me."**

Some mothers reported that their own knowledge of health-related benefits and entitlements came from other beneficiaries, welfare advocacy groups and community organisations rather than Work and Income sources. One mother characterised her experience:

> **"I know that they have extra things and sometimes it is an advance or loan and they take it out of your benefit – they may have something to help if the children got sick but I wouldn't know about it because they don't tell you."**

There was a broad perception that case managers are not proactive enough in informing their clients about how to manage the costs of health problems, especially emergency expenses.

Reluctance to Discuss Health

Many factors contribute to women's reluctance to discuss health concerns, and not just serious ones, with their case manager. First, some sole mothers have generally adversarial and untrusting relationships with case managers and Work and Income – often perceived as struggles for power and control – which inhibit comfortable discussion about personal health issues.

Second, some sole mothers expressed frustration over "unnecessary" and "frequent" case manager re-assignments. One woman regarded this as a deliberate control strategy:

> **"If you get on really well with a case officer, they see that as a threat and you tend to be taken away from them... they don't want too close a relationship to develop... you're more likely to talk to them about things… but it doesn't happen because they whip them away from you. Just as things are starting to come right, basically."**

Changing case managers was seen as a setback by some sole mothers because trust must be re-established, difficult background information conveyed again, and inconsistent approaches accommodated. Some DPB mothers reported that they were not told Work and Income's reasons for the re-assignment.

Third, the open office environment can be an obstacle. Some women compensate for the lack of privacy by talking quietly, but others said that open offices and publicly visible computer screens made them reluctant to raise health-related issues or discuss them in depth:

> **"I think it's quite difficult if you're talking about emotional things and you're exposed to everybody."**

> **"I think I would have to be really desperate to go there [to talk about a health matter]... given the way the office is arranged."**

These sensitivities are increased in small communities where beneficiaries might know each other. Clients in this context spoke of their particular reluctance to talk about nervous breakdowns, abuse from ex-partners, or concerns about children's delinquency.

Fourth, some clients thought that disclosure of health-related information would increase their vulnerability to Work and Income surveillance and control. Keeping "out of their way", maintaining a low profile and "not rocking the boat" were effective coping strategies:

> **"As long as they put the basic money in there I won't ask more of them and I don't really want them asking things of me. I don't think they would think it relevant that I was feeling unwell."**

Even a trusted case manager was a risk. The information might be used against the client by other departmental staff – "it just comes back and bites you".

Fifth, not talking about health is perceived as a way of maintaining some self-esteem and integrity. "You've got all these bunch of strangers you don't know from Joe Bloggs. Are you going to talk?" Some sole mothers felt Work and Income regarded health–work links as contentious and disputable, and thus thought that telling the department about their health would affect the credibility of their overall circumstances. As one client put it, "they'd probably think you're pulling the wool over their eyes".

Finally,[7] reluctance can be related to a more general discomfort with the stigmatisation and humiliation that some ascribe to the entire welfare experience. A Work and Income visit was characterised as "walking into the guillotine every day", "a meat factory", or "like going to the doctors... a whole row of doctors sitting in a line". And as one client commented, "when you are actually down, you don't want to talk to anybody about anything, that is the hard part. You just want to shut yourself away".

DISCUSSION

Our research does not permit judgements about the veracity of beneficiary statements concerning the health–work relationship, but it does highlight the complexity of the case management assessment and decision-making context. Health is clearly a multi-dimensional issue for many DPB mothers as they strive to move off benefits and into employment. Respondent reports that poor family health restricts their work activities could signify the presence of serious physical disease or chronic conditions that affect them personally, or that affect their children or other family members who require support. On the other hand, such reports could also reflect feelings about being unable

7 An additional factor influencing women's willingness to discuss health concerns was cross-cultural differences in talking about health issues. This will be the subject of a separate future analysis.

to cope emotionally, lacking control over personal circumstances, being trapped in poverty, or having their confidence and dignity damaged.

This complexity also affects how clients interact with a social welfare system that some claim underestimates their health concerns. Clients are implicitly aware of the tensions that arise as work expectations bring the relatively personal sphere of health more into the public sphere to be officially scrutinised and evaluated. Suppression or deferral of health-related discussions by both clients and case managers – for a variety of structural, interactional and cultural reasons – complicates matters further.

Health problems are worsened by clients' primary identities as mothers with exclusive responsibility for their dependants. Concern about children's wellbeing is often under-appreciated in a mother's transition from welfare to work. Leaving an ill child for employment reasons makes most women feel like a "bad mother". Going out to work is viewed by some DPB mothers as contributing to a child's behavioural problems and leading to a downward spiral in family dynamics and wellbeing. In contrast, other mothers view paid work – even stressful, low-wage work – as the key ingredient for their family's wellbeing.

Finally, in order to understand the health–work nexus, we must consider how poverty dominates the lives of these women, making them more vulnerable to health-related setbacks than more advantaged members of society. While creative strategies are often employed to manage health problems and costs, the relative lack of financial and socio-cultural resources limits their options in dealing with these problems. The uncontrollable and unpredictable elements of health make can make sole mothers nervous about their ability to cope, and some argue for a more "holistic" understanding of "health" and its relationship to unpaid caring work and employment. A social welfare system that views low income, poor health, childcare problems, and paid work as discrete components frustrates some DPB mothers, who know from experience that they are related.

IMPLICATIONS FOR POLICY AND PROGRAMME DELIVERY

This research raises a number of complex policy issues that can only be highlighted briefly in a paper of this scope.

- Case management training needs to be sensitive to the health-related complexity of some clients' circumstances. While some sole mothers may resist queries about health in an initial encounter, an effective case manager should have the skills to raise and discuss health issues, and to understand how health relates to client motivation and capacity to engage in sustained paid work.
- Interventions to improve health status should be made earlier in the DPB experience, well before discussions focus on the need to find paid work.

- Case managers need to encourage mothers to think realistically about how they will deal with unexpected or periodic child illness before they begin working.
- Case managers need to be aware of the full range of counselling services and community resources available in order to assist clients with health-related issues. (In some cases, we realise that suitable services may not be available within the community.)
- Clients must receive full and proactive disclosure of all health-related benefits and allowances.
- Benefit levels must ensure that clients can better manage the unanticipated direct and indirect costs of health emergencies. Alternatively, more resources need to be provided for those clients with special health needs.
- Parents of school-aged children should not be asked to pay for primary health care services, especially those relying on social benefits. Health-related costs, even with existing government subsidies, seem to be too high for some beneficiary families.
- Governments need to consider expanding statutory sick leave provisions and encouraging employers to offer more flexible work arrangements for families with children. This would require widespread public consultation, especially with employers and employees groups.

The Government has already made policy changes affecting the transition to paid work for sole-parent beneficiaries by removing the work test in April 2003. This was an important acknowledgement that some sole mothers might need to postpone paid employment while dealing with family or personal problems while others might be ready for paid work before all their children reach school age. However, we feel that the new focus on case management needs to address those aspects of the welfare experience that beneficiaries say are making them feel undermined, disempowered and dependent. Otherwise, the health and wellbeing of some sole mothers could be further damaged in the transition to employment.

REFERENCES

Baker, Maureen (2001) *Families, Labour and Love: Family Diversity in a Changing World,* Allen & Unwin, Sydney, and UBC Press, Vancouver.

Baker, Maureen (2002) "Child poverty, maternal health and social benefits" *Current Sociology,* 50(6):823-838.

Baker, Maureen, and David Tippin (1999) *Poverty, Social Assistance and the Employability of Mothers: Restructuring Welfare States,* University of Toronto Press, Toronto.

Cancian, M., R. Haveman, T. Kaplan, D. Meyer and B. Wolfe (1999) "Work, earnings and well-being after welfare: What do we do?" in S. Danziger (ed.) *Economic Conditions and Welfare Reform: What are the Early Lessons?* Upjohn Institute, Kalamazoo, Michigan.

Corcoran, Mary, S.K. Danziger, A. Kalil and K.S Seefeldt (2000) "How welfare reform is affecting women's work" *Annual Review of Sociology* 26:241-269.

Curtis, Lori J. (2001) "Lone motherhood and health status" *Canadian Public Policy* 27(3):335-356.

Dorsett, Richard and Alan Marsh (1998) *The Health Trap: Poverty, Smoking and Lone Parenthood,* Policy Studies Institute, London.

Edin, Kathryn and Laura Lein (1997) *Making Ends Meet: How Single Mothers Survive Welfare and Low-Wage Work,* Russell Sage Foundation, New York.

Ellwood, David (2001) "The US vision of work based reform: Promise, prospects, and pitfalls" presented to the National Social Policy Conference, University of New South Wales, Sydney, Australia, 4-6 July.

Goodger, Kay (2001) "Recent trends in the employment rate of sole mothers in New Zealand" *Social Policy Journal of New Zealand* 16 (July):191-198.

Goodger, Kay and Peter Larose (1999) "Changing expectations: Sole parents and employment in New Zealand" *Social Policy Journal of New Zealand* 12 (July):53-70.

Harris, K.M. (1996) "Life after welfare: Women, work and repeat dependency" *American Sociological Review* 61: 407-426.

Hunsley, Terrance (1997) *Lone Parent Incomes and Social Policy Outcomes: Canada in International Perspective,* School of Policy Studies, Queen's University, Kingston, Ontario.

McMillan, Karen E. and Heather B. Worth (2001) "Working against them: Health status in a sample of single mothers on welfare" presented to the Australian Sociologists' Association Annual Conference, Sydney, December 13-15.

Millar, J. and K. Rowlingson (eds.) (2001) *Lone Parents, Employment and Social Policy: Cross-National Comparisons,* The Policy Press, Bristol.

New York Times (2003) "House approves GOP welfare legislation" 13 February, available at www.nytimes.com.

O'Connor, Julia S., Ann Shola Orloff and Sheila Shaver (1999) *States, Markets, Families: Gender Liberalism and Social Policy in Australia, Canada, Great Britain and the United States,* Cambridge University Press, Cambridge.

Pryor, Jan and Bryan Rodgers (2001) *Children in Changing Families: Life After Parental Separation,* Blackwell Publishers, Oxford.

Riccio, J. and S. Freedman (1995) *Can They All Work? A Study of the Employment Potential of Welfare Recipients in a Welfare-to-Work Program,* Manpower Demonstration Research Corporation, New York.

Sarfati, Diana and Kate Scott (2001) "The health of lone mothers in New Zealand" *New Zealand Medical Journal* 114(1133):257-260.

Tippin, David and Maureen Baker (2002) "Managing the health of the poor: Contradictions in welfare-to-work programs" *Just Policy* 28(December):33-41.

Vosko, Leah (2000) *Temporary Work: The Gendered Rise of a Precarious Employment Relationship,* University of Toronto Press, Toronto.

Whitehead, Margaret, Bo Burström and Finn Diderichsen (2000) "Social policies and the pathways to inequalities in health: A comparative analysis of lone mothers in Britain and Sweden" *Social Science and Medicine* 50(2):255-270.

Wilson, Moira (2000) "The policy response to the employment taskforce and changing patterns of domestic purposes benefit receipt: A cohort analysis" *Social Policy Journal of New Zealand* 14(July):78-103.