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Single mothers getting by: cultural and structural violence in public policy

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SINGLE MOTHERS GETTING BY: CULTURAL AND STRUCTURAL VIOLENCE
IN PUBLIC POLICY

A Thesis

Presented To

Eastern Washington University

Cheney, Washington

In Partial Fulfillment of the Requirements

for the Degree

Masters of Science in Public Administration and Anthropology

By

Amara E. Bates

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MASTER'S THESIS

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ABSTRACT

From the birth of government funded welfare in 1935 through current discussions of welfare reforms, the media and politicians have used rhetoric to make poor single mothers the “other.” This paper will apply Galtung’s model of the rhetorical and enacted route from cultural violence to structural violence ending in direct violence to this case. To explore the in the creation and “reform” of the welfare system, I will use discourse from various sources such as addresses to congress, public policy, media sources and women’s personal accounts as well as analyze directly the policies that were created in response to this discourse. This will demonstrate how demonizing welfare and its recipient’s shifts focus from the real problems that create poverty and inequality. A comparison of two states, Idaho and Washington State, with opposing public policy and political practice relating to the use and access of healthcare, the experiences of single mothers headed households can be analyzed further.

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Chapter 1

Single mothers getting by

The issue of single mothers and health insurance is personal for me. I was 19 when I became pregnant with my oldest child. It was 1993 and I was living in a small town of about 5,000 people in North Idaho. I had not planned to become pregnant. I did not have medical insurance and was completely overwhelmed by the prospect of becoming a mother. I was living with my boyfriend; he was the manager of a local restaurant which provided him with benefits including medical and dental insurance. However, as we were not married, I didn't qualify for his medical insurance. I called every insurance company in the phone book and got the same answer: my pregnancy was a preexisting condition. I turned to the state for help. I filled out the paper work and was told that our annual income of \$22,000 was just over the income qualifications for medical insurance. I was shocked. We were barely making it; a \$10,000 hospital bill would completely break us. I was desperate. I kept putting off my first doctor's appointment for fear I couldn't pay. I wasn't taking prenatal vitamins either as I wasn't aware of what I needed to be doing to keep myself and my baby healthy. I made one last attempt at our local health and welfare office. I brought in a copy of every bill we paid monthly for the last 12 months along with our paycheck stubs showing how much we took home. I handed them to the lady in the office and asked how am I supposed to pay 100% out of pocket for this pregnancy? I would gladly pay for insurance but my pregnancy will not be covered. After looking through the proof of my monthly expenses she granted me medical insurance to cover only the expense of my pregnancy with this stipulation: if I ever again applied for medical insurance to cover a pregnancy in the state of Idaho I would be denied (even if I

qualified) and billed for this pregnancy also. I agreed; I didn't have the luxury of worrying about future babies. I thanked her and left, considering this a victory. It was a victory. I could now go to the doctor and get the care I needed. What about all the women who weren't as lucky as me? Was this really lucky? Why is our healthcare more of a luxury than a way to meet basic human needs? My second child was born while I was married. I had health insurance! Our cost after the insurance covered its portion was roughly \$4,000; the hospital expected to be paid within 12 months. Our income hadn't changed much since our first child. To pay the bill and avoid bankruptcy I needed to drop out of school at the local community college and go back to work to pay the hospital bill. Seventeen years later, I was a divorced single mother and full time student with another unplanned pregnancy. Despite a diagnosis that should have left me infertile and the use of birth control my third child was on his way. This time I was living in Washington State. I had applied for Basic Health several years prior to provide insurance for my children and myself. My monthly payment varied as my income varied from year to year. At the time I was paying \$35/month. I called my insurance provider when I found out I was pregnant. After doing a quick income verification they switched me to the maternity benefits plan. I was living with my boyfriend and father of my unborn baby which I disclosed. By the rules of Washington State for maternity benefits, because we were not married, his income was not counted in determining my eligibility for maternity benefits. I had a high risk pregnancy but I was taken care of, my baby was taken care of and I did not have a huge hospital bill stressing me. I even graduated the following year with my BA in Anthropology. My third pregnancy took place during welfare reform of 2010 and the introduction of the Affordable Care Act (ACA). I was ecstatic to think that we as a

country could transition our healthcare into a single payer plan and take away the elitism of American healthcare. That didn't quite happen; however, the US is making strides in the right direction. My experience embodies the problem I will be discussing here: how the changing rules around welfare and healthcare for single mothers and their children can be understood using the lens of structural violence. Why, in a country where we're so wealthy, do a large number of single mothers and children not have access to healthcare and to the other necessities of life (income, childcare, etc.)? What does it say about our society that we went from a situation in which single mothers and children were seen as meritorious recipients of society's aid to one where they're seen as burdens? What does it say that we define "welfare" as bad, but "corporate welfare" as an unalloyed good?

My first experience was prior to welfare reform in 1996. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was a major overhaul of the welfare system. Temporary Assistance to Needy Families (TANF) replaced Aid to Families with Dependent Children (AFDC). This new act incentivized states to move welfare recipients off the welfare rolls and into steady employment, mandating work related activity requirements and sanctions if work goals were not met; limited cash assistance to 60 months lifetime benefits; increased federal funding for childcare subsidies; and promoted marriage to reduce the number of out of wedlock pregnancies. With AFDC, all individuals that met certain requirements were entitled to benefits. Under the new law, TANF and Child Care and Development fund (CCDF) was funded by a block grant, which gave the states more power to decide how their cash assistance programs would work. The grants were a fixed amount based on how much the federal contributions had been made to each state's AFDC, JOBS (and other related welfare to work programs),

and emergency assistance programs. States could decide to not give assistance even if families fell within the guidelines for the programs. For many states, this created a windfall of federal money as they could choose to spend less than the block grant on cash assistance. This made an incentive to move more people off the welfare rolls, as the states could use any remaining money from the block grants for other programs written into the PRWORA. In turn, TANF program funding would not grow with each new eligible family, forcing states to either supplement with their own funds or not provide services to all eligible families (Loprest, P., Schmidt, A., and Dryden Witte, A., 2000; the law itself can be seen at <http://www.gpo.gov/fdsys/pkg/BILLS-104hr3734enr/pdf/BILLS-104hr3734enr.pdf>.)

The new Act included financial incentives to the states to promote marriage and punished single women having children out of wedlock by excluding children born to single women after the passing of the Act from receiving financial benefits. An underlining attitude was fulltime, stay-at-home mothering was a luxury for women that were married and middle class or have substantial financial resources to do so (Mink, and Solinger, 2006). Even with this massive overhaul intended to reduce them, single mother-headed households never saw a significant drop but in fact steadily increased. Currently, about 4 out of 10 children are born to unwed mothers and 9,029,000 households are headed by single mothers (CDC, 2015 with 2013 data). The number of single parent households has more than doubled from twelve percent in 1970 to twenty-eight percent in 2013. Households headed by single mothers have increased from eleven percent of all households in 1970 to twenty-four percent of all households in 2012 (Vespa, Lewis, and

Kreider, 2013). As the number of these households grew, so did the social stigma associated with these women and their children (Mink and Solinger, 2006).

This study emerged from work I had done previously, some of which will be used to understand the questions posed here. In 2009 I interviewed single mothers in both Washington State and Idaho as part of an extensive research project. I asked them several questions on how they went about their daily lives and the strategies they used. Every single woman expressed the importance of having adequate and affordable healthcare for their children and themselves. Washington State offered reasonably good health insurance with a generous income guideline in order to include more people than Idaho. The women living in Washington were able to obtain insurance for their children. They were aware of Basic Health or other medical care options and expressed less concern with the ability to obtain needed healthcare for themselves and their children. The women in Idaho either didn't have health insurance or were noticeably concerned as to how to cover needed health care for their problems. As per the PRWORA, Idaho had much lower income qualifications than Washington State for programs like Medicaid. Alice, a single mother in Idaho summed up her medical experience

...for medical, you can't make any more than \$320 bucks a month and if you make more than \$320 bucks a month you can't get Medicaid. Ok so I make \$800-\$900 a month: my rent is this much, my electric is this much and I need transportation to maintain my job, buying clothing, buying things kids need for school, for summer, for everything. I can't afford to go to the doctor. I need my tooth pulled right now. I don't have Medicaid now because Obama decided to give \$25 extra dollars a week on unemployment which I'm grateful for but that put me over the limit and now I can't get medical. So now with all the bills I have to pay how am I gonna pay to get my tooth pulled? My son's medication is \$170 a month and they still haven't approved my son for Medicaid; so how am I supposed to pay that? ...I think that the people who are working should get Medicaid and the people who are actually trying to work and making ends meet should be the ones to get medical coverage because they are trying. They are

trying to not be in the system but because they can't get Medicaid and they can't afford food and other stuff. They get right back into the system because you can't afford it unless you make \$15-\$20 bucks an hour"

Welfare reform and single mothers have gone hand-in-hand for decades in the United States and how single mothers will be affected long term after the ACA passed is unknown as it has not been long since the law was enacted and it has not yet been fully implemented for a variety of reasons. One significant difference from prior government assistance programs such as PRWORA, TANF, and AFDC is the primary focus was not to assist single-parent headed households. The ACA does not make this distinction as it provides health insurance based on income rather than household makeup.

Several studies show there is a direct need for the safety net of healthcare for single mother-headed households. However, when various actors within the United States positioned the rhetoric to make poor single mothers the "other" in order to validate welfare reform as a political agendas, structural and cultural violence began to dictate social outcomes. "Demonizing welfare allows the country to ignore the economic and social conditions that produce poverty and inequality – class, race, gender, the economy and the inadequacies of the low wage labor market"(Handler and Hasenfeld, 2007, 3).

Understanding why some values are held as important even if they appear to hurt particular populations, perpetuate discrimination and force a particular lifestyle is critical, such as the preamble of the PRWORA promoting heterosexual marriage as the only way to successfully raise a family. In the 1920s through the 1950s it was not only acceptable for single women to receive welfare in order to stay home and raise their children but was expected, especially for white, widowed single mothers. As more women of color began to demand equal access to ADC cash benefits or other government subsidized programs,

attitudes about single mothers began to transform to a demonization of this population often through racial stereotyping (Mink and Solinger, 2003).

The racialization of welfare or playing the 'race card' and decades of racial stereotypes had turned the issue of those deserving of welfare into a 'black problem' by the 1960s.

The cultural attitude in the US was one of suspicion and racism toward people of color (Abramovits, 2006, p. 32). With this new perspective, welfare reform laws could be pushed through with less resistance at the expense of single mothers and their children.

Johan Galtung's (1969, 1990) research on violence and peace offers an explanation for a culture's transformation in attitude and action against a particular population by proposing a theory of different types of violence.

Galtung (1969) defines violence within societies by discussing three interrelated kinds of violence: cultural, structural, and direct violence. When violence of any type is inflicted, it prevents a person from reaching their full potential. This violence can be expressed through actions, words, attitudes, structures or systems that cause psychological, social, physical or environmental damage. All three types of violence can reinforce the existence of the others and perpetuate scenarios in which each type of violence individually or collectively are perceived as normal and expected. Galtung (1969) argues that there is a causal connection from cultural to structural violence ending in direct violence. Structural violence is at the left end and cultural violence is at the right end of the base of a triangle invisibly while direct violence is on the vertex visibly. Direct violence is visible as behavior with either physical and/or verbal acts of aggression. Those acts of direct violence, however, are rooted deeply within cultural and structural systems kept in place by the powers that be and those that either support it or at the very

least accept as the norm. The culture then convinces its members to see exploitation and repression as normal and especially not as exploitation of a vulnerable population within the culture. This latter part is cultural and structural violence.

A violent structure will leave its mark not only on the body but also on the mind and spirit. A lack of medical attention within a country that has superior medical facilities, equipment, personnel and medicine can be viewed as direct violence. The structures that lead to those outcomes are structural violence, while the ideology that supports and maintains those structures is cultural violence. Violence can be viewed as a needs deprivation or “one group treating another group so badly that they feel a need for justification and eagerly accept any cultural rationale handed to them...Direct violence is an event. Structural violence is a process with ups and downs, cultural violence is an invariant, a permanence, remaining essentially the same, given the slow transformations of basic culture” (Galtung, 1990, 294). Regular criminal activity can be seen as the oppressed trying to get out of the cage, to redistribute wealth, get even, and seek revenge within a system in which direct and structural violence creates a needs deficit. Regardless of the type of violence, violence breeds violence. To be fair, entire cultures should not be classified as violent; however, one can say that aspect A of Culture C is an example of cultural violence (Galtung, 1969).

Actual or direct violence can take many forms. It can involve the use of physical force, like killing or torture, rape or sexual assault, and beatings; verbal violence, such as humiliation or put downs; threats to use force; and deprivation (Galtung, 1990). He describes direct violence as the avoidable impairment of fundamental human needs or life

which makes it impossible or difficult for people to meet their needs or achieve their full potential (Galtung, 1969).

Cultural violence, according to Galtung (1990), is any aspect of a culture that can be used to legitimize direct or structural violence. These are the prevailing attitudes and beliefs everyone has been taught since childhood about the power and necessity of violence. Those aspects of culture, the symbolic sphere of our existence exemplified by religion and ideology, language and art, empirical science and formal science (logic, mathematics) that can be used to justify or legitimize direct or structural violence by the continuous exposure to such imagery. Stars; crosses and crescents; flags, anthems and military parades; the ubiquitous portrait of the Leader; and inflammatory speeches and posters are all examples of cultural violence (Galtung, J, 1990). In the case discussed here, ideology and attitudes about single mothers and their children constitute cultural violence. Often the media was used to perpetuate and reinforce ways in which the general population viewed single mothers and their children.

Structural violence is defined as social structure or social institutions that may harm people by preventing them from meeting their basic needs. In other words, members of one group, class, gender, or nationality have different access to goods, resources and opportunities than other groups, classes, genders, or nationalities. This unequal access is built into the social, political and economic systems. The object of structural violence may be persuaded not to perceive this at all. It is silent. Often this is experienced through public policy and legislation Galtung (1990).

Direct violence can be very blatant and obvious to all or somewhat private as people struggle to satisfy some very basic human needs. The following examples illustrate

structural and cultural violence pertaining to single mothers and their experiences; it does not focus specifically on healthcare, as these various kinds of assistance are often grouped together in popular discourse. In following the triangle of violence, examples of societal perceptions of single mothers can help demonstrate how public policy pertaining to healthcare coverage and access has been formed, proposed, passed and becomes law. An example of cultural violence aimed at single mothers can be seen in *New York Times* bestselling author Ann Coulter's 2009 book titled *Guilty: Liberal "Victims" and their Assault on America*. She discusses single mothers as a social problem in great detail. The following is an excerpt from her book:

We have "single mothers" because more than a million women choose to have children out of wedlock every year in America, and do not then wed or give the babies up for adoption. By their own choices, they consign their children to starting life with second-class status. Likewise, we can't blame mothers who get divorced for being single mothers: We should blame both mothers and fathers. And divorced mothers should be called "divorced mothers," not "single mothers." We also have a term for the youngsters involved: "the children of divorce," or as I call them, "future strippers." It is a mark of how attractive it is to be a phony victim that divorcees will often claim to belong to the more disreputable category of "single mothers."...Getting pregnant isn't like catching the flu. It involves a volitional act by which single mothers cause irreparable harm to other human beings -- their own children. Single mothers also foist a raft of social pathologies on society. Look at almost any societal problem and you will find it is really a problem of single mothers (p. 36).

A few years ago, a Republican candidate nominee hopeful, Mike Huckabee, said "Most single moms are very poor, uneducated, can't get a job and if it weren't for government assistance their kids would be starving to death and never have healthcare"(Huckabee, 2011). These examples make it clear that cultural violence is setting the stage for structural violence and direct violence toward single mothers and their children to take place without much opposition. These examples are not limited to right-wing activists; indeed single mothers themselves express these ideas.

As stated above, I began my research on single mother-headed households by interviewing single mothers living in Washington State and Idaho. Their stories show how cultural and structural violence plays a part in their lives. The stigma of receiving government help was at the forefront of all the women's decisions when figuring out how to care for their children.

Yolanda was a divorced mother of 2 living in Washington/Idaho when I interviewed her. Her relationship with her husband had been rocky but they were going to counseling and trying to make things work. One day at church, her husband leanded over just before the service was over and told Yolanda she had until the end of the day to move her and the children's things out of the house. She had a newborn and a two year old. She was now a single mother at the age of 36.

I think others view us as needy. Like we are reliant, like I am on state assistance and I get that a lot that because I am a single mom and that I have to be treated differently or I am trying to manipulate the system and try to get rich off of it. I'm just trying to keep my family fed. I asked for- my daughter has at least 2 appointments a week and he (newborn) was sick so he had an appointment every week and so I called the state and I said I need help with gas. My mom is letting me borrow her car but I need help with gas. I can't make what you give me last. They said- you need to manage your money better. I said why don't I bring you everything I have to pay that's not unnecessary but have to and you show me what has to be cut. And please remember that my ex only has to pay \$50 a month in child support, \$25 apiece. He is disabled but he can work just fine, during our marriage he worked a total of 4 months. He can work just fine but he knows if he works then he has to pay more in child support. So he chooses not to. I went to them and I said I don't know if you have paid attention to how much diapers cost but \$50 isn't ever going to buy diapers to last the month. And now on his own increased it to \$75 a month. Oh wow, thank you, now I can actually buy a full box of diapers. But I know you're not supposed to but they give me a lot of food stamps, more than I can use so I say to my mom and dad I will buy food for you to help you out and you buy diapers for the kids or hairspray or toothpaste or whatever little necessities I need and I will buy the food. So 3 for us I get \$563 a month and my rent is \$350 and electric is \$30 and I have to have a phone and that's \$50 something and fortunately with a 2 year old. I have cable, you have to

have cable. That's not including diapers and gas. Thank goodness the state- my insurance picks up the formula because he is on special formula.

Georgia, in Washington/Idaho became a single mother under different circumstances.

When she found out she was pregnant she got married right away. She felt that was the expectation.

I got pregnant with my first daughter when I was really young. I was 19. Well not like really young, but what else was I going to do? So I got married right away because I was pregnant and I was married for almost 10 years and I did a lot of growing up in those 10 years 19- 30 and I just decided that I wanted to be by myself and find out who I am because I was never independent. So yeah, I got divorced and now I'm raising my 2 children and going to school.

While she was married she explained how the cultural discourse on single motherhood influenced her opinions of other single mothers. Now she is living a very different experience than what she perceived.

You know you do what you gotta do and I don't think everybody looks at it that way. I saw myself doing the same thing. I was judging her for getting state help and getting all her loans and getting all this money and doing side jobs under the table so she could still get her state money. No, you do what you can to make ends meet because all this stuff she was getting that I thought was all this money isn't enough. I have nothing. You should have seen me today when I went shopping to buy school supplies. I said ok you can have on pair of pants and we will get your shoes at Ross.

But if I got sick, I don't know what I would do. *Have you tried to apply for basic health?* Right now they have cut it. I had to have a root canal and I went to a community dentist. They work on a sliding scale and gave me 75% off. It was \$1000 so I had to pay \$250 which is still a lot of money for me especially because I have none. I have another tooth that's hurting and will most likely need a root canal...My mouth's a mess and you can't get better unless you can get it taken care of. . And as far as dental, if I have rotten teeth, who's going to hire me? Who will take care of my kids if I'm sick and can't get the help I need? I get \$600 a month in child support and I can't get medical because that's too much money.

Both women express an awareness of how judgments aimed at her as a single mother make her life harder. Georgia even admits that her own attitudes have changed since she became a single mother. She used to completely accept the

cultural discourse that single mothers are taking advantage of state money while cheating on the side. Now she finds that these mothers have little choice.

However, they continue to feel themselves and their children suffering under the judgments of others.

Structural violence is also easy to see in the lives of single mothers. Single mothers are more likely to struggle with poverty than other families. In order to “help” women with children off the welfare rolls, welfare to work became a component of the PRWORA.

This part of the law transitioned women off of welfare by providing them basic skills to qualify for a job; most were entry level. Linda Gordan offers this critique of this piece of legislation “There is a double standard of welfare provision for men and women. One source of this differential treatment is our gender system, including norms that women, especially mothers, should be primarily domestic and supported by men. The failure of several decades of “workfare” programs can only be explained in terms of fundamental ambivalence on the part of legislatures, welfare professionals, and voters about whether public support of single mothers is better or worse than sending mothers into the labor force.. the lack of gender analysis obscures the labor-market sex segregation that makes it difficult for women to get jobs that provide even as good an income as welfare provision” (Gellman, 1999).

The problems are clear in the interviews I did with single mothers as well. Lisa, a single mother of two living in Idaho/Washington, relayed her experience as she attempted to stay off of government assistance and work to provide for her children.

I found that a little over a year ago, I was in the same situation. I did not want to ask for help (state assistance) and I was – I ended up at the point where the more extra hours I worked to try to pay the bills the more I was paying a babysitter and

I was never making ends meet completely and I could barely afford my rent. I didn't even have a car payment. I had a crappy old car at the time.”

Nikki, also a mother of two living in Washington, worked three jobs to pay her bills:

I was working at the Palm Court in the afternoons on my days off at the Davenport waiting tables, and then I was working at Shenanigans in the evenings and then I was working at Penny's doing hair 4 days a week. So I only worked 4 days a week at Penny's and had 3 days off that I had my other jobs. That's what I had to do and that's when I had play money, I don't have play money cause I don't have time to have 3 jobs. I would never see my kids”

Charlene, single mother of one child living in Idaho/Washington, recalls her mother's experience as a single mother.

Well it was during the Reagan administration and mom was trying to get an education because being a single parent of 2 little girls and holding down a job and it was very difficult for her on numerous occasions because like I said the Reagan administration if I remember correctly, mind you I was only 7 or 8 and never knew we didn't have anything because my grandmother made sure that we didn't know that. But food stamps got cut, federal funding to single moms got cut during that administration and so she was out working 2 jobs and still going to school, trying to raise us, trying to have a social life and it was very difficult for her. I find it very difficult for me now to do the same thing.

Dena, a single mother of some number of children living in Washington, reflects on her financial strain due to a lack of benefits.

I just got Basic Health and I am so thankful. This is my first month with it. I haven't had insurance for the last several years. Actually I have \$15,000 in medical bills that are in collections over a couple of different things that happened in the last 5 or 6 years that I didn't have insurance for and couldn't pay for still. And I can't afford to add more to it. I couldn't afford to pay for the medical that my employer offered either so I had none or I wasn't eligible for medical from my job because of my varying work hours. So I went without for years.

These mothers all reflect how the underlying conditions – the kind of work they can find, their lack of access to health insurance, and the like – create difficulties that make it hard to thrive or even survive. These conditions are the kinds of things that Galtung refers to as structural violence, conditions that make it difficult or impossible to meet their basic

needs. Over the next two chapters, this thesis will explore the ways in which cultural and structural violence has played out in the shifting rhetoric about assistance to single mothers and their children and in the legal and practical framework that structures the assistance that they receive. Chapter Two will focus on the period before the welfare reform of the 1990s; Chapter Three will focus on the 1990s welfare reform and what's happened since. Chapter Four will return to a local focus, looking at the ways in which the experience of single mothers around healthcare in Washington State and Idaho reflects the differing pathways that states have taken in the period since welfare reform. Chapter Four will conclude by returning to Galtung's ideas of cultural and structural violence to understand the experience of single mothers in Idaho and Washington.

Chapter 2

History of Welfare: Part I

The idea of welfare to help the needy has existed for many centuries. Poverty exists among all nations, industrialized and otherwise. However, poverty in modern industrialized countries like the United States exists not because there are too few resources to adequately provide for those in need. Instead, an ideology or set of ideologies that prevent the use of resources in this way have a strong influence on policy makers and resonates with and influences voters. This ideology is a kind of cultural violence as conceptualized by Galtung and discussed in the previous chapter.

It is fair to say that a constant attitude about the poor in the US has been one of suspicion with the belief that the poor are immoral and fall easily into irresponsible behavior. Some have argued that welfare is a woman's issue, more specifically a single mother issue. The question of how to help and treat single mother-headed households has plagued the United States from its formation. Strong feelings of worthiness or lack thereof depended on the circumstances of how these women became single mothers. Welfare worthiness was further stratified with ideas about race and illegitimacy along with the ambivalence that seems to align with public policy, public attitudes and issues surrounding single mother-headed households.

I have identified three phases in the development and implementation of the set of policies the US came to call "welfare" in the twentieth century. Phase one, during the Great Depression, emphasized the development of welfare with the goal of financially assisting some single mothers, usually widowed and white, to stay home and raise their children. Other types of groups, such as the elderly and disabled, also benefited from the

new policies. In phase two, the years between 1935 and 1975, the welfare state in the US grew exponentially largely in response to population growth, emergence of new needs, the liberalization of program rules, trade union victories, civil rights, women's liberation and other movements (Abramovitz, 2006). At this time, discourse around policy making began to transition away from assisting women with raising their children to blaming the country's economic ills on those relying too heavily on government money and social programs to survive. Attitudes about race and gender also began to surface as a driver for policy change, first as welfare expanded to different kinds of women and then as racism and sexism began to lead policy makers to rethink how "deserving" those welfare recipients are. Phase three brings us to the last 20 years, which are marked by two large shifts: Bill Clinton's welfare reform of the 1990s and the Barack Obama's nationwide healthcare reform of the 2000s. Welfare provision and reform is closely tied to healthcare public policy in the US. One cannot understand how single mothers and their children receive healthcare in the United States without understanding the shifts in welfare as well, as the two were closely linked before welfare reform. The unlinking of those services created a set of issues for women which are still being worked out as the ACA is incompletely implemented due to legal challenges. The massive overhaul and restructuring of how federal and state governments handled the welfare rolls in the 90s started a trend of a steady stream of policy proposals and changes pertaining to those relying on government subsidies as a safety net. The rest of this chapter and the next explore these phases of the creation and reform of welfare systems in more detail.

The situation with healthcare is a little more complicated. The following list is a timeline created by Katherine Schwartz (2009) of the healthcare development and reforms happening in conjunction with welfare reform, updated slightly here to reflect the ACA:

- 1900-1935 - medical care assistance provided in an *ad hoc* manner by civic and religious groups, primarily to the “deserving” poor.
- 1935-1945 - Social Security Act passed, creating the rise of public hospitals and clinics for the poor , beginning of two-tiered system of medical care.
- 1945-1965 - Private insurance coverage expands setting the stage for Medicaid.
- 1965 - Medicaid and Medicare implemented, to provide insurance to the poor and the elderly.
- 1990s - Efforts to slow Medicaid spending growth, through waivers and welfare reform.
- 1997 - Creation of the States Children’s Health Insurance Program (SCHIP), to
- Early 2000s- Efforts to control Medicaid spending growth and states experiments to expand options for poor people.
- 2010- Passage of comprehensive health care reform bill, Patient Protection and Affordable Care Act. (ACA)
- 2012 – Supreme Court rules that states do not have to implement the Medicaid expansion envisioned in the ACA, leaving a substantial number

of single mother-headed households in over 20 states without access to either Medicaid or subsidized health insurance through the exchanges.

Source: (Katherine Swartz, 2009), with ACA update by author; it can be found online at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8347.pdf>

At the turn of the twentieth century an interest in the wellbeing of women and their children began to take hold; it eventually turned into the maternalist movement. The First National Congress of Mothers was held in 1897. In the opening address Mrs. Theodore W. Birney described the importance of motherhood, "...the highest and holiest of all missions- motherhood...while nature has set her seal upon woman as the caretaker of the child; therefore it is natural that woman should lead in awakening mankind to a sense of the responsibilities resting upon the race to provide each newborn soul with an environment which will foster its highest development...the keystone of that bridge will be maternal love..." (Birney, 1897). This powerful sentiment took hold; in 1908 Theodore Roosevelt embraced this idea of "deserving mothers" and their children. In his Address to the Delegates at the First National Congress in America on the Welfare of the Child, he starts off by saying "there is no other society which I am quite as glad to receive as this." He continues: "The man is a poor creature who does not realize the infinite difficulty of the woman's task, who does not realize what is done by her who bears and rears the children; she who cannot even be sure until the children are well grown that any night will come when she can have it entirely to herself to sleep in" (Roosevelt, 1908).

Supporting women and children financially soon followed. Illinois was the first state to experiment with state aid to dependent children by enacting the Funds to Parents Act in

1911. The new law gave money to poor families, usually single mother-headed households headed by widows, on a regular basis to help them pay for food, shelter and other basic necessities for themselves and their children (Mink and Solinger, 2003, 25). In 1913, the Act was revised to the Aid to Mothers program upon recommendation of Judge Pinckney of Chicago. These revisions excluded fathers from receiving grants; it also made deserted and/or divorced wives and unmarried women land owners were also made ineligible (Abbot, 1916). Recipients had to live within the county providing the funds for three years and have US citizenship. A case study was presented to the courts describing the O'Brien family as the model family intended to receive such aid. Mr. O'Brien died from gastritis, leaving behind his wife and 5 children, ages 12 months to 11 years. Mrs. O'Brien was observed to be in very poor health requiring many trips to the doctor and the family was living in a basement described as "filthy, damp and dark." At the end of the court's investigation, the O'Brien family was granted a pension of \$40 a month. This amount was lowered as the children grew old enough for employment, supplementing the family's income. The family was regularly visited by a case worker who observed "This family will soon be self supporting, has greatly improved in health and standard of living, will probably move to better quarters." Mrs. O'Brien's health had greatly improved and she was able to take care of the house and children in a respectable manner (Mink and Solinger, 2003, 37).

After Illinois' success, many states began offering similar assistance to mothers with dependent children. However, the trend of only offering assistance to those mothers deemed "worthy" stayed a constant. Women who were divorced, who had never married, and women of color generally remained ineligible. Non-white women experienced

double discrimination as they were considered better suited for wage work than motherhood (Mink and Solinger, 2003).

The stock market crash in 1929 ushered in the Great Depression. Suddenly the problem extended far beyond single mother-headed households. The middle and working class of the time, under immense social and economic pressure, needed and demanded a better response from the government (Kilty and Segal, 2006). The Committee on Economic Security (1935) reported that 18,000,000 people, including the elderly and children, relied upon emergency relief to survive and 10,000,000 workers had very few options for employment beyond relief work. Millions of people had lost their life savings as well as having a severe decrease in their wage earning ability as a result of the economic depression. The “first” New Deal took place during the years 1933-1934 to assist the failing banks with the Banking Act of 1933 (Greene, 2013). The Federal Emergency Relief administration provided 500 million for relief operations for the poor and emergency employment for thousands of unemployed Americans (FERA Collection, 2015). In 1935, the Committee on Economic Security stated that on average 2.25% of workers were unable to work due to injury on the job or an incapacitating illness. Twenty percent of low income urban families had medical care and related expenses that went above \$100, equivalent to \$1736 in 2015, according to the BLS inflation calculator. The total money spent recovering from illness in these families was on average between one quarter and one half of the family’s total annual income. At least a third of the elderly were dependent on others for care. Middle-aged people were the group hit the hardest as they were expected to care for those the young and old who were unable to care for themselves while trying to provide some sort of economic security for themselves. The

Committee's recommendations included health insurance for low-income individuals, the creation of employment insurance and unemployment compensation as well as a system of old age security. For children and their parents, the report recommended providing aid to fatherless children, child care services, child and maternal health services, and financial security for children (Committee on Economic Security, 1935).

In response to these recommendations, the "second" New Deal in 1935 proposed by Franklin D. Roosevelt included unemployment compensation; old-age benefits, including compulsory and voluntary annuities; federal aid to dependent children through grants to states in support of existing mothers' pension systems; services to aid the homeless, neglected, dependent and crippled children; additional Federal aid to State and local public health agencies; and the strengthening of the Federal Public Health Service. It was quickly passed by Congress and in 1935 the U.S. federal welfare state came into being (Social Security, 2015).

As part of the New Deal, the Social Security Act allowed the federal government to take control of social services at a federal level (M. Abramowitz, 2006, 23). In a radio address on the third anniversary of the Social Security Act, Franklin Roosevelt discussed the success of Act but added, "[t]o be truly national, a social security program must include all those who need its protection." (Roosevelt, 1938, paragraph 17). In 1939, the Social Security Act was amended to include the whole family of the insured worker and provide benefits for widowed mothers and their children in the event of the insured worker's death, transforming what was a retirement program for workers into a family-based financial security program (Roosevelt, F., 1938). The monetary compensation was raised to a more adequate amount, more occupations were covered, and old age benefits were

scheduled to begin January 1, 1940. Other new additions were child's insurance benefits, wife's insurance benefits (for women who did not qualify for primary insurance), and widow's insurance benefits (Mink & Solinger, 2003).

These new amendments divided single mothers into two categories: widowed mothers with dependent children and never married or divorced mothers with dependent children. Children were deemed as "dependent" if they were under the age of 16. Widowed mothers qualified for survivor's benefits under Social Security while never married and divorced women did not. Instead, they qualified only for federally funded Aid for Dependent Children (ADC) in addition to any state funded mother's pension programs. ADC was a federal grant allowing states to provide monthly cash payment to families where the mother or father was incapacitated, deceased, or otherwise absent from raising their children (Hansan, 2015). Unlike the federal survivors benefits which were provided to all insured families, children had to be categorized as "needy" to receive ADC and state cash benefits; this was true, as Louisiana statute put it, if they were "deprived of parental support or care by reason of death or continued absence from the home, or by physical or mental incapacity of a parent" but were living with a qualified guardian (Louisiana Mother's Pension cited in Mink and Solinger, 2003). In practice, this was largely limited to widows in early years.

By the end of 1940 every state but Connecticut, Illinois, Iowa, Kentucky, Mississippi, Nevada, Texas, and Alaska had adopted ADC. Criteria for what made a qualified dependent for ADC, however, varied between the states. About a third of the states deemed children ineligible for ADC if they had had relatives who were legally liable and financially able to support them. The age at which they ceased to qualify ranged between

16 to 18 years old. Nineteen states had limitations on the amount of property the family may possess and still be eligible. Most states allowed various near relatives to apply, but some only allowed the mother to be the applicant. About half of the states had maximum allowances; others stipulated that a child must be brought up in “a manner compatible with his health and general welfare” and within all the general framework the states provided assistance based on “the framework of these varying legal provisions, additional variations in administration, resulting from economic conditions, public attitudes, and ability of personnel” (U.S. Department of Labor, 1942).

In the 1940s it became very apparent that the provision of ADC would become and remain a viciously debated policy issue. By the end of the decade both experts and ordinary Americans were split and vocal about who were considered the “worthy poor” and hence should receive ADC payments. During this first generation of federal-level experts, poor mothers had the right to request ADC benefits if they felt that working would cause harm or neglect to their children. The Federal Bureau of Public Assistance was critical of state agencies that put pressure on mothers with young children to go to work. They argued welfare benefits should be high enough that a mother could stay home and care for their children. It was considered by some cheaper to pay the mothers to take care of their own children than to subsidize daycare when mothers were at work (Mink and Solinger, 2003).

Mothers who chose to take a job rather than live exclusively off of federal assistance to raise their children were also under scrutiny. The country’s values of being a hardworking, self-sufficient individual paired with ADC offering what many felt was an inadequate supplement to income, encouraged single mothers to look for employment.

The increasing demand for workers due to the war further encouraged this trend. Jane M. Hoey, a federal welfare administrator, said in 1943, “Where a mother has been willing to forego the material advantages of job income for the benefit to her children of her uninterrupted presence in the home, agencies are sometime hindered in helping her make this decision by prevailing community attitudes which emphasize the pre-eminent values of economic hardship” (Hoey, 1943).

Between 1942 and 1948, the Bureau of Public Assistance pushed to include all poor Americans who qualified under ADC and other public assistance programs. This increased the number of black recipients from 21% to over 30% (Mink and Solinger, 2003). Studies like one administered by the Cook County Bureau of Public Welfare in 1945 showed that ADC was already inadequate in supporting families because the grant benefits did not adjust with cost of living from year to year. A Chicago wartime study (Kasman, 1945) of mothers, divorced and deserted, showed out of the 100 families, all of whom were receiving ADC but voluntarily chose employment because the ADC grant was not enough to pay for all the monthly living expenses, sixty-seven women were African-American. Not only did this show that ADC money was insufficient to support a family in at least some locations but again it underlines the idea that African- American women have held jobs and were expected to do so much longer than white women. Three-fourths of the group had little or no previous work experience and most did not have an education past grammar school. The types of jobs they could get were often at odd hours or had a long commute time. Daycare options were often inadequate with older children taking care of themselves while mom was at work. Of the 199 children in the study, 94 children, or almost 50 percent, had no supervision while their mother was at

work. “On a whole, the care of the children was haphazard and failed to assure them of a constant and reliable supervision. Serious physical or emotional problems were overlooked and the children were in need of services, particularly medical attention that they did not receive” (Kasman, R., 1945). Mothers chose employment, often fulltime, to reach a desirable standard of living for their family even though it often took away from their ability to be caretaker for their children.

A. J. Liebling, a columnist for the *New Yorker*, wrote in 1947 about the stigma of receiving government help and the sensational depiction of the underserving poor the media often portrayed. He argued that the media helped to increase the distaste for relief recipients, particularly single mothers, by reporting facts that could not be proven or by leaving out crucial information about the woman in question and her eligibility for government assistance to make her look worse. Relief recipients were on the rise which meant there would soon be a need to raise taxes. He argued that it was believed that the best way to go about controlling the steadily increasing welfare rolls was to “shout that the people on relief don’t deserve to be there and to imply that officials of the Welfare Department are Communists who are packing the relief rolls to run down free enterprise” (Liebling, 1947).

Liebling goes on to describe how the constant scrutiny and unprovable stories about relief fraud sparked a wave of reinvestigation of caseloads. By law, people seeking aid should wait no longer than 48 hours but were now waiting weeks. A 1947 story in *The Washington Post* quoted in Liebling’s article started by saying “Thousands of destitute men, women and children in need of home relief are forced to wait weeks for help. Indigent families who apply for relief must now wait a week for an interview and another

two weeks for a visit from a case investigator.” These 2 articles point out how other media stories impacted thousands of families in their biggest time of need with the sole purpose of selling more magazines and newspapers; sensationalized stories of welfare abuse did just that. Here we see clear links between cultural violence, the newspaper accounts that criticize aid recipients; structural violence, the slowdown in the processing of cases; and direct violence, the impact those changes had on families.

Between 1940 and 1945, the number of female wage earners increased by five million. Immediately after World War II, the number of women working in factories declined as production managers refused to rehire them as factories transitioned to peacetime work and putting the returning men to work. As the 1950s approached, the service sector expanded, hiring large numbers of women. In a study conducted by the Department of Labor, Women’s Bureau, nearly 75 percent of women expressed the desire to continue working after marriage and having children. Of that number, 94 percent of non-white women planned to continue working. The vast majority, 84 percent, of women who planned to work said they had no other alternative. By comparison, 11 percent of both married and single women supporting their families stated they were the only wage earner, indicating that marriage does not always supply a male financial provider for the family (Department of Labor, Women’s Bureau, 1946). During a 1951 debate in Congress titled “Fraud and Waste in Public Welfare Programs,” Representative Burr Harrison of Virginia claimed that “Behind an iron curtain of secrecy and concealment we have today a miniature welfare state in actual operation, a welfare state that spends public money for luxuries for the underserving and for the financing and encouragement of improvidence and illegitimacy. The cornerstone of this miniature welfare state is secrecy

and concealment” (Sited in Mink and Solinger, p. 153). This argument that secrecy was harmful led to the passing of the Jenner Amendment in October 1951. It was now law that states would continue to receive Federal money only as long as they made the names of those who were on their welfare rolls available to the public. This was done with the idea that people would look for work or ask relatives for help rather than apply for ADC benefits and have their situation revealed publicly, thus decreasing the number of beneficiaries (Mink and Solinger, 2003).

Politicians rarely cited facts or actual studies to debate how to handle welfare fraud. Instead, stories of overblown instances of fraud were used to demonize all single mother-headed households. Fraud was used more as a trigger word to create an emotional response from legislators during bill proposals; it was presented as the rule, not the exception. Again, the media played a part in elaborate stories presented in Congress as facts. In the same 1951 presentation to Congress, Mr. Harrison of Virginia talked about the “career of a woman who, without physical disability or dependent children at the age of 42, had drawn \$50,000 in relief money. As a side line, she engaged in the policy numbers racket. The official records show that welfare case workers knew of this activity and protected her from police detection” (Mink and Solinger, p. 149, para. 10). He went on to explain in detail how the welfare department employees went to great lengths to buy her shoes. She had a closet full of evening gowns and fur coats. Welfare department employees used government vehicles to bring her relief checks but under federal law, her name remained a secret. On February 7, 1951, Mr. Davis of Georgia suggested that the states “[adopt] a resolution calling attention to the fact that this inordinate secrecy has proved to be a hindrance to the proper and just administration of the social security laws,

and it adopted a resolution calling for the repeal of this secrecy provision.” Mr. Harrison continued with many alleged cases of fraud including a letter from Fred Tew of the *Detroit Press*, which said, “A reading of the stories will prove conclusively, I believe, that social workers and welfare administrators have used the confidentiality of the records as a shield for their own malpractice... the *Free Press* has been able to show how coddling by social workers has ruined the characters of many persons to such an extent that they are content to live off the taxpayers’ labors” (Cited in Mink and Solinger, p. 148-154, 2003). Legislation such as this is an example of structural violence; it explicitly tried to encourage single mothers to not apply for ADC by making that status even more clearly culturally deemed second class and undesirable.

Despite the bleak depiction by politicians and the media, studies conducted on the outcomes for ADC recipients painted a different picture. One 1952 study is one of the most detailed studies done. This study found that with ADC most children were able to stay with their mothers instead of the family completely dissolving, saving family members from permanent emotional and even physical damage. Families were functioning relatively well under enormous hardship. Delinquency, crime, child neglect and children born out of wedlock were occurring less. Lifetime dependency on ADC payments was not a problem: the median length of time on ADC was 25 months. One out of five families received payments for 12 months and only eleven percent received ADC for as long as seven years. Living conditions of families on ADC were often poor; about half of ADC recipients did not have electricity, private inside flush toilet or inside running water. It was not unusual for the maximum allowable payments to not meet the family’s financial requirements. For example, a mother with two children received \$90

per month, equivalent to \$807 in 2015 according to the BLS inflation calculator. The national median income in the U.S. in 1952 was \$3,900, equivalent to \$36,630 in 2015 (Current Population Reports, 1952). That payment, then, was only 36% of the average income. This study goes on to explain that there was evidence that “the higher the income per person of these ADC families, the better were such items as housing and the educational achievements of children” (Blackwell and Gould, 1952).

The 1960s saw a steady increase of welfare recipients for a number of reasons: a rapid increase in the child population, substantial increase in the total number of families in the population, an even greater relative increase in the number of families headed by women, and improvements in assistance standards given by increasing living costs and additional Federal funds made available to the States under the 1956 and 1958 amendments to the Social Security Act (Mink & Solinger, 2003, 175). A comprehensive study done by the Bureau of Public Assistance (1960) provides a good picture of what single mothers faced in current politics and how ADC made an impact. A rising number of households headed by women with children born out of wedlock were not receiving ADC benefits. “[A]n estimated 2.5 million surviving children [were] registered as illegitimate at birth from 1940 through 1957, 1 million were white and 1.5 million, nonwhite. In late 1958, fewer than 10 percent of the white, and fewer than 16 percent of nonwhite, children in this group were living in Aid to Dependent Children Families in which the father had not married the mother”(para.16). The report goes on to say that as many as 1.2 million illegitimate nonwhite children were being supported without any ADC assistance in comparison to about 200,000 illegitimate white children who were not receiving ADC assistance. The marked difference in the rate of nonwhite children not receiving ADC compared to white

children can be explained; nonwhite single mothers and families were not encouraged to apply for benefits. These numbers reflect an overall national estimate with the level of ADC participation varying from state to state. The report observed that state legislators had begun to propose laws to exclude illegitimate children if born out of wedlock to a mother who was already receiving assistance for older children. These proposals died in committee, as they were deemed unconstitutional by the state or vetoed by the governor. For now, all who qualified could be approved for relief. However, this trend of focusing on maternal behavior as a determining factor for defining who should receive assistance would continue.

ADC was renamed to AFDC in 1962, to add the term "family" to the program name. During the 1960s, this program came to be seen by policy makers as a short term solution; its responsibility from this perspective was to help the poor who relied on government assistance to become independent and self-sustaining citizens. AFDC was not to be treated as a long term solution. At the same time, the steadily increasing number of women in the workplace made it less sympathetic to categorize mothers as people who should be non-earners. Earlier, government-subsidized programs allowed mothers to stay home with their children and did not require them to work outside their homes to support the household. Now, AFDC was supplemental help while women prepared for employment to support their family. In the years between 1950 and 1964, the number of AFDC recipients almost doubled from 2.2 million to 4.3 million. Demographic trends played a part in the dramatic increase; the US population in those years increased by just over a quarter (26%) (Census Bureau, 2000). However, the bulk of the change was created by increased divorce and desertion, women-headed households, and the addition of caretaker benefits (monetary

benefits to caretakers of dependents who qualify for SSI) (Mink and Solinger, 2003). Civil rights movements in the 1960s led to African-Americans demanding additional economic rights, including improved access to AFDC, along with civil rights. The media began depicting negative images of African-American poverty as the root cause of financial strain on the US economy (Mink and Solinger, 2003). The Economic Opportunity Act in 1964 further reconceptualized single mothers from stay-at-home caretakers of children to persons who can and should be working to support their children. Politicians argued that AFDC recipients would be better workers and better parents if they participated in workfare programs. For the first time, AFDC ceased to focus on its original concept of allowing single mothers to stay home and raise their children; now it emphasized preparing women to work outside the home with incentive programs and training. Negative rhetoric about the recipients and legislation targeting the poor and needy began to take its toll. Welfare recipients needed a voice to counteract legislators making up stories to pass laws or the media's increased stigma of poverty. In response, the National Welfare Rights Organization (NWRO) was formed on August 28, 1967, with 5,000 dues-paying members representing over 20,000 welfare recipients, a small percentage compared to the overall number of those on government-funded programs. Their concept was simple: equal rights for all Americans, focusing on ensuring that all families would have an adequate income. Most of the NWRO groups were located in the ghettos and barrios of the largest US cities but a few rural groups were also formed to try and reach as many people as possible (National Welfare Rights Organization, 1967).

In 1963 the poverty threshold was established by the Social Security Administration. It was devised to define poverty in a quantifiable means of measurement. The poverty threshold

is used to categorize the number of poor Americans and is updated yearly by the US Census Bureau (Institute for Research on Poverty, 2015). The poverty calculation does not include important things like transportation, the cost of fuel, child care or healthcare for those who qualify. Instead, Mollie Oshansky, the economist who established the poverty threshold using the Department of Agriculture economy food plan. This calculates the poverty line by multiplying the cost of food for a family of three by three. The assumption is in all cases that the cost of food is a third of the living expenses and the rest of the money is used for housing, utilities and taxes. This is the only definition of poverty used to determine who will receive help and who will not and has not been revised since 1963 (Albeda, and Folbre, 1996).

A Gallup poll titled "America's Attitudes about Welfare" spanned the 1960s. Only 20% of those polled felt that too much money was being spent on welfare, while 18% thought not enough money was spent and 33% thought that the amount spent was about right. Only 7% of those polled felt that most relief recipients were dishonest, while 61% agreed that there is 'some' cheating, indicating that most believed that deceitful use of the system was not the norm. When asked about relief programs more generally, 43% favored them while only 6% wanted to do away with such programs. In general, attitudes revealed a strong belief that able bodied relief recipients, especially men, should find any gainful employment or do some kind of community improvement work. Another trend among Americans was the idea that decisions about the provisions of welfare payments should take place at a state or city level, not the federal level. Despite a focus on male work, the strongest emotion of disdain appeared when asked about single mothers specifically. When polled about unwed mothers who continue to have children, answers were judgmental. Responses reflected the

idea that women should work to support their children, even suggesting placing the mothers in institutions or sterilizing them to prevent further pregnancies. One person was quoted saying, “They should be allowed one mistake. But, then, there should be no more relief after that” (Gallup, 1972, q.53a). Another frequent suggestion was to “stop giving them relief money” (Gallup, 1972, q. 3j); other ideas for unwed mothers included jail terms, rehabilitation, job training, supplying birth control information, compulsory psychiatric care, and fines for any illegitimate children born. Only about 1 in 10 favored an increase in welfare payments with each birth (Gallup, 1972). Single motherhood appeared to be the least desirable status according to the answers and opinions of Americans. Here again we see cultural violence: a set of beliefs and understandings of single mothers as people who should be penalized.

In 1964 Lyndon B Johnson declared the War on Poverty stating “An America where every citizen shares all the opportunities of his society, in which every man has a chance to advance his welfare to the limit of his capacities...There are millions of Americans – one fifth of our people – who have not shared in the abundance which has been granted to most of us” (Johnson, 1964). The Economic Opportunity Act of 1964 offered new avenues to help those living in poverty with several jobs and education programs including Headstart, a preschool program for 3 and 4 year olds in very low income homes. Following the passage of this Act, The Food Stamp Act of 1964 was signed into law. This program was developed to provide low income households with better nutrition while utilizing the abundance of food produced in the US (The Food Stamp Act, 1964). On July 30, 1965, Medicare and Medicaid, a national health insurance program, was created for those too poor afford medical care. Originally Medicaid only covered those receiving ADC cash

payments, but this has since changed. Medicaid will be discussed in greater detail in chapters 3 and 4. Shortly, Johnson's Great Society programs were in full swing. Food Stamp program and Medicaid were essential to single mother-headed households, assisting mothers in providing care for themselves and their children.

As the 1970s approached, activism around welfare and single mothers increased. A press release "Operation Nevada" issued by the NWRO (1971) described Nevada's massive welfare reduction, based on the ideas that 50% of welfare recipients falsified information when applying for benefits. The NWRO said that 3,000 people were terminated and another 4,500 had benefits reduced without a fair hearing. Here we see how cultural violence (press release) leads to structural and direct violence (termination of benefits). As a result of NWRO protests, a court ruling set three requirements, 1) recipients must be given 7 days written notice, 2) the reasons why benefits are to be cut off must be clearly stated, and 3) the way a person goes about requesting a fair hearing to appeal that decision must be explained. None of the three requirements had been met by the state welfare department's actions. In response, the NWRO moved their annual meeting from East Brunswick, New Jersey, to Las Vegas, Nevada, to more effectively protest these actions. Welfare recipients from 40 states along with lawyers came to Las Vegas to join in the protest against the state's welfare department. Those people whose benefits were cut off or reduced were found through organized door knocking. The state continued to terminate or reduce welfare checks without a fair hearing, prompting lawyers into a legal battle with the welfare department. After weeks of protesting about unmet demands, the Clark County welfare director, Vincent Fallon, promised service to local people who followed the proper channels. This response did not meet their demands. A Las Vegas NWRO leaflet from

1971 says that when mothers approached their case workers about how they were going to survive without financial help, the response was in some cases “since they had a pretty face and figure, they should know how to make their money.” At the time there was a strong movement for legalizing prostitution (Ruth Rosen, 2012).

During the first part of the 1970s, myths about welfare recipients were used as a pretext for public policy, despite work by the Department of Health, Education and Welfare (1971) to dispel these myths. In an address to Congress, Russell B. Long (1971) said, “We do not know if mothers receiving AFDC continue to have illegitimate children for the sake of increasing their welfare payments. But the study conducted by the Department of Health, Education and Welfare shows an astounding amount of multiple illegitimacies. In the 1969 study 721,000 families – 44 percent of all families on AFDC – had illegitimate children...[and we] must recognize that illegitimacy and family breakups are social problems that have made a major contribution to the recent precipitous increases in the welfare rolls” (Long, 1971, para. 10).

At the same time, Johnnie Tillmon (1972) a leader in the NWRO, shed a different light on single mothers as welfare recipients. She starts off her article "Welfare Is a Woman's Issue" with this powerful statement “I'm a woman. I'm a black woman. I'm a poor woman. I'm a fat woman. I'm a middle aged woman. And I'm on welfare. In this country, if you're any one of those things – poor, black, fat, female, middle aged, on welfare – you count less as a human being. If you're all those things, you don't count at all. Except as a statistic.” She goes on to point out that “forty-four percent of all poor families are headed by women... that means that there is no man around. In half the states there really can't be men around because A.F.D.C. says if there is an “able-bodied”

man around, then you can't be on welfare. If the kids are going to eat, and the man can't get a job, then he's got to go. So his kids can eat." Tillmon compares marriage to a man and receiving AFDC by describing the latter as a "super sexist marriage" by observing that while on AFDC, women are not to have sex at all as a condition of aid; they may even be forced to have their tubes tied, they have no right to protector privacy, or even real say in what she buys with her money. "Politicians are talking about A.F.D.C. Politicians are talking about us – the women who head up 99 per cent of the A.F.D.C. families – and our kids. We're the 'cancer', the 'underserving poor.' Mothers and children." She goes on to point out that a full-time job does not mean an adequate income. The federal minimum wage of \$1.60 per hour still leaves the single mother-headed household of four below the Government's official poverty line. Tillmon's view illustrates how cultural and structural violence continued to plague single mothers, especially African-American women, in the early 1970s.

Many politicians argued that the "income disregard", a standardized amount of monthly income that is not counted to determine eligibility for cash assistance, made it possible for poor women who did not work or worked only irregularly but only received assistance to have better incomes than women working full-time jobs without assistance (Cohen and Ball, 1967). These politicians pushed for a national expectation that single mothers should enter the work force in addition to or instead of receiving cash assistance. At the same time, government-subsidized daycare programs were condemned and eventually vetoed by President Nixon, while white middle-class stay-at-home mothers were praised. So not all women were expected to work; for middle-class women, staying at home to focus on children was admirable. This decade also showed an increasingly

negative attitude about welfare recipients. The media again stepped in by pairing images of people of color with crime or other socially deviant actions (Mink & Solinger, 2003, p. 337-339). Once again, cultural violence was being used to justify shifts in the legal system that created greater structural violence aimed at single mothers and their children. A *New York Times* article, "When You Just Give Money to the Poor," discussed President Richard Nixon's proposed Family Assistance Plan in 1970 (Cook, 1970). The plan was simple: give Americans who earn less than a certain yearly monetary amount a stipend to help them "make ends meet". Before this could be proposed to Congress, The New Jersey Urban Experiment took place to find out if the families would put the money to good use or squander the money and encourage laziness. The Federal Office of Economic Opportunity (OEO) conducted the study, in which they gave additional money to 1,359 families, many of them 2 parent families. They found that a majority of the 1,359 families participating put the money to good use by paying off bills and improving their living conditions. The families receiving the aid on average worked just as hard as they had before they received the extra money. This plan was also shown to save the taxpayers money compared to paying welfare; a quick calculation by the OEO found that it would cost roughly \$72-\$96 per family to administer which was much less than the \$200-\$300 per family per year that it cost to administer welfare at that time. The physiological benefits were also encouraging. Dr. Wilson who conducted the study said, "Under the welfare system, welfare workers come around and investigate and keep you constantly checking. In welfare you are judged guilty until you are proved innocent. People view the income system as a token of trust in them, and I am convinced that this is tremendously important. This shift in attitude has a significant influence on behavior" (Cook, 1970).

While a modest version of this would eventually be implemented as the Earned Income Tax Credit (EITC), a broader and most substantial version of such a program remained a pipe dream.

President Ronald Reagan, a long time anti-welfare advocate who assumed the presidency in 1980, set the tone of welfare reform for the 1980s. Reagan's agenda for welfare reform included eliminating welfare fraud (which he represented as widespread and problematic), reducing federal spending limits for welfare programs, creating work requirements, and devolving control of welfare programs to the states. Additionally, his rhetoric focused on a set of anti-welfare notions that harshly judged the reproductive decisions, values, and behavior of the poor (Kilty & Segal 2003). The President generated lasting imagery when he told and retold a story about a "welfare queen" who had fraudulently received \$150,000 through the welfare system by using eighty aliases, thirty addresses, twelve different social security cards and four fictional dead husbands. This woman did not actually exist, as later investigation would prove. (Dreier, 2004). Nonetheless, this kind of rhetoric set the stage for new laws restricting to welfare to pass with ease.

The Omnibus Budget Reconciliation Act of 1981 changed four criteria for qualifying for Aid to Families with Dependent Children (AFDC) and the food stamp program. The first gave states the ability to develop their own work incentive (WIN) programs to help move families from welfare dependency to job-based self-sufficiency; it included the flexibility to develop job alternatives, including community work experience. Second, it required states to target assistance to the neediest by setting a total income limit of 150% of the State's need standard for those receiving assistance. Previously, many state formulas were based on a standardized income, which excluded a portion of income to meet certain basic

needs and childcare costs; now all income had to fall below this level. The third change altered further how income limits were calculated. In calculating incomes to determine need, states were now to count additional sources of income that were previously excluded: step parent's income after appropriate disregards; the value of food stamps and housing subsidies an AFDC family receives to the extent this value is duplicated by money for food and housing in the AFDC payment; Earned Income Credit (EIC) for those eligible to receive it. Non-recurring income was also counted along with any non-essential equity in excess of \$1000. With all of these additions and restrictions, many more people would not qualify for cash assistance. Fourth, program administration was improved by retrospective accounting and monthly recipient reporting. As part of this, the laws required recovery of all overpayments and payment of past underpayment to current recipients and elimination of payment to those eligible for amounts less than \$10 (Department of Health and Human Services, 1982). These changes had huge impacts on the working poor. In 1982, in New York City alone, 16,000 people were cut from the food stamp program and 9,600 AFDC recipients were disqualified from services. Another 50,000 AFDC and 130,000 food stamp receivers had their allotment reduced. The majority of the people affected were employed as well as receiving aid. In a *New York Times* article, Federal Cuts Frustrate "Working Poor" Mother, Mrs. Hurst sums up a general attitude, "I am one of the angriest women you could find. They're penalizing the very people who want to do for themselves, who don't want to depend on the government to do it for them." (Bennetts, 1982).

During the 1980s, roughly 60% of children lived in a single-parent family at some point prior to turning 18 (Kahn and Kamerman, 1988). Nearly 83% of the AFDC recipients were divorced, separated or never-married women and their children. Widows at this time were

more likely to have adequate income due to survivor benefits through SSI (Social Security Insurance). In 1985 the poverty rate for single mother-headed households reached 54% while all other families experienced a 12% poverty rate (Kahn and Kamerman, 1988).

Ronald Reagan pushed for welfare reform during both of his terms as president. Toward the end of his second term, the Family Support Act of 1988 was passed. The five sections of the law addressed:

- 1) Court mandated child support and establishing paternity. The State would be penalized if a predetermined number of illegitimate births to mothers receiving AFDC or IV-D services did not have established paternity. In turn, States would be incentivised for funding parental genetic testing. Also, they were required to work at locating and collecting child support from non-custodial parents residing in different states.
- 2) Job support training for AFDC recipients. All states were required to have a fully operating JOBS program by October 1, 1992, and supply education, job skills training, job development and placement, and job readiness activities. Included must be at least two of the four following options: job search, CWEP or other work experience programs, work supplementation, and on-the-job training.
- 3) Support services such as guaranteed childcare for AFDC families as they transition to independence. All families will remain eligible for Medicaid for up to 1 year after losing AFDC due to employment.
- 4) Other AFDC amendments requiring States to have a AFDC-UP (unemployed parent) system to address the issue that AFDC broke up

families, as it was only available to single parent families. Now unemployed fathers could live at home without disqualifying the family from AFDC benefits. All AFDC-UP families must remain eligible for Medicaid on an ongoing basis, regardless of whether or not a state limits cash benefits for such families.

- 5) Demonstration Projects were authorized to study various possibilities for enhancing the futures of poor children and their parents (Family Support Act 1988)

This and other related legislation was the preface for the major welfare reform of the 1990s, which will be addressed in the next chapter.

Chapter 3

History of Welfare: Part II

By the 1990s it had become clear that healthcare through Medicaid and related programs was a critical piece of the story of single mothers and their children and would have to be addressed in future welfare reforms. In 1965, as part of Title XIX of the Social Security Act, Medicaid was established as a jointly federal and state funded program to provide medical and health related services to the poorest Americans. Federal statutes, regulations and policies provide broad guidelines for states who then defined their own eligibility guidelines. In the Balanced Budget Act of 1997, CHIP (Children's Health Insurance Program, also known as SCHIP, the State Children Health Insurance Program until 2009) was added for children who did not qualify for Medicaid and would otherwise be uninsured; in most states minors living in households making 200% or less of the poverty line were eligible. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and the Patient Protection and Affordable Care Act (ACA) as amended by the Health Care and Education Reconciliation Act of 2010 extended CHIP funding through fiscal year 2015. Under CHIP, states may elect to provide coverage to qualifying children by expanding their Medicaid programs or through a state program separate from Medicaid (Annual Statistical Supplement, 2011). Chapter four will discuss in greater detail how Medicaid and CHIP were implemented in states by comparing the states of Washington and Idaho prior to the passing of the ACA and after its partial implementation.

During the 1980s and 1990s, the Christian Right grew in popularity and influence. The rise of conservative think tanks such as the Heritage Foundation, The American Enterprise Institute, the Hudson Institute, Empower America and others flooded mainstream media with the help of paid lobbyists, books, and articles. One important theme was the support of traditional family and church structures to help enforce the ideal of a two-parent, heterosexual married union as the only successful way to raise a family. This kind of rhetoric further demonized single mother-headed households; and had a negative effect on access to healthcare and health for people living in these households. It also set up public policy such as the PRWORA to pass, become law, and further inflict structural violence on single mothers and their children. The rest of this chapter will discuss the impact of welfare reform in the 1990s and finish with current policy, particularly the changes to health insurance under the ACA. This chapter will further explore what these policy changes meant to single mother-headed households still considering structural and cultural violence as the means for policy and social change.

In the mid-1990s, anti-welfare rhetoric was high. In response, activist and progressive scholars began publishing more studies arguing that poverty, particularly for women and children, was more structural rather than behavioral. Randy Albelda and Chris Tilly, authors of *Glass Ceilings and Bottomless Pits: Women, Income, and Poverty in Massachusetts* (1994), pointed out three important trends shaping women's economic status at the time.

- 1) Fewer women were getting and staying married. In 1992, over 40% of all adult women in the United States were not married. One out of six women was a single mother.

2) More women were in the paid labor force. Nationwide, in 1947, 30% of women were working or looking for work; by 1992 that percentage had more than doubled to 76%.

However, women still earned less than men per hour – 67 cents on the dollar in Massachusetts.

3) Both nationwide and in Massachusetts, half of all people in poor families were in single-mother families in 1992; this is double the percentage of poor families that were single-mother families in 1955.

Progressive proponents of welfare reform suggested that in order for real progress to happen, policies needed to reflect the real reasons for poverty. For example, the idea that “a rising tide lifts all boats” or that economic growth would fix most situations of poverty is not borne out by the facts, as the benefits of growth do not have to be equally distributed. From 1979 to 1987 in Massachusetts, two-adult families without children experienced an increase in income of 36% while single-mother households saw an increase of only 2%. As general economic growth was clearly not changing matters, Albelda and Tilly argued that explicit policies need to be created to truly help raise poverty stricken households out of the “bottomless pits.” They called for several initiatives: establish a minimum cash benefit and then index benefits to inflation; revamp eligibility requirements that currently excluded needy families from receiving those benefits; provide universal healthcare and child care benefits so women can obtain these benefits without returning to welfare; improve child support system; and provide education and training to women so that they can obtain jobs that pay a living wage once they leave welfare (Albelda and Tilly, 1997).

By the 1990s, it was broadly accepted by politicians that some kind of welfare reform was necessary to better serve the populations in need without raising concerns of overspending or dependency. This partially reflected a further increase in women's employment and partially a continued racially-based "profiling" of welfare recipients. Still, what was needed in the new welfare laws remained in question. The 1990s marked another significant transition in nature of the US welfare state. Even before Bill Clinton campaigned for presidency, he promised to "end welfare as we know it;" as president he set out to put a new model into practice (Handler and Hansenfeld, 2007).

However, the political winds were blowing in a different direction. As we saw in the last chapter, welfare reform and demonizing single mothers have gone hand-in-hand for decades in the United States. In 1996, Republicans offered the Personal Responsibility Act as their form of welfare reform. The main points of their proposal were to reduce government dependency with a new set of policies: attack illegitimacy by monetarily rewarding states that promote marriage, require recipients to enter work programs, and cap total welfare spending. As part of this, they proposed to give states greater control over how to provide benefits and work programs, as well as how to set requirements. Existing welfare programs such as Aid to Families with Dependent Children (AFDC), which combined monetary aid and health insurance, were eliminated. Two new programs were introduced: Temporary Aid to Needy Families (TANF) and the Personal Responsibility and Work Opportunity Act (PRWORA). These programs reduced the number of welfare recipients by imposing lifetime benefits limits for each recipient and restricted who was eligible for benefits. The federal maximum lifetime limit for TANF benefits for mothers was now 60 months. However, states could impose additional limits

or expand them under certain circumstances. For example, in some states TANF recipients can only receive TANF cash benefits for 24 months within a 60-month period. This means that once the 24 months has been exhausted, recipients are not eligible again for another 36 months. States can also choose exceptions or create extensions to the federal guidelines for a variety of circumstances, such as medical reasons or lack of work due to high unemployment if the recipient has looked for work diligently (Cheesebrough, 2002).

The PRWORA separated monetary aid and health insurance by removing the automatic enrollment into Medicaid and State Children's Health Insurance Program (SCHIP) when the applicant qualified for cash benefits (Cawley, Schroeder and Simon, 2006). This was intended to be helpful: to avoid individuals from losing health insurance when their TANF lifetime benefits expired, policy makers separated the benefits. However, in practice this made enrollment in these programs more difficult; receiving health insurance required a separate application. Confusion in filling out the application or simply not knowing that now a separate application was needed decreased the number of individuals receiving Medicaid and SCHIP. Some states required the applications to be filled out at home and mailed in. Errors on the application meant disqualification for health insurance, although assistance in filling out the forms was often hard to find. Food stamp access was similarly affected (Cawley, Schroeder and Simon, 2006). Studies show that children who qualify for Medicaid but remain unenrolled are more likely to have unmet medical needs. "One of the unintended consequences of welfare reform was to adversely impact the health insurance coverage of economically vulnerable women and children, and that this impact was several times larger than the previous literature

provides” (Cawley, Schroeder and Simon, 2006, p. 486). With the passing of the PRWORA, it became law to withhold basic human necessities such as access to adequate healthcare that should otherwise be abundantly available in a country as wealthy as the US. This is a strong indication of structural violence. Services like healthcare and food benefits became more difficult for single mothers and their children to obtain. It can then be argued that the poorest single mother-headed households’ experienced direct violence in the form of untreated or prolonged illnesses or other ailments, as well as the loss of resources normally considered to be basic human rights such as access to nutritious food. Even access to adequate shelter was made more difficult both by the difficulties in access to food stamps and healthcare coverage on the one hand and the strict limits to cash assistance on the other.

The effects on health through the 1990s welfare reform are as follows. First, as families leave the welfare rolls, they often stop receiving Medicaid and food stamps, even though they are still eligible if they apply for food benefits and Medicaid separately. While some families may receive private health insurance from work to offset the loss of Medicaid, those without may use less healthcare and possibly have worse health outcomes. Second, welfare reform may impact the family’s economic resources. Less money to spend on healthcare has the potential to directly affect health status and health outcomes, especially with copayments. Third, loss of cash and other benefits under welfare reform could increase the stress level of an individual which is associated with worse health outcomes (Bitler, Gelback, and Hoynes, 2004). In a study by Kneipp (2002), after welfare reform in 1996, 12% of single mothers interviewed reported that at least one person in their family had to go without healthcare because there was a more important need such as food or

shelter. They reported that affordability was the largest barrier to receiving healthcare, with 58% of the women reporting they could not afford healthcare even with full time employment. However, having full-year insurance coverage for every member of the family eliminated affordability as the main reason for not receiving healthcare. Other studies cited in Kneipp (2002) said that close to 50% of all single mother-headed households did not receive Medicaid even though they were eligible.

In 1994, Jan Hagen and Liane Davis used focus groups to ask women in Washington, DC, about welfare, teen pregnancy, and time limits on welfare. The importance of receiving health coverage was clear. Women told stories of their experience with welfare and Medicaid:

Medicaid is what put me on this. I asked my husband to quit his job and get medical. Because he had a job, they wouldn't help me at all...I needed [medical insurance] to have my child. I needed the doctor. I needed the hospital stay. I needed to have my tubes tied so I could quit having them. I was 25 years old with five children. I needed it to stop, and I couldn't do it. The first four weren't paid for. The fourth one, it got so bad I spent one day in the hospital – saw the doctor one time before I had the child. I needed help. I went down to welfare to get medical assistance. They said, "No, he has a job." I told him to quit his job because I could get more from the system than what he could provide.

Another told a similar story, "I think it's like a roller coaster. Once you get up there, you realize you can't pay for medical, you can't pay for childcare, you can't pay for your transportation, and then you wonder why you are working." (Hagen and Davis, 1994). This affected how single mother access needed programs like Medicaid.

The PRWORA new structure had impacts on health care for single mothers and their children. As more single mothers entered the work force they had less time in general to do day-to-day things to take care of the household. This new time crunch also may have led to a difference in how they handled their children's medical needs. On the one hand,

there has been an increase in the overall subjective wellbeing in single mother headed families that began as a result of the PROWAR and TANF reforms (Herbst, 2013). This is not surprising, as welfare reform also led to an increase in incomes among low skilled individuals (Bitler, Gelback, and Hoynes, 2005, pg. 311). However, the same is not true for access to healthcare. Welfare to work programs focused on helping individuals to receive qualifications to gain employment in an entry level position. These positions did not pay enough to buy private health insurance; if the employer didn't provide it then these women needed another option. As shown above, health insurance is a resource that is considered a necessity by single mothers for themselves and their children; that need had previously driven some women onto welfare. Having health insurance increases the likelihood of receiving adequate healthcare when needed. Uninsured children who are eligible for state health care but do not obtain it add to policy concerns. They may receive less medical care than children with insurance (Bitler, Gelbach, and Hoyes, 2005). When health care is sought, the parent may take the child to the emergency room instead of a doctor's office creating more economic hardship.

Anderson and Eamon (2004) found that low income women compared to TANF leavers have less work experience because they did not have the job training TANF recipients were required to obtain through the JOBS program. Therefore insurance instability is more likely. Job stability was most important to insurance coverage among low income mothers. Thirty-nine percent of the women who did not change jobs between 1995 and 1997 experienced health care instability compared to seventy-five percent who had two or more jobs during the same time period. In 2002, TANF went through a recertification process, the changes were to include encouraging marriage or penalize non marriage and

increase the number of hours TANF recipients were required to work. These strategies do little to increase health care stability (Anderson and Eamon, 2004).

Another barrier to receiving adequate health care is paid sick leave. Almost forty percent of single mothers in 1996 reported that they did not have paid sick leave (Kneipp, 2002). In this study, the respondents did not report a lack of sick leave a deterrent for healthcare overall, but as a burden on financial resources. More than thirty percent of working single mothers who faced losing work for two weeks or more because of illness between 1985 and 1990 and thirty-six percent who had a child with a chronic illness did not have sick leave (Heymann, Earle, and Egleston, 1996 cited by Kneipp, 2002). Having a job that does not offer paid sick leave suggests that other services need to be in place for these low income households to ensure adequate healthcare is available to children with chronic illnesses.

A study “The Health of Poor Women under Welfare Reform” (Cawley, Schroeder, and Simon, 2005) showed that chronic exposure to economic, social, and environmental stresses for women living in poverty, particularly single mothers, decreased the health of poor women after welfare reform. The women who were receiving cash assistance before welfare reform had more health problems after the reform when compared to a national sample. Although some women did experience economic and social gains, many still lived with economic hardship, demanding work and family, and poor neighborhood conditions. Few resources were available to alleviate any of these problems. Those who entered the labor force due to welfare reform through programs like Workforce generally increased their incomes enough that they lost medical coverage but were not offered insurance through their entry level jobs. Kaplan,, et al.

(2005) found that not only did the lack of health insurance affect the overall health of single mothers but also the other resources they lost, such as money assistance, impacted their health negatively.

Overall, welfare reform prior to the passing of the ACA has been connected by researchers not only to a lack of health insurance coverage but also a reduction in receiving healthcare due to affordability concerns. Preventative care, such as checkups, breast exams, and Pap smears are avoided because the women do not have insurance or the money. Breast exams and Pap smears dropped 7-10 percent during the period of reform. During this same time, women who needed to visit a doctor but chose not to go because it was unaffordable increased as much as 16 percent (Bitler, Gelbach, and Hoynes, 2005).

The healthcare situation for single mothers and their children was intended to change with the Affordable Healthcare Act, which became officially accessible to all US citizens on January 1, 2014. Bill Clinton had made a previous attempt at healthcare reform during his presidency in the 1990s but was unsuccessful. President Obama began his push for healthcare reform as a senator and as a platform as a presidential candidate. In a 2007 speech, "The Time Has Come for Universal Healthcare," he said:

On this January morning of two thousand and seven, more than sixty years after President Truman first issued the call for national health insurance, we find ourselves in the midst of an historic moment on health care. We already spend \$2.2 trillion a year on health care in this country... we also have to ask if the employer-based system of health care itself is still the best for providing insurance to all Americans. We have to ask what we can do to provide more Americans with preventative care, which would mean fewer doctor's visits and less cost down the road. We should make sure that every single child who's eligible is signed up for the children's health insurance program, and the federal government should make sure that our states have the money to make that happen. (Obama, 2007)

The passing of the ACA was very different in comparison to the PRWORA welfare reform of 1996 and welfare policy prior to 1996. Previous legislation was specific to single parent-headed households predominantly headed by single mothers. With the ACA, all Americans regardless of household makeup or marital status can qualify for health insurance, often with government subsidies. I will touch briefly on the basics of the ACA and discuss in detail one aspect of the ACA, the Medicaid expansion and what that means to single mothers and their children.

The ACA was signed into law by President Barack Obama on March 23, 2010. This put into place a series of healthcare reforms and protections for the consumers. To date, the White House website (White House, 2015) says that 105 million Americans no longer have lifetime dollar limits on their coverage. Over 129 million Americans with preexisting condition can no longer be denied coverage; insurance companies cannot drop coverage when a customer gets sick because of a mistake on the application or for any other reason. As of 2015, 54 million people have benefited from free preventative screenings and \$2 billion has been rebated to consumers. More than 16 million previously uninsured Americans now have health insurance. Moderate to low-income households can qualify for a premium tax credit to assist with the purchase of health insurance through the marketplace. The tax credit can be paid in advance to the insurer to lower monthly payment or the tax credit can be claimed once a year when taxes are filed (IRS, 2015).

Healthcare coverage has become more affordable in several different ways. First, insurance companies are mandated to follow the 80/20 rule which means 80 percent of premiums paid must go to medical care rather than advertising, overhead, or bonuses.

Any overcharge, such that less than 80% of premiums go to medical care, must be sent back to the consumer as a rebate. Second, insurance companies are required to report why they are raising rates and by how much if it goes over 10 percent. Third, those Americans who are not offered insurance through work can now qualify for a rate reduction if they meet the financial requirements. Fourth, young adults who do not have insurance through their jobs can stay on their parent's insurance until the age of 26. Fifth, preventative benefits such as cancer, diabetes, and blood pressure screenings must be provided for free. Sixth, women do not pay more now for health insurance because they are a woman. 8) American's are now guaranteed the right to appeal decisions to cover healthcare costs (White House, 2015).

In some ways equally important, health care is available to all. The health insurance marketplace is a website with private insurance plans that must accept all applicants; no one can be denied access due to pre-existing conditions that often affect poorer individuals. The marketplace also gives the consumer a more convenient and easier place to purchase health insurance that fits their specific needs. Most of the people shopping on the Marketplace qualify and are receiving financial help with paying for their premiums (<https://www.healthcare.gov/quick-guide/>).

The Obama administration claims that the passing of the ACA turned receiving healthcare into a human right, in contrast to the New Deal of 1935, where farmers, sharecroppers and domestic servants were purposely excluded. In the southern states large numbers of African-Americans and in the North recent immigrants from Europe largely held these jobs, while native-born whites were more likely to be in jobs that were covered (Miles, 2012). Enroll America uses a data driven approach to provide a much

more accurate picture of who is and is not enrolled in health insurance. They target parts of the country with low health insurance enrollment rates. The number of uninsured adults fell from 16.4 percent of the population in 2013 to 11.3 percent in 2014 (Enroll America, 2015). The *New York Times* summarized Enroll America's work as a push back against inequality, as it has redistributed income in the form of health insurance or subsidies; the groups of people that benefit the most are Blacks, Latinos, young people ages 18-36 and women. Prior to the ACA, companies could and did charge higher premiums for women and older adults (Quealy and Sanger-Katz, 2014).

The ACA as passed required every state to expand their Medicaid coverage to include everyone 18-65 with incomes up to 138% of the federal poverty level, regardless of their age, family status, or health. Children 18 or younger were to be similarly eligible at least up to 138% or higher in every state (Healthcare.gov, 2015). The Medicaid expansion should have improved the health of newly unemployed people, as most of them fall into that income group and studies have shown that "[t]he expansion of Medicaid has been associated with improved healthcare coverage and reduced mortality" (Jost and Rosenbaum, 2012). However, in another study, expanding Medicaid did not reduce mortality. In the 2008 recession, the largest group of workers who were laid off were middle aged with children in middle school and high school (Baicker, et al., 2012). Because this group had relatively poor access to affordable health insurance, chronic disease diagnosis was delayed when it was most likely treatable with less costly treatments then waiting for severe symptoms and a higher risk of death (Sommers, et al., 2012). This study found that mortality rates drop when Medicaid expansion is implemented to cover adults, especially those 35-64 years old, minorities, and those

living in the poorest areas. Those who received insurance under the Medicaid expansion reported significant improvement in self-reported health the first year (Sommers, et al., 2012).

The Medicaid expansion was challenged by political figures and in 2012, the Supreme Court ruled it unconstitutional to require states to expand Medicaid, making it a voluntary decision for each State's governor. This creates an insurance coverage gap in many states, as subsidies are not provided under the ACA for those who should have been eligible for Medicaid. Each state had existing rules about who qualified for Medicaid that limited it to incomes far lower than the 138% of the poverty line in the ACA. For these individuals, their incomes are too high to get Medicaid under their state's current rules, but their incomes are too low to qualify for subsidies buying coverage in the ACA marketplaces (Miles, 2012).

An additional oversight was discovered when the IRS interpreted a portion of the ACA about conditions for qualifying for premium tax credits when employer insurance is offered. Large numbers of Americans, including 460,000 children, qualified for Medicaid or CHIP programs but could not receive this health insurance due to what is now called the family glitch. According to the ACA, an individual who is offered health insurance by their employer that equals or is less than 9.5% of the individual's income has been offered "affordable" insurance. This loophole does not take into account the cost of insurance for the remainder of the family, which could in fact cost well over 9.5% of household income. The Family Coverage Act fixes this glitch if the family's cost of insurance is greater than 9.5%, then they can qualify for premium tax credits for the

purchase of health insurance (Frankin, 2014). The bill was introduced June 12, 2014 but has not been enacted (Family coverall Act, 2014).

At this point, it is too soon after the ACA was enacted and too many glitches have affected the access to health insurance for low-income families to know how single mother-headed households will fair with the ACA and related legislation. Chapter four will discuss in detail Medicaid and related services by comparing the legal structure and experience of women in Washington State, a progressive state and fiscally conservative Idaho.

Chapter 4

A Tale of Two States

The past two chapters have focused on the experience of single mothers around welfare and health care from before the New Deal to the present using a cultural and structural violence lens. This chapter focuses on the different experiences single mothers have had since the 1996 welfare reform by comparing two states – Washington and Idaho – and how their different implementation of welfare and healthcare systems since that time shows two pathways followed in the United States. Washington is a classically progressive Democratic-controlled state, while Idaho is a strongly conservative Republican-controlled state. In a 2012 Gallup poll Idaho was identified as the 7th most conservative state in the US, while Washington was the 7th most progressive state in the US (Newport, 2012). This same trend can be seen in presidential approval rating of President Obama. Idaho's approval of President Obama in 2014 was 25.1% compared to Washington's 44.1% (Gallup, 2014). How each state's residents feel and vote on social and fiscal issues leads to who is elected and what laws are passed, how tax money is budgeted, what social services are available and to whom. There is a distinct difference between the two states in how many single mother-headed households qualify for government programs such as Medicaid. This comparison can help us make sense of the experiences of women and healthcare in Washington and Idaho.

My research interest in single mother-headed households began when I conducted one-on-one interviews with single mothers living in Washington State and Idaho in 2009. I found that the women living in Idaho reported increased stress when it came to health

insurance and healthcare and other social safety nets like daycare assistance because Idaho offered such assistance only to families with very limited incomes, while Washington provides them to a much larger array of families. The women in both states were thankful for any help they received but most expressed a desire to not be on government assistance long term. In some cases, they had such poor experiences either applying for benefits or maintaining them that they opted to go without health insurance (Medicaid), food benefits (SNAP), or daycare assistance. Medicaid was the most sought after and obtained by the single mothers I interviewed, even more than food stamps and cash assistance. This fact is what encouraged me to look deeper into the history of the health insurance and healthcare single mothers received.

A study by Annette B. Ramírez de Arellano and Sidney M. Wolfe (2007) evaluated all Medicaid programs in the US. At that time (before the ACA), Medicaid eligibility was determined by meeting two sets of qualifications. First, recipients must fall within one of the “categorical” groups that is eligible: AFDC-eligible individuals as of July 16, 1996; whether or not they are currently eligible for cash benefits; all children born after September 30, 1983, living in households with incomes of up to 100% of the Federal Poverty Level (FPL); as well as a variety of other categories that do not normally affect single mothers and their children. If the individual meets the categorical restrictions, financial tests are applied. States had limited flexibility in modifying income standards for Medicaid eligibility; however they could decide how “countable income” is defined. Certain types of income can be excluded from the state definition of “countable income,” making their eligibility criteria broader without violating income standards. The following are among the “income disregards” that can be excluded from countable

income: a certain portion of earned income during the first few months of employment, a given dollar amount as a child care allowance, and a set amount for married couples. The ACA expanded the eligibility requirements for Medicaid considerably. However, the Supreme Court later allowed states to accept or reject those expanded requirements, making the range of Medicaid eligibility between states even greater.

Among the criteria for Medicaid enrollment and program execution, Ramírez and Woulfe identified two important differences between states. First, coverage under SCHIP for children who fell above FPL differed by state. Second, eligibility for women's services, such as services for pregnant women and those with breast and/or cervical cancer, differed by state. In their rankings based on these differences, Washington State ranked fourth overall in the nation for providing these additional services while Idaho ranked forty-fourth. Idaho restricts its coverage of pregnant women to the lowest mandated poverty level. It does not cover other populations such as parents of children covered by SCHIP. Idaho also has restrictions and limitations on most Medicaid covered services. This means that even if people qualify for programs they may not have access to many of the services offered in states like Washington that has a broader benefits package.

Basically, large numbers of people, such as single mothers, are excluded from Medicaid based on where they live (Ramírez de Arellano and Wolfe, 2007).

Idaho is a typical right-wing state with a fiscally conservative agenda. This means their elected officials tend to avoid policy that increases government spending. A common place to cut back on spending is entitlements such as Medicaid which Idaho has done as seen in Ramírez de Arellano and Wolfe's study. Washington State's policy tends to jump across the aisle to consistently liberal legislation and offers more public assistance

programs with generous income guidelines to assist a greater number of people. This can be seen in how Washington State put in place a health insurance program similar to the Affordable Care Act of 2010 almost thirty years ago.

In 1987 Washington State introduced a pilot program to provide access to health insurance for a large number of low income residents. The program was similar to Medicaid but the state-run program did not receive additional federal match funds (FMAP). Developed exclusively for Washington State residents, this program was the first of its kind in the nation. Basic Health (BH) became a permanent program in 1993; it was divided into 3 separate programs to help the largest number of people. The three groups are:

1. Basic Health, which is state subsidized and provides health insurance to Washington State adult residents with income at or below 200% of the federal income guideline (FIG). Basic Health is unique because it is an insurance program, not an entitlement program; it partners with the private sector using market based non-regulatory approach. Any adult, regardless of parental status, can qualify if they meet the guidelines.
2. Maternity Benefits Programs coverage includes prenatal care, labor and delivery, postpartum care, childbirth education, maternity support services, family planning, transportation to appointments, maternity case management, dental care, physical therapy, hearing, and vision (eye exams and glasses) qualify up to 200% FPL
3. Medicaid coordination which includes Basic Health *Plus* covering children under 19 offering in addition to the Basic Health benefits

described above extended benefits including vision care, dental care, non-emergency transportation to medical services, no waiting period for preexisting conditions, no deductible or coinsurance, all with no monthly premiums or copayments. Qualify up to 200% FPL (Cody).

The primary objective of the program was to help low income people pay for their privately provided health insurance with state sponsored subsidies. The state appropriated funds to cover a predetermined number of members. In the 2009/2011 biennium, \$337 million was budgeted for this program. Basic Health members pay a premium share which varies between individuals based on income, family size, choice of Health Plan and where they live. Community outreach programs, foundations, and Native American tribes contract with Basic Health to pay a portion of their member's premiums and the state which pays the remaining portion (Cody).

Washington's health insurance plans included several options that target low-income populations that would not qualify for Medicaid but were unlikely to have other health insurance options available. In essence, Basic Health is very similar to the Medicaid expansion of the ACA. Under the ACA, Washington State continues to reach as many people as they can in providing affordable health insurance by expanding Medicaid under the ACA guidelines. Adults, whether parents of dependent children and childless adults, can qualify for Medicaid with an income of 138% or less the Federal Poverty Level (FPL) (Cody; Johnson, 2013).

On the other hand, Idaho opted not to expand Medicaid under the ACA and did not expand on its very limited Medicaid eligibility. Parents of dependent children are covered if they make 26% of less of the FPL, while all adults without dependent children are

excluded. There is also a significant difference in CHIP eligibility for children under 19. In Washington State, children are eligible if their household incomes are less than 317% of the FPL, while in Idaho, they are only eligible if their household incomes are less than 190% of the FPL (Henry J. Kaiser Family Foundation, 2012).

As of 2014 Washington State offers more healthcare services than states like Idaho because of the Medicaid expansion. This means that not only can more adults, including single mothers, access healthcare but they also have more types of healthcare and providers to choose from than those who receive benefits in Idaho. Additional medical coverage and benefits in Washington include:

1. Dental care for adults as well as children (children's dental care is standard under CHIP)
2. Unlimited mental health appointments; if mental health coverage is included at all in most other programs, the number of visits is sharply limited
3. Access to expanded types of mental health providers, including; Licensed Advanced Social Workers, Licensed Independent Social Workers, Licensed Mental Health Counselors, Licensed Marriage and Family Therapists and Psychologists.
4. Expanded preventative care like the shingles vaccine, oral contraception, and screening for conditions like substance abuse and autism.
5. Allowing licensed Naturopathic Physicians to serve as primary care doctors.

6. Increased coverage for assistive devices, like wheelchairs and accessories.

(Henry J. Kaiser Family Foundation, 2012)

While the difference between the legal situation in Washington and Idaho is clear, the interviews I conducted along with other research has indicated that the experiences of healthcare by single mothers living in these two states are more complicated. In 2009, I interviewed 15 single mothers living in Washington and Idaho. Using information from the interviews and additional research in the literature, I later developed a survey using Survey Monkey on healthcare and single mother headed households. For this study, I asked single mothers questions about obtaining health insurance, the status of their health and health care for themselves and their children. I used snowball sampling through social media and direct email to recruit respondents. I asked questions that were answered using a Likert scale and open ended questions. The survey ran from November 25, 2012 until March 15, 2013. Of the ninety-five completed surveys, thirty-six were Washington residents and eleven respondents lived in Idaho. The rest of the respondents lived in several different states, none of which provided enough data to use. I have included questions from the interviews and survey.

Single mothers in both Idaho and Washington State had a more difficult time securing consistent health insurance for themselves than their children; they stated that cost was the main reason for not having insurance. Some of the mothers also listed preexisting conditions as a reason for not having insurance. For their children, the only barrier they reported in obtaining health insurance is cost in both Idaho (44.44%) and Washington State (35.29%). No women in Idaho relied on Medicaid, Medicare, or some other state program for her own health insurance as none of them could financially qualify, as they

can only make a very small amount of money and still qualify for these programs. The percentage of women in Idaho without insurance was 45%. In Washington State a similar number of women, 46%, either went without insurance or used Medicaid, Medicare or some other state insurance; here state-subsidized insurance helped fill the gap for uninsured single mothers.

To add perspective, almost half of the single mothers (43%) in Idaho reported their annual income to be under \$24,999; 67% of Washington residents reported the same income level. Low income women in Washington were more likely to have health insurance, primarily because of better access to state-subsidized insurance. The single mothers in Idaho had no choice but to purchase health insurance because it is significantly more difficult to qualify for state subsidized insurance than in Washington State.

This led to a few difference in healthcare outcomes. The largest difference was that the single mothers living in Idaho were far more likely to report not going to a doctor when they felt they should because of cost than Washington mothers. This data supports how the women in Idaho I interviewed treated their healthcare needs; they also reported skipping doctor's visits for financial reasons. The respondents in both states reported cost was a less important factor when deciding to seek medical care for their children. This is because the income standards for CHIP, which covers minor children, are much higher by federal regulation. A family making the median household income can be eligible if the number of people in the household is large enough.

Over all, differences in how women reported their experience of healthcare between Washington and Idaho are surprisingly small. Interestingly, many differences favor Idaho residents, which is noteworthy because it remains considerably more difficult to qualify for health insurance in Idaho. I asked mothers to rate their answers to several questions about their ease and problems with access to medical care on a Likert scale. Differences between mothers in Washington and Idaho are discussed here if they were .4 or greater. Idaho respondents felt that it was easier to schedule urgent doctors' appointments when a child was ill or the parent was ill, felt they and their children were generally physically healthy, and felt that their job allowed more flexibility to schedule time off for doctor's appointments. Whether that reflects real differences in access between Idaho and Washington, perhaps because more people are covered in Washington, or differences in expectations, such that Idaho mothers are not as demanding as their Washington counterparts, is unclear.

While the survey I conducted of single parent-headed households and healthcare showed minimal perceived differences on the short hand, long term effects could substantially change the economic status and future of low-income families, specifically single mother-headed households. Future research on this topic could include the difference economically and in personal perception between purchasing employer-provided health insurance and a much cheaper public option such as Basic Health or Medicaid. We know that out of pocket cost was the most important factor that these mothers reported considering when choosing health insurance and going to a doctor when needed. This was a large determinant for Idahoan single mothers deciding against healthcare when it was needed. Denying affordable health insurance to low income single mothers does not

make sense as health insurance is relatively inexpensive for minor children and to a large extent for the younger healthy adults who are their parents. A lack of insurance creates an environment of high stress. Something like a broken arm or appendicitis can mean financial catastrophe for these households. Even studies like the Oregon study, that show little short-term improvement in health outcomes from providing health insurance, show a considerable financial impact on these households (Baicker, et al., 2013).

A recent study, The Moving to Opportunity Experiment (Chetty, et al., 2015), shows a positive long-term impact to helping low income families. Researchers randomly selected 4,604 families living in high poverty housing projects during the years 1994-1998 living in 5 large US cities. The experimental group was given housing vouchers with the requirement to move to a census tract with a poverty rate below 10 percent. The second group was given section 8 vouchers with no contingencies; the control group maintained access to public housing but did not receive a voucher. Early results showed no difference between the groups, but the long-term differences for the children of these families were striking. The differences, however, took over a decade to emerge. Using data from tax returns, they found that the children that had moved with their families when they were under the age of 13, had a 31% (\$3477) higher pay than the mean (\$11,270) income for the control group. Other findings included that the children from the experimental group had a significantly higher college attendance and attended better colleges, lived in lower-poverty neighborhoods as adults, and female children were less likely to become single mothers as adults. Moving to a different neighborhood while the child was under the age of 13 proved to be the most beneficial age as the older adolescent children had a mean similar or slightly worse compared to the control group.

While this study did not relate specifically to healthcare, it has some interesting implications for health care. First, one can infer that better jobs and higher income could provide better access to healthcare and health insurance for these children. Second, it helps to make sense of a contradiction in previous work. Studies of Medicaid coverage have at best shown mixed results for health outcomes. The best study, done in Oregon over the last few years has shown no differences in health outcomes. This study took advantage of an oversubscription to a Medicaid expansion to create a control group to compare those who received new insurance and those who did not. It showed that there was little immediate effect on health outcomes in the short term (Baicker, et al., 2013). The same was true of the Moving to Opportunity Experiment, which initially showed no significant findings. Only after several years had gone by were the outcomes of the study noteworthy. The real impact wasn't on the adults who moved, but on what happened to those children as they became adults. The same may well be true of CHIP: the benefits may not be from the slight decline in the already low mortality and morbidity among minor children and their parents, but rather from the ways in which those children and mothers build a strong relationship with health-care providers that will last through the rest of their lives. Creating studies that will measure this will be difficult and take decades to show health outcomes. But such outcomes are important to try to measure, as we know that life expectancies remain much lower for children of low-income families than for upper-middle class whites.

Conclusion

In this paper, I have used a cultural and structural violence lens to look at the experiences of single mothers and their children from before the Great Depression to the present.

Then I took a closer look at the experience of single mother-headed households in two states, one progressive and one conservative, organized very differently politically and in public policy.

Even in the most progressive parts of the United States, the rhetoric about single mothers portrayed by the media and public figures has treated single mothers as a problem to be solved, a social and economic dreg. While single mothers remain a hidden population, public policy and social rhetoric has created a social perception that they are a dangerous part of society and something that needs to be eradicated or at the very least a condition that needs to be cured. Many attempts have been made to shrink the number of women belonging to this group. At the federal level, this led to an expansion of assistance from the 1930s to the 1980s, but from then on a systematic decrease in aid to single mothers and their children. This has recently been slightly reversed with the enactment of the ACA, which proposed to subsidize health insurance partially or completely for these women. However, political concerns have allowed some states to not implement the parts of the ACA that were intended to help many of the poorest families who should have been eligible for the Medicaid expansion.

This history, then, has led to different outcomes, however, with conservative states creating punitive systems that try to eradicate poverty by providing little assistance to these women and their children, while progressive states have somewhat less punitive systems, focused on "curing" the conditions that have led to this "problem". As this

chapter shows, the national policy debates have played out over the last few decades in very different ways in red and blue states. Understanding part of why brings us back to the ideas of cultural and structural violence.

Cultural violence starts as the prevailing attitudes and beliefs that we as a society are taught as the norm. An ideology forms that legitimizes structural and direct violence. Media is often used to perpetuate and reinforce the ways in which the general population views groups as either acceptable or unacceptable. Structural violence prevents people from reaching their full potential to the point where exploitation and repression is a normal everyday occurrence. This can prevent people from meeting their basic needs. In the United States, the most important part of this system of structural violence is the legal system that has been put in place over time. At first, “good” single mothers, white widows, were lionized and supported, while other women were ignored. As the number of divorced, never married, and brown single mothers increased and began to demand equal assistance, single mothers came to be perceived and then treated as an undesirable population that hurts the sanctity of the society as a whole. It has been accepted as public policy especially since the 1970s, to limit the amount of help this population receives to survive to the extent that single mothers have limited healthcare and other safety nets available to ensure the success of raising healthy children. Women have been conditioned with these kinds of structures and the cultural violence that supports them so that they often feel that they can’t or should not push for more help. We can see this today; in Idaho, single mothers don’t critique their lack of health insurance, but simply accept it as given. As a whole, single mothers feel they need to manage supporting their households with little or no help from the government or from the men in their lives.

My experience as a single mother is not very different from that of the women I interviewed and surveyed. I've battled social stigmas, misconceptions and welfare policy to help my children have the best possible life in a scenario they have no control over. When I was exposed to them, the ideas about structural and cultural violence resonated in how I have made sense out of my own experiences. Demonizing single mothers doesn't help reduce or limit the number of households that fall in this group. This has been proven over and over as these household numbers continue to grow. Also, focusing on single mothers as bad or irresponsible creates large gaps in the kinds of public policy that can actually create a positive difference. Cultural and structural violence have created an incredibly limited range of possibilities to help single mothers and their children that politically remain possible. Social scientists and policy makers should care about this as the number of children living in poverty or in low-income single mother-headed households is about 7 out of 10 children (Mather, 2010). If we are to ensure that all children have opportunities to become healthy successful adults, rethinking the kinds of cultural and structural violence that has led to the present situation will be necessary.

APPENDIX A

QUESTIONS: STRATEGIES OF SINGLE MOTHERS

Strategies of Single Mothers

1. How long have you been a single parent?
2. How many children do you have and what are their ages?
3. What challenges do you face daily?
4. What do you feel is your greatest challenge?
5. Do you feel like there is anything you have given up or missed out on because you are a single parent?
6. Do you feel that there are benefits to being a single parent?
7. What is your relationship like with the father of your children/child?
8. Is he actively involved with the children?
9. How do you feel his relationship has changed with the children?
10. How do you feel your relationship has changed, if at all, with your children?
11. Are you married or have a significant other?
12. How do your children get along with him?
13. What is an average day like for you?
14. What do you do for fun?
15. Do you feel you have enough time for yourself?
16. Is there anything you would change about your life right now that could make things easier for you as a single parent?
17. Is there anything I haven't asked about that you would like to tell me?

APPENDIX B

SURVEY: Healthcare in Single Mother Families

Consent Statement at start of survey

My name is Amara Rieken. I am a graduate student at Eastern Washington University and Master's Degree candidate. This survey data will be used for my master's thesis and for conference presentations of other publications. It has been approved by the Institutional Review Board at Eastern Washington University.

The following is a short survey asking questions about your experiences as a single parent with healthcare. The survey should take about 15 minutes to complete. Participation is voluntary and anonymous. Survey Monkey will remove any identifying features when survey is returned to me. You are not obligated to answer every question and may stop at any time. By continuing to the survey, you acknowledge that you have read this statement and agreed to take part in this study.

If you have any concerns about your rights as a participant in this research or any complaints you wish to make, you may contact Ruth Galm, Human Protections Administrator at 509-359-6567 or rgalm@ewu.edu.

I am very grateful for your participation.

Amara Rieken
amara.rieken@eagles.ewu.edu

Survey- Healthcare in Single Mother Families

1. What is your age? a) 18 to 24 b) 25 to 34 c) 35 to 44 d) 45 to 54 e) 55 to 64 f) 65 to 74 g) 75 or older
2. What is your gender? Female ___ Male ___ Other___
3. Please describe your race/ethnicity.
4. Please describe your child's or children's race/ethnicity.
5. What is the highest level of school you have completed or the highest degree you have received? a) Less than high school degree b) High school degree or equivalent (e.g., GED) c) Some college but no degree d) Associate degree e) Bachelor degree f) Graduate degree
6. Do you consider yourself a single parent? Yes ___ No ___
7. Do you currently have children under the age of 18 living with you? Yes ___ No ___
8. If so, what are your children's ages?
9. Do you make the primary healthcare decisions for your children?
10. What is your approximate average household income? a) \$0-\$24,999 b) \$25,000--\$49,999 c) \$50,000-\$74,999 d) \$75,000-\$99,999
11. Do your dependent children currently have health insurance, or not? Yes, they do ___ No, they do not___
12. Do you currently have health insurance, or not? Yes, I do ___ No, I do not___
13. How do you receive your health insurance? a) Employer Provided b) Private c) Military d) Tribal e) State or Government Subsidized f) Other (please specify)
14. Have you used alternative types of medical care? Check all that apply. a) Massage b) Acupuncture c) Naturopathy d) Homeopathy e) Traditional Chinese Medicine f) Ayurveda e) Other (please specify)
15. What are the reasons you chose to use alternative medical practices? Check all that apply. a) Lack of health insurance b) Alternative Medicine works better c) Used in conjunction with a medical doctors orders d) Cost e) Access to medical facility d) Other (please specify)
16. What illnesses have you used alternative medicine for in the past?

17. Does having health insurance improve your health? Yes___ No___ Undecided___
18. Have you used government subsidized health insurance such as Medicaid or Medicare, for yourself? Yes___No___
19. Have you used government subsidized medical insurance such as Medicaid or Medicare for your children? Yes___No___
20. Do you receive the flu shot every year? Yes___No___
21. Do your children receive the flu shot every year? Yes___No___
22. Who administers the flu shot? a) Doctor/Nurse b) Local drug store (Walgreen, Rite Aid, etc.) c) Walk in clinic d) Other (please specify)
23. Are your children fully immunized? Yes___No___Unsure___
24. If not, why?
25. What is the job title for your current position?
26. Does your job allow the flexibility to leave for doctor's appointments? Yes___No___
27. Do you feel your job is in jeopardy if you need to leave for medical reasons for either yourself or kids? Yes___No___
28. How easy is it to schedule urgent appointments with your doctor when you're ill? a) Extremely easy b) Very easy c) Moderately easy d) Slightly easy e) Not at all easy
29. How easy is it to schedule urgent appointments with your doctor when your children are ill? a) Extremely easy b) Very easy c) Moderately easy d) Slightly easy e) Not easy at all
30. When your children are ill, what symptoms do they exhibit that urge you to take them to the doctor?
31. Do you rely on Urgent care facilities or the hospital when you are unable to see your regular doctor? Yes ___ No___
32. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you try to make any appointments to see a specialist?
33. Have your children seen a specialist in the last 12 months?

34. A regular dentist is one you would go to for checkups and cleanings or when you have a cavity or tooth pain. Do you have a regular dentist?
35. Have you seen your regular dentist in the last 12 months?
36. If not, why?
37. Have your children seen their regular dentist in the last 12 months?
38. If not, why?
39. How reasonable are your health insurance provider's rates for health insurance for your dependent(s)? a) Extremely reasonable b) Very reasonable c) Moderately reasonable d) Slightly reasonable e) Not at all reasonable
40. How reasonable are your health insurance provider's rates for health insurance for you? a) Extremely reasonable b) Very reasonable c) Moderately reasonable d) Slightly reasonable e) Not at all reasonable
41. How physically healthy are you? a) Extremely healthy b) Very healthy c) Moderately healthy d) Slightly healthy e) Not at all healthy
42. How reasonable are your health insurance provider's rates for health insurance for your dependent(s)? a) Extremely reasonable b) Very reasonable c) Moderately reasonable d) Slightly reasonable e) Not at all reasonable

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