



Culture, Class, and Service Delivery: The Politics of Welfare Reform and an Urban Bioethics Agenda

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INTRODUCTION

On August 22, 1996, the US Congress and President Clinton ushered in a new era of social and health policy through their endorsement of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).¹ Otherwise known as “welfare reform” legislation (Pub L No. 104-193), this law altered the eligibility of society’s poorest citizens for public assistance. Block grants to the states replaced the former cash-based Aid to Families with Dependent Children (AFDC) program.

Three primary themes reflected a new approach to welfare policy and state flexibility: (1) the institution of mandatory work requirements and explicit state targets, (2) the categorical exclusion of illegal immigrants and some classes of legal immigrants, and (3) the delinking of eligibility for Medicaid from welfare.² This last provision in particular is having a profound impact on health care access as welfare and Medicaid caseloads decline quite precipitously in many states. The circulation of policy narratives and social science research about persistent poverty in the urban environment, in this context, is embedded deeply in a discussion about those who are “leaving” welfare (whether for “work” or because of sanctions) without health insurance and other safety nets to sustain their transition.

The objective of this article is to analyze some of the health policy implications of welfare reform in the context of a historical urban bioethics agenda. Current welfare reform efforts among the states have generated far-reaching changes in how the urban poor receive health and social services. These policy debates have produced ethical dilemmas that question the value and role of governmental intervention to ameliorate the effects of poverty among a racially segregated and diverse urban population. The concentration of poverty in racially segregated urban neighborhoods represents a unique historical theme in 20th century urban America. Since at least the late 19th century, competing ideas about whether diverse urban cultures and “races” should have access to state-sponsored health and social services have formed a basic part of policy discourse about the social and economic status of urban communities.

This paper analyzes how the historically specific context of contemporary welfare policy reflects the continuity of several themes about how the social and health status of some urban communities and cultures are chiefly a product of behavioral and cultural characteristics and not the negligence of the state.

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Numerous policy dilemmas have been created by welfare reform related to health care access. Welfare reform has created several significant challenges in terms of financial and nonfinancial barriers to service delivery for an often-disenfranchised poor and immigrant population. States have taken diverse roads to exercise their newfound flexibility in welfare policy. Some have instituted mass educational campaigns to educate families about continued eligibility for Medicaid and other insurance options, for example; other states and localities are engaged in diversionary tactics to discourage identification of eligible households and enrollment by denying applications on request.³ And even though the stated goal of welfare reform is to foster independence and self-sufficiency, the transition to self-sufficiency has been made difficult by obstacles that deny access to services and implement a 5-year waiting period for Medicaid and Temporary Assistance to Needy Families (TANF) coverage for newly arrived immigrants.

Public health leaders, welfare recipients, and other public officials and antipov-erty advocates continue to point to the denial of health care to immigrants, the institution of time limits on benefits, the sanctioning and removal of individuals from participation in welfare and health programs, and the failure to provide supportive health and social services to immigrants and nonimmigrants alike. These policy debates have also provided evidence that PRWORA simultaneously has reified stereotypes about the urban poor and blocked access to crucial health and social services among society's most vulnerable.

Welfare reform might even be seen as a stage at which the potential for "administrative evil" exists.⁴ As Adams and Balfour assert in their award-winning book, *Unmasking Administrative Evil*, the concept of administrative evil arises when a state action emanates from a "technical rationality" that accepts a "moral inversion, in which something evil has been redefined convincingly as something good."^{4(p2)} This inversion often occurs, they contend, when there are "surplus populations" who, as "the objects of public policy programs are considered expendable, or rendered 'socially dead' and portrayed as unwanted vermin, or as a blight on society." It is the call of Adams and Balfour for a "public ethics" that I find most compelling:

Public administration must also, and primarily, be informed by a historical consciousness that is aware of the fearsome potential for evil on the part of the state and its agents, and by a societal role and identity infused not only with personal and professional ethics but also with a social and political consciousness—a public ethics—that can recognize the masks of administrative evil and refuse to act as its accomplice.^{4(ppxxix)}

Their statement begs several questions related to a bioethical analysis of current efforts to address health and service needs among the poor: How do policy discourses reflect representations of a diverse urban environment? With respect to service delivery, specifically, what are our moral and ethical societal obligations to ensure that people receive health care? How do we address the ethical issues created by the denial of care to certain legal classes of immigrants? What are the ethical dilemmas created by the exclusion of those who are eligible for health coverage under Medicaid and other public programs when state actions deter enrollment purposefully? Finally, what about the imposition of time-limited benefits through a policy prescribing a 5-year lifetime limit on receipt of public assistance? With respect to the last question, some states have moved to impose a more restrictive 3-year lifetime limit. These are all questions that might be answered through a bioethical analysis informed by historical analysis.

HEALTH AND THE URBAN ENVIRONMENT: A HISTORICAL CONTEXTUALIZATION

If we expect to foster a broad debate about the ways in which a bioethical analysis might influence health policy development in the urban environment, then first, we have to strive for an analysis of urbanism in a historical context. Culture and class are historically contingent categories with meanings that have shifted over time. Contemporary debates about a segregated and spatially concentrated urban poor reflect historical debates and tensions about obstacles to greater social and occupational mobility among black and immigrant poor urban Americans.^{5,6} Historically, culture, race, and class have been invoked as analytical categories both to differentiate social groups and to define social stratification; at the same time, they have been fashioned to discriminate and to stigmatize. During the early 20th century, culture would become more fluid as an analytical category for application to new central, southern, and eastern European immigrants on their way to becoming classified as “white,” while race established a rigid biologically based explanation for concepts applied to blacks.^{7,8} In general, however, perceptions of innate racial and cultural differences were expressed through a wide variety of studies related to aptitude, aspirations, and habits of diverse urban dwellers.

Ideas about the impact of unique characteristics on the habits and social status of urban residents also helped to legitimize public policy action in public health and other policy domains.^{7,9} Patterns of segregated delivery systems and a refusal to address health conditions among blacks and newly arrived immigrants during the first half of the 20th century stemmed from a belief, in many cases, that public intervention would not change what were perceived as destructive and, at times, immutable deterministic characteristics. Health officials would also trace racial and ethnic disparities in health and social status to hereditary influences, for example. In one stirring commentary in the mid-1890s on these ideas, Rebecca J. Cole, the second black woman medical doctor in the United States, admonished her colleagues for attributing tuberculosis among blacks to the “fate of all exotics” rather than the housing and “condition of the cellar” in poorer urban neighborhoods.¹⁰ Social historians of medicine and science and public health scholars such as Charles Rosenberg, Vanessa Northington Gamble, Alan Kraut, Nancy Krieger, Kenneth R. Manning, David Rosner, David Barton Smith, and David Williams, among others, have illustrated how perceptions of cultural, racial, and class differences have contributed to the exclusion of the urban poor (and clinically trained elite as well) from health care institutions.^{6,11}

Even as urban social reformers and public health officials from the 1890s on would agitate for housing and public health legislation to address health differentials, they would frame blacks, the Irish, and other newly arrived eastern, central, and southern European immigrants in racially and culturally deterministic terms and assert, as Richards, an chemist trained at Massachusetts Institute of Technology in Cambridge, did in 1907, that “the tenement dweller and the recent immigrant can know little of the best ways of keeping clean in a strange land.”^{12(p59)} Others, such as Cole, a physician activist, would remind her colleagues that the prevalence of tuberculosis among blacks was related chiefly to economic opportunity and generally poor social status.

Cole fought such ideas, she stated in an 1896 issue of *Woman's Era*, so that “people may not be crowded together like cattle, while soulless landlords collect fifty per cent on their investments.”^{10(p4)} Cole's work and the emerging social science work of researchers such as W. E. B. DuBois,⁷ in this context, would also establish

the multifactorial origin of disease and in the process undermine monocausal and reductionist explanations for disease that emphasized inherent biological and behavioral characteristics. And, even as the gradual acceptance of the germ theory and knowledge of bacteriologic transmission and specific contagion would act as a catalyst for public and private intervention to address the health of those in urban centers with the knowledge that there were material agents at work, historian Charles Rosenberg¹³ stressed that moral arguments remain attached to explanations of differential health status as public health officials and others defined the environmental factors that were important for predisposition. It is also evident that this slow transformation to more environmentally based explanations also derived from a newly rationalized fear that “they”—meaning new European immigrants and blacks—could infect “us,” a native-born and white Protestant population.¹⁴ Such fears were revealed as well in the “eugenics” movement, which sanctioned segregation and sterilization, for example, as public health strategies that reinforced racial difference and state indifference to broader social and health needs in these communities.

The intention of this analysis is not to document historical continuity between late 19th and early 20th century perceptions of the urban environment and contemporary policy dilemmas related to health care access, but rather to stress that historical analysis can be germane for policy formation and the framing of an urban bioethics consciousness. The historical context can promote an understanding of how earlier debates about the urban environment supported specific health and public policy options based on cultural and class perceptions of urban dwellers. An exploration of these historical processes within an urban bioethical framework can continue to reveal how the development of public health and health care options to intervene (or not) to safeguard health in the urban environment are linked to how society, decision makers, and the poor (who are commonly objectified in analyses of poverty) view urban identity in its many formations.

AN URBAN BIOETHICS AGENDA AND THE DILEMMA OF LIMITED ACCESS UNDER WELFARE REFORM

In an era of devolution, during which states have exercised greater authority in their choices about program eligibility and the management of their social welfare and health programs, an urban bioethics agenda can foster attention on the barriers to health care access that exist in all communities, but particularly those made vulnerable by welfare reform’s restrictions on service delivery.^{15,16,17} The passage of PRWORA reflected a far-reaching debate about how blocked opportunity and behavior patterns obstruct social and occupational mobility among the urban poor. The passage of the TANF welfare legislation in 1996 was meant to strengthen perceptions that the poor were lazy, nihilistic, and devoid of a moral imperative to earn an honest wage; at the same time, it was meant to put forth a new ideological and philosophical perspective that the experience of families on welfare (though not necessarily the experience of living in poverty) should be ephemeral and transitory.

However, a full consideration of the public health costs associated with the exclusion of whole classes of citizens and noncitizens has yet to foster substantial changes in public policy in the US Congress. Public officials have contributed to the marginalization of the poor everywhere, particularly among racially defined and spatialized urban communities, as federal policy continues to deny access to new immigrants.^{3,18} Although legislation has been introduced to restore benefits to pregnant women, children, and immigrant children, such piecemeal approaches to restoration of benefits fails to capture the essence of welfare reform as a form of

administrative evil. Again, to use the concept of Adams and Balfour, these communities remain surplus populations devoid of access to health care and other service delivery options.

At bottom, inattention to history in the current policy environment, which Adams and Balfour remind us is “an open invitation to administrative evil,” continues to stigmatize poor communities. A historically contextualized urban bioethics agenda in a historical context can make authoritative statements that call for the restoration of benefits in legislation based on a recognition of the detrimental impact of earlier xenophobic and racist arguments for the exclusion of various communities in the history of the United States. In addition to the implementation of severe restrictions on the receipt of health and social benefits, contemporary welfare reform efforts have also incorporated earlier conceptions of the “deserving” and “undeserving” poor that fuel public responses to the perceived problem of “welfare” and not poverty.

Social policy historians have analyzed how public welfare and social insurance programs have incorporated these ideas throughout the 20th century, particularly in relation to blacks and other immigrants viewed as marginal. For example, historian Linda Gordon has demonstrated how the Social Security Act of 1935 created a two-tier system in which mainly white and immigrant men became eligible for unemployment compensation and retirement benefits, while blacks and women, who largely were excluded from participation in anything but Aid to Families with Dependent Children before Congressional action during the early 1970s.^{19(p5)} Payment levels differed dramatically, and as Gordon notes, “public assistance was inferior—not just comparatively second-rate but deeply stigmatized.” Current debates about welfare, Medicaid, and health policy in general also reflect these demarcations as states grapple with how the identification and participation of spatially concentrated and racially defined urban communities in Medicaid and other programs will offend white and middle-class consumers in their decisions about whether to enroll in these programs.

The negative impact of welfare reform on the health and social status of individuals and communities is also reflected quite poignantly in the implementation of the State Children’s Health Insurance Program (SCHIP). Title XXI of the Social Security Act, SCHIP provides states with options to expand health insurance to low-income children.^{2,20} However, eligibility is limited based on welfare reform requirements, meaning that states, for example, may not use federal money to cover children who may be ineligible because of their immigration status. There are also cases in which children have been denied services for failure to produce a social security card or documentation about the nativity of the child’s parents.³

The implementation of SCHIP in October 1997 was expected to improve health care access for the over 11.5 million children who lacked health insurance coverage in the United States. Welfare reform legislation has impeded a recognition of expanded health care coverage for all children. Approximately 1 million children lost insurance coverage because of welfare reform as states honored covenants that stipulated immigrant exclusion. States have also moved in aggressive ways to establish new eligibility guidelines and income requirements after the decoupling in August 1996 of Medicaid eligibility from the receipt of TANF. Outreach strategies launched under SCHIP have become very critical as a way to reach not only those households with members without coverage and with household members living under 200% of the federal poverty level, but also those who are Medicaid eligible and not enrolled.

In the absence of more comprehensive legislative mandates that establish eligi-

bility for populations left out of the safety net, it is crucial that health policy leaders and urban bioethicists promote a public discourse that encourages states to conduct aggressive outreach campaigns to identify those households that are eligible. This is not to mention the need for a more compassionate public policy that grants access to those needing care regardless of citizenship status. Data from the US Census Bureau also indicate that almost 40% of those in households with people who are foreign born lack health insurance coverage, inhibiting their access to critical preventive and primary health care services.²²

CONCLUSION

Culture and class remain contested terrains in policy narratives about the right of the urban poor to access health and social services delivery systems under welfare reform. An urban bioethics agenda is needed to address these dilemmas that have arisen in the context of PRWORA and had an impact on access to health and social services in the urban environment.^{2,18} Such efforts, however, must address the intellectual framing of the urban poor, as well as the public policies that inscribe deterministic and stereotypical ideas about the poor alongside incomplete portraits of barriers to greater social and occupational mobility.

The focus of social science researchers on the delineation of behavioral characteristics among an urban “underclass” in some instances further marginalizes and stigmatizes an already isolated urban poor. Even though Wilson, the Harvard sociologist who popularized the term “underclass” in his earlier research, has now largely disowned it, tales and stories abound in the social policy and health literature. The media also commonly underscore perceptions that establish rumor as social science and promote stereotypes that the poor are lazy and unwilling to work. Wilson, who has analyzed contextual and neighborhood factors such as the migration of jobs to the suburbs, has also declared stance that is in opposition to those, such as New York University political science professor Lawrence Mead, who embrace a “culture of poverty” thesis and have set the tone for some welfare reform initiatives by arguing that behavior, and not joblessness, is the key. “My guess,” Mead stated after welfare reform was enacted in 1996, “is that culture came first, and drove away the economy or the good jobs, rather than the other way around.”^{21(p3)} These statements continue to have dramatic impacts on the stigmas attached to public programs by promoting the idea that those in spatially concentrated racial and ethnic groups in urban areas are not members of the working class. Such perceptions have also contributed to a belief that those who participate in publicly subsidized social welfare and health insurance programs do not work.

Whether one accepts that the denial of health care to citizens and noncitizens in contemporary America derives in large part from the promotion of images of the poor as pathological, states have moved steadily to institute a variety of policies under welfare reform that continue to prescribe narrower eligibility criteria for access to service delivery systems. This is occurring as the US Congress hesitates to restore excluded populations, and there are reports of questionable practices targeted at those who are eligible based on current legislation. On several occasions, for example, the Civil Rights Division of the US Department of Health and Human Services has made inquiries (and issued sanctions) in cases for which state and local governments have discriminated against potential Medicaid and TANF applicants by ignoring regulations that stipulate that applications be delivered to applicants on request in a timely manner.³

While it is the explicit responsibility under welfare reform of the US Congress to pass legislation restoring eligibility to excluded populations, an urban bioethics agenda framed in a historical context has much to offer prevailing policy discourses.

If, as political theorist Stone notes, a policy alternative is to be judged “by the company that it keeps,” then urban bioethicists can offer human rights paradigms and additional policy alternatives based on assessments of earlier historical experiences of stigmatization that embodied similar forms of evil.²³

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