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Sources of stigma for means-tested government programs

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Abstract

Stigma has been shown to discourage participation in means-tested government programs. Prior research cannot explain why this deterrent effect varies in intensity across different individuals and programs. We develop a more comprehensive model of the possible determinants of stigma associated with means-tested programs than has previously been suggested by studies of welfare stigma. We test hypotheses using unique data based on interviews with 1405 respondents in 10 states and the District of Columbia, USA. The results suggest that there are two distinct forms of stigma related to participation in means-tested government programs: one related to self-identity, the other to the anticipation of negative treatment. Both forms of stigma are more pronounced for Welfare compared to Medicaid. The sources of stigma identified by conventional treatments of welfare stigma (e.g., individual attributions of responsibility for poverty) have significant explanatory power, but neglect other important influences. We find that stigma is exacerbated by poor health and by minority status. Stigma is also fostered by the ways in which means-tested programs are implemented, including negative interactions with case workers, long waiting times, and, for Medicaid, applications for benefits in alternative enrollment sites such as health centers or hospitals. These findings suggest new points of leverage for addressing the potentially deleterious consequences of stigma.

Keywords: Stigma; USA; Means-tested programs; Welfare; Medicaid

Introduction

Depending on the program, between one and two-thirds of eligible Americans forego participation in means-tested government programs for which they are eligible (Blank & Ruggles, 1996; Moffitt, 1987). Various factors have been shown to contribute to this low "take-up", including confusion about administrative requirements and burdensome enrollment processes (Stuber & Kronebusch, 2004). Low take-up has also been attributed to the so-called "welfare stigma" (Moffitt, 1983). The stigmatized character of certain public benefits may have implications beyond program participation. Researchers have suggested that stigma can profoundly undermine recipients' well-being and their relationships with others (Crocker, Major, & Steele, 1998) and may even contribute to long-term dependency in anti-poverty programs (Kerbo, 1976). Although program-related stigma can have a variety of undesirable consequences, little is known about how this stigma is generated or about how policymakers might mediate its effects. This

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study broadens our understanding of stigma related to means-tested programs.

Conceptual framework

The conventional model of welfare stigma

In his seminal research, Goffman (1963, p. 3) defined stigma as "an attribute which is deeply discrediting" in a given society. Applied to certain anti-poverty programs, this negative attribution involves the perception that individuals who participate lack the independence and autonomy that is expected when contending with vulnerable circumstances.

Rainwater (1982) argued that the stigmatization of recipients in means-tested programs can be seen as a special case of the stigmatization of poor people in the United States. In the eyes of many Americans, being poor constitutes a form of social deviance because pulling oneself out of poverty is believed to be both possible and praiseworthy. As a result, people on public assistance have been labeled as lazy, lacking in ambition, shiftless, morally weak, and even bad parents (Rainwater, 1982; Soss, 2000). The conventional portrayal of welfare stigma links these negative attitudes to broadly shared cultural perceptions about deservingness and individual responsibility for poverty.

However, certain individuals are protected from such pejorative assessments and are viewed as deserving of aid. This includes individuals who are sufficiently needy, who have no alternative sources of assistance and whose needs are not seen as self-inflicted (Cook & Barrett, 1992). For example, children are often seen as deserving recipients of public assistance although parents who claim assistance on their children's behalf may still experience stigma. The depiction of single mothers receiving cash assistance as "welfare queens" implies that receiving support is a lifestyle choice that is made willingly and even eagerly (Gilens, 1999).

Another possible shield against welfare stigma involves explanations for poverty that deemphasize failure on the part of the individual. If jobs are seen as scarce, a person cannot be faulted for being unemployed. Because Americans base their assessments of the health of the economy at least in part on the local economic conditions in their own community (Conover, Feldman, & Knight, 1987), one would expect that residents of localities with high unemployment rates would be more understanding about the difficulties of finding a job and thus, persons living in poverty should face less stigma.

Negative attitudes about welfare recipients are reinforced through media portrayals of the poor and by policy elites (Gilens, 1999; Iyengar, 1990). However, the act of seeking public benefits also exposes individuals to potentially negative responses from those administering program benefits. Consistently, recipients describe their experiences of applying for public assistance as unpleasant and negative (Goodban, 1985; Piven & Cloward, 1993). Case managers' negative attitudes about welfare recipients have been identified as one cause of poor treatment (Goodsell, 1985; Lipsky, 1980). Other potential signals of stigma include (a) long lines in waiting areas, since delayed access serves as an indicator of social status (Lipsky, 1980; Sarat, 1990) and (b) program requirements that require disclosure of personal information, which may be perceived as unduly intrusive, depriving public assistance recipients of the privacy accorded to "ordinary citizens" (Spicker, 1984).

From the conventional portrayal of welfare stigma, the following hypotheses related to the formation of stigma and means-tested programs emerge: (1) individual attributions of responsibility for poverty will lead to increased stigma; (2) societal attributions of responsibility for poverty will lead to decreased stigma; (3) negative experiences applying for benefits will lead to increased stigma, and (4) individuals in greater need will perceive less stigma with the exception of single mothers who may perceive more stigma. We enrich this model by delineating two forms of stigma and by identifying additional factors that influence stigma associated with means-tested programs.

Meanings and forms of stigma

We distinguish two forms of stigma: *identity* and *treatment* stigma. Identity stigma is related to concerns about being labeled with and internalizing negative stereotypes associated with users of means-tested programs. Many Americans, including those from low-income households, hold negative opinions of individuals participating in means-tested programs (Hochschild, 1996, Klugel & Smith, 1986). For reasons that are not well understood, these stereotypes lead some recipients to adopt negative self-characterizations, though others in the

same program avoid this outcome. This social–psychological mechanism has been documented for other stigmatized conditions as well, such as mental illness (Link & Phelan, 1999).

By contrast, treatment stigma reflects a concern about being treated poorly by others. These "others" might include friends, family, acquaintances, service providers, or program administrators. The same negative stereotypes that undermine self-identity may lead "others" to treat recipients poorly.

Because treatment stigma involves the expected actions of other parties, it is related to the concept of discrimination, but it remains distinct in an important way. Treatment stigma may be anticipated, even if a person has not actually experienced discriminatory treatment. For example, administrative practices that are not inherently discriminatory (such as questions about personal finances or living arrangements) may be interpreted by potential recipients as such. Because identity and treatment stigma are interpreted from the perspective of potential program beneficiaries and are therefore overlapping, the distinction between the two has typically been overlooked. We distinguish them here because we hypothesize that different cognitive processes and social contexts influence each form.

An expanded model of the determinants of stigma

Multiple stigmas

Building on the conventional model of welfare stigma, research from social psychology identifies additional factors that may shape the stigmatization process. Research on illness-related behavior suggests that multiple forms of stigma may reinforce one another and exacerbate their combined effects. For example, Crandall (1991) wrote about the multiple stigmatization of people with AIDS. He argued that AIDS-related stigmatization stems from both social and illness frames. The social frames involve society's rejection of behaviors like homosexuality and injection drug use. Because AIDS is a contagious disease for which there is no cure, there is an additional source of stigma, because those with AIDS are also viewed as a threat (Sontag, 1978).

We hypothesize that the stigmatization of public assistance recipients also reflects the reinforcing influences of multiple sources of stigma. We explore stigma related to race and stigma linked to ill health because these attributes are associated with poverty in the US (Kaplan, 2001). Researchers have noted that Americans frequently hold negative stereotypes about Blacks (Brigham, 1974) and one area where these stereotypes are pervasive relates to images of American poverty (Gilens, 1999). Contemporary and salient images of the poor, e.g., the homeless beggar, the welfare queen, the heroin addict, are closely associated with being Black in both the mass media and the public's imagination (Klugel & Smith, 1986). As a consequence, Blacks may more readily internalize the negative stereotypes of people on public assistance than would otherwise comparable White Americans. Thus, we hypothesize that Blacks will be more likely to perceive identity stigma compared to Whites. We also hypothesize that Blacks perceive more treatment stigma relative to Whites because Blacks are the targets of discrimination and prejudice in general (King & Williams, 1995) and thus, may also be more sensitive to perceptions of negative treatment from those administering public benefit programs.

As social psychologists have explored the impact of multiple stigmas, they have also recognized that their effects may be mediated by social context. We expect to observe lower levels of treatment stigma from program participation among Blacks living in communities with a higher concentration of racial minorities because they will be less likely to experience the catalyzing effects of repeated discrimination. Relative to Blacks living in more racially mixed or White communities, those in communities with a high concentration of racial minorities may also experience social norms protective against pejorative self-assessments and identity stigma.

The correlation between poverty and ill health may also induce multiple forms of stigma. In the conventional model of welfare stigma, one would expect that recipients in ill health would feel more deserving and less stigmatized for their participation in means-tested programs. Conversely, the multiple stigma perspective suggests that persons in ill health often face a variety of negative stereotypes, which we hypothesize will lead them to perceive higher levels of identity and treatment stigma. Due to medical advancements in disease prevention, increasing illnesses particularly those associated with behaviors such as smoking and alcohol consumption are being considered the fault of the individual (Lupton, 1995). Illnesses that are contagious and for which there is a lack of treatment become a fearful threat (Crandall, 1991) or induce symbolic distancing (Sontag, 1978).

Protective attributes

The broader literature on disease-based stigma has identified psychological attributes of individuals that may lessen stigma formation including self-esteem and self-efficacy. These self-protective strategies will be more effective for some people than others. Self-esteem is defined as a general feeling of self-worth or self-acceptance. We expect that self-esteem will mitigate identity stigma and thus, individuals who report higher self-esteem will perceive less identity stigma. We also expect that high levels of perceived self-efficacy, the extent to which an individual believes that he/she has the capacity to produce a desired outcome or to control one's external environment, may lessen the formation of treatment stigma.

Program-specific stigma

When researchers and policymakers discuss stigma in the Medicaid program, they presume that this stigma is derived from the program's historical association to welfare (Mann, 1999). However, we anticipate that the extent of stigma will differ for welfare and Medicaid for several reasons. First, the nature of Medicaid may diffuse concerns that the benefits are being abused (Cook & Barrett, 1992). Because welfare is a cash benefit, once it is distributed, recipients can determine how it will be used. There is less freedom when using Medicaid because recipients can use the benefit only to access health care services. Second, Medicaid recipients (who are not on welfare) may be perceived as more deserving than welfare recipients. While many Americans believe that those on welfare are undeserving (Cook & Barrett, 1992), Medicaid may evoke different evaluations because it is widely recognized that many people who are working (socially productive members of society) do not have access to health insurance (Jacobs & Shapiro, 1996). Third, there are differences in enrollment practices for welfare and Medicaid. States are required by federal law to allow residents to apply for the Medicaid in alternative locations such as hospitals and health clinics although implementation of this policy varies substantially by state (Rosenbaum, Maloy, Stuber, & Darnell, 1998). This may reduce personal exposure to potentially hostile administrators, lessening the stigma experienced by those who actually apply for benefits. In addition, removing Medicaid enrollment from welfare offices has a symbolic connotation that may affect the attitudes even of those who do not personally apply for Medicaid benefits, reducing the broader sense of public stigma for this program. For these reasons, we hypothesize that both identity and treatment forms of stigma will be less prevalent for Medicaid as compared to welfare.

Methods

Study design and data collection

Between April and December 1999, patients were interviewed at 25 community health centers in 10 states (California, Texas, Colorado, Idaho, Michigan, West Virginia, Pennsylvania, South Carolina, Massachusetts, and Missouri) and the District of Columbia. We selected the states to ensure geographic and ideological variation. Leadership at the National Association of Community Health Centers identified several health centers within each state and we selected at random two health centers, one in an urban setting, the other from a rural area. Patients were interviewed throughout the day at each site selected according to when they signed in to see a provider. The first patient to sign in at the center was asked whether he/she would be willing to participate in the study. Subsequent participants were recruited by asking the next person to sign in after the interviewer completed her previous interview.

All interviews were conducted while the patient waited to see a clinician or at the conclusion of his/her medical visit. A total of 1686 people were approached to participate in the study; 281 refused or were unable to complete the entire interview due to time constraints, resulting in a final sample of 1405 completed surveys, a response rate of 83.3%. Interviews were administered in person by research staff and lasted between 20 and 30 min. Participants were offered $10 compensation and were given the option to be interviewed in Spanish (16%) or English (84%). Respondents are representative of community health center patients nationwide in terms of their race and ethnicity, income and health insurance status.

The sampling strategy reflected our understanding of the social processes from which stigma emerges. Prior research suggests that stigma is not simply, or even primarily, generated from the attitudes of the population that is stigmatized, but also from those who share their community (Cohen, 1999). By collecting the data at community health centers, we were able to identify not only adults who

were current or potential participants in welfare or Medicaid, but also persons who are part of the broader social networks with whom these individuals interact on a regular basis. We assume that individuals who have no prior program experience form views about stigma and the processes that generate it not only from their interactions and knowledge of individuals with program experience, but from presumptions about how they would behave if faced with similar circumstances.

Measures

Dependent variables

We created identity and treatment indices of stigma for both cash assistance and Medicaid. Responses for each component question were on a five-point Likert scale that ranged from strongly disagree to strongly agree. Each index was constructed from a series of equally weighted items. Scales were created using principal component factor analysis. For each scale, Cronbach's alpha statistic was used to assess how well the items measured a single unidimensional latent construct. Variables with a factor loading of 0.32 or greater, which reflects at least 10% overlapping variance, were considered part of a specific factor (Comrey & Lee, 1992). Items and basic statistics for each variable are presented in Table 1.

Survey questions measuring identity and treatment stigma were generally asked of respondents in an indirect way with the assumption that people's responses about others would be informed by views of themselves. Because many of the questions required respondents to ascribe negative characterizations to themselves (e.g., laziness), questions in the third person were expected to produce more reliable responses. The use of indirect questions also allowed us to measure broad perceptions among all respondents, even among respondents with no prior experience with welfare or Medicaid.

Explanatory variables from the conventional model of welfare stigma

The variables used to test the conventional model of welfare stigma fall into three categories: (a) individual versus societal responsibility for poverty, (b) prior experiences with welfare or Medicaid, and (c) personal characteristics that could affect a person's self-perception of need. To assess individual attributions of responsibility for poverty, respondents were asked, ''Most people who do not succeed in life are lazy.'' As documented in Table 1, a little over half of respondents believed this was true. An index was constructed to assess whether respondents attributed poverty to societal causes. As Table 1 reveals, many respondents favored structural explanations for poverty. We included as a third explanatory variable the percent of community residents who were unemployed in 1999 (the year of the interviews), expecting that high rates would make structural explanations of poverty more salient.

Three variables were used to assess prior experiences with welfare or Medicaid. Respondents were asked if they had received cash assistance or Medicaid during the previous 2 years. For those who had, we constructed an index of respondents' subjective experiences while applying for and participating in either program. In addition, respondents were asked how long they had spent at the welfare office during their most recent visit. Respondents who had not participated in or applied for welfare or Medicaid in the last 2 years were assigned the mean value for respondents from the same community based on the assumption that a program's local reputation is established by the average experience of residents' interaction with local officials. (This biases coefficients on the experience variables toward zero.)

Neediness was measured by three variables, each of which has been shown in past studies to capture some aspect of public conceptions of need (Miller, 1992): annual household income, whether the household has only one parent (as compared to two parent households and households without children), and the number of children in the household. Not surprisingly, the income reported in this sample was quite limited; 29% of the respondents lived in single parent households.

Explanatory variables for the expanded model of stigma

We identified minority status and ill health as two such attributes that may exacerbate stigma. Self-reported race and ethnicity are used to construct dichotomous variables identifying the most prevalent minority groups: Blacks and Latinos, representing, respectively, 29% and 34% of the respondents who were interviewed for this study. To test the hypothesis that Blacks living in minority communities will be less likely to perceive stigma, we include a measure of the racial mix of the county of residence (percent Black ranged from 0.1% to

Table 1
Definition, range, mean and reliability of variables

Variable label	Items	Range	Mean	α
Dependent variables				
Identity welfare stigma	I worry that being on welfare would make me lazy. The average women on welfare has too many kids. Once people start to receive welfare they usually stay on it for more than 2 years. Many people in my neighborhood on welfare are lazy. Many people on welfare drink too much. Many people in this country on welfare are lazy.	1–5 where 5 is high stigma.	3.16	0.67
Treatment welfare stigma	The application process for welfare is humiliating. Many people are treated poorly when they apply for welfare. When applying for welfare, you have to answer unfair questions about your personal life. When participating in welfare, the rules take away your personal freedom. Many people on welfare do not want other people to know they are on welfare. There are a lot of people in this country who do not respect a person on welfare.	1–5 where 5 is high stigma.	3.33	0.64
Identity Medicaid stigma	I worry that being on Medicaid would make me lazy. Many people in my neighborhood on Medicaid are lazy. Many people in this country on welfare are lazy.	1–5 where 5 is high stigma.	1.84	0.58
Treatment Medicaid stigma	The application process for Medicaid is humiliating. Many people are treated poorly when they apply for Medicaid. When applying for Medicaid, you have to answer unfair questions about your personal life. When participating in Medicaid, the rules take away your personal freedom. Many people on Medicaid do not want other people to know they are on Medicaid. There are a lot of people in this country who do not respect a person on Medicaid.	1–5 where 5 is high stigma.	2.42	0.72
Explanatory variables				
Conventional model of welfare stigma				
Responsibility for poverty				
Individual attribution	Most people who do not succeed in life are lazy.	0–1 where 1 is lazy.	0.53	—
Societal attribution	The extent to which poverty is attributed to: low wages, not enough available jobs, employers taking advantage of their workers and the minimum wage not being high enough.	0–1 where 1 is society is to blame for poverty.	0.80	0.65
Unemployment rate	County rate (1999).	2.6–13.1%	3.91	—
Prior experience				
Waiting time	Length of time waited the last time at the welfare office.	0–1 where 1 is waited a long time.	0.29	—
Quality of experience	Those with prior experience were asked if the experience was humiliating and uncomfortable and if they felt trusted, respected, and valued as a person.	0–1 where 1 is bad experience.	0.58 for welfare.	0.75
			0.48 for Medicaid.	0.85

Table 1 (*continued*)

Variable label	Items	Range	Mean	α
Recent experience	Enrolled in welfare/ Medicaid over the last 2 years.	0–1 where 1 is enrolled in the last 2 years.	0.20 for welfare. 0.49 for Medicaid.	—
Markers of need				
Income	Annualized income in $.	0–$11,000	$7123	—
Single parent	Versus two parents.	0–1 where 1 is single parent.	0.29	—
Children	Number of children in household.	1–9	1.37	—
Expanded model of stigma				
Protective attributes				
Self-efficacy	I often feel helpless in dealing with the problems of life. I always make the most of every opportunity.	0–1 where 1 is efficacious.	0.70	0.61
Self-esteem	All in all I am inclined to think I am a failure.	0–1 where 1 is high self-esteem.	0.93	—
Multiple stigmas				
Latino	Versus non-Latino White.	0–1 where 1 is Latino.	0.29	—
Black	Versus non-Latino White.	0–1 where 1 is Black.	0.34	—
Percent Black	Percent of Black residents in county.	0.10–62.9%		21.6
Black × %Black	Interaction between Black and percent Black.	0–62.9		12.8
Poor physical health	Physical health problem in past 4 weeks.	0–1 where 1 is physical health problem.	0.34	—
Poor mental health	Mental health problem in past 4 weeks.	0–1 where 1 is mental health problem	0.30	—
Program-specific stigma				
Site of enrollment	Location where respondent last applied for Medicaid.	0–1 where 1 is not in welfare office.	0.45	—
Knowledge of enrollment sites	Unaware that Medicaid can be applied for outside of welfare offices.	0–1 where 1 is unaware of enrollment reform.	0.42	—
Deservingness	How many people on welfare/ Medicaid would you say take benefits they do not need?	0–1 where 1 is all or most (0 is some or none).	0.63 for welfare. 0.56 for Medicaid.	— —
Abuse	How many people on welfare/ Medicaid would you say cheat the system?	0–1 where 1 is all or most (0 is some or none)	0.65 for welfare. 0.55 for Medicaid.	
Control variables				
Education	More than a high school education.	0–1 where 1 is more than high school.	0.62	—
Gender			0.85	—
Age				
26–35	Versus under 25.	0–1 where 1 is 26–35.	0.33	—
36–45	Versus under 25.	0–1 where 1 is 36–45.	0.21	—
46+	Versus under 25.	0–1 where 1 is 46+.	0.20	—

almost 63%) and an interaction term based on the race of the respondent and the racial mix of the county. To assess poor health, respondents were asked if over the previous 4 weeks they had any problems with work or other daily activities as a result of their physical health or emotional problems (such as feeling depressed or anxious). Thirty-four percent of respondents reported that work had been limited by physical illness; 30% by emotional problems.

To assess whether stigma might be ameliorated by personality attributes that were correlated with high levels of reported self-esteem or self-efficacy, we made use of standard measures of these concepts from the literature. Respondents reported relatively high levels of self-esteem and self-efficacy.

To capture distinct aspects of the Medicaid eligibility process, we determined using two questions whether states had effectively implemented federal law allowing enrollment outside of welfare offices. The first asked respondents if they knew that Medicaid enrollment did not require going to a welfare office. Over half of our respondents were aware of these enrollment changes. Respondents who were enrolled in Medicaid were also asked where they had last applied for benefits (the choices were: welfare office, health clinic, WIC office, in a hospital, at home or other). Fifty-five percent of our respondents had enrolled in Medicaid at a location other than a welfare office.

To assess other domains of program-specific stigma, we assessed the extent to which respondents believe persons on Medicaid as compared to welfare are deserving of the benefit or abuse the system. The majority respondents believed that recipients in both programs are undeserving. Most felt that beneficiaries in both programs abused the system though this belief was more prevalent for welfare than for Medicaid.

Statistical analyses

We report the distributions of perceived identity and treatment stigma associated with Medicaid and welfare. We estimated four regression models to identify factors from the conventional and expanded models of stigma associated with identity and treatment stigma for welfare and for Medicaid. Because the conventional model takes into account the relationship between prior experiences and stigma and many respondents did not participate in Medicaid or welfare within the last 2 years (51% and 80% of the sample, respectively), we estimated all models in two ways. First, we limited the sample to people with program experience. Second, to be consistent with our conceptualization that stigma emerges not just from persons who use the programs but from individuals in the broader population, we used the full sample. Since the results (including the coefficients on the experience variables) were comparable, we report only the results from the full sample. We incorporated into each model individual-level demographic characteristics (age, sex, and education) as well as state fixed-effects. Generalized estimating equations were used to adjust the standard errors of the parameter estimates for the clustering of responses by state and community health center.

Results

The distribution of stigma related to means-tested public programs

Respondents indicated that there is substantially more stigma associated with welfare as compared to Medicaid (Fig. 1). For example, 22% of respondents reported high levels of identity stigma for welfare, whereas only 6% reported high levels of identity stigma associated with Medicaid. More respondents reported treatment stigma than identity stigma in both programs.

Testing the conventional model of welfare stigma

Many of the factors identified in the literature on welfare stigma remain significant in our regressions, though not always in the expected direction (Table 2). Individual attributions of responsibility for poverty (as measured by the belief that people who do not succeed are lazy) are associated with higher levels of identity stigma for both the welfare and Medicaid programs. Unexpectedly, the index measuring societal causes of poverty is also positively related to identity and treatment stigma for both programs.

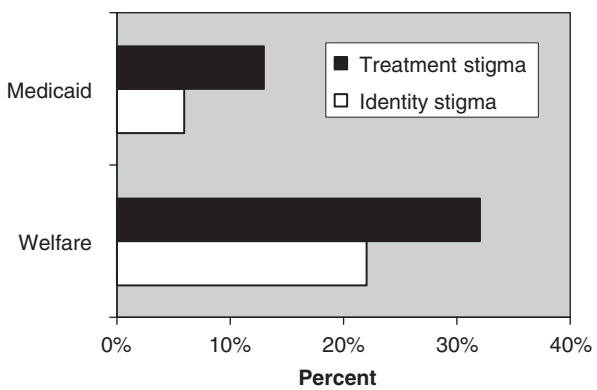

Fig. 1. Distribution of identity and treatment stigma for welfare and Medicaid. The distribution for identity welfare stigma has been calculated using only the three items used in the identity Medicaid stigma index. The items for treatment Medicaid stigma and treatment welfare stigma are also comparable.

Table 2
Expanded model of stigma related to program participation ($N = 1405$)

	Identity welfare stigma		Treatment welfare stigma		Identity Medicaid stigma		Treatment Medicaid stigma	
	ß	se	ß	se	ß	se	ß	se
Conventional model of welfare stigma								
Responsibility for poverty								
Individual attribution	0.62*	0.08	0.02	0.07	0.61*	0.08	0.05	0.08
Societal attribution	0.30*	0.14	0.84*	0.13	0.17	0.14	0.51*	0.13
Unemployment rate	0.008	0.02	−0.03	0.02	0.005	0.02	−0.004	0.02
Prior experiences								
Waiting time	0.03	0.21	0.44*	0.19	−0.35	0.20	0.15	0.19
Quality of experience	0.14	0.23	1.77*	0.21	0.31	0.17	1.82*	0.17
Recent experience	−0.11	0.08	−0.04	0.07	−0.06	0.06	−0.24*	0.06
Markers of need								
Income	−0.78	3.27	−0.32	2.98	1.26	3.25	1.54	3.12
Single parent	−0.15	0.08	−0.17*	0.07	−0.09	0.08	−0.19*	0.07
Number of children	0.008	0.02	0.03	0.02	−0.02	0.02	−0.004	0.02
Expanded model of stigma								
Protective attributes								
Self-efficacy	−0.19	0.11	−0.29*	0.10	−0.23*	0.11	−0.37*	0.10
Self-esteem	−0.18	0.15	0.07	0.14	−0.37*	0.15	−0.18	0.14
Multiple stigmas								
Latino	0.26*	0.08	−0.20*	0.07	0.15*	0.08	−0.12	0.07
Black	0.19	0.12	0.21*	0.11	0.27*	0.12	0.18	0.11
Percent Black	−0.008*	0.003	0.004	0.003	0.003	0.003	0.005	0.003
Percent Black × Black	−0.002	0.003	−0.01*	0.003	−0.008*	0.003	−0.009*	0.003
Physical health problem	0.03	0.06	0.05	0.06	0.05	0.06	0.13*	0.06
Mental health problem	−0.08	0.06	0.19*	0.06	−0.05	0.06	0.17*	0.08
Program-specific stigma								
Site of enrollment	–	–	–	–	0.02	0.08	0.06	0.09
Knowledge of other sites	–	–	–	–	0.10	0.07	0.17*	0.08
Deservingness	1.26*	0.19	0.09	0.17	0.90*	0.20	0.50*	0.19
Abuse	1.74*	0.19	0.42*	0.17	1.03*	0.19	0.71*	0.18
Control variables								
More than high school	−0.09	0.06	0.08	0.05	−0.10	0.06	0.04	0.06
Female	0.04	0.08	−0.03	0.07	−0.12	0.08	−0.06	0.07
Age 26–35 versus under 25	0.03	0.07	−0.03	0.07	0.22*	0.08	0.04	0.07
Age 36–45 versus under 25	0.13	0.08	0.10	0.07	0.23*	0.07	0.10	0.08
Age 46+ versus under 25	0.09	0.09	0.26*	0.07	0.08	0.08	0.21*	0.08
State fixed effects								
Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.
State 1	−0.77*	0.21	−0.20	0.19	−0.62*	0.21	−0.22	0.20
State 2	−0.65*	0.20	−0.16	0.18	−0.41*	0.20	−0.30	0.19
State 3	−0.71*	0.23	−0.08	0.21	−0.38	0.22	−0.13	0.21
State 4	−0.84*	0.23	−0.12	0.21	−0.56*	0.23	−0.31	0.22
State 5	−0.57*	0.18	−0.21	0.17	−0.30	0.18	−0.21	0.17
State 6	−0.89*	0.24	−0.31	0.22	−0.33	0.24	−0.29	0.23
State 7	−0.71*	0.21	−0.27	0.19	−0.67*	0.21	−0.15	0.20
State 8	−0.99*	0.23	−0.40	0.21	−0.54*	0.23	−0.29	0.22
State 9	−0.52*	0.18	0.02	0.17	−0.53*	0.19	−0.27	0.18
State 10	−0.70*	0.27	0.02	0.24	−0.60*	0.26	−0.24	0.25

*Significant at the $P < 0.05$ level.

Individual characteristics that might serve as markers of need do relatively little to diffuse stigma. However, single parents report lower levels of stigma, particularly treatment stigma, compared to respondents from two-parent households. Past exposures to Medicaid and welfare have a powerful influence on perceived stigma. Respondents who felt bad the last time they applied for welfare or Medicaid reported higher levels of treatment stigma. Long waiting times contributed to increased perceptions of treatment stigma for the welfare program. Those with recent program experience were less likely to perceive treatment stigma for Medicaid.

These results provide evidence that distinctive processes are associated with the formation of treatment and identity stigma. In general, the treatment forms of stigma are, not surprisingly, more closely related to perceptions of external circumstances: attributions of societal responsibility and to negative prior interactions with program administrators. Conversely, identity stigma is more related to individual attributions of responsibility for poverty.

Testing the expanded model of stigma

Many of the factors we introduce as part of the expanded model prove to be consistently correlated with stigma (Table 2). Protective attitudes come into play for both welfare and Medicaid, with self-efficacy having a more consistent influence than self-esteem, particularly for treatment stigma. As expected, disconnecting Medicaid enrollment from welfare offices appears to reduce treatment stigma. Perceptions that recipients of welfare and Medicaid are undeserving and that they cheat the system leads to greater levels of identity and treatment stigma, although this relationship is more pronounced for identity stigma.

Most crucially, findings from the expanded model demonstrate a number of ways in which multiple stigmatizing characteristics magnify the intensity of stigma. Consistent with expectations, Blacks report higher levels of identity and treatment stigma for either program than do Whites. Unexpectedly, although Latino respondents report higher levels of identity stigma, they indicate lower levels of treatment stigma than do Whites. Social context appears to alter the impact of multiple stigmas. Blacks living in communities where there are more racial minorities report less stigma, particularly treatment stigma. Ill health further magnified program stigma. Those who report mental or physical health problems report more treatment stigma for both welfare and Medicaid.

The expanded model documents additional differences in the determinants of the treatment and identity forms of stigma. Treatment stigma appears to be more responsive to multiple stigmatizing characteristics and to perceptions of personal self-efficacy. By contrast, identity stigma is more responsive to beliefs about recipient's deservingness and perceptions of program abuse.

Discussion

The sources of stigma identified by the conventional model of welfare stigma had significant explanatory power, but this portrayal is too simplistic. There are two distinct forms of stigma related to means-tested programs: one related to self-identity, the other to anticipation of negative treatment. Further, the prevalence of stigma is more pronounced and differently influenced for welfare as compared to Medicaid. We have also demonstrated that the conventional portrayal of welfare stigma neglects other important influences including multiple stigmatizing characteristics, protective personality characteristics, and feedback from the ways in which means-tested programs are implemented. Respondents in poor health were more likely to perceive the treatment form of stigma. Race and ethnicity exacerbate stigma in complex ways, related in part to the demographic composition of the local community.

Before we discuss the findings, it is important to recognize the methodological limitations of this study. First, although respondents are representative of community health center patients nationwide, the results can only be generalized to the broader population with caution. Future studies should attempt to capture broader stigmatizing influences such as the effects of the media or the perspectives of more advantaged individuals, in addition to the perceptions of actual and potential program participants and their immediate social networks. Second, because many respondents did not have recent experience in either Medicaid or welfare, the relationship of stigma to prior program experience was imprecisely estimated. The substitution of average community perceptions for those who had no recent program experience from the same community leads to downward biases in the estimated influence of experience. A third limitation

was that the measures of stigma and some of the factors that may have affected stigma (such as self-esteem) were not measured comprehensively. The length of interviews was limited to ensure high levels of participation and so, some concepts were crudely measured.

Notwithstanding these limitations, this study expands our understanding of how stigma associated with means-tested programs is created. We consider three sets of implications from this study: (1) how stigma effects program participation, (2) the extent to which stigma can be addressed by interventions, and (3) questions that hold promise for future research.

Implications of stigma for program participation

We first consider the implications of our findings for program participation. As anticipated, there is substantially less stigma reported for Medicaid than for welfare. This finding is consistent with other research showing that stigma is a greater deterrent to welfare than it is to Medicaid participation (Stuber & Kronebusch, 2004) and with recent findings showing that public attitudes toward Medicaid are quite positive (Kaiser Family Foundation, 2005). It appears that Medicaid has a programmatic identity that is distinct from welfare, which is encouraging given the efforts of policymakers to disconnect Medicaid from welfare during the mid-1990s. However, it is also important to note that although stigma is less prevalent for Medicaid than it is for welfare, the determinants of stigma in the two programs are similar. These results suggest that states have additional opportunities to further promote Medicaid as a program that is independent from welfare and further reduce stigma.

Some observers might argue that stigma is not necessarily an undesirable attribute in a public program. When policymakers are concerned about moral hazard (i.e., the substitution of government assistance for work) but find it expensive to verify which potential beneficiaries are truly needy and deserving, stigma may provide a useful means of deterring inappropriate use of benefits. But its utility in this role depends on who is deterred. Ideally, one would like stigma to deter participation by those with less pressing needs or alternative sources of support.

We found that treatment stigma, in practice, may deter use in exactly the wrong individuals. Treatment stigma is exacerbated by poor health—meaning that those most in need of Medicaid may be least likely to participate. These perverse effects are not surprising. Conceptions of mental illness in our society include a disparate array of negative attributes including unpredictability and dangerousness, weakness and incompetence, and a generalized attribution of "badness" (Link & Phelan, 1999). These negative attributions have been compounded by a long history of discriminatory treatment (Clausen, 1981). Increasingly, persons suffering from poor physical health also experience stigma and discrimination, reflecting the belief that some illnesses are caused by short-sighted lifestyle choices or impose large costs on public and private payers.

Our finding that stigma is magnified for Blacks and for Blacks living in communities with few African Americans raises a different set of questions about stigma as a way to control moral hazard. Long-standing concentrations of poverty in African American communities have created the public image of poor Blacks as being dependent on welfare (Gilens, 1999; Klugel & Smith, 1986). It is therefore ironic that Blacks actually experience intensified stigma, which deters program participation (Stuber & Kronebusch, 2004).

It is not simply our findings related to poor health and race that raise concerns with stigma as a rationing system for public benefits. Consider our measures of neediness. In this case, the problematic results involve patterns that were not revealed in our findings. The finding that respondents who are destitute or supporting large families experienced just as much stigma as those with moderate income and few children should concern policymakers.

Potential for addressing problems associated with stigma

Because the effects of stigma seem ill-targeted and may have other counterproductive effects on the well-being, treatment decisions, and the health of stigmatized populations (Link & Phelan, 1999), policymakers should consider how to ameliorate them. In this sense, the conventional portrayal of welfare stigma as the product of shared cultural norms is problematic. If welfare stigma was inherent in American culture, as some scholars have suggested, it would simply be a fact of life, an unavoidable problem associated with any income-tested program. The findings from this study suggest otherwise. Negative prior enrollment experiences contribute to stigma suggesting that efforts to

change the culture of the institutions that serve recipients of means-tested programs will reduce stigma, which might have otherwise seemed to be more intractable for policymakers.

In Medicaid, reforms in the enrollment process are associated with reduced treatment stigma. Yet, research has concluded that nearly half of all health centers are not engaged in this activity and that state support is the most important factor in centers' decision not to offer this service (Rosenbaum et al., 1998). This study suggests that increasing the availability of alternative enrollment sites may increase participation in the Medicaid program through the reduction of stigma.

We show that different cognitive processes and social contexts influence the formation of the identity and treatment forms of stigma. To mitigate these effects, different types of interventions may be needed. For example, to mitigate the negative effects of identity stigma, negative attitudes about public assistance recipients held both by stigmatizers and the stigmatized must be reduced. To combat the effects of treatment stigma, interventions may need to address the culture of the institutions that serve recipients. Too often in the broader literature on stigma these two dimensions are left undifferentiated neglecting important points of leverage for each.

Questions for future research

A number of our findings raise questions for future research, four of which are most noteworthy. First, it was surprising to find that the endorsement of structural causes of poverty were positively associated with stigma. The fact that societal attributions of responsibility for poverty affect treatment stigma and not identity stigma provide a clue to explaining these findings. Perhaps people who think poverty is due to societal causes have come to expect worse treatment from others, particularly program administrators. Additional research is needed to test this explanation.

Second, unexpectedly we found that single parents perceive less treatment stigma than parents in two-parent households. These findings suggest single parents may have developed coping skills allowing them to view themselves as in need of government assistance despite the negative rhetoric that exists about them. Coping skills have been documented in other stigmatized populations (Miller & Kaiser, 2001). Additional research is needed to determine if single parents have developed coping skills in this context and if they are emotional, cognitive, or behavioral in nature.

The third set of intriguing results involved minority status. It is noteworthy that Latinos were more likely to perceive identity stigma, but were less likely to perceive treatment stigma than either Whites or Blacks. This may reflect a more conservative political culture in the Latino community that creates harsher self-judgments involving dependence. These connections need to be more fully explored.

Finally, while not a focus of this study, this study shows substantial interstate variability in perceptions of identity and treatment stigma. This belies the standard presumption that welfare stigma is so deeply rooted in American cultural values that it is ubiquitous. Appropriately conceived interventions might reduce attitudinal barriers to program participation in what are now high-stigma states. Additional research using a general population sample is needed to uncover factors contributing to this state variation such as differences in political culture and ideology, varying racial and ethnic composition in states, variation in program design, differential exposure to negative media coverage of program recipients, and variations in negative political rhetoric both about means-tested programs and recipients.

Conclusion

In this study, the stigma associated with means-tested government programs is shown to be complex in its origins. Findings suggest that perceptions of stigma are determined, in part, by the nature of the benefit that is being provided. Ultimately, the role of stigma in means-tested public programs must be addressed through open policy debate about the relative merits and demerits of using stigma to reduce problems of moral hazard. Too often in the past, political leaders have seemed more intent on using rhetoric about welfare to further their political agendas or personal electoral prospects, paying less attention to the consequences for the programs' performance at helping those who are judged to be needy and deserving. We believe that stigma can and must be seen as an instrument of public policy. Its effects can be refined through more careful ongoing assessments of the impact of stigma on program participation, and a more constructive

effort to shape those consequences in ways that further socially valued goals.

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