



National Poverty Center Working Paper Series

#07-14

June, 2007

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Access to Social Services in Urban and Rural America**

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Mismatches and Unmet Need:
Access to Social Services in Urban and Rural America

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May 29, 2007

Paper originally presented at the University of Kentucky Center for Poverty Research conference, *Ten Years After: Evaluating the Long-Term Effects of Welfare Reform on Children, Families, Welfare, and Work*. Portions of this paper are drawn from a forthcoming book at Yale University Press entitled, *Out of Place: The New Geography of the Safety Net*.

Introduction¹

How do society and our communities assist low-income populations? Typically, welfare cash assistance, Food Stamps, Medicaid, and the Earned Income Tax Credit (EITC) are identified as primary sources of support for poor populations. These prominent antipoverty programs compose only a part of how society and communities help low-income populations. Instead, social services that promote work activity and greater personal well-being (e.g., job training, adult education, child care, substance abuse or mental health services, temporary emergency assistance) have become a primary method for assisting low-income families. Whereas annual governmental spending on welfare and the EITC total about \$10 billion and \$40 billion respectively, governmental expenditures for job training and social service programs reach about \$34 billion (in \$2006).² Today, social service programs compose a larger share of governmental safety net expenditures than many scholars and policymakers recognize.

Many low-income workers struggle with persistent human capital, physical health, mental health, child care, or transportation barriers to employment that are addressed by social service programs. For example, the Women's Employment Study (WES) found that over a 6 year period, two-thirds of poor mothers met the diagnostic criteria for a mental health disorder and half reported a physical health problem. Moreover, it is estimated that anywhere from 44 to 58 percent of welfare recipients experience multiple barriers to employment including low educational attainment, physical health problems, a child with a disability, and mental health problems.³ Pavetti and Kauff (2006) find long-term recipients of welfare struggle with many different barriers to employment. Of particular concern, the authors found low cognitive functioning, severe physical health limitations, and untreated

¹This project was supported by research grants from the Brookings Institution, Brown University, Department of Housing and Urban Development (HUD), University of Kentucky Center for Poverty Research, and the Rural Poverty Research Center, and with support from the Institute for Research on Poverty at University of Wisconsin-Madison and the Institute for Policy Research at Northwestern University. The author thanks Donna Pavetti for comments on a previous draft.

²Congressional Research Services. 2003. "Cash and Noncash Benefits for Persons with Limited Income: Eligibility Rules, Recipient and Expenditure Data, FY2000-FY2002." Report # RL32233, p. CRS-10.

mental health problems to be so prevalent among long-term welfare recipients that many were unable to complete basic household tasks, let alone balance work and household responsibilities.⁴

Given such needs, it is not surprising that many poor households draw assistance from social service agencies at some point. For example, a 2006 study of low-income populations in and around Pittsburgh concluded that 43 percent of individuals from high poverty neighborhoods received help from a social service agency in the previous year.⁵ Edin and Lein (1997) find that 22 percent of poor single mothers not receiving welfare received temporary emergency or in-kind assistance from public and nonprofit agencies that totaled approximately \$165 per month. Thirty-one percent of welfare recipients were found to receive help from governmental and nongovernmental agencies outside the welfare system.⁶ In another study, the authors found that poor single mothers contacted over a dozen separate nonprofit organizations for help with different needs in a given year.⁷

Not only are social service programs critical elements of the safety net for low-income populations seeking economic self-sufficiency, but they increasingly occupy the void left by retrenchment of more commonly identified public assistance programs. Today, there are more than 60 million Americans living near or below the poverty line and the number of families living below the poverty line has increased by almost 20 percent since 2000.⁸ Yet, in any public safety net programs are not expanding to meet need. Welfare caseloads have declined by more than 60 percent since 1996 and recent reauthorization of welfare reform policy will likely accelerate the pace of welfare caseload decline in the coming years. Occurring simultaneously with decreases in welfare caseloads have been lower enrollment

³Women's Employment Study. 2004. *The Women's Employment Study: A brief review of findings from a panel survey of current and former welfare recipients.* University of Michigan; Urban Institute. 2006. *A decade of welfare reform: Facts and figures.* http://www.urban.org/UploadedPDF/900980_welfarereform.pdf.

⁴Pavetti, LaDonna A. and Jacqueline Kauff. 2006. *When Five Years Is Not Enough: Identifying and Addressing the Needs of Families Nearing the TANF Time Limit in Ramsey County, Minnesota.* Washington, D.C.: Mathematica Policy Research, Inc.

⁵Gutiérrez-Mayka, Marcela and Elisa Bernd. 2006. "How is the Region Doing? Human Service Use and Service Availability in Allegheny County, PA." *The Forbes Funds.* http://www.forbesfunds.org/docs/2006Tropman_study2.pdf.

⁶Edin, Kathryn and Laura Lein. 1997. *Making Ends Meet.* New York: Russell Sage Foundation, p. 151.

⁷Edin, Kathryn and Laura Lein. 1998. "The Private Safety Net: The Role of Charitable Organizations in the Lives of the Poor." *Housing Policy Debate.* 9(4): 541-73.

rates for Food Stamp and Medicaid among eligible low-income households. Many states are seeking strategies to reduce Medicaid expenditures and trim programs available to low-income populations. We should expect low-income households becoming more detached from public components of the safety net will become more reliant on community-based service organizations when seeking assistance with basic material needs or securing employment.

Providing social services also poses a number of different challenges than the delivery of cash assistance. Unlike welfare cash assistance, Food Stamps, or the EITC, social services cannot be mailed or electronically transferred to an individual. Instead, poor persons must make regular visits to service providers to receive assistance and these visits must be incorporated into daily commutes between home, work, and child care that often do not involve access to reliable automobile transportation. Also unlike cash assistance programs that may carry an entitlement or guarantee of assistance to those who are eligible, there is no guarantee that low-income households will live in neighborhoods that are home to social service agencies. Not all high poverty neighborhoods are proximate to the wide range of services necessary to address the array of barriers to employment experienced by low-income populations. Policymakers and scholars should pay attention to whether spatial mismatches in access to social service providers exist within communities, because inadequate access to service providers can be tantamount to being denied assistance.

Issues of service accessibility also matter because there is evidence that the geography of poverty has shifted over the past decade. Not only are there fewer high and extreme high poverty tracts in many cities, but poverty rates appear to be rising faster in suburban than in urban areas.⁹ These changes may lead to changing or growing mismatches between those seeking help and those capable of providing

⁸U.S. Census Bureau. 2006. Poverty Status Status of Families, by Type of Family, Presence of Related Children, Race, and Hispanic Origin: 1959 to 2005. <http://www.census.gov/hhes/www/poverty/histpov/hstpov4.html>.

⁹Berube, Alan and Elizabeth Kneebone. 2006. "Two steps back: City and suburban poverty trends, 1999-2005." Washington, D.C.: The Brookings Institution, Metropolitan Policy Program, The Living Census Series; Jargowsky, Paul A. 2003. "Stunning progress, hidden problems: The dramatic decline of concentrated poverty in the 1990s." Washington, D.C.: The Brookings Institution, Metropolitan Policy Program, The Living Census Series.

help. Service agencies, often less mobile than poor populations, may find it challenging to adequately respond to these shifts in the geography of poverty. Agencies may also be unable to maintain funding or client caseloads given demographic changes in their communities. Even low-income families moving away from the central city to be in safer neighborhoods or closer to job opportunities, however, will continue to struggle with barriers to employment. Social service agencies will be critical resources for these families, particularly as they move away from traditional social support networks. The problem for these “destination” communities is that many commit few public or private resources to programs addressing the needs of the working poor. Relocating facilities to new neighborhoods simply may not be an option, particularly if there is little funding to help organizations acquire, move, or renovate space.

Apart from adequate access, successful delivery of social services also requires providers operate in a stable funding environment. Unpredictable or volatile revenue streams will make it difficult for agencies to maintain consistent programming or staffing, which are necessary to complete implementation of program cycles and to adequately assist persons in need. Although there may be the perception that public and private support for social service programs does not change appreciably from year to year, service agencies operating at the street level experience substantial changes in the mix of revenues from year to year. Such changes matter, as providers that cannot secure steady or reliable revenue flows will be forced to cut staff, reduce program offerings, and limit the number of people served.

Although there are few studies, proximity to services providers appears to affect individual outcomes. Welfare recipients with mental health and/or substance abuse problems in Detroit who lived closer to service providers were more likely to utilize services than those living further away. For instance, a white recipient at-risk for mental health problems with access to providers double the metropolitan mean would be 25 percent more likely to utilize services than the same respondent with mean access to providers. Qualitative interviews in Philadelphia reveal that low-income women are

more likely to favor service providers nearby and providers in safe communities, over those far away and those located in particularly dangerous areas of their neighborhoods.¹⁰

Finally, social service programs will be critical to meeting the rising needs of poor families created during prolonged economic recession, but the manner in which we provide those services may not allow programs to expand to meet increased need. In looking at the impact of recent job losses on communities in Michigan, it appears that severe or sustained economic recession will increase volatility in housing arrangements, increase food insufficiency, and lead to negative health impacts on adults and children.¹¹ While demand for social services increases during recessionary periods or downturns in regional labor markets, however, both governmental and nongovernmental resources for social service programs decline when the economy slows. As a result, the safety net is less counter-cyclical than we might imagine as it may not be responsive to growing demand for assistance during a recession.

Several research questions emerge as we consider the challenges of administering social service programs to poor populations. Where do our communities provide assistance to poor and near-poor households? Do gaps or mismatches in access to social services exist in our communities? How do providers finance services for low-income populations and do these revenue streams shift frequently? How often do cuts in funding lead to instabilities or inconsistencies in service delivery?

To begin to answer these questions, this chapter examines data from the Multi-City Survey of Social Service Providers (MSSSP) and the Rural Survey of Social Service Providers (RSSSP), which I conducted with social service providers helping low-income populations in three metropolitan areas and four multi-county rural sites respectively between November 2004 and June 2006. Working from a detailed database of service providers in each site, trained interviewers conducted over 2,200 telephone interviews with program managers and executive directors. Each survey contains detailed

¹⁰Kissane, Rebecca Joyce. 2003. "What's Need Got to Do With It? Barriers to Use of Nonprofit Social Services." *Journal of Sociology and Social Welfare*, 30(2): 127-48, p. 136.

geographically-sensitive information on services provided, clients served, funding, and organizational characteristics from a range of governmental, nonprofit, and faith-based social service providers.

This chapter will proceed as follows. First, I briefly present a history of the American safety net that explains how social service programs have become central components within our local safety nets. Next, I explain how the current service-based safety net is more sensitive to the spatial location of service agencies than is typically understood. In addition, I discuss how funding for social service programs is less counter-cyclical and more volatile than aggregate federal expenditure data would suggest. Drawing upon data from the MSSSP and RSSSP, I explore social service provision within several different rural and urban settings. In particular, I focus upon mismatches and instabilities within the provision of social service programs. Finally, I conclude by discussing the implications of a patchworked and volatile service-based safety net for future social welfare policymaking.

Social Services versus Welfare Cash Assistance in the Safety Net

Even though the common impression of antipoverty assistance in America is of welfare cash assistance, there have been dramatic changes to the character of safety net assistance in the last forty years. Welfare cash assistance, a prominent and rapidly growing component of safety net during the latter third of the 20th Century has receded in recent years. Social service-based forms of assistance, however, have steadily expanded in size and importance since 1970. Most scholarly and popular accounts of the safety net miss these shifts in social assistance, perpetuating misperceptions of how the safety net actually provides help to the poor.

Although AFDC was of modest size when established in 1935, the number of recipients increased eight-fold from 534,000 in 1936 to 4.3 million in 1965. The AFDC caseload tripled in the three decades following the War on Poverty, reaching a historical high of 14.2 million persons receiving about \$32

¹¹Kresnak, Jack. "Getting a grip on poverty: More state, metro Detroit kids worse off as agencies seek answers." *Detroit Free Press*,

billion in assistance in 1993 (in \$2006). Persistent expansion of welfare caseloads and expenditures eventually led to passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), commonly referred to as welfare reform. PRWORA replaced AFDC with the Temporary Assistance for Needy Families (TANF) program, which sought to reduce welfare dependency and promote work activity among recipients by requiring work as a condition of assistance, limiting lifetime welfare receipt to five years, and expanding state discretion over welfare program administration. Implementation of welfare reform and the robust economy of the 1990s combined to produce striking decreases in welfare caseloads over the past 15 years. From 1996 to 2005, the number of welfare recipients dropped from 12.6 million to 4.6 million – a decline of nearly 70 percent. Public expenditures for welfare cash assistance similarly diminished, as federal and state expenditures for TANF welfare cash assistance totaled approximately \$12 billion in 2004 (in \$2006).¹²

By comparison, funding for means-tested social service programs addressing basic material needs or seeking to improve personal well-being steadily increased in the latter third of the 20th Century. Prior to the War on Poverty very little governmental funding was targeted at social service programs for which provided substance abuse or mental health services, food pantries, emergency assistance, child care assistance, employment services, adult education, housing assistance, or transportation assistance to low-income populations. For instance, federal social service expenditures totaled about \$124 million in 1954, with state and local social service program expenditures reaching \$600 million.¹³

Beginning with expansion of social service program funding through different Titles of the Social Security Act (SSA) during the late 1960s and the creation of dozens of new social service programs,

June 26, 2006.

¹²Coll, Blanche D. 1995. *The Safety Net*. New Brunswick: Rutgers University Press; and Stevens, Robert B. 1970. *Statutory History of the United States: Income Security*. Chelsea House Publishers: New York; U.S. Department of Health & Human Services, Administration for Children and Families. 2001. Average Monthly Families and Recipients for Calendar Years 1936 – 2001. <http://www.acf.hhs.gov/news/stats/3697.htm>; Department of Health and Human Services. 2000. Temporary Assistance for Needy Families (TANF) Percent of Total U.S. Population, 1960-1999. <http://www.acf.hhs.gov/news/stats/6097rf.htm>; Department of Health and Human Services. 2004. Fiscal Year 2004 TANF Financial Data. http://www.acf.hhs.gov/programs/ofs/data/tanf_2004.html.

governmental funding for social services increased steadily after 1970.¹⁴ Yet because social service programs receive funding from many different federal, state, and local agencies, it is challenging to derive an accurate estimate of public social service expenditures. Data from Congressional Research Services (CRS) provides a conservative estimate of social service spending, which includes federal, state, and local expenditures for job training, child care programs, and the Social Services Block Grant (SSBG). It should be noted that while these data are the best available on annual social service spending, they dramatically understate the size and scope of public social service financing. A more accurate estimate would count a wide range of governmental job training, adult education, substance abuse and mental health treatment, community development, food, housing, and energy assistance programs that CRS figures do not include.

Even with these limited data, however, the comparisons between social service expenditures and welfare cash assistance are striking. Figure 1 shows that federal, state, and local government spent \$18.5 billion (in \$2006) on CRS' defined social services in 1975, roughly half that spent on AFDC cash assistance (\$31.5 billion in \$2006). Public expenditures for this narrow definition of social services almost doubled in real dollars between 1975 and 2002, reaching approximately \$34 billion (in \$2006).¹⁵ In contrast, welfare cash assistance expenditures have declined by two-thirds during the same period and totaled less than \$11 billion in 2002 (in \$2006).

(Figure 1 about here)

¹³Smith, Steven Rathgeb and Michael Lipsky. 1993. *Nonprofits for Hire*. Cambridge (MA): Harvard University Press, pp. 51-53. Expenditures reported here are not corrected for inflation.

¹⁴Social services began to receive substantial support from Title IV-A of the Social Security Act (SSA) in the late 1960s and early 1970s. Eventually these funds were transferred to Title XX of the Social Security Act and then consolidated into the Social Services Block Grant (SSBG) in 1981. Later, programs such as the Comprehensive Employment and Training Act (CETA), Job Training Partnership Act (JTPA), and Workforce Investment Act (WIA) would fund tens of billions of dollars in employment services to low-income youth and adults. The Community Services Block Grant (CSBG), the Community Development Block Grant (CDBG), and the Substance Abuse and Mental Health Services Administration (SAMHSA) have administered billions of dollars in grants and contracts social service agencies. Medicaid also has provided states and communities with several billion dollars in fees and reimbursements for substance abuse and mental health programs in recent years, particularly programs that help expecting mothers or women who have recently given birth. See Steven Rathgeb Smith and Michael Lipsky. 1993. *Nonprofits for Hire*. Cambridge (MA): Harvard University Press, p. 53-55; House Committee on Ways and Means, U.S. House of Representatives. 2004 *Green Book*, pp. 277-304.

In addition to the increase in social service spending and the decline in welfare cash assistance, Figure 1 indicates that the Earned Income Tax Credit (EITC) has expanded to become the largest means-tested program providing cash assistance to low-income households in America. The EITC provided \$40 billion in credits to 19.8 million working poor families in 2002 (in \$2006) and today is the source of almost four times as much cash assistance for low-income families as TANF.¹⁶ Yet, one must work to receive the EITC, which makes social service programs that alleviate barriers to employment even more critical than was the case when welfare cash assistance was more prominent and the EITC played a modest role in the safety net.

While welfare reform has led to caseload reduction and lower expenditures for cash assistance, Figure 1 masks a dramatic shift in the nature of welfare assistance itself. Recurring monthly welfare checks, defined by the law as “assistance,” are no longer the primary source of assistance for welfare recipients. Instead, welfare-to-work programs now fund a range of social services that are defined as “non-assistance,” which include childcare, job search assistance, mental health services, substance-abuse treatment, domestic violence counseling, and temporary income support intended to support work activity and help recipients overcome barriers to employment. Moreover, many states have taken advantage of the option to transfer TANF funds to the CCDBG and to the SSBG. Rather than a welfare system reliant on welfare checks, the system now uses a wide range of tools to transform individual behavior, increase work-readiness, and promote economic self-sufficiency.¹⁷

Indicative of historic change in the character of welfare assistance, the percentage of federal welfare dollars devoted to cash assistance fell from 77 percent in 1997 to 33 percent in 2004. At the same

¹⁵Of this \$34 billion in social service spending in 2002, about \$8 billion (in \$2006) was child care assistance through the Child Care Development Block Grant (CCDBG) or TANF.

¹⁶U.S. House of Representatives. *2004 Green Book*, p. 13-41; Steve Holt. 2006. “The Earned Income Tax Credit at Age 30: What We Know.” The Brookings Institution, Metropolitan Policy Program, Survey Series.

¹⁷Parrott, Sharon, Liz Schott, Eileen Sweeney, Allegra Baider, Evelyn Ganzglass, Mark Greenberg, Elizabeth Lower-Basch, Elisa Minoff, and Vicki Turetsky. 2007. “Implementing the TANF Changes in the Deficit Reduction Act: ‘Win-Win’ Solutions for Families and States.” Second edition. Center on Budget and Policy Priorities and Center for Law and Social Policy. <http://www.clasp.org/publications/tanfguide.pdf>.

time, the percentage of federal welfare dollars going to non-cash assistance increased from 23 in 1997 percent to 58 percent in 2004. When taking transfers to the CCDBG and SSBG into account, 64.6 percent of federal TANF monies were spent on social services in 2004. TANF-funded social services and transfers to other service programs totaled about \$17.5 billion in 2004 (in \$2006).¹⁸

(Figure 2 about here)

Although governmental funding for social service programs has increased substantially since the mid-1970s, government is dependent upon local nonprofit service organizations to deliver social service programs to the poor. As a result, both the number of nonprofit service agencies and the total revenues of the nonprofit service sector have increased dramatically since 1970. For example, the number of organizations filing nonprofit status with the IRS increased by 115 percent between 1977 and 1997. Similarly, another study concluded that the number of nonprofit social or human service providers increased by 47.3 percent from 1989 to 1996. Growth in the nonprofit human service sector may have been even more rapid in recent years, as the number nonprofit service providers were found to increase by 41.1 percent from 1992 to 1996. Data from the National Center for Charitable Statistics (NCCS) indicate that the number of nonprofit human service and job training service providers increased by 60 percent between 1990 and 2003 (26,059 to 41,707). Revenues for social service nonprofit organizations more than doubled from 1977 to 1997 in real dollars, with revenue from government sources increasing by 200 percent.¹⁹ According to NCCS data, total revenues for nonprofit human service organizations doubled in real dollars from \$51 billion to \$101 billion between 1990 and 2003 (in \$2006 dollars).²⁰

Based on these many different data points, it is reasonable to estimate that governmental and nonprofit agencies combine to spend somewhere near \$200 billion for services targeted at disadvantaged

¹⁸Department of Health and Human Services. "TANF Financial Data." <http://www.acf.hhs.gov/programs/ofs/data/index.html>.

¹⁹Lester M. Salamon, pp. 30-33, "The Resilient Sector: The State of Nonprofit America," in Salamon, Lester M.(Editor). *State of Nonprofit America*. Washington, DC, USA: Brookings Institution Press, 2002; Boris, Elizabeth T. 1999. "The Nonprofit Sector in the 1990s." in *Philanthropy and the Nonprofit Sector in a Changing America*, eds. Charles T. Clotfelter and Thomas Ehrlich. Bloomington: Indiana University Press, p. 9; Twombly, Eric C. 2001. "Human Service Nonprofits in Metropolitan Areas during Devolution and Welfare Reform." *The Urban Institute, Center on Nonprofits and Philanthropy, Charting Civil Society*, No. 10. p. 2.

populations each year, perhaps even much more. Contrary to popular impressions about antipoverty assistance, therefore, the American safety net spends nearly twenty times as much on social services for poor people as it does on welfare cash assistance.

Access and Stability within the Safety Net

Replacing cash assistance with locally-provided support services might be viewed by many policymakers, program managers, and policy experts as a positive development in the American welfare state – a development that will improve our ability to promote work and self-sufficiency among low-income populations. The prevalence of barriers to employment among low-income populations has led many to emphasize social service programs as pathways for improving work outcomes among the poor. Communities can tailor programs to fit the needs and nonprofit capacities of poor neighborhoods, creating local safety nets that may be more attentive to individual circumstances and more capable of creating collective solutions to poverty. For critics of welfare cash assistance, swapping welfare checks for community-based social services supporting work activity removes the negative behavioral incentives embedded within the welfare system which discourage employment and promote dependency. Further, the non-monetary support offered through social services will be viewed as less vulnerable to fraud or opportunism.

Merely shifting to a service-based safety net, however, does not guarantee that communities will be able to translate these possibilities into realities. Poor families receiving services to increase work or address persistent barriers to employment may still find their food, shelter, and clothing needs unmet by social service programs. The social service program emphasis upon individual-level factors associated with poverty may lead community leaders and policymakers to pay less attention to the structural causes of poverty. Moreover, there is no entitlement to social service assistance among low-income populations

²⁰Author's estimates of 501(c)(3) organizations based on data from the National Center for Charitable Statistics.

and communities are not obligated to provide particular social service programs. In the end, promoting economic self-sufficiency and improving the well-being of low-income families in a service-based safety net hinges on how well we provide services to those in need.

Of primary concern should be issues of service accessibility. Social services cannot be mailed or electronically transferred to an individual. Instead, poor persons must often visit a social service agency to receive assistance, complete a set of classes, and to attend sessions or meetings. Ensuring that low-income populations have adequate spatial access to social service providers is critical, therefore, as inadequate availability or accessibility of social services is tantamount to being denied aid in a service-based welfare system or safety net.

Proximity to service providers should matter for several reasons. To receive assistance, one must know about the agencies and services available. Poor persons are more likely to have information about agencies operating in their immediate community or neighborhood, than in communities and neighborhoods farther away. Similarly, caseworkers are likely to provide low-income individuals with information about programs and resources nearby. Service providers located in one's immediate neighborhood or community may be more trusted than providers located further away. Greater trust and familiarity with an agency will likely increase a poor person's propensity to seek help from that agency. Proximity to providers also reduces the burden of commuting. Regular visits to a provider must be incorporated into daily commutes between work and child care. Greater distances complicate commutes and increase the travel costs of program participation, which in turn hampers the ability of an individual to receive help. Limitations of public transportation in many high poverty areas and low rates of automobile ownership among low-income households make it even more critical that providers are located nearby.

Although we proceed as if social service provision is equitable from place to place, community to community, access to social service agencies in actuality varies both across and within communities.²¹ Some communities have access to many organizations, others have access to few. Variation in access to social service agencies is in part a function of where providers choose to locate. The availability of grants and contracts may lead agencies to locate within particular neighborhoods, municipalities, or counties over others. Some agencies may choose to be closer to concentrations of low-income individuals in order to achieve economies of scale for service delivery; others may locate to be proximate to potential private donors, clients who generate fee revenue, or partnering service organizations. Service providers may find location options constrained due to lack of adequate facilities in other areas, or insufficient funds to relocate or acquire new facilities.

Not only should we be concerned with where nonprofit service organizations locate and whether they are accessible to the poor, but whether those agencies are stable sources of support for low-income populations. Stability and predictability of service delivery are a function of the consistency and reliability of service funding. Funding dictates staffing, resources, facilities, programs available, number of clients served, and length of time clients spend on waiting lists. Increased funding can enable service providers to expand the range of services offered or increase the number of clients served. Lost funding can force agencies to pare back programs, staffing, numbers of clients served, and hours of operation. At the extreme, loss of an entire contract or grant can jeopardize the very existence of a service organization.

Identifying how revenues and resources are allocated across our neighborhoods is critical, therefore, if we are to generate insight the spatial distribution of service providers and how it might change over time.²² The degree to which new service providers are able to enter a community or neighborhood is shaped by the availability of funding for social assistance programs in those

²¹Wolch (1996) argues that neither policymakers nor scholars adequately weigh the impact of federal social policy change on local communities and isolated poor populations reliant upon service providers, p. 651.

communities or neighborhoods. Whether or not an agency is able to relocate or acquire additional space is determined by revenue flows. To the extent that resources or revenues for social assistance are not well-matched to areas of need, mismatches in the provision of aid to the poor are likely to occur.

Beyond the geography of safety net financing, social service funding is less countercyclical or less likely to expand with need than might otherwise be expected. Government funding of social services is vulnerable to cuts particularly when the economy lags, tax revenues dip, and deficits rise. Consider the service-oriented welfare system of today versus welfare cash assistance of a decade ago. Prior to 1996, welfare was viewed as an entitlement and the number of families receiving AFDC increased when need increased. Today, welfare no longer functions like an entitlement system. Meeting an eligibility standard does not guarantee receipt of assistance from TANF. Time limits, work requirements, and federal work requirements make it difficult for states to expand welfare caseloads during economic downturns. A comparison of poverty rates and welfare caseloads before and after welfare reform highlights the weak or absent countercyclical properties of TANF. From 1989 to 1992, the number of families in poverty rose by 20 percent and the number of families on welfare grew by 27.1 percent. In contrast, the 18.9 percent increase in the number of families living below the poverty line between 2000 and 2003 was accompanied by an 8 percent decrease in the number of families on welfare during that time period.²³ Social service funding, as shown in Figure 1, has been more volatile than other types of safety net expenditures historically. For example, CRS data shows a 60 percent real dollar decline in federal job training and social service spending in the 1980s, from \$31 billion in 1980 to \$12.6 billion in 1990 (in \$2006).²⁴

Research suggests that nonprofit service agencies increasingly have become dependent upon public revenues in the last few decades. So while public funding has been a powerful catalyst for

²²Marwell, Nicole P. 2004. "Privatizing the Welfare State: Nonprofit Community-based Organizations as Political Actors." *American Sociological Review*, 69(April): 265-91.

²³U.S. Census Bureau. 2006. Number of Families Below the Poverty Level and Poverty Rate: 1959 to 2005. <http://www.census.gov/hhes/www/poverty/histpov/hstpov13.html>; Department of Health and Human Services. 2001. U.S. welfare caseloads information. <http://www.acf.dhhs.gov/news/stats>.

expansion of the nonprofit service sector, dependence upon public revenues that are responsive to economic trends will make the nonprofit service sector extremely vulnerable to cuts in government programs. Moreover, nonprofit grants, private giving, and other philanthropic gifts, key components of revenues for nonprofit service providers, also contract during recessionary periods or during periods when other charitable causes demonstrate more pressing need.²⁵ For instance, Wolff (1999) shows that the share of private giving to nonprofit human service organizations declined from 23 percent in 1955 to 12 percent in 1985, then fell further to 8 percent of all giving in 1995.²⁶

While policymakers, community leaders, and scholars can recognize that access to social service agencies may be critical, there is relatively little data or research to indicate whether programs are properly targeted or allocated throughout our communities. As a result, we have very few intuitions about what services are available, who provides these services, and who is being served.

Social Service Provision in Urban and Rural America

To provide a snapshot of social service provision in urban and rural communities, I analyze data from two recent surveys of social service providers conducted between November 2004 and June 2006: the Multi-City Survey of Social Service Providers (MSSSP) and the Rural Survey of Social Service Providers (RSSSP). The MSSSP conducted telephone survey interviews with executives and managers from 1,487 social service providers in three cities (Chicago, Los Angeles, Washington, D.C.). Similarly, the RSSSP interviewed administrators from 724 agencies in southeastern Kentucky, south-central Georgia, southeastern New Mexico, and the border counties of Oregon-California.

²⁴Congressional Research Services. 2003. "Cash and Noncash Benefits for Persons with Limited Income: Eligibility Rules, Recipient and Expenditure Data, FY2000-FY2002." Report # RL32233, p. CRS-8.

²⁵DeVita, Carol J.. 1999. "Nonprofits and Devolution: What Do We Know?" in *Nonprofits and Government: Collaboration and Conflict*, eds. Elizabeth T. Boris and C. Eugene Steuerle. Washington, D.C.: The Urban Institute Press, pp. 213-33, pp. 220-21.

²⁶Wolff, Edward. 1999. "The Economy and Philanthropy." in *Philanthropy and the Nonprofit Sector in a Changing America*, eds. Charles T. Clotfelter and Thomas Ehrlich. Bloomington: Indiana University Press, pp. 82-83.

Both surveys interviewed governmental and nongovernmental providers from a number of different service areas (welfare-to-work, job training, mental health, substance abuse, adult education, housing, emergency assistance, youth programming), which report serving populations near or below the federal poverty line. Respondents were asked to provide detailed information on services provided, clients served, funding, location, and organizational characteristics from a range of governmental and nonprofit service providers. Unique in structure and content, the MSSSP and RSSSP highlight where service providers are located, how services and client demographics vary by geography, and how challenges facing providers differ across different communities. With response rates that exceed 60 percent in each site, these surveys contain the most unique, comprehensive, and geographically sensitive data about social service provision currently available.²⁷

Who provides help in our communities? While most funding for social service programs comes from government agencies, the majority of providers delivering social service programs on the ground are nonprofit organizations. Anywhere from 52 percent in rural New Mexico to 74 percent in metropolitan Washington, D.C., identify as nonprofit organizations (see top panel of Figure 3). Government agencies are prominent in each local safety net, accounting for about one-quarter to forty percent of all service agencies in these seven different sites. It does appear, however, that government agencies compose a larger share of help-giving organizations in rural safety nets. For example, more than 40 percent of active service organizations in Kentucky, Georgia, and New Mexico, are government agencies, while less than a quarter of active service providers in Chicago and Los Angeles are government agencies. Faith-based service organizations play a prominent role in urban and rural safety nets, as one-fifth to one-third of service agencies interviewed in each site self-identified as religious nonprofits. The share of religious nonprofits was notably higher in rural Kentucky and Washington, D.C.

²⁷See Appendix 1 for more detail about the MSSSP and the RSSSP. A very small percentage of service providers in these seven communities self-identify as for-profit. As a result, most of the analyses that follow are restricted to nonprofit and governmental agencies.

(36.3 percent and 29.8 percent respectively) than in the rural border counties of Oregon and California (12.6 percent).

(Figure 3 about here)

As shown in Figure 3, a large share of the organizations operating in each community report modest budgets. Consistent with impressions that providers in urban areas have access to more public resources and must serve greater numbers of people than providers located in rural areas, most agencies in urban areas report annual budgets in excess of \$200,000. Roughly one-third to one-half of rural agencies report budgets below \$200,000.

Median monthly caseload totals, not reported in Figure 3, provide further insight into the capacity of service providers. Government agencies maintain much larger caseloads than secular or religious nonprofit organizations. For instance, the median government agency in Washington, D.C. maintains a monthly caseload that is five times that of the median nonprofit agency (500 versus 100 clients respectively). Similar patterns are present in the four rural locations, where government providers serve twice as many clients as nonprofit organizations (200 versus 100 clients respectively). The median nonprofit organization in an urban area does not appear to serve larger numbers of clients than in rural areas. Larger caseloads reflect both greater resources for programs and assistance, as well as the obligation of public agencies to provide programs or services to a wide range of individuals. Religious nonprofits in southeastern Kentucky and south-central Georgia are much smaller than their counterparts in the West or in urban settings. For instance, the median religious nonprofit in the rural Southeast serves 40 clients per month, compared to median monthly caseloads of 200 among religious providers elsewhere. Such differences in the size and capacity of the service sector between the South and other parts of the country likely reflect higher poverty rates, fewer public resources, and limited numbers of well-resourced nonprofit service organizations in the rural South.

Whom do our local safety nets target for assistance? In large part, it appears that social service providers target most of their efforts at poor women. Anywhere from 60 to almost 90 percent of providers in these urban and rural settings maintain caseloads that are majority female (see third panel of Figure 3). This likely reflects the tendency of social policy to focus upon women and those caring for children, but is a striking reminder of how marginalized poor men are within communities and safety nets. Perhaps surprising given a sample of agencies focused on low-income populations, only twenty percent to one-third of providers in these sites maintain caseloads that are predominately composed of welfare recipients. It is telling, however, that when asked about changes in demand from welfare recipients, about one-quarter of all providers in both urban and rural areas report serving larger numbers of welfare recipients than in previous years. Caseloads also appear to be drawn from the immediate community. Roughly 60 percent of providers in the MSSSP sites maintain client caseloads that are mostly from within 3 miles. Although it is difficult to apply a three mile rule to rural agencies that serve populations dispersed across vast areas, nearly all rural providers report that a majority of their clients live within the same county.

What do local safety nets offer to those in need? Despite examining service providers in seven very different settings, the bundle of services offered in each community appears quite similar. Employment services are offered by one-third to one-half of all agencies (see the bottom panel of Figure 3). Temporary or emergency food assistance apart is also common among providers operating in different urban and rural settings. Many organizations provide some type of assistance with finding affordable housing. Although not always statistically significant, some differences in service provision do emerge when looking at Figure 3. For instance, adult education, outpatient mental health, and outpatient substance abuse services are more common among providers in urban locales than in rural areas. About 40 percent of agencies in Los Angeles and Washington, D.C. offer adult education services, compared to around one-quarter of agencies in the rural western sites. Approximately 15 percent of

agencies in three of the four rural areas offer outpatient mental health services, compared to 27 percent of providers in Washington, D.C. and 42 percent of providers in Chicago. Data from the MSSSP and RSSSP cannot explain why differences in service delivery exist, but it seems likely that the variation observed in large part mirrors local needs, priorities, attitudes about poverty, and resources.

Barriers to Service Receipt

Policymakers and researchers often proceed as if the failure of clients to attend a meeting or complete a program reflects personal choice. Yet, given that social service programs often require clients to attend regular repeated sessions or meetings, factors commonly identified as barriers to employment (e.g., poor health, physical disability, mental health problems, lack of transportation resources, low literacy) may also affect patterns of service utilization. To explore the factors that may inhibit successful completion of social service programs, the RSSSP asked rural service providers about barriers to service receipt frequently observed by agency staff. Results are presented in Figure 4.

Difficulty arranging child care is one of the most prevalent barriers to service receipt in all four rural regions. Roughly 30 percent of providers in each rural locale (40 percent of providers in Oregon-California border counties) identified child care as a frequent problem that clients face when trying to attend treatment sessions or make appointments. Reflecting the transportation challenges in rural areas, transportation barriers to service receipt also were prominently reported by agencies in all four rural sites. For instance, one-third of providers in the border counties of California and Oregon indicate that problems securing transportation was a frequent barrier to service receipt. Forty-three percent of providers in Southeastern Kentucky identify transportation problems as the most common barrier to service receipt. Interestingly, transportation barriers appear more prominent in Kentucky, Oregon, and California, perhaps an indication that automobile transportation is more essential in rural areas with challenging mountainous topography where county highways bend around mountains.

(Figure 4 about here)

Substance or alcohol abuse also is a frequent barrier to service receipt, reported by 19 percent of providers in Georgia, 26 percent of providers in Kentucky and New Mexico, and 35 percent of providers in the Oregon-California site. About 20 percent of providers in each rural site indicated that physical health problems were a common barrier or obstacle to service receipt. Low literacy or difficulty completing paperwork correctly was found to be frequent barriers to service receipt about 20 percent of the time. Finally, although the prevalence is low compared to other types of barriers to service receipt, domestic violence appears to play a non-trivial role in shaping how the rural poor access safety net resources.

These data suggest that poor persons seeking help face challenges similar to those experienced when seeking employment. Many service providers, particularly those with few resources or a narrow programmatic mission, may be ill-equipped to address these different and likely multiple barriers to service utilization. Because social services are central to our local safety nets and critical to accessing other types of social benefits, however, communities should be more serious in their consideration of which factors limit service receipt among the poor.

Poor Persons' Access to Services

To assess whether services are properly matched to the geographic location of poor populations, I calculate service accessibility scores for residential Census tracts in Chicago, Los Angeles, and Washington, D.C. These scores weight for capacity by summing the number of clients served by agencies within three miles of a tract and dividing that sum by the number of poor persons within three miles to capture potential demand for assistance. Scores are divided by the metropolitan mean to allow for comparisons across Census tracts. I calculate three separate access scores, which reflect accessibility of basic needs assistance (e.g., emergency cash or food assistance), mental health and substance abuse

services, and employment services (e.g., job training, job placement, adult education). All things being equal, it is assumed that services are more readily accessible if a person seeking help is nearby an agency that offers relevant services, has resources available, and that is not overwhelmed by demand for assistance from the surrounding community. See Appendix 2 for more details about these service access scores.

Service accessibility scores reported below can be interpreted to make comparisons between a residential tract and the metropolitan average, as well as between two residential tracts: Residential Tract or Neighborhood A with an access score of 1.10 for employment services is located within 3 miles 10 percent more employment service opportunities than the metropolitan mean tract; Residential Tract or Neighborhood B with an access score of 0.90 is located near 10 percent fewer employment service opportunities than the metropolitan mean tract. Access scores can also be used to reflect the magnitude of differences in access between two neighborhoods or two types of Census tracts. For instance, if Neighborhood A has an access score of 1.10 and Neighborhood B has an access score of 0.90, then it can be said that Neighborhood A has access to 22 percent more opportunities than Neighborhood B ($1.10 \div 0.90 = 1.22$). If providers are equitably located or distributed, then service accessibility scores should be close to 1 and will be comparable across different neighborhoods. Mismatches in service accessibility or availability will exist when high poverty areas will be proximate to fewer providers than low poverty areas, or vice versa. Figure 5 charts service accessibility scores for low (0 to 10 percent), moderate (11 to 20 percent), high (21 to 40 percent), and extreme high poverty (+40 percent) tracts in each city, as well as across tracts with low (0 to 25 percent) versus high percentages (+75 percent) of blacks, Hispanics, and whites.

In many instances higher poverty neighborhoods have less access to social services than low poverty neighborhoods, particularly in Chicago and Los Angeles. For example, low poverty tracts in Chicago have access to about forty percent more employment service opportunities as high and extreme

high poverty tracts (see first column of Figure 5, 1.16 versus 0.84 and 0.85 respectively). Low poverty tracts in Chicago have access to twice as many mental health and substance abuse services as higher poverty tracts. Perhaps even more surprising, low poverty tracts in Chicago have access to about fifty percent greater access to basic needs services than high poverty tracts. Very similar patterns are apparent in Los Angeles, where low poverty tracts have about twice as much access to employment services as high poverty and extreme high poverty tracts (1.28 versus 0.77 and 0.63 respectively). In short, both cities exhibit evidence of mismatches in service accessibility across low and high poverty areas.

(Figure 5 about here)

Although metropolitan Washington, D. C. displays the same basic relationships between poverty rate and service accessibility, there are no statistically significant differences in access scores across low and high poverty Census tracts. This is due in large part to the concentration of poverty within a few neighborhoods and the compact nature of urban geography in the District of Columbia, where a three mile radius brings many high poverty tracts within three miles of a service provider. As a result, we should expect providers to be more equitably distributed within compact cities like Washington, D.C. and less equitably distributed across more sprawling cities like Chicago and Los Angeles. Nevertheless, 50 percent of all tracts in Washington, D.C. with a poverty rate over 20 percent are in areas of the city that have low levels of access to basic needs and employment services (access scores of .75 or lower). Despite few differences at the mean, therefore, many high poverty neighborhoods in Washington, D.C. either are distant from service providers or contain demand for assistance that far exceeds capacity of providers located nearby.

The racial variation in service accessibility which emerges in Figure 5 also is quite striking. Neighborhoods with high percentages of black and Hispanic residents have far less access to social service providers as neighborhoods that have a small percentage of minority residents or are predominately white. Such findings are true across each of the different access scores calculated. For

example, tracts in Washington, D.C. where more than 75 percent of the residents are black have half as much access to employment services as tracts where fewer than 25 percent are black (0.54 versus 1.24 respectively). Likewise, tracts with a small percentage of blacks in Chicago had access to about 70 percent more employment service opportunities than tracts where at least three-quarters of the population is black (1.17 versus 0.68 respectively). Similarly, tracts where more than three-quarters of residents identify as Hispanic have much less access than tracts that are mostly white. Looking at access scores for Los Angeles, for instance, the middle panel of Figure 5 indicates that predominately Hispanic tracts have access to many fewer employment services than tracts with a small percentage of Hispanics (0.82 versus 1.20 respectively). Not only is the safety net mismatched by need and poverty, therefore, but living in neighborhoods highly segregated by race also significantly diminishes access to the safety net.

Service accessibility has a different meaning in rural places. Simply assessing which providers are within three miles may not be very meaningful given the great distances one might have to commute between towns or to a county seat. Providers in one town or county seat may be willing to serve populations outside that town or location, but most rural towns are a considerable distance apart. These distances between towns limit the extent to which the absence of a particular program or provider can be remedied simply by traveling to a neighboring town or community, where that program or provider may be located. Moreover, the dispersal of population and low densities of potential clients outside of main town areas may prevent service providers from locating outside of county seats or population centers, even if unmet needs are recognized in more isolated portions of a rural community. In rural places, therefore, having access to a reliable automobile and/or living in a population center may be even more critical determinants of service access than in urban places.

As survey respondents indicated, most low-income persons in rural areas must take about fifteen minutes by automobile to travel to an agency to receive assistance. The mean travel times for clients were 18 minutes in southeastern Kentucky, 14 minutes in south-central Georgia, 17 minutes in the Oregon-

California border counties, and only 12 minutes in southeastern New Mexico. Consistent across all four rural sites, about 70 percent of providers reported clients traveled an average of 10 to 20 minutes by car to receive assistance. Fifteen percent of all rural providers indicated the average travel time by car was more than 20 minutes. For most clients in rural areas, even 10 to 20 minutes of automobile travel often translate into significant distances (more than 5 or 10 miles) that must be covered to receive help.

Population concentration in rural areas should be an important determinant of service accessibility as well. Providers may be well-dispersed in rural areas or regions with multiple population centers or large county seats, but more highly concentrated in places with few population centers. Along these lines, both the Georgia and New Mexico rural regions included in the study have a few population centers. The towns of Waycross and Douglas are of central importance in the Georgia site, while much of the population in the New Mexico site resides in or near the towns of Clovis and Roswell. It follows, therefore, that 61 percent of providers in the Georgia site were located within 10 minutes of Waycross or Douglas, and 40 percent of providers in the New Mexico site were within 10 minutes of either Clovis or Roswell. By comparison, the southeastern Kentucky and Oregon-California border sites have a number of sizeable rural towns located throughout each region. In these two rural sites, no more than 10 percent of providers were located within 10 minutes of any given town. Poor persons living outside of the main population centers in rural New Mexico and Georgia may face even greater barriers to accessing services than their counterparts in outlying areas of the Kentucky and Oregon-California sites.

Funding of Social Service Agencies

Understanding the manner in which social service agencies finance programs should be key to understanding both mismatches and identifying volatility in service provision. Although governmental agencies primarily draw funding from public sources, nonprofits draw funding from four key sources: government grants or contracts; Medicaid reimbursements; grants or contracts funded by nonprofit

organizations or foundations; and, private giving from individuals. Each survey asked nonprofit providers whether they received funds from one of these four sources and then to estimate the share of total funding from that particular source. Nonprofit agencies are deemed to be dependent or heavily reliant upon a particular revenue source if they receive at least half of total revenue from a given source.

Fitting with changes in safety net financing over the past forty years, government grants and contracts are the most critical source of funding for nonprofit social service providers. Nearly three-quarters of all nonprofit service providers in both urban and rural areas report receiving federal, state, and/or local government funds in the most recent fiscal year (see top panel of Figure 6). The prevalence of public revenues does appear to vary some according to whether state and local governments spend greater or lesser amounts of social service programs. More than 80 percent of nonprofit providers in Chicago and along the Oregon-California border report receiving government funds, which should be expected given the size of social welfare expenditures in those states. Forty-three percent of providers in rural Georgia report receiving public funds, consistent with the State of Georgia's history of limited governmental support for antipoverty programs.

(Figure 6 about here)

Nonprofit service providers receiving governmental funds are quite dependent upon those funds, as government funding composes more than 50 percent of total revenues for about half of all nonprofit service providers receiving public funding. Nonprofit organizations dependent upon government grants and contracts are larger organizations (budgets over \$1 million) that typically offer resource- or capacity-intensive services such as substance abuse, adult education, or employment services to low-income individuals.

Many nonprofit agencies that bundle basic health care, maternal health programs, and mental health services with other types of support services can be eligible for Medicaid reimbursement of

qualifying procedures.²⁸ Yet, there is limited data available on Medicaid expenditures, which makes it difficult to generate an accurate assessment as to how important Medicaid revenues are to nonprofit social service providers. Based on data from the MSSSP and RSSSP, nearly one-quarter of nonprofit service providers report receiving Medicaid funding, although prevalence varied substantially by community. For example, thirty-seven percent of all providers in Chicago and 30 percent of providers in New Mexico receive Medicaid funding or reimbursement, a rate twice that reported in Los Angeles (16 percent), metropolitan Washington, D.C. (16 percent), or southeast Kentucky (13 percent). While few rural nonprofits report Medicaid, it is a particularly key source of funding for those that do. Half of all rural nonprofits receiving Medicaid depend on those revenues for at least 50 percent of total organizational revenues, compared to less than ten percent of urban nonprofits reporting Medicaid revenue.

While nonprofit grants and private philanthropy are prominent components of nonprofit social service organization budgets, these revenue sources account for a small share of total revenues in most instances. For example, 76.6 percent of nonprofit service organizations in Washington, D.C. report revenue from nonprofit organizations or foundations, with 87.9 percent receiving revenue from private giving. Similar patterns can be found among nonprofits in Chicago and Los Angeles, albeit at slightly lower rates. Absent large private philanthropies, about 50 percent of rural nonprofits report receiving funding from other nonprofit organizations and much a smaller percentage of those agencies that receive such funds are dependent upon them. On the other hand, rural nonprofits are more reliant upon private giving than urban nonprofits. Private donations and philanthropy constitute more than 50 percent of

²⁸Tami L. Mark, Rosanna M. Coffey, Rita Vandivort-Warren, Hendrick J. Harwood, Edward C. King, and the MHSA Spending Estimates Team. "U.S. Spending For Mental Health And Substance Abuse Treatment, 1991-2001." *Health Affairs* Web Exclusive, March 29, 2005; Smith, Steven Rathgeb. 2002. "Social Services" in *State of Nonprofit America*. ed. Lester M. Salamon. Washington, D.C.: The Brookings Institution, pp. 150. Salamon (2003) states that 70 of federal assistance to nonprofits came in the form of fees or subsidies for services, much of it through Medicaid and Medicare. See, Lester M. Salamon 2003. *The Resilient Sector: The State of Nonprofit America*. Washington, D.C.: The Brookings Institution, p. 18.

total revenue for more anywhere from one-quarter to three-quarters of nonprofit service organizations receiving private funding in the RSSSP sites.

In addition to identifying the prevalence of funding from various revenue streams, we should be interested in the frequency with which funding streams are cut or reduced in size. Of particular concern are cuts to a primary or key source of revenue. Since program funding has an inherent “blockiness” quality, programs often are funded in full or not at all. Any loss or increase in a primary revenue source will have significant impact upon how an agency operates. Lost funding creates obvious challenges for service agencies, particularly if organizations cultivate few other funding sources and cannot find substitute revenues readily. Beyond seeking replacement funds, agencies may have to choose whether to reduce staff, lower program costs, or trim client caseloads in order to fit program activities within a more constrained budget.

When looking at increases and decreases in funding sources in the three years prior to the survey, both urban and rural service providers show substantial volatility or change in the composition of agency funding. Although it varies by site, anywhere from one-third to fifty percent of providers in these survey sites report a decrease in at least one funding source over the previous three years. Indicating that funding decreases may be offset by increases in other revenue streams, comparable percentages of agencies report an increase in a given revenue source over the three years prior to the survey. While the MSSSP and RSSSP do not contain enough detail about funding to discern whether increases and decreases in funding leave agencies with in net positive or negative budgetary position, it does appear that many agencies reporting lost funds from one source do not replace those funds with increased funding from another source. Of agencies reporting a funding cut in the previous three years, 61 percent of urban providers and 76 percent of rural providers did not experience an increase in other funding sources over that time (not shown in Figure 6). Rural service agencies in the Southeast appear hardest hit

in recent years, as 86 percent of agencies in Georgia and Kentucky that report a recent funding decrease do not report funding increase during the same time period.

Another indicator that service provision may be more volatile than might otherwise be imagined, a significant share of service agencies reported a decrease in a key source of funding in the three years prior to the survey. This is true across both public and nonprofit agencies operating in rural and urban areas. Almost one quarter of all providers in Los Angeles (23.5 percent) and Chicago (22.3 percent) saw a decrease in funding from a primary revenue stream, whereas 12.8 percent of providers in Washington, D.C. report a decrease in a primary revenue source. Similarly, 20 to 35 percent of rural service agencies report a decrease in a primary revenue source within the previous three years.

Volatility of Service Delivery

Any cut in program funding will have an immediate effect upon nonprofit service providers. Reduction in governmental and nongovernmental revenue sources will create fiscal uncertainty and instability that can force agencies to make immediate modifications to service provision. Accordingly, the MSSSP and RSSSP ask service providers whether recent funding problems or shortages have forced changes to service delivery. In particular, agencies experiencing funding decreases were asked whether they had pursued any of the following four responses to such funding losses in the previous year: reductions in staffing levels; reductions in services offered; reductions in numbers of clients served; or temporary closure of their facility.

Far from operating stable programs year to year, it appears providers in both urban and rural areas experience substantial volatility in service provision. For instance, 71 percent of urban service providers and 77 percent of rural providers experiencing a decrease in funding report reducing staff, reducing services, reducing clients served, or temporarily halting operations in response. Figure 7 compares the prevalence of each response across the seven locations.

(Figure 7 about here)

Reducing staff was the most common strategy for coping with funding cuts. About half of all providers in Washington, D.C. and nearly two-thirds of all providers in Chicago and Los Angeles retained fewer staff as a result of funding problems, perhaps trying to provide the same level of assistance with fewer personnel. Although at lower levels, roughly one-third of all rural providers also trimmed staff in response to funding cuts. Given that service organizations are typically understaffed, particularly in rural areas, the loss of staff members is likely to shrink the organization's capacity to serve. Cuts in staff will mean longer waiting times for program applicants, more burdensome caseloads for staff, and less time for staff to work with clients or assess client needs.

A nearly equal share of service organizations report simply reducing services offered to low-income clients as a result of funding cuts. Fifty-three percent of governmental and nonprofit providers in Los Angeles indicated they reduced services to cope with lost revenues, with anywhere from 24 percent of providers in New Mexico to 47 percent of providers in Chicago reporting the same. Slightly fewer providers indicate reductions in the number of clients served. For instance, roughly one-third of providers in Chicago, Washington, D.C., south-central Georgia, and the border counties of Oregon-California reduced the number of clients served following funding cuts.

About five percent of agencies in both urban and rural areas report temporary closures in response to decreases in funding. Taken alone this is a small, but nontrivial, reduction in service capacity across our communities. Yet, initial phone calls to agencies listed in community directories indicated that an additional ten to fifteen percent of agencies listed in the most current community service directories were no longer operational. Combining these temporary closures with organizations that were not operation at the time of the survey, it is apparent that a sizeable share of the service capacity within local safety nets faces difficulty operating successfully from month to month, year to year.

Finally, although not reported here, accessibility scores reflecting proximity to different service delivery reduction strategies in urban areas indicate that high poverty tracts were proximate to anywhere from three to nine times as many providers reducing service delivery as a result of funding cuts as low poverty tracts. For instance, individuals living in high poverty tracts in Washington, D.C. were nearly six times as many service providers who reduced staff to cope with funding cuts as low poverty tracts. High poverty tracts in Chicago had access to three times as many providers reducing the number of services in response to funding cuts as low poverty tracts. Even more dramatic, high poverty tracts in Los Angeles had twice as much access to providers that temporarily shut down due to funding cuts as the average tract and almost nine times as much access to temporary shutdowns as low poverty tracts. Volatility in the contemporary safety net appears to have a particularly negative effect on already hard-pressed and disadvantaged communities.

Discussion

When examining social service provision in three different urban locations, this paper finds evidence of striking spatial mismatches and volatility in the contemporary safety net. Poor urban and rural areas have access to far fewer social service agencies than lower poverty areas. Low-income households living in high poverty urban neighborhoods in Chicago and Los Angeles have access to far fewer service opportunities than low-income households in affluent neighborhoods. Even more consistent across different urban settings, persons living in neighborhoods composed predominately of racial minorities have access to about half as many service opportunities as those living in predominately white residential neighborhoods. Similarly, rural poor populations are often required to travel long distances by automobile to receive services. Rural poor populations living in more isolated areas or without reliable automobile transportation face nearly insurmountable spatial barriers to service providers. Also, there is evidence that social service agencies in rural and urban areas frequently

experience volatility in funding. Nearly all providers reporting cuts to program funding are forced to make serious reductions in service delivery as a result.

There is reason to believe that inequality in access to the safety net compounds other place-based inequalities we observe in communities today. Poor quality schools, substandard housing, inadequate transportation resources, and limited access to job opportunities all have spatial correlations similar to those found here for service provision. It is a bitterly ironic reality of the safety net that the social service programs designed to reduce the impact or prevalence of these social problems, are mismatched from communities in need. Policymakers, community leaders, and scholars should not be surprised that low-income, low-skill workers have persistent difficulty achieving greater economic self-sufficiency and trajectories – the safety net simply reinforces the obstacles to opportunity that low-income populations confront each day. A safety net mismatched from need will not be well-suited to remedy persistent poverty, no matter how well we understand the antecedents of that poverty. Insufficient distribution of social assistance and service providers undermines the success of safety net programs, the efficiency with which the safety net operates, and the ability to promote better outcomes among the poor.

Mismatch and instability in service provision are the cumulative product of many separate and disconnected decisions that government, nonprofit agencies, and individuals make about which programs, populations, and agencies to support. Intuitively, one might think greater governmental expenditures for services and transportation programs will eliminate the disparities and mismatches described here. While greater resources would improve access to the safety net, simply spending more will not alter structural flaws within the safety net that lead it to be out of place with respect to need. For instance, even after four decades of social service program expansion gaps and volatility in service delivery persist. Nor are transportation solutions alone likely to address the instability and underprovision of services in high poverty neighborhoods.

Yet, maintaining a public financial commitment to the safety net is a necessary condition for improving how communities help the poor. Because of the interdependency of the public and private safety nets, policymakers and community leaders should be particularly attentive to the impact of cuts to governmental social service programs. Cuts in public funding of social services will have powerful ripple effects throughout local safety nets. Nonprofits that lose public funding will find it difficult to maintain programs and remain operational. Decreases in governmental social service funding will increase the vulnerability and volatility of the nonprofit service sector, rather than enhance private commitments to the safety net. Retrenchment of public social welfare programs, therefore, jeopardizes the very foundations of the safety net more profoundly than is commonly realized.

Expanding access to safety net programs will require creative community strategies for linking persons in need to service agencies. Improved access to the safety net will hinge on building systems that better link persons in need with community resources and service providers. First, public and nonprofit agencies should also invest resources in better understanding the individual-level and structural barriers to social service utilization. Complementing these efforts, communities could seek to improve outreach efforts of social service organizations to better distribute information about services available near high poverty neighborhoods. One key component of such efforts to improve the quality of information about services available may be well-maintained 2-1-1 telephone systems that would link persons in need to relevant community service agencies nearby.

Communities should begin to consider more aggressive metropolitan or regional planning for the delivery of antipoverty assistance and social services. Rather than allocate funds by program, organization, or municipality, more attention should be given to ensure that funding flows to areas with the greatest need. Multi-year guaranteed grants or contracts can be awarded on the condition that providers locate within certain neighborhoods or areas. Public agencies can attempt to match private funds targeted at underserved areas, rewarding community-based service providers who seek to operate

among the hardest-to-serve areas and raising revenues from nongovernmental sources. One-stop facilities can be expanded to provide low-overhead space to a wider range of service providers.

Reallocating resources will not come without controversy. Since there are few places where the resources are adequate to meet needs, no community will feel there are excess funds to share. NIMBY sentiment may lead other communities to resist becoming the destination for a particular service provider. Reallocation of resources may run counter to the missions of foundations and umbrella organizations to distribute funds widely in communities. Distribution of public funds is likely to be heavily rooted in subtle forms of patronage. Donors do not easily see how their giving would be better invested in neighborhoods to which they have little connection and for causes that seem distant from their everyday lives. Shifting how we fund and target social service programs, therefore, will require the collaboration of both the nonprofit and public service sectors.

The United Way of Greater Toronto (UWGT) provides a recent example of how communities can work together to address mismatches in service provision. Over the last few years, the UWGT has shifted its mission to respond to increasing poverty in the inner-tier suburbs of Toronto and the presence of few service providers in those communities. Through the Strong Neighbourhoods Task Force, the UWGT has begun to target millions of dollars in resources at thirteen neighborhoods with rising need, but few agencies that provide social services. Funds from UWGT will support the creation of community hub facilities delivering services and programs to previously underserved low-income populations in metropolitan Toronto. In addition to generating private funding for this initiative, the UWGT also has sought to improve collaboration among federal, provincial, and local government agencies and area nonprofits to better address the needs of high poverty areas outside central city Toronto.²⁹

²⁹United Way of Greater Toronto. "Poverty By Postal Code." April 2004. http://www.uwgt.org/who_we_help/pdfs/PovertybyPostalCodeFinal.pdf; United Way of Greater Toronto. 2005. "Strong Neighbourhoods." http://www.uwgt.org/who_we_help/pdfs/SNTF-web_report.pdf; Jeff Gray. "Report Finds Shortchanged Neighbourhoods; Nine Areas with Many New Immigrants and the Very Poor Lack Social Services." *The Globe and Mail (Canada)*. July 1, 2005, p. A9.

States and communities should also consider new strategies for providing service agencies with resources to acquire new facilities and relocate to be more proximate to populations in need. Programs that allow nonprofits to renovate and/or acquire space in underserved communities can help nonprofits overcome the resource hurdles to relocating to or expanding within high poverty neighborhoods. One example is the Illinois Facilities Fund (IFF), a nonprofit organization that helps other nonprofit service providers secure proper facilities and plan for future facility needs. IFF offers nonprofit service agencies a mix of technical assistance with facilities planning, data resources to aid facilities decision-making, and access to financial resources that can help acquire or expand facilities. By addressing the space needs of agencies, IFF helps nonprofits better position themselves in the service delivery marketplace. With a loan portfolio of only \$111 million, IFF has helped nonprofits serving almost 200,000 low-income clients finance more than 2 million square feet in space.³⁰ Given that nonprofits like IFF can be self-supporting through fees and loan payments, such solutions can represent a low-cost approach to strengthening the nonprofit service sector and reducing mismatches in assistance.

To complement governmental support of social service agencies, communities should increase private support for programs that help low-income populations. Given the resource dependency of many service agencies, communities should support efforts by nonprofits to cultivate more diverse and durable revenue sources. Increasing volunteerism within nonprofit service organizations may also help to strengthen nonprofit service organizations. Although volunteers cannot provide direct services in all instances, volunteers can help maintain facilities or performing basic administrative tasks, volunteers can allow many nonprofit service agencies to dedicate staff and financial resources to service delivery. Volunteers also can help nonprofits develop client outreach efforts or conduct fundraising campaigns, which will strengthen nonprofit service organizations and increase their service capacity in the long-term. Finally, local foundations and funds can provide information to private donors about community needs,

³⁰Illinois Facilities Fund. Annual Report 2004-05. <http://www.iff.org/resources/content/2/6/images/2006annualrep.pdf>

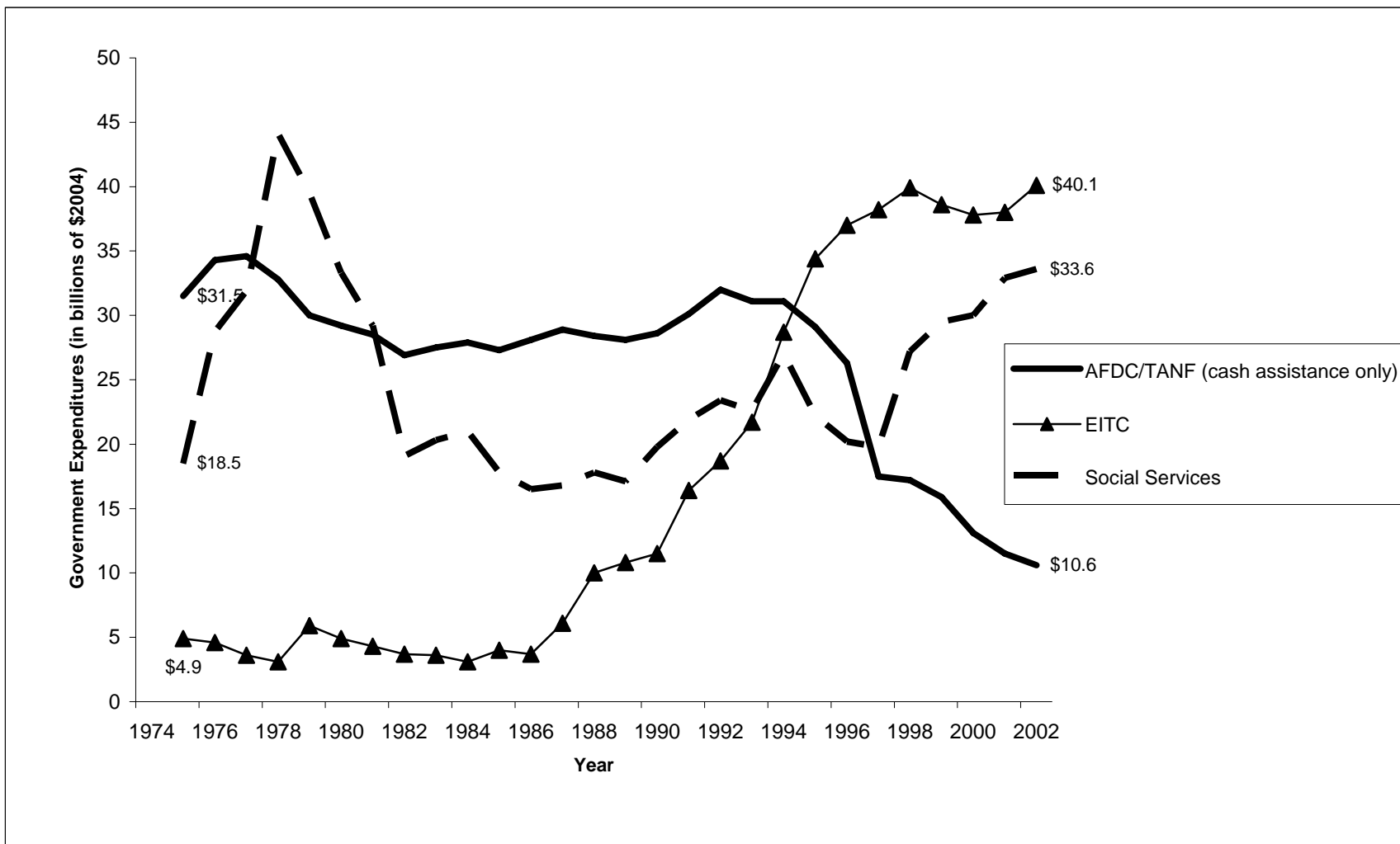
program outcomes, and places where private donations are most needed. Such information can connect private donors to important causes and needs that otherwise might go overlooked.³¹

Evidence of a mismatched and volatile social service sector also has implications for research on poverty and the safety net in America. Greater attention should be given to the bundle of services and supports that states and communities provide to low-income populations. Not only does this require a shift in orientation, but also in data collection. Many of the large data sets used to study poverty in America are not designed to address issues of service utilization, nor are they geographically representative of a particular region, state, or city. Just as more research has focused on work outcomes among low-income mothers since the passage of welfare reform, more scholarship should investigate the determinants of service utilization among low-income populations. A better understanding why certain individuals seek assistance, follow up on referrals, or fail to complete programs, will improve how local service agencies provide assistance to low-income populations.

Social service providers are the critical thread that tie together our local safety nets and determine how communities assist poor populations. Retrenchment of welfare and greater budgetary pressure on other public safety net programs suggest that local social service agencies will become even more integral sources of support for the poor. With income inequality widening and poverty rates increasing, it is likely need for assistance also will increase in the coming years. Because of the fragmented nature of social service provision, however, we have given less thought to whether the safety net is well-equipped to meet changing demand for assistance. Community leaders, policymakers, and scholars, therefore, should engage issues of social service accessibility and stability to ensure that the safety net meets current need and the challenges that the future might pose.

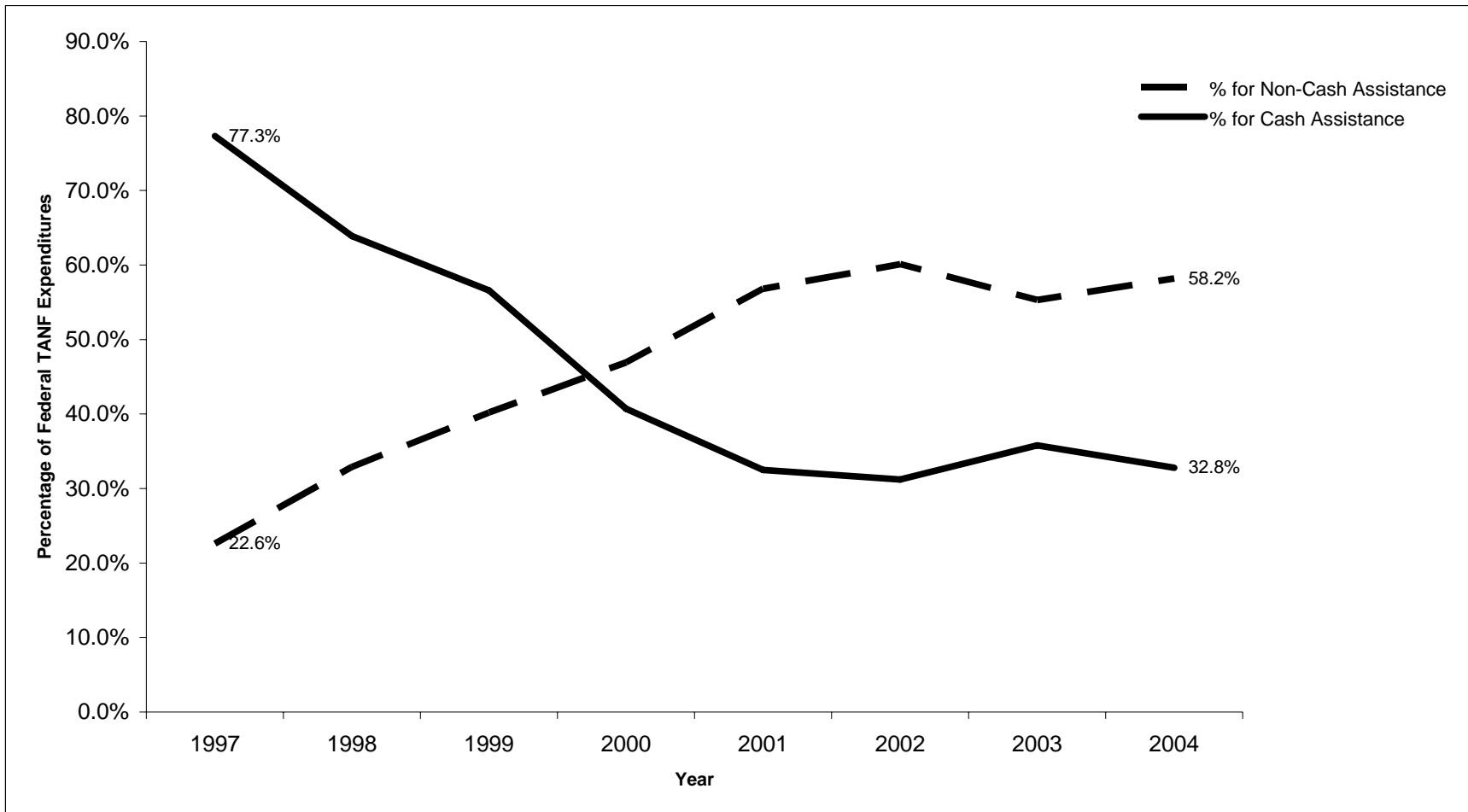
³¹Wolpert, Julian. 1999. "Communities, Networks, and the Future of Philanthropy." in *Philanthropy and the Nonprofit Sector in a Changing America*, eds. Charles T. Clotfelter and Thomas Ehrlich. Bloomington: Indiana University Press, p. 235.

Figure 1: Federal, State, and Local Cash Assistance, Social Service, and Earned Income Tax Credit Expenditures, 1975-2002 (in \$2006 billions)



Sources: Congressional Research Services; U.S. House of Representatives, 1998 Green Book; U.S. House of Representatives, 2004 Green Book; Department of Health and Human Services.

Figure 2: Percentage Change in Federal TANF Expenditures, 1997 – 2004



Source: Department of Health and Human Services.

Figure 3: Characteristics of Service Providers in the MSSSP and RSSSP

	Chicago	Los Angeles	Washington, D.C.	Kentucky	Georgia	New Mexico	Rural Oregon/Calif.
Type of Organization							
Governmental	23.9	36.5	24.2	40.7	41.8	42.9	31.4
Nonprofit	70.9	59.9	73.6	58.3	54.4	51.8	62.6
Secular Nonprofit	50.2	40.9	43.5	21.2	23.9	32.1	48.7
Religious Nonprofit	20.2	18.3	29.8	36.3	29.9	19.1	12.6
For Profit	5.7	4.3	2.5	1.8	4.5	6.0	7.3
Size of Annual Budget							
More than \$1 million	59.2	43.3	35.1	21.9	25.0	32.8	37.8
\$1 million - \$200,000	27.7	31.0	37.8	18.8	20.0	25.0	29.9
\$200,000 - \$50,000	9.2	14.8	19.2	30.2	33.3	17.2	20.1
Less than \$50,000	3.8	10.9	7.8	29.2	21.7	25.0	12.2
More than 1/2 Clients							
Are Women	61.3	58.1	68.5	79.1	74.6	88.8	68.0
Receive Welfare	26.9	20.1	21.8	33.1	35.0	35.1	32.9
Live Within 3 Miles	64.5	64.6	60.9	na	na	na	na
Live In County	na	na	na	89.9	79.3	96.2	96.9
Are African American	45.7	11.2	45.5	0.0	40.9	0.0	0.0
Services Available							
Mental Health	41.5	30.9	27.3	15.5	17.9	14.9	34.9
Substance Abuse	33.9	35.4	22.9	19.0	26.9	14.9	26.8
Find Affordable Housing	43.3	29.9	42.4	45.7	48.5	24.1	38.5
Adult Education/GED	24.8	40.9	41.7	30.2	33.8	22.1	25.4
Employment Services	45.9	48.6	55.3	43.5	43.5	39.1	33.2
Emergency Assistance	40.1	23.4	38.7	27.6	25.0	11.5	17.9
Food Assistance	42.9	45.6	54.5	65.5	50.0	39.1	42.2
N	445	548	399	116	69	87	198

Note: Reported numbers are percentages of all service organizations interviewed.

na – Survey question not asked.

Sources: Multi-City Survey of Social Service Providers and Rural Survey of Social Service Providers

Figure 4: Perceived Barriers to Social Service Receipt in the RSSSP

Barriers to Service Receipt Clients Frequently Encounter	Kentucky	Georgia	New Mexico	Rural Oregon and California
Difficulty Arranging Child Care	31.9	28.8	27.4	39.7
Problems with Transportation	42.5	23.9	17.7	32.6
Difficulty Keeping Appointments due to Substance or Alcohol Abuse	25.7	19.0	25.7	35.2
Physical Health Problems or Illness	18.8	20.6	16.9	31.9
Fear of Stigma or Personal Concerns	8.9	11.5	16.9	26.8
Tough to Make Appointment Due to Work Schedule	4.4	11.3	16.5	21.4
Low Literacy or Difficulty Completing Paperwork	20.0	18.2	15.3	16.2
Domestic Violence	4.8	1.8	12.2	9.4
N	116	69	87	198

Note: Reported numbers are percentages of all service organizations interviewed.

Source: Rural Survey of Social Service Providers

Figure 5: Access to Social Service Providers

	Access to Employment Services	Access to Mental Health/ Substance Abuse	Access to Basic Needs Assistance
Chicago			
Poverty Rate 0-10%	1.16 ^{abc}	1.36 ^{abc}	1.23 ^{abc}
Poverty Rate 11-20%	0.88 ^a	0.79 ^a	0.78 ^a
Poverty Rate 21-40%	0.84 ^b	0.60 ^b	0.79 ^b
Poverty Rate +40%	0.85 ^c	0.63 ^c	0.84 ^c
Percent Black 0-25%	1.17 ^a	1.25 ^a	1.15 ^a
Percent Black +75%	0.68 ^a	0.55 ^a	0.64 ^a
Percent Hispanic 0-25%	1.07 ^a	1.09 ^a	1.10 ^a
Percent Hispanic +75%	0.72 ^a	0.55 ^a	0.63 ^a
Percent White 0-25%	0.72 ^a	0.56 ^a	0.68 ^a
Percent White +75%	1.28 ^a	1.57 ^a	1.26 ^a
Los Angeles			
Poverty Rate 0-10%	1.28 ^{abc}	1.35 ^{abc}	1.14 ^a
Poverty Rate 11-20%	0.99 ^a	0.83 ^a	0.95
Poverty Rate 21-40%	0.77 ^b	0.77 ^b	0.91 ^a
Poverty Rate +40%	0.63 ^c	0.86 ^c	0.88
Percent Black 0-25%	1.05	1.02	1.03
Percent Black +75%	0.50	0.85	0.66
Percent Hispanic 0-25%	1.20 ^a	1.30 ^a	1.22 ^a
Percent Hispanic +75%	0.82 ^a	0.57 ^a	0.89 ^a
Percent White 0-25%	0.72	0.68 ^a	0.71 ^a
Percent White +75%	0.96	1.27 ^a	1.27 ^a
Washington, D.C.			
Poverty Rate 0-10%	1.03	0.95	0.97
Poverty Rate 11-20%	0.88	1.05	1.14
Poverty Rate 21-40%	1.06	1.36	1.04
Poverty Rate +40%	0.80	1.00	0.72
Percent Black 0-25%	1.24 ^a	1.22 ^a	1.17 ^a
Percent Black +75%	0.54 ^a	0.64 ^a	0.60 ^a
Percent Hispanic 0-25%	--	--	--
Percent Hispanic +75%	--	--	--
Percent White 0-25%	0.58 ^a	0.67 ^a	0.64 ^a
Percent White +75%	1.48 ^a	1.47 ^a	1.35 ^a

Note: ^{a,b,c} Difference of means is significant at the .10 level or below.

Sources: Multi-City Survey of Social Service Providers and Rural Survey of Social Service Providers

Figure 6: Sources of Support for Social Service Providers in the MSSSP and RSSSP

% of Nonprofit Agencies Receiving...	Chicago	Los Angeles	Washington, D.C.	Kentucky	Georgia	New Mexico	Rural Oregon/Calif.
Gov't Grants/Contracts	83.8	70.8	63.5	59.1	43.2	61.9	82.6
% with funding that are defined as dependent on government revenues	64.4	50.0	42.2	40.5	57.1	47.8	56.4
Medicaid	37.0	16.4	15.5	13.4	16.2	30.2	24.4
% with funding that are defined as dependent on Medicaid revenues	9.1	9.5	5.2	57.1	40.0	41.6	57.1
Nonprofit Grants	76.1	62.4	76.6	47.7	29.0	50.0	60.7
% with funding that are defined as dependent on nonprofit revenues	13.5	9.5	22.0	13.3	28.6	25.0	14.8
Private Giving	80.1	72.0	87.9	84.9	66.7	68.3	57.4
% with funding that are defined as dependent on private giving revenues	7.2	21.9	19.1	39.6	75.0	29.6	26.2
% of All Agencies Reporting...							
<i>Decrease in Funding from Any Revenue Source in Previous 3 Years</i>	43.8	39.6	30.1	51.7	44.9	36.8	52.5
<i>Increase in Funding from Any Revenue Source in Previous 3 Years</i>	43.6	33.4	50.4	26.7	24.6	40.2	41.9
<i>Decrease in Funding from a Primary Revenue Source in Previous 3 Years</i>	22.3	23.5	12.8	35.3	20.3	20.7	30.8
% of All Agencies with Funding Problems in Past Year Reporting...							
Reductions in Services Offered	6.9	52.6	36.7	29.6	39.7	23.8	39.3
Reductions in Number of Clients	35.6	43.7	31.7	20.0	32.8	23.8	30.3
Reductions in Staff	64.1	64.4	45.8	35.3	35.3	34.5	46.2
Reductions in Hours of Operation	na	na	na	10.3	17.7	8.3	16.3
Temporarily Shut Down Site	5.8	5.6	10.0	4.3	14.7	3.6	4.6

Note: Reported numbers are percentages of all service organizations interviewed.

na – Survey question not asked.

Sources: Multi-City Survey of Social Service Providers and Rural Survey of Social Service Providers

Appendix 1: Multi-City Survey of Social Service Providers and Rural Survey of Social Service Providers

The Multi-City Survey of Social Service Providers (MSSSP) and Rural Survey of Social Service Providers (RSSSP) are telephone surveys of executives and managers from more than 2,200 social service providers in three cities (Chicago, Los Angeles, Washington, D.C.) and four high-poverty rural areas. The RSSSP was completed in four high-poverty multi-county rural regions. The south-central Georgia site is composed of 8 rural counties: Atkinson; Bacon; Ben Hill; Berrien; Coffee; Jeff Davis; Pierce; and, Ware. The southeastern Kentucky site includes 8 rural counties: Bell; Clay; Harlan; Jackson; Knox; Laurel; Rockcastle; and, Whitley. The site in south-central New Mexico is composed of a six-county region: Chaves; Curry; DeBaca; Eddy; Lea; and Roosevelt. The Oregon-California border site is composed of ten counties (California: Del Norte, Modoc, and Siskiyou; Oregon: Coos, Curry, Douglas, Jackson, Josephine, Klamath, and Lake). Respondents were drawn from databases of governmental and nongovernmental service agencies constructed for each city or rural region from community directories, social service directories, county agency referral lists, phonebooks, and internet searches. Providers included in the survey operated in a number of service areas (welfare-to-work, job training, mental health, substance abuse, adult education, emergency assistance). Agencies that provided services on site to low-income populations broadly defined were contacted to complete a longer telephone survey.

The MSSSP database contained 2,953 agencies eligible for the longer survey. Between November 2004 and August 2005, a survey team contacted each of the 2,953 eligible using a five-callback minimum rule. Efforts to complete the longer telephone survey identified 770 agencies not eligible for the survey. Telephone surveys were then completed surveys with 1,487 of the remaining 2,183 social service providers, for a response rate of 68 percent. The RSSSP database contained 1,270 agencies and churches eligible for the telephone survey. Again, 186 agencies were deemed ineligible for the survey as efforts to complete the longer telephone survey progressed. Surveys were completed surveys with 724 of the

remaining 1,084 social service providers between November 2005 and August 2006, for a response rate of 66.8 percent.

Appendix 2: Calculating Service Accessibility Scores for the MSSSP

Service accessibility scores are calculated for each Census tract in the three study sites. Scores are calculated by first summing the total the number of clients served by agencies within 3 miles of each residential Census tract. This figure provides a sense of the supply of services or capacity of service agencies within three miles of a given tract or neighborhood. To account for potential demand for services, I calculate the number of individuals with income below the poverty line within 3 miles of each residential tract. A radius of 3 miles is selected because interviews with social service program managers indicate that clients typically are not expected to commute more than a few miles to a social service provider.

With these data, I calculate a set of demand-, distance-, and organizational-weighted service accessibility scores as follows:

$$IA_i = \sum(W_j) \div \sum(P_j) \text{ for } d_{ij} = 0 \text{ to } d_{ij} = 3 \quad (1)$$

Where, IA_i is a particular initial access score. W_j reflects the number of clients served in a typical month. I sum the number of clients served (W_j) and number of poor persons (P_j) across tracts j within a 3 mile radius (d_{ij}) of tract i . To make service accessibility scores more readily interpretable, I divide each tract's score for a given access measure IA_i by the metropolitan area mean score for that particular access measure. Thus, the scores reported below will reflect service accessibility for a given tract with respect to the mean tract in the area.

$$A_i = IA_i \div \text{Metropolitan Mean of } IA_i \text{ across } j \text{ tracts} \quad (2)$$