

1 Introduction

HEALTH CARE ACCESS IN AMERICA AND THE FORMAL-INFORMAL HYBRID HEALTH CARE SYSTEM

Latondra Harris and I sat in folding chairs in the courtyard behind her public housing apartment unit.¹ She was a heavyset woman and smoked a lot. She was also quite sociable and greeted many of her neighbors who walked by while we were sitting outside. She called out to them by name and laughed and joked with some of them. Latondra was open about sharing her life experiences with me, and she answered many of my questions before I was even able to ask them. She explained that she had worked for the greater part of her adult life, most recently in a staff position at a nearby university. This job had paid well and had good benefits, including health insurance. She had stayed in that position until her husband died and her then teen-aged children began to skip school and get into trouble with the authorities. Believing that her kids needed greater supervision, she decided to leave her job, which at times kept her away from home for ten hours or more. She explained this to me with mixed feelings. On the one hand, she believed that her increased presence at home had helped her kids make it safely through high school. On the other hand, she felt that taking so much time away from the formal labor market had made it impossible for her to find another job.

During our conversation, Latondra explained that she suffered from many health problems, including high cholesterol, high blood pressure, arthritis, fibroids, and “a mild form of depression.” She had a primary care doctor whose office was located near her home, and he had given her several different prescriptions to treat her various health problems. She explained, however, that she did not see the doctor as often as he would like because she could not afford the fifty dollars he charged per visit. Although her children sometimes gave her money, and she earned some money from babysitting, paying for her medication was difficult. Without insurance, her cholesterol medication alone cost around \$200 per month. Because of this, Latondra would borrow medications from her sister, who suffered from some of the same illnesses. Sometimes, however, she went without any medication.

Latondra told me that she had recently been feeling sicker than usual. She explained: “Yesterday was a bad day for me. It was a real, real bad day for me. It started OK, I wasn’t feeling [anything], but then, all of a sudden, everything in me was hurting. I couldn’t move, I had chills, I was shaking. And you know, I’m not a heat person, you know [it’s hot out] . . . and I’m sitting outside and I’m actually freezing and I’m hurting from the top of my head to my fingertips to the bottom. It was the most excruciating pain that I’ve ever experienced.”² She said that her children had urged her to go to the doctor, but she felt it would be useless. She reasoned that “if [the doctor is] going to send me to do any tests, I can’t do that ‘cause I can’t pay for any of that. It’s just like between a rock and a hard place.” Latondra explained that she had experienced similar pain one time before, about a month prior. She thought that she was likely developing fibromyalgia, which would explain why her body hurt so much.

Two years after our initial conversation, I returned to Latondra’s apartment to schedule another interview with her. When I rang her doorbell, no one answered. I asked one of her neighbors, a good friend of hers, if she knew when Latondra might be home. The neighbor told me that Latondra had passed away. She had been admitted to the hospital the year before with stomach pain and doctors had decided to remove her gallbladder. According to her friend, during the surgery doctors learned that Latondra was “full of tumors.” She had cancer and it had spread throughout much of her body before she ever received a diagnosis. She was just fifty-three years old when she died.

The United States is distinct from other developed countries in that it does not have a single, national health care system that aims to ensure universal access to health services for all its citizens. Instead, the health care system in the United States is decentralized and fragmented, and care is financed and delivered through a mix of private and public approaches and multiple subsystems (Fry et al. 2005; Shi and Singh 2010). Private health insurance is provided by employers or self-purchased by individuals, and the government provides coverage through the Medicaid and Medicare programs.³ Central components of health care delivery in the United States include a private health care sector, the military medical system, and an additional “safety-net” system, which aims to make health services available to vulnerable, underserved populations. These include low-income individuals and families, people who are uninsured or underinsured, and Medicaid beneficiaries (Wright and Perry 2010; Shi and Singh 2010).

Due, in part, to its decentralized and fragmented nature, access to health services in the United States is not equal and, in fact, differences in access are highly patterned. These differences tend to fall largely along class as well as racial and ethnic lines; individuals who are low income, live in socioeconomically disadvantaged communities, and belong to racial and ethnic minority groups have less access, on average, than others (Kirby and Kaneda 2005; Andersen et al. 2002; Mayberry, Mili, and Ofili 2000; Brown et al. 2000). In addition to facing more barriers to obtaining medical care, people belonging to these groups are often at a higher risk of a range of diseases, and thus have a greater need for health services. Low-income adults,⁴ for example, are more likely to report having fair or poor health than those with higher incomes (Pamuk et al. 1998; National Center for Health Statistics 2012), and low socioeconomic status is linked to many health problems, including cardiovascular disease, hypertension, arthritis, diabetes, and many types of cancer, among others (Adler and Newman 2002). As recently as 2016, 43 percent of low-income adults ages 19–64 in the United States reported being unable to access some aspect of care because of the associated costs, such as going to the doctor or getting a prescription filled (Osborn et al. 2016). Although there has been significant—and successful—effort to improve access to care through the expansion of insurance coverage under the Patient Protection and Affordable Care Act (ACA), insurance coverage gains have recently stalled.

Between 2016 and 2017, the uninsured rate actually increased for some groups. Today, millions continue to face barriers to care and a significant number of these are poor minorities (Artiga, Orgera, and Damico 2019).⁵

Findings from this research, as well as the vignette above about Latondra, highlight an important tension that defines the health care experiences of many people living in contemporary U.S. society. It is one in which individuals with pressing health care needs are often unable to access the medical care necessary to address these needs. This discrepancy between need and access gives rise to a question that is fundamental to understanding the health and well-being of such individuals: If people face difficulty accessing care, how do they treat their health problems when they become sick? In this book, I examine this question and present an analysis based on fieldwork conducted in the Jackson Homes public housing development, a low-income, urban African American community.

Existing studies on access to care tend to emphasize determinants of access to health services. Researchers in fields including medical sociology, social epidemiology, and public health have examined individual-level characteristics, such as insurance status, income, education, and race and ethnicity, as well as community-level factors, such as the percentage of people living in poverty, the percentage of people uninsured or publicly insured, and the availability of public hospitals and community health facilities. This is in an effort to investigate how these factors shape access to care (e.g. Andersen et al. 2002; Isaacs and Schroeder 2004; Mayberry, Mili, and Ofili 2000; Brown et al. 2000; Kirby and Kaneda 2005). Drawing heavily on statistical analyses, this research has aimed to provide insight into why some people are able to access care while others are not and what type of care—preventive, acute, emergency, or other—people have access to.

Although surveys revealing determinants of access are inarguably essential for understanding people's health care experiences, in this book I take a different approach. In particular, I draw on participant observation within Jackson Homes as well as qualitative interviews with Jackson Homes residents and doctors who work with low-income, urban African American populations in an effort to understand what people do when they have a health problem but are unable to access care.⁶ Whether a person is able to obtain different forms of care is one component of that per-

son's health care experience. Fully comprehending these experiences requires insight into the strategies that people develop if they are unable to get care through formal health services.

HOW DO THE URBAN POOR TREAT HEALTH PROBLEMS?

Common Conceptions

Existing research offers three explanations about how the urban poor treat their health problems. The first is that, if we don't include the military medical system, there are, in essence, two health care sectors in the United States. In their review of sociology and health services research, Wright and Perry (2010) explain that studies identify a private, for-profit sector through which middle- and upper-income people get care and an additional sector that is used by low-income people who are publicly insured or uninsured. This second sector comprises what is commonly referred to as the safety-net health care system, which includes core facilities like community health centers, public hospitals, and private clinics and hospitals that provide a disproportionate amount of care to vulnerable populations. These facilities are committed, either through legal mandate or their mission, to serve socioeconomically disadvantaged populations (Institute of Medicine 2000). As part of this commitment, these facilities are designed to have low barriers to entry. Public hospitals and some community health centers, for instance, are required to provide care regardless of patients' ability to pay, and other community health centers offer care according to a sliding scale that takes into consideration a person's income level and family size. These facilities are also frequently located in areas that are considered medically underserved, including inner-city urban locations, in which there are few other health care options available (Institute of Medicine 2000). In this two-sector model, the safety-net health care system is there to catch those who are unable to get care through health care facilities utilized by higher-income people. According to this conceptualization, the urban poor, including both the uninsured and Medicaid beneficiaries, often seek care in this safety-net system when they are in need of health care.

The second explanation is that low-income people, and particularly the uninsured, rely on emergency rooms for not only emergency care but also

routine care. According to this explanation, emergency departments form part of the safety-net health care system along with public hospitals and community health centers. This is because, since the 1986 Emergency Medical Treatment and Labor Act, emergency rooms are required to treat all individuals who arrive at their doors, independent of insurance status and ability to pay. Many studies make this claim and explain that low-income people seek care in emergency departments because they lack other options (Padgett and Brodsky 1992; U.S. General Accounting Office of 1993; Albrecht, Slobodkin, and Rydman 1996; Newton et al. 2008).

This explanation is frequently perpetuated in popular media accounts, which lament the overcrowding of emergency rooms by low-income people and attribute problems like long wait times to this group's inability to get care elsewhere. This explanation was particularly popular before the implementation of the ACA. In 2008 in the *New York Times*, for example, several articles expressed this view. In an editorial piece, the authors declared, "Uninsured patients—and those who have no primary care doctor—flock to emergency rooms for routine coverage, clogging the system" ("Emergency Room Delays" 2008). In another piece, the author explained, "As increasing numbers of the unemployed and uninsured turn to the nation's emergency rooms as a medical last resort, doctors warn that the centers—many already overburdened—could have even more trouble handling the heart attacks, broken bones and other traumas that define their core mission" (Abelson 2008). Such warnings have recently reemerged as health care reform once again becomes a central political issue, and media outlets continue to promote the idea that the poor and uninsured rely on emergency rooms (see "How Uninsured Americans Affect" 2017; Groppe 2017).

A third explanation for how the urban poor treat their health problems not only considers the use of formal health services but also takes into account behaviors that occur outside of the formal health care delivery system. Several studies have shown that poor Latino immigrants not only get care at public hospitals and community health clinics but that, when they are unable to access care at such facilities, they also use traditional methods that have roots in their country of origin. These include herbs, teas, folk healers, and prayer (Menjívar 2002; Ransford, Carrillo, and Rivera 2010). Research that looks specifically at the experiences of African Americans presents similar findings and suggests that religion and the use

of herbal and home remedies play a central role in African Americans' health care strategies (Eiser and Ellis 2007). Looking specifically at access to care, Becker, Gates and Newsom (2004) found that their low-income, uninsured African American participants rely on cultural practices like prayer and home remedies, often with only limited input from biomedical approaches and medical professionals. When people are unable to access care, the authors assert, these cultural practices emerge as primary health care strategies.

A Formal-Informal Hybrid Health Care System

In this book, I propose a fourth explanation about the health care experiences of the black urban poor that is in some ways similar to those described above but is also distinct in important ways. While my participants seek care through emergency departments, public hospitals, and community health centers, many are unable to get continuous care through these facilities. As a result, they use informal strategies for treating health problems. These strategies, however, do not typically involve cultural practices or traditional remedies like those described above. Indeed, the residents I interviewed and observed maintain a conventional biomedical orientation toward health care; they think about the treatment of health problems in terms of obtaining care from medical doctors and taking pharmaceutical drugs. The informal strategies they develop thus align with this orientation.

Most notably, I found that people who face obstacles to care gain access to health-related resources through their social ties, meaning through their connections to other individuals. These resources include items like pharmaceutical drugs, canes, walkers, wheelchairs, and health insurance cards. Residents' ties to people I call intermediaries—individuals who have access to hospitals or clinics either as patients or employees—are especially important for obtaining such resources. Due to their structural position in relation to (a) people who face obstacles to accessing care and (b) the health care organizations that provide care, these intermediaries are able to perform an important function: they act as informal resource brokers. Through their brokerage behaviors, these intermediaries either enable direct access to health care facilities or informally distribute resources like medication and medical equipment to care-seeking

individuals who normally face obstacles to health care. I label this form of brokerage as informal because it occurs in ways that violate established rules, regulations, and norms of the formal health care system.

Intermediaries include doctors, friends, and family members of the person seeking care, as well as other residents of the housing development. Some doctors keep special, unauthorized “stash” of medication for their low-income patients who have difficulty purchasing medication independently. Doctors also sometimes give poor patients money out of their own pocket to help them pay for needed care. People with health insurance go to doctors in an effort to get medication or other resources for their sick and uninsured friends and relatives, and they also lend uninsured friends and relatives their health insurance card so that they can be seen directly by a doctor. And some people with insurance act as “street entrepreneurs,” using their insurance status to get items like asthma inhalers, antibiotics, canes, walkers, and wheelchairs as a way to generate extra income; after getting these items through the formal health care system, they sell them in the underground economy to people who face barriers to accessing formal health services.⁷

And it is not just people who face obstacles to care who use ties to intermediaries to obtain health-related resources. Sometimes even those who do not face what are traditionally considered barriers to care—such as being uninsured or not having the financial means to pay for care—use these strategies. They have a variety of reasons. Some, for instance, get health-related resources from friends, family, or street entrepreneurs because they do not trust their doctors or the health care system. Others do this in an attempt to exercise control over their health and health care. And still others use such strategies because it is at times easier or more convenient than going through the formal health care system.

One central aim of this book is to demonstrate that the way the health care system functions *in practice* for my participants is different from what we commonly perceive. In practice, their health care experiences are shaped by both the formal characteristics of the health care system and also an informal social realm. In using the term *formal*, I refer to the institutional and institutionalized aspects of the U.S. health care delivery system. This includes organizations like hospitals and clinics, the legal and official roles of people who participate within these organizations (including doctors and

patients), and the rules, regulations, and norms that determine how health care is to be delivered within the health care system. Entities like federal agencies, state medical boards, professional associations, and individual hospitals and clinics establish these rules, regulations, and norms. In using the term *informal*, I refer to a set of behaviors carried out by individuals (including doctors and patients) that occur, as mentioned, in ways that *violate* the rules, regulations, and norms of the formal system. These behaviors involve facilitating access to services and resources to people who face obstacles to participating in the formal system in the ways described above. These behaviors should be understood as stemming directly from the formal system; the formal system imposes certain eligibility requirements on individuals in order to get health care (e.g., individuals must have insurance and/or be able to pay co-payments) and is thus structured in a way that keeps some people from being able to get care. The formal system, in other words, engenders the need for such informal behaviors.

In the formal-informal hybrid system, not only factors like having health insurance or being able to pay for out-of-pocket medical costs but also the social ties that individuals have to intermediaries become important for how people treat their health problems. As a result, the behaviors and experiences of those who participate in this hybrid system—care seekers and intermediaries—are shaped by formal health care organizations and their associated regulatory structures and by the social dynamics that exist between the various actors involved. These social dynamics themselves are shaped by the contexts in which the actors are embedded. In some instances this includes the neighborhood context in which they live, while in others it includes specific health care facilities and the broader health care system.

The notion of formal-informal hybridity is not new to sociology. A basic tenet within the sociology of organizations, for example, is that organizations and the systems they comprise are not merely formalized structures in which people strictly adhere to institutionalized rules and regulations, but that people's behaviors within these organizations and systems are also guided by informal structures, meaning informal norms, goals, expectations, and patterns of behavior (Scott 2003, 59). In research on health care, medical sociologists have also pointed out the existence of formal-informal hybrid forms. Researchers have shown, for example, that the care an

individual receives is not just the formal care provided by medical professionals in settings like hospitals and clinics but is also the informal care provided by others, such as family members (Anderson and Bury 1988; Olesen 1989; Thomas, Morris, and Harman 2002). Informal care can also include other types of behavior, like the cultural practices described above. What I emphasize in this book, then, is not the existence of both formal and informal aspects of health care. Rather, I aim to uncover the formal and informal features of a specific hybrid system of health care that low-income people use daily to treat their health problems.

The idea of the formal-informal hybrid system and the findings that I present throughout the book are important for thinking about questions that have been critical in health-related fields like medical sociology, social epidemiology, and public health, as well as the field of urban sociology. In terms of health research, the idea of a hybrid system is related to the long-standing question of how people's social networks affect their health. In terms of urban sociology, it is related to the question of how poor urban residents obtain the resources needed to survive in the face of significant structural constraints. In the following sections I discuss each of these questions as they have been examined in existing literature and situate my findings within this literature.

SOCIAL NETWORKS, SOCIOECONOMIC STATUS, AND HEALTH

Socioeconomic status (SES) is a strong predictor of morbidity, mortality, and disability, and the positive association between SES and health is well-established. Beginning with the publication of the Whitehall studies by Marmot and colleagues (Marmot, Shipley, and Rose 1984; Marmot et al. 1991), in which the authors found health inequalities among British civil servants of distinct employment statuses, numerous studies have replicated this SES gradient in health. According to this gradient, people at higher SES levels experience better health, on average, than those below them, and this holds true for all levels of SES (Adler and Ostrove 1999; Williams 2005; Matthews, Gallo, and Taylor 2010). Moreover, the health effects of SES are largest at the lowest SES levels, and living in poverty can

be particularly health-damaging (Adler and Newman 2002; Matthews, Gallo, and Taylor 2010). Today, considerable attention is given to examining why this relationship between SES and health exists. How is it, researchers ask, that a person's SES "gets under the skin" (Adler and Ostrove 1999; Taylor and Seeman 1999, 210; Matthews, Gallo, and Taylor 2010, 169)?

Researchers propose several explanations for the relationship between SES and health. In terms of low SES and health in particular, they write that low-SES people are more likely to live and work in physical environments that are harmful to their health, to engage in health-damaging behaviors like drinking and smoking, to have a sedentary lifestyle, and to have less access to healthy food, recreational facilities, and quality health care. Researchers also write that there is something different about the social and interpersonal environments of low-SES groups that affects their health. Central to this is the idea that people at lower socioeconomic levels experience more negative life events, like income loss, job strain (i.e., high levels of demand at work combined with low levels of control), unemployment, and interpersonal conflict. As a result, they have a harder time meeting their health care needs and they also experience higher levels of stress, which has been shown to adversely affect people's health (Adler and Newman 2002; Brunner 1997; McLeod and Kessler 1990; Matthews, Gallo, and Taylor 2010). At the same time as they experience more negative events, researchers explain that low-SES individuals also have fewer resources to cope with these events. These include fewer social network resources (McLeod and Kessler 1990; Williams 2005; Adler and Newman 2002; Brunner 1997; Matthews, Matthews, Gallo, and Taylor 2010).

When health researchers discuss the social networks of low-income people, they often suggest that these networks lack key health-protective qualities. This view is pervasive and is found in sociology, psychology, social epidemiology, and public health. For example, in their influential theory of social conditions as fundamental causes of health inequalities, Link and Phelan (1995) propose that we see SES differences in health persist over time because lower-SES people do not possess important flexible resources. These include knowledge, money, power, prestige and, importantly, what the authors call "beneficial social connections." Additional research, often under the rubric of psychosocial resources and health, assumes this same position. Taylor and Seeman (1999), for instance,

examine whether resources like social support might have a mediating effect on the SES-health relationship. This is the idea that poorer people experience worse health outcomes in part because they have less social support. Drawing on past studies, the authors explain that social support decreases at lower levels of SES and conclude that social support is a plausible factor in helping to explain the SES-health relationship. Adler and Newman (2002) make similar claims. In their discussion of SES disparities in health, they write that isolation and lack of engagement in social networks, which strongly predict health status, are two important characteristics that can help us understand the worse health of low-SES people. They also write that increasing social trust should be explored as a way to improve health disparities, suggesting that low levels of interpersonal trust are more prevalent among low-SES people. Finally, and more recently, in their review of the literature, Matthews, Gallo, and Shelley (2010) propose a model that they call *reserve capacity*. According to this model, a central reason for low-SES people's worse health is that they have a "smaller bank of resources" to draw from when coping with hardship. These resources, the authors write, include interpersonal resources like social support and social integration.

Although the research reviewed above offers many insights, the pervasive idea that supportive social networks vary positively with SES leaves readers with a certain impression about low-income people and the communities in which they live and participate. In particular, this research leads readers to apply a deficit model of social relationships to low-income groups. From this model emerges an image of people who face significant challenges on a day-to-day basis (e.g., job strain, unemployment, and poor health), and they seemingly do so with limited help from others. To the extent that low-income people do have social relationships, the suggestion is that these relationships do not necessarily provide them with valuable resources and are likely in fact to generate problems such as interpersonal conflict that may actually negatively affect their health.

In this book, I show that the social relationships of my participants are quite different from what we would expect based on this past research. I contend that my participants are more socially integrated and receive more social support than what this research suggests. My participants are not isolated from one another and, in fact, have social ties through which they

obtain a range of resources. These ties are locally based, meaning that people have ties to others living in their neighborhood. They also include ties to people who work in hospitals and clinics, including doctors at these facilities.

I also show that the resources my participants obtain through their social networks are different from what has been traditionally recognized in past research. In discussing the support that people receive through their social ties, researchers emphasize resources in the form of emotional and instrumental support, where *emotional support* refers to information that leads a person to believe that she is cared for, loved, valued, and esteemed, and *instrumental support* refers to tangible aid such as childcare, financial assistance, help with household chores, and transportation (House, Umberson, and Landis 1988; Bloom 1990; Thoits 2011; Adler and Ostrove 1999; Taylor and Seeman 1999; Cohen 2004). While many of my participants do obtain these resources through their social networks, other types of resources are also available through their social ties. Through their local ties, these include pharmaceutical drugs, insurance cards, medical equipment, and medical manuals. Through their ties to doctors and other staff at hospitals and clinics, some low-income patients receive resources such as money, medication from unauthorized stashes, and transportation. I therefore maintain that we should reconsider our understanding of the social networks of low-income groups and how their social networks operate in ways related to health.

An important finding that I will present is that my participants have contradictory ways of thinking about and discussing their social networks and the extent to which they give and receive social support. While doing fieldwork, I frequently heard residents of Jackson Homes make statements like “I stay by myself” and “I keep to myself” when describing their relationships with other residents. I learned, however, that these statements are often in contradiction to their actual behaviors. Although they often make such statements, in reality many participate in activities with other residents and in fact exchange a range of goods and services with other community members. Given this contradiction between what people say and what they do, it is possible that research that relies principally on self-reports of people’s social-network and social-support activities does not adequately capture the reality of their exchange relationships

and the resources they give and receive through social ties. Importantly, this is a dominant approach used in scholarship on social networks and health. I thus maintain that when health researchers study the social relationships of the urban poor, we need to consider the existence of this contradiction to avoid drawing misinformed conclusions about social networks, how they operate, and the resources that are available through them.

SURVIVAL STRATEGIES OF THE URBAN POOR

How do the urban poor survive? More specifically, in the face of socioeconomic disadvantage, how do they get the resources needed to meet daily demands? How, for example, does a single mother who earns only a minimum wage feed and clothe her family? How does she obtain childcare, which often costs more than she earns? And how do adults who experience long bouts of unemployment or work in low-wage jobs afford housing?

In examining these questions, urban-poverty scholars have emphasized people's social ties as a primary medium through which valuable resources pass. They have explained that people are situated within social networks and that goods and services such as food, clothing, money, transportation, and childcare flow through these networks. While many have demonstrated such network-based exchange (Aschenbrenner 1975; Edin and Lein 1997; Domínguez and Watkins 2003; Desmond 2012), perhaps the most influential and well-known study in this area is Carol Stack's investigation of life in "The Flats," a poor, urban African American community. In her study, Stack (1974) highlights the role of kin and kin-like others in the provision of resources in poor urban communities, and she portrays intricate and highly organized systems of exchange, with family and friends being primary exchange partners.

Other scholars, however, have questioned whether such descriptions accurately reflect the social lives of the black urban poor. These researchers argue that over the last several decades, poor urban communities, particularly African American communities, have witnessed a corrosion of social cohesion, and now, people who live in socially and economically disadvantaged neighborhoods provide little, if any, support to friends and family

(Eggebeen 1992; Hogan, Eggebeen, and Clogg 1993; Roschelle 1997). Additional research argues that not only do the black urban poor no longer exchange network-based assistance to the extent they did before, but many actually have few social ties of any kind (Wacquant and Wilson 1989; Tigges, Browne, and Green 1998), not just those that provide support. Additionally, researchers have found a greater prevalence of mistrust and noncooperation among this group (Smith 2007; Levine 2013). As a result, some argue, many residents of poor, urban communities have developed highly individualistic strategies for solving problems (Sánchez-Jankowski 1991; Anderson 1999; Furstenberg et al. 1999, Furstenberg 2001; Smith 2007). Taken together, findings from this research suggest that while social ties and social network strategies could once be used to explain how poor urban residents were able to obtain resources to meet their daily needs, this argument is not adequate in explaining the experiences of low-income African Americans living in urban areas more recently. As Hogan, Eggebeen, and Clogg (1993, 1454) write succinctly, “The effective kin network that provided support to multigenerational, matrifocal African American families in past decades appear to be of limited relevance today.”

While support for what can be called the “social ties thesis” has declined, some researchers have begun to take a distinct analytical approach to the study of urban poverty, particularly over the last decade. These researchers argue that in the contemporary American city, formal organizations are playing an increasingly integral role in shaping the access that poor urban residents have to resources. In her study of community-based organizations in Brooklyn, for example, Nicole Marwell shows that such organizations are central in distributing various goods and services directly to the poor, including affordable housing, employment, childcare, and elderly assistance (Marwell 2007; Marwell and McQuarrie 2013). Additional research has demonstrated that, with the implementation of welfare reform, there has been a reshaping of the safety-net welfare system in the United States. It has shifted away from financial assistance for the poor toward programs and services that promote work and economic self-sufficiency. Allard (2009) explains that, accompanying this shift, local public and private nonprofit organizations have become responsible for providing programs like job training, adult education, substance abuse treatment, and cash, food and housing assistance. Small (2006; 2009a)