

Effects of family structure on children's health and medical care: Focus on single-father families

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The proportion of children residing in single-father families in the United States has increased dramatically over the past thirty years. The number of single-father families quintupled between 1970 and 2003 (U.S. Bureau of Census, 2003), a phenomenon largely due to an increase in single-parent families headed by previously-married fathers (Garasky & Meyer, 1996). By 2003, single-father families represented 17 percent of all single-parent families with children (U.S. Bureau of Census, 2003). While this represents only six percent of all families with children, single-father families are one of the fastest growing family types, increasing at a rate faster than single-mother families (Meyer & Garasky, 1993; Bianchi, 1995). While there exists some research on differences in child well-being associated with residing in a single-father family virtually nothing is known about the health care experiences of children residing in this family structure. The existing research regarding the effects of family structure on health care outcomes compares the experiences of children living with single mothers to those living with married parents. This paper extends this research to include single fathers.

Examining single-father families, aside from their increasing presence as a family form, is also important as family structure is associated with various child outcomes. Prior work finds that several important child outcomes vary along gender of the single parent. Hoffman and Johnson (1998) find that adolescents who reside in father-custody families have a significantly higher risk of drug use compared to adolescents living in other family structures. Moreover, youth living with a single father have more school problems and take part in risky health behaviors more frequently than children living in single-mother families or married-parent families (Harris, Cavanagh, & Elder, 2002). Children in single-father families exhibit worse behavior, and are slightly disadvantaged in terms of cognitive skills compared to children living with a single mother (Downey, Ainsworth-Darnell, & Dufur, 1998). Adults who grew up in a single-father household obtain approximately one-half year less of education than their counterparts who grew up in single-mother households (Downey, Ainsworth-Darnell, & Dufur 1998). Biblarz and Raferty (1999) for example found that children from single-mother families consistently do better than those raised in single-father families (or stepfamilies), once socioeconomic status has been taken into account. They further find that single-father families and step-father families have about the same negative effect on children's attainment.

In addition to differences in total household income, single-parent families may lack the social capital, parental communication, and parental supervision skills (e.g. Coleman, 1988) that two-parent families have. All of these skills are salient in parents' decisions to seek care for their children as well as their ability to arrange such care. A contrasting theory suggests that single mothers seek more medical care on their children's behalf than parents in two-parent households since single mothers lack a partner with whom they can affirm whether the severity of their children's symptoms necessitates medical care (Angel & Worobey, 1988). This theoretical ambiguity is reflected in the empirical literature on family structure and children's access to; existing studies paint a somewhat complicated portrait of the interplay between residing with a single mother and health care outcomes among children.

Prior work offers minimal conceptual guidance regarding the influence of the gender of the single parent on access to care outcomes among children. What little is known implies that children in single-father families likely fare worse on access to care outcomes than children in other family structures. Existing research suggests that children's health investments are disproportionately made by mothers (Case, Lin, & McLanahan 2000; Case & Paxson, 2000). If health investments are indeed the purview of mothers, then children residing with single fathers may use less care than children in single-mother families. Furthermore, Downey (1994) finds that single mothers are more involved with day-to-day activities of children (examples include attending school events and knowing their children's friends) than single fathers, suggesting that mothers may be more attuned to changes in their children's health conditions than single fathers. This may translate into higher care receipt among children of single mothers relative to those of single fathers.

Several studies suggest that children of single mothers use more health care, as measured by having any physician visit in the past year (Cafferata & Kasper, 1985). A recent study finds that this is true only for low socioeconomic status (SES) families (Heck & Parker, 2002). On the contrary, Cunningham and Hahn (1994) report that children in single-mother families use less care, and that single mothers are less likely to report having a usual care provider for their children (Simpson et al., 1997). Finally, several studies suggest that single-mother families do not differ from two-parent families in health care use (Newacheck, 1992; Chen & Escarce, 2006), although one study reports that this is only true for high SES households (Heck & Parker, 2002). This paper builds off of a previous study that found that children who reside in single-father families exhibit poorer access to health care than children in other family structures; and that, unlike residing in a single-mother family, the effects of residence in a single-father family do not vary by poverty status (Leininger & Ziol-Guest, In press).

Data and Methods

The data for the study are from the National Survey of America's Families (NSAF), a nationally representative probability sample of the civilian, non-institutionalized population under the age of 65. The NSAF was conducted by the Urban Institute with the goal of collecting information on the health and well-being of children and adults in the aftermath of the shift of fiscal and administrative responsibilities for social policy programs from the federal government to state governments. The Focal Child and Adult Pair data files of the 1999 and 2002 rounds are combined to include information at the child- and family-levels for approximately 70,000 children between the ages of 0 and 17. A household adult defined as the "most knowledgeable adult" (MKA) regarding the sample child's education and health care was chosen as the respondent for the sample child. All information in the data file was gathered from the MKA. The overall response rates for the Focal Child files were 65% and 55% for the 1999 and 2002 rounds, respectively.

The key independent variables in the analyses are measures representing different family structures, which were created from a family structure variable available in the Focal Child file of the NSAF. Three types of families are used in the analyses: families with two married parents in the household, families headed by a single mother, and families headed by a single father. Children living with two cohabiting but unmarried adults are excluded as are children living with

neither of their parents. Family structure may play an important role in these children's access to medical care, however they are not the focus of the current study.

The dependent variables focus on dental and doctor visits in the past year, as well as postponement of necessary health care. The MKA reported on the number of dental visits (for children age three and over), the number of emergency room visits, number of mental health visits, and the number of other doctor and health professional visits. Further, the MKA reports on whether or not any necessary dental or doctor visits were postponed for the child. Negative binomial regressions are run for the number of visits and logistic regressions are run for the postponement measures.

All preliminary regressions include the following covariates immigrant status, sex of child, age of the child, fair/poor health status of the child, presence of a limiting condition of the child, race of the child, the education of the MKA, categorical income dummies, the presence of a working parent in the household (including a dummy indicating that there is missing information on this measure), home ownership status, and the number of people residing in the household. Descriptive statistics and regression results were calculated using the weights provided by the NSAF; standard errors were calculated using Taylor-series linearization. These weights correct for the complex sample design of the survey as well as make the appropriate adjustments for unit nonresponse.

Preliminary regressions suggest that single mothers take their children to the emergency room more than other families; single mothers and single fathers take their children for mental health visits more than two-parent families; single fathers take their children to health care professionals less than other families; children of single fathers are less likely to have had a hospital stay compared to other families; single mothers are more likely to postpone necessary dental and doctor visits compared to other families; and single fathers are less likely to report postponing necessary doctor visits compared to other families. Future analysis will examine likelihood of visits, as well as sub-sample comparisons based on SES and insurance status. An attempt will also be made to try to determine which two-parent families are step-families.

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Table 1
Weighted Descriptive Statistics

	Two-Parent		Single Mother		Single Father	
	Mean or %	SE	Mean or %	SE	Mean or %	SE
<u>Number of visits in past year</u>						
Dentist	1.84	0.02	1.66	0.03	1.83	0.07
Emergency room	0.32	0.01	0.62	0.02	0.38	0.03
Mental health	0.38	0.02	0.88	0.05	0.71	0.10
Other health	3.29	0.03	3.48	0.07	2.64	0.12
<u>Health care dichotomous measures</u>						
Any hospital stays	7%	---	8%	---	4%	---
Postpone dental care	5%	---	10%	---	6%	---
Postpone medical care	2%	---	5%	---	2%	---

Note: Adjusts for complex sample design.

Table 2
Preliminary Regression Coefficients

	Single Mother		Single Father			
	Coefficient	SE	Coefficient	SE		
<u>Number of visits in past year</u>						
Dentist	0.02	0.03	-0.01	0.04		
Emergency room	0.24	***	0.04	-0.02	0.09	
Mental health	0.82	***	0.13	0.96	***	0.22
Other health	0.05	+	0.03	-0.17	***	0.05
<u>Health care dichotomous measures</u>						
Any hospital stays	1.05		0.10	0.67	*	0.12
Postpone dental care	1.67	***	0.15	1.08		0.20
Postpone medical care	1.51	**	0.22	0.57	*	0.16

Note: Number of visits are negative binomial regression coefficients and dichotomous measures are odds ratios.