

Review of the health of children in one-parent families

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SUMMARY. *The evidence from the few published studies concerning the physical health of children in one-parent families, suggests that these children have both a higher rate of hospitalization and a higher consulting rate with their general practitioner than two-parent children. There is also an indication that children in one-parent families suffer more health problems in the home than children in two-parent families. However, the studies that have been reviewed provide neither detailed nor confirmed results and at present the character of child health in one-parent families remains uncertain.*

Introduction

THERE have been many reports in both the UK and the USA of the possible effects upon children of living in one-parent families, with the behavioural development of the children receiving particular attention.¹⁻¹³

The social and demographic characteristics of one-parent families in the UK have also been compared extensively with those of two-parent families.^{9,10,14-20} Although the differences are small it has been shown that one-parent families more frequently come from lower social classes and suffer financial hardship.^{9,10,19,21} Maternal care is difficult to define but it has been suggested that one-parent children receive a lower standard of care than two-parent children. For example, one-parent children may have a more stressful home environment and lone parents have less time to devote to them because of their sole responsibility for the family.^{8,10,11,16,22}

If the characteristics of one-parent families are compared with the factors that are claimed to be associated with child health disadvantage²³ the reports would suggest that one-parent children are at a disadvantage compared with two-parent children. Despite the indication that children in one-parent families may be more at risk, little research on their health has been carried out. Some studies that have investigated the life of one-parent families have included limited questions on health but few have looked in detail at the morbidity of the children. The relevant published information from British studies is reviewed in this paper and a summary is included in Table 1. No other references to child health in one-parent families have been found.

Review of the literature

Broken homes

An early study by Rowntree, using data from the National Study of Health and Development, looked at the effect of a broken home on the health of children.¹ The broken home category ex-

cluded illegitimate children and only included children from homes that had been broken for at least two years. The study was conducted in the post-war period (1950-52) when the percentage of the national population who were single parents was 3.8%; this is very different from the figure of 13.7% estimated in 1981.²⁴ Consequently, the results of this study are of limited value when considering the present situation of one-parent families.

The report by Rowntree, published in 1955, stated that children from broken homes had no more hospital inpatient admissions than those from stable families.¹ The physical development of the children had been measured when they were four and six years of age. At four years of age the children from broken homes were slightly shorter and lighter than their matched partners from stable families, but this difference had disappeared by the time they were aged six years. The children were matched for sex, order of birth and social class and the birth weights of the two types of children were found to be similar. Illness occurring in the home or seen by the general practitioner was not assessed.

Families receiving supplementary benefit

In 1972 a study of the characteristics of families receiving family income supplement was published.¹⁷ It was reported that 20% of the fatherless children in the study had been admitted to hospital compared with 12% of the children from the two-parent families where the father was sick or unemployed. The reasons for admission were not discussed. All the parents were asked questions about their children's general health but the results for the single mothers were not separately identified. The conclusion that one-parent children are admitted to hospital more frequently than children in two-parent families cannot be drawn because the one-parent families were not representative of the general population of one-parent families — families where the single parent was a father were not included and the single mothers in the study were all in full-time employment.

Health problems

An extensive study by Hunt — *Families and their needs; with particular reference to one-parent families* — was published in 1973.²¹ The study was carried out by the Office of Population Censuses and Surveys in five areas in Britain. Single-parent status was clearly defined and the reliability of the sample of one-parent families was assessed in the report.

When the parents were interviewed for the survey they were asked if any of their children had particular health problems or any physical or other handicap. In four of the areas studied the percentage of fatherless families who had at least one child with a health problem slightly exceeded that for two-parent families. The difference ranged from 4.2% to 4.9%. The percentage of motherless families who had a child with a health problem was lower than that for either the fatherless or the two-parent families in all areas. Hunt suggested that fathers may be less knowledgeable about health problems or less likely than single mothers to become alarmed.

Neither the time period over which the children might have had health problems nor the type of health problems discussed were defined in the study. The analysis did not include detailed information about the type or frequency of illness experienced. Therefore, these results do not provide an accurate comparison of the illness experienced by children from different families.

Table 1. A summary of the published studies on child health in one-parent families.

Reference	Date of study	Details of families/children	Ages of children (years)	Main conclusions of study
1	1950–52	85 children from broken homes 85 children from stable homes	4–6	Children from broken homes had no more hospital inpatient admissions than those from stable homes.
17	1969	228 fatherless families 120 two-parent families with the father sick/unemployed	0–16	More fatherless children were admitted to hospital than two-parent children.
21	1970	1845 one-parent families 1895 two-parent families	0–18	More fatherless children than two-parent children had health problems. Fewer motherless children than two-parent children had health problems.
9	1965/69	848 one-parent families 13 514 two-parent families	7 and 11	Boys from fatherless and two-parent families were equally likely to be absent from school. One-parent girls were more frequently absent than two-parent girls.
25	1977	69 one-parent families 69 two-parent families	0–16	One-parent children consulted their doctor more frequently than two-parent children.
26	1972	319 fatherless children 4499 two-parent children	5–11	Fatherless children showed a tendency to be shorter than two-parent children.
27	1975	719 one-parent children 2482 two-parent children	0–5	More one-parent than two-parent children had accidents requiring medical attention. One-parent children had a higher admission rate after an accident.

Absence from school

In 1976 a study of the one-parent children in the National Child Development Study was published.⁹ Absence from school was used as an indicator of health but this is not a reliable measure of illness as the family situation can influence school attendance. It was shown that more mothers from one- than two-parent families were in full-time employment so the one-parent children were more likely to have a better record of school attendance — if they were ill there would be no one at home to care for them unless the mother could be absent from work.

In this study there was no difference in the number of days that boys in fatherless and two-parent families were absent from school. The girls in one-parent families were more likely to be absent than their two-parent counterparts and the daughters of lone fathers had the highest rate of absence. The increased need for lone fathers to contribute to the care of their siblings and the home may account for this difference.

Morbidity

The morbidity in one-parent families seen at one general practice was reported by Bolden in 1980.²⁵ This study provides some indication of the use made of primary care services by one-parent families and their reasons for consultation. The study was small; 69 one-parent families were studied and the children were matched for age and sex with those in two-parent families. The consultation rates were higher for one-parent children than for two-parent children — 2.2 consultations per year for one-parent children and 1.8 consultations per year for children in two-parent families. The consultations of one-parent children were less likely to be about respiratory illnesses and were more often concerned with accidental injury or psychiatric problems when compared with those of two-parent children. However, the differences found in the study were small and not statistically significant.

Physical development

Data from the National Study of Health and Growth has been used to describe the physical development of primary school children from one- and two-parent families.²⁶ Data from a large sample of families were used, including 319 fatherless children — motherless children were excluded. The results showed that the fatherless children had a tendency to be shorter than those from two-parent families. When the heights were adjusted for birthweight, number of siblings, parental height and maternal education the difference was accounted for by low birthweight and short parental stature. Measurements of weight for height and triceps skinfold indicated an increased tendency towards obesity among the fatherless children but the differences were not statistically significant.

Accidental injury

The most recently published paper concerns the Child Health and Education Study which investigated accidental injury of pre-school children in one-parent, step-parent and two-parent families.²⁷ When the children were five years of age information was obtained from the parents about any accidents the children had experienced since birth, that had been sufficiently serious to require medical attention. The one-parent children were slightly more likely to have had accidents than the two-parent children (47.3% of the one-parent children and 42.7% of the two-parent children). Other factors were also found to be associated with accident rates. Family status was found to be less important than the number of household moves, low maternal age and 'perceived poor behaviour in the child'. Whereas the association between these factors and increased accident rate was statistically significant, the association between family status and increased accident rate was not. However, these factors were more common in the one-parent families, and may

provide an explanation for the increased accident rate for children living in these families. Family status alone was shown to be the most important variable when hospital admission after an accident was considered. The proportion of children in one-parent families admitted to hospital after receiving an accidental injury was nearly twice that in two-parent families and the association of family status with hospital admission was significant ($P < 0.001$).

Discussion

The literature that has been reviewed here represents the extent of the present knowledge of child health in one-parent families.

The studies indicate that one-parent children may have a higher rate of hospital admissions than two-parent children.^{17,27} The reasons for the admission of children from the two types of family have only been compared in the study of accidents in pre-school children,²⁷ and no studies have specifically investigated the patterns of hospitalization in children from one- and two-parent families.

It may also be necessary to consider the behaviour of single and married parents when their children are ill. The marital situation of parents could influence their capacity to care for an ill child and alter the likelihood of hospitalization. The study of accidents in pre-school children showed that the child's parental status was the most important factor in determining whether or not that child was admitted to hospital.²⁷

Only one of the reviewed studies has investigated morbidity by using data from general practitioner records.²⁵ Although the study was small, and used data from only one practice, the results are important because they provide a comparison of the consultation rates of one- and two-parent children. The one-parent children consulted their general practitioner more frequently than two-parent children. The difference was small and could possibly be attributed to a difference in the behaviour of the parents when their children were ill rather than to increased morbidity in the children of single parents.

Our knowledge of the illnesses which do not receive medical attention occurring in one-parent families is extremely limited. The only study to have considered the health of one-parent children in the home was performed by the Office of Population Censuses and Surveys.²¹ The report of the study suggested that one-parent children have more health problems than children in two-parent families. However, the report did not consider the frequency of illness for each child, the type of illnesses the children suffered or the duration of the illness episodes.

The study of the one-parent children from the National Child Development Study shows the difficulty of using school records as a source of information concerning child health.⁹ They do not provide a reliable measurement of childhood illness as there may be differences in the reasons for non-attendance between one- and two-parent children.

If growth is considered to be a measure of physical health, the results of the National Study of Health and Growth indicate that the physical health of one- and two-parent children may be similar.²⁶ The survey did show that fatherless children had a tendency to be shorter than two-parent children but this was primarily associated with low birthweight and short parental stature.

Definition

A problem that becomes apparent from this review is the variation in the definition of a one-parent family. Single parents can be single unmarried mothers, separated or divorced parents, or parents whose marital partner has died. They also include an

increasing number of single fathers.

Rowntree's study¹ compared children from broken homes with children living in stable families rather than one- and two-parent families. Health visitors decided the status of the family and only homes where a legitimate child continued to live with his or her remaining parent were included in the broken home category. Other studies have looked at one type of one-parent family. For example, the Department of Health and Social Security study of fatherless families receiving supplementary benefit.¹⁷

Ferri, who considered the children from the National Child Development Study,⁹ used a detailed definition of one-parent families which encompassed the many types of single parents. She regarded a child as living in a one-parent family if the child was being cared for by a natural mother or father alone, without help from a parent substitute of the opposite sex living in the same household. This definition excludes single parents who live with others whether they are a parent substitute or the grandparents of the child. These single parents might be receiving financial and emotional support that would influence their behaviour and the home environment of their children.

A further problem of definition is the length of time a family is required to be one-parent before the health of the child might be considered to be disadvantaged. Unless there is an element of stability in the family situation the child's health could be a reflection of family upheaval rather than of a one-parent family. We would suggest that a family could be defined as a one-parent family if the parent had been living alone with the child for at least one year.

Further research

To further our knowledge of the health of children in one-parent families there is a need for more detailed research into their use of the primary health care and hospital services. Perhaps more importantly the morbidity of one-parent children in the home should be investigated. A study of illness in the home would provide a more accurate picture of the health of one-parent children.

Previous research has suggested that the health of one family member may be linked with the health of the rest of the family.²⁸ A comparison of the pattern of health in one- and two-parent families could show whether or not the parents' health affected the health of their children and influenced their tendency to report illness.

The wealth of research on child health disadvantage that has been reviewed by Blaxter²³ suggests that the pre-school child is at a particular risk from factors influencing health. Once children are at school their teachers can observe their health but during the pre-school period children's health is especially dependent upon parental care. Therefore, the health of pre-school children in one-parent families may be an important subject for study.

In summary, this literature review has shown that one-parent children may suffer more illness than children in two-parent families. No firm conclusions can be made from the studies that have been discussed because there is little information available about the health of one-parent children.

If children in one-parent families have a higher morbidity than children in two-parent families then they merit special attention from the primary health care services. In order to provide one-parent families with particular care, primary health care workers require a greater knowledge of the illnesses that one-parent children suffer, and of the response of the parents to the child's illness.

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