

PARENT CHARACTERISTICS AND CHILDREN'S HEALTH PROBLEMS

Barbara J. Logue, Ph.D.

Children do not get to choose what kind of family they are born into. Their parents' characteristics inevitably influence the quality of their lives and whether or not they reach their full potential as adults. This report considers four key parental characteristics -- family structure, education, poverty status, and type of health insurance, and their relationship to selected measures of children's health. A concluding section considers policy implications, including the role of premature parenthood in causing or exacerbating children's health problems.

Data come from the 2009 National Health Interview Survey (NHIS). The NHIS is our chief source of information on the health of the American people. It covers a broad range of health topics on the civilian noninstitutionalized population. Thus the survey excludes children living in long-term care institutions, whose health tends to be considerably worse than that of children living in their own homes.

The NHIS sample is too small to provide reliable state-level data. But another recent survey found that Mississippi ranked in the bottom quartile among the states on thirteen indicators of child health system performance, including access, quality of care, and potential to live healthy lives.¹ Moreover, since Mississippi adults, on average, are poorer, less educated, and sicker than other Americans, and include proportionally more single-mother families, state-level figures on children's health, if available, would no doubt look worse than the national statistics shown in this report.

Background

For health survey purposes, "parents" include not just biological parents but also adoptive, step, in-law, and foster parents. The NHIS defines parent's education as the highest grade of school completed by the mother and/or the father living in the same household as the child. Information is not gathered on the educational attainment of parents residing elsewhere. Family structure refers to whether the child lives with two parents or only with his/her mother. Poverty status is based on the family size and income thresholds established each year by the U.S. Census Bureau. Finally, health insurance separates those with private insurance coverage from those relying on Medicaid or another public insurance plan.

These four parental characteristics are obviously interconnected. For example, parents living below the poverty line are often poorly educated, lack job skills, and suffer from mental health problems.² Poor children, moreover, are much more likely to live with a single parent, typically their mother. In Mississippi, poverty is highly concentrated among single-mother families with minor children. Census data for Mississippi show that low educational attainment is associated with low levels of labor force participation, relatively high unemployment, and a high risk of poverty.³

Children's Health Indicators

Overall health status. Parental disadvantages are connected to reports of fair or poor overall health status for their children. As the table shows, parents lacking a high school diploma, living in poverty, or heading a mother-only family were all more likely to report that their child's general health was fair or poor. Those dependent on Medicaid or other public plans experienced worse health than children covered under a private plan. Although not shown in the table, the highest fractions of children whose health was described as excellent lived in families with two parents, where parents had more than a high school education, were not poor, and had access to private health insurance.

Asthma. Asthma, an incurable but manageable lung condition, is the leading serious chronic illness of children in the nation, and "the third leading cause of hospitalization among children under the age of 15."⁴ It is also a common cause of missed school days.⁵ Many cases are "hidden" or undiagnosed. According to the American Lung Association, more than half of current asthma cases are due to allergies to pollen, mold, insects, animals, or other sources. Secondhand smoke exposure is an important risk factor, and many other irritants such as air pollution and paint fumes may trigger symptoms or worsen them.⁶

SELECTED PARENT CHARACTERISTICS AND CHILDREN'S HEALTH, 2009

<u>Parent Characteristic</u>	<u>Child Health Indicators</u>					
	<u>Overall Health Status</u>	<u>Has Asthma^a</u>	<u>Has Learning Disability^b</u>	<u>Missed 11 or more School Days^c</u>	<u>Takes Prescription Medication^a</u>	<u>Unmet Dental Need^d</u>
	<u>Fair/Poor^a</u>					
<u>Parents' Education</u>						
Less than H.S. diploma	3.8%	9.5%	10.9%	4.6%	10.4%	9.7%
H.S. graduate/GED	2.3	10.7	9.2	4.9	12.3	8.3
More than H.S.	1.1	9.2	7.3	4.9	14.4	6.3
<u>Poverty Status</u>						
Poor	3.6	14.0	11.9	6.4	15.2	10.1
Near poor	2.5	9.6	10.8	6.2	13.6	10.9
Not poor	0.8	8.4	6.1	4.1	13.3	4.5
<u>Family Structure</u>						
Two parents	1.3	8.0	6.9	4.3	12.6	6.4
Mother only	2.9	14.5	11.3	7.0	16.5	9.0
<u>Health Insurance</u>						
Private	0.9	8.4	6.3	3.9	13.4	4.3
Medicaid or other public	3.4	12.3	12.5	7.0	15.7	6.9

- a) Ages <18.
- b) Ages 3-17.
- c) Ages 5-17.
- d) Ages 2-17.

SOURCE: B. Bloom, R.A. Cohen, and G. Freeman, *Summary Health Statistics for U.S. Children: National Health Interview Survey, 2009* (National Center for Health Statistics, Vital Health Stat 10 (247), 2010) pp. 9, 13, 15, 19, 29-30, 47.

As the table shows, the relationship between parents' characteristics and children's asthma is mixed. Prevalence is lowest for the children of the most educated parents, but higher for the offspring of high school graduates than for those having less than a high school diploma. Greater educational attainment of parents may increase the chance of their child being diagnosed with asthma, as such parents may be more alert to symptoms and better able to afford treatment, whether they have private medical insurance or not.



The relationship between poverty and asthma prevalence is strong, and asthma is the most common chronic condition among poor children.⁷ Since low-income parents are more likely to live in neighborhoods where air quality is poor, their children face a higher risk of asthma. Asthma prevalence is almost twice as high among children in mother-only families compared to those in two-parent homes.

Learning disabilities. There is an inverse relationship between parent's education and the percentage of children having a learning disability, with the highest percentage (10.9 percent) of such children belonging to parents with less than a high school diploma and the lowest percentage (7.3 percent) among the most educated. Likewise, being poor, living in a mother-only family, and being on Medicaid or other public insurance are all associated with higher fractions of learning-disabled children. A growing body of evidence shows that poor children experience mental deficits that affect language development and their ability to plan, remember details, and pay attention in school.⁸

Not surprisingly, the poorest children are those most likely to receive special education or early intervention services.⁹ Poverty is associated with more behavior problems among children, such as aggression, acting out, antisocial behavior, and poor mental health; among adolescents, poverty is associated with higher

rates of non-marital pregnancy and criminal activity.¹⁰ Not surprisingly, low family income is also linked to lower levels of educational attainment among the children.¹¹

Missed school days. The fraction of children missing eleven or more days of school in the last twelve months due to illness or injury varies only slightly among the three parental education categories. Family structure, type of insurance, and poverty are all linked to higher percentages of children who miss a significant number of school days.



In addition to asthma, poor children suffer from higher rates of other chronic conditions, including diabetes, hearing, vision, and speech problems.¹² They also have higher rates of health-related activity limitations and acute illnesses such as colds and flu.¹³ Thus they are far more likely than children in the near-poor or not poor groups to have excessive absences. Whereas only 4.3 percent of children in two-parent families missed eleven or more days, the fraction of offspring of single mothers was higher, at 7.0 percent.

Use of Prescription Medications. The NHIS included questions about children's regular use of prescription medications for at least three months. Parents' educational attainment was positively associated with children's use of medication. The percentage of children taking prescriptions routinely rose from 10.4 percent for parents who did not finish high school to 12.3 percent for high school graduates and 14.4 percent for those with more than a high school diploma. Better-educated parents may be more consistent in seeing that their children take prescribed medicine and better able to afford prescriptions for chronic health problems, whether covered by insurance or not. Poor children, those living in mother-only families, and those lacking private health insurance are also more likely to require long-term medication than children in other situations.

Unmet dental needs. The NHIS queried parents about the unmet dental needs of their children, asking if there was any time in the past year when the child needed dental care but did not receive it due to lack



of money. Untreated dental problems can affect a child's ability to speak, eat, and learn.¹⁴ Predictably, lower parental education and being poor or near poor are associated with greater unmet dental needs among children. Children in single-mother families are disadvantaged relative to those in two-parent situations. Finally, unmet dental needs are more common among children on Medicaid or other public insurance than among their counterparts with private coverage.

Policy Implications and Conclusion

The data in this report clearly indicate that having less educated parents, poor parents, parents unable to afford private health insurance, and living in a single-mother family are all associated with worse health outcomes for children. The statistics suggest a role for greater efforts among policy makers to raise educational levels, provide decent health care coverage to all, reduce poverty and, wherever possible, prevent child health problems before they begin. But, for Mississippi, a strong case can be made as well for reducing the number of children born to unmarried mothers.

When and whether to become a parent is, or should be, one of the most carefully thought-out decisions in a person's life. Sadly, however, the first state-level analysis of unintended pregnancies shows that about 40 percent of pregnancies nationwide are unwanted or mistimed; the highest fraction of unintended pregnancies (65 percent) occurred in Mississippi. Of these unintended pregnancies, two out of three were deemed (by the woman) to be mistimed (that is, too early in her life), and one in three unwanted. The majority, however, (66 percent) resulted in a life birth, meaning that 66 women in every 100 experiencing a mistimed or unwanted pregnancy went on to have a child anyway.¹⁵ The data also indicate non-use or ineffective use of contraception by a group of women who clearly stated that they did not want a baby at the time they became pregnant.



Why does it matter if a pregnancy is unintended? According to the authors of this study, "unplanned births have been associated with numerous undesirable outcomes, inadequate or delayed initiation of prenatal care,

use of alcohol and tobacco during pregnancy, premature birth, low birth weight, lack of breastfeeding, and negative physical and mental health outcomes among children.”¹⁶



Nearly one in four births in the state in 2009 (the most recent data) occurred to mothers with less than a high school education. More than half of all births (55.2 percent) occurred to unmarried mothers; for nonwhites, the figure was four out of five (79.9 percent).¹⁷ Three out of four of these mothers were not teenagers. The number of births to unmarried mothers in Mississippi have been rising over time, not declining. Most devastating, from a child welfare perspective, is the fact that the poverty rate for single mothers with minor children in the state was 51.5 percent in 2009; in sharp contrast, among married couples with minor children, only 9.0 percent lived in poverty.¹⁸

Many child health issues may result from a larger problem that may be called “premature parenthood.” Parenthood occurs too soon when the parents are too uncommitted (to each other or to raising their child together), too immature, too sick (from illicit drug use, for example), too poorly educated, too lacking in job skills, or otherwise ill-equipped to take on the tremendous responsibility of raising a child to become a productive citizen. Their bad decisions incur many negative consequences in both the short run and the long run.

For children, good health is an important prerequisite for school achievement. The effects of poor health on education begin early and last a lifetime. Clearly, feeling unwell and missing school days can limit a child’s success in elementary school and high school, possibly resulting in dropping out prior to graduation. Census data for Mississippi show that young adults (ages 18 to 34) with health problems are substantially less likely to have earned a high school diploma or GED and less likely to be enrolled in college than their healthier counterparts.¹⁹ Hence health problems early in life are key factors behind children’s educational inadequacies and, ultimately, their shortcomings as workers and increased likelihood of dependence on the public purse when they reach adulthood.

Although the negative effects of poverty on children’s brains can be reversed, expensive and “incredibly intensive interventions” are required in the attempt.²⁰ Furthermore, the connections between childhood poverty and health extend into adulthood and old age. By age 50, people who were poor as children have a higher risk of chronic diseases such as diabetes and hypertension, are more likely to have been diagnosed with heart disease, and are more likely to have suffered a stroke or heart attack than their non-poor counterparts; such disparities tend to become more pronounced with advancing age.²¹ Negative effects on labor force participation and earnings are likely for such individuals, as is forced early retirement due to health problems and reliance on transfer payments and publicly-funded health care.



Poverty statistics alone suggest the severe disadvantages faced by the children of unmarried mothers and set the stage for a lifetime of problems. While it is important to provide health care to poor children and attempt to reduce poverty rates in the state, prevention of premature parenthood alone would go far toward achieving these ends. One cannot read the daunting list of negative outcomes that many children endure without asking why so many parents have children too soon, why so many unmarried women choose to bring a fatherless child into the world, and why this happens in an age when cheap, safe, and effective birth control is readily available. Policymakers need to address questions of attitudes, values, and motivation underlying premature parenthood if the state’s economic woes, educational deficiencies, and health problems are ever to be remedied.

Notes

1. “U. S. Variations in Child Health System Performance: A State Scorecard,” at www.commonwealthfund.org.
2. Katherine Magnuson and Elizabeth Votruba-Drzal, “Enduring Influences of Childhood Poverty,” Institute for Research on Poverty, University of Wisconsin-Madison, Discussion Paper No. 1348-08, September, 2008, pp. 9-10.

3. Barbara J. Logue, "Education Pays Off in Mississippi," *Mississippi's Business*, December, 2003, p. 10.
4. American Lung Association, "Childhood Asthma Overview," at www.lungusa.org.
5. *Ibid.*
6. *Ibid.*
7. Janet Currie and Wanchuan Lin, "Chipping Away at Health: More on the Relationship between Income and Child Health," *Health Affairs* 26(2): 331-344 (2007).
8. Greg Toppo, "Study: Poverty Dramatically Affects Children's Brains," *USA Today*, December 8, 2008.
9. P. F. Adams, P. M. Barnes, and J. L. Vickerie, Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2007 (National Center for Health Statistics, *Vital Health Stat* 10 (238), pp. 6, 22.
10. Magnuson and Votruba-Drzal, *op. cit.*, p. 18.
11. *Ibid.*, p. 22.
12. *Ibid.*, p. 20.
13. Currie and Lin, *op. cit.*
14. U.S. Government Accountability Office, "Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay," GAO, September, 2008.
15. L. B. Finer and K. Kost, "Unintended Pregnancy Rates at the State Level," *Perspectives on Sexual and Reproductive Health* 43: [doi:10.1363/4307811](https://doi.org/10.1363/4307811), 2011 (online version).
16. *Ibid.*
17. Mississippi State Department of Health, *Vital Statistics Mississippi*, 2009, pp. 10-11.
18. American Community Survey, 2009, at www.census.gov.
19. Barbara J. Logue, "Education and Health," *Mississippi's Business*, April, 2003, p. 1.
20. Toppo, *op. cit.*
21. Magnuson and Votruba-Drzal, *op. cit.*, p. 20.