The Health of Single Fathers

Demographic, Economic and Social Correlates

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ABSTRACT

Background: The proportion of families headed by single fathers is increasing in many developed countries. The purpose of the present study was to examine the impact of single parenting on the self-rated health of Canadian fathers living with children, and the extent to which this relationship can be explained by social, demographic, and economic factors.

Methods: Secondary analysis of data from a national community health survey. The sample studied consists of 15,662 Canadian men aged 15-64, living with at least one child under the age of 25.

Results: Compared to partnered fathers, single fathers had poorer self-rated health. The relationship between partner status and self-rated health could be completely explained by single fathers' older age, lower income, and higher rate of unemployment.

Conclusions: Single fathers experience poorer perceived health. This effect appears to result from the economic and social disadvantage associated with raising children alone rather than from single parenting in and of itself. These findings, in combination with previous research, suggest a need for provincial and federal policies to target the well-being of both single mothers and single fathers.

MeSH terms: Fathers; single parent; health

While most single parents are female, the proportion of families headed by single fathers is increasing in many developed countries. For example, in Canada, the number of families headed by single fathers increased by 16% between 1996 and 2001, compared to an increase of 3% among families headed by mothers.¹ Similarly, in the United States, the number of families headed by single fathers grew at more than double the rate of families headed by single mothers during the 1980s.²

In light of this shift in demographic patterns in parenting and the large body of research linking single parenting with poorer health among women,³⁻⁹ it is important to understand the impact of single parenting on men's health and the extent to which this impact may be explained by social and economic disadvantages associated with raising children alone. In contrast to research on women's health,^{10, 11} studies of inequalities in men's health to date have paid less attention to the intersection of family roles with economic and social factors.

In this paper, we study the self-rated health of Canadian fathers living with children under the age of 25, comparing men with and without partners. We then examine the extent to which socio-demographic, economic, and social factors explain the relationship between single fatherhood and health.

METHODS

Data

The present study involved analysis of Statistics Canada's Canadian Community Health Survey (CCHS) data.¹² Collection of CCHS data, first cycle, described in detail elsewhere,¹³ began in September 2000 and continued over a 14-month period. The CCHS targeted persons aged 12 and older living in private dwellings in the 10 Canadian provinces and 3 territories. Individuals excluded from the sampling frame were those living on Indian Reserves, full-time members of the Canadian Armed Forces, institutional residents, and residents of some remote areas in Ontario and Quebec. The overall response rate for the CCHS was 84.7%.

The total sample size for the CCHS was 133,300. For the purposes of the present study, we selected a subsample of 15,662

La traduction du résumé se trouve à la fin de l'article.

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men between the ages of 15 and 64 years who reported having at least one child under the age of 25 living in the home at the time of the survey.

All analyses were conducted using the sampling weights provided by Statistics Canada. For the determination of statistical significance, a more conservative estimate was computed by dividing the weighting factor by the mean weight for the complete sample.⁵ Reported percentages and odds ratios are weighted while reported sample sizes are the actual number of observed subjects.

Study variables

The dependent variable in this study was self-rated health. Participants were asked to rate their general health on a 5-point scale ranging from 'excellent' to 'poor.' We collapsed this variable into two categories: better health ('excellent,' 'very good,' or 'good') and poorer health ('fair' or 'poor').^{14,15}

The primary independent variable studied was partner status. Non-cohabitating men with at least one child under the age of 25 living in their household at the time of the survey were considered single fathers. Of the 1,028 men meeting these criteria, 78.1% were separated/divorced or widowed, 17.1% were never married and 4.4% were currently married. Partnered fathers were defined as men living with a spouse or partner and at least one child under the age of 25 at the time of the survey. We examined fathers' age and presence of young children in the household as possible confounders. In the absence of more precise measures, parenting a young child was used as a proxy for family demands. Thus, fathers with one or more children five years of age or younger were compared to those whose children were older than five. Fathers' age was grouped into three categories: 15-34, 35-49, and 50-64 years.

The remaining independent variables were: income, employment status, and four types of social support. These variables were chosen on the basis of previous research with women indicating a strong association between single parenting, economic and social disadvantage, and poorer health.^{3,5,6,16} Income was based on total household income from all sources in the 12 months before the interview, relative to the number of people in the household. Using Statistics

TABLE 1

Demographic, Social and Health Characteristics of the Study Population, by Partner Status, Canadian Community Health Survey, 2000-2001

	Partnered % (n=14,634)	Single % (n=1,028)
Age*		
15-34	19.3	10.7
35-49	59.4	58.9
50-64	21.3	30.4
Children ≤5 yrs in household*		
Yes	36.9	9.9
No	63.1	90.1
Income adequacy*		
Low	6.7	12.0
Middle	17.6	21.7
High	75.6	66.3
Employed*		
Yes	79.1	71.9
No	20.9	28.1
Self-rated health*		
Poorer ('fair' or 'poor')	7.3	12.3
Better ('excellent,' 'very good' or 'good')	92.7	87.7
Social support (mean & SD)		
Tangible*	14.4 (2.4)	11.2 (4.1)
Affection*	11.1 (1.7)	9.0 (3.0)
Positive social interaction*	14.3 (2.5)	11.7 (3.9)
Emotional and informational*	27.6 (5.7)	22.8 (7.9)

* p<0.01

Canada's income adequacy definitions, three income categories were formed: low, middle, and high. Employment status was a dichotomous measure, comparing respondents who had a job during the last 12 months to those who did not.

The measures of social support in the CCHS are based on the Medical Outcomes Social Support Survey (MOS)¹⁷ and consist of four dimensions. Emotional/ informational support is comprised of eight questions concerning whether the respondents have someone who would listen and advise them in crisis situations. Tangible support is assessed with four questions about whether respondents have someone to take them to the doctor and help them with daily activities if needed. The three items that make up the affection subscale assess the amount of affection the respondents receive (e.g., shows them love, makes them feel wanted). Positive social interaction consists of four questions concerning the extent to which the respondents are involved in enjoyable social situations (e.g., has someone to have a good time with or relax with). For each subscale, higher scores indicate greater levels of social support. Previous research provides support for the reliability and construct validity of the four MOS scales.¹⁷

Analyses

Bivariate analyses were conducted to examine the demographic, social and health

profile of study participants. Differences between single and partnered fathers were tested using chi-square tests for categorical variables and t-tests for continuous measures.

Multiple logistic regression¹⁸ was used to examine the relationship between partner status and perceived health, after adjusting for various socio-demographic characteristics, economic and social support measures. Independent variables were entered in blocks, the sequence of entry theoretically guided by our research questions: Model 1: partner status; Model 2: age, presence of young children in the household; Model 3: income group and employment status; and Model 4: tangible support, affectionate support, positive social interaction, and emotional/informational support.

RESULTS

Characteristics of the study sample

The demographic, social, and health characteristics of the study sample, according to partner status, are shown in Table 1. Compared to partnered fathers, a significantly greater proportion of single fathers were in the oldest age category and did not have a young child living in the household. Single fathers were also less likely to be employed and were more likely to be in the lowest income group. A significantly greater proportion of single fathers report-

TABLE II

Hierarchical Models Showing the Relationship of Partner Status, Socio-demographic Characteristics, and Social Support to Poor Self-rated Health (n=15,662)

	Model 1 OR (95% CI)	Model 2 OR (95% CI)	Model 3 OR (95% CI)	Model 4 OR (95% CI)
Partner status				
Partnered	1.00	1.00	1.00	1.00
Single	1.61 (1.19 - 2.17)	1.39 (1.03-1.88)	1.18 (0.87-1.62)	1.01 (0.73-1.41)
Age				
15-34		1.00	1.00	1.00
35-49		1.12 (0.86-1.47)	1.26 (0.96-1.66)	1.23 (0.94-1.61)
50-64		1.90 (1.39-2.59)	2.00 (1.47-2.74)	1.94 (1.42-2.66)
Children ≤5 yrs in household				
No		1.00	1.00	1.00
Yes		0.69 (0.55-0.86)	0.65 (0.52-0.82)	0.65 (0.52-0.82)
Income adequacy				
High			1.00	1.00
Middle			1.80 (1.45-2.19)	1.76 (1.45-2.14)
Low			3.42 (2.71-4.32)	3.17 (2.50-4.02)
Employed				
Yes			1.00	1.00
No			2.13 (1.79-2.53)	2.13 (1.79-2.53)
Social support				
Tangible				1.05 (1.00-1.10)
Affection				1.00 (0.93-1.07)
Positive social interaction				0.90 (0.85-0.96)
Emotional and informational				1.00 (0.98-1.02)

ed poorer self-rated health. On all four measures of social support, single fathers reported significantly lower levels of support than partnered fathers.

Correlates of self-rated health

The models based on incremental addition of variable-blocks showing the relationship of partner status, socio-demographic characteristics, economic, and social support measures to self-rated health are displayed in Table II. Model 1 shows the crude relationship between partner status and self-rated health, indicating that single fathers were over 1.5 times more likely than partnered fathers to report poorer self-rated health. Results in subsequent models show this relationship diminished as key covariables were added. In Model 2, with the addition of age and the presence of young children, single parent status remained a statistically significant correlate of poorer self-rated health. Being older (50-64 years) and not having young children in the household were associated with an additional increased risk of poorer self-rated health. In Model 3, with the addition of the economic variables, the relationship between partner status and self-rated health was weakened and was no longer statistically significant. When the social support variables were added to the model, the relationship between single father status and self-rated health was diminished further. As shown in Model 4, older age, not having children aged five or under in

the household, low and middle income adequacy, unemployment, and lower levels of positive social interaction fully accounted for the relationship between single-father status and self-rated health.

DISCUSSION

We found that single fathers living with children were significantly more likely to report poorer self-rated health than partnered fathers. The association between single-parent status and poorer health outcomes has been consistently found in previous research with women.^{4-9,16,19,20} The few studies that have examined the health of men in relation to their parent and partner roles have similarly reported poorer health among single fathers, compared to partnered.^{7,21}

Our findings also show that the poorer self-rated health of single fathers is explained, in large part, by demographic differences between the two groups and the more limited economic and social resources available to single fathers. When pertinent demographic and economic characteristics were taken into account, the relationship between single parenthood and the risk of poorer health was no longer statistically significant.

The influence of demographic factors

The addition of demographic characteristics, fathers' age, and parenting young children in Model 2 substantially reduced the

strength of the relationship between single-father status and perceived health. Consistent with previous research,²² we found the risk of poorer self-rated health to be significantly greater for older men in our sample.

The presence of young children in the household was associated with a lower risk of poorer self-rated health, even after adjusting for a number of covariates including fathers' age. Thus, the common assumption equating the presence of young children with greater demand, and therefore poorer parental health status, may not apply in all circumstances. Previous research suggests that the relationship between parenting and health is complex and that the quality and style of parenting is a more important determinant of well-being than simply the occupancy of that role.²³⁻²⁵ Unfortunately, information on the quality of the parent role was unavailable in this data set.

The influence of economic factors

With the addition of income adequacy and employment status in Model 3, the relationship between partner status and poorer self-rated health was no longer statistically significant. Thus, the poorer self-rated health of single fathers in our study was largely due to their lower income adequacy and lack of employment, relative to partnered fathers. The importance of economic circumstances has been similarly identified in research comparing partnered and single

mothers, but contrary to our findings, economic factors do not completely account for the elevated health risks of single mothers.^{6,7} Our findings are consistent with a large body of previous research which has repeatedly demonstrated a relationship between lower economic resources and poorer health.^{26,27}

The influence of psychosocial factors

The addition of social support variables in our analytic models further diminished the relationship between partner status and self-rated health. Associations between social support and a variety of health outcomes have been consistently reported in the research literature.²⁸⁻³⁰ In the present study, however, deficits in perceived positive social interaction were especially critical in explaining the poorer self-rated health of single fathers. One likely consequence of being a single parent is having fewer opportunities to socialize with other adults, which in turn may result in feelings of social isolation and distress. Alternatively, poor health may influence the quality of social interactions. The lack of statistically significant association between the other types of social support and self-rated health is puzzling. Though consistently reported, the relationship between social relationships and health is not well understood and likely encompasses multiple behavioural, material, psychological and physiological pathways.²⁸

Limitations

There are several important limitations to the present study. All variables are based on self-reported information, thus reporting biases cannot be ruled out. Because we used cross-sectional data, we could not determine the extent to which poorer self-rated health might have contributed to participants becoming single fathers, or to lower incomes and poorer levels of social support. We did not have access to potentially important information, such as custody arrangements. It is likely that among single fathers there is variability in terms of the other parent's level of involvement in their children's lives; this could have positive or negative effects on the parents' health, depending on the nature of their relationship with each other and with their children. We also do not have data on how fathers in our study became single parents,

on the duration of single parenting, or on the number of children in the household.

CONCLUSIONS

Our study of 15,662 fathers living with children found that the absence of a partner was significantly associated with poorer self-rated health. Socio-economic and social support variables were important contributors to the relationship between partner status and health and are likely pathways through which single fathering affects health. These findings, in combination with previous research, suggest a need for provincial and federal policies to target the well-being of both single mothers and single fathers.

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RÉSUMÉ

Contexte : La proportion des familles dirigées par des pères seuls est en hausse dans plusieurs pays développés. Le but de cette étude était d'examiner l'effet de la monoparentalité sur la santé autoévaluée des pères canadiens habitant avec leurs enfants, et la mesure dans laquelle ce lien peut s'exprimer en fonction de facteurs sociaux, démographiques et économiques.

Méthode : Analyse de données secondaires provenant d'une enquête nationale portant sur la santé dans les collectivités. L'échantillon étudié était composé de 15 662 Canadiens de sexe masculin âgés de 15 à 64 ans, habitant avec au moins un enfant de moins de 25 ans.

Résultats : En comparaison de celle des pères vivant en couple, la santé autoévaluée des pères seuls était moins bonne. Le lien entre l'état civil et la santé autoévaluée pouvait s'expliquer entièrement par l'âge plus avancé, le revenu plus faible, et le taux de chômage plus élevé des pères seuls.

Conclusion : Les pères seuls perçoivent leur santé comme étant moins bonne. Cet effet semble provenir d'une situation économique et sociale désavantageuse liée au fait d'élever seul des enfants, plutôt qu'au seul fait d'être chef de famille monoparentale. Ces résultats, combinés à ceux d'autres travaux de recherche, tendent à démontrer le besoin de politiques provinciales et fédérales propres à agir sur le bien-être des pères seuls, comme sur celui des mères seules.

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