

# The Family in America

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## **Prescribing Poison: Why ObamaCare Delivers the Wrong Family Medicine**

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**“WHEN IT COMES TO THE COST OF HEALTH CARE,”** President Obama declared in 2009, “this much is clear: the status quo is unsustainable for families, businesses and government. America spends nearly 50 percent more per person on health care than any other country.” Americans indeed heard a great many ideas from the Obama administration to reduce the staggering cost of care: establishing a public health-insurance program and then negotiating discounts with medical providers serving those insured by that program; reducing waste and fraud in medical care; investing in wellness initiatives that combat obesity, sedentary lifestyle, and smoking; guaranteeing access to preventative medicine; requiring transparent pricing of medical services; reducing unnecessary diagnostic tests; cutting administrative costs—and the list goes on. Indeed, Democratic Rep. John B. Larson of Connecticut indicated that lawmakers were casting their nets widely in searching for ways to contain runaway health-care costs. “All ideas are on the table,” he said, “even the bad ones.”

The need to rein in health-care costs has indeed grown urgent. National expenditures have risen from \$28 billion in 1960 to more

than \$2.5 trillion in 2009.<sup>1</sup> Even if numbers are adjusted for inflation, Americans have witnessed more than just a dramatic escalation of health-care costs. This has been an explosion. Yet despite claims to the contrary, the Obama administration and its allies never put *all* ideas for dealing with this explosion on the table. Indeed, some very good ideas—namely, those that would rein in health-care costs by reinforcing marriage and family life—never appeared on the Obama administration’s list at all.

Moreover, some measures that the Obama team vigorously endorsed—and now is enacting—exacerbate the health-care crisis by further weakening marriage and family life. Congressman Larson was thus perhaps revealing more than he intended when he acknowledged that some bad ideas were “on the table” when the Democrats framed their health-care reform. For close scrutiny of the Obama administration’s effort in championing health-care reform reveals a fundamental animus toward family ties that are essential to safeguarding good health and to providing care. This animus can only mean that President Obama and his allies care more about enlarging their political power than they do about reducing the burdens of health care. Only such animus can explain the presence of some very bad ideas in the Obama formula for health care—and the absence of some much-needed good ones. In the long run, this policy prescription can only prove toxic to the nation’s health.

The possibility of checking health-care costs by renewing marriage and family life would likely strike the Obama administration as absurd and irrelevant. It shouldn’t. A growing body of epidemiological evidence identifies an enduring marriage and an intact family as powerful safeguards of health. What is more, researchers report that even when illness does strike the married couple or the intact family, those afflicted can often receive care at home rather than in a hospital and in many cases can even do without the costly care of the sort that only professionals can provide. In contrast, researchers find that adults living without a spouse and children living without both parents are often those who most desperately need professional care in the costly setting of the hospital.

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1. See U.S. Bureau of the Census, *Statistical Abstract of the United States*, 2010 edition, Table 127.

### **Wedlock as the Ultimate Health Protector**

The sheer volume of research documenting the health-protecting effects of marriage and family life precludes more than a brief summary. Such effects came into view long ago, as soon as researchers began to apply modern statistical techniques to epidemiological data. As a pioneer in this area, British scholar William Farr recognized in 1885 the significance of wedlock as a safeguard for health: “Marriage is a healthy estate. The single individual is more likely to be wrecked on his voyage than the lives joined together in matrimony.”<sup>2</sup> Since the late-nineteenth century, Farr’s conclusion has found repeated corroboration among epidemiologists. Writing in 1985, a team of researchers writing in *Social Science and Medicine* summarized a great deal of research in a ringing endorsement of Farr’s conclusion: “One of the most consistent observations in health research is that married [people] enjoy better health than those of other marital statuses,” adding that “this pattern has been found for every age group (20 years and over), for both men and women, and for both whites and nonwhites.”<sup>3</sup>

At the beginning of the twenty-first century, researchers from Wayne State and Pennsylvania State Universities strongly confirmed that a “major benefit of marriage is better health, with the best health accruing from long-term stable marriages.” The Wayne State and Penn State scholars acknowledge that marriage patterns have changed as more and more Americans have avoided or postponed wedlock or have terminated their marital unions through divorce. Yet they insist, “The significance of marriage [in affecting health] has not diminished—marriage has powerful and pervasive health benefits.” “The consistency of the health benefit of marriage, across all domains of health, is remarkable,” report the researchers, who note that this benefit holds for men and women and for all ethnic groups.<sup>4</sup>

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2. William Farr, “Marriage and Mortality,” *Vital Statistics: A Memorial Volume of Selections from the Reports and Writings of William Farr* (London, 1885; rpt. Metuchen: The Library of the New York Academy of Medicine/The Scarecrow Press, 1975), pp. 438–31.
  3. Catherine K. Riessman and Naomi Gerstel, “Marital Dissolution and Health: Do Males or Females Have Greater Risk?” *Social Science and Medicine* 20 (1985): 627.
  4. Amy Mehraban Pienta, Mark D. Hayward, and Kristi Rahrig Jenkins, “Health Consequences of Marriage for the Retirement Years,” *Journal of Family Issues* 21.5 (2000): 559–86.

Any doubt as to the healthiness of the married state should give way before a 2009 study published by researchers from Johns Hopkins and the University of Chicago. This study offers “strong support” for the hypothesis that “the short-term effects of marital status . . . extend to the long term and accumulate over the life course.” More particularly, this study establishes a clear pattern favoring those in enduring marriages: “Those who have never married have more mobility limitations, rate their health as worse, and show more depressive symptoms than the married. Those who have married once and remained married are consistently, strongly, and broadly advantaged.”<sup>5</sup>

To be sure, epidemiologists can explain some part of the advantage that married people enjoy over unmarried peers as merely the consequence of self-selection: sick people don’t marry or cannot maintain a marital union if they do. But the evidence indicates that such self-selection accounts for only a relatively small part of the advantage. In trying to explain why married mothers enjoy better health than their unmarried peers, an international team of researchers frankly acknowledge in a 2000 study that selection effects “cannot explain most of the excess risk” evident among the single mothers.<sup>6</sup> American demographer John E. Murray likewise discounts self-selection as a plausible explanation of the benefits associated with marriage, adducing evidence in another 2000 study that marriage *per se* does provide “independent protection of health and life.” After reviewing mortality data for a large sample of men, Murray asserts, “marriage induced lower mortality . . . even with controls for health status in adulthood.”<sup>7</sup>

Researcher Debra Umberson explains the protective effects of marriage and parenthood when she argues that both wedlock and parenthood exert “a deterrent effect on health compromising behaviors,” such as heavy drinking, drug use, and smoking, by giving spouses and parents a

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5. Mary Elizabeth Hughes and Linda J. Waite, “Marital Biography and Health at Mid-Life,” *Journal of Health and Social Behavior* 50 (2009): 355–56.
  6. Margaret Whitehead, Bo Burstrom, and Finn Diderichsen, “Social Policies and the Pathways to Inequalities in Health: A Comparative Analysis of Lone Mothers in Britain and Sweden,” *Social Science and Medicine* 50 (2000): 255–70.
  7. John E. Murray, “Marital Protection and Marital Selection: Evidence from a Historical-Prospective Sample of American Men,” *Demography* 37.4 (2000): 511–21.

sense of “meaning, obligation, and constraint.”<sup>8</sup> Of course, the health-enhancing effects of marriage and parenthood constitute an integral package: the evidence is clear that unmarried parenthood endangers health. In a 2000 study, data from two national surveys conducted in France suggest that married mothers with children at home enjoy the kind of health improvement predicted by “role enhancement” theory but that, in contrast, single mothers suffer from “very unfavorable outcomes in terms of perceived health and malaise symptoms.”<sup>9</sup>

Nor should it be supposed that marriage protects only physical health. Again and again, researchers identify wedlock as a prime safeguard of psychological well-being. Ohio State researcher Catherine E. Ross reports that “unmarried persons with and without children have higher levels of depression than married persons with or without children.”<sup>10</sup> It is predictable, then, that MacArthur Foundation researcher Corey L. M. Keyes would find that married men and women are much more likely than their unmarried peers to enjoy the optimal state of mental health labeled “flourishing,” while unmarried men and women are much more likely to suffer from the poor mental state described as “languishing.” Summing up, Keyes concludes that married individuals are significantly more likely than their unmarried peers to manifest “very good or excellent” mental and emotional health.<sup>11</sup> Being unmarried, conclude researchers from Johns Hopkins University in a 2000 study, predicts adverse mental health more reliably than does “high physical job strain.”<sup>12</sup>

Marital status proves particularly decisive in determining the psychological well-being of mothers. In a 2006 analysis of data collected from

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8. Debra Umberson, “Family Status and Health Behaviors: Social Control as a Dimension of Social Integration,” *Journal of Health and Social Behavior* 28 (1987): 309–16.
  9. Myriam Khat, Catherine Sermet, and Annick Le Pape, “Women’s Health in Relation with their Family and Work Roles: France in the Early 1990s,” *Social Science & Medicine* 50 (2000): 1807–25.
  10. Catherine E. Ross, “Neighborhood Disadvantage and Adult Depression,” *Journal of Health and Social Behavior* 41 (2000): 177–87.
  11. Corey L. M. Keyes, “The Mental Health Continuum: From Languishing to Flourishing in Life,” *Journal of Health and Social Behavior* 43 (2002): 207–22.
  12. Hilde Mausner-Dorsch and William W. Eaton, “Psychosocial Work Environment and Depression: Epidemiologic Assessment of the Demand Control Model,” *American Journal of Public Health* 90 (2000): 1765–70.

a nationally representative sample of American mothers, researchers find that “odds of experiencing psychopathology are lowest for married mothers,” with never-married mothers manifesting significantly more vulnerability to such psychopathology and divorced/separated mothers evincing even worse vulnerability.<sup>13</sup> A 2005 study by researchers from Johns Hopkins reaches similar conclusions, finding that mothers who are “not married or living with the biological father” are “disproportionately” represented among those manifesting depressive symptoms.<sup>14</sup> Mental illness requires treatment, so it is quite understandable that when Canadian scholars scrutinize a data set collected in Ontario in 1990 and a national data set collected in 1994–95, they find that “single mothers are between two and three times more likely to have sought help for mental health concerns in the previous 12 months than married mothers.”<sup>15</sup>

### **Married Parents Boost Children's Health**

Marriage not only protects the health—physical and psychological—of adults but also of children born to, and living with, their married parents. When researchers from Kent State University examine national data, they find that children of married parents enjoy decidedly better health than peers from broken homes. “Marital status,” remark the Kent State scholars, “is related to the health status of all the family members, including both parents and children.”<sup>16</sup> When pediatric researcher David Wood examines the impact of “trends in family structure,” he also discerns a sobering trend. As the number of children living in single-parent homes has multiplied, Wood notes, a growing number of them have been exposed to health problems incident to poverty. Wood points out that “fifty-five percent of children who live in single-parent, mother only families are poor,

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13. Tracie O. Afifi, Brian J. Cox, Murray W. Enns, “Mental Health Profiles Among Married, Never-Married, and Separated/Divorced Mothers in a Nationally Representative Sample,” *Social Psychiatry and Psychiatric Epidemiology* 41 (2006): 122–29.
  14. Cynthia S Minkovitz et al., “Maternal Depressive Symptoms and Children’s Receipt of Health Care in the First Three Years of Life,” *Pediatrics* 115 (2005): 306–14.
  15. John Cairney et al., “Single Mothers and the Use of Professionals for Mental Health Care Reasons,” *Social Science and Medicine* 59 (2004): 2535–46.
  16. John Guidubaldi and Helen Cleminshaw, “Divorce, Family Health, and Child Adjustment,” *Family Relations* 34 (1985): 35–41.

compared with only 10% of children in two-parent families.” Predictably, Wood highlights child poverty as the reason for “higher rates of poor health and chronic health conditions” among affected children resulting in “higher rates of hospital admissions, disability days, and death rates.” Even when poverty does not expose children to illness, it typically has “a detrimental impact on [their] intellectual, emotional, and physical development.”<sup>17</sup>

What Wood sees impresses an entire research team from Albert Einstein Medical School. Analyzing data collected from more than 57,000 children during the 1990s, this team finds that family structure predicts children’s health more reliably than ethnicity or parental education. “Those [children] not living in two-parent families,” the Einstein team acknowledges, “were in poorer health than those in two-parent families.”<sup>18</sup> Looking specifically at mental health, investigators from the Pittsburgh School of Medicine find a similar pattern, calculating that “children from single-parent households were roughly twice as likely to be identified with psychological problems” as were children from intact families.<sup>19</sup>

Surveying the same ground, a task force appointed by the American Academy of Pediatrics underscores the importance of family structure in a joint statement on “Family Pediatrics” published in 2003. The academy team views “paternal absence” as the root cause of “multiple and sometimes lifelong disadvantages” that go far beyond “health problems” to include “problems with school attendance, achievement and completion; emotional and behavioral problems; adolescent parenthood; substance abuse; and other risk behaviors.” Given the dismal patterns in single-parent homes, the task force underscores the advantage of keeping children in two-parent households: “Unequivocally,” they write, “children do best when they are living with [two] mutually committed and loving parents

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17. David Wood, “Effect of Child and Family Poverty on Child Health in the United States,” *Pediatrics* 112 (2003): 707–12.

18. Laurie J. Bauman, Ellen J. Silver, and Ruth E. K. Stein, “Cumulative Social Disadvantage and Child Health,” *Pediatrics* 117 (2006): 1321–27.

19. Kelly J. Kelleher et al., “Increasing Identification of Psychosocial Problems: 1979–1996,” *Pediatrics* 105 (2000): 1313–21.

who respect and love one another.”<sup>20</sup>

And let no one suppose that the scholars have in view cohabiting couples or stepfamilies in endorsing such an ideal for child-rearing: these scholars explicitly warn that cohabitation tends to “produce worse outcomes for children” than does parental marriage, and they remark that parental re-marriage after divorce so complicates a child’s life that, “in general, children who are raised in a stepfamily do [only] about as well as do children of single mothers.” The source of good health and much else is clearly wedlock: “Marriage,” the task force explains, “is beneficial in many ways,” in large part because “people behave differently when they are married. They have healthier lifestyles, eat better, and mother each other’s health. Being part of a couple and a family also increases the number of people and social institutions with which an individual has contact; this . . . increases the likelihood that the family will be a successful one.” Given this background, the academy could only adopt one stance: “The task force favors efforts to encourage and support marriage.”<sup>21</sup>

Pediatric authorities are indeed justified in speaking of an intact parental marriage as “beneficial in many ways.” Researchers report that compared to single parents, married parents are more conscientious about seeing that their young children receive timely vaccinations and other preventative medical care.<sup>22</sup> And no preventative medical care is more important than breastfeeding. Again and again, researchers have documented the immunological, nutritional, and neurological advantages of breastfeeding. With good reason, scholars now regard “human milk [as] the gold standard for infants’ nourishment,” a marvelous nourishment that enhances “children’s cognitive and educational abilities” even as it shields infants from “urinary-tract infections, lower and upper respiratory-tract infections, diarrhea, allergic diseases, otitis media, bac-

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20. American Academy of Pediatrics Task Force on the Family, “Family Pediatrics,” *Pediatrics* 111 Supplement (2003): 1541–53.

21. *Ibid.*

22. See Barbara H. Bardenheier et al., “Factors Associated with Underimmunization at Three Months of Age in Four Medically Underserved Areas,” *Public Health Reports* 119 (2004): 479–85; see also Minkovitz et al., “Maternal Depressive Symptoms.”



terial meningitis, botulism, bacteremia, and necrotizing enterocolitis.”<sup>23</sup>

With good reason, public health officials in California worry about the “large financial implications” of the nation’s depressed rates for breastfeeding. These researchers calculate that “for every 26 women who exclusively breastfeed for 4 months, one LRTD [lower respiratory tract disease] hospitalization might be avoided . . . and each such hospitalization in infancy costs on average \$3500 [in 2003 dollars].” Since, “respiratory disease severe enough to require hospitalization has been reported to increase the risk of childhood asthma 10-fold,” these officials suggest that greater reliance upon breastfeeding could make a significant dent in annual costs for childhood asthma through age 17 years, costs that were already reading in excess of \$1.6 billion in 2003.<sup>24</sup> But far too few American children enjoy the tremendous advantages of breastfeeding, and family breakdown is a prime reason: Researchers find that married mothers are significantly more likely than unmarried mothers to breast-feed their babies.<sup>25</sup>

As children grow older, married parents are also more successful than unmarried parents in steering those children away from health-harming substances, such as tobacco,<sup>26</sup> alcohol,<sup>27</sup> and illegal drugs.<sup>28</sup> Married parents come out ahead of unmarried parents even in seeing that their maturing children eat right, regularly engage in recreation, and control

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23. See Steven J. Haider, Alison Jacknowitz, and Robert F. Schoeni, “Welfare Work Requirements and Child Well-Being: Evidence from the Effects on Breast-Feeding,” *Demography* 40 (2003): 479–97.

24. See Lela Rose Bachrach, “Breastfeeding and the Risk of Hospitalization for Respiratory Disease in Infancy,” *Archives of Pediatric and Adolescent Medicine* 157 (2003): 237–43.

25. See Julie Scott Taylor et al., “Duration of Breastfeeding Among First-Time Mothers in the United States: Results of a National Survey,” *Acta Paediatrica* 95 (2006): 980–84.

26. See Rebecca L. Collins and Phyllis L. Ellickson, “Integrating Four Theories of Adolescent Smoking,” *Substance Use and Misuse* 39 (2004): 179–209.

27. See Merete Osler, Merete Nordentoft, and Anne-Marie Nybo Andersen, “Childhood Social Environment and Risk of Drug and Alcohol Abuse in a Cohort of Danish Men Born in 1953,” *American Journal of Epidemiology* 163 (2006): 654–61; see also Naomi R. Marmorstein and William G. Iacono, “Longitudinal Follow-up of Adolescents with Late-Onset Antisocial Behavior: A Pathological Yet Overlooked Group,” *Journal of the American Academy of Child and Adolescent Psychiatry* 44 (2005): 1284–91.

28. See Richard H. Needle, S. Susan Su, and William J. Doherty, “Divorce, Remarriage, and Adolescent Substance Use: A Prospective Longitudinal Study,” *Journal of Marriage and the Family* 52 (1990): 157–59.

their weight.<sup>29</sup>

The pervasive influence of an intact parental marriage on children's health helps account for the longevity of that influence. Researchers examining patterns among young adults are finding that those who grew up in an intact family enjoy markedly better health than do peers who did not. Investigators at Iowa State University and the University of North Carolina—Chapel Hill show in a 2003 study that living in a single-parent family as an adolescent predicts “early problem behavior,” “school failures,” “stressful work and economic events,” all of which lead to subsequent “poor physical health” in young adulthood.<sup>30</sup> But the long-term harm that family failure inflicts on children is matched by long-term psychological harm: researchers at Penn State find that “children who experience parental divorce while growing up tend to report a comparatively low level of psychological well-being in adulthood.” Unfortunately, parental divorce is now so common that it helps account for a measurable “decline in the mean psychological well-being of the population” as a whole.<sup>31</sup> Consistent findings also appear in a 1997 study by a team of Harvard epidemiologists, who identify the distinctively high incidence of both physical and mental illness among the children of divorced and never-married parents as the reason that these children require pediatric and psychiatric services significantly more often than do children of married parents.<sup>32</sup>

### Family Breakup and Extended Care

The long-lasting physical and psychological harm that children suffer when their parents divorce can shorten their lives: in a stunning 2005

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29. See K. A. Thulitha Wickrama, K.A.S. Wickrama, and Chalandra M. Bryant, “Community Influence on Adolescent Obesity: Race/Ethnic Differences,” *Journal of Youth and Adolescence* 35 (2006): 647–56; Sara Gable and Susan Lutz, “Household, Parent, and Child Contributions to Childhood Obesity,” *Family Relations* 49.3 (2000): 293–300.

30. K. A. S. Wickrama et al., “Linking Early Social Risks to Impaired Physical Health during the Transition to Adulthood,” *Journal of Health and Social Behavior* 44 (2003): 61–74.

31. Paul R. Amato and Juliana M. Sobolewski, “The Effects of Divorce and Marital Discord on Adult Children's Psychological Well-Being,” *American Sociological Review* 66 (2001): 900–21.

32. Gwendolyn E. P. Zahner and Constantine Daskalakis, “Factors Associated with Mental Health, General Health, and School-Based Service Use for Child Psychopathology,” *American Journal of Public Health* 87 (1997): 1440–48.

study, researchers at the RAND Corporation and the University of California, Riverside, identify “parental divorce as the primary early life social predictor of life-span mortality risk,” with children from divorced families dying an average of four years earlier than did their peers reared in intact families.<sup>33</sup> If the experience of a parental divorce does not put them in an early grave, it may make it particularly difficult for aging adult children to avoid residence in the nursing home—or at least long stays in the hospital. One of the worst consequences of a parental divorce is that it sharply reduces the likelihood that the children affected will themselves grow up to make a successful marriage.<sup>34</sup> Men and women who cannot make a successful marriage will find themselves exposed to all the hazards—medical and psychological—associated with singleness. What is more, with no spouse, an aging man or woman will find it hard to stay at home while convalescing from an illness. The problem is particularly acute if the illness is a chronic one.

With nursing-home costs already running well more than \$130 billion annually,<sup>35</sup> policymakers have reason to fear the consequence of family disintegration. As he contemplates the implications of high divorce rates and low marriage rates for future health care, RAND analyst Peter Morrison warns that “the care spouses traditionally have provided one another will be far less available” because of high divorce rates and depressed marriage rates. Moreover, the Birth Dearth of the late-twentieth century means that aging Baby Boomers “will have few adult children to fill the role of caregiver, because they produced so few offspring.”<sup>36</sup> Researchers at Vanderbilt are bracing for “intergenerational conflict”

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33. Leslie R. Martin et al., “Longevity Following the Experience of Parental Divorce,” *Social Science and Medicine* 61 (2005): 2177–89; see also Mark D. Hayward and Bridget K. Gorman, “The Long Arm of Childhood: The Influence of Early-Life Social Conditions on Men’s Mortality,” *Demography* 41 (2004): 87–107.

34. See Paul R. Amato and Danelle D. DeBoer, “The Transmission of Marital Instability Across Generations: Relationship Skills or Commitment to Marriage?” *Journal of Marriage and Family* 63 (2001): 1038–51.

35. U.S. Bureau of the Census, *Statistical Abstract of the United States*, 2010 edition, Table 134.

36. See Peter A. Morrison, “The Current Demographic Context of Federal Social Programs,” N-2785-HHS/NICHHD, The RAND Corporation, September 1988, pp. 9–12.

over escalating nursing-home costs.<sup>37</sup> An international team analyzing nursing-home care in a 2005 study highlights the importance of marital status for aging men and women: in the first place, “married adults [are] healthier than unmarried adults within every population group (including age, sex, race, or ethnic groups) and within groups with similar health indicators (whether they [are] smokers, disabled, or physically inactive, for example)”; in the second place, even when they do suffer from poor health, “married older people are less likely to enter a nursing home [than are unmarried peers] because their spouses are often available to care for them.”<sup>38</sup>

Even if not dealing with a long-term disability that might necessitate admission to a nursing home, aging Americans with no spouse and few or no children will find it exceptionally costly and difficult to deal with an illness requiring hospitalization. After poring over Medicare records for more than 609,000 patients, a research team at Harvard concludes that, compared to peers without spouses, elderly patients with spouses experience decidedly “shorter lengths of stay” in the hospital. The researchers document this pattern of shorter hospital stay for patients with spouses for both men and women, though the pattern was particularly pronounced for men. “Not having a spouse at home,” the authors of the new study suggest, “may impede discharge.” In this 2003 study, the researchers compare only the married and the widowed, in part because divorce and cohabitation are “currently rare among the elderly.” But these Harvard researchers see divorce and cohabitation rapidly “becoming more common” among older Americans. Consequently, they anticipate that “as the fraction of the elderly population that is married declines, the impact of marital status on health-care choices could be quite important. . . . Spouses, after all, are far more than just help at home: they are partners in the planning of one’s life and the confrontation of adversity.”<sup>39</sup>

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37. Wayne A. Ray et al., “Impact of Growing Numbers of the Very Old on Medicaid Expenditures on Nursing Homes: A Multi-State, Population-Based Analysis,” *American Journal of Public Health* 77 (1987): 699–703.

38. Kevin Kinsella and David R. Phillips, “Global Aging: The Challenge of Success,” *Population Bulletin* 60.1 (2005): 3–39.

39. Theodore J. Iwashyna and Nicholas A. Christakis, “Marriage, Widowhood, and Health-Care Use,” *Social Science and Medicine* 57 (2003): 2137–47.

The impact of marital status on hospitalization stays shows up again in a 2001 British study. Looking at thirty years of data for bed occupancy in health and social facilities in the United Kingdom, the British scholars point to the “much lower use of health and social care beds” by the married than by the unmarried. The researchers, in fact, marvel that the apparent health advantage that married British subjects enjoy over unmarried peers “increased dramatically during the 1970’s, [and] has been maintained since then, so that by 1991, married people represented only 10% of the total population occupying health and social beds in the UK.” The researchers underscore the fact that “this decrease in bed usage among the married occurred despite their continuing, albeit declining, majority status within the general population.” They further emphasize as remarkable “the positive relationship between marriage and health [that] has increased steadily since the 1970’s onwards, despite the challenges to marriage in modern society.”<sup>40</sup> Those challenges to marriage on this side of the Atlantic—where marriage rates continue to tumble even as divorce rates remain high—can only add hundreds of billions of dollars to the already frighteningly annual bill (\$696.5 billion for 2007<sup>41</sup>) for hospitalizing sick Americans.

### **Effects of Maternal Employment and Daycare**

Although the dwindling number of intact marriages deserves first consideration in assessing adverse family trends that drive up health-care costs, it is not the only one deserving scrutiny. Maternal employment merits attention as well, for at least two reasons. In the first place, maternal employment—like out-of-wedlock childbearing—sharply reduces the number of women who give their children the health benefits of breastfeeding. Pediatricians recommend that mothers exclusively breast-feed their babies for six months, and then continue breastfeeding as part of their children’s nutrition for a year.<sup>42</sup> However, officials at the Centers

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40. P. M. Prior and B. C. Hayes, “Marital Status and Bed Occupancy in Health and Social Care Facilities in the United Kingdom,” *Public Health* 115 (2001): 401–06.

41. U.S. Bureau of the Census, *Statistical Abstract of the United States*, 2010 edition, Table 134.

42. See American Academy of Pediatrics, “Policy Statement: Breastfeeding and the Use of Human Milk,” *Pediatrics* 115.2 (2005): 496–506.

for Disease Control and Prevention worry about “the sharp decline in any breastfeeding between 2 and 3 months,” apparently because of mothers’ “return to work and school.”<sup>43</sup> Indeed, a 2003 Ohio University study concludes, “Only 10% of full-time working mothers breastfeed their 6-month-olds compared with almost 3 times that number of stay-at-home mothers.”<sup>44</sup> As already noted, babies deprived of breastfeeding are distinctly vulnerable to a host of problems, especially respiratory illnesses of a sort that often result in costly hospitalization.<sup>45</sup> Researchers at Emory University and the Food and Drug Administration thus have good reason in a 2005 study to stress “reduced health-care costs” when mothers do breastfeed their babies.<sup>46</sup> Unfortunately, at a time when the employment rate for *married* mothers with children age one year or younger stands at 58 percent,<sup>47</sup> these reductions of health-care costs will remain merely hypothetical for too many at-risk children.

Meanwhile, real rather than hypothetical health-care costs will grow as a consequence of employed mothers leaving their children in daycare. For institutional daycare exposes young children to serious risks. “Outbreaks of infectious diseases occur frequently within the daycare setting,” warn researchers at an International Conference on Child Day-Care Health. These researchers see “the elevated risk of acquiring infectious diseases in this setting . . . as an important health issue.”<sup>48</sup> So pronounced is this risk that children in daycare are hospitalized at a rate four-and-a-half times as high as that for children cared for at home.<sup>49</sup> Further quantifying the problems associated with daycare, researchers

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43. Ruowei Li et al., “Prevalence of Breastfeeding in the United States: The 2001 National Immunization Survey,” *Pediatrics* 111 (2003): 1198–1201.

44. Jacqueline H. Wolf, “Low Breastfeeding Rates and Public Health in the United States,” *American Journal of Public Health* 93 (2003): 2000–09.

45. See Bachrach, “Breastfeeding and the Risk of Hospitalization.”

46. Ann DeGirolamo et al., “Intention or Experience? Predictors of Continued Breastfeeding,” *Health Education and Behavior* 32 (2005): 208–26.

47. U.S. Bureau of the Census, *Statistical Abstract of the United States*, 2010 edition, Table 586.

48. Richard A. Goodman et al., “Proceedings of the International Conference on Child Day Care Health: Science, Prevention and Practice,” Supplement to *Pediatrics* 84 (1994): 986–1020.

49. See David M. Bell, “Illness Associated with Child Day Care: A Study of Incidence and Cost,” *American Journal of Public Health* 79 (1989): 479–83.

from the University of Washington focused a 2003 study on “increased utilization of health-care services” among daycare children, when compared to children cared for at home. More specifically, the researchers calculated that compared to peers cared for at home, children placed in daycare were almost three times more likely to have made at least one visit to a doctor’s office (adjusted Odds Ratio, 2.8), twice as likely to have visited an emergency room (adjusted Odds Ratio, 2.0), and almost three times as likely to have received a prescription medication (adjusted Odds Ratio, 2.8). Predictably, “this increased utilization translated into an estimated difference of \$343 per child in total annual health-care expenditures.”<sup>50</sup>

The daycare-related hospitalizations are typically for the insertion of drainage tubes (tympanostomy tubes) in the inner ear because of repeated ear infections. Parents who place their infants in daycare are in fact exposing them to slightly higher risks of recurrent ear infections than mothers who smoke twenty cigarettes a day.<sup>51</sup> Besides ear infections, many other illnesses—including tuberculosis, Hepatitis A and Hepatitis B, meningitis, bronchitis, influenza, rubella, and gastroenteritis—strike daycare children with such frequency that when *Pediatric Annals* devoted a special issue to the problem, the title of the lead editorial rang out: “Day Care, Day Care: Mayday! Mayday!”<sup>52</sup> With almost 60 percent of American preschoolers and 20 percent of all infants and toddlers under the age of two placed in institutional daycare as of 2005,<sup>53</sup> the cry of Mayday should be resounding quite loudly.

The gravity of daycare disease is aggravated by the fact that daycare children are receiving antibiotics at a rate almost four times that of children cared for at home, so incubating “antibiotic-resistant organisms.”

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50. Michael Silverstein, Anne E. Sales, Thomas D. Koepsel, “Health Care Utilization and Expenditures Associated with Child Care Attendance: A Nationally Representative Sample,” *Pediatrics* 111 [2003]: e317–e375.

51. See John L. Ey et al., “Passive Smoke Exposure and Otitis Media in the First Year of Life,” *Pediatrics* 95 (1995): 670–77.

52. Robert A. Hoekelman, “Day Care, Day Care: Mayday! Mayday!” *Pediatric Annals* 20 (1991): 403.

53. Table FAM3.B: “Child Care: Percentage of Children Ages 0–6, Not Yet in Kindergarten by Type of Care Arrangement and Child and Family Characteristics, 1995, 2001, and 2005.” *Forum on Child and Family Statistics*. Federal Interagency Forum on Child and Family Statistics, n.d., <<http://www.childstats.gov/americaschildren/tables/fam3b.asp>>.

Health officials understandably worry that these super-microbes will spread beyond the daycare centers in which they originate, so “increasing the potential for poor outcomes of common infectious diseases” and creating “a serious problem worldwide.”<sup>54</sup>

### **ObamaCare’s Assault on the Family**

Given the epidemiologically indisputable importance of marriage and family-based home life, policymakers serious about reducing health-care costs ought to be concerned with safeguarding and renewing both marriage and family life. But even a casual look at the initiatives put forward by the Obama administration and its Democratic allies in Congress will establish that they are not such policymakers. If anything, President Obama and his allies seem intent on weakening marriage and family life yet further!

First consider the sizable marriage penalties built into the health-care reform packages initially passed by the Democrats in both congressional chambers. Under the initial House version of this reform, if a cohabiting couple earned \$50,000 (\$25,000 each), they would pay only \$3,076 for health care, compared to \$5,160 for a married couple with the same income. But it gets worse: no government subsidies would be available for married couples once their household income reaches four times the official poverty level. So if a hypothetical married couple earns \$64,000 (\$32,000 each) in 2016, their health insurance premiums under this plan are projected to be approximately \$15,000, compared to just \$5,684 for an unmarried couple with the same income. *Washington Times* editorialists found it “impossible to imagine a policy any more anti-family than that.”

The Senate version of health-care reform—the basic framework of what Congress eventually passed—did reduce this marriage penalty somewhat (making the married couple earning \$50,000 pay only 48 percent more than their unmarried counterparts, rather than the 68 percent penalty in the House plan). But then the Senate version hits higher-income married couples with an income-tax surcharge not faced by cohabiting

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54. Sandra J. Holmes, Ardythe L. Morrow, and Larry K. Pickering, “Child-Care Practices: Effects of Social Change on the Epidemiology of Infectious Diseases and Antibiotic Resistance,” *Epidemiological Reviews* 18.1 (1996): 10–26.



couples with the same income: a married couple with \$400,000 in income would pay a \$1,350 tax surcharge that an unmarried couple with the same income would not pay. The *Washington Times* editorialists are on-target in labeling these marriage penalties “worse even . . . than [President Obama’s] broken promises” because “by discouraging traditional marriage, ObamaCare would further undermine the single most important building block of stable communities. That’s about as unhealthy as policy can get.”<sup>55</sup>

Just as unhealthy—even toxic—have been the Obama administration’s initiatives on daycare. Instead of framing a policy reflecting an understanding of the health dangers inherent in daycare and the health advantages of maternal child-care and breastfeeding, the Obama administration has announced that it is increasing by \$1.6 billion the federal daycare block grant, which helps pay for out-of-home childcare. The administration has also proposed doubling the child- and dependent-care tax credit, giving two-income households a bigger tax break for using out-of-home childcare. What do couples who somehow manage to care for their own children—often at considerable sacrifice—receive under the administration’s new policies? Nothing whatsoever. Charles A. Donovan of the Heritage Foundation complains that these new policies “represent more tilting of the tables in favor of only one set of family decisions about child care.” Donovan indeed calculates that the Obama administration may soon be putting as much as “\$900 into the pockets of families that purchase institutional daycare while offering nothing to couples that sacrifice time with each other, or added income, to raise their own children.”<sup>56</sup> Anyone who reads the medical literature knows that the family decisions favored under President Obama’s policies neither foster good health nor help hold down health-care costs.

If President Obama and his allies understand the first law of public policy (“You get more of what you subsidize, less of what you tax”), then it is hard to believe that they genuinely care about health care. The suspicion

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55. “ObamaCare’s Marriage Penalty; Democrats Tax Couples for Saying ‘I Do,’” [editorial], *The Washington Times*, January 14, 2010, p. B2.

56. Charles A. Donovan. “Obama Reignites the Mommy Wars.” McClatchy Tribune News Service, February 3, 2010.

grows that at bottom the health-care initiative is about expanding the power of government and so rewarding left-leaning constituents. If this initiative derived from a genuine concern for health and an authentic desire to control health-care costs, it would not undermine marriage and family life. It would appear, tragically, that leading Democrats were at best disingenuous when they said that in the effort to improve health care, “All ideas are on the table, even the bad ones.” It seems that while bad family-and-marriage-harming ideas were scattered all over their table, not one solid family-strengthening idea was anywhere to be found.

Perhaps leading Democrats are so politically invested in the leviathan welfare state that they dare not affirm the social institution that liberates ordinary citizens from debilitating clientage within that welfare state. Sociologist David Popenoe warns that “the inherent character of the welfare state by its very existence help[ed] to undermine family values or familism—the belief in a strong sense of family identification and loyalty, mutual assistance among family members, and a concern for the perpetuation of the family unit.”<sup>57</sup> Consequently, those who have advanced their political careers through enlarging the welfare state—and those leading the Obama effort to reform health care clearly belong in this category—have done so by harming the family and imperiling all of the health-care benefits that only the family can provide.

If any policymakers are indeed serious about health-care reform that affirms and protects the family, thereby genuinely safeguarding health and reducing health-care costs, they must look elsewhere. They might, for instance, consider the Heritage Foundation’s sane proposal for “chang[ing] laws and regulations at the federal and state level to enable individuals and families to own and control their own health-care policies and to take them from job to job without tax or regulatory penalties” and for allowing “individuals and families [to] be free to choose health plans that accommodate their own ethics and morals.” This, Heritage analysts explain, “means we must also transform Medicare, Medicaid, and SCHIP so that individuals and families have a broad choice of health plans and providers and that those providers are directly accountable to

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57. David Popenoe, *Disturbing the Nest: Family Change and Decline in Modern Societies* (New York: Aldine de Gruyter, 1988), pp. 196–239.

patients for their quality of care.”<sup>58</sup> On a policy-reform table so crowded with possibilities that even Democrats admit that “bad” ideas were in the mix, somehow these good health-care reform ideas got left out.

Also suspicious by its absence are health-reform ideas advanced by family scholar Allan Carlson. Carlson has outlined an entire package of family-friendly tax proposals, including the helpful recommendation that “taxpayers . . . be granted a 25 percent credit against their total FICA tax for each elderly parent or grandparent residing in the taxpayers’ home.”<sup>59</sup> In the longer run, Carlson recommends “prudent steps to dismantle the Medicare-Medicaid regime, so that the real benefits and advantages of life within the natural family can come back into play,” suggesting that “expansion of private medical accounts” might start this process.<sup>60</sup>

Also helpful in allowing “the real benefits and advantages of life within the natural family [to] come back into play” would be ending government regulations currently forbidding insurers to use family-based actuarial data in setting health-insurance rates. Since accurate risk assessment is, in the words of one authority, “at the heart of the insurance system,” it is surely time to allow insurers to consider marital status in issuing health insurance as they already do in writing up policies for auto insurance.<sup>61</sup> Especially at a time when numerous cultural, economic, and political forces work against marriage, allowing individuals who still make their marriage work to enjoy some small financial benefit in paying for health insurance seems not only fair but actuarially justified.<sup>62</sup> As Richard Epstein has pointed out, when lawmakers deny health insurance companies any information about “elements relevant to the accurate pricing of risk” (including marital status and sexual preference), they make people

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58. “Health Care: Statement of Purpose,” *Leadership for America*, The Heritage Foundation, n.d.

59. Allan C. Carlson, *Fractured Generations: Crafting a Family Policy for Twenty-First-Century America* (New Brunswick, N.J.: Transaction Publishers, 2005), p. 130.

60. Allan C. Carlson, “The Natural Family Meets the Moral Hazard at National Health Care Gulch,” *The Family in America*, August 2005, pp. 7–8.

61. See Kenneth S. Abraham, “Efficiency and Fairness in Insurance Risk Classification,” *Virginia Law Review* 71 (1985): 403–51.

62. See Bryce Christensen, “A Calculated Risk: Making Health Insurance an Ally of the Family,” *The Family in America*, December 1998, pp. 2–3.

“more likely to engage in riskier activities,” so endangering health.<sup>63</sup>

No doubt conscientious policymakers can formulate other family-friendly ideas for health-care reform. But these few make a good start. They certainly should replace the bad family-subverting policies that President Obama and the Democratic Congress have advanced.

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63. Qtd. in Carlson, “The Natural Family,” p. 7.