HUMAN WELLBEING, THE NATURAL FAMILY, AND NATURAL LAW

Allan C. Carlson

"In the end, it is *family structure* that matters."

It is not uncommon in America today, especially among academics, to accuse Christians and others identified as "conservative" of suppressing and ignoring the lessons of modern science. The accusations most often involve issues of biological evolution and global warming. In fact, much clearer examples of politicized science, where the empirical evidence is bent and distorted to accommodate ideological needs, can be found among these critics themselves when the subject is the effect of family structure on human health and wellbeing.

An increasingly widespread assumption today is that family structure should not matter relative to good health: all family types are equal; if and when certain family forms appear actually to cause physical harm, ranging from diminished lives to premature death, the response immediately called for is that

* Thank you to Bryce Christensen, Nicole King, and Robert W. Patterson for their help in identifying and analyzing the research results found in this essay.

Communio 41 (Fall 2014).

of crafting new "policy interventions" where state resources and programs attempt to ameliorate the effects of living outside a natural family.

The present article argues, on the contrary, that the actual lesson taught by the biological and social sciences is simple and clear. The path to good health is largely determined by certain behaviors:

- Have the good fortune to grow up in a home with both of your natural parents, who are married;
- Have the good fortune to have numerous siblings;
- Attend religious services weekly, throughout your life;
- Remain sexually chaste until marriage;
- Marry at a relatively young age;
- Remain married and faithful to your spouse throughout your life;
- Have and raise children of your own;
- (For women) Breastfeed your children for extended periods;
- (For women again) Focus your labor first on the home, with outside paid work considered secondary;
- Do not smoke tobacco, nor use illicit drugs, nor drink alcohol to excess.

This list should sound familiar, for it also represents the common lessons about personal behavior taught by Christian social ethicists over the centuries.

The negative lessons regarding human health, as taught by the sciences, are equally clear. To the degree that such matters are within an individual's power of choice, avoid: single parenthood, childlessness, divorce, the "one child" family, the life of the adult singleton, unmarried cohabitation, step or blended families, infant formula, alcohol, tobacco, illegal drugs, secularism, sexual experimentation, and non-marital sexuality.

This list too should sound familiar, for it is also a kind of summary of the dominant social trends of our age. Behaviors that ought to be avoided are not only growing in frequency, they are also commonly defended, or even celebrated as part of a new paradigm of "morality." All the same, the staggering "health crisis" in contemporary America can be largely explained by a shift in family

structure over the last fifty years, from a reasonably strong normative natural family order (excepting the cult of the cigarette) found as late as the mid 1960s to the social and moral chaos of 2014.

OBESITY EPIDEMIC: A CASE STUDY

The evidence backing such generalizations is overwhelming, appearing during recent years in the standard research journals, despite the ideological biases rampant in the academy. Investigations into the causes of obesity, for example, underscore the health-giving effects of the natural family and the consequences of movement away from this manner of life.

Childhood obesity attracts attention because it is a major precursor to adult diabetes, heart disease, and other major health problems. And its incidence has grown quickly over the last half century. Researchers at Wake Forest University note that the child obesity epidemic occurred during a period of significant change in family living arrangements. In 1970, 85 percent of American children lived with married parents; only 66 percent did so in 2010. Over the same forty years, the percentage of children living with a single mother more than doubled, from 11 percent to 23 percent. As they conclude: "children from mother-only households are at substantially increased risk for living in poverty, a major risk factor for childhood obesity and poor health outcomes."[1]

More controversially, the same team reports that child obesity soared while Americans witnessed "a substantial growth in women's labor force participation, increasing from 43 percent in 1970 to 66 percent by 2009." Indeed, other studies have confirmed this close linkage of childhood obesity to maternal employment. A group at Temple University and the University of Minnesota, using a sample of 3,709 parents of adolescents, found that "full-time employed mothers reported fewer family meals, less frequent encouragement of their adolescents' healthful eating, lower fruit and vegetable intake, and less time spent on food preparation, compared to part-time and not-employed mothers."

1. Joseph A. Skelton et al., "Etiologies of Obesity in Children: Nature and Nurture," *Pediatric Clinics of North America* 58.6 (2011): 1333–54.

Unsurprisingly, the same employed mothers were significantly "more likely to have fast food for family meals." In striking contrast, "few differences [in teenage diets] were observed by fathers' employment status."[2] Meanwhile, a team of public health scholars in Scotland emphasizes a similar point, finding that "the number of family meals eaten per week was inversely associated with overweight in the children up to age seven years." Importantly, this tie between mothers' employment and obese children was not a function of income. Indeed, it was the working "mothers of higher socioeconomic status" who were most likely to produce overweight children. Put another way, families cannot buy their way out of the risk of childhood obesity.[3]

Other changes in family structure have contributed to the obesity epidemic. Irish researchers, for instance, report to no great surprise that "parental obesity is a predominant risk factor for childhood obesity." More provocatively, they add, "Children from one-parent families were found to be at significantly higher odds [47 percent] of overweight and obesity than children from two-parent families."[4]

However, the effects of this absence of—most often—fathers pales alongside the risks posed by the absence of siblings. Epidemiologists in Cyprus, Estonia, Sweden, Italy, Hungary, Germany, Spain, and Belgium analyzed data for 12,720 children, ages two to nine, living in these eight countries. Remarkably, they found that single children were 52 percent more likely to be overweight than were children with brothers and/or sisters. Among those ages six through nine, the propensity of young "singletons" to be overweight rose to 70 percent. Such results were "robustly observed." Why? The researchers report that single children are more likely to be in sole-parent homes, more likely to consume sugar, less likely to play outdoors, and more

2. Katherine W. Bauer et al., "Parental Employment and Work-Family Stress: Associations with Family Food Environments," *Social Science and Medicine* 75.3 (2012): 496–504.

3. George Osei-Assibey et al., "The Influence of the Food Environment on Overweight and Obesity in Young Children: A Systematic Review," *BMJ Open* 2.6 (2012): e 001538.

4. Elimear Keane et al., "Measured Parental Weight Status and Familial Correlates with Childhood Overweight and Obesity at Age 9," *PLoS One* 7.8 (2012): e 43503.

likely "to have parents supportive of food as a reward and television in the bedroom."[5]

The same results have been found in the United States. Using data on 17,565 children who entered kindergarten in 1998–99, researchers at Children's Hospital in Los Angeles found that "family structure was significantly associated with the obesity rate"; a relationship that grew ever stronger as the children grew older. Moreover, "[i]n every grade we found that children with no siblings had higher BMI (Body Mass Index) and a higher probability of being obese than children with siblings." Explaining this finding, the research team suggests that brothers and sisters may "serve as a stimulus for child-to-child interactions, cooperative play, or activities that increase the time each child devotes to physical activity."[6]

Still another cause of obesity is family breakdown. In an article entitled "Does Family Instability Make Girls Fat?" researchers at the universities of Houston, Pennsylvania, Iowa, and Louisiana State emphatically answer "yes." Examining the effects of multiple transitions in family structure on teenage Body Mass Index, they discovered no effect on boys; among girls, however, "[a]s relationship instability becomes more common . . . daughters' likelihood of being [overweight/obese] rises."[7]

In sum, family structure matters greatly when the question is obesity. There is "a substantial marriage premium" for children *born to* married couples "in outcomes encompassing cognitive, behavioral, and health domains," including body weight. This advantage was still there when the children reached age five. Conversely, the children of unmarried parents "are . . . significantly more prone to anxiety/depressive symptoms, aggressive behaviors, obesity, and asthma by age five." Moreover, stability was not the issue: even children in "stable non-traditional"

---

5. Monica Hunsberger, "Overweight in Singletons Compared to Children with Siblings," *Nutrition & Diabetes* 2.7 (2012): e 35.

6. Alex Y. Chen and José J. Escarce, "Family Structure and Childhood Obesity, Early Childhood Longitudinal Study—Kindergarten Cohort," *Preventing Chronic Disease* 7.3 (May 2010): A50.

7. Daphne C. Hernandez et al., "Does Family Instability Make Girls Fat? Gender Differences Between Instability and Weight," *Journal of Marriage and Family* 76 (February 2014): 175–90.

settings exhibited significantly higher levels of obesity, when compared to those with "unstable" married parents. In the end, it is *family structure* that matters.[8]

DIVORCE DISORDERS

Examining the origins of poor health more broadly, divorce stands out as a primal cause. For example, an investigation by French, Canadian, and American public health specialists found that children who experience parental divorce report much worse health as young adults, when compared to children growing up in intact households. With data drawn from the Paris metropolitan area in 2005, the team found a strong "association between family disruption in childhood and poor self-perceived general health status." Indeed, such young adults were nearly twice as likely to be experiencing "poor . . . general health status" and 80 percent more likely to report "poor psychological wellbeing."[9] Similarly, health scholars at Boston University found that single men in an American sample—divorced or never married—had a decidedly higher "rate of hospital utilization within thirty days of hospital discharge" than did women. This was a consequence, they showed, of the "social isolation" common to men living without women.[10]

The act of divorce has also been linked to numerous specific health disorders. For example, the occurrence of migraine headaches among children has increased alarmingly over the last thirty-five years. Such headaches are also predictive of future physical and psychiatric ailments. Studying the problem, pediatric researchers from Italy, Austria, and Turkey found that "stressful life events in childhood" were a causal factor; the most prominent

8. Terry-Ann L. Craigie, Jeanne Brooks-Gunn Waldfogel, "Family Structure, Family Stability, and Outcomes of Five-Year-Old Children," *Families, Relationships, and Societies* 1.1 (2012): 43–61.

9. Christelle Rousit et al., "Family Social Environment in Childhood and Self-Rated Health in Young Adulthood," *BMC Public Health* 11 (22 December 2011): 949.

10. Shaula Woz et al., "Gender as Risk Factor for 30 Days Post-Discharge Hospital Utilisation: A Secondary Data Analysis," *BMJ Open* 2.2 (18 April 2012): e 000428.

of these was "a higher rate of divorced parents."[11] An Australian research team, examining an equally alarming increase in adolescent self-harm, traced a source of the problem back to parental divorce and remarriage. "Children who were living in a step or blended family arrangement," they summarized, faced "2.28 times the risk for hospitalization" from deliberate self-harm, when compared to children in intact families.[12]

These negative health effects of divorce last lifetimes, for both the adults and children affected, although such lifetimes tend to be much shorter. In a meta-analysis of 104 studies published between 1955 and 2011, and covering more than 600 million men and women from twenty-four countries, a research team at McGill University found that divorced and separated men and women—at all age levels—faced a mortality "hazard ratio" 51 percent higher than that found among married men and women. For younger age groups, the increase in risk was 60 percent. And despite decidedly more tolerant attitudes toward divorce in 2011 than in 1955, they also found that "the risk of mortality among divorced and separated persons has been relatively stable over time." Emotional and biological currents running much deeper than "public opinion" are clearly at work.[13]

LIVING ALONE, CHILDLESSNESS, AND OTHER PERILS

Other behaviors that deviate from the natural family model also exhibit specific negative health effects. A study of adults in Finland found that "living alone" has a strong statistical linkage to "long-term life dissatisfaction." This orientation to life was, in turn, "an indicator of long-term health hazards," i.e., increased mortality, including suicides and unintentional injuries, work disability, and

11. Aynar Özge et al., "Overview of Diagnosis and Management of Pediatric Headache; Part 1: Diagnosis," *Journal of Headache Pain* 12.1 (February 2011): 13–23.

12. Francis Mitrou et al., "Antecedents of Hospital Admission for Deliberate Self-Harm from a 14-Year Follow-Up Study Using Data Linkage," *BMC Psychiatry* 10 (18 October 2010): 82.

13. Fran Shor et al., "Meta-analysis of Marital Dissolution and Mortality: Reevaluating the Intersection of Gender and Age," *Social Science and Medicine* 75.1 (2012): 10.1016.

coronary heart disease.[14] Bearing a child outside marriage delivers a similar health penalty to the women involved. Measuring the health of women at age forty and using an American sample of women who experienced a first birth outside of marriage before age thirty-six, the researchers found the single mothers to be in significantly poorer health, compared to their married peers.[15]

Tellingly, not having children at all also carries its own health penalty. Australian researchers at Deakin University found that "childless women reported statistically significant poorer general health, vitality, social functioning, and mental health." Moreover, this was not just a result of "hopes unfulfilled" or age. Even "young women who intended to remain childless reported significantly poorer mental health compared to young women who intended to mother."[16] Even the number of hours worked by husbands compared to wives has remarkable effects. For example, men with wives who work "moderately long" (41–49) hours per week have significantly worse health than husbands with wives working forty hours or less. For women, the health penalty comes to those with husbands who work *less than* ten hours a week, or not at all. Meanwhile, "women married to husbands working *very long* (fifty-plus) hours have the highest predicted health score."[17]

Similar results emerge in other health domains. Preterm—or early—births (PTB), for example, are "important" precursors to "serious neo-natal morbidity, severe childhood disability, and perinatal and neonatal mortality." And researchers at Oxford, Columbia, and Michigan universities have found that the risk of PTB for women of all ages runs 38 percent higher among unmarried mothers, when compared to their mar-

14. Teemu Rissanen et al., "Biological and Other Health-Related Correlates of Long-Term Life Dissatisfaction Burden," *BMC Psychiatry* 13 (2013): 202.

15. Kristi Williams et al., "Nonmarital Childbearing, Union History, and Women's Health at Midlife," *American Sociological Review* 76.3 (June 2011): 465–86.

16. Melissa L. Graham et al., "An Examination of the Health and Wellbeing of Childless Women: A Cross-Sectional Exploratory Study in Victoria, Australia," *BMC Women's Health* 11 (10 November 2011): 47.

17. Sibyl Kleiner and Eliza K. Pavalko, "Double Time: Is Health Affected by a Spouse's Time at Work?" *Social Forces* 92.3 (2014): 983–1007, emphasis added.

ried peers. Among women ages thirty-six to forty, the odds of PTB were 70 percent higher among the unmarried.[18] The related problem of Low Birth Weight (LBW) also shows the same relationship to family structure. A study of African American women found that while only 2 percent of infants born to married mothers had LBW, 10 percent of those born to unmarried mothers did.[19] Assessing the causes of serious accidental injuries in childhood, British researchers found children significantly more likely to suffer burns and fractured bones in "single-adult households," compared to "two-adult" ones.[20]

TOBACCO, ALCOHOL, AND DISEASE

Poor health driven by alcohol and tobacco use also derives, in part, from considerations of family structure. Concerned that even now "smoking is the leading cause of death" in Canada, a research team studied the "socioeconomic" patterns of smoking in the Great White North. They discovered that when compared to married peers, Canadians who were single, divorced, and separated were almost twice as likely to smoke. Moreover, marital status also predicted how likely a smoker might be able to quit: those who have succeeded are more than twice as likely to be married.[21]

Smoking's substantial negative effects on babies in utero are well documented, including Low Birth Weight, reduced fetal growth, preterm birth, asthma, sudden infant death syndrome, and hyperkinetic disorders. A study in Italy found unmarried pregnant mothers to be 2.3 times more likely than pregnant married women

18. Abdulrahman M. El-Sayed, Melissa Tracy, and Sandro Galea, "Life Course Variation in the Relations between Maternal Marital Status and Preterm Birth," *Annals of Epidemiology* 22.3 (2012): 168–74.

19. Debbie S. Barrington, "The Increasing Protection of Marriage on Low Birth Weight Across Two Generations of African American Women," *Journal of Family Issues* 31.8 (August 2010): 1041–64.

20. Elizabeth Orton et al., "Independent Risk-Factors for Injury in Pre-School Children: Three Population-Based Nested Case-Control Studies Using Routine Primary Care Data," *PLoS One* 7.4 (5 April 2012): e 35193.

21. Daniel J. Corsi et al., "Socioeconomic and Geographical Patterning of Smoking Behaviour in Canada: A Cross-Sectional Multilevel Analysis," *PLoS One* 82 (2013): e 57646.

to use tobacco.[22] Among Australia's relatively poor, those who were "never married or single . . . were . . . significantly more likely to smoke," when compared to their married, low-income peers.[23]

Concerning alcoholic beverages, Finnish researchers have drawn a clear relationship between alcohol-related deaths and "social isolation." When compared to married persons, crude death rates attributable to drink among individuals living alone "were about five-fold higher for men and three-fold higher for women."[24] In America, sociologist Joseph Wolfe reports that when compared to married persons, separated and divorced men and women are significantly more likely to "binge drink," which contributes to a variety of health ailments.[25] A study by researchers at the University of Maryland and Johns Hopkins also found that unmarried African Americans living in urban settings are much more likely to abuse alcohol, to smoke cigarettes, and to employ illegal drugs, when compared to those who are married. Moreover, the protective benefits of marriage here "only translate to those individuals who remain continuously married"; the divorced fall back into substance abuse and poor health.[26]

POSITIVE LESSONS

Shifting from "negative" lessons about health to "positive" ones, the overall story remains the same. Norwegian women who breastfed infants for a total of at least twenty-four months were

22. Laura Lauria, Anna Lamberti, and Michele Grandolfo, "Smoking Behavior Before, During, and After Pregnancy: The Effect of Breastfeeding," *The Scientific World Journal* (March 2012): 154910.

23. Jamie Bryant, Billie Bonevski, and Christine Paul, "A Survey of Smoking Prevalence and Interest in Quitting among Social and Community Service Organization Clients in Australia: A Unique Opportunity for Reaching the Disadvantaged," *BMC Public Health* 11 (26 October 2011): 827.

24. Kimmo Herttua et al., "Living Alone and Alcohol-Related Mortality: A Population Cohort Study from Finland," *PLoS Medicine* 8.9 (20 September 2011): e 1001094.

25. Joseph D. Wolfe, "Age at First Birth and Alcohol Use," *Journal of Health and Social Behavior* 50 (December 2009): 395–409.

26. Kerry Green et al., "Marriage Trajectories and Health Risk Behaviors among Urban African Americans," forthcoming in *Journal of Family Issues*.

nearly *six times* less likely to suffer subsequently from heart attack, high blood pressure, obesity, and diabetes, when compared to women who had not breastfed; and married women were three times *more likely* to meet that target, compared to those who were unmarried or divorced.[27] Similar numbers come from Scotland, this time focused on the benefits of breastfeeding for infants, including dramatic immunological and developmental advantages. Researchers examined the health records for 731,595 babies born between 1997 and 2009. They discovered at the six-to-eight week checkup that 36 percent of the infants born to married women were still being exclusively breastfed, compared to only 19 percent of those with cohabitating mothers, and a mere 9 percent born to single mothers.[28]

Marriage and natural family living deliver other positive gifts, ranging from good diet to good sleep to good education. A Lithuanian study found that "family structure was a significant predictor of nutrition inequalities" among Lithuanian adolescents; specifically, when compared to peers in broken homes, girls who lived in intact families were eating significantly more healthy vegetables and fewer unhealthy snack foods.[29] Canadians found the same pattern among their country-folk: "married individuals and those with children consume fruits and vegetables" significantly more often than do those who are unmarried or have no children.[30]

Inadequate sleep has been closely associated with impaired immune function, excessive body weight, and psychological illness. A recent study conducted in southwest Texas found among a predominantly Hispanic population that "[l]onger sleep

---

27. Siv T. Natland et al., "Lactation and Cardiovascular Risk Factors in Mothers in a Population-Based Study: The HUNT-Study," *International Breastfeeding Journal* 7 (2012): 8.

28. Omotomilola Ajetunmobi et al., "Informing the 'Early Years' Agenda in Scotland: Understanding Infant Feeding Patterns Using Linked Data Sets," *Journal of Epidemiology and Community Health* 68.1 (2014): 83–92.

29. Apolinaras Zaborskis et al., "Trends in Eating Habits among Lithuanian School-Aged Children in Context of Social Equality: Three Cross-Sectional Surveys 2002, 2006, 2010," *BMC Public Health* 12 (19 January 2012): 52.

30. Sunday Azagba and Mesbah F. Sharaf, "Disparities in the Frequency of Fruit and Vegetable Consumption by Socio-Demographic and Lifestyle Characteristics in Canada," *Nutrition Journal* 10 (25 October 2011): 118.

durations were associated with being married," with such women enjoying an especially strong sleep advantage.[31] Returning to Finland, researchers examined the effects of health-enhancing and health-degrading behaviors on schooling. Once again: "The importance of family structure was . . . confirmed, [with] adolescents living with both parents having a greater probability of good educational attainment."[32]

BEATING THE "BIG C"

Remarkably, the very acts of marrying and bringing children into the world have strong anti-cancer effects. Drawn by "an increase in the excess mortality" among the Norwegian unmarried, a research team at the University of Oslo examined the data gathered from 441,556 men and women diagnosed with cancer from 1970 to 2000. They concluded that "[n]ever-married cancer patients appear to have had increasingly poor survival prospects compared to the married over the last four decades." Why? Marriage delivers "social support" and "economic advantages" that encourage "a healthier lifestyle." Persons within a marriage tend to have better "mental health at the time of diagnosis." Persons with spouses are more likely than the unmarried to visit a physician at the first occurrence of symptoms. Most importantly, "[r]aising children appears to have a positive effect on cancer survival, probably because children induce a healthier lifestyle and . . . may provide support during treatment and later."[33]

Other broad health-giving effects related to natural family living have been documented. A study of "social determinants of health across the lifecourse" in San Francisco (!) found an amazingly strong correlation between a childhood spent with

---

31. Alisa B. Kachis and Carmen Radecki Breitkopf, "Predictors of Sleep Characteristics among Women in Southwest Texas," *Women's Health Issues* 22.1 (2012): e 99–e 109.

32. Leena Kristiina Koivusilta et al., "From Childhood Socioeconomic Position to Adult Educational Level—Do Health Behaviours in Adolescence Matter? A Longitudinal Study," *BMC Public Health* 13 (2013): 711.

33. Håkon Kravdal and Astri Syse, "Changes Over Time in the Effect of Marital Status on Cancer Survival," *BMC Public Health* 11 (14 October 2011): 804.

two parents and an adulthood of good health. This held true whether measured by self-report ($p = 0.0003$) or by physical functioning ($p = 0.001$).[34] When viewed through a person's likelihood to utilize basic medical screening, a related result appears: "An individual's marital status was found to affect attendance rates, with non-attenders more likely to be single." Why? "The decision to attend a [medical] screening is often made by the [marital] partner."[35]

Considering cancer, health researchers at Brigham Young University examined over 2.7 million case studies in the USA between 2000 and 2007. They discovered that "Married individuals were significantly more likely to receive a cancer staging [complete diagnostic exam]" than were unmarried peers. The presence of a spouse was again the key.[36] Similarly, Canadian investigators at the University of Toronto and McGill University who studied heart attacks found that "earlier attainment of medical care may be one reason why married men have a lower risk of cardiovascular mortality than their single counterparts." Concerned wives show up once more as a health-giving variable.[37]

FAITH, FAMILY, AND HUMAN THRIVING

Sociologists have long commented that religion is the obverse side of the family coin. When one thrives, so does the other; when one weakens, so does the other. As mediated through the family, belief in God and church attendance do have health-giving effects. Social workers at the University of Michigan, study-

34. Irene H. Yen et al., "A Community Cohort Study about Childhood Social and Economic Circumstances: Racial/Ethnic Differences and Associations with Educational Attainment and Health of Older Adults," *BMJ Open* 3.4 (2013): e 002140.

35. Ruth Dryden et al., "What Do We Know About Who Does and Does Not Attend General Health Checks? Findings from a Narrative Scoping Review," *BMC Public Health* 12 (2012): 723.

36. Ray M. Merrill et al., "Unstaged Cancer in the United States: A Population-Based Study," *BMC Cancer* 11 (21 September 2011): 402.

37. Clare L. Atzema et al., "Effect of Marriage on Duration of Chest Pain Associated with Acute Myocardial Infarction before Seeking Care," *Canadian Medical Association Journal* 183.13 (20 September 2011): 1482–91.

ing a sample of 17,000 high school seniors, found that "student religiosity" (as measured by frequency of church attendance tied to self reports) is "robustly" related to lower levels of smoking, binge drinking, and marijuana use. Moreover, "school religiosity" (measured by the mean of student religiosity scores) has an independent positive influence: "The protective effect of individual-level religiosity against substance use is enhanced in more religious contexts."[38]

Religiosity also plays a strong role in delaying unhealthy teenage sexual behavior. Using 2002–2005 data from the National Survey of Youth and Religion, sociologists found that both "religious salience" (how teens personally felt about the importance of religion) and regular church attendance significantly reduced the odds of teenagers engaging in sexual intercourse. A second study confirmed that result, also finding that teenagers were much less likely to lose their virginity as the religiosity of their friends rose.[39]

Given the proven linkage between bearing children within marriage and good health, it is also important to note that women who report that religion is "very important in their daily life" have both higher intended and higher actual net fertility. Using data from the National Survey of Family Growth for the years 1997 to 2002, researchers found that such women had an average of 2.3 children. Those for whom religion was "somewhat important," 2.1; those not religious, only 1.8.[40]

LONG AND HAPPY LIVES

The ultimate test of good health is longevity: living long and liv-

38. John M. Wallace Jr. et al., "Religiosity and Adolescent Substance Use: The Role of Individual and Cultural Influences," *Social Problems* 54 (August 2007): 308–27.

39. Amy M. Burdette and Terrence D. Hill, "Religious Involvement and Transitions into Adolescent Sexual Activities," *Sociology of Religion* 70.1 (Spring 2009): 28–48; and Amy Adamczyk, "Socialization and Selection in the Link between Friends' Religiosity and the Transition to Sexual Intercourse," *Sociology of Religion* 70.1 (Spring 2009): 5–27.

40. Sarah R. Hayford and S. Philip Morgan, "Religiosity and Fertility in the United States: The Role of Fertility Intentions," *Social Forces* 86.3 (March 2008): 1163–88.

ing well. Once again, family structure is the key variable. A study of male British civil servants found that "[f]or all-cause mortality in men, being unmarried was associated with a higher mortality risk," 77 percent above that of the married. This proved to be the strongest of all "social support" variables.[41] An American survey of 15,646 adult men and women found that "being never-married" was "positively associated with all-cause mortality," a nice way of describing early death.[42] Among a sample of 75,000 English and Welsh adults, investigators found that "[r]elative to men in long-term first marriages, never-married men, widowers, . . . men divorced for between ten and twenty years, and men in long-term remarriages had raised mortality 1991–2001": that is, they were significantly more likely to die. Among women, those who were "nulliparous" (childless) also had higher risk of death, while women who had only one birth "had raised odds of long-term illness," compared to those with larger broods.[43]

Norwegian economist Kjersti Norgård Berntsen summarizes the matter well, including the lessons from changes over recent decades. Using data collected between 1964 and 2007 on aged Norwegians, she found lasting marriage to be the strongest predictor of good health; conversely, "[t]he odds of death are highest for divorcees followed by never married and widowed." In addition, as women abandoned the homemaker role for market labor over this period, they paid a large price: "excess mortality" affected only men in the 1960s; by 2007, women had caught up and were dying at premature ages equal to the men.

All the same, Berntsen also reports that "[r]elative differences in mortality by marital status have increased from 1971–2007." Married people live longer; the unmarried die earlier. Why? She notes the economic advantages to be found in

41. Silvia Stringhini et al., "Socioeconomic Status, Structural and Functional Measures of Social Support, and Mortality: The British Whitehall II Cohort Study, 1985–2009," *American Journal of Epidemiology* 175.12 (June 2012): 1275–83.

42. Chirumathi Sabanayagam and Anoop Shankar, "Income Is a Stronger Predictor of Mortality than Education in a National Sample of U.S. Adults," *Journal of Health, Population, and Nutrition* 30.1 (March 2012): 82–86.

43. Emily M. D. Grundy and Cecilia Tomassini, "Marital History, Health and Mortality among Older Men and Women in England and Wales," *BMC Public Health* 10 (15 September 2010): 554.

marriage: "specialization, economies of scale, and pooling of wealth." More important, though, are the "protective effects of marriage; especially the way that "a spouse may exert control on behavior."[44] Jason Peters, a blogger for the website *Front Porch Republic*, captures the same truth when he routinely labels his wife as "the Counter of Cocktails," the one who keeps him from indulging in the vices that would undermine his health.

PROOF?

The weary reader may now ask: What has been the point of this laborious journey through the tangled, jargon-ridden worlds of social and medical research? The answer: this is one of those exhilarating occasions when a writer can demonstrate the existence of the natural law by relying on the frail statistical constructs of the sciences. God's intent for the creatures formed in his image screams out here: when still young, be chaste; avoid behaviors, foods, and substances throughout your life that would damage your mind and body; on reaching adulthood, marry and remain faithful; become one flesh with your spouse, sexually and economically; bear and raise a good number of children; and guide your family in worship and service to the triune God. Your reward will not only be in heaven; you will also enjoy good health here on earth. This is science talking, not some gray-haired theologian.

The statistics on family disintegration in North America and Europe over the past fifty years are sobering in a different way. While this writer will spare readers these details, it is critical to note that sharp declines in marriage and marital fertility rates, alongside soaring rates of divorce, cohabitation, out-of-wedlock births, and intentional singlehood and childlessness *form a—and arguably* the—*primary cause of the health care crisis in contemporary America* and beyond.

Existing attempts to ameliorate the negative consequences of family structural change always seem to fail. For example, one scheme designed to assist distressed children caught in their

44. Kjersti Norgård Berntsen, "Trends in Total and Cause-Specific Mortality by Marital Status among Elderly Norwegian Men and Women," *BMC Public Health* 11 (6 July 2011): 537.

parents' divorces has been "joint custody." Even in progressive Sweden, though, results are not encouraging. Compared to peers residing in intact homes, twelve-year-old children living in joint custody arrangements still suffer serious and significant deficits in "moods and emotions," "school satisfaction," "parent relations," "peer relations," "autonomy," "self-perception," "psychological well being," and "physical health."[45] Countless others urge new, state-funded initiatives that would deliver "emotional and practical supports," financial aid, and new "support networks." Alas, they are never sufficient. Such efforts to do what intact families had once done inevitably turn to coercion. The new Affordable Care Act ("Obamacare"), for instance, will slap financial penalties on hospitals that "demonstrate higher rates of readmission within thirty days after discharge," a problem largely confined to the unmarried. Even so, otherwise sympathetic analysts admit that "the extent to which readmissions are preventable" by anything other than marriage "is debated."[46]

AN ALTERNATIVE

Actually, we can measure the enormous health-care costs imposed by family breakdown over the past fifty years. The touchstone in this case is Samaritan Ministries. Operating for about a decade as an alternative to health insurance, Samaritan arranges to pool the health-care costs of its members. Monthly gifts (in lieu of insurance premiums) are then made to individual households facing health costs. Those who join this ministry must be professing Christians (cf. Rom 10:9–10; Jn 3:3) and must sign a statement of faith, which resembles the Apostles' Creed. Importantly, members also must agree:

- to attend church regularly (at least three out of four weeks per month);

45. Malin Bergström et al., "Living in Two Homes—A Swedish National Survey of Wellbeing in 12- and 15-Year-Olds with Joint Physical Custody," *BMC Public Health* 13 (2013): 868.

46. Woz, "Gender as a Risk Factor for 30 Days Post-Discharge Hospital Utilisation," e 000428.

- "not to abuse any legal or prescribed substance, [to] abstain totally from illegal drugs, and [to] abstain from tobacco use" (although a celebratory cigar on the birth of a child is specifically excepted);
- to choose either to abstain totally from alcohol consumption (communion wine excepted) or to limit consumption to modest amounts;
- to "[a]bstain from any sexual activity outside of traditional Biblical marriage as designed by God between one man and one woman";
- to "not sue each other in the civil courts or before other government agencies."

All member families must present a statement signed by their pastor or church leader certifying that they meet the above requirements.[47]

At present, this ministry has 34,000 member households, involving 111,000 people. These numbers have doubled over the last three years. This ministry, and others like it, actually won a legal exemption from the rules of "Obamacare." Remarkably, *but predictably*, the cost savings for this form of shared protection are dramatic. Recently, the average family household has made health-care gifts to others in the system of about $325 per month.[48] This is about *one-third* of the cost that a family would pay for comparable, and conventional, coverage under a health insurance plan.[49]

Samaritan Ministries explains this low "monthly share" in several ways: Members are reminded to pray for the member whose need they give to; since reimbursements rather than direct payments are frequently involved, members avoid tests and treatments they believe are unnecessary; and members look for the most cost-effective ways to receive needed medical care. Of course, they also avoid tobacco, alcohol in excess, illegal drugs,

47. *Guidelines for Health Care Sharing: November 2013* (Peoria, IL: Samaritan Ministries, 2013): 14–15.

48. The maximum that a family can receive for any single health-care need is $250,000. A higher cap is available for those joining a "Save to Share" supplemental program.

49. Phone interview with ministry executive James Lansberry (7 April 2014).

and non-marital sexual behaviors, which sharply reduces the incidence of vice-driven disease.

However, the key variable may again be family structure. Samaritan Ministry vice president James Lansberry reports that "well over 90 percent" of members are married couples with children present or older married couples whose children have grown. Cases of intentional single-parenthood (i.e., not caused by a spouse's death) or of divorce and remarriage are rare (although *not* otherwise disallowed) on the membership list.

Recasting this ministry through a cost-accountant's eyes and on a national scale, it appears that *two-thirds* of current American health-care costs would vanish if citizens strove to live in accord with God's plan and the natural law relative to sexuality and family life. More importantly, all persons would also enjoy dramatically better personal health and longer, happier lives. □

Allan C. Carlson *is president of The Howard Center for Family, Religion, and Society in Rockford, Illinois and editor of* The Family in America: A Journal of Public Policy.