WOMEN IN TODAY'S LABOR FORCE

A Woman's View of Women at Work

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Are women to be liberated, only to take on the poorer health common among men? By the turn of the next century, the relative health of women is projected to decline as they increasingly enter the world of paid work and their lives take on some of the advantages and the problems that traditionally have belonged to men. Women's mortality rates from heart and respiratory diseases, for example, are expected to be higher than in the mid-1970's, while the rates for men will be lower. They will die more often from liver cirrhosis at a pace almost equal to that of men. And they will not experience improvements from vascular and digestive conditions as much as men (1). Whether or not these shifts occur will be due in part to those who have professional and institutional responsibility for occupational health. For women more than ever will play out their lives in occupational arenas.

More than half of all women age 16 or more were in the labor force by 1978. Almost 54% of them were married and living with their husbands; one in five of those couples had children under age 6. The rest of the female work force was about equally divided among divorced, separated or widowed, and single. The women in these nontraditional households formed part of that growing share—40%—of adult Americans who now either live alone or have experienced divorce; this compares with 25% in 1972 (2). Furthermore, better than one in ten women workers are heads of families, two-thirds of them have children under 18 years of age.

In short, well over half of the working women have either shared or sole economic responsibility for themselves and younger dependents as well, the role traditionally that has been held by men. Taken together, these changes in American households are bringing shifts in how much and what kinds of paid work women do, as well as what and how much they can buy.

The patterns developed in recent years in women's personal consumption behavior are well known. For example, about a third of all women now smoke; and among those who are separated and divorced, and those who are employed—especially managers, administrators and blue collar workers—up to 55% are smokers. These statistics parallel those of men (3). More than one in four women are problem or potential problem drinkers (4). The average women weighs as much as 20% above her ideal weight and consumes about 400 calories a day more than she needs (5). While she gets about as much regular exercise as man, she engages less in sports activities (6). These "signs of affluence" are health risks which women, as well as men (though in different degrees), carry with them into the occupational setting.

Women, however, bring with them health risks imposed by low income and poverty more than do men. About 30% are individuals or heads of household living in poverty; their diets are 20-30% deficient in calories and almost 50% are deficient in iron, according to

the Health and Nutrition Survey (7). These women are not only particularly vulnerable to economic inflation and recession, to price rises and poor job opportunities, they are also among the first to experience adverse health consequences—more so, if they are pregnant. The unemployment rate is higher for women than for men, especially if they are black or family heads. The majority are in the low paying occupations—ie, clerical and services work—and earn overall no more that 60% of a man's earnings.

When given the opportunities for comparable jobs, women face the same work environment risks as men: asbestos, toxic chemicals, coal, noise, heavy workloads and rotating workshifts. From 1-2 in 10 are now in hazardous job categories.

Whatever the strains at the job, the constraints on women off-the-job are greater than those of men. Working women are less likely to have a spouse or partner to help care for their children. Even when spouses are present, employed women spend more time each week in unpaid work. Overall, they are left with about six fewer hours of free-time per week for recreation or other leisure activities (8).

The health risks of women at work then are not merely the hazards of the job, but include those risks that are part of what it now means to be an affluent American; for example, overeating, drinking and smoking, and lack of vigorous physical activity. They also include low income, undernutrition and sub-standard living conditions. While women have an increasing economic responsibility for themselves and their families, they are having to assume that responsibility with fewer chances to get and hold a well-paying job and at a higher cost in time to themselves.

It is not surprising that such women tend to overeat, drink and smoke to excess, and have elevated blood pressure and serum cholesterol or other forms of chronic illness (9). This pattern is especially true among women in traditionally "male" occupations or with those who attempt a career and run a household (10).

The final dimension in this composite of health concerns for working women relates to their role in human reproduction. Not only is the state of the women's health important, but the health and welfare of the unborn—a part of about 9% of the female work force—must be considered. Yet in spite of additional types of risks, women are denied the means to deal with them more often than not; for example, maternity benefits under employee health plans provide hospital and medical care and disability payments comparable to nonmaternity health conditions for less than 40% of the covered workers.

This overall picture suggests that the task of protecting and improving the health of women workers calls for programs and policies that can help compensate for their health risks. In the most immediate sense, it means that health practitioners teach and reinforce healthful habits and safety practices, refer persons to community resources for child or prenatal care or food stamp programs, and help women understand their rights and entitlements.

More importantly, the health professional should work with management, unions and other groups to initiate and support workplace programs that will improve health-promoting options. These options may include educational programs, more healthful foods in cafeterias and vending machines, segregated smoking areas, exercise breaks, smoking cessation and weight control clinics, child care arrangements, prenatal and other high-risk monitoring, reduction in environmental safety and health hazards, flexible workday scheduling, equalization of health plan benefits and coverage, and the

extension and improvement of unemployment insurance. Support for such changes at the state and national policy levels and by professional associations and responsible agencies will go far toward easing the development of such programs. Work settings that are most familiar to us ought to lead the way.

Improvements in occupational health need a trade-off between women and men. In fact, those that will aid women will also help men, especially those men who are now at high risk. Furthermore, as household and family patterns continue to change, child care will become a problem for single and married men. And they too will benefit from flexible worktime and maternity leaves.

In summary, a woman's view of women at work is no different than any perspective that seeks to enhance the health of persons at work. It takes into account those health risks that are carried into the job world because of one's social status and inherent living conditions. It views biological vulnerabilities and assets within the composite risks of the worksite. It then attempts to design programs to compensate for cumulated risks and to minimize future risks. Although specific programs will vary because employees' risks differ, the program strategy and the goal—health improvements—are the same.

REFERENCES

1. Mushkin, S. and D. Wagner. 1978. Expected Mortality as a Criterion in Health Policy Evaluation. Report No. 12, Public Services Laboratory, Georgetown University, Washington, DC.
2. Munger, F. 1979. The changing political context of American family policy. University of North Carolina Institute for Research in the Social Sciences Newsletter **64** (2).
3. HEW, Office of Smoking and Health. 1979. Smoking and Health; A Report of the Surgeon General, Washington, DC.
4. HEW, Office of the Secretary. 1978. Third Special Report to the US Congress on Alcohol and Health, Washington, DC.
5. Milio, N. 1979. Complementary Policy Options in Primary Care and Ecological Health Improvement Interventions; Working Papers. (Research funded by Health Services Research Center, University of North Carolina, Chapel Hill under a core grant from the National Center for Health Services Research.)
6. National Center for Health Statistics. 1978. Exercise and participation in sports among persons 20 years of age and over; US, 1975. Advancedata **10.**
7. Milio, N. Making Health; Toward A Health Policy Strategy for Prevention. FA Davis, in press, Philadelphia.
8. Owen, J. 1976. Workweeks and leisure. Mo. Labor Rev.
9. Haynes, S. 1978. The relationship of psychosocial factors to coronary heart disease in the Framingham Study. Am. J. Epid. **107**(Part I):362-80, 384-400.
10. Milio, N. (In press).
11. National Center for Health Statistics. 1977. Pregnant workers in the US Advancedata **11.**

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