Preventing Disease: Objectives for the Nation." It also wanted to provide recommendations that could be best addressed by other Federal agencies and by State and local governments. We have recommendations that can be best addressed by the private sector and voluntary organizations. And finally and most importantly, the Task Force presented recommendations which women themselves can best address.

Women's Health: A Course of Action

Social Factors Affecting Women's Health

JACQUELYN H. H. GENTRY, PhD

Dr. Gentry is Chief, Science Communication Branch, National Institute of Mental Health, Alcohol, Drug Abuse, and Mental Health Administration, Rockville, MD. The article is based on her presentation at the National Conference on Women's Health, held in Bethesda, MD, June 17–18, 1986.

THE REPORT OF THE Public Health Service (PHS) Task Force on Women's Health began with a chapter on the social factors affecting women's health. It is really the societal context within which we live that shapes our definitions of health and illness, shapes the way we try to maintain health or deal with illness, defines our access to health services, determines the cost of those services, and influences the character of the service we receive.

When we consider women's health, a natural first level of study is to compare it with men's health, and there we find our initial paradox: You and I probably will live 7 to 8 years longer than our male counterparts, but we will log more doctor visits, more disability days, higher rates of illness, and greater use of health services—even when the statisticians control for pregnancy-related conditions. The biologists postulate some reasons for this paradox, but not all the answers lie in biology—some of them are the result of the way we live.

In the studies that were done for the PHS Task Force on Women's Health, we who worked on the Social Factors Committee reviewed a wide range of research on demographic, economic, and social conditions that affect morbidity and mortality. Our report highlighted findings in five areas:

- cultural and social values and attitudes
- the relationship of economic status to health
- labor force participation, occupation, and health status
- family, household structure, social supports, and health
- interactions with the health care system

Some social factors that influence the health behavior of women and men have a differential effect, and some of the factors seem to be part of the bedrock of our socialization and sex role behaviors. For example, women's greater willingness to report symptoms and seek health services leads to early identification and treatment of illnesses and thus protects our health. We women take fewer risks than men, and that tends to protect us from many accidents and injuries, but the other consequence is that we do not enter into as many competitive activities that lead to fitness and mastery of the environment. In addition, some postulate that society's expectation of more passive and dependent behavior on the part of women is associated with the fact that depression is so much more prevalent among women than among men.

Other social factors influencing our health behavior shift with changes in our society, and we do not always know what direction those influences will take. In recent years we have seen some major changes that influence women's health. Among those changes, we believe that the most important are (*a*) the increasing rates of poverty among women, (*b*) the entrance of large numbers of women into the labor force, and (*c*) the increasing proportion of older women. All of these changes have implications for women's health status, their health behaviors, and their access to health services.

We know that economic disadvantage is associated with health disadvantage, and we know that women are economically disadvantaged relative to men regardless of age, race, ethnicity, education, or employment status. Moreover, we know that the economic gap between women and men is widening, and that more and more women live in poverty. Poor people are likely to face frequent illnesses because of poor nutrition, poor living conditions, high levels of stress, and reduced access to health

care. Then, when they get sick and miss work or lose jobs, they are likely to become even poorer.

For a long time, poverty rates have been especially high among Black, Hispanic, and Native American women—especially those who are single heads of households. And now they are being joined by the "nouveau poor"—white middle-class women raising children alone and older women. Overall, it is alarming to realize that more than three-fourths of the poor in this country are women and children.

The rapid rise in the participation of women in the labor force has been a mixed blessing for women: Work outside the home provides income, status, and self-esteem and generally is associated with good health. But it also brings exposure to occupational hazards and frequently to additional stress— particularly since employed women still assume nearly all responsibility for household management and child care.

Since women have lower rates of employment, more intermittent employment, and lower earning power than men, they are at a disadvantage with regard to health insurance coverage, pension plans, and social security benefits.

I want to highlight some of the Task Force recommendations that address the factors I have mentioned:

First, we recommend longitudinal research to assess how the interaction of social and biological factors affect women's health over the life course. Second, we ask for more attention—in research and service delivery—to the health problems of mid-life and older women.

'Overall, it is alarming to realize that more than three-fourths of the poor in this country are women and children.'

We appeal for efforts to increase access to health care for women who are underinsured, elderly, or isolated socially or geographically.

We recommend that women as individuals—as well as organizations that are interested in women's well-being—do the following:

- Stay informed about issues that affect women's health.
- Promote public education on health matters.
- Participate in the personal and political processes that empower women and promote their health.

Women's Health: A Course of Action

Women's Physical Health and Well-Being

DUANE F. ALEXANDER, MD

Dr. Alexander is Director of the National Institute of Child Health and Human Development, National Institutes of Health, Bethesda, MD. The article is based on his presentation at the National Conference on Women's Health, held in Bethesda, MD, June 17–18, 1986.

Synopsis

A relatively small number of physical disorders are unique to women, are more prevalent or serious in women, or require special prevention or intervention strategies in women. Among the earliest of these to appear developmentally are precocious puberty, for which an effective treatment has recently been developed, and anorexia and bulimia, which are increasing in frequency among young women without effective treatment. Arthritis, diabetes, lupus erythematosus, gallstones, and osteoporosis are other diseases in this category.

Reproductive health concerns are a major focus of women's health. The hundred-fold reduction in maternal mortality related to pregnancy is one of the major public health achievements of this century. Despite effective contraceptives, over half the pregnancies in this country are unintended; thus, solving the related problems of infertility and unintended fertility are research priorities. Improving pregnancy outcome, particularly reducing the rate of prematurity, also needs increased attention.