Combining employment and family in Europe: the role of family policies in health

Lucía Artazcoz1,2,3,4, Imma Cortés1,2,4, Vanessa Puig-Barrachina3,5, Fernando G. Benavides2,3, Vicenta Escribá-Agüir2,6,7, Carme Borrell1,2,3,4

1 Agència de Salut Pública de Barcelona, Spain
2 CIBER en Epidemiología y Salud Pública (CIBERESP), Spain
3 Universitat Pompeu Fabra, Barcelona, Spain
4 Institute of Biomedical Research IDIBAPS (IUB-Sant Pau), Barcelona, Spain
5 Interface Demography–Department of Sociology–Vrije Universiteit–Brussels, Belgium
6 Centre for Public Health Research (Health Inequalities Area), Valencia, Spain
7 Nursing Department, University of Valencia, Valencia School for Health Studies, Regional Ministry of Health, Generalitat Valenciana, Valencia, Spain

Correspondence: Lucía Artazcoz, Agència de Salut Pública de Barcelona, Pl. Lesseps 1, ES-08023 Barcelona, Spain, Tel: 34932384565, Fax: 34932384558; e-mail: lartazco@aspb.cat

Objectives: The objectives of this study were: (i) to analyse the relationship between health status and paid working hours and household composition in the EU-27, and (ii) to examine whether patterns of association differ as a function of family policy typologies and gender. Methods: Cross-sectional study based on data from the 5th European Working Conditions Survey of 2010. The sample included married or cohabiting employees aged 25–64 years from the EU-27 (10,482 men and 8,882 women). The dependent variables were self-perceived health status and psychological well-being. Results: Irrespective of differences in family policy typologies between countries, working long hours was more common among men, and part-time work was more common among women. In Continental and Southern European countries, employment and family demands were associated with poor health status in both sexes, but more consistently among women. In Anglo-Saxon countries, the association was mainly limited to men. Finally, in Nordic and Eastern European countries, employment and family demands were largely unassociated with poor health outcomes in both sexes. Conclusions: The combination of employment and family demands is largely unassociated with health status in countries with dual-earner family policy models, but is associated with poorer health outcomes in countries with market-oriented models, mainly among men. This association is more consistent among women in countries with traditional models, where males are the breadwinners and females are responsible for domestic and care work.

Introduction

Although many studies on the combined effect of employment and housework on health have been performed on women,1,2 recent studies have found that women and men feel equal levels of work–family conflict (WFC)3 and that WFC is as harmful for men as it is for women.4 On the other hand, most existing studies of the relationship between health status and paid and unpaid work have analysed single countries5,6 or have compared a small number of countries and their results are contradictory.7,8 Apart from methodological reasons, these contradictory results could be explained by differences between countries.

According to the time availability approach, to balance work and family demands, longer working hours, which among breadwinners are often a consequence of family financial stress,9,10 are likely to result in a time-squeeze, and consequently in poor health status.11 In contrast, the family demands approach posits that the greater the household demands, the more difficult it is to balance work and family.12 In fact, both approaches are complementary.

To understand the influence of family on health and well-being among workers, family policies that can influence the sexual division of the roles of family caregiver and breadwinner, as well as their associated demands, should be taken into account.13,14 Korpi’s15 typology of family policy models is based on the levels of traditional family support—with a male breadwinner and a female responsible for domestic and family work—and dual-earner support that a country may have. Korpi’s original typology comprises three family policy models: (i) the dual-earner family policy model (Nordic European countries), characterized by intermediate levels of traditional family support, high levels of dual-earner/dual-carer support and with reproduction work actively allocated to the state; (ii) the traditional family policy model (Continental European countries), which has high levels of traditional family support and low levels of support for female participation in the labour force and (iii) the market-oriented family policy model (Anglo-Saxon countries), which is characterized by low levels of both traditional and dual-earner support, with reproduction work considered as a private responsibility and largely allocated to the market. A fourth model has been proposed for post-communist countries, and is characterized by high levels of both traditional and dual-earner support, with high female participation in paid work and a traditional division of housework.16 Finally, Southern European countries are characterized by a strong ‘familialism’, with a family/kinship solidarity model characterized by an asymmetrical gender division of work, low female participation in the labour market, the essential role of women in providing care within kinships and the provision of few care services and poor family subsidies by the state.17

None of the previous studies on the relationship between health status and paid and unpaid work have considered the potential differences between the five family policy models in place in the EU-27 countries. The objectives of this study were: (i) to analyse the relationship between health status and paid working hours and household composition in the EU-27, and (ii) to examine whether patterns of association differ as a function of family policy typologies and gender.
Methods

Data

The data proceeded from the 5th European Working Conditions Survey of 2010, a representative sample of non-institutionalized persons aged ≥15 years who were in employment during the reference period. Details of the survey are reported elsewhere.\textsuperscript{18} For the purposes of this study, we selected a subsample of all married or cohabiting employees aged 25–64 years living in the EU-27 countries (10 482 men and 8882 women).

Variables

Health outcomes

Data on self-perceived health status were elicited by asking respondents to describe their general health as ‘very good’, ‘good’, ‘fair’, ‘poor’ or ‘very poor’.\textsuperscript{19,20} This variable was dichotomized by combining the categories ‘fair’, ‘poor’ and ‘very poor’ to indicate poor self-perceived health, and ‘very good’ and ‘good’ to indicate good perceived health. Subjective well-being was measured using the World Health Organization-Five well-being index, which has been shown to be a reliable measure of emotional functioning and a good screen for depression. A dichotomous variable was created, where a score of ≤50 indicated poor psychological well-being, although not necessarily depression.\textsuperscript{21}

Predictor variables

Data on subjects’ paid working hours were collected using two questions: ‘How many hours do you usually work per week in your main paid job?’ and ‘On average, how many hours a week do you work in job(s) other than your main paid job?’ The responses for each question were summed and grouped into four categories: <30 hrs (part-time work), 30–40 hrs (reference category), 41–50 hrs and >50 hrs (the last two categories were considered long working hours). Household composition was described by recording the number of children at home (0, 1 or ≥2), cohabitation with individuals aged >64 years (yes/no) and partner’s employment status (employed, unemployed, homemaker, retired, unable to work because of sickness or other). ‘Other’ employment statuses included individuals on child-care or other leave, relatives working for a family farm or business, student and other.

Country typologies

Countries were grouped according to an adaptation of Korpi’s typology of family policy models, which was expanded to include two more country typologies and all EU-27 countries according to the classification proposed by Thévenon\textsuperscript{22}: Continental (Austria, Belgium, Germany, France, The Netherlands and Luxembourg), Anglo-Saxon (Ireland and the UK), Eastern European (Czech Republic, Estonia, Hungary, Lithuania, Latvia, Poland, Rumania, Bulgaria, Slovenia and Slovakia), Southern European (Cyprus, Greece, Spain, Italy, Malta and Portugal) and Nordic countries (Denmark, Finland and Sweden).

Adjustment variables

The analysis was adjusted for age, current occupational category, according to the 2008 International Standard Classification of Occupations\textsuperscript{23} 1 digit categories, grouped into three categories, upper (1 and 2), middle (3–5) and lower (6–9) and type of contract (permanent, fixed-term temporary, temporary via an employment agency and no contract). Non-permanent contracts have been associated both with the decision to have children and with poor mental health status.\textsuperscript{24}

Data analysis

First, a bivariate analysis was carried out to test for gender differences in all dependent and independent variables, using the chi-square test for categorical variables and the t-test for age. Second, we fit multiple logistic regression models adjusted for age, occupational category and type of contract. To test for a linear trend between health outcomes and number of children, multivariate logistic regression models were fit, including the predictor variable as a continuous variable, and computing the Wald test. All analyses included weights derived from the complex sample design and were stratified by gender and country group.

Results

General description of the sample

Table 1 shows the general characteristics of the sample. The prevalence of poor health outcomes was lowest in Nordic countries and highest in Eastern Europe. Irrespective of differences in family policy typologies between countries, working long hours was more common among men, and part-time work was more common among women. While the proportion of men working >50 hrs per week was highest in Anglo-Saxon countries (13.5%), the proportion of women working part-time was also highest in these countries (50.2%). In all countries, men were more likely to work in lower employment categories. Working without a contract was more common in Anglo-Saxon and Southern European countries. In all countries, the proportion of men in lower occupational category was higher than women. In Continental and in Southern European countries, men were more likely than women to have permanent contracts.

In Continental and Southern European countries, women were more likely to live with ≥2 children than men. The proportion of individuals living with people aged >64 years was higher in Eastern European countries. In all countries, women were more likely to have an employed partner, whereas the highest proportion of men with homemaker partners was observed in Southern European countries, followed by Anglo-Saxon and Continental countries.

Self-perceived health status

In Continental countries, long working hours were associated with poor self-perceived health status in both sexes, although the magnitude of the association was higher among women. Women from these countries who worked part-time were more likely to report poor self-perceived health status. Moreover, women who lived with individuals aged >64 years or whose partner was unemployed had poorer self-reported health status [adjusted odds ratio (aOR) = 2.14, 95% confidence interval (CI) = 1.24–3.67 and aOR = 1.75, 95% CI = 1.12–2.73, respectively]. Men living with a partner who was unable to work due to sickness were also more likely to report poor health status.

Both paid working hours and household composition were associated with poor self-perceived health status among men from Anglo-Saxon countries. Those who worked >50 hrs per week, lived with children, or were living with a partner who was retired or whose employment status was ‘other’ were more likely to report poor self-perceived health status. Part-time work was associated with good health status among Anglo-Saxon women only (aOR = 0.56, 95%CI = 0.40–0.79).

In Eastern European countries, poor health status was reported by women whose partner’s employment status was ‘other’. In Southern European countries, living with people aged >64 years (aOR = 1.79, 95% CI = 1.00–3.20) and having long working hours (aOR = 2.73, 95% CI = 1.32–5.65 for working >50 hrs per week) were related to poor self-perceived health status among men and women, respectively. Finally, in Nordic countries, paid working hours and
household composition were not associated with poor self-perceived health status, either among men or women (table 2).

**Psychological well-being**

In Continental countries, the associations between psychological well-being and paid working hours and household composition among women were more consistent than among men. Among females, the prevalence of poor psychological well-being increased with the number of paid working hours (aOR = 4.59, 95% CI = 2.48–8.50 for working >50 hrs per week compared with those working 30–40 hrs) and the number of children (aOR = 1.69, 95% CI = 1.36–2.11 for living with ≥2 children). Additionally, as for self-perceived health status, women who lived with an unemployed partner were more likely to report poor psychological well-being (aOR = 2.80, 95% CI = 1.45–5.40, respectively).

As observed for self-perceived health status, poor psychological well-being among Anglo-Saxon males was related to both long working hours and household composition. Men who worked >50 hrs per week, lived with children or lived with a partner who was retired or unable to work due to sickness were more likely to report poor psychological well-being. Conversely, living with a homemaker partner was associated with better well-being. The results in women were similar to those observed for poor self-perceived health status.

Among people from Eastern European countries, men who lived with an unemployed partner or women who lived with a homemaker partner were more likely to report poor psychological well-being. In Southern European countries, long working hours, number of children and living with people older than 64 years were associated with poor well-being in both sexes. Finally, neither paid working hours nor household composition was associated with reported well-being among Nordic males, whereas females were more likely to report poor well-being if they lived with a partner who was unable to work due to sickness or whose employment status was ‘other’ (table 3).

**Discussion**

As far as we are aware, ours is the first study of the relationship between employment and family demands and health status to be carried out in a large, representative sample from the EU-27 countries, and in which, five family policy models are compared. It overcomes some limitations of previous research. For example, family demands were measured through household composition. Although many studies have measured family demands through hours of housework, this indicator tends to be over-reported by both sexes and the factors that influence the degree of over-reporting vary between men and women. Moreover, there are gender differences in the number of work hours allocated to flexible and inflexible housework. Additionally, the study has taken into account partner’s employment status, which may be related to both paid working hours and family demands. Finally, the sample was
Odds ratios are adjusted for all the independent variables.

Among females, but only to poor self-perceived health status among women. Long working hours were related to both health outcomes more consistently associated with poor health outcomes among women. In Continental countries, employment and family demands were largely unassociated with poor health outcomes in both sexes. In Anglo-Saxon countries, the association between employment and family demands and health was mainly limited to men and (iii) in Nordic and Southern European countries, employment and family demands were largely unassociated with poor health outcomes in both sexes.

### Table 2: Association between poor self-perceived health status and paid working hours and household composition stratified by country and sex

<table>
<thead>
<tr>
<th>Employment and family demands</th>
<th>Continental</th>
<th>Anglo-Saxon</th>
<th>Eastern European</th>
<th>Southern European</th>
<th>Nordic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% aOR 95% CI</td>
<td>% aOR 95% CI</td>
<td>% aOR 95% CI</td>
<td>% aOR 95% CI</td>
<td>% aOR 95% CI</td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid working hours a week</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-40 hrs</td>
<td>21.6 1</td>
<td>10.8 1</td>
<td>27.2 1</td>
<td>22.2 1</td>
<td>25.0 1</td>
</tr>
<tr>
<td>&lt;30 hrs</td>
<td>17.2 0.78</td>
<td>0.51-1.21</td>
<td>14.0 1.05</td>
<td>0.53-2.11</td>
<td>17.5 0.91</td>
</tr>
<tr>
<td>41-50 hrs</td>
<td>26.0 1.45</td>
<td>1.20-1.76**</td>
<td>8.6 0.79</td>
<td>0.50-1.26</td>
<td>26.3 1.12</td>
</tr>
<tr>
<td>&gt;50 hrs</td>
<td>29.0 1.80</td>
<td>1.26-2.57**</td>
<td>28.2 4.40</td>
<td>2.82-6.87***</td>
<td>30.3 1.44</td>
</tr>
<tr>
<td>Household composition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>23.5 1</td>
<td>11.9 1</td>
<td>34.9 1</td>
<td>18.0 1</td>
<td>19.4 1</td>
</tr>
<tr>
<td>1</td>
<td>23.2 1.14</td>
<td>0.96-1.38</td>
<td>16.6 2.37</td>
<td>1.52-3.70**</td>
<td>26.1 0.79</td>
</tr>
<tr>
<td>&gt;2</td>
<td>21.3 1.00</td>
<td>0.83-1.21</td>
<td>12.4 1.79</td>
<td>1.14-2.82*</td>
<td>26.4 0.81</td>
</tr>
<tr>
<td>Living with people &gt;64 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>22.7 1</td>
<td>13.2 1</td>
<td>28.7 1</td>
<td>22.4 1</td>
<td>17.3 1</td>
</tr>
<tr>
<td>Yes</td>
<td>27.3 1.26</td>
<td>0.33-4.84</td>
<td>30.0 0.37</td>
<td>0.03-4.44</td>
<td>32.3 1.79</td>
</tr>
<tr>
<td>Partner employment status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>22.6 1</td>
<td>12.0 1</td>
<td>28.3 1</td>
<td>20.7 1</td>
<td>16.2 1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>23.5 0.72</td>
<td>0.47-1.09</td>
<td>9.1 0.70</td>
<td>0.07-6.88</td>
<td>30.1 1.00</td>
</tr>
<tr>
<td>Homemaker</td>
<td>23.1 0.89</td>
<td>0.71-1.13</td>
<td>16.4 1.38</td>
<td>0.87-2.18</td>
<td>25.5 0.89</td>
</tr>
<tr>
<td>Retired</td>
<td>31.7 0.81</td>
<td>0.40-1.66</td>
<td>38.5 8.11</td>
<td>1.05-62.51*</td>
<td>59.0 1.38</td>
</tr>
<tr>
<td>Unable to work due to sickness</td>
<td>41.5 2.00</td>
<td>1.03-3.88*</td>
<td>41.7 3.10</td>
<td>0.77-12.43</td>
<td>38.6 0.90</td>
</tr>
<tr>
<td>Other</td>
<td>163.3 1.30</td>
<td>0.85-2.00</td>
<td>22.2 4.53</td>
<td>1.68-12.27**</td>
<td>16.3 0.87</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid working hours a week</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-40 hrs</td>
<td>25.8 1</td>
<td>19.1 1</td>
<td>29.9 1</td>
<td>18.9 1</td>
<td>15.6 1</td>
</tr>
<tr>
<td>&lt;30 hrs</td>
<td>19.6 1.25</td>
<td>1.05-1.50*</td>
<td>12.9 0.56</td>
<td>0.40-0.79**</td>
<td>29.4 0.94</td>
</tr>
<tr>
<td>41-50 hrs</td>
<td>36.2 2.32</td>
<td>1.69-3.18**</td>
<td>18.5 1.06</td>
<td>0.63-1.79</td>
<td>28.5 0.96</td>
</tr>
<tr>
<td>&gt;50 hrs</td>
<td>51.1 4.80</td>
<td>2.59-8.88***</td>
<td>19.0 1.19</td>
<td>0.51-2.73</td>
<td>36.0 1.24</td>
</tr>
<tr>
<td>Household composition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>28.8 1</td>
<td>15.6 1</td>
<td>33.0 1</td>
<td>15.8 1</td>
<td>20.0 1</td>
</tr>
<tr>
<td>1</td>
<td>22.6 0.86</td>
<td>0.70-1.06</td>
<td>20.5 1.54</td>
<td>1.05-2.62*</td>
<td>31.9 1.00</td>
</tr>
<tr>
<td>&gt;2</td>
<td>19.6 0.81</td>
<td>0.66-0.99</td>
<td>13.1 1.05</td>
<td>0.71-1.54</td>
<td>26.0 0.79</td>
</tr>
<tr>
<td>Living with people &gt;64 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>23.0 1</td>
<td>15.8 1</td>
<td>29.9 1</td>
<td>17.5 1</td>
<td>17.5 1</td>
</tr>
<tr>
<td>Yes</td>
<td>50.6 2.14</td>
<td>1.24-3.67**</td>
<td>21.2 1.28</td>
<td>0.44-3.79</td>
<td>31.4 0.93</td>
</tr>
<tr>
<td>Partner employment status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>22.0 1</td>
<td>15.3 1</td>
<td>27.3 1</td>
<td>18.6 1</td>
<td>16.7 1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>36.3 1.75</td>
<td>1.12-2.73*</td>
<td>21.7 1.43</td>
<td>0.74-2.78</td>
<td>36.6 1.20</td>
</tr>
<tr>
<td>Homemaker</td>
<td>30.0 0.81</td>
<td>0.19-3.56</td>
<td>33.3 2.76</td>
<td>0.29-26.24</td>
<td>35.3 1.61</td>
</tr>
<tr>
<td>Retired</td>
<td>38.9 0.71</td>
<td>0.48-1.07</td>
<td>21.2 1.46</td>
<td>0.60-3.52</td>
<td>46.6 1.05</td>
</tr>
<tr>
<td>Unable to work due to sickness</td>
<td>45.9 1.87</td>
<td>0.92-3.79</td>
<td>22.7 1.98</td>
<td>0.69-5.67</td>
<td>35.0 0.97</td>
</tr>
<tr>
<td>Other</td>
<td>35.0 1.25</td>
<td>0.47-3.36</td>
<td>0.00 0.00</td>
<td>– 60.9 3.69</td>
<td>150.9-0.99**</td>
</tr>
</tbody>
</table>

Adjusted odds ratios (aOR) and 95% confidence intervals (95% CI). 5th European Working Conditions Survey, 2010.

Note: % refers to the prevalence of poor self-perceived health status in each category.

*P < 0.05; **P < 0.01; ***P < 0.001; Wald test with P < 0.05.

Odds ratios are adjusted for all the independent variables.

Restricted to salaried workers, who usually have less flexibility to balance work and family demands.

This study has produced three main findings: (i) in Continental and Southern European countries, employment and family demands are associated with health status in both sexes, although these associations are stronger and more consistent among women; (ii) in Anglo-Saxon countries, the association between employment and family demands and health was mainly limited to men and (iii) in Nordic and Eastern European countries, employment and family demands were largely unassociated with poor health outcomes in both sexes.

### Continental countries

In Continental countries, employment and family demands were more consistently associated with poor health outcomes among women. Long working hours were related to both health outcomes among females, but only to poor self-perceived health status among men, and to a lesser degree than among women. For both sexes, living with ≥ 2 children was related to poor well-being. However, the mechanisms of these associations are likely to differ between sexes.

In Continental countries, which are characterized by strong male breadwinner models, the number of children may represent a financial stress for the family that forces men to work long hours, potentially resulting in poorer health status. In contrast, the double burden of paid and family work could be the main mechanism for the association between job and family demands and poor health outcomes among women.

However, another mechanism could also be relevant among women. The proportion of women living with ≥ 2 children was significantly higher than that among men, which suggests that family financial stress related to number of children may push women into the labour market. In the context of the current economic crisis, the inactivity rate among women has decreased throughout Europe, and women in many countries are now making a considerable contribution to household income. Moreover, living with an
unemployed partner, which is another potential source of family financial stress, was related to both poor health outcomes among women. Finally, it should be noted that women were more likely to have temporary work contracts, which has previously been shown to be related to both economic vulnerability and poorer working conditions. Therefore, a combination of work overload, family stress, was related to both poor health outcomes among men, who generally have the breadwinner role, may be primarily due to family financial stress related to the number of children they live with and not to childcare work. Booth et al. suggested that in UK, women are in a society that views childcare as a private responsibility and is usually assigned to women. Therefore, women's incomes are secondary to men's. Childcare is viewed as a private responsibility and is usually assigned to women. Therefore, the consistent association observed between number of children and poor health status among men, who generally have the breadwinner role, may be primarily due to family financial stress related to the number of children they live with and not to childcare work.

Anglo-Saxon countries

In these countries, employment and family demands were more consistently associated with poor health outcomes among men. Our observation that long working hours are associated with health outcomes among men is consistent with that of a previous study that examined the relationship between long working hours and several health outcomes in countries with different welfare state typologies, in which Anglo-Saxon males were found to have the worst situation. This finding was explained by the forced nature of long working hours, which were related to family responsibilities. Anglo-Saxon countries have a strong male breadwinner model, and women’s incomes are secondary to men’s. Childcare is viewed as a private responsibility and is usually assigned to women. Therefore, the consistent association observed between number of children and poor health status among men, who generally have the breadwinner role, may be primarily due to family financial stress related to the number of children they live with and not to childcare work.
makes it hard for them to combine work and family, by providing little or inappropriate childcare or by institutionalizing low female pay, and then it is hardly surprising that they want to work fewer hours in the market sector to increase hours for domestic work and job satisfaction.

**Eastern European countries**

In some respects, the situation in Eastern European countries resembles that in Nordic countries, with extensive labour-market rights and the availability of care services for parents. Moreover, some countries have additional regulations that limit overtime for parents with children. Consistently, poor health outcomes were not associated with long working hours, number of children or living with people older than 64 years in either sex. This result is consistent with a study that found that Eastern European women reported less WFC than women in the West.17

**Southern European countries**

In Southern European countries, the association between health status and long working hours and number of children was more consistent among women. As in the case of women from continental countries, a selection of women with more children into the labour market may exist. The proportion of women with ≥2 children was higher than among men, and the highest among the countries examined. This is especially striking when we consider the fact that the female fertility rate in Southern Europe is lower than in other Western European countries.37 It has been reported that in the context of the economic crisis, Italian and Spanish women want to stay in the labour market or need to guarantee a second income to maintain the family’s income, for instance to pay the monthly mortgage bill. Therefore, family economic needs may push women into the labour market. This adds to their greater domestic workload in the context of both minimal public childcare support and men’s limited contribution to housework. Moreover, as in continental countries, women were less likely than men to have permanent contracts. As described earlier, the mechanisms of these associations in countries with traditional family models are likely to differ between sexes, resulting from family financial stress, poorer working and contractual conditions and work overload among women, and family financial stress among men.17

Living with people older than 64 years was associated with both health outcomes among men and with poor well-being among women. These results could be explained, not only by caring responsibilities that in Southern European countries are usually assigned to women, but by the dramatic increase in evictions in Southern European countries during the economic crisis, such that many workers are forced to live with their parents, resulting in less favourable living conditions that could adversely affect their health status. However, this is speculative and requires further research.

**Nordic countries**

The Nordic countries’ dual-earner/dual-carer model focuses on professional care and parental sharing, which promotes the employment of mothers. Moreover, the quality of public care services is high and the working conditions of care workers are good.41 Consistent with this, neither paid working hours nor the number of children was associated with poor health outcomes in these countries. This finding is consistent with the study of Boye, who did not find any significant association between well-being and hours of paid work or housework in either men or women. Additionally, living with a partner who was unable to work due to sickness was associated with poor well-being among women, which is consistent with many studies of informal care and health status. These gender differences could be related to the greater involvement of Nordic women in care work, as family responsibilities are still greater among women in these countries.

**Limitations**

This study may be limited by the approach used to classify countries. While various typologies have been proposed for categorizing welfare state regimes, none has been generally accepted as standard. The one used in this article is based on family policies and is consistent with the conceptual framework of this study. While there clearly is variability between countries within each typology, it is probably much lower than the differences between country typologies. Finally, although we have primarily attributed our results to differences in family policies typologies, differences in labour-market policies or cultural factors that are closely related to family policies could also partly explain our findings.

**Acknowledgements**

The authors thank the European Foundation for the Improvement of Living and Working Conditions for access to these data. The European Foundation for the Improvement of Living and Working Conditions and the UK Data Archive bear no responsibility for their further analysis or interpretation.

**Funding**

This research was supported by the European Community’s Seventh Framework Program (FP7/2007-2013, grant agreement number 278173): ‘Evaluating the impact of structural policies on health inequalities and their social determinants and fostering change’ (SOPHIE) project.

**Conflicts of interest**: None declared.

**Key points**

- Previous studies about the combined effect of employment and housework on health have found contradictory results.
- Apart from methodological reasons, these contradictory results could be explained by differences in family and labour market policies between countries.
- In European countries with dual-earner family policy models, long working hours and family demands are largely unassociated with poor health status.
- In the rest of countries, among men, these associations are likely to be the result of their traditional role as breadwinner, whereas among women from countries with traditional family policies, they seem to be explained by the combination of poor working and contractual conditions, work overload and family financial stress that pushes them into the labour market.
- The economic crisis could at least partly explain the more consistent association of long working hours and family demands with health status among women in countries with traditional family policy models.

**References**

21 Bech P, Olsen LR, Kjoller M, Rasmussen NK. Measuring wellbeing rather than the

20 Segovia J, Bartlett RF, Edwards AC. An empirical analysis of the dimensions of


14 Pfau-Effinger B. Welfare state policies and the development of care arrangements.

13 Pfau-Effinger B. Socio-historical paths of the male breadwinner model – an

9 Artazcoz L, Corte`s I, Escribá-Aguir V, et al. Understanding the relationship of long

8 Lahelma E, Arber S, Kivela¨ K, Roos E. Multiple roles and health among British and

7 Strandh M, Nordenmark M. The interference of paid work with household demands

6 Arcas M, Noeva A, Artazcoz L. Gender inequalities in the association between

5 Walters V, McDonough P, Strohschein L. The influence of work, household

4 Krantz G, Berntsson L, Lundberg U. Total workload, work stress and perceived

3 Plantenga J, Remery C. Flexible Working Time Arrangements and Gender Equality—

2 Thévenon O. Family policies in the OECD countries: a comparative analysis. Popul

1 Krantz G. Gendering the comparative analysis of welfare states: an unfinished


Press JE, Townsley E. Wives’ and husbands’ housework reporting. Gender, class, and


van Veldhoven MPM, Beijer SE. Workload, work-to-family conflict, and health:


Artazcoz L, Borrell C, Benach J. Gender inequalities in health among workers: the


Artazcoz L, Artieda L, Borrell C, et al. Combining job and family demands and being


Leschke J, Jepsen M. The economic crisis – challenge or opportunity for gender equality


Booth AL, Van Ours JC. Job satisfaction and family happiness: the part-time work


Plantenga J, Remery C. Flexible Working Time Arrangements and Gender Equality—


Kalwij A. The impact of family policy expenditure on fertility in Western Europe.


Garcia M, Mateo I, Maroto G. El impacto de cuidar en la salud y la calidad de vida

de las mujeres [Impact of caregiving on women’s health and quality of life (in


Costa G, Sabatiniello S. Local welfare in Italy: Housing, employment and child care.


Orloff AS. Gendering the comparative analysis of welfare states: an unfinished