

The Social Context of Women's Health

Trends in educational attainment, employment, reproduction, family composition, and access to health care are propelled by social, economic, and political influences, and these influences shape the roles women maintain in their families and in larger society.

Population Growth

As of 1995, there were 134 million women in the U.S. Their composition by race/ethnicity¹ is:

White	83%
Black	13%
Hispanic	10%
Asian & Pacific Islander	4%
American Indian, Eskimo, & Aleut	1%
Total Number	134 Million

Percents add to more than 100% due to duplication within subcategories.

The population growth rates for men and women are higher among the Hispanic population (3.5% in 1994) than among White non-Hispanic (0.8%) or Black (1.5%) subgroups. It is likely that the growth of the Hispanic population will continue, given that Hispanics make up a large percentage of the population of women of reproductive age.¹

Educational Attainment

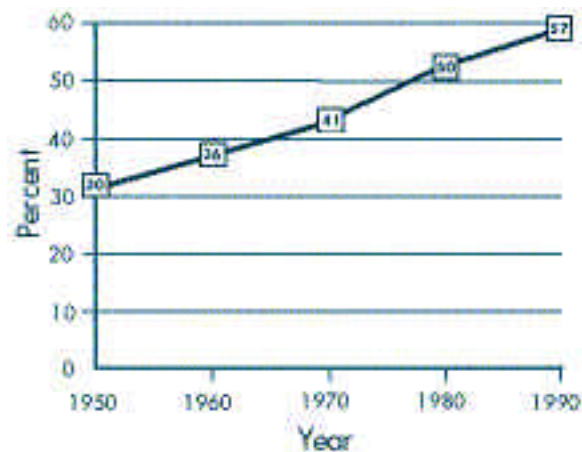
Historically, women have obtained fewer years of education than men, and minority groups have received fewer years of education than Whites. Gaps in educational attainment, however, have been closing in recent years. In 1993, 19% of women and 25% of men aged 25 and older held at least a bachelor's degree. Among women 25-29 years of age, 13% of Blacks and 25% of Whites were college educated.² Although the gaps in educational attainment have narrowed between women

and men and among racial groups, persisting differences may contribute to restricted employment opportunities and decreased earning potential for women, particularly Black women.

Employment

The U.S. Census Bureau reports a dramatic increase in the proportion of women in the labor force since 1950. In 1950, about 30% of working-age women were employed.³ By 1994, this figure reached 59%, though the rate of growth has declined in recent years.

Women's Participation in the Labor Force, U.S.



Increases in the proportion of women with children as well as parents in two-parent families who are employed outside the home highlight the need to address child care issues and support systems for women with multiple responsibilities.

Research to date has examined the impact of paid employment and caregiving on women's physical and psychological health. Some studies have found an association between employment and good health as measured by self-esteem, perceived health and physical functioning, suggesting that particular aspects of the work environment contribute to health for some women.^{4,5,6}

However, with regard to paid employment, excessive employment is linked with poor health. Exacerbations of particular chronic diseases such as hypertension have been associated with employment stresses.⁷ High-demand and low-control jobs, the lack of employment, and absence of family responsibilities have also been associated with poor health.^{6,8} Psychological health also is affected negatively by time constraints, conflicting responsibilities, and non-supportive work environments.⁸

Reproduction

In 1996 the birth rate (14.7 births per 1,000) was the lowest in two decades and the fertility rate (65.5 births per 1000 women aged 15-44 years) was the lowest in a decade.⁹ Fertility rates continue to demonstrate differences by race with Hispanic (104.4) and Black (70.8) women having higher rates than White (64.7) women.⁹

Since the 1970's, the number and proportion of first births to women in their 30s have increased dramatically.¹⁰ Since 1982, the percentage of all women of reproductive age who are voluntarily childless^{*} has increased (6.6% in 1995 vs 4.9% in 1982), whereas the percentage of women who are involuntarily childless has remained constant (2% in 1995 and 1982).¹¹ Among Black, White, and Hispanic women, those with less education are more likely to have given birth than those with a college degree.¹¹

The ways in which leave policies such as the 1996 Family and Medical Leave Act influence the health of women by affecting job promotions, support systems among colleagues who perform the work of the absent employee, and balance of family and work responsibilities are largely unknown.

Family Composition

Increasingly, women and men are delaying marriage.¹² In 1994, the median age at first marriage was 26.7 years for men and 24.5 years for women, compared with 23.2 years for men and 20.8 years for women in 1970.¹² There also has been a substantial increase in the proportion of young men and women who have not yet married. Between 1970 and 1994, the proportion of women aged 30 to 34 who had never married tripled.¹

In 1994, female-headed households accounted for 18% of all families compared with 11% of all families in 1970.¹ Among Black families, the proportion of female-headed households (48%) was notably higher than among White families (14%).¹

Household Economic Status

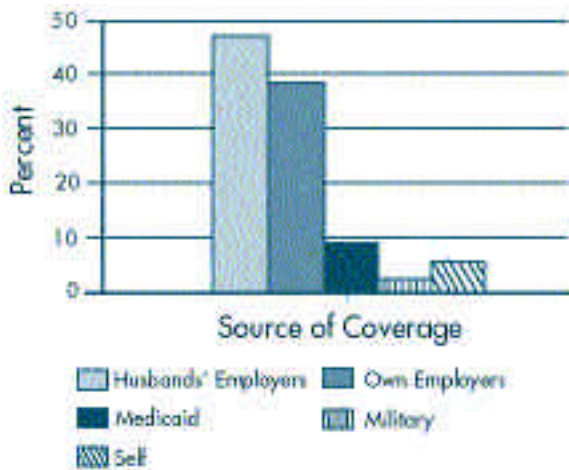
Female-headed households are at an economic disadvantage compared with male-headed and married couple households--median incomes in 1994 for these households were \$18,545, \$29,849, and \$43,129 respectively. The poverty rate is 46% for female-headed families with children compared with 23% for male-headed households, and 9% for married couple families.¹

Financial Access to Health Care

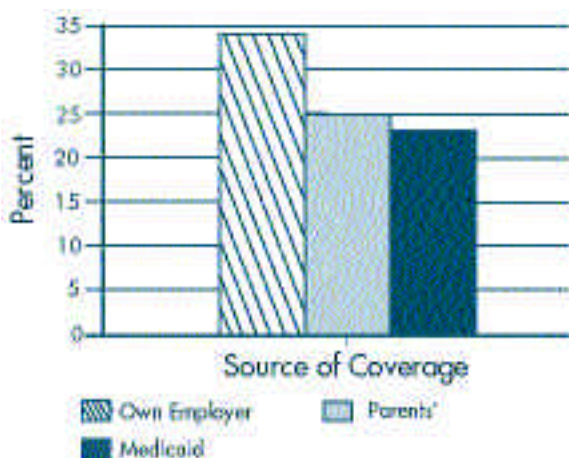
Among women who have health insurance coverage, most are insured through their own or through their husbands' employers.¹¹ About 14 percent (4.3 million) of all women were uninsured in 1995.¹¹ Although health insurance does not guarantee access, it is a prerequisite for obtaining health care services for most women.

The sources of health insurance coverage for married women in 1995 include employers, Medicaid, military, self.¹¹

* Voluntarily childless: fecund (able to have a birth) or using contraception. Involuntarily childless: currently childless, expect to have no children in their lifetimes, sterile for reasons other than contraception, or impaired fecundity.



Other data sources detail health insurance coverage for unmarried women. For those 15-44 years of age in 1995, sources include employers, Medicaid and parents.¹¹



Caregiving

In addition to contributing solely or substantially to their families' incomes by working outside the home, many women are also the primary caregivers of children and aging parents. As with paid employment, excessive and conflicting responsibility are associated with the poorest physical health. Not surprisingly, caring for ill children or spouses also is associated with poor physical health. Prolonged caregiving durations and initial caregiving situations (1 year or less) are associated with various aspects of diminished psychological health by reducing self-esteem and increasing role conflict.¹³

Recent federal and state welfare reforms are designed to promote self-sufficiency. Increasing women's participation in the workforce may contribute to psychological health while expanded role conflict may detract from it. Moreover, few welfare reform provisions address child care issues and access to health care for women. The increased employment of women in low skilled jobs may reduce access to health care by eliminating coverage under Medical Assistance. Increasing child care demands and reduced access to health care may reduce the health of poor women -- an already vulnerable population.

References

- 1 U.S. Bureau of the Census, 1995. *Women in the United States: A Profile. Statistical Brief*. Washington, DC: Bureau of the Census, Economics and Statistics Administration, U.S. Department of Commerce.
- 2 Adams A, 1995. *Educational Attainment in the United States: March 1993 and 1992* (Current Population Reports, Series P20-476). Washington, DC: U.S. Government Printing Office.
- 3 Sepielli PJ, Palumbo TJ, 1995. *Labor force and occupation. Population Profile of the U.S., 1995* (Current Population Reports, Series P23-189). Washington, DC: U.S. Government Printing Office.
- 4 Ross CE, Mirowsky J, 1995. Does employment affect health? *Journal of Health and Social Behavior* 36(3):230-243.
- 5 Pugliesi K, 1995. Work and well-being: Gender differences in the psychological consequences of employment. *Journal of Health and Social Behavior* 36(1):57-71.
- 6 Verbrugge LM, 1985. Gender and health: An update on hypothesis and evidence. *Journal of Health and Social Behavior* 26:156-182.
- 7 Brett KM, Strogatz DS, Savitz DA, 1997. Employment, job strain, and preterm delivery among women in North Carolina. *American Journal of Public Health* 87(2):199-204
- 8 Verbrugge LM, 1986. Role burdens and physical health of women and men. *Women & Health* 11(1):47-77.
- 9 National Center for Health Statistics, 1997. *Births, Marriages, Divorces, and Deaths for 1996*. Hyattsville, MD: National Center for Health Statistics, Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services.
- 10 Ventura SJ, 1989. *Trends and Variations in First Births to Older Women, 1970-86*. Vital and Health Statistics 21(42). DHHS Publication Number: (PHS) 89-1925. Hyattsville, MD: National Center for Health Statistics, Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services.

- 11 Abma J, Chandra A, Mosher W, Peterson L, Piccinino L, 1997. *Fertility, Family Planning, and Women's Health: New Data from the 1995 National Survey of Family Growth. Vital and Health Statistics 23(19)*. Hyattsville, MD: National Center for Health Statistics, Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services.
- 12 Saluter AF, 1997. *Marital Status and Living Arrangements*. Current Population Reports (series P20- 484). Washington, DC: U.S. Government Printing Office.
- 13 Bullers S, 1994. Women's roles and health: The mediating effect of perceived control. *Women & Health* 22(2):11-30.

This **Issue Summary** is one in a set of thirteen, prepared as part of an initiative -- Perinatal and Women's Health: Charting a Course for the Future -- sponsored by the Maternal and Child Health Bureau in partnership with the Women's and Children's Health Policy Center at the Johns Hopkins School of Public Health. The intent of this work is to highlight policy and program areas needing to be addressed to ensure the continuous improvement of health care and services related to perinatal and women's health over the coming decade.

Copies of this and the additional Issue Summaries listed below can be accessed by contacting: National Maternal and Child Health Clearinghouse at 703/356-1964.

1	The Social Context of Women's Health
2	Women's Reproductive Health and Their Overall Well-being
3	Women's Experience of Chronic Disease
4	Depression in Women
5	Abuse Against Women by Their Intimate Partners
6	The Nutritional Status and Needs of Women of Reproductive Age
7	Women's Physical Activity in Leisure, Occupational and Daily Living Activities
8	Effects of Drug and Alcohol Use on Perinatal and Women's Health
9	Effects of Smoking on Perinatal and Women's Health
10	Pregnancy Planning and Unintended Pregnancy
11	Issues in PregnancyCare
12	Health Care Services and Systems for Women of Reproductive Age
13	Public Health Roles Promoting the Health and Well-being of Women

The Social Context of Perinatal and Women's Health

Cynthia S. Minkovitz, Katherine M. Baldwin, Gillian B. Silver

This summary is based on a paper written by Cynthia S. Minkovitz, MD, MPP and Katherine M. Baldwin, MSW.

Development of this summary was supported in part by a Cooperative Agreement (MCU 249386) from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

©Women's and Children's Health Policy Center, Johns Hopkins University, 1998



Women's and Children's Health Policy Center
WCHPC