Gender inequalities in the association between family demands and health in Spanish workers

M. Marta Arcas¹, Ana M. Novoa²,³, Lucía Artazoco²,³,⁴,⁵

¹ Unidad Docente de Medicina Preventiva i Salut Pública Parc de Salut Mar-UPF-ASPB, Barcelona, Spain
² Agència de Salut Pública de Barcelona, Barcelona, Spain
³ Institut d’Investigació Biomèdica (IIB-Sant Pau), Barcelona, Spain
⁴ Universitat Pompeu Fabra, Barcelona, Spain
⁵ CIBER de Epidemiología y Salud Pública (CIBERESP), Spain

Correspondence: Lucía Artazoco, Agència de Salut Pública de Barcelona, Pl. Lesseps 1, 08023 Barcelona, Spain, tel: +34 93 238 45 65, fax: +34 93 238 45 58, e-mail: lartazo@aspb.cat

Background: The aim of this study is to analyse gender inequalities in the relationship between family demands and health in working and cohabiting population. Methods: A total of 9108 men and women aged 25 to 64 years who were employed and cohabiting were selected from the 2006 National Health Survey of Spain. Outcome variables were self-perceived health status, mental health, daily sleeping hours and leisure time sedentarism. Explanatory variables were household size, living with children <15 years, living with adults between 65 and 74 years, living with adults >74 years and having a hired person for housework. Multivariate logistic regression models were fitted, stratified by gender and social class and adjusted for age. Results: Household size was related to poor self-perceived health status, poor mental health and leisure time sedentarism in both men and women manual workers. Moreover, it was also related to sleeping 6 h or less a day among manual worker women. Having a hired person for housework was protective for self-perceived health status in both women and women. Conclusion: Family demands are mainly related to manual workers’ health, among both men and women. Whereas the association between family demands and poor health status among women could be explained by their greater housework and caregiver demands compared with men, among men, given their role as the main breadwinner in the home, it could be due to financial problems. The relationship between family demands and health should be studied in a combined framework of gender and social class.

Introduction

The gendered division of work, together with the socialization of gender and gender inequalities in power relations and in access to resources, explains the health inequalities between men and women.¹ The gendered division of work attributes the main responsibility for domestic work to women, even if they have a paid job, while paid employment and the role of breadwinner are attributed to men.² This pattern is reproduced even in countries with progressive gender attitudes, such as Sweden.³,⁴
Research on health determinants and inequalities often reflects this division. Thus, for men the analysis has generally focussed on occupational social class, forgetting the study of the relationship between their health and the home setting. For women, the research has focussed on the context of multiple roles, emphasizing those of wife and mother, paid work being considered a secondary role.  

Studies based on multiple roles have reported contradictory results. According to the theory of role enhancement, multiple roles have a positive effect on health. There is evidence of better health indicators among women in employment than among full-time housewives, without this being attributed to reverse causality; however, according to the theory of role overload and role conflict, the work overburden resulting from combining family life with a job can have damaging effects on health.  

These contradictions in the literature are mainly due to certain methodological problems, such as an inadequate characterization of each role, failing to consider social class, the restriction of the analysis to a single health indicator or not taking into account the interaction between family demands, gender, social class and occupation.  

In addition to gender, it is also important to include social class as another axis of inequality, since there is evidence of worse health indicators among less favoured social classes. According to the concept of intersectionality, social class and gender are two axes of social inequalities (as well as race, ethnicity, caste and sexuality) that interact with each other and could influence health inequalities.  

In Spain, the study of multiple roles and combining family life with a job is still under-developed and suffers some of the mentioned limitations. A study conducted among Catalan population observed class-related patterns in the differences in health between women in paid employment and full-time housewives, whereby family demands were related with poor health in women of lower educational level but not among those with a high educational level. Another study also performed in Catalonia in 1994 observed an association between family demands and worse health indicators in manual class women, but not in men, nor in women of more advantaged social classes, findings which were not confirmed in the study by Regidor et al. conducted in 2003 in Spanish population.  

Despite the massive incorporation of women into the labour market in recent decades, Spain is a country with conservative gender attitudes and under-developed social and conciliatory policies. This fact, added to the mentioned limitations of the literature on multiple roles, makes it necessary to study the health consequences of combining family life with a job, integrating gender and social class.  

The aim of the present study was to determine gender inequalities in the relationship between family demands and health in working and cohabiting population, and to examine whether the patterns differ by social class.  

Methods  

Study population and design  

This is a cross-sectional study based on the 2006 Spanish National Health Survey (ENSE-2006), conducted in a representative sample of people aged >16 years, residing in Spain in 2006 (N=29 478) and which included questions about domestic and family work, health status, health-related behaviours, consumption of medicines and access to and utilization of health services. Data were collected through face-to-face interviews at home between June 2006 and June 2007. Response rate was 96.1%, 35.4% of which corresponded to individuals who replaced the original selected sample. The population used in the present study were men and women aged 25–64 years old, in paid employment and cohabiting (n=9837). People who were temporarily off work for 3 or more months at the time of the interview were excluded (3.7% of the study population), as were those in part-time work (3%) and people whose social class had not been recorded (0.7%). The final sample included 9108 people.  

Outcome variables  

Health status  

(1) Self-perceived health status: it referred to 12 months prior to the interview. This indicator measures a person’s perception of physical and mental status and has been shown to be a good predictor of death. The variable was dichotomized into poor (regular, poor or very poor health status) and good self-perceived health (good or very good).  

(2) Mental health: it was measured with the 12-item version of the General Health Questionnaire (GHQ-12), designed to screen for the presence or risk of minor psychiatric disorders and extensively used in community and occupational settings. The responses are Likert-type items (0–3). Each item was classified as absent (score <2) or present (score ≥2). The total score was dichotomized into poor (≥3 items present) and good mental health (<3).  

Health-related behaviours  

Behaviours were related to lack of free time for oneself, which could be due to difficulties in combining family life and a job.  

(1) Daily hours of sleep: total number of hours slept per day, dichotomized into ≤6h (this category accounted for 25% of the study population) and >6h.  

(2) Leisure time sedentarism: <20 min of physical activity in leisure time during the previous 2 weeks.  

Explanatory variables  

Family demands  

(1) Number of household members: 2, 3, 4 or >4 members (including the interviewee).  

(2) Living with children <15 years.  

(3) Living with persons between 65 and 74 years.  

(4) Living with persons >74 years.  

(5) Having a hired person for housework.  

Stratification variables  

(1) Sex.  

(2) Social class: based on the occupation of the interviewee. We used the Spanish adaptation of the British Registrar General’s Scale, which classifies occupations into Class I (managerial and senior technical staff and freelance professionals), II (intermediate occupations and managers in commerce), III (skilled non-manual workers), IVa (skilled manual workers), IVb (partly skilled manual workers) and V (unskilled manual workers). The variable was dichotomized as non-manual (classes I, II and III) and manual class (IVa, IVb and V).  

Statistical analysis  

A descriptive analysis of the study variables was carried out, and the distribution by sex was compared within each social class group using chi-squared and Student t-tests. Bivariate and multivariate logistic regression models were fitted for each outcome variable to study its relationship with family demands. OR and their 95% CI were obtained. The existence of linear trend in the variable ‘number of household members’ was examined using the Wald test. All analyses were stratified by sex and social class and adjusted for...
age, as a continuous variable, and the sample weight was taken into account. The analysis was conducted using the statistical package 'SPSS 17.0'.

**Results**

Table 1 presents the characteristics of the sample studied. The prevalence of poor self-perceived health status was significantly higher among women, particularly among those of manual class. Non-manual women and manual men had similar prevalences. With regard to daily hours of sleep, manual women reported sleeping ≤6 h more often than men, differences which were not observed in the non-manual class. The prevalence of sedentarism in manual workers was similar in both genders, and higher than in non-manual workers, in which women showed a higher prevalence. Living with elderly persons was more common in women, independently of their social class, whereas living with children <15 years was only less common among manual women. Finally, having a hired person for housework was much more common in the non-manual class, particularly among women.

With regard to the association between family demand variables and outcome variables in non-manual class (table 2), in men the number of household members showed a significant positive association with having poor self-perceived health, but an inverse one with poor mental health. Moreover, household size was associated with leisure time sedentarism in women (OR = 2.00; 95% CI = 1.26–3.18). In men, living with children <15 years increased in 33% the odds of sleeping ≤6 hours per day and the variable living with persons between 65 and 74 years reduced it in a 57% and showed a significant association with poor mental health. Living with persons >74 years was associated with sleeping ≤6 h per day among women and with leisure time sedentarism among men. Finally, having hired help to do housework was protective for self-perceived health status in both men and women.

In manual workers (table 3), the number of household members presented a significant association with poor self-perceived health in both men (OR = 1.56; 95% CI = 1.07–2.27) and women (OR = 1.85; 95% CI = 1.27–2.70), and with poor mental health (OR = 1.91; 95% CI = 1.06–3.46 and OR = 1.77; 95% CI = 1.16–2.71, respectively). Moreover, having more than four members in the household was significantly related with sleeping ≤6 h daily in women and with leisure time sedentarism in both genders (OR = 1.46; 95% CI = 1.04–2.03 in men and OR = 1.75; 95% CI = 1.21–2.55 in women). Living with children <15 years reduced in 35% the odds of presenting poor self-perceived health among women but increased in 35% the odds of sleeping ≤6 h per day among men. Men and women living with persons between 65 and 74 years were less likely to report ≤6 daily hours of sleep (OR = 0.41; 95% CI = 0.17–0.97 for men and OR = 0.55; 95% CI = 0.32–0.94 for women). Living with persons >74 years presented a significant association with poor mental health in men. Lastly, both men and women with a hired person for housework were less likely to report poor self-perceived health, but significantly only in men (OR = 0.52; 95% CI = 0.31–0.88), and men with this condition were less likely to report ≤6 daily hours of sleep.

**Discussion**

This study, based on a large and representative sample of the Spanish population, provides further evidence of gender inequalities related with combining family life with a job. Unlike earlier studies, it includes both men and women and examines the role of social class. The main results of the present study are as follows: (i) in both manual class men and women, the household size is associated to poor self-perceived health status, poor mental health and leisure time sedentarism; (ii) in manual class women, it is also associated with fewer hours of sleep; and (iii) having a hired person for housework is protective for self-perceived health status in both men and women.

The number of household members appears to be a good estimator of family demands. In manual women, a positive association was found with the four outcome variables, and the variable presents a linear trend in all except daily hours slept ≤6. These findings are consistent with those observed in the studies by Artazcoz et al., although they did not observe associations with poor mental health or leisure time sedentarism. In contrast, Regidor et al. found no association between poor self-perceived health and household size in women, although they did not stratify by, but rather only adjusted for, socio-economic position.

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**Table 1** Characteristics of the sample studied (percentages)

<table>
<thead>
<tr>
<th>General characteristics</th>
<th>Non-manual</th>
<th>Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men (n = 2691)</td>
<td>Women (n = 1686)</td>
</tr>
<tr>
<td>Age in years (mean and SD)</td>
<td>43.4 (9.0)</td>
<td>41.1 (9.1)</td>
</tr>
<tr>
<td>Health status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor self-perceived health</td>
<td>15.6</td>
<td>21.7</td>
</tr>
<tr>
<td>Poor mental health</td>
<td>11.9</td>
<td>18.9</td>
</tr>
<tr>
<td>Health-related behaviours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily hours slept ≤6</td>
<td>25.0</td>
<td>24.3</td>
</tr>
<tr>
<td>Leisure time sedentarism</td>
<td>36.7</td>
<td>43.3</td>
</tr>
<tr>
<td>Family demands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of household members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 members</td>
<td>23.0</td>
<td>26.4</td>
</tr>
<tr>
<td>3 members</td>
<td>27.3</td>
<td>28.8</td>
</tr>
<tr>
<td>4 members</td>
<td>37.7</td>
<td>32.9</td>
</tr>
<tr>
<td>&gt;4 members</td>
<td>12.0</td>
<td>11.8</td>
</tr>
<tr>
<td>Living with children &lt;15 years</td>
<td>51.7</td>
<td>50.4</td>
</tr>
<tr>
<td>Living with persons 65 and 74 years</td>
<td>2.2</td>
<td>5.5</td>
</tr>
<tr>
<td>Living with persons &gt;74 years</td>
<td>3.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Having a hired person for housework</td>
<td>24.0</td>
<td>30.8</td>
</tr>
</tbody>
</table>

Spanish National Health Survey 2006.

a: ≥3 items of GHQ-12 present.
b: ≤20 min of physical activity in leisure time during the previous 2 weeks.

The proportion of missing values was under 3% in all variables except ‘mental health’ where they ranged between 4.2% and 6.7%.
It is noteworthy that there was a consistent association between household size and the health of manual women more than consistent than in earlier studies and fits in with the theories of overburdening and role conflict.7–9,16,25 However, these associations have not been observed among non-manual women, probably because they can afford those resources that can lighten the load of domestic and family work, such as hired home help, kindergartens or residences for dependent people. Most women, probably because they can afford those resources that can lighten the load of domestic and family work, such as hired home help, kindergartens or residences for dependent people. Most of these associations have not been observed among non-manual women, probably because they can afford those resources that can lighten the load of domestic and family work, such as hired home help, kindergartens or residences for dependent people. Most women, probably because they can afford those resources that can lighten the load of domestic and family work, such as hired home help, kindergartens or residences for dependent people. Most women, probably because they can afford those resources that can lighten the load of domestic and family work, such as hired home help, kindergartens or residences for dependent people. Most 19 In Spain, the contribution of women to domestic work is very low:26,28; according to the ENSE-2006, it was of an average of 3.4 h per day among manual women and 0.7 among manual men; in the non-manual classes the corresponding figures were 2.7 for women and 0.8 for men. It should also be considered that economic difficulties are more common in larger households; this can represent a source of pressure for the breadwinners, who would have to work longer hours or accept difficult job conditions to increase income and keep their job.29,30 In fact, in our sample, manual men presented higher maximum job demands to increase income and keep their job.29,30

### Table 2 Adjusted OR for the association between each outcome variable and family demands in non-manual social class

<table>
<thead>
<tr>
<th>Number of household members</th>
<th>Poor self-perceived health status</th>
<th>Poor mental health</th>
<th>Daily hours slept ≤6</th>
<th>Leisure time sedentarism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>2 members 1 b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 members 1.61 (1.12–2.33)</td>
<td>1.14 (0.77–1.69)</td>
<td>1.04 (0.68–1.61)</td>
<td>1.33 (0.90–1.95)</td>
<td>1.54 (1.08–2.19)</td>
</tr>
<tr>
<td>4 members 1.16 (0.80–1.69)</td>
<td>0.92 (0.61–1.40)</td>
<td>0.94 (0.60–1.50)</td>
<td>1.16 (0.77–1.75)</td>
<td>1.43 (0.99–2.07)</td>
</tr>
<tr>
<td>&gt;4 members 2.42 (1.55–3.76)***</td>
<td>1.07 (0.64–1.81)</td>
<td>1.64 (0.94–2.84)</td>
<td>1.37 (0.62–2.27)</td>
<td>2.00 (1.26–3.18)***</td>
</tr>
<tr>
<td>Living with children &lt;15 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.16 (0.86–1.56)</td>
<td>1.13 (0.81–1.59)</td>
<td>1.40 (0.96–2.03)</td>
<td>1.33 (1.02–1.72)*</td>
</tr>
<tr>
<td>Living with persons &gt;65 and 74 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.86 (0.54–1.37)</td>
<td>1.57 (0.98–2.50)</td>
<td>2.37 (1.17–4.80)*</td>
<td>1.38 (0.82–2.32)</td>
</tr>
<tr>
<td>Living with persons &gt;74 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.01 (0.59–1.72)</td>
<td>1.06 (0.60–1.89)</td>
<td>1.97 (0.96–4.03)</td>
<td>0.82 (0.43–1.57)</td>
</tr>
<tr>
<td>Having a hired person for housework</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.73 (0.56–0.96)*</td>
<td>0.66 (0.50–0.87)**</td>
<td>0.96 (0.72–1.28)</td>
<td>0.94 (0.71–1.25)</td>
</tr>
</tbody>
</table>

**Spanish National Health Survey 2006.**

a: OR with 95% CI adjusted for all explanatory variables and age. *P < 0.05; **P < 0.01; ***P < 0.001.

b: Wald test with *P < 0.05.

c: Wald test with *P < 0.01.

### Table 3 Adjusted OR for the association between each outcome variable and family demands in manual social class

<table>
<thead>
<tr>
<th>Number of household members</th>
<th>Poor self-perceived health status</th>
<th>Poor mental health</th>
<th>Daily hours slept ≤6</th>
<th>Leisure time sedentarism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>2 members 1 b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 members 1.24 (0.93–1.67)</td>
<td>1.29 (0.92–1.79)</td>
<td>1.61 (0.98–2.63)</td>
<td>1.28 (0.88–1.87)</td>
<td>0.84 (0.62–1.13)</td>
</tr>
<tr>
<td>4 members 1.24 (0.91–1.69)</td>
<td>1.16 (0.84–1.61)</td>
<td>2.15 (1.29–3.56)**</td>
<td>1.28 (0.88–1.86)</td>
<td>0.98 (0.71–1.34)</td>
</tr>
<tr>
<td>&gt;4 members 1.56 (1.07–2.27)*</td>
<td>1.85 (1.27–2.70)**</td>
<td>1.91 (1.06–3.46)*</td>
<td>1.77 (1.16–2.71)**</td>
<td>0.68 (0.46–1.01)</td>
</tr>
<tr>
<td>Living with children &lt;15 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.81 (0.64–1.03)</td>
<td>0.65 (0.50–0.85)**</td>
<td>0.95 (0.67–1.36)</td>
<td>0.77 (0.58–1.04)</td>
</tr>
<tr>
<td>Living with persons between 65 and 74 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.05 (0.56–1.97)</td>
<td>0.80 (0.50–1.28)</td>
<td>0.35 (0.00–1.59)</td>
<td>1.24 (0.74–2.09)</td>
</tr>
<tr>
<td>Living with persons &gt;74 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.28 (0.80–2.04)</td>
<td>0.90 (0.55–1.47)</td>
<td>2.95 (1.66–5.27)***</td>
<td>0.91 (0.51–1.62)</td>
</tr>
<tr>
<td>Having a hired person for housework</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.52 (0.31–0.88)*</td>
<td>0.69 (0.43–1.10)</td>
<td>1.00 (0.53–1.89)</td>
<td>0.82 (0.47–1.42)</td>
</tr>
</tbody>
</table>

**Spanish National Health Survey 2006.**

a: OR with 95% CI adjusted for all explanatory variables and age. *P < 0.05; **P < 0.01; ***P < 0.001.

b: Wald test with *P < 0.05.

c: Wald test with *P < 0.01.
This was provoked by the increasing costs of housing and mortgages.3,1 Thus, it is plausible to attribute the association between family demands and poor health status in manual men to the role of main breadwinner in situations of economic vulnerability. This is reinforced by the fact that these associations were not observed in studies using populations prior to this debt increase3,16,25 but does occur in the study by Regidor et al.17, which is based on more recent data (2003). In non-manual men, the associations between the outcome variables and household size were inconsistent, presenting a positive association with poor self-perceived health status, but an inverse one with poor mental health. The greater consistency observed among manual class men can probably be explained by the stronger relationship between household size and economic problems and would be in consonance with previous studies showing the relationship between poor mental health and indicators of family demands0 or with low household income.32 Future studies should investigate the possible relationship between economic stress and health more deeply.

Previous studies have found that women with a hired person for housework were less likely to report poor self-perceived health25, but here the findings are more consistent, being in this way in all the groups analysed. In men, hiring help could suggest a household free of economic difficulties, whereas among women it could represent a lightening of domestic workload. However, this is an hypothesis and should be explored in future studies. Moreover, it must be considered that hiring help usually reproduces the gendered division of domestic work. Men tend to view hired help as a way of avoiding their household responsibilities and do not change their minor contribution in domestic work. Women do not change their behaviour as a main responsible at home, they supplement hired help with their own labour and supervise it.33 According to intersections perspective, these patterns could be reproduced in more or less intensity depending on the social class, i.e. our results show a lower effect of hiring help in improving self-perceived health among manual women.

Men of both social classes and manual women living with persons between 65 and 74 years were less likely to report ≤6 daily hours of sleep. There is evidence of worse health indicators in women who are responsible for elderly people.24,33 However, recent studies have observed evidence in the opposite direction among manual women,3,15 which could be explained because elderly, but still autonomous, people could lighten workload by providing emotional and/or instrumental support in the household. However, to test this hypothesis, information on the physical condition of such persons and their role in the household would be needed.

Overall, with regard to living with elderly persons or with children, the associations found were few and followed erratic patterns probably because both situations could be related to health in different directions.6,36 This reinforces the use of the number of household members as the best indicator of domestic and family demands among working and cohabiting population.

The results of this study are in accordance with and reinforce the concept of intersectionality. We have shown that the association between gender and health status is modified by social class and vice versa.39 In the last years, it is being discussed the way public health policies must incorporate this perspective, but the intersectionality approach in health is scarcely considered in quantitative research. The paucity of adequate quantitative methods has led to an imbalance in the literature in favour of qualitative approaches.40 This study adds to the research of health inequalities under a quantitative approach.

In conclusion, family demands are mainly related to manual workers’ health, among both men and women. The reasons could differ by gender due to the gendered division of work. Whereas among women family demands might represent an increase in family and domestic workload and hence overload and role conflicts, among men, as the main breadwinners of the household, economic vulnerability could be a source of stress. In non-manual workers, both men and women, few associations are observed between family demands and the various health indicators analysed, and the pattern is erratic. These results highlight the need to tackle the relationship between health and combining family life and a job, using a framework that jointly considers gender and social class, from both the research and political points of view.

Conflicts of interest: None declared.

**Key points**

- The studies on the relationship of combining work and family life with health have conflicting results, and few of them focus on Southern Europe.
- These contradictions may be due to differences in social and cultural contexts but also to some methodological problems including a lack of an adequate characterization of family and work roles, not considering social class, restricting the analysis to a single health indicator and not taking into account the interaction between family demands, gender, social class and work.
- In this study, carried out in Spain, the number of household members is mainly associated with indicators of poor health status and health-related behaviours among non-manual workers and having a person hired for domestic work is protective for self-perceived health status in men and women of both social classes.
- The gendered division of labor suggests different mechanisms for this finding by gender: the overload and role conflict for women and the role of breadwinner for men.
- These results call attention to the need to face up to the relationship of combining family life and work with health, using a framework that jointly considers gender and social class, from both the research and political points of view.

**References**

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