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Combining a job and children: contrasting the health of married and divorced women in the Netherlands?

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Abstract

The research question of this paper is whether the combination of paid employment and taking care of children promotes or damages the health of married and divorced women in the Netherlands. To answer this question, data are used from 936 women aged 30–54 years who were either living with a partner ($N = 431$) or divorced and living alone ($N = 505$). The findings show that combining a job outside the home and childcare does not harm women's health, irrespective of the length of the working week and the age of the children. In fact, some work–childcare combinations are associated with better health. This is true for both married and divorced women and especially holds true in the case of a part-time job and having older children. Two effects are responsible for the findings: enjoying good health enables mothers to work outside the home (selection effect) and working outside the home promotes mothers' health (health effect).

Keywords: Employment; Childcare; Women; Divorce; The Netherlands

Introduction

In the Netherlands, female labour force participation has increased substantially in recent decades. Whereas no more than a quarter (26%) of all women aged 15–65 worked outside the home in 1960, this proportion had climbed to over a third (37%) in 1989 and to more than a half (51%) in 1999 (NCBS, 1960, 1989, 1999). The increase in female labour force participation may be attributed almost entirely to changes within the group of married women (Pott-Buter, Tijdens, Plantenga, & Janssens, 1998). Whereas in the past it was not customary—or in some cases even forbidden[1]—for married women to have a paid job, a substantial proportion of married women now remain active in the labour market. The percentage of married women with a paid job rose from 7[2] in 1960 to 31 in 1989 and to 45 in 1998 (NCBS, 1960, 1989, 1998a). Note, however, that most of these jobs are part-time. A majority of women decide to work fewer hours following the birth of their first child (Van der Lippe, 1993; Van der Vinne, 1998).

Successive time budget surveys have shown that this strong increase in paid employment among married women has not led to a substantial redivision of unpaid work between men and women (Van den Broek, Knulst, & Breedveld, 1999; Van der Lippe, 1997). Household and family responsibilities are still largely the domain of women. In 1995, women spent an average of 21.9 h a

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[1] In the past, women in certain professions were dismissed on the grounds that they became married or pregnant. Dismissal of female civil servants upon marriage was abolished in 1957; for teachers, the law was abolished in 1958. It was not until 1976 that the Dutch parliament passed a law under which dismissal upon marriage or pregnancy was forbidden for all women (Van Eijl, 1997).

[2] This percentage is given in the population census. The actual percentage of married women in paid employment was higher. Until fairly recently, seasonal employment, domestic services and work by women in family businesses were not included in national censuses; jobs of less than 15 h a week were also excluded (Moreé, 1992). Moreover, a substantial proportion of married women in part-time, paid employment preferred to be registered as housewives (Pott-Buter et al., 1998).

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week on housework and 3.7 h on caring for children and other household members (total 25.6 h); in 1975 this figure was 28.6 h (25.5 h housework and 3.1 h caring duties). Men, on the other hand, spent an average of 2.9 h more per week on household and family responsibilities in 1995 than in 1975: an increase from 8.2–11.1 h a week. Men, moreover, tend to spend these hours on the less tedious aspects of housework and childcare (Knijn, 1992; Van der Lippe, 1993, 1997). These days, for example, they are more inclined to wash the dishes, vacuum the house and put the children to bed, but tasks such as cleaning the kitchen floor, the windows or the lavatories, ironing and changing nappies are primarily left to their wives. So, for married women in general and mothers in particular working outside the home generally means having to take on an additional role: women still tend to assume prime responsibility for homemaking duties, alongside their paid jobs.

Divorce does not improve women's circumstances but leads to undertaking increased household and childcare responsibilities. Divorced women are almost always granted custody over their children. Co-parenthood is still very uncommon in the Netherlands (Kalmijn & De Graaf, 1999). Even today, the most common parental access arrangement is that the children stay with their fathers every other weekend and that public and school holidays are divided amongst both parents. This means that as a rule, responsibility for day-to-day childcare is assumed by divorced women, and that they must inevitably combine these duties with paid employment.

It has been said that combining work and children could damage women's health. Having to divide one's attention and time between 'babies and briefcases' could, for example, lead to a conflict of roles and put a strain on women, which in turn could result in fatigue, stress and, eventually, in illness (Van Poppel, 1996). Balancing work and children could, conversely, improve women's health since working outside the home could make a welcome change from the less pleasant activities and situations at home, and vice versa. In this article, we shall examine the effects of combining a job and childcare on the health of married and divorced women aged 30–54 years. The central research question is: Does combining work and children promote or damage the health of married and divorced women?

Past research

The study of the relationship between women's various roles and their state of health is not new (Dutch studies: Bekker, 1995; Guérin, De Heus, & Diekstra, 1997; Groenendijk, 1998; Van Reekum, 1988; Veerman & Verheijen, 1984. Non-Dutch studies: for a review, see Baruch, Biener, & Barnett, 1987; Menaghan & Parcel, 1990; Repetti, Matthews, & Waldron, 1989; Waldron, Weiss, & Hughes, 1998).[3] The main focus in earlier work was women's role as employees and mothers.[4] Studies arrived at the almost unanimous conclusion that combining a job outside the home and childcare *seems* to promote women's health rather than to have a harmful effect on their health. However, in most cases this conclusion is drawn because there appears to be a positive correlation between health status and the two individual roles. In other words, both paid employment and having children are individually and positively related to women's state of health.[5] As a result, working mothers tend to be in better health than housewives. Only a few Non-Dutch studies also found a relationship, either positive or negative, between health status and the combination of employment and motherhood (e.g., Nathanson, 1980; Waldron & Jacobs, 1989).

These findings are often explained by the *role accumulation* hypothesis, namely that each individual role encompasses specific elements that promote people's health. For example, a job outside the home offers social contacts, professional challenges, a sense of responsibility, self-respect and self-worth as well as an income of one's own and less financial dependence on one's (ex-) partner or the state. Childcare, on the other hand, offers intimacy and affection, responsibility for dependents and an opportunity to be of importance to others. People who combine both these roles are able to develop their talents to the full, which is an enriching experience and makes it less likely that they will feel stuck in a rut. Apparently, this welcome variety in one's life outweighs the time and energy one needs to invest in these roles.

Despite the overwhelming consensus between these studies, the findings should be interpreted with due care. Almost all the studies measured women's health at one

[3] Health has several dimensions. The studies we refer to focus on the differences between women in mortality, physical health or psychological distress. Measurement of the latter two greatly differs. For instance, subjective health, chronic diseases, mobility problems, limitations to carry out activities of daily living and the use of medicine, are just a few examples in which physical health is measured.

[4] Some studies also address the role of women as wives, in addition to examining their role as employees and mothers. Note, however, that these studies tend to be interested in the degree to which women's health is *protected* by marriage rather than in the effect on women's health of caring for others, in this case for the partner.

[5] Agreement between the studies is strongest with respect to the positive relationship between women's health and paid employment. There is less agreement regarding the positive relationship between women's health and the presence of children: a number of studies did not find any significant health differences between childless women and mothers (for an overview, see Macintyre, 1992; Ross, Mirowsky, & Goldsteen, 1990).

point in time; possible differences in health status between the groups of women distinguished prior to the time of the survey were not taken into account. As a result, the direction of cause and effect remains open. Paid employment and childcare can be a source of good health. However, it may be a matter of self-selection in the sense that balancing work and children is only an option for women who are in good health in the first place. Even though none of the researchers exclude the possibility that selection effects may have affected their research findings, they still draw the conclusion that a job and motherhood promote women's health.

A positive relationship between having children and health may be partially the result of self-selection. Women who have health problems will be less inclined or may be less able to have children. Two arguments can be put forward in support of the view that self-selection also affects women's labour force participation. First, employers are placing ever-greater demands on the health status of their employees and the selection of employees on the basis of their health is therefore becoming stricter. As a result, people who (continue to) have a job, tend to be in good health. This is the so-called 'healthy worker effect' (Marcus & Siegel, 1982; Nathanson, 1980). A second argument is that the notion persists that it is the duty of men to earn an income for their families. Men with health problems are therefore less likely to stop working of their own accord. For women, on the other hand, having a paid job is still often seen as a personal, voluntary choice. As a result, women in general and mothers in particular are encouraged to withdraw from the labour force, and the decision to devote oneself entirely to housework and childcare is widely respected in the Netherlands. Many women therefore tend to combine a paid job and family responsibilities only if it does not constitute too much of a burden, that is to say, if they are physically and mentally able to cope with 'working a double day'. Given the above, we shall pay explicit attention to possible selection effects when answering our central research question. In the analysis we shall adjust for any health problems that were suffered or contracted in the past.

A second drawback of the studies that have been conducted so far is the simplistic distinction that researchers tend to make between women with and without a paid job and between women with and without children living in the parental home. The health effects of being in paid employment may be related to the level of job and the length of the working week. The above-mentioned positive elements of working outside the home apply primarily to high-level, more 'extensive' jobs; whereas low-level, part-time work tends to be tedious and heavy with limited career prospects and opportunities for personal development. As for childcare, it is expected that the health implications will be related to the age of the children. The younger the children, the more care they need.

Differentiating between type of job and age of the children is particularly relevant when women combine paid employment with childcare. In the Netherlands, most women still give priority to the family. Compared to most other European countries, Dutch women are less inclined to put out a great part of the childcare to someone outside of the household. As a result, their situation on the labour market is usually adapted to the situation at home (Visser, 1999). This is particularly clear immediately after the birth of a child, when an overwhelming majority of women exchange their full-time job for a part-time job (NCBS, 1998b). Under these circumstances, balancing work and children will generally be felt as a welcome relief rather than a heavy burden. Having a full-time—or almost full-time—job in combination with young children may, on the other hand, have a detrimental effect on women's health. However, this relatively small group of women has largely been overlooked in studies that merely distinguish between whether or not women have a paid job and children living at home. In order to determine the extent to which the burden of (combining) a job and children affects women's health, this study will explicitly address the length of the working week and the age of the children.

A final drawback of existing research regards the specific group of women studied. Most studies that examine the health effects of juggling the responsibilities of motherhood and employment tend to study married women only. However, paid employment and family roles often have different implications for divorced women. On the whole, divorced women are more likely to work out of financial necessity and they receive no assistance from a partner in the performance of their homemaking duties. As a result, it is quite likely that the health implications of combining a job and children differ for divorced women and for married women. Therefore, it is important to separately analyse these two groups of women.

Source of data and measuring instruments

The data used have been taken from the research programme *Scheiding in Nederland* (Divorce in the Netherlands, SIN). For the purpose of this programme, interviews were held with 2346 people aged 30–75 years in the second half of 1998. The respondents constituted a stratified sample, subsumed under one of the following three categories: (a) first-married, (b) divorced persons who are not remarried, and (c) divorced persons who are remarried. The divorces, in which the two latter groups were involved, do not necessarily refer to first marriages.

The sample was drawn from the population registers of 19 municipalities of varying sizes from all parts of the Netherlands. For more details on the survey, see Kalmijn, De Graaf, and Uunk (2000).

Besides the number of marriages, information is gathered on the number of times respondents had cohabited three years or longer in the past and whether or not they live together with a partner at the time of interview. On the basis of this information, the respondents are regrouped into one of the following two categories: (1) married and unmarried cohabiting couples, for the first time or more, and (2) ever divorced (once or several times) living alone.

Since we are interested in the health implications of labour force participation and childcare, this article will deal exclusively with women aged 30–54. In the sample, data about all the relevant variables were available for 936 women. Given the possible substantial differences between women currently living with a partner (group 1, $N = 431$) and previously partnered women currently living alone (group 2, $N = 505$), separate analyses were carried out for these two categories. We shall not take into consideration the number of times these women were married or lived in a consensual union, nor shall we make a distinction between marriage and extra-marital cohabitation when addressing existing or past relationships. For the sake of simplicity, we shall speak of married women when referring to women who currently have a partner and of divorced women when referring to women who currently do not have a partner.

In the SIN survey, respondents were asked to assess their state of health, the dependent variable in this paper. The question was formulated as follows: "How would you rate your general state of health?" The answer categories were: (1) bad, (2) not too good, (3) reasonable, (4) good, and (5) very good. Although there are several drawbacks to this subjective health indicator, it appears to be an accurate predictor of mortality and it correlates strongly with various objective health measures (Deeg, 1998; Idler & Benyamini, 1997).

The two following dichotomous variables were included with regard to women's paid employment and family responsibilities: the variable *work*, indicating whether the woman concerned had a paid job, and the variable *children*, indicating whether the woman in question had one or more children. These two variables were further subdivided. The category of working women was decomposed by the average number of hours a week in paid employment. Four categories were distinguished: (1) 1–11 h; (2) 12–23 h; (3) 24–35 h; and (4) 36 h or more. Since the number of hours women work outside the home correlates highly with their job level, this latter factor has not been included in the analyses. The variable *children* was broken down on the basis of the age of the youngest child. The following four categories were distinguished: (1) 0–4 years; (2) 5–12 years; (3) 13–18 years; and (4) 19 years or older. This classification is based on the assumption that caring duties diminish as children grow older. The last category consists mainly of women whose children have already left the parental home.

As mentioned, we are interested in the effects of paid employment and childcare on women's health. Since women's state of health can, in turn, affect their decisions to participate in the labour market or to have children, the analyses will adjust for past differences in state of health between the groups of women. In order to measure the existence of past health problems, the SIN survey asked respondents whether they suffered from chronic physical diseases or disabilities that impair their activities of daily living.[6] Their answers (0 = no; 1 = yes) resulted in the dichotomous variable *chronic disease/disability*. The respondents were also asked whether they had ever received treatment from a medical consultant for a period of three months or more, resulting in the creation of the dichotomous variable *prolonged medical treatment* with a value of 1 for women who had undergone such treatment and a value of 0 for those who had not.

The analyses were also adjusted for differences by the woman's age (30–54 years) and by her educational level. This adjustment is necessary because both the state of health itself and the health determinants may be correlated with these two variables. Numerous studies, for example, have shown that people's health deteriorates as they grow older and that the more highly educated are in better health than people with a low level of education (Fengler, Joung, & Mackenbach, 1997; De Klerk & Hessing-Wagner, 1999; Pot & Deeg, 1997). In addition, highly educated women tend to be more active in the labour market, whereas lesser-educated and younger women are more likely to be housewives (Latten & Cuijvers, 1994; Liefbroer & Dykstra, 2000). The level of education was measured with the aid of two questions. Respondents were first asked their highest level of education when they left full-time education. They were then asked whether they had continued their education later in life, and if so which level of education they had ultimately attained. Seven categories were distinguished for both questions, ranging from 'primary education or lower' to 'university education'. Where the level ultimately attained was

[6] Those who reported a chronic disease/disability, were also asked from which age they have this health problem. It turns out that most of them suffer from a chronic illness for quite a long time (mean duration: 12 years).

Table 1
Percentage distribution of independent variables (column percentages)[a]

	Total ($N = 936$)	Married ($N = 431$)	Divorced ($N = 505$)
Married (% yes)	46.0	100.0	0.0
Employed (% yes)			
No job	32.8	36.2	29.9
Working 1–11 h	6.1	7.4	5.0
Working 12–23 h	18.1	21.6	15.0
Working 24–35 h	20.3	16.9	23.2
Working 36 h or more	22.8	17.9	26.9
Children			
Never had children	15.3	10.2	19.6
Youngest child 0–4	10.1	16.3	4.8
Youngest child 5–12	24.5	30.9	19.1
Youngest child 13–18	20.6	17.7	23.1
Youngest child 19+	29.5	24.9	33.4
Chronic disease or physical disability (% yes)	24.5	23.2	25.5
Prolonged medical treatment in past (% yes)	35.1	36.0	34.5
Age			
30–34 years	9.2	11.1	7.5
35–39 years	19.8	22.3	17.6
40–44 years	26.0	28.8	23.8
45–49 years	24.5	20.2	28.1
50–54 years	20.5	17.6	23.0
Level of education attained			
Primary education or less	4.2	3.0	5.1
Lower vocational training	16.5	17.4	15.6
Secondary education	14.3	15.3	13.5
Intermediate vocational training	25.4	26.5	24.6
Higher education	9.7	7.7	11.5
Advanced vocational training	21.0	21.8	20.4
University education	8.9	8.4	9.3

[a] *Source*: SIN '98.

higher than the level achieved in full-time education, the highest level attained was decisive.

Table 1 presents descriptive information on each of the independent variables. At first glance, the employment status of married women is the most striking. The percentage of married women in paid employment (64%) is much higher than the national average (45%), as mentioned in the introductory section. Aside from the differences in the age group considered—30–55 compared with 15–65—one must realise that paid jobs of less than 12 h a week are not included in the national statistics. In our sample, more than 7% of the married women works less than 12 h a week. Furthermore, Table 1 shows that the differences in characteristics between married and previously married women are in accordance with the research results regarding women's likelihood of divorce. Compared to their married counterparts, divorced women are highly educated, more often childless, and less likely to have very young children. It is interesting that the health status of women does not seem to play a key role in the likelihood of divorce. A more or less similar percentage of past health problems are found among both married and divorced women.

Results

Work and health

In the upper part of Table 2, columns 1 and 3 show the average state of health (range: 1 (bad)–5 (very good)) of married and divorced women, respectively, in relation to the average number of hours worked outside the home per week and adjusted for differences in age and level of education. There were clear differences in state of health between working and non-working women: women in paid employment tend to be in better health than full-time housewives ($F = 49.16$, $p < 0.001$). Although this applies to both married and divorced women, health differences between working and non-working women are much greater within the group of

Table 2
Average state of health (range: 1–5) among married and divorced women in the 30–54 year age group, by employment and motherhood status, adjusted for differences in age and education and health differences in the past[a]

	Married ($N = 431$)		Divorced ($N = 505$)	
	adj. for age and education (1)	adj. for age, education and previous health problems (2)	adj. for age and education (3)	Adj. for age, education and previous health problems (4)
Employment status				
Having a job	3.98	3.93	3.90	3.83
Working 1–11 h	3.85	3.87	3.92	3.98
Working 12–23 h	4.01	3.97	3.93	3.90
Working 24–35 h	3.95	3.90	3.96	3.85
Working 36 h or more	4.00	3.92	3.81	3.73
No job	3.65	3.74	3.34	3.50
Motherhood status				
Having children	3.88	3.87	3.75	3.74
Youngest child 0–4	3.87	3.89	3.70	3.73
Youngest child 5–12	3.95	3.89	3.81	3.79
Youngest child 13–18	3.87	3.83	3.80	3.74
Youngest child 19+	3.88	3.89	3.76	3.74
Never had children	3.58	3.70	3.65	3.68

[a] *Source*: SIN '98.

divorced women (married: $F = 14.84$, $p < 0.001$; divorced: $F = 39.97$, $p < 0.001$). Within the group of working women, on the other hand, there appeared to be no significant differences in state of health. This means that the average number of hours worked per week is not related to good or poor health. Differences in the state of health between married and divorced women are greatest among those who do not have a job outside the home and among those who work more than 36 h a week. In both cases divorced women are in poorer health (no job: $F = 7.20$, $p < 0.01$; 36 h or more: $F = 3.26$, $p < 0.10$).

Two explanations can be put forward for the health differences between working and non-working women. One can either argue that working outside the home promotes women's health (the health effect) or that enjoying good health enables women to have a job outside the home (self-selection). Comparing columns 1 and 3 with columns 2 and 4, respectively, shows that both explanations are likely to be valid. In columns 2 and 4 the relationship between having a paid job and one's state of health is adjusted for the two measures of health differences in the past. It appears that health differences between working and non-working women are much smaller after adjustment has taken place. On average, women who have suffered chronic diseases/disabilities and/or prolonged medical treatment in the past are less likely to have a paid job, or else they have a 'small' part-time job of less than 12 h a week. More 'extensive' jobs, on the other hand, tend to be performed by women who have not had health problems in the past. However, health differences between working and non-working women remain significant (married: $F = 8.12$, $p < 0.01$; divorced: $F = 17.45$, $p < 0.001$). In other words, apart from the fact that healthy women are better able to participate in the labour force, having a job also appears to promote women's health.

Children and health

In the lower part of Table 2, columns 1 and 3 show that on average women with children are in better health than women without children ($F = 6.01$, $p < 0.05$). However, this correlation is only significant in the case of married women (married: $F = 6.04$, $p < 0.05$; divorced: $F = 1.07$, $p = 0.302$). When these figures are adjusted for health problems in the past (see columns 2 and 4), we see that the differences in health status may be partially attributed to selection effects: women without past health problems are more likely to decide to have children. However, there still appear to be differences in health between married mothers and childless married women ($F = 2.87$, $p < 0.10$). In other words, apart from the fact that women's state of health appears to be one of the factors determining whether or not they have children, caring for children appears to have a beneficial effect on the health of married women. Furthermore, caring for young children does not seem to put a heavier strain on women's health than caring for older children. The health status of mothers is barely affected by the age of the youngest child. Finally, the greatest health differences between married and divorced women are

found within the group of mothers with the oldest or the youngest children, with divorced women in poorer health. These differences are not significant, however.

Combining work and children in relation to health

We have seen above that having a paid job appears to promote the health of both married and divorced women, regardless of the average number of hours worked per week. However, whether or not these working women also take care of (young) children was not taken into consideration. The positive effect of labour force participation on women's health could therefore be related to the fact that in most cases their employment circumstances are compatible with the situation at home. This could mean that most women who work outside the home are either childless or have older children, whereas most mothers with young children have (temporarily) given up their jobs, or have a part-time job that can be easily combined with their caring duties. In the latter case, a job may be a welcome change from the lives these women lead—and thus beneficial to their health—rather than a heavy additional burden. In order to determine whether this is actually the case, we have examined health differences between women based on the pressures of balancing 'babies and briefcases'. Figs. 1 and 2 present the average state of health of married women in relation to both their employment and family situation, controlling for age and educational differences (Fig. 1) and previous health status (Fig. 2). Figs. 3 and 4 show similar results for divorced women.

What is immediately apparent from Figs. 1 and 3 is that the positive relationship between paid employment and health is manifested primarily among married and divorced mothers with children aged five and over. Health differences between working and non-working mothers are most marked when the children are over eighteen ($F = 51.55$, $p < 0.001$), followed by mothers whose youngest child is aged 13–18 ($F = 13.74$, $p < 0.001$). The smallest, yet significant health differences are found among mothers whose youngest child is aged 5–12 ($F = 4.07$, $p < 0.05$). Comparing Figs. 1 and 3 with Figs. 2 and 4, respectively, shows that these health differences may be attributed in part to health selection: in order to be able to combine a job with caring for children, women need to enjoy good health. After adjustment for this fact, the health differences found between working and non-working mothers with a youngest child aged 5–12 years is no longer significant. However, if the youngest child is older than twelve, health differences persist (age youngest child nineteen years or older: $F = 22.20$, $p < 0.001$; age youngest child 13–18 years: $F = 11.33$, $p < 0.01$). So, combining a job

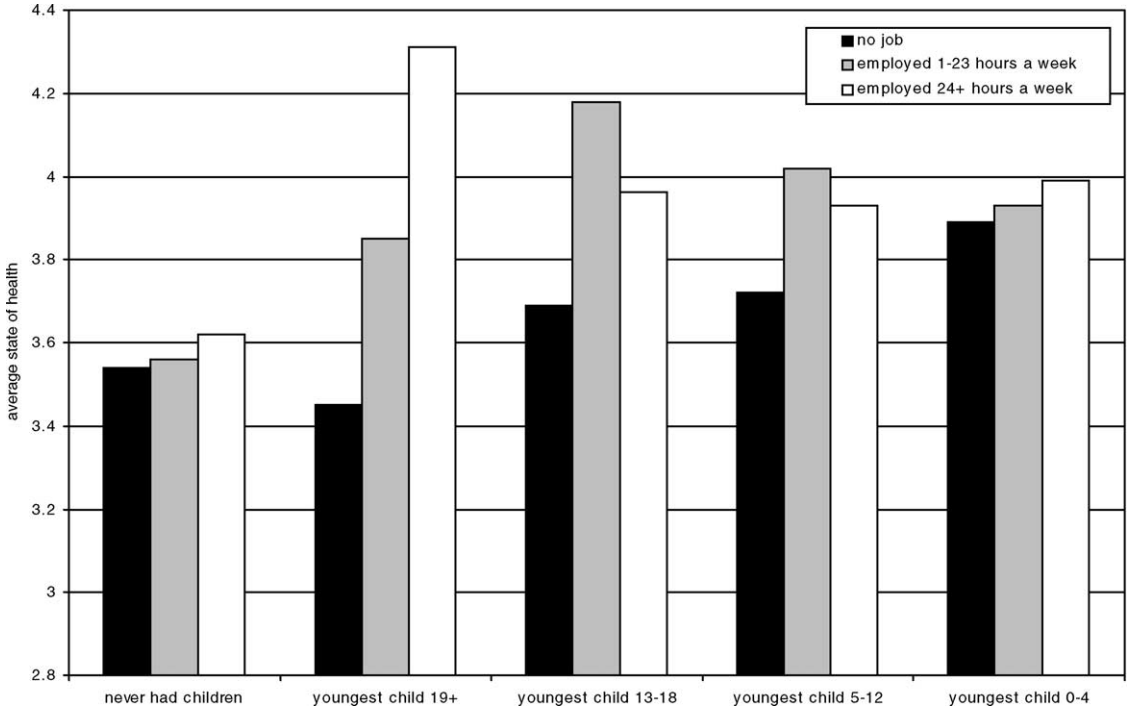

Fig. 1. Health differences among married women in the 30–54 year age group, by family and job situation, adjusted for differences in age and education.

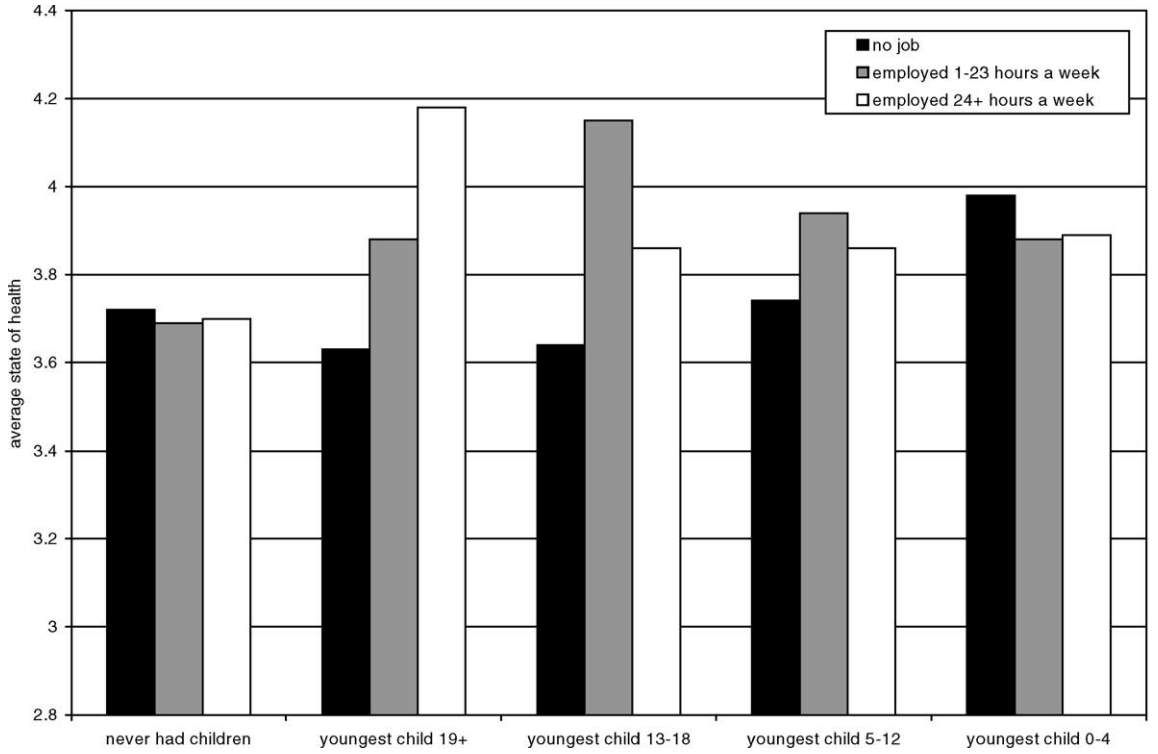

Fig. 2. Health differences among married women in the 30–54 year age group, by family and job situation, adjusted for differences in age and education and health differences in the past.

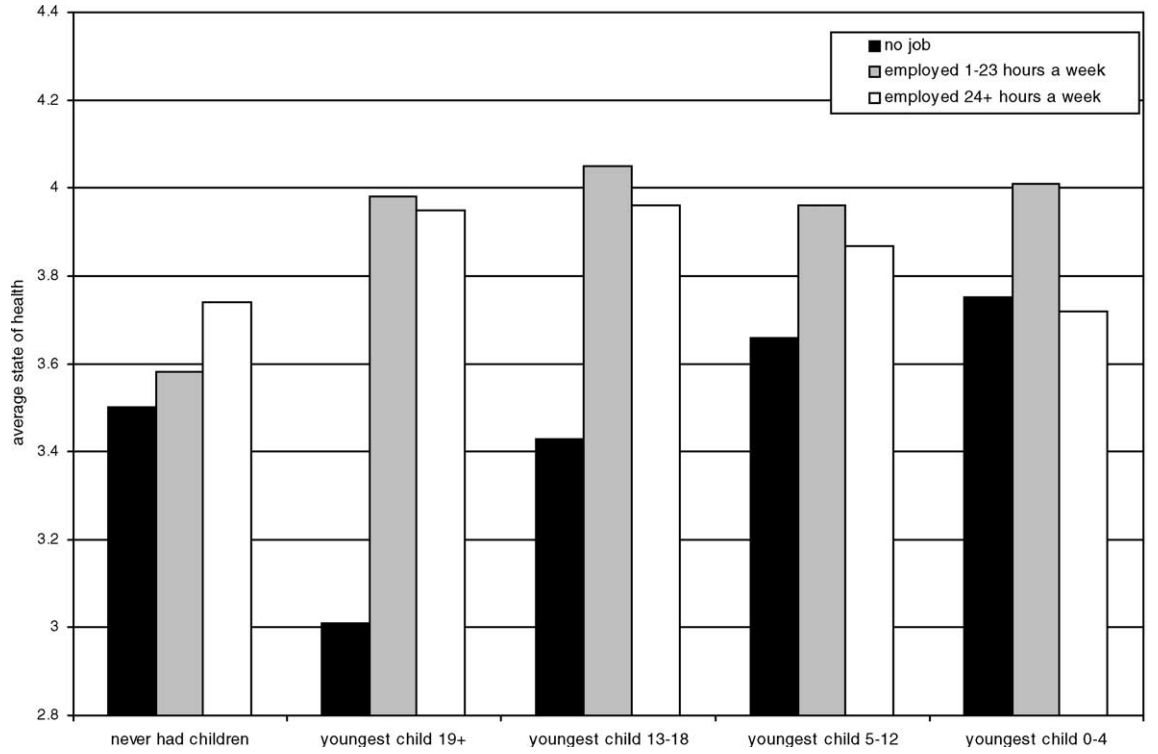

Fig. 3. Health differences among divorced women in the 30–54 year age group, by family and job situation, adjusted for differences in age and education.

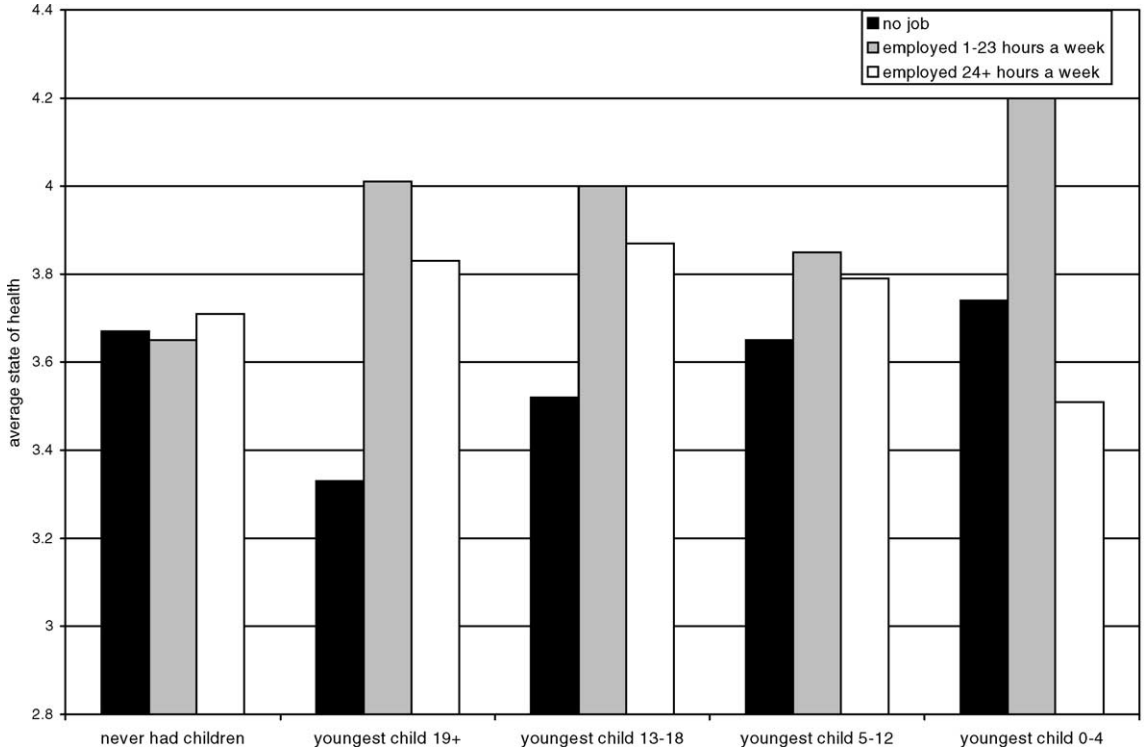

Fig. 4. Health differences among divorced women in the 30–54 year age group, by family and job situation, adjusted for differences in age and education and health differences in the past.

with caring for children older than four is not detrimental to the health of married and divorced women. In fact, balancing these responsibilities appears to promote health once the children have left primary school. Upon closer examination, we see that the work–childcare combination promotes health most strongly among women with a part-time job of less than 24 h a week. These jobs appear to be most compatible with homemaking duties. The only exception is found among married women with adult children, most of who live outside the home. The positive effect on the health of these women is strongest for those in paid employment for an average of 24 or more hours per week. It is likely that children in this age group require so little care that these responsibilities do not conflict with a longer working week.

The situation is different for mothers with one or more children under five. Health differences between married working and non-working mothers are not significant with young children. In this group, the average state of health of women in paid employment is only fractionally higher (Fig. 1), and after adjustment for health problems in the past fractionally lower (Fig. 2) than that of women without a job. This suggests that the advantages of working outside the home are 'disrupted' by the pressures of having to combine a job with childcare. However, substantial health differences do exist among divorced mothers with young children. On average, divorced mothers of preschool children with a part-time job of less than 24 h a week are in better health than divorced women who do not combine childcare and a paid job (Fig. 3), the more so after these figures are adjusted for health problems in the past (Fig. 4). Differences in health status are not found between full-time housewives and divorced mothers of preschool children with a job of at least 24 h a week. However, if health problems in the past are taken into account, the average previous state of health of the latter turns out to be better. In other words, divorced young mothers who succeed in combining childcare with a long working week tend to be physically robust.

A final noteworthy finding was that labour force participation was not associated with the health of married and divorced women without children. Among married childless women, this is also the case prior to adjustment for health problems in the past. Although paid employment appears to have a positive effect on the health of divorced women without children—working women in general, and those with a long working week in particular, tend to enjoy better health—this effect disappears following adjustment for health problems in the past. Those who are in good health tend to work on average 24 or more hours a week.

Summary and discussion

This article clearly shows that having a job and children is positively correlated to women's health in the Netherlands. Women in paid employment enjoy better health than full-time housewives, and mothers are healthier than women without children. At first glance, this finding does not come as a surprise. After all, numerous earlier studies have arrived at the same conclusion. However, our research is significant in that it differs substantially from past studies on a number of points.

The first difference is that our analysis has adjusted for health problems suffered in the past. This sheds light on the question of causality: Does having a job and caring for children have a beneficial effect on women's health (the health effect), or conversely, does good health enable women to combine childcare with a job (selection effect)? Although most previous studies have used cross-sectional data without adjusting for past health differences between the groups of women distinguished, they tend to attribute the positive correlations found entirely to health effects. Our research has called these conclusions into question. It has found that the positive relationships between paid employment and health as well as between having children and health are partly the result of self-selection: a higher proportion of women who participate in the labour force and who have ever had children have not had health problems in the past.

A second important difference is that, whereas past studies tended to focus on married women only, our study also included divorced women. When these two groups of women are compared, we see first and foremost that caring for children appears to have a beneficial effect on the health of married women in particular. There were no significant health differences between single divorced women with and without children. The positive effect of childcare on health may be 'disturbed' for divorced mothers because they are unable to share caring duties with a partner. The positive health effect of labour force participation, on the other hand, is stronger among divorced women. Divorced women appear to derive more benefit from the positive aspects of having a job. These advantages include forging social contacts and earning an income. For divorced women, unlike married women, these kinds of advantages are more difficult to achieve if they do not have a paid job. To strengthen this argument, further analyses are needed in which social networks and material circumstances are included as possible intervening variables between paid employment and health outcomes (Arber, 1997).

A third difference between our study and previous research is that the current study has examined the degree to which the health effects of working and caring differ, depending on the length of the working week and on the age of the children. We found that these effects hardly differ when they are examined separately. Women's health is promoted quite simply either because they are active in the labour market (married and divorced women) or because they take care of their children (married women). This is not the case when childcare is combined with a job. Once the children of both married and divorced women have reached the age of five, the job-child combination is highly correlated with good health, irrespective of the number of hours worked per week. However, for mothers of children aged 5–12, this positive correlation seems largely to be the result of self-selection: healthy women are most likely to combine childcare with a full-time or part-time job; the combination hardly promotes the health of women in this category. Finally, the health of mothers with one or more children under the age of five is neither negatively nor positively affected by paid employment if they are married. For those who are divorced, combining childcare with a part-time job (less than 24 h per week) appears to be most conducive to good health.

This latter finding is particularly interesting in light of the recent debates regarding plans of the Dutch government to oblige single mothers on social security with preschool age children to enter the labour force. Since 1996, single mothers on social security with children over four years have been required by Dutch law to enter the labour market; single mothers with one or more children under the age of five have so far not been required to find a job (Jehoel-Gijsbers, 1998). However, last year the Dutch government announced plans obliging them to participate in the labour force for a minimum of 20–24 h a week. Opponents of the bill argue that this job-child combination will have a detrimental effect on the health of these women. They point out that caring for young children, combined with paid employment, will put too much of a strain on most divorced women. The findings of our study do not support this argument. A paid job even appears to have a beneficial effect on the health of young, divorced mothers, as long as their working week is short (less than 24 h a week). Taking care of very young children combined with an 'extensive' job, on the other hand, does not improve the health of divorced women. This combination is mainly found among those women who had on average the fewest health problems at an earlier stage of their life. Finally, the current study has only examined possible *direct* effects of labour force participation, childcare and a combination of the two on women's health. Combining work and children may well take a heavy toll on women, the harmful health effects of which may not manifest themselves until a later date. We propose that future research address this issue.

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