

## DOMESTIC WORK, HOUSEWORK AND HEALTH

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**Abstract:** *The article presents the findings obtained via empirical research made by the Research Group EPSY, about the application of the gender approach to the study of health in two working groups, housewives (as an example of domestic work) and caregivers (as an example of working in people's homes), in comparison with other working groups, both women and men. Some data could indicate that housewives' health and welfare are worse than that of women working outside the home. Our findings: Housewives claim to have worse health than men, but not worse than the rest of the women. Caregiver women are the ones with the worst health in all of the groups. Women indicate that they have more physical pain than males. But they do not have lower self-esteem.*

**Keywords:** *Housewives' health, caregivers' health, gender approach to health*

Within the general reference framework of inter-gender relationships and health, in the present work the aim is to think, from the findings obtained via empirical research made by the Research Group EPSY, about the application of the gender approach to the study of health in two working groups, housewives (as an example of domestic work) and caregivers (as an example of working in people's homes), in comparison with other working groups, both women and men.

Reproductive work and that of looking after others (both formally and informally, but particularly in the former) are perhaps two of the occupations (if not the two occupations) which can most clearly show the influence of gender-related variables, in the sense that both occupations are usually socially defined as characteristic, as prototypical of the female role in society. This is so completely the case that it is still difficult to find sufficiently numerous, representative groups of domestic workers or male caregivers. This frequently means (and of course it is the case with the empirical data presented in this case), that one has to abandon, at least for the moment, making any comparison of results between men and women performing these two types of activity. This is unfortunate, since it would be highly useful and revealing as well when analysing gender influence. From the research group we are part of, research projects are starting including men and women in works related to caring, although in the data presented here it has not yet been possible to bring together a sufficient number of male caregivers to make comparative analyses possible.

# HOUSEWIVES, CAREGIVERS AND HEALTH

## Housewives

In Spain, the most characteristic phenomenon as far as levels of female occupation are concerned, is the drastic reduction in the number of housewives in recent years; for example, by the nineties the figures had passed from 68% in 1965 to 39% in 1991 (De Miguel, 1992). Steadily, women have been joining the workforce and for many of them domestic chores have ceased to be their main activity.

From an early period, different aspects of health began to show a relationship with being a housewife. Already in the National Health Survey (*Encuesta Nacional de Salud*) in 1987 (*Ministerio de Sanidad y Consumo*, 1990, (Ministry of Health and Consumption) the conclusion was reached that women see themselves as having more aches and pains than men and as being more prone to chronic pains, so that at the same age, women see themselves sicker than men. Going more deeply into these aspects, De Miguel (1992) presented a list of illnesses or symptoms which housewives claimed to be suffering from in the previous month, because "*housewives constitute a population which is very vulnerable to all types of pains*" (page 98).

In his data, 46% of housewives claim to have suffered during the previous month depression, anxiety or stress and more than 20% showed some physical pain, rheumatism, headache, insomnia, flu, etc.

These data could indicate that housewives' health and welfare are worse than that of women working outside the home. This has been confirmed in some studies (Escalera and Sebastián, 2000; Nathawat and Mathur, 1993; Thakar and Misra, 1999), and this worse well-being- these authors point out- could be linked to the relative deprivation of the role of housewife and her wish to have the chance to self-fulfillment and self-realization. There have also been studies of possible work injuries suffered by housewives; for example, in the III Annual Congress of the Epidemiology Association of Hong Kong (2001) Vivien Yip, of the China University of Hong Kong presented a work with a reduced number of participants (20 housewives who had worked full time at home for between 6 months and 15 years) which concluded that an inadequate and too short a rest break is frequently the main cause of several muscular injuries affecting the hand and the forearm of women housewives. More than 50% of these female patients complained of problems in their shoulder, the elbow and hand, whereas 40% had problems in other parts of the body. Half likewise pointed out that these problems, the symptoms of which lasted for more than 6 months, affected their work, whilst 15 per cent considered their symptoms to be affecting their leisure activities. Yip defended the idea that housewives are subject to a heavy physical and mental burden in their work and more studies should be carried out to determine the causes of their injuries, which account for an ever increasing number of cases treated in specialised clinics.

In effect, some of the characteristics of domestic work can, in themselves, have negative consequences for those doing it. Among these characteristics it is worth mentioning (Durán, 1986, 1988): the physical work required; handling instruments, tools and products which can be harmful for health; its lack of specific definition (including tasks of reproduction, implementation, management, socialising, etc.) and its variability

according to circumstances (presence of children or not and their age, occupations of family members, etcetera); their non-stop nature (no free time or holidays) and in homogeneous time and space (mixing places for work, family relations and rest); the isolation in which they carry on their work, with the consequent disconnection from social life and difficulty in social networking; and, last of all, the fact that it is a job which is cyclical, poor, repetitive, with little reward and low estimation.

That is, the argument put forward is that doing nothing else but domestic work can give rise to an important deficit in the affection-family, sociocultural, personal autonomy, economic, work and leisure and free time areas, which could be the origin of most of the health problems which are shown at times by housewives.

However, reviewing the studies which have analysed the characteristics of housewives indicates that we are dealing with a very complex reality. The existence or otherwise of multiple roles to perform (depending on whether one is exclusively a housewife or whether one works outside the home) has a complex effect on women's welfare and health (Stephens and Townsend, 1997). Some data support the hypothesis that performing a large number of roles has a negative effect on women, so that the overload brought on by the role and various demands are correlated negatively with health and welfare (Crosby, 1991; Lundberg, 1996).

But, on the contrary, the so-called "theory of role accumulation" based in turn on empirical data, shows that the existence of multiple roles exerts a shock-absorbing effect against the negative consequences of any of the roles, so that the negative aspects of a role can be offset thanks to the possibility of performing other roles (Barnett, 1997; Baruch and Barnett, 1986; Crosby, 1991; Vandewater, Ostrove and Stewart, 1997). In fact, when housewives perform other roles which are not strictly family ones they have higher levels of self-esteem and satisfaction, and this impinges on welfare (Adelmann, 1993; Miller, Moen and Dempster, 1991). It would appear that housewives' chores are more routine ones and, consequently, more negative (Lennon, 1994).

And, to finish this short description, other factors have also been pointed out. One, for example, is that the important thing is not the number of roles performed but the quality of them, so that when the balance between the cost and benefits obtained from performing these roles is favourable for women, the impact on satisfaction and welfare is highly positive (Baruch and Barnett, 1986), or what is fundamental when producing effects is the voluntary nature of the role playing (Goldberg, Greenberger, Hamill and O'Neil, 1992; Jenkins, 1996).

To sum up, what we can conclude at a general level is that, as pointed out by Yoder (2000), performing different roles in life is of benefit for some women and under certain conditions. From these empirical works, we can point to a set of these circumstances which clearly impinge, since their effect has been seen in works with empirical data:

- The income level of the family unit, the possibility of hiring help, the number of members in the unit, etc., (for example, Artacoz, Borrell and Benach, 2001).

- Whether there are children or not. The highest levels of health and welfare in working women compared to housewives do not get support just after giving birth (Walker and Best, 1991), since female employees show greater stress levels.

- Some other positive aspects of domestic work are also pointed out (Izquierdo and Martí, 1992). That of not having to bear division of labour, the work can be organ-

ised and carried out according to the criteria of the person performing it; the housewife is in direct contact with the people who benefit from her labours. There are, of course, negative aspects: socially it is not considered as work nor is it valued as such either by society or by its beneficiaries because it does not produce exchange values only ones for immediate private use and consumption (Casas, 1987). The women themselves consider housework as one of the professions with the lowest social prestige (Casas and Sallé, 1986).

- Possibly the negative effects are particularly so in the long term. Researchers from the Department of Epidemiology and Public Health of London University followed up 1,200 women aged between 15 and 54. Their health was analysed at the age of 26 and 54 using a questionnaire, along with details of their working history, marital status and number of children for each decade of their lives from the age of 20. The effects were shown in the group of older women; by the time they reached the age of 54, women who had been companions or wives, mothers and employees, were healthier than women who had not performed these three roles. Those who had been housewives for all or most of their life and had not worked were more likely to have signs of bad health. The conclusion to be drawn from the research is that long-term benefits for the health of the working woman outweigh the short-term stress of this role. (McMunn, Bartley, Hardy and Kuh, 2006).

All of this complexity can be related to the explanation of apparently contradictory findings. Starting with the review of some examples of data we can prepare the following general picture:

1. In many cases housewives do not seem to have worse health

2. In the case of some housewives who apparently have the worst health some clarifying comments would be needed:

The differences are not statistically significant (for example, in the work by Artacoz, Borrell, Rohlf, Beni, Moncada and Benach (2001).

Social class is more important than being a man or a woman (Khlát, Sermet and Le Pape, 2000) with French data; Artacoz, Borrell, Benach, Cortés and Rohlf, 2004, with Spanish data).

The pattern is more consistent for women with the lowest educational levels and only for certain indicators of health (for example, in the work of Artacoz et al., 2004).

The sample of housewives used is significantly older than those who are not housewives (for example, in the work by Ferrer, Bosch and Gili, 1998), so we cannot know whether the worse health is due to being a housewife or to being older. In fact, in our own studies (Sánchez López, Cardenal and Sánchez-Herrero, 2003) there is a frequent appearance of an item of data that housewives and women in general from the 45–65 age group show a less favourable perception of their physical health and a greater level of general physical pain. But this is not necessarily the case with the lower age group.

## Caregivers

Various research works carried out in our country during the nineties consistently confirm that the family is the main provider of health care. From the total of

care received by older people, 80-88% is received exclusively from family members, whereas formal services are provided in 3%. In the case of people with other kinds of dependence, the figures range from 50% in the case of psychic deficiencies or 70% with physical disability and 83% in the case of those not severely ill.

20.7% of adults in Spain help an elderly person with whom they live in providing help for daily activities (AVD), and 93.7% of them have family links with the person they are looking after, whereas 24.5% of women provide help, only 16.6% of men do so.

In the group of caregivers, according to IMSERSO (2005), 84% of those looking after the dependent elderly in our country are women; if we consider these data as valid it seems that the traditional family model and the traditional woman's role as provider of care and affection are still in vogue. In this same IMSERSO report it was indicated that health problems can complicate the work of carers. 50% of caregivers interviewed suffer some form of chronic illness (basically bone problems, and emotional troubles, characterised by symptoms of depression, sadness or distress); and 7% had some physical, psychological or sensory handicap. According to Crespo and López (2007) these problems certainly date from prior to the person being a caregiver, but the conclusion could be drawn that indeed in many cases there is a direct relationship with the very fact of being a carer.

Different studies make it clear that the main caregiver has to bear on a daily basis unforeseen challenges and has bouts of losing control of him/herself, and showing physical and emotional health disorders (Valles, Gutierrez, Luquin, Martín and López de Castro, 1998). The "caregiver syndrome" is not only a clinical syndrome, since non-medical repercussions are involved in social and/or economic aspects. This syndrome is characterised by the existence of a plurisymptomatic pathology which usually affects and has repercussions on all areas of the individual (Pérez Trullen, Abanto and Labarta, 1996). Other psychological symptoms which appear in caregivers are stress, anxiety, irritability, manifestations of grief, dependency, fear of illness, changes in behaviour, a sense of guilt at not properly looking after the patient and mood swings in affection which can lead to the appearance of suicidal tendencies (Mace and Rabins, 1991). It is generally assumed that people taking on the task of looking after a dependent family member are exposed to a source of stress which leads them to be vulnerable, affects quality of life and increases the risk of suffering several physical problems, as well as emotional disturbances (Crespo and López, 2007).

The international bibliography offers us several recent works which, using the meta-analysis technique, enable us to have a relatively complete picture of some key aspects of male/female caregivers' health (for example, Pinquart and Sorensen, 2003; 2007; Vitaliano, Zhang and Scanlan, 2003).

Therefore, the general picture appears to be clearer than in the case of housewives; the health of male/female caregivers is affected by the selfsame act of caring.

When we talk of informal care we are speaking in most cases of support provided by members of the immediate family network; but the distribution of the caring role is not homogeneous in families. The typical profile of the carer is that of a woman, housewife, directly related (in general, mother, daughter or wife), and who lives with the person being looked after. Gender, cohabitation and family relationship are the most

important variables in the case of predicting which person from the family nucleus is going to be the main carer. The fact that informal care is mainly female shows clearly the differing care burdens imposed on men and women (García-Calvente, Mateo-Rodríguez and Maroto, 2004).

As indicated by Pizurki, Mejía, Nutter and Ewart in the document *The role of women in healthcare*, published by the WHO in 1988, the female stereotype, is characterised, (as a result of socialising), by submission, passiveness, dependency, emotionalism and with the ability of women to care for others.

In this sense, a research project co-ordinated by Ángeles Durán (1999) on the invisible costs of illness highlights the magnitude of the non-monetarised contribution of women to the health service in our country. Similarly, this research makes it clear that illness produces in unpaid caregivers poverty, dependency and, often, risks of infection and social exclusion.

Taking all these precedents into account, the work presented now centres on investigating several health indexes and their relationship with two psychological variables, one of these a health-prone variable and the other being a pathogen-prone one, in a group of housewives and in a small group of informal women carers, and, comparing them with other groups of men and women in other work situations. To have a better understanding of the comparisons between the different groups, a study was also made of the general differences in each of the variables studied between men and women.

## QUESTIONS WHICH WE AIM TO ANSWER

Starting from the above-mentioned approach, the questions raised which we will endeavour to answer by investigation are the following:

1. Who has the worst health? That is:
  - a) Are there differences between men and women in questions of health?
  - b) Is there a substantial difference between being a housewife or a caregiver?
2. Are there differences between variables according to groups? (Specifically in Self-esteem (S), as an example of health-prone variable and Anxiety (A) as an example of pathogen-prone variable.
  - a) Are there differences in SA between men and women?
  - b) Is there any substantial difference between being a housewife or a carer?
3. The relationship between those variables (SA) and health, are they different in different groups?:
  - a) Are the relationships between health and SA different dependent on whether we are dealing with men or women?
  - b) Is there any substantial difference between being a housewife or a caregiver?

That is, the object presented in the work is to analyse some aspects related to health and psychological variables which traditionally (taking as a base the findings of previous research) have shown their relationship with health in groups of women who are domestic workers (for example, housewives) and women who are working in the home (for example, family caregivers) in comparison with groups of mothers who are

working outside the home or are unemployed and groups of men who are in paid work or unemployed. As a result, the aims of the research have been, firstly, to compare the different groups of women and men on several health indexes and, secondly, to evaluate whether the factors related to their health in each group of men and women are similar or present differential profiles. Probably gender has the power to explain the findings obtained.

## **RESEARCH PROCEDURE**

Once the problem has been centred by means of the questions we aim to obtain answers to, and once it has been made clear which is the basic methodology chosen, the next step was to profile (albeit very briefly), the basic aspects of the research .

### **Participants**

Given the well established findings from previous research, which show a clear relationship between a low socioeconomic level and worsening of health, it seemed important to control this influence, through homogenisation of the social class of all the participants. Since, moreover, the most frequent socioeconomic level in Spain as a developed country, is the middle class, the interest of the research centred on participants of this level. They were chosen according to whether they belonged to the different work groups we sought, in such a way that the sample was made up of Housewives (N = 305), Woman working outside the home (N = 300), Unemployed women (N = 297), Working man (N = 301) and Man unemployed (N = 298). Since the housewives' group cannot have, for the moment, their parallel group amongst the men (due to their being in short supply and, as a result, they are not representative), the number of women (N = 901) was of necessity higher than that for men (N = 600). The age range was between 27 and 65. The caregivers' group is being recruited. The results presented here are based on 28 informal caregivers, from the same age range. The scarce number of males (2) making up part of this group was not for the moment included in the analyses.

### **Instruments**

A very broad sociodemographic questionnaire (and one) tested in previous research (Sánchez-López et al., 2003; Sánchez-López, Cardenal, Aparicio & Patró, 2005; Sánchez-López, Aparicio and Dresch, 2006 and Aparicio, et al., submitted for evaluation), where it had shown itself to be efficient, was applied to all the subjects. To evaluate the health variables the same instruments already tested in the different research work of the research group, whose references coincide with the previous ones was used. To evaluate anxiety a standard instrument (Inventory of Situations and Responses of Anxiety, ISRA, Miguel Tobal and Cano Vindel, (2002) was used. To evaluate self-esteem one of the most classic instruments, Rosenberg's Scale of Self-esteem, which has already shown its good psychometric characteristics in the Spanish population, was used.

### **Data analyses**

Data analyses which are suitable for the questions raised and easy to use have been chosen. for the questions raised. Whenever possible, mean differences and correlations

have been calculated. Of course, it has been essential in order for them to be taken into account that the values (differences and correlations) were statistically significant, and that the effect size was, at least, moderate, to make sure that the conclusions that might be reached had a solid base.

## RESULTS

To avoid making the presentation of this work excessively long and calculated, only those which, while being statistically significant, reach a moderate effect size (indicated with a yellow background) or high (marked with a blue background) are included.

The presentation of the findings is organized in accordance with the questions raised:

### 1. Who has the worst health? That is:

#### a) Are there differences in health between men and women?

Table 1. Comparison in means, standard deviations, t and effect size between Men and Women (only differences with a moderate or high effect are included).

	Physical pains			
	M	DT	<i>t</i>	<i>d</i>
Men (N=600)	13.99	3.87	-10.80***	-0.49
Womens (N=901)	16.34	4.77		

\*=  $p < 0.05$ , \*\* =  $p < 0.01$ , \*\*\* $p < 0.001$ .

Size of the effectSize: Low = 0.20; Moderate = 0.50; High = 0.80

The sole health index in which differences between men and women appear is that for Physical pains. With a moderate value, women list more physical pains than men.

#### b) Is there any substantial difference between being a housewife or a caregiver?

Table 2. Comparison in means, standard deviations, t and effect size between Housewives and Carergivers with all the other working groups (only differences with a moderate or high effect are included).

	Self-perceived health				Physical pains			
	M	DT	<i>t</i>	<i>d</i>	M	DT	<i>t</i>	<i>d</i>
Housewife			--	--			--	--
working woman								
Housewife			--	--			--	--
Unemployed woman								
Housewife			--	--	16.65	4.78	-6.21***	-0.56
Unemployed man					13.93	3.95		
Housewife			--	--	16.65	4.78	7.43***	0.54
Working man t					14.04	3.80		
Housewife			--	--	16.65	4.78	2.99***	0,52
Women carers					18.92	3.83		
Women carers	6.62	1.67	-3.11***	0,6	18.92	3.83	3.58***	0,70
Working woman	7.64	1.58			16.23	3.80		
Women carers			--	--	18.92	3.83	3.73***	0,72
Unemployed woman					16.11	4.76		
Women carers	6.62	1.67	-2.93***	0,57	18.92	3.83	6.67***	1,2
Unemployed man	7.58	1.69			13.93	3.95		
Women carers	6.62	1.67	-3.21***	0,63	18.92	3.83	6.49***	1,2
Working man	7.67	1.61			14.04	3.80		

\*=  $p < 0.05$ , \*\* =  $p < 0.01$ , \*\*\* $p < 0.001$ .

Size of effect: Low = 0.20; Moderate = 0.50; High = 0.80

The differences between the different groups according to their employment situation only appear clearly in Physical pains. The caregivers, even with some high effect sizes, appear with more physical pains than the rest of the groups, including the housewives, and with worse Self-perceived health, although in this case with only moderate effect sizes, and with no differences compared to unemployed women.

Regarding housewives, they only mention more physical Pains than men (both those who are working and those out of work), with a moderate value, but there are no differences with the rest of the women. In Self-perceived health, there are no differences between housewives and the rest of the groups, both men and women.

## 2. Are there differences between some health-prone (self-esteem) and pathogen-prone (anxiety) variables?

a) Are there any differences in SA between men and women?

There are no differences either between Self-esteem or Anxiety between women and men.

b) Are there substantial differences between being a housewife or being a carer?

There are no differences in Self-esteem between any group.

## Anxiety:

Table 3. Differences in **total anxiety** (means, standard deviations, t and also effect size. Only differences with a moderate or high effect size are included.)

	M	DT	t	d (tamaño del efecto)
<b>Housewife (N=305)</b>			--	--
Working woman (N=300)				
<b>Housewife (N=305)</b>			--	--
Unemployed woman (N=297)				
<b>Housewife (N=305)</b>			--	--
Unemployed man (N=298)				
<b>Housewife (N=305)</b>	23.92	13.00	7.53***	0.56
Working man (N=301)	16.72	10.38		Moderate
<b>Female carers</b>			--	--
Working woman (N=300)				
<b>Female carer</b>			--	--
Unemployed woman (N=297)				
<b>Female carer a</b>			--	--
Hombre parado (N=298)	19.76	13.77		
<b>Female carer a</b>	25.52	13.25	-3.97***	-0.73
Working man (N=301)	16.72	10.38		Alto
<b>Female carer</b>	25.52	13.25	--	
<b>Housewife</b>	23.92	13.00		

\*=  $p < 0.05$ , \*\* =  $p < 0.01$ , \*\*\* $p < 0.001$ .

Size of the effect Low = 0.20; Moderate = 0.50; High = 0.80

Housewives and caregivers are differentiated only from men, but only providing the latter work. In the first case, the effect size is moderate, in the second it is high.

### 3. Are the relationships between those variables (SA) and health different in women and men?

a) Are the relationships between health and SA different depending upon whether we are talking of men or women?

Table 4. Correlations between self-esteem and anxiety and health indexes in men and women (Only correlations with a moderate or high effect size are included).

<b>Self-esteem</b>	Total sample	Men	women	<b>Ansiedad</b>	Total sample	Men	Women
Substance abuse	--	--	--	Substance abuse	--	--	0.30**
Visits to doctor	--	--	--	Visits to doctor	--	--	--
Self-perceived Health	0,292**	0,297**	--	Self-perceived Health	-0.59**	-0,56**	-0,57**
Physical pains	--	--	--	Physical pains	0.54**	0.51**	0.52**
Chronic illness	--	--	--	Chronic illness	--	0.32**	--

\*\*\*p<0.001 \*\*p<0.01 \*p<0.05

Equivalence table proposed by Cohen: r = 0.10 equivalent to an effect size : d = 0.20 = LOW; r = 0.30 equivalent to effect size : d = 0.50; = MODERATE; r = 0.50 equivalent to effect size: d = 0.80 = HIGH

The relationships are not basically different. Anxiety is more important than Self-esteem in relation to health, in both sexes. Self-esteem, perhaps, appears related in men, but not in women. With regard to Anxiety, the relationship is important with regard to Physical pains and Self-perceived health (high effect size), both in men and women. The difference between the latter is manifested in the relationships between (Anxiety and Chronic illness, which only appears in men (moderate) and between Anxiety and Substance abuse, which only appears in women (moderate).

**b) Is there a substantial difference between being a housewife and being a caregiver?**

Table 5 Correlations between self-esteem and anxiety and health according to worksituation. (Only correlations with a moderate or high size effect are included)

<b>Self-esteem</b>	<b>Housewives</b>	Unemployed women	Women in work	Unemployed men	Men in work
Substance abuse	--	--	--	--	--
Visits to the doctor	--	--	--	--	--
Self-perceived help	0,313**	--	--	--	0,325**
Pains	--	--	--	--	--
Chronic illness	--	--	--	--	--
<b>Anxiety</b>	<b>Housewives</b>	Unemployed women	Women in work	Unemployed men	Men in work
Substance abuse	0.30**	0.34**	--	0.30**	--
Visits to the doctor	--	--	--	--	--
Self-perceived health	-0,64**	-0,51**	-0,57**	-0,61**	-0.48**
Physical pains	0.53**	0.56**	--	0.53**	0.50**
Chronic illnesses	--	--	--	0.43**	--

\*\*\*p<0.001 \*\*p<0.01 \*p<0.05

Equivalence table proposed by Cohen:  $r = 0.10$  equivalent to an effect size  $d = 0.20$  =LOW;  $r = 0.30$  equivalent to an effect size:  $d = 0.50$ ; = MODERATE; $r = 0.50$  equivalent to an effect size:  $d = 0.80$  = HIGH

Given the size of the female caregiver sample, it is practically impossible for the correlations to be significant, so these data are not included. In spite of this, the correlation between anxiety and physical pains appears significant ( $p < 0.05$ ), with a value of 0.463 (close to the size value of the high effect). This, given the circumstances of the small number of female caregivers hitherto evaluated, is a highly significant item of data.

As a general question from these data it can be said that there exists very little relationship between self-esteem and physical health. As for the rest, the profile which is most akin to that of Housewives is that of unemployed men. Regarding relationships between health and Anxiety, there appears a new health index, Substance abuse, which is only related (moderately) to anxiety in housewives, and in unemployed men and women. As occurred in the case of Self-esteem, the profile most akin to that of housewives is that of unemployed men, and, in this case, also of unemployed women.

## CONCLUSION AND DISCUSSION

To have available a general picture, below we include the questions from the research, answered from the results discovered.

### 1. Differences in health

**1.1 Are there any differences in health between men and women?** Only in Physical pains.

**1.2 Is there any noticeable difference between being a housewife and being a caregiver?.** Housewives: Only from men. Caregivers: Yes, from all the other groups

### 2. Are some health- prone variables (Self Esteem) and pathogen-prone variable (Anxiety) related to health (SA)?:

**2.1. Are there differences in SA between men and women?** No

**2.2. Is there any noticeable difference between being a housewife and a female caregiver?** Not in self-esteem. In Anxiety, both are differentiated only from men and only if the latter are in work

### 3. Relationships between those variables (SA) and health

**3.1. Are the relationships between health and SA different depending upon whether we are dealing with women or men?** Basically, no. Self-esteem is related to Health more among men. Chronic illness (with anxiety) in men and substance abuse (with anxiety) in women appear for the first time.

**3.2. Is there any noticeable difference between being a housewife and being a caregiver?** Reliable data are not yet available on Women caregivers (Though the data point towards a similar profile to that for the housewife). The profile of relationships between Health and Self-esteem which is most akin to Housewives is that of Unemployed men. The profile of the relationships between Health and

Anxiety most similar to that for Housewives is that for unemployed women and unemployed men.

So,

A) When men and women are compared in general, there are few differences in the aspects of health which have been evaluated in this work, including variables such as Self-esteem and Anxiety and their relationship with Health. Only women indicate that they have more Physical pain than males. Women do not have worse Self-esteem than males (which is consistent with the data for the meta-analyses carried out so far on this topic, as we have pointed out above), and if anybody has related Self-esteem and Anxiety, it is men and not women. Consequently, it does not seem pertinent to continue giving the message that one of the basic problems with women in general, and in relation with their health, is their lower self-esteem.

B) Housewives claim to have worse health than men, but not worse than the rest of the women. They are not differentiated from the other groups of men or women in Self-esteem but they do have higher scores than men in Anxiety, provided the latter are not unemployed. In the case of the women, the relationships between Self-esteem and Anxiety with Health are more similar to those of unemployed men, thus perhaps highlighting the influence of gender-linked stereotypes: males who are out of work (being the employment a value socially associated with the male gender) are more akin to the “weakest” (worse health, higher Anxiety).

Caregiver women are the ones with the worst health in all of the groups. But they do not have lower self-esteem and in the case of Anxiety they are only differentiated from men and only then if the latter are not unemployed out of work. The trend of the data on their profile they show in relationships between Anxiety, Self-esteem and Health would also indicate that their profile would be similar to that of Housewives. The negative effect on health of the task of caring (in the conditions in which these women do it), is also confirmed with these data, but neither do they have lower Self-esteem, as is sometimes stated without much in the way of empirical data available, and their scores in Anxiety also indicate their similarity to unemployed men, and perhaps for the same reasons mentioned previously.

Even if it might be a finding which is tangential to the aims established in this work, it is also worth pointing out that there are clear differences in discriminatory effectiveness between the different health indexes used, and this might well merit consideration for future work. In fact, the most effective indexes have been Physical pains and self-perceived Health. That of Visits to the doctor does not seem to be an effective discriminator, so its future use should be discussed.

In closing, as future prospects to be able to continue studying the topic more profoundly, the need to increase the number of women caregivers should be stressed, along with the inclusion of male caregivers in the study, even when aware of the practical difficulties involved in this. But probably the findings seen in the comparison between one and another would offer enough reward for any efforts made, through everything that is involved in having available men carrying out tasks which clash with the traditional roles assigned for each sex. Similarly, it is necessary to include mental Health measures to complete the picture of subjects' health.

Will as a general conclusion, perhaps it can be anticipated that the data presented continue to support the hypothesis of basic equality between women and men in many aspects, and the confirmation that the differences produced are usually much more related to things such as what work people do. Thus, the latter may imply linking or a mismatch in the values socially assigned to each of the two sexes.

## **DOMÁCÍ PRÁCE, PRÁCE V DOMÁCNOSTI A ZDRAVÍ**

**Abstrakt:** Příspěvek se zabývá otázkami vztahujícími se ke zdravotnímu stavu populace ve Španělsku. Pojednává o postavení ženy v domácnosti, o roli pečovatelky, o úskalí dlouhodobé péče v rodinném kruhu a o tradicích péče o nemocné či seniory ve Španělsku. Autoři se zaměřili na rozdíly mezi muži a ženami v otázkách zdraví, na rozdíly mezi úlohou ženy v domácnosti a ošetřovatelem/-kou, na rozdíly mezi proměnnými podle vytyčených skupin (v Sebeúctě (S) jako příkladu proměnné sklonu ke zdraví a Úzkosti (A) jako příkladu proměnné náchylnosti k patogenům. Autoři analyzují, zda existují rozdíly v SA mezi muži a ženami, zda existuje nějaký podstatný rozdíl mezi ženou v domácnosti a pečovatelkou, zda jsou vztahy mezi proměnnými (SA) a zdravím různé v různých skupinách.

**Klíčová slova:** zdraví, žena v domácnosti, role ženy, ošetřovatelka, pečovatelka, tradice, muži pečovatelé, úzkost, sebeúcta, práce v domácnosti