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Short Communication

Work-family conflict is a public health concern

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ABSTRACT

Objectives: The objective of this commentary is to describe how the deleterious health effects of the competing demands of work and family roles are a public health issue that deserves immediate attention.
Study design: This is a commentary article; therefore, there is no study design.
Method: I reviewed and summarized existing research on work-family conflict as it relates to public health action.
Results: Work-to-family conflict (WFC) is pervasive among US working adults and is higher in the US than in other developed countries. Time, energy, and behaviors invested in fulfilling work responsibilities often compete with fulfilling family responsibilities, with numerous deleterious effects on employee health including sleep, cardiometabolic risk, stress, depression, and anxiety. WFC is a potent source of stress for working Americans, a major contributor to healthcare costs, and a predictor of mortality. US policies have lagged woefully behind the increasing competition between work and family demands.
Conclusion: Work-to-family conflict is a public health concern that deserves immediate attention. Until governmental support for adults' work and family lives improves, WFC will continue to be a significant risk factor for public health. Including WFC in public health research and interventions will improve population health and advance health equity.

Amidst the COVID-19 pandemic, conflict between work and family roles has magnified in individuals' private lives and in public discourse; perhaps a silver lining of the pandemic is that it put a spotlight on how incompatible work and family roles can be. Before the COVID-19 pandemic, work-family conflict (i.e., time-, strain-, and behavior-based interrole conflict [1]) among US working adults had been increasing since the 1980s, with concomitant employment and family demographic changes [2]. Manufacturing jobs declined while jobs in education, health care, professional services, and service industries grew. Today, fewer companies operate on a standard, daytime schedule, and the contract between employers and employees has become tenuous [3]. In addition, US families have become increasingly complex and diverse. Today more couples are cohabiting, divorcing, and remarrying; substantially fewer children are living in two-parent households; more mothers are participating in the labor force and are primary caregivers in the household; and more adults have both parenting and elder care responsibilities [2]. Over this same period, the US government's response to transformations in work and families has been hugely deficient.

Work-family conflict (WFC) is higher in the US than in other developed countries, yet US policies have lagged in supporting adults' often-competing work and family responsibilities [2]. For example, paid family leave prevents many American's from choosing between caring for a sick family member and losing wages, or far worse, losing their job. Although often portrayed as a "women's issue" or a "mothers' issue," a meta-analysis of more than 250,000 workers did not show substantial gender differences in WFC; men, too, have reported high WFC [4]. WFC is pervasive in the US and predicts numerous health outcomes and even mortality among working adults [5]. WFC is a public health concern that deserves immediate attention.

Once viewed as separate spheres, decades of research documents that experiences at work and at home intersect with short- and long-term repercussions for employee health. WFC can impair mental health and psychological well-being; it has been associated with more burnout, depression, and anxiety, as well as lower life satisfaction. WFC can also have significant effects on physical health, including poorer sleep and perceived health, as well as higher cardiometabolic risk [6]. Furthermore, individuals with more WFC tend to engage more in unhealthy behaviors, such as smoking, alcohol use, medication overuse, poor diet, and sedentary behavior [6]. WFC is a potent source of stress for working Americans, a major contributor to healthcare costs, and a predictor of mortality. One study found that more than 120,000 deaths each year in the US could be attributed to workplace factors, including work-family conflict [5]. Thus, understanding experiences of work-family conflict

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can improve understanding about population health disparities.

Research documents various work, family, and individual antecedents of WFC. First, WFC varies by working conditions, including long work hours, nonstandard work schedules, low job control, and low supervisor support [7]—all of which are also major workplace stressors linked to health care costs and mortality [5]. Working conditions vary by industry and jobs overall and within organizations and work units, specifically. Compared to adults with professional and managerial jobs, low-income and working poor adults are more likely to have jobs characterized by conditions conducive to WFC, while also less likely to have access to benefits from their employers to mitigate it [2]. Although middle-class employees tend to have less precarious jobs with better working conditions than low-income employees do, on average, they too tend to have inadequate work-family supports. Workers with more resources generally, have greater access to resources to help them successfully manage work and family responsibilities; workers with fewer resources and who could potentially benefit the most from work-family resources, are less likely to have access. Thus, government and workplace work-family supports are not only limited but also they are inequitable among working Americans.

Second, family characteristics and experiences influence WFC. WFC varies by expectations and time demands in each family role (e.g., partner, parent, and caregiver) and the extent to which these roles interfere with one another. While a partner can be a source of support in coping with WFC, they can also be a source of additional stress depending on their health, working conditions, and own experiences of WFC. The number of children, their ages, and their health and abilities can have differential impacts on working parents. Caring for an aging parent while employed can also increase WFC, particularly when caregiving is more time- and emotionally-intensive.

Third, individual characteristics also contribute to diversity in WFC experiences. Factors tied to health disparities, such as gender, race, ethnicity, education, social class, and immigration status, are associated with WFC. In addition, research indicates that experiences of discrimination tied to these social identities predict WFC. For example, in a national sample of African American women in Fortune 1000 companies, workplace racial bias was positively associated with WFC [8]. This finding highlights that systemic barriers, such as racism, increase the risk of WFC.

Multiple factors create and perpetuate WFC in the US, which necessitates a multi-systems public health approach to research and prevention. Here I discuss two systems: the government and organizations. First, the US government needs to make swift and significant advances in work-family policies, such as paid family leave and paid sick leave, to reduce WFC and promote the health of Americans. According to the OECD, as of 2018 the US was the only country among 41 without government-mandated paid leave [9]. A social justice framework is necessary for creating equitable work-family policies and potentially reducing health disparities among working Americans.

Second, organizations need to invest in workplace culture initiatives that deconstruct norms and expectations about the "ideal worker" while building a person-oriented culture of care [2]. Within the context of culture change, organizations need to provide comprehensive and equitable workplace policies, such as flexible work arrangements, reducing WFC while improving employee, family, and organizational outcomes. Recognizing how pervasive and destructive WFC can be, the Work, Family, & Health Network designed an intervention to reduce WFC called STAR. STAR involved increasing employees' control over their work schedules and training supervisors to be supportive of employees' family responsibilities, within an overall cultural shift to prioritize completing high quality work by deadlines, regardless of where or when employees do the work. STAR successfully reduced WFC, without increasing work hours or perceived job demands [10]. Compared to employees in the control condition (i.e., business as usual), employees in STAR showed significant improvements in health, including better sleep and lower stressor reactivity. Furthermore, the health benefits of STAR extended beyond the employee to their children, including sleep regularity and quality, and the organization (e.g., safety compliance). In addition to culture initiatives, organizations need to redesign jobs to improve work-family fit and, in turn, workers' health.

Public health action is critical in reducing the deleterious health consequences of WFC. Until there are improvements in governmental support for adults' work and family lives, WFC will continue to be a significant risk factor for public health. Mitigating WFC will help achieve Healthy People 2030's goal to "create social, physical, and economic environments that promote attaining the full potential for health and well-being for all." Including WFC in public health research and interventions will improve population health and advance health equity.

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Not required because this manuscript is not reporting human subjects research.

Declaration of competing interest

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