

Job Content Quality and Self-Rated Health:

Is There a Difference for Working Poor and Non-Working Poor?<sup>Δ#</sup>

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## Abstract

Minimal attention has been given to the quality of low-wage jobs in the U.S. The purpose of this study was to identify the job content quality factors associated with self-rated health status for working poor individuals, and to determine whether the identified factors are the same for non-working poor individuals. Data were from the 2002 National Study of the Changing Workforce, a nationally representative study. Two sub-samples were compared: (a) respondents living in households earning less than 250% of the federal poverty threshold (FPL) ( $n=548$ ); and (b) respondents living in households earning at or above 250% of the FPL ( $n=2036$ ). Results showed that high psychological demands and low supervisor support for work-family issues were associated with poor health for working poor individuals, while low decision latitude, supervisor support for work-family issues, and coworker support were associated with poor health for non-working poor individuals. Findings suggest that all jobs do not equally affect employees' health status. Implications for research, workplace policy, and federal public policy activities that may improve the health of the working poor in the U.S. are presented.

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## Job Content Quality and Health:

### Is There a Difference for Working Poor and Non-Working Poor?

As debate continues over what are the best means for reducing poverty and increasing economic self-sufficiency among Americans in the lowest income brackets, a growing population of workers poses additional challenges for researchers and policymakers. These workers, often referred to as the “working poor,” are individuals who are working for wages and salaries, yet still earn incomes near or below the poverty line. Since Welfare Reform in 1996, this share of workers has grown significantly, with many welfare recipients leaving the rolls to enter jobs that pay low wages and offer minimal benefits, limited security, and few opportunities for advancement (Kazis, 2001). Furthermore, over the past two decades, 86% of the new job growth has been within service-based industries (Presser, 2000), and this trend seems to be continuing. According to the Bureau of Labor Statistics, low-wage service occupations are second in terms of fastest-growing and predicted job growth through 2012 (Hecker, 2004).

Despite concerns about the increasing numbers of working poor in the U.S., minimal information is known about the quality of their jobs beyond access to employee benefits such as health insurance and sick leave (See Levin-Epstein, 2006). Knowledge about job quality is important, because data suggest strong associations between poor job content quality and ill health, including cardiovascular disease, stress, hypertension, and depression (Johnson & Hall, 1988; Karasek 1979, Karasek & Thoerell, 1990; Karasek, Baker, Marxer, Ahlbom, Theorell, 1981; Karasek, et al., 1988; Kasl, 1996; Thoerell & Karasek, 1996). For example, Karasek (1979) observed that the psychological demands of work in combination with limited decision-making latitude and low skill utilization contributed to employees’ poor behavioral and physical health. Godin and Kittle (2004) found that middle and upper income workers who reported job

strain and low control in the workplace experienced higher rates of mental health problems. Conversely, Mackie, Holohan, and Gottlieb (2001) found that workers who reported being involved in decision-making processes with their supervisors experienced lower levels of job strain and depression. These findings indicate that employees' experiences on the job affect their overall well-being.

Secondly, knowledge about job content quality among the working poor is important because the workplace factors that contribute to job quality, such as supervisor support, learning opportunities, and input into decision making, have been associated with employment outcomes, including job commitment and retention. (Bond & Galinsky, 2006; Bond, Galinsky & Hill, 2005; Bond, Galinsky, & Swanberg, 1997). More specifically, employees in high quality jobs are more likely to be committed to their jobs and want to continue working in their jobs compared to employees in low quality jobs (Bond, et al., 2005).<sup>1</sup> This research implies that job content quality may be an important component in understanding labor force attachment and contributors to poor health among the working poor, who are vulnerable to employment in lower quality jobs (Lambert, 1999; Lambert & Haley-Lock, 2004).

Given the limited research on job content quality among the working poor and given the relationship of job content quality to health and employment outcomes, the purpose of this study was twofold. First we examined what job content quality factors were associated with perceived physical health status for the working poor. Second, we examined whether these factors differed for the non-working poor. This study has the potential to inform future research on the working poor, including better understanding of the relationship between workplace policy and low-

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<sup>1</sup> Bond et al. (2005) identified six job factors that make up an effective workplace: job autonomy, learning opportunities on the job, supervisor support of work and family matters, co-worker support, input into management and decision making, and flexible work arrangements. In essence, effective workplaces are comprised of quality jobs that incorporate the aforementioned factors.

income workers' health status. Additionally, findings may contribute to more informed state and federal public policies aimed at increasing economic self-sufficiency and improving economic well-being among low-income workers.

### Defining Working Poor

A variety of definitions have been used to classify individuals as “working poor.” The U.S. Department of Labor (DOL) (2002) defines working poor as any individual who spends at least 27 weeks in the labor force, but whose income falls below the official poverty threshold. DOL has identified four groups of people most likely to be working poor: (a) women with children, (b) minorities, (c) young workers, and (d) individuals with lower educational levels, with the greatest risk for high school dropouts. These workers most often are employed in service industry occupations followed by employment in agricultural production industries (i.e., farming, forestry, fishing).

Some researchers have argued that using the federal poverty threshold as a “cutoff” does not adequately represent the number of families who are struggling to make ends meet. Waldron, Roberts, and Reamer (2004) include as working poor those families with a combined work effort of at least 39 weeks in the last year among household members 15 years and older, but with total annual household incomes below 200% of the federal poverty line. Using this definition, working poor families account for 27.4% of all working families in the U.S. These workers primarily are employed in the low-skill service sector or in sales-related jobs. Still others argue that even 200% of poverty leaves some working families without important resources and lacking economic self-sufficiency. For example, in a hearing on Welfare and Medicaid Reform (1996) Davis noted that nearly one-half of working families earning 250% of poverty or less are either uninsured or depend on public assistance for health insurance coverage. Whether earning

200% or 250% of poverty, these families face multiple challenges to stable employment, including lack of accessible and affordable childcare, transportation difficulties, and depression (Polit, Widom, Edin, et al., 2001). Recognizing these challenges, a number of states permit access to critical work supports, such as child care and fuel subsidies, for families who earn up to 250% of poverty (Miller, Molina, Grossman, & Golonka, 2004). For the purposes of this research, we have used the more liberal definition of working poor to include those workers earning less than 250% of poverty.

### Job Content Quality

#### Historical Trends in Job Content Quality and Health Research

Over the last 27 years, the demand-control-support model developed by Karasek (1979) and expanded by Johnson and Hall (1988) and others (e.g., Pelfrene et al., 2002) has dominated research on job content quality. The demand-control-support model suggests that jobs high in psychological demands and low in decision latitude create psychological strain and negative health effects for the worker (Karasek, Brisson, Kawakami, Hourtman, & Bongers, 1998). Alternatively, jobs high in psychological demands and *high* in decision latitude (thus providing the worker with job control to manage the demands) generally produce feelings of job satisfaction and motivation to learn new things (Karesak et al., 1998). Although the focus of the job-demand-support model is primarily psychological job demands, it does include physical exertion and labor as potential stress-producing factors.

Task-focused and emotional support from coworkers and supervisors is the third dimension of the demand-control-support model. According to the model, jobs with high demands, low control, and low support produce the most risk for physical illness (Johnson, 1986; Johnson & Hall, 1988; Karasek & Thoerell, 1990). Conversely, jobs with high demands, low

control, and *high* support have reduced risk of physical illness, indicating the important moderating role of social support in the workplace.

Other studies using a similar demand-support-control model have underscored the finding that psychosocial factors in the workplace, such as decision-making latitude, psychological demands, and skill discretion, are associated with absenteeism due to sickness, even after controlling for other confounding variables (Christensen et al., 2005; Melchior, Niedhammer, Berkman, & Goldberg, 2003; Nielsen, Rugulies, Smith-Hansen, & Kristensen, 2004; Northe, Syme, Feenye, Shiple, & Marmot, 1996). For example, Christensen et al. (2004) found that high levels of skill discretion in a technical services company predicted low sickness absence. Similarly, Pelfrene and colleagues' (2002) analyzed over 5,000 women and 16,000 men in Belgium and found that psychological and physical demands were directly related to psychological distress, including symptoms of depression and anxiety. Pelfrene et al. did not find evidence that high social support moderated the relationship between high psychological demands and resultant psychological distress.

#### Recent Trends in Job Content Quality Research

Although the framework for understanding the relationship between job content quality and employee health is well established, the changing nature of work and workforce demographics has led to more recent investigative efforts to expand upon the demand-control-support model to better reflect jobs in the 21<sup>st</sup> century (Bond et al., 2005; Bond et al., 1997; Marmot, 1999). For example, Marmot and colleagues (1999) noted that to examine the effects of work environments on employees' emotional and physical well-being, changes in the nature of work over the last 30 years need to be considered. These changes include: (1) greater psychological and emotional demands and fewer physical demands; (2) more service sector

employment; and (3) the dominance of computer and automated information processing (Marmot, 1999). Additionally, the face of the U.S. worker has changed in the last quarter century. More workers are now single parents, partners in a dual earner couple, and family members with caregiving responsibilities (See Bond et al., 1997). Recent data show that 85% of wage and salaried workers in the U.S. live with at least one family member and have daily family responsibilities (Bond et al., 2002). More than 75% of partnered employees have spouses or partners who also work. Forty-eight percent of workers have dependent children. Nearly one-fifth of workers care for an elder family member or friend, and another 48% expect to have this responsibility in the next five years (Bond et al., 2002). These data show that most workers are balancing the demands of both work life and home life.

Despite the changing face of today's worker, most workplaces base their policies on what legal scholar Joan Williams (2000) calls the "ideal worker." This employee works full-time, willingly works overtime, and takes nominal time off for family responsibilities and caregiving. Among the working poor, few can realistically meet the demands of the "ideal worker" given their family responsibilities in conjunction with limited financial resources, and this causes a mismatch between work and family responsibilities and expectations. As a result of this institutional mismatch, low-income working families, especially those with young children, strategically and sometimes precariously balance their work and caregiving responsibilities. Jobs with limited schedule flexibility or input into schedules create significant strain for these workers (Presser, 1998, 2000; Swanberg, 2005). Likewise, supervisors who are inflexible to their employees' personal or family circumstances contribute to their employees' stress and possibly risk losing good workers (Hill, Hawkins, Ferris & Weitzman, 2001; Kossek, Barber & Winter; Tausig & Fenwick, 2001) Swanberg (2005) suggests that temporal and structural factors

associated with meeting job and family demands create significant strain for workers employed in low-wage jobs. That is, a particular shift assigned to an employed parent may not be the primary cause of strain, but rather it is the *timing* of the assigned shift in combination with an employed parent's caregiving responsibilities that may produce strain. Marmot and colleagues (1999) suggest that the previously constructed ideas about job quality may not "fit" with the contemporary nature of work, especially for the working poor, many of whom are employed in the service economy.

In response to the work of Marmot (1999), Swanberg (2005) and others (e.g. Bobak, Marmot, Pikhart, Rose, & Hertzman, 2000; Ferrie et al., 2001) who suggest that studies of the relationship between workplace psychosocial factors and employee health need to consider factors associated with the contemporary workforce, Author Citation (under review) used nationally representative U.S. data to investigate an expanded model of workplace factors associated with employee health. They found that flexibility on-the-job, a factor not previously considered in the traditional demand-control-support model of job content quality, was significantly associated with better self-reported health status. This finding underscores other work that suggests job content quality in the new millennium needs to be more thoroughly studied and better understood, especially in relation to the potential effect on workers' health.

In view of the documented need to better understand job content quality for workers in the U.S., the goal of this research was to fill a gap in the literature regarding job content quality among the working poor in the United States, because a growing proportion of workers in the U.S. are employed in low-wage jobs (Hecker, 2004; Presser, 2000). As such, it seems critical to understand the effect of working conditions on employee health and well-being. Low-income workers are vulnerable to unstable employment and poor health that may be exacerbated by

working conditions. The research questions guiding the study are: (a) What job content quality factors influence health for the working poor in the United States? (b) Do these factors differ between the working poor and non-working poor? Findings have the potential to inform workplace and federal policies aimed at improving the health and well-being of the working poor in the U.S.

## Methods

### Data

We used the 2002 National Study of the Changing Workforce (NSCW) (Families and Work Institute, 2004) for this study. The Families and Work Institute began the NSCW in 1992, and it has surveyed representative samples of the nation's labor force every 5 years on all aspects of employment, including the quality of the work environment. Additionally, the NCSW includes variables important to this study, including: (a) demographics, (b) earnings, (c) workplace characteristics, and (d) physical health status.

The NCSW is based on a stratified unclustered random probability sampling design. Using a computer-assisted telephone interviewing (CATI) system, phone interviews lasting approximately 45 minutes were conducted with participants who met the following inclusion criteria: (a) at least 18 years of age; (b) earning wages or salaries from employment or a self-operated income-producing business within the civilian labor force; (c) residing in the contiguous 48 states; and (d) not among the institutionalized population. In the 2002 survey, 2,810 of the 3,504 participants were wage and salaried workers. The overall response rate for the NCSW was 52%. See the Families and Work Institute ([www.familiesandwork.org](http://www.familiesandwork.org)) for additional information on data collection and sampling.

## Sample

For the present study only the wage and salaried respondents who had complete data were used ( $N=2,584$ ). Specifically, two subsamples were selected for comparison:

(a) respondents who were living in households earning less than 250% of the federal poverty threshold ( $n=548$ ); and (b) respondents who were living in households earning greater than or equal to 250% of the federal poverty threshold ( $n=2036$ ). Demographic information for the two groups is summarized in Table 1.

## Outcome Variable

*Physical health status* was measured using a single-item indicator, which asked respondents to rate the quality of their health (1=poor; 2=fair; 3=good; 4=excellent). Research has shown that a single-item, self-rated health question is a reliable indicator of physical health status in the general population, including being a good predictor of mortality and health care use even after adjusting for functional status and comorbid conditions (De Salvo, Bloso, Reynolds, & Mutaner, 2006; DeSalvo, Fran, McDonell, & Fahn, 2005; Eriksson, Unden, & Elofsson, 2001; Jenkinson, Wright, & Coulter, 1994; Malm, Svensson, Karlsson, & Fridlund, 2003; Mercer, Layde, & Guse, 2001). A frequency distribution of the ordinal variable indicated that only 40 respondents reported “poor” health. Thus, we collapsed the health variable into a dichotomous variable, so that 1=fair or poor health and 0=good or excellent health. This ensured cell sizes of ample size to conduct the analyses.

## Predictor Variables

*Demographic variables* included sex, age, ethnicity, educational status, marital status, urbanicity, children under 18 in the household, elder care responsibilities, and full-time/part-time work status. Sex was measured dichotomously (1 = male and 2 = female). Age was a continuous

variable. Ethnicity was a categorical variable: (a) White, non-Hispanic; (b) Black, non-Hispanic; (c) Latino/Hispanic; and (d) other. Marital status included three categories: (a) married; (b) living with a partner in a marriage-like relationship; and (c) single. Education was categorized into: (a) high school/GED or less; (b) some college/post-secondary school; and (c) four-year college degree or more. Urbanicity was classified as urban, suburban, or rural. The presence of children under 18 years and elder care responsibilities were measured dichotomously (1=yes 0=no). Work status also was measured dichotomously (1=full-time; 2=part-time).

*Decision latitude* was measured using the mean of six items on a 4-point Likert scale (1=strongly disagree; 4=strongly agree). Three items (allowed to make one's own decisions, decision freedom, and has lots of say) reflect the employee's level of decision authority, and three items (ability to learn new things, repetitive work, and creativity required) reflect the employee's level of skill discretion. Higher scores indicated more decision latitude, and scale reliability was calculated at  $\alpha = 0.67$ .

*Traditional psychological demands* were measured by the mean of seven items on a 4-point Likert scale (1=strongly agree; 4=strongly disagree): (a) have to work hard; (b) have to work fast; (c) never enough time; (d) excessive work; (e) conflicting demands; (f) hectic; and (g) often interrupted. *Higher scores* indicated fewer demands, and scale reliability was calculated at  $\alpha = 0.79$ .

*Supervisor support for work issues* was measured by the mean of five items on a 4-point Likert scale (1=strongly disagree; 4=strongly agree): (a) supervisor keeps me informed; (b) supervisor recognizes a good job; (c) supervisor has realistic expectations; (d) supportive with work problem; and (e) supervisor is competent. Higher scores indicated greater supervisor support. Scale reliability was calculated at  $\alpha = 0.83$ .

*Co-worker support* was measured using the mean of three items on a 4-point Likert scale (1=strongly disagree; 4=strongly agree). These items included: (a) coworkers are friendly; (b) coworkers are interested; and (c) coworkers work together. The scale reliability was calculated at  $\alpha = 0.75$ , and higher scores indicated more coworker support.

*Physical demands* were measured by a single item on a 4-point Likert scale (1=strongly agree; 4=strongly disagree): job is physically demanding/tiring. The item was stated in the reverse, so that a *lower score* indicated a more physically demanding job.

*Job insecurity* was measured by the mean of five variables. Three were dichotomous (1=no 0=yes) and reflected the possibility of job loss (recent and future layoffs and reduced work hours when work is slow). Two were measured on a 4-point Likert scale (1=strongly disagree; 4=strongly agree) and reflected opportunities for advancement (career possibilities and valuable skills). *Higher scores* indicated more job security. Scale reliability was calculated at  $\alpha = 0.35$  for the insecurity/job loss items and  $\alpha = 0.59$  for the advancement items.

*Supervisor support for work-family issues* was measured by the mean of five items on a 4-point Likert scale (1=strongly disagree; 4=strongly agree), including: (a) fairness about personal/family needs; (b) accommodates family/personal business; (c) understands personal/family issues; (d) comfortable bringing up personal/family issues; and (e) cares about effects of work on personal/family life. *Higher scores* indicated greater supervisor support for work-family issues. Scale reliability was calculated at  $\alpha = 0.87$ .

*Workplace flexibility*, or the policies and practices that aid employees in meeting their work, family, and personal responsibilities (Lambert 1999; Bond 2001; Bond 2002; Swanberg 2005) was measured using the mean of nine items that assess temporal and spatial forms of flexibility. Three items measured general satisfaction with schedule on a 4-point Likert scale

(1=strongly disagree; 4=strongly agree) and included: (a) control over schedule, (b) satisfaction with schedule, and (c) difficulty taking time off for personal/family issues. Six items were measured dichotomously (1=yes; 0=no) and reflected access to flexible or alternative work arrangements. These items included: (a) work from home, (b) days off for sick child without losing pay or vacation time, (c) choose starting and quitting times, (d) work a compressed work week, (e) change schedule daily, and (f) decide when to take breaks. Higher scores indicated more flexibility, and scale reliability for these items was calculated at  $\alpha = 0.63$ .

### Data Analysis

Stata 9.0 was used to analyze all data. The *svyset* command was used to account for the survey design and weighting. First, independent samples *t*-tests (for continuous variables) and cross-tabulation (for categorical variables) were used to compare demographic and job content quality variables between the working poor in good health and the working poor in poor health and between the non-working poor in good health and the non-working poor in poor health using the *subpop* command. Given that the independent bivariate analyses results indicated the demographic and job content quality factors associated with physical health status were different for the working poor and non-working poor groups, we ran separate multivariate regression models for each group. Specifically, we ran a backward stepwise multiple logistic regression model for each subsample (working poor and non-working poor), where all significant variables were entered simultaneously into the model. A cutoff value for removal was set at  $p=0.10$  for all variables apart from significant demographic confounders. A backward stepwise procedure was utilized, because we wanted to explore which factors would emerge as significant among the eight job content quality variables that have been previously associated with employee health, controlling for demographic confounders in each group. Categorical variables were dummy

coded (0,1) in all regression models, and the reference categories are noted in the tables of results. Our final models included only those variables that were significant at the  $p \leq .10$ .

### Results

Table 2 presents the results of the cross tabulations and *t*-tests for the working poor and non-working poor samples. Significant demographic variables for the *working poor* sample included: education ( $p < .001$ ), marital status ( $p = .01$ ), and age ( $p = .02$ ), and for the *non-working poor* sample included: sex ( $p = .01$ ), marital status ( $p = .001$ ), education ( $p < .001$ ), ethnicity ( $p = .01$ ), and urbanicity ( $p = .01$ ). In general among the *working poor*, those who were in poor health had less education, were older, and fewer were married compared to those who were in good health. In general among the *non-working poor*, a larger proportion of those in poor health was female, had less education, was single or living with a partner, was a person of color, and resided in a rural area compared to those in good health. In the *working poor* sample, there were statistically significant differences on all job content quality variables between workers in good and poor health except for skill discretion ( $p = .11$ ) and coworker support ( $p = .07$ ). In the *non-working poor* sample, there were statistically significant differences on all job content quality variables between workers in good health and workers in poor health.

Table 3 presents the results of the backward stepwise regression for the *working poor* sample. After controlling for demographic confounders, psychological demands were statistically significantly associated with poor health (Adjusted Odds Ratio [AOR]: 0.63,  $p = 0.01$ ), and supervisor support for work-family issues was marginally associated with increased odds of a worker reporting poor health (AOR: 0.77,  $p = 0.08$ ). Findings imply that high job demands and low supervisor support for work-family issues contribute to poor health status for working poor individuals.

Table 4 presents the results of the backward stepwise regression for the *non-working poor* sample. After controlling for demographic confounders, decision latitude (AOR: 0.70,  $p=.01$ ), supervisor support for work-family issues (AOR: 0.71,  $p=.01$ ), and coworker support (AOR: 0.77,  $p=.05$ ) all were associated with increased odds of a worker reporting poor health. That is, among non-working poor respondents, those who reported having less decision latitude, less supervisor support for work-family issues, and less co-workers support also were more likely to report poor physical health status.

### Discussion

The purpose of this investigation was to determine which job content quality factors are associated with perceived poor physical health status for the working poor, and then to determine whether these job content quality factors differ from the factors that are associated with poor physical health among non-working poor. To date, much of the discussion about the working poor has focused on wages, access to health benefits, and access to sick or family leave (Heymann, 2000; Levin-Epstein, 2006; Swanberg, Pitt-Catsouphes & Drescher-Burke, 2005; Williams, 2006). While these factors are important for quality of life among working poor families, researchers may be overlooking an important aspect of work that contributes to health and well being: the quality of employees' jobs.

Three important findings emerge from this investigation of the job content quality factors that influence health for the working poor and whether these factors differ between the working poor and non-working poor. First, this study provides additional evidence that employees' self-rated health status is associated with job content quality. In both the working poor and non-working poor samples, several job factors emerged as associated with respondents reporting poor or fair physical health. This is an important finding for employers, because employee health costs

are the single fastest growing expense in workplaces (National Coalition on Health Care, 2006). These findings suggest that if organizations seriously consider modifying workplace practices as one strategy to reducing employee health costs, they may want to consider different strategies for improving job content quality within different categories of workers in the labor force. Workplaces need to consider a range of solutions that best fit the process and components of different jobs across all earnings categories.

Second, the finding that different job factors were associated with self-rated health status for the two employee samples underscores recent evidence that suggests the meaning of job content quality is job specific (Kristensen, Bjorner, Christensen & Borg, 2004). The original demand-control-support model (Karasek, 1979; Karasek & Theorell, 1990) suggests that high psychological job demands in association with low decision latitude produces psychological strain and results in negative health effects (Karasek et al. 1998). However in this study, among the working poor greater perceived job demands were associated with poor self-rated health and supervisor support for work-family was marginally associated with poor self-rated health, while decision latitude dropped out of the model. Conversely for the non-working poor group, decision latitude, rather than psychological demands, emerged as a job factor associated with perceived health status, along with supervisor support for work-family matters, and co-worker support. Based on these findings, “all jobs are not created equal” insofar as influencing an employees’ self-rated health status. To some extent, it is not surprising that the job characteristics associated with poor health for lower income employees differ from the job characteristics associated with poor health among higher income workers. Among jobs that pay low wages, employees typically are expected to conduct routine job tasks within rigid parameters. Characteristically, it seems logical that the seven factors that constitute psychological job demands (have to work hard; have

to work fast; never have enough time to complete work; excessive work; conflicting job demands; hectic pace; and often interrupted while trying to complete tasks) are associated with perceived poor health among lower wage earning employees. That decision latitude did not emerge as an important factor in self-rated health status for the working poor sample may reflect the nature of low-income jobs, which often encompass responsibility for supervisor-assigned fixed tasks with little or no employee authority to determine what tasks are completed when. Thus, decision latitude is not an expectation of the job, and so it does not have as great an effect on employees' self-rated health status as it does for higher income jobs.

Third, this study provides further evidence that supervisors' responsiveness to employees' work-family matters is a job characteristic that should not be overlooked in the 21<sup>st</sup> century workplace. While the work-related supervisor support measure was not statistically associated with self-rated health for either sample, supervisor support for family matters was marginally and significantly associated with perceived health among both the working poor and non-working poor samples, respectively. The changing nature of work in conjunction with evolving demands on working families calls for a reexamination of the factors that have traditionally and collectively been viewed as job content quality (Author Citation, under review; Bond et al., 1997; Bond et al., 2005; Marmot, 1999; Swanberg, 2005). This study's results mirror those of other investigations that have identified supervisor support for work-family issues as a job characteristic associated with a variety of personal and organizational outcomes, including minimizing the conflict associated with managing work and family demands and maximizing employee retention, recruitment, and productivity (Batt & Valcour, 2003; Berg, Kallenberg & Appelbaum, 2003; Eaton, 2003; See Perry-Jenkins, Repetti, & Crouter, 2000). As employers

continue to refine workplace policies and practices, it is clear they must focus on the work-family interface and its relationship to employee well-being and productivity.

### Implications

Results from this study have important implications for the field of organizational psychology, research, workplace policy, and federal public policies.

*Organizational Psychology.* Changes in employment trends and family caregiving arrangements are among the most fundamental shifts that have occurred in the 21<sup>st</sup> century, and these changes have had (and will continue to have) an impact on the quality of life for diverse families. Scholars from a variety of disciplines, including psychology and occupational health, have contributed significantly to the discourse on working families (see Pitt-Catsophes & Swanberg, 2006 for review) suggesting that the institutional mismatch between the needs of working families and the needs of workplaces has a profound effect on the daily health and well-being of working families. Our analyses suggest that improving job content quality may have a positive effect on employee health and help to reduce employer health care costs. Workplace-based strategies designed to improve job content quality for lower income and other workers would be most effective if they are specifically designed to address the salient concerns and circumstances of particular populations of workers.

Mor Barak (2005) argues for the utilization of workplace policies and practices as a strategy to assist employees in meeting their work and family responsibilities. We take this argument one step further by suggesting that strategically improving job content quality also would benefit employee health. Considering our study within the broader job content quality literature, it seems apropos that practice professions (e.g. psychology, behavioral health, and social work) more actively pursue avenues for improving job conditions for working people,

especially the working poor, who face additional barriers to health and well-being. We highlight several opportunities for psychologists and other professions to engage in research, workplace policy, and federal public policy activities that may improve the lives of working poor individuals and families.

*Research.* Previous work on job quality has suggested that job demands, job control, and support from supervisors and co-workers constitute, at least in part, the construct of job quality. Our findings suggest that perceived job quality may have different meanings for different populations of workers, and therefore the job characteristics associated with perceived health may differ according to different classifications of workers. To fully understand the relationships between job quality and employee health in the 21<sup>st</sup> century and among different populations of workers, additional research is needed. In particular, to better assist working poor families, more knowledge is needed about the relationship between job quality and well-being of the working poor. Although Karasek's (1979) demands-control model and Johnson's (1986) expanded demands-control-support model are among the most widely tested of occupational health, many of these studies rely on traditionally male occupations, middle to higher income occupations, or data collected before 1990 (De Lang, Taris, Kompier, Houtman, & Bongers, 2003). Our findings suggest that given the changing nature of work, family life, and the economy, an examination of the meaning of job content quality and its subsequent relationship for different populations of workers is over due. New original research in this area (e.g., Grzywacz, Bass & Linney 2005; Swanberg & James, 2007) may help to more fully understand the complex relationships between job conditions, employee health, and family well-being. Organizational psychologists are uniquely positioned to pursue further examination into this area because of their perspective

about how individuals, in this case low-wage employees, are affected by and function within the context of their environments.

*Workplace policy.* Results from this study suggest that psychological job demands are significantly associated with poor health among the working poor. Employers that rely on a low-wage workforce would benefit from redesigning management practices and/or workplace processes to reduce job demands, as this also may reduce the incidence of poor employee health and associated costs. Results further suggest that supervisor support for work-family matters is significantly associated with the health of both the working poor and non-working poor. Given previous research (De Lang, et al., 2003) and findings from this study, organizations may benefit from employing strategies that integrate employee-responsive supervisory practices into management training. Workforce development funds could be utilized for pilot projects aimed at changing supervisory and management attitudes about work-life issues. Additionally, tax incentives could be provided to businesses with large numbers of certain categories of workers (e.g. hourly and low-wage workers) that implement creative approaches to workplace flexibility. Supervisor and management curricula could be designed to inform organizational leaders about the effects of job conditions on employee health and well-being and the costs to employers. Moreover, organizational psychologists could serve as private-public liaisons within organizations to assist securing public funds and tax incentives available for training and development in employee-responsive practices.

*Public policies.* Recent poverty and workforce development policies have been aimed at increasing economic self-sufficiency through long-term employment. Interestingly, none of these policies has considered the role of job quality in job retention and long-term economic stability, despite research that suggests job quality is a critical component of the work environment and

ongoing labor force attachment. Given the findings from this study within the broader literature on job quality, it seems that job content quality should be integrated into future policies. For example, one-stop employment centers funded through the Workforce Investment Act could incorporate job content quality into assessments of available job opportunities. Based on these assessments, workers could be matched with prospective employers that offer a work environment that best “matches” their family life and responsibilities. County welfare agencies also could incorporate job content quality into employment matching services when they are assisting cash recipients in meeting their required work effort. In both cases, by matching workers with employers that offer the kinds of workplace supports needed to manage family responsibilities, the likelihood of long-term employment is enhanced.

#### Study Limitations

Although this is one of the first studies to examine whether the job characteristics associated with self-reported ill health differ between the working poor and non-working poor, results should be understood within the context of the study limitations. First, the 52% response rate is low compared to other national studies (e.g., National Comorbidity Survey-Replication Response Rate [*RR*] = 76.1% [Kessler et al., 2004]; National Survey of Drug Use and Health *RR*=78.6% [SAMHSA, 2003]), so findings may not be generalizable to all working poor in the U.S. Second, the NSCW data are cross-sectional. Thus, these findings provide information about the nature of the relationships between significant job content quality factors and self-rated health status, but no causal claims may be made. Additional longitudinal studies are warranted.

#### Conclusions

In this study we found the job content quality factors associated with self-rated health status differed for working poor and non-working poor individuals. Specifically, we found that

high psychological demands and low supervisor support for work-family issues were associated with poor health for working poor individuals, while low decision latitude, supervisor support for work-family issues, and coworker support were associated with poor health for non-working poor individuals. Findings suggest that “all jobs are not created equal” insofar as effects on employee health are concerned. Organizational psychologists and other practice professionals should engage in research, workplace policy, and federal public policy activities that promote employee-centered supervisory practices across different job categories and match potential employees with employers that align with work-family needs to improve the health of the working poor.

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Table 1. Demographic characteristics

Variable	Working Poor ( <i>n</i> =548) %	Non-Working Poor ( <i>n</i> =2036) %
Sex		
Male	51.3	51.3
Female	48.7	48.7
Education		
High school/GED or less	60.8	35.5
Some college	29.9	29.4
4-year college degree or more	9.3	35.1
Marital Status		
Married	40.9	65.6
Living with partner	7.4	6.8
Single	51.7	27.6
Ethnicity		
White, non-Hispanic	61.8	79.5
Black, non-Hispanic	14.5	8.7
Hispanic/Latino	20.2	6.7
Other	3.5	5.1
Urbanicity		
Urban	53.9	55.9
Suburban	19.3	23.3
Rural	26.8	20.7
Age	<i>m</i> =33.59	<i>m</i> =43.28

Table 2. Comparison of Variables of Interest according to Health Status across Working Poor and Non-Working Poor Samples

Variable	Working Poor			Non-Working Poor		
	Good Health %	Poor Health %	<i>p</i> -value	Good Health %	Poor Health %	<i>p</i> -value
Sex			0.52			0.01
Male	52.0	48.9		52.5	44.7	
Female	48.0	51.1		47.5	55.3	
Education			<.001			<.001
High school/GED or less	56.6	74.5		33.7	45.6	
Some college	32.4	21.7		30.0	31.7	
4-year college degree or more	11.1	3.7		37.3	22.7	
Marital Status			0.01			0.001
Married	43.4	32.7		67.0	58.3	
Living with partner	6.0	12.1		6.0	11.0	
Single	50.6	51.7		27.0	30.7	
Ethnicity			0.53			0.01
White, non-Hispanic	61.5	62.8		80.4	74.8	
Black, non-Hispanic	15.1	12.8		7.9	13.0	
Hispanic/Latino	19.6	22.4		6.9	5.7	
Other	3.9	2.0		4.8	6.5	
Urbanicity			0.24			0.01
Urban	54.6	51.8		56.9	50.4	
Suburban	17.9	23.9		23.5	22.3	
Rural	27.6	24.3		19.5	27.3	
Children <18 years in house			0.61			0.34
Yes	56.7	53.4		91.5	89.5	
No	43.3	46.6		8.5	10.5	
Elder Care Responsibilities			0.41			0.68
Yes	31.9	36.8		36.1	34.8	
No	68.1	63.2		63.9	65.2	
Work Status			0.77			0.97
Full-Time	67.1	68.8		85.7	85.6	
Part-Time	32.9	31.2		14.3	14.4	

Table 2 Continued

Variable	Working Poor			Non-Working Poor		
	Good Health <i>m</i>	Poor Health <i>m</i>	<i>p</i> -value	Good Health <i>m</i>	Poor Health <i>m</i>	<i>p</i> -value
Age	32.91	35.01	0.02	43.15	44.01	0.23
Job Content Quality						
Physical demands*	2.42	2.12	0.01	2.61	2.38	0.01
Supervisor work support	3.60	3.47	0.03	3.50	3.30	<.001
Coworker support	3.49	3.37	0.07	3.46	3.23	<.001
Psychological demands*	2.84	2.63	0.01	2.37	2.47	0.04
Skill discretion	2.76	2.68	0.11	2.98	2.72	<.001
Job insecurity*	2.42	2.29	<.001	2.50	2.43	0.01
Workplace flexibility	1.43	1.36	<.001	1.51	1.41	<.001
Supervisor work-family support	3.31	3.12	0.02	3.31	3.01	<.001

\*These variables are reverse coded, so lower scores indicate greater demands and insecurity.

Table 3. Backward Stepwise Regression Results: Job Content Quality Variables Associated with Poor Health for the Working Poor ( $n=548$ )

<b>Variables</b>	<b>Odds Ratio</b>	<b>95% Confidence Interval</b>	<b><i>p</i>-value</b>
<b>Educational Levels</b>			
High school/GED or less	Ref	Ref	Ref
Some college	0.52	(0.31-0.86)	0.01
4-year college degree or more	0.42	(0.19-0.92)	0.03
<b>Marital Status</b>			
Married	Ref	Ref	Ref
Living with partner	2.06	(0.88-4.79)	0.09
Single	1.25	(0.75-2.08)	0.38
Age	1.03	(1.01-1.05)	0.01
Psychological demands	0.63	(0.46-0.87)	0.01
Supervisor support for work-family	0.77	(0.57-1.04)	0.08
Model $\chi^2$		30.67 ( $p<.001$ )	
-2 Log likelihood		220.50	

Table 4. Backward Stepwise Regression Results: Job Content Quality Variables Associated with Poor Health for the Non-Working Poor ( $n=2036$ )

<b>Variables</b>	<b>Odds Ratio</b>	<b>95% Confidence Interval</b>	<b><i>p</i>-value</b>
Sex			
Male	Ref	Ref	Ref
Female	1.43	(1.07-1.91)	0.02
Ethnicity			
White, non-Hispanic	Ref	Ref	Ref
Black, non-Hispanic	1.77	(1.13-2.76)	0.01
Hispanic/Latino	0.88	(0.47-1.62)	0.67
Other	1.43	(0.79-2.61)	0.24
Educational Levels			
High school/GED or less	Ref	Ref	Ref
Some college	0.89	(0.62-1.27)	0.52
4-year college degree or more	0.59	(0.41-0.85)	0.01
Marital Status			
Married	Ref	Ref	Ref
Living with partner	1.26	(0.74-2.16)	0.40
Single	1.11	(0.82-1.51)	0.49
Urbanicity			
Urban	Ref	Ref	Ref
Suburban	1.13	(0.80-1.61)	0.47
Rural	1.45	(1.02-2.07)	0.03
Decision latitude	0.70	(0.55-0.91)	0.01
Supervisor support for work-family	0.72	(0.58-0.88)	0.01
Coworker support	0.77	(0.60-0.99)	0.05
Model $\chi^2$		97.92 ( $p<.001$ )	
-2 Log likelihood		673.02	