Families and Work Institute

2008 National Study of the Changing Workforce

NSCW 2008

THE STATE OF HEALTH IN THE AMERICAN WORKFORCE:

Does Having an Effective Workplace Matter?

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Kerstin Aumann
Ellen Galinsky

Families and Work Institute

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INTRODUCTION AND OVERVIEW

Health care is not only "in" the news—it IS the news. Almost everyone seems to agree—surprisingly for the first time—that the path we are on is an untenable route to increasing costs and diminishing returns, yet the path we should take remains unclear. The President, members of Congress, insurance companies, medical coalitions, employers, unions, experts, civic groups and many citizens are in a pitched battle to win our hearts and minds.

Families and Work Institute (FWI) enters this fray with national data revealing some serious findings about the state of U.S. employees' health that we think should be considered in the debates:

- employees' physical health shows downward trends;
- men's health has been deteriorating more than women's health;
- mental health has remained stable over the past six years—but a large proportion of the workforce show signs of clinical depression;
- sleep problems are pervasive; and
- stress levels are rising.

The United States has a system where health care promotion and protection are the purview of employers. Whether or how much this role begins to shift, our findings argue convincingly that employers must consider another role beyond providing health care insurance and wellness programs. The work environment—where each of us spends most of our waking hours—has a considerable impact on our health and well-being. Improving the work environment is a low- to no-cost investment that every employer should make if we are truly to reform health care, reduce spiraling health care expenditures and actually improve health in America.

WHAT IS THE STATE OF HEALTH OF THE AMERICAN WORKFORCE?

In 2002 and again in 2008, Families and Work Institute asked employees across the U.S. a series of questions about their physical and mental health as part of our nationally representative, comprehensive ongoing study of the U.S. workforce, the National Study of the Changing Workforce.[1] A comparison of findings from both years reveals that the state of health of the American workforce is deteriorating.

PHYSICAL HEALTH

Perceptions of Overall Health

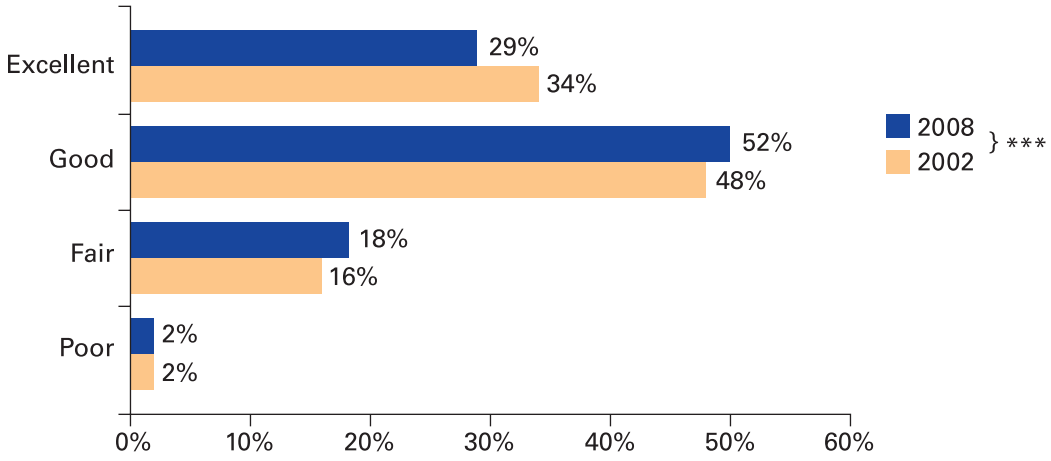
FINDING: Less than one third of employees (29%) today say their overall health is "excellent"—a significant decline of 5%.

Employees were asked to rate their current state of health overall. Although these are employees' own perceptions and not an objective physical assessment, one could argue that individuals' perceptions are their realities.

Responses suggest that overall health is declining among the American workforce compared with six years ago, as shown in Figure 1.

The percentage of employees rating their overall health as *excellent* has dropped significantly by six percentage points from 34% in 2002, down from 29% in 2008.

Figure 1: Employees' self-assessment of their current state of overall health



Source: Families and Work Institute. 2002 NSCW (N=2,810), 2008 NSCW (N=2,765). Statistically significant changes between survey years are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

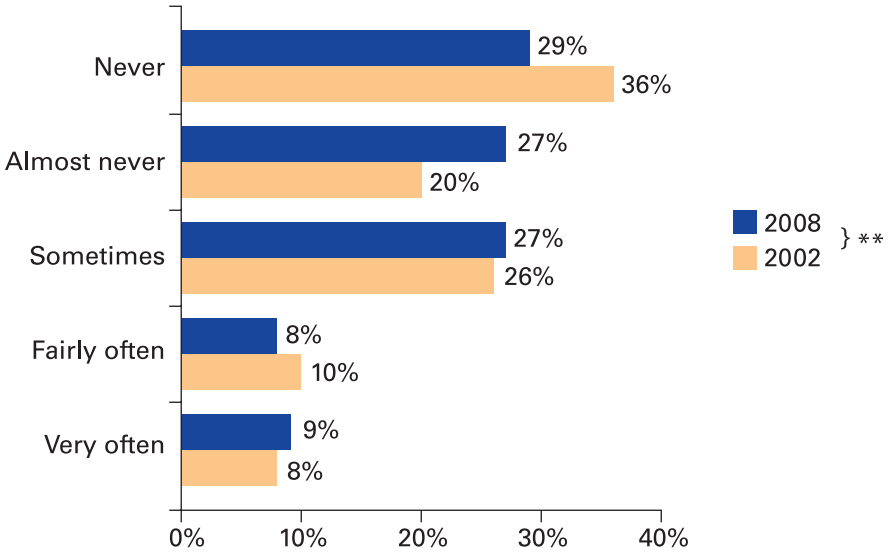
Frequency of Minor Health Problems

FINDING: Minor health problems are becoming more frequent among American employees.

Employees were asked how often they had experienced minor health problems in the last month, such as headaches, upset stomachs or insomnia. Their responses, depicted in Figure 2, indicate that fewer employees in 2008 are free from minor health problems in the last month than they were six years ago.

In fact, the percentage of people reporting that they *never* experience minor health problems in the last month is 29% in 2008, whereas it was 36% in 2002.

Figure 2: Frequency of minor health problems in last month



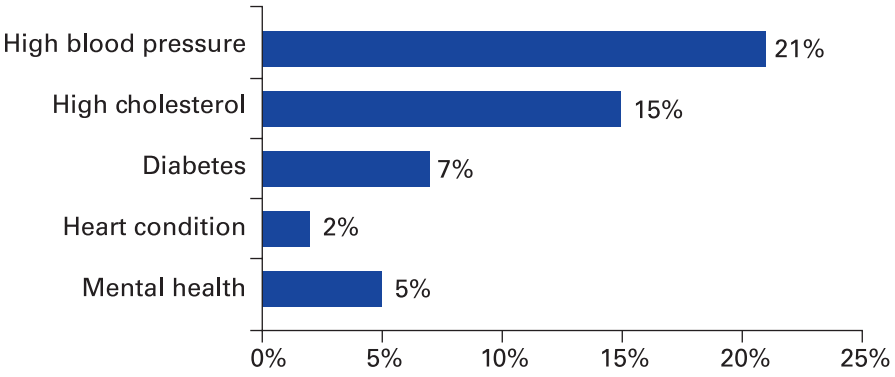
Source: Families and Work Institute. 2002 NSCW (N=2,803), 2008 NSCW (N=2,768). Statistically significant changes between survey years are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

Chronic Health Problems

FINDING: Just more than one in five employees is currently receiving treatment for high blood pressure.

High blood pressure is a chronic condition that has been linked to a number of health problems, such as strokes or heart attacks. Thus, its reported pervasiveness (21%) presents a potentially serious health concern for the American workforce. In addition, 15% of employees are being treated for high cholesterol. These findings are presented in Figure 3.

Figure 3: Percentage of employees who currently receive treatment for…



Source: Families and Work Institute. 2008 NSCW (N=2,758).

(Un)healthy Lifestyles

FINDINGS: A closer look at the lifestyles of American employees reveals that there is room for improvement.

- **Despite widespread efforts to reduce smoking and the pervasiveness of strict non-smoking policies in American workplaces, more than one in five (21%) employees still smokes.**
- **The majority of employees do not exercise on a regular basis.**
- **Nearly two out of three employed individuals (62%) are overweight or obese.**

The Centers for Disease Control and Prevention (CDC) recommend that for important health benefits, adults, at a minimum, should engage in 150 minutes of moderate or 75 minutes of vigorous aerobic and strength-training activities on two or more days a week.[2] Current data from the NSCW reveal that many employed adults fall short of the recommended minimum of physical activity.

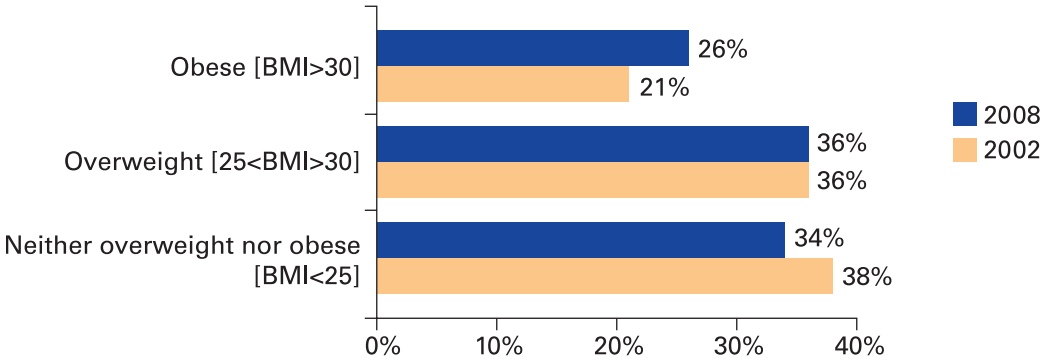
- Nearly half of U.S. employees (48%) have not engaged in regular physical exercise in the last 30 days. For example:
  - Just over one in five employees (21%) reports not engaging in *any* rigorous physical exercise in the last 30 days.
  - Slightly more than one in four employees (26%) reports exercising infrequently—from one to seven times in the last 30 days.
- 28% of employees report exercising somewhat regularly in the last 30 days—between eight and 16 times or approximately twice to four times per week.
- Another 25% of employees have exercised on more than 16 separate occasions in the last 30 days.

The low level of physical activity—or lack thereof—among nearly half of the American workforce does not bode well for important health outcomes linked to insufficient exercise. Most importantly, regular physical exercise is related to maintaining a healthy weight, which in turn decreases health risks, such as high blood pressure, heart disease and diabetes.

Statistics from the Centers for Disease Control and Prevention about weight, such as Body Mass Index (BMI), are, indeed, cause for concern.[3] Their findings are presented in Figure 4.

- In 2008, about two thirds of the U.S. workforce can be classified as either overweight or obese.
- These findings represent an increase. In 2002, 21% of the workforce was obese compared with 26% in 2008.

Figure 4: Body Mass Index categories of employed adults age 18 and older



Source: Centers for Disease Control and Prevention (CDC); 2008 and 2002 Behavioral Risk Factor Surveillance System Survey.

MENTAL HEALTH

Findings from the National Study of the Changing Workforce show relatively little change over the past years with respect to employees' mental health. Still, our 2008 data reveal—as they did six years ago—that substantial proportions of American employees suffer from mental health issues, such as depression, sleep problems and high stress levels.

Depression

FINDING: One third of the workforce shows signs of clinical depression.

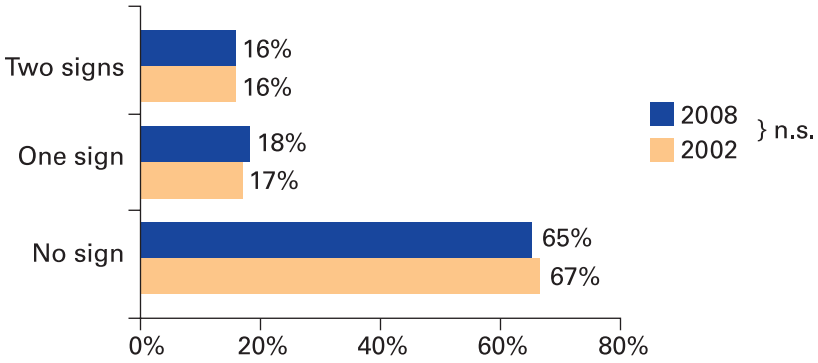
A standardized depression screening tool with two questions was included in the 2002 and 2008 NSCWs.[4] These questions are:

- During the past month, have you been bothered by feeling down, depressed or hopeless?
- During the past month, have you been bothered by little interest or pleasure in doing things?

A "yes" answer to one or both of the questions above suggests that a person should be referred to a health professional to determine if he or she is clinically depressed.

Our findings in Figure 5 indicate that signs of depression among U.S. employees have remained stable over the past six years. Still, having one third of the workforce reporting one or two symptoms and thus being at risk for clinical depression should be considered a serious issue. It is important to note that only 5% of the workforce (reported in Figure 3) say they are receiving treatment for depression.

Figure 5: Number of signs of clinical depression



Source: Families and Work Institute. 2002 NSCW (N=2,810), 2008 NSCW (N=2,755). Statistically significant changes between survey years are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

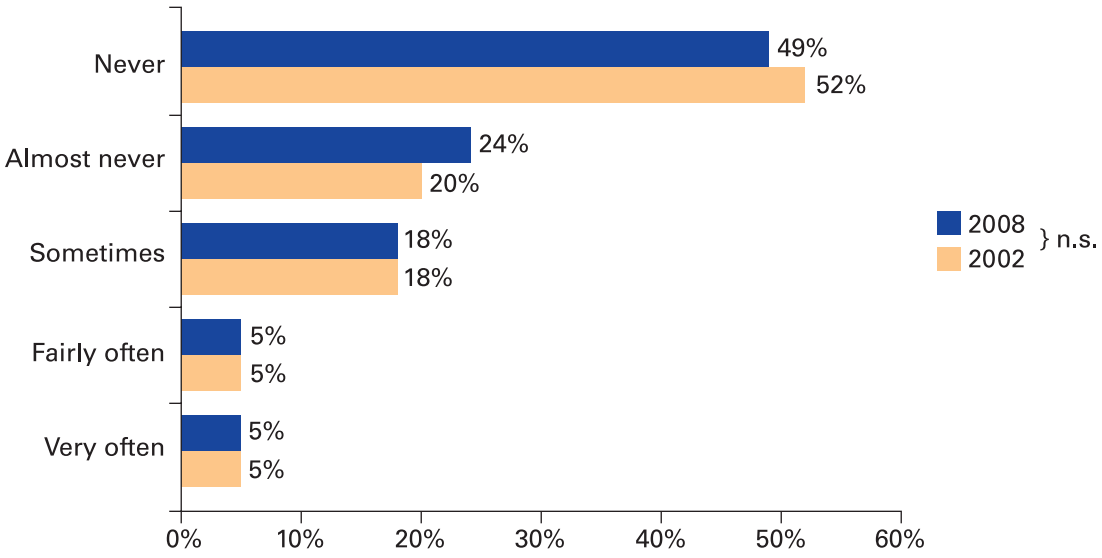
Sleep

FINDING: A significant proportion of the American workforce has sleep problems.

The question we have used in the National Study of the Changing Workforce since 2002 asks employees *directly* about how often they have experienced sleep problems that affect their job performance in the last month.

- Our findings (shown in Figure 6) indicate that there has been little change since 2002. Nevertheless, the percentage reporting sleep problems is noteworthy—more than a quarter (28%) of employees has experienced sleep problems that affect their job performance in the last month at least *sometimes*.
- Furthermore, 10% of employees report having sleep problems *often* or *very often*.

Figure 6: Frequency of sleep problems affecting job performance in last month



Source: Families and Work Institute. 2002 NSCW (N=2,805), 2008 NSCW (N=2,765). Statistically significant changes between survey years are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

The 2008 study also probes the nature of employees' sleep problems. We find that:

- One in five employees (21%) *very often* or *fairly often* has trouble falling asleep. Another 22% *sometimes* have trouble falling asleep. Only one third (34%) reports *never* having had trouble falling asleep in the last month.
- Nearly one third (32%) of employees reports awakening too soon and having trouble going back to sleep *very often* or *fairly often* with another 26% reporting *sometimes*. Just under one in four (23%) employees has *never* experienced awakening too soon in the last month.

Stress

FINDING: Stress levels are rising.

The National Study of the Changing Workforce includes a standardized measure of perceived stress that has been linked to physical health problems in other research.[5] The questions are:

In the *last month*, how often have you felt …

- nervous and stressed?
- that you were unable to control the important things in your life?
- confident about your ability to handle your personal problems?
- that things were going your way?
- that difficulties were piling up so high that you could not overcome them?

The positive questions were reversed scored and then all of the items were averaged to create an index of overall stress. A comparison between 2002 and 2008 data shows that the average stress level of the American workforce has increased significantly over the past six years.[6]

Using the five questions above as stress indicators, we found that 43% of employees report experiencing three or more indicators of stress *sometimes*, *often* or *very often*. These data provide an early warning sign that there could be an increase in stress-related illnesses among the American workforce. In fact, our data presented above also indicate that the frequency of minor health problems, such as headaches, upset stomachs or trouble sleeping, has increased—conditions that can be caused or aggravated by stress.

WELL-BEING AND ENERGY

FINDING: Life on the job can affect an individual's level of energy in their life off the job.

We include energy among the measures we examine in this report because energy is critical to investing in one's life at work, at home or in the community. In fact, employers see energy as a marker for employee engagement and the organizations' subsequent success in the marketplace.

There has been little change over the past six years in the impact of work on employees' energy for their home lives.

- Nearly one third (32%) of employees reports that their work has a primarily negative impact on their lives off the job by draining energy, so that they don't have enough left over for their personal or family life.

- Importantly, 30% of employees report the opposite—their work provides them with *more* energy for their personal or family life.
- 38% of employees report a balanced effect of work on their energy at home, such that negative influences of work draining their energy for their home lives is counterbalanced by its opposite—work energizing home life.

FINDING: Employees' personal or family life is more likely to have a positive impact on the level of energy they bring to their work than the other way around.

While the nature of the impact of work on employees' home life is fairly well balanced among positive, negative and neutral, the impact of employees' personal or family life on work is more positive. That may be surprising to some employers, where home life has traditionally been seen as competing with work.

- Nearly half of employees (49%) report that their personal or family life provides them with more energy for their jobs.
- Only 12% report that their home life undermines their energy for work.
- 39% report a balanced impact of their personal or family life on their energy levels at work.

While these findings are generally good news, there is a slight, but statistically significant, downward trend in the percentage of employees reporting a positive impact of their home life on their energy at work.

- Although 49% of employees report a positive impact, this percentage is down by five points from 54% in 2002.

It is possible that family life requires more energy today for many reasons—such as the increase in dual-earning families, family economic insecurities, the increase in elder care responsibilities and so forth.

WHAT DEMOGRAPHIC CHARACTERISTICS MAKE A DIFFERENCE IN 2008?

FINDINGS: Significant differences in employee health in 2008 exist not only across age groups, but also across other demographic characteristics.[7]

- **Not surprisingly, younger employees (under age 30) are more likely to report better overall health and are less likely to receive treatment for a chronic physical health problem than their older colleagues.**
- **Men are less likely than women to report experiencing minor health problems, sleep problems and high levels of stress.**
- **Middle- and high-wage and –income employees fare better than their low-wage/low-income counterparts[8] on many of the health and well-being indicators in this study, including their overall health, the frequency of minor health problems, depression, sleep problems and stress levels.**
- **Employees who live with a spouse or partner also report better health and well-being than their single colleagues, including better overall health, fewer signs of depression, less frequent sleep problems, lower stress levels and a more positive impact of home life on energy brought to work.**
- **Employees with children under the age of 18 in their households are less likely to report being treated for a chronic health problem. Employees without children under 18, however, report less frequent minor health problems, less frequent sleep problems, lower levels of stress, a more positive impact of their work on their energy at home and a more positive impact of their home life on their energy at work.**

These findings are depicted in Table 1.

Table 1: Demographic characteristics predicting more positive health outcomes in 2008

More positive health indicators	Age	Gender	Income level	Relationship status	Any child aged < 18
Better overall health	Under age 30		Middle- and high-wage and –income	Married/ partnered	
Less frequent minor health problems		Men	Middle- and high-wage and –income		No child(ren)
Less likely to receive treatment for chronic health problem	Under age 30				Child(ren) at home
Less likely to receive treatment for mental health issue					
Fewer signs of depression			Middle- and high-wage and –income	Married/ partnered	
Less frequent sleep problems		Men	Middle- and high-wage and –income	Married/ partnered	No child(ren)
Lower stress level		Men	Middle- and high-wage and –income	Married/ partnered	No child(ren)
Positive impact of work on energy at home					No child(ren)
Positive impact of home on energy at work				Married/ partnered	No child(ren)

Source: Families and Work Institute. 2008 NSCW (N=2,231 to 2,736). Only significant relationships are depicted.

WHAT DEMOGRAPHIC CHARACTERISTICS MAKE A DIFFERENCE IN EXPLAINING CHANGES BETWEEN 2002 AND 2008?

FINDING: The downward trend in employee health over the last six years cannot be explained by age—other factors make a difference.

Not surprisingly, as employees get older, they are more likely to experience health problems and decreased overall health. Thus, one might argue that the deterioration we find in employees' health over the past six years is due to the aging of the workforce. Our data, however, show that the average age of employees—41 years—has not changed significantly since 2002.

In order to investigate the patterns of changes between 2002 and 2008 more thoroughly, we conducted regression analyses, examining the impact of the age, the gender and the income level of employees.[9]

Our data suggest that the aging of the workforce does not explain the decline in employees' health: the health of older employees (age 30 and older) has not changed more than that of their younger colleagues (under 30)—while employees of other demographic groups have experienced significant declines over this time period. For example, there are differences in the magnitude and nature of change over the last six years between men and women and among employees of difference income levels.

FINDING: Men have experienced more significant declines in the last six years than women. As a result, the gap between men and women is narrowing with respect to their physical and mental health and well-being.

Overall, male employees tend to report better physical and mental health than female employees. This pattern may be due to social and cultural norms where men are generally less likely to talk about and seek treatment for health issues.

Yet, we find that this pattern is changing. Overall health has decreased more significantly among male employees than among female employees. Men and women are now equal in terms of their perceived overall physical health.

- In 2002, men were significantly more likely than women to report *excellent* overall health—37% of men compared with 31% of women.
- In 2008, 31% of men and 29% of women reported their perceived overall health as *excellent*.

Similarly, the frequency of experiencing minor health problems has increased more significantly among men than among women.

- The percentage of male employees who report experiencing *no* minor health problems in the last month was 41% in 2002, dropping to 34% in 2008.
- The percentage of female employees who report experiencing *no* minor health problems in the last months has declined less than it has among men—29% of women report no minor health problems in the last month in 2002 compared with 24% of women in 2008.

FINDING: Middle- and high-wage and –income employees fare significantly better in mental health than low wage/low-income employees, but the gap is decreasing as trends in mental health converge across income levels.

Overall health has declined for all income levels. Not surprisingly, the percentage of low-wage/low-income employees who report their overall health as *excellent* is lower than that of middle- and high-wage and –income employees in both survey years. Similar patterns hold for other health and well-being indicators, including frequency of minor health problems and indicators of feeling stressed and overwhelmed.

Further, our data reveal different trends in mental health for low-wage/low-income versus middle- and high-wage and –income employees. Middle- and high-wage and -income employees remain significantly less likely to show signs of depression than low-wage/low-income employees—but the percentage of middle- and high-wage and –income employees who show *no* signs of depression has declined slightly, while that of low-wage/low-income employees has increased. Thus, there is less difference between these two groups than there was six years ago.

HOW DO VARIOUS ASPECTS OF HEALTH RELATE TO ONE ANOTHER AND TO WORK OUTCOMES?

FINDING: Employees' physical health, mental health and well-being are linked.

As expected, many aspects of health and well-being are related to one another. For example, better overall health is associated with less frequent minor health problems, more frequent exercising, less treatment for chronic health conditions, less frequent sleep problems, lower levels of stress, as well as a more positive impact of the job on energy levels at home and a more positive impact of home/personal life on energy levels at work.

The relationships found in our nationally representative sample for the 2008 NSCW are presented in Table 2 and are generally consistent with both conventional wisdom and research findings from other studies.

Table 2: Relationships between employee health and well-being measures

	Overall health	Frequency of minor health problems	Frequency of exercise	Treated for high blood pressure	Treated for high cholesterol	Treated for diabetes	Treated for heart disease	Treated for mental health	Indicators of depression	Frequency of sleep problems	Stress level	Energy: Positive impact of job	Energy: Positive impact of home
Overall health		↘	↗	↘	↘	↘	↘	↘	↘	↘	↘	↗	↗
Frequency of minor health problems	↘		↘	↗	↗	↗	↗	↗	↗	↗	↗	↘	↘
Frequency of exercise	↗	↘		↘	↘	↘	↘	↘	↘	–	↘	–	↗
Treated for high blood pressure	↘	↗	↘		↗	↗	↗	↗	–	↗	–	–	–
Treated for high cholesterol	↘	↗	↘	↗		↗	↗	–	–	–	–	–	–
Treated for diabetes	↘	↗	↘	↗	↗		↗	–	–	–	–	–	↘
Treated for heart disease	↘	↗	↘	↗	↗	↗		–	–	↘	–	–	–
Treated for mental health	↘	↗	↘	↗	–	–	–		↗	↗	↗	↘	↘
Indicators of depression	↘	↗	↘	–	–	–	–	↗		↗	↗	↘	↘
Frequency of sleep problems	↘	↗	↘	↗	–	–	↗	↗	↗		↗	↘	↘
Stress level	↘	↗	–	–	–	–	–	↗	↗	↗		↘	↘
Energy: Positive impact of job	↗	↘	–	–	–	–	–	↘	↘	↘	↘		↘
Energy: Positive impact of home	↗	↘	↗	–	–	↘	–	↘	↘	↘	↘	↘	

Source: Families and Work Institute. 2008 NSCW (N=2,690 to 2,764); ↗ indicates positive relationship significant at a minimum of p<.01 ↘ indicates negative relationship significant at a minimum of p<.01, — indicates no statistically significant relationship.

FINDING: Employees' physical and mental health, stress levels, sleep quality and energy levels all significantly impact important work outcomes of interest to employers, such as engagement, turnover intent and job satisfaction.

Generally, employees in better physical and mental health, with lower frequency of sleep problems and lower levels of stress are more likely to be highly engaged and satisfied with their jobs, as well as less likely to plan to leave their current jobs.[10] Those employees whose jobs have a positive impact on their energy at home, and vice versa, are also more likely to be engaged, satisfied and plan to remain with their employers.

Table 3 summarizes the relationships between employee health and well-being and work outcomes. For example, 35% of employees who rate their current overall health as excellent are highly engaged in their jobs, compared with only 25%, 22% and 27% of employees who rate their overall health as good, fair or poor, respectively.

Table 3: Relationships between employee health and well-being and positive work outcomes[11]

Positive outcomes	Perceived overall health				
	Excellent	Good	Fair	Poor	Sig.
High engagement	35%	25%	22%	27%	***
High job satisfaction	59%	52%	40%	38%	***
Not at all likely to leave job	62%	63%	52%	41%	***
	Frequency of minor health problems				
	Rarely/ never	Sometimes	Often/ very often		Sig.
High engagement	30%	22%	26%		***
High job satisfaction	58%	46%	42%		***
Not at all likely to leave job	66%	56%	47%		***
	Indicators of depression				
	None	One	Two		Sig.
High engagement	32%	19%	17%		***
High job satisfaction	60%	38%	30%		***
Not at all likely to leave job	68%	48%	42%		***
	Frequency of sleep problems				
	Low	Moderate	High		Sig.
High engagement	35%	26%	22%		***
High job satisfaction	64%	54%	35%		***
Not at all likely to leave job	67%	64%	45%		***
	Stress level				
	Low	Moderate	High		Sig.
High engagement	42%	25%	21%		***
High job satisfaction	76%	51%	30%		***
Not at all likely to leave job	78%	61%	43%		***
	Impact of job on energy for personal/family life				
	Positive	Mixed	Negative		Sig.
High engagement	40%	26%	17%		***
High job satisfaction	69%	52%	32%		***
Not at all likely to leave job	66%	61%	51%		***
	Impact of personal/family life on energy for job				
	Positive	Mixed	Negative		Sig.
High engagement	32%	24%	18%		***
High job satisfaction	58%	48%	32%		***
Not at all likely to leave job	64%	56%	53%		***

Source: Families and Work Institute. 2008 NSCW (N=2,293 to 2,767); statistically significant differences are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

FINDING: Employees who report that they are currently being treated for chronic physical conditions are less likely to plan to leave their current positions than employees who are not being treated for these conditions.

As shown in Table 4, 68% of employees currently receiving treatment for high blood pressure say they are not at all likely to look for a new job within the next year, compared with only 58% of employees who are not being treated for high blood pressure. Perhaps employees with pre-existing conditions do not want to risk becoming uninsured or being penalized for their disabilities with another health care carrier.

On the other hand, receiving treatment for chronic diseases, such as high blood pressure, high cholesterol, diabetes and heart disease is not significantly related to employee engagement and job satisfaction.

FINDING: Employees who report currently being treated for a mental health issue are significantly less likely to be satisfied with their jobs and significantly more likely to want to leave their current position.

Table 4: Relationships between treatment status for chronic physical and mental health issues and positive work outcomes

Positive work outcomes	Currently receiving treatment for	NOT currently receiving treatment	Sig.
	High blood pressure		
High engagement	25%	28%	n.s.
High job satisfaction	47%	52%	n.s.
Not at all likely to leave job	68%	58%	**
	High cholesterol		
High engagement	27%	27%	n.s.
High job satisfaction	49%	52%	n.s.
Not at all likely to leave job	68%	59%	***
	Diabetes		
High engagement	22%	28%	n.s.
High job satisfaction	53%	51%	n.s.
Not at all likely to leave job	66%	60%	*
	Any serious heart condition		
High engagement	36%	27%	n.s.
High job satisfaction	55%	51%	n.s.
Not at all likely to leave job	63%	60%	n.s.
	Mental health issue		
High engagement	18%	28%	**
High job satisfaction	35%	52%	*
Not at all likely to leave job	52%	60%	**

Source: Families and Work Institute. 2008 NSCW (N=2,320 to 2,760); statistically significant differences are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

HOW DO WORKPLACE POLICIES AND BENEFITS IMPACT EMPLOYEE HEALTH?

Health Insurance

Health insurance benefits are usually the first thing that comes to mind when thinking about the role of employers in helping their workforce stay healthy.

- In fact, we find that while 83% of U.S. employees have access to health insurance offered by their employers, more than three-quarters (77%) of U.S. employees are covered by health insurance offered by their employers.
  - Among those enrolled in their employer's health insurance plan, 20% have the plan paid for *entirely* by their employer.
  - 74% have the plan *partly* paid for by their employer.
  - 6% of employees have *no* employer contribution to the cost of their health insurance plan.
- 27% of U.S. employees have health insurance from another source (e.g., a spouse's employer), regardless of availability of health insurance through their jobs.

FINDING: 2008 NSCW data indicate that 10% of employees are not enrolled in employer health insurance regardless of availability or in another source of health insurance.

Thus, 2008 NSCW findings reveal that wage and salaried employees are more likely than the general U.S. population to have health insurance either from their employer or another source. The U.S. Census Bureau recently released figures on the health insurance coverage of all Americans in 2008. According to their data, 46.3 million Americans, or 15% of the population, are without health insurance, compared with 10% of wage and salaried employees as indicated by 2008 NSCW data.[12]

Further, the U.S. Census Bureau reports that the number of individuals covered by employer health insurance has declined from 177.4 million in 2007 to 176.3 million in 2008.

According to 2008 NSCW data, among the 37% of employees who are not covered by their employer health insurance, we find:

- Just over half of these employees (52%) have chosen not to enroll in their employers' health care plan. The majority (77%) of these employees who chose not to participate say they have coverage from another source. For the remaining 24% of employees who chose not to participate, we can only speculate what their reasons are. For example, it may be possible that they cannot afford to pay the premiums.
- 48% of employees not covered by their employer health insurance work for employers that do not provide access to a health insurance plan. The majority (69%) of employees who do not have access to health insurance through their employers do have coverage from another source. The remaining 31% do not have coverage from their employer nor from another source.

- Income level makes a difference. Low-wage/low-income employees are less likely to have access to employer health insurance. They are also less likely to receive employer contributions to the cost of insurance, if available through their employer. Not surprisingly therefore, low-wage/low-income employees are less likely to enroll in an employer health plan, if available. Finally, low-wage/low-income employees are less likely to enroll in insurance from another source.
  - 65% of low-wage/low-income employees have access to an employer health plan compared with 88% of middle- and high-wage and –income employees.
  - 12% of low-wage/low-income employees with access to health insurance through their jobs have no employer contributions to the cost of health insurance, compared with 5% of mid- and high-wage and –income employees.
  - 55% of low-wage/low-income employees who have access to employer health insurance are enrolled in their employer health plan, compared with 81% of middle- and high-wage and -income employees.
  - 65% of low-wage/low-income employees who do not have access to or are not enrolled in their employer's health insurance are enrolled in health insurance from another source compared with 80% of middle- and high-wage and -income employees who are not enrolled in their employer's health plan.

FINDING: Having employers contribute financially makes a difference—among employees with access to health insurance through their job, 89% of employees whose employer pays for the plan entirely are enrolled, compared with 78% of those whose employers pay partly and 49% of those whose employers do not contribute at all.

This pattern holds for both low-wage/low-income and mid- and high-wage and –income groups, although low-wage/low-income employees are substantially less likely to enroll in an employer plan without financial contributions from the employer than their more advantaged counterparts.

- Among low-wage/low-income employees with access to employer health insurance, only 33% of those who do not receive employer contributions are enrolled in their employer health plan, compared with 68% of mid- and high-wage and –income employees.
- These data are alarming because, as noted above, low-wage/low-income employees are significantly less likely than mid- and high-wage and –income to have employers pay for part or all of their health insurance.

FINDING: Overall, 22% of low-wage/low-income employees have no health care insurance from their employers or from another source—compared with 6% of middle-and high-wage and –income employees.

FINDING: Employees who are enrolled in health insurance through their employer or from another source are significantly less likely to plan to seek another job and report better physical and mental health than those who do not have health insurance coverage through their jobs or from another source (Table 5).

Table 5: Relationships between health insurance enrollment and positive outcomes[13]

Positive outcomes	Enrolled in health insurance (employer or other source)	Not enrolled in health insurance	Sig.
High engagement	27%	28%	n.s.
High job satisfaction	53%	39%	***
Not at all likely to leave job	63%	30%	***
Excellent overall health	30%	25%	***
Low frequency of minor health problems	56%	39%	***
No sign of depression	68%	44%	***
Low frequency of sleep problems	25%	11%	***
Low stress level	22%	13%	***

Source: Families and Work Institute. 2008 NSCW (N=2,331 to 2,768); statistically significant differences are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

Because one might assume that the relationship between health insurance enrollment and outcomes is affected by income-level, we conducted a second set of analyses using regression procedures to control for differences in income. These analyses revealed that the relationship between health insurance enrollment and outcomes is similar for employees of all income groups.[14]

Still, health insurance enrollment makes a greater difference for turnover intentions among middle- and high-wage and –income employees than among low-wage/low-income employees. It is possible that middle- and high-wage and –income employees have higher expectations than low-wage/low-income employees that they should enroll in health insurance from their employer or another source, such as a spouse's employer.

- 69% of middle- and high-wage and –income employees with health insurance say they are not at all likely to leave their jobs compared with 36% of the middle- and high-wage and –income employees with no insurance—a striking difference of 33 percentage points.
- 40% of low-wage/low-income employees with health insurance say they are not at all likely to leave their jobs compared with 27% of low-wage/low-income employees without health insurance—a difference of 13%.

Paid Sick Days

FINDINGS: Sixty-two percent of American employees receive at least five paid days off per year for personal illness.

- **Low-wage/low-income employees are much less likely to receive at least five paid sick days—only 46% do—compared with 67% of middle- and high-wage and –income employees.**
- **Employees who receive at least five paid days off per year for personal illness report significantly better work and health and well-being outcomes (Table 6).**

Table 6: Relationships between paid sick days and positive outcomes

Positive outcomes	At least five paid days off for personal illness	Less than five paid days off for personal illness	Sig.
High engagement	29%	25%	**
High job satisfaction	55%	46%	***
Not at all likely to leave job	68%	48%	***
Excellent overall health	30%	30%	n.s.
Low frequency of minor health problems	58%	47%	***
No sign of depression	70%	59%	***
Low frequency of sleep problems	26%	20%	***
Low stress level	23%	18%	***

Source: Families and Work Institute. 2008 NSCW (N=2,273 to 2,701); statistically significant differences are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

We also conducted a set of regression analyses to control for income level. These analyses revealed that the relationship between paid sick days and outcomes is similar for employees of all income groups for most outcomes with the exception of engagement and of sleep problems—these are different for low-wage/low-income employees than for middle- and high-wage and –income employees.[15]

- Sick days have a greater positive effect on the engagement of low-wage/low-income employees—36% of these employees who receive at least five paid sick days per year are highly engaged in their jobs compared with 27% of those who do not receive paid sick days, a statistically significant difference (p<.001).
- There is no significant difference in the engagement of middle- and high-wage and –income employees who receive at least five paid sick days (28% are highly engaged) compared with those who do not (24% are highly engaged).
- Not having at least five paid sick days has a greater impact on the frequency of sleep problems among low-wage/low-income than among middle- and high-wage and –income employees. While 26% of less advantaged employees who receive paid sick days report rarely or never having sleep problems, only 13% of low-wage/low-income employees who do not receive paid sick days do—a statistically significant difference of 13 percentage points (p<.001).
- Among middle- and high-wage and –income employees, the difference between those who receive paid sick days and those who do not is less dramatic with respect to the frequency of sleep problems: 25% of middle- and high-wage and –income employees with paid sick days report infrequent sleep problems compared with 23% of those without paid sick days (p<.01).

Paid Vacation Time

FINDING: Seventy-eight percent of American employees receive paid vacation time.

- 86% of full-time employees receive paid vacation days, compared with 41% of part-time employees (p<.001).
- American employees receive an average of 15 paid vacation days per year, although there is quite a bit of variability (SD=8.6 days) and half of the workforce receives 15 days or less.
- Still, American employees often do not take all the paid vacation days they are entitled to.
  - The average number of vacation days taken in the last year is 12.9 (SD=8) and half of the workforce took 13 days or less.
  - 60% of employees took all of their vacation days – 39% took fewer vacation days than the number for which they were eligible.
  - 5% of employees entitled to paid vacation took no vacation days at all.
- The longest vacation taken, on average, was 9 days (SD=5.5) and half of employees took their longest vacation for 8 days or less. This includes any weekend day and paid holidays during that time.
  - The most frequent length of the longest vacation was seven days—22% employees took this time for their longest vacation.
  - 24% took five days or fewer for their longest vacation.
  - 54% took six to 12 days or more for their longest vacation.
  - 22% took 13 or more days for their longest vacation.

FINDING: Having paid vacation time bodes well for personal health and well-being as well as job satisfaction and intent to stay in one's job.

As shown in Table 7, employees who have access to paid vacations are more likely to be satisfied with their job, to plan to remain with their employers, to have fewer minor health problems, fewer symptoms of depression and lower levels of stress.

Table 7: Relationships between paid vacation time and positive outcomes

Positive outcomes	Receive paid vacation time	No paid vacation time	Sig.
High engagement	28%	27%	n.s.
High job satisfaction	52%	49%	*
Not at all likely to leave job	65%	43%	***
Excellent overall health	29%	33%	n.s.
Low frequency of minor health problems	56%	47%	***
No sign of depression	68%	58%	***
Low frequency of sleep problems	25%	19%	***
Low stress level	22%	16%	***

Source: Families and Work Institute. 2008 NSCW (N=2,318 to 2,753); statistically significant differences are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

FINDING: Longer vacations offer greater benefits than shorter ones.

Employees who take long vacations (i.e., 13 consecutive days or more, including weekends or holidays) are more likely to be satisfied with their jobs and to want to stay in their jobs.[16] They are also more likely to have less frequent minor health problems, depression and sleep problems. These findings are shown in Table 8.

Table 8: Relationships between length of longest vacation and positive outcomes

Positive outcomes	Longest vacation <6 days	Longest vacation 6-12 days	Longest vacation 13+ days	Sig.
High engagement	25%	25%	27%	n.s.
High job satisfaction	51%	51%	57%	*
Not at all likely to leave job	62%	64%	80%	***
Excellent overall health	27%	30%	31%	n.s.
Low frequency of minor health problems	52%	58%	61%	***
No sign of depression	64%	70%	74%	*
Low frequency of sleep problems	20%	25%	27%	***
Low stress level	18%	24%	25%	n.s.

Source: Families and Work Institute. 2008 NSCW (N=1,510 to 1,750); statistically significant differences are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

Summary

Our data suggest that workplace benefits and policies, such as providing access to health insurance and paid time off both for personal illness and for vacations are associated with better outcomes for employees and employers.

DOES HAVING AN EFFECTIVE WORKPLACE MAKE A DIFFERENCE ON EMPLOYEES' HEALTH AND WELL-BEING?

Our data suggest that the answer is "yes."

WHAT IS AN EFFECTIVE WORKPLACE?

Effective workplaces recognize that employees are an organization's greatest resource and make a critical difference in the organization's ability to not merely survive, but to thrive. To be truly effective, a workplace—its design, practices and policies—must benefit both the organization *and* its employees.

Why Do We Need Effective Workplaces?

Increasingly, changes in workforce demographics and gender roles are making the need for effective workplaces a more compelling business issue.

FINDING: Gender roles at home and at work have changed significantly over the past three decades.

- Women are now in the workforce in almost equal numbers as men, a trend bolstered by the current recession, which has cost more men their jobs than women.[17]
- Four out of five couples are dual-earner couples today. The percentage of dual-earner couples has increased substantially and significantly over the past three decades (from 66% in 1977 to 80% in 2008).[18]
- Women in dual-earner couples contribute about 45% of the family income on average, a significantly greater portion than in 1997 when women contributed an average of 39%.[19]

Thus, these changes could mean that families are under greater pressure, and that is, in fact, the case.

FINDING: Work-life conflict is rising.

The percentage of employees experiencing some or a lot of work-life conflict has increased significantly from 34% in 1977 to 46% in 2008.[20]

- Work-life conflict has increased especially among men. The percentage of men reporting a lot of work-life conflict has increased significantly by six percentage points from 9% to 15%. Overall, nearly half (49%) of men now report experiencing some or a lot of work-life conflict, up from just over one third (34%) in 1977
- In comparison, the percentage of women experiencing a lot of work-life conflict has increased by two points from 11% in 1977 to 13% in 2008.[21] Overall, 43% of women report some or a lot of work-life conflict in 2008, up from 34% in 1977.

FINDING: Employees who report some or a lot of work-life conflict are less likely to experience positive work and health and well-being outcomes. (Table 9).

Table 9: Relationships between work-life conflict and positive outcomes

Positive outcomes	Some/a lot of work-life conflict	Little/no work-life conflict	Sig.
High engagement	24%	31%	***
High job satisfaction	40%	61%	***
Not at all likely to leave job	56%	63%	**
Excellent overall health	28%	33%	***
Low frequency of minor health problems	47%	60%	***
No sign of depression	58%	72%	***
Low frequency of sleep problems	19%	28%	***
Low stress level	14%	26%	***
Positive impact of work on energy at home	18%	39%	***
Positive impact of home life on energy at work	46%	52%	**

Source: Families and Work Institute. 2008 NSCW (N=2,047 to 2,437); statistically significant differences are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

Employees are experiencing a "time famine" that seriously undermines health and well-being in addition to compromising positive work outcomes.

The majority of employees feel they do not have enough time for the important aspects of their personal lives.

- 60% report not having enough time for themselves.
- 63% report not having enough time to spend with their partner or spouse.
- 75% report not having enough time to spend with their children.

Half of employees (50%) feel their jobs *sometimes*, *often* or *very often* deprive them of enough time for their families and important people in their lives—to the detriment of health, well-being and work outcomes.

Table 10: Relationships between frequency of not having enough time for family/important people because of work and positive outcomes

Positive outcomes	Frequency of not having enough time for family/important people because of work			Sig.
	Never/rarely	Sometimes	Often/very often	
High engagement	32%	23%	21%	***
High job satisfaction	63%	49%	27%	***
Not at all likely to leave job	66%	59%	47%	***
Excellent overall health	35%	24%	25%	***
Low frequency of minor health problems	61%	51%	41%	***
No sign of depression	74%	61%	51%	***
Low frequency of sleep problems	30%	14%	16%	***
Low stress level	30%	14%	10%	***
Positive impact of work on energy at home	43%	21%	13%	***
Positive impact of home life on energy at work	54%	47%	41%	***

Source: Families and Work Institute. 2008 NSCW (N=2,332 to 2,767); statistically significant differences are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

Six Criteria of Effective Workplaces

Over the past six years, Families and Work Institute has engaged in a research journey to define the elements that make up effective workplaces. Based on our 2008 National Study of the Changing Workforce data, we have identified six criteria of effective workplaces that include both work and non-work factors, all of which benefit both the employee *and* the organization.[22] The six criteria and their respective content are described in Table 11.

Table 11: Criteria of effective workplaces

Opportunities for Learning
- My job lets me use my skills and abilities.
- The work I do is meaningful to me.
- My job requires that I be creative.
- I get to do different things on my job.
- My job requires that I keep learning new things.

Autonomy
- I have a lot of say about what happens on my job.
- I have the freedom to decide what I do on my job.
- I can be myself on my job.

Work-Life Fit
- My supervisor cares about the effect of work on my personal/family life.
- My supervisor is responsive when I have personal/family business.
- I have the co-worker support I need to successfully manage my work and family life.
- I have the schedule flexibility I need to successfully manage my work and family life.
- My work schedule/shift meets my needs.

Supervisor Support for Work Success
- My supervisor is supportive when I have a work problem.
- My supervisor recognizes when I do a good job.
- My supervisor keeps me informed of things I need to know to do my job well.

Culture of Trust
- I trust what our managers say.
- My managers deal ethically with employees and clients.
- My managers seek information and new ideas from employees.

Satisfaction with Earnings, Benefits and Opportunities for Advancement
- I am satisfied with my earnings from my job.
- I am satisfied with my benefits from my job.
- I am satisfied with my opportunities for career advancement.

Source: Families and Work Institute. 2008 NSCW.

DOES AN EFFECTIVE WORKPLACE MAKE A DIFFERENCE?

We examined the empirical relationships among the six workplace effectiveness factors, an index of overall effectiveness based on a combination of all six criteria, and work and health and well-being outcomes.[23]

Work-Related Outcomes

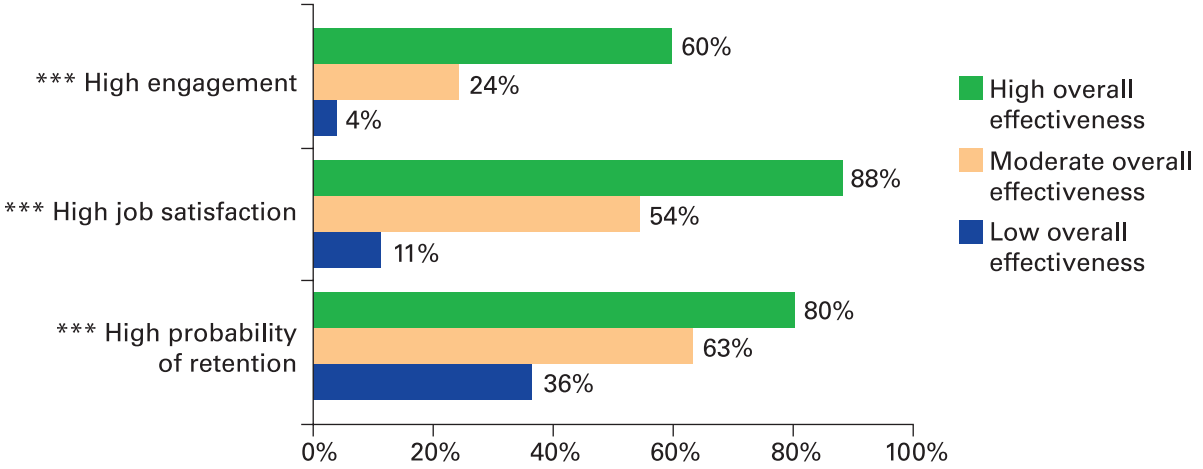
We examined the following three employee attitudes:

- employee engagement;
- job satisfaction; and
- turnover intentions.

These work-related outcomes are of immediate interest to employers because organizations with employees who are highly engaged, satisfied and plan to remain with the organization are in a better position to achieve important business goals and objectives than organizations whose workforce is disengaged, dissatisfied and likely to look for new jobs elsewhere.

The results of our analyses are summarized in Figure 7 and in Table 12.

Figure 7: Relationships between varying levels of overall workplace effectiveness and positive work outcomes[24]



Source: Families and Work Institute. 2008 NSCW (N=2,054 to 2,296); statistically significant differences are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

Table 12: Impact of six workplace effectiveness criteria and the index of overall workplace effectiveness on work-related outcomes[25]

	Greater engagement	Greater probability of retention	Greater job satisfaction
Culture of Trust	✓		✓
Supervisor Support for Work Success	✓	✓	✓
Opportunities for Learning	✓	✓	✓
Autonomy	✓	✓	✓
Satisfaction with Earnings, Benefits and Opportunities for Advancement	✓	✓	✓
Work-Life Fit	✓	✓	✓
Index of Overall Workplace Effectiveness	✓	✓	✓

Source: Families and Work Institute. 2008 NSCW (N=2,642 to 2,653); relationships statistically significant at $p \leq .05$ are depicted by ✓.

FINDING: Providing an effective workplace benefits employers.

- Employees are more likely to be engaged and satisfied in their jobs when they work in effective workplaces, as defined by all six criteria.
- Five criteria—satisfaction with earnings, benefits and opportunities for advancement, work-life fit, opportunities for learning, supervisor support for work success, autonomy and culture of trust—have a positive effect on probability of retention.
- Greater overall workplace effectiveness, a summary index that includes all six criteria, is strongly related to greater engagement, job satisfaction and desire to stay with the organization.

FINDING: Some aspects of an effective workplace are more important than others in affecting work outcomes.

- As shown in Table 13, opportunities for learning is the most important predictor of engagement relative to other effective workplace dimensions, but it is a relatively less important predictor of job satisfaction and turnover intention.
- Work-life fit is the second most important predictor of job satisfaction and intent to stay in one's job, but is ranked fourth as a predictor of engagement.

Table 13: Effective workplace dimensions significantly predicting work outcomes rank-ordered by relative importance[26]

Greater engagement	Greater job satisfaction	Greater probability of retention
1. Opportunities for Learning	1. Satisfaction with Earnings, Benefits and Opportunities for Advancement	1. Satisfaction with Earnings, Benefits and Opportunities for Advancement
2. Culture of Trust	2. Work-Life Fit	2. Work-Life Fit
3. Autonomy	3. Culture of Trust	3. Opportunities for Learning
4. Work-Life Fit	4. Autonomy	4. Supervisor Support for Work Success
5. Satisfaction with Earnings, Benefits and Opportunities for Advancement	5. Supervisor Support for Work Success	5. Autonomy
6. Supervisor Support for Work Success	6. Opportunities for Learning	

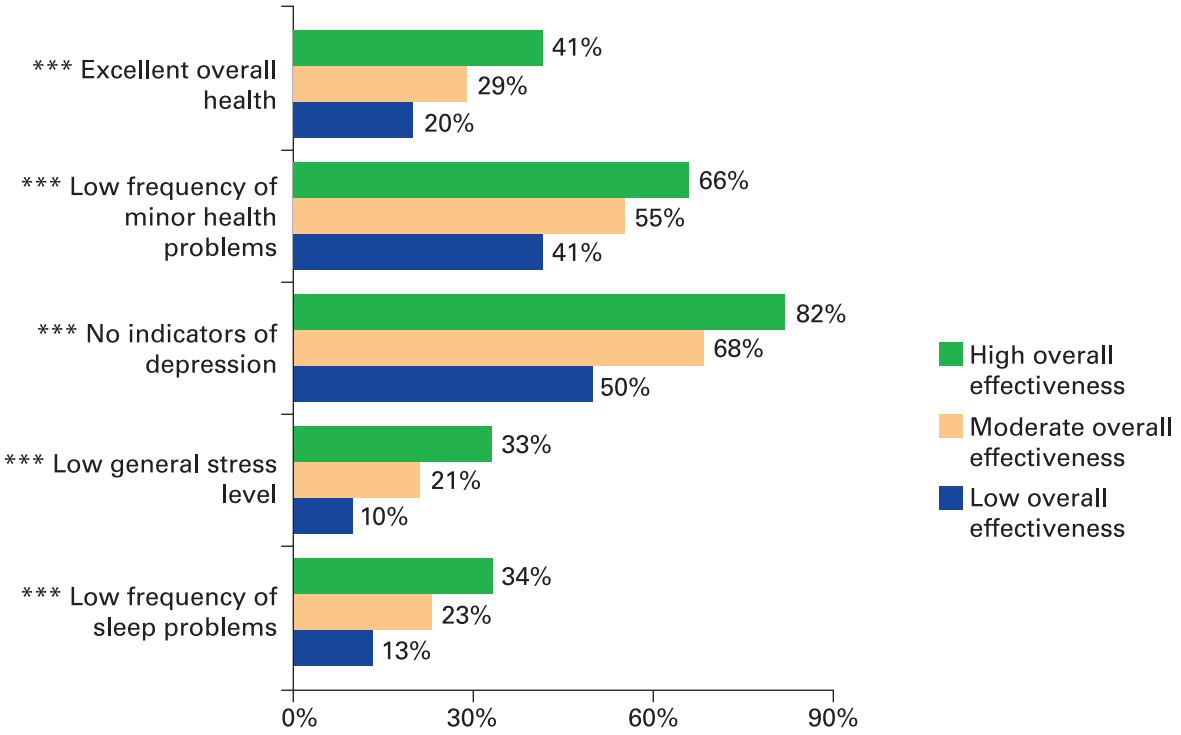
Source: Families and Work Institute. 2008 NSCW (N=2,470 to 2,769).

Health and Well-Being Outcomes

FINDING: Employees in effective workplaces have better health and well-being.

Figure 8 and Table 14 summarize our findings for the relationships between the six workplace effectiveness criteria, the index of overall workplace effectiveness and employee health and well-being outcomes.

Figure 8: Relationships between overall effectiveness and positive health outcomes



Source: Families and Work Institute. 2008 NSCW (N=2,443 to 2,456); statistically significant differences are denoted as * (p<.05), ** (p<.01), *** (p<.001), n.s. (not statistically significant).

FINDING: The six individual workplace effectiveness criteria are related to various health and well-being outcomes.

- Overall workplace effectiveness had a positive effect on employee health and well-being outcomes across the board.
- With the exception of treatment for chronic physical health problems and positive impact of home life in energy at work, all health and well-being outcomes were significantly predicted by two or more workplace effectiveness criteria.

FINDING: The most frequent predictor of health and well-being outcomes is work-life fit (predicting seven outcomes), followed by autonomy and satisfaction with earnings, benefits and opportunities for advancement (each predicting five outcomes).

- Employees who have greater work-life fit are more likely to experience:
  - Better overall health
  - Less frequent minor health problems
  - Fewer signs of depression
  - Less frequent sleep problems
  - Lower stress levels
  - Positive impact of their job on their energy level at home
  - Treatment for mental health issues

Note above that six of these outcomes are positive. Employees who have greater work-life fit, however, are also more likely to report receiving treatment for a mental health issues. It is possible that employees who have the support of supervisors and colleagues for managing personal or family issues feel more comfortable seeking treatment for a mental health problem than employees who do not receive support from their supervisors or peers at work.

- Culture of trust is associated with only one well-being outcome—employees who experienced a culture of trust at work are more likely to report that their jobs give them more energy for their life at home.
- Opportunities for learning is the only criterion to have some negative effects on employee health and well-being outcomes. For example, employees with more challenging jobs are more likely to experience minor health problems and sleep problems. An analysis of relative importance, though, reveals that opportunities for learning is a less important predictor of these outcomes than satisfaction with earnings, benefits and opportunities for advancement, autonomy and work-life fit. Thus, the potentially negative effects of job challenge on employee minor health problems and sleep problems may be counterbalanced by increasing these three dimensions.

  In a separate analysis, we found that job challenge is associated with higher levels of stress. Because we felt that this relationship may be more complex, we conducted a regression analysis. We find that job challenge increases stress levels. Thus, job challenge appears to undermine some of the employee health and well-being outcomes by raising stress levels. Recall, however, that job challenge is the highest ranked predictor of employee engagement, so it has positive features as well.
- When examining the relationships among each of the six effectiveness criteria and health and well-being outcomes, we find that stress is predicted by the most number of factors. We also find that there are no significant relationships with respect to treatment for chronic physical health problems (i.e., high blood pressure, high cholesterol, diabetes, heart disease) and for greater probability of a positive impact of home life on energy at work. In other words, employees are no more or less likely to receive treatment for a chronic health problem or experience a positive impact of their home life on their level of energy at work.

Table 14: Impact of six workplace effectiveness criteria and the index of overall workplace effectiveness on health and well-being outcomes[27]

	Better overall health	Less frequent minor health problems	Less likely treated for chronic health problem	Less likely treated for mental health problem	Fewer signs of depression	Less frequent sleep problems	Lower stress level	Positive impact of job on energy at home	Positive impact of home on energy at job
Culture of Trust								✓	
Supervisor Support for Work Success							✓	✓	
Opportunities for Learning		More likely				More likely			
Autonomy		✓		✓	✓	✓	✓		
Satisfaction with Earnings, Benefits and Opportunities for Advancement	✓	✓			✓	✓	✓		
Work-Life Fit	✓	✓		More likely	✓	✓	✓	✓	
Index of Overall Workplace Effectiveness	✓	✓	✓	✓	✓	✓	✓	✓	✓

Source: Families and Work Institute. 2008 NSCW (N=2,642 to 2,653); relationships statistically significant at $p \leq .01$ are depicted by ✓.

FINDING: Some aspects of an effective workplace are more important than others in affecting health and well-being outcomes.

Table 15 shows significant predictors rank-ordered in terms of relative importance for the outcomes of overall health, frequency of minor health problems, signs of depression, sleep problems and stress.

- Satisfaction with earnings, benefits and opportunities for advancement is ranked first in relative importance for all five outcomes.
- Work-life fit is the second most important predictor for better overall health, low frequency of sleep problems and low stress levels.
- Autonomy is the second most important predictor for low frequency of minor health problems and fewer signs of depression.

Table 15: Effective workplace dimensions significantly predicting health outcomes rank-ordered by relative importance[28]

Better overall health	Less frequent minor health problems	Fewer signs of depression	Less frequent sleep problems	Lower stress level
1. Satisfaction with Earnings, Benefits and Opportunities for Advancement	1. Satisfaction with Earnings, Benefits and Opportunities for Advancement	1. Satisfaction with Earnings, Benefits and Opportunities for Advancement	1. Satisfaction with Earnings, Benefits and Opportunities for Advancement	1. Satisfaction with Earnings, Benefits and Opportunities for Advancement
2. Work-Life Fit	2. Autonomy	2. Autonomy	2. Work-Life Fit	2. Work-Life Fit
	3. Work-Life Fit	3. Work-Life Fit	3. Autonomy	3. Autonomy
	4. Opportunities for Learning		4. Opportunities for Learning	4. Supervisor Support for Work Success

Source: Families and Work Institute. 2008 NSCW (N=2,471 to 2,769).

DEMOGRAPHIC DIFFERENCES IN THE IMPACT OF EFFECTIVE WORKPLACES

The impact of workplace effectiveness varies for employees with different demographics.[29]

Differences Between Men and Women

Overall effectiveness, culture of trust and supervisor support for work success have a similar effect on the work and health and well-being outcomes of men and women.

Other factors, however, have a stronger effect on one gender than on the other. Some of these findings may be counter-intuitive. They are shown in Table 16.

FINDING: Men are more positively affected by having satisfaction with earnings, benefits and opportunities for advancement in their jobs and a good fit between their work and personal or family lives.

FINDING: Women are more positively affected by being challenged in their jobs and by having autonomy.

Table 16: Gender differences in effect of effective workplace dimensions and overall effectiveness

	Stronger effect for men	Stronger effect for women
Culture of Trust		
Supervisor Support for Work Success		
Opportunities for Learning		Greater job satisfaction
Autonomy		Better overall health
Satisfaction with Earnings, Benefits and Opportunities for Advancement	Greater job satisfaction	
Work-Life Fit	Better overall health	
Overall Effectiveness		

Source: Families and Work Institute. 2008 NSCW (N=2,769); only statistically significant effects ($p<.05$) are reported.

Differences Between Employees Under Age 30 and Over Age 30

Employees under 30 are more likely to be impacted by specific characteristics of an effective workplace than older employees.

FINDING: Employees under the age of 30 are negatively affected by having more autonomy and more job challenge in terms of their overall health and their mental health.

As shown in Table 17 these negative effects are balanced by other characteristics of an effective workplace that have a positive impact.

FINDING: Being treated with respect has a greater effect on employees under age 30 and is associated with fewer signs of depression.

FINDING: More supervisor support for work success and greater work-life fit affect employees under 30 more strongly than employees aged 30 and older. Both characteristics are associated with better overall health.

Table 17: Age group differences in effect of effective workplace dimensions and overall effectiveness

	Stronger effect for employees under age 30	Stronger effect for employees age 30/older
Culture of Trust	Fewer signs of depression	
Supervisor Support for Work Success	Better overall health	
Opportunities for Learning	Poorer overall health	
Autonomy	More signs of depression	
Satisfaction with Earnings, Benefits and Opportunities for Advancement		
Work-Life Fit	Better overall health	
Overall Effectiveness		

Source: Families and Work Institute. 2008 NSCW; (N=2,769) only statistically significant effects (p<.05) are reported.

Differences Between Low-Wage/Low-Income Employees and Middle- and High-Wage and –Income Employees

Overall effectiveness, work-life fit, satisfaction with earnings, benefits and opportunities for advancement and supervisor support for work success all affect middle- and high-wage and –income employees more strongly than their low-wage/low-income counterparts. Other dimensions have a stronger effect on low-wage/low-income than on middle- and high-wage and –income employees. These findings are depicted in Table 18.

FINDING: Challenging jobs are more likely to have a negative impact on the physical and mental health of low-wage/low-income employees than middle- and high-wage and –income employees.

Further, the potentially negative effects of more challenging jobs on the mental health of low-wage/low-income employees can be balanced when they are treated with more respect.

FINDING: Being treated with respect by managers and supervisors has a stronger effect on the mental health of low-wage/low-income employees than middle- or high-wage and –income employees.

Table 18: Income-level differences in effect of effective workplace dimensions and overall effectiveness

	Stronger effect for low-wage/ low-income employees	Stronger effect for middle- and high-wage and –income employees
Culture of Trust	Fewer signs of depression	
Supervisor Support for Work Success		Less likely to turnover
Opportunities for Learning	Poorer overall health More signs of depression	
Autonomy		
Satisfaction with Earnings, Benefits and Opportunities for Advancement		Greater job satisfaction Less likely turnover
Work-Life Fit	Less likely turnover	Better overall health
Overall Effectiveness		Greater job satisfaction Fewer minor health problems

Source: Families and Work Institute. 2008 NSCW (N=2,200 to 2,642); only statistically significant effects ($p<.05$) are reported.

CONCLUSIONS AND IMPLICATIONS

IMPLICATIONS FOR HEALTH CARE REFORM

Findings from the National Study of the Changing Workforce reveal that the health of the U.S. workforce shows signs of declining, making the call for reforming health care all the more urgent.

IMPLICATIONS FOR ORGANIZATIONS

Although the provision of health care is expensive, providing effective workplaces is not.

Employers are well aware that wellness programs can make a difference, but are much less aware that effective workplaces should be considered part of promoting wellness.

Every workplace, small or large, can undertake efforts to treat employees with respect, give them some autonomy over how they do their jobs, help supervisors support employees to succeed on their jobs and help supervisors and co-workers promote work-life fit. Providing satisfaction with earnings, benefits and opportunities for advancement is more complex, especially during periods of business downturn, but ensuring that there is open and regular communication about the financial state of the organization can help employees weather economic storms. Similarly, organizations should not forget that access to good benefits and opportunities for career advancement inform employees' perceptions of their personal satisfaction with earnings, benefits and opportunities for advancement. Thus, especially in bad economic times, organizations should think creatively about ways to ensure access to benefits and career development opportunities. Finally, providing reasonable challenges and learning opportunities can have a positive effect on employee engagement and job satisfaction.

In addition, organizations can promote wellness by monitoring overwork and providing and encouraging employees to take their vacations.

IMPLICATIONS FOR EMPLOYEES

The daily "grind" of our lives on and off the job makes it easy to forget how various factors—like too much stress, too little sleep or exercise—affect our long-term health. We often blame our modern lifestyles for simply not allowing us enough time for healthy behaviors and choices. This report demonstrates, however, that good health is more than simply a function of having time to exercise or relax.

As employees, it behooves us to look closely at the extent to which our jobs contribute to or hinder our personal well-being. This includes not only employer policies about paid sick time, vacation or health insurance, but also the very nature and design of our jobs and workplaces.

When evaluating job opportunities, employees should ask themselves whether a particular job and work environment fits their needs on a variety of dimensions, including:

- Does this job meet my economic needs in terms of pay, benefits and advancement opportunities?
- Do the culture of the organization, my supervisors and colleagues generally support a degree of fit between my work and personal life that works for both me and the organization?

- Are there opportunities for challenge and learning appropriate for my needs and expectations? Are there factors in the workplace to counterbalance the potentially stressful aspects for challenging work?
- Am I comfortable with the level of autonomy this job offers? Does it allow me to get my work done in the most effective and least stressful way?
- Do managers and supervisors support and help employees succeed at their jobs? Would I thrive under the kinds of support offered?
- Is there an overall culture of respect for people? What did I experience in the job interview, in the way that other employees talk about how they are treated and in the way others have treated me?

For those employees already in organizations where they are not experiencing some aspects of an effective workplace, they should ask themselves if they can make changes in their current job or move to another supervisor/position.

Careful consideration of these factors will not only help enhance the quality of life during a substantial portion of our waking hours, but also achieve and maintain better physical and mental health throughout our working lives.

ENDNOTES

[1] Technical Background: Various data sources were used for this report. The primary sources are the Families and Work Institute's 2002 and 2008 National Study of the Changing Workforce (NSCW) surveys as well as the 1977 Quality of Employment Survey (QES) conducted by the Institute for Social Research at the University of Michigan with funding from the U.S. Department of Labor. The NSCW builds directly upon the 1977 QES, which was discontinued after the 1977 round of data collection. Both the NSCW and QES are based on random samples of the U.S. workforce.

The 2008 NSCW includes 2,769 wage and salaried employees from the total sample of 3,502. The 2002 NSCW includes 2,810 wage and salaried employees from the total sample of 3,504. NSCW total samples include wage and salaried employees who work for someone else, independent self-employed workers who do not employ anyone else, and small business owners who do employ others. NSCW total samples for each year average about 3,500 employed people. All NSCW samples are adjusted to reflect (i.e., weighted to) recent U.S. Bureau of the Census statistics on the total U.S. population to adjust for any sampling bias that might have occurred. The response rates for all NSCW surveys are above 50%, applying the conservative method of calculation recommended by the American Association for Public Opinion Research. In 2008, the response rate was 54.6%. In 2002, the response rate was 52%. The estimated maximum sampling error for the total wage and salaried sample is approximately +/- 1%. The telephone interviews in 2008 and 2002 were conducted by Harris Interactive, Inc.

The report also incorporates findings published by the U.S. Centers for Disease Control and Prevention (CDC) from the 2008 and 2002 Behavioral Risk Factor Surveillance System (BRFSS) survey. Data drawn from government sources are always noted as such.

Various statistical tests for significance were used for this report: Pearson chi-square for comparing nominal scale variables, Mantel-Haenszel chi-square for comparing ordinal scale variables and logistic regression for evaluating relationships between ordinal scale variables. When we speak of "differences" between groups over time or "relationships between variables," these differences/relationships always represent statistical significance at the $p<.05$ level or (typically) better.

All cross-year comparisons of independent random samples made adjustments for the design effects associated with each sample. These adjustments reduce the "effective size" of the samples for purposes of statistical tests, making it more difficult to find statistically significant differences. When sample sizes are reported, we use the original sample weightings without adjustments for design effects.

When reporting findings from U.S. government surveys, we do not provide information about the statistical significance of group differences. Because these survey samples are so large, an absolute difference of almost any size is statistically significant at $p < .05$ or much better.

[2] Centers for Disease Control and Prevention guidelines for physical exercise for adults: http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html

[3] Body Mass Index (BMI) is calculated from a person's height and weight and serves as a reliable indicator of body fatness. BMI is commonly used to screen people for weight categories that may lead to health problems. Adults with a BMI of 25 or higher are considered overweight. Adults with a BMI above 30 are considered obese.

[4] This two-question depression scale is based on the Center for Epidemologic Studies Depression (CES-D) Scale. Studies have found that these two questions taken from the larger scale are a good screening tool e.g., Whooley, M.A., Avins, A.L., Miranda, J. & Browner, W.S. (1997). Case-finding instruments for depression: Two questions are as good as many. *Journal of General Internal Medicine*, 12, 439-445.

[5] Cohen, S., Kamarck, T. & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24, 385-396; Cohen, S. & Williamson, G (1988). Perceived stress in a probability sample of the United States. In S. Spacapam & S. Oskamp (Eds.) *The social psychology of health: Claremont Symposium on applied social psychology*. Newbury Park, CA: Sage.

[6] Response categories for the stress questions were 1=never, 2=rarely, 3=sometimes, 4=fairly often, 5=very often. The questions were averaged to create an index of overall stress level ranging from 1 to 5. Cronbach's alpha was .70. In 2008, the average was 2.33 (SD=.78), up from 2.28 (SD=.78) in 2002—a statistically significant change (p=.024).

[7] Differences in health and well-being measures by demographic characteristics were evaluated with regression analyses including the predictors sex (male, female), age (under 30, age 30 and older), relationship status (single, living with partner/spouse), income level (under 200% of federal poverty line, at or over 200% of federal poverty line), children under the age of six living at home (yes, no), and children under the age of 18 living at home (yes, no). Sleep and stress are numeric scales, and were tested with GLM (univariate ANOVA). Perceived overall health, frequency of minor health problems, signs of depression, impact of work on energy at home and impact of home on energy at work are ordinal responses and were tested with ordinal logistic regression models. Treatment for chronic health problem and treatment for mental health problem are binary responses and were tested with binary logistic models.

[8] We define low-wage and low-income employees as having household incomes below 200% of the 2008 federal poverty threshold. Our estimates are based on weighted average federal poverty thresholds for families of different sizes. Poverty threshold data are drawn from the U.S. Bureau of the Census, Current Population Survey Annual Social and Economic Supplements. In 2008, the poverty threshold for a family of four is an annual income of $22,025 or less. Thresholds for persons under the age of 65 years are used in these analyses. Household incomes below 200% of the federal poverty threshold fall (approximately) in the bottom quartile of the family-size adjusted income distribution. Middle-income households fall (approximately) into the second and third quartiles, high-income household into the top quartile.

[9] We conducted hierarchical linear regression analyses with survey year (2002, 2008), demographic predictors and interaction terms (demographic predictor*survey year) for respondent sex (male, female), age (under age 30, age 30 and older), income level (<200% of federal poverty line, ≥ 200% of federal poverty line).

[10] Employee engagement was measured with four items, which were converted to z-scores and then averaged. Cronbach's alpha =.71. Sample items include "I look forward to going to work" (1=strongly disagree to 4=strongly agree) and "How often do you think about good things related to your job when you're busy doing something else?" (1=never to 5=very often). Job satisfaction was measured with three items, which were converted into z-scores and then averaged to create a scale. The items included "All in all, how satisfied are you with your job?" (four-point scale from 1=not satisfied at all to 4=very satisfied), "Knowing what you know now, if you had to decide all over again to take the job you now have, what would you decide?" (1=definitely NOT take job, 2=have second thoughts, 3=take same job again without hesitation) and "If a good friend of yours told you that he or she was interested in working in a job like yours for your employer, what would you tell your friend?" (1=advise against it, 2=have some doubts about recommending it, 3=strongly recommend it). Cronbach's alpha was .78. Turnover intent was measured with a single item "Taking everything into consideration, how likely is it that you will make a genuine effort to find a new job with another employer within the next year?" The item had a three-point scale (1=not at all likely, 2=somewhat likely, 3=very likely).

[11] We converted engagement and job satisfaction into 3-point scales in which low = bottom 25% (bottom quartile) of scores, moderate = middle 50% of scores (quartiles 2 and 3), high = top 25% of scores (top quartile).

[12] U.S. Census Bureau, 2009 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC).

[13] Excellent overall health was defined as a response of "excellent" to the perceived current state of overall health measure (1 = poor, 2 = fair, 3 = good, 4 = excellent). Low frequency of minor health problems was defined as a response of "rarely/never" to the question about how often the respondent had experienced minor health problems, such as headaches, upset stomach or insomnia, in the last month. No sign of depression was defined as a "no" answer to both depression screening questions. For a measure of low frequency of sleep problems, we converted the sleep measure into a 3-point scale in which low = bottom 25% (bottom quartile) of scores, moderate = middle 50% (quartiles 2 and 3) of scores, high = top 25% of scores (top quartile). For a measure of low stress level, we converted the stress measure into a 3-point scale in which low = bottom 25% (bottom quartile) of scores, moderate = middle 50% (quartiles 2 and 3) of scores, high = top 25% of scores (top quartile).

[14] We tested whether health insurance coverage had differential effects for low-wage/low-income vs. middle- and high-wage and –income employees with univariate GLM models with tests for interaction between income-level and health coverage. Separate analyses were conducted for each outcome.

[15] We tested whether access to at least five paid sick days had differential effects for low-wage/low-income vs. middle- and high-wage and –income employees with univariate GLM models with tests for interaction between income-level and health coverage. Separate analyses were conducted for each outcome.

[16] Respondents who reported receiving paid vacation days were asked about the length of their longest vacation in the past year, including any weekend days and holidays during that time. Responses were given in or converted to days. Based on the number of days of the longest vacation, we then calculated a three point scale for short, moderate and long vacations in which short vacations = bottom 25% (bottom quartile) of number of days, moderate vacations = middle 50% (second and third quartile) of number of days and long vacations = top 25% (top quartile) of number of days.

[17] Bureau of Labor Statistics, Economic News Release, February 2009.

[18] Galinsky, E., Aumann, K. & Bond, J.T. (2009). *Times are changing: Gender and generation at work and at home*. New York, NY: Families and Work Institute.

[19] Ibid

[20] Work-life conflict is a bi-directional measure, reflecting both work interfering with life off the job and life off the job interfering with work.

[21] Galinsky, E., Aumann, K. & Bond, J.T. (2009). *Times are changing: Gender and generation at work and at home*. New York, NY: Families and Work Institute.

[22] Hypotheses about effective workplace dimensions were developed based on based research, including Bond, J.T., Galinsky, E. & Hill, E. J. (2004). *Flexibility: A critical ingredient of an effective workplace*. New York, NY: Families and Work Institute; Bond, J.T. & Galinsky, E. (2006). *How can employers increase the productivity and retention of entry-level, hourly employees?* New York, NY: Families and Work Institute; Galinsky, E., Carter, N. & Bond, J.T. (2008). *Leaders in a global economy: Finding the fit for top talent*. New York, NY: Families and Work Institute and Catalyst. The hypothesized dimensions were then evaluated empirically with confirmatory factor analysis and reliability analysis based on Cronbach's alpha.

[23] An index of overall workplace effectiveness was calculated based on measures of the six workplace effectiveness dimensions. Scales for the six workplace effectiveness dimensions ranged from 1 = least effective to 4 = most effective and correlated with one another (Cronbach's alpha = .83). The index of overall workplace effectiveness was created by averaging the six dimension measures.

[24] The index of overall workplace effectiveness was converted to a 3-point scale in which low = bottom 25% (bottom quartile) of scores, moderate = middle 50% (quartiles 2 and 3) of scores and high = top 25% (top quartile) of scores.

[25] Because work and health outcomes are correlated, a multivariate analysis including all work and health and well-being outcomes was conducted. The following variables were used as controls: gender (male, female), age (under 30 vs. age 30 and over), income level (below vs. above 200% of federal poverty line), relationship status (single vs. living with partner/spouse), employment status of partner/spouse (employed vs. not), parental status (any child(ren) under age 6 in the home vs. not; any child(ren) under age 18 vs. not). One multivariate analysis included all six workplace effectiveness dimensions as covariates, a separate multivariate analysis was conducted with overall workplace effectiveness as covariate. Results for work and health and well-being outcomes are reported separately.

[26] Relative importance of the dimensions as predictors of work-outcomes was determined by relative weights analysis.

[27] See endnote 27 for description of multivariate analysis.

[28] Relative importance of the dimensions as predictors of work-outcomes was determined by relative weights analysis.

[29] Potentially different strengths of relationships of effective workplace dimensions and overall workplace effectiveness with outcomes for employees of different demographic groups were evaluated with hierarchical linear regression models. Each outcome was evaluated separately. One set of regression models included the index of overall effectiveness and interaction terms for specific demographic comparisons. A second set of regression models included all six workplace effectiveness dimensions and their respective interaction terms for specific demographic comparisons. Each regression model controlled for gender (male, female), age (under 30 vs. age 30 and over), income level (below vs. above 200% of federal poverty line), relationship status (single vs. living with partner/spouse), employment status of partner/spouse (employed vs. not), parental status (any child(ren) under age 6 in the home vs. not; any child(ren) under age 18 vs. not).