research update

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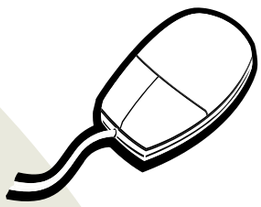

An Environmental Scan of Workplace Wellness Programs in Alberta

Despite strong evidence about the benefits of regular physical activity, two-thirds of the industrialized world may not meet minimum physical activity standards (Craig, Russell, Cameron, & Beaulieu, 1999; US Department of Health and Human Services, 1996). This inactivity is a major public health concern (Bouchard, Shephard, & Stephens, 1994; US Department of Health and Human Services, 1996) with related social and economic costs (Colditz, 1999; Katzmarzyk, Gledhill, & Shephard, 2000).

A recent Health Canada initiative (Health Canada, 1999; Health Canada & Canadian Society for Exercise Physiology, 1998), along with the Catalonia Declaration (Autonomous Government of Catalonia, 1996) and the US Surgeon General's *Report on Physical Activity and Health* (US Department of Health and Human Services, 1996), identified the workplace as a key setting for encouraging physical activity adoption and maintenance in the adult working population.

The workplace is a good location to promote physical activity for several reasons, e.g., its established channels of communication and existing support networks. Workplaces also develop corporate norms of behaviour (Shephard, 1996).

How the Centre Designed this Environmental Scan

To find out more about the existing workplace wellness programs in Alberta (especially programs that include physical activity), the Alberta Centre for Active Living surveyed both private and public workplaces (n = 30) across the province. Respondents included occupational health nurses (9, 30%); health or wellness coordinators/consultants (9, 30%); health and wellness team leaders (5, 16.7%); human resources directors (2, 6.7%); and other personnel (5, 16.7%) in charge of the workplace wellness program.

An Environmental Scan of Workplace Wellness Programs in Alberta gives a snapshot of Alberta workplace wellness programs, including aspects such as

- the kinds of workplaces that offer programs (e.g., public vs. private sector, size of organizations);
- how long the programs have been running;
- how many employees participate;
- whether organizations involve employees in planning the programs;
- how much the programs cost;
- how organizations make staff aware of the programs;
- whether organizations have established partnerships with community or private fitness facilities;
- how many organizations offer flexible work schedules to allow their employees to be active during the workday;
- whether companies promote active commuting to and from work;
- how employees perceive the benefits of workplace wellness programs.

Highlight of Results

Positive indicators include the following.

- Many organizations report employee involvement in planning and implementing wellness initiatives (83.3%).
- A relatively high percentage of organizations assessed employee needs (70%).
- Eighty per cent of participating organizations offer recreational opportunities to their employees.
- A relatively high number provide structured physical activity programs either for groups or individuals.
- The high percentage of participating organizations with in-house exercise facilities (73%) could indicate that some Alberta employers are increasingly aware of the importance of physical activity in the workplace.
- Although this figure could be improved, it is encouraging that almost 70% of organizations with in-house exercise facilities provide supervision by qualified personnel at least some of the time.
- Respondents noted many benefits from workplace wellness programs. These include
  - increased awareness of healthy living and a greater likelihood that people would make positive changes to become healthy;
  - higher staff morale, an increased sense of belonging, and a general sense of satisfaction;
  - increased ability to attract new staff and increased staff retention;
  - decreased absenteeism; and
  - positive relationships established between management and employees as a result of the initiatives.
- Finally, 76.7% of all participating organizations offer flexible time schedules, so that employees can find a convenient time to exercise within the workday.

Areas of Concern

Our data indicated that it may be difficult for small organizations to provide their own in-house exercise facilities. According to our results, these companies may not have fully explored the possibility of forming partnerships with other organizations to access exercise facilities.

Furthermore, in several cases, both organization size and sector (i.e., public vs. private) seemed to influence the wellness and physical activity opportunities offered to employees. Public companies more often formed partnerships to obtain group discounts at local fitness facilities than private ones (58% vs. 23.1%). In addition, the percentage of companies forming this kind of partnership increased as company size increased.

Apparently, many organizations did not see physical activity as more than fitness-oriented exercise. What seems missing is an awareness of the broader, more individual, and inclusive concept of active living as a "user-friendly" and efficient way to increase employees' physical activity and subsequent health outcomes (Poon, Zuck, Plotnikoff, & Horne, 2000).

This lack of awareness is also illustrated in the low percentage of organizations that promote active commuting (50%) or using the stairs in the workplace (30%). This latter finding is particularly noteworthy since studies show that point-of-decision prompts to encourage using the stairs are a simple, inexpensive (yet efficient) strategy to increase levels of physical activity in community settings (US Department of Health and Human Services, 2001).

The full report is available at www.centre4activeliving.ca/research/Reports/2004EnviroScan/index.htm.

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Alberta Sport, Recreation, Parks & Wildlife Foundation
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Alberta Centre for Active Living
Research and education for the promotion of physical activity

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How Do Family and Neighbourhood Characteristics Contribute to Raising Healthy Children?

Both families and neighbourhoods have a measurable impact on children's health. Families who are poor or poorly educated and neighbourhoods where many of these families live produce children with more health problems.

What Is this Research Project About?

While we know that the early years have a lifelong impact, we are less certain about which characteristics of children, families, and their neighbourhoods contribute to healthy development. In this project, we compared individual, family, and neighbourhood characteristics for children from birth up to age eight and related these characteristics to children's health outcomes.

Methodology

For this study, we analysed longitudinal data from federal, provincial, and local sources on whole populations, i.e., all children born in Saskatoon and Regina between 1992 and 1995.

We measured the stability of the children's family income from birth until they were eight years old. We then compared income stability with the children's health during this eight-year period and made further comparisons on a neighbourhood level.

To assess family income stability, we considered whether families had received income support from the government (and for how long). We measured stability over the eight years and not just income support at a point in time, as has been common in previous studies.

We also created a categorical variable for family income stability that included four alternatives: no support, short-term support (one to two years), intermittent support (received in stops and starts over the eight years), and long-term support (three or more years of consecutive support).

To measure health status, we looked at birth outcomes: low birth weight (less than 2,500 grams), small for gestational age (newborns below the tenth percentile for gestational age), and pre-term birth (before 37 weeks). We also considered health outcomes, i.e., number of physician visits and number and length of hospitalizations.

Finally, as we had neighbourhood level data, we investigated a spatial variation of childhood outcomes by geographically mapping research results.

Research Questions and Key Findings

a. How does family economic stability affect children's health?
To answer this, we asked several questions.

Do children born into poor families have more health problems at birth?
Yes. Children born into poor families were more likely to be born pre-term or underweight. For example, in Regina, we found that children born in poor families were almost twice as likely to have a low birth weight or to be born pre-term than other children. ("Poor" was defined as below Statistics Canada's Low Income Cut-off (LICO)).

Are children in families receiving income assistance visiting doctors and being hospitalized more often than other children?
Yes. Children in economically unstable families visited the doctor more and were hospitalized more than other children. For example, in Saskatoon, children in families receiving short-term income assistance were one-and-a-half times more likely to be hospitalized than children in families with no income assistance.

b. What family and neighbourhood characteristics are important in children's health?
We found parents who were single, poor, Registered Indians, first-time mothers, or mothers who had previously had a stillborn baby were more likely to have a pre-term or underweight baby.

Neighbourhoods with more single-parent families, more poor families, and more poorly educated parents (defined as those who had left school before completing grade 9) were more likely to have pre-term or underweight children.

In addition, these children visited the doctor more and were hospitalized more than other children. We also found that these children were more likely to be males, younger children, Registered Indians, parented by single parents, and/or poor.

c. Is children's health affected more by the family's income or by the neighbourhoods they live in?

The answer to this question varied depending on the health outcome measured. For pre-term births, family income appeared to matter more than neighbourhood. Pre-term children were more likely to be born in a poor family than to be born in a certain kind of neighbourhood.

However, for other health outcomes, neighbourhoods appeared to matter more than family income. In Saskatoon, we found that children born in poor families had 6% more visits to the doctor than children from the general population. In contrast, children living in poor neighbourhoods had 10% more doctor visits than children from the general population.

We also found patterns at the neighbourhood level. Neighbourhoods with more single-parent families had more low-birth weight babies. In Regina, these neighbourhoods tended to cluster at the northern edge of the city. In Saskatoon, they are west of the river, in the central area, and further west. Maps with this data overlaid on neighbourhoods are available for use by policy and program planners.

Further Comments on Findings

We have consistently found in this and our other studies that children have more health problems when they grow up in poor neighbourhoods where there are more poorly educated adults, where people move frequently, and where single parenting is common.

In Saskatoon, almost twice as many underweight children were born into families that had received income assistance for five or more years (30%) than in families with no assistance (17%).

We have found that at all economic levels, very pre-term children (those born before 34 weeks) visited the doctor more in their first year of life. However, by their second birthday, children in wealthier families had reduced their number of doctor visits, catching up to other children, while children in poor families continued to lag behind, visiting the doctor more frequently.

What Are the Public Policy and Practice Implications of Our Results?

Policy-makers, program planners, and others working with children and families can use our results in a number of ways, including

- identifying and supporting vulnerable families and neighbourhoods;
- assessing the impact of long-term vs. short-term family income assistance on children;
- choosing between geographically targeted or diffused intervention programs;
- deciding on the scale of interventions (family, local area, regional/provincial) for specific problems;
- promoting local economic development and stability.

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Research and education for the promotion of physical activity

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