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MANAGING WORKPLACE HEALTH PROMOTION IN MUNICIPAL ORGANIZATIONS

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som för avläggande av filosofie doktorsexamen i arbetslivsvetenskap vid Akademin för hälsa, vård och välfärd kommer att offentligen försvaras fredagen den 27 februari 2015, 13.15 i Beta, Mälardalens högskola, Västerås.

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Abstract

The workplace is a suitable setting for health promotion, not least due to the amount of time employees spend at work. Previous research indicates large variations in employers' handling of workplace health promotion (WHP) efforts. However, more empirical knowledge of how WHP is handled in public sector organizations is needed.

The overall aim of the thesis was to explore how WHP is managed and implemented in municipal organizations. The thesis draws on health promotion as the point of departure, further accompanied with concepts related to organizational change and implementation research.

The thesis is based on three studies using different empirical materials. Both quantitative and qualitative research designs were used. In the first study, questionnaires were sent to both top managers and employees in a nationwide random sample of 60 of the 290 municipal social care organizations in Sweden. Data were analysed at the organizational level, linking WHP measures provided by the employer to employee health. In the second study, interviews concerning the management of WHP were carried out with senior managers representing various departments in two municipalities. The third study analysed the implementation of a health-promoting leadership programme, and the interviews made, concerned the experiences of line and middle managers participating in the programme.

The results show that the provision of individual- and organizational-directed WHP measures was associated to employee health at the organizational level. Furthermore, the senior managers described WHP management as components contributing to the organization's capacity for WHP. However, they mainly described WHP as providing healthy lifestyle activities, and mapping working conditions and employee health. In the study analysing the implementation of the leadership programme, line and middle managers described employee involvement as an enabling factor, whereas high workload and lack of senior management support were barriers described. Recurrent organizational changes and other politically-initiated projects and routines were also pointed out as competing events in the implementation process.

From this thesis, it can be concluded that WHP management is dominated by measures directed towards the individual employee and needs to include more of psychosocial and organizational measures. Finally, the varied organizational conditions for municipal managers as well as the support from senior management and human resources staff needs to be considered and ensured as part of an active and continuous WHP practice.

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Abstract

The workplace is a suitable setting for health promotion, not least due to the amount of time employees spend at work. Previous research indicates large variations in the ways that employers provide and manage workplace health promotion (WHP) efforts and programmes. To understand these variations, further empirical knowledge of how WHP is managed in public sector organizations is needed.

To assist in this effort, this thesis aimed to explore how WHP is managed and implemented in municipal organizations. Drawing on health promotion as a point of departure, this thesis also identified and applied concepts related to organizational change and implementation research.

Using both quantitative and qualitative research designs, three studies were conducted using different empirical approaches. In the first study, questionnaires were sent to both the top managers and employees of a nationwide random sample of 60 of the 290 municipal social care organizations in Sweden. The collected data were analysed at the organizational level to investigate the associations between WHP measures offered and employee health. In the second study, interviews concerning the management of WHP were conducted with senior managers representing various departments in two municipalities. In the third study, interviews were conducted with line and middle managers participating in a health-promoting leadership programme to analyse its implementation in two municipal organizations.

The findings of the studies revealed that individual- and organizational-directed WHP measures are associated with better employee health at the organizational level. In the second study, senior managers mainly described WHP as providing healthy lifestyle activities, and mapping working conditions and employee health. In the third study, which examined the implementation of the leadership programme, line and middle managers described employee involvement as an enabling factor and, high workload and lack of senior management support as barriers. They also described recurrent organizational changes and other politically initiated projects and routines as competing events in the implementation process.

From the findings of this thesis, it can be concluded that WHP management is dominated by measures directed towards the individual employee and that WHP needs to include more of psychosocial and organizational measures. Finally, the varied organizational conditions and support from both senior management and human resources staff is necessary to maintain active and continuous WHP practices.

To 'La familia'

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I. Larsson, R., Ljungblad, C., Sandmark, H., & Åkerlind, I. (2014). Workplace health promotion and employee health in Swedish municipal social care organizations. *Journal of Public Health*, *22*(3), 235-244.

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II. Larsson, R., Åkerlind, I., & Sandmark, H. (2014). Managing workplace health promotion in municipal organizations: the perspective of senior managers. Accepted for publication in *Work: A Journal of Prevention, Assessment and Rehabilitation.*

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III. Larsson, R., Stier, J., Åkerlind, I., & Sandmark, H. (2014). Implementing health-promoting leadership in municipal organizations: managers' experiences with a leadership program. Accepted for publication in *Nordic Journal of Working Life Studies.*

Contents

Abbreviations

HR	Human resources
NPM	New Public Management
OHS	Occupational health and safety
SWEM	Systematic work environment management
WHO	World Health Organization
WHP	Workplace health promotion

Introduction

The modern working life is characterized by high demands and capacities for organizations to change. This need for change is in turn influenced by economic and political processes and trends, such as globalization, rapid technology development, and increasing demands for flexibility and efficiency. These trends affect all types of organizations, regardless of whether they are privately or publicly managed. The change processes affect organizational conditions, thereby affecting the working conditions and health of employees in both private and public sector organizations (Landsbergis, 2003). A range of new management ideas and practices has come with these trends (Sandberg, 2013). These managerial ideas, often characterized by management in private companies emphasizing market and efficacy thinking, have been labelled New Public Management in the public sector (NPM; Hood, 1991). Simultaneously, this development of new management practices in public sector organizations has meant a shift from bureaucracy towards more of a market focus, but without a complete abandonment of bureaucracy (Hall, 2012). However, there are indications that these broader reforms and new management practices have changed the conditions for management and work in Swedish public sector organizations (e.g. Hasselbladh, Bejerot, & Gustafsson, 2008). Although studies have investigated the health consequences of organizational changes and other phenomena deriving from the modern working life, fewer studies have investigated how changed organizational conditions have come to frame management, working conditions, and workplace health in the municipal sector (Härenstam & Östebo, 2014). Furthermore, few studies have analysed how the management of the work environment and health promotion as such, are influenced by changing organizational conditions and management practices in municipal organizations. It is this complex municipal organizational context that sets the broader scene for this thesis.

Different approaches to improve the work environment and workplace health

In Sweden, there is a long tradition of developing the work environment where legislation, provisions, and other actions related to the work environment have contributed to reducing the risk of physical injuries, accidents, and chemical exposures. Although these actions have been successful in many respects, work-related problems remain common, including job strain and high levels of stress at work (Arbetsmiljöverket, 2012). The traditional work environment approach has mainly focused on individuals and the physical work environment regarding direct health hazards such as occupational accidents, chemical exposure, and heavy lifting (Källestål et al., 2004). These kinds of actions seems to be insufficient to meet the 'new' type of work-related ill health. In organizations, occupational health and safety (OHS) work has, therefore, been complemented by various health-promoting interventions focusing on individual, organizational, and environmental factors affecting employee health. There is relatively extensive knowledge of risk factors for the occurrence of job stress, work-related illness and disorders (e.g. Karasek & Theorell, 1990; Siegrist, 1996). However, less is known about the actual content of health-promoting initiatives at the workplace and how health-related change processes are managed in organizations. There is also limited knowledge concerning the extent to which workplace health is incorporated into the general management of organizations.

During the last decade, there has been a shift in research focus, from identifying physical and psychosocial risks in the work environment from an individual perspective, towards the influence of organizational factors on working conditions and health (Bolin, Höckertin, & Marklund, 2010; Härenstam, Marklund, Berntson, Bolin, & Ylander, 2006). This line of research involves both studies of a larger number of workplaces (e.g. Bolin, Marklund, & Bliese, 2008; Marklund, Bolin, & von Essen, 2008) and case studies (e.g. Kankkunen, 2009). Previous occupational health research on the 'change process' in organizations has investigated the potential health consequences of downsizing, restructuring, and other economically driven change processes (e.g. Vahtera, Kivimäki, & Pentti, 1997). However, organizational change from a work environment perspective differs from a purely economic perspective. This latter type of change process may instead be considered as health promotion intervention in the workplace with an explicit focus on developing workplace health (Härenstam, 2010).

Previous research on health promotion at the workplace has mainly focused on the health behaviour of employees, but since the late 1990s, a shift towards leadership, organization of work, and work environment has been noted (Shain & Kramer, 2004). Although this shift in research focus has given rise to slightly different lines of research concerning *workplace health promotion (WHP)*, several reviews underline the need for a comprehensive

approach to WHP that includes both individual-directed and organizational-directed measures (Goetzel & Ozminkowski, 2008; Goldgruber & Ahrens, 2010; Källestål et al., 2004). Generally, research evaluating the effectiveness of different types of WHP interventions has shown positive results in terms of improved employee health and well-being (Kuoppala, Lamminpää, & Husman, 2008; Sockoll, Kramer, & Bödeker, 2009; Soler et al., 2010). However, this support for improved employee health is more consistent for individual-directed interventions compared with organizational interventions (Montano, Hoven, & Siegrist, 2014; Sockoll et al., 2009). Although previous studies have examined the content and implementation of WHP-related interventions (e.g. Nielsen, Fredslund, Christensen, & Albertsen, 2006; Saksvik, Nytrø, Dahl-Jørgensen, & Mikkelsen, 2002), research evaluating workplace health interventions highlights that process issues are often absent or poorly described in intervention studies, making it difficult to assess the implementation of such interventions (Egan, Bambra, Petticrew, & Whitehead, 2009; Murta, Sanderson, & Oldenburg, 2007).

Additionally, previous research on workplace health interventions generally agrees on the need for senior management support and commitment (Murta et al., 2007; Nielsen, Randell, Holten, & Rial González, 2010; Saksvik et al., 2002). Theoretically, it has been emphasized that WHP needs to be integrated into the organization's management of the business and not be considered as a separate organizational process (Chu et al., 2000). Although senior management is often recognized as a key stakeholder in WHP, the importance of management commitment to various work environmental issues remains more rhetorical than empirically supported (Kamp & Nielsen, 2013). Instead, studies show that there are variations in how organizations deal with and manage WHP (Black, 2008). Therefore, more knowledge is required regarding how WHP is managed and related to the organization's general management, as well as aspects related to other management systems for work environment and human resources. As previous research on how WHP is managed has been dominated by studies of private companies, additional studies of public sector organizations are needed (Svartengren et al., 2013).

The research problem and rationale of the thesis

Health-related issues are given much attention in contemporary Western society. This is reflected in people striving to enhance their personal health, as well as organizations and governments efforts to improve the health of their employees and populations.

Beyond this broader health perspective, this thesis focuses on WHP and its management and implementation in municipal organizations. Following previous research, this thesis employs an organization-oriented approach to work and health (Härenstam et al., 2006): the research focus is directed

towards the organizational level as opposed to the individual level. Previous research has recommended organizational-level interventions as a more desirable approach than individual-level interventions because they address upstream factors and the roots of unhealthy working conditions (Montano et al., 2014). However, scientific reviews of WHP interventions repeatedly report that these interventions more frequently focus on individual health behaviour than organizational factors affecting employee health (e.g. Sockoll et al., 2009). The same pattern is shown in local projects at workplaces where healthy lifestyle activities are used in response to increased levels of sickness absence and work environment problems.

This thesis focuses on comprehensive WHP as such, and as a means to enhance employee health. By doing this, WHP is viewed as an organizational practice used alongside other practices in the organization. Moreover, WHP is seen as a practice extending across different organizational levels, as well as involving issues related to the management and implementation of such an organizational practice. Little is known about WHP from this perspective in public sector organizations. Furthermore, studies have noted the complexity surrounding municipal managers and challenges to balance various interests from politicians, employees, and citizens of the municipality (Cregård & Solli, 2012). Based on the knowledge gap, some initial questions posed in the thesis were as follows: Which types of WHP measures are used? How is WHP managed in municipal organizations? To what extent is WHP related to other management systems? What enables and hinders implementation of WHP? How is WHP supported? Given the organizational focus of this thesis, these initial questions were reconstructed into empirical studies mainly using municipal managers as informants. This focus is also supported by research underlining the importance of management support and commitment, but simultaneously indicating that the literature is prescriptive rather than based on empirical findings (Kamp & Nielsen, 2013). Additionally, the formal role as a manager involves responsibilities related to the work environment. Therefore, this research has involved both the perspective of line and middle managers, as well as that of senior managers.

Besides WHP, this thesis draws on two other multifaceted key concepts: *management* and *implementation*. The concept of management is commonly described as either an entity or a function. As an entity, management is characterized by a group of people with certain power and responsibility to make decisions and ensure that these are realized. As a practice, management includes a range of activities, such as organizing and coordination, which often follows objectives or an agreed-upon policy. In this thesis, management is mainly viewed in line with the thinking of management as a practice. Similar to the concept of management, implementation is a wide-ranging concept surrounded with some conceptual confusion. In this thesis, the following definition is used: ‘all real actions taken to implement the intervention, being best understood as an interaction (or even co-production)

between the actors implementing the intervention and the target system' (Bauer & Jenny, 2013, p.10). These two key concepts are inter-connected in that implementation is often viewed as putting decisions, programmes, or policies into practice. Even though managerial activities are primarily associated with managers in the organizations, it is important to stress that other organizational actors participate and may also have an influence on how to manage WHP.

Although WHP originates in the field of public health, the view on WHP in this thesis encompasses a broader perspective, not only related to employee health, but also from a wider perspective on the working life, comprising management and change in a municipal organizational context.

Disposition of the thesis

This thesis consists of three papers accompanied by this 'kappa' text, which summarizes and connects the included studies. The kappa consists of eight sections. After this first section, which introduced and presents the background of the research problem, the second section presents both the overall and specific aims of the thesis. The third section describes previous research on management and implementation of WHP in order to provide insights into the relevant research field. In the fourth section, the conceptual framework of the thesis is further described. The fifth section describes the methodology, including methods used for data collection and data analysis in the studies (papers). The sixth section summarizes the findings of the papers included in the thesis. In the seventh section, these findings are discussed in relation to previous research and implications for theory and practice. Moreover, the strengths and limitations of the research design and methods used are discussed. Finally, the conclusions are presented.

Aim of the thesis

Overall aim

The overall aim of this thesis was to explore how workplace health promotion (WHP) is managed and implemented in municipal organizations.

Specific aims

Aims for included papers:

I. The aim was to investigate employers' management characteristics, their provision of WHP measures, and employee satisfaction with WHP in relation to employee health in Swedish municipal social care organizations.

II. The aim was to explore how WHP is managed and incorporated into the general management system in two Swedish municipal organizations.

III. The aim was to analyse how line and middle managers experience and describe barriers and enablers in the implementation of a health-promoting leadership program in municipal organizations.

Scope and delimitations of the thesis

This thesis is based on an organization-oriented approach. Although employees are involved in WHP as both recipients of health-promoting activities and actors, this thesis does not primarily focus on employee health at the individual level. Instead, it focuses on the management and implementation of WHP, and how organizational actors in this case, municipal managers describe aspects related to WHP content and processes. This also includes the managers' descriptions of interactions with other WHP stakeholders (e.g. human resources (HR) staff, employees) at other levels of the organization, as well as the organizational conditions that surround managers. Despite the organizational focus, it must be emphasized that the organization level is not an entirely coherent level of analysis. In papers I and II, the department level represents the level of analysis, whereas in the paper III the work group level (unit) forms the level of analysis. Although specific WHP measures were linked to employee health in paper I, this thesis does not intend to assess the effectiveness of WHP in terms of employee health. Additionally, the thesis does not include all aspects of the entire regulated OHS management system, but rather aspects related to work organization and psychosocial work environment, as well as the voluntary and individual side of WHP focusing on healthy lifestyle activities for the employees. Although the health-promoting leadership programme analysed in paper III was also implemented in a number of German organizations, note that all studies in this thesis were carried out in Swedish municipal organizations. Finally, the thesis aims to describe the current practices of WHP, and to a lesser extent, to prescribe any detailed recommendations for future practices.

Previous research

Research *for* WHP and *on* WHP

The research regarding WHP can be categorized in various ways; Björklund (2008) describes two different lines: (i) research *for* WHP and (ii) research *on* WHP. Research *for* WHP is described as the dominant line of research and concerns the development of various programmes and practices for WHP. As this line of research has a development-oriented objective, the studies encompassed within it include those examining best practices and those evaluating the health and economic outcomes of WHP. In contrast, research *on* WHP applies a critical perspective to WHP. An important distinction between the two lines of WHP research is that the primary intention of research *on* WHP is not to provide explicit guidance on how WHP programmes should be designed or conducted to improve workplace health. Instead, research *on* WHP aims to problematize WHP in relation to the predominant health discourse and what this contemporary discourse means for the relationship between employees and management within organizations (e.g. Holmqvist & Maravelias, 2011; Zoller, 2003). Björklund (2008) argues that research *on* WHP is scarce in Sweden, most likely because Swedish occupational health research has been based on a predominately biomedical health perspective. Thus, most research concerning WHP to date could ultimately be considered research *for* WHP.

Although studies related to these two lines of research can be identified among WHP studies, their further categorization is hampered by the fact that WHP is defined in different ways. This fact becomes clear when comparing studies conducted in the United States (US) and Europe (Frick & Zwetsloot, 2007). In the US, WHP usually focuses on the health behaviour of employees, as evidenced by the use of surveys of WHP in the US and systematic reviews of US studies defining WHP in terms of various health behaviours (Goetzel et al., 2014; Linnan et al., 2008; Soler et al., 2010). In Europe, WHP studies often assume a broader scope incorporating the work organization and the work environment, and thus reflecting the content of the *Luxemburg Declaration of Workplace Health Promotion in the European Union* (European Network for Workplace Health Promotion, 2007). Recent reviews of this general pattern in the US literature on WHP has led to emphasis on the need for broader approaches to WHP and development of a healthy workplace culture (Aldana et al., 2012; Goetzel et al., 2014).

Regarding these differences in research focus, the research presented in this thesis primarily concerns the research *for* WHP and aligns with the broader view of WHP applied in most European studies. However, it goes beyond this perspective by examining studies from the critical research tradition to further problematize the management and implementation of WHP in municipal organizations.

Previous research *for* WHP

Several scientific reviews have shown that WHP can contribute positively to the health and well-being of employees. Systematic reviews support the effectiveness of WHP interventions in improving general health (Rongen, Robroek, van Lenthe, & Burdorf, 2013; Sockoll et al., 2009) and reducing health risks (Soler et al., 2010). Among them, one review presents moderate evidence that WHP interventions focusing on exercise, lifestyle, and ergonomics are more beneficial and reduce sickness absence more greatly than educational and psychological measures implemented alone are (Kuoppala et al., 2008). However, scrutinising these reviews indicates that the vast majority of studies have examined WHP interventions directed towards the health behaviour of employees (e.g. Harden, Peersman, Oliver, Mauthner, & Oakley, 1999; Sockoll et al., 2009). Consequently, most studies use individual-level data as the basis for data analysis. Recent reviews of WHP interventions conducted in the Nordic countries show similar results, with interventions focusing at individual behavioural change rather than workplace change (Torp, Eklund, & Thorpenberg, 2011; Torp & Vinje, 2014).

Over the last decade, the research focus has shifted towards investigation of the influence of organizational factors on employee health (e.g. Åkerlind, Schunder, & Frick, 2007; Stoetzer et al., 2014; Svartengren et al., 2013). In accordance with this development, a comprehensive approach to WHP has emerged, emphasizing not only the importance of individual-directed WHP interventions but also the work organization and the psychosocial work environment (European Network for Workplace Health Promotion, 2007). This comprehensive approach to WHP has been supported in scientific reviews (Goetzel & Ozminkowski, 2008; Goldgruber & Ahrens, 2010). A similar shift in research focus has also occurred regarding research using closely related concepts, such as healthy workplaces and organizational health, but with a more explicit focus on organizational effectiveness and productivity (e.g. DeJoy & Wilson, 2003; Grawitch, Gottschalk, & Munz, 2006).

Accordingly, recent years have witnessed an increased interest in research into organizational-level interventions involving the psychosocial working conditions that improve employee health (Nielsen et al., 2010). These types of interventions aims to change the way work is organized, designed, and managed in the workplace, and thus involves changing social, structural, and

political aspects of the organization (Nielsen, 2013). Reviews of individual-directed WHP interventions assessing various health behaviours show that these interventions yield relatively consistent positive effects on employee health (e.g. Goldgruber & Ahrens, 2010). However, evidence of the effectiveness of organizational-level interventions on employee health has proven weak and inconsistent (Montano et al., 2014; Sockoll et al., 2009) despite the assumption that organizational health interventions are more likely to produce sustainable effects by addressing upstream factors (e.g. job demand and leadership) important for employee health (LaMontagne, Keegel, Louie, Ostry, & Landsbergis, 2007). However, Sockoll et al. (2009) argue that the lack of evidence of the effectiveness of organizational health interventions can be attributed to the fact that these types of interventions are more complex than individual-directed interventions, and therefore have been evaluated to a lesser extent.

In addition to research into organizational health interventions, more empirical and comparative research investigating organizational factors in a larger number of organizations has been requested (Arnetz & Blomkvist, 2007). In Sweden, several recent studies of both private companies and public sector organizations have investigated organizational factors influencing employee health (Ljungblad, Granström, Dellve, & Åkerlind, 2014; Stoetzer et al., 2014; Svartengren et al., 2013). Among them, a study of a large number of municipal social care organizations found that factors in the psychosocial work environment (e.g. social climate), developmental leadership and health-specific measures (e.g. fitness activities) are related to better employee health less sickness absence in the organizations (Ljungblad et al., 2014). Despite these recent developments, more empirical research is needed to shed light upon the complexity surrounding WHP practice.

Management of workplace health

Previous research on management of workplace health is multidimensional but often relate to the regulation of the work environment. This focus can be explained by the implementation of legal requirements for organizations in many countries to conform to mandatory OHS management systems (Frick & Zwetsloot, 2007). In Sweden, OHS management is regulated by the systematic work environment management (SWEM) system, which mandates that employers ensure that ill health and accidents are prevented to achieve a satisfactory work environment (Swedish Work Environment Authority, 2001). Recent years have witnessed attempts to assess the effectiveness of such OHS management systems. Among them, a rare systematic review in this field of research reported that OHS management systems can yield improved employee health but noted the lack of evidence with which to make definitive recommendations for or against certain types of management systems. Instead, other studies have focused on the implementation of OHS systems

(e.g. Saksvik, Torvatn, & Nytrø, 2003) and closely related systems to manage work-related stress (Mellor et al., 2011; Mellor, Smith, Mackay, & Palferman, 2013). Recently, two reviews of the implementation of the SWEM system concluded that weak goal orientation, lack of monitoring of results (i.e. not only follow-up of routines), and lack of economic incentives are hindering effective implementation of SWEM in Sweden, and thus improvements of the work environment (Frick & Johanson, 2013a; Frick & Johanson, 2013b).

Other studies have focused on aspects of workplace health management other than the implementation and effectiveness of OHS management systems. A typology of health management identifies 12 major approaches and differentiates between approaches that relate to the management of *business effects on health* and approaches that relate to the management of *health effects on business* (Frick & Zwetsloot, 2007). According to this typology, OHS management is related to the former and WHP to the latter approaches (cf. in line with the research *on* WHP tradition). However, it might be more fruitful to clarify the differences between mandatory OHS management systems (e.g. the Swedish SWEM system) and WHP as a voluntary approach to workplace health management. It may also be productive to clarify that differences related to OHS management mainly focus on identification of occupational risks while those related to WHP aim to incorporate positive measures and resources to improve employee health, although this is not always reflected in the empirical research (Torp & Vinje, 2014).

Beyond clarifying these theoretical categorizations, recent literature, particularly in the US, has renewed the argument that WHP and OHS should be integrated (Hymel et al., 2011). Although this reasoning reflects a US view on WHP (i.e. one mainly focusing on health behaviours), it is argued that WHP and OHS activities are managed in a fragmented way by organizational actors (e.g. HR staff and safety committees) operating in independent silos (Schill & Chosewood, 2013). As such, WHP and OHS should be viewed as parallel pathways for the promotion and protection of employee health (Hymel et al., 2011; Sorensen et al., 2013). An integrated approach to workplace health 'blending' WHP and OHS has recently been defined as follows: "a strategic and operational coordination of policies, programs, and practices designed to simultaneously prevent work-related injuries and illnesses and enhance overall workforce health and wellbeing (Sorensen et al., 2013, p. 13). A recent review supported this integrated approach to workplace health in terms of its effects on employee health but not on economic outcomes (Pronk, 2013).

In addition to calling for more research into an integrated approach, researchers have argued that WHP needs to be integrated into an organization's general management system and operational plans (Chu et al., 2000). In accordance with this argument, some researchers have asserted that WHP should, be viewed as an issue of strategic importance for an organization

that is closely linked to business processes and human resource management (Zwetsloot & van Scheppingen, 2007). In Sweden, several studies adheres to this view of health as a strategic resource in the organization. Among these studies, a few assumed this view from the field of management control and accounting to, for example, analyse a governmental attempt to implement so-called health statements[1] aiming to reduce high levels of sickness absence in Sweden (Almqvist, Backlund, Sjöblom, & Rimmel, 2007). In general, the findings of these studies indicate that health statements have only modest impact on municipal organizations, indicating that integration of health into general management is complex and that integration with other forms of management has gradually subsided (e.g. Sjöblom, 2010). However, the findings of one study of an intervention project integrating WHP and health statements indicate that WHP programmes of high quality (i.e. that take a comprehensive approach and high levels of management and employee involvement) are associated with better psychosocial working conditions and employee health compared with WHP programmes with lower quality (Vinberg & Landstad, 2014).

While the review of previous research presented above indicates that the empirical research concerning how WHP is managed is limited, it is not an extensive review. Nevertheless, its findings are supported by a review of the broader work environment literature that conclude the extent to which work environment efforts are integrated into general management remains more prescriptive than supported by the empirical findings (Kamp & Nielsen, 2013).

Implementation of WHP

Review of previous studies indicates that the research into the implementation of WHP is more limited than the research investigating the effectiveness of WHP on employee health (Weiner, Lewis, & Linnan, 2009). It also indicates that because reviews of organizational health interventions have yielded inconsistent results, there remains a great need for investigation of how various workplace health interventions are implemented (e.g. Montano et al., 2014). Moreover, reviews of previous research indicate that the primary reason why organizational health interventions tend to fail is not the existence of problems in intervention design and content but rather poor implementation (Biron, Karanika-Murray, & Cooper, 2012). In intervention research, this aspect of poor implementation has been labelled *programme failure* as opposed to *theory failure* that indicate a focus on the underlying intervention theory that is not producing the intended effects (Kristensen, 2005). However,

[1] Health statements refer to reports based on a management control model that aim to draw attention to and promote actions related to improved working conditions as a way to reduce costly sick leave for organizations.

lack of knowledge regarding implementation has also been underlined in systematic reviews of organizational health interventions. Specifically, these reviews have shown that few intervention studies illuminate that investigation of process-related and contextual issues of how and why interventions work is lacking and, if present, generally poorly describes these issues (Egan et al., 2009; Murta et al., 2007). The consequent lack of information concerning the implementation of various interventions could hinder learning and led to further difficulties in examining the relevant process and contextual issues when planning for the implementation of future organizational health interventions (Montano et al., 2014).

The previous 'process studies' of organizational health interventions that do exist illustrate several process-related and contextual issues that influence successful implementation. Among these issues, several are recurrently described as influential when implementing organizational health interventions, including management support (or commitment), employee participation (Nielsen et al., 2006; Nytrø, Saksvik, Mikkelsen, Bohle, & Quinlan, 2000; Saksvik et al., 2002), unclear roles and responsibilities (Aust, Rugulies, Finken, & Jensen, 2010; Nielsen et al., 2006; Saksvik et al., 2002), lack of ownership (Biron, Gatrell, & Cooper, 2010), social climate (Nytrø et al., 2000), and competing projects and reorganization (Saksvik et al., 2002). Beyond intra-organizational issues, several external factors, such as political reforms, affect the entire organization, and therefore also influence the implementation of organizational health interventions (Bejerot & Hasselbladh, 2013). Among the many process-related and contextual issues that may affect organizational health interventions implementation, a recent review of individual-directed WHP programmes identified over 50 barriers and facilitators (Wierenga, Engbers, Van Empelen, Duijts, & Hildebrandt, 2013). While many of these issues are likely relevant to organizational health interventions as well, the interventions are multifaceted, multi-component programmes and complex change processes that involve many stakeholders (Biron et al., 2012).

Recent research has identified line and middle managers as important organizational actors in the implementation of organizational health interventions (Hasson, Villaume, von Thiele Schwarz, & Palm, 2014; Nielsen, 2013). Their importance lies in their responsibility for implementation of change, while the importance of senior management typically rest in their responsibility to make formal decisions regarding interventions and organizational change (Nielsen & Randell, 2013). Moreover, line and middle managers are usually expected to be active participants in WHP interventions. As such, these managers could be viewed as co-creators in the intervention who play a crucial role in hindering or facilitating the implementation of change (Nielsen, 2013; Nielsen & Randell, 2013). This contention is supported by empirical studies describing middle managers as being simultaneously resistant to change (Saksvik et al., 2002) and, paradoxically,

as driving forces in change due to their responsibility to promote employee engagement in the intervention (Hasson et al., 2014). Additionally, a recent intervention project conducted with Swedish municipal managers illustrates the importance of organizational conditions on these managers, not least regarding development of their own working conditions and health (Berntsson, Wallin, & Härenstam, 2012; Härenstam & Östebo, 2014).

Previous research *on* WHP

Studies within the research *on* WHP link modern management principles with contemporary discourses of health (Holmqvist & Maravelias, 2011; Maravelias, 2006; Zoller, 2003). When this reasoning is applied to health promotion at the workplace, WHP is argued to reflect a discourse with an excessive focus on employee health and the adoption of a healthy lifestyle (Holmqvist & Maravelias, 2011). Thus, WHP can be understood as giving employers and managers increased control over employees' health, which, in turn, can intrude on the personal integrity of the employees as well as contribute to organization of the employees' private sphere (Björklund 2008; Holmqvist & Maravelias, 2011; Maravelias, 2006).

Although empirical research *on* WHP is rare, the morality involved in WHP is a recurring theme in the research literature (Green, 1988; Holmqvist, 2009). The critical perspective that this line of research encompasses has also been discussed in the general literature on health promotion emphasizing, for example, the limits on or increase in individual freedom and the risk of 'blaming the victim' (Carter, Cribb, & Allegrante, 2012). Lately, the relevant moral issues have also been addressed in empirical WHP studies (Robroek, Van de Vathorst, Hilhorst, & Burdorf, 2012; van Berkel et al., 2014). Research into stakeholders' views of WHP have illustrated that while managing lifestyle behaviours is mainly viewed as a responsibility of the employee, employers view this responsibility in terms of a duty while employees view it in terms of maintaining autonomy (van Berkel et al., 2014).

A contribution of the critical research *on* WHP is identification of the connection between WHP and organizational research and concepts such as managerialism. According to Zoller (2003), WHP tends to encourage employees to identify with managerial ideology, which enforces the values of efficiency and hard work. A consequence of this discourse when incorporated into WHP might be reduced employee voice, making resistance more difficult by leading employees to become preoccupied with personal achievements. Other critical studies emphasize the risk that an extensive individual focus on employee health and well-being may overshadow a focus on topics that are more important in preventing ill health at the workplace (e.g. Holmqvist, 2009).

Conceptual framework

Perspectives of health and the concept of health promotion

Health is a complex concept encompassing a range of meanings varying from a biomedical to a holistic perspective (Blaxter, 2010). The concept of health has therefore been defined differently over the years and inspired extensive theorising and debate (e.g. Huber et al., 2011). Given the complexity of the concept, it has proved challenging to operationalize and measure health (Blaxter, 2010). In occupational health research, health has usually been defined in terms of its antitheses: ill health and disease. From this biomedical perspective, health is viewed on the basis of pathogenesis, meaning that health is viewed as the absence of disease (Boorse, 1977). In contrast, the humanistic perspective defines health as more than the absence of illness and disease. Following a humanistic view on health, Nordenfelt (1995) define health as a holistic concept in which a person's health is considered as the person's ability to achieve his/her vital goals given standard circumstances. Similarly, the work of Antonovsky (1987) reflects a positive view on health emphasizing a focus on personal resources and capacities to create health, rather than risk factors for ill-health and disease. Applying the term *salutogenesis* to describe the origin of health, he emphasized the need to make use of available resources as well as problem-solving capabilities.

A holistic and positive view on health is also reflected in the concept of *health promotion*. This view is encompassed in the Ottawa Charter for Health Promotion, which refers to health as a resource in people's everyday lives (World Health Organization, 1986). Unlike disease prevention, which focuses on reducing the risk of ill health and occurrence of disease, health promotion is defined as a 'process of enabling people to increase control over and to improve their health' (World Health Organization, 1986). By drawing on a holistic view of health, the concept of health promotion also builds on a socio-ecological model of health in which health is influenced by a complex interplay of individual, organizational, and environmental factors (Stokols, Pelletier, & Fielding, 1996).

The concept of health promotion emphasizes the importance of the *setting*, the social context (e.g. the workplace) where people perform activities on a daily basis and in which various socio-ecological factors interact to influence their health and well-being (World Health Organization, 1998). In tandem

with a focus on the setting is the argument for creating *supportive environments for health*, that enable people to develop capabilities and self-confidence regarding their health and protect them from health risks (World Health Organization, 1991). To achieve this goal, supportive environments should be developed in the immediate vicinity of people and encompass access to health resources and opportunities for empowerment. Effective health promotion requires the development of knowledge, skills, commitment, structures, systems, and leadership. Together these aspects contribute to *capacity building* for health promotion, which includes the knowledge of individual staff as well as the support and structure for health promotion in any given organization (Smith, Tang, & Nutbeam, 2006). In this thesis, WHP is adopted within the framework of health promotion, and thus reflects a holistic view of health.

Workplace health promotion (WHP)

The *workplace health promotion* (WHP) movement can be related to two different lines of development. Whereas the first line focuses on achieving a healthy lifestyle by addressing individual health-related behaviours, the second line, whose origins lie in health promotion and the setting approach proposed by the WHO, focuses on a broader repertoire of health determinants to reduce health inequalities (Bauer & Jenny, 2013). Consequently, the settings-based approach to WHP requires assuming a broader view of the entire work system, including its dynamics, stakeholders, and power structures (Bauer & Jenny, 2013). Following the way in which WHP is conceptualized by the second line, this thesis views WHP as a process-oriented approach, which aims to develop a healthy work environment as a means to improving employee health (Bunton, 2010).

Although there is no strict and agreed-upon definition of WHP, the intentions of WHP is reflected in the following description of WHP: 'as the combined effort of employees, employers and the community to improve the health and wellbeing of people at work' (European Network for Workplace Health Promotion, 2007). Drawing on this definition, taking a *comprehensive* approach to WHP mirrored in existing conceptualizations of WHP accentuating the importance of the work organization and work environment, as well as the active participation and personal development of employees, can be proposed (European Network for Workplace Health Promotion, 2007). Given the underlying *public health perspective* in this WHP tradition, a comprehensive approach clearly encompasses both higher-level upstream structural, organizational, and environmental factors as well as lower-level downstream factors, such as individual behaviours as determinants of employee health (Åkerlind et al., 2007; Dejoy & Wilson, 2003). This assumption means that employee health can be viewed as a product of both

individual behaviour and the work organization (e.g. Shain & Kramer, 2004). Accordingly, organizations can promote employee health by strengthening personal health practices and resources by offering various health-specific programmes and measures, as well as by forming a well-functioning work organization, beneficial for employee health (Chu et al., 2000; Shain & Kramer, 2004). The health-specific measures provided may, in turn, vary from individual-directed measures (e.g. fitness activities and lifestyle guidance) to organizational support for WHP (e.g. health ambassadors, projects, and health-promoting leadership).

Although WHP has emerged as an independent field of research and practice alongside the more established areas of job stress and OHS, it is often difficult to differentiate these related fields of research. One distinction, however, is that WHP more explicitly focuses on identifying positive health factors (e.g. employee participation) alongside more traditional occupational risk factors (e.g. heavy lifting). Similarly, it is difficult to distinguish WHP from other workplace health approaches when WHP is put into practice, at which point it becomes difficult to differentiate between health-promoting and preventive actions. Despite potential conceptual ambiguities and limitations regarding WHP, it is used as a central theoretical concept in this thesis.

Healthy organizations and related concepts

Beyond the concept of WHP, lie several closely related theoretical concepts. An idea that unites these concepts, is that the individual and the organization do not constitute two independent entities; instead, they interact, and working conditions and health are the products of this interaction (Bauer & Jenny, 2013). Thus, employees work within what constitutes their health-determining environment. According to the concept of *organizational health,* the health of employees and organizational outcomes are inseparable and determined by the on-going interaction between employees and the organizational context (Bauer & Jenny, 2013). A similar reasoning applies to the concept of the *healthy work organization* (DeJoy & Wilson, 2003), which implies that healthy work systems may be distinguished from their unhealthy counterparts by determining whether they contribute to the health and well-being of employees and, simultaneously, to the productivity and profitability of the organization. A third concept is the *healthy workplace*, which, building on a similar idea as the healthy work organization, emphasizes a two-fold approach towards employee health and organizational performance. According to Grawitch et al. (2006) this latter concept is based on two assumptions: (i) it is possible to identify key indicators/factors that characterize good working and organizational conditions and (ii) creating a good work environment leads to healthier and more productive employees, which in turn leads to increased production and competitive advantage for the organization.

Although there is considerable overlap among concepts related to the employee and organizational health, there is no consensus on how to define a 'healthy workplace' (Lindberg & Vingård, 2012). The lack of consensus is also reflected in the use different conceptual models for healthy workplaces that place different emphases on their value for employees and employer. Nevertheless, all these concepts have both similarities with and differences from WHP. A similarity uniting all the related concepts and WHP is recognition of and a focus on both individual and organizational aspects by the related concepts and the comprehensive approach taken by WHP. A difference is that WHP places less emphasis on organizational aspects related to performance and productivity than the related concepts. Given the organizational approach applied and the organizational focus of the related concepts, these concepts are used as additional points of reference to WHP in this thesis.

Process, content and contextual thinking

The general concepts of *process*, *content*, and *context* are widely used in the scientific literature, including the organizational change literature and research. In general terms, the *content* of organizational change can be viewed as the *what* providing direction for the change, whereas the *process* can be viewed as the *how* concerning the implementation of change (Burke, 2011). This way of thinking about organizational change has evolved within the process-oriented research on organizational change, as well as in reaction to criticism of the rationalist approach to change as a means of providing simple programmes and (read: linear) explanations on how and why changes occur (Caldwell, 2005). In addition to the content and processes, process-oriented research is strongly influenced by a contextual perspective (Pettigrew 1997; Pettigrew, Woodman & Cameron, 2001; Dawson 2003). In the organizational change literature, the context can be conceptualized as the *where*, *when*, and *who* of change (Burke, 2011). Dawson (2003) argues that organizational change should also be viewed in relation to the *politics* of change, which means considering 'political' activities as acts of resistance, conflict, and negotiation often manifested among organizational actors (e.g. management, unions, and employees) involved in organizational change. Although this explicit power dimension was lacking in early approaches to organizational change, it has been emphasized in later discourses (e.g. the constructionist discourse; Caldwell, 2005).

In this thesis, the concepts of process, content, and context are parts of the conceptual framework as a way to guide the conception of how WHP is managed and implemented within a municipal organizational context. The choice of this framework is also related to the encompassing of a process-oriented focus within the concept of WHP.

Methodology

Research design

To fulfil the overall aim of the thesis, both quantitative and qualitative research designs were applied. The combination of quantitative and qualitative methods was intended to be complementary and provide breadth and in-depth knowledge concerning how WHP is managed and implemented in municipal organizations (Creswell, 2009). A quantitative study (paper I) precedes two studies in which the data were collected and analysed using qualitative methods (papers II and III). Consequently, one idea of the research design was that the quantitative study could provide knowledge of how WHP is handled by a wider sample of municipal organizations, whereas the qualitative studies were intended to provide qualitative descriptions and in-depth knowledge related to WHP management and implementation in the municipal organizations. Although various research designs were applied, one design may constitute a more primary method (Morgan, 1998). The present thesis relies somewhat more on the use of qualitative methods and qualitative descriptive data. Although both quantitative and qualitative designs were used, all studies were guided by a comprehensive view of WHP, as well as illuminating WHP from a managerial perspective within a municipal organization context. Given the organizational focus of the thesis, the included studies are also united by the use of the organization[2] as the level of analysis.

Research settings

The studies in this thesis were conducted in Swedish municipal organizations. In Sweden, municipalities are self-governing local authorities responsible for providing welfare and infrastructure services for its citizens. These services may be provided by the municipality itself or by contracting private welfare providers. This means that the municipalities are themselves large public

[2] Note that the organization is not an entirely uniform level of analysis (see Härenstam et al., 2006). In this thesis, paper I investigated municipal social care organizations (department level), and paper II investigated various municipal departments, whereas paper III involved work groups part of work units (work-group level). The studies are united in that they intend to say something about organization and management rather than about individuals.

sector employers with about a fifth of the Swedish workforce. Municipalities are also politically governed organizations with the Municipal Assembly as their highest decision-making body. In the first study (I), a larger national sample of municipal social care organizations was investigated. The sector of elderly and social care is a significant part (35%) of the municipal operations (Swedish Association of Local Authorities and Regions, 2008). Studies II and III were conducted in two large municipal organizations located in the Stockholm-Mälardalen region, which is a densely populated part of Sweden. Both municipalities are categorized as larger cities (i.e. ~ 100, 000 inhabitants; Swedish Association of Local Authorities and Regions, 2011). Together these two organizations employ approximately 19, 000 persons. Because of the gender-segregated labour market in Sweden, both organizations are characterized by many female-dominated workplaces in childcare, education, as well as elderly and social care.

Design and data collection in the studies

This thesis consists of three empirical studies, one of which had a quantitative design and two with qualitative designs. The studies were based on different empirical material, such as questionnaires, interview data, and documents (Table 1). The studies are presented in three corresponding papers.

Table 1 Overview of the studies

	Design	**Setting**	**Participants**	**Data collection**	**Data analysis**
Question-naire study *Paper I*	Cross-sectional	Nationwide random sample of municipal social care organization (*n* = 60)	Top managers (*n* = 60) Employees (*n* = 9270, 8082 in analysis)	Question-naire to managers Question-naire to employees	Independent *t*-tests Spearman's correlation Multiple linear regression analysis
Interview study *Paper II*	Qualitative design	Two municipal organizations	Senior managers (*n* = 14)	Semi-structured interviews Documents (e.g. operational plans)	Qualitative content analysis
Case study *Paper III*	Case study	Two municipal organizations	Participating line and middle managers (*n* = 11) Senior managers (*n* = 5)	Semi-structured interviews Documents (i.e. action plans) Notes	Thematic analysis

The questionnaire study (paper I)

A cross-sectional study was conducted with data from a nationwide random sample of Swedish municipal organizations in the sector of social care of elderly and disabled people. Using the organization sampling frame approach (Kalleberg, 1994), a random sample of 60 organizations was drawn from the total population of 290 municipal social care organizations in Sweden. Thereafter, a representative sample of employees was drawn from each organization (n = 15, 871). The social care organizations differed in the number of employees, and therefore, the subsample from each organization was adjusted to be representative for each organization (M = 265; range = 96–397 employees). The random sample included municipal social care organizations from different socio-demographic types of municipalities as well as from various geographic parts of Sweden. However, the sample did not include Sweden's three largest municipalities.

Based on the sampling strategy, two different questionnaires were used to collect data from the employer and the employees, respectively. The employer questionnaire was sent by e-mail to the top manager of each social care organization (n = 60). Before the questionnaire was sent out, it was reviewed for content validity by a group of workplace health experts (i.e. researchers, organizational consultants, and trade union representatives) and pre-tested in four municipal social care organizations (DeVellis, 2003). After several reminders and removal of detailed follow-up questions, all top managers responded to the questionnaire. Data collection was mainly completed in 2009 concerning the conditions in the social care organizations in 2008.

The second questionnaire was sent out in 2008 to a representative sample of 15, 871 persons registered as employees (i.e. nursing aides, assistant nurses, and personal assistants) in the same 60 municipal social care organization in 2006. In total, 9270 persons responded to the questionnaire (response rate 58.4%) with response rates varying between 44% and 70% for the organizations. Of the respondents, 93% were women, and the mean age was 48 years. Sixty-four percent had worked more than five years at their current workplace.

Measurements

Data from top managers

The questionnaire for the top managers was developed for the present study as we were not able to find any existing validated questionnaires aiming to investigate the provision of WHP measures at the organizational level. The questionnaire covered the following four areas: (i) organizational characteristics, (ii) management characteristics, (iii) scope and organization of WHP measures, and (iv) occupational health services. Questions were inspired by previous work (Dellve et al., 2008; European Network for

Workplace Health Promotion, 1999), probing actual conditions concerning written policies, routines, and measures as opposed to top managers' general attitudes towards WHP.

The background questions assessed organizational and management characteristics. Two questions were used to assess *organizational characteristics*: the total number of employees and the number of subordinate managers in the municipal social care organization. *Management characteristics* were assessed by five questions covering operational plans, quality management systems, and policies for human resource management, leadership and employee participation in decision making. Response options were 'yes' and 'no'.

Furthermore, the following overarching question was asked about *organizational-directed* WHP measures: *Which of the following forms of support for WHP has been offered by the organization?* Three forms of organizational support were assessed (i.e. health-promoting activities, knowledge, and project), and the response options were 'yes' and 'no'. The support of activities addressed health-promoting activities during working hours and financial compensation for health-promoting activities after working hours. Knowledge support addressed appointed health ambassadors and specifically employed WHP coordinators. Additionally, project support addressed local health projects and participation in work health-oriented networks for the employer.

Similarly, the following overarching question about *individual-directed* WHP measures was included in the questionnaire: *Which of the following measures have the employees been offered (had access to) through work?* The following WHP measures were assessed: health profile assessment, lifestyle guidance, fitness activities, medical check-up, counselling, employee questionnaire, work environment education and individual work/workplace adjustment. Response options were 'internal', 'external', and 'occupational health service', which were later recoded into 'yes' or 'no'. This question was recoded as 'yes' if the respondent answered at least one of the three response alternatives, and as 'no' if no response was given.

Finally, three yes/no questions assessed *occupational health services* covering agreement, routines for needs assessment, and routines for following up on actions by the occupational health services.

Data from employees

Employee *self-rated health* was measured by a single question: *How would you rate your general health status?* A five-point Likert-type scale was used (1 = 'very poor'; 5 = 'very good') (Eriksson, Undén, & Elofsson, 2001). Self-rated health was aggregated and used as the primary outcome variable.

Finally, one question concerned the *satisfaction with the employers' contribution to health promotion and fitness*, which was answered on a five-

point Likert-type scale (1 = ‘do not agree at all’; 5 = ‘agree completely’). This variable was also aggregated in the analysis.

The responses to these two questions were derived from a broader survey of employees further described by Ljungblad et al. (2014).

The interview study (paper II)

The study was based on a qualitative design to explore how WHP is managed and incorporated into the general management system in the organizations. Qualitative interviews with senior managers were conducted to gain an understanding of how WHP is handled within two municipal organizations.

Purposeful sampling was employed, and the senior managers were selected to represent upper-level management, such as the head of larger departments or a member of the department’s managerial board (Patton, 2002). The strategic selection of participants sought for senior managers to represent a variety of municipal departments with varied experiences (cf. maximal variation; Patton, 2002). The senior managers were approached and recruited through e-mail. Their names and contact information had been obtained from the municipal HR departments or by searching the municipality’s websites. In total, 19 senior managers were approached, and 14 agreed to be interviewed. They represented the following departments: elderly and social care, childcare and education, urban planning, environment, HR, and municipal district administration. On average, these departments had 250 employees, but they varied between 35 and over 500 employees. Of the managers interviewed 11 were women and three were men. The mean age was 54 years (range = 38–63).

The interviews were semi-structured and conducted individually using an interview guide with open-ended questions (Kvale & Brinkmann, 2009; Patton, 2002). The interview guide contained three general themes: WHP including work environment, leadership strategies, and organization.

During the interviews, probing and follow-up questions were used to encourage the participants to elaborate on their answer and give examples. The interviews were conducted at the manager’s workplace, lasted 31–70 minutes (average 48 minutes), and were audio-recorded.

Documents such as health-related municipal policies, operational plans, and annual reports for the departments, as well as annual reports for the whole municipality, were collected and used as complementary data (Yin, 2009). The documents were primarily used to contextualize the interview data and gain a better understanding of WHP strategies and the municipal settings (Bowen, 2009). All data were collected from autumn 2012 to spring 2013.

The case study (paper III)

The leadership intervention

The intervention investigated in the case study consisted of a leadership programme that focused on rewarding and sustainable health-promoting leadership[3]. The programme was conducted in two municipal organizations, and 18 line and middle managers and their employees (n = 259) participated in the programme.

The overall intention of the leadership programme was to change the leaders' behaviours into more rewarding and health-promoting ones, as well as to demonstrate whether leadership training can encourage such behaviours among managers and improve employee health and well-being. Therefore, the programme involved on-the-job training of real-life leader behaviours as opposed to solely lecture-based knowledge. Another essential idea was that the leadership programme was extended over a longer time covering 13–15 months. Theoretically, the leadership programme was based on transformational leadership (Bass & Riggio, 2006) and the job demands-resources (JD-R) model (Bakker & Demerouti, 2007), meaning that managers can influence their employees' health both by job demands made on them and by creating job resources.

In practice, the leadership programme included both theoretical and practical elements, such as leadership theory, goal setting, and evaluation with feedback. The participating line and middle managers and their employees were offered a broad range of intervention activities such as leader workshops, coaching, diary writing, observations, and lectures. The programme also included a team workshop that aimed to develop action plans for the programme (including goals, target areas, and responsibilities) based on the results of survey data (i.e. baseline measurement).

Design and data collection

The present study applied a qualitative, holistic case study design in order to analyse the implementation of the health-promoting leadership programme. The case study design was chosen because it is appropriate when investigating complex processes in their natural context (Yin, 2009). In this study, the leadership programme was used as a single case of implementing a workplace health intervention in two municipal organizations.

Data for the study were mainly collected by semi-structured interviews with line and middle managers participating in the leadership programme. These managers had voluntarily signed up for participation in the programme. All participating managers (n = 17; as one of the participants dropped out of the programme) were invited for interviews, and 11 of these managers chose

[3] See Rigotti et al. (2014) for more detailed information about the design, content and outcomes of the health-promoting leadership programme.

to be interviewed. The interviewed managers represented different municipal services, including elderly care, pre-school, elementary school, school kitchens, social service, property management, and urban planning. These managers were responsible for work units with 5–42 employees. As the leadership programme was planned for work groups with 15 employees, part of work units were usually selected to participate in the programme, and the size of these work groups varied between 5–23 employees. Of the interviewed line and middle managers, eight were women and three men, and their age varied between 35 and 62 years.

In addition to the interviews with line and middle managers, five interviews were conducted with senior managers. These interviews were intended to obtain information about how the leadership programme was viewed and communicated to senior management.

Individual semi-structured interviews were conducted using a thematic interview guide with open-ended questions (Kvale & Brinkmann, 2009; Patton, 2002). The interview questions concerned the programme content, implementation process, effects, and contextual issues. The interviews with the senior managers were conducted in a similar way as with the line and middle managers, although with a wider focus concerning WHP management at the department level. In the interviews, probing questions were used to let the managers develop their answers and give examples. All interviews were audio-recorded and lasted between 28 and 60 minutes (average 40 minutes). The interview data were collected during autumn 2012.

Furthermore, documents were collected and used as complementary data (Yin, 2009). In total, these documents consisted of notes from six of eight leader workshops and all the action plans created as part of the leadership programme.

Data analysis

Statistical analysis

The statistical analyses in questionnaire study (I) were based on data from the top managers (n = 60) and aggregated data from 8082 employees working in the sector of municipal social care at the time for data collection in 2008. All analyses were performed at the organizational level.

In the analyses, *self-rated health* was dichotomized to poor health (scores of 1–3) and good health (scores of 4 and 5), and thereafter aggregated to the organizational level and used as the proportion of employees with poor health (i.e. level of employee health) in each of the 60 organizations (M = 0.26, SD = 0.05, range = 0.17–0.41). After aggregation to the organizational level, poor health was transformed to a logarithmic variable to achieve a normal

distribution. The second variable from the employee survey, *employee satisfaction with WHP*, was handled in the same way as the self-rated health variable. First, it was dichotomized (i.e. response options 1–3 = not satisfied; options 4 and 5 = satisfied) and then aggregated to the organizational level, and used as the proportion of employees satisfied with WHP (i.e. scores of 4 and 5) in each organization ($M = 0.38$, SD = 0.15, range = 0.07–0.70).

Following an initial descriptive analysis of data from the top managers, differences in log-transformed aggregated levels of self-rated health between organizations, with and without certain WHP measures, were analysed using independent *t*-tests. After the *t*-tests, the WHP measures with remaining significant differences after multiple comparison corrections by Hochberg's method (Hochberg, 1988), were merged into two different WHP indices. The organizational WHP index included two significant variables concerning organizational-directed WHP measures (i.e. local WHP projects and WHP coordinators), which were merged into a sum score index (0–2 scores). An individual WHP index was created using the same approach, merging the three significant individual-directed WHP measures (i.e. health profile assessment, fitness activities, and medical check-up) into a sum score index (0–3 scores). The Kuder-Richardson formula 20 (KR-20) for dichotomous variables (DeVellis, 2003) was used to assess the internal consistency of the indices. The values for the organizational WHP index and individual WHP index were 0.74 and 0.65, respectively. The correlations between WHP indices, employee satisfaction with WHP, and the level of employee health were tested by Spearman's rank correlation coefficient.

Lastly, a multiple linear regression analysis was performed to investigate associations between the two WHP indices and employee satisfaction with WHP in relation to the level of employee health. As the two WHP indices were not linearly associated with the level of employee health, they were recoded into dummy variables prior to the regression analysis. In addition, the number of employees (= organizational size) was used as a control variable in the regression analysis. All statistical analyses were performed using SPSS for Windows, and the level of statistical significance was set at $p \leq 0.05$.

Qualitative analyses

All interviews in the two qualitative studies were transcribed and prepared for analyses. Two types of qualitative analytical procedures were used. In the interview study (II), the data were analysed using a qualitative inductive content analysis (Elo & Kyngäs, 2008). This analysis started with reading through the transcripts several times to gain a comprehensive understanding of the text. In the next phase, codes were identified by open coding, in which notes and key words were written down while reading the text. Thereafter, codes with similar content were grouped into categories and further consolidated by collapsing categories with similar content. The analysis was

initially conducted by the first author and subsequently discussed and reviewed by the co-authors. These discussions helped to verify the accuracy of categories and logic of the grouping of the data. A supplementary analysis of 25 documents was also conducted. This analysis involved skimming (superficial review), reading (closer review), and interpretation (Bowen, 2009). This analysis was guided by the study aim and focused on how WHP was described and conceptualized in WHP-related documents and general operational plans. The document analysis of the operational plans mainly involved content explicitly related to WHP.

In the case study (III), a theoretical thematic analysis was employed (Braun & Clarke, 2006). The analysis was guided by a processual framework (Dawson, 2003) building on a processual perspective, which is concerned with how people experience change processes. First, the framework was used for locating and sorting the data systematically. Then, the framework, covering three areas – *substance of change* (i.e. scale, type of change, and characteristics of change), *context of change* (i.e. internal and external conditions for the organization), and the *politics of change* (e.g. resistance) – was applied in the thematic analysis. After reading the transcribed interviews, initial codes were generated and sorted into potential themes guided by the framework for data analysis. The themes were further discussed with the co-authors and refined thereafter. Further, the case study included a supplementary review of documents (i.e. action plans). All action plans created in the leadership programme were examined and analysed using a summative content analysis. Altogether, about 20 documents were included in the analysis.

Research ethics

The studies were conducted in accordance with good research practice, which means that fundamental principles of information about the research, informed consent, and confidentiality were taken into account (Vetenskapsrådet, 2011).

All participants received written information about the aim and design of the study. Participants were then given the opportunity to decide whether they wanted to participate or not. For the interviews with managers, both verbal and written consent was obtained. The interview material was made confidential and protected from unauthorized access. In any research, it is important to be cautious with personal information. Furthermore, information on individual organizations and workplaces may be considered sensitive information which managers and employees do not want to spread publicly. For these reasons, the names of the municipalities included in the interview study (II) and case study (III) are not shown. Moreover, the rather limited number of senior managers in the two municipal organizations carries a risk

of identifying persons in relation to the quotes presented in the papers, which can be avoided with confidentiality.

All studies were approved by the Regional Ethical Review Boards (EPN) in Sweden. The questionnaire study presented in paper I was approved by the EPN in Linköping (Dnr: 81/08), and the other two studies (II, III) were approved by the EPN in Uppsala (Ref: 2012/183).

Summary of findings

Paper I

The aim of this explorative study was to investigate the employers' management characteristics, their provision of WHP measures, and employee satisfaction with WHP in relation to employee health in Swedish municipal social care organizations.

The results of this study indicate that, in terms of WHP content, individual-directed WHP measures were more commonly provided than organizational-directed WHP measures in the municipal social care organizations (75% versus 54% on average). The most common of the individual-directed WHP measures was occupational health and safety education (87%, $n = 52$), and the least common measure was medical check-up (55%, $n = 33$). Concerning the organizational WHP measures, financial compensation for participation in health-promoting activities outside working hours was the most common (66%, $n = 40$), and participation in work health-oriented networks for employers was least common. Only a quarter of the social care organizations participated in such networks ($n = 15$). Most organizations had a written policy regarding WHP (80%, $n = 48$).

All of the WHP measures were tested in relation to the level of employee health (i.e. self-rated health) in the social care organizations. Concerning the *individual-directed WHP measures*, there were significant differences between organizations, with better employee health (i.e. lower proportions of poor employee health) in organizations providing the following three measures: health profile assessment, fitness activities, and medical check-up. These three measures were merged into an individual WHP index, which was negatively correlated with proportions of poor employee health ($r = -0.61$, $p < 0.01$), indicating that more WHP measures are related to better health among employees.

A corresponding analysis of the *organization-directed WHP measures* showed significant differences in employee health, indicating better health for organizations providing WHP coordinators and local WHP projects. These two measures were merged into an organizational WHP index, which was negatively correlated with proportions of poor employee health ($r = -0.48$, $p < 0.01$), indicating that more WHP measures are related to better health.

Additionally, the findings indicate that *employee satisfaction with WHP* was negatively correlated with proportions of poor employee health ($r = -0.34$, $p < 0.01$). This means that higher employee satisfaction with WHP was related to better health.

In a multiple linear regression analysis, both the individual and organizational WHP indices, as well as the proportion of employees satisfied with WHP were associated with employee health in the municipal social care organizations. These models were also controlled for the number of employees in the organizations (= organizational size), but this did not change the main results.

The study also investigated a few selected *management characteristics* in terms of policy documents put in place. A clear majority of the municipal social care organizations had operational plans (87%, $n = 52$), and a scant majority had some kind of quality management system (63%, $n = 38$). Written policy for human resources management (64%, $n = 38$), and written leadership policy for managers (59%, $n = 35$) were also in place in a scant majority of the organizations. About half of the organizations had a written policy for employee participation in decision making (53%, $n = 32$). However, there were no significant differences in employee health between social care organizations with or without these selected management characteristics (as indicators of a well-functioning organization).

Paper II

The aim of this study was to explore how WHP is managed and incorporated into the general management system in two Swedish municipal organizations.

The management of WHP at the municipal departments was described by the senior managers as a set of components that together comprise resources (i.e. knowledge, skills, leadership, structures, and systems) which contribute to build an *organizational capacity for WHP*.

In practice, a *problem-solving cycle* was used to manage WHP and to provide a structure for concrete actions related to workplace health. In the problem-solving cycle, an annual employee survey was used to map working conditions and employee health, and this survey served as an important managerial control instrument. However, the senior managers described challenges related to the implementation and especially the follow-up of action plans based on the results from the employee survey.

Furthermore, the findings illustrate that the approach used to manage WHP is extensively *dominated* by the use of *fitness programs* emphasizing the promotion of healthy lifestyle activities supporting individual behavioural change. There are also both *internal* and *external resources* available to support the management of WHP. The internal resources (e.g. HR staff) can be used to support managers with various WHP activities, such as assisting in the development of action plans and WHP measures based on the results from the annual employee survey. The external resources (e.g. occupational health services), on the other hand, are used more reactively to manage occupational health and safety issues and high levels of sick absence among employees.

In addition, the *building of leadership competence* was described by the managers as related to the management of WHP. Although comprehensive leadership programs were provided, explicit elements of WHP were limited in these programs. The findings also illustrate that *policy* documents related to WHP give little practical guidance regarding how to manage WHP and its integration with more traditional OHS issues.

Overall, these components of WHP were described as loosely connected rather than fully integrated parts. The management of WHP seemed to be partially incorporated into the general management system in the organization, and most evident in relation to the annual employee survey mapping working conditions and employee health, as well as the use of other health data (e.g. sick leave data).

Paper III

The aim of this study was to analyse how line and middle managers experience and describe barriers and enablers during the implementation of a health-promoting leadership programme in municipal organizations.

The first of two main themes that emerged from the interviews was *renewal of leadership training*. The leadership programme was described by the line and middle managers as a new and interesting way of conducting leadership training because it includes programme characteristics emphasizing employee involvement. Overall, the managers responded positively to the main content of the programme and reported the team workshops with their employees as the most important and enabling of the programme activities. There were also programme activities that were used to a lesser extent, with diary writing and coaching as the clearest examples. *Process-related issues* were exemplified by the managers as either enabling or hindering the implementation of the leadership programme. In relation to the action plans that were developed in the programme, specific goals and earlier experience of organizational development were seen as enabling factors, while the lack of the same was considered as a barrier. Although the programme was seen as a new way to conduct leadership training, the managers had difficulties identifying effects and describing new work practices emanating in the leadership programme. The timeframe of the programme was a challenge, as the managers were not used to leadership training being so lengthy and time-consuming. Thus, they found that the programme was competing with day-to-day work tasks, making it difficult to maintain activities related to the programme action plan.

The second theme identified was *dynamics and politics of change in the municipal organizational context*. The line and middle managers described the organizational context as dynamic and characterized by competing projects, initiatives, and restructuring processes. Moreover, the findings indicate varying organizational conditions for managers in their respective departments, with managers describing a generally high workload and often inadequate or no support from senior managers, making it challenging to drive change. The managers also operated within dynamic organizations characterized by organizational change, leading to difficulties to finding time for things beyond everyday managerial work. To be active within politically governed organizations means that the managers, and ultimately, the implementation of the leadership programme, was influenced by sudden political decisions and initiatives coming before other changes.

Discussion

General discussion

The overall aim of this thesis was to explore how WHP is managed and implemented in municipal organizations employing an organizational approach and assuming a managerial perspective. In this general discussion, the findings from the three empirical studies that were conducted to examine WHP management and implementation are discussed in relation to previous research and the conceptual literature following a thematic structure.

Comprehensive and narrow perspectives on WHP

The conceptual literature on WHP often advocates taking a comprehensive approach to WHP emphasizing the influence of both individual and organizational factors on employee health (DeJoy & Wilson, 2003; Shain & Kramer, 2004). There is, however, inconsistency in the literature and research regarding the meaning of a comprehensive approach, with conceptualizations varying from a model encompassing a fixed number of health-specific measures in WHP programmes to a socio-ecological model of employee health emphasizing the influence and interplay of individual, organizational, and environmental factors (Stokols et al., 1996). However, one unifying aspect is the understanding that a comprehensive approach to WHP includes more than a single WHP measure of employee health. Despite these limitations, employment of a comprehensive approach to WHP served as an important starting point in this thesis.

In terms of comprehensiveness, the findings in this thesis indicate that the balance between individual- and organizational-directed measures tilts towards the former, as shown in studies (I, II). The findings from the interview study (II) indicate that the interviewed senior managers depict WHP as dominated by the provision of fitness programmes focusing on behavioural change and a healthy lifestyle. Although the questionnaire study (I) had a more explicit focus on WHP measures, its results similarly indicate that individual-directed WHP measures are more common than organization-directed measures in the investigated municipal social care organizations. Previous research has described the challenge of balancing individual and organizational WHP interventions. A few qualitative studies illustrates the risk that an extensive focus on fitness programmes and other individual-

directed WHP measures can overshadow other, more significant organizational risks (Mellor & Webster, 2013). This risk was illustrated in a study of a health project that found that attention to psychological and physical overload is often neglected in favour of a focus on healthy lifestyle activities (Frick, 2013). On the contrary, Bond (2004) argue for non-abounding actions directed towards the individual employee, although the overall research focus has shifted towards organizational factors and interventions. Nevertheless, the findings of this thesis (I, II) indicate that there is a distinction between the comprehensive view of WHP described in the conceptual literature and its practical content and application.

Framed in theoretical terms, this distinction can be related to Argyris and Schön's (1974) contrasting theories of action. The practical application of WHP may be described as the *theory-in-use* reflecting actual (organizational) behaviours. In contrast, the comprehensive view reflected in the conceptual literature describes the *espoused theory* in which words are used to convey to professionals and researchers how WHP could be put into practice. Although these theories espoused in the organizational learning literature to explain how professionals act within organizations, they are used here to attempt to clarify the potential mismatch between WHP in theory and practice. This use of these theories is supported by reviews emphasising the complexity of the research field and the lack of empirical research regarding theoretical models of healthy workplaces (Lindberg & Vingård, 2012). In this context, it is important to remember that the results of single studies depend on the operationalization of WHP, and, as shown in the questionnaire study (I), the difficulty of comparing the results of one study with other studies in which WHP has been defined and measured differently (cf. Plath, Köhler, Krause, & Pfaff, 2008). Additionally, the findings from the case study (III) present a partly different picture regarding the health-promoting leadership programme, one involving more aspects related to the psychosocial work environment than the other two studies (I, II). Although it is difficult to compare different studies, it should be noted that several reviews have provided support for the effectiveness of employment of a comprehensive WHP approach (Goetzel & Ozminkowski, 2008; Goldgruber & Ahrens, 2010).

The difficulty of defining WHP can be addressed by examining how WHP is viewed differently in the US and Europe. These differences in definitions are reflected in the content and design of WHP programmes and research, with the focus on health behavioural change in the US and a broader view focusing on aspects such as employee participation and the work environment in the Nordic countries (Goetzel et al., 2014). This assumption of a narrower or broader view of WHP is also relevant to the discussion of the criticism directed towards WHP. One argument in the critical literature is that WHP reflects a discourse with an excessive focus on the importance of employees embracing a healthy lifestyle (e.g. Holmqvist & Maravelias, 2011; Zoller, 2003). Although critical research *on* WHP is limited compared with other

aspects of WHP, the moral issues involved in WHP have been examined in empirical studies (Robroek et al., 2012). Relating this research *on* WHP to the findings of this thesis, one clear example is the significance given to provision of employee fitness programmes maintaining a healthy lifestyle (II). In line with this finding, Holmqvist and Maravelias (2011) argue that WHP means adopting a new corporate health ethic, which assess the 'whole employee' (including his/her health status) and not solely the employee's work performance. Several of the managers interviewed in study II, however, depict an ambiguous attitude, with employees questioning the employer's involvement in their health.

Another risk mentioned in the critical literature is that focusing on WHP could overshadow the taking of preventive actions in the work environment. Although it is important to raise awareness of the moral issues involved in WHP, critical studies have often adopted a narrow rather than a comprehensive approach towards WHP. This leads the critical literature to be sometimes contradictory in the sense that it also emphasizes the importance of the work environment (e.g. Holmqvist, 2009). This criticism might be considered odd from a European point of view, as the work environment is already encompassed within the conceptualization of WHP (European Network for Workplace Health Promotion, 2007). However, given the findings of this thesis, criticism of taking an individual-directed WHP approach might not be entirely unjustified.

WHP as an integrated practice in the organizations

As indicated in this thesis, integration is a recurrent theme in the WHP literature (e.g. Chu et al., 2000). As such, it is important to distinguish among the various types of integration described in the literature. Recently, the integration of WHP and OHS has gained renewed research interest. Such interest may partly be related to the launch of the Total Worker Health programme in the US (Schill & Chosewood, 2013), which aims to overcome practical problems involved with workplace health issues often being treated separately and by actors (e.g. OHS and HR staff) working in independent silos (Hymel et al., 2011). As already mentioned, WHP is conceptualized differently in the US, and thus that reasoning behind how WHP and OHS could (or 'should') be integrated is not entirely transferable to Nordic working life. However, the senior managers interviewed in study II revealed that while they place much focus on providing fitness programmes, they give little attention to improving the psychosocial work environment, and do not make connection between fitness activities and work environment issues. These findings thus indicate that integration of inter-related workplace health issues remains a challenge for these managers' organizations and framed with US terminology, that they place greater attention on WHP than more traditional OHS issues.

The lack of integration is further underlined by the fact that results of the fitness programmes and activities does not appear to be followed-up in the annual employee survey administered by these managers' organization. This lack of follow-up may be explained by that fact that this survey is standardised and highly centralized despite its being a managerial tool. However, it is important to note that findings emerging from studies may be affected by the study design. The findings from the case study (III) revealed that psychosocial work environment issues are the predominant issues in relation to more health-specific activities in the action plans. Although health-promoting leadership can be viewed in different ways by different organizational actors (see Eriksson, Axelsson, & Axelsson, 2011), only one way of viewing health-promoting leadership is related to the organization of fitness activities. Nevertheless, the challenge of integrating different workplace health areas remains.

In addition to the integration of WHP and traditional OHS issues, recent call is for intervention research to place more attention on OHS regulation when implementing workplace health interventions (e.g. Karanika-Murray, Biron, & Cooper, 2012). For example, LaMontagne, Noblet, and Landsbergis (2012) argue that OHS regulations can help facilitate the implementation of WHP interventions. The lack of integration between intervention content and OHS regulations is noted in the present thesis as well, being most apparent in the implementation efforts of the health-promoting leadership programme described in study III. Although this programme mainly addressed issues related to the psychosocial work environment, few of the line and middle managers described the programme as linked to the OHS management system. However, this omission cannot only be explained by a lack of interest or knowledge among individual managers. Instead, it may be related to a general lack of attention placed on the psychosocial work environment in organizations and in the current SWEM system. In the future, such lack of attention may be resolved by the implementation of a new regulation concerning the organizational and social work environment addressing such issues as workload and work-related conflicts that is currently being developed in Sweden.

However, recent reviews have identified several factors hindering the implementation of the existing SWEM system in Swedish organizations (Frick & Johanson, 2013b). Another challenge is that the psychosocial work environment is sometimes seen as more complicated than the physical work environment, as it involves people and not only physical and chemical occupational risks. However, the relationship between the current leadership programme and the SWEM system could have been emphasized during the programme implementation, as it is an issue of intervention design and not only of implementation. For example, the action plans created as part of the leadership programme, could have been linked to existing plans within the SWEM system. Although such integration is not a guarantee for a more

effective implementation, it could create a connection between programme activities and the OHS system. In their interviews, the line and middle managers who tried to integrate action plans from the leadership programme with existent action plans reported that they viewed doing so as an enabler during the implementation process (III).

A third form of integration advocated in the literature is integration of WHP into the general management of the organization. It is argued that such integration would require WHP and employee health to be placed one the organizational agenda, contributing to the view that WHP is not a separate organizational process (Chu et al., 2000). Instead, WHP would be viewed as a strategic issue for the organization linked to human resource management and other business processes (Zwetsloot & van Scheppingen, 2007). According to the senior managers interviewed in study II, one example of such integration is the use of the results of the annual employee survey in municipal organizations to link the management control system and monitor working conditions and employee health within the organization. However, the managers also described several challenges related to the use of this employee survey, including the difficulty of implementation, follow-up, and reflection on the actions taken before the following year's employee survey. Therefore, the findings in this thesis are more in line with the 'sidecar' metaphor emphasizing that WHP is an issue distinct from that of general management of the organization (Frick & Johanson, 2013b; Kamp & Nielsen, 2013).

These findings are most likely not exclusive to the two investigated municipal organizations, as they are in line with the research into OHS management systems (European Agency for Safety and Health at Work, 2010). Indeed, previous research suggests that ideals regarding a good work environment can compete with ideals regarding efficiency and profitability that are incorporated into the general management of the organization (Frick & Johanson, 2013b). If this is the case, integration between the work environment and general management may be hampered, a result directly opposed to the arguments put forward in conceptual models of healthy workplaces contributing to both employee health and organizational improvement (Grawitch et al., 2006).

Support of WHP

Work on WHP usually involves many organizational actors and stakeholders at various levels within and outside the organization (Auvinen, Kohtamaki, & Ilvesmaki, 2012). As this thesis focuses on how WHP is managed, managers at different levels within the organizations were examined as obvious organizational actors. In the case study (III), many of the line and middle managers described a lack of involvement by senior managers in the health-promoting leadership programme. Although not all managers reported this lack of involvement, those who did so reported either experiencing it as a

barrier during the implementation process or as needing little or none of it. This contradiction in description by middle managers has recently been pointed out in research into public sector managers' handling of workplace health (Tappura, Syvänen, & Saarela, 2014). For example, Tappura et al. (2014) found a general lack of organizational support and that managers do not always turn to their senior managers for support when it is needed. Instead, subordinate managers often search for individual solutions to problems and turn to managerial colleagues for emotional support.

However, many conceptual models of WHP identify senior management as key actors and their support as a critical prerequisite for successful WHP (e.g. World Health Organization, 2010). Although not an explicit aim in study II, a few of the senior managers reflected on their role in WHP, often in terms of participating in various fitness activities and advocating for their employees to do the same. Such role modelling should not necessarily be underestimated, but there are often other and more important issues related to general working conditions within a comprehensive WHP approach that require the support of senior management (Black, 2008). However, few empirical studies support the idea that active management support leads to successful WHP implementation. Although this connection may seem obvious, the research instead indicates that lack of management support negatively affect the implementation of organizational health interventions (Nielsen et al., 2010). A similar pattern is also seen when scrutinizing the broader literature on implementation of health promotion actions, which identifies management support as affecting implementation (e.g. Durlak & DuPre, 2008).

Often thought of as resources with knowledge to support work related to WHP, HR departments and staff are other stakeholders that might be involved in WHP. From the findings of the case study (III), it can be concluded that HR staff had limited involvement in the implementation of the health-promoting leadership programme examined in this thesis and were, consequently an unused resource. For example, HR staff could have supported managers and work groups formulating suitable goals and with the implementation of action plans, particularly as the line and middle managers described these issues as barriers during the implementation process. This reasoning is in line with a recent study in which both the provision of hands-on support as well as expert knowledge were pointed out by HR staff as their contribution to the implementation of an organizational health intervention (Hasson et al., 2014).

Likewise, the senior managers interviewed in study II described that they viewed and to some extent used HR staff as resources. In relation to WHP, they described HR staff as involved at different stages in the problem-solving cycle, mainly in relation to the creation of action plans based on the results of the annual employee survey. Given the challenges described in the coming stages (i.e. implementation and follow-up) that will make it difficult to fulfil the problem-solving cycle, it is conceivable that HR staff could be more involved in these stages as well. In accordance, Hasson et al. (2014) assert that

HR staff often feel that their skills are not fully used in relation to the implementation of WHP. However, it should be noted that stakeholders hold different power positions in WHP, implying that not just mere interest and knowledge in WHP comes into play (Auvinen et al., 2012). Despite the potential importance of HR staff, there seems to be a lack of studies describing HR staff and their potential supportive role in WHP.

In addition to views regarding the role of HR staff, the questionnaire study (I) showed that the provision of specific WHP coordinators could be related to better employee health in the investigated organizations. To my knowledge, this finding has not been reported in previous research, but instead to the provision of WHP programmes (Linnan et al., 2008). Besides these internal supportive resources, use of external resources, such as occupational health services, can be considered. However, in Sweden the supportive role of occupational health services in WHP has mainly remained rhetorical. This fact was supported by the senior managers in study II, in which they described using the occupational health services mainly to solve problems related to certain OHS risks and handle sickness leave by employees.

Another way to support WHP is by creating certain projects providing structure for handling WHP in the organization. In this regard, the results of the questionnaire study (I) show that provision of local WHP projects is related to better employee health in the organization. Although projects may indicate an ambition to develop employee health, it should be noted that provision of projects might be risky because there is often overconfidence in implementation of projects. For example, there are difficulties in transferring projects into daily work, and possible long-term effects of project implementation (Svensson, Aronsson, Randle, & Eklund, 2007). Additionally, studies indicate that there might be a risk in implementation of WHP projects in which psychosocial factors are neglected in favour of healthy lifestyle activities (see Frick, 2013).

Organizational conditions and politics influencing WHP

Recent research indicates that there are large variations among Swedish municipal managers in their working experience and organizational conditions (Berntsson et al., 2012; Härenstam & Östebo, 2014). In study III, varied organizational conditions were found to influence the implementation of the health-promoting leadership programme. The line and middle managers described working conditions, such as high workload and broad responsibilities, as well as organizational changes and politically initiated projects as barriers influencing the implementation of the leadership programme. Consequently, these barriers were viewed as constraining the managers' ability to act as drivers of change. These findings are in line with previous research into managers' opportunities to manage work environment issues and of high workload as a major barrier in the management of the work

environment (Forsberg Kankkunen, Ylander, & Höckertin 2010; Tappura et al., 2014).

In addition to these barriers, some differences among municipal operations were noted by the line and middle managers, a finding that accords with previous studies revealing different organizational conditions for municipal managers working in differently gendered operations (Björk, 2013; Forsberg Kankkunen, Bejerot, Björk, & Härenstam, 2014; Kankkunen, 2009). For example, the finding of one study indicated that managers working in female-gendered operations are responsible for more employees and received less support from their senior managers and politicians compared with their colleagues in technical services (Kankkunen, 2009). Although not a main finding in this thesis, a similar gendered pattern was noted among the line and middle managers involved in the leadership programme. This finding indicates that working and organizational conditions need to be recognised when planning and designing various kinds of comprehensive WHP interventions, as well as for the general management of WHP.

The findings of this thesis can also be related to internal and external political influences. For example, while political intentions are reflected in different policy documents, the findings in study II indicate that WHP-related policies give relatively little practical guidance. It may, however, be argued that the intention of a policy document is not to give detailed practical guidance but rather overall direction regarding an issue. Nevertheless, the senior managers indicated that the policies describing the work environment, health policies, and leadership in the organizations appear loosely coupled to various WHP practices. An exception, however, are the guidelines for financial compensation for fitness activities, for which the policy documents provide the managers with clear guidance. This exception is interesting, as it concerns both fitness activities and economic benefits. However, as shown in study I, none of the investigated WHP-related management policies could be associated with better employee health.

These findings regarding policy documents can also be discussed in relation to the status given to WHP in the investigated organizations, which can also be viewed as providing legitimacy to issues concerning the work environment and workplace health. From a more critical point of view, it might be questioned to what extent policy documents reflect a genuine concern with WHP. Frick and Zwetsloot (2007) discuss how organizations desire to portray themselves as employers paying great attention to workplace health to promote their corporate image. In study III, several senior managers discussed the municipality and its aspirations to be seen as an attractive employer, with a few describing WHP as contributing to corporate image promotion. They thus agree with the view that, Swedish municipalities must simultaneously improve their image and working conditions to be seen as attractive employers that can recruit younger people to offset the large number of retirees.

The political influence can also be discussed in relation to the general management of municipal organizations. That municipalities are 'political employers' influenced by, not only broader political reforms but also by themselves being politically governed organizations is an additional dimension, as is the fact that all organizational changes are subject to intra-organizational politics (Dawson, 2003). Previous research shows that NPM-inspired practices affect managerial work by, for instance, giving rise to conflicting objectives among the needs and requirements of administration, managerial accounting, and municipal operations (Forsberg Kankkunen et al., 2014). In this thesis, NPM-inspired practices were manifested through the implementation of various administrative routines and systems, described by the line and middle managers in study III as competing for the attention, time, and resources needed to implement action plans developed within the leadership programme.

Another example of NPM-inspired practice is the procedure for conducting the annual employee survey described in study II. This survey could be described as following a standardised process and as highly centralised. Although important to map working conditions and employee health, this type of measurements often receives undue importance (Power, 1997). If the employee survey is not followed by action, there is a risk that its administration leads to suspicion of and criticism from employees (Nielsen, Abildgaard, & Daniels, 2014). In this regard, the senior managers described subordinate managers as experiencing difficulty in implementing action plans partly as a result of the centralisation of the employee survey process.

Although the employees are not primarily targeted in this thesis, they are obvious organizational actors in WHP and employee participation is often pointed out as an important success factor in WHP (European Network for Workplace Health Promotion, 2007). In the case study (III), it was, for example, shown that earlier experiences of organizational change facilitate the implementation of the health-promoting leadership programme. Dawson (2003) argues for the politics of change as involving conflicts and negotiation in organizational change. By doing this, the employees are seen as active organizational actors rather than passive recipients of change (Karanika-Murray & Biron, 2013). According to the interviewed line and middle managers, this political dimension was not particular pronounced in the implementation of the leadership programme. This may be related to the participatory approach and positive message that surrounded the leadership programme, which ultimately aimed for improved employee health. Even though employee involvement is reported as important for the implementation of various WHP initiatives, in the end, senior management still has the powers to control resources, priorities and decisions related to WHP implementation.

Reflections on WHP theory

This thesis draws on WHP using health promotion as a conceptual basis, which proved to be a conceptual challenge during its development. Besides being conceptualized differently, the field of health promotion has been criticised as lacking its own theoretical basis (McQueen, 2007). Rather, both health promotion practice and research has been dominated by the use of socio-behavioural theories aiming to explain individual behavioural change. In reaction, the recent decade has witnessed arguments for broadening the theoretical scope of health promotion. Describing the field as largely concerned with social change, culture, and politics as contexts, McQueen and Kickbusch (2007) argue for use of social theories in health promotion. According to their view, social theories have often been unappreciated or unarticulated by those active in the field. In this thesis, WHP has been framed within a development-oriented view and as a collection of 'change initiatives' aiming to improve employee health. Therefore, this thesis attempted to apply concepts originating in the organizational change literature, as was most evident in the case study (III), in which these concepts were applied as an analytical framework. Nevertheless, more research must examine WHP theory, not least because the findings of this thesis indicate that WHP practice remains characterized by WHP measures related to individual health behaviours. There are, however, several positive developments in this theoretical respect, and broader theoretical models also aiming to conceptualize WHP in terms of processes and resources for organizational health development have recently been proposed (see Jenny & Bauer, 2013).

Methodological considerations

This thesis utilized multiple research designs, methods, and sources of data (Yin, 2009). The studies included implemented different research designs and intended to contribute with both breadth and in-depth knowledge concerning how WHP is managed in municipal organizations. In the studies, different sources of data were used (e.g. questionnaires, interviews, and documents), although qualitative interview data formed the main empirical material for analysis in the interview study (II) and the case study (III). In both these studies, documents were used as complementary data. The questionnaire study (I) was based solely on questionnaires. However, two different (independent) questionnaires were used, and the research design allowed for combination of data from top managers (i.e. employer) with data from the employees within the same organizations. This method of collecting data from one key informant representing the organization has previously been suggested and used in organizational research (Kalleberg, 1994).

Moreover, different organizational actors participated in the research, and thus contributed with information and insights regarding WHP. However, because the thesis used a managerial perspective, the data were mainly collected from line, middle and senior/top managers. In addition, the senior managers recruited for the interview study represented different municipal departments, contributing with varying experiences of how WHP was managed. Similarly, the line and middle managers who participated in the health-promoting leadership programme also represented different types of municipal operations. Therefore, the line and middle managers could contribute with their experience of WHP in relation to managerial work and organizational conditions in their respective municipal operations.

Besides these strengths, there are also limitations that need to be considered. The questionnaire study was based on a cross-sectional design, and all analyses were performed using aggregated data at the organizational level, which must be considered when interpreting the results. More specifically, this means that causal conclusions cannot be drawn. Inference to the individual level was not intended and should not be done due to the potential for ecological fallacy (Diez-Roux, 1998). Furthermore, the use of a non-validated questionnaire for collecting employer data on WHP could be considered a limitation. However, this questionnaire for the top managers followed a conceptual idea used in previous questionnaires for OHS management asking questions about actual conditions. However, as we were not able to find a questionnaire with this design for WHP, the aim of the particular study required development of a new questionnaire.

In the qualitative studies, it is important to keep in mind that several of the invited line, middle, and senior managers chose not to participate in the interviews. The main reasons for not participating were lack of time due to a high workload or change of jobs. It is possible that this favoured managers who were particularly interested in WHP, and led to less varied accounts on how WHP is managed in these two organizations. Based on interview data (II, III), the preliminary analysis was conducted by the author of this thesis. To reduce the potential limitation of having only one person perform the analysis, the initial analysis was discussed with the co-authors. In these discussions, descriptive categories and interpretations were examined during the analytical process, which reduced the limitation of having only myself perform the analysis. Thereby, these discussions contributed to ensure the trustworthiness of the emerging findings. Additionally, the documents were critically assessed, meaning that the original intention and audience of the documents were considered. The documents were not treated as complete recordings of planned or implemented actions, but rather as a complement to interview data (Bowen, 2009).

Although the qualitative studies intended to approach managerial processes related to WHP (II, III), they were not considered ‘process studies’ in the sense that they followed a change process longitudinally with recurring

field work (Langley, Smallman, Tsoukas & Van de Ven, 2013; Van de Ven, 2007). Instead, the interviews with managers were conducted at one point in time, mainly asking questions about the current situation or in retrospect. Consequently, the line and middle managers were asked to describe the implementation of the leadership programme retrospectively.

Furthermore, it is appropriate to reflect upon the generalizability and transferability of the findings. All studies were conducted in public sector organizations, and more specifically, in Swedish municipal organizations. The questionnaire study was based on a nationwide random sample of Swedish municipal social care organizations, meaning that the findings concerning the provision of WHP measures most likely are generalizable to other municipal social care organizations in Sweden (at least at the time of study). However, inference to the three largest municipal organizations in Sweden should be avoided, as these were not represented in the sample. These organizations differ in that they are more complex and internally diversified than the studied organizations. In the qualitative studies, transferability of the findings to other situations and settings could be considered. The findings of the interview study could be transferable to settings with similar organizational conditions, that is, departments in larger local governmental organizations. The applicability of the findings from the case study can be discussed in terms of their application to other situations and similar conditions. In this study, some of the described barriers and enablers have been reported in previous research, making it likely that these issues are important when similar workplace health interventions are implemented in comparable public sector organizations (Patton, 2002).

Finally, it has been emphasized that the external validity and use of the findings are best assessed by the potential users of the knowledge (Lincoln & Guba, 1985). For this thesis, the most likely users are HR staff, line, middle, and senior managers within public sector organizations.

Future research and practical implications

The findings of the thesis reveal the need to conduct research within two main areas.

First, the extent to which WHP is integrated with other approaches aiming to sustain and improve workplace health and whether use of an integrated approach is superior in terms of improved employee health need to be examined. Such research includes studies focusing on relations between OHS regulation systems and other implemented workplace health interventions. Within this line of research, the much-discussed and often advocated integration of workplace health into the general management should be further scrutinized.

Second, the organizational conditions surrounding line and middle managers in the municipal sector needs to be investigated. Although these conditions have been investigated recently (e.g. Forsberg Kankkunen et al., 2014), an explicit research focus on line and middle is required to identify the actions that should be taken in relation to WHP. Such research entails exploration of the managers' working and organizational conditions; their relations and communication with other stakeholders in WHP, employees, HR staff, union representatives, and senior management; and the influence of and support provided by these stakeholders to these managers. Within both lines of research, the broader political context influencing policy, intervention implementation, and other WHP-related practices in public sector organizations need to be considered.

To a large extent, the practical implications of the findings of this thesis are related to the implementation and follow-up of WHP. The findings of the two qualitative studies indicate that managers require practical support in managing and implementing action plans and various WHP measures. At the same time, they indicate that managers should take advantage of currently available supportive resources in the organization, such as HR staff, and that the scope of leadership programmes should be broadened by including content explicitly related to a comprehensive WHP approach. The findings also contribute to the knowledge regarding barriers to and enablers in the implementation of workplace health interventions. Together with consideration of the general working and organizational conditions of operating managers, this knowledge could be incorporated into planning for future interventions. Finally, the findings indicate that follow-up of WHP should not only examine employee health data, but also elucidate the extent to which proposed action plans and WHP measures are actually implemented.

Conclusions

This thesis contributes to the knowledge regarding how WHP is managed and implemented in municipal organizations, primarily how WHP is experienced from a managerial perspective at the organizational level.

The findings of the questionnaire study shows that WHP measures aim at reaching both the individual and the organization as a whole. Although individual-directed WHP measures are used to a greater extent than organizational-directed WHP measures in the organizations investigated, the existence of both types of WHP measures can be associated with the level of employee health in these organizations, unlike the existence of WHP-related management policies as indicators of a well-organized organization.

The findings of the interviews with senior managers indicate that WHP of their organizations is dominated by provision of fitness programmes mainly focusing on managing the individual health behaviours of the employees. This implies that organizational interventions and work environment factors are given less attention and need to be further addressed. They also indicate that although an annual employee survey is used as a managerial tool for mapping working conditions and health and the results of the survey are intended to be incorporated into subsequent action plans, there are doubtfulness concerning the implementation and follow-up of these plans. This doubt arises from the use of a highly centralized survey process, which leaves little time to implement WHP measures. Accordingly, WHP needs to be strengthened regarding the implementation and follow-up of action plans, as well as that HR staff could be more involved in this process. Moreover, WHP and OHS are viewed as two partly linked, but separate workplace health approaches, revealing the need for closer integration of WHP and OHS, as well as the incorporation of WHP into the general management system.

The findings of the case study indicate that employee involvement is described as enabling the implementation process of the health-promoting leadership programme. The importance of the different organizational conditions for the managers is also underscored. This conditions includes politically initiated projects and organizational changes as competing for the attention, time, and resources of the managers. Senior management and HR staff must also be more closely tied to the leadership programme by providing line and middle managers with more supportive functions and facilitating their role as drivers of change in interactions with employees.

The final conclusion of this thesis is that future research needs to consider the political context in which WHP initiatives are managed and implemented in municipal organizations. Achieving this aim require consideration of the different stakeholders in WHP, ranging from individual employees to politicians, and the interplay among them.

Svensk sammanfattning

Arbetsplatsen kan ses som en arena för hälsofrämjande insatser inte minst med tanke på den tid som anställda tillbringar på arbetet. Tidigare forskning visar dock på variationer avseende hur olika arbetsgivare hanterar hälsofrämjande insatser och det behövs ytterligare kunskap om hur hälso- och arbetsmiljöarbete styrs i offentliga organisationer.

Det övergripande syftet med avhandlingen var att utforska hur hälsofrämjande arbetsmiljöarbete styrs och genomförs i kommunala organisationer. Teoretiskt sett tar avhandlingen avstamp i kunskapsområdet hälsofrämjande arbete men relaterar också till begrepp och teori inom organisations- och implementeringsforskning.

Avhandlingen baseras på tre empiriska studier och både kvantitativa och kvalitativa metoder har använts. I den första studien undersöktes hälsoarbetet i ett representativt urval av 60 kommunala vård- och omsorgsorganisationer i Sverige. Ett frågeformulär besvarades av förvaltningschefer och ett urval av medarbetare inom kommunal vård- och omsorg. I studien analyserades tillhandahållna hälsofrämjande insatser i relation till de anställdas hälsa på organisationsnivå. I den andra studien genomfördes intervjuer med förvaltnings- och/eller verksamhetschefer från olika förvaltningar i två kommuner. Dessa intervjuer handlade om styrningen av hälso- och arbetsmiljöarbete utifrån förvaltnings-/verksamhetsnivå. I den tredje studien analyserades implementeringen av ett ledarskapsprogram i två kommunala organisationer. Ledarskapsprogrammet syftade till att cheferna skulle utveckla ett hälsofrämjande ledarskap och intervjuer genomfördes främst med linje- och mellanchefer som deltagit i programmet.

Resultaten visar att både individ- och organisationsinriktade hälsofrämjande insatser erbjöds anställda i kommunala vård- och omsorg samt att båda typerna av insatser kunde relateras till de anställdas hälsa. Vidare beskrev de intervjuade högre cheferna styrning av hälso- och arbetsmiljöarbetet som bestående av en uppsättning av aktiviteter tillsammans bidrar till organisationens kapacitet att bedriva ett välfungerade hälso- och arbetsmiljöarbete. Det praktiska hälso- och arbetsmiljöarbetet präglades dock av friskvårdsinsatser samt kartläggning av arbetsförhållanden och hälsa genom årligt återkommande medarbetarundersökningar. I studien av ledarskapsprogrammet framkom att linje- och mellanchefer betraktar de anställdas deltagande som betydelsefullt i implementeringen av programmet.

Däremot ansågs hög arbetsbelastning och brist på stöd från verksamhetsledningen utgöra hinder i implementeringsprocessen. Återkommande organisatoriska förändringar och projekt beskrivs som andra hinder som konkurrerade med de deltagande chefernas möjlighet att implementera ledarskapsprogrammet.

Slutsatser av avhandlingen är att hälsofrämjande arbetsmiljöarbete domineras av friskvårdsinsatser samt att detta arbete behöver breddas för att inkludera psykosociala och organisatoriska faktorer i arbetsmiljön. Vidare behöver organisatoriska förutsättningar för kommunala chefer inklusive stöd från högre chef och HR personal ges större uppmärksamhet i det praktiska hälso- och arbetsmiljöarbetet. Avhandling stödjer även idéen om att hälso- och arbetsmiljöarbetet är beroende av ett aktivt och kontinuerligt arbete och inte kan betraktas som en given och etablerad praktik.

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