

WORKHEALTH RESEARCH AND EVALUATION PROGRAM

Research Project 4 Impact Evaluation

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Executive summary

This report for the impact evaluation of WorkSafe Victoria's WorkHealth Program has been prepared as part of the WorkHealth Research and Evaluation Program conducted by Monash University School of Public Health & Preventative Medicine and Institute for Safety Compensation and Recovery Research. The WorkHealth program aims to improve the health, wellbeing, safety and productivity of the workforce in Victoria by reducing the risk of type 2 diabetes and cardiovascular disease. At the time of this report, the WorkHealth program has undertaken nearly 600,000 WorkHealth checks of Victorian workers at their workplace, and has provided over 700 workplaces with the opportunity to implement health and wellbeing activities through their WorkHealth grants program.

The impacts of the WorkHealth program were evaluated at the workplace and employee level, guided by the WorkHealth program logic. The program logic impacts focused on the following areas:

- Workplace health promotion activities and capacity to support staff health and wellbeing;
- Adoption of healthy lifestyles and behaviours;
- Workplace physical and policy environment;
- Worker vitality, morale and perceptions of occupational health and safety;
- Business attention/investment in workplace health and wellbeing.

The evaluation aimed to assess whether participating workplaces and workers considered that the short and medium term impacts of the program had been met and to:

- Understand how effective it has been in supporting workplaces to undertake health and wellbeing programs for their employees to promote health and safety; and to
- Determine the organisational drivers of successful and sustainable workplace health promotion initiatives.

The evaluation utilised a mixed-methods research design. All workplaces that had accessed WorkHealth checks were invited to complete an online survey which collected quantitative data from workplaces about their participation in the WorkHealth program and their health and safety practices (response rate=19.6%, n=2,649). Qualitative data was then collected at 27 workplaces sampled by geographic location, industry type and organisational size. This involved an interview with the health and wellbeing coordinator at

the workplace (n=30) and a focus group was held with 4-8 employees (n=27). In total, 157 employees participated in the evaluation. Finally, twelve in-depth interviews were conducted with broader stakeholders to provide understanding about the program at a strategic level. No baseline data was available to measure impacts and no workplace or other objective indicators were used in this impact evaluation. Whilst some data elicited from the evaluation shed light on the process of the program in addition to the impact, this evaluation provided invaluable contextual information to understand the impact of the program on workplaces and organisational change, and to assist in future planning. Limitations to the evaluation included poor representation of industries opting into Phase 2 of the evaluation or withdrawing when they realised participation was unfeasible for their workplace. H&W coordinators were also expected to recruitment focus group participants due to ethical requirements which had an impact on participation rates for this group.

The evaluation highlighted three key ways in which impact can be understood: contextual impacts, program impacts and impacts that may influence the future direction of the program. The impact evaluation found that for many workplaces, WorkHealth has provided their first opportunity to engage in a comprehensive on-site health program, particularly for those workplaces which accessed a WorkHealth grant. Prior to engaging in the program, many employers reported they had focused their resources on occupational health and safety policies and programs but did not have the capacity to implement health and wellbeing programs for their employees. Participating in the WorkHealth program afforded them the opportunity to see the benefits of workplace health programs for employee health, safety and productivity.

Employer engagement with the program was primarily driven by perceptions of the potential for increased employee wellbeing, and in some cases, productivity. Another major driver for employer engagement was the WorkHealth media coverage across the lifespan of the program, which raised awareness about worker health among employers and employees. Both workplaces and key stakeholders in the evaluation considered that WorkHealth checks had raised awareness about employee health and wellbeing in the workplace, which in turn generated discussion between employees about their personal health. In some workplaces, the employer used the Profile Report to start discussions with employees to encourage healthy behaviours. However whilst employers believed that it was their

responsibility to provide workers with opportunities to improve health, ultimately they felt that responsibility for health and wellbeing sat with individual employees. This may be related to the focus of the program being on lifestyle behaviours, which were viewed as less amenable to change in the work setting.

Employee participation in the WorkHealth checks was driven by perceptions of the quick, convenient and professional nature of the check to measure their health status. Focus group attendees who had chosen not to participate in the WorkHealth checks cited several reasons for their decision, including concerns around the confidentiality of their results; this reportedly deterred many workers from participating. Other concerns related to the quality of the health check tests and advice, including confusion around the non-fasting nature of

Two-thirds of focus groups discussed concern relating to the accuracy and quality of WorkHealth checks.

checks; many workers reported that consequently they did not take their results seriously or take further action. This has important implications for the quality control and individual tailoring of advice

to WorkHealth check participants about their level of risk and suitable interventions for their particular needs. Whilst some employees reported in the focus groups that they did make substantial changes to their lifestyle after a WorkHealth check, this proportion was very small and supports the evidence in the literature that screening alone cannot be used as an effective strategy to change the health behaviours of workers. Employers observed that the WorkHealth checks did not seem to have been taken up by those most at risk of chronic disease due to particular lifestyle factors; this has important implications for future targeting.

Workplaces which accessed a WorkHealth grant in addition to WorkHealth checks reported greater positive impacts with regard to employee health behaviours, workplace culture and improvement in morale and safety; although no objective indicators were accessed to validate these claims. The findings also revealed that workplaces that then made a move towards stronger engagement in health and wellbeing programs were influenced by workplace culture and support from management. This was also the case when there were perceptions that management had some responsibility for health and wellbeing, or where workplaces had put responsibility on the employer to support employee health and

Workplaces that accessed a WorkHealth grant were more than twice as likely to report that they had made subsequent changes to their workplace.

wellbeing. These workplaces were more likely to engage effectively in the program. The evaluation indicated that sustainability of workplace health and wellbeing programs is considered to be difficult if the capacity building needs of the workplace were not resolved. This includes support from senior management and resources to shift workplace culture. Employees in focus groups were also apprehensive about whether health promotion initiatives would detract from traditional Occupational Health and Safety programs, which they considered to be essential for employers to provide.

Employer respondents to the survey reported a low usage of the Healthy Workplace Kit and the majority of these workplaces reported only utilising the posters. Whilst some

Only 18% of workplaces reported using the Healthy Workplace Kit

workplaces did report finding it a useful resource, both workplaces and key stakeholders highlighted that the design of this resource was most appropriate for white-

collar, larger workplaces. Whilst quantitative data did not show a difference between in blue and white collar trends, the breakdown of specific industries showed that there were clear trends between use of the Kit components in relation to specific industries.

Overall, the WorkHealth program has made an important impact by placing employee health and wellbeing and potential impacts on worker safety and productivity, on the agenda of many workplaces across Victoria. This has facilitated discussion within workplaces to extend their focus beyond occupational health and safety and begin to realise the productivity benefits of not only safe employees, but also employees that are healthy. However, these changes will only be sustainable if additional organisational drivers for workplace health promotion are addressed, including management support, leadership and workforce competencies. If this can occur, workplaces will have a greater readiness for change to enable them to build on their WorkHealth experience to date. The evaluation also highlighted that organisational size and industry type had the greatest influence on readiness and ability to make these changes for employee health and wellbeing. Smaller, blue-collar organisations considered that they were less likely to have the capacity to move forward in this area and were still primarily focused on managing their traditional occupational health and safety requirements.

Investment in the WorkHealth program has been considered worthwhile by both workplaces and key stakeholders, however key stakeholders were clear in asserting that sustainability of these accomplishments is dependent on ongoing investment into the program to build on the initial gains achieved by the WorkHealth program. They also acknowledged that post-2013 the program should focus on directions generated from the research and evaluation conducted on the program, and direct resources to where the greatest need sits for Victorian workers and workplaces. Stakeholders articulated this as balancing investment between WorkHealth checks for workers most at risk, and a focus on building the capacity of workplaces to sustain their own health and wellbeing activities alongside occupational health and safety requirements to create safer and healthier workplaces.

The evaluation highlighted several research gaps which generated further research and evaluation project suggestions for the WorkHealth program:

- WorkHealth would benefit from a more focused evaluation of the Grants program. A more targeted sampling framework, from that used in this evaluation, would enable an exploration of the program to understand in more detail the impacts and outcomes of this program.
- Blue-collar industry employees are at much higher risk of chronic disease and their associated risk factors. Further research is also needed to explore the drivers of engagement in workplace health programs by blue-collar industries that go beyond the responsibilities of occupational health and safety.
- The impact evaluation explored the concept of responsibility for worker health; however there are many questions around whose responsibility it is to provide health programs for employees, especially with regard to the funding of resources and required leadership. A more in-depth exploration of the question of responsibility for workplace health programs will better enable the planning and coordination of workplace health initiatives.

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1. Introduction

This report presents the findings from the impact evaluation for WorkSafe Victoria's WorkHealth Program. Monash University School of Public Health & Preventative Medicine and Institute for Safety Compensation and Recovery Research were contracted to conduct the research and evaluation of the WorkHealth Program between August 2010 and August 2012. The research and evaluation program comprises four research projects:

Project 1: Follow up worker study

Project 2: WorkHealth check data

Project 3: Impact Modelling

Project 4: Process and Impact Evaluation

This is the report for the Impact Evaluation component of Project 4. The process evaluation was completed in August 2011 and the results are reported in a separate report (Joss, 2011). The impact evaluation aimed to assess the short and medium term effects of the program on its participants and stakeholders, considering the broader context within which the program is operating to provide data to inform program planners and stakeholders about whether the objectives of the WorkHealth program have been achieved.

1.1 Overview of the WorkHealth program

WorkHealth is a five-year program which commenced in mid 2008 and is funded until December 2013. It targets the connection between modifiable lifestyle risk factors, workplace injury and chronic disease across the entire workforce. The program promotes health and wellbeing in the workplace, and offers voluntary activities for both individuals and employers to raise health awareness, support positive lifestyle choices and create healthy, safe and productive workplaces.

The WorkHealth program comprises four key areas:

WorkHealth checks

The WorkHealth check is the primary activity of the WorkHealth program. Conducted in the workplace, a WorkHealth check is a no cost 15-minute health assessment of a participant's lifestyle factors, waist circumference, and non-fasting blood cholesterol, blood pressure and

blood glucose level. The checks are available to every Victorian worker and conducted by specifically trained/qualified service provider.

Lifestyle programs

After attending WorkHealth checks, workers who have been identified to be at medium or high risk of Type 2 diabetes and/or cardiovascular disease are recommended to participate in a lifestyle program. WorkHealth Coach is currently running as the lifestyle program for WorkHealth check participants who are identified as being at medium or high risk of Type 2 diabetes or cardiovascular disease.

Workplace health promotion grants

The workplace health promotion grants provide one-off funding to organisations that wish to run a health promotion program within their workplace to promote the health and wellbeing of their employees. At the time of the evaluation, workplaces need 50% or higher employee participation in WorkHealth checks, greater than \$1 million remuneration and at least 10 or more workers based in Victoria to become eligible for a WorkHealth grant.

Workplace capacity building tools

The WorkHealth capacity building tools are resources designed for workplaces to promote healthy lifestyles and behaviours. There is a suite of tools available to Victorian employers from the WorkHealth website, including the Healthy Workplace Check and the Healthy Workplace Kit, needs assessment template, project planning and evaluation templates, sample workplace policies, posters and information about program ideas and other resources and organisations that can assist workplaces to become more health promoting.

1.2 Focus on workplace health promotion

The World Health Organization (2010) describes a healthy workplace as *one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of workers and the sustainability of the workplace*. Workplace health promotion programs are considered a cost effective strategy to reduce absenteeism and presenteeism and improve the health and wellbeing of employees including reduced injury and claims and improved return to work (Aldana, Merrill, Price, Hardy and Hager, 2005; Goetzel and Ozminkowski, 2008).

Workplaces provide a beneficial setting because they have the ability to reach large population groups and provide an ideal infrastructure for programs to support the physical, mental, economic and social wellbeing of the working population (Glasgow, McCaul, and Fisher, 1993). Whilst traditional OHS has made apparent improvements to workplaces by reducing injuries and occupational diseases, this focus needs to be broadened to promote health in the workplace in order to create a healthier workforce and impact on productivity (ENWHP, 2007).

Healthy and safe workplaces can be created through implementation of health promotion strategies where employees engage in appropriately designed health activities whilst following safety practices. To be able to do this, workplaces must adapt the work environment and provide meaningful activities for employees to engage in to support employees to improve their health to recognise employee responsibility in their own health. In Victoria, the WorkHealth program afforded workplaces the opportunity to participate in a workplace health program. Investing in workplace health required strategic coordination for program planning to ensure that the WorkHealth program impacted workplaces.

1.3 Research Aim

The aim of this evaluation was to understand the organisational impacts of the WorkHealth program as a workplace health promotion strategy to improve the health, wellbeing and safety of Victorian workers.

The following research questions guided the evaluation design:

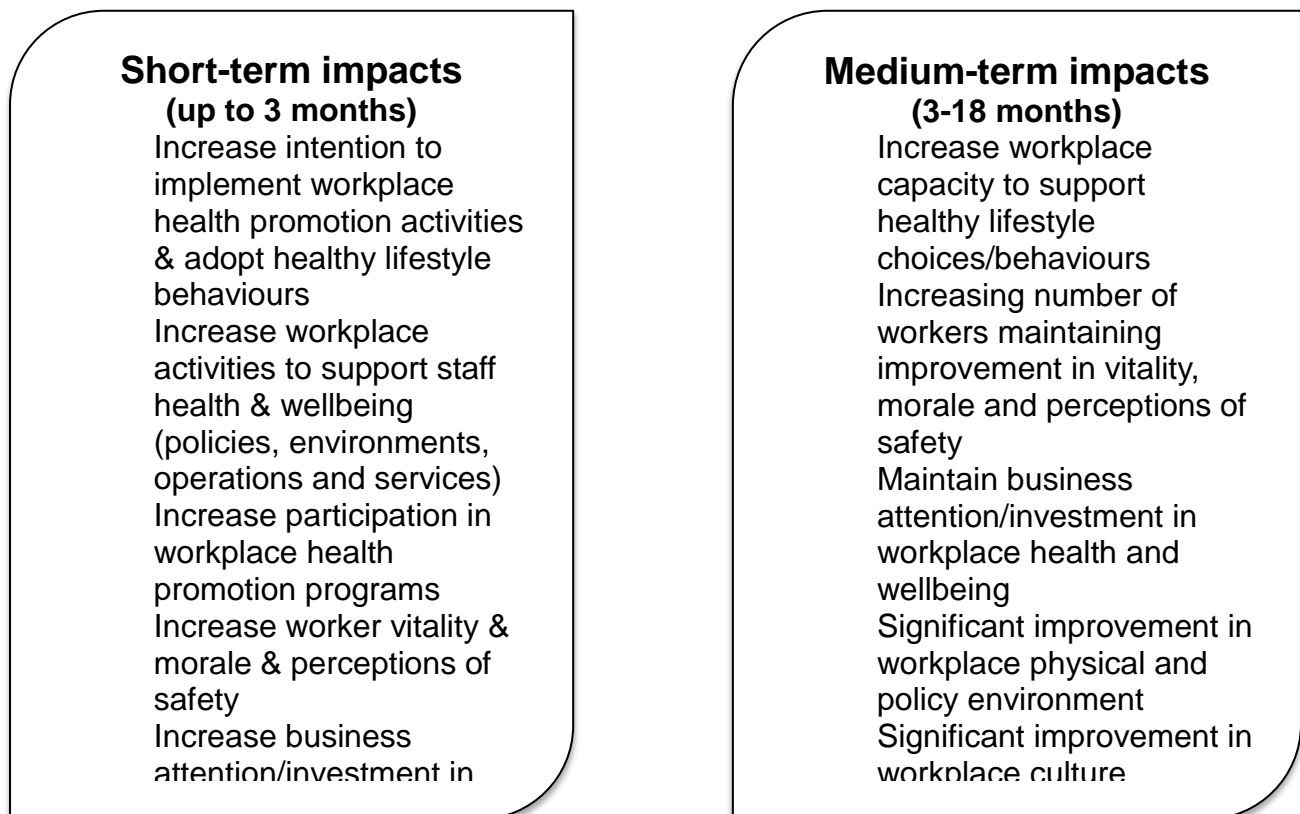
1. How effective has the WorkHealth program been, as considered by participating workplaces and workers, in supporting workplaces to undertake health and wellbeing programs for their employees to promote the health and safety of their workers?
2. What do participating workplaces consider are the organisational drivers of successful and sustainable workplace health promotion initiatives?

1.4 Scope of the evaluation

The WorkHealth high-level program logic diagram designed by Aspex Consulting (2010) guided the evaluation design and methodology. The relevant components of the program are presented below. The program logic impacts identify workplaces as the key setting for the program's impacts to occur. The evaluation design therefore focused on workplaces

that have been involved in the WorkHealth program as a unit of analysis. This focus complements the prospective study (Project 1), which investigates the impacts that the WorkHealth program has had on the individual (participant).

Figure 1: WorkHealth program logic impacts identified for the impact evaluation



The key areas for exploration in project 4, drawn from the program logic impacts are:

1. Health promotion activities in the workplace
 - a. Barriers and enablers
 - b. Comparison of WorkHealth funded activities and non-WorkHealth funded activities;
2. Workplace culture to support health and wellbeing
 - a. Culture of care vs. culture of compliance
 - b. Perceptions of occupational health and safety
3. Capacity building drivers for health and wellbeing programs
 - a. Leadership, partnerships, organisational development, resource allocation and workforce development

Timing of the evaluation

The impact evaluation was conducted from January to August 2012. Data was collected from workplaces between February and July 2012. These workplaces had engaged with the program at different times since 2009. It must be noted that during this time, the Healthy Workplace Grants program went through several iterations and were only offered to medium and large workplaces based on remuneration for the whole organisation. In this evaluation, workplace size was identified using remuneration for a single site or branch of a whole organisation as this was felt to be most relevant to capture specific changes in the workplace for health and wellbeing activities.

2. Methodology

2.1 Evaluation design

Impact evaluations determine the short and medium term impacts of a program based on the objectives of the program. Figure 2 identifies how an impact evaluation fits into the logic of program planning and evaluation.

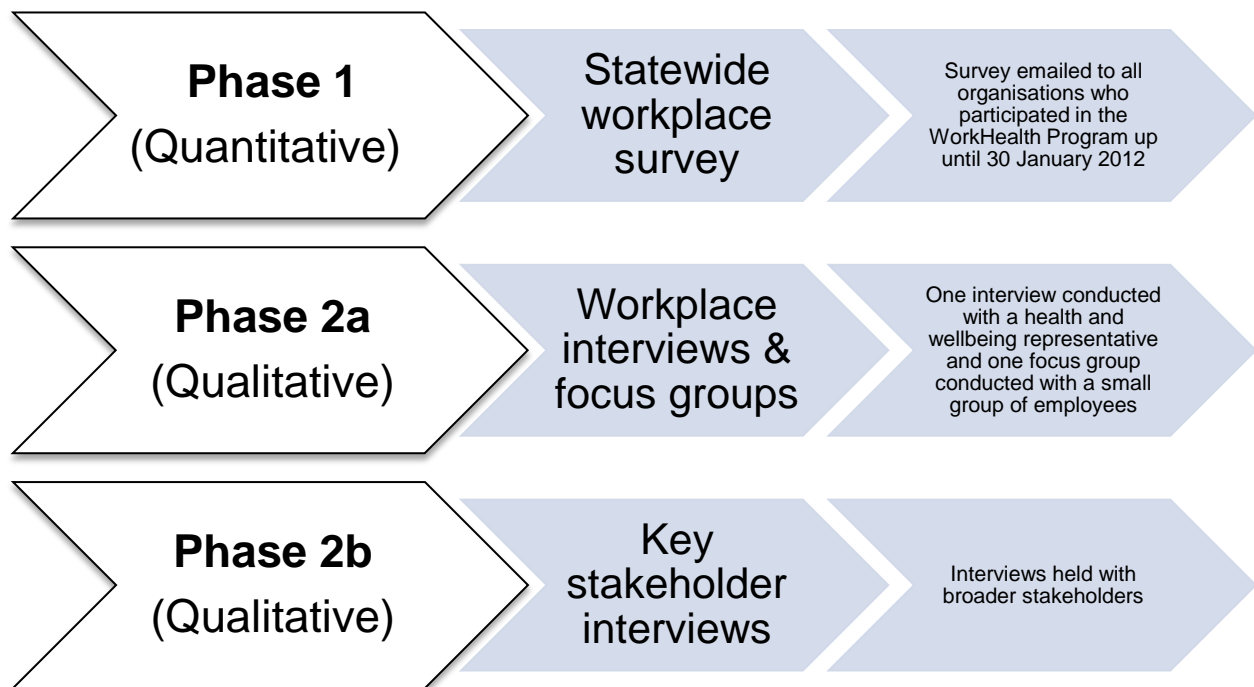
This impact evaluation benefited from a mixed methods design. Mixing methods is a type of triangulation where different types or measures of data collection techniques are used to cross-examine the same phenomenon, increasing the validity and reliability of the findings (Neuman, 1997). Mixed methods designs bring together the strengths of quantitative and qualitative methods to answer research questions for which single methodological approaches alone, cannot do justice (Patton, 2002).

Figure 2: Planning and evaluation cycle (adapted from Hawe, Degeling and Hall, 1993, p.78)



This evaluation mixed quantitative and qualitative methods sequentially in two phases which is depicted in the flow chart below (Figure 3). In Phase 1, a state-wide workplace survey was designed to collect quantitative data from workplaces which had participated in the WorkHealth Program. The survey asked broad questions about involvement in the program and enable a breadth of data to be collected about the program. In Phase 2, qualitative data was collected through in depth interviews and focus groups held within workplaces. In addition a series of key informant interviews were held with members of the Broader stakeholders.

Figure 3: Mixed methods evaluation design



2.2 Sampling strategies

2.2.1 Phase 1 (State-wide workplace survey)

All workplaces¹ registered in the WorkHealth program up until 30th January 2012 were considered eligible to participate in Phase 1 of the evaluation. Workplaces were identified by their unique WorkHealth policy number². WorkSafe provided the researchers with a contact list of 15,921 organisations. The data set was cleaned and workplaces were deleted if the contact details (primary email, name of contact person, employer ID) were missing or incomplete. 14,142 eligible organisations were sent an email invitation to participate in the evaluation via the online survey program SurveyMonkey. A further number of workplaces were also screened out due to:

¹ A workplace was defined as any group which independently applied to participate in the WorkHealth program

² Policy numbers were assigned to whole corporations through to specific branches or sites workplaces

- Invalid email addresses (such as entering “N/A” or “none” into the ‘Primary email address’ field)(n=503);
- Minor typing mistakes in their email addresses (such as entering commas instead of full-stops) and were amended and accepted (n=271);
- Organisations had already blocked SurveyMonkey³ from sending them links to any surveys (n=135)

2.2.2 Phase 2 (Workplace interviews and focus groups; key informant interviews)

A sample was determined from the workplaces which agreed to participate in further research at the end of the online survey. A sampling matrix was used where geographic location, industry type, workplace size and the capacity which the workplace participated in the program determined 24 different “organisational types”. Two workplaces within each organisational type were included in the sample to allow for comparison and validation of findings.

Workplace size

Small workplace: A business with a remuneration of less than \$2 million;

Medium workplace: A business with a remuneration of \$2million to 9.9 million;

Large workplace: A business with remuneration of \$10 million or more.

Industry Type

Defined using WorkCover Industry Classification (WIC) which is based on the Australian and New Zealand Standard Industrial Classification (ANZIC):

Blue (B) collar industries are Agriculture, Forestry, Fishing and Hunting; Mining; Manufacturing; Construction; Transport, Postal and Warehousing.

White (W) collar industries are Electricity, gas and water; Wholesale trade; Retail trade; Accommodation & Food Services; Information Media & Telecommunications; Financial and Insurance Services; Rental, Hiring and Real Estate Services; Professional, Scientific and Technical Services, Administrative and Support Services; Public Administration & Safety; Education & Training; Health Care and Social Assistance; Arts & Recreation Services; Other Services.

³ www.surveymonkey.com

A list of key stakeholders was provided to the researchers by WorkSafe (n=15). Key stakeholders were telephoned to explain the evaluation and invite participation. A confirmation email was sent with a formal letter if the key stakeholder agreed to participate. 4 key stakeholders identified a nominee within their workplace to participate in the interview.

2.3 Data collection instruments

2.3.1 State-wide Workplace Survey

The state-wide workplace survey (Appendix A) comprised 29 closed questions. Of these, 11 closed questions asked additional open questions to illicit further information. Questions in the survey were assigned into three sections: demographic data about the workplace, participation in the WorkHealth Program and additional questions about context for occupational health and safety and health and wellbeing policies and programs at the workplace. At the end of the survey, participating workplaces were given the opportunity to participate in further research (Phase 2).

2.3.2 Workplace interviews and focus groups

Semi-structured interviews were conducted with the health and wellbeing (H&W) coordinator at each participating workplace. Many workplaces did not have someone in this formal role but identified the person best suited to comment on health and wellbeing programs and policies; this was usually the person who had completed the state-wide survey. An interview schedule (Appendix B) was used with five key questions and relevant prompts to guide the discussion. Questions asked about their experience with the program, exploring the barriers and enablers of workplace health promotion activities and the impacts on the health and wellbeing of their employees. Question prompts were structured around the capacity of the workplace to undertake health and wellbeing activities including intention to implement further activities beyond those funded by the WorkHealth program.

Focus groups were conducted with a group of 5-8 employees to explore the impact of their participation or non-participation in WorkHealth checks and Healthy Workplace grant activities. Participants were voluntarily recruited through the H&W coordinator, who was provided with a promotional flyer and sign-up sheet. An interview schedule (Appendix C)

with four key questions and related prompts asked focus group participants about their experiences of participating in the WorkHealth program and observed changes, the organisational culture for health and wellbeing programs and perceptions of health and wellbeing in the workplace. Participants and non-participants of the WorkHealth program were invited to participate in the focus group.

2.3.3 Key stakeholder interviews

Broader stakeholders were invited to participate in a semi-structured interview (Appendix D). Five key questions with related prompts were asked to understand the effectiveness of partnerships at a strategic level for program implementation. Questions covered the key stakeholders involvement in the program, advice and support provided to WorkHealth, and observed challenges and successes of the program in relation to its impact.

2.4 Data collection methods

2.4.1 Ethics Approval

A Low Risk Project Involving Humans Ethics application was approved on December 10th 2011 (**CF11/0011 - 2011001976**). This application was submitted after the WorkHealth Impact Evaluation Plan had been accepted by the Steering Committee on October 5th 2011 and reviewed by the WorkHealth Internal Evaluation Team.

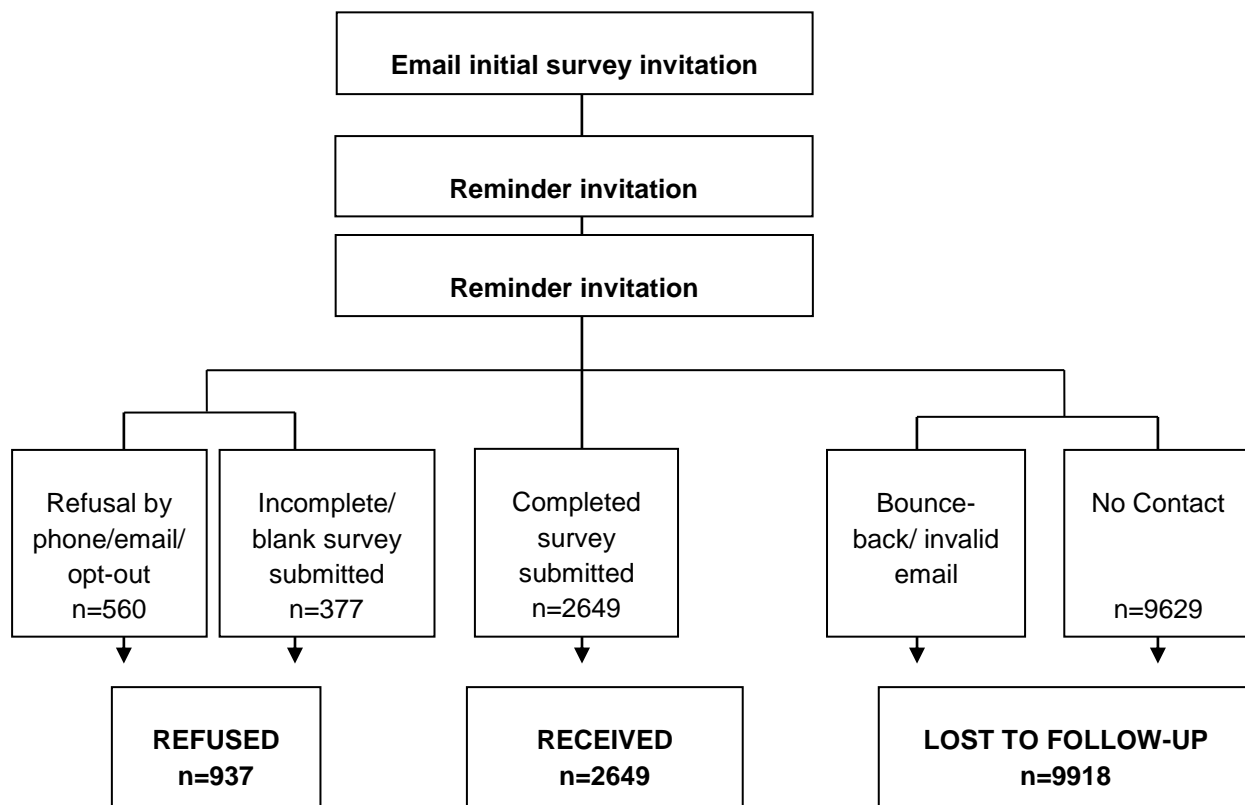
2.4.2 Phase 1 (State-wide workplace survey)

A total of **13,504** workplaces were sent invitations to participate in the study using the online survey program SurveyMonkey⁴. The survey was live from February 20th 2012 to April 15th 2012 (eight weeks). Reminder emails were sent out on March 5 2012 (start of third week) and March 19 2012 (start of fifth week). During the eight weeks the survey was live, there were 289 bounce-backs due to invalid email addresses. The bounce-backs were manually scanned for minor errors (spelling of name in email address not matching recorded name of contact person). 44 bounce-back emails were amended and invitations were resent. Participants were able to opt out of the study by clicking on a link in their invitation email (n=458). A further 102 people contacted the research team via email and requested to be

⁴ www.surveymonkey.com

opted out of the study. These participants' details were recorded in a spreadsheet with their provided reason (if any), and manually removed from the email list.

Figure 4: Data collection flow chart



2.4.3 Phase 2 (Workplace interviews and focus groups; key informant interviews)

At the end of the online survey (Phase 1), respondents were invited to provide contact details to participate in further evaluation of the WorkHealth. Workplaces which consented to participate in further evaluation were eligible to participate in Phase 2.

The contact details of all workplaces which opted in to further evaluation were entered into an Excel spreadsheet and stratified based on workplace size (remuneration of site/branch), industry type (blue or white collar), location (metropolitan, rural area), and then the capacity they participated in the WorkHealth Program (WorkHealth checks only or WorkHealth check and receiving a WorkHealth grant).

Two workplaces were randomly selected from each cell and contacted by phone. A confirmation email was then sent to confirm their interest and to discuss the feasibility of the focus group and interview. In the case of withdrawals or loss to follow up, workplaces were

continually randomly selected into the “organisational type” categories until the sampling matrix was filled with confirmed participant workplaces. Recruitment was limited when in some cases there was only one appropriate workplace to fill a cell, or none at all. Interviews and focus groups were digitally recorded. All participants were provided with an explanatory statement and consent form. Consent forms were completed and signed and returned to the researchers.

2.4.4 Limitations of the evaluation design

Research design

Due to the fact that no baseline data was available, impact objectives had to be measured using self-reported data. Whilst conducting a focus group with employees as well as an in-depth interview with a H&W coordinator assisted in validating data from each source, no further objective measures were used, and thus data could be vulnerable to some biases.

Industry recruitment

Whilst there was a good representation of industries opting into Phase 2 of the evaluation, a number of workplaces from particular industry types (Education and Training, Construction) withdrew when contacted after they realised that a focus group would not be feasible within their work schedule. This led to a skewed representation of industry types.

Recruitment of focus group participants

Due to ethical requirements, the researchers were only able to directly contact the H&W coordinator at the workplace. H&W coordinators were then required to recruit their employees into the study with support materials provided by the researchers. As a result, focus group participation rates were varied depending on the time and effort H&W coordinators put towards this task.

2.5 Data management

Databases, spreadsheets and transcripts were stored in an electronic folder which was password protected and only accessible by the researchers. Audio files were de-identified by the researchers before they were sent to the transcription company. All consent forms obtained from the research participants were stored in a locked cupboard. To comply with

Monash University ethics requirements, data will be retained for a minimum period of five years.

2.6 Data analysis

Responses from SurveyMonkey were downloaded into SPSS 20 for statistical analysis and cleaned. Descriptive statistics were conducted on the complete data set. Frequencies, cross-tabulations, proportions, means, medians and modes were calculated.

During data collection in Phase 2, both researchers discussed emerging themes and key points after visiting each workplace. Three basic coding frameworks were then developed for key stakeholder interviews, H&W coordinator interviews and focus groups as preliminary themes emerged from discussions between the researchers.

After each visit to a workplace, the audio files of interviews and focus groups were de-identified and sent to a Melbourne-based company for transcription. Transcripts were typed verbatim into a word document and sent back to the researchers to be uploaded into QSR NVivo 9.

Transcripts were then coded using open and focused coding as a dynamic process to sort and organise the data (Liamputtong, 2010). The researchers then reviewed the coding frameworks together to ensure their relevance and made appropriate changes so that the codes within the three frameworks covered all aspects of the program impact. The transcripts were then coded using selective coding to construct concepts and themes emerging from the three data sources and connecting these together to answer the evaluation research questions (Liamputtong, 2010).

3. Evaluation results

The results of the evaluation are presented in four sections. Firstly, the demographics of participating workplaces and interviewees are illustrated. Data is then presented about the context in which the program has been implemented before describing the impact that the participants considered the program has had on workplaces. The report ends with a section on future directions which includes a set of areas to consider for the future of the program.

3.1 Phase 1 demographics of participant workplaces

2,649 surveys were completed; this is a response rate of 19.6%. Table 1 illustrates the demographics of participating workplaces. Survey respondents reflected the same demographics as program participants. Participating workplaces were most likely to be small, white-collar, metropolitan workplaces from the private sector, accessing WorkHealth checks only.

Table 1: Demographics of participant workplaces in the survey

Demographic characteristic	Frequency	Percentage
Industry type:		
Blue collar	689	26.0%
White collar	1960	74.0%
Industry divisions:		
Accommodation and Food Services	73	2.8%
Administrative and Support services	72	2.7%
Agriculture, Forestry, Fishing and Hunting	74	2.8%
Arts and Recreation services	61	2.3%
Construction	191	7.2%
Education and Training	483	18.2%
Electricity, Gas, Water and Waste services	35	1.3%

Financial and Insurance services	67	2.5%
Health care and Social Assistance	278	10.5%
Information Media and Telecommunications	23	0.9%
Manufacturing	356	13.4%
Mining	13	0.5%
Other services	57	2.2%
Professional, Scientific and Technical services	433	16.3%
Public Administration and Safety	28	1.1%
Rental, Hiring and Real Estate Services	41	1.5%
Retail Trade	154	5.8%
Transport, Postal and Warehousing	60	2.3%
Wholesale Trade	150	5.7%
Workplace size by employee number:		
Small (1-19 employees)	1498	56.5%
Medium (20-199 employees)	986	37.2%
Large (>200 employees)	165	6.2%
Workplace size by remuneration:		
Small (< \$2 million)	1560	58.9%
Medium (\$2- 9.9 million)	791	29.9%
Large (>\$10 million)	298	11.2%
Sector:		
Not for Profit sector	442	16.7%
Private sector	1741	65.7%
Public sector	466	17.6%

Location:		
Metropolitan Melbourne	1742	65.8%
Regional City	421	15.9%
Rural Victoria	486	18.3%
Program involvement:		
WorkHealth checks only	2399	90.6%
WorkHealth checks AND Healthy Workplace grant	174	6.6%
Don't know/Unsure	76	2.9%
Year of participation in WorkHealth program:		
2009	150	5.7%
2010	971	36.7%
2011	1578	59.6%
2012	312	11.8%

At the closure of the survey, 513 workplaces (19.4%) opted into Phase 2 of the evaluation. After the recruitment phase, 27 workplaces across Victoria agreed to participate in Phase 2 data collection. Table 2 indicates that just over half (55.6%) of participating workplaces were from white-collar industries; there was a fairly even distribution of workplace size (small = 33.3%, medium = 29.6%, large = 37.0%), and an even distribution from metropolitan (51.8%) and rural (48.2%) locations. It also shows that nearly half (40.7%) of participating workplaces were from the Manufacturing industry, which accounted for nearly all (91.6%) blue-collar workplaces.

Table 2: Sampling matrix for Phase 2 participating workplaces

	Metropolitan						Rural					
	Small		Medium		Large		Small		Medium		Large	
	B	W	B	W	B	W	B	W	B	W	B	W
WHC	Manufacturing	Wholesale trade	Manufacturing	Healthcare & Social Assistance	Manufacturing	Healthcare & Social Assistance	Manufacturing Manufacturing	Accomm. and food services Healthcare & Social Assistance	Manufacturing	Healthcare & Social Assistance Accomm. and food services	no orgs to choose from	Public admin. & safety
WHC & Grant	Transport, postal and warehousing Manufacturing	Wholesale trade	no orgs to choose from	Wholesale trade	Manufacturing Manufacturing	Other services Wholesale trade	no orgs to choose from	no orgs to choose from	no orgs to choose from	Electricity, Gas and Water Supply Healthcare & Social Assistance	Manufacturing Manufacturing	Electricity, Gas and Water Supply

As illustrated above, there was a near-even spread in Phase 2 of both workplaces which had accessed a grant, and those which participated in the WorkHealth checks only. White-collar workplaces were slightly over-represented (55.5%). Blue-collar workplaces were mainly from the Manufacturing industry; researchers attempted to represent diversity, however workplaces such as those in the Construction and Agriculture industries cited that it would be logistically unfeasible to hold a focus group with employees. Similar difficulties were had in recruiting workplaces from the Education industry. 74.0% of Phase 2 workplaces were from the Private sector, 18.5% were Public sector and only 7.4% were Not For Profit.

Across the 27 participating workplaces, 30 in-depth interviews were conducted with Health and Wellbeing (H&W) coordinators and 27 focus groups were conducted with a median number of 6 employees in each group (total n=189). The gender of participants was slightly biased towards female participation (65.8%).

12 key stakeholder interviews were conducted with broader stakeholders. Most interviewees were from the health sector or industry groups (Table 3). Due to the small number of key stakeholder interviews detailed demographic data is not provided about interviewees.

Table 3: Key stakeholder interviewees by sector

Partner sector	Interviews (n)
Health	4
Industry groups	4
Government	1
Union	1
Service provider	2

3.2 Investing in workplace health

Data generated from the evaluation highlighted four key themes that help to understand the broader influences of the program:

- Planning of the WorkHealth Program,
- Leadership provided by WorkSafe,
- Responsibility for health and wellbeing, and
- The connection between occupational health and safety and health and wellbeing.

The data for this section, on the whole, was generated from key stakeholder interview discussions due to the strategic nature of the themes.

3.2.1 WorkHealth program design

Key stakeholders engaged in discussion about the strategic planning and development of the WorkHealth program at the start of their interviews to provide context to their involvement in the program. They highlighted the political challenges of planning the design of a state-wide program to align with the brief provided by the government. They also acknowledged that the aim of the program was to offer WorkHealth checks to all Victorian workers, which did not always align with the expectations of program. Whilst '*hindsight's always 20/20*', they planned a program to improve worker health within an allocated time frame and budget.

'WorkHealth is a part of the system, it's not you know - it is not something that is going to achieve everything in its own right. It was only ever set up and funded initially to do - set up and deliver WorkHealth checks and fund them.'

-Key stakeholder

Building on this discussion, key stakeholders also reflected on the targeted approach of the program. In many of the interviews, stakeholders reflected that a more focused targeting strategy to offer WorkHealth checks would have been more effective, identifying worker age as a fundamental determinant of risk but also included industry type and socio-economic status as driving factors to target the roll-out of WorkHealth checks.

'We had a Greenfield site here, so we had to decide what might be the best program. And we've spent a lot of money on this program. And it may well in the longer term prove to be very successful, who knows, but I guess when you're saying there's \$200 million to be spent, what is the best way to spend that in order to improve workers' health, my question remains whether this was the best way to do it, and whether it could've been done in a more focused way, taken a more concerted approach in certain areas, because it's been a bit of a ready-fire-aim sort of approach that we've taken.'

- Key stakeholder

'It's clear the risk factors for chronic disease increases in age but also they're higher for lower SES and population groups that have particular disadvantages. And the interesting thing with WorkHealth is where we've got the poorest uptake of even the health checks is amongst the over 50 blue-collar males, who are the group that are most at risk of chronic disease [sic].'

- Key stakeholder

3.2.2 WorkSafe Victoria

Overall, stakeholders saw the leadership provided by WorkSafe for a work health program as politically advantageous because it *'got health on the agenda for employers and union'* and has enabled engagement with industry and union groups which traditionally had not worked in the workplace health space previously.

'The impact is good in that it's raised the profile of worker health, you know. Having WorkSafe involved is key because they've got all the connections with employers anyway and there's that extra power that they have when they speak.'

- Key stakeholder

'WorkHealth is designed and constructed to prevent. So I think that's good and I think having it in a place that engages as strongly as WorkSafe does with employers and unions is a great combination because they represent - that represents a connection to the people who at least have a pretty significant ability to re-shape the thinking and design of workplaces over time.'

- Key stakeholder

However there was also a level of cynicism at the start of the program about WorkSafe's connection with a health promotion program given their core business has always focused on safety in the workplace. This cynicism was often attributed to experiences with claims or their concern around the confidentiality of their health information gathered through the checks or lifestyle programs and how this may affect their employability.

'You didn't often see the WorkSafe logo with WorkHealth in that first 12 months and I think that was quite clever because some of the calls we were making initially were - not everyone's had a great experience in the past with WorkSafe, especially some of the smaller operators, they may have been burnt years ago with some sort of claim or something that didn't go their way, so they were fairly reluctant to do anything that was WorkHealth or WorkSafe.'

- Key stakeholder

'The program's been up and running since 2009, there's always going to be some scepticism from various organisations, unions and employees even [sic] with the program, especially when it's got the WorkSafe brand on it.'

- Key stakeholder

Stakeholders also spoke about their partnership with WorkSafe during the planning and implementation of the program. Most stakeholders acknowledged the difficult task WorkSafe has coordinating all the interest groups. Most stakeholders felt that WorkSafe

have done a good job to ensure meaningful consultation, however there were stakeholders who identified that:

'Your opinion isn't always taken up but that's always the way in this sort of program. There are many interests and many opinions.'

-Key stakeholder

3.2.3 Beyond occupational health and safety

Overall, H&W coordinators commented that their workplace was primarily concerned with adhering to OH&S requirements before they had capacity to consider implementing health promotion activities for their employees. The connection between occupational health and safety (OH&S) and health promotion in the workplace emerged as a key discussion point in both interviews and focus groups. Responses indicated that workplaces were making the shift from OH&S at different rates. Many workplaces were concerned with 'ticking the OH&S boxes' similar to this H&W coordinator from a small, blue-collar, rural workplace:

'As long as they arrive alive and go home alive'; whilst others conceptualised health more holistically: 'the health of our people is really important. And just general health, so you know we do a lot of occupational hygiene monitoring with respect to our plant environment, making sure that our guys are right but also just on a general health basis we want to know that, you know, our group are doing OK and that they're healthy.'

- H&W coordinator, rural, medium, blue-collar

Survey results indicated that as a result of the WorkHealth Program 7.1% of participants made changes to their workplace for falls prevention and 12.9% for injury prevention. H&W coordinators conveyed the importance of health promotion but always as a secondary agenda item to OH&S requirements. The capacity of the workplace to shift from safety and injury prevention was driven by two key factors: support from management and workplace culture around responsibility for employee health and wellbeing. Some workplaces did acknowledge a change which had often started through their participation in the WorkHealth program.

'So they do see that this - the health and wellbeing fits with their focus on safety and focus on zero tolerance. That's zero tolerance for behaviour as well as lack of safe

acts [sic], you know, like abuse of PPE [personal protective equipment] and all that kind of thing. So health and wellbeing fits in well because they're saying, "We care about you. We won't accept you taking shortcuts and risking your health and we also care about your health and wellbeing", so it's a really good match.'

- H&W coordinator, metropolitan, small, blue-collar

'So I guess the [workplace] sees a lot of its responsibility is covered by compliance with legislation, and the other stuff is touchy feely stuff, feel good stuff...we have a walking group and our staff can attend if they want to go...they can come in, you know, with staff time. But there's not the mechanisms necessarily there to support them to all attend.'

- H&W coordinator, rural, medium, white-collar

Interviews with key stakeholders acknowledged the importance of safety and injury prevention in the workplace, but described the need for industry groups and workplaces to shift their agenda beyond OH&S to improve employee health.

'I think they do need to be aligned and spoken about in the same sentence as opposed to being separate...The 'H' is totally skimmed over in these instances because safety is probably always going to be number one for good reason. But there needs to be a bit more depth in that.'

- Key stakeholder

Key stakeholders also spoke about the leadership that would be required for this shift to take place. From observations by key stakeholders throughout the life of the WorkHealth program, WorkSafe Victoria was seen as an appropriately skilled leader to bring about this change at a State level.

'And Victoria I think has proven itself to be a leader in OH & S, and undoubtedly it's proven it's a leader in this area. I mean there's nowhere else in the world that's done this. And I think it's a great image for us to have, and so again I'd hate for us to lose that.'

- Key stakeholder

'Looking at the WorkSafe strength around what can they start to operationalise within their OH & S system, so through their OH & S training can they start weaving in all the prevention promotion stuff, you know, is it possibly time to start thinking about some of the things we know like sedentary behaviour and whatever, like how can we put that more seriously into all of their regulations.'

- Key stakeholder

Health and Wellbeing coordinators were able to clearly articulate the occupational safety needs of their employees but less able to articulate how they might improve the wellbeing of their employees.

'This sort of side of it is more relatively new than the side of it, you know, manual handling, that sort of stuff, has being around for a long time but actually, you know, checking of health and you know - it's not an aspect that we've necessarily looked at in any great depth before'

- H&W coordinator, rural, small, white-collar

Employees conceptualised the responsibility of OH&S and health and wellbeing differently depending on their previous experiences within their own workplace. Whilst good OH&S practice was considered mandatory, employees exposed to health promotion activities identified the benefit of employers going beyond safety regulations and embracing wellbeing activities. This discussion was also influenced by workplace culture and perceived responsibility for employee health and wellbeing which elicited very different ideas from participants.

'They both integrate because if you're not healthy then you're not going to have a very safe workplace'

- FG, rural, large, blue-collar (grant)

'Your personal health and wellbeing and workplace safety are two separate things'

- FG, rural, small, blue-collar

'There are personal health issues and then there are I think, there are broader occupational health issues and then there's a kind of a line where those two lap over.'

- Key stakeholder

When probed further into their views on 'where the line is drawn' between personal health and workplace health and safety, many employees discussed an aversion to their employer trying to influence their general lifestyle behaviours. Workers viewed physical health related to diet and exercise as less amenable to change in the workplace setting, and were more interested in health and safety issues which they could see had relevance to their working environment and ability to do their job. Few employees identified the link between lifestyle-related health and productivity.

Mental health and safety

Whilst many focus group participants did not feel that health and wellbeing programs focused on lifestyle behaviours were appropriate for the workplace, there was clear interest in mental health and safety across the vast majority of focus groups. Support for mental health activities or programs was raised in 70% of focus groups. In several cases, this was discussed in relation to exposures to a focus on mental health and wellbeing in their current or previous workplaces, or in response to specific incidents.

'Probably four years ago, we had some fairly hefty stress claims, OH&S, and that prompted a lot about looking at the health side of it. Stress is pressure, stress can come from a lot of other avenues, health and the way people think... This is the other soft side of OH&S, the way people think as they come to work or they conduct themselves and the way they look after themselves mentally and physically.'

- FG, rural, large, white-collar

Several focus group participants noted that they could see a direct causal relationship between work conditions and mental health; employees commonly related mental health to work performance, and therefore viewed it as a relevant concern for their employer.

'It's been really focused on physical health ... but I'd like to see a little bit more on, you know, helping people realise a more life-work balance and dealing with stress, dealing with difficult people, dealing with the mental side of stuff. That's what's important at work.'

- FG, metropolitan, large, blue-collar

'I think more on the mental health and job stress is probably a lot more - I think would affect individual plus also work performance as well, more so than the physical activity, and the physical effects of lack of activity.'

- FG, metropolitan, small, blue collar (grant)

Focus group participants at several workplaces expressed that understanding and addressing mental health was a part of keeping up with current expected standards of employers. This theme emerged more strongly in workplaces that had accessed a WorkHealth grant than those which had only accessed the WorkHealth checks.

"I think mental health in this day and age is extremely important especially around stress and work life balance from that perspective. Yes, your physical health will certainly play a part but mental health in this day and age because there's a lot more pressure on people... so I think you should be focusing on that side of things more so than your physical health."

- FG, metropolitan, large, white-collar (grant)

This finding is complemented by data from the workplace survey which revealed that 81.6% of workplaces that had accessed a grant reported having pre-existing policies related to workplace bullying, compared to 57.1% of workplaces that had only accessed the checks. Similarly, workplaces with a grant were more likely to report having policies related to work-life balance.

Health and wellbeing coordinators commonly agreed that mental health and safety was an important issue in the workplace which warranted attention in order to demonstrate best practice management, support their employees and for productivity reasons.

'I think keeping people up to date with work health and safety and being aware that mental health is a big issue in the work place is - is only beneficial to our company.'

- H&W coordinator, metropolitan, large, white-collar (grant)

However there were considerable variances in the types of approaches taken to addressing these issues, and if any actions had been taken at all. Coordinators without training in disciplines such as Human Resources commonly described feeling 'out of depth' when attempting to address mental health and safety at work.

'We don't have a policy on wellbeing and mental health within - in the workplace which is akin, as I see a connection there for these psycho-social hazards which we have to address - because you're looking at things like fatigue and bullying and stress and so-forth. So I see that it ties together but I'm not clear in my mind how I'm going to actually put that into a policy or address it.'

- H&W coordinator, metropolitan, small, blue-collar

Frequent comments were made in both interviews and focus groups that the scope of the activities in the grant menu options did not adequately address mental health and safety.

3.2.4 Responsibility for employee health and wellbeing

Responsibility for the improvement of employee health and wellbeing in the workplace was considered differently by evaluation participants. All participants understood 'responsibility for employee health and wellbeing' as provision of health and wellbeing activities in the workplace rather than adhering to legislative requirements. The survey data indicates that nearly two thirds (60.7%) of workplaces identify a shared responsibility for employee health and wellbeing. Further analysis indicated that as workplace size (employee number) increases employee responsibility decreases (↓9.7%) and shared responsibility increases (↑14.4%). There was also a shift for workplaces that were less likely to identify that there is no focus on responsibility (↓ 4.7%). A similar trend was observed with increasing workplace size (remuneration).

Table 4: Perceptions of responsibility for employee health, by level of participation in WorkHealth

In your organisation, who is considered to be primarily responsible for employee health?	Level of participation in program	
	WorkHealth checks only	WorkHealth checks & grant
Both employer and employee	1436 (59.9%)	123 (70.7%)
Employer	148 (6.2%)	9 (5.2%)
Employee	489 (20.4%)	23 (13.2%)
Neither, there is no focus on responsibility	278 (11.6%)	15 (8.6%)
Don't know/Unsure	48 (2.0%)	4 (2.3%)

Analysis also revealed that workplaces which had accessed a healthy workplace grant were more likely to perceive responsibility as shared and less likely to indicate their workplace placed responsibility on employees or that there was no focus on responsibility (Table 4). Similar trends were observed with workplaces which identified supporting the implementation of health and wellbeing programs and workplaces to describe their culture as proactive in supporting employees to participate in health focused programs and activities.

Both Health and Wellbeing (H&W) coordinators and employees had varying ideas about responsibility of employee health. Most H&W coordinators explained that whilst their workplaces should provide opportunities for employees to improve their health, ultimately it was the responsibility of the employee to make changes to improve their wellbeing. They associated the benefits of employer responsibility with productivity and absenteeism rates and often felt that health and wellbeing activities within the workplace should be driven by the employee, rather than the employer.

Table 5: Perceptions of responsibility for health by organisation's approach to health and wellbeing

In your organisation, who is considered to be primarily responsible for employee health?	Organisation's approach to health and wellbeing		
	Proactive	Does not tend to be proactive	Neither/Not sure
Both employer and employee	982 (73.4%)	294 (43.4%)	331 (52.3%)
Don't know/Unsure	7 (0.5%)	13 (1.9%)	36 (5.7%)
Employee	182 (13.6%)	200 (29.5%)	144 (22.7%)
Employer	100 (7.5%)	37 (5.5%)	25 (3.9%)
Neither, there is no focus on responsibility	67 (5.0%)	134 (19.8%)	97 (15.3%)
Total	1338 (100.0%)	678 (100.0%)	633 (100.0%)

'I see health and wellbeing as a benefit, as an employer of choice type of activity, I don't see it as a responsibility to provide health and wellbeing incentives. I think it's

something that we can promote, we can provide but at the end of the day you are responsible for your own health and wellbeing.'

- H&W coordinator, metropolitan, large, blue-collar (grant)

'I think it is something that we do - I don't think it's a responsibility of the employer to ensure that each employee is healthy, but if it's an added benefit that you can do or offer it will it improve efficiency, reduce sick leave, and a general better wellbeing within your staff.'

- H&W coordinator, metropolitan, large, white-collar

Employees also believed that employers had responsibility for their safety but were not required to put policies or programs in place that would improve their health and wellbeing.

'I think being injured at work while doing a job for work, is their responsibility; it's not their responsibility to make sure the person follows the rules, but they should make sure that the environment is safe. But as for health and stuff, I mean that would be the incentive, I don't think that's up to an employer to make sure that you're healthy.'

- FG, metropolitan, small, blue-collar

3.3 Program Impact

The impact on the WorkHealth Program was explored in both phases of the evaluation. To understand where changes were made, the evaluation looked at the journey workplaces take when they engage in the program. Whilst most workplaces only access WorkHealth checks, the evaluation results of the grants program and Healthy Workplace Kit are presented before the key organisational drivers for workplace health are reported, and their influence on a workplace's ability to undertake workplace health programs.

3.3.1 Engagement in the WorkHealth Program

Most H&W coordinators reported that they initially chose to engage in the WorkHealth program to show their employees that they *'cared and provided them with an opportunity to improve their health'*. Whilst the sign-up for the WorkHealth Program is managed by the employer, the evaluation results also indicated that this process was often driven by the employees who were prompted by the media advertisements and subsequently asked their employer to organise WorkHealth checks at their workplace.

'It was a wide media campaign at the time, widely advertised on TV and all that; they were running ads every five minutes... Here at work quite numerous of us then went and asked "When will it come here!" Some people couldn't wait until they came here.'

- FG, metropolitan, large, blue-collar

Most workplaces reported that prior to the WorkHealth check; they had only offered the flu vaccination or employee assistance programs. The WorkHealth checks were often the first opportunity for workplaces to engage in a free comprehensive workplace health program, especially if they were able to access a healthy workplace grant.

'The annual flu vaccinations and that's about it. And responding when an injury occurs, getting appropriate treatment but nothing - there was nothing happening.'

- H&W coordinator rural, large, blue-collar (grant)

'Oh, they might have ran a Movember or, you know, The Biggest Morning Tea might have been done in one office but there was nothing like we have now.'

-H&W coordinator, rural, medium, white-collar (grant)

Productivity

H&W coordinators spoke about the productivity benefits of healthy employees revealing that the financial benefits of investing in workplace health programs was very important to them including reduced absenteeism and presenteeism and increased retention rates. Whilst not all coordinators were part of the senior management team at their organisation, they highlighted the need for employers to understand the cost-benefit of making this investment.

'One of the things that we have tried to do is to show companies just how the tangible savings that have been made.... So if you do have your hundred staff go through this, get them on an exercise regime, a voluntary one, get them eating fruit and vegetables at work because you pay \$100 a week to bring fruit and veggies in and these sort of things, and then at the end of two years you can show demonstrably that there's been an improvement in health for your company and for your employees, then that's going to be the real benefit, but there has to be that demonstrable link I think.'

- Key stakeholder

'From the employer perspective, yeah, obviously maintaining people's health means that they would be here longer and have more energy and, you know, be able to help the side out and, you know, reduce absenteeism.'

- H&W coordinator, rural, medium, blue-collar

However most workplaces did not record this information in their system and if this information was recorded it was not analysed for strategic planning. In the survey, respondents indicated that the majority of absenteeism (67.9%) in their workplace was due to colds, influenza or viruses, or that absenteeism was 'very low' or 'not a problem'. Other causes of absenteeism included job dissatisfaction (11.7%) and job stress (8.3%).

'If we had the numbers, you know, the top management tend to work very well with numbers and figures so if you put look, this equals that amount of time lost or financial, you know, loss, maybe that will be a turning point for them. I don't think they have been presented with that data up until now.....If they can translate the figures of absenteeism and budget into the importance of doing that, then there is a chance. Until they see figures and until they change their mind about it, nothing will happen.'

- H&W coordinator, metropolitan, large, white-collar (grant)

A few workplaces did observe that they had noticed some general changes in health behaviours among employees, which had reportedly reduced absenteeism however none of the participating workplaces had collected data in order to measure this change and so feedback was anecdotal.

'We haven't have had anyone really sick lately, which is quite good. Yeah, the last six months have been great, because they have made a few eating changes and it's helped them a little bit.'

- H&W coordinator, rural, small, blue-collar

Focus group participants also acknowledged that investment in employee health improved the productivity of the business however they did not directly link this with the expectation that their employer should therefore offer health and wellbeing programs. They also

commented that involvement in WorkHealth programs improved workplace culture because the employer was seen to be caring and supportive of their health and wellbeing in turn impacting on retention rates.

'Healthy body, healthy mind is good productivity at the end of the day. Yeah, everybody wins I think.'

- FG, metropolitan, large, blue-collar

'Businesses are going under, they cannot afford to keep increasing people's salaries so what else are they going to do to incentivise people to stay with the business? Once you lose employees you don't have a business so you've got to look at other ways of trying to retain your staff.'

- FG, metropolitan, large, white-collar

3.3.2 WorkHealth checks

The evaluation generated data about the WorkHealth check from both Phase 1 and 2 of the impact evaluation. At the time of this report, nearly 600,000 WorkHealth checks have been conducted across Victoria since the start of the Program. Qualitative data revealed that for many workplaces, this was the first time they had engaged in WorkHealth checks and only one quarter (25.8%) of survey respondents indicated that their workplace offered regular health risk assessment/health checks. Analysis of survey responses revealed that the larger the workplace (employees & remuneration), the more likely the workplace is to conduct regular health risk assessments/checks. Workplaces that described their workplace culture for health as proactive were also twice as likely to have regular health checks and public sector organisations were 50% more likely to conduct regular checks at their workplace than the private sector. However, there were no clear differences between industry type and location of workplace.

Employee participation

Employee motivation to participate in a WorkHealth check was varied. Most commonly, employees cited the quick and convenient way of '*checking up*' on their health status. For some employees, this meant accessing a health check for the first time, in particular testing their cholesterol and blood glucose levels.

'It was just probably an opportunity too, just to find out where you were with your own health and you know, know how you're travelling.'

- FG, rural, medium, white-collar

Older focus group participants also highlighted age as a driver for participating in a health check. Many employees identified cholesterol levels as a health indicator they were 'meant' to get tested as they aged.

'We're not getting any younger, we're like an aging workforce so it was time to sort of take stock, I suppose... It's sort of a chance to just check things out in general.'

- FG, rural, large, blue-collar (grant)

Focus group data revealed that for many workers, the WorkHealth check was the first time that they had attended a general check-up. For some participants, this was related to poor access to health care; the WorkHealth checks provided them with an opportunity that they had not previously been privy to.

'The way the medical system is round here, you can't [see a doctor]. If you want to see your own doctor, you know, it could take three or four weeks to book in.'

- FG, rural, large, white-collar

'Not even when I'm sick. I don't go [to the doctors]. Costs too much money.'

- FG, rural, medium, blue-collar

Many other participants expressed that they felt that going to the doctors was reserved for when one is 'genuinely' sick. Despite some recognising that they could be at risk of serious conditions due to their weight and lifestyle, very few workers saw occasional check-ups as a priority; there was a clear dichotomy in views about being sick as opposed to being unhealthy.

'And human nature is too, if it ain't broke, you don't fix it, so you don't go to the doctor until you're sick so that's where the health checks really come in, is that they encourage people in - within the working environment to go along.'

- FG, metropolitan, large, white-collar

'You go to the doctor for other things, other serious things but you kind of neglect the basics.'

- FG, metropolitan, small, blue-collar

Several male participants emphasised that they in particular would not usually have gone to a doctor for a check-up because of their gender.

'Nah, I didn't go to the docs, being a man and all... There are lots of blokes that used to be like what I was [sic], never went to a doctor unless something went wrong, you know.'

- FG, rural, small, blue-collar (grant)

Focus group data suggests that the WorkHealth checks have had some success in providing checks to at-risk individuals who had not previously accessed health services for screening of chronic diseases. However at a number of workplaces, both employees and H&W coordinators observed that the checks had not been taken up by those most at risk of chronic disease due to particular lifestyle factors.

'They all did [sic] come along apart from a couple that just wouldn't come- actually the ones who needed it most.'

- H&W coordinator, rural, small, white-collar

'Oh some people I heard that are overweight haven't - they don't want to because they don't want to know. People have said to me, "Why would I go? I already know I'm unhealthy".'

- FG, rural, large, blue-collar (grant)

Most commonly, focus groups participants described that they had accessed the WorkHealth check not because they felt that they could be at risk, but simply because it was free and available to them.

'I was healthy. I knew I would be... I had nothing wrong but I - but it's good to see if you have.'

- FG, rural, large, blue-collar (grant)

'I think a lot of it though is sort of preaching to the converted, the ones that take – like, are taking notice of it and participating are probably aware already of their health and wellbeing whereas the - probably some that aren't maybe should.'

- FG, rural, large, white-collar

Media campaigns

Employers and employees both noted that the media campaigns launched throughout the life of the WorkHealth program have had a beneficial impact on raising awareness of the WorkHealth checks (at the time of data collection, the 'Suppose' campaign was airing on television). Many workplaces discussed this as an influencing factor for participation in the program.

'We also had our employees asking, they'd heard it on the radio and they - like, so we'd already sort of booked it and so they were asking "oh can we get this done?", so that came from a few employees from what they heard on the radio, yeah.'

- H&W coordinator, metropolitan, large, blue-collar

'They have those ads on the telly that - is it the lady collapsing? And my kids now say, "Have you done that?" Harassing me.'

- FG, rural, large, white-collar (grant)

Key stakeholders also acknowledged that the media campaign had a positive impact on raising awareness of the Program and workplace health. However, they also clarified that media strategies do not ensure behaviour change which is an important outcome of workplace health promotion.

'So it's not often these days that I make an inquiry to an organisation that hasn't heard of WorkHealth. So I think all of the WorkHealth marketing campaigns have worked in getting the name and program out there.'

- Key stakeholder

'Again, it's hard to know whether TV advertising is the right way to go to get employers involved. I mean there's no doubt more targeted things you can do and that WorkHealth has done to get employers involved but yeah, it really depends what

the target is. I mean the target is mainly employers, and mass media may not be the most cost-effect [sic] way.'

- Key stakeholder

Coercion to participate

At several workplaces, employees cited that they had felt coerced by the health and wellbeing coordinator or management to participate in the WorkHealth checks.

'If we said, "No", Elaine⁵ would get very, very upset with us.'

- FG, metropolitan, large, blue-collar (grant)

Several health and wellbeing coordinators described the process of implementing the WorkHealth checks as 'a hard sell' in the earlier stages of the program: *'I guess initially got a bit of cold response but we sort of pushed it and pushed it and pushed it.'*

- H&W coordinator, rural, large, blue-collar (grant)

While some health and wellbeing coordinators described their intentions as benevolent, the Healthy Workplace grant was also discussed as a strong driver to fill as many places as possible. Coordinators described processes of having several 'rounds' of checks in order to reach the required participation rate to access a grant.

'So second time it was driven to get that grant, because I knew without the grant I would not be allowed to spend any budget to introduce anything for the staff, the employees.'

- H&W coordinator, metropolitan, large, white-collar (grant)

Participants from several organisations occasionally described each having completed more than one WorkHealth check at their workplace. Some workers stated that this was in order to assist in boosting participant numbers to enable their workplace to be eligible for a grant.

⁵Pseudonyms have been used to protect participant's identities

'The second time I didn't want to do it... But they needed one more so I did it.'

- FG, metropolitan, small, white-collar (grant)

Non-participation in the WorkHealth checks

Focus group attendees who had chosen to not participate in the WorkHealth checks cited several important reasons for their decision. Concerns around the confidentiality of their results deterred many workers from participating; this issue was raised in approximately one-third of focus groups. Employees expressed an uncertainty regarding whether or not their employer would have access to their results and felt that it could lead to discrimination against them in the future.

'Someone said to me they didn't want to come in there because they thought the company will get all that information and then they'll know everything about me.'

- FG, rural, large, blue-collar

Observations were made that this was raised most frequently by older workers in focus groups and particularly in the blue-collar industries. This was also raised by key stakeholders who had roles in promoting the checks to organisations.

'The major issue for us with our workers is their inherent scepticism and mistrust of authority and concern around their specific health information being misused and potentially affecting their employability. Those sorts of issues are very real issues so extending that to those additional service offerings or - or WorkHealth coach specifically is always going to be a tough job.'

- Key stakeholder

'But of course if you've got somebody moving away from a piece of machinery you might have to stop the machinery, you might have to change the system, you might have to get somebody else on there [sic]. So they had issues, whereas in a professional organisation you tend to find someone who moves out of their office, they can go back into it quickly and there's a gap in time that doesn't need replacing. So I think it was easier for white-collar workers to do it than for blue-collar workers.'

- Key stakeholder

In addition, concerns relating to WorkSafe's access to the data were also raised. Focus group participants and health and wellbeing coordinators both voiced queries about whether or not results could be used against individuals or organisations in the case of compensation claims and insurance premiums.

'We had a WorkSafe Inspector here and I was surprised when she asked us whether we were participating in the health check because - and my husband heard that too and I knew what he was thinking. It is, it's a Big Brother thing.'

- H&W coordinator, metropolitan, small, blue-collar

'Employers were concerned about loss [sic] productivity particularly in lost time, unions were concerned about where the information would go from - from the health checks and who would hold that information and were concerned about maintaining confidentiality and the anonymity of the participants and so things like the associated health coaching, telephone coaching and the associated research were all problematic and remained problematic for the program for the industry stakeholders.'

- Key stakeholder

It was suggested in interviews and focus groups that greater clarity around privacy and data management when promoting of the program might enhance the uptake of checks among individuals and organisations with these concerns. A stakeholder noted that some organisations had required extra reassurance before agreeing to offer the checks at their workplace; word of mouth was also described as useful for assuaging confidentiality-related fears.

'Employees, organisations, after speaking with their colleagues or their network, you know, understand that it isn't an invasive program at all, that it's free and that it's quite straight forward.'

- Key stakeholder

Another commonly discussed rationale for non-participation was that some people were already actively engaged with the health care system and preferred to see their regular treating health professionals.

'I go to the GP all the time so I know that I'm fit and healthy.'

- FG, metropolitan, large, white-collar

Other reasons for non-participation related to the assumption that the check would not provide any new information to them. Some employees had pre-supposed the advice that would be given to them and felt that it would not have been useful.

'I don't need somebody to tell me what I need to eat so I'm smart enough to know what I should be putting in my mouth'

- FG, metropolitan, large, blue-collar

Workers in the health care industry agreed almost unanimously that they felt that the checks did not offer anything that they were not already privy to in their work environment.

'If I feel unwell I do my own blood pressure, I prick my own finger, I get the girls to do an ECG. I've done ECGs on work colleagues before. Blood pressure, did the blood pressure and a finger prick on a nurse this morning. So we have access to everything... It's not value-added for our environment.'

- FG, metropolitan, large, white-collar

A number of health workers who did choose to have a WorkHealth check stated that they had participated mostly out of curiosity, and did not see added benefits of the check.

Quality of the WorkHealth checks

When reflecting on experiences in the WorkHealth checks, many focus groups discussed their perceptions of quality of the checks. There was a consensus of general satisfaction among most groups that the checks were *'convenient'* and *'professional'*.

'I thought it was pretty quick and very clear... All the information that you got given at the end was easy to understand. So I didn't find anything a problem with the whole process.'

- FG, metropolitan, medium, blue-collar

'We've always had extremely good quality of people coming out and running the checks... They do what they do really well and I've found them very helpful because I've always had one... It's meant to be exactly what it is, a 15 minute check to give you some information and to alert you to some things. For example with me being at

risk of type two diabetes, that was a tap on the shoulder to me to pay more attention to that and people who say that they thought it would be much more in depth well that's - it's simply not possible in 15 minutes so, no, I think that for what they are they're fine.'

- H&W coordinator, metropolitan, large, blue-collar

However in more than two-thirds of focus groups, participants vocalised their queries of the accuracy of results that they had received during the checks. This was found consistently across organisational types, industries and locations.

'Let's say it was 5.1, when I got it done at the doctor it was 6.4. So I was just about running naked around the car park thinking woo-hoo I've got my cholesterol down to 5.1. But then when I got it done properly it was 6.4, so it wasn't as good as I thought it was.'

- FG, metropolitan, small, white-collar

As described above, some participants felt a false sense of security after good results; others reported 'scary' results which when followed up were revealed to be false alarms.

'I had feedback from a few of the employees that their readings were incorrect, so their blood pressure was showing quite high whereas they went to do the follow up at the doctors and it came back normal. And a few of them were frustrated that it was misleading information.'

-H&W coordinator, metropolitan, large, white-collar

There was particular concern regarding the non-fasting nature of the cholesterol and blood glucose tests. Employees reported considerable confusion over whether the test could be accurate if they had not fasted, due to their pre-conceived ideas of what the tests should involve. This was common even among participants who had never had their cholesterol or blood-glucose levels tested previous to the WorkHealth checks.

'As far as the cholesterol was concerned I sort of thought, well, we weren't fasting, how correct was that?'

- FG, rural, small, white-collar

‘Cholesterol- aren’t you supposed to fast for that? See, no one said that to me, so I hadn’t fasted so I don’t know how accurate things were, if you know what I mean?’

- FG, rural, medium, white-collar

These stories of negative experiences reportedly spread across workplaces, and had tangible ramifications on whether or not others followed up their results with other health professionals.

‘There was one other person who actually rushed off to the doctor and found that, yeah, the reading was quite different so I didn’t bother.’

- FG, metropolitan, large, white-collar

‘We didn’t know what to make of the results. To take them seriously or not.’

- FG, metropolitan, small, white-collar

It was commonly expressed that participants felt that the checks presented a great opportunity to many workers, but only if *‘done properly’*.

‘It’s probably not necessary if they can’t get it right or can’t get it accurate or close.’

- FG, rural, small, blue-collar

Relevance of checks

A strong theme emerged around the desire to expand content of the WorkHealth check or make it more relevant to specific industries or population groups. Employees in the manufacturing industry in particular felt that hearing tests would be highly relevant and well-regarded.

‘Hearing is probably one that they should have checked’

- FG, rural, large, blue-collar (grant)

A number of these workplaces did not currently provide hearing tests for workers, despite current State legislation which requires them to be provided when noise levels exceed a certain threshold in a working environment. Several workers also highlighted that although they might currently be in a workplace with safe noise levels, their previous exposures to

hearing damage at work warranted testing and could be valuable to include in a general check-up. Suggestions were also made for skin cancer checks to be included due to their relevance for outdoor workers.

Perceived benefits of the WorkHealth checks

The main benefits to employers of offering the WorkHealth checks (reported by H&W coordinators) related to *'raising awareness'* or *'generating discussion'* around health. Some coordinators reported that the checks had been *'an eye opener'* for their employees and had encouraged them to think about their lifestyle.

'I would say in the two years since we did that... there is more talk about health, exercise and lifestyle than there was at the outset.'

- H&W coordinator, metropolitan, medium, blue-collar

This was aligned with a key stakeholder's perception of the purpose of the checks.

'It's more like the checks are just a lever to begin the conversation with the workplace around how you can become more health-promoting, or how the local shops can start serving more healthy food because all the businesses in the area have said we've got a problem with diabetes. So you know, it's a conversation-starter rather than an end in itself.'

- Key stakeholder

For workplaces which already had an 'established' focus on health, the checks were described as useful for maintaining this stance and *'fitting in'* with their independent activities. However the majority of H&W coordinators only perceived tangible benefits for individuals, rather than for the employer.

'I think of it as a gift to individuals, but it didn't do anything per se for the employer.'

- H&W coordinator, metropolitan, medium, blue-collar

The personal benefits of the checks for employees were commonly described as either *'reassurance'* or *'the opportunity to find out something that I probably knew but hadn't had confirmed'*. In approximately one-third of focus groups, a participant described their results

as ‘a *wake-up call*’; in some instances, this was enough to motivate the individual to change their lifestyle behaviours in order to lower their risk of CVD and diabetes.

‘My results came all borderline [high-risk] but no surprise to the way I live anyway so I expected that. But it woke me up. I thought gee, I’d better start changing my methods... I started changing my methods on eating more veggies, drinking more water, cutting alcohol. I gave up smoking. So the effect was good. It was like a wake-up call. It just becomes so easy then to - for me, to keep a healthy life now... I’ve gone back to my doctor and had a full check-up once again and they [the results] all came out really well.’

- FG, metropolitan, large, blue-collar

‘Yeah, it [cholesterol level] was like sky-high. I was really, really ill and basically if I kept on the road of how I was I would have probably had a heart attack or something like that. So it helped me.’

- FG, metropolitan, medium, blue-collar

While these stories encapsulate the optimal outcomes of the checks, more commonly, many focus group participants reported that they had not made any changes since their check-up. Employees who were found to be at-risk of chronic disease in their check occasionally reported that they had followed-up the results with their doctor to validate the results but for many, this still did not prompt a change.

‘I did go and see the doctor, I haven’t gone and had the blood tests or any of that stuff yet but I’m supposed to.’

- FG, rural, small, blue-collar

H&W coordinators frequently likened the impact of the checks to the proverb ‘*You can lead a horse to water, but you can’t make it drink*’, recognising the limitations of addressing lifestyle behaviours in the workplace setting. Employees listed a number of reasons for not making or sustaining behaviour change; as expected, these commonly related to the pressures of their family or personal lives, time constraints, financial difficulties or poor access to facilities and resources.

‘As much as you’d love to be able to make that sort of change, you just - you can’t.’

- FG, rural, medium, white-collar

3.3.3 WorkHealth grants

Data about the WorkHealth grants program was elicited from focus group participants and interviewees. Several questions in the survey also asked specific questions about this component of the program.

Participation in grant activities

Employee participation in grant-funded health and wellbeing initiatives was found to be strongly associated with the scheduling of activities and the support of management. Several key stakeholders raised concern about blue-collar industry participation in health and wellbeing activities, as they had observed that these employers were less willing to offer activities within working hours due to lost productivity.

'We've noticed that blue collar or more factory type of businesses, are very reluctant to give their workers additional time off'.

- Key stakeholder

This was confirmed in a number of interviews with H&W coordinators who described the difficulties in scheduling activities around their company's workload.

'That was a challenge... We're a manufacturing company as well so it's important to get all these types of things done... So to try and get the right balance of times and when - depending on what has to be manufactured at the same time to be able to fit in the certain programs as well, that was difficult. We just don't have the ability to say, "Well we're just going to stop production for 45 minutes while we do that".'

-H&W coordinator, rural, large, blue-collar (grant)

H&W coordinators from both blue and white-collar workplaces consistently reported that unless employees were allowed to participate in activities within work hours, they were much less likely to participate. Participating in activities after hours was described as particularly problematic for workers with families, shift-workers and in rural areas where commute is longer. In some cases, poor out-of-hours participation was able to be addressed by negotiation with management to allow employees to attend planned grant activities during work hours.

'You know, it was sort of outside those bounds, you know, because you're asking them to do something in their own time and - You know, and if they're not a hundred percent interested they just won't attend.'

- H&W coordinator, rural, large, blue-collar (grant)

'When I said to my manager, look, I've got the funds and we've got approved for that amount, I'm having this session and the class is half empty, what can I do? Then she went back and said that - ring those managers and say that they can attend during their working hours, and so that increased the numbers a little bit. So people basically did not want to give away their lunchbreak.'

- H&W coordinator, metropolitan, large, white-collar (grant)

However focus group participants also described the challenges of attending grant activities during working hours, due to the nature of their job role. Workers frequently described being 'technically' supported to attend, but not practically; this often reflected the degree of support from management for employee health and wellbeing initiatives.

'I was meant to go to that stress [seminar] and I was looking forward to it but I was too busy and I couldn't go. How ironic is that? Too stressed.'

- FG, rural, large, white-collar (grant)

'I don't feel that every staff member had the opportunity to attend. We were supported if we wanted to go but the practicalities of it didn't always allow.'

- FG, metropolitan, large, white-collar (grant)

Several H&W coordinators emphasised the beneficial impact of employee contribution to planning on rates of participation in activities. Conversely, workplaces where grant activities had been planned with no consultation of employees often reported poor uptake of activities; in these cases, focus group participants were more likely to express that they felt that the program was irrelevant to their interests and needs.

'There's been a lot more uptake in it this year because people are now starting to be quite vocal about things that they would like to do. So there's a lot more participation within the business and probably next year we'll be looking at entering teams in indoor soccer and things like that, those activities as well.'

- H&W coordinator, metropolitan, small, white-collar (grant)

While data from many workplaces links program success to planning and implementation factors, some H&W coordinators instead attributed low rates of participation to a lack of interest from employees. This has reportedly deterred some organisations from investing in workplace health promotion in the future.

'Actually, it's all about the staff... You've got to get the staff involved, and that's the hard part.'

- H&W coordinator, metropolitan, small, blue-collar (grant)

'If the staff don't want it, what's the point?'

- H&W coordinator, metropolitan, large, white-collar (grant)

Focus group participants and H&W coordinators also discussed that like the checks, the grant activities were not frequently taken up by those most in need, based on risk of chronic disease. It was frequently mentioned that the *'same groups of people'* participated in all of the activities; these people were often described as the more proactive and already-healthy employees.

'I think it's people who are motivated anyway are going to do it...It's the same old Vegemites that do it every time.'

- FG, rural, small, white-collar (grant)

WorkHealth Grant application

The design of the grant application process was raised by key stakeholders and H&W coordinator interviewees. Key stakeholders were concerned with the relevance of some menu items in the application menu. They believed that this impacted on the uptake and rollout of the program for workplaces most at risk in blue-collar industries.

'So there's a rigidity about even the criteria that doesn't understand the way industry works.'

- Key stakeholder

'Well, I did sense that there was a bit of a middle class bias, really.....'

-H&W coordinator, metropolitan, small, blue-collar (grant)

They were also concerned about the level of impact some of activities may have in workplaces given the lack of existing evidence for these activities. Fruit boxes was mentioned on several occasions as a *low picking* activity that required little effort for a workplace to organise but that also had little long-term impact on employee health and wellbeing.

'Fruit boxes and all that type of thing is, you know, it's a good thing but it's not going to necessarily have a huge benefit to preventing chronic disease.'

- Key stakeholder

H&W coordinators also discussed the range of menu options available to them. Most coordinators found the suggestions a helpful guide because this was the first time they had run a health and wellbeing activity and reflected that they were *unsure where to start* when their application was approved whilst others felt that it was *too restrictive*. Several workplaces also described being unsure about whether to focus on choosing activities to attract high numbers of employees or activities that would engage their employees most at risk and realised that most appropriate choice of activities has a direct impact on participation rates and potential behaviour change of employees. Some workplaces felt that this would have been resolved through more support from WorkSafe in the application and implementation process and reflected on the trial and error process they went through:

'I think you know if someone sort of came out and sort of said "oh how's it going, where are you at, what's the - where's the, you know, blockages or, you know, what's" - I think that's probably a good idea.'

- H&W coordinator, metropolitan, large, blue-collar (grant)

'I mean I've run one that was appalling it was a complete waste of money but that's how you learn.'

- H&W coordinator, metropolitan, large, blue-collar (grant)

WorkSafe data recording the approximate numbers of workplaces accessing each menu item (current as at 18/06/12) shows that policy and physical environment options were taken up less frequently comparative to information seminars and nutrition and fitness

classes. Apart from the required general health and wellbeing policy, the highest rate of uptake from the range of policy options was the development of a mental wellbeing policy (18.6%), followed by physical activity (15.6%) and healthy eating policies (13.3%). In terms of the uptake of improvements to physical environments, 27% of workplaces chose to purchase fitness equipment, 12.5% installed bicycle storage facilities and 3.7% installed height adjustable desks.

Perceived benefits of the WorkHealth grants

Workplaces which accessed a WorkHealth grant reported a wide variety of benefits both for their staff and for their organisation. H&W coordinators described how the grant enabled them *‘to offer a diverse range of activities to their employees that would not usually be available’* and characterised accessing a WorkHealth grant as akin to *‘dipping the toe in the water’* in relation to attempting workplace health promotion. For some workplaces, the program has represented an attempt to shift their workplace culture to become more health promoting. However workplaces with a grant were often those which already had a proactive approach to health and wellbeing:

‘It really gave us the stimulus to - this last 12 months do a lot more of the proactive things that we wanted to do with our program that’d been running for years which tended to be a one off - once a year type program’

- H&W coordinator, rural, large, white-collar (grant)

The survey asked all respondents to identify changes they had made in their workplace as a result of their involvement in the program. Table 6 shows the reported changes made by workplaces which accessed WorkHealth checks only compared to those that had also accessed a WorkHealth grant. Workplaces that accessed a WorkHealth grant were, in most cases, more than twice as likely to report that they had made subsequent health-promoting changes to their workplace. Workplaces which had only accessed WorkHealth checks were most likely to make changes in the area of work-life balance, flu vaccinations and healthy eating/diet management. Workplaces which had also accessed a WorkHealth grant were most likely to make changes to healthy eating/diet management, physical activity and flu vaccination. Interestingly, the greatest difference between WorkHealth check only workplaces and those with a grant were holistic therapies, health and fitness screening and

mental wellbeing. Overall, changes in the area of mental wellbeing were most notable between workplaces with a grant and those without.

Table 6: Reported workplace changes made as a result of participating in the WorkHealth program, by level of participation

Type of change	WHC only	WHC & Grant
Alcohol guidance	95 (4.0%)	27 (15.5%)
Environmental policies	134 (5.6%)	17 (9.8%)
Ergonomics	191 (8.0%)	28 (16.1%)
Falls prevention	172 (7.2%)	10 (5.7%)
Flu vaccination	360 (15.0%)	59 (33.9%)
Health and fitness screening	122 (5.1%)	45 (25.9%)
Healthy eating/diet management	343 (14.3%)	85 (48.9%)
Holistic therapies	28 (1.2%)	13 (7.5%)
Improved workplace infrastructure	65 (2.7%)	20 (11.5%)
Mental wellbeing	152 (6.3%)	53 (30.5%)
Pain management	10 (0.4%)	2 (1.1%)
Physical activity	239 (10.0%)	76 (43.7%)
Stress management	129 (5.4%)	41 (23.6%)
Tobacco/Smoking cessation	132 (5.5%)	29 (16.7%)
Injury prevention	310 (12.9%)	21 (12.1%)
Work-life Balance	408 (17.0%)	50 (28.7%)
None	894 (37.3%)	19 (10.9%)

As part of the WorkHealth grants program, workplaces were required to develop a general health and wellbeing policy. A number of H&W coordinators described this as a useful process to formalise and document existing ideas or review out-dated policies; others found

it to be ‘new ground’ to allow them to explore what they could or should do. Conversely, a small number of coordinators stated that they saw it as an administrative hurdle which was unlikely to impact on ‘real-life’ practices. However as stated, the majority found this process to be beneficial for their organisation.

H&W coordinators were grateful for the opportunity to run activities at their workplaces, but several were pragmatic about their impact, voicing their concerns about the sustainability of the activities:

‘I don’t think that the program would have influenced people or made any change because it’s a once a month, half an hour, it’s not long enough. If that was offered as an ongoing every week, half an hour, it might have made - yeah, it would have maybe made some changes but because it’s a once - as I said one session, half an hour, it’s not going to make any difference.’

H&W coordinator, metropolitan, large, white-collar (grant)

Qualitative data from a range of organisations also describes the positive impact of grant activities on morale and social cohesion. Both focus group participants and H&W coordinators reported that the activities had brought employees together in a social setting; in several cases this was stated to have improved working relationships and productivity.

‘We probably are more productive because we can get like along with each other and we’re not like “oh I have to go to work”.’

- FG, metropolitan, small, white-collar (grant)

‘I didn’t feel like I really knew anyone else from - like I saw them and said hello and stuff but really didn’t feel like I knew them. And for example through the walking challenge that really gave me a sense of really getting to know a whole lot of people that although I worked with I didn’t really know much about, hadn’t really spent much time with. And that really then opened up my social circles I think and just the ability to be - to work with other people.’

- FG, metropolitan, small, white-collar (grant)

Improved team morale and social cohesion were discussed by focus group participants as a key benefit of participating in grant activities. Employees described supporting each other

to make healthy behaviour changes at work and being encouraged by colleagues to come along to grant activities, grouping together to go for walks during lunch and supporting each other in smoking cessation. Focus group participants also reported feeling motivated to make changes when senior staff or management demonstrated positive role-modelling.

'I look at the manager, he lost weight and I heard that he learned how to eat the proper food. And then he is like come on, come on, join, join, you know. So I did.'

- FG, metropolitan, large, blue-collar (grant)

H&W coordinators also described an increase in team morale as a positive outcome from grant activities. Activities which were designed with a competitive element like the Global Corporate Challenge were reported to be most successful in creating improved team morale. Also, workplaces with multiple sites or diverse staff reflected that the activities created a *talking point around the office that's been really good for morale* to bring the multi-site teams together.

'I think people are enthusiastic about it, they like it, they want it and my experience is that in - over the years that anything that we do that encourages some kind of team activity has always helped and in our business we've got really a mixed group of staff.'

- H&W coordinator, metropolitan, small, white-collar (grant)

'I think the program brought people together and it created a different focus, like an interest for them. Because we've got production staff, factory workers that are doing the same thing every day and this was like something new.'

- H&W coordinator, rural, large, blue-collar (grant)

In addition, some H&W coordinators observed a change in the vitality of their staff due to participation in physical activity grant activities. Whilst this was not directly related back to productivity levels, several H&W coordinators described increased alertness as a result of participation in lunchtime walking groups.

'From the people that I know have been participating in the exercise program I know that there are some people who actually value the lunch time walk, they've lost some

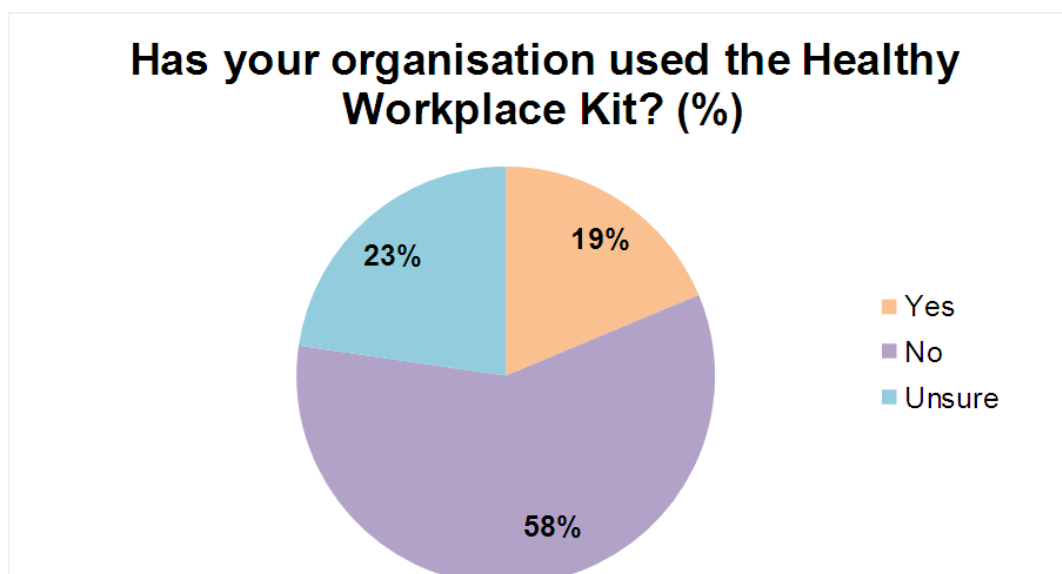
kilos, they enjoy the social interaction of getting out and about at lunchtime having a break. Previously they might've actually stayed behind their computer, ate their lunch, continued to work, they might've been getting a little bit tired in the afternoon and gone for a three o'clock break or something or other or a coffee to get them up for the last bit of the day so I know we've got individuals who actually - who have actually benefited.'

- H&W coordinator, rural, large, white-collar (grant)

3.3.4 Healthy Workplace Kit

Only one fifth (18.7%) of survey respondents identified using the Healthy Workplace Kit. Healthy workplace grant recipients were twice as likely to use the Kit compared to workplaces that had only accessed WorkHealth checks. As workplace size increased, the Kit was more likely to be used. There were no other trends for demographic data around the use of the Kit.

Figure 5: Has your organisation used the Healthy Workplace Kit?



The use of the Kit was discussed predominantly in H&W coordinator interviews where recollection about it was varied. Many H&W coordinators were unsure of what the Kit was, even after being prompted by the researcher: *'I certainly don't remember anything in a green box, I know there's been a lot of information.'*

- H&W coordinator, metropolitan, large, blue-collar (grant)

For those workplaces that had used the Kit, on the whole, feedback was positive and they described engaging well with the different components depending on their workplace type and their need for the different components to support their activities. Some workplaces mentioned that they were *still going to their website quite a bit and downloading some of their tools that they have on there*. Often however, H&W coordinators from blue-collar workplaces pointed out that they felt the Kit had been designed to support large white-collar workplaces which made some of the component irrelevant to their workplace situation.

'I'm sure it's a really useful resource in some places, but I found it very much targeted from my take on different organisations, more the big place that could be doing more stuff than we could do.....So I thought it was a good guide. I just don't think it was universally useful'

- H&W coordinator, metropolitan, medium, blue-collar

'And I'm still going to their website quite a bit and downloading some of their tools that they have on there.'

- H&W coordinator, metropolitan, small, white-collar (grant)

Key stakeholders also had mixed opinions about the appropriateness of the Kit as a capacity building tool for employers, especially with regard to blue-collar workplaces.

'I think it's a good kit, I think probably for many industries that - and particularly white collar, fairly stationary workforces -that would perhaps work reasonably well.'

- Key stakeholder

In other interviews, stakeholders questioned whether the Kit has been able to provide the support workplaces need to bring about change. This was supported by some H&W coordinators who felt that other support strategies, such as the consultant advice in the grant activities enabled them to achieve more, and the Kit alone was not enough to implement change at their workplace.

'The health promotion kit is a bit of a ticker box kind of initiative to have a resource available there, but a lot of the feedback obviously from employers has been disappointing within that, you know, outside of a couple of posters and the calendar

*sort of information, but is that necessarily building the capacity of that employer?
Possibly not. I think that they've been a bit disappointed with that.'*

- Key stakeholder

'I did find it useful but I'd had - the provider that I found were probably most useful to me because you don't have as much time as you'd like to really read about it yourself and get the whole detail down but having a provider come out and give you that information was also in conjunction with the kit.'

- H&W coordinator, metropolitan, large, white-collar

Components of the Kit

Further analysis about the specific components of the Kit indicated they were used at quite different frequencies, according to survey participants. Table 7 shows that the Kit's posters were most commonly used and all other components of the kit were much less likely to be utilised, especially the audit and evaluation tools.

Table 7: Components of the Healthy Workplace Kit reportedly used by workplaces

Component	Frequency	Percentage
Posters	469	17.7%
Desk calendar	87	3.3%
Audit tool	42	1.6%
Health and wellbeing needs survey	90	3.4%
Health and wellbeing mission statement and policy statement	71	2.7%
Healthy workplace action plan template	68	2.6%
Evaluation tools	45	1.7%

Table 8: Kit component use by industry division

Industry divisions:	Posters	Audit tool	Evaluation tool	Action plan template	Desk calendar	Needs survey	Mission & policy statement
Accommodation & Food Services	2.8%	0.0%	0.0%	1.4%	6.8%	1.4%	2.7%
Admin. & Support services	1.9%	1.4%	1.4%	2.8%	2.8%	4.2%	5.6%
Agriculture, Forestry, Fishing & Hunting	2.1%	0.0%	0.0%	1.4%	2.7%	1.4%	0.0%
Arts & Recreation services	2.8%	0.0%	0.0%	1.6%	3.3%	4.9%	1.6%
Construction	9.6%	1.0%	2.1%	1.6%	4.2%	1.6%	1.0%
Education & Training	17.1%	1.0%	1.9%	2.5%	1.7%	2.9%	2.7%
Electricity, Gas, Water & Waste services	1.5%	0.0%	0.0%	8.6%	14.3%	5.7%	5.7%
Financial & Insurance services	3.2%	0.0%	1.5%	1.5%	7.5%	3.0%	1.5%
Health care & Social Assistance	11.5%	4.0%	2.2%	5.0%	4.0%	4.3%	2.2%
Information Media & Telecommunications	0.6%	4.3%	0.0%	0.0%	8.7%	4.3%	4.3%
Manufacturing	15.4%	1.7%	1.7%	2.0%	2.0%	5.3%	2.2%
Mining	0.9%	0.0%	0.0%	7.7%	7.7%	0.0%	0.0%
Other services	1.9%	3.5%	1.8%	0.0%	0.0%	1.8%	3.5%
Professional, Scientific & Technical services	13.9%	0.9%	2.1%	1.8%	2.8%	2.5%	3.0%
Public Admin. & Safety	1.3%	7.1%	3.6%	7.1%	7.1%	7.1%	3.6%
Rental, Hiring & Real Estate Services	1.5%	0.0%	0.0%	0.0%	2.4%	0.0%	2.4%
Retail Trade	5.1%	1.3%	1.9%	1.9%	4.5%	3.9%	3.2%
Transport, Postal & Warehousing	1.7%	5.0%	1.7%	10.0%	5.0%	3.3%	3.3%
Wholesale Trade	5.3%	2.0%	2.0%	2.0%	2.7%	4.7%	4.7%

The survey results showed that other components of the kit were used more specifically by particular types of workplaces; the biggest difference was seen by analysis of specific industries. Table 8 describes what proportion of each industry utilised each component of kit, showing that some industries utilised specific components of the kit and none of the others. For example, the mining industry used the action plan template and desk calendar most, but did not engage with all other components of the kit.

Posters were most likely to be used by the Education and Training (17.1%), Manufacturing (15.4%), and Professional, Scientific and Technical services (13.9%) industries. They were also more likely to be used by large workplaces with more than 200 employees (24.2%); use of the posters was positively associated with increased size of the workplace (employee number and remuneration). This trend was also seen for the other components of the Kit and workplace size. In interviews however, H&W coordinators reported that the poster designs were not necessarily helpful to workers and were often placed in the H&W coordinator's office rather than a general area. This was particularly notable in blue-collar industries.

'[The Kit] really didn't hit the mark. I - I think I opened it and I looked at it and it was probably just a little bit - I just didn't find it relevant.... Unskilled labourers are a little bit more receptive to, you know, the bright colours and that sort of stuff of, you know, cartoons and the short, sharp message that's not too complicated. What I found was a lot of the posters that were actually out there were actually quite, you know, explanatory or they - they really required you to interpret a lot from the picture and just saw that the work force that we have being so unskilled and so low socio economic that people just wouldn't - wouldn't pick up on it.'

- H&W coordinator, rural, large, blue-collar (grant)

3.3.5 Organisational drivers for workplace health

Whilst assessing the impacts of the WorkHealth program, important data has also been generated pertaining to the drivers of workplace health promotion which are external to the program. These include workplace culture, leadership, workplace policies and workforce competencies. Each of these factors was found to be influential to the capacity of organisations to successfully implement health promotion initiatives.

Workplace culture

50.5% of survey respondents described their workplace as having a proactive approach to employee health and wellbeing. Location of workplace and sector were not associated with differences in proactivity according to survey results, however as shown in Table 9, results did indicate that an increase in workplace size increased the likelihood of an organisation being proactive in their approach to health and wellbeing. White-collar workplaces were also more likely to identify their culture for health and wellbeing as proactive (53.0%) than blue-collar workplaces (43.5%).

Table 9: Approach to health and wellbeing by employee number

Organisation's approach to health and wellbeing	Employee number site/branch			
	1-9	10-19	20-199	>200
Proactive	407 (45.5%)	275 (45.5%)	540 (54.8%)	116 (70.3%)
Does not tend to be proactive	236 (26.4%)	156 (25.8%)	258 (26.2%)	28 (17.0%)
Neither/Not sure	251 (28.1%)	173 (28.6%)	188 (19.1%)	21 (12.7%)
Total	894 (100.0%)	604 (100.0%)	986(100.0%)	165 (100.0%)

Most employees described the culture of their workplace as being projected '*from the top*' or determined by the actions and attitudes of management. The vast majority of workplaces which accessed both a WorkHealth check and a grant identified the organisation as having an existing culture of care; this was discussed in both interviews and focus groups:

'I remember from induction was that they said, "We want you to come to work to work but not to survive. We want you to go home at the end of your day and, you know, spend time with your family". You know, "have a life outside of work". It's very positive. It's a place that people want to be and work, and you - I have been here for a very long time... People are wanting to put in because the company is supporting them; they want to support the company.'

- FG, metropolitan, medium, white-collar (grant)

This suggests that there is an association between positive culture and engagement with the grants program. The few exceptions to this theme involved scenarios where a H&W

coordinator was attempting to shift an uncaring culture projected by an unsupportive management. For these workplaces, it was reported that the program was met with mixed success; while employees were appreciative of being provided with health and wellbeing activities, often the lack of support from management continued to interfere with facilitating employees to actually participate. Focus group participants also discussed their opinions on whether they felt that they were *'actually allowed'* to attend activities in conjunction with whether their managers vocally encouraged them to do so or also attended sessions themselves. H&W coordinators in these workplaces suggested that their senior management was more focused on productivity and *'dollar signs'*, and did not value workplace health and wellbeing activities.

A number of workplaces identified their industry type and the *'nature of our work'* as a reason for not being able to implement further health and wellbeing initiatives. It was observed that manufacturing industries did generally tend to have a greater focus on productivity and end-of-day outcomes; however this evaluation has captured several examples of blue-collar workplaces successfully engaging in workplace health promotion. A key stakeholder agreed that leadership and culture was a stronger driver than industry, in terms of implementing health initiatives:

'Maybe not so much industries. Maybe more so organisations that have had a history of health and wellbeing culture, like they're more mature in their understanding or they've got leaders that understand the investment in employee health and wellbeing. So you know you could have an employer from a blue-collar industry that understand investing in employee health and wellbeing that will happily pay, you'll have someone in exactly the same industry that won't want to have a bar of it.'

- Key stakeholder

Negative culture was also reported to have emerged from the bottom-up, where employees were viewed by coordinators to be unreceptive to health and wellbeing initiatives. The survey data revealed that worker culture and attitude was felt to prevent the adoption of health and wellbeing initiatives in 20.8% of blue-collar workplaces and 10.3% of white-collar workplaces. Negative worker culture and attitude was also found to be associated with increased size of organisation (remuneration and employee number). Coordinators

discussed the challenges of implementing health and wellbeing activities in these environments:

'Unfortunately from a cultural basis when you've got a group of people that are perhaps overweight, are all doing shift work, drink quite a bit, don't have active lifestyles, they're comfortable with each other, so to make - to get those guys to shift, which is my target, I'm not sure of the answer. My only incentive I can see is maybe financial gain, so do something that has financial prize money, something like that that has a prize that will make them start it in the first place.'

- H&W coordinator, metropolitan, small, blue-collar (grant)

Leadership

At all levels of the evaluation, leadership was discussed as a fundamental driver of workplace health. As has already been discussed throughout this report, leadership has influenced the success of the WorkHealth program in organisations in various stages of planning and implementation of the checks and grant process. These included: employee motivation to participate, facilitation of employees to attend activities, encouragement of behaviour change and future investment in health and wellbeing initiatives.

A number of workplaces discussed the challenges of not *'having [employee] health built into anyone's position'*. 64.0% of survey respondents reported their workplace had employed a health and safety representative whilst only 22.9% reported their workplace had a health and wellbeing representative. Both key stakeholders and H&W coordinators discussed the importance of having *'someone with that drive'* in the fall back of not having a person employed to work in a health and wellbeing role. It was not uncommon to see the WorkHealth program being driven by an employee whose role it was not built into, out of personal interest or belief in the benefits of workplace health initiatives for employees.

'I had to go out of my way and even put my own funds into some of the things to get this happening, to get this going. I saw it as my project. I've been in the company almost two years and I felt when I started there was not much offered for employees, for their wellbeing. And being in HR maybe, that's - having the sort of HR I guess in me, wanting to provide something - some supports, some care for the employees, not just from a business perspective but from their personal wellbeing as well. So because there was nothing in place, that was my drive. To give something to them.'

- H&W coordinator, metropolitan, large, white-collar (grant)

However a number of these H&W coordinators commented that it would not be sustainable for them to continue driving health and wellbeing initiatives without support from management and paid time dedicated to a specific role.

'If the management doesn't believe in the program and they don't sort of push it, and they resist it and actually put barriers in your place that you can't - even if you have your initiative and you want to do something but barriers are put in the way that you cannot overcome them, it's really hard. You're got to be really wanting to do it, to drive it and stay back in your time basically to do it in your own funds and in your own time. I strongly believe that we need a person, a dedicated person for that - to have that responsibility, to have those things written in their job descriptions to do it.'

- H&W coordinator, metropolitan, large, blue-collar (grant)

Focus group participants from these workplaces also acknowledged the value of their health and wellbeing 'champion' and the deficit of management support.

'If you took Angela out and left this stuff to the owners it would not happen, nothing would happen. We'd be rotting here. And they wouldn't care. And that's just honesty.'*

- FG, rural, small, white-collar

Conversely, some organisations described having management that genuinely supported health and wellbeing initiatives as 'essential, absolutely essential' to the success of the program.

'[Driving the program]'s absolutely going to have to be from the figure head person, the owner or the - yeah, it has to be, because that's where the investment comes from. That's where the resource allocation comes from, so it will be.'

- H&W coordinator, metropolitan, medium, blue-collar

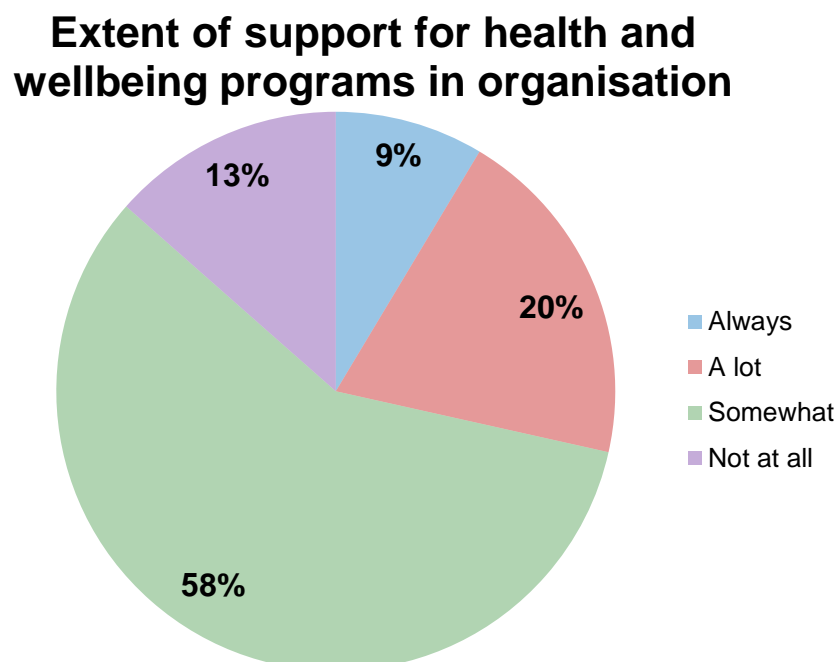
'So to actually show that [the company] cares, we were able to provide you with time, paid time during work hours, participate in these programs, we're going to give you the tools to do something to improve your health, improve your lifestyle, you can bring your partners and spouses into our sessions, all of that type of thing. They see

that [the company] is actually caring, giving something back to them as an employee, therefore morale improves, they get on-board with the programs. So I would say that that's definitely the case in our situation.'

-H&W coordinator, rural, large, white-collar (grant)

Figure 6 illustrates that over half of respondents (59.9%) described their workplace as committed or very committed to developing a healthy workplace. Further analysis revealed that workplaces with a grant were more likely to report a committed management than workplaces with checks only. This commitment is most often demonstrated through flexibility of working hours (52.5%), promoting compliance to safety standards (50.8%) and positive role-modelling (39.0%). However, only one-third of participating workplaces reported that commitment was demonstrated through the allocation of resources for employee health and wellbeing activities. Workplaces with a grant were more than twice as likely to report resource allocation (67.8%) compared to those with checks only (30.1%).

Figure 6: The extent to which health and wellbeing programs are supported in organisations



Some H&W coordinators expressed that they had hoped that the grants program would 'win over' management and convince them of the value of investing in employee health. However a number of coordinators described this as difficult process.

'Look, they're not - they're okay. It's very new for a lot of them who have been here a long time and it [health] hasn't been a focus. It's taken time to get buy-in - - - I mean they're not brilliant and not super excited about it but many of them are participating in certain areas so for me it's a slowly, slowly approach, yeah.'

- H&W coordinator, metropolitan, large, white-collar (grant)

Other H&W coordinators reported that their management were still unwilling to invest to due financial restrictions. Some additionally mentioned that their management had not seen a financial benefit to the program and this may have influenced their decision.

'Unless there's a dramatic improvement in the economic climate... I can't see this company putting money into that really.'

- H&W coordinator, metropolitan, large, blue-collar (grant)

Key stakeholders observed the need for health and wellbeing to be integrated into regular business practice in order for widespread change across organisations to occur.

'I think we're starting to see information like this included in annual reports for large companies, but I think if that sort of started to filter down to those SMEs [Small and Medium-sized Enterprises] where it was something that was reported on annually, then you would see it become more of a part of business really. Until that happens, then it's always going to be a 'nice to have', until it becomes something - that's not compulsory - but something that has a business aim and you would have to address.'

- Key stakeholder

Organisational policies for health

The survey asked several questions about organisational policies for workplace health. 36.1% of workplaces reported that health and wellbeing was identified in their organisation's strategic business plan and only 20.4% reported that their organisation had a formal plan for creating a healthy workplace. The survey also indicated that workplaces which identified employee health and wellbeing in their strategic plan were 6 times more likely to have a formal plan for creating a healthy workplace than workplaces that did not identify health and wellbeing on their organisational plan. Workplaces were also asked to

identify what policies they have in place to promote health and wellbeing. There were marked differences dependant on workplace size (remuneration) as illustrated by Table 10. Similar trends were seen for workplace size (employee number) and industry type. White collar workplaces were much more likely to identify formal grievance procedures, healthy food in workplace cafeteria and flexible working schedules than blue-collar workplaces.

Table 10: Policies at workplace to promote health and wellbeing by workplace size (remuneration)

What policies does your organisation have in place to promote health & wellbeing?	Workplace size (remuneration)		
	Small (<\$2 million)	Medium (\$2-9.9 million)	Large (>\$10 million)
Environmental/Go green	282 (18.1%)	235 (29.7%)	107 (35.9%)
Flexible work schedule	766 (49.1%)	337 (42.6%)	131 (44.0%)
Formal grievance procedures	483 (31.0%)	407 (51.5%)	192 (64.4%)
Family access to health & wellness programs	43 (2.8%)	60 (7.6%)	42 (14.1%)
Healthy food in workplace cafeteria	160 (10.3%)	139 (17.6%)	74 (24.8%)
Negotiated workload	341 (21.9%)	142 (18.0%)	40 (13.4%)
Occupational health and safety policy	935 (59.9%)	626 (79.1%)	275 (92.3%)
Reimbursement for use of health facilities	43 (2.8%)	48 (6.1%)	44 (14.8%)
Total	1560 (100.0%)	791 (100.0%)	298 (100.0%)

Organisational policies were often considered by H&W coordinators as part of their general business rather than a proactive response to health and wellbeing for employees. In some workplaces, they mentioned that health and wellness was often an agenda item in their occupational health and safety meetings.

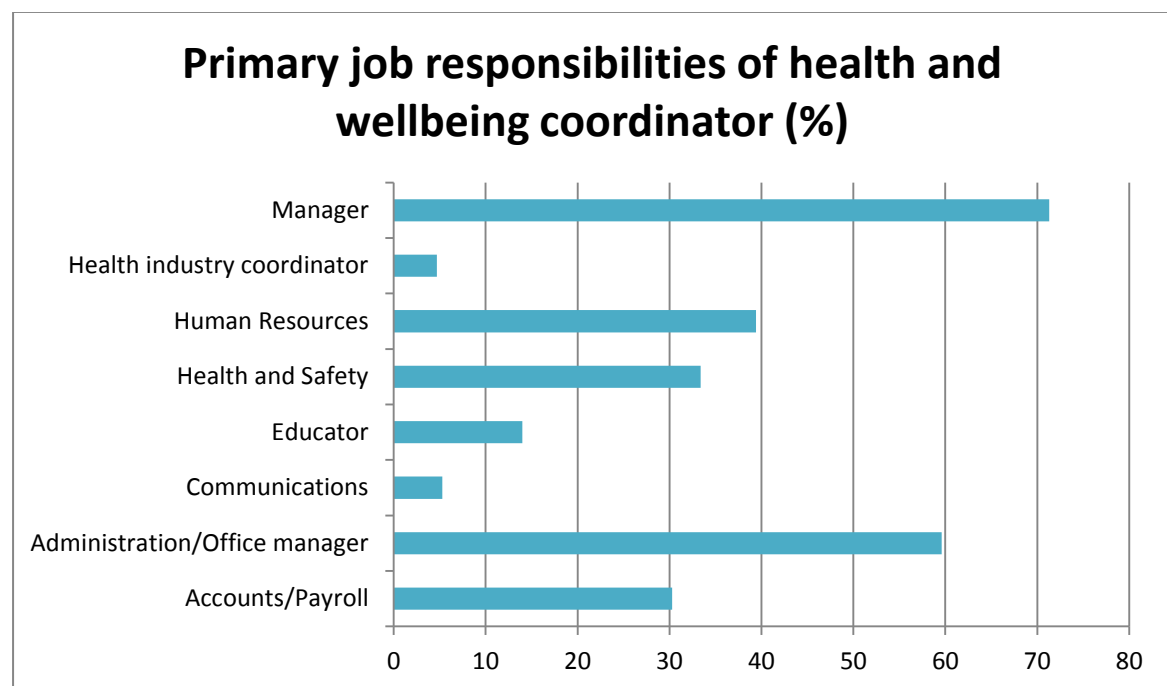
'I don't know that people would always see that as being - you know, see that as workplace health promotion, maybe staff wouldn't see it as a benefit but around flexi time and family friendly practice and about perhaps having more sense of control and ownership around their own workplace and the things that they can do or change.'

- H&W coordinator, rural, medium, white-collar

Workforce competencies

The majority of respondents completing the survey identified that they held a managerial position (39.4%) or Administration/Office manager position (31.9%). Only 11.9% identified their job as Health and Safety as identified in Figure 7. The importance of competencies for workplace health and wellbeing emerged as a clear theme in interviews with H&W coordinators and key stakeholders.

Figure 7: Job responsibilities of WorkHealth program coordinators



Many of the stakeholders spoke about the importance of well trained personnel to plan and coordinate workplace health activities. They reflected on the complexity of the role which often required skill sets from health promotion, occupational health and safety, human resources and organisational behaviour.

'If the occupational health people were educated on wellness as well as safety, as part of their backgrounds, well then this wouldn't be an issue at all.'

- Key stakeholder

'I think really critical is that the people involved have to be prevention/health promotion-trained, and linked into the latest system's thinking and all of that. Because if it's just going to be that corporate-wellness sector doing the same old thing, we're not going to get anywhere.'

- Key stakeholder

H&W coordinators identified in the most part that they did not have any formal skills relating to this role and so could only rely on experience if they had acquired it in previous roles. Perceptions about skills sets for this role were varied. Some H&W coordinators felt that interpersonal skills were required alone whilst others acknowledged the need for more formal training in health promotion and occupational health and safety. Alongside the workforce competencies, coordinators also spoke about the motivation required to push the health and wellbeing agenda forward within a workplace.

"I haven't actually got any formal training in health or that sort of background. I had a bit of input with a previous organisation as far health and wellbeing and a bit in OHS, but I have a real interest and passion for that sort of field, so I think that helps.'

- H&W coordinator, rural, medium, white-collar (grant)

'I knew absolutely nothing when I started but I've done a lot of - as I said, I've done a lot of reading on it, a lot of talking to people, calling people who do know what they're doing and possibly there would've been somebody better qualified to do it than me but I was the only one prepared to take it on, in fact people said to me, "I would've just thrown that in the bin" which I think is horrifying because it's a great opportunity but a lot of people wouldn't have wanted to take on the extra work that I've taken on.'

- H&W coordinator, metropolitan, large, blue-collar (grant)

'All these organisational skills, maybe a bit but people skills to go and talk to people about the program and encourage them to attend, and maybe just my own personal want or wish to give back to employees to make them feel special and cared for. I

don't know whether they're individual personality skills or whether they're my HR soft skills but, yeah.'

- H&W coordinator, metropolitan, medium-white collar (grant)

3.4 Program directions

3.4.1 Sustainability at an organisation level

'Certainly through the history of promotion and prevention in the past decade or so in Victoria we kind of know that sort of small grants, one-off interventions don't work.'

- Key stakeholder

The ability for workplaces to make sustainable changes through their participation in the program was driven by a number of organisational factors. Firstly, H&W coordinators described difficulty in the planning and implementation process of the grant activities, mostly related to the timelines set by WorkSafe. In several cases, this resulted in a short burst of activities offered to employees with no lead-in to the activities and nothing planned after the activities ceased. Many focus group participants voiced frustration about this approach:

'It's gone like from nothing to full on rather than sort of like a gradual introduction. And then it'll all stop. It would've been nice to have something a little bit more gradual.'

- FG, metropolitan, large, blue-collar (grant)

In the context of workplaces, which had never offered health initiatives prior to WorkHealth, employees offered insight into the need for ongoing activities in order to effectively influence the attitudes and behaviours of workers:

'Coming into a workplace like this you're not going to win everyone over straight away. They're going to sell off a product, pick up a couple along the way so they've just got to keep on evolving and keep on offering those things to try and build on that and build on that because if you just stop you can't say "Here it is, go do it, do it or not" and then walk away, eventually people slip into their old habits. Those things have to keep on evolving and keep on being offered really.'

- FG, rural, large, blue-collar (grant)

The greatest challenge to sustainability was the hesitation or unwillingness of management to invest in future health initiatives – in the health promotion field, this one-off funding approach is called ‘short-termism’. At many workplaces, both the checks and the grant were seen as a ‘*once-off opportunity*’ due to the limited funds available for ongoing employee health and wellbeing. Many H&W coordinators voiced this frustration and understood their organisational needs to build capacity, including resources.

‘If there was no \$10,000 [grant] we wouldn’t have done any of it and unfortunately moving forward, because there will be no more funds after this program is complete, I can’t see them putting anything in place on a permanent basis as much as I’d like to.’

- H&W coordinator, metropolitan, large, white-collar (grant)

H&W coordinators described workplaces that do not have a readiness for change and the ability to invest ongoing resources into workplace health and wellbeing programs, as having only benefited from the WorkHealth program in the short term; this was the case for workplaces with a grant as well as those that only accessed the checks. In several cases, H&W coordinators described how they hoped to continue health and wellbeing activities despite their employer’s lack of commitment. This often included asking employees to financially contribute to the program; however as described previously, workers were reluctant to participate in workplace activities if they are asked to pay.

‘The minute you ask people to hand out money you’re not going to get that attendance’.

- FG, metropolitan, large, white-collar (grant)

H&W coordinators described the perceived success of the program as only having a minor influence in gaining the management’s attention for future investment. Coordinators frequently mentioned tight budgets and the poor economic climate as most important for dictating future funding for health, as well as the need for solid evidence about the financial benefits of investment.

All H&W coordinators from the public sector mentioned that they felt restricted with what they could invest in with relation to health and wellbeing, as they were dealing with ‘*public money*’. The majority of these workplaces were reported to have an existing focus on

health, and the organisational capacity to enable them to successfully implement health initiatives. All reported positive reception from employees to the grant activities and solid rates of participation; the grant was discussed as an opportunity to *'do things that we already wanted to do'*. However coordinators were unsure as to what future health initiatives were appropriate whilst considering their *'public or corporate image'*.

'We're a state government public sector organisation. From a public relations point of view the customers - from a core business point of view they want [us to do] our core business, not for our staff to be having stress relief massages or anything like that.'

- H&W coordinator, rural, large, white-collar (grant)

These workplaces were therefore uncertain whether future resources could be allocated towards health and wellbeing programs. H&W coordinators from Not For Profit organisations also reported that future investment was not likely, due to extremely tight budgets and stretching of resources.

The popularity of non-sustainable activities from the grants menu options was also another obstacle to bringing about long-term change at the workplace without ongoing company investment. Data from WorkSafe has shown that menu options such as developing health promoting policies and infrastructure were taken up far less frequently than options such as fruit boxes. Observations were noted from the qualitative research that the 'upstream' and more sustainable options were more frequently taken up by workplaces which already had an embedded focus on health prior to the WorkHealth program. In these cases, the WorkHealth program has reportedly *'not created a change as such'*, but has complemented existing activities and investments.

'They wanted you to have a wellbeing policy- well we already had that, a smoking policy- already had that, responsible drug and alcohol- already had that so and of course we already had the gym... the company paid out our gym fees, the treadmills etcetera. So I've used the grant money to buy smaller items for the gym and everyone's been very appreciative of that but we were lucky we already had a gym in place to buy equipment for, companies that don't have that it wouldn't - they wouldn't have been able to do it.'

- H&W coordinator, metropolitan, large, blue-collar (grant)

Conversely, few organisations reported that they can see the WorkHealth program having a lasting effect on employee health at the conclusion of the grant activities, due to the nature of the menu items that they chose, and the lack of future funding. The majority of stakeholders discussed a desire for the WorkHealth program to focus on long-term, sustainable change using evidence-based initiatives. One stakeholder discussed the difficulties in translating this at an employer level.

‘Early on, the feedback was very much about moving away from just one-off events and I think [WorkSafe] have been quite receptive to that, it's just I think their challenge in getting employers to think that way as well.’

- Key stakeholder

Other stakeholders expressed a broader ambition to influence the planning and forethought of organisations across the state to encompass employee health.

‘We need to change the way big employers and everyone thinks about the design of workplaces, so that every new workplace, you know, every new building, right, every new organisation, everyone should now have - should have in their heads and in their hearts and in their minds and in their plans and all of that, a different desire to what we've had for the past 20 or 30 years.’

- Key stakeholder

3.4.2 Further investment in WorkHealth

‘The fact of the matter is there are 2.8 million people who work every day, have workplaces and WorkHealth is a great focusing notion and we can do much more with that.’

- Key stakeholder

Discussion about the future of the WorkHealth program and further investment in workplace health promotion in Victoria was covered in all key stakeholder interviews. All interviewees agreed that the efforts of the program should be continued beyond December 2013 to build on the current success of the program. Stakeholders also highlighted the importance of continual investment into the health of workers (in Victoria).

'To us the critical things for the future are firstly that WorkHealth as a program continues because it would be disastrous to stop the program that - where we've invested so much in getting to this point, but it's not an end point, you know. We're one big step towards - on a long journey.'

- Key stakeholder

"It would be a concern to me if it was allowed to die because there has been such an investment now. I know there will still be money available, and this money hasn't reduced the amount of surplus that's still in WorkSafe or WorkCover or whatever. And to have spent this sort of money over four years and then just let it wither and die I think would be wrong, so I hope the government does decide to pick it up, rebrand it if necessary, and take whatever is believed to be the logical next step. And there must be some logical next step that we can garner out of the sort of tangible information that will be coming through from the research that's being obtained now.'

- Key stakeholder

They did however highlight that a 'second phase' of WorkHealth should focus its resources differently. Key questions were raised as illustrated below. They decided that current research and evaluation evidence should be consulted when determining future directions of the program along with where the greatest need lies. This was often identified as blue-collar industries, smaller workplaces, and older and migrant workers.

'Yes, I mean I think we need to add value to the program, you know, we've raised awareness to health issues and what's the next step? What do you do with that? Where do you go with it? I think that's the key.'

- Key stakeholder

'Now, sure, if you're critical you say that's all the easy pickings have been done and now there's the really hard ones, all the small hard workplaces are still to come and it's done all of the easy ones, sure. But it's still a big achievement.'

- Key stakeholder

Stakeholders were also adamant that if the Program continues, WorkSafe should still provide the leadership for the program. The important connection between occupational health and safety and wellbeing in the workplace was raised again as an important reason for this decision. Stakeholders felt that the program was best placed under the auspice of WorkSafe who would be able to build this connection.

'Just also in looking at the WorkSafe strength around what can they start to operationalise within their OH & S system, so through their OH & S training can they start weaving in all the prevention promotion stuff, you know, is it possibly time to start thinking about some of the things we know like sedentary behaviour and whatever, like how can we put that more seriously into all of their regulations and all of that.'

- Key stakeholder

Many key stakeholders also reflected on the significant contribution they believed their organisation had played in shaping the WorkHealth program but also highlighted the need for dedicated leadership to direct workplace health promotion in Victoria. WorkSafe was acknowledged as the appropriate organisation to provide this leadership by most key stakeholders.

'I mean there can be some real opportunities down the track for them to build in health to their regular OH & S training and systems and all that, like I think that's kind of where this needs to go as well.'

- Key stakeholder

4. Discussion

The results of this evaluation provide understanding about the perceptions of the impact of the WorkHealth program within workplaces. These findings have been enriched with strategic insights from key stakeholders. The results have been used to determine if there have been impacts in the areas identified within the program logic. Below the discussion has been arranged into the key program logic themes to understand these impacts.

4.1 Workplace capacity to support healthy lifestyle choices and behaviours

'It's hard to say whether it's had an impact in terms of behaviour change because I guess that's - it won't tell us. But certainly I think that it's opened the doors in terms of getting employers and unions and others on board with the concept. And so in terms of policy impact, I think it's had a policy impact.'

- Key stakeholder

The WorkHealth program afforded many workplaces their first opportunity to participate in a multi-component health and wellbeing program. Whilst the WorkHealth checks raised awareness about the importance of employee health for employers and provided employees across Victoria the opportunity to check their health status, the results show that in most cases WorkHealth checks alone did not have a sustainable impact on influencing lifestyle behaviour changes to improve employee health and wellbeing. WorkHealth checks also do not have the ability to change workplace practices to become more health promoting for employees.

Workplaces accessing a WorkHealth grant were more likely to identify changes in workplace capacity to support healthy lifestyle choices and behaviours for their employees

Nearly 50% of organisations with a grant reported making changes to support healthy eating, compared to only 15% of workplaces accessing checks only.

because of the experience of directly participating in activities which encourage a positive change in health behaviours. Workplaces which implemented activities

positively influenced their workplace culture and in some cases improved support from senior management. This had more sustainable impacts for employee behaviour change if workplaces were able to continue with health activities beyond the life of the WorkHealth

program. However, sustainable changes were usually observed when the workplaces had an existing culture of care and were continually investing in employee health and wellbeing. Common barriers to workplace capacity included access to resources, support from senior management and leadership to coordinate workplace health and wellbeing.

This evaluation has shown that whilst the program has raised awareness, and in special cases had lifesaving impacts through identifying risk factors or providing opportunities to improve health, for many participants the program did not result in healthy lifestyle changes that were ongoing. This can be attributed to the complexity of health behaviour and behaviour change models where increased knowledge and awareness do not always lead to a change in health behaviour; these models acknowledge that there are several other environmental and psychological factors that attribute to an individual's ability to improve their lifestyle. Further, a risk for broad approaches is that because more advantaged workplaces are more likely to take up WorkHealth programs, albeit inadvertently, intervention inequalities are the result.

4.2 Improvement in vitality, morale and perceptions of safety

'For us it's a great value-add to be able to promote this to our members, it gives them another reason to come to us, you know, to look after their industrial relations needs or their occupational health needs, and now they're starting to call us with this health - you know, when health is on the agenda.'

- Key stakeholder

The program logic identified worker vitality and morale and perceptions of safety as a potential program impact. The evaluation highlighted that these three areas were conceptualised separately by participants in interviews and focus groups. The evaluation results have shown that the program had a greater impact on perceptions of safety than vitality or morale in the workplace. The results highlighted that prior to the WorkHealth program, employers were primarily concerned with adherence to occupational health and safety requirements, but have now expanded their visions to strive for a more comprehensive approach to health and wellbeing. Whilst the program afforded workplaces the opportunity to participate in health and wellbeing programs, workplace capacity (funding resources, support by management, leadership) directly influenced their ability to broaden

the approach to worker health. Employees had a better understanding of safety in the workplace than the promotion of health and wellbeing. The evaluation showed that there was an expectation by employees that employers would provide a safe workplace for them, which was also driven by legislative requirements. This included an interest in the inclusion of mental health and safety and employees acknowledged a direct influence between their work conditions and mental health.

Whilst participation in WorkHealth checks did not show to have any effect on worker morale, employers and employees did describe that the WorkHealth grant activities did encourage team building, social cohesion and morale, especially physical activities which

Employees reported that participation in grant activities improved their working relationships with colleagues and increased team morale.

brought employees together over lunch breaks or across work sites within the same organisation. The team spirit was also described in workplaces that had run weight management programs where

encouragement from peers was particularly important for motivation.

Improvement in vitality was rarely mentioned in focus groups or interviews. There was an acknowledgement by a few workplaces that participation in the WorkHealth grants program had improved the vitality of its participants which helped to reduce presenteeism, however it was difficult to assess whether WorkHealth checks had any impact on vitality. WorkHealth check participants did report feeling better after knowing the state of their health; but any change in behaviour was influenced by multiple other factors including participation in WorkHealth grant activities.

4.3 Business attention and investment in workplace health and wellbeing

As discussed throughout this report, business attention and ongoing investment in health and wellbeing is crucial to the success and long-term impacts of the WorkHealth program at an organisational level. As previously mentioned, employer investment in workplace health promotion activities was reported to have been hindered by a lack of information about the benefits of engaging in

Only one-third of workplaces reported allocating resources to support employee health and wellbeing.

programs to improve employee health. Many workplaces reported that they do not record information about absenteeism, presenteeism or retention rates to enable them to make business decisions about the cost-effectiveness of workplace health promotion. This deficiency in data has also meant that workplaces have not observed financial benefits as

an impact of the WorkHealth program, and as a result may not be willing to invest in the future.

While the program was reported to have put employee health and wellbeing on the agenda as a discussion point for many workplaces, H&W coordinators described having mixed success in ‘convincing’ management to invest further funding. Workplaces with a management-driven ‘culture of care’ were likely to be those with ongoing health and wellbeing initiatives already, and thus did not need to be persuaded. Those without a culture of care tended to be more financially driven; strong promotion of the financial benefits of employee health and wellbeing programs may therefore be beneficial in future, to influence investment in ongoing workplace health programs.

For certain organisational types, business attention may have been gained, but barriers to investment have prevented any future allocation of resources for health and wellbeing. For smaller workplaces (both employee number and remuneration size), organisational capacity including financial and human resources will likely continue to restrict their ability to provide health initiatives. Organisations in the Not For Profit sector reported similar difficulties. Workplaces in the public sector reported public accountability as a major influence for future investment. Unless ongoing external funding was available, coordinators in the above demographics reported that there was difficulty in ensuring that WorkHealth activities could be made sustainable at their workplace or that future investment in other health and wellbeing activities would be made.

4.4 Improvement in workplace physical and policy environment

Changes to the workplace physical and policy environment were not as marked as other impacts of the program. The survey results showed that changes to physical environments (such as improved workplace infrastructure) as a result of participating in the program were

Changes to improve physical environments were more than four times as frequent in workplaces which accessed a grant as well as checks.

infrequent for workplaces only accessing WorkHealth checks. WorkSafe data shows that grant options which allowed workplaces to improve their physical environments were unpopular

comparative to information seminars and nutrition/ fitness classes. These findings demonstrate that although changes to physical environments were made less frequently

than other areas of change, they were still more likely to happen as a result of accessing a WorkHealth grant compared to participating in the WorkHealth checks only.

As part of the WorkHealth grant process, all workplaces were required to develop a health and wellbeing policy. It can therefore be inferred that the grants program directly led to an improvement to policy environment for organisations that did not have an existing policy, as it was a mandatory process and outcome. However the uptake of more specific policies (such as mental wellbeing or healthy eating policies) was relatively low compared to other activities. The relative disinclination of workplaces to invest their grant funds into physical and policy environments is likely to affect the long-term impacts of the WorkHealth program and sustainability, especially within organisations which are not willing or able to continually invest their own resources into health and wellbeing. Workplaces which did choose to invest in infrastructure and policy are likely to be more able to maintain and demonstrate their focus on health and wellbeing, and continue supporting employee health beyond their involvement in the WorkHealth program.

4.5 Improvement in workplace culture

‘Health is part of the culture now, so it is on the table at all times.’

- H&W coordinator, metropolitan, medium, white-collar (grant)

Half of workplaces participating in the survey identified their organisational culture as proactive towards employee health and wellbeing; this was positively associated with increased workplace size, with large organisations being 30% more likely to report a proactive culture for health. There were also marked differences between industry types where blue-collar workplaces were less likely to have a proactive culture for health and wellbeing and more likely to report worker culture as preventing the adoption of health-related initiatives. This indicates that certain organisational types need more support to assist this shift which can also be attributed to perceived benefits of capacity for health and wellbeing programs.

Only 50% of workplaces identified their organisational culture as proactive towards employee health and wellbeing.

The evaluation results indicate that participation in the WorkHealth program has acted as a driver for raising awareness around employee health and wellbeing. As discussed, workplaces which accessed a WorkHealth grant were observed to already have a more

positive culture for health and wellbeing than those that accessed the checks only. Grant activities were however linked to improved social cohesion and working relationships, which was in turn associated with increased participation in activities and promoting healthy behaviour change.

Participation in the program enabled senior management at many workplaces to be exposed to the benefits of investing in employee health and wellbeing. Whilst this exposure cannot always be measured in terms of change in culture, it did reportedly bring about a shift in 'thinking' and put health promotion on the agenda for many workplaces.

5. Research gaps

The following research gaps have been generated from the impact evaluation research. They provide suggestions about further investment into research and evaluation of the WorkHealth program:

1. *WorkHealth Grant program:*

Targeted evaluation about the drivers of sustainable workplace health promotion programs would be beneficial to better understand the impacts and outcomes of the WorkHealth Grant program. Since its implementation in November 2010, the program model has been through several iterations which the sampling framework for the impact evaluation was not able to include. A more targeted sampling framework would enable an exploration of the program to understand in more detail the impacts and outcomes and the drivers for sustainable workplace health promotion programs. Some of these workplaces utilised a grant and had time for organisational change to occur and can provide good insight into the long term changes that may have occurred as a result of the program. WorkSafe would benefit from a more focused evaluation of the Grants program.

2. *Blue-collar workers:*

The results of this evaluation and the WorkHealth check data (Project 2) indicated that workplaces from blue-collar industries were less likely to engage in the WorkHealth program. Blue-collar industry employees are at much higher risk of chronic disease and their associated risk factors. Further research is needed to explore the drivers of engagement in workplace health programs by blue-collar industries that go beyond the responsibilities of occupational health and safety. This is also an issue for equity as the inverse care law reminds us – those who would most benefit from programs are the least likely to take them up so more in-depth understanding of the most effective ways to engage blue-collar industries and their workers is critical for WorkHealth to meet its core objectives.

3. *Responsibility for workplace health:*

WorkHealth has led a comprehensive, large-scale, multi-component health program for workers over five years; however there are other large organisations also working

in this space including the Victorian Health Promotion Foundation and the Department of Health. The impact evaluation explored the concept of responsibility for worker health, which was strongly linked with the current shift from occupational health and safety in the workplace to health and wellbeing programs. However there are many questions around whose responsibility it is to provide health programs for employees, especially with regard to the funding of resources and required leadership. The evaluation looked at the perspectives of employees, employers and organisations from different sectors through the key stakeholder interviews, but a more in-depth exploration of the question of responsibility for workplace health programs will better enable the planning and coordination of workplace health initiatives.

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7. Appendices

A: State-wide Workplace Survey

WorkHealth Organisational Survey

Basic information

The next six questions will ask for some basic information about your organisation.

***Q1. To which industry does your organisation belong?**

- ☐ Accommodation and Food Services
- ☐ Administrative and Support services
- ☐ Agriculture, Forestry, Fishing and Hunting
- ☐ Arts and Recreation services
- ☐ Construction
- ☐ Education and Training
- ☐ Electricity, Gas and Water Supply
- ☐ Health care and Social Assistance
- ☐ Manufacturing
- ☐ Mining
- ☐ Professional, Scientific and Technical services
- ☐ Public Administration and Safety
- ☐ Retail Trade
- ☐ Transport, Postal and Warehousing
- ☐ Wholesale Trade
- ☐ Other Services

***Q2. My organisation is located in:**

- ☐ Metropolitan Melbourne
- ☐ Regional City
- ☐ Rural Victoria

***Q3. My organisation is in the:**

- ☐ Private sector
- ☐ Public sector
- ☐ Not for Profit sector

***Q4. Approximately how many employees does your organisation have in Victoria?**

- ☐ 1-19
- ☐ 20-199
- ☐ 200+ employees

WorkHealth Organisational Survey

*Q5. What is the annual remuneration of your organisation?

(Victorian site/s only)

- ☐ Less than \$2 million
- ☐ \$2 million to \$9.9 million
- ☐ \$10 million or more

*Q6. What is your job responsibility?

- ☐ Accounts/Payroll
- ☐ Administration/Office manager
- ☐ Communications
- ☐ Educator
- ☐ Health and Safety
- ☐ Human Resources
- ☐ Health Industry Coordinator
- ☐ Manager
- ☐ Other

WorkHealth Program

The next section will ask about your organisation's involvement in the WorkHealth program.

*Q7. Were you responsible for the management of the WorkHealth Program at your workplace?

- ☐ Yes, I was responsible for organising WorkHealth checks
- ☐ Yes, I was responsible for organising WorkHealth checks and the management of the Workplace Healthy Grant applications
- ☐ No, that person is no longer with the organisation
- ☐ No, that person has moved to a different business section within the organisation
- ☐ No, someone else has been responsible for managing the WorkHealth program
- ☐ No, other (please specify)

WorkHealth Organisational Survey

***Q8. When did your organisation participate in the WorkHealth checks?**

- ☐ 2009
- ☐ 2010
- ☐ 2011
- ☐ 2012

Month:

***Q9. In what capacity has your organisation participated in WorkSafe's WorkHealth program?**

- ☐ We have participated in WorkHealth checks
- ☐ We have participated in WorkHealth checks AND accessed a WorkHealth workplace health promotion grant
- ☐ Don't know/Unsure

a) If you answered yes to accessing a WorkHealth workplace health promotion grant, please identify how you used your grant? (e.g. held healthy cooking demonstrations)

WorkHealth Organisational Survey

***Q10. As a result of your participation in the WorkHealth program (WorkHealth checks/Healthy workplace grants), has your organisation made any changes to promote healthy lifestyle behaviours?**

- ☐ Alcohol guidance
- ☐ Environmental/Go Green policies
- ☐ Ergonomics (new or modified equipment)
- ☐ Falls prevention
- ☐ Flu vaccination
- ☐ General wellbeing
- ☐ Health and fitness screening
- ☐ Healthy eating/diet management
- ☐ Holistic therapies (e.g. meditation)
- ☐ Improved workplace infrastructure (e.g. installation of bike racks)
- ☐ Mental wellbeing
- ☐ Pain management
- ☐ Physical activity (e.g. walking group)
- ☐ Stress management
- ☐ Tobacco/Smoking cessation
- ☐ Work accidents/injury prevention
- ☐ Work-life Balance
- ☐ None
- ☐ Other (please specify)

***a) In what year were these changes made?**

- ☐ 2009
- ☐ 2010
- ☐ 2011
- ☐ 2012

***Q11. Has your organisation used the WorkHealth Healthy Workplace Kit?**

- ☐ Yes
 ☐ No
 ☐ Don't know/Unsure

WorkHealth Organisational Survey

a) If yes, please identify which components of the kit you used to make your workplace healthier?

- ☐ Posters
☐ Desk calendar
☐ Workplace audit tool
☐ Workplace health and wellbeing needs survey
☐ Health and wellbeing mission statement and policy template
☐ Healthy workplace action plan template
☐ Evaluation tools
☐ Other

b) How did your organisation use each component of the kit to make your workplace healthier?

c) How did you access the Healthy Workplace kit?

- ☐ Downloaded it from the WorkHealth website
☐ It was mailed to our organisation
☐ Don't know/Unsure

Workplace health and wellbeing

This section will ask questions about your organisation's approach to workplace health and wellbeing (NOT related to the WorkHealth program).

***Q12. Is employee health and wellbeing identified in your organisation's strategic or business plan?**

- ☐ Yes
☐ No
☐ Organisation doesn't have a strategic or business plan
☐ Don't know/Unsure

***Q13. Does your organisation have a formal plan for creating a healthy workplace?**

- ☐ Yes
 ☐ No
 ☐ Don't know/Unsure

If yes, what year was this first introduced?

WorkHealth Organisational Survey

***Q14. Which of the following best describes your organisation's approach to health and wellbeing?**

My organisation:

- ☐ Is proactive in supporting employees to participate in health focused programs and activities
- ☐ Does not tend to be proactive in supporting employees to participate in health focused programs and activities
- ☐ Neither/Not sure

***Q15. To what extent are senior management committed or not committed to developing a healthy workplace?**

- ☐ Very committed
- ☐ Committed
- ☐ Somewhat committed
- ☐ Not committed
- ☐ Don't know/Unsure

How does your workplace demonstrate its commitment to supporting healthy lifestyles?

(Tick all that apply)

- ☐ Allocating resources for employee health and wellbeing activities (e.g. time, space or money)
- ☐ Positive role-modeling
- ☐ Flexibility of working hours
- ☐ Rewards and recognition
- ☐ Promoting compliance to safety standards

Other (please specify)

***Q16. In your organisation, who is considered to be primarily responsible for employee health?**

- ☐ Employer
- ☐ Employee
- ☐ Both employer and employee
- ☐ Neither, there is no focus on responsibility
- ☐ Don't know/Unsure

WorkHealth Organisational Survey

***Q18. Does your organisation have a health and safety representative?**

☐ Yes

☐ No

☐ Don't know

***Q19. Which of the following Occupational Health and Safety policies and procedures does your organisation currently have in place?**

☐ Fire safety and evacuation

☐ First aid

☐ Health and safety risk assessment

☐ Manual handling

☐ Noise elimination

☐ Protective clothing

☐ Workplace bullying

☐ Other

***Q20. What prevents your organisation from adopting safer Occupational Health and Safety practices?
(tick all that apply)**

☐ Nothing/no barriers

☐ Cost

☐ Time

☐ Worker culture and attitude

☐ Lack of management commitment

☐ Workplace layout and physical facilities

☐ Small company so don't need to consider

☐ Lack of evidence to support health and safety for our organisation

☐ Other (please specify)

WorkHealth Organisational Survey

***Q21. In your organisation, what are the main causes of absenteeism?**

(tick all that apply)

- ☐ Workplace accidents
- ☐ Back strain/pain
- ☐ Chronic disease (cardiovascular disease, diabetes etc.)
- ☐ Job stress
- ☐ Job dissatisfaction
- ☐ Other (please specify)

***Q22. Does your organisation offer regular health risk assessments/ health checks?**

- ☐ Yes ☐ No ☐ Don't know/Unsure

***Q23. Does your organisation have a committee concerned with health and wellness?**

- ☐ Yes ☐ No ☐ Don't know/Unsure

***a) Does your organisation have a health and wellness representative(s)?**

- ☐ Yes ☐ No ☐ Don't know/Unsure

***Q24. To what extent does your organisation support the implementation of health and wellbeing programs?**

- ☐ Not at all
☐ Somewhat
☐ A lot
☐ Always

WorkHealth Organisational Survey

*Q25. Has your organisation implemented initiatives in any of the following areas?

- ☐ Alcohol guidance
- ☐ Environmental/Go Green policies
- ☐ Ergonomics (new or modified equipment)
- ☐ Falls prevention
- ☐ Flu vaccination
- ☐ General wellbeing
- ☐ Health and fitness screening
- ☐ Healthy eating/diet management
- ☐ Holistic therapies (e.g. meditation)
- ☐ Improved workplace infrastructure (e.g. installation of bike racks)
- ☐ Mental wellbeing
- ☐ Pain management
- ☐ Physical activity (e.g. walking group)
- ☐ Stress management
- ☐ Tobacco/Smoking cessation
- ☐ Work accidents/injury prevention
- ☐ Work-life Balance
- ☐ None
- ☐ Other (please specify)

*Q26. In what format have these health and wellbeing initiatives been delivered?

- ☐ Information for workers (e.g. noticeboards, brochures, online information, seminars)
- ☐ Individual activities (e.g. stress management program, work/life balance plan)
- ☐ Group activities (e.g. walking groups, cooking classes, meditation classes)
- ☐ Organisation-wide strategies (e.g. healthy canteen policy, provision of bike racks)

a) Have any of these initiatives been self funded?

- ☐ Yes
 ☐ No
 ☐ Don't know/Unsure

If yes, which initiatives were self-funded?

WorkHealth Organisational Survey

*Q27. What policies does your organisation have in place to promote health and wellbeing?

- ☐ Environmental/Go green policies
- ☐ Flexible work schedules
- ☐ Formal grievance procedures
- ☐ Health and wellness program access for family members
- ☐ Healthy food in workplace cafeteria
- ☐ Negotiated workload
- ☐ Occupational health and safety policy
- ☐ Reimbursement for the use of community health facilities (e.g. gym membership)
- ☐ Other (please specify)

*Q28. What local partnerships have been formed to implement your health and wellness program (e.g. nurse at community health centre)

- ☐ We have not formed any partnerships outside our organisation
- ☐ Yes we have formed partnerships to help us implement our health and wellbeing programs

List of local partners for health and wellbeing programs

*Q29. What prevents your organisation from adopting health and wellbeing activities?

- ☐ Nothing/no barriers
- ☐ Cost
- ☐ Time
- ☐ Worker culture and attitude
- ☐ Lack of commitment from management
- ☐ Workplace layout, construction and physical facilities
- ☐ We have a small number of employees so don't need to consider
- ☐ Lack of evidence to support health and wellness for our organisation
- ☐ Other (please specify)

We would like to visit some organisations to find out more about your experience of the WorkHealth program at your

WorkHealth Organisational Survey

workplace and your involvement with workplace health promotion programs. The research will involve an in-depth interview with you, and a focus group with a small group of employees at your organisation. Participation in this part of the evaluation is completely confidential and anonymous.

***Q30. Is your organisation interested in participating in further evaluation of the WorkHealth program?**

- ☐ No thanks, we do not want to be involved in further evaluation
- ☐ Yes, we would be happy to participate in further evaluation

Contact details:

If you would like to participate in further evaluation research, please enter your contact details below

Contact details

Organisation name:	<input type="text"/>
Contact name:	<input type="text"/>
Contact email address:	<input type="text"/>
Contact phone number:	<input type="text"/>

If you have any further questions regarding this research, please contact Nerida Joss on (03) 9903 1652 or nerida.joss@monash.edu

Thank you for participating in this component of the WorkHealth Impact Evaluation. Your responses are valuable and appreciated. Your responses to this survey are confidential and anonymous.

B: Invitation emails to participating workplaces (Phase 2)

Subject: WorkHealth Program Evaluation



Dear [First name, last name],

WorkSafe has provided us with your contact details because your organisation has participated in the WorkHealth program. Your organisation will have taken part in WorkHealth checks and may also have accessed a Healthy Workplace grant. We are writing to invite you and your organisation to participate in the WorkHealth Impact Evaluation conducted by the Monash Centre for Occupational and Environmental Health at Monash University.

WorkHealth is a WorkSafe initiative aiming to improve the health, wellbeing and safety of Victorian workers. The program is responding to the cost of absenteeism in Victoria caused by injury and illness. It also aims to improve workplace indicators such as reduced absenteeism and injury rates which contribute to a healthier workplace.

This evaluation will assess the short term outcomes of the program and explore changes within workplaces after participation in the WorkHealth program. The data will inform WorkHealth planners and stakeholders by identifying where improvements can be made.

The first stage of the evaluation involves an **online survey**. It will ask you questions about your organisation's participation in the WorkHealth Program. It will also ask you about the health and wellbeing policies and programs implemented at your workplace. If you believe that there is someone in your organisation better suited to completing this survey, please forward this email on to them to complete on behalf of the organisation.

The survey will take about **20 minutes** to complete. It does not have to be completed in one sitting. This survey is *anonymous* and your information is *confidential*.

The survey can be accessed online by **clicking** on the following link or **copying and pasting** the address into your web browser:

https://www.surveymonkey.com/s.aspx?sm=iMqKpCRndtp_2fjtkZtYZv5A_3d_3d

The survey will be available from *February 20th* through to *April 20th 2012*. If you have not responded, two reminders will be sent to you via email during this period.

At the end of the survey you will be asked if you would like to participate in further research. This

involves an interview with yourself (about 45-60 minutes) and a focus group with a small group of employees at your organisation (about 60 minutes). A member of our research team will come to your organisation or a place that is convenient to you to chat with you. Information disclosed in the interview and the focus group will be confidential and anonymous. Participants can withdraw from the evaluation at any time.

Your support in this evaluation is valued and appreciated. If you have any questions, please feel free to contact us.

Kind Regards,

Nerida Joss
Research Fellow
Monash Centre for Occupational and Environmental Health
Monash University
(03) 9903 1652
workhealthevaluation@monash.edu

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list.

https://www.surveymonkey.com/optout.aspx?sm=iMqKpCRndtp_2fjtkZtYZv5A_3d_3d

C: Explanatory statement and consent forms

WorkHealth Impact Evaluation Explanatory Statement

My name is **Nerida Joss** and I am a **Research Fellow** at the Monash Centre for Occupational and Environmental Health at Monash University. I am the Project Manager for the WorkHealth Impact Evaluation. WorkHealth is a WorkSafe program aiming to improve the health, wellbeing and safety of Victorian workers.

The aim/purpose of the research

This research will assess the short term results of the WorkHealth Program. It will also explore how workplace health programs can contribute to employee health and wellbeing.

What does the research involve?

This research involves an interview which will take approximately 60 minutes of your time.

Inconvenience/discomfort

It is unlikely that this research will cause inconvenience or discomfort and the interview will not include sensitive issues. If you withdraw from the research, the information you have already given will not be used.

Can I withdraw from the research?

Participation is completely voluntary. If you decide to participate you may withdraw at any stage. You can also choose not to answer questions which you feel are too personal or are uncomfortable answering.

Confidentiality

Your answers will be kept confidential at all times. Only general themes and short, unidentifiable quotes will ever be published from the data.

Storage of data

Data will be kept on University premises in a locked cupboard for 5 years. Electronic data will be password protected by the researcher. This is a Monash University regulation.

Use of data for other purposes

A report and journal articles will be written using the findings of this research. Results may also be presented at conferences. It will not be possible to identify you in these publications.

Results

If you would like to be informed of the research findings, please contact me on (03) 9903 1652 or email nerida.joss@monash.edu.

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:	If you have a complaint concerning the manner in which this research <CF11/0011-2011001976> is being conducted, please contact:
<p>Professor Malcolm Sim</p> <p>Director, Monash Centre for Occupational and Environmental Health (MonCOEH)</p> <p>Monash University</p> <p>The Alfred Centre</p> <p>Alfred Hospital</p> <p>Commercial Rd,</p> <p>Prahran 3004</p> <p>Ph: +61 3 9903 0582</p> <p>http://www.coeh.monash.org/</p>	<p>Human Ethics Officer</p> <p>Standing Committee on Ethics in Research Involving Humans (SCERH)</p> <p>Building 3d</p> <p>Research Office</p> <p>Monash University VIC 3800</p> <p>Tel: +61 3 9905 2052 Fax: +61 3 9905 1420</p> <p>Email: scerh@adm.monash.edu.au</p>

Thank you

Nerida Joss

**Consent Form – In-depth Interviews of Health and Wellbeing Coordinators
– Focus group with employees**

WorkHealth Impact Evaluation

NOTE: This permission form will remain with the Monash University researcher for their records

I agree to take part in the WorkHealth Impact Evaluation. The evaluation has been explained to me. I have read the Explanatory Statement which I keep for my records. I understand that agreeing to take part means that:

1. I agree to participate in a focus group ☐ Yes ☐ No

2. I agree to allowing the focus group to be recorded ☐ Yes ☐ No

and

I understand that my participation is voluntary and that I can choose not to answer any question during the focus group and that I can withdraw from the focus group at any stage.

and

I understand that any data used to report the results of the research will not contain names or identifying characteristics of participants.

and

I understand that any information I provide is confidential.

Participant's name:

Signature:

Date:

D: Health and wellbeing coordinator interview schedule

Key Question	Prompts	Definitions/Notes
<p>Tell me about your experience being involved in the WorkHealth program</p> <ul style="list-style-type: none"> • WorkHealth checks, • WorkHealth grant • healthy workplace kit 	<ul style="list-style-type: none"> • How did you get involved? • Who provided the leadership around getting involved? • Employee participation • Has your organisation been involved in workplace health promotion programs previously? • What do you understand by the term workplace health? 	<p>Check for definition around health and safety vs. health promotion</p>
<p>Has your organisation's involvement with the WorkHealth program changed the way your organisation considers the health and wellbeing of its employees?</p>	<ul style="list-style-type: none"> • Outcomes/changes to policy, programs, infrastructure • Changes in absenteeism, presenteeism • Workplace culture • Culture of care v culture of compliance • Performance/productivity • Injury reduction • Changes in employees – i.e. health improvements 	<p>Health and safety vs. health promotion</p>
<p>What do you believe have been the benefits of the WorkHealth program?</p>	<ul style="list-style-type: none"> • WorkHealth checks/ grants • Culture around workplace health promotion • WorkHealth grant • Healthy workplace kit • Future plans for organisational change/development • Local partnerships 	<p>Capacity – organisation's ability to identify, mobilise and address important and relevant problems (Stokols 1992)</p>
<p>Have there been any barriers to implementing the WorkHealth program? Can you tell me about them?</p>	<ul style="list-style-type: none"> • Resource allocation • Organisational development • Workforce development • Partnerships • Leadership 	
<p>Tell me about <u>other</u> workplace health initiatives that your organisation has been involved with?</p>	<p>Health as a priority?</p> <ul style="list-style-type: none"> • Resource allocation • Organisational development • Workforce development • Partnerships • Leadership 	<p>Org development – policies and procedures, org culture, strategic directions etc.</p> <p>Workforce development – training and education</p>

E: Employee focus group interview schedule

Key Question	Prompts	Definitions/Notes
Tell me about your experience with the WorkHealth program	<ul style="list-style-type: none"> • Participators v non participators • How did you first hear about the program? • What was your experience of the WorkHealth check? • Have there been any changes to your organisation after the WorkHealth checks were conducted e.g. new health and wellbeing activities? • What does health and wellbeing mean for you within your workplace? 	Check for definition around health and safety vs health promotion
*Your organisation has been a recipient of a grant through the WorkHealth program – can you tell me about how the money was used?	<ul style="list-style-type: none"> • Employee contribution to planning and implementation process • Factors for participation • Impact on employee health and wellbeing 	<i>*NB 24 of 48 organisations will be able to answer this question – see sampling framework</i>
Tell me about the occupational health and safety programs and policies within your organisation	<ul style="list-style-type: none"> • Level of importance for employees • Culture of care vs. culture of compliance • Absenteeism and presenteeism 	
Tell me about the health and wellbeing programs within your organisation	<ul style="list-style-type: none"> • What factors would affect or have affected your participation in a workplace program to improve your health? 	<p>Organisational climate</p> <p>Relationships with co-workers</p> <p>Perceived control over matters at work</p> <p>Heavy workload</p> <p>Clarity of responsibilities</p> <p>Supportiveness of supervisor and management</p>

F: Key stakeholder interview schedule

Key Question	Prompts
Tell me about your involvement with the WorkHealth program	<ul style="list-style-type: none"> • When did your organisation become involved at a strategic level? • Reasons for participating at a strategic level
What advice have you provided to the WorkHealth program (checks/grants)?	<ul style="list-style-type: none"> • Vision • Planning • Implementation/Delivery of program • Evaluation • Technical skills and knowledge
Have you provided support to increase the capacity of the WorkHealth program (checks/grants)?	<ul style="list-style-type: none"> • Resources • Leadership • Partnership building • Time • Other
Tell me about your experience as a key informant for the program. I'm interested in the challenges and successes you have experienced.	<ul style="list-style-type: none"> • Communication • Leadership • Negotiation and conflict • Partnership facilitation and management • Decision making
What impact do you think the program is having on building capacity and interactions in stakeholders more broadly. Can you give a specific example and describe its impact?	<ul style="list-style-type: none"> • WorkHealth checks • Lifestyle programs/WorkHealth Coach • Healthy workplace grant • Capacity building tools • Health promoting workplaces