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Debate

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Culture, management and finances as key aspects for healthy workplace initiatives

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Summary

The aim of this study was to qualitatively explore the barriers and enablers to implementing healthy workplace initiatives in a sample of workplaces based in Perth, Western Australia. In-depth interviews were conducted with representatives from 31 organizations representing small, medium and large businesses in the Perth metropolitan area which reported having healthy workplace initiatives. In total, 43 factors were mentioned as influencing the implementation of healthy workplace initiatives. Factors appearing to exert the most influence on the implementation of health promoting initiatives in this sample were culture; support from managers and staff; collaboration with industry providers; financial resources circumstances and the physical environment. These factors appeared to be mutually reinforcing and interconnected. Findings suggest there may be merit in applying an organizational development lens to the implementation of workplace health promotion initiatives as this could assist in leveraging enablers and minimizing barriers.

Key words: workplace health promotion, implementation, qualitative research, barriers and enablers

INTRODUCTION

There is a growing body of evidence demonstrating that workplace health promoting initiatives are beneficial for improving health outcomes (Sorensen *et al.*, 2004; Anderson *et al.*, 2009; Conn *et al.*, 2009). As a consequence, the implementation of comprehensive workplace

health promotion strategies is gaining traction globally, especially in Australia (Pomerleau *et al.*, 2005; Noblet and La Montagne, 2006; World Health Organization/World Economic Forum, 2008; Arena *et al.*, 2013; Miller *et al.*, 2015; Neuhaus *et al.*, 2014). With the primary goals of improving the work environment and increased productivity, these strategies are normally aimed at enhancing the positive health behaviours of employees (e.g. increasing opportunities for physical activity, improving dietary habits, reducing workplace stress, increasing mindfulness) and reducing unhealthy lifestyle practices (e.g. tobacco use, alcohol consumption) (Rongen *et al.*, 2013). These strategies are implemented into the workplace via a number of methods including the provision of healthy environments (e.g. smoke free venues), the enactment of healthy workplace policy (e.g. healthy food provision policy and catering; safe service of alcohol policies), the provision of health enhancing products and equipment (e.g. colouring books, sit-stand desks), health education seminars (e.g. nutrition literacy classes, cooking classes, goal setting), online self-monitoring programs, physical activity groups (e.g. running, yoga, aerobics, resistance training) and smoking cessation programs (Anderson and Larimer, 2002; Rongen *et al.*, 2013; Cahill and Lancaster, 2014). Programs are typically conducted for 3 months to 2 years, with the number of participants varying across different workplace settings (Rongen *et al.*, 2013).

Adults spend a considerable portion of their day at work, making the workplace an ideal setting for health promotion initiatives (Sorensen *et al.*, 1998; Wyatt *et al.*, 2015). Furthermore, there is an opportunity to access considerable segments of the population via the workplace that may not otherwise be privy to health promotion programs and initiatives (Sorensen *et al.*, 1998; Goetzel and Ozminkowski, 2008; Anderson *et al.*, 2009; Conn *et al.*, 2009). As a result, understanding the factors that influence the implementation of workplace health promotion initiatives is vital. While there is literature outlining the barriers and enablers to employees' participation in workplace health promotion programs (Devine *et al.*, 2007; Fletcher *et al.*, 2008; Blackford *et al.*, 2013; Rongen *et al.*, 2014), there is a limited body of research that explicates the barriers and enablers to the implementation of workplace health promoting initiatives, from the perspectives of those in managerial or employer roles (Mellor and Webster, 2013). Furthermore, there is a paucity of research on this topic in Australia, the setting of the current study.

Some commonly identified enablers to the implementation of workplace health promotion initiatives include the presence of strong support and endorsement from leadership or management. Other enablers include sufficient resources dedicated to the initiatives, comprehensive communication efforts, stakeholder involvement, a sense of ownership over the initiatives coupled with the organic evolution of programs, enjoyable participation that is not mandated and the regular presence of 'quick wins' to provide continual momentum and engagement (Mellor and Webster, 2013; Wyatt *et al.*, 2015). Some commonly identified barriers include difficulty integrating the health initiatives as a unified entity, navigating the balance between a focus on occupational health and safety versus health and wellbeing, the lack of buy-in or readiness on the part of managers to act upon their ability to monitor or improve their employees' health, a lack of belief in the possibility of sustained changes, environmental constraints and a target-driven culture focussed more on productivity than health and wellbeing (Mellor and Webster, 2013; Wyatt *et al.*, 2015). Mellor and Webster (2013) advocate for further research in different contexts to gain a more nuanced understanding of factors influencing successful implementation. To address the paucity of research conducted in Australia from the point of view of employers and managers, the aim of this study was to qualitatively explore the barriers and enablers to implementing healthy workplace initiatives in a sample of workplaces based in Perth, Western Australia.

METHODS

To support the exploratory nature of the study, a grounded theory approach was taken (Bush *et al.*, 2003; Roddy *et al.*, 2006; Andronikidis and Lambrianidou, 2010). Solely deductive investigations can be limited, therefore the use of a grounded theory approach can facilitate greater conceptual diversity with respect to the inductive analysis being undertaken.

Recruitment

Businesses registered with the *Healthier Workplace WA* (HWWA) program were invited to take part in the study. HWWA is a government funded initiative to improve the health of workers in Western Australia. HWWA businesses were eligible to participate in the study providing they had a healthy workplace policy or program in place. Policies or programs could centre on a range of issues including mental health, smoking, alcohol use, healthy eating or physical activity. A random selection of workplaces registered with HWWA was telephoned by a research assistant to invite them to participate in the study. Potential study participants

were informed that their involvement would include an in-depth interview about the healthy workplace policies and programs taking place at their workplace, with specific questions pertaining to the barriers and enablers to the implementation of these initiatives. At the time of recruitment, potential participants were informed that they would receive AU$80 reimbursement as compensation for the time involved in taking part in the study.

Sample

In total, 31 businesses were recruited into the study (response rate 35%). Using the Australian Bureau of Statistics' (2001) definition for business size; 13 businesses were categorized as large (200+ employees), 13 medium (20–199 employees) and 5 small (0–19 employees). The representatives interviewed were employed in a variety of roles; 2 were health promotion professionals, 9 were occupational health and safety officers, 12 human resources managers, 1 was an educator and 9 people were employed in other roles (e.g. director, communications manager and administration officer). The demographic characteristics of the workplaces are presented in Table 1.

Data collection

Ethics approval was granted by the University of Western Australia Human Research Ethics Committee. An interview guide was developed by the research team and pilot tested with five individuals with a background in health promotion. The semi-structured interviews were conducted by the first and second authors, as per guidelines set by Fontana and Frey (1994). On an average, each interview took 30 minutes to complete. All interviews were held at the participating workplaces to allow the researchers the opportunity to make observations based on workplace environments and provide a setting most convenient to the interviewees. To commence the interview, broad and general questions were asked relating to current workplace health initiatives and workplace culture. For example, 'If you could describe your workplace in a few sentences what would you say?' The questions specific to the barriers and enablers to the implementation of workplace health initiatives were raised with respect to current programs or policies in place. For example, 'Can you tell me what kind of things made it easy to implement your healthy cooking classes?'

Data analysis

Each interview was digitally recorded and transcribed verbatim prior to being uploaded into QSR NVivo10 (QSR International Pty Ltd., Melbourne, Australia) for coding and analysis. All data were de-identified to preserve the anonymity of the workplaces and workplace representatives. As part of the grounded theory approach, both deductive and inductive processes were utilized to enable a thematic analysis of the data (Maykut and Morehouse, 1994; Creswell, 2007), and a constant comparison process was incorporated to promote accuracy (Strauss and Corbin, 1990). The initial coding schema was guided by the literature and included some of the following themes: workplace culture, employee attitudes to healthy lifestyle choices, the physical environment and costs. As emergent themes arose, they were added to the coding framework as inductive nodes; previously coded data were recorded to the newly identified themes (as per Glaser and Strauss, 1967; Strauss and Corbin, 1990). All data were coded by the first author; with samples of data coded by the second and third authors to contribute to the trustworthiness of the data. To facilitate the interpretation of the data, the full transcripts and content of the nodes were read and re-read several times by the research team. Matrix and text searches were conducted to assist with the thematic analysis of data and to elucidate issues of most relevance to the different workplaces involved in the study (Schutt, 2012).

RESULTS

In total, 43 factors were identified as influencing the implementation of healthy workplace initiatives. These operated at various levels, namely individual, interpersonal, workplace and the community/broader society. These were categorized into a number of key broad factors that acted as either enablers or barriers depending on the situation-specific circumstances of the individual workplaces (Table 2). The most important factors were (1) the existing culture of the business, (2) support from peers, managers and beyond the organization and (3) economic and environmental considerations. There was some variation in the prominence placed upon these factors depending on the size of the business. Each priority factor is discussed in turn below, including distinctions that emerged based on the organizational size.

Culture

Organizational culture was a primary influence on the implementation of health promoting initiatives (including policies and programs). In this context, culture referred to the attitudes, practices and social norms regarding health within the organization. Organizational culture could be described as positive, neutral or antagonistic towards healthy behaviours. When the existing culture was positive towards healthy behaviours, implementation of health promoting initiatives was easily supported.

Table 1: Demographics characteristics of workplaces

Interviewee number	Position	Industry classification	Size	Workplace classification
S1	Health Promotion Professional	Other	Small	Not for profit
S2	Health Promotion Professional	Health and Community Services	Small	Public
S3	Director	Wholesale Trade	Small	Private
S4	Associate	Professional Scientific and Technical Services	Small	Private
S5	Director	Professional Scientific and Technical Services	Small	Private
M1	Administrator	Education	Medium	Not for profit
M2	Human Resources Manager	Education and Training	Medium	Not for profit
M3	Human Resources Manager	Manufacturing	Medium	Private
M4	Travel Officer	Public Administration and Safety	Medium	Public/Government
M5	Human Resources Manager	Government Administration and Defense	Medium	Public
M6	Client Services Manager	Financial and Insurance Services	Medium	Private
M7	Human Resources Manager	Education	Medium	Private
M8	OH&S Officer	Other	Medium	Public/Government
M9	Human Resources Manager	Manufacturing	Medium	Private
M10	Administrative Officer	Mining	Medium	Public
M11	OH&S Officer	Construction	Medium	Private
M12	OH&S Officer	Communication Services	Medium	Private
M13	OH&S Officer	Construction	Medium	Private
L1	Educator	Education	Large	Private
L2	Communications Manager	Education	Large	Public
L3	OH&S Officer	Other	Large	Private
L4	Travel Coordinator	Health Care and Social Assistance	Large	Public/Government
L5	OH&S Officer	Mining	Large	Private
L6	Human Resources Manager	Health Care and Social Assistance	Large	Not for profit
L7	OH&S Officer	Mining	Large	Private
L8	OH&S Officer	Administrative and Support Services	Large	Public/Government
L9	Human Resources Manager	Health Care and Social Assistance	Large	Public/Government
L10	OH&S Officer	Other	Large	Public/Government
L11	Human Resources Manager	Health and Community Services	Large	Not for profit
L12	Human Resources Manager	Transport and Storage	Large	Public
L13	Administrative Officer	Transport and Storage	Large	Public

> *It can actually work in the wrong way if you've got the wrong attitude. If you've got a bad culture, you're not going to get good changes or good policies. There's no question of that, but the reaction to specific requirements is coming from the internal culture and we do have some pretty healthy people here to start with.* (M6)

Alternatively, when the culture was neutral or antagonistic towards healthy behaviours, health promotion initiatives were met with more resistance and consequently were less successful.

> *We tried to go down the survey path of making this a non-smoking workplace but we got a big pushback and it didn't happen.* (M2)

Noticeably, the term 'culture' was mentioned by interviewees from small organizations less often and, therefore, may not have been consciously considered as important to the implementation of health promoting initiatives in these businesses. This may partially be related to the referent power of key individuals, a factor that is discussed in the section on 'support'. Alternatively, it may be a difference in terminology associated with business size. For instance, interviewees mentioned recruitment strategies that maintained their organizations' *environment* rather than *culture*.

> *Right from the outset it was a no smoking environment that was non-negotiable. We've had different staff at different times and that's always part of our interview process, we say 'This is a non-smoking environment.' You can't prejudice against people that do smoke but I want them aware that the building and its environment are non-smoking.* (S3)

High turnover

A factor that appeared relevant only to small businesses was the impact of a small, transient workforce. Small

Table 2: Factors that influence the implementation of health promoting initiatives in the workplace

Factor	Business size		
	Large	Medium	Small
Culture			
• *High turnover*	Highest	Highest	
• *Commitment to change*	Lowest	Lowest	Lowest
Support			Highest
• *Managerial support*			Highest
• *Supportive staff members*			
Collaborating with industry providers			
Financial resources			
• *Resources*			Lowest
• *Climate*			
Physical environment			Lowest

The cells indicate the priority of the factors based on frequency with which the concept was raised within the interviews.

numbers of staff that were continually changing made maintenance of a specific culture within the business more challenging, which appeared to impact health initiatives.

> *We often have staff for only 12 months and then there'll be a new lot of staff. So we're always changing. How do you keep the health initiative going if you're constantly changing your staff or the team?* (S1)

Commitment to change

Implementing health-promoting options was viewed as a cultural change and brought with it the usual amount of resistance. For large and medium sized organizations it was acknowledged that the change could take several years.

> *When it started, health and wellbeing was not even on the radar, wasn't even looked at and over the last five years we've pushed it a lot.* (M11)
> *I think it's been so many years that it is now ingrained… It's a little bit of a, dare I say, paradigm shift.* (L1)

Commitment to change appeared to impact large and medium businesses but did not appear to happen to the same extent as in the small businesses that participated in the study. This may indicate that a small number of employees allowed change to happen at a faster pace.

Support

Support involved people acting as champions to endorse and promote the initiative being implemented. This involved both key managerial staff and a core group of enthusiastic employees, or champions, who were reported to be essential for success.

Managerial support

Interviewees often mentioned that the support of people within management was fundamental for the success of health initiatives being implemented.

> *We at HR, Safety, and Payroll make up the support team with one person managing us and together as a support team we're driving it to engage everyone else and get it on board. But the CEO still has to agree with it and support it.* (M3)

However, managerial support was influenced by organizational size. In small organizations managerial support appeared to be the most important influence on implementing health initiatives. While the support of key managers was also an important enabler for large businesses, it was not mentioned as often as the fact that initiatives generated from upper management needed the support of other managers and staff members to become established.

> *The Managing Director came up with this and it was a matter of people bringing ideas. Well that wasn't going to help unless somebody drove it, so that was why at the time I was… I headed up our safety working group and as part of the safety working group it was sort of down to the safety working group to monitor it, or maintain, so… and also as part of HR I suppose, as wellness. That's when I started up this and I thought, OK, well let's just work out some kind of calendar that can keep going.* (M2)

In addition to the need for initial support for and/or endorsement from managers, their ongoing support for, and participation in, the initiatives encouraged other staff to be involved. This sometimes included management actively participating in the initiative.

> *I think having management participate demonstrates their commitment and the importance of it.* (L7)

In some circumstances, a monetary incentive to participate that was provided by management was mentioned as evidence of managerial support. Such incentives included competition prize money or a bonus payment for being involved in an initiative. Further, several interviewees mentioned that their initiatives had stopped due to lack of managerial support, while others felt managerial support was the reason their initiatives were implemented.

The Director General put up $400 of his own money on the basis that if anyone could beat him in terms of percentage weight loss he would hand over the $400; and he ended up handing over the $400. (L10)

So by riding three days a week I'm achieving the Occupational Health and Safety policy, which my company is strong on. The policy states that if an employee rides to work three days a week, they will get a bonus. So they might get a few thousand dollars at the end of the year. It's a direct and obvious incentive. So it's fully supported by management. (L9)

Supportive staff members

An important factor for implementation was having key staff members who were eager to introduce health-promoting activities into their workplace and act as catalysts that could encourage others towards healthy practices. This was referred to by interviewees from large, medium and small businesses. Such people acted as champions to promote change.

It's a prior interest of somebody in the organisation, they bring it into the work environment and then it sort of fuels others that have either got prior interest or a little bit of thought that they might be interested in it. (L8)

People are more proactive. We have specific champions in certain areas, like for the health team we have key people. For example, when we have one of the head engineers champion participating it motivates the whole team. (M5)

Now if it hasn't been a directive it's just an enthusiastic staff member who says I'm doing this, do you want to come and do it with me? I'm going for a walk at lunch time, shall we just do our meeting as we walk round the block? So they seem to have some good impact. It's just the sustainability of that. (S2)

What started off as one person riding to work, next minute there's another bike there and then there's another bike and then you walk up through the car park and you see all the bikes in the back of the cars and so it just seemed to increase. (L2)

Using staff whose personal interests and positions within the workplace were aligned with health-promoting goals served to generate a broad base of support which provided leadership for health-promoting activities and motivated others to participate. Conversely, when there was no one responsible for promoting health in the workplace it made the implementation process more difficult.

We do try a lot of initiatives out there sort of every so often, and we do try and maintain it, but it's very difficult at times – not having dedicated staff to do it. (S2)

Collaborating with industry providers

Numerous interviewees from businesses of all sizes mentioned their involvement in promotional days such as 'R U OK Day' (www.ruok.org.au) and 'Ride2Work Day' (www.bicyclenetwork.com.au/rtw). For smaller organizations, these events provided cost-effective (i.e. free or inexpensive) opportunities to promote healthy behaviours and an opportunity to link their small workforce with others.

We've done Ride2Work Day because we can link with the hospital, and the wellness team. A couple of our staff members have been involved in that for the past two years. And so with that we have had a basic cycling workshop around that time. (S2)

In conjunction with promotional days, interviewees from medium and large size businesses also mentioned their businesses joined charity fundraising events and corporate challenges as a means to motivate their staff towards healthy behaviours. Smaller organizations reported little engagement in these activities.

The Biggest Morning Tea; we support Cancer Council, so we'll tend to tailor it to that and then we'll do some fun stuff around that as well, so that's where we also get a bit of benefit from the charities. For instance, we're doing the Big Walk this weekend (M11)

Gaining support from a health fund appeared common among large and medium size business but not in small businesses. This was attributed to the negotiation power created by having a large number of staff making the business relationship beneficial for both parties.

Company X is going to help us organise pedometers and we'll do a bit of an online walking team after Christmas when everyone's put on a few kilos. This year we also got Company X involved, so for anyone that takes out private health with them, we get a percentage put towards our Wellness Committee. (L7)

We had Pilates happening which was good. Again we had this because it was part of a deal we had with Company Y as a corporate member, they provide a certain amount of money that you can use towards different activities that are health based. (L11)

Financial resources

Financial resources were an important factor for all organizations, independent of size. Interviewees referred to the way in which workplace financial resources and the general economic climate impacted the implementation of healthy business initiatives. Not surprisingly, the financial resources available to an organization, regardless of size, affected their capacity to implement healthy

workplace initiatives. This was, however, dependent on what was considered a healthy workplace initiative as some activities, such as lunchtime walks, are inexpensive.

> *The oil and gas companies of the world can afford to invest money into having programs and having people that are solely dedicated to providing healthy workplace services, whereas we just don't have the money for that.* (L12)
>
> *We set up a 'terms of reference' so we could get an idea of what people wanted and what we could do; even in the remote and regional areas. We looked at what we would require for funding. Unfortunately, the funding request, which was internal, got knocked back.* (L9)

Financial investment in workplace health promotion was sometimes the result of strategic human resource initiatives in times of low unemployment to attract and retain staff.

> *At that time, the boom was in full blow, and the people employed were highly attractive to the resource sector. We were haemorrhaging, we had something like at 28, 29% separation rate and it was almost unsustainable. I was given the remit to stabilise the workforce and so we looked at it from all different perspectives of how could we make our organisation an employer of choice in the State? That's when we started to introduce some of the health initiatives on the basis of making this a workplace where people like to come to work and so forth, you know, that's when we introduced fruit bowls. That was where the whole health initiative started from, it was to try and stop people wanting to leave.* (L3)

In a similar vein, several interviewees mentioned becoming an 'employer of choice' to support recruitment and retention of staff, which provided an incentive for organizations to consider healthy workplace initiatives.

> *This is sort of embedded because we've got a contract in place, the workplace is paying fairly reasonable money for this to happen, and we'd like to see returns, and plus you know to assist in making the workplace an employer of choice.* (L10)

The wider economic climate was of particular concern for large and medium sized businesses. Such non-financial incentives were deemed more necessary when the economic situation was difficult. When the economic climate was financially buoyant, there appeared to be more emphasis placed on healthy workplace initiatives. It was acknowledged that the primary motive for introducing such initiatives was staff retention and not necessarily solely based on concern for staff well-being *per se*.

> *They've been around (healthy workplace initiatives) for a while. I think there was a push around 2009 when, I think, most businesses in the resources sector recognised that they needed to do these things. Then the Global Financial Crisis hit and it all fell away.* (L12)

Physical environment

Another factor, aligned with economic resources, was the workplace's physical environment. Interviewees from various size businesses felt that if the workplace had facilities conducive to healthy choices, it was easier for employees to engage in these options. Facilities such as showers and bike racks were considered necessary to support physical activities such as cycling to work. Kitchens, including the cutlery and crockery essential for cooking, provided the opportunity for employees to make their own food, which could promote healthier eating options. It also enabled the introduction of initiatives that promoted healthy eating such as classes to introduce people to healthy cooking. In addition, a few interviewees mentioned that their premises had standing workstations which were viewed favourably.

> *Actually thinking about that now (an initiative to increase physical activity), one of the reasons it didn't work is we've only got one shower here.* (L13)
>
> *There was a lot of negotiation, but basically in the new building they made heaps of extra showers, which will help promote physical activity.* (M4)
>
> *There is a kitchen in there and they cook. This year we've had a nutrition program happening where we had someone come in and do cooking demonstrations with a healthy eating plan.* (L6)
>
> *I try to encourage employees to make lunches here, as I suppose that stands a chance of being healthier. We have a fully equipped kitchen to enable them to prepare things.* (S5)

DISCUSSION

Factors appearing to exert the most influence on the implementation of health promoting initiatives in this sample were culture; support from managers and staff; collaboration with industry providers; financial resources circumstances and the physical environment. These factors appeared to be mutually reinforcing and interconnected. For instance, while an organizational or social culture that advocates healthy behaviour is fundamental to implementing a health initiative, the existing culture is also strategic for obtaining staff and managerial support. However, regardless of existing culture, without the support of influential managers an initiative

may not have the capacity to continue. If factors affecting implementation of health promoting initiatives are entwined in this manner, in order to maximize the likelihood of overcoming the barriers it may be advantageous to incorporate multi-faceted strategies when implementing such initiatives (as per Elliott *et al.*, 2014).

The present study illuminated several findings in relation to the factors affecting implementation of healthy workplace initiatives in an Australian setting, including the importance of workplace culture, managerial support and financial resources. Further, it has provided new evidence concerning the prioritization of factors—i.e. those which are considered most important—thus, providing insights into where efforts to improve implementation success and mitigation of potential barriers can best be targeted.

As has been demonstrated in previous research and in the present study, the existing culture of the organization had a substantial effect on the implementation of health promotion initiatives (Mellor and Webster, 2013; Wyatt *et al.*, 2015). The culture of an organization is shaped by the values shared by all or most of the employees (Weiner *et al.*, 2009). Similar to establishing social norms within a group, the most important values become the accepted norm within the organizational setting (Weiner *et al.*, 2009). During the process of introducing a new initiative, employees form judgements about the extent to which the initiative is congruent with their values (Klein and Sorra, 1996; Weiner *et al.*, 2009). The findings in the current study indicate that there appears to be a 'benchmark' established by the culture of the organization which is also used in the process of evaluating the fit. An existing culture that supports healthy initiatives may induce participation regardless of its fit with individuals' values, especially if the organization has high social capital with an established environment of trust (Jung *et al.*, 2011).

It has been suggested that even in the context of a strong implementation climate, initiatives may not succeed if they do not fit the values of the employees as individuals, or the culture of the organization (Klein and Sorra, 1996; Weiner *et al.*, 2009). In this context, the implementation climate is the employees' shared impression regarding the extent to which the specific initiative is supported by the organization (Klein and Sorra, 1996). This impression is established by the degree to which employees are expected to become involved in the initiative, and rewarded or reprimanded for compliance. The competing influences caused by the existing situation and the implementation climate are particularly pertinent for implementation of health promotion initiatives where the implementation climate is likely to be weak due to the lack of legislation concerning workplace health promotion. This means that other factors such as managerial support may become more important, as has been shown elsewhere (Orlandi, 1986; Witte, 1993; Crump *et al.*, 1996). This also presents a rationale for public health agencies to advocate for change to legislation and regulations that can have a positive impact on health and wellbeing. These could include amendments to building design codes (e.g. the need for newer buildings to have showering facilities sufficient for floor space, bike racks, locked bike cages and easy-to-locate public access stair cases) and occupational health and safety requirements to ensure health and wellbeing is not an option extra (e.g. including health and wellbeing goals in policy documents and ensuring staff inductions incorporate and emphasize these goals).

The emphasis placed on the necessity for managerial support of health initiatives highlights the importance of this factor when implementing such initiatives in the workplace. Previous research conducted in USA promotes the notion that managerial support is crucial for the success of health promotion in the workplace (Orlandi, 1986; Witte, 1993; Crump *et al.*, 1996; Wyatt *et al.*, 2015). Linnan *et al.* (2007) noted that while most managers agree that employers have a responsibility toward employees' occupational health and safety, there is not similar consensus regarding employer responsibility for employee health *per se* (Linnan *et al.*, 2007; Pescud *et al.*, 2015). Similarly, discussion in the current study indicated there were varying levels of support provided by managers and employers for their organizations' workplace health initiatives. Further, the success of the organizational health initiatives appeared somewhat dependent on managerial support, which indicates a necessity for targeting and educating managers regarding the benefits of workplace health promotion. In addition, public health agencies can work with organizations of various sizes to identify key personnel, who are not necessarily upper management, but those holding influential roles, to participate in workplace health and wellbeing training to gather support and affect change throughout the workplace.

The financial resources available for health promoting initiatives to be implemented were also commonly referred to as enablers or barriers. The economic climate of the organization affected financial expenditure on health promotion activities and workplace facilities such as showers, kitchens and bike cages. Best practice guidelines for successfully introducing health promotion initiatives into workplaces indicate that the work environment is

one of the most important factors (Chapman, 2004; The Health and Productivity Institute of Australia, 2007). Sparling's (2010) positional article on successful workplace health promotion also included the workplace physical environment as one of the key issues to be considered. In these instances, environmental factors included access to facilities such as gyms, showers and kitchens. The current study emphasizes the practical application of these guidelines. However, paradoxically, allocation of financial resources is determined by senior management and, therefore, support from that quarter would increase the likelihood of creating an appropriate environment. This means that agencies advocating for change need to consider building cases that demonstrate that initiatives do not have to have expensive components. This means that in times of financial hardship, workplaces can still incorporate health and wellbeing initiatives into their usual business with changes such as alcohol free events, healthy catering, no-smoking rules and walking meetings, thus removing the need for costly initiatives such as gym memberships.

Where to from here?

Within the public health discourse, there are frameworks devised for guiding health program implementation (Frieden, 2014). There are however calls for the need to view public health problems from different viewpoints and couch them within frameworks from other relevant disciplines (Green, 2006; Glanz and Bishop, 2010). Therefore, applying an organizational development lens to the implementation of workplace health promotion initiatives could assist in leveraging enablers and minimizing barriers (Michaels and Greene, 2013; Batras *et al.*, 2016; Chappell *et al.*, 2016). The literature on change theory suggests assessing the need and urgency for change as critical first steps (Kotter, 1996). Understanding what is valued within the existing culture facilitates framing a compelling argument for moving into the future. The identified enabler of managerial and peer support is consistent with the recommendation to create a powerful guiding coalition (Kotter, 1996). If change agents lack legitimate or referent power their efforts will be foiled by organizational dynamics and entropy. The enabler of having financial and physical resources is consistent with the recommendation for empowering others to embrace and act on the vision for change: eliminating obstacles, changing systems and structures, and encouraging new actions (Kotter, 1996). Finally, the enabler of taking a long-term perspective to implementing workplace health is consistent with the recognition that change is messy and many organizations make the mistake of declaring the change process complete too soon (Kotter, 1996).

LIMITATIONS

This qualitative study is limited by its small sample size meaning that it is not possible to generalize findings to a broader segment of the population as they are only representative of the interviewees taking part in the study. Future research could involve a larger and more diverse sample of interviews from a broader range of workplaces. In addition, workplaces without involvement in a state-based healthy workplace program or without health promoting initiatives could be included to contrast findings between those who have implemented initiatives and those who have not. While the monetary incentive provided was to compensate interviewees for any inconveniences caused through their participation in the study, it may have biased the sample. The validity and credibility of the findings, are however upheld by the interpretive and methodological rigour used in the study (as per Silverman, 2013).

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