Attitudes Toward Workplace Health Promotion; Low-Wage Employees

Perspectives on Workplace Health Promotion Among Employees in Low-Wage Industries

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Abstract

Purpose. *Study goals were to (1) understand the attitudes of employees in low-wage industries toward workplace health promotion, including views on appropriateness of employer involvement in employee health and level of interest in workplace health promotion overall and in specific programs, and (2) determine the potential for extending workplace health promotion to spouses and partners of these employees.*

Approach. *The study used 42 interviews of 60 to 90 minutes.*

Setting. *Interviews were conducted with couples (married or living together) in the Seattle/King County metropolitan area of Washington State.*

Participants. *Study participants were forty-two couples with one or more members working in one of five low-wage industries: accommodation/food services, education, health care/social assistance, manufacturing, and retail trade.*

Method. *The study employed qualitative analysis of interview transcripts using grounded theory to identify themes.*

Results. *Employees consider workplace health promotion both appropriate and desirable and believe it benefits employers through increased productivity and morale. Most have little personal experience with it and doubt their employers would prioritize employee health. Employees are most interested in efforts focused on nutrition and physical activity. Both employees and their partners support extending workplace health promotion to include partners.*

Conclusion. *Employees and their partners are interested in workplace health promotion if it addresses behaviors they care about. Concern over employer involvement in their personal health decisions is minimal; instead, employees view employer interest in their health as a sign that they are valued. (Am J Health Promot 2015;29[6]:384–392.)*

Key Words: Workplace, Spouses, Domestic Partners, Health Promotion, Prevention Research. Manuscript format: research; Research purpose: descriptive; Study design: qualitative; Outcome measure: behavioral; Setting: workplace; Health focus: fitness/physical activity, nutrition, weight control, smoking control; Strategy: skill building/behavioral change, policy, culture change

PURPOSE

Chronic diseases are the leading causes of mortality and morbidity among working-age adults.[1] Risky health behaviors such as tobacco use, sedentary lifestyle, and poor nutrition are strongly linked to chronic disease.[2,3] Working-age adults regularly engage in these behaviors.[2,4]

Workplace health promotion (WHP) can reach a large proportion of adults,[5] and employers increasingly recognize the impact of modifiable health behaviors on their bottom lines.[2,5] Most employers believe they can reduce their health care costs by influencing employees to adopt healthier lifestyles.[6] Employers' costs are also affected through increased absenteeism, presenteeism, and higher-than-average turnover among employees with chronic diseases.[2]

Workplaces employing more than 1000 people are most likely to offer WHP,[7,8] and most of what we know about WHP is based on large workplaces. Research on employee perceptions of WHP has focused primarily on those working for large employers.[9–11]

WHP efforts at small and mid-sized companies are less studied but still

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important. Fifty-five percent of employees are employed by companies with fewer than 1000 total employees,[12] and many of these are low-wage jobs (annual household incomes less than $35,000).[13] Employees receiving low wages are more likely to exhibit risky health behaviors compared to the higher-paid workforce.[4,13]

Our previous work focused on WHP at mid-sized companies in low-wage industries; most were not offering much WHP.[14,15] Reasons for not offering WHP included lack of financial resources and staff time, as well as doubts regarding return on investment, both overall and for their particular industries. Many employers believed that employees did not want their employers involved in their health and doubted whether employees would be interested in WHP. Employers also repeatedly expressed concern about being viewed as intrusive by employees.

But are these perceptions accurate? Do employees in low-wage industries lack sufficient interest and resent employer interference in their health? Several previous studies suggest that employees in smaller, lower-wage industries are generally receptive to WHP,[16,17] although most research around employee attitudes toward particular programs and policies did not focus specifically on those working in low-wage industries.[18,19] There is also a lack of research on what employees in these industries believe about the appropriateness of employer involvement in employee health behavior, what types of programs are most appealing or feasible in these settings, and how best to promote them.

Further complicating the picture, some research indicates that employees holding salaried, full-time positions in white-collar industries are more likely to participate in WHP,[20,21] even while their lower-wage counterparts may have more need for programs aimed at encouraging behaviors that reduce risks for chronic disease. A significant body of research demonstrates disparities in health outcomes associated with income and social class, with employees of lower socioeconomic status suffering disproportionate rates of disease compared to those of higher status.[4,22,23] In comparison to higher wage earners, employees with low wages are also significantly more likely to use tobacco, be physically inactive, and eat poorly.[24] Thus, it is not surprising that WHP researchers have advocated for focusing more effort on understanding attitudes and behaviors of working-class employees to develop WHP programs that are both appealing and effective for this group.[25]

The primary purpose of the research described in the upcoming text is to better understand the attitudes of employees in low-wage industries (hereafter "employees" unless otherwise specified) toward WHP, including views on appropriateness of employer involvement in employee health, level of interest in WHP overall and in specific WHP programs, and preferences around promotion and communication. We sought to dig deeply into the beliefs of employees to develop a comprehensive portrait of this understudied population's attitudes regarding diverse aspects of WHP.

In addition to examining WHP aimed at employees, we also explored the potential for extending WHP to spouses and/or partners (hereafter "partners"). Many employers in low-wage industries offer some form of health insurance to partners, so partners impact their overall health care costs. Research indicates that personal health decisions are strongly influenced by partners.[26–29] Including partners could increase the effectiveness of WHP both through expanding the reach of employer-based wellness efforts and by improving employee adoption and maintenance through social interaction with the partner.

Our previous work indicates that low-wage employers are open to involving partners, but only if employees supported it and didn't view WHP extended to employee partners as intrusive or inappropriate.[15] Currently, little is known about whether including partners in WHP would appeal to employees and partners or what types of programs would elicit the most interest. Thus, a secondary purpose of this research is to better understand the attitudes of both employees and their partners regarding the inclusion of partners in WHP efforts.

APPROACH

This study used a qualitative approach. Semistructured, in-person interviews were conducted with couples (defined as romantic partners, married or unmarried, who live together). Interviews, which are well-suited to gathering detailed information on topics that lack a well-defined knowledge base, allow for in-depth probing and the opportunity to explore unexpected responses.

Couples were interviewed together by one interviewer. All participants signed informed consent forms prior to being interviewed. Each couple received either $50 ($25 per person) or $100 ($50 per person) as a thank you for their time. The incentive increased toward the end of the recruitment period because of the difficulties in recruiting couples. Protocols and survey instruments were approved by the University of Washington's Institutional Review Board. In preparing this manuscript, we followed the consolidated criteria for reporting qualitative research guidelines.[30]

Setting

Interviews took place in Seattle, Washington. Most of the interviews were conducted in a conference room at the University of Washington Health Promotion Research Center; a small number of participants preferred to be interviewed at their residence.

Participants

Couples were recruited through paid announcements in local newspapers, online postings (Craigslist, SeattleTimes.com), and flyers posted in approximately 25 Seattle-area workplaces. Six of these workplaces participated in a prior WHP intervention study conducted by the research team.

Couples were eligible to be interviewed if they lived together and if at least one partner currently worked in one of five target industries (accommodation/food services, education, health care/social assistance, manufacturing, and retail trade). These industries were selected because they are low wage (mean salaries $<$ $45,000), and among low-wage industries, these five employ the most U.S. employees (at the time we designed

this study).[31] Because we did not screen participants on their annual household income, we refer to employees in low-wage industries as opposed to low-wage employees.

METHODS

Health Survey

Prior to the start of the interview, each member of the couple completed a brief survey about health status (self-reported weight, daily physical activity) and health-related behaviors (cancer screening, diet, physical activity, and tobacco use). Most questions were adapted from the Behavioral Risk Factor Surveillance System (www.cdc.gov/brfss). Couples completed this survey independently, with each person rating his or her own health and behaviors. The researchers collected these data in order to describe the health and health risks of the sample and to determine whether health risk behaviors were associated with interest in specific WHP programs.

Interview Guide

The researchers developed an interview guide containing questions and probes to elicit comments and conversation around two core research aims: (1) understand employees' perceptions and beliefs about WHP, including their views on the appropriateness of employer involvement in employee health and what types of programs they consider most appealing, and (2) determine the level of interest among partners in participating in WHP offered by employees' companies, views on appropriateness, and preferred communication channels. The concept of WHP was defined for participants in broad terms; anything a company offered that was intended to improve employee health was considered a form of WHP. Under this definition, programs, policies, and communications on topics ranging from educating employees on the value of flu shots to encouraging participation in a lunchtime walking group counted as WHP.

All participants (employees in low-wage industries and their partners) were asked to provide detailed reactions to three specific types of WHP: informational brochures promoting regular cancer screening (rated only by participants age 45 or older); gym discounts; and a physical activity program, Active For Life (AFL), which was described by the interviewer and detailed in a brochure. AFL, offered by the American Cancer Society, is an evidence-based 10-week team-based program that encourages participants to set their own goals for increasing the amount of physical activity they get each day.[32] Employees were asked about their own interest as well as the potential appeal of including their partners in such a program. Partners were encouraged to talk about scenarios under which they would be most likely to enroll in a program offered through a workplace that is not their own.

Questions about WHP efforts currently in place at employees' current workplaces, general interest in WHP, types of WHP considered most appealing, and preferred mode for WHP-related communication were directed at the "qualifying" employees, defined as the member of the couple that currently worked in one of the five target industries (two additional participants who worked in other low-wage industries were also asked these questions). Partners who worked in a higher-wage industry, or were not presently employed, were not asked these questions. Thus there were two types of couples interviewed: couples with one member working in a low-wage industry and couples with both members working in a low-wage industry. For the first type of couple, each member responded to questions directed at qualifying employees and those intended for partners. Including both types of couples ensured that results reflected the full universe of relevant partnerships.

To aid our understanding of the types of health behavior challenges employees in low-wage industries and their partners face, we asked couples to describe a health behavior each member had tried to change in the past year.

One team member (P.A.H.) wrote an initial draft of the interview guide, which was then reviewed and revised by the research team. To fine-tune the guide and prepare the interviewers, test interviews were initially conducted with colleagues of the research team. The final test interview was conducted with a couple consisting of two qualifying employees.

Data Collection

Interviews were conducted between September 2010 and April 2011. Couples were interviewed by one of three members of the research team: P.A.H. (PhD), K.H. (MA), and C.C.T. (MPH). Each interview lasted approximately 60 to 90 minutes. To ensure accuracy, all sessions were audiotaped. Health surveys were administered by the interviewer.

Data Analysis

Interviews were recorded and transcribed verbatim by a commercial transcription service (Proof Positive Transcriptions, Garland, Texas). Transcripts were imported into Atlas.ti, a software program for managing and analyzing qualitative data. A member of the research team (P.A.H.) developed the coding structure by first reading through the transcripts and identifying prominent themes. Guided by grounded theory, she then incorporated feedback from other research team members, resulting in a final set of codes and subcodes. The coding structure is available from the authors on request.

To ensure consistency in how codes were assigned, two team members (K.H., C.C.T.) jointly coded the first four interviews. The remaining interviews were then individually coded by the same team members, who periodically reviewed each other's coding to confirm agreement in coding decisions. During this process, minor adjustments were made to the coding structure. Both the interview guide and the coding structure are available from the authors on request.

RESULTS

Interviews were conducted with 42 couples (84 individual participants). Demographic characteristics of participants are presented in Table 1. Participants were slightly younger, more likely to be African-American, and less likely to be Hispanic than residents of King County, Washington (where Seattle is located).[33] The industries most frequently represented were health care/social assistance and food ser-

Table 1
Participant Characteristics (N = 84)*

Characteristic	No. (%)
Sex	
Male	42 (50)
Female	42 (50)
Age	
Mean (range)	41 (21–67)
Race/ethnicity†	
White	53 (63)
African-American	17 (20)
Asian	5 (6)
Pacific Islander	2 (2)
AIAN	2 (2)
Other	3 (4)
Prefer not to answer	1 (1)
Hispanic or Latino	3 (4)
Education	
High school or less	13 (15)
Some college	32 (38)
College graduate	39 (46)
Industry‡	
Health care/social assistance	19 (30)
Accommodation/food services	18 (28)
Retail trade	12 (19)
Manufacturing	8 (12)
Education	5 (8)
Other low-wage industries	2 (3)

AIAN indicates American Indian and Alaska Native.

* Some percentages do not sum to 100 due to rounding.

† Participants could choose multiple categories, so percentages sum to more than 100%.

‡ Industries reported for qualifying (low-wage) employees only. Sixty-four participants worked in qualifying industries, 17 were unemployed or worked at home, and 3 worked in nonqualifying industries.

Table 2
Results of Health Survey*

	No. (%)		
	Total (n = 84)	Male (n = 42)	Female (n = 42)
Weight status (self-reported)			
Normal weight	34 (40)	14 (33)	20 (48)
Overweight	34 (40)	18 (43)	16 (38)
Obese	16 (20)	10 (24)	6 (14)
Food			
Eats fast food weekly	30 (36)	17 (40)	13 (31)
Drinks soda daily	13 (15)	6 (14)	7 (17)
Usually/always eats while busy	33 (39)	17 (40)	16 (38)
Physical activity			
Meets recommendation†	58 (69)	26 (62)	32 (76)
Fair/poor health	11 (13)	7 (17)	4 (10)
Smoker			
Current	22 (26)	11 (28)	11 (26)
Former	23 (27)	10 (25)	13 (31)
Cancer screening‡			
Cervical cancer	—	—	35 (83)
Age-eligible for screening	31 (37)	15 (36)	16 (38)
Mammogram	—	—	11 (69)
Any colon screening	10 (32)	6 (43)	4 (29)
Current on all eligible screenings	60 (71)	33 (81)	27 (68)

* Some percentages do not sum to 100 due to rounding.

† Participants reported getting either 150 minutes per week of moderate physical activity or 60 minutes per week of vigorous physical activity (Centers for Disease Control and Prevention recommendation for minimum weekly physical activity).

‡ Rates are for meeting cancer screening guidelines. Cervical cancer: women had a Papanicolaou test within the past 3 years; mammogram: women age 50 and older had a mammogram in the past 2 years; colon cancer: men and women age 50 and older had either a fecal occult blood test in the past year, a flexible sigmoidoscopy in the past 5 years, or a colonoscopy in the past 10 years.

vice/accommodation. Although participants held a range of jobs, the most common were food server, health care assistant, and child care provider. None of the qualifying participants held a senior-level or managerial position.

Health Survey

Results from the health survey indicated that most of the participants considered themselves to be in good health, and the majority of the participants were physically active (Table 2). About 60% were overweight or obese, and 26% were current smokers; these rates are similar to those of low-income residents of King County, Washington.[34]

Interviews

Key findings identified from the final set of coded material are presented in Table 3. Representative quotes are presented in the upcoming text.

Current Employer Efforts Around WHP. Almost half of the couples interviewed included a qualifying employee currently working for an employer that provides some form of WHP. The most commonly cited types of WHP were gym discounts, free gym memberships, or access to an onsite gym. Health-related communications, such as newsletters with fitness tips and healthy recipes, or postings about the benefits of biking to work, were also mentioned by many employees. On-site flu shots, either free or subsidized by the employer, were mentioned by several employees. However, no qualifying employee described WHP that included all or most of the criteria recommended by the National Institute for Occupational Safety and Health, the Centers for Disease Control and Prevention (CDC) agency responsible for setting recommendations around workplace health programs.[35] Most of the WHP efforts made by employers were minimal.

Although relatively few employers offer tobacco cessation programs, some employees mentioned that smoke-free policies at their worksite had helped them cut down on the number of cigarettes they smoke. None of the employees mentioned subsidized healthy food at their worksites, though a few did note healthy options in meetings or the cafeteria.

Reasons for Lack of WHP. When qualifying employees at organizations that do not currently offer WHP were asked

Table 3
Key Findings From Interviews

Discussion Guide Topic	Finding
What employers currently offer	Half of employers offer some form of WHP
	Few take comprehensive approach to WHP
	Gym discounts/free gym memberships/access to on-site gym
	Health-related communications
Why some employers don't offer WHP	Not an organizational priority
	Emphasis on profit and bottom line, not employee health
	Logistical challenges
Interest in WHP	Majority are interested
	Could improve employee morale and promote team building
	Appropriate for employers to offer WHP
	Skepticism over employer interest in offering WHP
Most appealing types of WHP	Physical activity programs most popular
	Nutrition, weight control also mentioned frequently
	Tobacco cessation, flu shots mentioned less
How employers should communicate about/promote WHP	In person is best
	E-mail acceptable but not as effective as in person
	Postings at worksite can be effective
	Use multiple channels
Active for Life	Most are interested for self or coworkers
	Questionable value
	Could appeal to coworkers
Gym discounts	Most are interested for self or coworkers
	Location is important
Cancer screening	Primarily positive reaction to brochure
	Personally useful
Extending WHP to partners	Partners open to it
	Gym discounts most preferred
	Could be social benefits
	Might not be logistically practical
	Communication would need to come via employee

WHP indicates workplace health promotion.

why their employers do not offer WHP, the most commonly cited reason is that employee health is not an organizational priority.

"*That's not the focus of the ownership. . . .*"

"*[WHP] is not part of the culture. . . .*"

Many also mentioned their employer's emphasis on profit and bottom line over employee health, as well as the sense that employee health is not worthy of investment.

"*The management values money and so that's what the whole focus is.*"

"*It's not important for them that somebody got sick or that somebody is overweight; they can replace them very easily.*"

Some also noted that the nature of the industry made wellness efforts difficult to execute (such as high turnover in restaurants or shift work in hotels) or that their company was just too small to offer WHP.

"*There's a lot of turnover, so it wouldn't be business-smart to put an emphasis on these people that are probably going to just take off in 6 months anyway.*"

"*They're just not big enough to hire someone to think about that.*"

General Interest in WHP. Most of the qualifying employees we interviewed expressed some degree of interest in having WHP at their worksites. Many noted that offering WHP could benefit the employer as well as the employees.

"*There are statistics that support that healthy lifestyles equal less days off . . . [an employer] could totally justify [WHP] because productivity would be better, employee morale would be better. . . .*"

Whether or not they currently had WHP made little difference; most were open to the idea of WHP generally, and some were enthusiastic.

"*I've never worked at a place that's ever offered anything like that. . . . I would love it.*"

Among the minority of employees not interested in having WHP at their worksites, nearly all of the comments related to the belief that employee health programs are not something a workplace generally provides.

"*It's just not something I would ever expect from [my employer]. . . .*"

No qualifying employee expressed the view that WHP efforts are intrusive or inappropriate. The more common response was that they could not imagine their employer making a serious commitment to improving their health and well-being.

Most Appealing Types of WHP. When we asked qualifying employees what kind of WHP they would find appealing, most named one or more types they would be open to considering. The most common behavior they mentioned was physical activity. About half of qualifying employees either brought up or reacted favorably to the idea of gym discounts or free gym memberships.

"*I've had about 50 jobs in my lifetime, and I've wished that all of them had gym memberships!*"

"*[Gym discounts] might be cool. . . .*"

Different types of physical activity programs were also mentioned, as well as time on the clock to exercise.

WHP focused on nutrition and healthy eating was also frequently mentioned. Providing healthy food onsite or subsidizing healthy food was the specific form of WHP mentioned most.

"*I wish that they would offer more healthy options for a lower price.*"

"*I would like to have vending machines at work . . . with healthier options.*"

WHP focused on weight control was also considered appealing, with Weight Watchers at Work the program most likely to be specified.

"*If they had the Weight Watchers program for all of our employees, I know that a lot of us would be interested in doing it together.*"

Several qualifying employees expressed interest in WHP efforts related to tobacco cessation or free or discounted immunizations, such as flu shots. Others would welcome health information (e.g., newsletters, classes). A number of qualifying employees expressed general interest in WHP or positive feelings about WHP already in place at their worksites without giving specific examples of services they wanted or liked. Finally, some qualifying employees said they wanted health/dental insurance or better insurance than they were currently offered. We distinguished between WHP and health insurance in our interviews, but qualifying employees without health insurance often pointed to it as their first priority.

Preferred Modes of Communication Around WHP. Most qualifying employees prefer that the employer communicate about WHP to them either in-person, such as at meetings, or via e-mail.

"*I would prefer [to be told in-person] so that you could ask questions.*"

"*E-mail works best. . . . I actually like reading stuff that's sent to me on my e-mail.*"

Many also mentioned postings at the worksite as an effective way to relay information. Several qualifying employees noted that communicating via multiple channels would be most effective, such as a supervisor providing information at a meeting, then following up with e-mail reminders and a flyer posted in the break room.

Reactions to Specific Programs. For the section of the interview focused on specific programs, we included all participants' reactions, because we wanted to assess the interest levels of both qualifying employees and their partners in participating in programs and using resources. We distinguished between participants who were interested in participating themselves and those who did not want to participate but thought that others at their worksite would be interested.

"Active For Life" (AFL)

No participant thought that it would be inappropriate for their employer to offer Active For Life. About a fourth reported that they would not be interested in participating. The remaining participants either expressed some degree of interest in participating or thought coworkers might be interested.

Among those employees positive toward AFL, a large number commented on how such a program could build employee morale or bond them with their coworkers.

"*It would make the workplace more fun, and I think that it would boost morale. . . .*"

"*I think that it would be beneficial, not only health-wise, but it would also lead to more team building and camaraderie.*"

A sizeable number of participants were unsure about whether they would actually participate, but could see how such a program might be beneficial.

"*I don't know if I would want to take part in it . . . but I can see the value.*"

A few stated that, while AFL did not appeal to them personally, they expected that their coworkers might react positively.

"*I would think that people at work would be interested in it that weren't as active as I am.*"

Overall, participants were positive toward AFL and comfortable with their employers offering it.

Gym Discounts

The majority of participants reacted positively toward employer-sponsored gym discounts, either for themselves or for coworkers.

"*I think that it's great if we had . . . like a gym membership discount. . . . Definitely, the gym thing would be nice.*"

"*. . . I have some coworkers that are interested in going to the gym.*"

About a fourth of the participants noted that their interest level would depend on the location of the gym.

"*I think that the location would probably be the biggest thing. . . .*"

Several participants wondered whether they or their coworkers would actually use it, referring to past experiences with employers who offered gym memberships that generated initial enthusiasm among employees but lack of long-term commitment.

"*A lot of people . . . might try it . . . but then peter out.*"

However, most of the participants could see value in an employer sponsoring gym discounts, even if uptake was uncertain.

Cancer-Screening Promotion

Of the participants who reviewed the cancer-screening brochures, a large majority were interested in receiving this type of information from their employer. The most frequent positive comments centered on the usefulness of the information to them personally. Some also suggested that by providing such a brochure, employers could demonstrate a concern for their employees' health.

"*I've never had a job that's done that . . . it would be nice.*"

"*[This brochure] would probably prompt me to [get screened] because I don't usually think about this stuff.*"

Among the very few with negative comments, most focused on not needing or already knowing the information contained in the brochure.

"*For me personally, I police myself . . . I don't need it.*"

Relationship Between Interest in Programs and Personal Health Behavior

To determine whether interest in particular WHP example programs differed by participants' current levels of risk, we looked at participants' self-reported physical activity and cancer-screening behaviors. Were the participants most favorable toward these types of programs already leading healthy lifestyles? We found that physically inactive participants expressed levels of interest in AFL and gym memberships similar to those meeting physical activity recommendations. In each group, half or more of the participants were positive toward their employers offering these programs. Similarly, most participants over age 45 were interested in receiving information about cancer screening regardless of whether they personally were up-to-date for the cancer screenings for which they were age eligible.

Personal Health Behavior Change

We asked all participants about a behavior change they tried to make within the past year. Consistent with the types of WHP they were interested in receiving, most reported trying to change their eating habits, get more physical activity, or lose or manage weight. Several participants tried to quit smoking or drink less alcohol. The remainder reported trying to change other behaviors, most commonly related to obtaining specific health care services or improving dental health. Most participants attempted to change health behaviors that standard WHP programs address.

Partners

Interest in WHP Through Partner's Workplace. Most partners of employees were open to participating in WHP efforts sponsored by their partner's employer, and several expressed great enthusiasm.

"*I would definitely be happy to participate [in WHP offered through partner's employer]. . . . I'd be excited!*"

Many noted that their level of interest would depend on the type of WHP, with gym discounts most preferred. However, a significant number of partners also mentioned the social benefits to participating in a physical activity program sponsored by their partner's workplace, such as AFL.

"*It's a good way to get to know each other's coworkers. . . .*"

Among those who were not interested in WHP offered by their partner's employer, most felt that the idea was appropriate, but it would likely be logistically impractical. Very few expressed a sense of discomfort with the idea of being included in WHP based at their partner's workplace.

Communication Preferences. Consistent with beliefs expressed by low-wage employers,[15] partners prefer that any WHP-related communication from their partner's employer come verbally via the employee. Postal mail addressed to both partners was mentioned the second most frequently. Partners were adamant that any communication meant for a partner should never exclude the employee.

CONCLUSION

Most employees we interviewed view WHP as both appropriate and, depending on the type, somewhat to very appealing, with programs addressing healthy eating and physical activity generating the most interest. Many also support efforts to expand WHP to partners, especially if it was logistically practical. Those who lack interest in WHP did not think they would be offended if it was present at their current workplace. Many also view WHP as morale boosting and evidence that their employers care about their health. Interestingly, the most common reaction to being asked about the appropriateness of health programs offered through the workplace was skepticism that their employers would ever take on such a role.

That employees consistently indicated that they would appreciate working for an organization that prioritized employee wellness is notable given our previous research with human resources managers.[15] We were struck by the disconnect between what these managers told us about potential negative employee reactions to WHP versus what employees themselves expressed. While human resources managers at low-wage worksites voiced the opinion that employees might perceive WHP efforts as intrusive and disrespectful of privacy, employees at similar worksites were nearly uniform in their assertion that WHP efforts demonstrated positive employer intent. Even employees who questioned their own interest in participating in WHP were consistent in the view that WHP signals concern for employee health.

Although most participants expressed interest in some type of WHP, it is not possible to determine from these interviews the percentage of employees that would sign up to participate, or sustain participation, in WHP efforts. Expressing interest in a hypothetical program and participating in an actual program are not the same. For example, more than half of the employees we interviewed expressed interest in gym memberships, but very few of those who currently or in the past had access to free or subsidized gym memberships mentioned having enrolled. Some previous research indicates that employees in low-wage industries are not as likely to participate in WHP as their higher-wage counterparts.[20,21]

Research suggests that these differences in participation rates may relate less to lack of motivation than to larger social and contextual influences that construct formidable barriers to employee participation.[36] These barriers include lack of familiarity with WHP or awareness of its value, as low-wage industries are less likely to offer it;[37,38] working conditions that hinder involvement such as shift or production line work;[36] and power differentials between management and labor, which

may create suspicion around management-sponsored programs aimed at employee behavior change.[36] That many of the employees we interviewed touched on such challenges supports the need for additional studies, ideally designed to help researchers both better understand the social and contextual factors affecting participation and what can be done to address them.

Despite questions around increasing participation, a central finding in this study is that employees in low-wage industries generally welcome efforts by employers to improve employee health, especially those related to increasing physical activity and supporting healthy eating. As these are the two areas of health behavior that participants were most likely to report having recently struggled with, they likely considered potential WHP with their present personal needs in mind. In addition, both employees and their partners were positive toward employers expanding WHP to partners. Further research could explore in detail what types of physical activity and healthy eating programs, as well as other forms of WHP, would be most likely to attract and sustain participation among both employees and partners.

Limitations and Strengths

This study has several limitations. Sampling was done by convenience. All of the couples were from the greater Seattle area, so findings may not generalize to employees living elsewhere. Employees and partners interested in participating in a study about health and wellness may hold more positive views of wellness initiatives than do those who chose not to participate. Many of the questions involved asking employees to speculate on programs they had trouble imagining their employers offering, which may render their responses less certain than if they had been exposed to a wider range of WHP. However, nearly half of the participants had some type of minimal WHP in place, which may have allowed them to have a general sense of their interest level for the programs described during the interview.

This study also has important strengths. The in-depth interview methodology allowed for deep probing into the key research questions, which would not have been possible with surveys. By interviewing both members of a couple, we were able to hear the direct perspectives of partners regarding WHP targeted toward them, which to our knowledge has not previously been studied. The participant pool was diverse, both demographically and in the range of industries represented.

Summary

Employees in low-wage industries and their partners are interested in WHP, especially if it addresses the health behaviors they care most about and is promoted effectively. As the Affordable Care Act continues to roll out, low-wage employers will be motivated to learn more about how to offer effective WHP that also appeals to their employees. These findings can be used to create and deliver programs that are tailored to the particular interests and needs of this workforce, and potentially to their partners as well.

SO WHAT? Implications for Health Promotion Practitioners and Researchers

What is already known on this topic?

Employees in low-wage industries may benefit from workplace health promotion, yet little is known about the types of programs they prefer, how to best promote them, and the appeal of including partners.

What does this article add?

Employees in low-wage industries are positive toward workplace health promotion, both for themselves and their partners. They are most interested in efforts focused on improving nutrition and increasing physical activity, as these are the health behaviors they are most apt to struggle with personally. However, most employees have little personal experience with workplace health promotion and are skeptical that their employers would prioritize it.

What are the implications for health promotion practice or research?

As the Affordable Care Act proceeds toward full implementation, employers in low-wage industries will be increasingly incentivized to offer workplace health promotion. Our research indicates that employees in these industries will welcome such efforts, both for the personal benefits of the programs and the positive effects on productivity and morale.

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References

1. Heron M. Deaths: leading causes for 2008. *Natl Vital Stat Rep.* 2012;60(6):1–94.
2. Loeppke R, Taitel M, Haufle V, et al. Health and productivity as a business strategy: a multiemployer study. *J Occup Environ Med.* 2009;51:411–428.
3. National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. The power of prevention chronic disease . . . the public health challenge of the 21st century; 2009. Available at: http://www.cdc.gov/chronicdisease/pdf/2009-power-of-prevention.pdf. Accessed January 31, 2013.
4. Huang Y, Hannon PA, Williams B, Harris JR. Workers' health risk behaviors by state, demographic characteristics, and health insurance status. *Prev Chronic Dis.* 2011; 8(1):A12.
5. Baicker K, Cutler D, Song Z. Workplace wellness programs can generate savings. *Health Aff (Millwood).* 2010;29:304–311.
6. Mello MM, Rosenthal MB. Wellness programs and lifestyle discrimination—the legal limits. *N Engl J Med.* 2008;359: 192–199.
7. Bondi MA, Harris JR, Atkins D, et al. Employer coverage of clinical preventive services in the United States. *Am J Health Promot.* 2006;20:214–222.
8. Linnan LA. The business case for employee health: what we know and what we need to do. *N C Med J.* 2010;71:69–74.
9. Crimmins TJ, Halberg J. Measuring success in creating a "culture of health." *J Occup Environ Med.* 2009;51:351–355.
10. Lemon SC, Zapka J, Li W, et al. Step ahead a worksite obesity prevention trial among hospital employees. *Am J Prev Med.* 2010; 38:27–38.
11. Schult TM, McGovern PM, Dowd B, Pronk NP. The future of health promotion/disease prevention programs: the incentives and barriers faced by stakeholders. *J Occup Environ Med.* 2006;48: 541–548.
12. US Dept of Commerce, US Census Bureau. Statistics about business size (including small business) from the U.S. Census Bureau. Available at: http://www.census.gov/econ/smallbus.html. Accessed January 31, 2013.
13. Harris JR, Huang Y, Hannon PA, Williams B. Low-socioeconomic status workers:

their health risks and how to reach them. *J Occup Environ Med.* 2011;53:132–138.
14. Hannon PA, Garson G, Harris JR, et al. Workplace health promotion implementation, readiness, and capacity among midsize employers in low-wage industries: a national survey. *J Occup Environ Med.* 2012;54:1337–1343.
15. Hannon PA, Hammerback K, Garson G, et al. Stakeholder perspectives on workplace health promotion: a qualitative study of midsized employers in low-wage industries. *Am J Health Promot.* 2012;27: 103–110.
16. Lassen A, Bruselius-Jensen M, Sommer HM, et al. Factors influencing participation rates and employees' attitudes toward promoting healthy eating at blue-collar worksites. *Health Educ Res.* 2007;22:727–736.
17. Sorensen G, Barbeau EM, Stoddard AM, et al. Tools for health: the efficacy of a tailored intervention targeted for construction laborers. *Cancer Causes Control.* 2007;18:51–59.
18. Gabel JR, Whitmore H, Pickreign J, et al. Obesity and the workplace: current programs and attitudes among employers and employees. *Health Aff (Millwood).* 2009; 28:46–56.
19. Loma L, McLuskey J. Pumping up the pressure: a qualitative evaluation of a workplace health promotion initiative for male employees. *Health Educ J.* 2005;64: 88–95.
20. Anderson LM, Quinn TA, Glanz K, et al. The effectiveness of worksite nutrition and physical activity interventions for controlling employee overweight and obesity: a systematic review. *Am J Prev Med.* 2009;37:340–357.
21. Sorensen G, Stoddard A, Ockene JK, et al. Worker participation in an integrated health promotion/health protection program: results from the WellWorks project. *Health Educ Q.* 1996;23:191–203.
22. Centers for Disease Control and Prevention. CDC health disparities and inequalities report—United States 2011. *MMWR.* 2011;60(suppl):1–114.
23. Margerison-Zilko C, Cubbin C. Socioeconomic disparities in tobacco-related health outcomes across racial/ ethnic groups in the United States: national health interview survey 2010. *Nicotine Tob Res.* 2013;15:1161–1165.
24. Pampel FC, Krueger PM, Denney JT. Socioeconomic disparities in health behaviors. *Annu Rev Sociol.* 2010;36:349–370.
25. Thompson SE, Smith BA, Bybee RF. Factors influencing participation in worksite wellness programs among minority and underserved populations. *Fam Community Health.* 2005;28:267–273.
26. Fung K. *Type 2 Diabetes: A Couples Study on Spousal Relationship and Health Behaviors* [Dietrich College Honors Theses Paper 12]. Pittsburgh, Pa: Carnegie Mellon University; 2009. Available from: http:// repository.cmu.edu/hsshonors/12. Accessed January 31, 2013.
27. Padula CA, Sullivan M. Long-term married couples' health promotion behaviors: identifying factors that impact decision-making. *J Gerontol Nurs.* 2006;32:37–47.
28. Trief PM, Morin PC, Izquierdo R, et al. Marital quality and diabetes outcomes: the IDEATel Project. *Fam Syst Health.* 2006;24: 318–331.
29. Tucker JS, Anders SL. Social control of health behaviors in marriage. *J Appl Soc Psych.* 2001;31:467–485.
30. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care.* 2007;19:349–357.
31. Bureau of Labor Statistics. May 2007 national industry-specific occupational employment and wage estimates. Available at: www.bls.gov/oes/current/oessrci.htm. Accessed August 7, 2013.
32. Green BB, Cheadle A, Pellegrini AS, Harris JR. Active For Life: a work-based physical activity program. *Prev Chronic Dis.* 2007;4:A63.
33. US Census Bureau. State and county quickfacts; 2013. Available at: http:// quickfacts.census.gov/qfd/states/53/ 53033.html. Accessed May 7, 2013.
34. Washington State Department of Health. King County, Washington chronic disease profile; 2009. Available at: http://www. doh.wa.gov/portals/1/Documents/Pubs/ 345-271-ChronicDiseaseProfile2012King. pdf. Accessed October 2, 2013.
35. National Institute for Occupational Health and Safety. Essential elements of effective workplace programs and policies for improving worker health and wellbeing; 2008. Available at: http://www. cdc.gov/niosh/docs/2010-140/pdfs/ 2010-140.pdf. Accessed June 6, 2013.
36. Linnan LA, Sorensen G, Colditz G, et al. Using theory to understand the multiple determinants of low participation in worksite health promotion programs. *Health Educ Behav.* 2001;28:591–607.
37. Linnan L, Bowling M, Childress J, et al. Results of the 2004 National Worksite Health Promotion Survey. *Am J Public Health.* 2008;98:1503–1509.
38. Sorensen G, Barbeau E, Hunt MK, Emmons K. Reducing social disparities in tobacco use: a social-contextual model for reducing tobacco use among blue-collar workers. *Am J Public Health.* 2004;94:230–239.

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