The workplace provides an important opportunity for health promotion, both in terms of allowing access to a large proportion of the adult population and encouraging developments within the workplace structure to improve health. This paper reports on the findings of a survey of Scottish workplaces carried out in 1996 for the Health Education Board for Scotland to assess the state of health promotion activity in the Scottish workplace setting. The results echo those from previous surveys in that most health promotion effort was centred around health and safety, smoking, and alcohol issues, particularly for the smaller and less well-resourced businesses. Under one-fifth of businesses surveyed addressed areas such as stress and mental health, which are being seen as increasingly important in terms of their contribution to the well-being of the employee and the organization. The main implication of these findings is that it is smaller businesses who potentially have the most to gain from workplace health promotion. In this context, the construction of relevant and sustainable health promotion programmes requires an organizational development perspective in order to encourage such businesses to regard workplace health promotion as part of good business practice.
assess the extent of change in workplace health promotion activity during the intervening 2 years. Findings from these phases of research will expand on many of the issues touched on in this paper and will form the basis of future publications.

Findings from previous surveys indicate that smoking and alcohol tend to be the main areas addressed as these are seen as legitimate concerns for employers (Waghorn et al., 1993; Health Education Authority, 1997). Other areas are tackled relatively infrequently, often due to lack of resources or the perception that they are not the responsibility of the workplace. Given the increasing emphasis on issues such as stress in the workplace and its potential impact on health (Cox, 1993), ascertaining to what extent health promotion action is still restricted to the above areas will inform the possible future direction for workplace health promotion in Scotland.

**Methodology**

The survey was carried out by the MVA Consultancy and conducted by post. The questionnaire included some general questions on whether the workplace had any health-related policies or implemented measures to improve the health of their employees, while other questions assessed the nature and extent of these in relation to specific topics, examined attitudes towards the benefits of workplace health promotion and possible constraints on doing workplace health promotion, and elicited general information on the workplace and the organization’s approach to dealing with health-related issues.

**Sampling**

The sample was provided by Market Location, a specialist business sample provider, and consisted of 1500 workplaces randomly selected from a sampling frame stratified by sector, location and size. This sample represented slightly over 1% of the target population. A disproportionate stratified sample was used in order to obtain sufficient returns from types of workplaces which are relatively under-represented or tend to have lower response rates, such as service sector or small workplaces. Although this approach resulted in a selected sample which was not representative of Scottish workplaces, it did mean that separate analyses could be carried out for each type of workplace (Health Education Board for Scotland and the MVA Consultancy, 1997). The private service sector was felt to be particularly relevant for this study since previous research has indicated that such workplaces are less likely to be actively involved in health promotion (Crosswaite and Jones, 1994a).

**The survey**

The draft questionnaire was intensively piloted with 100 randomly selected Scottish workplaces. This involved contacting initial non-respondents to establish whether they were experiencing difficulties in completing the pilot questionnaire, as well as more in-depth exploration of design issues with a further sub-sample. The finalized questionnaire was posted to the selected sample, and considerable effort put into achieving a high response rate using postal and telephone reminders. A survey of non-respondents was also conducted at the end of the survey. Responses were obtained from 1041 workplaces. This represents a response rate of 73% for the 1419 in-scope workplaces, while 5% of the selected sample were out of scope (business closed, telephone number untraceable, etc.). Response rates varied by sector and size, with the public service sector and medium/large workplaces having the highest response rates (91 and 77%, respectively), and the private service sector and small workplaces having the lowest (66 and 56%, respectively). The sample structure and overall response rates are shown in Table I.

**Analysis**

The primary analysis examined the extent and nature of health promotion activity in the workplaces in the sample, as well as their perceptions regarding the likely benefits of and constraints on doing workplace health promotion. This article presents the results of these analyses by sector, size and level of health promotion activity. The
Health promotion in the Scottish workplace

Table I. Response by sector and size

<table>
<thead>
<tr>
<th>Sector</th>
<th>Selected sample</th>
<th>Achieved sample</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>primary industry</td>
<td>300</td>
<td>216</td>
<td>72</td>
</tr>
<tr>
<td>manufacturing</td>
<td>400</td>
<td>271</td>
<td>68</td>
</tr>
<tr>
<td>private service</td>
<td>700</td>
<td>463</td>
<td>66</td>
</tr>
<tr>
<td>public service</td>
<td>100</td>
<td>91</td>
<td>91</td>
</tr>
<tr>
<td>No. of employees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 10</td>
<td>523</td>
<td>293</td>
<td>56</td>
</tr>
<tr>
<td>11–99</td>
<td>504</td>
<td>395</td>
<td>78</td>
</tr>
<tr>
<td>≥ 100</td>
<td>473</td>
<td>353</td>
<td>75</td>
</tr>
</tbody>
</table>

categories for these variables are defined as follows:

- Sector: primary industry, manufacturing, private service, public service.
- Size: small (less than 10 employees), medium (between 10 and 99 employees), large (100 employees or more).
- Level of health promotion activity: none, low (active in one to three areas of health promotion), average (active in four or five areas), high (active in six or seven areas), very high (active in eight areas or more).

Motivation to undertake workplace health promotion was assessed using two questions. The first examined the perceived likelihood of various benefits which could result from workplace health promotion. These benefits were classified according to whether the main beneficiaries were the workplace or the employees. The mean score within each category was then used as an indicator of the perceived positive impact of health promotion on the workplace and the employees. A similar indicator was constructed from a question asking about the potential impact of constraints on commitment to undertake workplace health promotion.

Each workplace therefore has three scores: perceived benefit to the workplace, perceived benefit to the employee and perceived impact of constraints. Likely impact is measured on a five-point scale with a high score indicating a positive outcome, such as a likely benefit or constraints having little effect on commitment to workplace health promotion. Analyses of the mean scores were carried out in relation to workplace sector, size and level of health promotion activity.

Since many of the differences found in this analysis were rather small, tests of statistical significance were carried out as an initial filtering process in order to identify potential patterns in the data. This was done using the one-way ANOVA procedure in SPSS. Since, overall, the observed differences proved to be significant despite their small scale, further post-hoc tests were applied to clarify where these differences lay. However, due to the relatively large sample size, there were still quite a few small differences which attained statistical significance at the 5% level, particularly for comparisons involving smaller number of groups, and so caution must be used in interpreting the findings. As a rough guide, mean differences of less than 0.2 on a five-point scale were not considered to be of substantive significance and the interpretation focused on the larger differences (greater than 0.3).

Results

Levels of health promotion activity

Activity levels for workplace health promotion varied markedly by sector and size of workplace. Public sector workplaces were most active with 80% having high or very high levels, while the least active were in the manufacturing and private service sectors (Figure 1). Large workplaces showed higher levels than small or medium ones (Figure 2), but these differences were less extreme.

The proportions of workplaces addressing different health-related topics showed wide variation (Figure 3). While 84% of workplaces overall addressed health and safety, 68% smoking and 64% alcohol issues, under 20% of workplaces were active in areas such as HIV/AIDS, healthy eating, exercise and dental/oral health. Workplaces with lower levels of health-related activity rarely addressed the less common health issues such as stress/mental health or exercise. Instead they
Smoking was restricted in all public sector workplaces, while this was the case in 63% of manufacturing and 74% of private service workplaces. Large workplaces were more likely to restrict smoking than small ones (89 compared with 62%) and more likely to provide smoking cessation support (31 and 7%, respectively).

**Alcohol**

Seventy-eight percent of workplaces imposed restrictions on alcohol consumption in the workplace. The proportion of workplaces with such restrictions were evenly spread throughout the different sectors and size of workplace. There were,
however, differences in the type of restrictions. For example, only 36% of public sector workplaces banned alcohol completely compared with 76% of manufacturing workplaces. However, a substantially higher proportion of public sector workplaces provided support for those with an alcohol problem (77%) and education on alcohol (47%), compared with 22 and 11%, respectively, for the manufacturing sector.

**Other areas**

While 41% of workplaces said they addressed issues relating to drug/substance use, less than a quarter of workplaces overall (23%) had a formal drug misuse policy. Public sector workplaces and those with high levels of health promotion activity were more likely to have a formal policy (40 and 71%, respectively).

Occupational health services were more often provided by public sector (74%) and large workplaces (55%), compared to 39% overall. The public sector was also more likely to have policies on stress/mental health (51% compared with 18% overall). In workplaces which had mental health policies, 72% recognized the right of employees to acknowledge undue stress, 69% provided access to counselling, 65% included provision to change working practice and 32% provided education on stress. Only 10% of workplaces took action to establish the health needs of their employees.

A small proportion of workplaces stated that they addressed issues around HIV/AIDS in the workplace (15%) and, as with stress/mental health, the majority of these were in the public service sector (60% of public service workplaces had an HIV/AIDS policy).

Seventy-two percent of workplaces provided kitchen facilities while 30% provided a canteen. Just over one-third of those with a canteen had a healthy eating policy (35%), with the public service and manufacturing sectors being more likely to do so (53 and 41%, respectively, compared with 21% for the private service sector and 34% for the primary sector).

Only 20% of workplaces said they encouraged employees to take exercise. As might have been expected, the large workplaces were more likely to provide facilities (44% compared to 37% overall) and subsidize employees’ use of external facilities (47 compared with 38% overall). However, medium-sized and small workplaces who encouraged physical activity among employees tended to do so by organizing sporting events (62% for medium-sized and 54% for small workplaces, compared to 38% of large workplaces).
Motivation for doing workplace health promotion

While there were no significant differences between the different sectors for perceived constraints, the public sector showed the most appreciation of the benefits of workplace health promotion compared with the manufacturing and service sectors (Figure 4). Large workplaces tended to have a more positive attitude overall than medium or small workplaces, though these differences were less marked for perception of constraints (Figure 5).

The most marked and consistent differences were in relation to the levels of health promotion activity (Figure 6). These are represented by a distinctive gradient in mean scores for the perception of benefits for employees and the workplace. While in this respect there was no significant difference between workplaces with average and high levels of activity, those with very high levels were clearly differentiated from the rest and expressed the most positive attitude. The results for the perception of constraints were somewhat less consistent since workplaces with no health promotion activity showed no significant differences compared with other workplaces. However, workplaces with high levels of activity were again differentiated from those with lower activity levels.
Fig. 6. Perceived benefits and constraints by level of health promotion activity.

To summarize, public sector and large workplaces showed more positive attitudes in terms of the benefits of workplace health promotion. Workplaces with high levels of health promotion activity were also more appreciative of the benefits and saw the constraints as having less impact than workplaces with lower levels, although the differences for this last measure were not as marked. This is not particularly surprising, but it does support the idea that barriers to workplace health promotion are both motivational and resource related, which implies that these two aspects should be taken into account when planning or implementing health promotion projects. Lack of evidence was not really considered as a barrier compared with lack of resources. In addition, the overall mean score for perceived benefits for employees is higher than that for perceived benefits to the workplace (mean difference = 0.297, $P < 0.001$ for a paired $t$-test), suggesting that workplace health promotion may be seen as more likely to benefit employees than the workplace.

**Discussion**

The survey findings show that alcohol and smoking are still the predominant issues currently being addressed in the majority of Scottish workplaces. It is therefore apparent that workplaces continue to feel the need to address these topics. However, the survey highlights several other areas of concern.

In total, 18% of workplaces had policies addressing stress/mental health issues. This is a relatively low level of activity considering that stress has been identified as the most pressing health issue for workplaces in a number of surveys (Cox, 1993). It has been suggested that up to 60% of all work absence may be caused by stress-related disorders (Kearns, 1986) and mental disorders constitute the second most common cause of sickness absence among women (Department of Social Security, 1993). Under the Health and Safety at Work Act 1974, employers have a statutory obligation to protect the mental health of their employees in the workplace, and to this effect, the Health and Safety Executive published an advice booklet dealing with the issue of stress (Health and Safety Executive, 1995).

Given the potential for health gain, the low profile of mental health promotion in the workplace strongly suggests that action to address mental health in the workplace is a priority (Crosswaite, 1996). This raises issues concerning organizational development since working conditions contribute to the mental health of employees, particularly lack of influence over work, repetitive tasks and long working hours. Conversely, poor mental health and unacceptable levels of stress affect job performance and thus impact on the organization.
(Cox, 1993). In order to effectively address mental health in the workplace, organizations therefore must be prepared to consider organizational factors, such as working practices and environment.

While 41% of workplaces stated that they addressed the issue of drug misuse, only 23% actually had a drug misuse policy. The impact of drug misuse in the workplace has similar potential implications as alcohol misuse in terms of health and safety. This constitutes a strong argument for employers to be encouraged to develop policies or stated procedures to deal with drug misuse, or extend their alcohol policy to cover all areas of substance misuse. The latter is preferable since it makes the employee more likely to admit to having a problem and allows the workplace to address the problem as it relates to job performance and safety, rather than becoming enmeshed in considerations of legality and morality which are not directly relevant to the organization (Health and Safety Executive, 1998).

Public sector and other large workplaces showed a more positive attitude towards health promotion, and this is reflected in the levels of activity. Small and medium sized workplaces viewed health promotion less positively. This is not surprising, however, since lack of resources and time have been identified as barriers to workplace health promotion (Waghorn et al., 1993; Crosswaite and Jones, 1994a; Health Education Authority, 1997) and these factors would be even greater constraints for smaller businesses. The results of this survey echo the findings of a study carried out by the Health Education Authority which highlighted the fact that employees of smaller workplaces are not being exposed to health promotion in the workplace at the same levels as those in larger organizations (Health Education Authority, 1997).

While it is rewarding to find that certain workplaces are very active in the field and have taken action to address key topic areas, the Green Paper Working Together for a Healthier Scotland (Scottish Office Department of Health, 1998) highlights the need to tackle the areas of inequity in Scotland’s health record. This is reflected in the Health Education Board for Scotland’s Strategic Plan (Health Education Board for Scotland, 1997) which stresses the importance of targeting small and medium sized enterprises. However, research in the workplace arena (Jones and Ross, 1994) has suggested that workplaces are more likely to divert resources to health action if the topic is perceived as being of direct relevance to them. Such issues were explored as part of the in-depth case studies which constituted the second phase of the SHAW evaluation and these findings will be presented in a forthcoming paper.

Conclusions

There are three main points which emerge from the above discussion. The first is the importance of targeting small and medium sized workplaces as they tend to have the lowest levels of health promotion activity. In Scotland, these represent approximately 98% of workplaces, but employ only 58% of the total workforce (Crosswaite and Jones, 1994b). So in terms of health promotion resources, targeting those with the greatest needs involves a considerable investment for somewhat restricted impact in terms of proportion of workforce. In many ways it is easier, and more cost effective, to target large organizations, although they are not ones who would most benefit. In other words, equity costs.

The second point is linked to the first and concerns the need for sustainable frameworks for workplace health promotion. If the smaller workplaces who are most likely to benefit from health promotion are also the least motivated and resourced, then efforts must be made to bring these workplaces on board in terms of convincing them of the positive impact of health promotion, and developing programmes that are relevant to them and can be implemented on a long-term basis.

This leads to the third point, which is that effective workplace health promotion will necessarily have to engage with organizational and structural issues, and thus be required to adopt a wider organizational development perspective. It is perhaps such a perspective which will encourage the smaller businesses to regard workplace health
promotion as part of good business practice and be more willing to invest in ways to support it.

References


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