Health Promotion Programs Sponsored By California Employers

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Abstract: A survey of California employers with more than 100 employees at one or more sites was undertaken to determine: 1) the nature and extent of health promotion activities; 2) plans for continuation and/or expansion of these activities; 3) plans for initiation of new activities; and 4) the relationship between reported health promotion activities and other characteristics of employers. Of 511 employers with whom interviews were attempted, 49 possible respondents could not be reached and 38 respondents refused to be interviewed, leaving 424 or 83 per cent. Almost one-half of the sites where interviews were conducted had fewer than 200 employees. A total of 332 (78.3 per cent) of employers offered one or more health promotion activities. The most frequent activities provided were accident prevention (64.9 per cent) and CPR (52.8 per cent) with other frequent programs including alcohol/drug abuse (18.6 per cent), mental health counseling (18.4 per cent), stress management (13.0 per cent), fitness (11.6 per cent), hypertension screening (10.1 per cent), and smoking cessation (8.3 per cent). Employers with at least one activity averaged 2.8 activities. The likelihood of having health promotion activities increased with company size. Establishment of new programs appeared to accelerate rapidly in recent years. (*Am J Public Health* 1983; 73:538–542.)

Introduction

Over the past 15 years, employers in the United States have accepted increasing responsibilities for the health of their employees. Employers pay an increasing proportion of the costs of employee health insurance; they have expanded health benefit packages to include dental services, initiated coverage for mental health problems, and increased personnel and expenditures to improve workplace safety and reduce occupational exposures.[1]

A substantial shift toward prevention is reflected in a 1978 Louis Harris poll commissioned by the Pacific Mutual Life Insurance Company. It showed that 79 per cent of business leaders and 89 per cent of labor leaders nationwide believed that our health care system should devote "more emphasis to preventive and less to curative medicine" whereas fewer than 6 per cent of each group believed the opposite.[2]

Some companies have mounted organized programs to help employees reduce or eliminate self-destructive behaviors, such as smoking or excess alcohol consumption, and to help them initiate healthier behaviors, such as aerobic exercise and making better food choices.* While several unpublished reports have chronicled the growth of health promotion activities, these reports have usually been limited to large employers; they have been based on a low response rate, and have generally covered only a portion of activities that can be classified as health promotion.

A 1978 survey of corporate health promotion and risk reduction activities by the Washington Business Group on Health sent to its 160 member companies, almost without exception among the Fortune 500, yielded 59 responses (36.9 per cent). Companies with programs targeted at specific risks ranged from 41 per cent offering stress management to 85 per cent providing cardiopulmonary resuscitation (CPR) classes.**

A 1979 questionnaire about corporate fitness and other health promotion programs was sent by Fitness Systems to major US companies listed in Fortune magazine, the 300 top Industrials and top 50 of each of the Life Insurance, Commercial Banking, Utilities, Retailing, Diversified Financials, and Transportation business sectors.*** Of the 22 per cent of companies from whom a return was obtained, about one-half had diet/nutrition counseling and/or smoking cessation, slightly more than one-third had stress management programs, two-thirds had alcohol/drug programs, and one-fourth had physical fitness programs. The extent of employee fitness programs in Canada was surveyed in early 1981 by the Canadian Public Health Association, with the financial support and consultation of Fitness and Amateur Sport Government of Canada. Among the 26 per cent of 800 companies responding, fitness programs were reported in

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*Some large companies with such programs include Campbell Soup, Control Data Corporation, IBM, Johnson and Johnson, Kimberly-Clark, Mattel, New York Telephone and Telegraph, and Xerox.[3–7]

**Washington Business Group on Health, A Survey of Industry Sponsored Health Promotion, Prevention and Education Programs, (compiled by A. Kiefhaber, A. Weinberg and W. Goldbeck), Washington, DC, December 1978 (unpublished).

***Fitness Systems, Corporate Fitness Programs: Trends and Results, Los Angeles, 1980 (unpublished).

25.4 per cent (N = 52), primarily (86 per cent of total programs) in companies with more than 500 employees.[8]

Insurance carriers are actively recommending that employers consider the adoption of employee health promotion programs. Both the Health Insurance Institute, on behalf of private carriers, and Blue Cross and Blue Shield Associations have published materials which cover program rationale, summarize the best known employer-sponsored programs, review positive effects on absenteeism and productivity, and report cost benefit analyses on these programs.[4,9] In addition, a number of carriers have sponsored a variety of programs for their own employees.[4,9]

Methodology

To gain further information about the situation in California, a survey was undertaken to determine the nature and extent of existing and planned health promotion activities among California employers. For purposes of the survey, health promotion activities were broadly defined.

A complete listing of all California private employers with more than 100 employees, based on unemployment insurance tax records as of December 1980, was obtained from the State Employment Development Department. After the 13,558 listings were stratified according to number of employees, employers were selected randomly to ensure a proportional draw to size. Telephone number location was performed by experienced survey researchers.

An attempt to develop a comparable list of labor organizations was unsuccessful.

In August and September 1981, experienced telephone interviewers called each selected employer and asked to speak to the person in charge of employee health programs, the medical director, or the health benefits director. The nature, purpose and auspices of the study were explained and cooperation requested. After receiving information on total company employees, number of sites, and number of employees at particular sites, the interviewer asked "to speak with the person . . . most knowledgeable about your organization's or your particular branch's health promotion activities." When that person was reached, a 30-minute structured interview was conducted to cover existing and planned health promotion activities. Of the 1,000 companies initially selected, 489 were excluded from the group appropriate for interiew based on reasons summarized in Table 1.

Of the 511 employers meeting the criteria of 100 employees at one site in California, and in operation, 424 (83.0 per cent) were finally interviewed.

Almost one-half (47.9 per cent) of the sites had fewer than 200 employees, almost an additional one-third (30.4 per cent) had 200–499 employees, and slightly more than one-fifth (21.7 per cent) had 500 or more employees, with two sites having over 10,000 employees.

Results

Among the 424 employers responding to the survey, 332 or 78.3 per cent offered one or more of the health promotion activities included in Table 2. The most frequent were accident prevention, offered by 64.6 per cent of all employers surveyed; CPR and choke saver, 52.8 per cent; alcohol and/or drug abuse programs, 18.6 per cent; and mental health/counseling, 18.4 per cent. Hypertension screening, smoking cessation, physical fitness, and stress management programs were made available by 8–12 per cent of the companies. The 424 companies offered a total of 938 health promotion programs, and those with at least one activity averaged 2.8 activities.

About three-fourths of the activities for which duration is known had been in place for less than six years and about one-half had been established within the four years prior to the survey (Table 3). The rate of initiation of new activities grew at an accelerating pace from 11.3 per year during 1962–1971 to 111.5 per year for the 1978–1981 period. Those of longest duration were primarily accident prevention activities.

Main departments or groups responsible for initiating

TABLE 1—Development of Survey Sample

Total listings pulled	1000	
Companies excluded		
Fewer than 100 employees at any one site in California*	378	
Company already interviewed	65	
Phone disconnected, no new listing; wrong number, no new listing	27	
No answer (at least 7 attempts)	15	
Other	19	
Total exclusions	489	
Companies appropriate for interviews		511
Respondent not available or refused		87
Completed interviews		424

*Based on unemployment insurance tax records submitted to the California Employment Development Department.

TABLE 2—Employer Health Promotion Activities

	Currently Offering Program		Planning New Programs
Health Promotion Activity	% of Programs (N = 938)	% of Employers* (N = 332)	% of Programs (N = 217)
Hypertension Screening	4.6	13.0	11.1
Smoking Cessation	3.7	10.5	9.7
Weight Control	3.4	9.6	7.8
Mental Health Counseling	8.3	23.5	3.7
Nutrition Training	2.3	6.6	6.0
CPR, Choke Saver	23.9	67.5	11.1
Exercise/Fitness	5.2	14.8	12.0
Drug/Alcohol Abuse	8.4	23.8	8.3
Stress Management	5.9	16.6	14.3
Accident Prevention	29.2	82.5	4.6
Cancer Risk Reduction	2.9	8.1	4.1
Other	2.1	6.0	7.4

*With at least one activity.

TABLE 3—Chronology of Health Promotion Activity Initiation

Time Interval	Number of Activities Initiated*	Average Number of Activities Added per Year
Prior to 1961	68**	—
1962–1971	113	11.3
1972–1974	45	15.0
1975–1977	188	62.7
1978–1981	446	111.5
TOTAL	860	

*Based on 860 activities for which duration was provided.
**52/68 activities were accident prevention.

activities were reported in descending orders as personnel (35.1 per cent), top management (20.5 per cent), safety group (18.2 per cent), medical department (14.3 per cent), and health benefits groups (7.4 per cent). Almost one-third were conducted by outside groups,‡ and about one-tenth were run by a combination of in-house and outside groups. Approximately two-thirds were offered continuously (Table 4). All employees were eligible for participation in 76.9 per cent of the programs, with other criteria for eligibility including work at a particular site or branch of the organization, executive job category, certain minimum tenure of employment, and particular types of jobs. As expected, increasing number of employees correlated positively with the likelihood of having one or more health promotion activity (Table 5). Of the 100–249 employee group, 66 per cent had at least one program, compared with 98.1 per cent of the 5,000+ employee group. Number of programs per active employer also showed a positive correlation with company size, with mean numbers of activities per employer ranging from 1.0 in the 100–249 employee group to 3.9 in the 5,000+ employee group.

Two-thirds of companies with any activity reported that they routinely evaluate the effectivenes of their health promotion programs. One-half of the individual programs were judged "very effective," and one-third "somewhat effective."

Among the 86 employers who offered no activities, respondents for the organizations deemed half or more of most of those mentioned "very desirable" or "somewhat desirable"; the "no activity" area received less than 35 per cent "desirable" answers.

Specific reasons most frequently cited for not having any existing activities were: "too costly" (100 per cent), "no need/employees healthy" (94.7 per cent), "too difficult to implement" (29.8 per cent), and "high employee turnover" (21.3 per cent). When asked, "In your organization, who has the influence to bring about the implementation of health promotion programs?", the company representatives mentioned top management (43.8 per cent), head of personnel (35.8 per cent), safety personnel (5.7 per cent), medical director (5.4 per cent), and health benefits director (4.2 per cent). Caution in interpreting the response to this question is necessary since many small companies may not have individuals assigned primarily to each of these functions, such as safety director, medical director or health benefits director.

‡Outside agencies used either to complement or to implement the health promotion programs included the Red Cross (135), local hospitals (47), the Heart Association (33), local fire or police departments (28), insurance carriers (26), Cancer Society (25), public health agencies (23), Safety Council (15), and a variety of other organizations (91).

Discussion

The survey technique used as the basis for this report has many inherent limitations. Only one individual at each company responded to questions. Responses are therefore

TABLE 4—Characteristics of Categories of Health Promotion Activities

Activity	Total Programs	On-site (%)*	Run By** In-House Personnel (%)	All Employees Eligible (%)	Offer on Continuing Basis
Hypertension Screening and Control	43	37 (86.0)	29 (67.4)	40 (93.0)	37 (86.0)
Smoking Cessation	35	27 (77.1)	21 (60.0)	34 (97.1)	17 (48.6)
Weight Control	32	24 (75.0)	19 (59.4)	22 (68.8)	19 (59.4)
Mental Health Counseling	78	36 (46.1)	33 (42.3)	63 (80.8)	59 (75.6)
Nutrition Training	22	15 (68.2)	12 (54.5)	17 (77.3)	11 (50.0)
CPR/Choke Saver	224	180 (80.4)	102 (45.5)	151 (67.4)	79 (35.3)
Exercise/Fitness	49	30 (61.2)	24 (49.0)	38 (77.6)	40 (81.6)
Drug/Alcohol Abuse	79	41 (51.9)	44 (55.7)	75 (94.9)	64 (81.0)
Stress Management	55	41 (74.5)	28 (50.9)	24 (43.6)	25 (45.5)
Accident Prevention	274	269 (98.2)	259(94.5)	236 (86.1)	232 (84.7)
Cancer Risk Reduction	27	21 (77.8)	15 (55.6)	22 (81.5)	14 (51.9)
Other	20	17 (85.0)	19 (95.0)	19 (95.0)	13 (65.0)
TOTAL	938	738 (78.7)	605 (64.5)	741 (79.0)	610 (65.0)

*Includes both those offered exclusively on-site and those offered both on-site and off-site.
**Includes those programs run exclusively by in-house personnel as well as those using both in-house personnel and one or more outside individuals or groups.

TABLE 5—Frequency Distribution of Number of Health Promotion Activities by Total Number of Employees*

Number of Activities	Number of Employees				Total Frequency	Total Activities
	100–249	250–749	750–4999	5000+		
0	49 (34.0)	26 (22.8)	10 (12.0)	1 (1.9)	86	
1	45 (31.2)	30 (26.3)	18 (21.7)	8 (15.1)	101	101
2	36 (25.0)	30 (26.3)	18 (21.7)	10 (18.9)	94	188
3–4	10 (6.9)	11 (9.6)	22 (26.5)	15 (28.3)	58	194
≥5	4 (2.8)	17 (14.9)	15 (18.1)	19 (35.8)	55	349
Total Organizations	144 (100)	114 (100)	83 (100)	53 (100)	394	832

NOTE: Per cent shown in parentheses

*The total number company employees was provided by respondents for only 394 employers, who collectively had 832 health promotion activities.

Chi square = 113.5, 30 d.f., p = <.0001; correlation coefficient = 0.433

strongly colored by individual perceptions, and probably therefore by tenure with the company and degree of involvement in the planning, establishment, and evaluation of health promotion programs. There is no commonly accepted definition of a health promotion activity. While the interview was designed to assess the methods used and the intensity of the activity, one individual may interpret an occasional lecture as constituting an activity while another may not. Nothing from this survey can be inferred about the quality of different programs; no attempts were made to determine such program effects as knowledge acquisition, behavioral changes, or changes in morbidity.

Respondents were given a list of choices for many of the questions. Although they were free to provide nonlisted responses or to indicate that they did not know the answer, this technique tends to reduce the variety of responses. The rate of acceleration of program initiation is probably overstated since many companies that initiated programs in the past may no longer be operating and many companies surveyed have probably come into being only within the last five or 10 years. Nonetheless, the trend itself is probably valid. Although California accounts for about 10 per cent of the US population, the degree to which results of this survey in that state can be generalized to the rest of the country is unknown.

Limitations notwithstanding, the survey revealed several findings which were not anticipated. It is surprising that 78 per cent of the companies have at least one health promotion activity, given the large proportion of small companies. Over one-half of companies reported accident prevention programs and CPR/choke saver programs. This may reflect the strong influences of state and federal government requirements for accident prevention programs and the strong Red Cross drive to teach cardiopulmonary resuscitation and the Heimlich maneuver. While corporate interest in employee mental health and in substance abuse problems has received considerable discussion in the lay press, less than one-fifth of companies had programs in either or both of these areas. Only one of 175 sampled companies with 100–249 employees offered a drug abuse/mental health program and only five of this group offered mental health counseling. Despite the major national effort to use the workplace as a prime site for high blood pressure detection and follow-up activities, only about 10 per cent of companies reported such activities, a slightly smaller number than reported exercise/fitness programs.

More companies (31) are planning to implement a stress management activity than any other type of activity, including those with more apparent measurable benefit, such as smoking cessation, drug/alcohol abuse, and hypertension screening and control.

Perceptions of the effects of health promotion activities are of considerable interest. The published literature contains little information on the effects of most health promotion activities at the workplace.[10] In may cases, companies either appear to feel it is not worth the considerable cost to do a careful evaluation or they do not have the appropriate internal resources to undertake such an effort. Attempts to evaluate the independent effects of health promotion activities can be thwarted because other variables in question—such as health insurance premiums, absenteeism, and turnover—are influenced by many unrelated and frequently unmeasurable factors. In this context, the willingness of respondents to indicate whether desirable effects were achieved is striking.

Another salient finding is the acceleration of growth in new programs over the past 10 years. Looking forward, it is notable that employers surveyed planned to continue over 99 per cent of existing activities. In addition, 217 new activities were projected. This latter group was composed primarily of the "newer" group of health promotion/disease prevention activities such as stress management, physical fitness, smoking cessation, weight control, and hypertension screening and control. In each of these areas, the number of planned programs was greater than 50 per cent of all existing programs, suggesting that the number of these programs will be growing more rapidly than in the past. The perceived positive effects of existing programs on morale and productivity and moderating effects on health care costs and utilization reinforce this prediction.

REFERENCES

1. Fielding JE: Health and industrial relations, *In:* Health Care and Industrial Relations: Costs, Conflicts, and Controversy. Institute of Industrial Relations, University of California at Los Angeles, 1981.
2. Health Maintenance, a survey conducted by Louis Harris and Associates of New York City, for Pacific Mutual Life Insurance Company, 1978.
3. Kotz HJ, Fielding JE (eds): Health, Education and Promotion, Agenda for the Eighties. A Summary Report. Washington, DC: Health Insurance Association of America and American Council of Life Insurance.
4. Berry A: Good Health for Employees and Reduced Health Care Costs for Industry, Washington DC: Health Insurance Institute, 1981.
5. Dedmon RE, Gander JW, O'Connor MP, Paschke AC: An Industry Health Managerial Program. The Physician and Sports Medicine 1979; 7(11):56–67.
6. Koerner DR: Cardiovascular Benefits for an Industrial Physical Fitness Program. J Occup Med 1973; 15(9):700–707.
7. Institute of Medicine: Summary of Proceedings of the National Academy of Sciences/Institute of Medicine Conference on the Evaluation of Health Promotion Activities in the Workplace, Washington, DC: NAS/IOM, 1980.
8. Results of the Employee Fitness Program Survey, Canadian Public Health Association, Canada, September 1981.
9. Cunningham RM: Wellness of Work: A Report on Health and Fitness Programs for Employees of Business and Industry. Chicago: Blue Cross Association and Blue Shield Association, 1982.
10. Fielding JE: Evaluation of Worksite Health Promotion Programs, *In:* Summary of Conference on Evaluation of Worksite Promotion Programs. Washington, DC: Institute of Medicine, National Academy of Sciences, 1981.

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International Association on Water Pollution Research and Control Announces 12th Biennial International Conference Call for Papers

The International Association on Water Pollution Research and Control (IAWPRC) has issued a call for papers for its 12th Biennial International Conference to be held in conjunction with the 10th Aquatech Exhibition, September 17–20, 1984 in Amsterdam, Netherlands.

Authors may submit papers for the several general sessions on water pollution, treatment, and control, or for three special themes: sewage treatment; special problems; estuaries, coastal and marine waters and inland seas; and interactions between particulate matter and water.

For further information and rules for manuscript preparation, contact IAWPRC, Alliance House, 29–30 High Holborn, London WC1V 6BA, ENGLAND. Manuscripts must be sent air mail to IAWPR by November 15, 1983. Papers and conference proceedings will be published in the IAWPR journal, *Water Science and Technology*.

NLN 16th Biennial Convention to Probe Key Nursing Issues

The National League for Nursing (NLN) announces its 16th Biennial Convention to be held June 1–4, 1983 in the Philadelphia Civic Center, Philadelphia, PA.

Designed to probe key nursing and health care issues and introduce participants to the latest in technique and technology, the convention program features keynote speaker Gail Sheehy, author of the best-selling *Pathfinders* and *Passages,* who will introduce the convention theme of "Take the Lead . . . Get the Spirit." Drawing upon her research and observations on life and the human psyche, she will discuss the spirit and qualities of leadership that may provide important clues for success by nurses, both individually and collectively.

Program sessions will range in scope from the influence of venture capital on health care delivery, to the implications of new electronic technology, to competition and collaboration between the proprietary and non-profit health care sectors. Several sessions will address current legislative and regulatory issues at the national and state levels.

For further information, contact Kevin L. Morrissey, Media Relations Manager, National League for Nursing, Ten Columbus Circle, New York, NY 10019. Telephone 212/582-1022.