

This thesis addresses the concept of health-promoting leadership. The findings show the importance of leadership for promoting the health of employees. Health-promoting leadership includes the knowledge and skills of the managers as well as the policies and structures of the organisation supporting a health-promoting workplace. It also includes leadership involvement in systematic development of both the physical and psychosocial work environment. The success of interventions aiming at developing a health-promoting leadership depends on how well they are integrated into an organisations culture and daily work.

Health-Promoting Leadership:

A Study of the Concept and Critical Conditions for
Implementation and Evaluation

Andrea Eriksson



Doctoral thesis at the Nordic School of Public, Gothenburg, Sweden 2011

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ISBN 978-91-86739-18-8

ISSN 0283-1961

Printed by Billes Tryckeri AB, Sweden 2011

Abstract

Aim: This thesis aims to describe and analyse the concept of health-promoting leadership, including critical conditions for implementation and evaluation of such leadership.

Methods: Three case studies and one conceptual analysis were conducted using qualitative methods, including interviews, observations and document analysis. The qualitative data material in study III was supplemented with quantitative material from a leadership survey. Study I was a qualitative case study of a Swedish industrial company characterized by a low sickness rate, a structure of self-managed teams and an organisational culture that aimed to develop employee skills and influence. Study II was a phenomenographic study of health-promoting leadership, as described by 20 individuals employed in Swedish municipalities. Study III was a case study of an intervention programme for the development of health-promoting leadership conducted in four city districts of Gothenburg, Sweden. Study IV was a case study on collaboration in workplace health promotion between municipalities in a Swedish region.

Results: Study I illustrates how a company leader developed and influenced organisational culture, including the employees' control over their work situation, participation and personal development. The results of this study emphasise the importance of considering contextual factors when evaluating the role of leadership in promoting health at work. Study II describes health-promoting leadership in three different ways: organising health-promoting activities, supportive leadership style, and developing a health-promoting workplace. Interviewees frequently linked good leadership in general with good employee health. Study III shows the importance of regarding the development of health-promoting leadership as a contribution to building organisational capacity for a health-promoting workplace. The intervention programme was implemented in an existing management group already producing action plans for workplace health promotion. Such integration is an important part of building organisational capacity for creating and sustaining a health-promoting workplace. Study IV shows that collaborative health-promoting leadership is viewed as a strategy to reduce the sickness rate among municipalities in a region. The study implies that collaborative workplace health promotion should be organised initially on a small scale, giving participants the time and opportunities to develop mutual trust. Moreover, Study IV demonstrates the importance of including participants with differing levels of knowledge and experience about workplace health promotion.

Conclusions: Health-promoting leadership can be defined as leadership that works to create a culture for health-promoting workplaces and values, to inspire and motivate employee participation in such a development. Health-promoting leadership can also be viewed as a critical part of organisational capacity for health promotion, including managerial knowledge and skills as well as organisational policies and structures that support a health-promoting workplace. Therefore, leadership involvement in the systematic development of both the physical and psychosocial work environment is important.

Keywords: Health promotion, leadership, workplace health, evaluation, collaboration, case study

Sammanfattning

Syfte: Det övergripande syftet med denna avhandling är att beskriva och analysera begreppet hälsofrämjande ledarskap, vilket även inkluderar förutsättningar för utveckling och utvärdering av ett sådant ledarskap.

Metoder: Kvalitativa metoder har tillämpats i avhandlingens alla studier, inklusive intervjuer, observationer och dokumentanalys. I studie III har det kvalitativa datamaterialet kompletterats med kvantitativa data från en ledarskapsundersökning. Tre fallstudier och en konceptuell analys genomfördes. Studie I var en kvalitativ fallstudie av ett svenskt industriföretag med låg sjukfrånvaro och med en arbetsorganisation som syftade till att utveckla medarbetarnas kompetens och inflytande i sitt arbete. Studie II var en fenomenografisk studie av hur hälsofrämjande ledarskap beskrevs bland 20 personer anställda i svenska kommuner. Studie III var en fallstudie av ett interventionsprogram för utveckling av hälsofrämjande ledarskap i fyra stadsdelar i Göteborg. Studie IV var en kvalitativ fallstudie av samverkan mellan kommuner i en svensk region kring att skapa hälsofrämjande arbetsplatser.

Resultat: Studie I visar hur en företagsledare har utvecklat och påverkat en företagskultur som främjar de anställdas kontroll över arbetssituationen, samt deras delaktighet och personlig utveckling. Resultaten visar på vikten av att ta hänsyn till kontextuella faktorer vid utvärdering av vilken betydelse ledarskapet har för att främja hälsa på arbetsplatsen. Hälsofrämjande ledarskap beskrivs i studie II på tre olika sätt: att organisera hälsofrämjande aktiviteter, en stödjande ledarskapsstil, samt att utveckla en hälsofrämjande arbetsplats. Konceptet användes ofta bland intervjupersonerna för att länka idéer om ett gott ledarskap i allmänhet till de anställdas hälsa. Studie III visar på vikten av att se ledarskap som ett bidrag till utvecklingen av en hälsofrämjande arbetsplats. Programmet genomfördes i befintliga ledningsgrupper som tog fram handlingsplaner för en hälsofrämjande verksamhetsutveckling. Denna typ av integration är ett viktig led i att utveckla den organisatoriska kapaciteten för att vara en hälsofrämjande arbetsplats. I studie IV sågs samverkan kring hälsofrämjande ledarskap som en strategi för att minska sjukskrivningar bland kommunerna i regionen. Studien pekar på vikten av att till en början organisera samverkan kring utveckling av hälsofrämjande arbetsplatser i mindre skala för att ge samverkansparterna tid och möjligheter att utveckla ett ömsesidigt förtroende för varandra. Studien visar också att det är viktigt att involvera olika samverkansparter med kompletterande kunskaper och erfarenheter om arbetshälsa.

Slutsatser: Hälsofrämjande ledarskap kan definieras som ett ledarskap som arbetar för att skapa en hälsofrämjande arbetsplatskultur. En sådan kultur innefattar värderingar som inspirerar och motiverar de anställda att delta i utvecklingen mot en hälsofrämjande arbetsplats. Hälsofrämjande ledarskap kan också ses som en viktig del av den organisatoriska kapaciteten för att främja hälsa, det vill säga chefers kunskaper och färdigheter såväl som riktlinjer och strukturer i organisationen som understödjer en hälsofrämjande arbetsplats. Det är därför viktigt med ett ledarskapsengagemang i den systematiska utvecklingen av både den fysiska och psykosociala arbetsmiljön.

Nyckelord: hälsofrämjande arbete, ledarskap, hälsa på arbetsplatsen, utvärdering, samarbete, fallstudie

List of papers

This thesis is based on the following papers, which in the text will be referred to by their Roman numerals:

Paper I:

Eriksson, A., Jansson, B., Haglund, B.J.A. and Axelsson, R. (2008), Leadership, organization and health at work: a case study of a Swedish industrial company, *Health Promotion International*, Vol. 23, No. 2, pp. 127–133.

Paper II:

Eriksson, A., Axelsson, R., and Axelsson, S.B. (2011), Health promoting leadership—Different views of the concept, *Work: A Journal of Prevention, Assessment, and Rehabilitation*, Vol. 40, No 1, pp. 75–84.

Paper III:

Eriksson, A., Axelsson, R., and Axelsson, S.B. (2010), Development of health promoting leadership—experiences of a training programme, *Health Education*. Vol. 110, No. 2. pp. 109–124.

Paper IV:

Eriksson, A., Axelsson, S.B. and Axelsson, R. Collaboration in workplace health promotion—a case study, *International Journal of Workplace Health Management* (in press).

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Introduction

Improving the physical and psychosocial work environment can potentially promote health for a large number of adults in society (Chu *et al*, 2000; Poland *et al*, 2000). The workplace is often defined as one of the most important settings for health promotion, and research suggests that leadership, organisational cultures and organisation of work are important determinants for employee health (Aronsson & Lindh, 2004; Shain & Kramer, 2004). Thus, the concept of workplace health promotion has evolved from individually oriented “wellness” activities to more integrative and holistic settings that promote employee health. The settings approach includes broad organisational and environmental determinants for health (Chu *et al*, 2000). Theories on organisational development as well as systems theory are regarded as essential to the development of health-promoting workplaces (Paton *et al*, 2005). Therefore, recent approaches to workplace health promotion include organisation of and the integration of health needs into organisational philosophy and management (ENWHP, 2007).

There is an ongoing academic debate on how to address health promotion effectiveness (McQueen & Jones, 2007). Views on public health have changed in the recent past, and today there is a greater focus on determinants of health rather than individual risk factors for disease (Potvin & McQueen, 2007). Because health is created and sustained in our daily environments, a key strategy for health promotion involves creating supportive environments for health (Haglund & Pettersson, 1998). This strategy is exemplified by the settings approach, which advocates intervention in daily environments like the workplace (Green *et al*, 2000). As many settings are intertwined, collaboration with partners inside and outside the workplace are further more seen as important for developing health-promoting settings (Poland *et al*, 2000).

The evaluation of health promotion should form an integral part of the planning and implementation of settings-based interventions (Nutbeam & Bauman, 2006). Earlier studies concluded that the settings approach to implementing and evaluating workplace health promotion requires more study, especially regarding the application of leadership

principles (Menckel, 2004; Poland *et al*, 2009). Although critical aspects of leadership are often acknowledged in connection with health-promoting workplaces (Shain & Kramer, 2004), the literature addresses the concept of health-promoting leadership only sparsely, and there is no consensus on how to define and evaluate health-promoting leadership. Therefore, this thesis aims to contribute to the development of the concept of health-promoting leadership (Rodgers & Kafli, 2000). It does not aim to study the *effects* of health-promoting leadership, but rather focuses on how different actors have chosen to define and apply the concept. Based on this analysis, the author will draw conclusions on critical conditions for implementing and evaluating health-promoting leadership.

Aims

The overall aim of this thesis is to describe and analyse the concept of health-promoting leadership, including critical conditions for implementation and evaluation of such leadership.

The specific aims include

- analysing the leadership and organisation, including the organisational culture, in relation to employee health in an industrial company (*Paper I*).
- describing and analysing different views of health-promoting leadership among managers and administrators involved in workplace health promotion in eight Swedish municipalities (*Paper II*).
- describing and analysing the experiences of a leadership training programme for development of health-promoting leadership in a Swedish municipality (*Paper III*).
- describing and analysing a case of interorganisational and intersectoral collaboration on health-promoting leadership involving nine municipalities in a Swedish region (*Paper IV*).

Conceptual framework

Health-promoting workplaces

Research of this thesis is based mainly on the settings approach, which includes different theories on how to create a health-promoting workplace. Explaining the concept of health-promoting workplaces requires an initial investigation into the concept of health promotion, followed by definitions that describe the difference between workplace health promotion and health-promoting workplaces. Finally, research about the different determinants of employees' health will be presented in order to discuss outcomes of health-promoting workplaces.

The concept of health promotion

The broad concept of health promotion encompasses both individual and structural approaches to health. The World Health Organisation (WHO) has exerted major influence on defining and developing this concept (Tones & Green, 2004). WHO's guiding principles and values on health promotion are set out in the Ottawa Charter, which defines health promotion as “*the process of enabling people to increase control over, and to improve, their health*” (WHO, 1986). According to this definition, health is not merely an absence of disease but also a resource for everyday life, including physical, mental and social well-being. The WHO definition concurs with Nordenfelt's (2004) view of health as individuals' ability to realise vital goals in life. In his opinion, realising vital goals leads to happiness (Nordenfelt, 2004).

In recent decades, health promotion has been reoriented from a biomedical and individual perspective towards a greater focus on socioeconomic conditions and shifting resources upstream to prevent problems before they occur (Rootman *et al*, 2001). Thus, the salutogenic approach developed by Antonovsky (1987) provides an important theoretical perspective in health promotion. Contrary to a pathogenic approach, which studies the

biomedical aspects of health, the salutogenic approach views health as a psychosocial concept and focuses on factors that promote and maintain that view (Antonovsky, 1987).

The principles and theories on health promotion mentioned above constitute an important basis for this thesis (i.e., subjective feelings of health and well-being are central for defining health). In this context, health and disease are not expected to exclude each other but, rather, the concept of health can be viewed as a continuum. This is illustrated by Eriksson's (1984) modified health cross, which shows that a person's subjective feelings of health or ill health can be independent of the occurrence or absence of medically diagnosed disease.

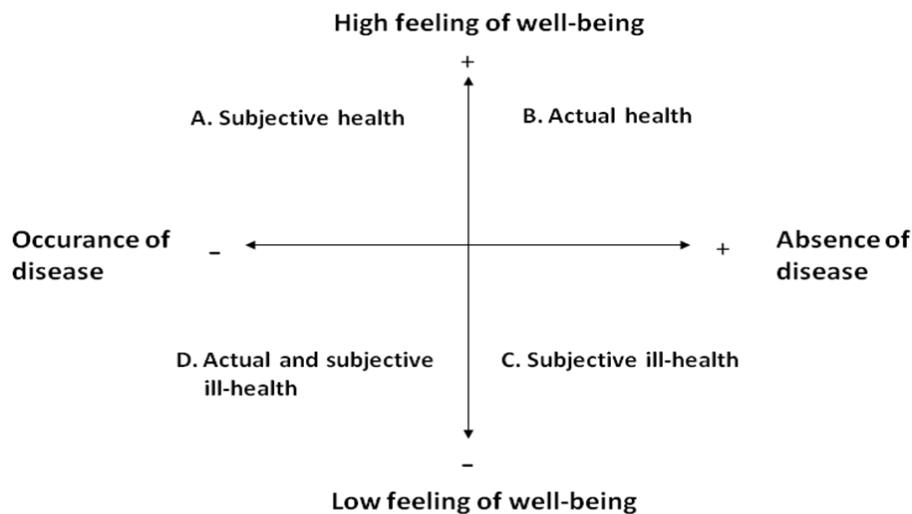


Figure 1. The individual's different health positions (modified from Eriksson, 1984, p.46).

One of the key strategies for health promotion outlined in the Ottawa Charter (WHO, 1986) is to create supporting environments for health. The Ottawa Charter is based on the assumption that *“health is created and lived by people within the settings of their everyday life; where they learn, work, play and love”* (www.who.int). The health promotion literature commonly refers to this strategy as a “settings approach.” The strategy focuses on interventions in our daily environments (e.g., workplaces, schools or sport clubs).

“Setting defines the ‘subject’ of intervention (individually and collectively), the location of health promotion and the frames of the setting itself as a target of intervention. Most health promotion activity is bounded in space and time within settings that provide the social structure and context for planning, implementing and evaluating interventions” (Green *et al*, 2000, p.1).

Green, Poland and Rootman (2000) claim that the settings approach is fundamental to health promotion theory because it exemplifies a more context-sensitive perspective. The settings approach is based on socioecological theories, emphasizing that health is created in complex and interrelated circumstances. Organisational capacity for a health-promoting setting includes not only the resources, policies and structures that support a health-promoting development but also the knowledge and skills of individuals, (Riley *et al*, 2003; Heward *et al*, 2007). The settings approach includes three key elements: creating supportive and healthy working and living environments, integrating health promotion into the ordinary and daily functioning of the settings, and developing collaboration between different settings that influencing the individual’s health (Dooris, 2004).

Workplace health promotion and health-promoting workplaces

The European Network for Workplace Health Promotion (ENWHP) has defined workplace health promotion as the efforts of employers, employees and society to improve the health and well-being of people at work. To achieve this, ENWHP has suggested improving the work organisation and encouraging the participation and personal development of employees (ENWHP, 2005).

According to Breucker (1997), workplace health promotion focuses on improving protection or growth factors rather than reducing risk factors (i.e., prevention strategies). Workplace health promotion strategies can be differentiated by determining whether they address situational factors (environment) or individual factors (behaviour). Behavioural

interventions commonly use behaviour-theoretical and learning-based psychological models. Efforts that address environmental factors are often based on various social psychological and sociological explanatory models (Breucker, 1997).

The concept of workplace health promotion has evolved from an emphasis on individual-oriented “wellness” activities to a more integrative and holistic settings approach (i.e., health-promoting workplaces) (Chu *et al*, 2000). Literature reviews conclude that participation, project management, integration and comprehensiveness are the success factors for implementing health-promoting workplaces (Chu *et al*, 2000; Sparling, 2010). Participation is defined as involvement of all staff in all phases (Breucker, 1997; Chu *et al*, 2000). Participation of the key actors as well as the target groups plays a crucial role in health-promoting interventions (Cargo *et al*, 2003; Bourdages *et al*, 2003).

Project management includes needs analysis, setting priorities, planning, implementation, continuous monitoring and evaluation. Integration means that programmes should be integrated into an organisation’s regular management practices and organisational plans (Chu *et al*, 2000). Health-promoting efforts that permeate the different levels of an organisational structure are likely to be more sustainable (Johnson & Baum, 2001).

Comprehensiveness signifies actions regarding both individual and environmental issues (Chu *et al*, 2000). A literature review concludes that health-promoting programmes will enhance employee health only when both individual and environmental issues are targeted (Shain & Kramer, 2004). For example, leaders who implement multifocused intervention strategies exert greater influence on long-term work attendance compared to single-focused strategies (Dellve *et al*, 2007a).

Similar concepts, including a holistic settings approach, are labelled as healthy workplaces, healthy work organisations or health-promoting organisations (Grawitch *et al*, 2006; Wilson *et al*, 2004; Parsons, 1999). Parsons (1999) includes efforts on an organisational, interpersonal and individual level, all based on an ecological systems framework, in the concept of health-promoting organisations.

Holistic concepts concur with a broad work environment concept developed in Scandinavia. The Scandinavian concept includes development of an overall prevention policy covering technology, organisation of work, working conditions, social relationships and the influence of factors related to the work environment (Frick, 2004). By the 1970s, Scandinavian countries had already designed and implemented reforms that strengthened regulation and participation and also provided competent advice regarding occupational health and safety management. In the 1980s, however, occupational health and safety activities still functioned as a “side-car” (i.e., they were not integrated into the general management of the workplace) (Frick, 2004). This can be compared to the difference between workplace health promotion and health-promoting workplaces. Employers’ responsibility to provide systematic work environment management has been enforced since the 1980s. For example, the Swedish work environment authority introduced provisions for systematic work environment management in 2001 (AFS 2001:1).

ENWHP (2005) declares that health promotion at the workplace allows new possibilities to combine productivity and health in the workplace. Concepts of organisational health, healthy organisations and healthy workplaces often include both worker well-being and organisational effectiveness (Murphy & Cooper, 2000; Lohela Karlsson, 2010). In this context, health promotion is viewed as part of an organisational development strategy to apply human resource management concepts (ENWHP, 2005). Research on human resource management links organisational performance to teamwork, flexibility, quality improvements, workplace empowerment, less absenteeism and reduced employee turnover. Some have argued that less repetitive work and higher decision latitude decreases alienation and increases feelings of job satisfaction. These processes are also called “quality of working life” and related to higher productivity (Huzzard, 2003).

On the other hand, it is necessary to consider different goals. Health promotion aims, first, to improve employee health. This primary goal is based on the Ottawa Charter, where the individual’s increased control over health determinants is central. Conversely,

a human resource perspective is driven by improved management and efficiency (Breucker, 1997).

Determinants for the health of the employees

Determining how to measure and analyse health in working life is critical, and studying the determinants for workers' health requires the development of suitable outcome measures. As discussed earlier, subjective feelings of health and health as a dimension of psychosocial well-being are central to the definition of health applied in this thesis. In this context, experience of health may, but not necessarily will, correlate with biomedical diagnoses of disease. Research shows that sick leave may indicate employees' health because it correlates with the physical, mental and social well-being of the employees (Marmot *et al*, 1995). However, a low illness rate may not always be conducive to healthy employees. Studies analysing sickness presenteeism show that health problems strongly determine sickness presenteeism and represent a risk factor for future sick leave (Bergström *et al*, 2009; Aronsson & Gustafsson, 2005). One study reported that the highest rates of presenteeism were found in the care, welfare and education sectors (Aronsson & Gustafsson, 2000).

Other outcome measures related to employee health include job satisfaction, organisational commitment and turnover intention (Shain & Kramer, 2004; Grawitch *et al*, 2007). A Swedish study that examined human service organisations showed a positive relationship between work attendance and male gender, high income, work commitment, job satisfaction, and positive feelings towards work (Dellve *et al*, 2007b). Another study showed that leadership support, resources for performing work and being content with the quality of performed work correlate with a low rate of sick leave at work (Aronsson & Lindh, 2004).

Extensive research has investigated the determinants of ill health. Machenbach *et al* (1994) concluded that processes that generate health probably have much in common with those that lead to ill health. However, deeper knowledge is lacking about whether

the factors that influence decreased health in work life differ from those that influence health (i.e., salutogenic processes) (Aronsson & Lindh, 2004; Antonovsky, 1987).

Antonovsky's (1987) research illustrates that healthy individuals experience comprehensibility, manageability and meaningfulness, which he labelled as a sense of coherence. This can be compared to the concept of positive health, where experiences of well-being (e.g., self-development, personal growth and purposeful engagement) likely contribute to reduced biological risk for disease (Ryff *et al*, 2004). Research confirms that a sense of meaning correlates with employee health (Hochwlder *et al*, 2005).

Scandinavian research on work environment has long been in the frontline, studying the importance of psychosocial work conditions for employee health and well-being (Sverke, 2009). Different aspects of what the literature has defined as the organisational work environment are important for employee health. The work environment includes a wide range of organisational determinants for health, including social relations, management style, organisation of work tasks, time schedules, mental and physical workload and gender segregation (Frick, 2004).

A balance between effort and reward promotes improved health among employees (Siegrist, 2002). Organising work that promotes a balance between employees' work and private lives also positively impacts employee health. In the literature, this is called work-life balance (e.g., flexible work hours) (Grawitch *et al*, 2007). However, such flexibility seems to reduce stress and improve well-being only when employees can choose their own work hours (Sparks *et al*, 2001). Another example of promoting a work-life balance is organisational policies on limiting overtime (Sparks *et al*, 2001).

Extensive research indicates that increased control over one's work environment plays a major role in health and well-being (Sparks *et al*, 2001). The demand-control model shows that support at work can balance the negative effects of low decision latitude and low control (Karasek & Theorell, 1990). Support can be categorized into emotional support, instrumental support, informational support and appraisal support (House, 1981).

Other studies have shown that high job demands in combination with high job control increases the capacity to learn and develop (Karasek, 1979, De Witte *et al*, 2007; Weststar, 2009). Because ability to increase competence at work promotes health and well-being, this is an important aspect of the demand-control model (Mikkelsen *et al*, 1999).

Not all studies support the demand-control model. Individual differences (e.g., the desire or need for control as well as coping skills) must be considered when contemplating changes in job autonomy or decision-making responsibilities because perceived lack of control may be stressful to some employees but not to others (Sparks *et al*, 2001).

A review study that examined kinds of workplace health promotion efforts showed that these efforts increase mental well-being and may also promote work ability and decrease sickness absence. The review finds, on the other hand, no effects on employees' physical well-being and well-being in general (Kuoppala *et al*, 2008). Few researchers have tested how individuals' health issues relate to broader models of organisational health and health-promoting workplaces. Grawitch *et al* (2006) investigated the characteristics of healthy workplaces and concluded that work-life balance, employee growth and development, health and safety programmes, recognition and employee involvement link to both employee well-being and organisational performance. Wilson *et al* (2004) have tested and validated a model of healthy work organisation, including organisational attributes, organisational practice, job design, job future, psychological work adjustment and employee health and well-being. Their study shows that work characteristics influence psychological work adjustment factors, which ultimately influence employee health and well-being (Wilson *et al*, 2004).

Gender is another important determinant for employees' health (Härenstam *et al*, 2000). The municipal care sector exemplifies a female-dominated sector, characterised by high sick leave and a psychosocial working environment that is perceived as worse than that of male-dominated municipal working sectors (Forsberg Kankkunen, 2009). One study shows that managers in female-dominated sectors of Swedish municipalities perceived

that they had less opportunity to address work environment issues compared to managers within more male dominated technical sectors. These perceptions seem to be gender-related, (i.e., related to a female- or male-dominated sector rather than to the gender of the managers) (Forsberg Kankkunen, 2006).

Socioeconomic factors also influence employee health (Härenstam & the MOA Research group, 2005). Socioeconomic factors influence for example differences in sickness absence and it is shown that there are higher rates of sickness absence among less skilled workers (North *et al*, 1993).

Health-promoting leadership

After describing the concept of leadership, this section summarises the role of leadership in health-promoting workplaces and then presents the author's definition of health-promoting leadership.

The concept of leadership

The literature separates “leadership” and “management.” Management, which is usually defined as focusing on formal systems and concrete issues, includes goal setting, implementation and evaluating existing plans and assuring the organisation's cultural values and common assumptions. On the other hand, leadership is defined as focusing on the unknown and on informal systems, and it is oriented mainly towards human relations and organising people. It includes putting change on the agenda, developing shared goals and values and creating new systems. It also includes inspiring individuals to question common assumptions and to change culture and values (Owen & Lambert, 1998; Kotter, 1990).

The division between leadership and management may link to the concepts of transformational and transactional leadership. Transformational leadership is defined as the leader's motivational effect on subordinates. According to theories of

transformational leadership, employees identify themselves with the leader, share his or her vision and are thus motivated to perform better. The outcome of such a leadership is, according to the literature, empowered employees who are taking more initiatives as well as increased commitment and self-confidence among employees (Burns, 1978; Bass, 1990).

A transactional leadership tries to motivate subordinates by appealing to their self-interest, focusing on achieving tasks and building good worker relationships in exchange for rewards. These two leadership approaches can be viewed as complementary; transformational leaders reshape and influence the environment, whereas transactional leaders monitor performance (Burns, 1978; Bass, 1990).

The application of transformational leadership can be compared to a general development in modern work life towards knowledge-based work (i.e., knowledge and competence of individual employees play an increasingly important role for performing work tasks) (Mintzberg, 1999). Described characteristics of knowledge-based work include greater reliance by organisations on confidence and common values rather than power and control. According to the descriptions of knowledge based-work, employees have extensive and specific knowledge about their work tasks whereas managers are coordinators who create internal understanding and support for work performance. Modern management theories often include socialisation as a steering strategy, wherein individuals acquire knowledge and skills to adapt to a particular work culture (Giddens, 2001).

Theories of transformational leadership are criticised for failing to define its mechanisms more closely. In summary, despite a huge number of studies in the field, researchers have not defined the characteristics that guarantee effective and successful leadership (Yukl & Lepsinger, 2004).

Yukl and Lepsinger (2004) suggest focusing on the situational nature of leadership and the importance of flexible leadership. They stress the need to (i) respond to

continually changing situations, (ii) find an appropriate balance among competing demands and coordinate leaders' actions. Managing human resources and relationships is seen as especially important when work is complex and difficult to learn and when the work task requires cooperation and teamwork. Yukl and Lepsinger include support, recognition, development, consulting employees, empowerment and team-building as key elements of a flexible leadership style. Moreover, organisations should view leadership as an aspect of employeeship, as it is suggested that effective leadership is executed when leaders and employees can mutually adapt to the others' needs (Møller, 1994).

The role of leadership in health-promoting workplaces

In the workplace, health-promoting efforts often depend on the good will of the management (Poland *et al*, 2000; Meggeneder, 2007). Some criticise the applications of the settings approach for not giving enough consideration to power relations that already exist within the setting (Poland *et al*, 2000). When implementing workplace health promotion, the support and participation of top management is obviously important (Breucker, 1997; Sparling, 2010). Leadership can legitimise health-promoting efforts and participate importantly in motivating and supporting subordinates (Yeatman & Nove, 2002). A study on health and safety interventions in the workplace identified several factors that hinder and facilitate implementation (Whysall *et al*, 2006). Hindering factors include management commitment, managers' general attitudes towards health, insufficient resources and prioritisation of production. Facilitating factors include supportive managers, local control over budget spending for health as well as good communication.

Research shows that leadership style may also influence the health of employees (Gilbreath & Benson, 2004; Nyberg *et al*, 2008; Nyberg *et al*, 2009; Kuoppala *et al*, 2008). One study concludes that leaders who use rewards, recognition, goal clarity and respect generate a high level of work attendance among employees of human service organisations (Dellve *et al*, 2007a). A study that reviewed the influence of leadership on employee health showed leaders who show consideration, initiate needed structure and

gives opportunities for employee control and participation positively influence health and job satisfaction. Other positive factors include the characteristics of a transformational leadership (e.g., leaders who inspire employees to see higher meaning at work, provide employees with intellectual stimulation or are charismatic) (Nyberg *et al*, 2005).

Attributes of transformational leadership (e.g., promoting empowerment and having a clear vision) are important elements for employee job satisfaction and commitment (Lok & Crawford, 2004). Transformational leadership contributes to self-development and reduces stress among employees. Conversely, transactional skills (i.e., task achievement) contribute to employees' well-being by clarifying performance expectations and reducing uncertainty (Sparks, Faragher, & Cooper, 2001). A literature review concluded that both a purely relationship-oriented leadership and a combined relationship- and task-oriented style yield positive effects on employee job satisfaction and productivity (Boumans & Landeweerd, 1993).

The literature also discusses the importance of support and supervision among employees. When work is difficult, management support contributes importantly to low levels of absenteeism due to sickness (Aronsson & Lindh, 2004). Satisfaction at work also relates to a high frequency of communication between supervisors and employees as well as a supportive leadership style for relating and communicating (Callan, 1993; Yukl, 2006). One study shows that regular communication from supervisors can buffer perceived job strain among employees (Harris & Kacmar, 2005).

According to de Vries and colleagues (1998), contextual factors (e.g., individual, task and organisational characteristics) determine the need for supervision among employees. The authors assumed that employees with extensive work experience will require little leadership when they receive extensive feedback about their tasks and cohesion in their work teams is strong. They show that a strong positive relationship between leaders' inspirational skills and job satisfaction, and between leadership support and work stress, can exist only when there is a high need for leadership. However, leadership that impose too much structure when subordinates need little leadership may negatively influence

subordinates' organisational commitment (de Vries *et al*, 1998).

Moreover, leadership behaviour and employee health are linked in a feedback loop, a two-way reciprocal process. Employees who report a higher level of well-being also perceive that their manager has a more supportive leadership style (Dierendonck *et al*, 2004). Hersey and Blanchard (2008) suggest that leadership style must adjust to the employees' shifting competence and commitment. However, employee motivation can be hard to predict (Thylefors, 1991).

A democratic leadership style contains fewer perceived stressors for subordinates (Sparks *et al*, 2001). Yukl (2006) concluded that 40 years of research on participative leadership has produced some studies that show increased satisfaction, effort and performance while others suggest the reverse. For example, one study showed that a high level of sick leave correlates with a democratic leadership style, including a high degree of participation in decisions. The same study showed that less frequent sick leave is associated with a leadership style that included goal clarity and a systematic way of organising work (Tollgerdt-Andersson, 2005). Waldenström and Härenstam (2006) conclude that good working conditions include a clear division of responsibilities and formal decision structures.

Bernin and Theorell (2004) describe methods that leaders' can use to create health-promoting organisational structures (e.g., creating conditions that influence the leadership style of lower level managers). Schein (2004) posited that the principal influence on the health of subordinates begins with the middle and low level managers. A recently published literature review concluded that numerous studies have empirically investigated and clarified the relationship between organisational leadership and a wide range of outcomes related to the psychological well-being of employees. Therefore, the authors recommended that future workplace health interventions should focus mainly on leadership development (Kelloway & Barling, 2010).

The concept of health-promoting leadership

Found mainly in the Scandinavian literature, “health-promoting leadership” is a relatively new concept that mostly refers to well-established organisational theories about the need for a democratic and supportive leadership style and a holistic view of health (Menckel & Österblom, 2002; Hanson, 2004). In the international literature, the concept of health-promoting leadership exists to a lesser extent (Polanyi *et al*, 2000).

Hanson (2004) defines three different aspects of a health-promoting leadership: personal leadership, pedagogical leadership and strategic health-promoting leadership. Personal leadership includes support, recognition, feedback, communication, clarity and goal-setting. Pedagogical leadership involves promoting both the well-being of employees and the achievement of organisational goals. Strategic health-promoting leadership is characterised by developing and implementing a healthy workplace.

The Hanson (2004) definition of health-promoting leadership resembles Shain and Kramer’s (2004) division of “management support” and “supportive management climate.” They define management support as supporting the health of individual employees through, for example, possibilities for health-promoting activities, flexible work hours and providing exemplary behaviour. On the other hand, Hanson ascribes a supportive management climate to organising work in a healthy and safety-promoting way (e.g., balancing the demands put on employees, increasing employee participation in the governance of their own work and adequately recognizing work performance).

Shain and Kramer’s (2004) division between management support and supportive management climate can be compared to the definitions of management and leadership, where management deals with organising and controlling different activities, while leadership focuses more on creating a shared culture and values to inspire and motivate the employees (Yukl, 2002). Both are necessary for an organisation, but leadership is more important for promoting organisational change and development (Daft, 1999). As discussed earlier, health promotion is the process of enabling people to improve their own

health (WHO, 1986). Thus, health promotion interventions include a participatory approach, where development work is conducted in cooperation with both employees and managers.

Against this background, health-promoting leadership concerns itself with creating a culture for health-promoting workplaces and values that inspire and motivate employees to participate in such a development (Eriksson *et al*, 2010). In other words, leaders regard employees as resources in the development of a healthy workplace. This kind of leadership can also be viewed as a critical part of an organisation's capacity for health promotion, including the knowledge and skills of the managers and the policies and structures of an organisation that supports a health-promoting workplace (Riley *et al*, 2003; Heward *et al*, 2007). In this context, this thesis focuses on leaders with a formal management position.

Critical conditions for the development of health-promoting leadership

This section summarises the critical conditions for the development of health-promoting leadership, including organisational development, leadership development, collaboration on workplace health promotion and evaluation of health-promoting workplaces.

Organisational development

As discussed above, health-promoting leadership can be viewed as part of the development of health-promoting workplaces. Leadership can also be viewed as the main driving force to promote organisational learning and development for change (Barrett *et al*, 2005). Parsons (1999) describes the role of leadership in health-promoting organisations, including support to a health-promoting organisational culture and applying a participatory approach when developing and evaluating comprehensive health-promoting policies and programmes.

A key question involves identifying mechanisms to sustain long-term health promotion

programmes. In this context, the importance of organisational capacity-building (i.e., developing the necessary infrastructure for sustainability) is emphasised (Swerissen & Crisp, 2004). The literature suggests that the critical factors for developing health-promoting workplaces include needs analysis, adaption of the implementation process to contextual factors in the specific workplace, continuous monitoring and ongoing evaluation (Demmer *et al*, 1995; Chu *et al*, 2000; Polanyi *et al*, 2005). Leadership and organisational development are critical for this type of implementation process (Paton *et al*, 2005; DeJoy *et al*, 2010). Organisational development and change management, in combination highly visible projects (e.g., specific health interventions) are key to understanding the healthy settings approach (Dooris, 2004).

Nytrø *et al* (2000) defines the critical aspects for health interventions that lead to organisational change, including

- a social climate that allows learning from failure,
- a participatory approach that allows the possibility of negotiating the design of the intervention,
- attention to conflicts of interests and tacit behaviours that change, and
- the ability to define roles and responsibilities for actions.

Dooris (2004) describes the need to balance top-down managerial commitment with bottom-up engagement as well as the importance of a health agenda that contributes to the institutional agenda. Conversely, it is also important to be attentive to the effect of organisational changes on employee health. Research shows that organisational changes influence the work environment and may increase dissatisfaction, burnout and absenteeism (Kuokkanen, 2007).

The variety and complexity of workplaces make them challenging settings for the implementation and evaluation of health promotion. According to contingency theory, there is not one best way to organise; rather, the choice of optimal actions in an organisation depends on the internal and external situation (Scott, 2003). The organisational structure, economic structure and organisational culture (including the

leadership culture) may differ significantly between organisations. In this context, culture is often defined as the basic assumptions that are held and shared by individuals within an organisation. Such assumptions are found in beliefs and values about the organisation, and they are expressed in symbols, processes and behaviours. These values may be related to career choice, job satisfaction and motivation for work performance (Schein, 2004).

Most researchers regard culture as something that is influenced by both internal and external factors and something that may be consciously managed by the leaders of an organisation (Schein, 2004). Lok, Westwood and Crawford (2005) conclude, however, that an organisation's subculture can be more important for employee behaviour than an overall culture.

Leadership development

As concluded above, leadership influences the health of employees in several different ways and managers play a key role for the development of health-promoting workplaces. Managers' general attitudes and conceptions towards health and health interventions are important for implementing workplace health interventions (Skagert, 2010; Whysall *et al*, 2006). One study shows, for example, that hindering factors for implementation are when managers do not understand the importance of health interventions or if they see the intervention rather as an extra workload (Whysall *et al*, 2006). To develop managers' knowledge and attitudes in health related issues can thus be seen as an important aspect of health-promoting leadership (Pearson *et al*, 2007).

Another study shows that training managers to recognise employees' need for rewards support and the balance between demand and control in their work positively affects employee health (Theorell *et al*, 2001). An intervention that is tailored to the specific psychosocial work environment and management style of work units also enhances the health of employees (Anderzén & Arnetz, 2005).

There are different methods for training and supporting leaders, including coaching, action learning in groups, mentor programmes and network programmes. Coaching is often defined as a goal-focused method of one-on-one learning, preferably resulting in behavioural change. Effective coaching should explore and assess constraints against development and reaching goals (Hernez-Broome & Hughes, 2004). Longenecker and Neubert (2005) conclude that coaching is an effective way of learning and supporting management development if it is embedded in the manager's work environment.

Action learning in groups encourages and enables reflection by challenging group assumptions and letting the group learn from their own experiences (O'Neil & Lamm, 2000). Group processes (e.g., team formation and working together) are important aspects of action learning in groups. The diversity of group members could lead to conflicts in team dynamics, but could also create an opportunity to discuss different viewpoints and ideas (O'Neil & Lamm, 2000).

Hernez-Broome and Hughes (2004) emphasise that leadership development embedded in a leader's work environment and including performance feedback is most likely to substantively influence the behaviour of the leader. A key issue here is how the learning and development of managers can contribute to the development of a health-promoting workplace. Researchers conclude that learning of individual employees leads to organisational learning only when policies, strategies or routines change (Svensson *et al*, 2004). This process requires a connection between training content and organisational context, and also with ordinary workplace development. Bertlett (2011) criticises traditional leadership training programmes that separate managers from employees. He stresses the importance of leadership training that facilitates agreements between leaders and followers on how leaders should lead and followers follow.

Managers represent a group characterised by high psychological demands and a high degree of decision latitude. Research emphasises the importance of social support for promotion of managers' own health (Bernin *et al*, 2001). Managers in female-dominant municipal sectors (e.g., social services and caregiving) need special support because they

often are challenged to balance the demands of creating a good work environment for their employees with organisational and political demands (Forsberg Kankkunen, 2009).

Leadership development may also provide a way to support managers' own well-being. One study suggested that structured management programmes (e.g., mentor programmes, management networks and lectures) can have some beneficial health effects for the participating managers (Jansson von Vultée & Arnetz, 2004). The study also suggests that programmes likely require combination with other forms of strategic initiatives if they are to have real influence on managers' health.

Collaboration in workplace health promotion

Cooperation between employer and employees is a key feature of the work environment act (1977:1160) in Sweden. Collaboration between different stakeholders and actors, both inside and outside the workplace, is recommended for developing health-promoting workplaces (ENWHP, 2007; Dugdill & Springett, 2001). Today, different sectors within society are characterised by increased differentiation and specialisation, leading to fragmented knowledge and competencies and implying risks for inefficient use of common resources (Miller & Ahmad, 2000). Solving complex societal problems requires collaboration among different actors and focus has increased on interorganisational and interprofessional collaboration within public health (Gajda, 2004). As a consequence, collaboration is a key principle of health promotion (Israel *et al*, 1998; Mitchell & Shortell, 2000; Rootman *et al*, 2001). In this context, interorganisational collaboration is defined as collaboration between different organisations, often from different sectors of society, whereas interprofessional collaboration involves collaboration between different occupations or professions (Fosse, 2007).

The public health literature offers no consensus on how to define collaboration or similar concepts (e.g., coordination and cooperation). These concepts are often described in terms of integration and pictured as points along a continuum of different forms or models of collaboration. On such a continuum, full integration are one end, coordination

is in the middle and linkages between autonomous organisations are at the other end (Danermark & Kullberg 1999; Leutz, 1999). Full integration is characterised by the development of new organisational units with pooled resources, coordination includes explicit management structures for control, and linkages are informal contacts between different organisations, providing joint services. Different models of collaboration may be appropriate in different situations (Ahlgren & Axelsson, 2005). Thus, collaboration is a broad term that includes many different models, ranging from a formal management hierarchy to informal agreements between different organisations or professionals (Axelsson & Axelsson, 2006).

Dealing with the “human” aspects of collaboration is time consuming and often represents the greatest challenge of collaboration (Whipple & Frankel, 2000). Establishing collaboration may be an instable process that requires negotiation among the perspectives, interests and goals of different actors (Eriksson *et al*, 2007). The difficulties in making different organisations collaborate are often underestimated. Therefore, researchers stress the need to consider the leadership and organisational aspects of collaboration. The challenges for leadership in inter-organisational collaboration differ from those in traditional hierarchical organisations (Gustafsson, 2007). Interorganisational collaboration requires leadership that can support shared responsibilities and joint exploration of suitable forms for collaboration and focus on the objectives of the collaboration (Backström *et al*, 2008). This is called altruistic leadership, which prioritises a common purpose and a concern for the society at large over the territorial interests of different organisations and professional groups (Axelsson & Axelsson, 2009).

Different organisational goals often include different reasons for collaborating. Thus, successful collaboration depends on compromises and agreements on the broad goals as well as more detailed descriptions of necessary actions (Huxham & Vangen, 2005), including formal structural arrangements to facilitate decisions and clear leadership as well as clear definition of objectives, tasks, roles and responsibilities (Bourdages *et al*, 2003). Trust between involved individuals and organisations are critical for these kinds of

agreements. (De Cremer & Stouten, 2003; Vangen & Huxham, 2003). Furthermore, collaboration requires adequate financial support and human resources, which require official support and legitimisation for the participating organisations (Bourdages *et al*, 2003; Mitchell & Shortell, 2000).

Few studies have investigated collaboration in workplace health promotion; although a number of collaboration projects have been launched over the years (see, for example, Menckel & Österblom, 2002; Hillring *et al*, 2005). Interprofessional collaboration is a common feature of such projects. Thus, external experts on workplace health promotion may collaborate with different internal actors in the work organisations. One study reported that organisations nominating a specific individual to liaise with external experts were more successful in building health promotion capacity. The role of the liaison is to facilitate programme implementation (e.g., by helping the external experts understand the organisational culture) (Lang *et al*, 2009).

Long-term outcomes of collaboration are also studied to a lesser extent (Axelsson & Axelsson, 2007). Therefore, the need to develop methods to follow the collaboration process over time, measuring sustainability and outcomes, is highlighted (Shortell *et al*, 2002; Eilbert & Lafronza, 2005).

Evaluation of health-promoting workplaces

Some criticise settings-based health interventions for their limitations in evaluating outcomes (Poland *et al*, 2000). The unique features of different organisations limit the utility of randomised controlled trials or other experimental methods of evaluation. Øvretveit (1998) argues that traditional experimental design is limited when studying social systems and the complex interaction between health interventions, individuals and their environment. Others argue that assessing intervention outcomes requires further study of the implementation process (Karsh *et al*, 2001). Dugdill and Springett (2001) suggest a holistic and innovative evaluation approach, applying action-oriented methods that involve both participating managers and employees. According to them, the reasons for participation in evaluation are to highlight the opinions and perspectives of different

stakeholders, guaranteeing that the powerless will be heard.

Evaluation is defined as a systematic assessment of a phenomenon (Karlsson, 1999). Vedung (2009) defines evaluation as a careful judgement taking place after completion of an event, to follow up, systematise and judge ongoing or finished activities and their results. The result of the evaluation may be used to correct mistakes and reinforce successes. Karlsson (1999) points out the value of not only describing the phenomena to be evaluated but also questioning what has been taken for granted.

According to Karlsson (1999), there are three evaluation patterns: outcome evaluation, process evaluation and interactive evaluation. Quantitative measurements and the control of goal fulfilments are central to outcome evaluation. Process evaluation focuses on the method of obtaining results and is often a qualitative assessment of activities. Interactive evaluation emphasises participation (i.e., stakeholder participation strengthens the influence of different actors). Although these three patterns of evaluation were developed chronologically, they have reinforced rather than replaced each other, leading to the development of new branches within evaluation (Karlsson, 1999).

Different categories of evaluations can be identified depending on the aim of the evaluation. If the aim is to improve ongoing activities, the evaluation can be defined as “formative.” If the aim is to examine whether activities result in expected outcome, the evaluation can be defined as “summative.” A third aim “develops knowledge” and “critically reviews activities.” This form of evaluation is often performed by researchers (Karlsson, 1999).

Nutbeam (1998) concludes that insufficient definition and measurement of outcomes of health-promoting actions have hindered the development of evaluation within health promotion. Therefore, Nutbeam developed an outcome model to describe the following levels of health outcomes:

- Health-promoting actions (e.g., education or advocacy).
- Health promotion outcomes (e.g., health literacy or healthy public policy).

- Intermediate health outcomes (e.g., healthy lifestyles or healthy environments).
- Health and social outcomes (e.g., decreased mortality and increased quality of life).

Logic models, also called programme theories, play an important role in evaluation in political science and are also used within health promotion (Vedung, 2009; Potvin *et al*, 2005). A logic model is a visual presentation of how different programme activities, through different mechanisms and under different conditions, are expected to lead to a certain outcome (e.g., a visualisation of different causal factors related to the problems targeted in an intervention) (Renger & Titcomb, 2002). Because it can be difficult to catch complex processes through programme theories, some recommend complementing programme theories with other evaluation models (Vedung, 2009). Potvin and colleagues (2005) stress the need to formulate programme theories that include social determinants for health and explain how to mobilise actors in processes of change. To understand dynamic changes and bridge the tension between subjective and objective knowledge, the authors also highlight a reflective approach.

Dugdill and Springett (2001) consider evaluation as a part of the workplace learning process, arguing that evaluation should be an integrated part of analysis, planning and implementation of health-promoting actions. In that way, the intervention could be better adapted. Argyris and Schön (1978) concluded that organisational learning occurs when employees react to changes in the internal and external environment by discovering and correcting errors in the theories upon which organisations base their actions. The authors describe common knowledge within organisations as behavioural maps. Ellström (1996) points out the need for organisations to include time for learning. He also stresses the importance of having opportunities to try out alternative actions as well as having time to value and reflect on the ongoing activities and their consequences. Ellström suggests that involving employees in the assessment and development of activities is an important aspect when organising opportunities for learning and reflection.

Research design and methods

As mentioned before, the literature offers no consensus on how to define, implement and evaluate health-promoting leadership. In a relatively new area of research, such as this, the principal concern of this thesis is an in depth exploration of the concept of health-promoting leadership as well as the different factors that influence its development. Thus, the studies herein used mainly qualitative methods, including interviews, observations and document analysis. Qualitative data material was supplemented by quantitative material from a leadership survey in one study (Study III). Three case studies (Study I, III and IV) and one conceptual analysis (Study II) were performed.

To reach a deeper understanding of different aspects of the development of health-promoting leadership, a case study design was chosen for study I, II and IV. Thus, this is a mixed-method design that uses different sources of evidence (Morse, 2003). Case study research aims for a holistic view of a phenomenon and gives possibilities to understand structures, processes and driving forces rather than cause-effect relationships (Gummesson, 2000). A case study is suitable when “how and why” questions are asked about contemporary events, over which the researcher has little control. Furthermore, a case study is suitable when there are no clear boundaries between phenomenon and context and contextual conditions need to be covered. This means that there are more variables of interest than data points, and the study needs to rely on multiple sources of evidence. Stake (2000) characterises case studies by their “thick descriptions” of a phenomenon. Both qualitative and quantitative data may be suitable for a case study, and multiple data sources can be used in order to give different perspectives of an interpretation (Stakes, 2000; Yin, 2009). Stake (2000) suggests that the selection of research cases should be based on cases that provide the greatest opportunity for learning.

Study II is a conceptual analysis of health-promoting leadership. A concept is constituted of cognitive images of a phenomenon (i.e., different dimensions, aspects or attributes of the reality that the researcher is interested in studying) (Rodgers & Knafl, 2000). In a broad sense, conceptual analysis means breaking down the content of concepts into their

“constituent” parts (Beaney, 2003). Study II analyses the concept of health-promoting leadership through an empirical study of what key concepts are associated with the phenomenon and how these different concepts interact. Conceptual analyses are often criticised on the basis that theories of a concept may not be “true” and that described meanings of a concept are not always used in practice (Laurence & Margolis, 2003). In study II, qualitative interviews were chosen for studying *what* is described as health-promoting leadership and *how* health-promoting leadership is experienced by a group of managers and administrators working with health interventions (Kvale, 1997; Möller & Nyman, 2005).

Qualitative methods like the ones employed in all four studies are criticised for limitations in generalisation. Although it is not possible to generalise results from qualitative studies to whole populations (statistical generalisation), it is suggested that analytic generalisation is possible (i.e., if the results are supported by theories or other empirical evidence, analytic generalisations can be done) (Yin, 2009).

The overall results from this thesis aim to contribute to developing the concept of health-promoting leadership. The research process can be illustrated through a so-called “hybrid model”, composed of three phases: an initial theoretical phase; a fieldwork phase; and a final, analytical phase (Rodgers & Knafl, 2000). Initially, a broad and cross-disciplinary description of different theoretical aspects related to the concept of health-promoting leadership was made, as presented in the conceptual framework of this thesis. In the fieldwork phase, different cases of health-promoting leadership were studied and presented in the results section. In the final analytical phase, the review of the literature, the theoretical analysis and the empirical findings were weighed together, contributing to a knowledge development of the concept of health-promoting leadership. This includes refinements in existing definitions, making explicit what has been implicit in the literature and a discussion of measurability of the concept (Rodgers & Knafl, 2000). The results of the final analytical phase are found in the discussion section.

Data collection

All four studies contained semi-structured interviews. Documentary studies and observations were used in two of the studies (Study I and Study IV). In Study III, the interviews were supplemented with the results of a leadership survey. All interviews, document analysis and observations were performed by the author of this thesis. The leadership survey in Study III was administrated by the studied city districts, as a part of their own development work.

A majority of the managers who participated in the studies of this thesis worked within sectors of social services and care (e.g., schools or elder care). Three of the studies were conducted within municipal settings (Study II–IV), and one was conducted in a private company (Study I). The data for Study I was collected during 2003, the data for study II during 2006 and the data for Study III and Study IV during 2006–2007.

Study I

Study I was a case study of a Swedish industrial company characterised by a low sickness rate, a structure of self-managed teams and an organisational culture that aimed to develop employees' skills and influence in their work. The data collected included one interview with the company leader, five interviews with employees, six observations of group meetings and organisational documents dating up to 15 years prior to the study.

The interviews were based on a semi-structured interview guide, including questions about work tasks, the organisation and the organisational culture, leadership, the communication and relationships between colleagues and the feeling of well-being related to work. The observations explored the different themes in the observational guide: physical and psychosocial attributes of the work environment, the participation and communication of different persons at meetings and the different activities performed during observations. The collected documents included both internal organisational documents (e.g., annual reports, company journals) and external documents (e.g.,

marketing surveys and newspaper articles about the company).

Study II

Study II was an interview study exploring how the concept of health-promoting leadership was described by 20 individuals employed by eight Swedish municipalities. A convenience sample of managers and administrators, representing different ages, backgrounds and positions within their municipalities, was made. Interviews were performed with 10 mid-level managers who had earlier participated in workplace health interventions, four personnel managers who had initiated workplace health promotion interventions, one area manager, one administrative director, two administrators and two project leaders who had been planning and managing workplace health promotion.

The interviewees were asked about their views on health, health promotion and health-promoting leadership. They were also asked about their general views on leadership and about perceived motives for developing health-promoting leadership. Interviewees responsible for initiating and designing efforts were asked why and how the initiatives were implemented.

Study III

Study III was a case study of an intervention programme for the development of health-promoting leadership taking place in four city districts in Gothenburg in Sweden. Seventeen semi-structured interviews were performed with 15 individuals. Nine of the interviewees were unit managers participating in a leadership training programme that aimed to create a health-promoting leadership. Four personnel managers, one project leader and one administrator were interviewed. The project leader and the administrator were interviewed twice.

The interviews were based on semi-structured interview guides and included questions about views on conditions for developing health-promoting leadership and how the

intervention was designed and implemented as well as the outcomes and experiences of the intervention.

The interviews were supplemented with quantitative data from a leadership survey, in which all managers in the studied district had been invited to participate. The survey was carried out annually as a part of the regular development work of the city; it measured managers' satisfaction with their work conditions and work environment. The survey contained in total 82 single item questions divided into 17 different areas of quality factors. Seven survey questions were selected relevant to Study III (see Appendix 3 in paper III).

The author of this thesis received files with summaries of the results of all survey questions from administrators of the districts. The survey was answered by 150 managers within the four studied districts. The summaries contained the mean result as well as the lowest and the highest value of each single question and also of each quality factor. Both the results of the entire district and each unit separately were reported in the summaries.

The author of this thesis asked if she could make observations on the meetings of the leadership intervention programme, but the participating managers declined, saying that her presence would disturb their group process.

Study IV

Study IV was a case study of collaboration in workplace health promotion in a Swedish region. Specifically, a collaboration project aiming at developing health-promoting leadership in nine Swedish municipalities was studied. The five members of the project group, who were responsible for developing the intervention, were interviewed. The interviewees were asked about perceived motives for collaboration on health-promoting leadership as well as how they perceived the work of the project group, including goals and roles. They were finally asked about hindering and facilitating factors for implementing collaboration on health-promoting leadership between the involved

municipalities.

Observations, which followed an observational guide during all the meetings of the project group, were also done. It was specifically observed how the goals of the project were expressed and dealt with, different topics and themes discussed including who initiated and participated in different discussions as well as how group processes developed at meetings. Finally, all available written project material were collected, including project plans, minutes from meetings, newsletters and project records.

Data analysis

Study I

The material of study I was analysed according to hermeneutical principles (Gadamer, 2004), aiming to explore the meaning of and understand a phenomenon through interpretation. The cultural and historical context is important for hermeneutic analysis. As humans, we cannot be separated from the traditions and traits of our society (Ödman, 2007). The understanding of a text is by alternating between parts of the text, the whole text, and the context. Interpretation and understanding is based on the researcher's preunderstanding of the phenomenon. The authors' preunderstanding of this study, which is presented in the conceptual framework of this thesis, includes theories on workplace health promotion, leadership and workplace factors influencing employees' health.

Study II

A phenomenographic method was used in the analysis of Study II, which meant that the variation of how persons interviewed experienced a phenomenon was studied (Marton, 1988). The data analysis aimed at understanding how people experience the phenomenon of health-promoting leadership (Sjöström & Dahlgren, 2002). Conducting phenomenographic research means to explore and reflect over other peoples' experiences and, thus, making statements about "*the world as experienced by people*" (page 118,

Marton & Booth 1997). In phenomenographic analysis, the researcher brackets his or her own experiences when exploring critical aspects of different ways persons experience a phenomenon (Marton & Booth, 1997). For Study II, the analysis focused on the different views that were expressed in the interviews, and they were actively compared with the literature after the analysis was performed. This process can be compared to phenomenological analysis, where the researchers' own experiences are held in focus with the aim to analyse more completely how a person experiences his or her world (Marton, 1988).

Study III and Study IV

Qualitative content analysis was applied mainly to the manifest content in Study III and Study IV (Graneheim & Lundman, 2004). To some extent, latent content analysis was also done. Performing a qualitative content analysis means acknowledgment that the analysis of the material is dependent on subjective interpretations and also on cooperation between the researcher and the participants. Manifest analysis included visible and obvious components of the text (e.g., informants' statements about project experiences). Latent content analysis meant that the underlying meaning and implications of different statements were analysed (e.g., implications of communication patterns at group meetings).

In Study III, a content analysis of all the transcribed interviews was performed. In this study, the results from the content analysis of the interviews were compared with the results from the leadership survey in order to confirm tendencies in the analysis. In study IV, content analysis was performed on the written summaries of the observations, the transcribed interviews and the written project material. Conventional content analysis was applied in both studies (i.e., categories were derived during the data analysis process) (Hsieh & Shannon, 2005). Although qualitative content analysis is a widely used research method, few papers published describe how to apply the method (Elo & Kyngäs, 2008). Graneheim and Lundman (2004) were followed in Study III and Study IV, as they present a comprehensive summary of procedures suitable for the aims of the studies.

Content analysis was performed by (i) sorting the different meaning units in the text under different themes and (ii) labelling the different meaning units with codes. A meaning unit is a constellation of words or statements related to the same theme (Graneheim & Lundman, 2004). The analysed text was then divided into different content areas (i.e., parts of the text dealing with different issues). The choice of the content areas was influenced by both the literature in the field and the different concerns expressed in the material. Finally, the main categories were formed, consisting of a group of content related to each other and describing a specific content area (Graneheim & Lundman, 2004).

The researcher's pre-conceptions

My own background and previous experiences have influenced why and how I have conducted the research of this thesis. When attending my first university courses in social psychology, I was fascinated by the application of theories on how people interact and are influenced by each other. My bachelor studies in human resource management gave me an academic platform for studying leadership, management and workplace learning. My strong interest for social issues resulted in a master's degree in public health sciences. Health promotion found a special place in my heart because it, in a practical manner, aims at improving equity and well-being in society.

After attaining my master's degree, I worked full-time with master's education in health promotion; this gave me a deepened theoretical knowledge in the field. Writing this thesis gave me an opportunity to combine my knowledge in human resource management and health promotion. Due to the time limitations for writing this thesis, and due to the aim to obtain an in-depth understanding of the concept of health-promoting leadership, this thesis is mainly based on qualitative methods. However, my experiences from public health sciences convinced me of the value of combining qualitative and quantitative methods.

Ethical considerations

The demands on ethical principals in research, as described by the Swedish Research Council (2002), were followed. Approval from an ethical committee was not needed, according to the law (2003:460). Written informed consent was obtained before performing all the interviews. This meant that all persons interviewed were given information about the research study both orally and in a written document at the beginning of each interview. The written document was signed by the participants; it contained information about the aim of the study, that the participation was voluntary and that they could withdraw from the study at any time. The document also informed participants that the study materials would be handled confidentially and that no names would be mentioned in the reports of the studies.

One ethical consideration arose from the fact that the researcher was introduced to potential interviewees by top managers or project leaders. This might have contributed to interviewees feeling obligated to participate. Therefore, each participant was asked if he or she wanted to participate or not without the presence of any other person. In Study III, some persons declined to participate in the research study.

Results

Study I: The role of leadership for promoting health at work

Since the early 1990's, the Health Promotion Research Group at the Karolinska Institute had followed the development of an industrial company in the Stockholm area. The company had a very low sickness rate and a work organisation that seemed to give employees a high degree of influence and job satisfaction. Therefore, it was interesting to conduct a case study of the company. More specifically, the purpose of this study was to analyse the leadership and organisation, including the organisational culture of the

company, in relation to the health of the employees. This meant that factors contributing to the employees' well-being and low sickness rate were studied.

The company had long experience with self-managed teams and an organisational culture that had the expressed aim of promoting the possibilities of the employees to develop their skills and influence over the work situation. The leadership in the studied company is oriented towards developing and actively promoting a culture and a structure of organisation, wherein the employees have a high degree of control over their work situation. According to the employees, this means extensive possibilities for personal development and responsibility as well as good companionship, which make them feel good at work. This is also supported by the low sickness rate of the company.

The results indicate that the leadership and organisation of this company may have been conducive to the health of the employees interviewed. However, the culture of personal responsibility and the structure of self-managed teams seemed to suit only those employees who were able to manage the demands of the company and adapt to that kind of organisation. Therefore, the findings indicate that the specific context of the technology, the environment and the professional level of the employees need to be taken into consideration when analysing the relation between leadership, organisation and health at work.

The company studied had a strong organisational culture. An important issue is whether the leadership and culture of the company included elements of putting social pressure on employees to work harder. Findings showed that those who did not fit into the company culture resigned, implying a healthy workers effect (i.e., the company employed skilled workers who were able to cope with its demands, resulting in a low sickness rate).

Study II: The concept of health-promoting leadership

There are many indications of the importance of health-promoting leadership, but very few studies have examined this leadership type and there is no consensus on the

definition of the concept. Therefore, Study II aimed to describe and analyse different views of health-promoting leadership among actors involved in workplace health promotion in eight Swedish municipalities. The study analysed how managers, administrators and project leaders, in interviews, described different views of the concept of health-promoting leadership. It was also analysed how they described their motives for developing such leadership as well as the necessary conditions for that.

The concept of health-promoting leadership was described in three different ways: “organising health-promoting activities,” “supportive leadership style” and “developing a health-promoting workplace.” Organising health-promoting activities meant that it was an important task for managers to initiate and support activities to promote the health and work satisfaction of the employees. Supportive leadership style meant that the most important aspect of health-promoting leadership was to support and motivate the individual employees. Many interviewees emphasised the psychosocial aspects, including the attitudes and behaviour of managers towards employees. Developing a health-promoting workplace, finally, was based on a wider view that stressed the responsibility of managers to develop a healthy physical as well as psychosocial work environment.

The main motives for health-promoting leadership were “instrumental motives” and “improved health.” The instrumental motives mentioned were decreased sickness rate as a mean to reduce costs, provide good services to the inhabitants of the municipalities and facilitate recruitment of employees. Improved health meant that the health and well-being of the employees was regarded as a goal in itself.

The critical conditions for health-promoting leadership were “organisational conditions,” “characteristics of individual managers” and “support to managers.” Organisational conditions included financial resources for managers as well as integration of health promotion in ordinary organisational development work and organisational culture. Characteristics of individual managers emphasised that development of managers’ competencies and attitudes was viewed as critical to a health-promoting leadership. Support to managers, finally, meant that the lonely and challenging aspects of the

leadership role had to be considered in the development of health-promoting leadership.

In developing a health-promoting workplace, it can be important to include all of the individual and organisational conditions mentioned in the interviews. Health-promoting leadership was to a great extent described as the same as good leadership. It seems that the concept of health-promoting leadership is often used to link ideas about good leadership to employee health. Organisational goals and management trends may also influence the motives and conditions for development of health-promoting leadership.

Study III: Development of health-promoting leadership

Although many researchers have pointed out the importance of leadership in creating health-promoting workplaces, very few studies have investigated the methods for developing health-promoting leadership. Thus, the purpose of Study III was to describe and analyse the experiences of a training programme for the development of health-promoting leadership. The more specific purpose was to identify critical aspects of such a programme as part of the development of a health-promoting workplace. A case study approach was used to illuminate the experiences of the leadership programme in four districts of a Swedish town.

The aim of the programme studied was to support the managers within the city districts in the development of health-promoting leadership, while the long-term goal was to reduce the sickness rate and increase work attendance by employees. The leadership programme was based on group discussions and reflections around a working material about health and health promotion at the workplace.

The results show the importance of regarding the development of health-promoting leadership as a contribution to the building of organisational capacity for health-promoting workplaces. This requires a comprehensive approach including individual and structural aspects as well as the integration of programme ideas into the practice of management. Moreover, it is shown that wider participation in the planning and design of

the programme is desirable. The concrete outcomes of the studied programme were action plans for workplace health promotion developed during the programme.

For the participating managers, the possibilities for reflections and sharing of experiences were also a positive aspect of the programme that may also have long-term effects on the development of health-promoting leadership. It would be important to follow the development of health-promoting leadership over a longer period of time, and also to develop measures for evaluation in order to better assess the outcomes of such interventions.

Study IV: Collaboration on health promotion leadership

Collaboration between different actors and stakeholders, both inside and outside the workplace, has been recommended in the health promotion literature as an important strategy for developing health-promoting workplaces. There are, however, many difficulties and tensions involved in making different organisations collaborate. Furthermore, there is limited research on barriers and facilitating factors for interorganisational collaboration on workplace health promotion. Therefore, Study IV aimed to describe and analyse a case of interorganisational collaboration on workplace health promotion. A project involving nine municipalities in a Swedish region was studied. The goals of the collaboration, the organisation of the project, the group process of the project group and critical conditions for collaboration were analysed.

In the project studied, collaboration on health-promoting leadership was seen as a strategy to reduce the sickness rate among the municipal employees. The members of the project group were mainly operating managers with limited knowledge of prevention and health promotion. They defined health-promoting leadership as good leadership in general, and they saw collaboration in leadership training as a guarantee for developing good leadership qualities among managers in the region. The best way to develop such leadership was considered to be through supporting good leadership and improving the general working conditions of managers in the municipalities. It was not clarified how

health-promoting leadership could contribute to the overall aim of decreased sickness rate.

The results indicate the importance of involving participants with different knowledge and experiences in the field (e.g., participants from different organisations, professions and positions). In this way, it may be possible to achieve an integrated form of workplace health promotion. It may also be possible to develop strategies for health-promoting leadership, which can contribute to a decreased sickness rate.

The results of the study also show that it may be wise to organise collaboration initially on a small scale, giving opportunities for the participating individuals and organisations to learn to collaborate and develop trust in each other before it is implemented on a larger scale. Collaboration on a centre for employee development had already been established and cofinanced by several of the participating municipalities as part of the overall development work on workplace health promotion in the region. In order to take advantage of such already established structures and sustain the collaboration for a longer period, it could be recommended to develop the collaboration on health-promoting leadership as a part of the activities of the centre.

Discussion

Results discussion

The overall aim of this thesis was to describe and analyse the concept of health-promoting leadership, including critical conditions for implementation and evaluation of such leadership. The results of this thesis show the importance of different aspects for defining and applying health-promoting leadership. Previous research shows that leadership may influence the employee health (Gilbreath & Benson, 2004; Nyberg *et al*, 2008; Nyberg *et al*, 2009; Kuoppala *et al*, 2008). Literature on health-promoting workplaces supports the enhancement of organisational determinants for health, including leadership and the way work is organised (Chu *et al*, 2000; Grawitch *et al*, 2006).

However, research on the conditions necessary for developing a leadership promoting employee health and how these conditions can be evaluated is lacking.

The three case studies of this thesis elucidated different aspects of leadership and leadership development from a health promotion perspective. One concept analysis illuminated how health-promoting leadership was described among municipal actors involved in workplace health promotion. The methods used in this thesis were mainly qualitative, and the material consisted mainly of interviews with managers employed in Swedish municipalities. Based on the results from the four studies, some conclusions on theoretical and practical implications for the development of health-promoting leadership can be drawn. The scientific contribution of this thesis describes and problematises the concept of health-promoting leadership, rather than providing causal explanations of how leadership influences the health of the employees. In the following discussion includes (i) an overall discussion of the concept of health-promoting leadership and (ii) implications for implementation and evaluation.

The concept of health-promoting leadership

The concept of health-promoting leadership is found mainly in the Scandinavian literature (Menckel & Österblom, 2002; Hanson, 2004), possibly because the concept is in accord with the general view of leadership in the Nordic countries. According to a literature review, Nordic leadership is characterised by a process-oriented style that encourages employees to participate and take responsibility (Backström *et al*, 2008). This view is believed to be related to the features of the Nordic welfare states, which includes a long tradition of investing in the organisational work environment (Backström *et al*, 2008; Frick, 2004). This thesis contributes to the development of the concept of health-promoting leadership and, thus, can be viewed as a continuation of Scandinavian work environment research (Sverke, 2009).

Study I illustrates how a company leader had developed and influenced a company culture, including employees' control over the work situation, participation and personal

development. The interviewed employees expressed these factors as health promotion. In the intervention studied in paper III, health-promoting leadership was defined in terms of values and attitudes towards the employees as resources in the development of a healthy workplace. In Study IV, health-promoting leadership was described as a means of decreasing sickness rates. In Study II, the concept of health-promoting leadership was described mainly in three different ways: organising health-promoting activities, supportive leadership style and developing a health-promoting workplace. To a great extent, health-promoting leadership was described in Study II as the same as good leadership. Interviewees often linked this concept to ideas about good leadership in general and also to employee health.

Based on literature studies health-promoting leadership was defined in paper III as leadership that is concerned with creating a culture for health-promoting workplaces and values to inspire and motivate employees to participate in such development (Eriksson *et al*, 2010). In the same way as both leadership and management are pointed out as necessary for an organisation (Kotter, 1990), both organising health-promoting activities and providing a supportive leadership style were viewed in paper II as important dimensions of a health-promoting leadership.

In summary, the theoretical implications of this thesis suggest that health-promoting leadership is a critical part of the organisational capacity for health promotion, including the knowledge and skills of managers and the policies and structures of the organisation supporting the development of a health-promoting workplace (Riley *et al*, 2003; Heward *et al*, 2007).

Implications for implementation

The studies of this thesis demonstrate the importance of both organisational development and the development of individual managers. Table 1 summarises practical implications for the implementation of health-promoting leadership, based on the results from this thesis. With the assistance of a check-list (Table 1), single programmes for health-

promoting leadership can be recommended for integration into the continuous and ongoing development of the workplace. This kind of integration may contribute to the notion that programme ideas are sustained and survive the turnover of specific employees who are engaged in the implementation of the programme (Scheirer, 2005).

Table 1: Suggestions of important aspects to consider when implementing health-promoting leadership

<u>Implementation aspects</u>	<u>Check-list</u>
Organisational capacity What is the existing organisational capacity for health? How can managers contribute to the development of the organisational capacity for health and the systematic work environment management?	▪ Organisational structures, policies and resources ▪ Individual skills and knowledge
Organisational development What do the existing organisational conditions look like? What needs to be improved to help managers develop a health-promoting workplace?	▪ How work is organised ▪ Involvement of employees ▪ Support from different organisational levels ▪ Interprofessional collaboration between different professional groups of the organisation ▪ Employee responsible for promoting the implementation
Development of individual managers What kind of support do individual managers need?	▪ Knowledge of workplace health promotion ▪ Possibilities for reflection ▪ Time and support for development work

Dealing with limited resources

The majority of the managers interviewed in this study were employed by Swedish municipalities. Managers in Study II and Study III described organisational conditions (i.e, frequent reorganisations and large work units) as hindering their ability to function as health-promoting leaders. Large structural changes in worklife, especially in the public sector have occurred in Sweden since the early 1990s. 'These changes are characterised by the ideas of the New Public Management. This means an increased focus on the client as consumer and on higher efficiency and productivity (Pollitt, 1990). Consequently, the public sector has been characterised by frequent reorganisation; several studies show a development of negative psychosocial working conditions (Härenstam & the MOA Research group, 2005; Theorell, 2006; Engström, 2009).

The collaboration in paper IV and some of the results in paper II can also viewed in the context of conditions of modern working life, described above (Härenstam & the MOA Research group, 2005). One important motive for collaboration expressed in paper IV was that the smaller municipalities in the region lacked resources for their own training programmes. Motives for health-promoting leadership expressed in paper II were instrumental motives (e.g., to decrease sickness rate as a mean to reduce costs, to provide good services to inhabitants of the municipalities and to facilitate recruitment of employees). In this context, the concept of health-promoting leadership seems to represent a new category of ideas inspired by New Public Management.

Developing managers' skills and giving them tools to develop health-promoting workplaces could be viewed as essential, but doing this without attention to their working conditions may only blame the victim. Interviews and the Study III survey show that managers lack sufficient time to implement health-promoting work. These results emphasise the need to deal with issues of health-promoting leadership on a higher political and administrative level than the single work units.

In Study II, the leadership role was viewed as challenging but lonely, and support to managers was expressed as a critical condition for the development of health-promoting

leadership. The managers interviewed in Study III appreciated the opportunity to reflect and share their experiences. Frontline managers within the public sector largely seem to need support in order to cope with limited budgets and constant organisational and societal changes (Skagert *et al*, 2008).

Organisational development

Study III shows the importance of integrating and adapting actions and interventions to the organisational context while aiming to develop health-promoting leadership. This idea is supported by the contingency theory (i.e., the choice of optimal actions in an organisation depends on internal and external factors) (Scott, 2003). In Study I, the company leader had developed a company culture that promotes employee awareness of company goals. He had furthermore developed an organisational structure that enables the decentralisation of responsibilities. The interviewed employees in the company perceived this as health promotion. However, the company leader had not considered how to integrate broader health issues into the company's organisational development.

In this context, organisational development involves systematically analysing, planning, implementing and evaluating the organisations' capacity as a health-promoting workplace, rather than focusing more narrowly on developing the health-promoting skills of individual managers (Parsons 1999; Scheirer, 2005). This can be compared with interventions aiming at first- or second-order change. Interventions leading to first-order change aim to change individuals' behaviour, making them able to better adapt to an existing system. On the other hand, second-order change produces changes in the rules and processes of an organisation (Swerissen & Crisp, 2004).

Paper II-IV provides processes that could lead to second-order change and thus contribute to the sustainability of health promotion interventions. Organisational conditions supporting the development of health-promoting leadership described in Study II included integration of health promotion in ordinary organisational development work and organisational culture. The intervention described in paper III organised managers of

smaller groups, who produced action plans on workplace health promotion. Such a participatory process, oriented towards problem-solving, is central for organisational change (DeJoy *et al*, 2010). This kind of approach can also be recommended for integrating programme ideas into the ordinary development of the work organisation. If the action plans lead to changes in policies, strategies and routines, organisational learning may occur (Svensson *et al*, 2004). Research shows that leadership development embedded in leaders' work environment and ordinary development of the workplace is most likely to be successful (Hernez-Broome & Hughes, 2004). Furthermore, this kind of development work requires that people in the organisation have time for learning and reflection (Ellström, 1996; 2001; Nytrø *et al*, 2000). In Study IV, a policy was suggested by the project group that the managers in the region could use 5% of their working time for personal leadership development. This may be a good strategy for an organisation to show that they support learning and development work.

In accord with previous studies, Study III shows that support from top management is critical to programme implementation, as is a participatory approach at all levels (Chu *et al*, 2000; Cargo *et al*, 2003; Bourdages, *et al*, 2003). A key issue within health promotion involves determining how to organise health interventions that combine top-down and bottom-up approaches (Laverack & Labonte, 2000). The intervention described in Study III included organising meetings with unit managers into smaller groups around working material regarding health promotion at the workplace. This concurs with Laverack and Labonte's (2000) suggestion of developing individual empowerment by building organisational capacity in smaller groups. Previous research shows that managers within female-dominated sectors of Swedish municipalities perceive that they have less opportunity to address work environment issues compared to managers within more male-dominated technical sectors (Forsberg Kankkunen, 2006). Thus, a critical issue involves whether the intervention also enhanced the unit managers' long-term possibilities to address work environment issues.

In the intervention presented in Study III, an external project leader with extensive knowledge on workplace health promotion was engaged to implement the project in

collaboration with administrators within the districts. The project leader was also responsible for seeking support for the intervention at different organisational levels. This collaboration was critical for initiating activities at the workplace and may also be seen as a good method for developing internal actors' competence on workplace health promotion. Previous research showed that this kind of interprofessional collaboration is a successful strategy for integrating and sustaining programme ideas over time (Lang *et al*, 2009; Goetzel *et al*, 2009).

The literature recommends integrating health promotion in ordinary organisational development work and taking advantage of already established organisational structures (Johnson & Baum, 2001). In the collaboration of Study IV, a centre for employee development had already been initiated and cofinanced by several of the participating municipalities as part of the overall development work on workplace health promotion in the studied region. When developing collaboration on health-promoting leadership, making use of these established structures is fruitful.

Implications for evaluation

The practical implications of this thesis can be summarised as the importance of evaluating whether a systematic approach for integrating issues of health-promoting leadership into organisational development already exists (Table 2).

Table 2: Important evaluation aspects when developing health-promoting leadership

<u>Evaluation aspects</u>	<u>Check-list</u>
Goals of the intervention	▪ Systematic analysis of health needs on an individual, group and organisational level ▪ Participatory approach when formulating goals ▪ Clear sub-goals and long-term goals
Activities initiated within the intervention	▪ Development of individual skills and knowledge ▪ Development of organisational structures, policies and resources ▪ Integration with other workplace activities and developments
Organisational conditions hindering or facilitating the implementation of the intervention	▪ Competence, structures, policies and resources of the organisation supporting health-promoting leadership ▪ Support for planned activities from different organisational levels ▪ Interprofessional collaboration between different professional groups of the organisation

Because this thesis regards health-promoting leadership as an important part of developing organisational capacity for a health-promoting workplace, it was important to evaluate the processes and the outcomes of health-promoting leadership. Study I indicates the importance of contextual factors when evaluating the role of leadership for promoting

health at work. In Study II, a number of individual and organisational conditions were regarded as critical for the development of health-promoting leadership. This thesis recommends including all of these conditions when evaluating health-promoting leadership. The conclusions from Study III posit the need to adapt and integrate successful interventions into the ordinary daily work of the organisation. Methods of self-evaluation provide organisations with opportunities to learn from their own experiences; therefore, they are useful when evaluating health-promoting leadership (Fitzpatrick *et al*, 2004).

There is a greater need to focus on health-related goals and sub-goals. In the project described in Study IV, discussions on health-promoting leadership were related to health issues only to a limited extent and they did not clarify how health-promoting leadership could contribute to the overall aim of decreased sickness rate. Nutbeam (1998) summarises that insufficient measurements of the outcomes of health-promoting actions have hindered the development of evaluation within health promotion. The development of health-promoting leadership can be viewed as long-term development work. Previous research on organisational development shows that it may take 3–5 years before outcomes, in form of increased well-being, can be measured (Nyberg, 2008). This shows the need for developing measures for intermediate health outcomes. The intervention presented in Study III resulted in action plans that could be considered as intermediate health outcomes of the programme. The plans specify and follow up health promotion actions within the ordinary work of the management group. In this context, leadership in relation to the organisations' competence, structures, policies and resources for becoming a health-promoting workplace can be viewed as a main concern that requires evaluation (Poland *et al*, 2009).

The results from the thesis studies also show the importance of looking at outcomes beyond sickness rates. The findings from Study I implied a healthy workers effect (i.e., a low sickness rate is due to the company employing skilled workers who were able to cope with the demands of the company). An important question is whether the characteristics of the company were really meant to be health promoting. The leadership

of the company can be compared to popular leadership ideas of a charismatic leader who motivates employees to be highly committed to the goals of the organisation (Peters & Waterman, 1982). This kind of leadership approach has been criticised for containing manipulative elements, where ideas critical to the existing organisational culture may be suppressed (Yukl, 2006). As health promotion aims at equity and social justice, unintended consequences of leadership interventions and benefits for different groups of employees can, in this context, be recommended for evaluation (Poland *et al*, 2005).

In conclusion, it is important to evaluate the leadership's contribution to a health-promoting workplace. This understanding may be obtained by analysing relations between the organisation of work, management and leadership and the health of individual employees. For example, measurements for a health-promoting organisation of work include the degree of demand-control and participation of the employees, and health-promoting measurements for management and leadership include communication and working climate. Finally, examples of measurements for the health of individual employees include self-rated health, job satisfaction and a sense of coherence (Dallner *et al*, 2000; Pejtersen *et al*, 2010; Eklöf *et al*, 2010).

Methodological discussion

Methodological considerations

The choice of the methods for the studies might have influenced the results of this thesis. Complementary methods (e.g., a comprehensive questionnaire survey to a greater number of managers and employees) would have provided broader picture of health-promoting leadership in different working sectors. In addition, the persons interviewed in Study II might have expressed their ideas about health-promoting leadership without revealing how they use the concept in practice (Laurence & Margolis, 2003).

Furthermore, the selection of informants for this thesis might have influenced the results. A majority of the persons interviewed for this thesis was employed by Swedish

municipalities and worked as managers. Interviewing persons within other sectors with other positions might have led to other results and revealed other perspectives of health-promoting leadership.

The interviews of study I expressed negative aspects of the leadership and organisation of the studied company only to a limited extent. The fact that the interviews took place at the workplaces of the informants, with the company leader present in the building, could have influenced these results. The informants in the other three studies did seem to express their opinions more openly (e.g., the informants in Studies III and IV criticised the studied projects).

The long-term outcomes of the projects in Study III and Study IV were not investigated. It would be important to follow the implementation of health-promoting leadership over a longer time period to draw conclusions on long-term conditions for the implementation of health-promoting leadership.

Trustworthiness

In qualitative research, it is important to discuss the trustworthiness of data collection and data analysis (Lincoln & Guba, 1985). Different issues of trustworthiness within qualitative research are labelled differently in the literature (Porter, 2007). However, most authors include the importance of discussing whether or not reasonable interpretations have been made and whether these interpretations were empirically covered. Kvale (1996) distinguishes between communicative validity and pragmatic validity. Communicative validity means that the credibility of a study is tested in a dialogue with others. Pragmatic validity, on the other hand, means that it is possible to show that the results are applicable in reality.

Furthermore, Kvale discusses analytical generalisation (i.e., the extent to which the findings can be applied to explain other situations), which includes analysis of the similarities and differences of the investigated situation and other situations (Kvale,

1996). This can be compared to discussions of external validity (i.e., whether it is possible to generalise the findings beyond the specific study and apply them to similar situations (Yin, 2009). However, Stake (2000) points out that the results of intrinsic case studies can't be generalised to other situations because they rely on the specific features of the case. The reader may comprehend and modify the results to their own context, making thick descriptions of the case desirable.

Pawson *et al* (2003) have chosen not to apply the concept of validity but rather to list issues more widely related to the scientific rigour of qualitative research. According to them, important issues related to trustworthiness include *transparency* (whether the process of knowledge generation is open to outside scrutiny), *accuracy* (whether the claims made are based on relevant and appropriate information) and *purposivity* (whether the method used fit the purpose).

The methods applied in the different studies of this thesis were chosen to fit the purpose of obtaining an in-depth understanding of the concept of health-promoting leadership. Descriptions of how and why the studies were conducted could contribute to the transparency of the studies. In Studies I, III and IV, multiple sources of data were used to empirically explore the different content areas of the studies. Consistency between the different data sources was used to confirm the trustworthiness of the results. In these three studies, descriptions of the cases relevant to the main analysis were provided (i.e., important features of the company, the programme and the collaboration were studied). To maintain confidentiality, some specific details of the cases have been omitted. In Study II, frequent quotations from study participants were used in the result section, helping the reader reach their own conclusions on the accuracy of the study.

The author of this thesis made all the preliminary analyses of the studies. In Studies II, III and IV, all authors were involved in the final analysis of the data and in the forming of categories. This process can be compared to communicative validity, as the researchers held intense discussions about the content and credibility of the final results. In Study III, feedback on the preliminary analysis was given by the project leader and administrator in

follow-up interviews. In Study IV, the project group and steering groups provided feedback in a meeting that presented the preliminary results. This kind of feedback can also be seen as a way of confirming the trustworthiness of the results. To some extent, pragmatic validity was reached when the result of the thesis was presented in scientific conferences and lectures, because the audience confirmed that the results were applicable in other contexts.

The extent of analytical generalisation was explored as the results of all studies were compared to relevant theories and findings from other studies. In Study I, the literature on health-promoting factors was already an important part of the process of collecting data, while in Study II, the results were more actively compared to the literature after the analysis was performed. In Studies III and IV, the results were compared to the literature parallel with the data analysis.

Conclusions and future research

Health-promoting leadership can be defined as leadership that is concerned with creating a culture for health-promoting workplaces and values to inspire and motivate the employees to participate in such a development. Health-promoting leadership can also be seen as a critical part of the organisational capacity for health promotion, including the knowledge and skills of the managers and the policies and structures of the organisation supporting a health-promoting workplace. In other words, this means including leadership engagement in the systematic development of both the physical and psychosocial work environment.

It is important to consider specific and contextual leadership conditions when formulating strategies for health-promoting leadership. Managers within the public sector often face limited resources and require different kinds of support to deal with their leadership tasks, including support from a higher organisational level for a health-promoting culture as well as organisational structures and policies that support the development of a health-

promoting workplace. A participatory approach is also essential, so that the concerns of frontline managers are also included when formulating strategies and interventions for health-promoting leadership.

A relevant strategy for developing health-promoting leadership would involve combining organisational development with the development of individual managers. For example, managers who meet in smaller groups and produce action plans on workplace health promotion can provide a relevant method for building the capacity of both the individual managers and the organisation.

To initiate a health-promoting development work, it can be recommended to get external help from experts with knowledge of workplace health promotion. Furthermore, the success of such development work depends on the integration of health promotion in ordinary organisational development and organisational culture. In this context, it can be recommended to take advantage of already established organisational structures as well as to promote collaboration between different organisational functions.

Future research should develop measures for the evaluation of health-promoting leadership, including both intermediate and long-term outcomes. Such research should include the competence, structures, policies, and resources of the organisation as well as different aspects of the well-being of the employees in these measures.

Acknowledgments

My journey as a doctoral student has finally come to an end, and I would like to express my sincere gratitude to everyone who has contributed along the way. I have been travelling light thanks to all your support. I am especially grateful to:

My main supervisor **Runo Axelsson** and my co-supervisor **Susanna Bihari Axelsson** for always being so available and keen to support me. I would especially like to thank Runo for helping me develop manageable research and for contributing invaluable skills in scientific writing. I would like to thank Susanna, especially for your critical eye and for always being genuinely concerned.

All present and former members of the **health management research group** for providing a positive and constructive research environment. A special thanks to **Arne Orvik**, who on several occasions so thoroughly reviewed and commented on my work.

All dear **colleagues** at the **Nordic School of Public Health** for providing friendship, laughter, constructive feedback on my research and keen support in practical matters. A special thanks to all **fellow doctoral students** for always being prepared to give support and share my daily concerns.

All dear **friends** and **colleagues** within the field of **public health sciences** for making it so inspiring and pleasant to do research in this field. A special thanks to **Bo J A Haglund** for so comprehensively introducing me to the world of health promotion.

All **participants** in my studies for your willingness to participate.

All my dear **friends** and **relatives** for being there for me as babysitters and keen supporters. A special thanks to **Peter** for all your help with both babysitting and proofreading.

My beloved parents **Marika** and **Sven-Erik** for all your concern and support and for always so strongly believing in me. My beloved siblings **Ulrika** and **Björn** for always doing what you can for me.

My beloved family: **Nicholas** for *all* different kind of support and for the sacrifices you have made, making it possible for me to write this thesis. **Eira**, **Viktor** and **Johanna** for being who you are and for everything I daily learn from you.

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