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Co-Creating the Good Job or the Extra Mile: Does Co-Creational Implementation of WHP Improve Working Conditions? **

Abstract

Workplace health promotion (WHP) can be the starting point for organizational development towards becoming a healthy organization offering good jobs. Participative processes are explicit standards for designing WHP thought to always be positive for the workforce. However, they may also result in employees creating ideal contexts for overexertion. This paper critically examines the potentials of co-creation in the employee health context and as standard for creating the good job. We do this analyzing the employee health-related co-creational processes in a faith-based hospital using multimethod organizational analysis with observational, ethnographic and interventional elements. The results indicate that the professionalism of the employees and sharing organizational goals can prevent co-creating more stress and strain.

Keywords: co-creation, workplace health standards, workplace health management, workplace health promotion
(JEL: I12, J24, J81, M14, M54)

Introduction

Organizations are traditionally required by law to implement at least basic health-protective standards and processes, to ensure employee safety plus to audit – depending on national law (Botero, Djankov, Porta, Lopez-de-Silanes, & Shleifer, 2004; Kanbur & Ronconi, 2018) – additional health-related issues such as psychosocial stress and strain, work-family-interference, etc. (Jespersen, Hasle, &

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** Date submitted: August 31, 2018
Revised version accepted after double-blind review: November 11, 2019.

 DOI: 10.5771/0935-9915-2020-2-232

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Nielsen, 2016; Kawakami & Tsutsumi, 2015; Leka, Jain, Iavicoli, & Di Tecco, 2015; Potter, O'Keeffe, Leka, Webber, & Dollard, 2019). In many countries, governmental bodies or closely related agencies check for compliance, and penalties can be very unpleasant (Johnson, Levine, & Toffel, 2017; Sojourner & Yang, 2015). However, the vast majority of these efforts are of a so-called pathogenetic perspective, focusing on what is detrimental for health and thus to be reduced or eliminated, making "a preventive culture in a broad sense (…) fairly uncommon" (Kortum, 2014, p. 162). Nevertheless, there are many efforts to improve this situation and to include health promotion as a salutogenic approach focused on empowerment and strengthening health resources. As the modern workplace becomes more complex, health in the work setting typically requires comprehensive assessments (Chia, Lim, Sng, Hwang, & Chia, 2019; Schulte, Pandalai, Wulsin, & Chun, 2012) and subsequent interventions targeting both: risks and resources (Jenny, Bauer, Vinje, Vogt, & Torp, 2017). This makes it necessary to go beyond prescribed regulations focused on the former, to assess the health needs of the workforce and to include the target group in designing good, health promoting working conditions (Goetzel et al., 2018; Henning et al., 2009; Kent, Goetzel, Roemer, Prasad, & Freundlich, 2016), creating the good job. The European Network for Workplace Health Promotion (ENWHP) also highlights the necessity of analysis and participation in the core quality criteria of workplace health promotion (WHP) programs (ENWHP, 1999, 2018). These can be the starting point for organizational development towards becoming a healthy organization (Badura, 2001, 2002). Workplace health management (WHM) then defines employee health as an organizational goal (Horváth et al., 2009).

Participative processes are explicit standards for designing workplace health promotion. They are postulated by expert agencies and seen as crucial (Breucker, 2000; Demmer & Stein, 1995; ENWHP, 1999; Lier, Breuer, & Dallmeyer, 2019), though no guarantee (Nöhammer, Schusterschitz, & Stummer, 2010; Nöhammer, Stummer, & Schusterschitz, 2014) for program success. However, employee participation in WHP as an expression suffers from a highly unclear definition (Glasgow, McCaul, & Fisher, 1993; Nöhammer et al., 2010; Sloan & Gruman, 1988), making it difficult to assess the degree the workforce was involved in designing the program. In this paper, we focus on the state-of-the-art: collectively discussed and designed WHP, which is why we employ the term co-creation. Co-creation is defined as "joint, collaborative, concurrent, peer-like process of producing new value, both materially and symbolically" (p. 644), which in management and organization literature is typically applied to organizations co-creating products and services with clients (Galvagno & Dalli, 2014). Among the various approaches and substantiations of the basic concept (Galvagno & Dalli, 2014; Grönroos, Strandvik, & Heinonen, 2015; Ind & Coates, 2013), co-creating internal processes has become an established method. In addition, the effects of WHP can depend on and be analyzed regarding co-creational processes and reach (Bauer & Jenny, 2013).

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In general, health-related innovations rely heavily on the acceptance and compliance of the target group (Stummer, 2006). This is especially the case for WHP, which is not compulsory for either the organization or the employees, but an additional offer requiring resources that should be used optimally. Thus, co-creating WHP with the employees, who are the experts of their work-related risks and resources configuration, is highly recommended by experts (Breucker, 2000; Demmer & Stein, 1995; ENWHP, 1999; Hassard et al., 2012). Among expected outcomes are better credibility, program quality and increased participation rates (Hassard et al., 2012; Kilpatrick, Blizzard, Sanderson, Teale, & Venn, 2015; Nöhammer et al., 2010; Nöhammer, Schusterschitz, & Stummer, 2013).

Advising WHP co-creation implicitly assumes employees will, in the course of the process, successfully act in their best interest and have a context safe enough to do so. However, this assumption has to be challenged (Argyris, 1977), asking if a co-creational implementation of WHP automatically improves working conditions. The question this paper aims to answer thus is: can employee co-creation of WHP help to create good work or can it also result in higher pressure and extra work? Since "to ask what is good work (….) is to ask what work does to us" (Clark, 2017, p. 63), also as opposed to what it should do and find out where changes are required, we critically examine the potentials of co-creation in the employee health context and as standard for creating the good job.

We do this analyzing the employee health-related co-creational processes in a faith-based hospital, as healthcare is a vital industry, its workers operate in high risk and strain settings (WHO, 2016), and faith-based organizations – through offering a more holistic work climate – may also expect more of all individuals (Aadland & Skjørshammer, 2012; Bolino & Turnley, 2003; Byrne, Morton, & Dahling, 2011). Together with being open for all as the core principle of workplace health promotion (Chu et al., 2000; ENWHP, 1999; Sparling, 2010), this is the reason why all employees of the hospital were included in our investigation.

Health – of others – is the central focus and expertise of hospitals and the shared value of its members (Glouberman & Mintzberg, 2001; Mintzberg, 2012), who may already have internalized going the "extra mile", depicting organizational citizenship behaviour (OCB) (Bolino & Turnley, 2003; Schusterschitz, Stummer, & Geser, 2014). Resulting behaviour, however, does not necessarily always lead to good organizational outcomes (Vogus & Iacobucci, 2016) and can also be exhausting for the individual (Anderson & Bolino, 2014; Bolino, Hsiung, Harvey, & LePine, 2015; Bolino, Klotz, Turnley, & Harvey, 2013; Somech, 2016). In certain circumstances, going the extra mile can thus have negative health effects for employees (Koopman, Lanaj, & Scott, 2016) and possibly even patients (Vogus & Iacobucci, 2016).

Co-creating ideal working conditions in a participative WHP process, therefore may possess inherent risks. Even though not intended, the workforce might end up

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creating ideal contexts for better overexerting themselves. In case a pro-social orientation is held towards the team, this may be alleviated should WHP be seen as preventive action protecting colleagues from overworking. Nevertheless, the high degree of professionalism could also result in unreasonably high health behaviour expectations, making WHP an additional strain. In the case study, we, therefore investigated the co-creational processes and their outcomes.

Background

Health is defined as complete and holistic well-being, not only the absence of illness (WHO, 1986). The latter is a pathogenetic viewpoint and oriented towards prevention and curation. To achieve the balance of challenges and resources needed for health (Hurrelmann, 2006), a salutogenic perspective is required. This is more proactive and analyzes what promotes health, mainly by focusing on resources (Antonovsky, 1997).

Health at the Workplace

In organization theory, considering employee health in the sense of ergonomics traces back to the time of Frederick Taylor (Dempsey, Wogalter, & Hancock, 2000). The employee was seen as a mechanical part of the organization (Voxted, 2017), and ergonomics improved their productivity. Research and experience have shown people have much more to offer at the workplace, for example, ideas, organizational citizenship behaviour and commitment. To achieve that, employee health protection has to take care of psychosocial issues, as well. Further aims include incurring no harm, ensuring workability (Ilmarinen, Gould, Järvikoski, & Järvisalo, 2008; Seitsamo, Tuomi, & Ilmarinen, 2008), improving employer branding and sustainability (Ehnert & Harry, 2012).

Health at work is a societal discourse, an individual issue and of organizational interest. However, the perspectives do not necessarily align, making this a very political debate and opening up ethical questions (Haunschild, 2003). In research and practice, health is conceptualized as multifaceted and not only consisting of various dimensions (Dahlgren & Whitehead, 1991) but also being a continuum (Antonovsky, 1997). Therefore, organizations wanting to introduce employee health management programs have to at least evaluate risks and resources. The European Commission issued a guideline listing aspects requiring consideration, including psychological and social factors plus their interactions already in 1996 (European Commission, 1996). To evaluate and then alleviate psychosocial as well as physical work-risks is mandatory in Austria and Germany since 2013/14 (Jiménez & Glaser, 2015). If possible, existing individual and organizational resources should be strengthened, too (Preuner, Stummer, Nöhammer, & Katzdobler, 2018).

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Depending on the job type, various aspects of health are more relevant than others. Physical, emotional or cognitive labour can be dominant or differently distributed in specific situations (Byrne et al., 2011). This means these individual resources are being used and need to be refilled according to the conservation of resources theory (Hobfoll, 1989). While many professions score highly only in one or two areas, some occupations require high-intensity effort in all labour types, for example, nursing, occupational therapy, medical doctors, physiotherapy, or care for elderly. Though worker protection standards in healthcare are very high, their focus is pathogenetic. The potentials of promoting individual and organizational resources have not yet been achieved.

Standards for health at work

In addition to mandatory national legislation, there are international standards for occupational health and safety. These can be either binding conventions due to international treaties or non-mandatory recommendations or guidelines (International Labour Organization ILO, 2018) and shall serve as tools on the "path to decent work" (International Labor Organization ILO, 2018). In this sense, standards are norms agreed upon (Durkheim, 1965). They are prescriptive and normative by definition – and express what should (not) be done *to others* – i.e. employees. Among the possible definitions of the noun "standard", the Webster Dictionary (Merriam-Webster, 2019) also refers to both – mandatory and non-mandatory meanings, plus highlights that a standard can be a support structure. WHP is non-mandatory, but employee participation is among the criteria used for evaluating the programs (Bauer & Jenny, 2013; ENWHP, 1999), and helps create a WHP developmental structure leading to interventions employees want and need. As this paper focuses on the effects of co-creation, we investigate standards in the meaning of support structures.

The International Labor Organization (ILO) works closely together with the International Organization for Standardization (ISO), which develops – among others – standards for management systems and helps translate overarching principles into daily management practice. In spring 2018, the most recent standard regarding health and safety at the workplace was introduced as ISO 45001:2018 "Occupational health and safety management systems- Requirements with guidance for use", replacing the former global standard OHSAS 18001. Having been designed with an expert team from over 70 countries and being compatible with other ISO standards, there are high expectations for better safety conditions and prevention activities in the future (Gasiorowski-Denis, 2018). Based on a Plan-Do-Check-Act cycle (Gasiorowski-Denis, 2018; ISO, 2018a) "[i]t provides a framework to increase safety, reduce workplace risks and enhance health and well-being at work, enabling an organization to proactively improve its OH&S [occupational health and safety; added by the authors] performance" (ISO, 2018b).

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Standards that focus on new challenges in the workplace (Becker & Engel, 2018; Ruhle, Siegrist, Süß, & Weiß, 2018) often need to be adapted to the specific organizational context and requirements. One of the crucial success factors highlighted also by ISO is employee participation in the process (ISO, 2018a). The workforce is a major expert group – especially when their health is concerned. The implicit conception of co-creation as standard for workplace health programs differs from the traditional, externally imposed health standards. These are more like if-then rules with thus predefined, overruling outcomes, which paternalistically protect the workforce. Now, the workforce itself (co-)defines what can or should be done to it – individually and collectively, thus combining an inward and outward orientation. Especially the latter is in line with seeing colleagues as internal clients (Conduit & Mavondo, 2001; Gilbert, 2000) for who value is (co-)created.

Co-creating WHP

Health promotion at the workplace is an effort designed to cover all areas relevant for health in the workplace and to profit the organization, society, and the individual. WHP thus by definition encompasses "the combined efforts of employers, employees and society to improve the health and well-being of people at work" (EN-WHP, 2007), and intends to improve contextual factors and individual behaviour. It should be designed in close alignment with employee needs (Nöhammer et al., 2010) and values, implicit health goals plus organizational requirements and considerations (Broesskamp-Stone & Ackermann, 2010). Depending on the health literacy of the workforce (Sørensen & Brand, 2011), the prevailing lay concepts of health (Svalastog, Donev, Jahren Kristoffersen, & Gajović, 2017; Williams & Williams, 1983) and specific health needs and inequalities in the target group, WHP programs can consist of expert suggestions for internal blind spots, (expert aided) participatory designed and bottom-up organized elements like ad-hoc jogging groups.

Often, WHP is perceived to be just a project. To achieve its complete potential, it should develop into a holistic approach, with employee health becoming one of the strategic aims (Horváth et al., 2009). Though this can create competing goals on the organizational level, these may likely align and become complementary on the macro-level (Smith, Erez, Jarvenpaa, Lewis, & Tracey, 2017). This is one of the reasons why work-related health standards are typically introduced into national law and global standards.

The structure for co-creating WHP programs is usually oriented on project management, with a steering group (management, occupational physician, workers council members, etc.) and, in adaptation of quality circles, so-called "health circles" (Aust & Ducki, 2004; Henning et al., 2009). These discuss health issues, ways to improve health resources and alleviate problems and feed this back to the steering

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group. Based on the suggestions of all circles, the latter then decides what to implement and prioritizes.

Employees participating in co-creating WHP should be interested in the topic and have valuable knowledge, plus communicative skills (Waseem, Biggemann, & Garry, 2018). In addition, they should share the goals of the organization (Vroom & Yetton, 1973) to prohibit destructive behaviour in the process. In-depth knowledge about health issues is not necessarily relevant, though awareness of health burdens and resources in the organizational context is, since based on these suggestions for change and WHP program design are made. The changes then need external resources and social permission (congruent norms) (Comelli & Rosenstiel, 2003). On the employee level, congruent norms refer not only to management and to the team legitimizing (new) health-promoting behaviour, but also to the participation in the WHP co-creation activities. In general, individual behaviour needs to be aligned with personal values (Verplanken, 2004), resulting in motivation plus knowledge and skills (Comelli & Rosenstiel, 2003). Value congruence at the workplace should be checked for regularly (Hauff & Kirchner, 2014). Though health is implicitly assumed to be a basic value and access to healthcare as a social right (Nunes, Nunes, & Rego, 2017), (lay) concepts of health (Svalastog et al., 2017; Williams & Williams, 1983) and health promotion (Noack, 1987) vary in their definition of health. Thus, ensuring a shared perspective on health when co-creating WHP is necessary.

Health as shared value serves as a basis while the WHP process should be designed to account for motivation, knowledge and skills by empowerment and seeing positive change in the organization. Therefore, applying change management principles is suggested for the introduction of WHP and to assist the process. In addition to a sense of urgency, creating organizational readiness for change is advisable, for example by establishing health-promoting internal (leadership) culture (Kotter, 2007). The variables then determining the rate of innovation adoption are interrelated and can be subdivided into (1) perceived attributes of innovations (is it judged as good by the individual), (2) type of innovation-decision (was participation possible), (3) communication channels used, (4) norms of the social system (are supervisors and colleagues in favour) and the (5) extent of change agents‘ promotion efforts (Rogers, 2003).

Even when the suggestions outlined above are followed, WHP programs can still fail. Among the major reasons are barriers to participation and low user interest (Nöhammer et al., 2014). While the former suggests that those who co-created WHP programs overlooked important aspects of its design, the second implies that they were the wrong to ask. There may even be an overlap due to employee socialization and lay concepts of health (Svalastog et al., 2017; Williams & Williams, 1983). Working in healthcare and especially in hospitals may lead to overrating

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own current health as a major comparison group are patients – who in most cases have a worse health status.

Hospitals as Settings for WHP

The health care sector has a very specific role in health promotion and prevention as its offers and services are a major component determining population and individual health. Moreover, it has a vital political and economic impact. Both aspects also influence the stability of society. It might be very natural that the perspective on health promotion and on what it means to be a healthy setting is very outwardly oriented in the health sector, focusing on the patients and the wider society. More often than not, the inward perspective is comparatively deficient, missing the fact that there are internal clients, as well. Not taking care of these may not only endanger the organization but eventually also the public. The health care sector and definitely hospitals present a very specific context and setting for WHP. Being highly complex, hierarchical settings, changes by nature can be more difficult to implement (Röthlin, 2013), not only due to more elaborate internal processes needing time. Nevertheless, the sector is used to innovation on a technical and procedural level, so project implementation issues are not problematic. In addition, an internal hierarchy can act in favour of WHP when the top management acts as change promotor. Moreover, co-creation as a participatory tool can act to fulfil autonomy needs in an otherwise very structured setting.

Hospitals are also high risk and reliability organizations. This requires an outspoken degree of mental awareness of all to ensure patient safety not only by compliance to all rules, regulations, and processes, but also by being alert continually as changes in health status can occur rapidly and require immediate and correct action (Weick & Sutcliffe, 2011; Weick, Sutcliffe, & Obstfeld, 2008). High stress levels and a focus away from oneself to others are consequences, to which financial pressures and frequent understaffing are added, creating even more strain (Hasselhorn et al., 2008; Hasselhorn, Tackenberg, Müller, & Group, 2003). Together with an expected shortage of personnel and other job requirements due to demographic change (more elderly in need of potentially more care, aging personnel) plus alterations in job expectations of the so-called generation Y, promoting the health of employees does not remain a nice to have matter (Ehnert & Harry, 2012). Besides, the high workload and partly excessive demands already have had their victims and continue to do so (Hall, Johnson, Watt, Tsipa, & O'Connor, 2016). This raises general awareness of employee health topics in the health sector. Certainly, this is leading to a cultural change towards greater efforts for employee health, but these processes take time – which is prolonged when not backed up by enough resources, as is frequently the case.

Though the major aim in the health sector is still curative and not prior preventive action or health promotion (Röthlin, 2013; Wieczorek, Marent, Osrecki, Dorner,

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& Dür, 2015), the latter are elements often by law included in the tasks of the sector's members. Due to these reasons, one should expect hospitals to be leading examples of employee health promotion. Research shows, nevertheless, that working conditions in the health sector are still among the most challenging for employee health (Aiken, Sloane, Bruyneel, Van den Heede, & Sermeus, 2013; Borchard, Galatsch, Dichter, & al, 2011) and resource conditions do not yet compensate for the demands. Therefore, WHP design and implementation has to be facilitated, using a low threshold approach and drawing on change management lessons plus accumulated best practice knowledge. As mentioned above, WHP has co-creation at its core but needs specific contextual requirements for that to be performed efficiently and effectively.

Though worker protection standards in the hospital are among the most strict (as the context is potentially highly hazardous), what the workforce would have to be protected from may be themselves. In the health sector and specifically in hospitals, staff health literacy by training and job design is very high. However, at hospitals, the health knowledge application is typically outward-oriented, so a change to the inward perspective may be a challenge. "Normal" for healthcare workers is a high degree of knowledge about illnesses, daily seeing and attending to ill people. The resulting conceptualization of what being sick means might gradually shift more towards very severe conditions. Also, hospital employees are very used to emergencies, (night) shifts and personnel shortages, all leading to being accustomed to having to be flexible time-wise. Moreover, they often are highly pro-social, making them prone to walk the "extra mile" (Bolino & Turnley, 2003; Schusterschitz et al., 2014) and create WHP programs allowing them to do so longer. Co-creation processes in WHP health may thus have unintended results. For this paper, we investigated the co-creational processes of WHP and their outcomes in a faith-based hospital.

Methods

We monitored and analyzed the process and outcomes of co-creating and implementing a holistic approach for employee health protection and promotion at a faith-based hospital in Styria, Austria, which has about 440 employees. All applying national health standards are implemented, creating a traditional basis for OH&S in which WHP was integrated. We were especially interested in how co-creation as implicit standard in OH&S would be enacted and if it would lead to co-creating "the extra-mile" (Bolino & Turnley, 2003; Schusterschitz et al., 2014) or not.

The new legislation on having to evaluate employee psychosocial health in Austria (Jiménez & Glaser, 2015) was taken as a starting point for introducing WHP action. So far, there are very few guidelines regarding the evaluation process. On the one hand, the methodological latitude allows for adjustments to very specific requirements. On the other hand, there is little guidance, though companies have to prove sensible action based on the results to governmental agencies (Preuner et al.,

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2018). As health is multifaceted, these actions should encompass pathogenetic and salutogenic approaches. Options for reaching this goal are mainly (a) integrating the evaluation into WHP or (b) using it as a (potential) start for WHP.

The hospital studied as a case for the present paper chose approach (b). Therefore, we followed the planning, implementation and evaluation design of a classical WHP project (Blattner & Mayer, 2018; Henning et al., 2009) supplemented by specific suggestions for the hospital setting (Pelikan et al., 2006) and the evaluation of psychosocial health at the workplace (Jiménez & Glaser, 2015).

Regarding its organization, the project had a steering group consisting of top management (including the religious order), worker council members, HR, pastoral care, and hospital-specific occupational group members like those responsible for hygiene. Hierarchically below this, the project team led by an internal project leader (one of the authors) was responsible for the operative aspects and for ensuring high process and program quality. For this, the other authors were included as external scientific supervision and process facilitation. Following the recommended course of action (Blattner & Mayer, 2018; Henning et al., 2009; Jiménez & Glaser, 2015), a multimethod organizational analysis with observational, ethnographic and interventional elements was set up. In a first step, we assessed the status quo via (a) compiling already existing data and (b) analyzing organizational peculiarities using interviews and a focus group. In a second step, we designed a quantitative questionnaire on psychosocial health covering the topic comprehensively in general (Jiménez & Glaser, 2015) and including items based on the results of step 1. The results of the survey were used for co-creating the WHP offer in a third step. We present the steps in detail in the following subsections.

1. Status quo Assessment

a. Organizational Analysis

   As the first step, we mapped all existing data on employee health aspects. These were organizational data, data on employee satisfaction, a work-family-conflict assessment and a patient satisfaction survey.

b. Management Perspective: Interviews

   As the second step, we conducted nine face-to-face qualitative, semi-structured, problem-centred interviews (Witzel, 2000) with the managers and group leaders of the organizational entities. One was done by the internal project leader, eight by a member of the scientific team. The average duration of the interviews was about 30 minutes. The goal of this part was to investigate specific issues in the organization influencing health to check which method for evaluating psychosocial health fit best and if specific items should be added. An emphasis was put on interfaces and characteristics of the organization differentiating it from others.

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For the questionnaire, items referring to strains resulting from suboptimal interface or change management were included (focus: employee voice).

c. Workforce Perspective: Focus Group

To cover the workforce perspective, the scientific team facilitated a focus group (Kitzinger, 1995; Wilkinson & Silverman, 2004) on organizational culture with 11 employees from all organizational areas who mostly had middle leadership positions. There were no financial incentives to take part, and participation was possible during working hours. We used summative content analysis (Schreier, 2014; Wilkinson & Silverman, 2004) for the accumulated data and focused on the issues highlighted by the group (Kidd & Parshall, 2000): value (in)congruences, for which items were included in the questionnaire.

2. Evaluation of psychosocial stress and strain at the workplace: Questionnaire

Based on the results of step 1 and on the list of questionnaires recommended for evaluating psychosocial stress and strain at work (Richter, 2010), a paper-and-pencil survey was designed. As a basic structure, we chose the KFZA (**K**urz**f**ragebogen **zur** **A**rbeitsanalyse, Short questionnaire for work analysis (translation by the authors) (Prümper, Hartmannsgruber, & Frese, 1995). This is a screening instrument for positive and negative impacts of the organizational and work-related structures. It provides an overview of 11 factors measured with 26 items. As we needed more detailed data, we combined (adapted) elements of the

- KFZA questionnaire,
- COPSOQ questionnaire (Copenhagen Psychosocial Questionnaire) (Nübling et al., 2018), a very broad screening instrument for psychosocial stress and strain at the workplace,
- BASA II Standard Version (Psychologische **B**ewertung von **A**rbeitsbedingungen – **S**creening für **A**rbeitsplatzinhaber II, psychological assessment of working conditions – screening for job holder II, translation by the authors) (Richter & Schatte, 2011), a screening instrument for assessing hazards regarding ergonomics, technical aspects, and organization, and
- MLQ questionnaire (Bass & Avolio, 1995)

with questions on the emotional strain, work and job satisfaction (including the intention to quit), plus leadership to create 11 topical scales. These were: versatility, social support and cooperation/teamwork, work quality and quantity, environmental stresses, information and voice, benefits and work-life-balance, emotional strain, leadership, work and job satisfaction, and scope of action. Moreover, employees had the option to make remarks. As the final part, we asked for demographic data (patient contact yes/no, working time and schedule, profession, age over/under 45 years, gender, tenure over/under 3 years)

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Adaptations to existing scales and items were necessary since we, for example, had to differentiate social support in more hierarchical levels. In addition, we included cultural and structural aspects derived from the interviews and focus-group (examples: over-qualification, intention to quit the current employer, items regarding time pressure and voice in change processes and conflicts). Also, we checked for duplication regarding the standard employee satisfaction survey that had been carried out online a few weeks before. Based on this comparison, some items regarding specific strains and resources were not necessary. Still, we kept excluding items to a minimum to improve the analysis.

The scaling of all (adapted) questions was kept from the questionnaires. Items we included were phrased fitted to the Likert type scales. Before carrying out the survey, we did a pre-test using an (enlarged) steering group. The steering group consisting of 9 people screened the questionnaire, the internal project leader and a member of the top management presented it to the Health and Safety Executive of the state (one item had to be excluded), and a pre-test was done with three employees from different occupational groups. No major changes were required.

The internal project leader provided all wards and areas with the necessary number of questionnaires (due to vacations/sick leaves only 391 in total). Employees could fill them in either during their working time or at home and then put them in one of the anonymous boxes in different areas of the house.

3. Co-creating the WHP offer

The aggregated results of the questionnaire were (a) presented at a steering group meeting and (b) to all employees. The data was afterwards discussed in (c1) employee focus groups and (c2) interviews with management to specify issues and to co-create interventions. All participative and co-creational activities were scheduled in close cooperation with the organization to not conflict with internal processes and requirements.

For the employee focus groups, seven health-circle-like small groups were organized (called health circles afterwards). Health circles are established elements of WHP to discuss work-related stresses, strains and resources in small groups (Henning et al., 2009). The goal is to develop a list of required interventions. Health circles have their roots in quality management (continuous improvement processes/quality circles) and can have various structures (Aust & Ducki, 2004). In our case, they were groups of employees from the same occupational group and/or hierarchical level: ward management, administration, nursing (3 groups), physicians[1], and medical-technical occupations. Per circle, we invited up to 11 people.

All circles were facilitated by a member of the scientific team. The results of the survey were presented as the start of the meetings. Then, employees defined and dis-

1 Due to time constraints, one of the physicians sent a colleague from nursing as substitute.

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cussed the priorities in their area and specified resources and strains. After this, they thought of interventions to improve their resource-strain context. All ideas had to be substantiated and explained. This list was then discussed and prioritized regarding urgency and alleviative and empowering potential. Determinants and barriers they saw regarding employee participation in the intervention or WHP offer were analyzed collectively. The final "product" of each circle was a list of interventions with a high likelihood of being helpful, possible, and accepted. The groups each met for about 2 hours and all participants had the chance to add further ideas afterwards by sending an email to the project group.[2] A complete series of traditional health circles (each circle meeting several times) was not necessary as there was enough data to build on. The final lists of the circles were aggregated together with the interview data (see below) by the scientific team, coded according to the questionnaire dimensions where possible, and otherwise freely coded based on the material. Examples for additional codes are behavioural interventions, work and physical structure, and profession-specific interventions. Moreover and separately, the results were grouped regarding the time required for implementation.

In addition, eight face-to-face semi-structured qualitative interviews with middle management (mainly chief physicians) were conducted addressing the same topics as in the small-group discussions from their perspective. The interviewees were also asked to comment on intervention ideas. One of the interviews had to be done by the internal project leader; the rest was conducted by a member of the scientific team.

As mentioned above, the results of this phase were structured thematically (Schreier, 2014) and where possible using the questionnaire dimensions, then regarding urgency and time requirement plus fed back to the steering group.[3] Also, employees with specific interests or skills were invited to create interventions based on these for their colleagues. Employees evaluated the subsequent behaviour-oriented interventions and the co-creational group settings using a standardized questionnaire.

Findings

In the following, the results of the survey and the subsequent tools (health circles and interviews) are described. For both, we report the findings relevant regarding co-creation(al processes).

Questionnaire

The questionnaire consisted of 12 pages (including one page of introductory information) and took about 15 minutes to complete (either during working time or at

2 However, this possibility was not used.

3 In addition, a complete WHP setup proposal was created by the scientific team and the project leader, which even received national funding to ensure a complete rollout (FGÖ Project Nr. 2787).

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home). Several boxes were put at various easy to reach places in the hospital, with an emphasis on locations hidden from view. 256 questionnaires could be included in the analysis, which equals a return rate of over 65 %. The distribution of the demographic data (see Table 1) was very similar to the organizational demographics. The majority (86.9 %) reported having patient contact. Close to 42 % stated working at day- and nigh-times, 11.5 % in shifts, 41.4 % only during daytime and 4.7 % had core time. Almost 60 % of the respondents were from nursing professions, close to 12 % physicians, about 5 % technical/service staff and about 15 % administrative personnel. Most (85.4 %) worked more than 20 hours per week, were already employed at the hospital for over three years (82.5 %), were below 45 years of age (65.3 %) and female (78.9 %).

Table 1. Demographics

Item	N	Value(s)
Patient Contact (yes/no)	245	86.9 %: yes
Working times (shifts, only daytime, day and night, core time)	227	11.5 %: shifts 41.4 %: only daytime 41.9 %: day and night 4.7 %: core time
Occupational group	243	11.9 %: physicians 59.7 %: nurses, nursing assistants 14.8 %: admin staff 8.6 %: further medical professions 4.9 %: technical staff, services
Hours (≤/> 20 hrs/week)	246	>20 hrs/week: 85.4 %
Duration with employer (≤/> 3 years)	246	>3 years: 82.5 %
Age (≤/> 45 years)	242	≤45: 65.3 %
Gender	242	78.9 %: female

Items regarding working conditions/strain were Likert scaled from 1–5 and were (re)coded to positive values for reporting the dimensional values in Figure 1 and Table 2 below. Social support and cooperation are split due to a different wording of the scales (and because the option of not having a direct supervisor existed for part 2). Though work quality and quantity are high, subsequent detailed analysis showed that this was not perceived as a major issue. Satisfaction levels and social support were good, the scope of action and emotional strain more problematic. In Table 2, the respective SD and N are shown.

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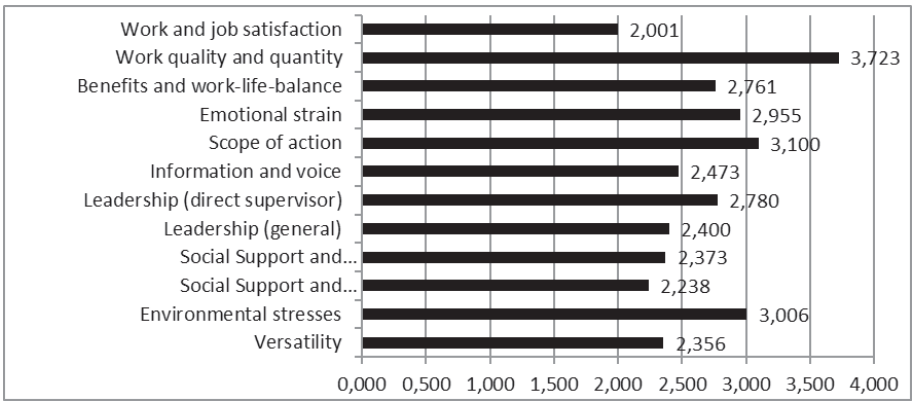

Figure 1. Means (dimensions).

Table 2. Values (Dimensions)

Dimension	Means	N	SD
Versatility	2,356	247	0,922
Environmental stresses	3,006	248	1,115
Social Support and Cooperation/Teamwork Part I	2,238	249	0,941
Social Support and Cooperation/Teamwork Part II	2,373	247	0,947
Leadership (general)	2,400	245	1,149
Leadership (direct supervisor)	2,780	243	1,136
Information and voice	2,473	247	0,942
Scope of action	3,100	233	1,507
Emotional strain	2,955	245	1,024
Benefits and work-life-balance	2,761	232	1,132
Work quality and quantity	3,723	247	0,821
Work and job satisfaction	2,001	240	0,685

Regarding aspects constituting "the good work", the survey data revealed that employees perceived their work to be very meaningful (48.8 %: very high agreement, 38.2 %: high agreement). However, the importance individuals placed on work varied greatly. For 15.7 %, work was of very high and very low importance respectively. 39.4 % saw problems at the workplace as their own, 16.9 % only to a very low degree. The majority (44.5 %) reported reliable social support of colleagues, while 9.1 % did not feel that way. In total, 35.4 % reported not having enough time for communication in the team, and 27.6 % stated that cooperation was mediocre, though trust towards colleagues was high (49.6 % agree, 25.2 % completely agree). The majority described the team climate as good (54.7 %) and 44.1 % reported having no influence on who they worked with.

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Work was accumulating often (24 %) or very often (44.5 %) despite an intensive pace. However, the items regarding quantitative overload had a high variance. Direct supervision was perceived as more supportive than management in general. 35.4 %, for example, reported they could trust their direct supervisor "stood behind them" and 37.4 % stated trusting that person completely.

Regarding changes affecting their work, 16.5 % and 41.3 % always or often had a say. Intention to change the employer or quit the profession were both very low: 46.5 % and 58.7 % respectively had never thought of this in the past year. The responses to the open question highlighted time pressures and issues where more voice and participation was wanted.

Health Circles and Interviews

All participants were highly motivated, committed and constructive. Providing insights into the setting, the survey results could be better contextualized and substantiated. While information and voice were reported as rather good in the questionnaire, the circles revealed that short-notice changes (for example due to sick-leaves) created high stress. Moreover, employees wanted more regular updates regarding long-term changes.

We grouped the intervention the groups created in topics as depicted in the table below (Table 3). As can be seen, the majority of the suggestions refer to setting-based interventions.

Table 3. Intervention Suggestions

Topic	Examples	Type
Work structure	introducing new occupational groups, improving process definitions	Setting-based
Workplace and interior design	offering more recreation rooms	Setting-based
Culture and communication	more collective activities outside work, more spiritual aspects	Setting-based
IT	creating own manuals	Setting-based
Profession specific ideas	changes in working clothes	Setting-based
Behaviour oriented offers	mindfulness training	Behaviour oriented
Further suggestions	reductions/subsidies for public transport	Setting-based

All employees shared the organization's mission and had a professional goal for excellence in their work that was also apparent in the survey. Achieving excellence was their major goal for the interventions, which is why most of the co-created inter-

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ventions were categorized as setting-based and not referring to classical WHP elements like nutrition, physical exercise and stress management. Also, none of the suggestions would increase the workload or pace, on the contrary.

The facilitator's suggestion to think about health behaviour elements for WHP had little effect. The results of prompts regarding design wishes were: to have behaviour-oriented offers on various days of the week, at different times and different locations, and requiring different fitness levels to make participation possible for as many activities for the highest possible number of employees. Also, information about the activities should be provided as soon as feasible in a specific section of the intranet.

Due to the high efforts regarding smooth integration, the internal acceptance of the process was very high, and participation did not result in the experience of stress but was experienced as a creative outlet, the opportunity for collective coping and for co-designing the organization's improvement. Reacting to the invitation to integrate special skills and talents, one group of employees designed an improvisation theatre happening with the option to donate for charity, one person offered a workshop on using local herbs, and some occupational groups offer advice to colleagues for questions belonging to their area of expertise.

Discussion

The purpose of the present study was to investigate if and how co-creation as an implicit requirement of modern OH&S/WHP design would lead to improved working conditions or result in negative effects for the workforce. The question is of particular relevance in hospitals, which are health expert organization but focus on clients regarding health issues. In case hospitals are owned by religious orders, they may have implicit doctrines regarding self-denial. Going the "extra mile" (Bolino & Turnley, 2003) may be considered normal, even if it results in own health issues (Anderson & Bolino, 2014; Bolino et al., 2015; Somech, 2016). Moreover, the health expert status of employees might lead to unrealistic expectations regarding WHP. Following a classical WHP project implementation approach, the evaluation of psychosocial stress and strain and subsequent intervention design was surveyed to study whether hospital employees would create a WHP offer resulting in more pressure.

To limit the likelihood for procedural or content-related problems, all interventions were aligned with contextual requirements and externally facilitated by the scientific team. In addition, we combined various group-setting designs with interviews. This ensured high idea-density without groupthink (Janis, 1971), at least theoretically. Should a shared mindset of the extra-mile or too high expectations regarding WHP prevail in all groups, co-creation in WHP could still result in designing more stress and strain. However, the desire to excel at the job by providing the best care and highest quality to the patients led to a focus on own core competencies and listing

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means ensuring these could be more efficiently enacted. Though the results of the quantitative questionnaire showed that problems at the workplace were highly internalized, this feeling of responsibility did not result in WHP suggestions that would allow for increasing pace, but in ideas for organizational optimization. Moreover, high knowledge about health and health promotion possibilities was not reflected in suggesting potentially time-consuming behaviour related ideas. It seems the professionalism (Mintzberg, 2003) of the employees even prevented this. They deeply shared the organizational goals (Vroom & Yetton, 1973) and wanted to create a setting in which they could perform their core tasks optimally, expecting improved productivity and overall quality, but also work satisfaction and well-being as results. Moreover, the good internal climate and cooperation orientation, as well as the small group discussions, made clear they were all in the same situation – and dependent on each other (much more so as most cannot choose who to work with). Thus, they also saw creating a good work setting as service for colleagues (Conduit & Mavondo, 2001; Gilbert, 2000) and subsequently themselves. The elements of the co-creation processes made what they needed nameable.

The context is traditionally the most difficult to change and seldom tackled in WHP processes. The results show that co-creation of health promotion based on a pathogenetically oriented standard – evaluating psychosocial stress and strain – is not only possible but can even result in employees co-creating a healthy setting. The latter include organizational culture, structure, processes, and job design. Co-creating WHP with committed employees makes engaging in these "soft", difficult to tackle aspects easier for organizations. Certainly, the employees in our study share the organization's goals, so collective idea generation processes can be promoted (Vroom & Yetton, 1973). The fact that co-creation not only occurred in the official settings provided but also by self-created offers (e.g. improvisation theatre group and herb workshops) shows employees really engage. In addition, the wish for more involvement of the religious order reveals the importance of the organizational identity and culture to the workforce.

Expert status regarding health, high identification with the job, high pro-social orientation and an organizational culture valuing "going the extra mile" all have the potential to create negative lock-ins for value-creation in the WHP process. However, our results suggest that in the hospital context, these might be protective factors. Moreover, (a) applying a project management structure and change management principles ensuring transparency, long-term change and quick wins, (b) promoting a high degree of participative plus a combination of top-down and bottom-up activities, and (c) putting an emphasis on ongoing open communication by presentations and discussions of results (Kotter, 2007; Rogers, 2003) seem to be supportive action (Svingstedt & Corvellec, 2018) for co-creating a healthy workplace.

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Conclusion and Open Questions

In modern societies, a lot is already in place to protect the workforce in traditional jobs like healthcare. Asking what they still have to be protected from is legitimate. First, many management theories can be misused, like co-creation in WHP. Therefore, protection against good concepts going bad is called for. This might also prevent a decoupling of the intention of standards and their mere implementation due to legitimization pressures (Meyer & Rowan, 1977). In our case, the overlap of content and discursive integration of all organizational legitimization aspects of "health" as value even added impetus. Second, strict time regimes and societal changes plus personal characteristics make it necessary to protect employees from themselves (overcommitment, extended availability, etc.). After all, private property rights – including those regarding the own body, time, and work – "entail the right to benefit or harm oneself" (Demsetz, 1967, p. 347). Third, how people are treated on the job depends on which educational background their managers have, since the knowledge about what constitutes a good job increases and the conception of man is refined in theories. Yet this also enlarges the possibilities of exploiting the newly found capacities or needs, just as WHP may increase health-knowledge about employees that could be misused.

Co-creation for WHP thus requires ethical, contextual, organizational and individual prerequisites the organization studied proved to provide. Surprisingly, the pathogenetic basis of the project – the evaluation of psychological stress and strain at the workplace – resulted not only in protecting against co-creating the extra mile but also in co-creating a more salutogenic culture, structure, job-design and improved internal processes.

WHP received and continues to get high support by management, which is vital. Co-creation and thus participation has to be a value in the organizational culture, or become one via using WHP also for cultural adaptation (Seaton et al., 2018). Otherwise, the company's wish for co-creative activities in the WHP context and the program itself will not be credible (Nöhammer et al., 2014) and employee engagement in co-creation will not yield its potential. Participating employees may not be completely honest by not voicing critical concerns, and not take the co-creational acts or themselves seriously enough to participate in a completely effective manner (Svingstedt & Corvellec, 2018), for example by yielding to compromise too early. In these contexts, the intended resource creation by WHP might even become a stressor, especially in large-scale projects (Raetze, Geithner, & Fassauer, 2018), in case of low actor competence or low internal trust levels (Waseem et al., 2018).

Profiting from a good climate and high staff health literacy, co-creation showed its potential for improving employee health conditions, but there are critical aspects to observe. Being a high risk and reliability organization, all aspects of the project have to be subordinate to organizational requirements. In addition, almost all employees are health experts, so including relevant stakeholders not only in the steering group

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but also employees of various hierarchical levels in all stages of the process is vital. In turn, the response and participation rates in employee health-related activities were very high, and the high internal support and drive even resulted in receiving national funding for a long-term WHP project.

The major limitation of this paper is that it is based on a single case. However, hospitals are not yet fully oriented versus health promotion (Wieczorek et al., 2015), and may have specific lacks regarding WHP (Schaffenrath-Resi, Eitzinger, & Stummer, 2010), though guidelines are available (Pelikan et al., 2006). External efforts do not yet lead to the desired effect, though changes in legislation are very helpful in legitimizing organizational engagement for employee health. Setting related limitations of our results could be that employees in hospitals are fully aware of the risk factors prominent in their jobs and engage in mindful organizing practices that would avoid co-creating an extra mile (Vogus & Iacobucci, 2016; Weick et al., 2008). Limitations by potential internal influences were reduced as the internal project leader was not involved in the data analysis and helped with data generation only by doing two interviews. The interviewees had consented to this and knew they could contact the project team with their ideas and also anonymously any time.

Based on a more extensive knowledge base, co-creation in the health context has high chances to result in additional value for all stakeholders and to improve the standards of good jobs. However, the potential lock-ins that conceal certain health protection requirements even in a co-creational process have to be investigated so they can be better avoided. Moreover, their potential deliberate misuse by management has to be tackled to ensure that deeper-lying issues are addressed.

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