CHAPTER 18

Workplace Health Promotion in Small Businesses

Daniel Stokols, Sari McMahan, and Kimari Phillips

INTRODUCTION

The present chapter addresses one of the most understudied yet potentially influential contexts for workplace health promotion: small business organizations. Small businesses are defined as firms employing between 2-500 employees (Mutchnick-Baku & Orrick, 1992; U.S. Small Business Administration [USSBA], 2000a). According to the 1996 data compiled by the U.S. Small Business Administration (USSBA), small firms represented 99% of all employers in the U.S. in 1995 (USSBA, 1998b). Employed approximately 53% of U.S. private sector nonfarm workers (USSBA, 2000a), and accounted for virtually all of the new net jobs created in the U.S. between 1993-1995 (USSBA, 2000a; Wellness Councils of America [WELCOA], 1998) (see Table 18-1). Yet, very little empirical research has been conducted previously concerning the particular stressors and health problems faced by small business workers, let alone the prevalence and effectiveness of health promotion programs in small firms.

Table 18–1 Profile of U.S. Small Businesses

- 24.8 million U.S. businesses have between 2-500 employees
- Nearly 99% of U.S. private firms have fewer than 19 employees
- U.S. small businesses represent 99% of all employers in the U.S.
- U.S. small businesses employ 53% of U.S. private sector nonfarm workers
- U.S. small businesses accounted for 76% of the net new jobs between 1993-1995
- Nearly 57% of U.S. small businesses occupy home-based work sites
- U.S. small businesses provide 67% of workers with their first-time job and initial on-the-job training
- U.S. small businesses employ higher proportions of younger (under age 25), older (age 65 and over), female, minority, less educated, and part-time workers
- U.S. small businesses produce 99% of the gross national product
- U.S. small businesses invent more than half the nation’s technological innovations
- A growing number of U.S. small businesses are owned and managed by women and minorities


The major purposes of this chapter are to describe the unique needs of small businesses relative to health promotion and to outline a conceptual model for meeting those needs. The proposed model offers a programmatic framework that identifies several health promotion strategies for small businesses, including those directed at changing employees’ health behaviors, improving conditions of the physical environment and corporate culture at work, and facilitating greater collaboration among small businesses, nonprofit organizations, and government agencies. The suggested model is applicable to companies of all sizes, but the level of priority and financial investment assigned to each of the strategies included in the model will vary between small and large firms.

Before presenting a conceptual model for promoting employee wellness in small businesses, it is important first to characterize the unique attributes and health promotion needs of small firms. The next section of the chapter describes these attributes and needs of small firms, and highlights the special opportunities and challenges associated with workplace health promotion in small companies.

OPPORTUNITIES AND CHALLENGES FOR WORKSITE HEALTH PROMOTION IN SMALL BUSINESSES

Earlier studies to evaluate the health and cost effectiveness of workplace health promotion (WHP) programs in the U.S. have focused primarily on very large companies employing thousands of workers rather than on small businesses (Everly & Feldman, 1985; Fielding, 1984; O’Donnell & Ainsworth, 1984; Pelletier, 1996). Three national surveys of WHP activities in the U.S., for example, omitted companies with fewer than 50 employees despite the fact that nearly 80% of the country’s private firms have fewer than 10 workers (Fielding & Fiscerich, 1989; USBA, 2000a; U.S. Department of Health and Human Services [US DHHS], 1993; Association for Worksite Health Promotion [AWHP], Mercer, & USDHHS, 1999). Similarly, the 1994 National Health Interview Survey (NHIS), a household-based probability survey conducted by the National Center for Health Statistics, examined the availability and use of WHP programs by U.S. workers but included only individuals working at a location with 50 or more employees (Gesch, Alleran, Petersen, & Murphy, 1998). The sampling restrictions imposed by these earlier surveys of WHP activities suggest that individuals working in small organizations—especially those employed by firms with fewer than 50 employees—comprise an understudied and underrepresented population in the research literature on health promotion.

Small business organizations constitute an exciting yet challenging target of opportunity for workplace health promotion in the coming decades. Because small firms employ the majority of American private sector workers, they represent a strategic, high-leverage context for improving the health of the U.S. population. Small businesses provide a highly advantageous context for promoting employee health in view of their unique social organizational, and environmental attributes (AWHP et al., 1999; Chenoweth, 1998; Muchnick-Baku & Orrick, 1992; WELCOA, 1998) (see Table 18-2). For example, small businesses have fewer people to accommodate, fewer administrative costs, and less space to manage; therefore, less time and money are required for communicating with employees about health and safety issues. Also, small busi-

<table>
<thead>
<tr>
<th>Table 18-2 Small Business Advantages in Workplace Health Promotion</th>
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</thead>
<tbody>
<tr>
<td>• Visible, accessible, and approachable top management</td>
</tr>
<tr>
<td>• Fewer people to accommodate</td>
</tr>
<tr>
<td>• Fewer administrative costs</td>
</tr>
<tr>
<td>• Less space to manage</td>
</tr>
<tr>
<td>• Less time and money required for communicating with employees about health and safety issues</td>
</tr>
<tr>
<td>• Easier to integrate and link health promotion objectives with business outcomes</td>
</tr>
<tr>
<td>• Interdependency among employees</td>
</tr>
<tr>
<td>• Supportive environment conducive to group participation</td>
</tr>
<tr>
<td>• Higher rates of employee participation</td>
</tr>
<tr>
<td>• More visible employee health improvements</td>
</tr>
<tr>
<td>• Simpler, less expensive data gathering for program evaluation</td>
</tr>
<tr>
<td>• Large and locally accessible marketplace for community health agencies and organizations to direct their free and low-cost services</td>
</tr>
</tbody>
</table>
neses report significantly higher rates of employee participation in workplace health promotion activities than do larger firms (AWHP et al., 1999). The sense of community among employees that typifies small business settings affords a supportive environment conducive to group participation in WHP programs; and among certain types of small businesses, such as rapidly expanding high-technology firms that have relatively low overhead costs, the requisite financial resources and organizational innovation can be directed toward the development of truly outstanding WHP programs.

Another factor within small companies conducive to their members' participation in WHP programs is that employee health improvements tend to be more visible to coworkers in smaller versus larger firms. The more visible health improvements are, the less resources a company needs to invest in promoting and formally evaluating program efforts. Because one of the keys to successful worksite health promotion is management involvement, small businesses also have the distinct advantage of having visible, accessible, and approachable top management. Thus, there are fewer layers in the decision-making process and less organizational bureaucracy to go through in order to get a supportive health policy formulated or a WHP program implemented quickly. In addition, the approachability of top management in small firms makes it easier to integrate and link health promotion objectives with business outcomes, thereby enabling the program to become established as an integral part of the organization's culture. Finally, small businesses constitute a large and locally accessible sector of the workforce toward which community health agencies and organizations can direct their free and low-cost services.

Despite the above-mentioned advantages and opportunities for health promotion in the context of small businesses, future efforts to implement effective workplace health programs for small business workers must confront certain complexities and challenges inherent in the economic organization of small firms, the variety of physical facilities used by small companies, and the greater vulnerability of employees in small firms to health problems as compared to workers in large corporations (see Table 18-3). Economic and organizational factors that have constrained the development of health promotion programs in small businesses include the lower profit margins of many small firms as compared to larger ones, which make it more difficult for small companies to invest in and sustain workplace wellness programs. Moreover, small businesses rarely include an owner or other individual who is expert in the design and implementation of health promotion programs. Small companies often feel overburdened by regulatory requirements and are hesitant to offer health programs that are not mandated by law (Chenoweth, 1995). And, although some health maintenance organizations (HMOs) and preferred provider organizations (PPOs) offer subsidies to support worksite health promotion programs, many of these health plan-sponsored programs require a minimum group size of 50 or more employees (Donaldson, Gooler, & Weiss, 1998).

**Table 18-3 Small Business Challenges in Workplace Health Promotion (WHP)**

- Lack of time—WHP is often a low priority for management, as productivity and cost issues take precedence
- Overburdened by safety and health regulations/legislation
- Poor financial support—lower profit margins limit funding for WHP
- Rising employer health costs
- Downsizing and shifts toward part-time, temporary, or "contingency" workforce
- Employee turnover
- Lack of formal departments and in-house experts responsible for WHP
- Constrained by the group-size requirement (usually 50+ employees) of many health-plan-sponsored WHP programs
- Diversity and geographic dispersion of physical work settings (e.g., offices, factories, warehouses, restaurants, schools, retail shops, vehicles, residences, satellite locations)
- Large percentage of workers with low socioeconomic status (SES)
- Large percentage of employees without health insurance and employee benefits
- Aging and ethnic diversification of the U.S. workforce
The great diversity of physical facilities used by small businesses also has made it difficult for health professionals and researchers to implement standardized health promotion programs tailored to the unique worksites of small firms. Worksites are those settings in which one or more individuals engage in work-related tasks, including the offices, factories, warehouses, and other facilities controlled by organizations, vehicles operated by employees (e.g., trucks, buses, taxis), and residential offices of home workers. Comprehensive approaches to workplace health promotion combine behavioral and lifestyle change strategies with those focusing on environmental restructuring and enhancement (Stokols, 1992; Stokols, Pelletier, & Fielding, 1996). Examples of environmental enhancement strategies include interventions aimed at improving the ergonomic features and social climate of work settings and reducing levels of noise, air pollution, and hazardous substances in those environments. Yet, because the majority of small businesses (firms with 200 or fewer workers) occupy home-based worksites (56.5% of all small firms in the U.S. were home-based in 1992 according to the USSBA, 1996), it is difficult to catalog the unique environmental and family circumstances faced by individuals working in these multipurpose (occupational/residential) settings. Moreover, the diversity of small business facilities makes it difficult to implement environmentally-based WHP programs in a systematic and replicable fashion.

Finally, the demographic composition of the small business workforce poses another set of challenges for the future development of health promotion programs in small firms. Whereas some small companies (such as law firms, medical offices, accounting firms, and internet-based companies) are quite profitable and their employees are very well-off, small firms as a group employ larger percentages of workers with low socioeconomic status than larger firms do (USSBA, 1998). Thus, although not all small firms and their employees are financially constrained, small businesses generally employ larger percentages of vulnerable employees (i.e., low-income and minority workers who lack health insurance) than do larger companies (Rubio & Arteaga, 2000). In view of the well-documented correlation between socioeconomic status and health status (Adler et al., 1994; Yen & Syme, 1999), the small business workforce consists not only an understudied and underrepresented group in the health promotion literature but also a highly vulnerable population in view of their greater susceptibility to illness and their relative lack of health insurance and employee health benefits.

The vulnerability of small business workers is likely to be exacerbated by contemporary societal trends (including the aging and ethnic diversification of the U.S. workforce, and rising employer health costs) and corresponding shifts toward corporate downsizing and part-time "contingency" work, reduced employee health benefits, and managed health care plans (HMOs, POSs) that offer greater financial support for worksite wellness programs to large, high-volume employers as compared to smaller firms (Donaldson et al., 1998; Dooley, Fielding, & Levi, 1996; Green & Cargo, 1994; Hudson Institute, 1987; U.S. Bureau of the Census, 1992, 1993). Moreover, the shift from manufacturing to office-based work, society's growing reliance on digital communications technologies, and the increasing demand for workers skilled in information technology will create greater competition for jobs and heightened levels of job insecurity among older, very young, and less-educated minority workers (Freeman & Aspray, 1999; Kocher, 1994; Special report: Rethinking work, 1994; Stokols, 1999; U.S. Department of Commerce, 1995, 1998). The greater prevalence of these vulnerable groups in small firms suggests that the small business workforce is increasingly becoming a strategic target for future workplace wellness programming efforts.

In the remaining sections of the chapter, we examine greater detail the unique circumstances of small businesses and the special challenges they face in their efforts to promote employee health. We begin by taking a closer look at the substantial impact of small businesses on the U.S. economy and the unique financial, demographic, facilities design, and health challenges faced by small versus large firms. We also examine the prevalence of WHP programs within small businesses and certain areas of WHP programming that have been relatively neglected by small firms. Particular attention is given to the challenge of providing more extensive health insurance coverage
and family health benefits to workers in small companies. This issue is discussed in light of recent national and regional surveys regarding the availability of health insurance benefits to employees of companies with fewer than 50 workers (McMahan, Stokols, Clitheroe, Wells, & Phillips, 1997; Rubio & Arteaga, 2000; USDHHS, 1997; Wilson, Deloy, Jorgensen, & Crump, 1999). Finally, in later sections of the chapter, we discuss several promising directions for future research and practice in the field of small business health promotion based on the findings from recent demonstration studies that have implemented and are evaluating the efficacy of workplace wellness programs in small firms (Chenoweth, 1998; Donaldson & Klein, 1997; Erturt & Holty, 1991; Stokols, Clitheroe, McMahan, & Wells, 1995; Torres, 1999; Wells, Stokols, McMahan, & Clitheroe, 1997).

UNIQUE CHARACTERISTICS AND NEEDS OF SMALL BUSINESSES RELATIVE TO HEALTH PROMOTION

As a basis for understanding the unique characteristics and special needs of small businesses relative to health promotion, this section of the chapter examines four key issues: (a) the impact of small businesses on the U.S. economy; (b) the typical focus of workplace health promotion activities in small companies as reflected in the data from recent national surveys; (c) the extent to which small businesses provide health insurance plans for their workers relative to larger companies; and (d) the plight of ethnic minority and low-income employees in small firms.

Impact of Small Businesses on the U.S. Economy

There were approximately 24.8 million small businesses in the U.S. in 1998 (with fewer than 500 employees). These include corporations, partnerships, and sole proprietorships (USBBA, 2000a). The cumulative impact of these firms on the U.S. economy is substantial. For example, small businesses produce 39% of the gross national product and invent more than half the nation's technological innovations. They also provide 67% of U.S. workers with their first-time jobs and initial on-the-job training (USBBA, 2000b). As well, small businesses offer employment and managerial opportunities to a broader array of age and socioeconomic groups than larger companies. Specifically, they employ larger percentages of workers under age 25 and over age 65, and those with lower educational levels, than larger firms do. At the same time, a growing number of women and minority group members are taking advantage of opportunities to own and manage small firms. Women-owned small businesses, for example, increased 89% from 1987-1997. Between 1987-1997, the number of African-American-owned firms increased 108%, and the number of Hispanic-owned firms rose 232%. There also has been a marked increase in the number of businesses owned by Asian and Pacific Islanders, American Indians, and Alaskan Natives during the same period (USBBA, 2000a).

Whereas small businesses offer a broad range of employment opportunities to diverse subgroups of the population, employees of small firms tend to be more vulnerable to financial and health difficulties than those working in large companies. The fact that small business workers, as a group, tend to be less educated and have lower incomes than their counterparts in large corporations makes them more vulnerable to many acute and chronic illnesses. Furthermore, part-time employment is more prevalent in smaller companies (20.5%) as compared to larger firms (17.4%). In fact, very small firms (fewer than 10 employees) hire part-time employees at a rate almost twice that of large firms (USBBA, 1998). Part-time workers and their dependents are much less likely to be covered by health insurance at work than are full-time employees (18% coverage for part-time vs. 82% for full-time workers, reported in USDHHS, 1997; see also Wilson et al., 1999). The greater vulnerability of small business workers to illness and injury also is reflected in the disproportionately higher number of work-related fatalities that occur in establishments with fewer than 10 employees. In addition, these individuals account for approximately 33% of all workplace fatalities and for about one million employer-related injuries each year (Twardowski, 1998).

The increased vulnerability of small business workers to various illnesses, relative to those working in large companies, suggests that workplace health
programs aimed at preventing and reducing medical problems would be especially beneficial to the employees of small firms (Chenoweth, 1995; Stoklos, Pelletier, & Fielding, 1995). Yet several international, national, and regional occupational health surveys have found that smaller companies offer significantly fewer worksite health and safety programs to their employees than larger firms. The findings from these surveys are outlined below.

**Health Promotion Activities of Small Businesses**

The Office of Disease Prevention and Health Promotion (ODPHP) of the U.S. Public Health Services conducted the 1985 National Survey of Worksite Health Promotion Activities (National Survey) to assess health promotion activities in private worksites with 50 or more employees (Fielding & Pisnerchla, 1989). In 1992, ODPHP commissioned the second National Survey to elaborate on the substance and prevalence of WHP programs in U.S. companies (USDHHS, 1993), and, in 1999, the findings of the third National Worksite Health Promotion Survey were published (AWHP et al., 1999). These surveys provided a basis for tracking changes in WHP activities between 1985-1999 and differences in the prevalence of WHP activities related to company size and industry type. The 1985, 1992, and 1999 surveys also compared the actual levels of WHP activities in U.S. companies with the goals and objectives outlined in *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (USDHHS, 1991) and, more recently, in *Healthy People 2010* (USDHHS, 1999). As noted earlier, all these National Surveys omitted companies with fewer than 50 employees.

The 1985 National Survey indicated that two-thirds of the participating companies offered at least one health promotion activity (Fielding & Pisnerchla, 1989). Smoking cessation, health risk appraisal, back care, stress management, and physical fitness programs were the most frequently cited health promotion activities at these worksites. Also, spouses and dependents of workers, as well as retirees, were found to have less access to corporate health programs than employees do themselves. Specifically, all permanent employees were eligible to participate in health promotion activities at 85.4% of the worksites, whereas spouses and dependents were eligible for these programs at only 30.1% and retirees at 30.4% of the participating companies.

The second National Survey found that by 1992, 81% of the worksites sampled offered at least one health promotion activity (USDHHS, 1993). The activities mentioned most frequently in the 1992 survey included injury prevention, physical fitness, smoking control, and stress management, with the prevalence of worksite smoking policies increasing by 118% between 1985-92. Both the 1985 and 1992 surveys indicated that larger companies sponsor a broader array of health promotion activities than smaller ones. In 1992, for example, worksites with 750 or more employees were nine times as likely to offer cancer screening programs than companies with fewer than 100 workers and about three times as likely to provide blood pressure control, physical fitness, and weight management programs.

The third National Survey found that by 1999, 90% of all worksites reported offering at least one health promotion activity, an increase of 9% from 1992 (AWHP et al., 1999). Among the WHP programs showing the greatest gains in prevalence were back injury prevention programs, which rose from 29% in 1985 and 32% in 1992 to 53% in 1999. As documented in the 1985 and 1992 surveys, the 1999 survey also found that worksites with large numbers of employees offer more health promotion services than smaller worksites. Yet, for most categories of WHP programs (including health screenings, health risk assessments, awareness information, and lifestyle change programs), smaller worksites reported higher rates of employee participation in worksite health programs than larger ones. According to the 1999 survey data, the availability of health promotion services to employees increases substantially within both small and large firms if access to such services is offered through a corporate health plan. Moreover, worksites of all sizes reporting that employee wellness was an important corporate goal offered more health promotion services, stronger evaluation efforts, and had higher utilization rates than those that did not identify employee health improvement as an explicit part of the company's mission.
The significant positive relationship between company size and availability of WHP activities, as documented in the 1985, 1992, and 1999 surveys, has been found in other international, national, and regional WHP surveys as well. In 1996, a postal survey of Scottish workplaces was carried out to assess the current state of health promotion activity in the workplace and to establish the context for the evaluation of Scotland’s Health at Work (SHAW) award scheme, which recognizes and encourages Scottish workplaces seeking to improve the health of their workforce (Docherty, Fraser, & Hardin, 1999). The results of the Scottish survey echo the findings of other surveys in that small- and medium-sized workplaces tend to have the lowest levels of health promotion activity. Based on national probability survey data gathered by the U.S. Centers for Disease Control and Prevention as part of the Business Responds to AIDS Program, Wilson et al. (1999) also found a significant positive correlation between company size and the availability of corporate WHP programs. Specifically, companies employing 100 or more workers were more likely to offer a variety of health promotion programs (e.g., physical activity, smoking cessation) than firms with fewer than 100 employees. An important aspect of the survey sample used by Wilson et al. (1999) is that it included companies with 15 or more employees, thereby representing a major segment of small businesses—those with 15–49 workers—that had been ignored by the earlier National Surveys.

The positive association between company size and availability of health promotion programs at the worksite was replicated in a regional survey of nearly 2000 small businesses based in Orange County, California (McMahan et al., 1997; Stolols et al., 1998). The sampling frame for this telephone survey, conducted by Interviewing Services of America on behalf of the University of California, Irvine Health Promotion Center (UCIHP), included the phone numbers of all Orange County, California, businesses employing between 2–500 workers. The companies participating in the UCIHP Small Business Workplace Wellness Survey (Small Business Survey) consisted of 2000 companies drawn randomly from the initial sampling frame. A unique feature of the Small Business Survey sample is that it included companies employing as few as 2–14 employees—"microfirms"—that had been excluded from the earlier national probability surveys. The exclusions of microfirms from earlier surveys of small business worksite health promotion is striking, considering the fact that 75–80% of U.S. companies employ fewer than 10 workers (Chenoweth, 1995; USSBA, 1998).

The results of the Small Business Survey not only corroborate the previously reported positive link between company size and the availability of WHP programs, but also reveal the markedly lower levels of WHP programs, activities, policies, and benefits available within microfirms as compared to companies with either 15–99 or 100–500 workers (see Table 18-4). For example, 9% of the firms employing 2–14 employees provided smoking cessation programs at the worksite, whereas 13.4% of the firms with 15–99 workers and 18.5% of the companies with 100–500 employees offered such programs at work. The corresponding percentages for stress management programs at the workplace, across the three company-size groups (from lowest to highest), were 9.2%, 13.6%, and 29.4%, respectively. Similarly, the percentages of firms providing workplace violence prevention programs at work were 11.1%, 20.2%, and 34.8%, respectively. This positive linear relationship between company size and WHP programs/activities is evident for most of the program categories listed in Table 18-4.

The generalizability of the Small Business Survey data is limited to Orange County, California. The findings from this regional survey, however, are provocative as they strongly indicate that WHP programs and activities are even more unavailable to workers in very small firms (i.e., microfirms employing between 2–14 workers) than to those employed by companies with 15–99 and 100–500 workers. Moreover, these data underscore the need for more extensive research at state and national levels and for WHP intervention studies focusing on the needs of individuals working in very small firms—a highly underserved population in the field of WHP research and practice.

The Small Business Survey findings summarized in Table 18-4 also indicate that the reduced availability of disease prevention and health promotion...
<table>
<thead>
<tr>
<th>Program, Activity, Facility, Policy, or Benefit</th>
<th>2-14 Employees (n = 337)</th>
<th>15-99 Employees (n = 936)</th>
<th>100-500 Employees (n = 250)</th>
<th>Total Number of Employees (n = 1823)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustable furniture</td>
<td>56.3%</td>
<td>59.3%</td>
<td>73.3%</td>
<td>60.1%</td>
</tr>
<tr>
<td>Americans with disabilities compliance</td>
<td>62.4%</td>
<td>79.4%</td>
<td>89.3%</td>
<td>74.9%</td>
</tr>
<tr>
<td>Cholesterol or blood pressure</td>
<td>6.7%</td>
<td>8.9%</td>
<td>20.6%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Diet/Nutrition</td>
<td>5.5%</td>
<td>7.0%</td>
<td>16.2%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Disease screening programs</td>
<td>5.2%</td>
<td>9.0%</td>
<td>14.3%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Drug-free policy</td>
<td>79.7%</td>
<td>85.8%</td>
<td>92.5%</td>
<td>83.5%</td>
</tr>
<tr>
<td>Emergency &amp; disaster training</td>
<td>36.4%</td>
<td>57.4%</td>
<td>69.7%</td>
<td>51.8%</td>
</tr>
<tr>
<td>Employee safety</td>
<td>24.8%</td>
<td>51.9%</td>
<td>77.8%</td>
<td>46.0%</td>
</tr>
<tr>
<td>Ergonomics</td>
<td>30.0%</td>
<td>46.6%</td>
<td>64.3%</td>
<td>43.3%</td>
</tr>
<tr>
<td>First aid</td>
<td>72.0%</td>
<td>50.1%</td>
<td>68.1%</td>
<td>46.3%</td>
</tr>
<tr>
<td>Fitness</td>
<td>7.5%</td>
<td>9.2%</td>
<td>20.2%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Hazardous materials</td>
<td>34.0%</td>
<td>52.7%</td>
<td>67.9%</td>
<td>48.2%</td>
</tr>
<tr>
<td>Health benefits available to dependents</td>
<td>58.0%</td>
<td>95.7%</td>
<td>97.9%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Health insurance</td>
<td>64.2%</td>
<td>83.7%</td>
<td>93.3%</td>
<td>78.2%</td>
</tr>
<tr>
<td>Healthy food</td>
<td>15.6%</td>
<td>26.7%</td>
<td>50.6%</td>
<td>26.2%</td>
</tr>
<tr>
<td>Immunizations</td>
<td>9.4%</td>
<td>16.5%</td>
<td>33.9%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Lockers</td>
<td>15.5%</td>
<td>28.6%</td>
<td>43.4%</td>
<td>26.1%</td>
</tr>
<tr>
<td>Lounge</td>
<td>36.5%</td>
<td>55.0%</td>
<td>70.8%</td>
<td>50.8%</td>
</tr>
<tr>
<td>No-smoking policy</td>
<td>78.6%</td>
<td>84.8%</td>
<td>86.9%</td>
<td>82.9%</td>
</tr>
<tr>
<td>Personal/Mental health</td>
<td>12.7%</td>
<td>19.0%</td>
<td>36.7%</td>
<td>19.9%</td>
</tr>
<tr>
<td>Safe work practices</td>
<td>52.4%</td>
<td>71.5%</td>
<td>84.1%</td>
<td>66.6%</td>
</tr>
<tr>
<td>Safety policy</td>
<td>81.0%</td>
<td>93.3%</td>
<td>97.2%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Sexual harassment policy</td>
<td>66.3%</td>
<td>84.3%</td>
<td>94.8%</td>
<td>79.5%</td>
</tr>
<tr>
<td>Showers</td>
<td>7.2%</td>
<td>14.3%</td>
<td>24.5%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>9.0%</td>
<td>13.4%</td>
<td>18.5%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Social activities</td>
<td>29.7%</td>
<td>44.8%</td>
<td>64.0%</td>
<td>42.2%</td>
</tr>
<tr>
<td>Stress management</td>
<td>9.2%</td>
<td>13.6%</td>
<td>29.4%</td>
<td>14.2%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>12.7%</td>
<td>21.1%</td>
<td>33.9%</td>
<td>19.9%</td>
</tr>
<tr>
<td>Suggestion box</td>
<td>25.0%</td>
<td>43.4%</td>
<td>67.1%</td>
<td>40.3%</td>
</tr>
<tr>
<td>Violence prevention policy</td>
<td>38.1%</td>
<td>46.4%</td>
<td>63.1%</td>
<td>45.8%</td>
</tr>
<tr>
<td>Weight management</td>
<td>7.2%</td>
<td>6.7%</td>
<td>14.4%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Workplace violence</td>
<td>11.1%</td>
<td>20.3%</td>
<td>34.5%</td>
<td>18.4%</td>
</tr>
</tbody>
</table>

Note: UCHPC = University of California, Irvine Health Promotion Center.

programs in the workplace among employees of very small companies is compounded by the lower capacity of these microfirms to provide health insurance benefits to their employees. Specifically, 64.2% of the Small Business Survey firms employing 2-14 workers offered health insurance to their employees, whereas 83.8% of the firms with 15-99 workers and 93.3% of those with 100-500 workers provided health insurance coverage to their employees. These differences in health insurance coverage across the three company-size groups are significant according to chi-square analyses computed on the dichotomous (yes/no) data on which the percentages listed in Table 18-4 are based (χ² = 124.51, df = 2, p < 0.001).
Furthermore, health insurance benefits were made available to workers' dependents in 38% of the companies with 2-14 employees, whereas health benefits were provided to workers' dependents in 92.7% of the companies with 15-99 employees and in 97.9% of those firms with 100-500 workers ($\chi^2 = 11.09, df = 2, p < 0.004$). Thus, the employees of very small firms not only have the most limited access to disease prevention and health promotion programs at work but also sustain the lowest rates of company-based health insurance coverage. The low rates of health insurance coverage for workers in very small firms is a major problem in view of the higher per capita medical costs paid by the owners of these firms (Kathawala & Elmutt, 1994). We turn now to a more detailed discussion of these economic and workforce wellness challenges currently facing the owners and managers of small businesses.

Health Insurance and Small Businesses

Small business employers have been hardest hit by medical care costs. Expenditures for health care plans totaled $145.7 billion in 1992 for businesses with fewer than 500 employees. Of that, $92.2 billion was spent on health care for those establishments with fewer than 100 employees. Health insurance premiums for small businesses are 26-50% higher than premiums for larger businesses (National Governor's Association, 1991).

In a report investigating insurance coverage and firm size, Berger, Black, and Scott (1994) found that the number of uninsured in the United States increased from 31.5 million to 35.5 million people between 1988-92. In 1992, almost 21 million (about 60%) of the uninsured were working. Most of the 35.5 million people who lacked health insurance coverage in 1992 were small business employees or their dependents (Wilcox, 1992). Estimated rates of health insurance coverage among small business workers vary across earlier studies. In a nationwide survey of 1,500 small businesses, Kathawala and Elmutt (1994) observed that 79% of the participating firms offered some sort of health insurance coverage to their employees, but only 49% of those employing fewer than 29 employees provided any such coverage. Among companies employing 501-500 workers, however, 94% of the firms provided health insurance benefits to their employees.

The more restricted access to health insurance benefits among workers in very small firms also was observed in a national survey conducted by the USDHHS (1997), indicating that 33% of small businesses with fewer than 10 employees offer health insurance coverage as compared with 96% of firms with 100 or more employees. The national Business Responds to AIDS Program (BRAF) survey conducted by Wilson et al. (1999) reported health insurance rates of 91.9% and 98% in companies with 15-99 and 100+ workers, respectively; but, as noted earlier, the BRAF survey sample omitted firms with only 2-14 employees, which are less likely to offer health insurance coverage to their members than larger employers.

In considering the issue of health plans relative to small companies, it is important to recognize that not all businesses can afford to provide health insurance for their workers. Providing a health promotion program may typically cost $5, $10, $50, $100, or $200 per employee per year, depending on the type of program (e.g., awareness level program, behavior change program, or comprehensive supportive environment program). (O'Donnell & Harris, 1994). Providing health insurance, on the other hand, costs approximately $2,000 to $6,000 per employee per year. The greater cost of providing employee health insurance suggests that small business managers will be more likely to try implementing a WHIP program than investing resources simultaneously to establish both WHIP programs and employee health insurance plans. Furthermore, to the extent that employees can access medical coverage through spouses or Medicare or that the employer is able to supplement employees' salaries so they can purchase insurance on their own, it may not make sense for the employer to provide medical insurance. Finally, reducing medical care costs through WHIP programs may not be as great a motivator for employers who do not provide medical insurance as compared to those firms that do provide employee health plans. The medical insurance payment dynamics are quite different for small versus large businesses. Unlike large corporations, small firms can lose their coverage if their claims are high, but cost savings resulting from low
utilization rates generally are not passed along to small businesses.

While acknowledging the above-noted barriers to employee health insurance coverage in small firms, it is also important to recognize that the findings from several earlier studies strongly suggest that the employees of very small companies are uniquely disadvantaged by their restricted access to medical benefits as compared to workers in larger firms. This is especially true for small businesses within the wholesale/retail, services, and manufacturing industries as compared to professional offices (e.g., legal and medical firms), finance firms, and rapidly expanding high-technology companies (California HealthCare Foundation & Mercer, Inc., 1999; Torres, 1999). Moreover, among employees working in very small firms in those industries, certain groups appear to be especially vulnerable to medical problems and financial hardships—namely, ethnic minority and low socioeconomic status workers.

The relative lack of health insurance coverage among small versus large business workers is an issue that is highly relevant to the development of future health promotion strategies in small business settings. Clearly, not all small businesses can afford to offer health insurance. Nonetheless, the absence of such coverage may create anxiety, insecurity, and greater financial and illness-related vulnerabilities among substantial segments of the small business workforce—all of which can seriously compromise the physical and emotional well-being of these individuals and their dependents and thereby undermine the effectiveness of WHP programming efforts in some small companies. The following section examines the particular needs of these vulnerable groups, namely ethnic minority and low-income employees of small firms.

The Plight of Ethnic Minority and Low Socioeconomic Status Workers in Small Businesses

Members of ethnic minority groups, especially those characterized by low household incomes and socioeconomic status (SES), face enormous financial and health challenges in the U.S. These persons are much more likely to be unemployed or underemployed (Dooley et al., 1996) and to lack family health insurance and worksite health benefits than are more affluent, high-SES individuals (Berger et al., 1994; Donaldson et al., 1995; Schaufhuter, Brown, & Rico, 1997; USDHHS, 1991). The disproportionate lack of access to adequate employment and health insurance coverage leaves low-income, uneducated, and minority group members particularly vulnerable to financial hardship and premature morbidity/mortality, owing to the pervasive and strongly positive correlation between SES and favorable health status (Adler et al., 1994; Yen & Syme, 1999).

Another source of vulnerability among low-income minority group members is the growing "digital divide" between them and more affluent, nonminority workers (U.S. Department of Commerce, 1995). Although the rate of computer ownership among U.S. citizens has risen in recent years (to about 33% of the population in 1998), the gap between computer "haves" and "have-nots" continues to grow. About half as many Black and Hispanic people own computers as do non-Hispanic Whites, and White households are three times as likely as Black households to have Internet access. In 1997, the difference in computer ownership rates between Whites and Blacks was 21.5 percentage points; and the difference between Whites and Hispanics was 21.4 percentage points (U.S. Department of Commerce, 1998). Moreover, computer ownership is positively correlated with educational attainment. About 63% of people with some college education own computers—a level of ownership that is about 10 times greater than for those who never attended high school.

The relative lack of access to computer training and ownership among low-SES minority group members will create even greater economic difficulties for them, as the demand for workers skilled in information technology continues to expand in the coming decade (Freeman & Aspray, 1999). For example, Kochhar (1994), analyzing data from the 1991 Current Population Survey of 50,000 U.S. households (compiled by the Bureau of the Census), found that small businesses were hiring college educated workers and creating jobs at the top end of the wage spectrum in greater proportions than in earlier years. The highest premium for computer users over nonsusers was
found in rapidly growing small firms, where a premium of nearly 24.8% in wages was observed. Thus, although the proportions of low-SES minority persons entering the small business workforce has grown in recent years, it is precisely these individu- als who lack the requisite training to compete for higher paying computer-based jobs in small high-technology firms.

Finally, low-SES minority individuals are disadvantaged not only by restricted financial resources, but also by starkly unequal incomes relative to other groups in society. Income inequality has been found to exert a negative impact on health status, above and beyond the effects of low SES and low levels of house- hold income (Yen & Syme, 1989). Some researchers (Kawachi, Kennedy, Lochner & Prothrow-Stith, 1997) have hypothesized that the deleterious effects of income inequality on health are mediated by the social isolation and relative deprivation experienced by dis- advantaged individuals, which in turn, lead to a de- cline of "social capital"—those "features of social or- ganization such as networks, norms, and social trust that facilitate coordination and cooperation for mu- tual benefit" (Putnam, 1995, p. 67). Thus, income in- equality, social isolation, and loss of social capital, along with restricted access to health insurance, tech- nology training, and full-time employment, are among the factors that place low-SES minority work- ers at highest risk for illness, injury, and financial hardship.

The National Health Interview Survey data re- ported by Grosh et al. (1998) clearly indicate that the availability of WHP programs is highest for employ- ees who are well-educated, White, and between the age of 25-54, and lowest for less educated and Black workers—groups that may have the most to gain from access to worksite health programs. Thus, one challenge facing the WHP field is to develop disease prevention and health promotion programs that reach these disadvantaged and underserved groups (Stokols, Allen, & Bellingham, 1996). Simply making more WHP programs available to underrepresented groups of workers, however, will not necessarily re- sult in health improvement for those individuals. To be effective, future worksite health programs for small businesses must address the specific needs of low-SES minority persons, as well as those of other underserved groups such as older workers, highly mobile employees (e.g., those whose jobs are vehicle- based), employees in rural locations, and blue-collar workers in injury-prone occupations (such as farming, mining, construction, and transportation) (McMahen, 1999; Scharf, Kidd, Cole, & Wehagen, 1999; Stokols, Clitheroe et al., 1995).

Earlier WHP research strongly suggests that the most effective worksite health programs include mul- tiple components (e.g., encompassing lifestyle modi- fication, changes in the work environment, personal- ized risk appraisal, and counseling) that identify the employees in an organization who are at most at risk for illness and injury, then provide programs that are tai- lored to their specialized needs (Deloy & Southern, 1993; Erfurt, Foote, Heinrich, & Brock, 1995; Erfurt & Holty, 1991; Foote & Erfurt, 1991; Fries, Harrington, Edwards, Kent, & Richardson, 1994; Harvey, Whit- mer, Hilbert, & Brown, 1993; Heaney & Goetzol, 1997).

For low-SES minority workers, small business own- ers first and foremost must develop cost-effective strategies for providing health insurance to their employees—for example, by partnering with other small firms to establish health insurance purchasing cooperatives (Chencwed, 1995; Schaufler et al., 1997; UCCHPC, 1998). Future WHP programs also should be designed to enhance social support and encourage a stronger sense of community among minority workers by incorporating culturally appropriate lan- guage and programming options that are consistent with the health beliefs and needs of a culturally di- verse workforce (Edmunson, 1995; Ramirez, 1994; Rubio & Arteaga, 2000; Torres, 1999).

Finally, greater efforts should be made by small business managers to offer on-the-job computer train- ing to their lower SES and entry-level employees (Donaldson et al., 1998; Freeman & Aspray, 1999). Several lines of research suggest that a major risk fac- tor for illness is job insecurity and that such insecurity is widespread among large segments of the small business workforce due to the greater volatility of small firms and the fact that a large proportion of low-income workers in small companies lack the requisite technological skills to compete for stable and high- paying jobs. Thus, computer skills training should be
considered as an important facet of future WHP programs targeted toward small business employees.

TOWARD MORE COMPREHENSIVE WORKSITE HEALTH PROMOTION PROGRAMS FOR SMALL BUSINESSES

The preceding discussion of small firms and their specialized needs relative to health promotion suggests the value of developing a conceptual model that can be used to identify: (a) important directions for WHP practice and research in small companies, and (b) a set of programmatic strategies that are uniquely tailored to meet the worksite health goals of small businesses (see Table 18-5). We next outline a conceptual model for organizing WHP activities in small firms and then discuss some recent case studies in which certain of the strategies outlined in the model are being implemented and evaluated for their efficacy within small business settings.

A Model for Meeting the Health Promotion Needs of Small Businesses

The proposed model of worksite health promotion reflects certain core assumptions. The first assumption is that comprehensive, multicomponent WHP programs are generally preferable to single-component and more narrowly targeted programs. We recognize that efforts to implement single-component WHP programs are sometimes more affordable than those involving multicomponent programs and that establishing even a limited WHP program in a company is preferable to neglecting health promotion activities altogether. Nonetheless, multicomponent WHP programs have some distinct advantages over narrowly gauged programs and often can be implemented in a cost-effective manner within both small and large firms.

The emphasis on comprehensive WHP programs in the proposed model is consistent with recent developments in the health promotion field. During the 1990s, the conceptualization of WHP programs expanded to include not only informational or awareness-raising strategies and behavioral/lifestyle change programs to foster improved employee health, but also facilities design and organizational changes to create a more healthful work environment (DeJong & Wilson, 1995; O’Donnell, 1988; O’Donnell & Harris, 1994; World Health Organization [WHO], 1994). This trend toward developing comprehensive worksite health programs reflects an increasing emphasis on the value of broad-gauged, integrated worksite health improvement strategies that encompass (a) individually-focused lifestyle change, self-care, clinical preventive

<table>
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<tr>
<th>Table 18-5 High-Leverage Strategies for Workplace Health Promotion in Small Businesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Management Training Strategies:</strong> Provide small business managers with educational training and resources to cultivate:</td>
</tr>
<tr>
<td>1. Sensitivity to cultural, gender-based, and age-related needs of employees</td>
</tr>
<tr>
<td>2. Awareness of multicomponent, comprehensive health promotion programs</td>
</tr>
<tr>
<td>3. Core competencies for designing, implementing, and evaluating comprehensive workplace health promotion programs:</td>
</tr>
<tr>
<td>• Manager training programs in the area of workplace health promotion.</td>
</tr>
<tr>
<td>• Practical, “how-to” programming guides and educational resources.</td>
</tr>
<tr>
<td>• Consultation services provided by knowledgeable workplace health promotion experts.</td>
</tr>
<tr>
<td><strong>Community Partnering Strategies:</strong> Provide small business managers with outside technical assistance and economic support to enhance worksite wellness using new community-based delivery systems to provide:</td>
</tr>
<tr>
<td>• Small business health insurance purchasing cooperatives</td>
</tr>
<tr>
<td>• Government-sponsored grants-in-aid for small business health promotion</td>
</tr>
<tr>
<td>• Corporate-community consortia for delivering medical and EAP services to small business workers</td>
</tr>
<tr>
<td>• Small business partnerships to facilitate collaborative workplace health promotion efforts (e.g., informal worksite wellness coalitions, support networks).</td>
</tr>
</tbody>
</table>
services, mental health management, and health awareness programs (Docherty et al., 1999; Fitz et al.,
1993; Green, 1984; McCormack & Alexander, 1980; U.S. Preventive Service Task Force, 1989; Vickery & Enos,
1996); as well as (b) organizational culture, policies, and benefits, (c) environmental change, facilities planning, and management strategies and (d) collaborative efforts with other businesses, nonprofit agencies, and government organizations in the community for purposes of promoting employee wellness and a healthy workplace (Allen & Allen, 1986; McLeroy, Bibeau, Steckler, & Glanz, 1988; McManus & Kung, 1999; Stokols, 1996; Wandersman et al., 1996). Comprehensive programs that integrate activities and policies spanning these four levels of analysis and intervention exemplify social ecological models of health promotion (Breslow, 1996; Green, Richard, & Potvin, 1996; Levi, 1992; Richard, Potvin, Kishchuk, Pirk, & Green, 1996; Stokols, 1992; Stokols et al., 1996; UCCHPC, 1988)." A second key assumption underlying the proposed model of health promotion is that the model is applicable to companies of all sizes, but the relative priority and effectiveness of the WHP strategies included in the model varies between small and large firms. Specifically, we suggest that certain combinations of WHP strategies are likely to afford greater leverage for achieving the worksite health goals of small companies than others. For instance, because small businesses typically lack formal departments and in-house experts responsible for wellness programming, the owners and managers of small firms must play a more active and central role in promoting worksite health than their counterparts in large companies. Thus, one promising strategy for small business health promotion is to place greater emphasis on developing educational resources and training programs designed to cultivate certain core competencies for small business managers—especially those skills that appear to be essential for effective delivery and maintenance of wellness programs in small firms. In subsequent sections of the chapter, we give particular attention to four managerial skills that are becoming increasingly important as a basis for promoting employee health in small companies: (a) sensitivity to cultural, gender-based, and age-related needs of employees, (b) an awareness of multicomponent, comprehensive health promotion programs, (c) the knowledge to design, implement, and evaluate comprehensive workplace health promotion programs, and (d) the ability to incorporate low-cost community resources into workplace health promotion programs. Examples of recently published training resources designed to enhance these core competencies of small business managers are the Health Promotion: Sourcebook for Small Businesses (WELCOA, 1998) and the Manager's Guide to Workplace Wellness (UCCHPC, 1998). Similarly, Design of Workplace Health Promotion Programs (O'Donnell, 1995) and Well Now: A Manager's Guide to Worksite Health Promotion (Eddy & Kahler, 1992) provide business managers with extensive hands-on information about the design and implementation of worksite wellness programs. An important direction for future research on WHP programs in small business settings is to evaluate the extent to which the managers of small firms are using these new educational resources and the extent to which these efforts are effective in enabling small business managers to cultivate new WHP competencies and skills. The findings from recent studies also suggest that to be maximally effective, health promotion training programs aimed at small business managers should be supplemented by community-based interventions.

The integration of these multiple levels of worksite health promotion provides the basis for establishing corporate health programs that go beyond individual behavior change to improve the collective health of all employees working in a particular location. Using the issues of smoking cessation as an example, the employers working at a particular company will be more likely, as a group, to refrain from or quit smoking if their employer offers not only a smoking cessation program targeted at high-risk workers (individual strategy), but also implements a "no-smoking" policy (organizational strategy), removes all smoking from the building (environmental strategy), and arranges for a local nonprofit agency (community strategy) to provide information to workers about the health and financial costs associated with smoking and the availability of local support groups to facilitate smoking cessation (Sorensen, Glasgow, Corbett, & Topor, 1992; Sorensen, Lund, & Franks, 1993).
designed to establish informal worksite wellness coalitions, support networks, and public/private sector consortia as a basis for promoting cost-effective, cooperative health promotion ventures spanning multiple employers, nonprofit organizations, philanthropic foundations, universities, and government agencies (Chenoweth, 1998; Donaldson & Klein, 1997; Pelletier, Klehr, & McPhee, 1988; Torres, 1999; UCHIPC, 1998; USDHHS, 1987; Wandersman et al., 1996). These organizational networking strategies, which create linkages between multiple businesses, community settings, and intervention targets (Richard et al., 1996), appear to be especially crucial for effective health promotion in small firms, owing to the special needs and more limited resources of small versus large companies. In the following sections of the chapter, we review recent efforts to cultivate core WHP competencies among small business managers and to establish community consortia for small business health promotion. We also examine the implications of these recent efforts for future practice and research in the field of health promotion.

Cultivating Core Competencies for Worksites Health Promotion Among Small Business Managers

Our earlier discussion of small businesses and their specialized needs relative to health promotion highlights a crucial core competency for small business managers, which can help promote more effective WHP programs in the 21st Century—namely, the development of cultural sensitivity and the ability to recognize and serve the needs of an increasingly diverse workforce. A business manager sensitive to the cultural, gender-based, and age-related needs of his or her employees will make concerted efforts to communicate directly with them about their health and family concerns in a linguistically appropriate and supportive manner; provide personalized health risk appraisals and counseling (e.g., with the assistance of outside consultants) to encourage health-promotive lifestyle changes; take the necessary steps to ensure a healthy and safe work environment; and, very importantly, offer company-sponsored health insurance and access to low-cost preventive services and medical care for employees and their dependents.

The previously noted findings that WHP programs tend to be most influential and effective when they incorporate multiple components tailored to the specialized needs of vulnerable workers (DeJoy & Southern, 1993; Ewart et al., 1993; Fries et al., 1994; Harvey et al., 1993; Heaney & Goetzl, 1997) underscore the value of cultivating at least two additional core competencies among small business managers for WHP: namely, an awareness and understanding of comprehensive, integrated WHP programs, and the ability to design, implement, and evaluate integrated multicomponent WHP programs. We turn now to a more detailed discussion of these issues.

Because small businesses typically lack in-house expertise and formal departments in the areas of human resources, medical services, and occupational safety and health, they face the complex challenges of (a) compiling/integrating research and regulatory information pertinent to these concerns and (b) designing and delivering effective worksite health programs based on that information. Typically, these tasks fall by the wayside in small businesses since their managers are confronted by more stringent time and resource constraints than those working in larger firms. Given these constraints, new training resources and consultation services must be developed to assist small business managers in their efforts to become more knowledgeable about worksite health and more capable of designing and implementing cost-effective worksite health promotion programs. As noted earlier, several resource books and hands-on programming guides have been developed in recent years to assist the owners and managers of small firms in these efforts (Eddy & Kahler, 1992; O'Donnell, 1995; UCHIPC, 1998; USDHHS, 1987; WELCOA, 1998).

The task of compiling and integrating information pertinent to the development of effective worksite health promotion programs is a daunting one because worksite health encompasses a wide array of research and practice areas, including occupational safety and health (OSH), employee assistance programs (EAP), employee wellness or worksite health promotion (WHP) programs, and employee benefits/rewards (DeJoy & Southern, 1993). According to DeJoy and Southern (1993), the first step in developing effective worksite health programs is the creation of a compre-
niheive health policy or mission statement by the company. The importance of this strategy is borne out by recent findings from the 1999 National Worksite Health Promotion Survey (AWHP et al., 1999), indicating that companies (of all sizes) identifying employee health improvement as an explicit part of their corporate mission undertake more extensive WHP efforts and report higher rates of employee participation in their WHP programs as compared to businesses lacking clear worksite health goals.

A prerequisite for establishing comprehensive and effective corporate health policies is a basic awareness and understanding among business managers of the many facets of worksite wellness (e.g., OS/HH, EAP, WHP, state and federal regulations, and human resources and benefit programs). In an effort to increase managers' awareness and understanding of these issues, several worksite health training programs and resource guides have been developed in recent years and tested for their effectiveness. For example, researchers at the UCI Health Promotion Center (UCIHP) developed the REACH OUT for Safety training program for small business managers to improve corporate awareness of, and compliance with, California's worksite injury and illness Prevention Program (IIPP) legislation (Injury and Illness Prevention Program 198, 1989; Wells et al., 1997). In this train-the-trainer program, the REACH OUT acronym represents the various worksite health requirements stipulated by California's IIPP law and was created to better communicate the relevant aspects of the legislation to business managers and to enhance managers' comprehension and memory of key regulatory requirements. Components of the REACH OUT training program include:

Responsibility assignment, Evaluation procedure, Accident investigation, Corrective action, Hazard prevention training, Obeying the law, Understanding through communication, and Tracking and Record-Keeping.

Wells et al. (1997) conducted a two-year field-experimental study of 130 firms in Orange and Los Angeles Counties, California. The results demonstrated that those companies randomly assigned to the REACH OUT training sessions during the first year of the study demonstrated greater managerial awareness of the IIPP regulatory requirements and achieved higher levels of corporate compliance with the law than the nonintervention firms that received the REACH OUT training at the conclusion of the study.

The UCIHP team subsequently developed a more comprehensive training program, the Small Business Workplace Wellness Project (SBWPP), which not only addresses occupational safety and health regulations but also encompasses individually oriented strategies of lifestyle/health behavior change, organizational policies and programs, facilities planning and management interventions, and collaboration among business organizations and other community groups, all aimed at achieving higher levels of worksite wellness, quality of working life, employee productivity, corporate cost containment and profitability (McMahan et al., 1997; McMahan, Stokols, & Phillips, 2000; Stokols, Chithere et al., 1995). To achieve these goals, UCIHP administered a Worksite Wellness Telephone Appraisal (Small Business Survey) to 2000 small businesses in southern California and developed several informational resources for managers and employees, including the
Workplace Health Promotion Information & Resource Kit, an interactive internet site (http://www.healthpromotioncenter.uci.edu) that provides detailed information about worksite health promotion (WHP) and numerous links to related internet sites, and a comprehensive WHP programming guide—the Manager's Guide to Workplace Wellness (UCIHEC, 1998).

The Manager's Guide to Workplace Wellness is organized into seven modules that provide information about the multiple components of comprehensive programs and policies (including the individual/behavioral, organizational, environmental, and community levels of WHP) and introduce managers to strategies for identifying employee health concerns and company health needs, planning and presenting workplace wellness programs (including lifestyle improvement, environment and safety, and workplace relations programs), and monitoring and evaluating these programs. The Manager's Guide also provides several practical tools for WHP, including copy-ready, self-administered forms for surveying managers and employees about their health concerns, checklists for conducting environmental health audits, descriptions of community resources that can be used by business managers to promote workplace wellness, and a program planner for planning, presenting, and monitoring WHP programs.

The effectiveness of the SBWWP in promoting higher levels of workplace wellness is being evaluated in a longitudinal (1996-1999) field-experimental study in which 80 small businesses are randomly assigned to four different training levels. Managers in the nonintervention (comparison) group received no WHP training or resources at the outset of the study; the second group received the Manager's Guide to Workplace Wellness at the outset of the study; the third group received the Manager's Guide and a follow-up WHP coaching visit by a member of the research team; and the fourth group received the training components provided to Group 3 and also participated in a partnering group with other business managers in an effort to facilitate community collaboration toward worksite health improvement.

Analyses conducted on the Small Business Survey data, gathered from nearly 2000 Orange County businesses during the first year of the SBWWP, indicated that the comprehensiveness (or multicomponent/integrative quality) of WHP programs is associated with higher levels of organizational health as reported by the managers of participating firms. The integrative quality of WHP programs was measured using multiple survey items that assessed the breadth, existence, and availability of multiple worksite health policies and activities within each of the participating firms (e.g., health risk appraisal and lifestyle change programs, physical environmental strategies, organizational policies, and employee health benefits, use of community resources for WHP). Preliminary findings suggest the potential value of comprehensive WHP programs is greater than those that are narrower in scope (e.g., implementing health change programs without implementing related policies).

The relative effectiveness of the SBWWP intervention components in promoting higher levels of worksite health in small businesses is being examined through a series of pre/postanalyses of employee wellness and related organizational outcomes associated with (a) use of the Manager's Guide to Workplace Wellness, (b) WHP coaching visits involving project staff and small business managers, and (c) participation in a small business partnering group aimed at fostering greater collaboration between businesses, nonprofit agencies, and government organizations.

A median split was performed on the comprehensive factor scores to identify companies with relatively narrow, unIntegrated WHP programs and those with broader-gauged, more integrated programs. Two five-point Likert scales were combined to measure manager appraisals of organizational health in their companies: “How would you rate the general health of your company’s employees during the last year?” (from excellent to poor), and “How would you describe employee morale at your company?” (from excellent to poor). An analysis of variance indicated that the managers of small businesses with more comprehensive WHP programs reported higher levels of organizational health than those representing firms with less comprehensive and integrated programs ($F = 10.77, df = 1, p < 0.001$).

These data are from a cross-sectional survey and must be viewed as preliminary in view of the methodological limitations inherent in retrospective, self-report surveys.
the development of WHP activities. Examples of outcomes to be measured include intervention group differences in employee health status and morale, quantity and types of WHP programs/activities offered by the company, and manager awareness about (a) the kinds of programs/activities that can be included in a WHP program, (b) the kinds of health risks their employees may be exposed to, and (c) the kinds of benefits their company might experience by implementing WHP programs. Although training resources such as the Manager’s Guide appear to be useful in enabling small business managers to develop more effective WHP programs, it is also likely that the value of these informational tools will be augmented substantially by the availability of community resources, such as outside WHP consultants and business-community coalitions, who can assist managers in their efforts to promote health in the workplace.

For instance, the processes of planning, presenting, and monitoring WHP programs entail several sequential steps: raising corporate awareness of workplace health concerns, conducting a WHP needs assessment, developing a broad-ranging corporate health policy or mission statement, selecting and implementing key program components in an integrated fashion, monitoring their effectiveness, and revising program components to enhance their effectiveness. Training resources such as the Manager’s Guide to Workplace Wellness provide a useful means for managers to learn about and implement these sequential phases of WHP programming. At the same time, however, the assistance of outside health promotion experts and business-community partnerships may prove invaluable to these managers of small firms who lack sufficient time and organizational resources to establish comprehensive, effective WHP programs on their own.

A broad array of community resources for WHP is potentially available to small business managers, however the managers themselves may not know how to locate and make use of the WHP expertise and assistance within their local communities and at state and national levels. An additional and critical core competency for effective WHP programming among small business managers is the capacity to identify and incorporate low-cost community resources into corporate health promotion programs. We turn now to a discussion of community-partnering strategies to link managers with these critical resources.

Enhancing Worksite Wellness through Community Partnering Strategies

An exciting new frontier for small business health promotion is the development of community coalitions and partnering groups, which can substantially augment managers’ efforts to develop comprehensive and effective worksite health promotion programs. An extensive research literature on the formation of community coalitions for health promotion presently exists (Brach & Gleason, 1990; Butterfoss, Goodman, & Wandersman, 1993; Conner, Tanjasiri, Davidson, Dempsey, & Robles, 1999; McLeroy, Kegler, Steckler, Burdine, & Wosztky, 1994; Pelletier et al., 1988; USDHHS, 1995; Wandersman et al., 1996); yet, prior studies have given sparse attention to the development of small business-community coalitions whose goal is to foster greater collaboration among small firms and community groups for worksite health improvement.

Nonetheless, several demonstration projects involving small businesses partnering with each other and various community groups to enhance worksite health have been spawned in recent years. These projects, which include corporate health-insurance purchasing cooperatives (Chenoweth, 1995), government-sponsored grants to small businesses for developing worksite health promotion programs (Czyzko & Laflas, 1991), mentoring initiatives matching interested business managers with managers from other local employers who are experienced in developing health promotion programs (Joint Venture: Silicon Valley Network, 1998), and community collaboration to provide low-cost employee assistance programs and medical services to low-SES workers (Donaldson & Klein, 1997; Torres, 1999), offer a provocative and informative glimpse into the field of small business health promotion during the 21st century. In the following section, we summarize some of these innovative community-partnering strategies for worksite health improvement.
Small Business Health Insurance Purchasing Cooperatives

We noted earlier that very small businesses are at a distinct disadvantage in working with HMOs and PPOs due to their more limited resources and purchasing power relative to large corporations. For example, many worksite health promotion subsidies provided to companies by HMOs are restricted to firms with 50 or more employees (Donaldson et al., 1998). Thus, small businesses increasingly are joining health insurance purchasing “cooperatives” to enhance their ability to provide high-quality medical benefits for their workers.

In Cleveland, Ohio, a group of small businesses formed a large purchasing pool, the Council of Smaller Enterprises (COSE). The council consists of 9,000 firms representing 54,000 employees and 120,000 dependents. All COSE members can purchase affordable health insurance coverage because the council has persuaded large insurers to offer their coalition the same advantages given to larger companies. The most important of these advantages is the clout to pressure doctors and hospitals to keep costs down. The COSE arrangement has been a successful cost-control strategy for its members, whose annual premiums typically rise only about one-fourth as much as they do for non-COSE businesses” (Chenoweth, 1998, pp. 129–130). Small business purchasing cooperatives similar to COSE are likely to arise in many other regions of the country, as managers confront the pressing demand for cost-effective health insurance coverage among their employees—especially low-SES minority workers (Schauffler et al., 1997).

Government-Sponsored Grants-in-Aid for Small Business Health Promotion

The Worksite and Community Health Promotion Program (WCHPP) was established by the Michigan Department of Public Health to provide small grants to companies with fewer than 500 employees, with the goal of assisting underserved firms in their efforts to develop and maintain cost-effective WHP programs (Chenoweth, 1995; Cyzman & Lafka, 1991).

Created in 1987, this state-sponsored program provides one-year WHP grants of up to $9,000 to small businesses. The grants are awarded on a quarterly basis. The WCHPP requires that WHP vendors be trained and certified by the state before working directly with the grant-funded firms. Also, the program requires that evaluative measures be gathered at each of the participating worksites to assess WHP processes and outcomes. A particularly valuable feature of this innovative program is its assignment of highest priority to small firms employing large percentages of low-SES and minority workers in the grant-making process. This Michigan-based program stands as an exemplar of government-sponsored support for small business health promotion which, hopefully, will expand to additional states in the coming years.

Corporate-Community Consortia for Delivering Medical and Employee Assistance Program Services to Small Business Workers

As noted earlier, one of the most pressing challenges facing the managers of small businesses is finding cost-effective ways of offering their employees clinical preventive services, employee assistance programs, and medical care for injury and illness. In southern California, two innovative coalitions involving small businesses, nonprofit agencies, and medical providers have been established to promote employee wellness: the Los Angeles Worksite Wellness Project (Torres, 1999) and The Pasadena Consortium (Donaldson & Klein, 1997).

The Los Angeles Worksite Wellness Project (LAWWP) is a three-year demonstration project that brings wellness education and basic health care to the worksites of medically underserved and uninsured low-wage workers in Los Angeles. The Project aims to increase health awareness and improve the health status of low-income workers by facilitating their use of existing health education and medical resources. The LAWWP links these traditionally underserved workers to community health resources by distributing information at the worksite that encourages healthy lifestyle choices, self-care, and timely utilization of medical services.

The LAWWP targets workers in the food processing, furniture manufacturing, and apparel/textile industries, all of which employ large percentages of low-income workers and typically do not offer health benefits or health education programs to their em-
employees. During its first two years, the LAWWP established worksite wellness programs at 10 small firms employing a total of 400 predominantly low-wage, Latino workers. Key components of the LAWWP include clinical preventive services, risk-factor screening programs, and health care utilization and referral. To deliver worksite health services in a cost-effective manner, the LAWWP has established a community network of nonprofit health providers who offer health education and screening programs to participating worksites. Also, to better achieve the health education goals identified by participating companies, the health awareness materials distributed at the worksite are culturally sensitive and linguistically appropriate.

An especially valuable feature of the LAWWP is that employees at each worksite receive personalized counseling on how to access community medical services in an efficient and timely manner. As part of this counseling process, uninsured workers are informed about the availability of free or low-cost services, while those workers with medical benefits receive assistance in contacting their designated medical providers. The LAWWP serves as a model program for delivering cost-effective health education and medical services to underserved small business workers in California and beyond.

The Pasadena Consortium (Consortium) was established as a low-cost delivery system for providing WHP and EAP services to small business workers (Donaldson & Klein, 1997). The Consortium, established in 1993 with funding support from The California Wellness Foundation, has provided community health services to more than 4000 small business workers. The Consortium was created to promote collaboration among businesses, nonprofit agencies, university researchers, and medical providers for purposes of enhancing worksite health among traditionally underserved employee populations. Like the WCHPP in Michigan and the LAWWP in California, the Pasadena Consortium targets ethnically diverse employees working in small companies, especially those that are owned by women and/or minorities. The Consortium's network of providers includes behavioral health specialists from both the public and private sectors. Participating vendors agree to provide health services and wellness education to managers, employees, and their families on a pro bono basis. Several intervention components that are being delivered as part of the Consortium (e.g., EAP services, wellness education and lifestyle change programs, and managerial training in WHP strategies) are currently being evaluated for their health and cost effectiveness. The number of small businesses participating in the Consortium has increased dramatically in recent years. The Pasadena Consortium, like the WCHPP and LAWWP described earlier, has established itself as an innovative model for future community-business partnerships that are intended to promote more collaborative and effective worksite health programs.

Establishing Small Business Partnerships to Facilitate Collaborative Worksite Health Promotion Efforts

At the University of California, Irvine, small business managers participating in the highest intervention group within the Small Business Workplace Wellness Project (SBWPP) were assigned to a small (8-10 person) WHP partnering group. The purpose of this group was to help managers of multiple companies identify common worksite health concerns and help them share resources and expertise. Ideally, these identified concerns would then be addressed through the development of joint WHP programs. This approach differs from the WCHPP, the LAWWP, and the Pasadena Consortium described earlier in that it entails a series of task-oriented discussion sessions and programming meetings where representatives from several small companies actively collaborate in the formulation of new WHP initiatives. Initial indications are that these small business partnering groups can serve as a powerful tool for promoting improved levels of worksite health within the participating firms. In effect, these partnering groups provide small business managers with interpersonal support and information exchange as they work together to design innovative and cost-effective WHP programs. By pooling their financial and personnel resources and sharing programming ideas, the managers of these firms may improve their capacity for identifying low-cost strategies for promoting
| Table 18-6 Community Resources for Workplace Health Promotion |

- **Government agencies** (e.g., the U.S. Small Business Administration, city and county health departments, state Occupational Safety and Health Administration [OSHA] consultation services) will provide free information about workplace health and safety and may be available to visit a workplace to offer suggestions.

- **Local health agencies and educational institutions** (e.g., chapters of national organizations such as the American Heart Association and American Cancer Society, hospitals/health clinics and HMOs, colleges and universities, and county [varies] offer a variety of free services, including informational brochures and pamphlets, speakers, training sessions, health education seminars, screening services, health fair, and health services.

- **Professional, industry, and service organizations** (e.g., chambers of commerce, service clubs, such as Rotary, Kiwanis, Lions; industry or professional associations appropriate for different companies) can provide free information, speakers, and assistance.

- **Community involvement opportunities** are available, which can help a company expand its health promotion efforts. For example, they can research the availability of local health-related services for employees, such as childcare and eldercare; they can post information about free local health services that might interest employees; they can help sponsor a health-related event for a local charity, such as a 5k walk/run; and they can encourage and reward employees for volunteering their own time within the community.

- **Networking and partnering with other businesses** (e.g., similar size, industry, or geographic region) can be a very powerful strategy for small business managers to increase the effectiveness and success of their health promotion efforts. For example, they may be able to identify other companies similar to theirs through their property management company, the local chamber of commerce, or professional and industry associations; they can pool financial and personnel resources with similar companies to provide shared workplace health promotion programs that might not otherwise be feasible, such as expanded health insurance coverage or a health fair; and they can establish an ongoing group of small business owners and managers who meet regularly to talk about the health of their businesses, including the health of their employees and the relative effectiveness of alternative health promotion strategies, wellness in their respective companies. An evaluation of the processes and outcomes associated with SBWHP's business-partnering intervention is currently being conducted (Stokols, Clidere, McMahan, & Vells, 1995). The results of this evaluation will provide detailed information about the effectiveness of the program and guide future efforts to establish corporate partnering groups for enhancing workplace health in small companies.

In sum, the development of business-community coalitions and partnering groups to promote more effective and comprehensive workplace health programs has emerged in recent years as a new and exciting frontier for future WHP practice and research. A variety of community resources are currently available to small business managers to assist them in their effort to establish effective WHP programs, as outlined in Table 18-6. The WHP field is likely to witness more extensive utilization of these community strategies and resources by the managers of small firms during the 21st Century.

**CONCLUSION: THE FUTURE OF HEALTH PROMOTION IN SMALL BUSINESSES**

The small business sector constitutes an extremely important part of the American economy. Roughly 80% of the nation’s workers are employed by companies with fewer than 500 employees. Small businesses are a tremendous source of innovation and account for most of the net job growth in the U.S. They also provide most first-time workers with the opportunity to enter the job market in America. At the same time, small firms face enormous financial and organizational challenges since they operate on tighter profit margins and employ higher percentages of low-SES, minority, and socioeconomically-untrained individuals than do large firms. They also lack the in-house expertise and corporate infrastructure (e.g., occupational safety and health specialists, human resource departments) to facilitate the establishment and maintenance of comprehensive worksite health programs. It is not surprising, then, that over the past two decades, the most extensive WHP programs and research studies have been implemented in companies with 500 or more workers.
Appendix: Online Resources for Small Businesses

- AllBusiness.com—Solutions for Growing Businesses
  www.allbusiness.com
- BenefitMall.com—Employee Benefits for Small Business
  www.benefitmall.com
- BizTalk—Small Business Community
  www.biztalk.com
- Business Resource Center
  www.morebusiness.com
- BusinessWeek Online
  www.businessweek.com/smallbiz/index.html
- ChamberBiz—The Ultimate Small Business Resource
  www.chamberbiz.com/
- Convey.com—Communication and Web Resources for Small Businesses
  www.convey.com
- Department of Social and Preventive Medicine,
  University of Queensland
  www.sun.edu.au
- Health On the Net Foundation
  www.hon.ch
- Health Canada Online—Small Business Health Model
  www.hcsc.gc.ca/hppb/ab workplace/pub/ smallbusiness/healthmodel.htm
- Heartland Healthcare Coalition
  www.nhco.org
- Idea Café—The Small Business Channel
  www.ideacafe.com
- National Health Information Center
  http://nhic-nt.health.org
- OneCore.com—Financial Expertise for Small Businesses
  www.onecore.com
- Partnership for Prevention
  www.prevent.org
- SmallOffice.com—Big Ideas for Small Business
  www.smalloffice.com
- Small Business Development Center, New York State
  www.smallbiz.suny.edu
- Small Business Resources
  http://smallbusinessresources.com
- SmallBizSavings—The Online Purchasing Alliance for Small Business Buyers
  www.smallbizsavings.com
- SmartAge.com—Smart Commerce for Small Business
  www.smartage.com
- University of California, Irvine Health Promotion Center
  www.healthpromotioncenter.uci.edu
- U.S. Business Advisor
  www.business.gov
- U.S. Chamber of Commerce
  www.uschamber.org
- U.S. Small Business Administration
  www.sba.gov
- Wellness Councils of America
  www.welcoa.org/prod_and_servs/sourcebooks/ sourcebooks.htm
- WomenConnect.com—Connecting Women in Business
  www.womenconnect.com
- Workz.com—Helping Small Businesses Grow and Prosper Online
  www.workz.com
To better meet the challenge of improving worksite health in the 21st Century, small business managers will need to find innovative ways of addressing the health needs of their workers and providing cost-effective preventive services, EAP programs, and basic medical care to both high-risk and less vulnerable employees. Accomplishing these tasks in the context of constrained budgets and a tight job market will not be easy and will require small business managers to acquire certain critical core competencies. These competencies include: (a) cultural sensitivity and the ability to recognize and serve the needs of an increasingly diverse workforce; (b) a basic awareness and understanding of comprehensive, integrated WHP programs; (c) the ability to design, implement, and evaluate integrated, multicomponent WHP programs; and (d) the capacity to identify low-cost community resources and integrate them into corporate health promotion programs.

The present chapter outlined a two-pronged approach for providing small business managers the wherewithal to cultivate these core competencies. First, new educational resources, including WHP training programs and hands-on programming guides, have been developed (e.g., UCHPC, 1998; WELCOA, 1998). These resources are being delivered to small business managers and tested for their effectiveness in several demonstration projects throughout the country. Second, new community-based delivery systems are being established to provide outside technical assistance and economic support to small business managers and to champion their efforts to address worksite health concerns in their companies. These new delivery systems include: (a) small business health insurance purchasing cooperatives (Chenoweth, 1995; Schaufele et al., 1997); (b) government-sponsored grants-in-aid programs for small business WHP activities (Chenoweth, 1995; Cyzman & Lafka, 1991); (c) corporate-community consortia for delivering medical and EAP services to small business workers (Donaldson & Klein, 1997; Torres, 1999); and (d) small business partnerships to facilitate greater WHP collaboration among managers from multiple firms (e.g., matched pairs of businesses with and without WHP programming experience and businesses in a similar geographic area or industry) (Joint Venture: Silicon Valley Network, 1998; UCHPC, 1998).

During the 21st Century, new WHP training resources for small business managers will be developed and refined, and community-based support networks for small business WHP will continue to expand and undergo rigorous evaluation for their health benefits and cost-effectiveness. A key issue that can be expected to receive greater attention in the coming years, from both WHP researchers and practitioners, is the challenge of achieving comprehensive worksite health programs that not only are beneficial to employees' well-being, but also sustainable by small companies over extended periods (Altman, 1995; Warmer, Wickizer, Wolfe, Schildroth, & Samuelson, 1988). It is at the expanding frontier of small business health promotion that these challenges of creating comprehensive, cost-effective, and sustainable worksite health promotion programs will be met.

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