Older health care workers' lived experience of promoting health in work life

by

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inspiring achievement

Declaration

I certify that this thesis does not incorporate without acknowledgement, any material previously submitted for degree or diploma from any university; and that to the best of my knowledge and belief that it does not contain any material previously published or written by another person except where due reference is made by reference. I also declare that at the time of publishing this thesis that I was working for the Tasmanian Health Service and that ethics for participation in this research was approved by Flinders University Social and Behavioural Research Ethics Committee, South Australia, Australia and the University of Tasmania, Social and Behavioural Research Ethics Committee.

Robynne Rankine 28 July 2018

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Abstract

This thesis is a report of a phenomenological study of older health care workers' lived experience of health in work life. The purpose of the study was to explore, identify and examine the meanings attached to the lived experience of health in work life and explore the prerequisites for health promotion to help ensure older worker health develops and is preserved.

Phenomenological inquiry was chosen as it places the researcher into the field of perception of the older worker, to see and feel the phenomenon through listening, to empathically understand the lived experience of older workers opening avenues of communication with this cohort. In addition, to examine this phenomenon a salutogenic lens was applied to Baum's (2008) socio-environmental health promotion framework and Brofenbrenner's (2005) socio-ecological developmental framework as they provided a way to conceptualise, examine and make visible older worker health in work life.

The context for this study was the Tasmanian Health Service and findings were based upon 171 participants in 13 focus groups and 3 semi-structured interviews undertaken with nursing, allied health professionals and health managers. An interpretive analysis was conducted to examine the different meanings of health for older workers. The identified themes were contrasted with the themes presented in the academic literature and the framing of health for this cohort was examined.

The analysis revealed that older workers offered a greater understanding of workplace health and a range of potential solutions to help improve workplace health in the Tasmanian Health Service. This illustrated how older workers' perspectives can enrichen health promotion solutions for older workers. Twenty context-specific recommendations were developed to improve workplace health in the Tasmanian Health Service.

Chapter 1: Introduction

> *The world is in the midst of a global "age-quake": The workforce is turning grey and is shrinking (Hatcher et al, 2006, p.3)*

This thesis is a report of a phenomenological study of the lived experience of health in work life with older health care workers. The purpose of the study was to explore, identify and examine the meanings attached to the lived experience of health in work life and explore the prerequisites for health promotion to help ensure older worker health develops and is preserved.

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This first chapter provides the conceptual framework for the study. It outlines the researcher's interest in the research enquiry into ageing, health and work life, defines the phenomenon of interest, the broad research question and the purpose of the research along with the public health significance of the research question. It concludes with an outline of how the dissertation is structured.

Ageing

In Australia, as in other developed countries workers aged fifty-five years and over vastly outnumber those aged younger than twenty five years (Jackson et al, 2006; Ilmarinen, 2006, 2001). A worker 55 years and over fits into what is known as the baby boomer generation who were born post World War Two, when there was a temporary increase in

the birth rate. Currently, in Australia there are 4.5 people of working age for every person over the age of sixty five and by 2032 the number is predicted to reduce to 2.7 (Commonwealth of Australia, 2010; 2013). The ageing of the baby boomers, which is largely the reason behind the projected decline in the overall participation rate, has had a major impact on the ageing of the labour force.

As a result of an increasingly ageing demographic in Australia the Productivity Commission (2004) reports fewer available younger workers together with an increase in the age of the overall workforce will result in socio-economic implications for the Australian workforce until at least 2040. As such, the government of Australia (Costello, 2004) urged its older citizens to continue working for as long as possible to reduce the strain on the retirement system. Older workers are needed to stay in the workforce longer to cover the shortage of skilled workers (Burke & Ng, 2006).

The Bureau of Statistics (CoA, 2015) projected that by 2021 one in four workers in the labour force (roughly 25%) could be fifty-five years of age or over, the highest proportion on record. In Tasmania the population is older and ageing more rapidly than any other Australian State; mature workers (over 45 years) make up nearly 43% of the employed workforce (Tasmanian Workplace Standards, 2013). In the Tasmanian Health Service, it is the first time in history that our workforce is ageing to such an extent that half of its professional workforce is approaching 55 years (THS Staff Health and Wellbeing Committee, June, 2015).

Up until recently health care organisations have looked at older workers through the lens of supporting and encouraging ‘retirement’ decisions as older workers leave the work force, or who retire to provide a renewal process for younger workers to enter the workforce. Now for the first time in history there are not enough younger health care workers to replace our older workforce. It is imperative that we find ways to keep our older workers healthy and at work (Waddell & Burton, 2006; Hirsch, 2003). I wanted to explore the thinking about older workers as an essential part of our workforce and to see how we could keep our older workforce healthy and at work past current retirement age.

The challenges of an increasingly aged work force presents opportunities for everyone, governments, employers, workers and their families to find ways to stay healthy and productive.

(Barros et al, 2015). Understanding the changing health care environment is important in keeping our older workers healthy and at work.

1.2 Why I wanted to conduct the research

This research emerged out of a professional and personal interest in health and older worker work life. My interest stemmed from my work as a workplace psychologist within the Tasmanian Health Service and I am an older worker, a 'baby boomer'. I work mainly in organisational development (OD) in a hospital setting coaching and educating managers and teams on psychological wellbeing, work team communication and behaviour to improve work culture and work environments.

As a workplace psychologist, I find it interesting to observe how economic rationality has radically changed the delivery of health services in recent decades. This is not to say the shift to economic considerations in health care delivery still doesn't seek to solve the health needs in the communities in which it serves. This shift in how health care is delivered has sought to improve the patient/client experience of health care through a shift from a service centred more 'paternalistic' welfare approach to a more health consumerist, individualist, person centred approach. As an older worker myself, this approach has an immense influence on older workers' own 'consumption' of health care where individualised choice and individualised risks are emphasised with the individual conceived as responsible for his/her health status. From this view point workers are responsible for their own health outcomes and as such the concept of health needs further exploration.

Moreover, my own experiences as a health professional led me to ask questions around the fundamental conflict between the increasing focus on business management concepts of organising health care. That is, the downsizing and cost cutting along with an increasing focus on economics and efficiency, compared with when the 'boomer' generation entered the health care professions as a calling. At that time the foundations of health care as a caring and giving practice were based on values such as compassionate care, altruism and nurturing as 'boomers' wanted to make a difference to people's lives. This conflict of views around meaning of health often results in considerable distress and tension in everyday practice for older health care professionals (Ruthjersen, 2007).

Nettleton, (2009) argues such exploration around the meanings of health must take the lay perspective that is non-professional/expert views into account. Further, Popay and

Williams (1996) propose qualitative research must find ways to accord local knowledge equal worth to other forms of knowledge (Peterson, 2013). This will, by providing solid evidence, then inform policy and practice.

For older health care workers health care delivery is radically different today than when they first trained in their health professions. If for only these reasons, it's important to have an understanding what it may mean for older health care workers to stay healthy in what health professionals say are turbulent times (Neilson, 2009). Further, understanding these ideological changes in health care provision may not only change the way we provide services for our patient/clients it may also have implications on how our older workers view their own health in work life and how the organisation can support the health of its workers.

I am an employee of the Tasmanian Health Service and a member of the staff health and well-being committee along with an occupational physician, nurses and health and safety professionals. The health promotion programs in the Tasmanian Health Service are based in the bio-social-medical model focusing on health assessments, vaccination programs, smoking cessation programs and monitoring all new workers for disease prevention and vaccination status. Interventions developed are aimed at supporting workers to take personal responsibility for joining a program and changing their lifestyle and behaviour to improve their health. The programs on offer include exercise classes, subsidised gym membership, smoking cessation, nutrition and stress management classes.

However, it is always difficult to fill the health promotion programs with the people the programs are trying to target, that is, the older half of our workforce with multiple chronic conditions and other health concerns. For the health and wellbeing committee, promoting the benefits of participating in health promotion programs are time consuming; on the whole, older workers would not enrol and/or were poor attendees. The committee approach was to try harder with success measured on program participation.

My research was initiated because I felt the Tasmanian Health Service needed to take a different approach from the bio-social-medical view of health promotion as outlined in Baum's (2008) health promotion framework to a broader view that included the socio-ecological approaches to health promotion (Baum, 2008, p.445). The local evidence suggests that the more 'paternalistic' medicalised approach to health promotion coupled with taking personal responsibility for behaviour change to improve health does not work.

Our health promotion committee motto was “we put on health promotion activities that we think best for our workers and they will come and participate and get healthier and take less sick days etc.” Ultimately, I want to develop socio-ecological health promotion programs and policy with and for our ageing health care work force.

1.3. Promoting health from a salutogenic and socio-ecological perspective

My own practice is based in positive psychology focusing on strengths and promoting wellbeing. I wanted to undertake research using an approach that explored in a work life context what resources are needed for the promotion of health in a positive sense. From a salutogenic perspective health promotion is defined as ‘the process of enabling people to increase control over and to improve their health’ (Nutbeam, 1998, p.351). This approach aims to empower people so they can partake in decisions important to their lives and thereby change the individual and environmental determinants of their health (Nutbeam, 1998). Further, this supports ENWHP (2006) definition of workplace health promotion as the combined effort of employers, employees, and society to improve the health and wellbeing of people at work. The European network for workplace health promotion (ENWHP, 2006) describes that WHP should be achieved by promoting the participation of workers in the whole process of WHP.

I am naturally drawn to a *salutogenic* approach to the way health is concerned with the genesis of health (Hanson, 2007). What creates health? What moves individuals in the direction of health? What needs to be promoted? I wanted to undertake this research to explore options with older workers themselves around what health promotion policy, programs and education would be if it focused on factors supporting health and wellbeing rather than those that cause disease. How we can improve health in our working life and strengthen the determining factors of health for older workers.

This research advances our understanding of older worker health in work life by moving towards an ecological approach using Bronfenbrenner’s ecological theory (1979, 2005). Bronfenbrenner initially developed his theory for child development and it’s now used more generally (Stokols, 2001). The ecological orientation provided by Bronfenbrenner (1979, 2005) presents a holistic framework to consider the environmental determinants or influences on older worker health in work life (Diagram 1). It is a suitable model as the

state of the modern healthcare workplace is busy, insecure, frenetic and fragmented and the workplace is influential on an employee's health and health promotion opportunities.

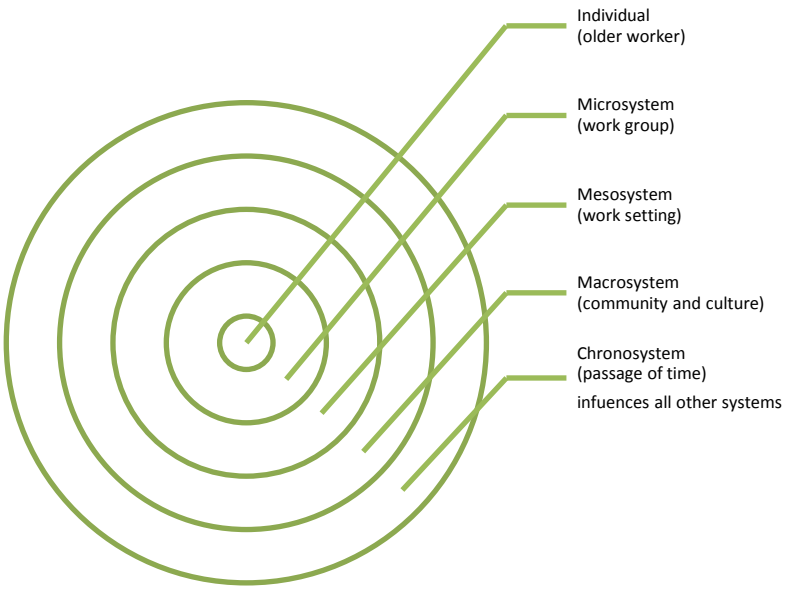


Diagram 1. Bronfenbrenner's ecological framework.

According to Bronfenbrenner's (2005) framework the environment is conceived topologically as a nested arrangement of concentric structures, each contained within the next. In describing this model the structures are referred to as the micro, meso, exo, and macro systems or environments (Bronfenbrenner, 1979, p.22). In Bronfenbrenner's framework the microsystem refers to face-to-face influences in specific settings, such as interactions within one's work group. The mesosystem refers to the interrelations among the various settings in which the individual is involved which may include the work setting. The mesosystem is the system of microsystems whereas, the macrosystem refers to the forces within the larger social system in which the individual is embedded and is interrelated with work life such as the community and government policy. The layers influence and are influenced (Bone, 2015) by the individual employees and imply reciprocal causation between the individual and the environment.

The framework presents a wide-ranging contextual model with which to "examine health problems encountered by individuals and groups in relation to the etiologic circumstances present in their day-to-day physical and social environments" (Stokols, 2001, p.29). He states that "The single challenge of our time is to establish and maintain healthy environments" (Stokols, 2001, p.6).

Further, Bronfenbrenner's (1999) model places emphasis on "the passage of time" (chronosystem) as another system of influence. The chronosystem adds another dimension understanding life and life situations are not static but rather change over time (Bronfenbrenner, 1999, p.20). This approach holds relevance to how older workers viewed work and health in their life course transitions.

To gain a deeper understanding it's timely to examine the multiple levels of influence on older worker health as the literature contains very little on the interplay within and between environments in work life.

1.4. The workplace as a setting for health

For many years the World Health Organisation (WHO) has advocated a settings approach to promoting health (WHO, 1986, 1991, 1997). At the centre of this approach is the recognition that people live their lives in complex social, cultural, economic and political environments that may improve or damage health in various ways (Dooris, 2009, 2006; Hanson, 2007; Paton et al, 2005; Chu et al, 2000). WHO (2001, 2009) asserts health promotion practice should focus on modifying aspects of the setting itself rather than solely changing individual's health-related behaviour.

On WHO's initiative, health promotion is applied within social settings such as workplaces and hospitals and has the task of creating within them what we call 'supportive environments' (1991). In the WHO's Health Promotion Glossary (1998), the term setting for health is explained as follows:

> *The place or social context in which people engage in daily activities in which environmental, organisational and personal factors interact to affect health and wellbeing.*
>
> *A setting is also where people actively use and shape the environment and thus create or solve problems relating to health. Settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organisational structure (p.19).*

The Ottawa Charter for Health Promotion states that 'health is created within the settings where people learn, work, play and love' (WHO, 1986, p.3). Perhaps the most important principle in workplace health promotion is the health of human beings (Hanson, 2007).

This makes the workplace a significant determinant of health for older workers. Individual factors such as wellbeing and job satisfaction are entwined with the work environment. As discussed in the Ottawa Charter (1986) 'the inextricable links between people and their environment constitutes the basis for a socio-ecological approach' (WHO, 1986, p.6) in promoting health.

Further, the World Health Organisation (WHO, 2007) described the work environment as one of the priority settings for health promotion into the 21st century, and the World Health Assembly of the WHO (2007) endorsed the "Workers Health: Global Plan for Action" aimed to protect and promote health in the workplace.

In addition, Whitehead (2006) argued a workplace is a place where workers spend a lot of time and is an environment catering for the physical, mental, social and economic wellbeing of its workers. When health promotion work is targeted at the setting, the social context and organisational conditions governing peoples' lives become part of the strategy to improve the conditions for health. As such more research is required that targets health promotion for our ageing workers at the settings level.

1.5 Public health significance

The Tasmanian Health Minister (2016) stated that Tasmania has some of the worst population health outcomes in the country. This prompted the Tasmanian State Government to give an undertaking to improve the state's population health and become the healthiest State by 2025 (Tasmanian Health Survey, 2016).

The Tasmanian Health Service workforce and its health outcomes mirror the general Tasmanian population and emulate Australia's worst health outcomes outside the indigenous communities in Northern Territory (CoA, Report of Ageing and Workforce, 2009; Tasmanian Population Health Survey, 2013). Tasmania has a smoking rate of 20% with health care workers reflecting this average. The prevalence of overweight and obesity in Tasmania's adult population is approaching 66% and our healthcare workforce mirrors the obesity statistics. Our older health care workforce mirrors the general population with three plus chronic conditions (Menzies Research Centre, 2012).

Imagine what an opportunity our older workers afford the Tasmanian Government's agendas to become the healthiest State by 2025. The Tasmanian Health Service is the

largest employer in the State with half of its workers over fifty years. The World Health Organisation (WHO) Ottawa Charter (1986) states:

> *To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capabilities (p. 3).*

The Tasmanian Health Service can support its older workers to have health as a resource in their everyday work life and in turn, take this resource into their home and family life and into the communities (Waddell & Burton, 2006) in which they live. The potential to influence health outcomes across the State is enormous. Additionally, our older workers could take good health into post work life. This research has the potential to influence health outcomes across the state and has great public health significance in improving Tasmanians' health outcomes.

1.6. Research approach

The nature of a person's health is by definition an experiential process. In this research I wanted to explore the meanings around health with our older workers using an interpretative phenomenology examining the individual older worker's relationship to the world. It is the older worker's interpretation of their experience in the world and the meanings they make of the experience this research was most interested in, that is, interpreting the phenomenon from the individual's perspective (Heidegger, 1962).

Interpretative phenomenology is a qualitative research method that specifically focuses on the lived experiences of human beings and is a study of the *lifeworld*, that is, the world as one experiences it (van Manen, 1997), the aim of which is to gain a deeper understanding of one's everyday experiences. Further, it is through the lived experience of others that allows the researcher to capture meaning in order to more fully understand the phenomenon of concern (van Manen, 2014). Phenomenology provides a structure for the examination of older workers' lived experience of health in their everyday work life.

1.6.1 The research question

Due to falling birth rates, fewer people entering the health care workforce and an increased demand for world class health care services, the retention of older workers has become a critical issue for healthcare organisations. Its vital health organisations understand the factors influencing older workers' health to develop strategies for supporting and promoting health in work life. Therefore, it fills a gap in understanding what being healthy in older workers' work life means and the contextual factors that can better support and promote their health at work. It will also assist in the formation of policies and practices addressing this particular issue. The research question under exploration is "What is your experience about health in work life".

For the purpose of this research, the term older workers refers to health care professionals over the age of fifty five working in clinical, managerial or health promotional roles either part, full time or casual within a public health organisation including hospitals and community health care centres. The term 'contextual factors' refers to those factors that address social, economic, environmental and political influences affecting health and they differ from those factors that produce disease. The determinants of healthy ageing and work refer to a workplace where older worker health and wellbeing incorporates the WHO definition of health (physical, mental and social) and not merely the absence of disease (WHO, 2004).

In addition, salutogenesis (Hanson, 2007) means promoting health and moving towards what it is that preserves or helps people improve their health. The term socio-environmental refers to Baum's (2008) health lens on the medical, behavioural and socio-environmental approaches to health promotion. The term social-ecological refers to Brofenbrenner's (2005) comprehensive ecological analysis on the way people develop including biological, genetic, social and environmental influences.

1.6.2 The purpose of the research

This research seeks to investigate the workplace determinants promoting healthy ageing at work in the context of the Tasmanian Health Service. The research's aim is to understand what older workers think will assist in the formation of policies and practices that specifically support and promote older worker health in work life. In doing so, the research attempts to uncover the various and diverse ways healthy ageing at work have been constructed and the organisation's role in supporting older worker health.

This study explores older workers' perspectives using a constructivist perspective with the underlying assumptions that meaning is socially constructed rather than an absolute truth (Crotty, 1998, 1996). That is to say that truth and meaning are dependent on people's interaction in the world (Willis et al., 2007). It is for this reason the older worker perspective is important in developing health solutions in the workplace that better support an ageing workforce. The primary intentions of the study were to explore using an interpretative phenomenological analysis older workers' own experience of health in work life to inform theory development in health promotion for this cohort. I explored the following areas to gain understanding:

1. How do participants experience health in work life?
2. What prerequisites help to ensure that health develops and is preserved in work life?
3. How do we bring about a trend towards better conditions for health in work life?
4. To theorise about this phenomenon and gain understanding for promoting healthy ageing at work.

1.7. The structure of the research

In order to provide solutions to the research questions and purpose of this study, this thesis is divided into five chapters, structured as follows:

- Introduction
- Review of Literature
- Epistemology, methodology and methods
- Findings
- Discussion and conclusion

Chapter 1: Introduction

This chapter introduces the reader to the context and purpose of the study and outlines the statement of the problem, research questions and the structure of the dissertation and definitions. The public health significance is discussed.

Chapter 2: Literature review

A narrative literature review was undertaken guided by a socio-environmental health promotion framework developed by (Baum, 2008). This methodology broadens the traditional medical and behavioural approaches to include a socio-environmental lens to how health and health promotional work is constructed and viewed in work life. The review of the literature is presented in five themes:

- The first theme introduces ageing and health at work.
- The second theme focuses on age management and occupational health services.
- The third theme focuses on ageing, health and how work ability has a deficit focus.
- The fourth theme focuses on the importance of the work environment and older worker health.
- The fifth theme looks at health promotion targeted at older workers and how it is defined by occupational health professionals.

Chapter 3: Epistemology, methodology and methods

This chapter details the epistemology, methodology and methods including the research aims and objectives. Before describing the specific methods used, the underlying theoretical perspectives of constructionism and interpretivism are outlined to set the context within the research methods that have been chosen. Following this, the phenomenological research methodology is presented along with a detailed description of the methods used for data collection and analysis. Key ethical issues and biases are addressed, along with quality principles underpinning the research. Advantages and limitations of the research design are considered and discussed.

Chapter 4: Findings

Chapter 4 provides a thematic analysis that examines what the concept of health means to older health care workers and how they thought the organisation could support its members to develop and maintain their notion of health. The actions older workers suggest need to be undertaken to improve health for this cohort are explored.

This chapter provides an analysis and brings the research findings together by discussing the framing of health identified from older workers responses and contrasting these with

the academic literature. The interpretative analysis uncovers aspects of an issue that are often silenced in health promotion.

Chapter 5: Discussion

Rethinking older worker health from a socio-ecological perspective has highlighted the importance of the setting for promoting health. The work environment and work community were found to be a substantial resource for health for this cohort. The discussion presents the socio-environmental health resources framework promoting older worker health in work life as four interconnected health resources:

- Health resource - workplace as a community
- Health resource - value a holistic approach to health promotion
- Health resource - health promoting setting
- Health resource - work and life alignment

Further, the contextual factors that the organisation can put in place to assist its older workers maintain and sustain their own notion of health are discussed. In addition, the processes by where the findings of this research are transferred to health promoting policy making are outlined. The conclusion to the research project highlights the main findings and answers the remaining research questions. The process by which these findings will influence future policy and practice for older workers in Tasmanian Health Service is outlined. Recommendations for future work in understanding older worker health in their work life will be addressed.

The Appendices include samples of all the materials used to conduct the research.

Chapter 2: Health in work life – a review of the literature

"To own the literature is to be familiar with what has been written by previous researchers that you know clearly how this idea of research has progressed over time and across ideas" (Garrard, 2007, p.6).

2.1. Introduction

Before gathering and analysing older health care workers' experience of what it means to be healthy in their work life, a review of the literature was undertaken to guide the methodology and analysis of data. The review was conducted to uncover the various views and scholarly thinking on the meaning of health for older workers, especially health care workers, its determinants and possible solutions. This study seeks to develop a new and fresh insight into effective strategies that the health care organisation can apply to assist its older workers develop and maintain their own notion of health.

As this research project focused on gathering key older health care workers' lived experience of health and work life to incorporate their views in developing possible workplace solutions, a narrative literature review approach was adopted. This approach included reviewing the evidence, summarising available literature and deriving conclusions on the balance of evidence, based on its quality, quantity and consistency (Baumeister & Leary, 1997; Green et al., 2006). This afforded the flexibility needed to tackle heterogeneous evidence and complex issues around work, health and ageing (Green et al., 2006).

The literature was not examined for strength of study design but rather the range of themes being presented on the dominant thinking around promoting older worker health and what it meant to be healthy in their work life. The review was narrative in order to match the aim of the study, i.e. understanding what health means for older workers in the context of their work life. Gaps or inconsistencies in the literature were also identified.

The range of themes identified in the literature provided a basis for the design of the qualitative research on older workers' own concept of health in work life and how they thought the organisation could assist older workers in developing and maintaining their

notion of health at work. In Chapter four, the themes identified in the review of the literature are further examined in light of older workers' own experience on this issue.

The purpose of this narrative literature review was to gather from the literature the dominant views and knowledge gaps on the ageing workforce in the context of the workplace as an important setting for promoting and maximising health for this cohort. Ultimately, this analysis provides a background and a starting point for refining health promotion in work life options for this cohort in the Tasmanian Health Service as discussed in Chapter five.

2.2. Method for the review of the literature

The two aims of this review were to: (a) evaluate the research evidence on the current thinking on health and work life for the older worker cohort; in order to do that, it had to (b) make sense of, and impose some order on the complex set of issues around work life and health for older workers.

The literature search was designed to guide the understanding on what promotes and maximises health in the work life of older workers as opposed to preventing ill-health. The narrative literature review has informed the overall research question and sub questions. In turn, these have informed the focus groups and one-on-one semi-structured interviews. In essence the literature informs the research journey and process (Baumeister & Leary, 1997).

The narrative literature review was guided by a health promotion framework initially developed by Labonte (1992) for promoting heart health and extended by Baum (2008, p. 445) to health promotion in general. There are three major approaches to health discussed: medical, behavioural and socio-environmental. 1) The medical approach, which tries to return sick people to a disease-free state; 2) The behavioural approach, which promotes healthy lifestyles; and 3) The socio-environmental approach, which is concerned with the totality of health experiences and the factors that help to create and maintain health. This includes those factors connected directly with people (bodies, behaviour and lifestyle), the environment and settings for health including work and the working environment.

The three approaches in the framework (Table 1.) differ in how they view health, how they define health problems, the interventions and strategies they advocate, and their focus on how they determine success.

Table 1. Approaches to Promoting Health

Approaches to Promoting Health			
	Medical	Behavioural	Socio-environmental
Focus	Individuals with unhealthy lifestyles	Individuals and group conditions	Communities and living environments
Definitions of health	Biomedical, absence of disease and disability	Individual practice of health behaviours (e.g. exercise and nutritious food)	Strong personal and community relationships. Feelings of ability to achieve goals and be in control
How health problems are defined	Disease categories (and physiological risk factors e.g. cardiovascular disease, diabetes, cancer and obesity). Medical definition	Behavioural risk factors (e.g. smoking, poor nutrition, lack of fitness, alcohol or drug abuse, poor coping skills). Expert definition	Socio-environmental risks (e.g. low income, unsafe or stressful living and working conditions). Psychological risk (e.g. isolation, lack of social support and low self-esteem). Equity a key factor. Communities involved in problem definition
Main strategies	Illness care, screening, immunisation and medical-managed behaviour change	Mass media behaviour change campaigns, social marketing and advocacy for policies to control harmful agents (e.g. drink-driving, smoke-free public places)	Encouraging community organisation, action and empowerment, political action and advocacy
Success criteria	Decrease in morbidity and mortality and decrease in physiological risk factors	Behaviour change decline in risk factors for disease	Individual have more control, social networks are stronger, collective action for health evident, decrease in inequities between population groups

Baum's (2008) framework outlines a socio-environmental framework that broadens the traditional medical and behavioural paradigm for health promotion to include creating the conditions for health as an alternative to only focusing on preventing ill-health (Hunter, 2009, 2004). Consistent with this approach, health is viewed as a positive attribute of wellbeing and quality of life rather than just the lack of illness where the body is regarded as an object that requires 'fixing' (Todres et al., 2009). The dynamic elements between these factors are only likely to succeed in promoting health when based on the understanding of these complexities (Chu et al., 2000).

The Baum model acknowledges the value of the medical and behavioural approaches but recognises they are more powerful when incorporated within the broader framework offered by the socio-environmental model (Baum, 2008). The evidence suggests that the people who experience the worst health status are more likely to have unsafe jobs (physically and/or psychologically) that may include stressful work environments involving high work demands, conflict, and continual change. (Baum, 2008, p.80) This approach seems to fit well within the current highly complex ever changing health care environment (Nettleton, 2009 p. 203).

Applying this framework gave a structure to examining the relevant literature on the workplace as a setting for promoting older worker health.

2.2.1 Methods undertaken for the Search Strategy

Published literature was included from 2000 to 2015. The period from 2000 was chosen as the starting point as organisations have been responding to an ageing workforce since the late 1990s (Silverstein, 2008). More recently, as the last of the baby boomers enter their late 50s and 60s, many organisations found they needed to re-examine the outmoded labour force model where older workers were continually replaced with younger workers (WHO, 2001). The research focus has now shifted to how to retain our workforce post traditional retirement age (Ng & Law, 2014). Where relevant, earlier referenced articles are also considered.

The starting point for the literature review is the Barcelona Declaration on Developing Good Workplace Health Practice in Europe (WHO, 2002, p. 2) which emphasised 'there is no public health without good workplace health'. The World Health Organisation (2008) in the Report on Commission on Social Determinants of Health also suggests the world of work might be the single strongest social determinant of health. The Luxembourg Declaration on Workplace Health Promotion in the European Union (WHO, 2007) increased the profile of the workplace as a public health setting. Locally, the Tasmanian Strategic Health Workforce Framework (2013) is starting to address the retention issues for our older workers for the first time.

There are varying definitions of what an older worker is with reference to age (Kunze & Reas, 2015; Evans et al, 2008; Buerhaus et al, 2003). The majority of scholars define an 'older worker' as one who is aged forty-five or older (Pitt-Catsouphes et al, 2015; Ng & Law, 2014; Loeppke et al, 2013; Musich et al, 2009). Even though it is not directly stated,

society in general classifies people in their mid-forties as middle aged with ‘older’ adults commonly perceived as being in their mid-fifties or sixty plus years of age (Musich et al., 2009; Evans et al., 2008). For the purpose of this study, older workers are defined as fifty-five years and older. This age group is characterised by beginning a retirement process that includes thinking about and openly discussing the pros and cons of leaving work, preparing for, timing of, and then actually leaving the workforce (Ng & Law, 2014).

This research is interested in understanding the enablers and resources of health from a positive perspective as older worker research often takes a negative approach, focusing on deficit and decline methodology (Ng & Law, 2014).

The search method included only English language articles and was limited to articles from developed countries. Articles relating to developing countries have been excluded due to their limited relevance. The search was conducted using the following sources: Google Scholar as it contains ‘grey literature’ and book/articles on workplace health, global workplace health policy and information on health and ageing; collections like Sage and Science Direct as they provide multidisciplinary and scientific full text journal articles.

Databases searched included: CINAHL, ERIC, Health Policy Reference Centre, Medline, PsycInfo, SocIndex and ProQuest ProQuest Dissertation & Thesis, DART—Europe, Global Health database, WHOLIS, Libraries Australia, Conference Papers Index, and OpenGrey as they are large multidisciplinary databases of peer-reviewed scholarly journals. Evidence based sites like Cochrane, TRIP and NHS were also searched as they bring together reliable information on the older health care workforce and the outcome effects of health promotion interventions.

To uncover the potential factors for what health means in the context of work life for older healthcare workers search terms were used that focused on what keeps older workers healthy at work. The following search terms were used: ‘older worker’, ‘ageing worker’, ‘mature worker’, with ‘occupational health*’. Each of the search terms were explored in PUBMED to find related MeSH headings and each of the Scope notes were also checked to find the most appropriate terms. Then the final search terms were modified for each search engine (see Table 2.).

The initial search terms for older health care workers have been combined with Boolean operators of ‘OR and ‘AND’ with ‘health intervention’, ‘health promotion’, ‘health program’, age-related health management strategies as the major combination of terms. The

inclusion criteria contained studies reporting on interventions aimed specifically at older workers.

To uncover the contextual socio-environmental factors the following search terms and combination were used; ‘work environment’ ‘health promoting organisation’, ‘workplace health promotion’, ‘work setting’, ‘hospital’. These have been combined with Boolean operators of ‘OR’ and ‘AND’ with ‘age*’, ‘old*,’ and ‘mature’.

Table 2. Search terms for the present study

Search Terms for Present Study
1. Older worker, ageing worker, mature worker 2. Work environment OR health promoting organisation OR workplace health promotion OR work setting OR hospital AND 1. 3. Occupational health AND 1 AND 2 4. Health intervention OR health promotion OR health program OR age-related health management strategies OR program AND 1 AND 2 AND 3 5. 1 AND 2 AND 3 AND 4

The searches were completed and an initial screening process carried out to compare titles and abstracts with the inclusion and exclusion criteria. Hasselhorn et al., (2014) found that in most scientific publications on work and health, ‘age’ has merely been regarded as a confounder to be adjusted. Articles exploring the older worker cohort in their own right were included and articles that explored ‘age’ only as a confounder variable were excluded.

Articles included in this review focused on the conditions for older worker health, the enablers of health and healthy work life and health interventions aimed specifically at older workers. Other seminal pieces of research on worker health have been included when older worker health and their wellbeing at work were a focal point to the research findings.

The body of literature focusing on retirement decision making was excluded except when the research focused on health promoting enablers for extending working life. The large body of research literature on ageing that focused solely on occupational medical diseases/illnesses and chronic health conditions e.g. heart disease, smoking and obesity were excluded, along with the large body of literature of the health impacts of shift work fatigue and sleep disturbance and mental health issues.

A total of 298 articles were identified of which 42 were excluded after reading the abstract. 170 articles were read in further detail to determine the relevance (see Diagram 2).

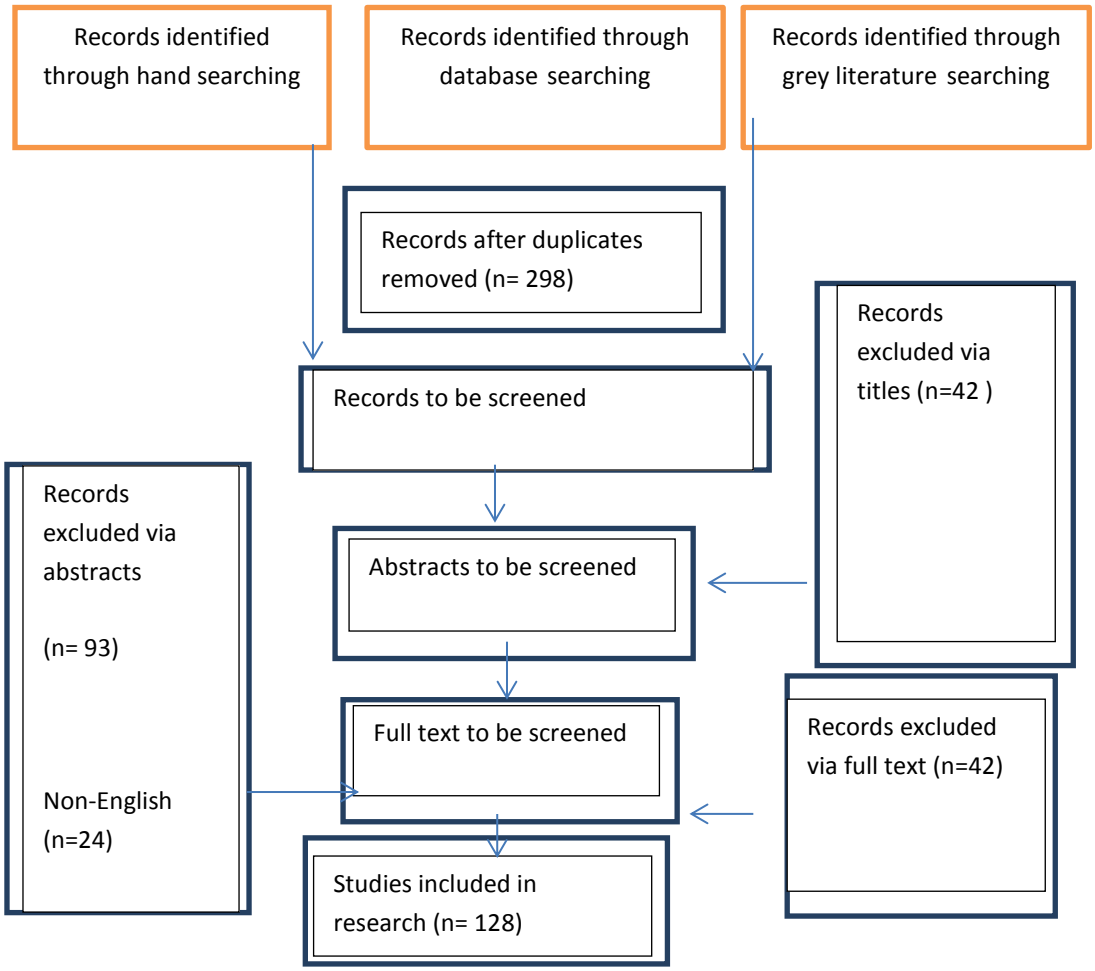


Diagram 2. Flow Chart of Search Results

In all, a total of 128 articles were deemed relevant to this project (conducted in a developed country and related to healthy ageing at work). These articles were then critically read to capture their main findings on the determinants of workplace health, its main determinants and possible workplace strategies to promote healthy ageing at work.

A narrative review of the literature indicates that for this cohort the determinants that view health and health promoting activities may differ from those that prevent ill-health or target individual lifestyle behaviour change. Older worker views may also differ from younger workers on health and work life. Contextual factors are also important in ensuring a healthier work life and the operationalisation of health promotion for older workers should

be re-examined. The literature review also found older workers' own views are underrepresented in the literature.

A thematic analysis was undertaken as it is a method for identifying, analysing and reporting patterns (themes) across data (Braum & Clarke, 2006). Thematic analysis was useful as it allowed the researcher to examine the underlying ideas, assumptions, and conceptualisations in order to gain understanding of the phenomenon in question. In thematic analysis the theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set. This research used thematic analysis as it allows active choices or interpretative work across the data set to find repeated patterns of meaning. From the review of the literature articles with key words were collated together, sorted and resorted into clusters of similar words that formed the themes that are presented below (Miles & Huberman, 1994; Baum & Clarke, 2006).

2.3. The themes identified in the literature

I was able to identify five broad themes from my scrutiny of the academic literature on what health means for older workers in their work life, as set out in Table 3. The themes aim to understand the meaning of health for this cohort in the context of their work life and how the workplace can help this cohort optimise their opportunities to improve their own health. The themes are ascribed by the socio-environmental health promotion framework developed by (Baum, 2008). This methodology broadens the traditional medical and behavioural approaches to include a socio-environmental lens to how health and health promotional work is constructed and viewed in work life.

Table 3. Themes identified in the literature search

Theme	Medical	Behavioural	Socio-ecological
Theme one	Ageing and health at work (30 articles)		
Theme two	Age management and occupational health services (26 articles)		
Theme three	Ageing, health and work ability is deficit focused (24) articles)		
Theme four			The importance of the work environment and

			older worker health (24 articles)
Theme five		Health promotion targeting older workers is defined by occupational health professionals (22 articles)	

Each theme will now be discussed in more detail.

2.3.1 Theme one: Ageing and health at work

In Hasselhorn et al., (2014) synthesis of the literature on age, health and work, they identified how older workers can experience both positive and negative effects of ageing. They found in some respects older workers to be the most skilled and productive workers but in other ways the most vulnerable. Hasselhorn et al., (2014) found older workers experienced ageing positively as personal development, wisdom, commitment to work, with more experience in social interaction and enhanced psychological and social work ability. A person's work ability is an indication of how well their health, skills and experience match the demands of their job (Naumanen, 2006). Hasselhorn (2006) explains how ageing can extensively enhance the broad and deep skills gained through a vast experience of life and work, clarifying how age can help compensate for weakened physical work ability associated with ageing. Notwithstanding, Hasselhorn et al., (2014) still ascribes the impact of ageing as declining work ability and vulnerability.

Further, Sluiter (2006) supports the workplace perspective that older workers health and work ability declines with age. Naumanen (2006) in his synthesis of the literature found work ability declines as we age due to a combination of individual, life style and work environment indicators such as heavy physical work, extreme stresses and unhealthy lifestyle. Loeppke et al, (2013) make clear there continues to be links between age and the prevalence of chronic ill health and ability to work. These approaches focus on deficit, decline and vulnerability of older workers as they age. It is not often that studies explicating the salutogenic aspects of ageing in work life are found (Kirsten, 2008).

Although, untangling the cause and effect connections between age and older worker health can be fraught, prior studies have provided some significant insights. Pitt-Catsouphes et al (2015) found over half of workers over 50 had one or more chronic conditions requiring regular management such as hypertension, diabetes and respiratory

conditions. Recent data indicates that workers over 50 are three times more likely than workers under that age to report that they are unable to work due to health problems (Adams et al, 2014).

Further, the limits imposed by ageing can be experienced negatively, just when people feel they are achieving expertise and recognition in their field, they begin to experience weakened physical work ability, including fitness, muscle strength, flexibility and a longer recovery time for illness and injury. Older workers may even experience ‘ageism’ and lower respect in the workplace and feel unnecessary or redundant (Naumanen, 2006). It was rare to find a study referring to ageing as an asset in the workplace.

The synthesis of the literature reviewed by McDermott et al., (2010) identified four specific conceptualisations of ageing at work: chronological ageing, mental ageing, biological ageing and social ageing. Literature describes chronological ageing as the linear passage of time thereby influencing other conceptualisations of ageing (Nilsson, 2015; Kunze & Reas, 2015). Mental, biological and social ageing in some literature are clustered and described as functional ageing (Nilsson, 2015; Koolhass et al., 2011).

Overwhelmingly, Costa (2005); Silverstein, (2008) found chronological ageing as the most common conceptualisation, where ‘age’ is seen as a vulnerability bringing changes to the body from a decline in brain cells to a decrease in muscle mass. Studies have shown that chronological ageing is significantly associated with a decreased work ability and early discontinuation of working life (Koolhass el at., 2011).

McDermott et al., (2010) in their extensive review of the literature found general agreement that all people age chronologically at the same speed, although, the way in which people physically age varies depending on genetics, lifestyle, health status, environment and occupation. All papers reviewed were in agreement that with ageing comes decline and diminished physical ability, slowing cognition and decreasing memory, impaired hearing and vision, and higher rates of musculoskeletal conditions (McDermott et al., 2010; Loeppke et al., 2013).

From the chronological perspective, the ageing worker is categorised by their ‘age’ with their mental and physical aspects equal to their chronological age. From this perspective age is seen to be synonymous with decline, being inevitable and related to the individual e.g. genetics and lifestyle. There is little anyone can do to influence the phenomena called

ageing (Koolhass et al., 2011). What is silent in the literature is older workers' own perspectives on the positive aspects of ageing.

The second body of literature on ageing, health and work emphasises the functional aspects of ageing and argues chronological age is not a reliable marker as the nature and extent of the decline and the effect on work performance varies between individuals (Naumanen, 2006).

Some studies have established that although some reduction in physical and mental capability and work ability is probably inevitable with age, older workers' psychological and social ability to work compensates for their declining physical work capabilities (Hasselhorn et al., 2014; 2006). Naumanen (2005) reflects older workers have more experience in social interactions with other people. The review of the current literature could not locate any further research on social ageing in the workplace.

However, there is consensus across this body of literature that in high physical demand jobs like in health care, the physical ability to work weakens between the ages of fifty and sixty years (Phillips & Miltner, 2015). Older workers experience both positive and negative effects of ageing where ageing can be experienced as affirming and fulfilling or as a weakened physical work ability, lower self-confidence and feelings of being unneeded (Loeppke et al., 2013). It would seem work organisation perceptions concentrate on the negative over the positive with older workers viewed as a liability.

What the literature search does tell us especially in the health care literature, is that the key words used to describe ageing in the literature are medically defined and illness related with a de-ability approach to health and ageing (Nettleton, 2009). The literature describes an increase in chronic conditions, loss of hearing and eye sight deterioration, increased injury rates and increased mental stress with ageing (Camerino et al., 2006). Further, the assumptions expressed are chronological ageing is seen as a 'decline' or 'deficit' with the passage of time impacting functional ageing including mental and cognitive ability, biological and social ageing (Ilmarinen & Tuomi, 2004b).

What is not contested in the literature is both the chronological and functional ageing focus on vulnerability as opposed to ageing viewed as an asset in the workplace. For the most part older workers as a group are viewed differently to younger workers (Gignac et al., 2006.) In the majority of cases older workers may be presumed to be more physically vulnerable and on the 'decline' as the natural direction for health in response to ageing.

For older health care workers there are further consequences of long term exposure to normal health care working environments that may increasingly become visible with age and influence their work ability (Silverstein, 2008).

The review of this body of literature has revealed ageing as situated in the medical model using Baum's (2008) framework where ageing is seen as a deficit and decline or vulnerability in the workplace. Overwhelmingly, the evidence suggests older workers manage their health in a different way to younger workers (Hasselhorn et al., 2014; Gignac et al., 2006; Wegman & McGee, 2004; Wegman, 1999). However, there is scant research to be found on the phenomena of ageing from a positive salutogenic perspective. The next theme explores how age is managed in the workplace.

2.3.2 Theme two: Age management and occupational health services

The dominant body of literature on workplace age management is viewed from the point of the occupational health professional (Phillips & Miltner, 2015; McDermott et al., 2010; Ilmarinen, 2006). McDermott et al., (2010) in their synthesis of the literature suggested that older workers' health may be improved by occupational health programs designed to counteract declining physical capabilities and reducing vulnerability to acute and chronic conditions. This body of literature views occupational health services and occupational health professionals as key in helping to improve older workers health at work (McDermott et al., 2010; Ilmarinen, 2006). Baum's (2008) health promotion framework locates this theme in the medical model where the health professional is expert.

From the occupational health professional's perspective employees as they get older are viewed through the lens of decline and deficit and considered susceptible to illness and therefore, less productive (Kirsten, 2008). The Finnish Institute of Occupational Health Study (2003) found in workers aged 55-65 years that 50% men and 60% of women had long standing health conditions that impacted on their work (Ilmarinen, 2006).

Carmichael et al., (2013); Ilmarinen (2006); Higgs et al., (2003) found health was one of the most noted causes in the literature as to why older workers retired early from work with approximately 17% percent of healthcare workers retiring early (earlier than they had anticipated) due to ill health. Davey (2008) suggests most of the research in the retiring early space focuses on the 'push' factors for retiring and lot more research needs to be undertaken that is uniquely related to the 'pull' factors in the workplace. Further, Davey

(2008) suggests focusing on factors that would promote health for older workers to support them staying working well past retirement age.

Occupational health services continue to focus on reducing individual health risks by health screening and lifestyle and individual behaviour change (Naumanen, 2006; Naumanen & Tuomi, 2001a) in the hope of enhancing older worker health. The literature reviewed found occupational health professionals view the world though a medical lens with a focus on illness prevention as a means of managing older worker health (Naumanen, 2006). From this perspective the medical model locates the problem of disease within the individual body. The medical view of the world examines the health of individuals in both the etiology and solution of health issues and the medical view emphasises the necessity of individuals to be responsible for their own health (Nettleton, 2009) in the hope they will be healthier and stay at work longer.

Further, llmarinen (2006) argues against the medicalisation or deficit or decline model of ageing, finding the approach of occupational health services untenable as performance differences within one age group were found to be much greater than between the age groups. The occupation health literature of older workers considers the decline of older worker's efficiency to be a result of a physical and mental degeneration process. Ilmarinen (2006) argues that chronological age is not the best way to measure performance or functional ageing. Again, little is mentioned in occupational health literature on the positives of ageing generally and social ageing specifically.

Viewing the issue more broadly, Black (2008) in her seminal research "Working for a Healthier Tomorrow" stated the issues around health and work should not be reduced to medical problems and medical solutions, necessary though they are to the solution. Black (2008) states:

> "*As a clinician, I am continually reminded of the impact of social and environmental factors on health and that when good health can best be restored by the provision of healthcare; the delivery of that healthcare needs to be sensitive to the patient's circumstances in the home, at work and in society p 8*".

Little has changed in the intervening years. Popay et al., (2003) found as far back as 1983 the World Health Organisation expressed there is little focus to educate or allow lay people to take a decisive part in creating their own health strategies as this is all too often left in the hands of professionals.

Contradictory, to her own research outcomes Black's (2008) solution to improving older worker health at work was to expand occupational health services where the occupational health professional is seen as the expert and where health problems are framed around individual choice, individual risk reduction, disease prevention and actions that target individual behaviour change.

Occupational health services promote older worker health through their own professional lens that is, treatment / risk reduction / preventing ill-health through individual lifestyle and behaviour change, rather than managing the conditions for health (Nettleton, 2009). Silverstein (2008) and Benjamin & Wilson (2005) suggest that to retain older workers, organisations will need to adopt workplace approaches that enhance the strengths and protect against the vulnerabilities of workers as they age. Loeppke et al., (2013) recommends a more individualised and holistic approach to improving older worker health. Paradoxically, occupational health professionals would be well placed to explore meaning of health in work life with older workers. The review could find no evidence of research in this space.

The above discussion has highlighted that in the workplace age management is viewed through the medical model lens of the occupational health professionals. Occupational health professionals are entrenched in the clinical/medical model where health is viewed as the absence of disease (Hunter, 2009). Occupational health professionals treat the person and often the reasons that impact the socio-environmental conditions for health and a health promoting work life are ignored and left unaddressed.

The inclusion of older workers' perceptions would be valuable for active age management at work. Crawford et al., (2010) research confirms more research is needed on older worker health. Thus, a major shift is being undertaken in this research to tap into the potential of older workers. Not many published studies have given consideration to what older workers conceive as their own notion of health in their work life. The next theme elaborates on the promotion of work ability to improve health for older workers.

2.3.3 Theme three: Ageing, health and work ability is deficit focused

Recently, age management theory concluded older workers' health and their functional capabilities were the basis for considering their work ability status (McLoughlin & Taylor, 2012). Within this body of literature 'work ability' refers to the interplay between all factors enabling an older worker to function well in a job (Kirsten, 2008) and workers' ongoing

capacity to perform their work. IImarinen (2009) refers to work ability as a worker having the mental and physical capacity to carry out whatever tasks are required in their work. When applying Baum's (2008) framework for health promotion this theme is located in the medical model where with ageing comes declining health and ability. The aim of this theme is to provide, through selective reference from an immense body of literature, a clearer understanding of the health effects of ageing and resultant work ability for older workers.

The basic notion for the promotion of work ability is the same for all age groups. Although, from the literature reviewed the concept of work ability has mainly focused on the older worker. Academic research by European countries has been mostly responsible for the development and promotion of work ability of mature age workers (Tuomi et al, 2001; Ilmarinen, 2012) and is based on four recommendations: (1) adjustments in the physical work environment; (2) adjustments in the psychosocial work environments; (3) encouraging healthy life style and (4) upskilling professional skills (McLoughlin & Taylor, 2012; Musich et al., 2009; llmarinen, 1999). The first two are focused on the work and the environment, whereas the focus of the second two is on the person. All are focused compensating for the deficits of older age.

McLoughlin & Taylor (2012) considered work ability of the older worker workforce as important because its promotion has been found to: reduce sickness, lesson the possibility of early retirement, decrease work absences, increase productivity and proficiency in the work force, and enhance the wellness and quality of life of workers, effects which have been seen to extend into retirement. Whilst the research found a positive correlation with work ability, the noticeable focus of work ability research has been on risk prevention and illness prevention, a deficit approach.

Camerino et al., (2006) agues the relationship between age and decreased work ability in the health care workforce is well established. In the health care environment when comparing ageing and health, the research suggests a corresponding increase in prevalence of chronic disease and injury with older age (Tuomi et al., 2001; Wegman, 1999; Shephard, 1999; Scales & Scase, 2000; llmarinen, 2001). Ironically, the research evidence also suggests older workers do not of necessity have considerably more sick leave despite increased illness and injuries associated with ageing (llmarinen, 2001, 2005; Benjamin & Wilson, 2005). This research seeks to understand the health needs of older

workers in their work life and how the workplace accommodates these different health needs.

The majority of work ability and ageing research focus is on deficit and decline with low work ability leading to early retirement. In the work ability literature ageing doesn't just signify an increase in ill health but also a greater risk of permanent health loss as chronic conditions typically begin in the middle years (Heikkinen, 1994; Koolhass et al, 2011). Additionally, the focus of research has been on work ability and how it has been found to decrease from around the age of 50 because of the physical requirements of work, the high level of stress, a less than healthy lifestyle and onset of chronic conditions with age (Naumanen, 2006). Again the focus has been on ill-health as opposed to the conditions for health at work.

Further, McLoughlin et al., (2012) argues that the work ability literature is now a contested space giving greater emphasis to the role that unfavourable work conditions have on the health and work ability of healthcare professionals. Where work ability is defined as a person's perception of the demands of the work environment and their ability to cope with these demands. McLoughlin et al., (2012) argues that the current concept and research on work ability emphasises the individual capacity without exploring the impact of the broader social influences on their work ability.

In the work ability literature Ilmarinen & Tuomi (2004b) found the demands of work environment include the physical and mental demands of work, support from co-workers and managers, and other organisational environmental factors. The health risks of reduced work ability and sickness-related limitations on professional performance of older health care workers are reported as caused by high physical work demands; stressful working environments and/or badly organised work (Ilmarinen, 2006; Ilmarinen & Tuomi, 2004).

In the report on 'Healthy Ageing for a Sustainable Workforce' (CoM, 2009) concerns were raised for health care workers. The report stated that normal consequences of ageing combined with demanding work processes found health care may adversely affect quality of life and health. Vickerstaff (2006) refers to health as pivotal in older workers' decisions to stay in the workforce and cites their health condition as an important determinant of older worker's continuation in the workforce past retirement age.

From a definition perspective, work ability is considered as the relationship between the resources a worker can draw on and their work demands (Gould et al., 2008). Often it is the individual that is treated however the causes or environmental factors for the individual's inability to work are overlooked and left unaddressed (Ilmarinen, 2006).

Ilmarinen (2006) found no general age dependent degeneration in physical or psychological proficiency with ageing. Rather, they found with ageing at work, within the healthy older worker the changes were in an individual's structure or makeup of their physical or mental efficiency not in the cohort as a whole. The academic literature focusing on healthy workers is under represented and limited literature has found that work ability does not change, it's the way we go about our work that is changed by the healthy older worker (Naumanen, 2006). A more productive approach to work ability research may be a refocusing from individual capacity to understanding the determinants of health for older workers in their work life. This study tries to address this gap.

Conversely, others argue the research evidence suggests that for older workers, as illness and injury increases with age, the impact on health and safety may outweigh the advantages of retaining an older workforce (Phillips & Miltner 2015). Research has shown that for this cohort, health status and their work ability are closely linked (Sheppard, 2000). Namely, for this cohort, reduced work ability is related to diminished productivity at work, increased long term illness and early non-disability retirement (McDermott et al., 2010). Although, the literature review found for work ability and early non-disability retirement, the socio-environmental component affecting retirement is often ignored and left unexplored.

The above discussion has highlighted work ability as a process of a person's resources in relation to work. Ilmarinen & Tuomi (2004b) refers to this as an individual's perceived ability to cope with the demands of work and their functional capacities (mental, physical and social resources) along with health, competence, attitudes and values (Ilmarinen & Tuomi, 2004b). The review has revealed underrepresented views in the literature: firstly the body of literature is focused on the individual as the key to improved work ability without primarily, seeking to understand older workers' own notion of health; secondly, the literature focuses overwhelmingly on the medical model and ill-health as opposed to understanding the determinants behind promoting health; thirdly, gaining an understanding from the older worker of the broader social forces influencing what it means to be healthy in their work life outside the biological makeup of the individual. The next theme explores the work environment as an important determinant for older work health.

2.3.4 Theme four: The importance of the work environment for older worker health

Using Baum's (2008) framework for promoting health this theme is located within the socio-environmental lens for promoting health. The Whitehall studies of the British public servants offered the strongest evidence in support of the claim work environments provide unique conditions that shape health outcomes (Marmot et al., 1999). These studies found that less control of the work environment was associated with higher rates of coronary illnesses, musculoskeletal and respiratory problems and mental illness. Stichler (2013) found the type of employment, the stress of the work environment, and low support from colleagues and managers affected older worker health. Another study showed that the work environment was positively correlated with mental wellness and personal development and growth (Lindfors, 2002).

The synthesis of the literature undertaken by Stichler (2013) and Wiggens & Hyrkas (2011) show the health care work environment has been actively studied in recent years especially in relation to the ageing nurse workforce. There have been numerous studies focusing on why older health care workers and particularly nurses continue to stay on at work past the customary retirement age and the importance of the work environment in retaining older nurses (Palumbo et al., 2009; Storey et al., 2009a,b; Cyr, 2005; Bell, 2006; Morsley & Paterson 2008). The literature draws attention to creating positive practice environments, leadership and job satisfaction as key socio-environmental determinants that greatly affect the health and ultimately the retention of older workers (Stichler, 2013).

The literature is replete with work environment research especially in the nursing literature although the majority of research articles undertake an extensive review of the current available academic literature (Ritter, 2011; Kirsten, 2008) rather than interviewing and meaning making from first-hand accounts. Their research identifies socio-environmental organisational factors that impact work life for example, job satisfaction, leadership and the practice environment. Radford & Shadlock (2015) in a study on older workers' intention to stay on past retirement age found that organisational factors outweighed personal factors and older work retention was influenced significantly by promoting a supportive work environment. Less well researched are older workers own meanings regarding health in work life on both the personal and environmental domains and how the work organisation can support them in sustaining their own concept of health. This research tries to address this gap.

In Canada in 2007 a systematic review of the literature was undertaken to ascertain the progress made on creating healthy work environment in Canadian health care (Shamian & El-Jardali, 2007). The research concluded that while some work had been done at the organisational level, there was little evidence to suggest that conditions for nurses and indeed other health care professionals had actually improved.

Even though, it is in the field of nursing where research on healthy workplaces has been the greatest (Shamian & El-Jardali, 2007), the health outcomes have not changed as the nursing profession is still plagued with high levels of sickness absence, back injuries, and staff turn-over, as hospitals continue to cut costs so they can achieve their financial targets (Shirley, 2006). Although, research continues to concentrate on improving these poor outcomes via improvements to nursing work environments (Ritter, 2011); the research focuses on managing risk rather than the conditions for health in work life. This research desired a new perspective for this already well researched topic, by seeking to understand the phenomena of ageing, health and work life from a health promoting socio-ecological perspective.

Within health care organisations the focus has shifted from improving work environments per se to improving the safety culture and safety systems of work (Halligan, 2011). Ritter's (2011) synthesis of the literature found the work environment impacted directly on patient safety finding unhealthy work environments resulted in increased safety occurrences. This refocusing of research from work environments to safe systems of work to reduce risk by reducing human error reflects the extent to which the repositioning of the work environment has taken place. The research focus is firmly on individual behaviour change to improve safety and reduce risks (Lindberg et al., 2008) over taking a broader socio-ecological approach. This concept around safety culture has significant implications, as there is still a paucity of research on the conditions that make a health promoting work environment as opposed to the conditions to make work safer and thus more favourable.

Black's (2008) UK Government review of *Working for a Healthier Tomorrow* found the working environment itself was a major bearing on older workers' intention to stay past retirement age. Kirsten (2008) identified the characteristics relating to the job older workers do are extremely important in terms of satisfaction, reward, and control. Thorsen et al., (2012) established that an unhealthy psychosocial work environment impacts the health and work ability of employees, along with Holt-Lunstad & Smith (2010) identifying the perceived social/relational environment as a well-established determinant of well-being

for the older worker cohort. Boumans et al., (2008) found the line manager was key to the retention of older workers and can lead to good health, well-being and improved performance. Stichler's (2013) research established line managers have a role in supporting people with health conditions that impact their ability to carry out their work responsibilities and adjust responsibilities where necessary. Janssen & Osinga (2002) found the quality of the relationship between leaders and team members is positively correlated with a greater commitment to the organisation by older workers and negatively correlated with their tendency to retire early. Sutinen et al (2005) identified negative associations between perceived management fairness and retirement thoughts and preferences.

The managers' attitudes were found to be especially important in respect to influencing older workers decreasing work ability. Kirsten (2008) reported role conflict, fears regarding making mistakes, inability to control one's work, the lack of feedback, appreciation and professional development as strong determinants of work ability. The literature reviewed reveals a fundamental link between a positive workplace culture and the way managers relate to older workers in health care environments (Ritter, 2011; Moen, 2007). A positive work environment is essential for the retention of our older healthcare workers.

Older workers commonly cite management or leadership as the reason and basis for leaving. Exiting the work environment is seen as the only option left in order to ensure workers' self-preservation (Barros et al., 2015). Moen et al., (2015) found that organisations still focus on developing generic one-size fits all HR policies and that this portends an unfortunate loss of older worker talent, skills and local knowledge. Understanding the determinants for health in work life of older workers from a salutogenic perspective may help shift the focus to a broader socio-ecological perspective of healthier work environments (Hanson, 2007).

Finally, health and well-being in our work life is not just a medical issue (Black, 2008). There is clearly serious need to consider what a healthy work life means for older workers from a socio-ecological viewpoint (Kirsten, 2008) rather than staying with the current focus on modifying human behaviour for both employees and their line manager. The current approach also fails to break the mould or shift the paradigm by neglecting older workers' own views on how the organisation can support their notion of a healthier work environment. New research needs urgent attention on the socio-environmental

determinants taking a ‘salutogenic’ approach that focuses on health potential rather than on the factors that cause disease (Kirsten, 2008).

The current review of the literature highlights the importance of the work environment as a socio-environmental determinant in promoting older worker health. However, the academic literature still focuses on unhealthy work environments e.g. eliminating safety risks and changing individual worker and manager behaviour. Despite the evidence that promoting healthier work environments improves health, particularly evidenced in the nursing profession, little has changed to tangibly improve the work environment for older workers (Ritter, 2011). The next theme explores targeted health promotion for older workers in the work setting.

2.3.5 Theme five: Older worker health promotion is defined by occupational health professionals

In western societies, the workplace is perhaps the greatest influence on health after the family. In fact, for older workers, the workplace may play a larger part in determining health into the future (Pitt-Catsouphes et al., 2015). As we are now living decades past current retirement age, having a job past current retirement age may influence an individual’s economic status and thus their health status in older life (Pitt-Catsouphes et al., 2015). It is the purpose of this review of the literature to identify health promotion targeted at older workers in the work setting. This theme is located with the behavioural lifestyle lens in Baum’s (2008) framework for promoting health.

The current review of the literature reveals that for this cohort, occupational health professionals’ view and give meaning to health in a particular way. Through the occupational health lens, health is seen as a problem that lies within the realm of individual behaviour and individual life style choice (Cheek, 2008). The emphasis for health promotion is towards preventing, minimising, eliminating health hazards at the workplace, undertaking individual health risk assessment and reduction programs aimed at individual lifestyle and behaviour change (Naumanen, 2005, 2006).

Many organisations are considering or are already involved in health promotion activities with the goal of decreasing absenteeism, improving the organisations’ image, reducing turnover, increasing productivity, and generally contributing to the wellbeing of employees (Crawford et al., 2010). Emphasis has been placed primarily on the individual’s

responsibility for adopting lifestyle behaviours conducive to preventing the major causes of death such as coronary and respiratory disease.

In the older worker cohort Strijk et al., (2009) is one of the few researchers targeting older worker health promotion interventions. This lifestyle and behaviour change intervention is aimed at changing behaviour, improving the vitality and health and ultimately prolonging the labour participation of this cohort. Although this intervention is one of the few targeting older workers it was aimed solely at improving vitality/health by a life style intervention e.g. exercise, nutrition and yoga. This focus on lifestyle change interventions has met with some success, although not to the degree anticipated as participation rates have been low. Reduced success may be because of different individual understandings of health and their contributing behaviours and individual preference for health promotion strategies (Cheek, 2008).

Naumanen (2006) suggests both the worker and the workplace perspective are important in promoting older worker health. Health promotions' aim from this perspective is to maintain and promote older workers' work ability and to develop working methods within the work environment to reduce risk and ill-health (Naumanen-Toumela, 2001a; Naumanen, 2006).

Most of the research undertaken describes health promotion needs for ageing workers from an occupational health professional's viewpoint (Naumanen, 2006). Questionnaires designed by occupational health professionals undertake research with occupational health professionals as the study participants, researching older worker health needs. The outcomes of these studies on health promotion needs of older workers reveal that an older worker is defined as a mature worker with health promotion defined as the early prevention of health hazards (Naumanen 2005). These types of studies reveal validity concerns regarding, once again, the occupational health professional as the expert and holder of the expert knowledge regarding this cohorts' health needs.

In one of the few studies researching older workers' views, Naumanen (2005) developed a model of health promotion based on older workers feedback. This type of study is rare in this body of literature. The study found although health promoting factors in both individual and work environment were well described by older workers, they also found identifying the factors did not guarantee actual adherence to health promoting behaviours in either their personal life or at the workplace. A limitation of this study is that the questionnaire

was based on the earlier findings from research with occupational health professionals (Naumanen, 2005); their lens formed the representation and construction of the health promotion questionnaire.

Naumanen's (2006) extensive review of the literature revealed that for this cohort the popular health promotion applications are aimed solely at programs assessing and reducing a worker's health risk, lifestyle and behaviour change. Improvements to a worker's health could be made through positive changes to living habits, attitude, lifestyles, relationships and by developing professional skills. Other essential factors for workers to remain healthy in the workplace are individual workplace agreements, being valued, a good work atmosphere and supportive leadership, co-operation and the opportunity for professional education (Naumanen, 2006). Health promotion has ignored the work environment to date.

Health Promotion policies reflect organisations' desire to help people work longer and be healthier. Policies can be realised by either influencing the frames of people's lives and activities or their behaviour that is as Vallgarda (2001) states they try to 'conduct their conduct'. Older workers must adjust their lifestyle choice to maintain fit for work status.

If health promotion is the '*process of enabling people to increase control over the determinants of their health thus to improve their health'* then the occupational health professional perspective may be missing critical evidence, that is older workers' own notion of health. Furthermore, MacDougall & De Leeuw, (2007) argue that organisations require a 'new culture of organisational management' where health promoters work with individuals to unlock their capacity to help change the way health promotion works. This research study endeavours to address this gap.

The ecological model of health promotion has been evident in the literature for decades although it has mainly focused on health problems rather than promotion of health that is, moving toward a 'salutogenic' perspective on what creates healthy individuals, and the communities they live (Dooris, 2009). The literature review found a void in health promotion research on what health means from the salutogenic perspective. This study tries to address this gap. As Kickbusch (2003) has echoed, this means a shift in focus from the deficit model of disease to understanding the health potentials inherent in the social and institutional settings of everyday life including work life.

Health promotion has become a contested space for the older worker cohort. A number of studies have found older workers were more likely to resist employers interfering with their health arguing lifestyle is a personal matter (Robroek et al., 2012). This mode of implementation has raised concerns about employer paternalism overruling employee autonomy and potentially invading their privacy (Carter et al., 2011).

Older worker health promotion participation levels are low and older workers were found to be more resistant to health promotion than younger workers although no statistical significance was found between older worker health and unhealthy lifestyle (Crawford et al., 2010). Further, evidence suggests older workers take care of their health differently compared with younger workers (Gignac et a.l, 2006). McDermott et al., (2010) recommends that health promotion interventions need to embrace a life course perspective to better address older workers' health, well-being and work ability.

The literature is nascent with research focusing on workplace health promotion constructed by occupational health professionals concentrating on risk reduction and lifestyle and behaviour change. Despite this, research on promoting health from the perspective of health promotion activities that target older workers' own notion of health are rare. Therefore, future interventions need to be tailored to strategies used by different age groups to look after their own health. A review of many interventions found older workers received the same intervention as younger workers (McDermott et al., 2010).

There has been little research on older worker health promotion from a broader socio-environmental perspective. Further, there has been little health promotion research that looks at older worker health from a salutogenic perspective of promoting health rather, research usually has a problem focus approach of reducing ill-health. Kirsten (2008) describes health promoting as 'the process of enabling people to increase control over the determinants of their health thus to improve their health'. Few studies have examined older workers' own experience of health, what it means to be healthy at work and how the workplace can best support older workers maintain their notion of health at work.

Occupational health professionals have high-jacked health promotion and orientated health promotion in a particular way they view and give meaning to health, that is individual behavioural and lifestyle change. Further, it is evident that theorists have difficulty in providing a common notion of health for this cohort as the meaning of health remains divorced from the setting in which the meaning is constructed. It is both possible

and important to unmask the meaning of health from older workers themselves. Capturing the employees' perspectives of health may help address the gap in current understandings of health in work life for older workers.

2.4. Purpose of the Study

In the older worker health and health promotion literature there has been little research undertaken from a salutogenic perspective where age is seen as a strength and resource for health in work life. Looking at health through a salutogenic lens may shed light on the health promoting possibilities available in work life not made visible before. Further, there has been scant research applying a salutogenic overlay to illuminate the broader socio-ecological context where relationships and meanings and the interplay of people and their socio-environmental setting are considered. Most of the research literature uncovered found health firmly embedded in the medical and individual lifestyle change literature with the health professional as expert and ageing was seen as deficit and decline.

To date, much of the research on ageing, health and health promotion is quantitative, cross-sectional, survey design where age is a variable. Where a qualitative approach has been undertaken much of the research has been descriptive and through the lens of the 'expert' occupational health professional. This research seeks to address this gap by seeking to understand older workers' own notion of health in the context of the work setting. There is a lack of the 'lived experience' research within the older worker cohort.

This research will focus on gaining a deeper understanding of older workers' own experience of health in their work life to inform theory development in health promotion for this cohort. Based on the results, findings of the review of this research contributes to filling an identified gap in understanding older workers 'health in work life' and how the organisation can better support promoting health for this cohort.

2.5. Conclusion

Most of the literature relating to older worker health in work life is located in the medical/ behavioural literature focusing on the individuals' own behaviour and lifestyle change. Further, workplaces focus on risk reduction where individuals are responsible for reducing/eliminating non-health behaviours. In addition, there is little research on older worker health from a salutogenic viewpoint where age is seen as a resource for health. A limited body of research concentrated on the importance of the work environment as a

setting for promoting health and where the literature advocated a socio-environmental lens, it mainly focused on the economic factors that impact health.

The major gaps in the literature are fourfold: there is scant research on older workers lived experience of health in work life; there is little research on the contextual factors including the environmental, social, economic and political influences affecting older worker health in work life; there is limited research from older workers themselves on health promotion strategies that would help them improve their own notion of health in the workplace and lastly, there is inadequate research on what the organisation could do to support older workers maintain and promote health in work life.

Chapter 3: Epistemology, Methodology and Methods

We can absolutely not rest content with mere works…..….we must go back to the things themselves (Husserl, 1982, p.252).

3.1. Introduction

The previous chapter explored the literature to determine current academic perspectives on older worker health in work life. The research objectives and associated questions were developed from the identified gap in the literature on older worker health in work life.

The research objectives were:

1. To explore older health care workers' experience of health in their work life.
2. To explore older health care workers' prerequisites for health promotion to help ensure health develops and is preserved.
3. Theorise about this phenomenon and gain understanding for promoting healthy ageing at work.

The knowledge base in this domain is limited and the answers are incomplete. We have insufficient information regarding how ageing workers perceive and think about their health in work life and how the workplace as a setting can promote health and how health promotion can impact and support them to take good health into post work life.

The overarching research question 'What is the experience of older workers about health in work life?' was investigated to address the gap between what is known about the meanings of health for this cohort and understanding the workplace determinants of health for older workers and how this knowledge is incorporated into health promotion needs in healthcare organisations.

In addition to the overarching research question three additional questions were developed from the major themes considered in the research literature that provided the focus for the empirical research design:

1. How do the contextual factors affect their health, e.g. environmental, social, political, and economic?

2. What health promoting activities help older health care workers achieve or maintain health in work life?
3. What could the organisation do to help participants maintain and promote health in work life?

Before outlining the methods used to address the research questions, this chapter outlines the research's underlying theoretical perspective to set the context within the specific research methods chosen. Following this, the research methodology presented leads to a detailed description of the methods used for data collection and analysis.

An overview of the theoretical framework and the questions each address is provided in Table 4.

3.2. Theoretical framework

Fundamental to the epistemology of this research is social constructivism and interpretivism phenomenology. Crotty (1998) suggests the theoretical perspective forms the ground from which the methodology is selected. The theoretical perspective according to Crotty (1998) is "the philosophical stance informing the methodology and thus providing a context for the process and grounding of its logic and criteria" (p.3). In this study, older workers' 'lived' experience of 'health in work life' is explored within the context of a healthcare work environment.

Table 4. Provides an outline of the theoretical framework adopted to provide clarity of understanding.

Table 4. Theoretical framework and research questions

Epistemology	Constructionism	Research Questions
Theoretical Perspective	Interpretivism Phenomenology	Research objectives
Methodology	Phenomenological Research	Q 1
Methods	• Focus Groups • Follow-up interviews • In-depth Interviews	Q 1,2,3, &4 Q 1,2,3, &4 Q 1,2,3, &4

Underpinning the conduct of this research, constructionism was adopted as the research epistemology. This epistemology has two fundamental principles. The first being, knowledge is not just passively received through the senses or by way of communication, but is actively construed by the knower (Cresswell, 1998). The second, the function of

knowing is adaptive and serves the subject's organisation of the experiential world through social interaction (Richie & Lewis, 2003).

An appropriate framework for this study is constructionism because the focus of the research design is to understand how older workers construe something within their experiential world, namely their 'health in work life'. The subject in this particular research project is *older workers*, and the interactive construct is *health in work life*.

Participants in this study draw on their personal background and knowledge to make sense of their world (Hughes & Sharrock, 1997) where the process of constructing meaning is subjective and active. Crotty's commentary on constructionism harmonises with this view of the construct older workers' health in work life:

> *There is no objective truth waiting for us to discover it. Truth, or meaning, comes into existence in and out of our engagement with the realities in our world. There is no meaning without a mind. Meaning is not discovered but constructed. In this understanding of knowledge, it is clear that different people may construct meaning in different ways, even in relation to the same phenomenon (Crotty, 1998, pp. 8-9).*

Constructionism is a broad epistemology and within its theoretical perspective is Interpretivism. This approach 'looks for culturally derived and historically situated interpretations of the social world; it is the study of the social action to which people attach subjective meaning' (Crotty, 1998 p. 67; Yanow, 2000). The theoretical perspective of interpretivism allows the researcher to gain access to the 'meaning' behind peoples' actions (Crotty, 1996; Yanow, 2000). The research for meaning is catalytic to the construction of older worker's health in work life.

Phenomenology was chosen as a methodology for studying older worker health in work life as it studies the lived or existential meanings that have shown themselves to individuals (Van Manen, 2014). It is in the framing of the question where the approach to both the epistemology and methodology become clear (Crotty, 1998). In this inquiry, the phenomenon was 'health in work life'. The people were healthcare workers.

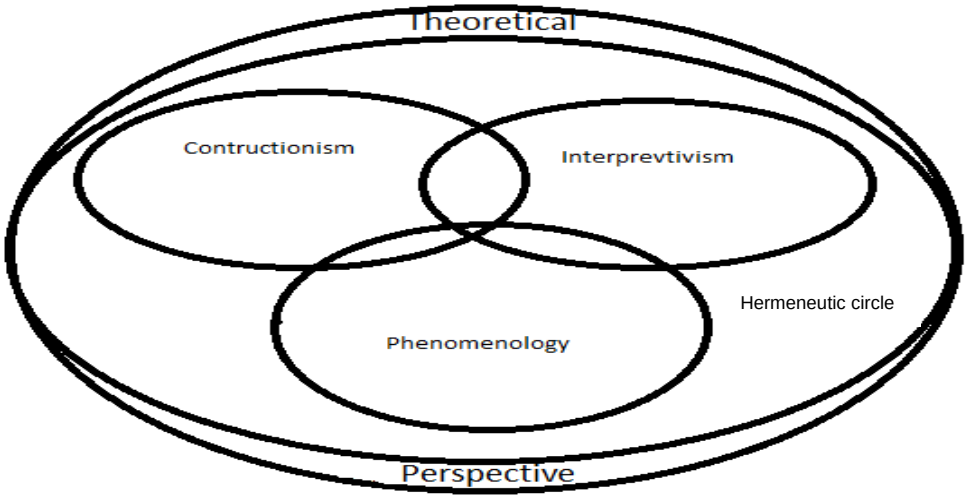
Hermeneutical' and 'interpretive' phenomenology are used interchangeably (Patton, 2002) but the term interpretive is more accessible. In this research project I will use the term 'interpretative' phenomenology and the hermeneutic circle where the researcher participates in making data. In phenomenological research the researchers do not acquire

new knowledge but come to interpret the phenomenon and gain a deeper understanding of what was already in the world.

The Hermeneutic Circle is defined as “A process of analysis in which interpreters seek the historical and social dynamics that shape textual interpretations” (Kincheloe & McLaren, 2000, p. 286). The process of being in the hermeneutic circle is an engagement in weaving to and fro, studying the parts in relation to the whole and the whole in relation to parts. It is this give and take with the circle that provokes a researcher “to review existing conceptual matrices in light of new understandings” (Kincheloe & McLaren, 2000, p.286).

One is always within the hermeneutical circle of interpretation. By virtue of their common culture and language both the researcher and research participants are viewed as sharing common practices, skills, interpretations, and everyday practical understanding (Ray, 1994). The discipline and intent of the hermeneutic circle is to “avoid projecting one’s own world onto the world of another” (Benner, 1994, xviii). Staying open to the text can reveal “blind spots, mysteries and otherness” (Benner, 1994, xviii). Diagram 3 is adapted from Benner (1994) and outlines the specific theoretical perspective nestled within the overall research project.

Diagram 3. Adapted from Benner (1994). Theoretical perspective



3.3. Rationale for Methodology

According to Kerry & Armour (2000), “it follows that research claiming to use a phenomenological approach must make explicit the ontological assumptions upon which it

is based" (p. 8). Heideggerian phenomenology (1962) or the interpretative approach was embraced in this inquiry for two reasons:

First, whereas, Husserl (1982) would have one attempt to bracket preconceived notions of biased suppositions about health in work life, Heidegger supports the belief that the researcher's history and understanding – in this case 'health in work life' is an important part of the findings (Parsons, 2010). Heidegger says we are self-interpreting, self-defining beings and every encounter entails interpretation based on personal history, in its 'historicality' (Heidegger, 1962). There must be an attempt to reconcile the presuppositions and historicality of the researcher and the participants' presuppositions and historicality.

The second reason an interpretative approach is being used is Heidegger's hermeneutic circle. The hermeneutic circle parallels the visual images of the socio-ecological framework discussed in the Introduction. This circular image seemed to be meaningful, not just a coincidence – nor an accidental thread. As was referenced in Baum (2008) in Chapter 2, on the socio-environmental framework of health promotion, the circle expresses the interaction between people and their environments (p. 204). Heidegger (1962) calls it the "circle of understanding" (p. 195). The hermeneutic circle does not allow a researcher to remain aloof or outside the inquiry. It invites one into the inquiry. The researcher becomes part of the circle as do the participants. The hermeneutic circle also allows the researcher and the participants to wander, ponder, gather, and to re-enter, at varying points on the circle. This approach, method, or philosophy fits an inquiry about older worker health in work life.

Ray (1994) sums up "the hermeneutic-phenomenological tradition or interpretative approach as ontological; a way of being in the social-historical world where the fundamental dimensions of all human consciousness is historical and socio-cultural and is expressed through language (text)" (p. 118). The language of older worker health in work life was heard through the hermeneutic circle.

3.4. Research Design

This research aimed to add a new viewpoint on older worker health promotion needs in healthcare organisations. A key determinant in deciding what research design to use is found in the research questions that ask how individuals experience a situation and how they give meaning to their experiences (Newman et al., 2010). The qualitative approach

used in this study allowed exploration of the meanings older workers attributed to their health in work life, their perspective, and their 'lived experiences'. As Burr (2003) notes, social constructionist meaning comes into being in, and out of human interaction, and more importantly becomes a tradition and culture through human interaction. Barkway (2001) places emphasis on the hold our culture has on us, explaining how it shapes the way we see and feel things providing us quite a definite view of the world.

Constructionism invites us to examine the phenomenon itself 'health in work life' as opposed to the subjective descriptive knowledge by older workers of the phenomenon, that is, how older workers think about 'health in work life' (Hughes & Sharrock, 1997). By focusing on the unique subjective experiences of a phenomenon one might miss that meaning is not largely constructed by individuals as they encounter a phenomenon one by one; instead the phenomenon is socially constructed (Barkway, 2001). That is, 'health in work life' is socially constructed – the culture shapes the way in which we see, feel and understand the phenomenon itself - giving us quite a definite view of the world (Richie & Lewis, 2003).

The major elements and assumptions of the phenomenologist worldview (Kincheloe & McLaren, 2000) that were incorporated into this research include:

- That individuals seek understanding of their world and that they develop meaning of their experiences through *interactions with others*;
- That participant meanings are multiple and layered; and
- That reality is co-created by the participants and the researcher and that the researcher is a part of the world they studied and the data they collect.

The theoretical perspective of phenomenology adopted in this research design provides conceptual clarity for the analysis of the various themes that were identified in the literature review. Five key themes from the analysis of the literature underpinned and informed the qualitative research:

1. Ageing and health at work
2. Age management and occupational health services
3. Ageing, health and work ability is deficit focused
4. The importance of the work environment in relation to older worker health

5. Health promotion targeting older workers is defined by occupational health professionals.

Interpretative phenomenology as a research design invites us to ‘critically examine’ (Crotty, 1996; Burr, 2003) the phenomenon ‘health in work life’ and allows us to examine our social constructions of ‘health in work life’ and free ourselves from the constraints of culturally derived understandings and to view things anew, or as Merleau-Ponty (1962, viii) suggests, to slacken “the intentional threads which bind us to the world”.

The use of phenomenology is suitable as it allows for in-depth descriptions of phenomena as lived experience to be collected in new and unexplored areas. As older workers are the largest cohort of our health workforce in Tasmania it is imperative to understand, support and promote their understandings of health in work life. Newman et al., (2010) commented that ‘fidelity to interpretative phenomenology’ is made difficult by the absence of a given method for conducting phenomenological research. They suggested the researcher is therefore required to use methodological approaches that are congruent with and operationalise the philosophical underpinnings of phenomenological research.

3.4.1 Sample

In interpretivist research, the researcher is highly involved in collecting and analysing the data (Cresswell, 1998; Denzin & Lincoln, 2000). Interpretative studies are generally concerned with issues of interaction and meaning (Blumer, 1969). These two elements of interpretative analysis provided the basis for a two-stage approach to the interpretation of the research.

Firstly, original experiences regarding the phenomenon of interest were collected from older healthcare workers through focus groups. One hundred and seventy-one (171) participants both female and male participated in thirteen focus groups across both rural and regional healthcare sites. Participants included nursing, allied health professionals and healthcare management staff. Secondly, a focus group method was chosen to examine the lived experiences of ‘health in work life’ in the context of a shared work environment and culture.

In addition, five of the focus groups’ participants were followed-up with further discussion on the summary narratives. These participants wanted to strengthen some potential actions identified in the focus groups. Further, three semi-structured one-on-one interviews

were employed to discuss and interpret the data gathered, identified themes and suggested potential actions. The semi-structured one-on-one interviews offered an opportunity to funnel the responses helping to achieve a consistency between the direction of the research, the data collection and the data analysis as regards the overall interpretative paradigm for the study (Blumer, 1969).

As is standard with phenomenological research study participants were selected using a purposeful sampling technique (Patton, 2002 p. 58). This meant that they were included due to their involvement with and knowledge of the topic under investigation. Health care workers in this study they were employed in regional and rural sites in Tasmania, Australia. The inclusion and exclusion criteria for participation were as follows;

Inclusion criteria:

- Currently employed in the organisation either part time or full time
- Fifty-five and over
- Working as a health professional e.g. doctor, nurse, allied health and/or health manager.

Exclusion criteria:

- Under 55 years
- Working as a contractor in the organisation
- Domestic, administration or manual worker

The Tasmanian Health Service (THS) newsletter carried an invitation to participate in the study. The newsletter was emailed to all employees. This invitation included a short summary of the study and what was required of focus group participants (Appendix 1). Employees who met these criteria and were interested in taking part in the discussions were asked to contact the researcher via email. Consent to participate form was sent out via email and potential participants were requested to sign and return the form via email if they wanted to participate in the research (Appendix 2). From this process focus groups were held on 13 healthcare sites with 154 participants putting their names forward. A total of 171 participants attended a focus group including staff that wanted to participate on the day.

From this process saturation of data was attained within the first four focus groups and common themes were found consistently reoccurring and were confirmed during the semi-structured interviews (Patton, 2002). Further, three healthcare workers put their names forward for one-on-one semi-structured interviews instead of attending a focus group. By happenstance, they were from nursing, allied health and health management areas. Again saturation of data was reached with the three semi-structured one-on-one interviews. Again, I checked in regularly with my supervisor and research support team to discuss saturation point in the data collection stage.

3.4.2 Instruments

An informal interview guide was developed as a flexible framework for questioning and covered the research objects. The following areas were explored with the participants:

1. How older workers define health in work life?
2. How the work environment supports health?
3. Understand how the contextual factors affect their health, e.g. environment, social, political, economic?
4. The underlying workplace determinants of health.
5. What health promotion would support older workers achieve or maintain health in work life?
6. Theorise about this phenomena and gain understanding for promoting healthy ageing at work.

Immediately, post each focus group and semi-structured interview the researcher drew out concepts, captured the narrative including the perceptions, thoughts, feelings and impressions of the material discussed.

When the summary narrative was sent to each participant the researcher ‘checked in’ with each participant on the following:

1. Does the narrative fit with their meaning of health in work life?
2. Does the narrative fit with their experience of health in work life?
3. Are there themes that reveal themselves as you read through the narrative?
4. Are there any parts of the narrative that they would like to change?
5. Are there any parts of the narrative that they would like to delete?
6. Are there any parts of the narrative that they would like to more fully elaborate on?

7. Having read the narrative are there any additional areas of their experience of 'health' in work life that they would like to tell me about?

An example of one summary narrative from Focus Group 4 is in Appendix 3.

Further the researcher kept a personal journal for reflection including written notes following interviews and throughout the data analysis process.

There were one hundred and seventy four participants in total with one hundred and seventy one in the focus groups:

- 111 Nurses – nurses, CNC's and CNE's;
- 32 Allied Health professionals;
- 24 Healthcare Managers;
- 25 were from rural sites;
- 12 were male the rest female;
- 6 volunteers – retired nurses.

3.4.3 Methods

Focus Groups

The focus group method gave the opportunity for participants to share and compare different experiences and perceptions that would not have been accessible without group interaction. In a constructionist view of the world the culture shapes the way in which we see, feel and understand the phenomenon itself (Yanow, 2000). A phenomenological approach was undertaken to try and understand the meaning our staff give to their health in work life and how best the workplace can support staff in promoting their own understandings of health and wellbeing at work.

Morgan (1997) stated that through group interaction "the researcher is able to observe how participants respond to each other, providing agreement and disagreement, asking questions and giving answers" (p.20). This approach gave the researcher the opportunity to collect direct evidence on how the participants themselves understand their similarities and differences or consensus and diversity regarding health in work life at work.

The focus groups were conducted by the researcher at a location convenient to the participants and were conducted in an informal atmosphere and format. A semi-structured

interview guide was used to encourage participants to feel free from constraints and to hear the interests of the participants themselves – the participants were encouraged to express their views openly and spontaneously. The numbers in each group ranged from ten to eighteen members and each group ranged from 60 to 90 minutes. There were 13 groups in total. At the beginning of each focus group the Information Sheet and Consent Forms were revisited.

The focus groups were not taped as it would have been too distracting, both to me as the researcher and to others if audio clarity was to be ensured. A research assistant was assigned to sit quietly at the back of the room to take notes on what was said, turn taking, nonverbal body language, long pauses, and intense agreement or disagreement.

I also noted key phrases during the formal conversations and transcribed these from memory as soon after each focus group conversation (Yanow, 2000). I kept a daily log in which I recorded meetings, encounters, physical details, and other observations. I wrote my inferences, impressions and feelings there, too, careful to identify these by keeping observational and interview data separate from the inferences I made based on them (Yanow, 2000).

Some potential sampling advantages of focus groups are that they can encourage participation from those who are reluctant to be interviewed on their own (Cresswell, 2014). Conversely, sometimes in the focus group situation participants can be wary, nervous, reluctant or awkward in talking in front of others (Morgan, 1997).

For the purposes of this study the focus groups were designed to be face-to-face and the semi-structured and questions were open-ended allowing the interviewer the opportunity;

> *To build a conversation within a particular subject area, to assist in facilitating the flow of the interview, to word questions spontaneously and within context, and to establish a conversational style (Patton, 2002, p.283.)*

Within this context, focus groups used explicit group interactions as part of the method (Morgan, 1997). In this context instead of the researcher asking each person to respond to a question in turn, people were encouraged to talk to one another to ask questions, exchange anecdotes and comment on one another's experiences and points of view (Cresswell, 1998). The purpose being to:

obtain descriptions of the life world of the interviewee with respect to interpreting the meaning of the described phenomena (Van Manen, 2014).

The older workers were given time to build upon the observations of others and build on the articulation of the points and concepts provided by others in the focus group. The structure of the interview guide allowed a free and flowing interaction amongst participants and facilitator. Establishing an atmosphere of trust and openness with all participants was important (Morgan, 1997). The focus group participants were encouraged to express their views openly and spontaneously giving voice to ideas, concepts and threads (Patton, 2002; Casey & Kreugar, 2000). The summary points provided by the data were agreed and recorded.

On completion of each focus group the researcher asked the participants if they would be interested in participating further in the study by receiving the summary narrative to check on the meanings the researcher took from the focus group. This process referred to by Van Manen (1990, p.99) seeks to answer the question "is this what the experience is really like?" If participants were interested in follow-up they were to leave their contact details with the researcher at the closure of the session. All participants wanted to receive the narrative via email. This process also assisted to minimise researcher bias.

By undertaking focus groups, the various understanding of health in work life from older worker perspective were heard, explored and represented with the aim of developing context specific health promotion program options (McDaid et al., 2005). This method is in harmony with the study's interpretative design.

Focus group follow-up

In interpretivist phenomenology the decision to use multiple interactions instead of a single focus group was based on advice gleaned from Benner (1994). She notes multiple interactions and observations allow for the emergence of patterns and themes and can help to reveal contradictions and surprises which might not have presented themselves in the first interview (Benner, 1994, p. 99). Merleau-Ponty (1962) describes it as often "what is said in interviews is different from what is meant" and it's important to follow up and clarify. In the follow up conversations the researcher sought to deeper understand their experience of health in work life in the context of work and what meaning the interviewee gave to their experience. Appendix 4 is an excerpt of one follow-up conversation regarding the narrative from Focus Group 4 (4aa).

Semi-structured one-on-one iinterviews

Three semi-structured interviews were conducted by the researcher with staff who wanted to participate in the research and sought more individual flexibility than a focus group, seeking a one-on-one individual interview format. The interviews were conducted between February and April 2015. Semi-structured one-on-one interviews allowed for deeper exploration with older workers on what health in work life means, the contextual factors contributing to older worker health in work life and how health promotion could be operationalised to promote health in work life for this cohort. Developing context specific health promotion options that would work in the health care work environment were discussed. The interviews focused on the emerging themes from the focus group data and were used as supplementary data (Liamputtong, 2009).

The emerging themes for older workers were the following:

1. Health in work life means work and life balance and work flexibility.
2. The concept of social ageing as strength and building a sense of community and social connectedness at work is essential to older workers' health.
3. A healthy work environment is a health promoting work environment.
4. Older workers' participation is the key to successful health promotion planning.
5. Humanistic managers are key in creating healthy organisations.

This supplementary data provided deeper insights into the meaning of 'health in work life' for older workers and provided a rich and detailed set of data about perceptions, thoughts and feelings, and impressions of people in their own world (van Manen, 2007) regarding 'health' in work life.

Qualitative research often uses interviews for data collection. In interpretivist phenomenological interviewing, the participant is at the centre of the interview (Patton, 2002). In interpretivist interviewing, the interview process acknowledges the meaning making experience and as a place for creating knowledge through the active collaboration of the interviewer and the interviewee (Holstein & Gubrium, 1997).

Interpretivism emphasises the dialogue and mutuality of the interview as characteristic of the research experience (Patton, 2002). It is about "the establishment of human-to-human relationship with the respondent and the desire to understand rather than explain" (Fontana & Frey, 2005, p.706). The quality of data is construed in the interview through

the interviewer's use of self, relationship building, the awareness of the flow of conversation, and understanding the theoretical and professional positions as well as the research question. "The skilled interviewer uses his or her person to communicate with people to create stories" (Nunkoosing, 2005, p698).

At the conclusion of the interview the narrative was derived from the transcription as Caelli (1991) explains "the narrative is different from the transcript" (p. 277) and "if you wanted participants to clarify and validate the data from the interview transcripts, those transcripts had to be reduced to narratives to focus on the central matter of the interview" (p.279).

Caelli (1991, p.274) states, that only after immersion in the data, many episodes of trying to make sense of the words does a realisation start to form, frequently data gave an "atmosphere". Multiple interviews allowed the story to be derived from the interviews "deriving narrative from transcript" (Caelli, 1991, p.278).

During each stage of data collection, the narrative derived from the interview transcription was given to each participant so that they may review the findings to determine whether it presented as a valid reflection of their experience. This process allowed participants to clarify, modify, include and add any new data they felt important (Patton, 2002).

Again, the same process was followed as with the Focus Group participants; when the summary narrative was sent to each participant the researcher 'checked in' with each participant on the following:

1. Does the narrative fit with their meaning of health in work life?
2. Does the narrative fit with their experience of health in work life?
3. Are there themes that reveal themselves as you read through the narrative?
4. Are there any parts of the narrative that they would like to change?
5. Are there any parts of the narrative that they would like to delete?
6. Are there any parts of the narrative that they would like to more fully elaborate on?
7. Having read the narrative are there any additional areas of their experience of 'health in work life' at work that they would like to tell me about?

In addition, further data gathered for reflection included written notes in the researcher's personal journal following interviews throughout the data analysis process (Liamputtong, 2009).

3.2. Key ethical issues and bias addressed

Ethics approval was provided both by Flinders University Social and Behavioural Research Ethics Committee in late 2013 and University of Tasmania Social and Behavioural Ethics Committee early in 2014. Permission to undertake the study within Tasmanian Health Service (THS) was provided by Chief Executive Officer (CEO).

De Vaus (2002) provides a detailed outline of the ethical process involved in focus groups and interviews which guided the data collection process. The letter of invitation informed participants the research was voluntary and they may withdraw at any time. Participants were also informed all individual data from the focus groups would be de-identified as it was collected. There were again informed that they could withdraw at the time, with the exception of withdrawing the data once the data was coded at the completion of the data collection period. This process was revisited at the beginning of each focus group and interview.

Participants were provided the opportunity to review summary narratives derived from the transcripts of the interviews and comment on them before they were included in the dissertation. They were advised of anonymity and the process for dissemination of the research findings.

Although interpretative phenomenology research is searching for meaning the potential for change by participants from the interpretative research process was acknowledged as an ethical concern of the research. The researcher made sure she was available for support if participants wanted to talk through choices that were instigated by his or her participation in the research. Rubin & Rubin (1995) asserts that;

> *The spirit, process, and form of qualitative research are woven together with the gossamer thread of ethics (p. 450) and that a break in that thread can erode of destroy research.*

Further, pressure to participate in the study was minimised by advertising the study in the THS newsletter with further information available on the health and wellbeing intranet website with potential participants required to contact the researcher via email in the first instance. The researcher did not seek opportunities to discuss the research process with other staff members in the organisation throughout the research process to help mitigate any potential participants feeling they ‘ought’ to participate in the research.

The possibility of question bias was minimised by making sure the questions used were directly linked to the purpose of the research (Yin, 2009). I developed the interview guide with my supervisor to ensure bias was reduced. The interview guide tested the questions against the aims and objectives of the project to ensure alignment. The final agreed interview guide was prepared in advance and the guide referred to during the research process.

All data collected was secured and stored in a locked cabinet at the researcher's office and not shared with anyone other than the individual participants. The transcripts of interviews, focus groups were stored according to principles that allowed for follow-up retrieval. All transcripts including narratives will be shredded and tapes erased or destroyed five years from the completion of the study.

3.3. Data analysis

The hermeneutic circle continued. I found myself weaving in and out of managing and analysing data as interpretivist phenomenology, as a research methodology, is not a linear process. The research approach is concurrent, iterative and integrative as data is collected and analysed with identified themes occurring simultaneously from the beginning of the research process (van Manen, 2014). This process continued until topics and themes from the research data. It is a challenge to document this process in a form that fully captures its complexity and the abstract nature of parts of the work. The analysis of the data in this section provides a written account of this part of the research journey.

3.3.1 Data analysis process

The framework method was the process used as a way to start to describe and define and categorise the data. Initial coding of the emerging data was undertaken as it was collected. For the management and analysis of qualitative data the framework method has been used since the 1980's (Gale et al., 2013; Ritchie & Lewis, 2003, 1994; Pope et al., 2000). Framework method developed by Ritchie and Spencer (1994) enabled themes to be developed inductively from the accounts (experiences and views) of research participants. Ritchie and Spencer (1994) argue framework method's prime concern is to describe and interpret what is happening in a particular setting. This method of data analysis was applied to the phenomena of 'health in work life' in a healthcare setting to explore older workers' different understandings of the mechanisms generating the phenomena.

The framework method is a process with a seven-step procedure of thematic analysis and involves shifting, charting and sorting data through:

A. Transcription
B. Familiarisation with the interview
C. Coding
D. Developing a working analytical thematic framework
E. Applying the analytical framework
F. Charting data into the framework matrix
G. Interpreting the data (Ritchie & Spencer, 1994).

A. Transcription

In the early stages of this research study to ensure consistency in transcription across the whole data set, I formed my research support team. My research support team (RH – note taker; BE a colleague who had just completed a qualitative PhD and had an active interest in phenomenological research) assisted me to check for inconsistencies in the formatting. As I was only concerned with the content, rather than the structure of participants' responses for analysis, I consulted my research support team to gain consensus on interpretation of responses e.g. nonverbal communication (such as laughter) and these were noted within the text. I supplemented each transcript with notes, made during and immediately after the focus group and interviews, for example noting background information and instances where views were given after the formal session had concluded (see Appendix 3 for the reading frame used).

B. Familiarisation with the interview

I thoroughly read and re-read each summary narrative developed at the conclusion of each focus group or participant interview to become familiar with the whole data set. I also recorded further impressions in the margins of narratives, for example where participants expressed exceptionally strong or contrasting views to their colleagues. In this case, this included one health manager who, contrary to other health managers in the group, disagreed strongly with the suggestion that health in work life was more of a product of providing a 'healthy' work environment. This manager argued strongly with the group that individuals were responsible for their own health regardless of the work environment.

Familiarising myself through reading and making notes in this way also enabled me, the researcher, to find my way easily around dozens of narratives later in the analysis.

C. Coding

I coded all the narratives. To begin with labels were given to each group participant using the group number 1-13, followed by the first letter of the staff members first name, followed by a letter for a subgroup (a) for allied health; (n) for nurse; and (hm) for health manager). If multiple first names were found in a particular focus group and subgroup a number was allocated e.g. (8s1n for Susan a nurse in focus group 8 and 8s2n for a Susie and a nurse).

Interesting segments of this text were highlighted in the left hand margin to describe the content of each passage with a label or code. This could range from only a few words, to parts of sentences or whole sentences. I then utilised the right-hand margin to record more detailed notes and ideas, for example questions for future reference as the analysis proceeded, and ideas for explanations or patterns in the data. Table 5 is an excerpt of initial coding from focus groups eight.

The highlighted text in the excerpt of open coding from Focus group 8 is from a nurse (8an) where she talks about her 'lived experience' of being healthy in work was directly related to the work environment where "*my stress levels don't continually go through the roof the minute I get to work*" and "*we all just work well together on the ward*". The researcher labelled the code as 'Work Environment' and as a constitute of that code 'Psychosocial Work Environment' and added notes on how aspects of the place/space of health promotion might influence the concept of health promotion in action. The researcher underlined and emphasised interesting parts of the data that she felt were worth coding or noting.

Table 5: Coding Label – Work Environment

Constitute coding labels	label	Focus Group 8 - 12 Participants	Notes and ideas
Health Promotion Embedded in Work Environment	8cn 8dn 8khm	If we had an exercise walking machine in our work environment that we and our patients could use – we could lead by example and facilitate health promoting messages without saying a word to our patients. Health promoting activities should be part of our work environment and could facilitate health promoting messages not only between healthcare professionals, also between patients and healthcare professionals. The workplace could better promote working in a health promoting environment e.g. healthy foods and drinks in the canteen, not allowing double shifts that really fatigue older workers and take days to recover.	*Health promoting activities need to be embedded into the work environment*
Psychosocial work environment	8in 8cn	When my stress levels don't go through the roof the minute I start a shift. When we all just work well together. Many older nurses work part time – health promotion needs to be made a part of work team rather than having to leave our work area.	*Health promotion should focus on improving the psychosocial work environment*
Team Based	8aa	Exercise classes need to accommodate shorter breaks - lunch time - 45 minute – if you have an exercise class or walking group it must be at worksite – better if team based.	*Health and wellbeing to be embedded into teams*

D. **Developing a working analytical thematic framework**

After I open coded all the narratives, I met with my support team to discuss the labels I had assigned to each passage. Working through a selection, they discussed each coded section in terms of why it had been interpreted as meaningful, what it told about the participants' experience of health in work life and how the code might be useful in answering this research question. Regular support team meetings facilitated our critical exploration of participant responses, discussion of deviant cases and agreement on recurring themes.

After further discussion with my supervisor a set of codes were agreed, each with a brief definition. This formed the initial analytical framework. Brief explanations of each individual code provided consistency of coding across the narratives. Table 6 below shows the five major code categories from the final analytical framework with constituent codes, and descriptions of codes.

Table. 6: Codes and Description

Codes	Description
Major Code • Health (H) **Constitute code** • Relationships • Social Ageing • Social connections, social support and social networks	My age is a social strength; Celebrate together for wellbeing; opportunities created to get to know colleagues; communities of practice around interest areas pertaining to health and wellbeing; ; giving back; good for self-esteem; Work is like a small community; Build a sense of community at work; Psychosocial work environment as important as the work itself; Positive organisation climate; Social connectedness; Community building; Socially supportive work groups; Social connections; Work community; Companionship at work; Social support Worker friendly workplace; Having respectful relationships with my colleague; Feeling valued for contribution to team; Being caring and compassionate with each other is essential to health; Connectedness is very important to health; Social belongingness is key to health; Celebrating together; Having fun with my colleagues at work.
Major Code • Work (W) **Constitute Code** • Work life balance • Flexible work arrangements • Individualised planning	Flexible work arrangements; Having time for work, rest and play; striving for a sense of equilibrium and stability; not having to rush to fit in everything; flexibility; work fits in with rest of life not the other way around.; Ability to have flexible work arrangements to fit individually with my needs; Work is good for your health; Work seen as part of life style; New ways of working; Flexible leave arrangement; Having plenty of time to recover from a shift; Time away from work valued by the workplace; Walking the dog is as important as being on shift; Having plenty of time for eating, sleeping, exercising and catching up with friends and family is essential to health and seen as essential by workplace; Being able to take leave when I want or need it; Being able to take leave for extended periods (long overseas trips) normalised in workplace. Older workers are quite reflective and maybe our occupational health areas could be more reflective on individual needs. My emotional health is important.
Major Code 1. Health Promotion (HP) **Constitute Code** • Health promotion embedded in work environment	Health promoting activities in teams; promoting health in every day work; create a health promotion space; making the work environment a health promoting work and work environment; Promoting health in every day work; Creating local working environments that support health and wellbeing; Exercise needs to be integrated into my work and work environment; Occupational health need to support individuals achieve their own

• Psychosocial work environment • Team based	health goals; Psychosocial health is key in health promotion; Health promotion is not something we do but something we are (health promoters); I need health promotion to be part of my daily work; Team wellbeing is essential to everyone's wellbeing; We model health promotion to our patients/clients; Health and wellbeing discussed in work teams; A health promoting space (as opposed to gym);
Major Code 2. Participation (P) **Constitute Code** • Consultation • Cooperation • Inclusion	Participation in decision making; staff wellbeing a focus of the organisation; Change the focus from the individual to embedding an organisational wellbeing culture; Work with me to achieve my own notion of health; Consult with me, Involve me in decisions that affect me and engage me; My opinion is valued and matters; Support and respect my decision and ability; Engaging with me around my health needs is important; Participation is essential in decision making regarding health promotion activities; Individualised health promotion plans; My health promotion needs seen as important.
Major Code 3. Managing for health (MH) **Constitute Code** • Person centred health planning • Humanistic management practice • Managers create work environment	Individually tailored flexible work arrangements; health and wellbeing modelled by leadership; Supportive work environment; supportive direct line management; Leaders treat people as 'human' resources not just resources, staff are valued and respected; Managers nurtures relationships; I'm seen as an asset; participatory management practices; Finding meaning in my work is very important and acknowledged as important by my managers; My manager knows me as a person and treats me as an asset; My manager spend time working with the team on how 'we do things around here' as a team; My manager values inclusivity; My manager values work life balance; My manager values me and my work; Managers create the psycho-social culture in which we work; managers determine the mental health of a work environment.

E. Applying the analytical framework

The researcher applied the final analytical framework to each of the coded focus groups and interviews by systematically going through each narrative transcript, attaching an appropriate major code from the analytical framework. Table 7 is an excerpt from the transcript of Focus Group 8 where the researcher systematically went through each transcript, underlining each meaningful passage of text and selecting and attaching an appropriate code from the final analytical framework. The researcher continued to make notes in the right hand margin.

Table 7: Applying the Analytical Framework

Coding labels		Focus group 8 15 staff	Notes and ideas
Major Code Health (H) **Constitute Code** • Relationship • Social Ageing and work • Social connections, social support and social networks	8aa 8fn 8pa 8sn 8in 8jhm	• Social support and my social networks maintain my health at work. • Developing a work environment of belonging and is supportive – building a sense of community at work. • Let's celebrate together more - morning teas and put some fun back into the workplace. • Work relationships the most important • If our work environment was truly healthy it would not allow bullying to continue. • Social connections promote wellbeing	*Connectedness and building a sense of community at work*
Major Code Work (W) **Constitute code** • Work life balance • Flexible work arrangements • Individualise work health needs	8aa 8am 8nn 8en 8pa 8sn 8fn 8dc	• I believe I am healthy when I have time for my self-care everyday • I guess it a sense of wellbeing – it's a sense of balance, of being able to do things and have time for all aspects of my life • It about balance – I like to work – I like to rest – I like to play – I like to be active • I want to travel interstate and overseas for extended periods and keep my job - flexibility. • 9-5 bound to desk mentality = productivity – again it all about flexibility • Lack of flexibility – not enough options e.g. 7am -7pm and be able to take/buy more leave or other more flexible arrangements • Flexibility becomes the norm of the workplace – e.g. older workers want to be able to visit grandchildren or elderly parents regularly. • When we work well together in harmony.	*Health in work life = balance and flexibility and meeting individual health needs* *Costs organisation more to offer flexible work arrangements.*
Major Code Health Promotion (HP) **Constitute Code** • Healthy work environment • Health	8pa 8nn	• If we had an exercise walking machine in our work environment that we and our patients could use – we could lead by example and facilitate health promoting messages without saying a word to our patients. • Health promoting activities should be part of our work environment and could facilitate health promoting messages not only between healthcare professionals,	*Work team - build health promoting activities as a part of normal work*

promoting • Team based	8in 8dn 8da	also between patients and healthcare professionals. • Exercise classes need to accommodate shorter breaks - lunch time - 45 minute – if you have an exercise class or walking group it must be at worksite – better if team based. • Mostly part time – needs to be made a part of work team rather than leaving work area. • The workplace could better promote working in a health promoting environment e.g. healthy foods and drinks in the canteen, not allowing double shifts that really fatigue older workers and take days to recover.	
Major Code Participation (P) **Constitute Code** • Consultation • Cooperation • Inclusion	8cn 8in 8cn 8aa 8dn	• I want to be asked • I want my workplace to work with me on my own individual health needs. • The health promotion on offer does not appeal to me • They only put on exercise classes in the gym – I have no time or inclination to go to the gym • I want to be included in health promotion planning if they want me to join in.	*Older workers wanted to be included in planning for health promotion*
Major Code Managing for health (MH) **Constitute Code** • Person centred health planning • Humanistic management • Managers create work environment	8pa 8dn 8pn 8va 8shm 8jn 8ia	• I want my manager to understand my health needs • I want my manager to get to know me • If only my manager valued me for me • My manager is the key to a health work environment. • I want my manager to work with me on meeting my needs to get my life and work in balance. • I have to work in a person-centred way - I want my manager to work with me in a person centred way. • For me being healthy means fitting work in with my life.	*Older workers thought their managers held the key to working in understanding and accommodating individual health needs.*

F. Charting data into the framework matrix

On completion of coding all the data using the analytical framework, the researcher summarised the data in a matrix for each code and each group. As illustrated in an excerpt in Appendix 5, the matrix comprised of one row per participant group and one column per major code. The researcher then abstracted data from narratives for each participant group and code, summarising it into the corresponding cell in the matrix. References to potentially interesting quotations were also highlighted using * or **/*** depending on how illustrative the quote was. For example, a quote from Focus Group 1 clearly demonstrated the point that health promoting activities should respond to the needs of employees, rather than the needs of the organisation:

> "we need to be very different in how we deliver health promotion based around what our employees need and I think at the moment we're not. We're still focused on what's easier for the organisation – a tick the box approach to health promotion" (1gn).

Many of the focus groups iterated this point wanting to participate in the decision making around promoting health and wellbeing at work.

G. Interpreting the data

A review of the matrix (Appendix 5) generated themes from the data set and made connections within and between participant groups and categories (Gale et al., 2013). This process was influenced both by the original research objectives and by new concepts generated inductively from the data. During the interpretation stage, the researcher tried to go beyond descriptions of individual cases towards developing themes (see Table 7 below) which offered possible explanations for what was happening within the data (Ritchie & Lewis, 2003).

Through the use of analytical memo writing ideas were generated, explored and fleshed out (Lempert, 2007) in discussions with my support team and supervisor. Table 9 is an example of a memo that was written about the category 'Health Promoting Work Environment' to develop the idea of tensions between the ideology of embedding health promotion into the work environment and the practicalities of delivering it on the ground. The researcher structured the memo with sub-headings, including a definition of the category, specific description that related to it, a summary of the raw data, discussion of any deviant cases, and further points for consideration and comparison. The researcher also used bullet points, bold and italic fonts and underlining to look for patterns within the

data and also included illustrative quotations in bold with references to the original transcripts.

Table 8: Interpreting the Data – Emerging Themes

Major Code	Category Code	Emerging Theme
Health	• relationships • Ageing a social strength • Social connections, social support and social networks	Relating well is a prime contributor to health Social relationships and social connectedness at work impact health. Work is a small community and we should think of it as a community.
Summary narrative	Ageing is seen as a social strength and positive relationships at work promote health.	
Work	• work life balance • flexible work arrangements • Individualise work health needs	Work life flexibility and work life balance are important health needs. Older workers need their health needs individualised – one size does not fit all.
Summary narrative	Flexible ways of working promote work life balance. Health in work life meant having enough time for all areas of one's life and work was just one part equal to all the rest.	
Health Promotion	• Health promotion embedded in work environment • Psychosocial work environment • Team based	A healthy work environment promotes health. Mental health and emotional health are supported in a healthy work environment. Health and wellbeing should be a core team activity.
Summary narrative	Health promotion interventions to be embedded into the social structures of the workplace.	
Participation	• Consultation • Cooperation • Inclusion	Older workers participate in all decisions regarding their health and wellbeing at work. To engage older workers is to ask them what would support then in promotion health.
Summary narrative	Older workers health promotion needs are different from the literature	
Managing for health	• Person centred health planning • Humanistic management • Managers create work environment	Supportive direct line managers are key in creating healthy work life Older workers want to be valued for their contribution. Older workers want their health needs individualised.
Summary narrative	Managers are essential in developing the work community; valuing person centred health planning needs around life balance, work flexibility.	

7.1 Memo writing

Memo writing assisted me gather my thoughts about what I was seeing in the data, the similarities and differences were captured and explored. Memo writing was a pivotal step in my interpretivist phenomenology research study. Between data collection and writing drafts is where I stopped and analysed my ideas about the codes and emerging categories (Charmaz, 2006). Potential categories were established, and the codes were identified through this activity.

Sifting through the memos helped me generate and clarify the theoretical outline or conceptual framework for the work. This approach assisted me in looking for similarities and connections within the data, where to locate codes and categories, and subsequent theoretical conceptualisations. Ideas and insights were developed and, as Miles et al., (2014) states, "memo writing forced me to stop and engage different categories – my memos formed a place for exploration and discovery around the ideas I had about what I had seen, sensed, heard and coded" (Miles et al., 2014 p.96).

Table 9: Memo: Health promoting work environment

Code 'Health Promotion'

Definition

- **Ideology versus practicality**

Older workers thought Health Promotion should be embedded into the work culture, work environment and into work teams. That health in work life should be an organisational responsibility and managers should embed into health promoting practice in their own work environments and work teams. They also thought they had a lot to offer on health promoting work environments if they were asked.

On the ground practicality of the organisation is that workplace health promotion is an individual's responsibility and lifestyle choice. The workplace believes that workers should find the time to participate in health promoting activities that the organisation provides e.g. the gym (everyone can access if they wish). They should only buy healthy food from the canteen and then we wouldn't need to sell unhealthy food etc.

Code description

Health in work life discussed in work teams; health modelled by leadership and management; staff wellbeing a focus of the organization; Change the focus from the individual to embedding an organisational wellbeing culture. Managers to be responsible for creating work environments that create health and wellbeing.

Summary of data

- **Embedded in work environment**

Participants thought health promoting activities should be part of the normal work environment: **"we don't time to come off the floor to participate in a health promotional activity we need to embed exercise into our daily work activity – like build in a circuit around the unit" (4hn)**. The work culture needs to be more focused on promoting health and wellbeing. **"Instead of leaving the working area to attend an exercise class etc. – the environment could have squats, stretches and weights built into work – work becoming a health promoting activity"(7pn)**. So by the end of the day/shift you had completed the circuit as part of your normal work day.

The canteen and the vending machines could be healthier and our leaders would be out promoting the importance of health at work. **" Where are our leaders when it comes to promoting health – all the executive team are overweight, over stressed, work long hours and they expect the same from us"** (7hm). **"With all these cut backs if I don't work to ten every night I do not get all my work done and then my job may be at risk – my director is not interested in my health and wellbeing just my work output"** (ghm).

Participants wanted our managers' leaders to take the lead in promoting health throughout the organization. There are lots of structures that affect our health and wellbeing at work. "If our (managers) were really serious about our health they would use individual and team rostering to help us achieve our own notions of health and they would stop double shifts and they would try to limit late followed by early shifts especially for older nurses" (5gn).

- **Psychosocial work environment focus**

All participants wanted health and wellbeing embedded into the social environment at work. **"I want to work in a strong supportive and collegial work environment – it's the work environment not the work that causes me lots of stress and I have lots of ideas on how we could change it – but I am never asked"** (11sa).. **"My age is my strength in social situations, I may not be as physically strong any more but I have much stronger social network and connections – I can get things done "** (nhm).

- **Team based health**

Participants wanted health promotion not be viewed as an individual responsibility but to be much more embedded into work teams. **"It's our work teams that make all the difference to our health and wellbeing and especially our mental wellbeing – we need our teams to have a focus on creating a health and wellbeing team culture"** (9sn). "**Wellbeing activities should be central to how our teams function. There needs to be democracy in decision making in our teams when it comes to our own health and wellbeing……"**(3fn).

Deviant cases

One healthcare manager did not agree that employee health was in any way a workplace responsibility. "People are unhealthy because they choose a life style that is unhealthy " (1ghm).

Points for further consideration

How do you become health promoting in our work teams and across the organisation?
How do you embed wellbeing as a core team and organisational value?
How would you go about individual planning around health and wellbeing needs?

3.7. Dependability, Confirmability and Transferability

3.7.1. Dependability and Confirmability

Dependability and confirmability can be demonstrated through the utilisation of an independent 'coalition of the willing' to offer assistance and support (Morse et al, 2008). In this case, my research support team assisted with cross checking the data collection and analysis. They were provided with a robust description of the methodology as well as a sampling of the interview transcripts from both the focus groups and the interviews. In addition, the 'coalition of the willing' were provided with the findings and interpretation of the data. Regular meetings critically explored participants' responses, discussing deviant cases and reaching agreement on recurring themes.

After studying all documents provided, my support team concluded the findings and interpretations were supported by the data. As a doctoral student you mostly work in isolation so in this research analysis, specifically my coding, was checked by my research supervisor.

3.7.2. Transferability

Lincoln and Guba (1985), state it is the researcher's responsibility to provide a store of data that will allow others to make judgements about whether the findings or the interpretation of the data would be applicable in another context. To this end I have provided a detailed account of the methodology and the logic behind the analysis so as to allow others to determine issues of transferability.

The research transfer itself was planned as part of the research method to be implemented at the end of study to close the gap from knowledge and theory into practice (Mitton et al., 2007). As both the researcher and an employee of the organisation I had to remain the researcher until the end of the research process. The aim of the research transfer was to transfer the knowledge gained from the study to improve the health promoting culture for older workers within the Tasmanian Health Service.

A research report based on the focus group and semi-structured interviews outcomes was circulated to the Board, the senior executive team, human resources and the THS employee health and wellbeing action group. The report recommendations have been incorporated into the Health and Wellbeing 'Feel Better' Program 2018 – 2020. A copy of the report is attached in Appendix 6. Further, the thesis and its findings will be sent to the

Tasmanian Department of Premier and Cabinet – Work, Health, Safety and Wellbeing Committee for consideration. Additionally, the thesis and its findings will be sent to Worksafe Tasmania to help inform their older worker health and wellbeing initiatives.

Although universally impossible, a level of transferability was achieved through providing the relevant background information of the study, a thorough accounting of the methods used and the study's findings. This study provides future researchers with a clear guide regarding the degree of transferability the present study would have for them in shedding light on their own research questions and findings.

Further, a salutogenic and ecological approach to research for this cohort is rare to find and the lessons from this project will be of interest to health psychologist researching through a positive psychology lens. In addition, as I was looking for the meanings of health in work life and how health in work life was experienced by this cohort I planned to wait until the data was analysed to develop a report on the findings.

3.8 Quality principles underpinning the research

Quality in the research project was addressed by following the quality principles below.

Reflexivity

Firstly, Liamputtong (2009) argues that researchers themselves are an integral part of their studies, it is impossible for them to be objectively distant from their research. Reflexivity acknowledges that researchers play a crucial role in how their data is shaped and analysed (Angen, 2000). They have their own personal perspectives and will inevitably bring these to the research process. Reflexivity should be seen as a resource not as a source of error or bias. Further, reflexivity of the researcher makes the research findings more credible (Liamputtong, 2009).

Similarly, Taylor & White (2000) claim one's own knowledge and understanding of the world influences the way issues are perceived. They argue researchers must reflect on their own knowledge, background and political beliefs which may impact their practice. Using a 'reflective' approach to one's work echoes a constructivist perspective in which meaning is a social construct and there is no absolute truth. Meaning is dependent on how individuals perceive and understand their world. As researchers do not always recognise the theoretical preconceptions they bring to the study they are conducting Brocki &

Wearden, (2006) acknowledge this as a problem that can undermine the accessibility and clarity of one's research process and findings. They suggest those conducting research to undertake a process by which their knowledge claims are critically analysed. Again, my research team and supervisor encouraged reflexivity.

For the researcher, prior knowledge and understanding of the world influenced the type of research undertaken. I work for the Tasmanian Health Service and I am an older worker. As an older worker this may have affected the interpretation and analysis of the findings in this study. Although my own older worker status may have strengthened the interpretation process by providing me with prior knowledge about being an older worker, as it was not possible to bracket my pre-understandings. Again, I was challenged by my research team and supervisor on various constructions of meanings when they seemed to reflect my experience more that the participants' lived experience.

Journal writing

Journal writing was used to improve the quality of the research. The researcher kept a reflective diary to promote reflexivity throughout the research regarding subjective experiences (Koch, 1995) and this formed a crucial part of the iterative process of data collection, analysis, and reflection. Reflexivity acknowledges as an older worker working as a health professional in the Tasmanian Health Service I am integral part of the research. Reflexivity occurred in place of bracketing pre-understandings of the topic, because it was not possible to eliminate all preconceptions when using a hermeneutic phenomenological approach (Koch, 1995).

Critical self-awareness is necessary to recognise the impossibility of maintaining an objective stance to the subject matter. Reflexivity means the researcher is aware of their own values, experiences, interests, assumptions and preconceptions that are likely to influence the collection and interpretation of qualitative data (Smith, 2015). It is important for the researcher to maintain an ongoing reflection on learnings within the process and how this may influence the analysis and interpretation of data.

Regular meetings with support team

To improve the quality of data, regular meetings were undertaken with my supervisor and with my support team co-checking the data and interpretations. This was to ensure I did not impose my own preconceptions on the actual lived experiences of older workers.

(Malterud, 2001). Quality was maintained and strengthened by a clear research practices by giving examples of raw date and detailing how the data analysis was conducted.

Audit trail

To document the various decisions, I initiated an audit trail specifically to note the structuring of themes. As an example, one entry included renaming the emerging theme 'ageing as a social strength' to 'relating well at work sustains older worker health'. Renaming this theme recognised that whilst ageing is a social strength for older workers, in relation to their health in their work life it was the quality of those social relationship, social support and social connections that impacted their health in work life. The strategy employed made sure the decisions I made stayed consistent and in no way negated prior decisions.

Member checking

Finally, member checking was used to ensure the participants' experiences were accurately translated into the data (Lincoln & Guba, 1985). This included giving participants the opportunity to determine the accuracy of the summary's findings relating to the focus groups and interviews (Johnson & Christensen, 2012) which increased the reliability of my findings by ensuring older workers' experiences were identifiable to them in the study's findings (Krefting, 1991).

Participants were asked to confirm or change what had been formulated to ensure what they said was accurately represented. They were asked whether they agreed with, or would like to add to or change their responses. Of the sixteen participants who gave feedback about the summary narrative, four participants made comments clarifying the interpretation of what I had sent to them. One participant reinforced points that were important to their experience of health promotion at work. Another participant was not sure saying he did not fully agree with "a healthy work environment promotes health" as it did not represented the fluidity of his own experience, such as taking personal responsibility to exercise and eat right. He thought this was his responsibility even though he did concur the workplace could do more to support this. No recommendations for more appropriate groupings were suggested.

3.9. Advantage and limitations of the study

This part of the study discusses the advantages and limitations regarding the research design of this thesis. Firstly, an advantage of using interviews and focus groups is that it gives the researcher a more detailed view of participants' perspective (Yin, 2009). Further, it is possible the theoretical knowledge obtained from this research can be applied to other similar individuals, groups or situations (Sandelowski, 2004; Carpenter & Sutto, 2008).

An advantage of using semi-structured one-on-one interviews was the participants were able to speak about the issues without concern others in the organisation were hearing what they had to say. The use of these interviews allowed the researcher to examine the perception of participants and how they give meaning to their experiences (Liampattong, 2009). This approach was effective in gaining deep and rich descriptions of older workers' experiences.

I had an overwhelming response to wanting to participate in the study that I had reached saturation point early on in the study and had many more participants than needed. Nearly every participant of the focus groups and interviews thanked me personally for giving them a chance to tell their story. The researcher included everyone who wanted to participate resulting in 171 participants, many more than what would be usual in a phenomenological study. All participants were able to be accommodated as focus groups were a part of the original study design.

Another advantage of the research design was the research evidence about health at work was not drawn from the literature. This study used interpretative phenomenology to explore older workers' *lived* experience of health in work life. Participants drew from their own lived experience and understandings about health in work life. I agree with Smith (2015) as using interpretative phenomenology as a data collection approach "*invited participants' to offer a rich, detailed, first person account of their experiences*". This was in keeping with the underlying aims of the study. In this study asking older workers about their own experience of health in their work life had not been something they previously been asked. This gave rigour to the study because the material asked about and collected was pre-reflective and experiential.

The purposeful sampling used by this study has a number of limitations. Johnson & Christensen (2012) point out the generalisability of a study to a wider population is limited

as representativeness of the older working population could be questioned. Related to the above limitation is there could be researcher bias (Creswell, 2014) when recruiting a non-random sample of participants. However, this is typically only considered to be a limitation when the researcher makes poor judgements (Creswell, 2014), the researcher had in place a research support group for reference and to minimise bias.

Further, when conducting a phenomenological study it is crucial all participants have sufficient experience of what is being investigated so they can reflect on it (van Manen, 2014). Each participant was able to reflect on their lived experience of 'health in work life' as they were older workers all employed in the health service at the time. However, the findings offer only a brief and time limited snapshot of the perceptions of one State's public health service over one period of time.

Another issue encountered during the data analysis phase of the study was interpreting older workers' accounts literally while at the same time searching for hidden meaning. Willig (2017) suggest a 'hermeneutics of suspicion' where interpretation is generated on the basis of a 'suspicious attitude' which aims to reveal a deeper meaning beyond the surface. 'Suspicious' interpretations seek to reveal a hidden meaning and in order to do this I needed to interpret the clues contained within the text. This means that surface meanings (e.g. as contained in the words that are written/spoken or the images presented) are not taken at face value but seen as signs which, if read correctly, will allow access to more significant, latent meanings. It was difficult at times to determine whether there was something hidden in what older workers said. In these instances I analysed the text around the extracts to gain further insight and to contextualise what was said (Ray, 1994). If I was still in doubt I met with my research support team or supervisor and we discussed contested possible meanings. As I had knowledge of the participants' interviews the final decision was made by me.

Considering all these limitations and challenges it is not surprising that Larkin et al., (2006) have said "accessing the experience of individual persons is notoriously problematic and complex pursuit" (p. 108) even using phenomenological research methods.

In research methodology, there are limitations associated with both data collection and data analysis. Interpretivist phenomenology answers questions about human issues and concerns, the how and what questions.

> *Interpretivist theory attests that one can only interpret the meaning of something from some perspective, a certain standpoint, praxis, or a situational context (Patton, 2002, 85).*

This research's scope about older worker health in work life and the findings presented can only be linked to the participants and the Tasmanian Health Service who volunteered to be part of the inquiry process through personal interview and focus group participation.

It has been postulated interpretative phenomenology cannot be reduced to a set of procedures and techniques, but it does have a stringent set of disciplines in a scholarly tradition associated with giving the best possible account of the text presented (Patton, 2002). The interpretation must be auditable and plausible, must offer increased understanding, and must articulate the practices, meanings, concerns, and practical knowledge of the world it interprets (Benner, 1994, p. xvii). In giving an account of the steps taken in the research process, the chapter supports the validity of the findings by demonstrating the rigour of the research activity.

Another limitation to the interpretative inquiry is the temptation to present the findings in the form of an assertion or prediction. However, as Bain (1995) so eloquently states:

> *Qualitative research provides insights into another's personal reality. A qualitative research project provides the reader not with generalisations, but with tools for reflection. That is, the concepts presented in the research thesis can be used as tools in reflecting about the reader's own experience. The knowledge produced is not a generalizable law of behaviour, but is new subjective knowledge constructed by the reader. The reader uses this new insight to create new meanings and actions in his or her own life. Is that knowledge valuable? Can it have an impact on other settings? I think the answer is yes (p. 244).*

3.10. Conclusion

This research was designed specifically as an interpretivist phenomenological approach to uncover the lived experience of older worker 'health in work life'. This research, embedded in a constructionist paradigm, explored what health meant to our older workers in their work life, the contextual factors that contributed to older worker health and how health promotion could be operationalised to promote health at work for this cohort.

The research design allowed considered dialogue between participants and researcher. The interpretation of older worker health in work life was guided by understanding the hermeneutic circle; the iterative process was complex and abstract in nature. Older worker ‘health in work life’ was explored on a personal level through focus groups and one-on-one interviews with an openness to hearing what others had to say about health in work life, emphasising the interpretive act of dialogue and understanding.

The quality principles underpinning the research were presented and an account of the ethical considerations and limitations for this study were listed and detailed. Data analysis revealed five broad categories that were later collated into five themes to describe the experience of ‘health in work life’ for older workers which are presented in the following chapter.

Chapter 4: Findings

Circles within circles, threads within threads, the loom of life is warp and weft, weaving meaning and purpose into the circle's text. The hermeneutic circle continued (Lauzon, 2001).

4.1 Introduction

The previous chapter described the methodology and methods used in this study. In this phenomenological study the goal is to develop direct contact with the lived experience of older workers and bring to light the meanings woven into the fabric of lived experience of health in the work domain. As phenomenology is not a linear process the hermeneutic circle continued by concurrent, iterative and integrative data collection, with analysis and conceptual theorising occurring simultaneously and from the beginning of the research process (Kincheloe & McLaren, 2000, p. 286).

This chapter presents the findings from analysing the older workers' focus groups and interview transcripts to detail their own experiences of what it means to be healthy in the work life domain. These findings should be valued for their depth and richness as opposed to their generalisability. The analysis revealed different meaning making for older workers' health in work life from the narratives found in the review of the literature.

The findings are presented thematically with five global themes with each having multiple sub-themes (Table 8). All of the themes are supported and substantiated with verbatim extracts from the older workers' transcripts to support their inclusion. In hermeneutic phenomenology many interpretations of individuals' lived experiences are possible (van Manen, 2014). With this in mind the interpretation of the researcher can and should be viewed as one of many possible interpretations.

The themes presented are not an exhaustive representation of all of the themes identified in the data after the older workers' transcripts were analysed. The themes attempt to reveal underlying and hidden meanings and are those that best represent the older workers' experiences of what it means to be healthy in their work life.

The framing of health and reflections were based on review of meanings of health, contextual factors affecting health and health promotion in the context of work life.

4.2. Findings

The research questions formed the framework for presenting the study findings.

1. What is the experience of older workers about health in work life?
2. How do the contextual factors affect their health, e.g. environmental, social, political, and economic?
3. What health promoting activities help older health care workers achieve or maintain health in work life?
4. What could the organisation do to help participants maintain and promote health in work life?

The phenomenon of health in work life revealed itself in the data through reflective questioning and musing on the essence of lived meaning for this cohort. As the analysis of the data was done, the transcriptions were read and reread during the process of analysis. In accordance with van Manen's (2014) detailed or line-by-line approach of isolating thematic aspects of a phenomenon, the researcher looked at each sentence of the data and asked, "What does this sentence or sentence cluster reveal about the phenomenon or experience being described?" (p.93). Understanding was enhanced by the application of the hermeneutic circle, an analytical process in which the parts are related to the whole and the whole to the parts (Patton, 2002).

> *similar threads started to intertwine, and examples of overlapping fibres made their appearance. There are essential threads, but there is no accidental thread – instead of identical threads there are similarities – you just don't get another thread – there is not just one thread that holds everything together - you get a cascade of threads that overlap and strengthen the research (Lauzon, 2001).*

Data from the framework method undertaken in Chapter 3 were organised into emerging themes as can be seen in Table 10. Table 10 presents the basic themes from Chapter 3 and develops through to global themes. These themes were to provide an overarching framework from which to view older worker health in their work life and health promoting activities to support their own notion of health in work life.

Table 10: From Basic Themes to Global Themes

Global Themes	Organising themes	Basic Theme
Balance in work-life promotes health	Flexible work arrangements	Work life balance is seen to underpin health in work life.
	Balance in life	Work needs to align with my life.
	Individualised health needs	Flexible work arrangements will keep worker working for longer
		Ask individuals what supportive work arrangements they need.
Relating well promotes health.	Positive relationships	Positive work relationships key to health
	Social ageing	Ageing is seen as a social strength in work life
	Social connection and support	Social connections and support underpin good health at work
	Work is a small community	
Managing well promotes health.	Person centred	Person centred health promotion planning is central to keeping workers healthy in work life
	Individualised health plans	Managers are key in developing a healthy work life
	Humanistic managers value older workers.	Older workers want to be able to individually tailor flexible work arrangements with their manager.
	Managers create the tone of the work environment	
A healthy work environment promotes health.	Embed in work	Health promotion needs to embedded into work environment
	Improve psychosocial health at work	The psychosocial work relational environment is the key to a healthy workplace
	Team based	Health promotions needs to be team based in work environment.
Health Promotion values older workers contribution.	Consultation	Participation in health promotion planning essential
	Cooperation	Engaging older workers in identifying their own health promoting needs will improve participation
	Inclusion	Older workers want participatory decision making in promoting health.

The prominent themes identified from the data as global themes on the meaning of what it means to be healthy in work life for our older workers. The five themes were:

Theme A: Balance in work-life promotes health.

Theme B: Relating well promotes health.

Theme C: Managing well promotes health.

Theme D: A healthy work environment promotes health.

Theme E: Health promotion values older workers contribution.

4.2.1 Theme A: Balance in work life promotes health

In seeking to explore meanings around being *healthy in work life* it became clear from the focus groups at this stage of older workers' lives, balance was central to the experience of health. It was important for older workers' health the work domain did not dominate in an older workers' life.

For example, older workers explained a balanced approach to life was most important in maintaining and sustaining health at this age and stage. To illustrate why balance in the work domain and life is so important, many focus group (fg) participants commented:

> *Work has intensified, and it affects my health - I need more time off to stay balanced (fg, 1, nurse).*
>
> *The rhythm of work does not fit so easily into my rhythm of my life anymore – work is always in crisis mode…. As I get older I need more time to get rest and recuperate if I am to stay healthy (fg, 3, health manager).*
>
> *All I have at home is my dog. I need to make time to walk the dog – I know if I am walking my dog everyday – I am coping with work and life – I am healthy (fg, 7, nurse).*
>
> *As I get older, healthy living for me is not just fitness and nutrition; it's balance in all parts of my life (fg, 7, nurse).*

We now live in a throwaway society and work life is like that – ageism – if you can't keep up you can leave – when all I want is some life and work balance (fg, 9, allied health).

Everyone is pulling at you a little bit….my daughter and granddaughter I care for, my team, you always feels like you are losing out in certain areas…. I take time for lunch…. I enjoy my lunch break - this helps keep me stay balanced and well at work (fg, 4, nurse).

For our older workers it was important for the workplace to understand and support older workers sustain a balanced approach to the work life domain as a protective resource for health maintenance.

Further, balance could be supported by the organisation by providing flexibility where work fitted in with older workers life style goals.

I am a carer of an adult child with a chronic mental illness and I am the main carer of an elderly parent – I need to be able to adjust my work schedule when I need to – this is almost impossible to get and it's very stressful just asking my manager. I just need the space to do what I need to do for my own health (fg 13, allied health).

I guess from my point of view, I need flexible work arrangements as I get older to stay healthy. I work part time each week. What I would really like is to work full time for a while and then have a few months off to travel and continue that pattern (fg, 9, nurse).

I would like to be able to roster my own shift preferences that fit in with my life style…I may get one or two shifts a fortnight that work for me the rest I have to change my life style preferences to fit in with the workplace. I am thinking of retiring - I am sick and tired of always accommodating work needs above my own personal health needs (fg,1, nurse).

My h*ealth is a balance between all areas of my life, work being just one part, my parents, my children and my grandchildren all need my time. I would like my workplace to understand and support me in finding the right balance* (fg, 10, health manager).

For me health is also the ability to blend my job in with the rest of my life so that I have balance. I want time to spend with my grandchildren, time in the garden and time to travel and time to read a good book. Although I am fit and healthy….. I guess I need work to be a bit more accommodating with time off (fg, 3, nurse).

My children live interstate and overseas and my extended family the same. For me I need time to travel and four weeks a year just doesn't cut it – I want time to travel and time to recover and if work were really trying to support my health they would allow me the flexible work arrangement I need (fg, 11, health manager).

From the above excerpts it can be seen that older workers wanted the organisation to support flexible work structures giving older workers the work-life balance they were seeking in the form they were seeking it; that would help support them to maintain and sustain their own notion of health.

Many older workers agreed they wanted more individualised work health arrangements, so they could achieve work-life balance. They saw work flexibility as the key. Many older workers commented that work flexibility impacted their thinking around when to retire. They thought more flexible work arrangements would keep older workers at work way past normal retirement age. For many older workers this sentiment was reiterated over and over again:

I am fifty-five and if my work life were more flexible-like I could take regular extended periods of time for travel and be able to come back to work each time, I would work another ten to fifteen years as I love my job – but I need to look after my own health needs (fg, 12, nurse).

I'm 56 I need time to work, I need time to play and I need time to recover. If the workplace would positively support me they would understand that I need a bit more in the work-life balance domain to maintain my health. I could actually work for many more years, but I probably will retire in the next year or so as I want more time to do the things I want to do – this means health (fg,7, nurse).

In my workplace healthy older workers leave work because of in-flexible work arrangements (fg,7, health manager).

I can't even find the time to go to the doctor or dentist for a check-up – as I get older I seem to need more check-ups - wouldn't it be great if my work could be flexible enough to allow me time to go to a few private appointments (fg, 2, nurse).

Semi-structured Individual Interviews

Semi-structured one-on-one interviews allowed deeper exploration of these new emerging constructions of health in work life. One of the emerging constructions of work life health for older workers was the notion of work-life balance. Follow-up in-depth interviews meant this construct could be explored to understand how balance in life and more flexible work structures could impact health in work life.

The interviews helped in gaining an understanding of the dynamic interplay among older workers and their socio-environment setting. Being able to explore the meaning of health at a deeper level showed how older workers in health care would like to see a move from a work centric to a more holistic person-centred approach to work flexibility and work life balance, where individual needs are seen as important as workplace needs. Older workers reaffirmed over and over again how work-life balance and work flexibility impacted their health. For example:

Interviewee 1(nurse) explained what work life balance and health meant:

When I can leave work on time and not ever feel guilty means I can fit in other activities that keep me healthy.

Interviewee 1 explored the contextual factors affecting her health in her work life:

The workplace has changed a lot over the thirty years I have been nursing ……the pace of work is affecting my health…work has intensified and there is no down time. I would truly like to see more flexibility. I cannot do night shifts or double shifts anymore. If the workplace could only accommodate my needs - I would like to see a 5 am start shift. I would be more than happy to begin a shift at 5am in the morning and finish at lunch time….work-life balance means making my health needs as important as work needs.

Interviewee 1 continued to explore the organisational environmental influences that affected her health in work life:

Of late I have been thinking more and more about retiring…… to continue working there would have to be a huge change in the way I am treated at work…..work needs to fit in with my life style and they need to ask me what roster/s would I like to do.

Health in my work life means being able to adjust my work life to fit my personal needs around life balance. It means as I get older I can come in early as I am awake between 4 and 5 am every day and be able to leave work early.

Interviewee 2 (allied health professional) discussed the importance of balance and the affects it has on her health were explored:

For me health means my personal needs are understood by my workplace. I need more flexible work arrangements. I need to take time off when I need to visit my three children working in three different states on the mainland, my parents and extended family who live in England in different cities. I need my workplace to understand and support me. My health is directly affected by the workplace. To date getting enough time off work when I need it has been impossible…….my manager just says no we are too busy.

Work just wants outputs and outcomes – I feel as if I am expendable – if I can't keep up - leave.

Health means balance in all area of my life.

Interviewee 2 went on to say:

Do you know I would stay at work for many more years if I could have my work life in balance with all my life.

Interviewee 3 (health manager) explained although she loved her job she often felt overwhelmed and overburdened and she wanted support from the organisation to help support her health with work-life balance:

When I was younger - work used to work in with my own bio rhythms – now its crisis mode from the moment I walk through the door – my work life has intensified.

Sometimes it's all too much. I would love to be able to come in at lunch time some days……..I would love to be able to use more of my sick leave as it takes me longer to recover even from a cold these days. I would like my manager to understand that I love my job but I have many other responsibilities.

Some days I just want to walk the dog, enjoy breakfast and then come into work. I know it will be chaotic when I get there and no letup and no time for a break…. I just run from one thing to another.

For me health means having the space to do what I need – work and life balance.

I just wish the healthcare work culture encouraged flexible ways of working – ways that worked for me.

Here flexible work arrangements mean working part time for part of the week, and oh by the way doing the same amount of work as if I were still full time. There is no flexibility to work full time for a given period and then take some block leave

When exploring health with older workers it would seem balance in work and life was essential to good health. Further, older workers would like to see the organisation support work-life balance in a way that worked for older workers. For example, many older workers commented flexible work arrangements accommodated young parents with maternity/paternity leave entitlements and working from home arrangements. For older workers who wanted extended leave periods for travel found flexible leave taken in a block outside of long service leave accruement was not easily accommodated by the healthcare organisation. Older workers wanted organisational support with flexible work practices that recognised, supported and accommodated their own notion of health in work life.

4.2.2 Theme B: Relating well

In the focus groups relating well was found to be essential to the older workers experience of health in the work domain. Relating well was also experienced as a key strength for older workers in the work domain. Older workers discussed how age is a social strength and how it contributed to successful ageing in the workplace. A health manager explained

'*My physical strength may be diminishing with age but socially I am so much stronger – I create positive supportive relationships in my workplace'* (fg, 6).

Many older workers spoke about how the social environment influenced workers' personal experience of health in the work domain. An older nurse commented '*We really focus on creating a healthy social environment at work and this really makes me feel well*' (fg, 5). Further, the concept of connecting with others and health appeared to go together. For example, many focus group participants commented:

> *Bring back the tea room- that's how we all connected in the past. (*fg 1-13 – this was reiterated in every focus group*)*
>
> *For me having respectful relationship with my colleagues makes me feel good.* (fg, 8, nurse)
>
> *Just going for a walk at lunchtime with a work friend supports my health. (*fg, 6, allied health*)*
>
> *Being connected with colleagues makes me feel healthier and happier. When I first came here it was hard to get to know the staff. I don't think we do enough socially at work. (*fg, 13, nurse*)*
>
> *Feeling connected and being able to talk with friends and colleagues* – that makes me well. (fg,9, nurse)
>
> *It (workplace) really impacts my health – I feel well when I am having great interactions with my peers and not so well when there is lots of conflict. (*fg, 10, allied*).*
>
> *Work has really changed for me over the years, I feel very isolated now - I work for three different departments and I am not included in any of the department's social events. I feel like an outsider, up until the last few years I loved my job but now I just don't enjoy my work as much anymore.* (fg, 3, allied health)

Many employees commented that the quality of their social relationships and how supported they felt underpinned how they experienced health at work.

> *I feel good when I connect with my colleagues…you know - have time to get to know others on my shift. (*fg, 2, nurse*)*

I feel healthy at work when I really connect with others in my work community – we need more morning teas together. (fg, 6, nurse)

The part of being healthy for me is having those around me whether they are personal friends at work or professional colleagues, support me and provide support to me. I have a circle of support and without it I wouldn't be healthy. (fg, 7, health manager)

I would say cooperative ventures with my colleagues make me feel healthy. (fg, 2, allied health).

Semi-structured Individual Interviews

In exploring contextual factors regarding health in work life further opportunities arose in the semi-structured interviews to use additional probing question. "can you tell me a time when you felt socially connected at work and how this related to your health in your work life?" All three interviewees discussed the workplace as a sort of replacement family and how important the sense of belonging was to the workplace and their team. Further, all were surprised by their answers:

Interviewee 1 (nurse) explained:

Two years ago, I went through a serious illness and I had to take a leave of absence from work. I was off for quite a while. So that allowed me time to step back and reassess as I was quite stressed about my work and my life. Having time off reenergised me in appreciating life. I began to ponder on 'do you actually have to get sick in order to get healthy?' I became more aware of the need for both a sense of belonging and balance in my life. On returning to work I found it was my relationships at work that sustained me – my colleagues help me stay well….we formed a little walking group at lunch time…..we smiled and laughed a lot together at work….lots of happiness….and lots of chaos too….but we still smiled and laughed.

Interviewee 2 (allied health professional) thoughts about connection and health:

I live alone and I realised some time ago that my workplace is where I connect socially. I love and need the sense of belonging – it's like my substitute family. My children have grown up and left home – the sense of connection and relationships

are so important. What keeps me at work is the wonderful social network I have. My friends in the workplace help keep me healthy.

My workplace is where I find my social support system.

It's a little community for me as it's where I spend a lot of my time.

Interviewee 3 (health manager) added some further comments about the importance of the social environment at work and her health.

What I am finally figuring out is that it is ok for me to have different ideas from others. It's my mental health that's really important to me and it's the quality of my work relationships keeps me mentally healthy.

When relationships are strained I feel unwell.

I live alone and I need positive support and connection from my colleagues and team. These connections keep me mentally healthy and at work – work is like my second family.

My work community keeps me mentally healthy.

Relating well and the sense of belonging to a community gave older workers a sense of wellbeing and meaning in their work life. This was something greater than the work contribution itself. Social connection, social support and social networks were essential to older worker health.

4.2.3 Theme C: Managing well

In the focus groups older workers discussed the importance of embedding a more person-centred approach to managing staff. This humanistic approach would take into account the individual needs of each worker in maintaining and sustaining their own notion of health. Further, older workers discussed the need for managers to work cooperatively with them and to take the time to get to know their team, their individual needs and what keeps them motivated, healthy and happy at work. Focus group participants commented:

A healthy workplace starts with how my manager manages first and foremost. It is really important that my manager sets aside time to get to know me and provide me with the support I need. (fg, 6, nurse)

I want my manager to value and encourage my work-life balance. I need time and space to do what I need to do. (fg, 11, nurse)

Health means to me that my age is accepted as strength rather than as a weakness. I feel like I should retire. (fg, 10, health manager).

I need a more personalised approach from my manager. My manager needs to get to know me and what I need to keep me healthy and at work. Instead she always puts what the organisation needs first. Personally, I am quite sick of feeling pressured to stay well, have my flu jabs, exercise and eat well and of course take no sick leave. (fg, 10, nurse)

My manager needs to get to know my strengths as an older worker and encourage me to grow at work – that will keep me healthy. (fg, 3, allied health).

My manager does not value me as a person only as a worker. I am not seen as an asset just as a cost. (fg, 4, allied health)

My manager pretends to care about my health, but I know its pretence. She tries to support my health needs but all she is really doing is monitoring my health activity to reduce sick leave. She needs to stop this ageist and harassing type of behaviour - it's a guise of being supportive. (fg, 7, nurse).

Semi-structured Individual Interviews

Older workers described how their managers 'appeared' supportive rather than actually being supportive regarding health needs in work life. However, many older workers thought their managers play a vital part in building a healthy work life. In the in-depth interviews this notion of supportive managers and building a healthy work life was examined in deeper detail.

Interviewee 1 (nurse) commented on the importance of humanistic management in the health care environment:

My manager promotes fitness programs put on by the gym. I would not be seen 'dead' in the gym. I resent feeling anxious and guilty because I don't have time or inclination to participate in these programs. I sometimes think that this pressure contributes to my feelings of not coping at work.

I'd rather she (manager) ask what I would like to do for my health and how she (workplace) can support me in reaching my health goals. I would like to see my manager engage with our work team and create a team environment that supports health.

The NUM (manager) creates a more or less stressful working environment.

Health to me means working in a supportive work environment.

Interviewee 2 (allied health professional) explored how her manager helps create the mental health or ill-health environment for workers:

I feel I can't even be sick. When I am home I feel guilty for being sick and that I should be at work. I'm expected to provide my home and mobile number to my manager so she can call me when she wants even when I am home sick. I think this is really unhealthy and I do not feel supported by my manger.

All the workplace wants is a resource to work. Everyone needs to switch off and rest – this is what's important for me to maintain my health – I wish the workplace would get that.

If my manager supported, my work and life balance – I would feel healthier immediately. *For me my manager is core to my own health in my work life.*

My work team is so important to me that what keeps me working.

When I laugh a lot with my colleagues at work – when works fun – I am healthy.

Interviewee 3 (health manager) wanted her manager to understand her as a person. The health manager wanted her own manager to accommodate and support her in achieving her own health goals. The major health goal in work life was having opportunity to undertake health promoting activities with work friends:

All I want to do to maintain my health is be able to do some wellbeing activities with my work friends. I would like some activities that build a really healthy work life for me. Maybe some meditation and yoga but really, I would like to do my health promoting activities with my friends.

As a manager I get very little time to spend with my friends at work. Health promotion activities would be such a good avenue for social connection and social support.

My up-line manager does not support my health and wellbeing needs she says that's what the workplace gym is for - book into a lunch time exercise class – I do not want to do an exercise class in the gym and what lunch time? What I would like to see is my manager working with me in building a healthy work environment – we could start with our team and move out across the whole organisation.

My manager is key to a healthier work life for me.

4.2.4 Theme D: Healthy work environment

From the narrative literature review health promotion programs primarily emphasised individual responsibility for adopting lifestyle behaviours conducive to preventing ill-health (e.g. encouraging people to exercise regularly, improve their diet, and refrain from smoking). This focus on lifestyle change has met with some success, although not to the degree anticipated. Reduced success may be because of different perceptions of the meaning of health in the context of their work life. The focus group participants wanted health promoting activities to be embedded into their teams and work environment. They had this to say regarding the work environment and 'health in work life'.

I would like an exercise circuit placed around my work environment so as I go about my day I could do all my exercise as part of my work day….this would truly show me that my health needs were important to the organisation. (fg, 9, nurse)

I would like to see water filters on all the wards, so staff could easily access as they go about their work and patients could access as part of their recuperation exercise. (fg,3, nurse).

Staff meetings could have a health and wellbeing agenda item and everyone could take five to discuss ideas. (fg, 7, health manager).

I believe every staff member starting a new job could undertake a 30 minutes health promoting eLearning as part of orientation to the new job. Imagine what a difference we could make if we truly became health promoting - not only to work and patients but our families and community as well. (fg, 12, allied health).

I would like to see a wellbeing room in each healthcare building and let the community run low cost exercise classes that staff can attend. (fg, 6, health manager).

Just something as simple as putting an alarm on in my calendar for every 30 minutes would help me immensely to move more at work. (fg, 7, health manager).

'We need to rethink the work environment and brainstorm more healthy options we could adopt like support each other to take the stairs instead of the lift even if it's only for a few floors…set up some healthy stair taking rivalry' (fg, 11, allied health).

There are lots of little things I could do….I could walk to a photocopier further away…..actually take a lunch break and only have a healthy lunch every day. This forum is such a good reminder of what being healthy means to me. (fg, 11, health manager)

Many discussed the importance of the socio-emotional work environment and how their teams worked together either improving health and wellbeing or diminishing it. Some comments:

It's the work environment not the work that causes me lots of stress and I have lots of ideas on how we could change it – but I am never asked. (fg, 5, nurse)

I can tell straight away when I walk onto the unit whether is going to be a good day or a bad one. (fg, 3, nurse)

Team wellbeing is essential to everyone's wellbeing (fg, 9, allied health)

Semi-structured Individual Interviews

In the semi-structured individual interviews further exploration was able to be undertaken in relation to creating a healthier work environment. 'Can you tell me what creates a healthy work environment' was explored in more detail. The exploration found older workers would like the workplace to focus more on a health promoting work environment rather than on individual behaviour change. Even though, individual responsibility was recognised as important factor in promoting health. Older workers wanted a move away from illness prevention and risk reduction focus to a work environment that focused on the conditions that produced and encouraged health with its workers.

Interviewee 1 (nurse) explored how we need to make our work environment healthier:

> *I want to age healthily in a healthy workplace.*
>
> *I would like to live the concept of being healthy in everything I do at work. I would like the work environment to reflect the importance of health and wellbeing for me.*
>
> *How can I help improve my health as I work? Why does the workplace not ask how it can help me improve my health?*
>
> *I could model good health practices as I attend patients – but usually I just run from patient to patient.*
>
> *Although, I could bend at my knees as I talk to a patient sitting in a chair. I could balance on one leg as I write up the patient notes. I could do a stretch between every patient – I could use a resistance band with a colleague as we are discussing a case.*
>
> *We are still illness and treatment focused – we do not promote health in our work environment.*
>
> *There is a lot I could do and a lot we could do as a team and have fun doing it if we decided to focus on improving our health in everything we do. I want to work in a healthy work environment.*
>
> *For me health means working in a health promoting working environment.*

Interviewee 2 (allied health professional) pondered on the possibility of changing her relationship with her work environment.

> *I wonder if I can be personally healthy, in a work setting that is not so healthy. How can we make our organisation healthy? Why can't I promote my health and my patient's health?*
>
> *We only focus on the clinical aspects of work? And I wonder why at first when you asked me about health in by work life I defined it on the professional side – like manager support and connections.*

I am thinking now – you know, I could do something for myself too, like walking at lunch or not eating donuts at the staff meeting? I could actually take some responsibility to create a healthier me and a healthier work environment.

I feel healthy when we are having fun at work.

I am healthier when my team mates are being healthier.

Interviewee 3 (health manager) wanted to find ways to turn the work environment a health promoting work environment:

I have no time in work time to attend exercises classes outside of my work environment – we have to find ways for exercise to be part of work.

There is so much we could do in our work environment to be healthier – I could actually make the healthy choice the easy choice.

We could eliminate immediately sweet and salty foods from our vending machine and replace with healthier snacks and drinks. Our work café could have healthier options.

One other thing we could do immediately is only have healthy fund raising snacks in our work environment – get rid of the chocolate bars, chips and coke.

Health is obviously not our priority so we all need to make it a priority. As I get older I realise I need to take responsibility to be healthier at work. I want to work in a healthy organisation.

As I get older my health is the most important and work needs to support my health needs.

I want to be part of a health promoting work environment.

Promoting health in work life meant for older workers that they worked in a healthy work environment that focused on promoting health for themselves and their patients / clients.

4.2.5 Theme E: Health promotion values older workers contribution.

This theme was defined by older workers' own perspectives as important in the development and participation of workplace health promotion. The majority of participants in the focus groups commented on how novel and empowering this forum opportunity was, as it actually asked older workers themselves what would work for them.

Health in work life was seen by the focus group participants as a broad definition of wellbeing; health was often used interchangeably with wellbeing and covered the physical, emotional, mental, social, and spiritual and the cultural wellbeing of the work community.

All participants wanted to be consulted and participate in decisions regarding their own health and wellbeing – in the same way consultation with patients/clients is written into the standards of health care. The focus group participants suggested.

> *It is really important to consult and participate with our patients and clients – then it is just as important for us as staff to be consulted and participate in decisions around promoting our health and wellbeing. (fg, 9, nurse)*
>
> *Embedding health and wellbeing as an agenda item on all team meetings like we already have safety, so everyone can have a say. (fg,4, allied health)*
>
> *The one-off programs don't work. We ran a weekly exercise program recently targeting the older obese worker. Hardly anyone showed up or was interested. (fg, 9, health manager)*
>
> *How I would promote health in our organisation is by improving our social connections at work - but no one asks me. (fg,11, nurse)*
>
> *I need harmony between home and work and I am a lucky one as my manager allows this. (fg, 8, nurse)*
>
> *Health promotion to me means building a healthy work community. I think this would make a huge difference to my health – but no one has ever asked. (fg,9, nurse)*
>
> *I think as an older worker my manager should be asking me how he can support my health needs. (fg, 8, nurse)*

I think my workplace should be asking me what would work for me and my health. (fg, 2, nurse).

I believe the workplace needs to value my contribution – the only thing we seem to value is the $$$$ bottom line. (fg,11, nurse)

A healthy organisation values its workers and includes them in decision making that will affect them. (fg, 9, allied health)

Semi-structured Individual Interviews

The semi-structured interviews provided an opportunity to explore the importance of participation in engaging older workers in workplace health promotion.

Interviewee 1 (nurse) explained that health in work life meant being valued enough by the workplace to be asked in a meaningful way how the workplace could support their own notion of health:

If the workplace were to actually ask me what I needed in the way of health promotion at work, I would say we need more emphasis on mental wellbeing and spiritual wellbeing.

My works helps me stay well.

I want us (workplace) to empower the whole work community to focus on what makes us feel healthy and well.

Instead the workplace focuses on jabs, exercise classes and washing hands. I know these are all important but what's more important to me is how we relate with each other and our patients and clients.

How I give back to my workplace …this helps keep me well. If the organisation were to ask me instead of telling me what's good for my health I may start to feel valued and needed for my own personal contribution.

Interviewee 2 (allied health) explored participation in promoting health at work:

I would like to be included in deciding what needs to be done to improve my own health. I want to participate in health promotion planning.

Personally, I feel I can eat well and exercise, but I would like to be able to contribute and make change in my workplace. I would like my manager to ask me how we can create a healthier work environment.

I could be an ambassador for health…be a good role model…with a little support from the workplace…..if only they were interested in asking me how.

Interviewee 3 (health manager) observed:

Supporting a healthier workplace involves asking me what my thoughts are in making the workplace healthier.

We should be included in strategic decision making around health promotion programs.

We need to reframe the way we look at our older workers – I think mostly the organisation is trying to get older workers to leave – to make for the younger ones - so why would they invest in health promotion that actually targeted older workers.

I feel like the workplace is trying to push me out…..I feel I work in an ageist workplace.

I am not just a resource or another commodity. We are human beings, with complex and different needs.

Perhaps it's time to reframe the role of work in our lives. Let's move past the industrial era and move into a more human centred approach to our workers.

How can we support each and every one of us to achieve our own idea of health?

Older workers wanted to engage and participate in decisions regarding health promotion strategies in their work environment.

4.3 Framing of health.

By analysing the themes that had emerged from the semi-structured interviews and focus group data, it became apparent the themes could be linked directly to Baum's (2008) socio-environmental model used to guide this inquiry. This link, however, was not explicit but implicit. The socio-environmental model broadens out the traditional medical and

behavioural paradigms for promoting health to include the conditions for health as an alternative to only focusing on preventing ill-health (Hunter, 2009). Participants' definitions did not preclude being ill and supported the idea that health (wellbeing) and disease are not part of a continuum, but rather two separate entities. One being pathogenic (illness prevention) and the other salutogenic (health promoting) world views.

In exploring the meanings of health with older workers, ageing was seen as an asset that came with many strengths. Older workers believed health was core to their wellbeing and essential to a sustainable working life. Older workers focused on their salutogenic strengths in their work life and commented on how the organisation treated ageing as a deficit or decline and a substantial risk to the organisation. As can be seen through the eyes of employee 89:

> *My manager frequently asks me when am I - planning to retire*.

This view of ageing as vulnerability or decline as something that needs to be managed reflects the medical paradigm dominating both health organisations and the literature on older worker health in work life.

The health literature on ageing in work life is encompassed in the work ability literature. Work ability focuses on older workers' functional capacity and how it declines with chronological ageing. Work ability was addressed through applied risk reduction and illness prevention strategies, a deficit approach to older worker health (McLoughlin & Taylor, 2012). On the other hand it was clear that older workers did not only view their health from a chronological or functional perspective that embodies the medical model, but from a more socio-environmental perspective where health in work life is seen as an imbalance concerning the demands of work and an older worker's individual health and wellbeing needs and their capabilities. As employee 31 explained:

> *Achieving balance as you get older is about reconstructing your life so it's not all about work.*

Older workers understood health more broadly specifically acknowledging ageing as an asset to be looked upon as a resource for health in work life. Participants viewed age as an asset especially in relation to social ageing which many participants believed improved health and wellbeing. Older workers focused on building health and wellbeing strategies into the way they worked. Whereas, the medical model focus is on functional ability and its

decline with age. This view dominates the literature on older worker health. Participants on the other hand commented this was only part of the story and health in work life needed to be viewed more from a social and environmental perspective.

Participants emphasised work-life balance as essential to the experience of heath in work life. The notion of balance was reiterated by participants and emerged as a significant theme. Work and life alignment as a crucial determinant for health for older workers was left silent in the ageing and workplace health literature. Achieving balance in the work domain was inferred in how participants experienced health in their work life. Balance in work life assisted older workers in maintaining and sustaining health. Further, balance in all of life's domains was seen as essential to the experience of health for the older worker cohort. They saw balance as key to good health and essential to staying on at work way past normal retirement age.

Participants commented if balance was referred to in the organisation it was as a lifestyle choice for the older worker to manage a decline in health. Employee 102 explains:

> *My manager often asks if I would like to drop to part time to achieve more balance in my life - she actually sees my age as a deficit a risk to be managed*.

Understandings from older workers suggest the literature on older worker health in work life needs to encompass broader definitions of what health in work life means to older workers.

Importantly, for older workers, participation in decision making on ways to maintain and sustain their own notion of health was at the heart of health in work life. Balance was a very good example; whilst balance was a theme emerging from the data, there were individual differences in how balance was expressed in their life.

Balance in work-life was discussed as an important factor in promoting wellbeing in the workplace and assisting in maintaining and sustaining health as workers age. Older workers focused on the benefits of salutogenic approaches to health concentrating on health potential of achieving balance between the work domain and all other domains in their life. Older workers cite the positive effect this has on both their health and work life. How balance was expressed was personalised, for example employee 113 states:

> *Balance is not necessarily about working less it's about knowing when to put work aside, use coping strategies, or knowing when to say no*.

For employee 31:

> *Balance means flexible work options* and for employee 79 'As *I get older I need balance in all areas of my life – work is just one aspect'*.

These research findings would support Naumanen (2006) research with a cohort of healthy older workers; the findings suggest that work ability does not change as we age; it is the way we go about our work that changes as we get older. Participants understood changing work practices and finding work and life alignment supported the conditions for their health and wellbeing.

For older workers health was seen as a determinant in working past the normal retirement age and health promotion as a way to maintain a sustainable working life. The focus for older workers health in work life was different from the understanding gained from the literature. The literature focused on illness and decline with age whereas, older workers embraced age as a resource and work good for their health in a balanced way.

The review of the literature on older worker health in work life was orientated toward age and decreasing work ability with age seen as a risk to be managed in the workplace. Older workers on the other hand emphasised the positives of ageing and broader socio-environmental influences on their health in work life that would assist in sustaining work longevity.

Contextual factors affecting health

The socio-environmental factors affecting the health of older workers are a key finding of this study. The contextual factors most important to participants' health were relating well, managing well and the importance of a healthy work environment along with promoting health by improving the wellbeing of their work environment. These were the most essential factors for supporting older workers to feel well and enjoy good health in work life.

Black's (2008) extensive research into health in work life placed emphasis on the importance of work on health. Marmot's (1999) research on health and work identified how important the work environment was on health. The nursing literature has a plethora of

findings relating the significance of the work environment on retention, job satisfaction, productivity, patient outcomes and worker health (see Radford & Shacklock, 2015 for a systematic review).

The literature on workplace health has frequently been reviewed using an extensive review research methodology (Radford & Shacklock, 2015) rather than exploring meaning making with older workers themselves. Participants reiterated that their personal health and wellbeing were impacted or enhanced by the health and wellbeing of their team work environment. Participants reported that health in work life means fundamentally a healthy work environment, stating a healthy working environment promotes individual wellbeing and wellbeing within their team and ultimately the organisation. For older workers the work environment is seen as an essential determinant for health and wellbeing.

Managing well has been researched comprehensively in the nursing literature regarding retention (Radford & Shacklock, 2015). Strong links have been found between a positive workplace culture and how a manager relates to older workers in healthcare environments (Ritter, 2011). Participants in this study confirm managing well was important determinant of health. Participants commented that managers needed to take the time to understand the needs of each worker and protect their dignity and promote wellbeing for each worker and the team as a whole. Furthermore, participants argued for managers to make time to really get understand their workers and to be aware of what motivates them. As employee 22 shared:

> *All I want is for my manager to get to know me as a person and what my personal wellbeing needs are*.

Participants viewed managing well from salutogenic strength-based approach and managers should view older workers as an asset. Participants thought managing well may begin to provide the conditions for health and wellbeing much sought after by older workers.

Relating well has been found in the research to positively correlate with psychological wellbeing (Lindfors, 2002). Relating well for participants meant having respect and professional courtesy in every interaction. Employee 107 summed up relating well as:

> *our social connections are what make me feel healthy at work*.

Holt-Lunstad et al., (2010) findings support how important the social and relational environment is as a determinant of wellbeing for the older worker cohort.

However, research has moved to refocusing research away from the social /relational conditions that make a positive work environment to the social/relational conditions impacting safe systems of work. The repositioning of research on the culture of the work environment to emphasise safety cultures and to reduce risk by reducing human error has ignored the broader conditions that make a health promoting work environment as opposed to the conditions to make work safe and thus more favourable (Lindberg et al., 2008).

Even though there has been a profusion of research on workplace health especially in the health industry (Shamian & El-Jardali, 2007) little has changed in improving the socio-environmental health of the workplace. Much of the research focus is on managing the work environment as a risk to the patient safety (Ritter, 2011) rather than focusing on the conditions for health for workers. In this research participants reiterated that they viewed age as an asset and a resource for health. Participants stated that little would change in creating a healthier work environment until research and the health organisation viewed its older workforce as an asset to be valued and support the conditions for their health in work life. Employee 3 explained:

> *I see myself getting stronger every year in areas that matter most - that is in my ability to relate well with my colleagues and my patients however this is not acknowledge in my workplace.*

A healthy work environment meant embedding health promotion into team work. For employee 76 this meant:

> *The psychosocial work team environment is key to a healthy workplace*.

Davey (2008, 2007) when studying the retiring early space found most research centred on the ‘push’ factors towards retirement rather than on the ‘pull’ factors towards staying on and working past normal retirement age. These finding may shed some light on the ‘pull’ socio-ecological factors facilitating older workers continual contribution in the workforce. For participants, retention issues would be better addressed by the work environment providing the conditions for health. Participants reiterated if the organisation’s health

promotion promoted a healthy work environment this would better support older workers sustain their own notion of health. Health promotion was summed up by employee 33:

Health promotion needs to focus on creating a healthy work team environment'.

This research study found the work environment along with managing and relating well to be strong determinants of older workers health in work life.

4.4 Conclusion

This chapter presented the findings from the qualitative analysis of older workers focus group and semi-structured individual interview data. Five global themes emerged and were discussed; balance in work-life, relating well, managing well, a healthy work environment and health promotion valuing older workers' contribution as key in creating a healthy work life.

In exploring the older workers' lived experience of health in the work life it was evident that a different narrative from the literature emerged from the data.

Older workers viewed ageing from a salutogenic and a broader socio-environmental perspective than the prevailing literature on older worker health. Participants regarded ageing as an asset and a social/relational strength to be valued in the workplace. They sought balance as essential to good health. There was definitely a shift from the individual responsibility and risk reduction to a broader socio-ecological perspective that highlighted the importance of the interaction between people and their environment. Older workers viewed line managers as central in creating the conditions for a healthy work life and valued participation in both planning health promotion and creating a healthy organisation.

The discussion chapter will discuss the significance of these findings for older worker health in the context of creating the broader conditions for individual health in work life, the remaining research questions will be answered, addressing the broader contextual factors affecting health in work life along with organisational support for this cohort's health in work life. The health promotion policy implication will be discussed along with the implications for further research from the findings of this study.

Chapter 5: Discussion

Work is about a search for daily meaning as well as daily bread, for recognition as well as cash, for astonishment rather than torpor; in short, for a sort of life rather than a Monday through Friday sort of dying. [Studs Terkel]

5.1 Introduction

The purpose of this study was to understand how older workers experienced health in work life and apply this understanding, to develop health promotion options specifically designed for the needs of older health care workers.

While the literature is replete with evidence regarding the individual, functional and lifestyle factors for older worker health, the first-hand understanding of health as a salutogenic resource as experienced by older workers in this study are rare. This gap was filled by exploring with older workers the meanings of health from a broader socio-ecological perspective to better understand the inextricable links between themselves and their environment.

In rethinking older worker health positive and broader ecological approach reflected the 'lived experience' of health in work life:

- Salutogenesis where health is experienced as a positive and ageing as a resource for health.
- Socio-environment perspective (Baum, 2008) emphasising the importance of expanding the view of older work health from merely the absence of disease or changing lifestyle behaviour to focus on the socio-environmental determinants of health.
- Socio-ecological (Brofenbrenner, 2005) perspective on human development where the interconnectedness between older workers and their immediate settings were seen as substantial resources for health.

Despite widespread recognition of the diverse health determinants operating in the workplace as a setting of everyday life (WHO, 2002), for older workers there has been

relatively little work on increasing understanding on how these health determinants operate in and through the work setting, directly and indirectly influencing health.

Reframing the contextual factors, the health promotion factors and organisational support factors will better enable the workplace to embed health promoting strategies for its older workers. Further, the processes by which the findings of this research are transferred into health promoting policy making are outlined in the research plan as well as areas for future research and the researches concluding comments. This final chapter will cover the following six sections.

1. The socio-environmental health resource framework for promoting older worker health in work life.
    a. Health resource - value a holistic approach to health promotion
    b. Health resource - Work and life alignment
    c. Health resource - Workplace as a community
    d. Health resource - Health promoting setting
2. Reframing the contextual factors impacting older worker health in work life.
3. Reframing older worker health promotion.
4. Reframing organisational support for older worker health.
5. Research transfer plan.
6. Areas for future research and conclusion.

5.2 The socio-environmental health resource framework for promoting older worker health in work life

To answer the overarching research question ‘What is the experience of older workers about health in work life’? The findings suggest that older workers’ experience of ageing and health are different from the literature. They viewed health more positively with an ecological focus viewing the work setting as a significant determinant of health in work life.

There were different themes identified by older workers who participated in the research than those identified in the literature review. The findings from this research illustrate how the gathering of older workers’ views can help to expand the understanding of complex issues by providing context-specific detail and a greater range of potential solutions relevant to the local health care environment than by using evidence based research alone.

Baum's (2008) socio-environment framework shed light on the differences between the literature review and older workers' own meanings of health and promoting health in work life. The literature review located older worker health mainly in the medical and behavioural approaches to the management and promotion of health in work life whereas, older workers viewed health in work life from a broader socio-environmental perspective.

Bronfenbrenner's (2005; 1999) ecological model of human development for older workers encapsulates the essence of the interconnectedness between older workers and their immediate settings. Bronfenbrenner (2005) depicted his model as a set of concentric circles with the person at the centre surrounded by the environmental influences or systems in which they were situated.

The findings revealed it was the socio-environmental factors that sustained health as a resource in the work setting. This analysis of data research adapted the concept of Bronfenbrenner's ecological model to form a framework that advances our understanding of the health resources important to older health care workers' health in work life. The framework depicted in Diagram 4 illuminates how health as a resource interacts and interconnects through the work environment and how these influence health.

Bronfenbrenner's (2005) model also drew attention to the dimension of time as an important system of influence. The concept of time for older workers was evident in this study with its dynamic interplay among all levels of available health resources influencing older worker health (Diagram 4.). The passage of time was viewed as important for older workers and influenced their own understandings of their health needs.

In addition, older workers viewed time as a positive not as a deficit where health was viewed as a resource and an important determinant for the quality of their work life. However, the literature review located time as linear and negatively associated with health and ageing. The literature on older worker health revealed ageing as part of the 'lifespan' that focused on older worker health as a deficit or decline and something to be managed as a risk in the workplace (Black, 2008).

For example, in the literature reviewed 'the passage of time' was described as 'linear' in contrast to the findings as 'woven' into the fabric of everyday life. Older workers experienced this passage of time weaving balance in work and life as an essential resource for health. Bronfenbrenner (2014, 2005) emphasised how interactions between people and their environment are constantly changing.

When comparing the different meanings between the literature and the experience of health in work life by older workers the divergent views were evident. Older workers viewed ageing from the more ecological viewpoint and experienced age as ‘passage of time’ part of a changing lifespan and a resource for health, whereas, the literature described older workers age as a linear lifespan leading to health viewed as deficit, decline and ultimately old age and death.

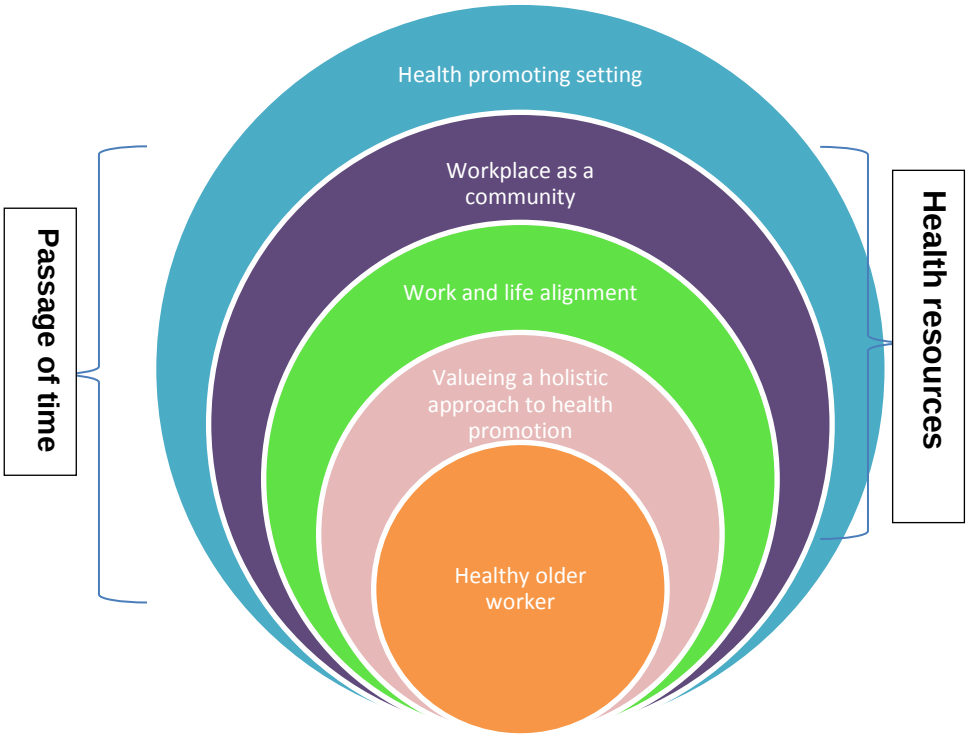


Diagram 4. Adapted from Bronfenbrenner (2005). The socio-environmental health resources framework for promoting older worker health in work life.

In addition, this socio-environmental health resources framework echoes the hermeneutic circle (Ray, 1994) of understanding by weaving the passage of time within the interactions between older workers and their environments. The concentric model represents older workers’ collective picture of the health resources available in the workplace to sustain and maintain their health. A strength for older workers that gained effectiveness with the ‘passage of time’ was relating well, a strength that improved with age and a health resource not only for themselves, but a strength they could promote in the workplace.

The socio-environmental health resources framework captured the experience of older worker health in work life and encapsulated older workers’ focus on a positive, salutogenic

concept of health and well-being. Salutogenic methods are empowering, ‘enabling individuals and groups to have a say in how health is promoted and valuing their perspective; supporting people to acquire the skills and confidence to take greater control over their health’ (Hanson, 2007, p.199). In addition, the literature review revealed health promotion is often problem focused (Dooris, 2009) and the findings from this study revealed the advantages of adopting a salutogenic lens to health for this cohort.

5.2.1 Health resource - value a holistic approach to health promotion

The socio-environmental health resources framework affirms older workers’ salutogenic approach to health promotion, refocusing health promotion from the deficit model of disease and ageing to promoting the health potentials inherent in the workplace setting itself (Lindstrom, 2010). The findings suggest for older workers a salutogenic approach to health promotion would improve the work life context by encouraging a supportive health promoting work community that encourages life and work alignment. These findings are in contrast to those of the literature that placed occupational health professions as key in managing older worker health as a ‘risk’ in the workplace (Naumanen, 2006).

For older workers the meanings of health were interrelated, connected to others and the work environment. This cohort supported a broader socio-environmental approach to promote older worker health as opposed to individual strategies to prevent ill-health or change lifestyle and behaviour. The socio-environmental health resources framework consists of concentric circles that flow from the meanings of health for older workers and represent a consolidated picture of a health promoting workplace environment as identified by older workers themselves. Note that the healthy older worker is in the central position and the health resources interconnect outward to health promoting setting for older worker health (Diagram 4.).

Placing focus on salutogenic experiences of older workers is in accord with the WHO description of health promotion and a health promoting work environment (WHO, 1986, 2001). The findings support a shift in emphasis to the health potentials inherent in the work environment itself for older workers.

The findings revealed for older workers health promotion was considered a resource for health as it enhanced the sense of belonging and connection to others and enriched their health and wellbeing at work. The findings suggested for older workers health promoting activities needed to be embedded in the work setting as part of everyday work life not a

separate activity. The findings support the Ottawa Charter for Health Promotion (WHO, 1986, p.1) aim to help people “reach a state of complete physical, mental and social wellbeing” as older workers seek health promotion to be embedded into everyday work life.

The findings reveal for older workers making the healthy choice the easy choice would mean finding ways to undertake health promoting activities as they work. The findings also revealed achieving holism was an important part of older workers experience in health promotion in the work setting. For example the findings suggest holistic health promotion for older workers included promoting health in the psychosocial work environment. Older workers expressed relating well as strength a determinant for health. Within the Ottawa Charter ‘holism’ is considered an essential issue in “developing strategies for health promotion” (p.3).

Using an holistic definition of health promotion moves the goal of health promotion as identified by Baum (2008) from identifying the diseases and conditions contributing to ill-health and the groups at risk, to identifying the complex interplay of factors which create health.

According to this research older workers support health promotion practices integrated into every day work life as a way to increase control over and improve their health. The findings suggest health promotion in practice still focuses on individual life style risk factors and behaviour change along with the organisation focusing on the employers’ legal responsibilities to provide a safe working environment (Ritter, 2011) as identified in the literature.

Dooris and Hunter (2007) advocate health promotion be integrated within the culture, routine life and core business of the workplace whereby health becomes an integrative goal of the workplace. In terms of integration the findings support a socio-environmental approach to health promotion where health is created in teams and workgroups and worksites instead of targeting individual risk behaviour and lifestyle changes that blames the individual. These findings support the WHO vision of workplace health promotion that places particular emphasis on improving the work organisation and environment and increasing workers’ participation in shaping the working environment (Hanson, 2007. p 262). However, as the literature confirmed for older workers, the work environment and its

effects on health are still the most neglected aspects of the work-health relationship (Naidoo & Willis, 2009. p. 218).

The finding revealed social and environmental factors affected older worker health in work life. Further, the findings suggest that identifying and targeting these factors in a holistic salutogenic approach would enhance their experience of health at work. The findings also suggest health promotion activities be initiated in the work setting without being defined as health promotion per say by applying a holistic settings based approach.

5.2.2 Health resource - Work and life alignment

Work and life alignment were characterised by a socio-environmental approach as influenced by the multiple settings that influence older worker health. The findings suggest if older workers had a good day at work, they were more able to cope with various situations in their private life, and vice versa. Work and life alignment were found to be an important health resource for older workers that not been identified in earlier workplace health research.

Older workers experienced health when the workplace accommodated individual preference in finding a balance between work life and life outside of work. The findings suggest for older workers 'managing the work-life roller-coaster 'as defined by Bryson et al., (2007) was essential to their experience of health in work life. This indeed fits within Bronfenbrenner's (2014, 2005) passage of time as the findings suggest older workers expect the work environment to reorient to older workers' own health needs and accommodate their life and work alignment needs. They worked to 'achieve the good life' as described by Bryson et al., (2007).

Older workers have embraced aspects of the economic paradigm including individualisation, increased choice and flexibility of work patterns. On the one hand the health care organisation has implemented these to improve efficiencies. On the other hand this refocusing may have created an unintended consequence for organisations as older workers call on the workplace to provide them with individualised life and work alignment options to optimise health in their work life.

In the health and ageing literature ill-health is reported as the main 'push' factor leading to early retirement (Humphrey et al., 2003). Conversely, in the extensive nursing literature on 'pull factors' for older nurses Myer & Amendolair (2014) found that extension of work life

could be encouraged if older workers had balance in their work and life domain. The findings highlighted the need older workers had around greater choice in how and when they work. Older workers' views are changing on health, ageing and work which may be an important element of future ecologies in which older workers operate and develop.

Flexibility in working arrangements was identified as a key health potential by older workers. The finding suggested expanding the notion of flexibility to include individual health promotion plans that identify resources for health to include leave arrangements and rosters of work that support work and life alignment. The findings recognised the requirement for structural change refocusing organisational need foremost to a partnership approach (www.enwhp) forming a shared understanding of the organisation and the older worker needs. The findings refine our understanding of the ways structural arrangements around flexible ways of working need to be expanded to enhance the work, home and leisure-life interface for older workers.

The findings established the dialectic link between older worker's private life and themselves as individuals in their work life. It is well established that work and the workplace are important social determinants of health (Joyce et al., 2010). This research broadened our understanding on how flexibility as a key determinant of health for older workers could be operationalised by the organisation. The findings also reflected the need by older workers for the organisation to work in partnership (www.enwhp) with a shared understanding regarding work and life alignment.

Older workers advocate health is created by nurturing self and others, having choice, making decisions and having a level of control over one's work life, where one is able to create working conditions that support the attainment of health for all its members. The findings established for older workers, work and life alignment were a resource for health.

The findings support work and life alignment and reflect the World Health Organization (WHO, 1986) statement that health is created and lived by people within the settings of their everyday life; where they learn, work, play and love.

5.2.3 Health resource - Workplace as a community

The workplace community as a health resource for older workers has not been identified in earlier research. The socio-environmental health resources framework for promoting older worker health highlighted the social structures and resources that enabled health in work

life. The findings suggest for older worker health, their social relationships and affiliations in work life have powerful effects on health and wellbeing.

Older workers' experience of community are similar to Berkman et al., (2000); Duchon & Plowman (2005) and Cherniack et al., (2011), and include sharing, mutual support and commitment that connect people to each other. The older worker idea of community is similar to the notion of Dutton & Heaphy (2003) on "high quality connections," that is, connections that are life-giving and not life-depleting. Osterman, (2000) notes a community exists when its members experience a sense of belonging or personal relatedness. The findings suggest a shift in focus in health promotion from life style groups that alienate older workers to building a sense of mutual support and community on the job.

In understanding the ways in which health is created or inhibited by the work environment, the findings suggest for older workers the work environment is seen as a social system that influences and contributes to both ill health and health. These findings support those found in the literature on the importance of the health environment on older worker health. In the workplace, Pfeffer (2006) refers to management practices that develop as well as damage social connections and contends in belonging to a work community, managers are crucial in building connectedness.

The findings showed for older workers managers and supervisors are crucial in creating positive work environments. Mitchell et al., (2001) show that when people feel connected in a community in which they work they are much less likely to leave. Also, evidenced by Shamian & El-Jardali (2007) who suggest supportive managers are essential in creating nurturing communities at work. Joyce et al., (2010) contend, psycho-social support from colleagues and managers in the workplace has been shown, in some studies to reduce ill-health effects. This view supports Baum's (2008) health promotion framework that expands the representations of health to include the socio-environmental elements as crucial in promoting health.

The longing for community is born in all of us (Duchon & Plowman, 2005; Parker & Gadbois, 2000). Too few managers understand the intense need to be part of something larger, even fewer understand how to tap that longing to support workers' health and wellbeing and productivity (Bennis, 1999, p.47). The findings support enhancing community building by a more holistic approach to health promotion in the work setting.

It is important to recognise that belonging i.e., being a part of a community can now be seen as part of what is required of a health promoting work environment. This is analogous to Bronfenbrenner's (2005) ecological perspective on health. For older workers strengthening the sense of community and connections at work directly impacts their health and wellbeing and supports the notion that work itself has been re-discovered as a source of belonging and connection to others.

The European Network for Workplace Health Promotion (2006) has defined health promotion as the combined efforts of employers, employees and society to improve the health and well-being of people at work. Thus effective health promotion requires us to focus on the places in which people live their lives (Dooris, et al., 2014). The findings suggest for older workers, health promotion programmes may be a mediating structure that could support the development of and strengthen existing work communities within organisations. The findings also reveal that older workers want the structures to work for them suggesting workplaces find ways to harness the natural communities within work settings to support health promotion.

The work community was a focus in the findings. Older workers yearn for a return to community, seeking a sense of connection with others. As Manion & Bartholomew (2004) reflect "community in the workplace is increasingly important". The findings support nurturing the health potential of community building inherent in the workplace context and so promote wellbeing and positive health.

5.2.4 Health resource - Health promoting setting

A socio-environmental approach for promoting heath in work life drew attention to the work setting as a resource for health for older workers. The findings revealed for older workers the work environment influenced their experience of health either by endangering health (Stokols, 2001) or contributing to health as a resource for good health. The findings supported a range of insights that supports the World Health Organization (WHO) statement that the workplace is 'one of the priority settings for health promotion into the 21st century' as it 'directly influences the physical, mental, economic and social well-being of workers and in turn the health of their families, communities and society' (WHO, 2010).

At the centre of the settings approach is the recognition people live their lives in complex social, cultural, economic and political environments that may enhance or diminish their health in various ways (Dooris, 2004; Green et al., 2000). The findings support (Dooris,

2004, 2006) health promotion that focuses on modifying aspects of the setting itself rather than solely changing individuals' health-related behaviour. The healthy settings approach seeks to find ways to strengthen the resources available to people and empower them to increase control over the determinants of health and to flourish (Dooris et al., 2014).

In terms of older workers the findings support Pitt-Catsouphes et al., (2015) suggestion the workplace setting may play an ever greater part in determining health into the future. Further, the World Health Organisation recognises health services as a key setting for health promotion (WHO, 2009). The findings are consistent with Kilpatrick et al., (2016) recent study in Tasmania suggesting the workplace as a promising setting for health promotion especially in building a culture of health within the organisational setting.

The settings approach seeks to make systemic changes to the whole environment. Interventions that address the workplace organisation and culture as a whole are less common but evaluation shows they are more effective (Dooris et al., 2007). The findings support systemic changes to older worker health promotion by embedding health promoting practice into the very fabric of work life. Giddens (1991) states if health is everywhere, then every place or setting can enhance or compromise health. This is in stark contrast with the health promotion literature using the setting as a convenient route to access individuals and to provide traditional health promotion focused on individual lifestyle change. The findings support Dooris, (2004) in that the workplace is a setting that we live our work life and it needs to be more conducive to health.

As Hanson (2007, p.75) reflects, the Ottawa Charter for Health Promotion (WHO, 1986) states that health is created within the settings where people learn, work, play and love, and that health promotion means to empower people so that they can participate in decisions important to their lives and well-being and thereby change the individual and environmental determinants of their health. The findings support older workers' participation in decision making on ways to make the work setting health promoting.

Further, the findings revealed older workers' experience of health is through the social in the work setting. For older workers connection with the work setting is an important determinant of health in work life, another requisite for health is to be able to participate in decisions that affect them. Zoller (2003, p.175) argues that traditionally workplace health programmes and initiatives have worked to 'fit the human being into work processes rather than to change the work processes to fit the human being'. The European Network for

Health Promotion (ENWHP) supports this approach by advocating effective workplace health promotion that involves employees in decision-making processes and developing a working culture based on partnership (www.enwhp.org).

In the Luxembourg Declaration (ENWHP, 2005) emphasis is placed on the fact that health promotion cannot be an activity on its own divorced from the rest of the workplace. Every workplace has its own unique potential preconditions for health promotion. The workplace as setting is both a life environment which influences health and a context – a setting for the work of health promotion.

The socio-environmental health resources framework for promoting health expands our understanding on the health potential inherent in a work setting from an older worker perspective. The findings are also consistent with the aspect in the literature that suggests older workers are responsible for their own health and life style behaviours and health status. Older workers propose health services reorient health promotion to support older workers' own notion of what maintains and sustains their own experiences of health in the work life context.

5.3 Reframing the contextual factors.

In answering the research question 'How do the contextual factors affect older worker health in work life?' the neo-liberal approach to health care was explored as it has altered conditions of the work environment for the baby boomer health professionals who entered the health professions as a 'calling', giving care as a service to the venerable. It is important to note this discussion is not an exhaustive analysis of neo-liberalism rather the discussion focuses on the relevant aspects experienced by this cohort on how the neo-liberal approach has reshaped the health care working environment.

Neo-liberalism is described as an economic paradigm that places economics and the free market at the core of human life (Hartman, 2005, p. 58-59; Harvey, 2005). Neoliberalism has displaced the social-democratic paradigm that was in place when the baby boomers entered the workforce where social wellbeing, caring and social justice principles were embedded in health service delivery (Callahan & Wasunna, 2006).

Further, this paradigm has changed the fundamental view that health and health care are human needs, based on social justice principles including ideas such as, altruism,

professional care and collegiality (Horton, 2007). This health care agenda views health care as a commodity where cutting costs to obtain a higher level of efficiency is considered more important than the public good (McGregor, 2001, p. 83).

In addition, the neo-liberal approach ignores how baby boomers view their work in health care as service to the 'vulnerable', 'altruistic' and where the 'professional' is seen as important in client-professional interrelationships and caring and connection seen as important within the work community. Care as service has become care for profit. For older workers, the neo-liberal approach devalues and de-professionalises health care practitioners by undermining the notions of professional expertise (Ruthjersen, 2007). Moreover, neo-liberalism commodifies professional health care services and the role, identity and expertise of health care professionals (Tomes, 2003, p. 97-98).

For older workers, neo-liberalism affects the purpose of health care, from being a noble cause for the 'common good' to health care becoming a commodity in the free market, based on commercial business practice of seeking profit. Neoliberalism affects the moral and caring nature of health care by undermining the concept of needs based health care (Ruthjersen, 2007). For older workers the meaning and purpose of the 'care' in health care work is being challenged by the neo-liberal health care environment they now find themselves.

For older workers, the neo-liberal health care working environment is shaped by a unique set of 'flexible' working conditions, such as part time work, casualisation of the workforce and short-term contracts. These types of flexible work options are undertaken so the organisation may respond to market needs, evoke economic efficiency, growth and profit (Hogstedt et al., 2007, p. 139, 148; Harvey, 2005, pp. 167-168). In this approach 'flexible' alters the health care professional's role, purpose and identity towards that of a self-serving worker whose skills are for sale to market requirements (Ruthjersen, 2007).

It is the neo-liberal belief that people are responsible for every aspect of their life including opportunities, success and health irrespective of external conditions (Barry, 2005, p. 155). Neo-liberalism promotes individual freedom and people should essentially be 'free to choose' health care that suit their individual needs (Folland et al, 2007, p. 525).

It is this individual freedom of choice in all aspects of life and health older workers are seeking from their workplace. For older workers freedom to choose would mean greater

individual freedoms around working conditions. In addition, for neo-liberalism to support its older workers maintain their own notion of health the organisation would need to reframe ‘flexible’ to include each individual older worker‘s needs regarding work and life alignment. To maintain the older workers’ notion of health, barriers to work and life alignment would need to be identified and addressed. Ruthjersen (2007) puts this succinctly, “to conceive the individual in isolation from the community upon which she ultimately depends is to deny her lived reality” (p.29).

Neo-liberalism has shaped the way older workers are seen by the organisation. Under this paradigm, older workers are framed as a risk to be to managed, a burden on the organisation and a cost rather than asset. Neo-liberalism promotes an individual’s responsibility for their health and wellbeing while it dismisses the socioecological (except economic) determinants for health (Horton, 2007).

Accordingly, for older workers there is a risk that promoting health will be undermined or ignored in a neo-liberal approach. With health and wellbeing thought of as a commodity it negatively shapes the possibilities for ensuring healthy communities including work communities. In this instance profitability and economic constraints may win over the social issues of health and wellbeing (Ruthjersen, 2007, p.30).

An alternative frame to retain our older workers and maintain and sustain their own notion of health would be to realign the neo-liberal approach in the health care work environment. Applied to the work environment this approach would redesign work time to align with older workers own ’passage of time’ resulting in work and life alignment. Humans live and work in shared communities yet neo-liberalism with its emphasis on the individual person ignores the community and ‘common good’ in health care. By reframing older workers as an asset and resource their natural tendency is to engender a sociable, caring and connected work community, a resource for health for the whole organisation.

The above are some reframing options for the neo-liberal health care environment. It is not suggested here these are the only options worth consideration in this context. Whereas, all the above are well worth discussing in light of how older workers experience health in work life, this thesis does not allow such an extensive analysis of neo-liberalism and its impact on the health care environment.

5.4 Reframing older worker health promotion.

In answering the additional question 'What health promoting activities help older health care workers achieve or maintain health in work life?' a salutogenic perspective to health promotion is discussed as a core approach to health promotion practice for older workers. The salutogenic approach to health promotion focuses on the health potentials inherent in the social and organisational setting of everyday life. This approach reflects older workers' own meanings and experience of health in work life. This is not an exhaustive analysis of salutogenesis nor the health promotion field as a whole rather the discussion focuses on a more holistic positive orientation to health promotion identified by older workers.

Promoting health for older workers is a complex phenomenon that can be explored either from a pathogenic or a salutogenic perspective (Bauer et al, 2006). Risk factors and illness prevention concerns are central within the pathogenic perspective, while salutogenic instead focuses on positive health resources for promotion of health (Hanson, 2010). This research revealed older workers were aware there were both salutogenic and pathogenic perspectives to health and wanted to engage in practices and behaviours which are health-promotive, moving towards the health pole of the health ease / dis-ease continuum.

A salutogenic perspective in health promotion is thus not considered equivalent to health promotion that focuses on the prevention of risk factors (Dietscher et al., 2016). Older workers in this research wanted to reframe the current approach to older worker health promotion away from health risk and reducing health risk factors to actively promoting health and a healthy working environment. Wherever older workers were on the health ease / dis-ease continuum they wanted to focus on salutogenic factors in promoting health and wellbeing.

This research further revealed that older workers understood that with chronological age came some functional changes in their health. They also described a workplace that only focuses on these changes as decline and deficit. Older workers described their health work as a health promoting activity and in turn wanted health promotion to have a 'salutogenic' approach that is moving towards health and not towards illness and disease. This positive health promotion approach, identified by older workers in this research, implies that the improvement of health is based on finding the factors which promote health for older workers and their working environment and strengthening them.

A salutogenic orientation, then, as the basis of older worker health promotion is supported by WHO (2002) clarification:

> For the successful development of workplace health promotion, it is important to identify factors contributing to development of health and to facilitate and strengthen impact of such factors conductive to health of all workers (p.27).

Health promotion for older workers fully embrace Hanson's (2007) view that sets out to bring together human beings and their situation or setting where environmental factors, social circumstances, mental process and physiological states interact and influence the experience of well-being as well as the occurrence of dis-ease (p.209). Further, my research supports (Dooris, 2006; Paton et al., 2005; Chu et al., 2000) findings that health promotion needs to empower people so they can partake in decisions important to their lives and thereby change the individual and socio-environmental determinants of their health.

From this research older workers require work environments to focus on creating the preconditions for health and well-being as a buffer to the normal stress and strains of health care work. They wanted the working environment to be a health promoting work environment. This research revealed older workers wanted to participate in creating healthy work environments.

Further, if health promotion for older workers was reframed away from individual risk reduction and disease prevention as proposed in Baum's (2008) framework, where older workers are seen as a burden on the organisation to health promotion strategies that recognised older workers as productive workplace citizens and valued their contribution in the health care organisation. This would not only strengthen the resources for health for older works but would also contribute to organisational success. For older workers health promotion needed to find the factors favouring well-being in the workplace.

As far back as 1986 the Ottawa Charter is clearly directed at a salutogenic approach, emphasising prerequisites for health rather than risks for illness, the Luxembourg Declaration (1997) comes out clearly in favour of salutogenic health promotion strategies stating:

> Workplace health promotion (WHP) is the combined efforts of employers, employees and society to improve the health and well-being of people at work (p.1).

This text is closely linked with WHO's intentions and expresses clearly what WHP means from a salutogenic approach (Hansen, 2007, p.90). Health promotion as defined by the World Health Organisation is the process of enabling people to increase control over the determinants of their health thus to improve their health (McDermott et al., 2010).

In addition, the Barcelona Declaration on Developing Good Workplace Health Practice in Europe (2002) continued to outline the importance of the workplace for both the individual's own 'health practice' and public health, stating:

> Individual health practices are shaped by our workplace cultures and values'
> 'No public health without good workplace health'.

This research reveals our older workforce align with WHO's intention to refocus health promotion away from prevention and illness and disease to refocus health promoting activities on the health resources available to individuals and the organisation which in they work. As the Ottawa Charter for Health Promotion named up in (1983, p.3) 'health is created within the settings where people learn, work, play and love'.

This research also highlights that unless there is a bridge between how older workers are seen by the organisation and how older workers view age as a resource for health in work life, little will be progressed in health promotion for this cohort. Older workers speak of health promoting work and healthy work environment is an everyday strategy for developing health in work life. Health promotion for older workers is directed at the positive embodying the idea of salutogenesis and a holistic view of health. Health promotion for older workers places greater emphasis on the work environment and the social nexus in the work community and is incorporated in everyday regular work.

This research supports McGillivray (2002) findings that health promotion includes employee participation, involvement and consultation to develop fit for purpose health promotion strategies to improve staff engagement and ultimately health outcomes.

5.5 Reframing organisational support

In answering the additional question ‘What could the organisation do to help participants maintain and promote health in work life?’ participation in decision making was identified by older workers as an important organisational support to improve health in work life. It is important to note this is not an exhaustive discussion on organisational support nor participation per say; in reframing organisational support for older workers, participation in decisions making was identified as a key way to play an active part in determining what supports their own notion of health in work life.

This research revealed one of the most crucial criteria for promoting health in this cohort is active participation in decisions that affect their health and wellbeing. This is a radical requirement in the health care environment as described by older workers themselves. In a sense we go from an expert perspective where occupational health professionals have the knowledge, to older workers’ own perspective which entails they have a say over their own situation, in the work environment, if any change is to be made.

The concept of participation within health promotion is not a new concept WHO from its earliest conception (1946) highlighted the importance of participation:

> Informed opinion and active co-operation on the part of the public are of the utmost important in the improvement of the health of the people (P. 100).

Since then, the conditions relating to participation has been part of the majority of documents which have been published by both WHO and ENWHP on workplace health promotion. In 2002, WHO published the criteria for health promotion to include the workforce at all levels to take part in a dialogue about health (p.27).

It is clear from this research that older workers own lived experience is vital in understanding the health in work life needs of this cohort. In this research older workers highlighted the gulf between what the experts (occupational health professionals) say is important and what older workers’ own understanding of organisational support for health in work life would look like.

The Ottawa Charter emphasis is placed on strengthening lay participation in decision making;

> Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities – their ownership and control of their own endeavours and destinies (p.6).

The theory is resolute on the importance of participation in decision making for health and health promotion to be effective. Older workers are adamant that participation is the key to promoting health and health promotion effectiveness. This research supports the theory that by creating greater participation, the health organisation will gain greater understanding, greater involvement, and a better adaptation to a healthy working environment.

From this research creating participation should happen in the social setting of the work group and work environment as it is these people who have to act (Lowe, 2010). Those who work in a particular work environment are those who know best how things are there, and what needs to be done. The organisation needs to know how to involve and listen to older workers in creating genuinely health-promoting work environments. To fully support health in work life older workers call for the health organisation to rethink, support and implement a genuine process for participation in decision making. The benefits of working in true partnership would generate 'profit' in a neo-liberal sense for older workers, the health care organisation and ultimately have a flow on effect within the communities in which they live.

It is indeed the limits of the current health promotion paradigm embedded in health care organisations that need to be reframed to being responsive to the needs of its older workers for promoting health in work life. There is a complete mismatch between what the organisation sees as important and what older workers are seeking. The transfer of this research is crucial in understanding the lived experience of older workers' health in work life and for the organisation to embed health promoting strategies that will maintain and sustain older workers' health in work life and also enable older workers to take better health into post work life.

5.6 Research transfer plan

The research focus explored the lived experience of older workers' health in work life to better understand the phenomenon and support health promotion for this cohort. For older

workers the organisation's ability to understand and resolve the different framings around health in work life will be crucial to older workers staying on past current retirement age.

The current frame for older worker health has age and health on the illness end of the illness / health continuum. Where age and health are seen as a risk a burden to be managed whereas, older workers frame age as a resource for health and a positive strength for the health care organisation.

The missing link for older workers is for the health care organisation to view health from a salutogenic perspective that is geared to health and wellness. The older workers in this research found many positives that come with age. For older workers this 'passage of time' enhanced social connectiveness and relatedness as was experienced by older workers as a health resource benefiting the organisation. This research highlights working past current retirement age for this cohort will be contingent on the work organisation coming to terms with these different perspectives.

This research uncovers a deeper value difference between older health care workers and the health care work environment. The neo-liberal work environment that older workers find themselves in is based in economics and efficiencies for profit. For older workers this is juxtaposed against the values that were in place when they entered the workforce where 'caring' and 'altruism' were the underlying values of entering the health care professions.

For older workers to stay healthy and thus stay at work health care organisations will need to reorient their perspectives on what constitutes health promotion for this cohort. From this research there is enough evidence in the data to show how the organisation sees its older workers and the evidence indicates it's time to listen and act. As Zoller (2003, p.175) suggests workplace health programmes and initiatives have traditionally worked to 'fit the human being into work processes rather than to change the work processes to fit the human being'. It is time for a different frame, an ecological lens that focuses on the positive, holistic and salutogenic approach to promoting older worker health in work life.

In Chapter 3 I discussed the importance of the research transfer plan to be implemented at the end of study. As discussed earlier in Chapter 3, it was important as the researcher and as an employee and an older worker to stay the researcher until the end of the research project. This research was conducted across the Tasmanian Health Service. This service supported this research and takes an active interest in improving its approach to workplace health and was keen to gain a deeper understanding of older workers' own

perspective of their health in work life and health promotion needs and how the organisation can better support these needs.

A research report was developed at the end of the study that outlined the context specific health promotion options for improving older worker health in work life. The research report was circulated to the senior executive team, occupational health and safety and wellbeing team to be used in the development of a comprehensive organisational wide workplace health promotion policy (see Appendix 6). Further a copy of the research report was sent to the Commonwealth Policy agency for Older Australians (COTA) and the Australian healthcare unions including the, ANF and HASCSU. In addition, it was sent to the Secretariat of the European Network of Workplace Health Promotion to help inform the workplace health promotion for older workers.

5.6.1 Older healthcare worker promoting health in work life options

The twenty health promotion policy options for promoting older worker health in work life (Table 11.) were developed as a way to transfer knowledge that fits with the local culture of the organisation. In providing policy options that have been developed from older workers themselves, the Tasmanian Health Service is more likely to adopt the suggested strategies than other forms of knowledge.

The health promotion options were developed from older workers' own perspectives highlighting the importance of using 'lived experience' to inform THS workplace health promotion policy and practice. Further, in using 'lived experience' the contextual factors that impact older worker health in work life are emphasised by older workers over life style changes to be undertaken by the individual.

The health promotion policy options are presented under each of the four health resources identified by the older worker cohort as health potentials available in the workplace to support health. The four health resources are:

1. **Value a holistic approach to health promotion**: Within this resource older workers would like to see health promotion to be incorporated within the work team and undertaken throughout the day /shift. Older workers thought managers were key in creating health promoting opportunities as part of normal work. Their health promotion examples are listed in Table 11.

2. **Work and Life alignment**: Older workers suggested that the work life balance policy include other options other than working from home options (front line health care workers are not able to access this option). Older workers would like to see shorter shifts and have longer annual leave options with leave without pay for extended periods supported by the organisation. See Table 11 for details.
3. **Workplace as a community**: Older workers wanted to stay on working as they really enjoyed the community building aspect of work life. They suggested managers were key in improving social connectedness and in helping build new connections in the workplace. There suggestions can be seen in Table 11.
4. **Health promoting setting**: Older workers wanted to work in a partnership and participation model with the organisation to create a health promoting setting at work and a focus placed on embedding wellbeing in the work environment. See Table 11 for suggestions.

Table 11 presents the list of 20 health promotion policy options to maintain and sustain older worker health in work life.

Table 11: List of twenty health promotion policy options for promoting older worker health in work life

1. Health resource - value a holistic approach to health promotion
Managers and older workers to work in partnership in developing team health promotion plans that incorporate activities that can be performed in work teams without being defined as health promotion per say.
Place health promotion on team agendas and support older workers' participation in decision making on ways to embed health promotion in the work setting.
Embed health promotion activities into work teams e.g. develop stretch and strength exercise circuits into every day nursing environments.
Managers to discuss with individual older workers on what health promoting activities they are interested in and managers to support participation.
Senior Management to be a champion of health promoting behaviour and model throughout the organisation.
2. Health resource - work and life alignment
As an organisation - open up dialogue with older workers on how work can better align with their whole of life needs – develop a good ideas process.

Develop ways that the organisation can work in a partnership approach (www.enwhp) with shared understanding regarding work and life alignment e.g. hold forums on work sites.
Develop individual heath promoting plans as part of individual work performance development plans that align with work and life balance.
Develop more roster options e.g. roster that begins at 5 am and finishes at noon. Develop shorter shift options e.g. 6-hour shift instead of 12-hour shift or 4-hour shifts. Offer leave without pay options for older workers e.g. travel overseas for an extended period.
Develop work flexibility options that cater for different team needs. These may be different for different groups' e.g. front-line health care staff and corporate services.
3. Health resource - workplace as a community
Managers to assist their older workers harness the natural communities of similar health interests within work settings to support health promotion.
Managers to recognise and encourage ways to discuss belonging and connection to others in work life and discuss how this impacts health and wellbeing at work.
Managers to introduce activities that build connectedness in their work teams e.g. birthday morning teas, recycling group, book club, other shared interest groups.
Managers to have a KPI on creating and building positive work environments.
Managers to have a KPI around building nurturing communities at work.
4. Health resource - health promoting setting
The organisation to embed education on health promoting ways of working within teams. Support older workers participation in decision making on ways to make the work setting health promoting.
The organisation to embed strategies into the Manager Inductions Program that promote team wellbeing.
A health promotion specialist / coach to support senior managers to embed wellbeing across the organisation to support retention of its older healthcare workers.
Staff wellbeing to have a regular space in the organisations newsletters.
Embed building a wellbeing culture as an organisational value along with organisational strategies to achieve this.

The above list presents the socio-environmental health resources framework for promoting older worker health in work life. The health promoting strategies brought

together the themes emerging from the older workers' lived experience of health in work life and reflects aspects relating to health promotion theories and concepts. Basing health promotion strategies in the socio-environmental health resources framework can assist older worker engagement in health promotion.

5.7. Conclusion

This research investigated the lived experience of older workers' health in their work life to develop context specific health promotion options for the Tasmanian Health Service to consider in improving older worker health. To better understand employee perspectives on the phenomenon, older workers of the Tasmanian Health Service were invited to join 13 focus groups and three semi-structured one-on-one interviews were conducted to examine the phenomena in more detail. The meanings of health were explored in the context of work life and how the workplace could better support older workers own notion of health in work life.

An interpretative analysis of the data collected found different assumptions on the way older worker health is viewed between the literature and how older workers themselves experience the phenomenon of 'health in work life'. The literature attributed decline and deficit with ageing and a risk to be managed in the workplace. The interpretive analysis illuminated how older workers experienced age as a strength with positive health potentials.

The literature dominating older worker health and health promotion practice is based in the medical model and the neoliberal paradigm that defines health as the responsibility of the individual and that health declines with age. The findings were fundamentally different from the literature. The analysis revealed the importance of reorientating the neoliberal perspective that targets the individual in taking more responsibility for improving their health. The findings revealed a novel application to the traditional neoliberal approach. Older workers reframed personal responsibility for health and organisational support to create individualised health promotion plans that would enable older workers to maintain and sustain their own notion of health.

This research found for older workers, promoting health through a salutogenic lens offered a deeper understanding of how older workers viewed their health potential as they age. The socio-environmental work setting was viewed as essential in creating the conditions

for health in work life for older workers. The contextual factors found the work environment as a health resource necessary in retaining this cohort past current retirement age, advocating a much broader role for the work setting in operationalising health promotion solutions.

These findings suggest there are significant challenges to overcome but is likely that reframing health in work life and health promotion will contribute towards the probability of work becoming a healthier, more satisfying and more productive experience for older workers and facilitate their continued contribution in the workforce. The findings provided a greater range of health promotion solutions than the current lifestyle solutions on offer in the workplace.

Twenty potential solutions were found through conducting this research that were applicable to the development of the Tasmanian Health Service health promotion policy in the future. These health promotion strategies focus on four areas of action for policy makers; valuing a holistic approach to health promotion, work and life alignment, developing a workplace as a community focused on connectedness and the workplace becoming a health promoting setting.

From this research, several areas could be researched into the future. To gain a wider representation, older workers' views could be broadened to include other healthcare organisations across Australia and internationally. Further, exploring the meanings and experience of health in healthcare settings could include the medical profession for a greater understanding of what constitutes health in work life for this cohort and possible health promotion solutions to improve health at work for older workers.

In conclusion, there is a clear need to create health promotion policies to make staying on at work attractive for our older workers. It is imperative that these policies are focused on assisting older workers to remain healthy and productive enabling them to take good health into post work life. There are still considerable methodological challenges to overcome but is likely that such a policy will contribute towards the possibility of working becoming a healthier, more satisfying, more productive experience for older workers and facilitate their continued contribution in the workforce.

When 'I' is replaced by 'We' even 'Illness' becomes 'Wellness'.

(Lauzon, 2001)

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Tables

Diagrams

Appendices

Appendix 1 – Information Sheet

INFORMATION SHEET

Title: Older Worker Health in Work Life

Investigator:
Ms Robynne Rankine
Workplace Health and Wellbeing Service
Tasmanian Health Organisation South
Ph: 6222 6814

Description of the study:
I am undertaking research into what is important for older worker health and the work-health relationship more generally. It is hoped this research will give THO-S a deeper understanding on how health promotion can better support older workers stay healthy and in the workforce for longer. This project is supported by Flinders University Public Health Department.

Purpose of the study:
This project aims to find out what is important for older worker health and how best to promote healthy ageing at work.

What will I be asked to do?

Focus Group Participants
You are invited to attend a focus group with the researcher who will ask you a few questions about your views listed below:

- Explore how older workers define health at work?
- Explore how the work environment supports health?
- Understand how do contextual factors affect their health, e.g. environment, social, political, economic?
- Explore what the underlying workplace determinants of health are?
- Understand what health promotion would support older workers achieve or maintain health?

The focus group will take about one and half hours. The researcher will keep field noted relating to the focus groups.
Interview Participants

You are invited to attend a one-on-one interview with the researcher who will ask you a few questions about your views on healthy ageing at work and how the workplace can better support healthy ageing – exploring similar questions as listed under the focus groups. The interview will take about 30 – 60 minutes. The interview will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file and then destroyed once the results have been finalised. This is voluntary

What benefit will I gain from being involved in this study?
The sharing of your experiences will improve the planning and delivery of future health promotion programs. We are very keen to deliver a service and resources which are as useful as possible to people.

Will I be identifiable by being involved in this study?
We do not need your name and you will be anonymous. Once the interview has been typed-up and saved as a file, the voice file will then be destroyed. Any identifying information will be removed and the typed-up file stored on a password protected computer that only the coordinator (Ms Robynne Rankine) will have access to. Your comments will not be linked directly to you.

Are there any risks or discomforts if I am involved?
Other group members in the focus groups may be able to identify your contributions even though they will not be directly attributed to you. The investigator anticipates few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigator.

How do I agree to participate?
Participation is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the interview or focus group at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form and send it back to me at robynne.rankine@dhhs.tas.gov.au.

How will I receive feedback?
Outcomes from the project will be summarised and given to you by the investigator if you would like to see them.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number: H0013651*). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au*

Appendix 2 – Consent form to participate in research

CONSENT FORM FOR PARTICIPATION IN RESEARCH

(by interview/focus group)

I ….....
being over the age of 18 years hereby consent to participate as requested in the Letter of Introduction for the research project on healthy ageing at work.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Letter of Introduction and Consent Form for future reference.
5. I understand that:
    - I may not directly benefit from taking part in this research.
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
    - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

Participant's signature……Date……..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….....

Researcher's signature……..Date…….

NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 8 and 9, as appropriate.

6. I, the participant whose signature appears below, have read the transcript of my interview and agree to the publication of my information as reported.

Participant's signature……Date……..

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number: H0013651*). For more information regarding ethical approval of the project the Secretary of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.*

Appendix 3 – Transcript Reading Frame

Administrative Details	*Reference*	*Other*
Transcript Reference		
Interview Type & Date		
Interviewer		
Reader Reference		

Section 2

Reader's General Impressions
1 Initial reading of your transcript Read the transcript through several times... initially quite quickly to gain a sense of the whole... then more carefully to hear the interview - imagine the interviewer's voice and the pai1icipant's voice hear the conversation as it gets underway, unfolds, and concludes.
1 Notes:
2 General impressions of the interview structure, format, processes and outcomes When you have heard the conversation ... write down your general impressions of the interview structure, format, processes and outcomes. What took place? What areas were covered? What is the structure of the interview? Is there anything about the interview itself that should be noted before more detailed interpretation takes place?
2 Notes:
3 General thoughts about what was gained by the interview in relation to the research topic. What information has been gained in relation to the research interest? What is the value of this? Why is this important? How have your ideas and understandings been challenged

As a 'detective': What hints, clues, questions, links, possibilities emerge and need following
4 Other general impressions Is there anything else that should be noted?
4 Notes:

Section 3. Specific Information: Content Analysis of the Transcript (Technical Reading)
Reference system: Transcript lines [eg 235-455]

1 Annotating the transcript

Read the transcript and begin working with it systematically...
Notice when the topic moves or the conversation shifts. Make an annotation in the margin re what this section is about (two or three words), note the line numbers that this part of the conversation covers. Work through the whole transcript until all the transcript has been broadly annotated.

In the sections below ... summarise the annotations, list topic and line numbers

1 Summary of Annotated Notes (and accompanying lines):

2 What does the transcript reveal about the topic

Summarise the interviewee's key information and the insights that emerge for you from this transcript about the topic.

2 Notes:

Section 7

Insights into Themes Emerging: Thematic Analysis (Interpretive reading)
(Reference system: page/s:paragraph/s:line/s [eg I:2-5:A or eg 1:2:3-5]

Instructions re themes
Take some time to think about the interviews as a whole. What have the interviews revealed? What is emerging?

Use the boxes below to record themes/concepts/aspects emerging for you in relation to the research. Use a different box for each separate idea or theme. Name the box. Write about the idea or theme. State your thinking and insights. Relate the insights and thinking to specific parts of the text or to general information gained in the interview.

1

2

4

5

Section 8. 'Other': Alternative and Non-conforming Perspectives (Interpretive reading)

(Reference system: page/s:paragraph/s:line/s *[*eg 1:2-5:A or eg 1:2:3-5]

General information re reading for alternative & **non-conforming perspectives**

One of the dangers with interpretive research is that researchers' assumptions and ways of thinking about the research can distort the interviewee's perspective, or can pre-empt the findings of the research. Sometimes this occurs because of the interview processes or the way the particular interview evolved. Sometimes it can happen in the content analysis or thematic analysis of the transcript because what 'stands out' to the researcher is so strong. One of the ways of minimising this type of research error is after the initial impressions, the content analysis and/or thematic analysis of the transcript have been undertaken is to undertake a read of the transcript for alternative and non- conforming perspectives.

To prepare for this type of reading the researcher usually engages in a couple of processes: alternative and non-conforming explanatory perspectives and frameworks.

1 Instructions re reading for alternative perspectives

Alternative Perspectives
Firstly, the researcher consciously puts aside the impressions and interpretations gained thus far, and try to look at the transcript with fresh eyes. Is there anything else in the transcript that has not been identified so far? Are there alternative positions or insights that the interviewee is trying to express during the interview that were missed or different to the what the interviewer picked up on? If as the reader of the transcript you were to read the transcript wearing 'different glasses' to the ones worn so far... Are there other ways of seeing what the interviewee is saying? Are there other ideas, insights, positions that can be identified? Are there bits that are missed that if we thought about them another way, could become significant?

Use the boxes below to record alternative perspectives which you think may be present in relation to the research. Use a different box for each separate idea. Name the box. Write about the idea. State your thinking and insights. Relate the insights and thinking to specific parts of the text or to general information gained in the interview.

1.1

1.2

1.3

2 Instructions re reading for non-conforming perspectives

Non-conforming Perspectives and Frameworks
Secondly, the researcher draws on all the understandings and impressions written about and gained thus far and tries out different explanatory frameworks to those postulated in the prior reading and coding of the transcripts.

Are there other ways of explaining what the transcript has uncovered?
Given the explanations posited by the researcher in the interpretation of the transcript include supporting and confirming material e.g. quotes/ text reference tie-backs; is there any part of the transcript that disconfirms the interpretation or theme? Review the transcript for non-conforming and disconfirming material.

Use the boxes below to record different explanatory frameworks which might be present or posited by the text or researcher? Record also non-conforming and disconfirming perspectives and frameworks which you think may be present in relation to the research. Use a different box for each separate idea. Name the box. Write about the idea. State your thinking and insights. Relate the insights and thinking to specific parts of the text or to general information gained in the interview.

2.1
2.2
2.3

Section 9.Summary in relation to the research aim and questions

What information has been gained in relation to the research aim and questions? Why is this important?
Write summary points and note any "so what's", implications etc.

NB This is early... and it is not meant to be repetitive rather it provides an opportunity to summarise key points if they have emerged **in** relation to the research questions.

Aiml The primary aims of this qualitative study are . ..
Ql
Q2
Q3
Q4
QS
Q6
Q7
Other

Appendix 4 – Draft narrative

Appendix 4 Draft Narrative	
Focus group 4aa 10 participants 21 February 2014	
Label	**Exploring Health** • Having enough time to go about the daily activities of everyday life – not feeling rushed and time pressured regarding getting to work and then by the time you get home from work - no time except for eating and sleeping. • Having a general sense of wellbeing – physical, emotional, social, mental and spiritual. • Time for self – it takes much longer these days just to get organised for work. • Not being sick – it takes much longer to get over being sick – important as you get older to focus on activities that maintain wellness. • Good mental health – no health without good mental health. • Workplace is social outlet – increase the connectedness across my workplace would add to my sense of wellbeing. • Social capital – giving back – makes me feel healthy and well • Having work and life in balance is good for your health.
	Exploring Work • Work life out of balance - takes longer than 8 hours – getting ready for work – getting to and from work. • Life out of balance – due to work - no time for social during the work week. • Provides good structure in your life. • Working in public sector health is community work – you feel like you are giving to the community. • My work is good for my health.
	The Work Environment • Social outlet – like a small village – feeling of community very important. • Needs flexibility – gives you freedom to do other things – shorter days, unpaid leave, work an 8 or 9 day fortnight. • Provide purchase leave scheme – need more flexibility around working

	options • Need to increase social activities on worksites. • Mental health is affected by work stress – always feeling like you are on a treadmill. • Workplace not older worker friendly regarding flexibility – the workplace is child commitment friendly – however, older working seeking time-off are seen as selfish and self-centred not workplace centred. • Building a work environment of support and belonging. • There is no health without a healthy work environment.
	Supporting Workers - Health Promotion • Need social outings – as a part of work. • Provide aerobic classes at lunchtime at my worksite. • Provide team based health promoting activities. • Build wellbeing into my daily work • Allocate a team member to focus on team wellbeing – maybe the social club turns into a wellbeing club. • Perception is THO-S gym is only for gym 'junkies'. • 'Feel Better' HP activities are not well communicated. • Gym could be more supportive for older workers.
	Prevention of Retiring Early • No one is interested in employee health – culture does not support health – from CEO to direct line supervisor – the organisation only pays lip service to employee health. • Workplace inflexible – even with HR policies – current management culture inflexible. • Retire early because work takes up too much of your time – no time for social inside or outside of work. • The workplace needs to support flexible work hours. • Change the workplace culture to support leave without pay/ or buy leave schemes to allow big chunks of time to be taken-off – e.g. 3/6/12 months then come back refreshed.
	The overarching narrative developed by the researcher from this focus group: • Work at this stage of the life cycle needs to be in balance with a more holistic approach to life. • Workplaces need to provide more flexibility with work hours. • The workplace needs to offer older workers - conditions regarding work in a much more person-centred way.

	• The workplace need to provide opportunities for connectedness and relatedness across the organisation. • Increased employee participation in workplace decision making • Workplace health promotion needs to be much more holistic than one-off physical activities and/or education sessions – HP needs to focus on building connectedness and relatedness into all activities. • The organisation and managers need to support health and wellbeing as a core value of the organisation. • Health promotion needs to be more individually focused using their own definition of health. • Develop work practices around the needs of employees. • Develop leaders and managers with employee personalised management style.

Appendix 5 - Charting data into the framework matrix

Category	**Exploring healthiness**	**Exploring Work**	**The Work Environment**	**Supporting workers- in health promotion**	**Staying on past current retirement age**
Theme	**Health means 'wellbeing' and is experienced differently for different people**	**Participatory management and decision making regarding promoting healthiness at work**	**Build a sense of community and social connectedness at work**	**Move health promotion from individual lifestyle responsibility to corporate responsibility – embed a wellbeing culture**	**The organisation values life balance as a key to an individual's health and wellbeing**
1. Focus group	Physical, emotional, mental and spiritual – healthiness = wellbeing***	Work could be much better for our health and wellbeing – the organisation should ask the workers how it can best support health and wellbeing.	The work environment needs to better support a community of workers rather than a bunch of individuals only interested in themselves	We need to be very different in how we deliver health promotion based around what our employees need and I think at the moment we're not. We're still focused on what's easier for the organisation – a tick the box approach to health promotion.	I want individually tailored flexible work arrangements*** that suit my lifestyle.
2. Focus group	Having time for work, rest and play and supportive work environment	I want work to be more flexible and I want the organisation to ask me what I need as an older worker***.	Build a lot more social connectedness into everyday work life. Need to be team based activities and build wellbeing activities into daily work life. ***.	If our leadership modelled wellbeing that would permeate throughout the organisation. Needs to be a organisation value that's embedded across the org.	Life balance is all about flexible work arrangements
3. Focus group	Not having to rush to fit everything into my work day – work fits	Being asked what I need – being part of the decision making process – not being	Psychosocial work environment important as the work itself. If we	I would know the workplace cared about me as a person if staff wellbeing became the	I want to feel valued as a person and that my manager asks me what I need to stay

	with the rest of my life not the other way around **(da)	told what good for my health – work very stressful – not the work but the way work is done – the way we communicate with each other..	focused on creating a health and wellbeing community this would impact directly on client care outcomes.	focus of all management interactions. My experience is the workplace makes us individually responsible for our own health – when it's the work environment that is unhealthy.	healthy and working – my manager supporting me in what I need is the key.
4. Focus group	Having a general sense of wellbeing. No health without mental health. Time for self – not being rushed.	Life out of balance due to work – no one asks what I need (aa follow-up). I want to be a part of the decision making that affects my health and wellbeing at work. In my private life I have more control of my health and wellbeing – at work the organisation has more impact and it is unhealthy.	Social outlet – like a small community – feeling of community very important	I want the organisation to take some responsibility in my healthiness. The culture is very stressful and my management keep making us do more with less	Culture does not support health – inflexible. Management does not support individuals in their choices.
5. Focus group	Having fun – we don't laugh anymore at work – where has the fun gone – work has got very serious	I want to be consulted – really consulted about what would support my health and wellbeing at work. This would mean my manager asking me how best she can support my health and wellbeing at work.	The workplace on one hand blames lifestyle choices on staff for poor health outcomes – yet on the other hand does not support staff in what would improve their health and wellbeing e.g. flexible work arrangements.	Our leadership only care about the work getting done – not the stress its puts us under. Need the organisation to embed wellbeing as a core value. Our senior leadership need to walk the talk.	Your line manager and the way they treat you – do they put your wellbeing first if they did - would stay on
6. Focus group	Having enough energy to get everything done that I need to get done in the day.	Get rid of double shifts and late followed by early shift***. I need to work a day job now that I am older.	Need to increase social activities on work sites – it's all about work now and no play – the workplace is far	Imagine the workplace asking me how it can support me in my health and wellbeing. I would say the organisation	As you get older you need more work like balance – it takes you longer to recover – get fatigued easer – need

	Having enough time in a day the older I get the longer it takes	I want to be asked what I need as an older worker.	too serious.	needs to start to value me and start asking me how it can help me achieve my goals - imagines a workplace like that.	manager to try to meet individual needs with leave?
7. Focus group	Healthiness means flexibility***. Healthiness means work fitting in with me other than the other way around.	Work to be more flexible – more flexible leave arrangement – work more with our energy levels that have peaks and through throughout the day/week etc.	Work environment not older worker friendly – older workers seeking time off are seen as selfish – we have child friendly now need to incorporate older worker friendly.	I want to be asked about what influences my health and wellbeing at work. I experience the work environment as very stressful – I can feel my blood pressure rising as soon as I enter the door.	If we could have blocks of time off to visit children interstate and overseas – may have elderly parents on top of this – reducing to 4 days a week does not help this.
8. Focus group	Means my mind and body feel healthy and not stressed**. Sleep gets affected by shift work. It's a sense of freedom – time	I want to be consulted and participate in what, how and when we look after our own health and wellbeing – work needs to focus on the work culture.	Focus on building a sense of community and belonging – RHH use to have this but lost over last ten years. Let's celebrate together. Work relationships the most important.	Health promotion needs to be team based and needs to focus on reducing stress in the work environment. When we all work together (an)**. The organisation itself needs to get healthy.	If you could take a few months of every other year and still have you job when you get back – I would stay working.
9. Focus group	Feeling in balance – work often makes you feel out of balance**	My manager treat me as a 'human resource' not just a resource. Often feel just a number not a person – we are all different with different needs.	Mental health at work is affected by workplace stress – you always feel you are on a treadmill – no down time any more.	Wellbeing needs to embed in the work environment – it all starts with how well we work together as a team and how well the work environment is and how well the organisation is.	My line manager understanding what my health and wellbeing needs are – be able to adjust my start and finish time as needed – just a more flexible approach by the organisation.
10. Focus group	Being able to fit exercise into my daily work – more team based wellbeing activities.	Work to focus more on not only the health needs of our clients/patients but on the health needs of the staff – let's make work healthier by focusing on building healthy activates	There is no health without a healthy work environment – my own health is affected by the high levels of workplace stress.	Health promotion needs to be offered on my worksite and preferable in my work team – we could do all sorts of things together to improve our wellbeing – let's start talking together.	More time off – I want to be able to take a couple of months of a year to visit family and friends dispersed all across the world.

		into our daily work***.			
11. Focus group	At this stage of my life work needs to fit into my life –so I don't feel so rushed – needs to work in with my natural daily rhythm.	I want work to ask me how they can better support my health and wellbeing needs at work	Need a more flexible work environment – that allows time off to do other things. I work hard and get all my work done – so it's not about productivity it's about flexibility.	I want to be consulted about my own health and wellbeing needs – everyone is different – I don't want to join a gym – so why can't the workplace support something I want to do.	To be able to work full time and then take off a couple of months in the middle of winter and then a month block over Christmas – I would work for another 10 years (60 gn).
12. Focus group	I want to feel my physical, mental, emotional health is valued and supported at work.	More flexible work arrangement – this would mean by manager asking me what I need***	I want us to feel part of a bigger team – working for the health and wellbeing for all – we work in healthcare why can't the work environment be more focused on staff health and wellbeing.	The workplace needs to stop pushing the individual to exercise more (as in attend an exercise class put on for staff at an inconvenient time and location) and make sure our everyday work is building on health and wellbeing – rather than stressing us out and making us more unhealthy.	I want more flexible work arrangement – 9-5 – with one moth of a year does not suit anymore – children, grandchildren, elderly parents both interstate and overseas.

Appendix 6 – Health promotion recommendations to improve older worker health

Older healthcare workers' lived experience of promoting health in work life

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Older worker health promotion recommendations to improve health in work life

Background

This report has been prepared by Robynne Rankine a doctoral student and Flinders University, Australia as part of a dissertation for a Doctoral in Public Health. The content of this report has been drawn from the research conducted on understanding health in work life and how the organisation can support promoting health in work life for its older workers.

The aim of this research was to address the question, 'what is the experience of older workers about health in work life?' For the purpose of this research, older workers refer to healthcare workers in allied health, nursing and health managers across the Tasmanian health Service. The research focus explored the lived experience of older workers' health in work life to better understand the phenomenon and support health promotion for this cohort. For older workers the organisations ability to understand and resolve the different framings around health in work life will be crucial to older workers staying on past current retirement age.

The current frame for older worker health has age and health on the illness end of the illness / health continuum. Where age and health are seen as a risk a burden to be managed whereas, older worker frame age as a resource for health and a positive strength for the health care organisation.

The missing link for older workers is for the health care organisation to view health from a salutogenic perspective that is geared to health and wellness. The older workers in this research found many positives that come with age. For older workers this 'passage of time' enhanced social connectiveness and relatedness as was experienced by older workers as a health resource benefiting the organisation. This research highlights working past current retirement age for this cohort will be contingent on the work organisation coming to terms with these different perspectives.

This research uncovers a deeper value difference between older health care workers and the health care work environment. The neo-liberal work environment that older workers find themselves in is based in economics and efficiencies for profit. For older workers this is juxtaposed against the values that were in place when they entered the

workforce where ‘caring’ and ‘altruism’ where the underlying values of entering the health care professions.

For older workers to stay healthy and thus stay at work health care organisations will need to reorient their perspectives on what constitutes health promotion for this cohort. From this research there is enough evidence in the data to show how the organisation sees its older workers and the evidence indicates it’s time to listen and act. It is time for a different frame, an ecological lens that focuses on the positive, holistic and salutogenic approach to promoting older worker health in work life.

This research was conducted across the Tasmanian Health Service. This service supported this research and takes an active interest in improving its approach to workplace health and is keen to gain a deeper understanding of older workers’ own perspective of their health in work life and health promotion needs and how the organisation can better support these needs.

Method

Fourteen focus groups were conducted across the Tasmanian Health Service with older workers and 3 in-depth interviews were conducted to follow-up on themes discussed by the participants in the focus groups. There were 173 participants in total from across the Tasmanian Health Service. Participants of this research were asked about their experience of health in work life, how the organisation could support their own notion of health and what actions they think should be taken to improve health in work life.

All interviews were tape recorded, transcribed and analysed. Close reading of the transcripts were undertaken by the researcher. Themes were identified as well as possible actions that could be undertaken to improve health in work.

Results

A set of 20 health promotion policy options have been developed. These options were compared against the academic literature reviewed over the last 17 years and only health promotion policy options that were identified by older workers have been included in this report.

Employee knowledge has been evidenced in the literature as valuable in promoting healthier workplaces. Yet most of the available research does not take into account the perspectives of employees in the design, implementation, participation or evaluation of workplace health promotion programmes and even less research is available that takes

into account older worker knowledge when developing health promotion policy solutions for workplace health promotion policy.

The Ottawa Charter for Health Promotion states that “health is created within the settings where people learn, work, play and love” (WHO, 1997, p.3). Health promotion is defined as ‘the process of enabling people to increase control over and to improve their health’ (Nutbeam, 1998) and means to empower people so that they can participate in decisions important to their lives and well-being and thereby change the individual and environmental determinants of their health (Nutbeam, 1998). The World Health Organisation (WHO) has for many years advocated a settings approach to promoting public health (WHO, 1991; WHO, 1997).

At the core of this approach is the recognition that people live their lives in complex social, cultural, economic and political environments that may enhance or harm health in various ways (Paton et al., 2005; Dooris, 2006; Chu et al., 2000) and that health promotion practice should focus on modifying aspects of the setting itself rather than solely changing individual’s health-related behaviour. Therefore as outlined in the Ottawa Charter there is still a need to further improve the workplace itself using a broader evidence base incorporating the views of employees as equally important to other forms of knowledge in order for individuals to increase their control over and improve their health.

Health promotion options were developed and are based on older workers’ own perspectives and take into account the academic evidence provided by the literature review. By combining these forms of evidence, a broad range of health promotion options were identified. These health promotion options are significant for highlighting the importance of using ‘lived experience’ to inform THS workplace health promotion policy and practice.

Further, in using ‘lived experience’ the contextual factors that impact older worker health in work life are emphasised by older workers over life style changes to be undertaken by the individual. The health promotion policy options are presented under each of the four health resources identified by the older worker cohort as health potentials available in the workplace to support health. The four health resources are:

1. **Value a holistic approach to health promotion**: Within this resource older workers would like to see health promotion to be incorporated within the work team and undertaken throughout the day /shift. Older workers though mangers were key in creating health promoting opportunities as part of normal work. Their health promotion examples are listed in Table 1.

2. **Work and Life alignment**: Older workers suggested that the work life balance policy include other options other than working from home options (front line staff are not able to access this option). Older workers would like to see shorter shifts and having longer annual leave options with leave without pay for extended periods supported by the organisation. See Table 1 for details.

3. **Workplace as a community**: Older workers wanted to stay on working as they really enjoyed the community building aspect of work life. They had many suggested as can be seen in table 1.

4. **Health promoting setting**: Older workers wanted to work in a partnership model with the organisation to create a health promoting setting at work. See Table 1 for suggestions.

Table 1 presents the list of 20 health promotion policy options to maintain and sustain older worker health in work life.

Table 1: List of twenty health promotion policy options for promoting older worker health in work life

1. Health resource - value a holistic approach to health promotion
Managers and older workers to work in partnership in developing team health promotion plans that incorporate activities that can be performed in work teams without being defined as health promotion per say.
Place health promotion on team agendas and support older workers' participation in decision making on ways to embed health promotion in the work setting.
Embed health promotion activities into work teams e.g. develop stretch and strength exercise circuits into every day nursing environments.
Managers to discuss with individual older workers on what health promoting activities they are interested in and managers to support participation.
Senior Management to be a champion of health promoting behaviour and model throughout the organisation.
2. Health resource - work and life alignment
As an organisation open up dialogue with older workers on how work can better align with their whole of life needs – develop a good ideas process.

Develop ways that the organisation can work in a partnership approach (www.enwhp) with shared understanding regarding work and life alignment e.g. hold forums on work sites.
Develop individual heath promoting plans as part of individual work performance development plans that align with work and life balance.
Develop more roster options e.g. roster that begins at 5 am and finishes at noon. Develop shorter shift options e.g. 6 hours instead of 12 hour shift or 4 hour shifts. Offer leave without pay options for older workers e.g. travel overseas for an extended period.
Develop work flexibility options that cater for different team needs. These may be different for different groups e.g. front line health care staff and corporate services.
3. Health resource - workplace as a community
Managers to assist their older workers harness the natural communities of similar health interests within work settings to support health promotion.
Managers to recognise and encourage ways to discuss belonging and connection to others in work life and discuss how this impacts health and wellbeing at work.
Managers to introduce activities that build connectedness in their work teams e.g. birthday morning teas, recycling group, book club, other shared interest groups.
Managers to have a KPI on creating and building positive work environments.
Managers to have a KPI around building nurturing communities at work.
4. Health resource - health promoting setting
The organisation to embed education on health promoting ways of working within teams. Support older workers participation in decision making on ways to make the work setting health promoting.
The organisation to embed strategies into the Manager Inductions Program that promote team wellbeing.
A health promotion specialist / coach to support senior managers to embed wellbeing across the organisation to support retention of its older healthcare workers.
Staff wellbeing to have a regular space in all of the organisations newsletters.

Embed building a wellbeing culture as an organisational value along with organisational strategies to achieve this.

Conclusion:

Twenty health promoting policy recommendations have been developed from older workers' knowledge on actions to improve health in work life. These health promoting policies recommendations aim to contribute to the evidence base for future developments in national older worker health promotion policy.

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