WORKPLACE HEALTH PROMOTION IN EUROPE

PROGRAMME SUMMARY

Over nearly a decade, the European Foundation for the Improvement of Living and Working Conditions has led a Europe-wide programme of research, policy development and training for workplace health promotion. New policies and services for health at work underline the need for comprehensive, integrated and participative measures. This booklet summarizes key results from the Foundation’s work.
WORKPLACE HEALTH PROMOTION IN EUROPE

PROGRAMME SUMMARY

EUROPEAN FOUNDATION for the Improvement of Living and Working Conditions
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The European Foundation for the Improvement of Living and Working Conditions has been active in the area of workplace health promotion (WHP) during the period 1989-1997. In this time the Foundation has commissioned the largest single research programme on WHP to take place in Europe and possibly anywhere in the world.

As part of this programme, work has been carried out in four phases in the areas of research, policy, training and dissemination of training. This brochure provides an overview of this work. In addition, this brochure describes some of the major developments in the area which have taken place during the period in Europe.

Many publications have been produced by the Foundation as a result of this work, details of which can be found at the end of the brochure.
In 1989 very little was known at a European level about the state of development of workplace health promotion, though there had been a small WHO initiative and some conferences on the subject had been held in Germany. The practice of workplace health promotion had been well described in the US, where significant elements of practice had developed since the 1970’s. However, no significant body of knowledge existed about the situation in Europe.

In the US, much was known about the extent of WHP, which was quite widespread, at least among larger US corporations (e.g. Sloan et al, 1985). In addition, the reasons why companies became involved in WHP were relatively clearly understood, as the structure of health care costs in the US meant that there was genuine economic incentive for employers to become active in the area. Moreover, there was a characteristic approach to WHP to be seen in the US: programmes and activities were largely focused on risk factors for single health problems such as heart disease and cancer; many of the health interventions sought to change the health-related behaviour of the worker; and the entire model of WHP was based on an epidemiological or risk factor reduction approach.

WHP programmes in the US were also notable for a number of other features – little emphasis seemed to be placed on the issue of
worker participation in the design and implementation of programmes, there was no apparent relationship between WHP activities and those of health and safety and there was little evidence of any interventions at the level of the work environment or organisation in all of its aspects.

When the Foundation project began, little was known about the prevalence of WHP at either European level, or indeed, at national level in most countries. It was not clear what the perspectives of the major players in the area might be, there was little European or national policy in the area, and it was not known what form WHP took in Europe or whether there was a distinctive European style of undertaking WHP.

It was in this context that the Foundation initiated their research programme into workplace health promotion in 1989. The early part of the programme sought to address a number of issues:

• What are the attitudes of the social partners towards WHP?
• What is the legislative background for WHP?
• What is the extent of workplace health promotion in European workplaces?
• What form does it take?
• Are there any examples of good practice in the area?

A research team was set up initially in seven of the Member States – Germany, Greece, Ireland, Italy, the Netherlands, Spain and the

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1The research team consisted of Friedrich Hauss, Institute for Social and health Research (IGES), Berlin; Zacharia Tsanglis, Ministry of Labour, Athens; Richard Wynne, Work Research Centre, Dublin; Sauro Garzi, CEDOC, Florence; Rob Grundemann, TNO, Leiden; Lusi Graca, National School of Public health, Lisbon; Salvador Moncada, Institu Municipal de la Salut, Barcelona; Jo Clarkson, Health promotion Authority for Wales, Cardiff.
UK (Portugal was added after the survey stage). The legislative background for WHP was documented, interviews were carried out with the key players influencing the prospects for WHP, case studies of best practice were undertaken, and a major survey of practices in more than 1400 companies was conducted. In a second phase of the research, case studies were undertaken which examined how multi-nationals operating in more than one Member State organise their WHP activities.

Before examining the results from this programme of research, it is important to examine the issues of what exactly constitutes WHP.
It was clear at the beginning of the research programme that there was no commonly accepted definition of workplace health promotion, and this is still the case to some extent. The literature offered a range of definitions, some of which were in conflict, while more seriously from the point of view of the research programme, there were very low levels of awareness about WHP among both key players and companies which were engaging in health activities.

Two approaches were adopted to overcome this problem. The first involved defining workplace health promotion in terms of the methods of approach to workplace health activity, i.e. to define it operationally in terms of a number of significant elements of an ideal approach to WHP, rather than in an abstract manner.

WHO (1984) outline five principles of approach to general health promotion, based on the ecological model of health. These principles have been adapted for use in the workplace by Wynne (1989) and state that workplace health promotion:

- *Is directed at the underlying causes of ill health*
- *Combines diverse methods of approach*
The nature of workplace health promotion

- *Aims at effective worker participation*

- *Is not primarily a medical activity, but should be part of work organisation and working conditions*

The second approach was used within the survey work, where it was essential that respondents were not confused by the usage of terms with which they were not familiar. For purposes of the survey work it was decided not to refer to WHP per se, rather to focus on health activity of any sort which might take place, and to enquire whether these activities took place to improve the health of the workforce.

This definition of workplace health promotion has been used throughout the research programme.
A survey of the national legislation in the 8 Member States and also of relevant international legislative initiatives revealed that there was no specific legislation dealing with WHP in existence in the early 1990’s (see Wynne and Clarkin, 1992, for details). Since then, while there have been significant updates of many national legislative acts in the area of health and safety, there are still no specific legislative instruments referring to WHP in any EU countries, with the possible exception of Germany and the Netherlands.

However, there are a number of international and national legislative acts which encourage the practice of WHP, though nowhere is it compulsory. These include:

- The Maastricht treaty, which gives competence to the EU to act in the area of public health, which has seen expression in the form of WHP initiatives by DG-V of the Commission.

- ILO Convention 161

- The Social Chapter which, inter alia, contains provisions on Freedom of information, rights to participation, the improvement of working conditions and health protection and safety at the workplace.
The legislative background

- The Framework and other EU Directives on health and safety, which contain provisions relating to comprehensive information and training in the area of health and safety and full consultation and participation rights to workers in the area of health and safety.

- The WHO initiative of developing the Ottawa Charter, which provides a framework for general health promotion.

These landmark pieces of international legislation, while not specifically referring to WHP, contain provisions which are entirely consistent with the approach to WHP defined within the research programme, emphasising as they do, rights to information, participation in health activities and a holistic approach to workplace health.

Since 1991, when the survey of legislation was concluded, there have been many changes to national legislation as a result of the Framework Directive, many of which have served to further encourage the level of WHP activity. For example, Dutch legislation now addresses the issue of workplace stress, and specifically allows for work design programmes as a means of preventing and managing such stress.

Moreover, there have been changes in Social Security legislation in recent years which have also served to encourage the practice of WHP. In particular, changes to Dutch and British legislation relating to how the costs of short-term absenteeism are carried, will have the effect of promoting health programmes aimed at combating such absenteeism.
An important part of the early work in the programme concerned an investigation of the perspectives of the Social Partners and other key players in relation to WHP. These were felt to be important as their attitudes and approach to WHP would be crucial to its further development in European workplaces. (See Wynne and Clarkin, 1992, for details).

In all, 87 interviews were carried out with representatives of the Social Partners, and with experts in the field in the eight countries in 1991. The main findings from these interviews revealed that there was a remarkably low level of awareness of workplace health promotion on the part of both employers and trade unions. Neither party tended to have an official policy on workplace health promotion and in many cases both employers and trade unions revealed little direct knowledge of the issues concerning WHP. To the extent that they had considered opinions, they tended to be broadly positive, but with a number of provisos. These concerned on the part of employers, the fear that employers would be made responsible for WHP, and on the part of trade unions, the fear that WHP might be used to discriminate against workers and that confidentiality needed to be preserved.

Government agencies (usually health and safety agencies and health promotion/education agencies) also tended to be unspecific
The attitudes of the social partners and key players

in their approach to WHP. Health and safety agencies generally did not see WHP as coming within their remit, while health education and promotion agencies, while recognising the validity of the workplace as a setting for health promotion, generally did not have plans to mount programmes within that setting.

Experts in the area tended to express more defined views on WHP, but many were quite pessimistic about the prospects for its development in the absence of Government led initiatives or real economic incentives.

Since this survey of the perspectives of the Social Partners and experts in the field was undertaken, there has been a transformation in attitudes towards WHP. Firstly, there has been a commitment by many health promotion agencies to undertake initiatives in the workplace setting. A good example of this is provided by the Health Education Authority in the England, where major initiatives in the National Health Service have been followed by initiatives in other workplace settings, or the Finnish Government programme of Maintenance of Work Ability. Secondly, the past few years has seen a growth in the numbers of private sector companies selling health promotion services to the public and private sector. In addition, many insurance companies with coverage of workers health have become active in the area. Finally, there has been a growth in absenteeism initiatives which have health promotion programmes at their core.

All of these initiatives have contributed to a raising of awareness of WHP in a number of the more active countries. However, there is little evidence that organisations of the Social Partners have adopted a more defined approach to WHP, although they commonly give support to the initiatives of health agencies. In addition, these advances in WHP activity are by no means universal throughout Europe. There is, therefore, still much work to be done in raising the profile of WHP among the key players in Europe.
The largest part of the work undertaken in the early phases of the Foundation programme was concerned with conducting a survey of the prevalence of WHP programmes in European companies (see Wynne and Clarkin, 1992, for details). This survey had the following objectives:

• To document the types of workplace health promotion activity which take place in workplaces in Europe

• To document how and why WHP initiatives are set up

• To examine the role of worker participation in the establishment of WHP initiatives

• To identify the characteristics of companies which are active in the area

The sample

More than 1400 companies responded to the questionnaire in seven countries, which represented an overall response rate of 23%. These companies were selected mainly on a regional basis within the larger countries (Germany, Italy, Spain and the UK),
while the samples from the smaller countries were drawn on a national basis. There were some differences in response rates between the countries, which varied from 11.3% in Germany to 37.4% in Greece. In addition, there were variations in the size of company which responded, with predominantly large or very large companies responding in Germany and small and micro companies responding in the smaller countries. However, most companies employed between 200 and 500 workers.

In general, the companies which responded were larger than average and were likely to have been more active in the health area than the non-responders. In practical terms, this means that the prevalence of workplace health activity was probably over-estimated. However, as the main thrust of the survey was to obtain a general overview of the types of health activity which took place, rather than to obtain an exact quantitative estimate of prevalence, this potential bias was not a problem.

How prevalent is health activity?
Respondents were asked to state whether any of thirty possible health related activities took place in their workplace. Furthermore, they were asked to state for all activities which took place, the extent to which trying to improve the health of the workforce was a consideration in that activity taking place. This latter question provided an indicator of whether health promotion was a factor in these activities taking place.

These thirty activities were grouped into five areas:

- Health screening
- Promoting healthy behaviour
- Organisational interventions
- Safety/physical environment
- Social and welfare
The findings indicated that the highest levels of health activity tended to be seen in larger workplaces, in workplaces which had specific health policies and budgets, and workplaces which had active health and safety committees. In addition, companies which had the active involvement of management in health activities tended to undertake more health activity.

Two important conclusions can be drawn from the findings:

• The most common health activities at work take place in the health and safety area, with up to 75% of companies reporting specific activities. Conversely, activities which still might be thought of as falling within the health and safety area (e.g. work organisation, job design), are relatively uncommon. Furthermore, activities which might be regarded as coming from the health promotion arena (e.g. eating, alcohol or smoking policies) tend to take place rarely.

• Many health activities take place for reasons other than the improvement of health. This finding has important implications for the marketing of WHP – it is not necessary to market health promotion solely in terms of health improvement.

How are health actions set up?

A major focus of the survey was to establish how health actions in the workplace were set up. A series of questions asking about what parties were involved in setting up the health initiative, when they were involved and to what extent they were involved were asked of respondents. In order to facilitate answering these questions, an idealised process of setting up health actions was described, involving four phases: the initial idea, planning, implementation and evaluation. In addition, four levels of involvement in the process were envisaged: information provision, consultation, participation and responsibility. These questions were in relation to six potentially involved parties: management, staff representatives, trade union representatives, health and safety representatives, occupational health staff and external consultants.
The main findings from this part of the investigation were:

- Management were most involved in the process of setting up health initiatives at all phases and with the highest degree of participation.

- Staff representatives and health and safety representatives were the next most involved groups, but at lower levels of participation than management.

- The other parties played lesser roles, both in terms of when they were involved and the extent of their participation.

- In general, management were always responsible for health initiatives, while the other parties level of involvement rarely exceeded participation.

These findings were related to the actual occurrence of health actions, whether they had health improvement as a component or not. While the findings from this analysis were complex, they revealed some interesting insights into how the different parties are involved in setting up the five classes of health activity. These were:

- In general, levels of participation by any party did not strongly predict health activity on their own.

- Involvement of Occupational health staff and health and safety representatives was most predictive of health activity.

- However, involvement of occupational health staff was associated with lower levels of health involvement by all other parties.

- Despite high levels of management participation, this was not generally associated with levels of health activity. In addition, management involvement was most associated with activities which did not have health improvement as a specific objective.
Why are health actions started?

There were two classes of reasons why organisations undertook workplace health activities - the benefits that might accrue to the organisation and the fact that health activity might be seen as a solution to a specific problem. Respondents were asked both open and closed questions in relation to these issues.

The most important reasons for undertaking health action were related to legislative provisions, health problems in the enterprise, problems of employee morale, personnel problems and productivity problems. These reasons were cited by more than 60% of companies in each case.

When asked to report on the benefits to the company using the same set of issues, it was notable that widespread benefits were perceived, especially in relation to staff morale and health problems. In addition, there were major unexpected benefits in relation to areas such as reduced staff turnover, reduced accident rates and staff morale. These perceptions of benefits were supported by the findings from open ended questions.

A second line of investigation into why companies undertake health actions is provided by a set of case studies of multinationals which is reported by Hauss (1992). In these case studies, the motivation for the company undertaking workplace health promotion was examined in detail.

From these case studies, it was apparent that there were a multiplicity of reasons why companies undertake health promotion in the workplace. In many cases, (often US multinationals), their health promotion programmes stem from more general human resource policies. In others, especially where there are hazardous processes undertaken, good practice in the area of health and safety has spilled over into the development of health promotion programmes. Other companies use their health promotion programmes as a means of initially attracting and then retaining their workforce, while others are concerned about company image.
In addition to these top level reasons for undertaking WHP, many companies stated that their programmes had evolved largely through the actions of committed and resourceful staff in key positions. In practice, therefore, the existence of a policy to promote health would rarely be sufficient to ensure that substantial health promotion might take place; the availability of resources and committed personnel is also necessary.

What explains health activity?

As part of the analysis of the survey data, a key question to be answered concerned what company characteristics predicted the levels of health activity within that company. This analysis examined such factors as the presence of health policies and health budgets within companies, the existence of occupational health departments and health and safety committees, and levels of involvement of the key players in the health activities.

While there were some differences in the company characteristics which explained specific health activities, the factors which explained high overall levels of health activity were:

- Company size – larger companies were more likely to have higher levels of activity
- Health and safety committees
- Health policies
- Health budgets
- Placing a high value on the health of the workforce
- The prompting factors of personnel problems, staff morale problems, improving public image of the company and productivity problems
- The involvement of occupational health staff and external consultants
These findings make intuitive sense, as there are solid grounds for believing that companies with resources and policies are more likely to be active in the health arena. However, they also point to a number of challenges for workplace health promotion and at the same time point to some opportunities for the promotion and development of health activity in the workplace.

Specifically, the results point to the need to develop strategies which can encourage SMEs and micro-enterprises to take up health activity. They also point to some of the steps which are necessary for such activity to take place – the need to create a health policy and the need to assign a health budget and other resources. While SMEs and micro-enterprises may not have the resources to fund, for example, occupational health departments, they should be able to develop health policies and to assign even small health budgets.
As part of the research phase of the programme, a major element of the investigation concerned the identification and documentation of case studies of good practice in the area. This proved to be a difficult part of the research, as in many countries, the practice of workplace health promotion was in its infancy. Nevertheless, more than 40 case studies of good practice of WHP were identified during two phases of the research.

These case studies were undertaken in companies located in 8 EU countries and they showed a wide variation in approach. Broadly speaking, three types of approach could be identified. The first came from a tradition of workplace participation and adopted a problem solving approach, and was characteristic of some of the Northern European countries.

The second approach was more characteristic of Southern Europe, and tended to involve a more paternalistic style of management towards the provision of welfare and health care to workers. It also tended to involve workers families and the wider community.

The third approach, which tended to be found in Britain and Ireland, had much in common with the US approach. This often involved the use of off-the-shelf health promotion programmes which were often to be found in US multinationals.
However, while these three general approaches could be distinguished, there were also many examples of more innovative approaches to WHP, where for example, social and psychological health issues were addressed by companies.
Late in 1992 it was decided to hold a high level conference of policy makers to publicise the results from the research phase of the programme. Approximately 100 participants, representing experts in the area, government agencies, researchers and employers and trade unions took part in the conference with the aim of identifying priorities for future action in workplace health promotion. The conference identified 4 areas of priority:

- Marketing of and incentives for workplace health promotion
- Organisational change for health (integrated WHP)
- Professional development
- Implementation – strategies, instrument and methods

On the basis of these priorities it was decided to first address the issue of professional development, i.e. training and education for WHP. This was done because it seemed that one of the major barriers to progress concerned the shortage of appropriate knowledge and skills among the professional groups likely to be involved in implementing WHP. This decision led to the development of the training specification for workplace health promotion.
As a result of the recommendations from the policy conference, the next stage of the Foundation programme directed itself towards the development of professional skills in the area of WHP.

As part of the development process, a survey of existing training initiatives in Europe in the area was undertaken which revealed that there were no widely known or available training/education courses which dealt with WHP. Even though there were courses in general health promotion, and a multiplicity of courses in the area of occupational health and safety, it was felt that no single course covered the specific knowledge and skills needed for WHP.

In developing a document to meet this skills and knowledge gap, a number of challenges had to be faced:

• There are a multiplicity of disciplines involved in the area, each with specific knowledge and skill gaps
• The need for training courses varied between professional groups
• The type of courses to be delivered would vary in duration, scope and depth
There would be a need to cater for both new courses and the integration of modules into different courses.

There are considerable national differences in relation to issues such as the training and educational infrastructure available for WHP, awareness of WHP, the professional groups involved and national strategies towards WHP, where these existed.

In order to face these challenges, it was decided that one of the guiding principles in developing a document to address training needs would be flexibility. This had to be expressed in terms of both the structure and application of the document. It was therefore decided not to develop a single training course, or even a set of training courses, but to develop a framework or specification for training, from which a range of training courses could be developed.

There are two significant structural aspects to the specification. These are:

1. A seven phase idealised health promotion process:
   - Marketing health promotion
   - Setting up structures
   - Assessing needs
   - Developing a plan
   - Implementing the plan
   - Evaluating the initiative
   - Amending the plan
2. A set of six roles which need to be fulfilled for successful health promotion:

- The expert
- The advocate
- The deliverer
- The participant
- The change facilitator
- The decision maker

These two structural elements form a two dimensional matrix, where the cells are filled with specifications for the skills and knowledge needed to undertake each role at each phase of the health promotion process.

The training specification represents a significant advance on most thinking in the area of WHP in a number of ways. Firstly, in specifying phases of the HP process concerned with marketing of the concept and the setting up structures, it explicitly recognises the difficulties which face practitioners in developing interest in WHP on the one hand, and in embedding WHP into the structures of organisational life. In addition, the central importance of assessing needs is recognised, not just in terms of expert defined risks to health, but also in relation to the self-defined needs of the workforce, which in practice, are often very different.

Secondly, in identifying the roles needed for successful WHP, the specification emphasises the fact that good WHP involves some level of organisational change, and that the participant is a legitimate and important driving force for the entire process. In addition, it recognises that the process is not expert led, but is supported by expertise.
The next phase of the programme involved the dissemination of the training specification, with the objective of supporting the implementation of the specification in a range of training and educational sites. This initially involved setting up three European regional seminars which had the twin purpose of explaining the nature of the training specification and of seeking to identify institutions interested in implementing the specification.

These seminars were held over a 10 month period in Copenhagen, Leiden and Valencia with more than 100 participants from a range of training and education institutions attending. In addition to these principal seminars, opportunities for dissemination of the specification at national and international conferences were taken.

As a result of these seminars, almost 40 training and educational Institutions showed sufficient interest in implementing the specification to become members of a user network for the specification. Setting up the user network was seen as a necessary support to implementation, especially as the specification represented a new concept to many network members, and also because the implementation process was being undertaken for the first time.

The users network should be seen as one among a number of supports which were offered to members in the implementation process. The full range of supports was:
• Membership of the network and participation in 4 meetings
• Production of a newsletter on implementation – SPECIFICS
• Development of an annotated bibliography on relevant literature
• Setting up a World-Wide-Web site
• Circulation of sample training courses and materials
• Sharing of implementation experiences

At time of writing, 25 Institutions had either already implemented the training specification (some in a number of courses), or were deep in the process of doing so. About 5000 people from a wide range of backgrounds from 12 Member States will have been trained on courses using the specification before the end of 1998. These backgrounds include occupational medicine, occupational nursing, health and safety representatives, health and safety engineers and a range of 3rd level students.

An evaluation study has revealed that the experiences of users of the specification to date has been almost uniformly positive both in relation to using the specification and the impact it has had on students. Only minor modifications to the specification have been suggested, and these suggestions have been incorporated into the final version of the specification.
The 1990’s have seen a large growth in activity in the area of workplace health promotion, some of which has been at least partly inspired by the Foundation’s work. At European level, DG-V of the Commission have begun to be active in the area through funding a number of research and development projects, and most visibly through the establishment of an EU-wide information and communications network.

The WHO European regional office have also become more active in the area through their efforts to set up a network of health promoting companies which has the function of developing and disseminating good practice. In addition, WHP is seen by WHO as a useful way of promoting the necessary re-orientation of occupational health services in the CEEC countries.

There has also been a large increase in activity at the level of national agencies for WHP, at least in some countries. Perhaps the most notable examples of this activity are to be found in Finland and the UK, where major WHP programmes are now underway.

In Finland, they have developed a programme called ‘Maintenance of Work Ability’, which is effectively a comprehensive approach to workplace health promotion. This programme is intended to be disseminated to and practiced in all Finnish workplaces within the next few years. As part of this
programme, a major training project is underway, which uses the training specification as a basis for training course design.

In the UK, the Health Education Authority have initiated some major WHP programmes in England in the 1990's. The biggest among these is the Health at Work in the NHS (National Health Service) programme, which has overseen the establishment of a large number of WHP initiatives. In addition, the HEA have also established a WHP quality award scheme which at time of writing has been awarded to several hundred workplaces. Similar schemes have been initiated in Scotland and Wales by the Health Education Board for Scotland and by the Welsh Health Promotion Authority. The training programmes which support these initiatives have also been influenced by the training specification.

There has been an increase in activity in Germany also, which has involved a number of players such as the Insurance companies (e.g. BKK) and the Federal Institute for Occupational Safety and Health (BAuA). A wide range of programmes have been put in place, including a quality award (BKK) and a programme aimed at SMEs and micro-enterprises.

The Netherlands has seen the creation of a new Institute for WHP (Centrum GBW) which has been very active in establishing workplace programmes. These have complemented the activities of other major actors in the Netherlands (e.g. TNO, the Public Health Schools). Collaboration between these Institutes has led to the creation of a plan for the further development of WHP training in the coming years.

Other countries have been slower to adopt WHP in a full way. However, even here, there are signs of increased activity at official level. For example, the Irish Ministry of Health is currently developing a policy and plan for the development of WHP in Ireland. There have also been some developments in training in Southern Europe in Spain, Portugal, Italy and Greece.
In 1990, when the Foundation began its WHP programme, the major challenges which faced the area included:

- Low levels of awareness of the area amongst the major players in most countries
- Low levels of activity within companies
- The predominance of US models of WHP
- No clear responsibilities for WHP among potentially interested agencies
- Lack of suitable tools to undertake WHP
- Shortage of professional knowledge and skills in the area

While these challenges have not yet been overcome, there has been considerable movement in relation to these issues. Awareness among the Social Partners has increased considerably in many countries and responsibilities have largely been assigned to the major players. In addition, there has been a major initiative in the area of professional development and a methodology for workplace health promotion in Europe has been developed (Wynne et al, 1996). Levels of activity within companies have also
increased, and there are now more and more good examples of integrated WHP available in many countries.

Despite these advances, and they have been significant, the development of WHP in Europe is now entering a new phase with its own challenges. This new phase is essentially concerned with consolidation and dissemination of good practice, as the battle to persuade the major players that WHP is a useful and worthwhile activity is currently being won. The 14 key challenges which face WHP into the next century are:

• Ensuring the spread of workplace health promotion in all countries – currently there are large differences between countries in relation to levels of awareness and activity

• Spreading the message beyond the public sector agencies responsible for WHP into all workplaces. These have largely been convinced, but workplaces still need to be convinced of the utility of WHP.

• The relationship between health and safety systems and occupational health systems, which have a much more widespread presence in the workplace, and workplace health promotion systems and personnel, which are only beginning to have a presence, needs to be clarified. The potential for conflict is ever present. There needs to be a proactive approach to the effective integration of both systems, at least in terms of general approach to health issues, if not in terms of actual staff. Opportunities for this integration exist due to the re-orientation of occupational health services which is currently taking place in many Member States.

• Though a number of pilot schemes and investigations are underway, there is no fully successful approach to delivering WHP to SMEs and especially to micro-enterprises. In effect, the current targets for WHP are the 10-15% of the European labour force who work for large enterprises. Public health goals cannot be achieved when confining WHP to such a small target group. Meeting the needs of workers in smaller enterprises will
The prospects of development of workplace health promotion

involve the development of new models of delivery and also perhaps of a new definition of good practice for this sector.

- Despite the establishment of a number of information dissemination networks, there is reason to believe that there is still a widespread lack of awareness of WHP among companies and among the personnel who might be expected to implement WHP. Information dissemination about methods, good practice and other issues needs to move beyond the circle of health professionals to the people who can use it for implementation.

- There are many systems within the workplace with which WHP can make common cause. The most obvious of these are health and safety and occupational health systems. However, opportunities to implement WHP are also provide by such systems as quality management, welfare systems, EAP programmes and a range of human resource systems. The challenge of integrating WHP with these systems, when useful to the cause of WHP, needs to be addressed.

- There is a real and major challenge to be faced in relation to the marketing of WHP. Current efforts to market WHP tend to be confined to selling it on the basis of costs and benefits and also in relation to health improvement. The scientific basis for these marketing pitches is not entirely clear. Equally, it is not clear that these are appropriate marketing strategies to take. More generally, those involved in marketing WHP need to address issues such as definition of the products and services of WHP and the different marketing strategies which will be needed for different segments of the market.

- There are currently relatively few methods and few tools widely available for implementing WHP. This situation in part arises because much WHP is expert driven, and because the effort has not been expended to develop tools and methods which are readily usable. If WHP is to become truly widespread, it will need to be implemented by non-professionals, albeit with potential support from professionals. The challenge therefore is to provide the methods and tools...
which can be used by any person in the workplace, not just by health professionals.

• Despite the advances which have been made during the 1990’s in convincing health agencies that they should consider WHP, there has been slower progress in convincing some of the more powerful professional groups. Specifically, groups such as occupational physicians and some health and safety professionals remain to be convinced that WHP is an activity they should practice. The task of persuading all relevant professionals remains to be completed.

• An issue of current concern to many is that of the economic costs and benefits of WHP. There is ample evidence from the US of the costs and benefits which operate there, but the difference in health care costs structures makes translation of these data to the European context impossible. Research on this issue needs to be conducted in the European context.

• There is still a need for the evaluation of WHP initiatives along a number of dimensions within the European context. These include the economic costs and benefits of WHP and its health impacts. In addition, there is a need to study the effectiveness of European models of WHP, which have not necessarily taken into account their efficiency or effectiveness.

• In spite of the advances which the current project has made in relation to boosting education and training for WHP, there is still a challenge to be faced in relation to the dissemination of training for a wide range of interested parties. Specifically, much more training needs to be developed for physicians and nurses, for health and safety specialists, and also for non-specialists such as management, human resource personnel and trade union representatives.

• At policy level, there are also a number of challenges to face. Firstly, there is the challenge facing public health systems – to what extent are they prepared to identify the workplace as a significant setting for their activities. An equal challenge faces policy makers in the occupational health field – to what extent
The prospects of development of workplace health promotion

are they prepared to face the challenge of re-orienting occupational health services against the background of the decline in traditional workplace health hazards.

• The approach to WHP outlined in this programme emphasises the need for integration, participation and comprehensiveness. In addition, it recognises that there are unique aspects to the workplace setting which do not affect other health promotion settings. This approach, while often endorsed by national and international agencies, is only rarely reflected in their practice, where more traditional approaches relying on education and on single issue approaches abound. It remains a major challenge to change the emphasis of the policy of the health promotion agencies at national and international level.

In identifying these challenges, it is necessary to identify what agencies might embrace them. There is a clear role for research funding agencies in relation to setting up research on costs and benefits of WHP, establishing delivery mechanisms to SMEs and micro-enterprises and the development and testing of methods and tools to support the implementation of WHP.

Current EU policy in the area has the objective of facilitating information exchange with a view to encouraging good practice. However, there are currently many countries where the practice of integrated and comprehensive WHP is practically non-existent. While the reasons for this situation are complex, it is also clear that the provision of information is unlikely to alter seriously the level of WHP activity in these countries. The EU needs to address itself to what more can be done to boost activity in the less active countries.

National and international agencies with responsibility for WHP need to take due account of the peculiarities of the workplace as a setting in developing their policies. In addition, there is a need to redefine the approach taken to more accurately reflect the philosophy of workplace health promotion. In effect this will mean moving from a focus on single issue interventions largely
emanating from the health education tradition towards a more balanced and integrated approach.

There are policy issues which governments might address. Perhaps chief among these are the resources issues – in general, the resources devoted to health promotion generally and WHP specifically are a very small part of the overall health spend. Another issue of importance concerns the distribution of costs and benefits related to health in general and sickness absenteeism in particular. Currently, most of the costs of such absences are borne by the State in Europe. Redistribution of some of these costs could significantly boost the level of effective workplace health promotion.

For employers organisations and trade unions, there is a need to be more aware of the potential of WHP to improve both of their interests – for employers, there are bottom-line benefits to be gained, while for trade unions there is the potential to not only to improve the health of their membership, but also to use WHP as a means of improving working conditions.
References


Also available as working papers from the Foundation:

Innovative workplace action for health: an overview of the situation in seven EC countries (EF/WP/90/35/EN)

Working for health at work: initiatives in seven countries of the European Community (SY/59/90/774.EN/FR/D/ES)

Workplace action for health: National reports
United Kingdom (WP/92/17/EN)
Germany (WP/92/18/DE/EN)
Ireland (WP/92/19/EN)
Italy (WP/92/20/IT/EN)
Netherlands (WP/92/22/NL/EN)
Greece (WP/92/24/GR/EN)

Action for health at work: the next steps
(EF/93/19/EN/DE/FR)

Workplace health promotion – a specification for training
(WP/94/EN/ES/DE/FI)
WORKPLACE HEALTH PROMOTION IN EUROPE

PROGRAMME SUMMARY

Over nearly a decade, the European Foundation for the Improvement of Living and Working Conditions has led a Europe-wide programme of research, policy development and training for workplace health promotion. New policies and services for health at work underline the need for comprehensive, integrated and participative measures. This booklet summarizes key results from the Foundation's work.