

## Workplace health promotion in the context of public health

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### Abstract

In modern societies, work is the source of most individual, corporate and community wealth. The level of each society's health is therefore particularly vulnerable to disruption caused by employee illness. Today healthy workplaces are one of the most important determinants of health. However, public health has tended to completely ignore health in the workplace and occupational medicine has tended to ignore it in part. This article refers to the Italian and European context and, through a review of international recommendations, research and direct field experiences, presents workplace health promotion as an important tool in the field of public health.

Through the years, several initiatives have been tested. One of the platforms that has demonstrated to be cost effective is based on the principles included in the Ottawa Charter which, when applied to the workplace, define workplace health promotion. In the last twelve years, the European Commission has recognized the workplace as a key determinant of health and has outlined a methodology of workplace health promotion as defined in the Luxemburg Declaration. The basis of this methodology is planning. Without correct strategy and policy development it will not be possible to create a sustainable society. The enforcement of Lisbon treaty seems to be a substantial step forward for Europe.

*Key words: health, safety, workplace, public health, workplace health promotion*

### Work and health

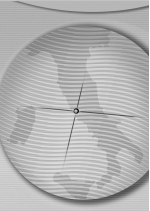
In modern societies, work is the source of most individual, corporate and community wealth. The level of health is therefore particularly vulnerable to disruption caused by illness among employees. Illness can involve absence, either short or long term, and leads to reduced productivity, long-term disability and even premature death. It can also end careers with a consequent loss of knowledge, skills and experience from companies and public organizations. What is becoming more widely recognized is how work itself can make people ill, with a high price paid by individuals, organisations and society in general:

- In 2008 in the European Union-27 there were about 7 million accidents at work, resulting in an average absence of more than 3 days for each of the employees involved.
- 8.6% of workers (20 million) in the EU experienced work-related health problems in the last year.
- Each year in the EU-27 350 million working days are lost due to work-related health problems and almost 210 million days due to accidents at work.

- 35% of workers consider that their health is negatively affected by their work.
- The costs of workplace-related illnesses in the EU-27 are estimated to be between 2.6% to 3.8% of Gross Domestic Product (GDP).
- The EU-27 is facing a substantial challenge due to population ageing, which is the result of low fertility rates and increasing life expectancy. The population is expected to become much older, with a marked change both in the absolute age structure as well as working-age populations, with the labour market more and more influenced by the older generation. This will have an impact on economic growth and leads to a mounting pressure on social protection systems.

Based on a dataset covering the EU-27 in 2005–06 in the WHO European region, three levels of job quality were identified:

- a) Nordic, including the Netherlands and the UK, Cyprus and Slovenia – high wages, good working conditions, high educational attainment and participation in training, high job satisfaction but also high work intensity;
- b) Southern – relatively low wages, low



participation in education and training, unfavourable working conditions and relatively large gender employment gaps;

- c) New Member States - low wages, unfavourable working conditions, but also relatively high educational attainment and low gender employment gaps. [1-8]

The current practice in public health and occupational health and safety has evolved over several centuries and shows marked differences in terms of operational and socio-political aspects. In only a limited number of countries (and even in these not completely) the health of workers has been addressed to a level that can be considered similar to that of other citizens. [9]

In the past, public health initiatives that involved the entire national community were oriented towards primary prevention and had placed a strong emphasis on environmental protection. However, public health initiatives have tended to ignore health in the workplace, and working conditions in factories, shops, farms and offices, for example, were seen as being beyond the scope of public health medicine.

But there were differences in the productive world: people working in agriculture have been almost entirely forgotten and for a long time craftspeople, commerce and office personnel didn't receive much attention either. The evolution of occupational health services mirrors that of industrial developments.

Historically, in the Eastern part of European WHO region, the working class had a relevant, if not privileged, status but the occupational health services were not significantly different from the Western world in practical terms. In some cases, e.g. East Germany, health services for the community were organized around factories. In the Soviet Union agricultural workers received the same services as the rest of the community.

Today public health services at both national and local levels are the responsibility of the State, and the health of people at work lies in the hands of owners and managers [10]. There are a number of governmental institutions with a degree of responsibility for workers health including Ministries of Labour and labour inspectorates. However the influence these bodies have on processes that protect and enhance workers health can vary considerably. Consequently, the attention and priority given to workplace health differs greatly from one workplace to another.

It is notable that the legal basis of public health and health in the workplace have evolved at different times, have major differences in approach and, as expressed previously, are under

the auspices of different state bodies. In many countries, and for many years, the curricula of medical schools and the training of other health workers was lacking in content on health and safety protection in the workplace and even today the situation regarding training in occupational issues remains poor in many countries.

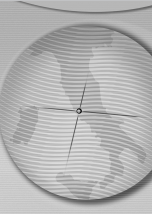
The walls of a factory or a craftsman's workshop and the boundaries of a farm act as a border with the people who live on one side having different health rights to those who work on the other side. This situation has arisen as a result of the different economic and political interests that apply and which often seek to maintain the status quo.

Generally speaking, the existing National Health Systems (NHS), as in Italy and UK, are based on a number of key principles including universality, equality and participation. It's fair to say that these principles are not consistently applied in the workplace setting with groups of workers being disenfranchised so far as workplace health is concerned.

More recently, Directives of the European Union have made the situation more complex by restating the central importance of business needs. In countries such as Italy, where the creation of the NHS brought the responsibility for the protection of employee health under the wing of public services, this caused some difficulty and confusion.

Instead, the new approach to disease prevention stated by WHO with the declaration of Alma Ata, 1978 was adopted. This stated that, "The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." This position was developed further in 1986 with the WHO Charter for Health Promotion. Unfortunately the situation in the field of occupational health did not change.

Almost everywhere in Europe the health of the single worker remained a matter of separate services, mainly provided by private sector organisations, with implementation at company level dependent on the interest and commitment of the individual enterprises. The general philosophy was based on the principle of the control of risk with consequent medical examinations to demonstrate a cause-effect relationship in order to provoke changes in the work environment. For environmental risk factors (dust, noise, gas, smoke ...) several limits (eg. Threshold Limit



Value,...) were enforced. Despite very great conceptual differences between the East and West there were nevertheless no significant differences in practical terms. Psychological risk factors were largely forgotten or underestimated and the organisation of work and its impact on health was universally ignored.

As we examine the situation regarding work related morbidity, mortality and other negative phenomena over this period of time we find that the health of workers has not improved significantly.

It's this situation that makes the proactive promotion of health at work such an important element of modern public health policies. [11]

The European Commission's position is that health and safety in the workplace is a priority action that has to be addressed across all levels of society by national governments, health and labour institutions, and social organizations. These organizations are united in their actions to make work safe, enhance the quality of working life and prevent occupational diseases, work related accidents and deaths. This can be clearly identified since the first directive on health and safety was approved and published by the European Commission in 1989. [12]

The emphasis on the promotion of employee health and well-being makes workplace health promotion (WHP) such an important element of a correct public health strategy. [13]

### The new way

The actions proposed by the Ottawa Charter have been translated into different situations and circumstances. The key statement is found at the end of the charter where it's recognised that achieving a high level of health among the population will require the action of many social and economic sectors. In order to be appropriate for the workplace, these actions have to be placed in the context of working life and culture. In doing so they establish operational activity that can resolve the historical separation deals in a new way by bridging the class division between employers and employees and between the community and the workplace. [14-16]

Subsequently, WHP came to the forefront of actions. Keeping people fit and healthy, maintaining their ability to work while also remaining active and productive members of society is a goal that can be achieved through the development of robust WHP programmes. These programmes enhance and extend existing occupational health, safety and hygiene procedures and, most importantly, contribute to the well being not only of the employees, but

also of the organizations and the communities in which they work and live. It is important to remind ourselves that this approach is based on:

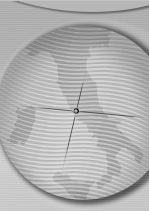
- building healthy corporate policy;
- creating supportive working environments;
- developing employee skills conducive to health;
- strengthening workforce action towards health;
- protecting the environment;
- re-orienting occupational health services. [17]

Nevertheless the promotion of health in the workplace took several different forms and has been led by many different professional groups.

In the beginning of the 1990's the concept of WHP was still enigmatic and difficult to define. The following approaches were used, and in some cases are still being used, each consisting of a different understanding of WHP:

- as behavioural prevention in the workplace - this approach is widely practiced, and aims to reduce the classical risk factors associated with individual behaviour, by adopting methods of behaviour directed prevention and health education in the workplace;
- as a component of expanded and modernised occupational health services (OHS) - while traditional health and safety focused on the elimination of physical and chemical risk factors, modern OHS concepts consciously incorporate factors such as work organisation and work design and consider WHP as an expression and elemental component of a holistic interpretation of health and safety;
- as a strategy to influence health determinants in the workplace - to improve health status WHP supports existing health promoting potentials (those of employees, workers groups, organisations, etc...) and acts on the important determinants of health;
- as a strategy to reduce absenteeism and presentism - absenteeism, presentism, poor morale and low motivation have a direct effect on a company's performance. In this context WHP is a component of company policy and supports strategies to reduce absenteeism;
- as a component of an organisational development strategy - modern management concepts (e.g. ISO14001) emphasise the function of human resources in the achievement of economic aims. WHP can create the necessary preconditions for the optimal exploitation of existing creativity and service potentials. [18-24]

At its most basic level, WHP consisted of initiatives directed at risk factors such as tobacco use and alcohol misuse for example or chronic diseases such as heart disease or cancer. This approach centres on the health related behaviours



of employees and goes under the term “lifestyle, epidemiological or risk factor reduction” approach. This type of WHP can often be developed and implemented by a single person. However, it has the inherent danger that when that persons’ role changes within the organization or should that person leave, then the driving force for WHP can be lost unless someone else is given the responsibility for developing the WHP programmes and in any case progress will be delayed.

At a higher level of development, WHP has to be positioned as a core element in the organizations’ corporate ethos and culture. This *organizational approach* has a distinct advantage over the lifestyle or behavioural approach. In order to achieve this position, it normally requires support at the most senior levels of management with responsibility for its implementation being shared among several individuals or departments. [25]

Worthy of mention in these developments are initiatives that linked WHP with other management theories such as Total Quality Management. The advantage of this development was the integration of WHP with quality which enhances the long-term sustainability of workplace health promotion activities.

Lead responsibility can lie within one of the many departments including human resource or occupational health and safety, etc. One of the most positive features of WHP is the fact that so many groups can contribute to it, and that it does not, indeed should not, lie in the domain of one group alone. [14-16]

This issue was well defined by Wynne [26] who adapted the five principles of general health promotion, based on the ecological model of health as developed by WHO in 1984 for use in a workplace setting [27]. Wynne states that WHP, “is directed at the underlying causes of ill health; combines diverse methods of approach; aims at effective worker participation; and is not primarily a medical activity, but should be part of work organization and working conditions.”

A significant step in the development of WHP took place in 1995 with the establishment of the European Network for Workplace health promotion (ENWHP). [28] The network consisted of representatives of occupational health and safety institutions, public health specialists and those involved in WHP in all EU Member States together with: Canada, Iceland, Liechtenstein and Norway. The Network received financial support from the European Commission (DG SANCO) and undertook a number of innovative projects that supported the development of WHP across Europe. [29]

“Healthy employees in healthy organisations” is the ultimate goal of the ENWHP. Using this goal, the Framework Directive on Safety and Health (Council Directive 89/391/EC) and the increasing profile of workplace as a public health setting, the ENWHP developed a strategy for WHP. [30] This strategy formed a key component of the “Luxembourg Declaration on Workplace health promotion in the European Union”. This Declaration laid down, for the first time, a common understanding of the concept, strategies and principals of WHP. It defined it as “the combined efforts of employers, employees and society to improve the health and wellbeing of people at work. This can be achieved through a combination of: improving work organisation and working environment; promoting active participation, and encouraging personal development.” [31]

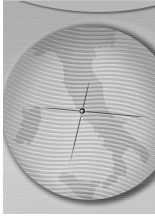
From this definition, it is clear that WHP is based on multi-component and multi-disciplinary cooperation and that it can only be successful if all key players (employers, employees, Unions, doctors, community, services, etc...) are committed to it.

Activity within the network since the launch of the Luxembourg Declaration has focused on to two main issues - identifying “Quality Criteria” for WHP and the identification and dissemination of “models of good practice”. [32]

Health promotion is often considered by employers to be an investment and consequently they expect the cost to be offset by a benefit. Thus, when WHP measures are implemented, employers tend to have high expectations of the outcome and success of these activities. For example, they hope to gain an economic advantage through lower absenteeism and accident rates, increased employee efficiency and motivation, higher quality products and services, improved company image and greater customer satisfaction. On the other hand, employees tend to expect better quality of life through increased work satisfaction, reduction of stress, an improved working environment and fewer work related health complaints. [33]

#### **Benchmark and models of good practice**

However, to gain the potential benefits, employers need to introduce sustained, comprehensive and effective WHP programmes. These programmes must be monitored and evaluated. [34,35] Aware of these needs the ENWHP, assuming that the statutory provisions on occupational health and safety were already fulfilled, established a set of quality criteria for WHP. [36]



The quality criteria have been formulated taking into consideration the model of the European Foundation for Quality Management. Naturally, the criteria are a benchmark for health promoting organisations. However, the criteria also form a framework for good practice. An organisation can take the criteria and compare its own activity against them. In doing so it will be able to determine where it stands and how far away it is from reaching its ultimate goals. It is important to bear in mind that as organisations have different resources and requirements, the criteria cannot and should not be considered as an absolute yardstick. There are twenty-seven criteria divided into six groups. Taken together they provide a comprehensive picture of the quality of WHP activities.

The groups are: WHP & corporate policy; Human resources & work organisation; Planning of WHP; Social responsibility; Implementation of WHP and results of WHP.

Across Europe, beginning in 1997 and up to 2006, a European consortium of experts under the name ENWHP identified and documented more than four hundred firms that had "Models of Good Practice". Each one demonstrates the fact that WHP is far from being an expensive and unrealistic exercise. [37-44]

### The new public health strategy

Experts in the field of public health worldwide agree on the necessity to adopt global strategies and make changes during times of crisis in order to be prepared to meet future demands. In other words, to contribute to the creation of a sustainable society. [45-48] A possible instrument could be a global WHP project whose main goals would be: enterprises taking responsibility for health; work organisation that is conducive to health; employers creating opportunities for employees to take greater control over their health and insuring working environments are safe and healthy. Of course, it will need a context in which the: Enterprise is recognized essential for the community; Tripartite consensus (agreement, plan); Control over the process by all social partners and confirmation of values from the past.

For example, the Italian NHS is quoted as one of the best in the world and the Italian welfare system assures a moderate coverage of the entire population. This model is based on a planning system both at central and regional/local level, National and Regional Health Plans, Local Health Agencies (LHA) Plans, Local integrated plans (between LHA and Municipalities) and then Health Pacts (all stakeholders are included under the coordination and control of Municipalities and Health Districts).

Eric Hobsbawm synthesised and expressed in the World Political Forum at Bosco Marengo in Italy, in October 2009: "The XX Century has been characterized by a religious struggle between two lay ideologies...socialism and capitalism... This opposition has been never realistic. The ex communist Countries, (after the fall of the iron curtain), were again absorbed in only one available perspective; the globalizing capitalism,...in its form of the free market. Consequences have been catastrophic. All countries of former Soviet Union have not yet overcome the repercussions...In Europe, some countries that assimilated the socio-capitalistic model of western Europe having a pro-capita revenue that is considerably lower. The reactions against the excesses of neo-liberalistic era have taken into form of public capitalism with a kind of regression to some aspects of soviet heritage. The simple imitation of the Western (system) has stopped to be a possible option" and then: "the crucial difference between economic systems it is not based on their structure but in their social and moral priorities"..."the end of communism resulted in a sudden disappearance of values, uses and social practices which shaped the life of entire generations...The western policy of neo-liberalism has underpinned on purpose welfare and social justice to the tyranny of Gross National Product: the as much as possible economic growth, voluntarily unequal. In such a way to undermine - and in some ex communist countries completely to destroy- the system of social assistance, welfare, values and goals of public services". And eventually: "The economic growth is not a goal but a means to give life to good, human and right societies".

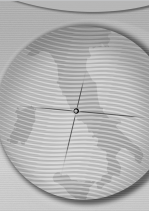
### Conclusions

There can be no doubt that the economic-financial crisis has created a new development model. The crisis has brought to light issues previously hidden, underestimated or disguised:

- growth of inequalities and growth of territorial imbalances;
- impoverishment of the social capital, globally understood, both as social networks and infrastructural heritage;
- reduction or destruction of the structures of Welfare and those for education/training.

Not to speak of environmental disasters, global warming, pollution and we can go on and on...

Many scholars and politicians (Giddens, for example) argue that to cope with these problems we need to reconsider a forgotten word: planning. Not necessarily an unavoidable contradiction does exist between market and planning. They



are adequate with appropriate ways of managing.

Planning can afford questions the market cannot solve, such as:

- the role of welfare in society;
- that of school and scientific knowledge;
- problems of culture;
- environmental aspects;
- how much to invest in basic national infrastructure;
- what to do with new technology how much to invest in it;
- and so on.

Planning is fundamental as we tackle our problems, especially if we are to develop better health in workers and ensure a more sustainable situation in work environments. This is especially relevant in small and medium enterprises (SMEs) where each organisation confronts many difficulties as it seeks to survive.

Putting health - in general terms - at the core of public action of society is one of the recommendations made by the WHO for the Eastern and Central Asian Countries and other Regions also. [49]

Nevertheless it is important to note that WHO

still does not consider the health of workers in its publications. Of particular concern is the state of play in the southern European countries, where the situation in many workplaces is not positive and is expected to get worse.

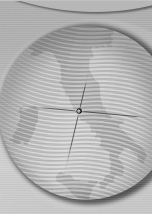
The Eurostat figures and other international organisations, such as the International Labour Organization, European Agency for Safety and Health at Work, The European Foundation for the Improvement of Living and Working conditions, demonstrate that fundamental research is needed to further extend our knowledge of what causes unhealthy work.

We maintain that there is the necessity to have a close cooperation between all European countries such as suggested by the ENWHP, to have a unique way of considering the health of people at work; to adopt a unique model for interventions in workplaces; to establish contacts and cooperation with the European Federation of Trade Unions in order to be aware of the situation across Europe, and to bring all areas up to the same high standard.

The enforcement of Lisbon treaty seems to be a substantial step forward.

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