

**Selection of speeches made at the conference
of the European Network for Workplace Health Promotion**

”Healthy Employees in Healthy Organisations”

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European Commission, Brussels

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Deputy Head of Department

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Future Perspectives of Health and Work from a European Union Perspective

by Pádraig Flynn

I am pleased that the Federal Institute for Occupational Safety and Health; and the European Information Centre at the Federal Association of Company Health Insurance Funds, have made it possible during the term of the German EU presidency to hold this conference. It is an excellent example of their successful co-ordination of the European Network for Workplace Health Promotion.

At this juncture, I would like to express my particular gratitude for the commitment and support of the many private and public organisations in this Network. Many of you are represented here today and without you the successful work in workplace health promotion would not have been feasible. And I'm sure that, in the future, we will all work together to improve the health of the people living in Europe.

Before I go on to the problems we are facing in health promotion, I would like to give you an overview of what I will be dealing with:

1. What challenges and tasks lie ahead of us in the field of work and health, above all health at the workplace?
2. What action have the European Communities taken to deal with these tasks?
3. What will the future activities of the European Union in health promotion be like?

1. Challenges and tasks in the field of work and health

Clearly, a range of new challenges are confronting health policy in the European Communities. A few random examples include genetics, the widespread use of new technologies and demographic change. More general socio-economic developments are also generating tremendous pressure on innovation which also impacts on the field of work and health.

For example, changes can be observed in:

- the structure, organisation and strategies of companies and workforces;
- the communication and information conditions; as well as
- the working and learning processes

The huge changes in company structures are of special importance. In large concerns, but mainly in small and medium-sized enterprises, these changes can, on the one hand, be summarised as the introduction of new production and management concepts.

On the other hand, there is an increase in employments which are subject to regulations, including those on occupational safety and health, but where these regulations can be difficult to apply, for example:

- fictitious self-employment and casual low-paid work;
- loan workers;
- temporary employment agencies;
- teleworking; and
- many models of outsourcing.

As a result, the "classic" company with its stable and predictable structures is heading towards a new flexibility involving:

- ever smaller, core, workforces;
- new forms of work; and
- greater mobility between jobs.

Overall, one can observe an increase in the number of small and medium-sized enterprises. These companies are subject to special conditions, particularly with regard to occupational safety and health and workplace health promotion, and they deserve more of our attention.

Direct consequences for all companies are:

- greater flexibility and constant adaptation of the fields of action;
- formation of small, mobile units working independently;
- resource exploitation through the participation of employees;
- open forms of communication and co-operation.

In this process of upheaval, the fact applies to all modern companies that they must achieve optimum service, customer and quality orientation with a core workforce, which is frequently smaller but better qualified. Another feature of the changes in company life - and not only within the European Union - is the increasing internationalisation of the economy.

Finally, the demographic development, above all of those people involved in the work processes, must be observed as regards its effects on workplace health promotion. The change in the age structure has, on the one hand, resulted in a higher proportion of older employees in the working population. On the other hand, this change also requires longer working lives to safeguard the 'agreement between the generations'.

This demographic development means that the group of older employees, is growing in relative terms. While at risk from poorer health and from sometimes outdated qualifications, these older employees offer a large but frequently untapped potential of experience and qualifications. This potential is not generally exploited as it should. Both the employees concerned and their employers suffer as a result.

Viewed overall - and also from this aspect of demographic development - human resources will be even more important to competitiveness in the future - both for individual companies and for the entire economy. The advent of the information society also demands a re-assessment of human resources: The knowledge needed for production and services is linked to people who need to remain healthy for as long as possible so that this expertise can be fully exploited.

It is at this point that workplace health promotion comes into play as an integral part of a company's human resources and health policy. Workplace health promotion must embrace a multi-tier strategy so that we can react to the requirements I have just outlined: Employees must:

- be protected against accidents, occupational illnesses and other job-related health risks;
- be able to use their knowledge and skills;
- have the possibility of personal development and advancement; ;
- have social security.

These will, on the one hand, reduce the costs and above all improve quality and thus strengthen customer ties. Companies of different sizes approach health promotion with different kinds of motivation. Scientific studies show that big companies tend to aim for a reduction in absenteeism by continuously improving the working conditions and thus achieve cost savings. By contrast, in small and medium-sized companies, the emphasis is more frequently on a general improvement in the working atmosphere and on their duty to care about the welfare of their employees.

The objective of workplace health promotion is therefore more than just protection against accidents and occupational diseases. It includes all the activities which serve to maintain and promote the physical and mental performance and motivation of the employees.

In modern companies strong involvement of the employees in this process is essential. I have already mentioned the changes in the communication and information conditions in society and at companies. Successful workplace health promotion is not feasible without intensive communication and constructive co-operation at all levels. This is shown repeatedly by models of good practice from companies, like those, for example, which the European Network for Workplace Health Promotion has secured to provide companies with assistance.

This leads me to my next point.

2. Action of the European Communities - Assistance Provided by the European Network for Workplace Health Promotion

In order to face up to the challenges and tasks in the field of work and health I have just outlined, extensive efforts have been undertaken in the European Communities. I would like at this stage to mention the "European Agency for Safety and Health at Work" in Bilbao as a representative example. The task of this Agency is to support the exchange of information between Member States on occupational safety and health.

Workplace health promotion projects are supported in addition to the wide variety of activities involved in occupational safety and health. In this connection the European Network for Workplace Health Promotion has been working since 1996 with the backing of the European Commission. All the Member States of the European Union and the countries of the European Economic Area work together in this Network.

The main objective of the Network is to identify exemplary models of good practice in workplace health promotion and disseminate them in the Member States. In the past, the Network primarily encouraged companies to assign greater significance to workplace health promotion and it will continue to pursue this policy in the future. At the same time, the Network has encouraged that health issues at the workplace be given greater consideration in political decision-making processes.

The "Luxembourg Declaration on Workplace Health Promotion in the European Union" marked the start of this work. This Declaration was adopted by all participating countries after intensive consultation in the Network and it has sent out a strong political signal. I would like to remind you here of a central passage in the Declaration which is an excellent reflection of the problems to be tackled:

"Workplace health promotion is the combined efforts of employers, employees and society to improve the health and well-being of people at work.

This can be achieved through a combination of

- improving the work organisation and the working environment;
- promoting active participation;
- encouraging personal development".

The Luxembourg Declaration has created for the first time at European Level a political platform which lays down a common understanding of workplace health promotion. This common approach compares with the past when the promotion of health in the workplace had been very different in the member states.

I am speaking on behalf of the entire Commission when I tell you that, from the perspective of public health, the workplace is an important location for providing information and exerting influence. We not only know this from our own everyday work experience but also from numerous scientific studies.

In this context the Network for Workplace Health Promotion not only represents a major element of the Communities' policy in the field of public health. It is also an important and sensible supplement to the activities of the European institutions responsible for statutory occupational safety and health.

The Network for Workplace Health Promotion has produced two very important results in the few years of its activities:

1. The set-up of international co-operation structures and the creation of a policy consulting concept for workplace health promotion
2. The collection of models of good practice in workplace health promotion.

On 1.

The establishment of the Network created an effective infrastructure for the exchange of experience between the participating countries. These co-operation structures ensure that positive and successful methods of workplace health promotion are disseminated as quickly as possible in the Member States.

The Network structure has above all considerably reduced the amount of work being duplicated. People also learn from failures, thus preventing the repetition of approaches which did not work well. As I have already told you, the common strategy as agreed in the Luxembourg Declaration has made a substantial contribution to this.

Last but not least, we in the Commission have found in the Network a competent partner and consultant for the future development of recommendations, strategies and draft policies in the field of public health in general as well as in workplace health promotion in particular.

On 2,
the collection of models of good practice in workplace health promotion.

The work of the Network in this area deserves special mention. This collection of successful models of workplace health promotion from all participating countries has made an outstanding contribution towards disseminating really good workplace health promotion practice in the European Communities. Companies throughout Europe can learn what success workplace health promotion can bring to them too.

May I extend my thanks to you for this productive work.

In this connection I would like to make special mention of the future activities of the Network already planned. While workplace health promotion at large companies has so far been the focus of work, emphasis will in future be placed on small and medium-sized enterprises.

May I remind you of my brief remarks on the changed working conditions in Europe at the start of my speech. An increasing number of people are working in small and medium-sized companies. Therefore, there is also a need for vigorous action at these firms to disseminate the philosophy and practice of workplace health promotion. I am expecting just as successful work in this new focal area as you have already achieved in recent years, and I wish you all the best.

The ongoing and future work of the Network for Workplace Health Promotion fits into the overall activities of the European Union in health promotion, which I would like to deal with now in the next and final part of my speech.

3. Future Health Promotion Activities of the European Union

At the outset, I viewed the requirements placed on health promotion, including at the workplace, from the perspective of future developments in the conditions of work and health. I would now like to focus on the future activities in this sector after the extension of the fields of action in the European Union's health policy following the Treaty of Amsterdam.

It must not be forgotten that the European Communities have been dealing with questions of health for forty years. The Treaty establishing the European Coal and Steel Community and the Euratom Treaty already contained regulations on safety and health at the workplace. With the Treaty of Maastricht, it has become a major objective of the health policy of the European Union to contribute towards a high level of occupational health.

A framework for action in the field of public health was submitted in 1993, to the European Parliament and the Council of Ministers and it came into force in March 1996. This framework includes the strategy of supporting health promotion as part of the health policies of the Member States through networks, information exchanges and pilot projects. It is within this framework that the Network for Workplace Health Promotion was also established.

The role of the European Communities is to:

- assist the Member States in their efforts on behalf of public health;
- help with the formulation and implementation of objectives and strategies;
- make a contribution towards occupational health in the entire population;
- disseminate the best examples of a health policy as a target for everyone.

An extension of the fields of action in health policy is provided for in the Treaty of Amsterdam. This reflects the growing consensus about the role of the European Union as regards health policy.

All directives of the Communities must now satisfy the criterion of health protection. Health and consumer protection, just like environmental protection, must be integrated into all the Communities' policies. This means that every directive issued by the Commission must take account of public health concerns. In future, the effects of a decision on the health of the people living in the European Communities will therefore be taken into consideration in advance. This will certainly also entail a greater need for information as regards the projects and networks which deal with health policy and promotion.

In addition to the prevention of illnesses, the improvement in the health of the population has now also become a declared objective; equally, the elimination of causes of risks to human health. Moreover, the main focus will continue to be placed on the prevention of illnesses.

All in all, a more comprehensive understanding of health policy has therefore been created. The elimination of causes of risks to human health also embraces measures to prevent accidents and violence as well as the improvement of working and living conditions which make people ill. The principle of subsidiarity of the European Union in health policy has, however, been retained. The different regulatory possibilities created within a narrow framework do not affect the area of health promotion.

With the Treaty of Amsterdam the role of the European Communities has faced up to the new challenges and changed circumstances. We will address this extended role with three focal points of action incorporating all the experience with the existing framework for action:

1. Improvement in information for the development of public health
2. Rapid reaction to threats to health
3. Tackling health determinants through health promotion and prevention.

Today, I would like to handle the third focal point of action: While the Maastricht Treaty stressed the prevention of illnesses in particular, today the emphasis is on improving the population's health, preventing human diseases and eliminating the causes of risks to human health. In this context the measures in this field of action must be geared towards improving the factors governing health. This is to be achieved through health promotion and prevention.

It must be taken into account that, in addition to individual hereditary factors, it is primarily the following factors that have to be observed:

- **Behaviour**, such as nutrition, exercise, consumption of alcohol, nicotine and drugs. Behaviour can be greatly influenced by social and cultural conditions, e.g. through education, information and training.
- **Environmental influences and socio-economic conditions**: Here, not only the working conditions but also the living conditions of people are important.

Health promotion will be aimed at ensuring that people increasingly gain control over the factors that determine their health and thus improve their health. As I have already stated, behaviour and situation prevention must be viewed to the same extent. On the one hand, the skills and abilities of the individual are to be promoted and strengthened, on the other hand, action must be taken to change and improve the social, economic and ecological environment. Both together will enhance the health of the individual and that of the entire population.

Without being able to go into the many facets governing health and thus health promotion, I would, however, just like to deal briefly with one particular aspect: risk behaviour. As we all know, this also plays a major role in working life.

Risk behaviour which causes accidents and injuries is especially important with young people. We will above all combat the fatalism that 'accidents will happen'. An integral part of the action programme is intended to show that accidents can be prevented if the right precautions are taken. The programme on health promotion will support every effort by Member States to provide information on prevention. The aim here is to change the basic attitude to safety and health in the general public. With this in mind we will now continue the work we have started using all the experience gained from the previous action programme and with ever greater commitment as well as initiate new campaigns such as

- Pilot projects;
- Education campaigns;
- Networks of organisations and experts;
- Development of guidelines and practical recommendations;
- Exchange of information and staff.

I hope that I can count on the support and co-operation of the Member States, of employers and of employees in making our new strategy a success.

Thank you for your attention.

The Importance of a Modern Workplace Health Policy as a Competitive Factor. Strategies and Experience of Siemens AG

by Günther Goth

Ladies and Gentlemen!

The fact that companies pursue a workplace health policy is as old as the companies themselves. However, in recent times it has assumed a completely new significance. This is attributable to the increasing shift in activities from production to complex work operations and the resultant higher qualifications of the employees.

Whereas, for example, 63 % of Siemens employees were industrial operatives and 37 % salary-earners in 1970, this ratio has now been reversed. Today, we employ 35 % blue-collar workers and 65 % white-collar workers. And may I add that of the 35% blue-collar workers, every other one is a skilled worker and highly qualified. In 1970, only one in five blue-collar workers held such qualifications.

This change in the field of work and the higher level of vocational training is also reflected in the workplace health policy. Whereas, for decades, categories like accident prevention, occupational safety and health or rehabilitation after illness were the focal points, today we pursue a holistic approach of health management.

I would like to outline to you what this approach is like in detail and what experience we have gained with it so far. We are convinced that we have adopted the right strategy and that a proactive health management systems pays off in the long term. The reason for this is the change in significance of the individual employee for the company. Let me just explain this in brief:

1. The Significance of Human Resources in Global Companies

As I have already mentioned, nowadays more than four out of five of our employees have a university or college degree or have completed vocational training - and the trend is rising. If you consider that three out of four of our company's products are less than five years old, you can clearly see what commitment a company of our size must undertake to pursue continuous innovation. We register over 6,500 inventions every year worldwide. That means 30 registrations on every working day of the year and you can certainly imagine what a tremendous amount of research and development work is behind these successes.

Ladies and gentlemen, these figures also clearly illustrate the enormous importance of "intellectual capital" for a high-tech company like Siemens.

The employees and

- their knowledge
- their performance and
- their motivation

are today what distinguishes one company from another. Their willingness to be innovative, their flexibility, their desire to co-operate over departmental and national boundaries and their learning capacity are competitive advantages which makes a company unique and not so easy to emulate. Employees today are no longer dispensable, as in Taylor's day, but are **the** crucial factor for success.

We now have 436,000 employees in 190 countries all over the world.

We develop, produce and market our products in so-called value-added groups, that means individual work is performed all over the world at those locations where we find the most favourable conditions in terms of know-how, infrastructure and low costs. For our employees, this means increasingly co-operating beyond departmental, national and cultural boundaries. They must be flexible, always willing to take on new tasks and co-operate in projects for limited periods. This places high demands on the willingness to communicate and co-operate, on acting with foresight, on their understanding of relationships and their ability to make 'correct' decisions and assume responsibility.

Nowadays, everything depends on the employees:

They implement and promote innovations, keep customers satisfied, work in teams and networks together - or maybe not.

They manage, motivate, decide, encourage - or maybe not.

They enjoy work and are fully committed - or maybe not.

This last point above all, enjoying work, should not be underestimated. Here, there has been quite a change in values linked to the changes in society, with greater affluence and a higher level of education. The attitude to work as the key element in life is increasingly being replaced - especially by younger, highly qualified employees - by an attitude which bears certain hedonistic traits. The demands placed on work have increased and changed in terms of quality. To reduce it to a common denominator: "Performance yes, but not performance as a result but performance as an experience."

While emphasis used to be placed on income, employees today set great store by personal responsibility and a broad latitude for action. They look for demanding tasks where they can develop their skills and potential. Income still plays an important role but certainly not the main role. Social security and an adequate income are viewed as normal ancillary conditions for starting work which are largely covered by law or collective bargaining agreements. The immaterial benefits of a company are of interest and a motivating factor. These include personal freedom of action, possibilities of further development, respect and recognition by superiors and, increasingly, international careers.

We as employers must gear ourselves to these demands. And we like to do so for the demands of the employees match the demands which arise inside the company. This has a major influence on the human resources policy and practical personnel work.

It must gear itself to the change in the expectations of the employees and create appropriate motivation incentives.

It must generate an environment in which the employees are prepared to work.

It must lay the foundations for a corporate culture everyone identifies with.

In other words: The knowledge, skills and desire of the employees and the leadership qualities of the management are the crucial competitive factors.

If these factors are O.K., we achieve success, but if not, we are not successful. The human resources policy at Siemens is therefore an integral element in the business policy.

Facets of the human resources policy include:

- the entire field of leadership and co-operation including the appropriate managerial instruments
- staff development, starting with further training courses down to the systematic development of managers
- the recruitment of young executives and their vocational training
- the pay systems

and last but not least

- workplace health management.

Under health management, we pursue a holistic approach, as I already stressed at the outset, which goes far beyond the freedom from illness as the opposite to being sick. I would like to explain this to you using five theses:

2. Five Theses on Health Management at Siemens AG

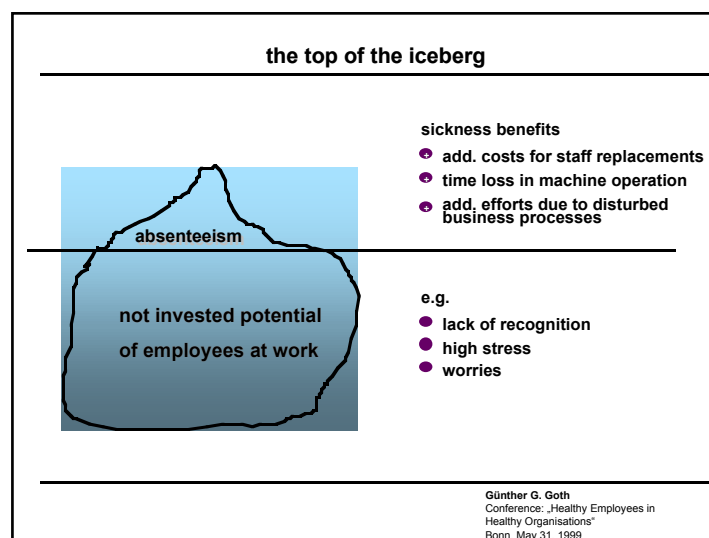
1. Health is more than freedom from illness
2. Health has a major influence on motivation and performance
3. Health promotion must be pursued in a proactive instead of a reactive manner
4. Health promotion is a managerial task
5. Health management pays dividends.

Let me now explain these theses in brief:

1. These: Health is more than freedom from illness

As a rule, laboratory medicine determines whether someone is healthy or ill. As soon as certain symptoms arise, blood values, blood pressure or heart rate are measured and appropriate treatment initiated. The employee is written off sick, as they say in the vernacular, and, after the treatment is over, he is certified as being healthy again. The employee is then 'fit for work' and returns to the company.

Numerous studies have, however, shown that this state of illness is only the tip of the iceberg as you can see from this diagram.



The large lump underwater which supports this iceberg and sustains it is much larger. It is the part which makes the iceberg so dangerous as you cannot see it. This is the potential of the employees present which is not exploited. The reasons for this are frequently mental stress, resulting for example from a lack of recognition, a lot of stress or worry, possibly about one's job. The symptoms may be tenseness, nervousness or even demotivation. The employees are not ill in the strict medical sense but are they therefore healthy?

Man is, after all, not a machine which functions like clockwork as long as the damaged parts are replaced and it gets enough oil. That doesn't work. Against this background, the World Health Organisation has developed a holistic definition of health which understands people as being physical/mental but also social beings.

"Health is the condition of complete physical, mental and social well-being and not only the freedom from illnesses and disorders."

Based on this definition, the Ottawa Charter of 1987 then underlined the major significance of work for health. I would just like to briefly quote the most important sentences: "The changing living, working and leisure conditions have a decisive influence on health. The way in which a society organises work, working conditions and leisure should be a source of health and not illness."

For the work organisation in a company, this therefore means not only promoting the health of the employees in the clinical sense, for example by means of accident prevention, occupational safety or ergonomics, but also creating conditions in which they can introduce and further develop their personalities and social skills conditions which they view as motivating, conditions in which they enjoy working.

The new forms of work organisation with greater project work and teamwork satisfy these demands in full.

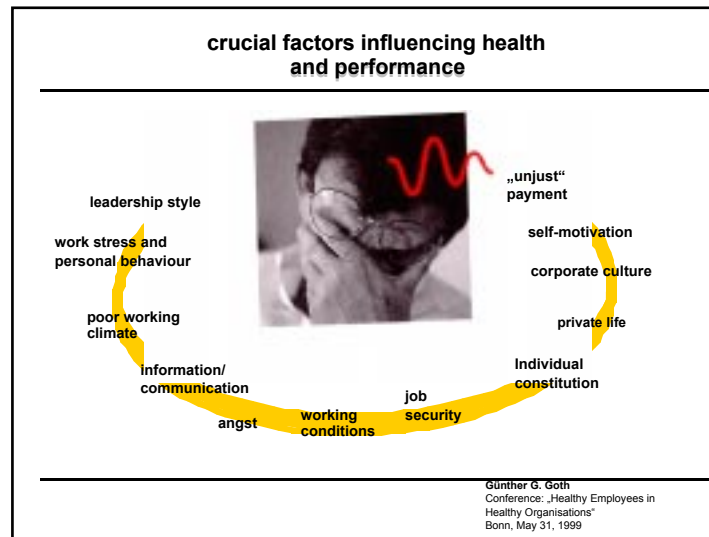
And so I now come to the second thesis:

2. Health has a major influence on motivation and performance

This insight and the fact that the social working environment has a major influence on motivation and performance are nothing new. The American Professor Elton Mayo had already verified this in the early forties in his famous Hawthorne studies. As a summary of his studies on American factory workers and the consequences of the increasing division of labour, he comes to the conclusion, and here I quote verbatim: "The number of unhappy people is increasing. For industrial societies it is quite characteristic that many of the groups formed are not very keen on working unreservedly with other groups. On the contrary, they usually show caution or animosity. In this way society is lowered to a state of stasis - to the state of the a chaotic conflict between interest and power groups."

And that, ladies and gentlemen, is one thing we cannot afford in industry today. We can only act successfully in the economic environment I described at the start when all employees commit themselves in full and co-operate without any limitations. We

have created the working structures in which this is possible. We have established managerial systems which are aimed at a culture of dialogue and trust. We give the individual maximum scope for action and possibilities of personal development.



In this diagram you can once again see the most important factors influencing health and performance. We tackle all these aspects in order to melt the iceberg. And this brings us to the

3rd thesis: Health promotion must be pursued in a proactive instead of reactive manner.

With this approach, both the company and the employees themselves play their part. **The company** by creating the general conditions in which the employees enjoy working, by offering the employees assistance in crisis situations, for example through the works medical service or social consultancy, by sensitising the employees to the high value of physical health, for example sport or healthy food and **the employees** by organising their working time so that they can also pursue health-promoting activities in their spare time, by stating openly what they dislike and what obstructs them in the company.

In order to firmly establish this proactive health promotion in the company, we initiated the project 'Top in Form' in 1996. This was not a programme to reduce sickness level but a programme which is focused on the health level. The starting point was a detailed analysis of the causes of absenteeism and obstacles to better performance. To this end, we firstly questioned various groups of people in the company, starting with the works physicians, representatives of the company health insurance fund, social consultants, safety experts, members of the works council and

managers down to those affected. We have just seen the result of this survey in the diagram, namely the factors which cause illnesses or impede performance and, if we recapitulate, you can see that many of the points mentioned relate to the subject of 'management and co-operation', for example, the direct leadership behaviour, working together at the workplace, information and communication, working conditions or the corporate culture.

It was therefore obvious from the outset that the most important levers had to be applied at these points, as you can see from this diagram.

It was also evident that all the employees had to be actively involved. Therefore, the project was run as a real mobilisation campaign where the individual projects were decided on site at the various locations in close collaboration with the works management, human resources manager, works council, works physicians and social consultants and implemented together with all employees. The activities ranged from 'small campaigns' such as lectures on healthy food or gymnastics in the lunch break down to changes in the work organisation, team coaching and management consultancy.

The project has since been completed and integrated into normal everyday working life. A work circle on health has been established at every location, comprising a representative of the works management, the human resources management, the works council, the occupational health service, and social consultants. The aim of this working group is to continue to pursue the objectives of 'Top in Form' and initiate health-promoting activities. However, we have now gone one step further and so I come to the

4th thesis: Health promotion is a managerial task

Based on the knowledge that numerous factors which impair performance or even make people ill are to be found in the field of co-operation, we have laid down these categories in specifications for all our managerial staff. For example, our managers are assessed as to what extent they promote co-operation in their team as well as with other teams. They must be accountable for what measures and to what extent they support the personal development of their staff and, finally, they are assessed by what they do to maintain their personal physical and mental capabilities. For the performance of different hierarchical groups is frozen into the iceberg which we have just seen. In order to thaw it out, levers must therefore be applied at all hierarchical levels. We have therefore established a human resources management system which is aimed at creating a culture of dialogue and trust. I would just like to briefly mention three elements to illustrate our philosophy to you:

In the so-called **DPR talks** for staff not covered by the regular pay scale and interviews for the employees paid under collective bargaining agreements, each employee discusses with his manager once a year the performance and potential of the employee. DPR stands for development, promotion and recognition. The aim is to ensure that every employee is optimally deployed and can enjoy continuous development. Concrete measures are then decided on together, for example participation at seminars, co-operation in projects, assignments abroad or a job change.

All employees also have the opportunity once a year during a **manager discussion** to give their direct superior feedback on how they experience this co-operation. This meeting is held in the presence of a neutral chairman where the team members initially write down on cards, without the manager being present, where they see the manager's strengths and weaknesses. The manager assesses himself at the same time. Then the self-assessment and the staff assessment are compared, critical points openly discussed and measures agreed on which are then evaluated the following year.

Our staff surveys, which we conduct at least every two years, also produce concrete agreements on changes. Here, the employees have the opportunity to comment anonymously and in writing on a wide variety of issues, starting with the customer benefit of their work, through the possibility of implementing new ideas, the type of co-operation in the team down to the social responsibility of the company. These surveys help to reveal sources of dissatisfaction and to find remedies before this dissatisfaction turns into demotivation or even inner resignation.

So you see, ladies and gentlemen, we adopt a wide variety of approaches with our health management system which go far beyond the direct physical well-being of our employees. However, we are convinced that, and this brings me to my

5th thesis, holistic health management pays dividends.

It would be totally nonsensical to compare the income and expense of a health management system, such as I have described, in purely economic terms. I would even go one step further and say that it is impossible.

Naturally, you can measure sickness levels and I can report that through 'Top in Form' we were able to reduce absenteeism due to illness from 4.4 % to 3.3 % in two years and this corresponds, of course, to financial savings.

I can also calculate that every year we spend roughly DM 100 million on the health care of our employees ,

- for 80 works physicians and their first-aid stations
- for occupational medical check-ups
- for our own spa facilities used by 2,100 employees every year
- for sports amenities
- for rehabilitation measures after serious illnesses
- for our own social consultants
- and for other health-promoting activities.

But trying to draw up a proper balance sheet would mean only analysing the tip of the iceberg in the cost/benefit sector. It would mean undoing the progress we have made with the introduction of the health management system and reducing the employee to a robot. How can you measure motivation and performance in units of currency?

Who would calculate the opportunity costs of commitment? No, that is not possible.

However, I am convinced that investments in the employees, regardless of whatever kind, always pay dividends. I would like to sum up with the words of Maxim Gorky - in spite of all the differences in economic attitudes: "When work is a pleasure, life becomes a joy", and I would like to add "for the employees and the employers".

WHP and Modern Occupational Health and Safety

– Current State and Perspectives

by Prof. Dr. Frank Pot and Rob Gründemann

Ladies and gentlemen, dear colleagues,

The work of our European Network is primarily to develop and to sell a concept, an approach. At the beginning of our conference it is therefore worthwhile to start with a clarification of our concept as it has been developed so far.

1 What do we mean by workplace health promotion (WHP) and where does it come from?

Is WHP a systematic and comprehensive approach to improve the health of the workforce?

The characteristics are:

pro-active: it goes beyond a piecemeal response to health problems as they arise.

whole health: it is focused on the whole of the individual, i.e. it seeks to deal with all the factors which influence the health of the person. It does not focus only on physical symptoms of disease, but also targets the psychological and social health and well-being of the person;

balanced approach: WHP addresses both the individual and the work environment in the broadest sense;

employee participation: participation is a basic requirement that WHP reaches its intended target; health improvement cannot be inflicted on employees from above.

needs-based: WHP takes into account the full range of needs of the workforce and in particular this context needs refer to a collection of different health related issues - personal preferences for action and objective and subjective risks.

The first International Conference on Health Promotion was held in Ottawa 1986, which created a charter for health actions, either in the workplace or in the community. This charter was framed in the context of the WHO Health for All by the year 2000 programme. At that moment very little was known at a European level about the state of development of workplace health promotion. This situation was different in the US; at that time a very specific approach to WHP existed already in the US. WHP was - and generally speaking still is - largely focused on risk factors for single health problems (such as heart disease and cancer) and aimed to change the health-related behaviour of the worker. The US model for WHP is based on an epidemiological or risk factor reduction approach and has been developed from more

traditional health promotion activities. The EU model started in the tradition of the quality of working life and is based on the ecological model of health proposed by the World Health Organisation (1984). This includes among others a focus on the population as a whole, rather than on people at risk for specific diseases; action on the determinants or causes of ill health; complementary methods or approaches; and effective worker participation.

The European Foundation for the Improvement of Living and Working Conditions played a major role in the development of WHP in Europe. From 1989 - 1997 the Foundation commissioned the largest single research programme on WHP in the world which covers areas as research, policies, training and dissemination of training (Wynne, 1997). In 1995 the European Commission established the European Network for Workplace Health Promotion. This network produced an agreed 'mission statement' and approach for WHP which has been subscribed by the network members and has been published as the Luxembourg Declaration (1997). The European Conference on Healthy Employees in Healthy Organisations is the first European Conference of this network.

2 How prevalent are workplace health promotion activities in EU and why do companies undertake such actions?

When the Foundation started, little was known about of WHP at either European or national level. It was not known what form of WHP took place in Europe or whether there was a distinctive European style of undertaking WHP. In this context one the first activities of the research programme of the Foundation was conducting a survey on prevalence of WHP activities in European companies (Gründemann & Lourijsen, 1991; Wynne & Clarkin, 1992). The survey took place in seven countries (Germany, Italy, Spain, Greece, Ireland, the UK and the Netherlands). 6157 questionnaires were sent to companies; 1451 companies responded. The response rate was 23.6%, quite low, but not atypical for this kind of surveys. The aim of the study was to assess the kinds of health activity which were taking place (not an absolute prevalence) and to examine how they were organised.

In the questionnaire a list of 30 possible actions was presented and the companies were asked whether the action had taken place in the organisation in recent years and to what extent improving the health of the workforce had been a consideration in the action. In the analyses the health actions were divided in five sections:

- health screening activities (executive screening, screening for all, at risk screening);
- healthy behaviour activities (e.g.: alcohol -,smoking -, healthy eating policy, exercise facilities);
- organisational interventions (e.g.: shift schedule - , job design, working time flexibility, HRM training);
- social welfare activities (e.g.: counselling support, stress control, community/social programmes);
- safety/physical environment activities (e.g.: protective clothing, automating hazardous processes, ventilation, interior design, noise reduction).

The most prevalent activities in the workplaces were concerned with safety and interventions to the physical work environment (see table 1). The least common activities were concerned with social/welfare and with organisational interventions. It is clear that many activities took place for other reasons than health improvement. These other reasons were largely concerned with fulfilling the provisions of legislation and to the provision of fringe benefits. The findings indicated a gap in the awareness within enterprises of the potential of many activities to influence health. This was particularly seen in relation to some of the organisational intervention activities.

Table 1. Proportion of activities which have health as a consideration

health activity	% taking place	% with health consideration
health screening activities:		
executive screening	45%	35%
screening for all	51%	40%
at risk screening	46%	40%
healthy behaviour activities:		
alcohol policy	28%	23%
smoking policy	37%	30%
healthy eating policy	37%	29%
exercise facilities	23%	18%
exercise/lifestyle classes	10%	8%
rest/social/shower facilities	47%	34%
health education	40%	34%
Organisational interventions:		
shift schedule design	24%	18%
job design	39%	32%
work organisation	47%	35%
working time flexibility	56%	39%
HRM training	55%	37%
social/welfare activities:		
counselling support	30%	27%
stress control	11%	10%
welfare support	31%	23%
support programmes	16%	16%

community/social programmes	25%	18%
health activity	% taking place	% with health consideration
safety/physical environment activities:		
toxic substance control	56%	46%
machinery guards	76%	66%
protective dothing/equipment	80%	70%
automating hazardous processes	47%	41%
individual workspaces	54%	44%
lighting	76%	64%
heating/air conditioning	74%	62%
ventilation	76%	65%
interior design	57%	46%
noise reduction	68%	58%

The cross country data have also been used for multivariate analyses. These showed national differences with higher levels of activity in the Netherlands and lower levels in the UK. But the principal predictors of levels of health activities appeared to be the health characteristics of the companies, like the presence of a health budget, the presence of an occupational health department, the presence of a health policy and the presence of a health and safety committee. Of the demographic factors, size was strongly associated with health activity factors. Larger companies reported more health activities than smaller companies.

The levels of involvement of six main actor groups (management, staff representatives, trade union representatives, health and safety representatives, occupational health staff and outside consultants) were not to associated with levels of health activity. The only exception was the involvement of occupational health staff, which was associated with more health activities.

Another question in the survey was related to the factors which prompted any of the health actions (see table 2).

Table 2: Prompting factors and benefits

	% reporting as a prompt	% reporting as a benefit
legislation	80%	N.a.
personnel/welfare	76%	62%
health	77%	76%
staff morale	73%	78%
absenteeism	63%	63%
productivity/performance	72%	62%
staff turnover	29%	36%
industrial relations	41%	62%
company public image	61%	64%
accident rates	56%	64%

The figures show that companies have multiple reasons for implementing health actions and that many have nothing to do with health issues. Furthermore the

patterns indicate that organisations react to both external pressure (legislation, industrial relations; company public image) and internal demands (personnel/welfare problems; health problems in the workforce).

Organisations also experience benefits from engaging in health actions and potential benefits seems to function as a push factor too. Significant benefits were claimed by more than 50% of the companies. For most of the areas, the percentage of respondents reporting benefits was more or less the same as those who reported the issue as being a prompting factor, with the exception of industrial relations, personnel/welfare and productivity/performance.

The information coming from this research project provided a lot of information for the further development of a strategy to deliver WHP to companies.

3 Demonstration projects in the Netherlands

In the Netherlands, workplace health and more specifically work stress have been important political issues. The final enforcement of the new Working Conditions Act in 1990 promoted risk management at the source. At the beginning of the 1990's several 'examples of good practice' were initiated in different branches of industry by the Ministry of Social Affairs and Employment and the Ministry of Public Health, Welfare and Sports. These studies were longitudinal in nature and were performed in a hospital, a construction company, a metal-products company and in regional institutes for mental welfare. The projects aimed at improving the health, safety and welfare of workers, thus reducing sickness absence and incapacity for work. Furthermore the projects were intended to provide a scenario for occupational health services, to enable them to initiate and carry out similar projects in other firms and companies (Jansen et al, 1995). The four projects were successful and showed that it is possible to perform a WHP project properly in different types of companies, that it improves the health of the workforce, and reduces the levels of absenteeism and disability. Moreover the projects showed that it is financial attractive for companies or other organisations to 'invest' in WHP. For example each invested Dutch guilder in the project in the construction industry resulted in a benefit of one-and-half a guilder over a period of two years. Similar results were found in the hospital project. In this project management agreed on investments to a total amount of 1.2 million guilders and after three years it had benefits between 1.6 and 2.6 million guilders as a result of cost savings due to decreased levels of absenteeism. Both calculations did not take into account benefits such as improved working atmosphere or increased productivity! Demonstration projects in other European countries show similar results.

4 The prospects for further development of WHP in Europe

The prospects of WHP in Europe have been improved considerably since the end of the 80's. Awareness among the major players has increased in most countries and levels of activity within companies have also increased. More and more good examples of integrated WHP are available. This conference of the European Network for WHP with a main focus on organisations presenting their experiences with WHP is a good example of the current status of WHP in Europe.

At the same time major changes in the world of work have been taking place over the last decade (Wynne & Gründemann, 1999; Houtman, 1999). These changes include:

- ❑ Changes in the demography of the labour market, which includes elements as the ageing of the workforce, increasing female participation rates, labour market deregulation and changes in job tenure which relate to the various forms of flexible work contracts.
- ❑ Changes in the nature of economic activity, which refers to trends as the increasing numbers of small and medium size enterprises, the reduction of the public sector, manufacturing and agriculture, changes in management practice (leading, for example to more outsourcing, downsizing etc.), the growth of the service sector and the globalisation of trade.
- ❑ Changes in the nature of work - important features include the increasing usage of and dependence upon computer and telecommunications technology, the growth of remote working, the automation of work processes and the continuous changes in skills and knowledge required for the job.

These changes in the world of work go together with changes in the concepts and practices regarding occupational safety, health and well-being.

- ❑ Changes in thinking on health, which include a growing awareness of the importance of preventive strategies, focus on general health and well-being, the increasing costs of health care and the high costs of disability.
- ❑ Changes in OSH practices, which include new hazards at work, a shift in emphasis towards health rather than safety, the growing importance of stress, increased emphasis on absenteeism management and an increasing recognition of occupation-related illness, including attention to reintegration/rehabilitation.

These developments are complex, involving the areas of public policy development, new developments in technologies, changes in business models and new thinking on public and occupational health. Most policy responses to these changes have been uncoordinated and sporadic in nature. Future action is needed to develop an

integrated and coordinated view, not only to understand problems properly, but also to ensure that future policy development proceeds from an adequate basis. The changes as mentioned do not necessarily have to imply threats on the health and well-being of the workers. There have also been positive changes in the ways in which employee health is dealt with at the workplace. The implementation of the Framework Directive has led to an increased focus on preventive activities, to a relative reduction in the prevalence of traditional health and safety hazards and to a re-organisation of occupational health care systems. Other examples of positive changes can be seen in Finland and the Netherlands.

Finland is the forefront of many new approaches to workplace health in Europe. One of these is the 'maintenance of work ability programme' (MWA). This programme aims at prevention of health problems and reintegration in order to allow ageing employees to continue to participate in the labour process as long as possible. Occupational Health Services (OHS) play an important role in these maintenance of work ability activities. The MWA programme is the Finnish answer on the rising average age of the working population and too high figures on early retirement and disability. Twenty five pilot studies have been carried out between 1990 and 1996. Results are very encouraging and demonstrate that poor or moderate work ability can be improved, while good work ability can be maintained. Moreover, there is also evidence that the life satisfaction of individuals who had participated in an MWA programme has increased significantly.

The Finnish example shows us the potential role of the OHS in the further dissemination of WHP and especially to SME's. To take this role OHS has to overcome some practical difficulties which at this moment act as barriers. These difficulties include the privatisation of OHS which in many cases has led to a much sharper business focus amongst OHS professionals and to the offering of services which only cover the bare legal minimum. Also at the educational and training level there are some difficulties where often OHS professionals have not been adequately trained in the skills needed for a broader approach. The move away at the conceptual level from a narrow definition of the function of OHS which focused on safety, towards one which has a more health oriented focus, has to be attended with a training programme for current and future OHS professionals. Finally to avoid the debate about the territory OHS professionals should increase their co-operation with health promotion agencies and take a joint initiative for further dissemination of WHP in Europe.

The example of the Netherlands is also related to control the high costs of social security. After a strong reduction in levels of absenteeism and disability mid 90's these figures are increasing again. Against this background it has become evident that long-term labour participation of workers can only be achieved when the working conditions are good and the company policy includes prevention of health problems and attention for individual growth. That's why the members of government consider further improvement of working conditions to be essential. Still too many workers have work-related health complaints. Government wants to introduce targets to reduce workplace risks. This will also enable the assessment of the effectiveness of government policy in this area. They started recently with general targets for noise reduction and RSI in VDU work. Unprotected exposure on damaging levels of noise has to be reduced with 50% in 5 years. RSI-related complaints in VDU work have to be reduced with 10 percent in three years. Targets for heavy lifting and work pressure are under development. In the Dutch tradition of social policy government tries to achieve these targets by making agreements on sector level with employer organisations and unions (e.g. for RSI in banking, noise reduction in the building industry and heavy lifting in the health care sector). Government supports the activities with money for research, information, example projects, monitoring and evaluation. A structural expenditure of 250 million DFL (120 million Euros) has been made available.

I come to my conclusions:

WHP has become a serious item on the political agenda and on the agenda of a growing number of companies. In my opinion the European Foundation for the Improvement in Working and Living Conditions originally and later on the European Network for Workplace Health Promotion have evidently contributed to these positive developments.

The changes in the world of work underline the need for an systematic and comprehensive approach of WHP as is advocated by the European Network. This approach is supported by other important networks, for instance the WHO Collaborating Centres in Occupational Health in their Global Strategy on Occupational Health for All (1995), but also the European Association of National Productivity Centres in their Memorandum on Productivity, Innovation, Quality of Working Life and Employment (1999). In our promotion of WHP we should not forget to emphasise the benefits for economic performance as well.

Economic success and corporate competitiveness are of prime importance both for the enterprise and its workforce. For development which is future-oriented, enterprises increasingly need qualified, motivated and efficient workers who are able and willing to contribute actively to technical and organisational innovations.

Healthy workers working in healthy working conditions are thus an important precondition for the enterprise to work smoothly and productively. An enterprise's economic goals do not - or should not - conflict with its goals relating to working conditions; rather, they complement each other. Ergonomically designed workplaces reduce physical workload and improve efficiency. A work organisation with a proper balance between psychological demands and control capacity reduces stress risks and contributes to continuous improvement of the business process.

Our European approach could be characterised by a balance of the simultaneous goals of productivity and health. This approach promises to achieve the best results for individual employees as well as companies.

References:

European Association of National Productivity Centres. Productivity, Innovation, Quality of Working life and Employment. Memorandum. Brussels: 1999.

Gründemann R, Lourijzen E. Health promotion activities at work in the Netherlands. Leiden: NIPG, 1991.

Houtman I. The Changing Workplace. Conference Work, Stress and Health '99: Organization of Work in a Global Economy. Baltimore: APA/NIOSH, 1999.

Jansen P et al. Gezonder werken: minder verzuim! Handleiding voor integrale gezondheidsbevordering op het werk (*Healthier work: less absenteeism! Guidebook for integrated Workplace Health Promotion*). Amsterdam: NIA, 1996

World Health Organisation. Health promotion: a Discussion Document on the Concept and Principles. Copenhagen: WHO, 1984

World Health Organisation. Health for All by the year 2000 programme. Geneva: WHO, 1986.

World Health Organisation. Global Strategy on Occupational Health for All. The Way to Health at Work. Geneva: WHO, 1995.

Wynne, R. Workplace Health Promotion in Europe. Dublin: European Foundation, 1997.

Wynne R, Clarkin N. Under Construction: Building for Health in the EC Workplace. Dublin: European Foundation, 1992.

Wynne R, Gründemann R. Ill-health and workplace absenteeism: new approaches to improve the health of a changing workforce. Dublin: European Foundation, 1998.

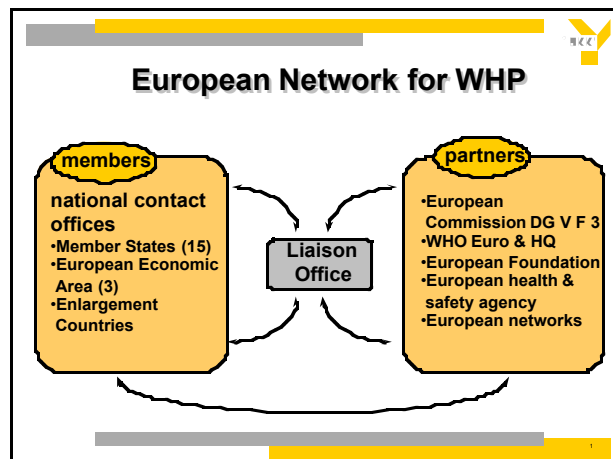
**Experience of the European Network
Success Factors and Quality of Workplace Health Promotion
by Dr. Gregor Breucker**

Ladies and Gentlemen,
may I extend a very warm welcome to you here in Bonn on behalf of the European Network for Workplace Health Promotion and the German contact office of the Network. I am particularly delighted that so many guests from so many countries are taking part in this conference.

Health and well-being at the workplace, that is the subject of this event. You can well imagine that, on more than one occasion, my staff have had a few doubts about the practical relevance of workplace health promotion during the stressful preparation and organisational run-up to this Conference: Constantly overworked due to tight deadlines as well as frequent interruptions and an overambitious superior, in other words the entire range of mental stresses that reduce well-being and health at the workplace.

Nowadays, such a work situation is daily routine in most organisations: Owing to ever increasing rationalisation measures, fewer and fewer employees have to do ever more work, stress increases with all its negative consequences for the individual employee but also as regards the work performance for the company or public organisation.

In my paper I would first of all like to present the results of the activities undertaken so far by the European Network.



The European Network for Workplace Health Promotion was founded in early 1996. It has therefore been operating for 3 1/2 years and is based on the action programme to promote health in the European Union. The member organisations, the national contact offices of the Network, mainly represent state occupational safety and health and a few come from the public health sector.

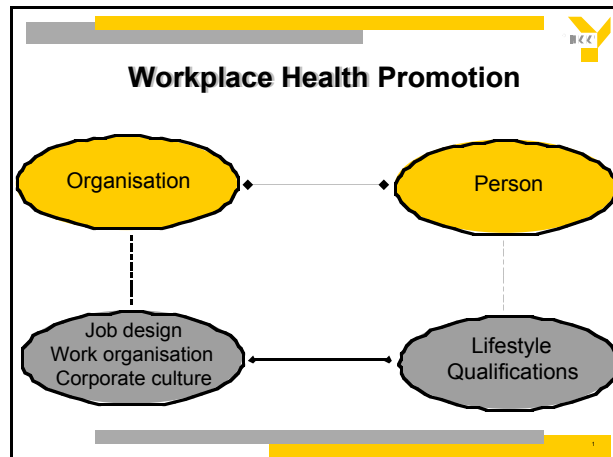
2. Activities and Results of the European Network WHP

The activities so far of the Network can be broken down into the following areas:

- the development of a common understanding of workplace health promotion
- the preparation of a policy platform for its own projects
- the establishment of an information infrastructure
- the description of success factors and quality demands placed on good practice
- the identification and dissemination of good practice.

At the same time, this has also been the agenda of a two-year project which the German contact office at the BKK Bundesverband has been in charge of and which is now coming to an end with this Conference.

It's always difficult at the beginning: You know that there are very differing concepts of health at the workplace in the regions of Europe. These differences also exist at national level, depending on interests and professional traditions. At the outset, many of the initial discussions among the circle of Network partners may have been reminiscent of the Tower of Babel - that was how difficult mutual understanding was at the beginning.



In many European languages the term "workplace health promotion" didn't even exist. In some member countries the term "workplace health promotion" has been imported, so to speak.

Basically, the various concepts move between the two extremes which you can see here. On the one hand, measures can be geared to the behaviour of the individual or aimed at the working conditions. Although no one today sees the situation in black and white, these extremes do in fact reflect the different traditions which exist. The definition of the European Network in the Luxembourg Declaration attempts to combine the various philosophies. Here, the common theme is 'comprehensiveness'. It relates to the need for all players to all pull together so that they achieve something in the end and it underlines the necessary interlinking of individual and structural measures. Moreover, this is also in line with procedure in practice; here, the "both-and" approach prevails, interlinked and co-operative concepts are simply more efficient.

2.1. Vision and Mission of the European Network

The common understanding of workplace health promotion which we have developed goes one step further: Our vision is 'Health Employees in Healthy Organisations' . It is simple and convincing because it touches on two central pillars of our existence: the need of the individual to be able to live and work in a healthy environment and the appropriate material and social basis.

Our concepts of health have undergone a change and the same, of course, applies to the meaning of a 'healthy organisation'. The much-discussed change in paradigms from the work society to the information and knowledge society also changes the significance of the term 'healthy organisation' through the increasing dissemination of new forms of work and organisation.

We view our purpose, our mission, as being to promote the dissemination of a modern workplace health policy which, in the final analysis, firmly anchors 'health' in all important decision-making areas of an organisation for the long term.

What are the factors, and here we come to the second stage, which distinguish successful strategies in actual practice?

2.2. Success Factors and Quality of WHP

Successful practice, and this will be impressively substantiated by the models of good practice presented at this Conference, is characterised by the following features:

- participatin
- integration
- comprehensiveness
- effective management

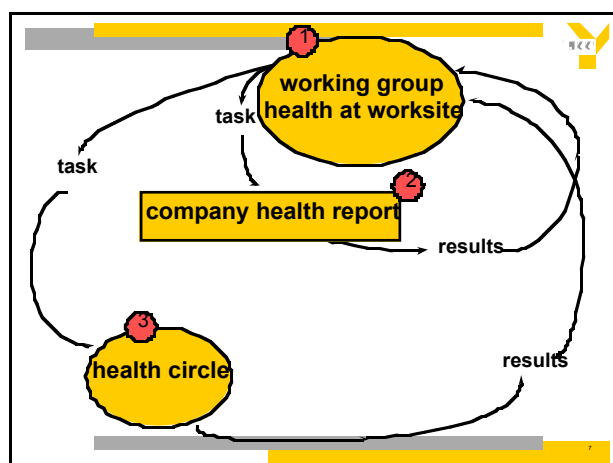
All the stakeholders in an organisation, in particular the employees, participate in decision-making as much as possible. That includes all company issues and, of course, health matters as well.

The subject of health is ideally integrated in all functions and decision-making areas in an organisation. The crucial factor is the day-to-day practice of all managerial staff.

The third success factor, 'comprehensiveness' relates, on the one hand, to the topic I've already mentioned, namely projects which are 'people-related' or 'structural' (that means aimed at working conditions). It is important for these two approaches to be linked to each other.

One example of this is the success model of workplace health promotion here in Germany. The starting point is the establishment of a steering committee in which all stakeholders participate. Before this stage is reached, it is of course essential to canvass intensively to find in-house promoters, possibly supported by external experts. In an ideal situation, decision-makers are also directly represented on this steering committee. This working group conducts a demand analysis; in Germany the expertise of the statutory health insurance finds in the field of analysing time lost due to illness has proven to be an extremely helpful instrument. Using these analyses, approaches for core problems in an organisation can be drawn up which then provide a sound basis for planning action. Subsequently, problem areas, i.e. departments,

and works with above-average absenteeism due to illness are identified for the establishment of health circles. These health circles are, in a manner of speaking, special quality circles for the subject 'health at the workplace'. Employees and superiors as well as representatives of all other groups and functions involved (works physician, human resources department, works council, occupational safety and health department etc.) come together at time-limited meetings to draw up suggestions for improvement on the basis of a problem catalogue (identified stresses) which has been compiled jointly and prioritised. The results of these time-limited project groups are reported back to the steering committee which then initiates the decision-making procedures on this basis.

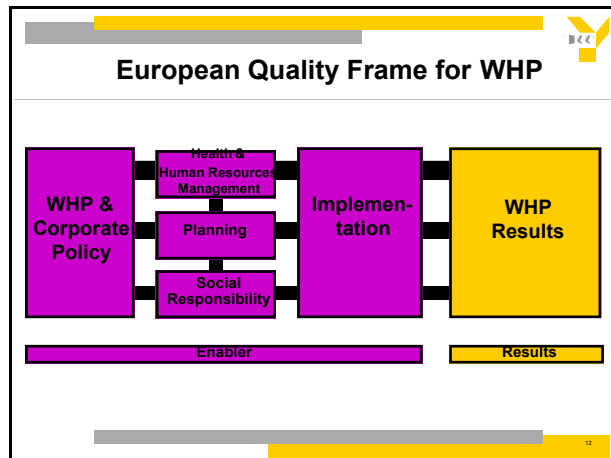


The company health insurance funds have been working for more than 10 years with this strategy; in particular those organisations represented at this Conference are excellent examples of this approach and can also provide impressive proof of the effectiveness of this procedure.

On the basis of the suggestions worked out in this manner, both stressful working conditions can be tackled and programmes on health-promoting behaviour offered as part of a continuous improvement process.

At the same time, this example clearly illustrates another aspect which is covered by the success factor 'comprehensiveness'. Holistic measures and programmes are both preventative and also contain resources-promoting elements. We know from health science, but even more so from our own experience of life, how important the positive forces in particular, for example self-confidence, are for the health for the individual. Health circles are an equally good example of the combination of preventative and resources-enhancing procedures. At the same time, the positive forces of an organisation are promoted through the systematic participation of the employees.

Finally, and here we come to the last success factor, all successful measures are based on a sound project management.



Proceeding from these success factors, the European Network then agreed on a basic catalogue of criteria for good practice. We intentionally avoided the aspect of standardisation. Our aim was rather to create an orientating framework for the assessment of health promotion measures in organisations which is large enough to allow for the different traditions in the various regions of Europe and, on the other hand, which can also provide a guideline for practitioners for their own action. This framework is based on a well-known quality management model and can therefore be immediately initiated and integrated into everyday practice.

As you can see, this model contains the building blocks, so to speak, of good quality in practice.

The building block 'WHP and Corporate Policy' means that WHP can only be successful if it is pursued as a managerial task and integrated in existing management systems. The building block 'Health and Human Resources Management' describes the requirements placed on a health-promoting human resources management and work organisation. The crucial factor here is that the organisation ensures through suitable processes that healthy jobs are designed. To this end, the social and educational preconditions for the employees have to be taken into account and they themselves must participate as much as possible in the planning and decision-making processes.

Nothing works without sound planning. Successful workplace health promotion schemes are based on a careful and regularly updated analysis of the actual situation.

The building block 'Social Responsibility' relates to the way an organisation treats natural resources and also covers its contribution towards supporting health-related initiatives at local, regional and higher levels.

The building block 'Implementation of Workplace Health Promotion' involves the comprehensiveness of activities I have already mentioned as well as the customary requirements placed on a sound project management (including the guarantee of continuous improvement).

In the cases where these criteria I have described represent the philosophy for action, positive results can also be expected, namely in relation to:

- customer satisfaction
- staff satisfaction
- the effects on health indicators
- and the effects on key company performance figures.

Analogously to 'comprehensive quality', the requirements placed on 'comprehensive health' are formulated here to a certain extent. In this expanded understanding the objective is not to see whether the qualifications of the course trainer for back problems satisfy a particular check list but whether the organisation has incorporated 'health' into its day-to-day processes and routines. If this is the case, inadequate qualifications of the course trainer will be systematically identified and improved as part of a continuous improvement process which also covers health promotion measures.

2.3. Documentation of Good Practice in Europe

I have therefore described the basis on which the Network, in a further stage, identified and documented exemplary models of good practice in all participating countries. You will find out the results in the breakout sessions today and tomorrow and at this point I would like to express my sincere thanks to the companies and organisations represented here for their commitment.

A total of 66 companies and public organisations are documented in this European collection of good examples. These case examples will be published at this Conference and then made available on the Internet through the national contact offices.

The collection of good examples and a description of their practical implementation is an indispensable and extremely promising strategy for the dissemination of workplace health promotion. For the companies and organisations which implement workplace health promotion are still in the minority. The obstacles include a lack of

resources, information and know-how as well as certain attitudes which still regard employees merely as a cost factor which can be minimised and any form of long-term staff care as superfluous or a luxury.

It is at this point that, together with the companies and public organisations represented here, we want to show in practical terms how health can be integrated into everyday working life so that both the health requirements of the employees are taken into account and so that the critical business processes - to use the language of process management - can be designed more efficiently.

We intentionally use the phrase good practice and not best practice. The companies and organisations which are presenting themselves here and which were included in the collection of models of good practice naturally represent a much larger circle of organisations in their respective countries which have made similar efforts. Nevertheless, with this Conference and the resultant activities of the contact offices, we want to pay tribute to the examples documented, on the one hand, their past activities in the field of workplace health promotion and, on the other hand, their willingness to support other organisations by providing information.

The spectrum of documented organisations is very broad. Very many different branches are represented, both private companies and public organisations. Small and medium-sized enterprises have intentionally been kept to a minimum as the Network initially concentrated on larger companies. Small and medium-sized enterprises will be the focal point of the Network's activities over the next 2 years. This sequence also follows, to a certain extent, the evolution of workplace health promotion: the initial successes were achieved in large companies which, with their pioneering work, paved the way for greater dissemination.

The basis for the selection and documentation is the general framework I showed you before to describe good practice of workplace health promotion. Naturally, the preparation of these general quality requirements depends on a large number of factors. These range from the specific culture of an organisation through the dominant profession down to regional and national traditions. And this wide variety which naturally arises is intended and regarded as being very positive.

Proceeding from the quality framework I have already described, we started to develop practicable instruments which can be of help to practitioners and decision-makers at companies in the planning and control of activities. One result of our activities is a relatively easy-to-use instrument which can be applied to the self-assessment of a company health policy in organisations. We have enclosed a copy

with your conference documents. In a further stage, check lists can be readily developed to make life more easy for practitioners in companies.

3. The Effectiveness of Workplace Health Promotion

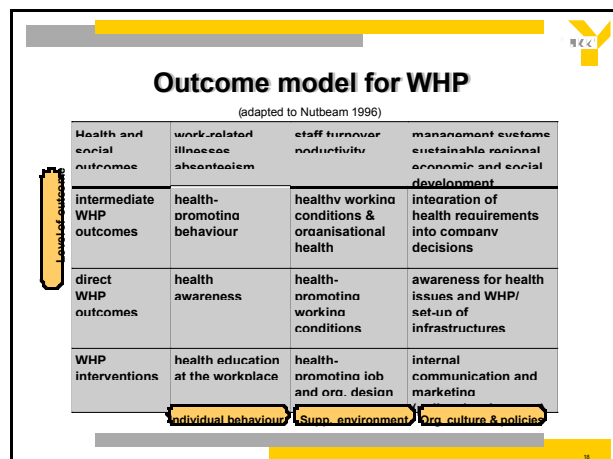
In many current discussions the effectiveness of workplace health promotion and health-promoting strategies is widely disputed. Demands from decision-makers for relevant proof of effectiveness are undoubtedly justified. Therefore, let me briefly outline our knowledge of the effectiveness and efficiency of workplace health promotion.

In this connection three questions are to be answered:

- ◆ What does WHP contribute towards improving health?
- ◆ What economic effects for the organisation can be expected from WHP measures?

And finally:

- ◆ What social effects are involved with WHP programmes?



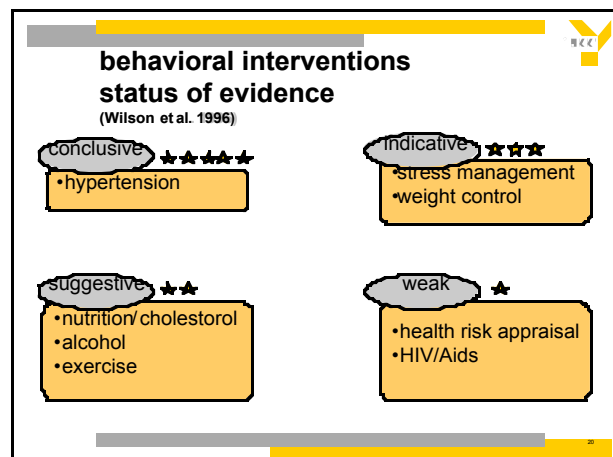
As a guide, I would like to fall back on a model which Professor Nutbeam developed to illustrate the outcome of general health promotion activities. You can see here the transition to workplace health promotion. On the outcome side a difference must first be made between three different levels, the direct outcomes, the medium-term outcomes and the more long-term social and health outcomes. On the intervention side, one can distinguish between behaviour-oriented measures, measures to design health-promoting working (environment) conditions as well as measures to develop a comprehensive health-promoting corporate structure.

The basic idea behind this model can be illustrated taking the sickness level as an example. As we know, this level is influenced by a large number of factors. Only some of these factors can be influenced by human resources measures. The effects

of workplace health promotion activities can mainly be determined in the short term. This applies to all three intervention areas (individual, subsystem, total organisation). Behaviour-oriented measures change the information level, attitudes and values but are only seldom able to achieve permanent changes in behaviour. They are not therefore ineffective. Whether, however, appreciable changes in behaviour actually occur depends on other factors which mainly relate to integration into the respective living and working conditions.

Measures relating to health-promoting job and organisation design are easier to assess when related to short-term results. Health circles often lead to changes in stressful working conditions which can be achieved quickly and without any great effort. Moreover, they consolidate the trust of a group in their skills of self-organisation and in their possibilities of influencing processes in an organisation.

Previous scientific results available on the effectiveness of WHP measures relate for the most part to behavioural interventions. As an example of this, I would like to briefly mention the results of an American study by Wilson et al. in which the effectiveness of WHP measures was estimated in various intervention areas in a very demanding process backed by experts. You can see here the result at a glance: Although one certainly has to be careful in interpreting such results, a large number of health effects can be substantiated simply with behavioural interventions.



If, in addition, one looks at the broad field of health-promoting job and organisation design, the proof for health-promoting effects of WHP schemes is remarkable. Health-promoting job and organisation design embraces a very broad spectrum of measures, starting with ergonomic measures through the design of jobs and work systems down to measures under a health-promoting human resources policy and the creation of an appropriate corporate culture. A large number of different disciplines produced valuable knowledge in this connection.

For example, the health effects of ergonomic measures in the field of musculo-skeleton disorders are empirically very well founded. Most studies report effects in an order of magnitude of 20 to 50% as regards the reduction in complaints.

Psychomental disorders as a result of the introduction of new technologies and the equally increasing intensification of the work processes are gaining in significance. Job design in particular plays a very important role here. The research results of Prof. Karasek have produced a lot of evidence for the connections between job parameters and health effects.

Workplace health promotion is an investment with direct and indirect economic benefit. Every organisation is interested in eliminating costs which are incurred through high absenteeism rates, staff turnover, reduced performance and production losses. According to calculations of the BAuA, the costs due to absenteeism in 1994 were roughly DM 91 billion in Germany. The statistics on types of illnesses surveyed annually by the company health insurance funds show that roughly 81% of all illnesses in 1997 fell into six illness categories.

These are:

Musculo-skeletal illnesses (29.2%)

Respiratory tract illnesses (16.8%)

Injuries and intoxication (14.1%)

Disorders of the digestion system (7.7%)

Cardiac/circulation illnesses (7.3%)

Mental disorders (5.8%).

The musculo-skeletal illnesses rank at the top of the table for incapacity to work. In addition to a lack of exercise, the main cause of these chronic/degenerative disorders are one-sided body posture at the workplace and physical stresses resulting in cramped posture.

On the basis of data from Denmark and Norway, the Northern Council estimated the proportion of widespread types of illnesses which were due to work. According to this study, the proportion of musculo-skeletal diseases is 33%, that of cardiac/circulation disorders 20%.

The scientific studies available mainly relate to lifestyle approaches in the USA and show here positive effects on absenteeism and expenditure on health care. In my opinion even more positive effects can be expected from holistic programmes which take working conditions and conditions of organisational structure into account. Evidence supporting the economic effectiveness of workplace health promotion is still a problem as regards measurement methodology. Here, considerable progress has

been made in recent years and so the future can also be viewed positively in this respect.

In addition to the health and economic effects, however, the social effects in particular are important because they provide information on the consequences of workplace health promotion and at the same time are an indication of the future potential of this approach.

In order to understand how workplace health promotion measures work, a look at the more recent know-how gained in socio-epidemiology is very informative.

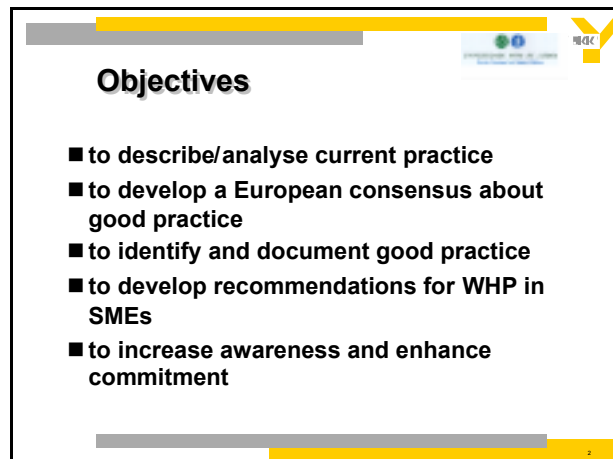
Today, we know very well that the health of the population is heavily influenced by living and working conditions. The crucial factors are not absolute living standards but rather the relative social position; in terms of income the factor involved is the relative levels of income not the absolute levels. The best evidence of this is the discovery of a strong international connection between income distribution and national mortality rates.

Furthermore, it can be assumed to be sufficiently substantiated that life expectancy in different countries improves considerably when the differences in income are reduced and the cohesion in a society increases. In the industrialised countries social factors are increasingly determining the quality of life whereas the importance of material factors is decreasing. Among the developed countries it is not the richest countries which have the best health figures but those countries which distinguish themselves by strong social cohesion and lower differences in income. Societies with strong cohesion place a higher value on a pronounced community life. Individualism and free market economy values are braked by social standards. These societies are in a position to generate more social capital. There is a lot of evidence to suggest that the health condition of populations is influenced to a large extent by the ability of a society to generate this social capital. And this is also a starting point for (workplace) health promotion measures. If they are based on the quality criteria I have already described, they support the formation of social capital in companies and public organisations. Health circles are another very good example of this. Owing to the resultant strong staff participation, they strengthen the trust of working groups in their own abilities if they are not only heard in matters of product quality but can also introduce their own health problems and develop proposals for their solution.

The picture which is now being created from a large number of scientifically founded pieces of mosaic describes an extremely important connection: the quality of our social life is one of the most powerful health determinants and it also appears to be influenced by the degree of differences in income.

Whether this population-related connection can also apply at the level of individual organisations initially remains to be seen but it definitely appears to be plausible.

4. The Future Strategies of the European Network



Over the next two years the Network will be focusing its attention with workplace health promotion activities on small and medium-sized enterprises. The basis for this work is the Cardiff Memorandum in which the Network agreed on specific priorities in this field. The core of the activities will be the implementation of another joint initiative of the Network in which the member countries will also be participating. The objectives of this project include a description and analysis of current practice in the countries involved. On this basis, positive examples of good practice are in turn to be documented for which a very specific approach must be developed. Parallel to this, the Network will develop political recommendations on the dissemination of workplace health promotion in the sector of small and medium-sized enterprises.

I believe that the European Network is on the right road to make an important contribution to this and I hope that we can continue on this route we have started out on. In my opinion, the only risk that could arise for the Network is the Christopher Columbus syndrome.

As you know, Columbus thought he had discovered India although he had arrived in America. He called the people there Indians although they were Americans. And to crown it all, he did all this with other people's money.

I believe that the Network will be in a position to avoid this syndrome. I wish you all an interesting Conference and thank you for listening.