

## EDITORIAL

# The evolution of workplace health promotion in Europe: the Italian case

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## Key words

Workplace • Health promotion • OHS

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## Summary

*In this paper the Authors describe the development of workplace health promotion in Europe and show how, despite the fact that they have developed independently of one other, the professional disciplines of Occupational Safety and Health together with Public Health have provided a common platform from which has*

*emerged this new philosophy – Workplace Health Promotion (WHP). Whilst the paper draws on the experience of countries throughout Europe, particular attention is paid to the developmental process in Italy.*

## Public Health and OHS

Current practice in Occupational Safety and Health (OHS) and public health 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) has the health of workers been addressed to a level that can be considered similar to that of other citizens [1]. In the past public health initiatives have involved the entire national community, been oriented towards primary prevention and have 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 are seen as being beyond the scope of public health medicine. In contrast occupational health and safety has largely based its actions on secondary prevention in relation to specific risks associated with the job being done.

Whilst public health at both a national and local level is the responsibility of the State, the health of people at work lies in the hands of owners and managers [2]. Consequently the attention and priority given to workplace health differs greatly from one workplace to another. State bodies with a degree of responsibility for worker health include Ministries of Labour and the labour inspectorate. However the influence these bodies exert on processes to protect and enhance worker health can vary considerably.

It is notable that the legal basis of public health and health in the workplace evolved at different times, have major differences in approach and, as has been 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 has lacked any content on health and safety protection in the workplace and even today the situation regarding training in occupational issues is still poor in many countries.

The walls of a factory or a craftsman's workshop and the boundaries of an agricultural concern act as a border, with the people who live on one side having different health rights to those who work on the other. 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.

In countries such as Italy in which control of workers health is in the hands of the National Health Service, the right to a healthy life is constrained by a number of factors including the economic background, the views of employers and the so called rules of the labour market and market forces.

In Italy towards the end of the 1970's, Law 833 transferred the control for worker health to local structures of the NHS. This move had the goal of making more equal the provision of services focusing on worker health and population health, although in reality the differences were not done away with completely. The reason for this is that the pre-existing laws that regulated the technical aspects of prevention and safety were not adjusted to the cultural and socio-political changes that had brought about the creation of the NHS. Also the laws regarding the working environment enacted after this date maintained this double standard. Typical examples are the regulations applying to noise and asbestos. These are completely different in the ways in which they apply to living conditions on the one hand and working environments on the other in terms of threshold levels, ways of ascertaining the existence of the hazard, and prevention regulations for example.

The NHS in Italy is based on a number of key principles. These include universality, equity and participation. It is 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. There are various reasons for this state of affairs, and it is not our purpose to examine them in detail; the main one – which also influences the life and development of the NHS – is undoubtedly tied to the predominant influence of economic considerations.

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 National Health Service brought the responsibility for the protection of the health of workers under the wing of public services this has caused some difficulty.

A thorough analysis giving a good picture of the application of the Framework Directive was completed by Vogel [3]. This process should be repeated to identify and examine the long-term effects of the Framework Directive and to obtain baseline information that would allow an analysis of the elements of the new approaches to worker health, which developed, in the final decade of the last century and a correct orientation of these approaches to be determined.

## From health promotion to workplace health promotion

A new approach to disease prevention began to evolve during the late 1970's and early 1980's. A major milestone in the development of this approach was the declaration of Alma Ata where it was stated, "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."

The key statement is found at the end of this quote where it is recognised that achieving a high level of health among the population will require the action of many social and economic sectors. This point was developed further in 1986 at the World Health Organizations Conference in Ottawa where a Charter for Health Promotion was launched. The Ottawa Charter as it has become known identified five key actions for health, namely:

- to build healthy public policy;
- to create environments conducive to health;
- to develop personal skills for health;
- to strengthen community action for health;
- to reorientate health services.

The success of the Ottawa Charter can be seen in the multitude of ways in which these actions have been

translated into different situations and circumstances. In order to be appropriate for the workplace these actions have to be placed in the context of working life and culture and in so doing they establish operational activity that can resolve the historical separation deals in a new way with bridging the class division between employers and employees [4-6].

Thus workplace health promotion is based on:

- the building of healthy corporate policy;
- the creation of a supportive working environment;
- the development of employee skills which are conducive to health;
- the strengthening of workforce action towards health;
- the re-orienting of occupational health services [7].

The promotion of health in the workplace can take several different forms and be led by many different professional groups. At its most basic level it consists of focused 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 as a result is termed the "lifestyle", epidemiological or risk factor reduction approach. This type of workplace health promotion can often be developed and implemented by one individual. However it has the inherent danger that when that persons' role changes within the organization or if they should leave, then the driving force for workplace health promotion can be lost unless someone else is given the responsibility of developing the workplace health promotion programme.

At a higher level of development, workplace health promotion can 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 that 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 [8].

Of note in these developments are initiatives that have sought to link workplace health promotion with other management theories such as Total Quality Management (TQM). A major beneficial aspect of this approach being that the integration of workplace health promotion into corporate culture greatly enhances the long-term sustainability of the health promotion activity.

Lead responsibility can lie with one of many departments including human resource (personnel departments), health and safety experts and, frequently, occupational health departments. One of the most positive features of workplace health promotion 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 [9-11].

This issue was identified by Wynne [12] who adapted the five principles of general health promotion, based on the ecological model of health as developed by World Health Organisation (WHO) in 1984 for use in a

workplace setting [13]. Wynne states that workplace health promotion, “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”.

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

- workplace health promotion as behavioural prevention in the workplace – This approach is widely practised, 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;
- workplace health promotion as a component of an expanded and modernised 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 regard workplace health promotion as an expression and elemental component of a holistic interpretation of health and safety;
- workplace health promotion as a strategy to influence health determinants at the workplace – To improve the health status workplace health promotion supports existing health promoting potentials (those of employees, workers groups and organisations, etc.) and acts on the important determinants of health;
- workplace health promotion as a strategy to reduce absenteeism – Absenteeism, poor morale and low motivation have a direct effect on a company’s productivity. In this context workplace health promotion is a component of company personal policy and supports strategies to reduce absenteeism;
- workplace health promotion as a component of an organisational development strategy – Modern management concepts (e.g. TQM) emphasise the function of human resources in the realisation of economic aims. Workplace health promotion can create the necessary preconditions for the optimal exploitation of existing creativity and service potentials [14-19].

A significant step in the development of workplace health promotion took place in 1995 with the establishment of the European Network for Workplace Health Promotion (ENWHP) [20]. The network consists of representatives of occupational health and safety institutions, public health specialists and those involved in workplace health promotion in all 15 Member States together with three countries from the European Economic Area, namely, Iceland, Norway and Liechtenstein. The Network receives financial support from the European Commission (DG Health and Consumer Protection) and has undertaken a number of innovative projects that support the development of workplace health promotion across Europe [21].

“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 out a strategy for Workplace Health Promotion (WHP) [22]. This strategy formed a key component of the Luxembourg Declaration on Workplace health promotion in the European Union. This Declaration set down for the first time a common understanding of the concepts, strategies and principals of workplace health promotion. It defined workplace health promotion 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;
- encouraging personal development”; (Luxembourg Declaration 1997).

From this definition it is clear that workplace health promotion is based on multisectoral and multidisciplinary co-operation and that it can only be successful if all key players (employers, employees, 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 workplace health promotion and the identification and dissemination of “models of good practice” at company level.

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 workplace health promotion 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 a better quality of life through increased work satisfaction, a reduction of stress, an improved working atmosphere and fewer work related health complaints [23].

### **WHP quality criteria and Models of good practice**

However to gain the potential benefits, employers need to introduce sustained, comprehensive and effective workplace health promotion programmes. These must be monitored and evaluated and changes made where appropriate [24, 25]. Aware of these needs the ENWHP, assuming that the statutory provisions on occupational health and safety were already fulfilled, has established a set of “Quality Criteria” for workplace health promotion [26]. The quality criteria have been formulated taking into consideration the model of the European Foundation for Quality Management. Naturally, the cri-

teria describe the situation in an “ideal” health promoting organisation. 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 this 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 in six groups. Taken together they provide a comprehensive picture of the quality of workplace health promotion activities. The groups are:

- workplace health promotion & corporate policy;
- human resources & work organisation;
- planning of workplace health promotion;
- social responsibility;
- implementation of workplace health promotion;
- results of workplace health promotion.

Across Europe, more than a hundred “Models of Good Practice” have been identified by the ENWHP. Each one demonstrates the fact that workplace health promotion is far from being an expensive and unrealistic exercise [27].

In Italy, the research group of the Department of Public Health – University of Perugia and the Department Training and Information – ISPESL has identified nine models of good practice drawn from companies of various sizes and that operate in different branches [28, 29].

The concluding part of this paper is a brief description of one of these models of good practice.

## Acroplastica s.r.l., Caserta

The company employs 69 workers and is a thermoplastic and thermosetting industry. The written guidelines on workplace health promotion are intended to ensure the safety and protection of all employees’ safety and protection at the workplace, to promote a healthy lifestyle and to prevent potential environmental hazards. The management team, the human resources department, staff representatives, the safety department and

the occupational medical service were jointly responsible for the development of the guidelines with the plant manager being responsible for the implementation of workplace health promotion activities.

The executive team controls all activities relating to health and safety, while staff representatives ensure that risks are detected and appropriate prevention action is taken. Staff surveys are conducted twice a year. They focus on work requirements and staff needs. In addition to statistics on days lost due illness and industrial accidents, and occupational medical reports, these surveys represent an important basis for planning workplace health promotion activities. Thanks to in-house “promotion programmes” and further training courses for the staff, the employees are given a chance to learn and refine their health promoting skills. On average, every employee spends 40 hours a year on training courses on quality management as well as health and safety issues. The need for future training is reviewed regularly. The employees are also involved in planning of new jobs and work processes. These measures are assisted by working groups which deal with quality issues on health and safety matters. The company also provides rest and break rooms and organises drug support programmes and various sport and leisure time events.

Since the company adopted this strategy in 1995, the employees are more satisfied with their working conditions, with the executive team and the working atmosphere. This has been evaluated with anonymous questionnaires and the results obtained in only five years are amazing: workers satisfaction over 97%; the number of smokers dropped to a significant 24% and the absenteeism rate dropped also to a 2%.

The number of accidents registered, in the period 1998-2000, are less than the one a year.

These processes have had also a positive impact on business (+ 39% in the last three years) and consolidating the position of the company on the European market. These strategies, in the last three years have carried to a series of other positive economic aspects for the company: the consumption of electricity and the production of refusals decreased respectively by 9% and 46%, while the number of employees increased by a good 26%.

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