

EFFECTIVE HEALTH AND WELLBEING PROGRAMS



Australian Government

Comcare

CONTENTS

1 EXECUTIVE SUMMARY 5

2 HEALTH AND WELLBEING PROGRAMS 8

2.1 Defining health and wellbeing programs 8

2.2 Examples of health and wellbeing programs 10

2.3 The development of health and wellbeing programs 12

2.4 Managing the costs and effects of workers' compensation 14

2.5 The workplace as a setting for health and wellbeing 16

2.6 The expansion of workplace health and wellbeing programs 17

3 HEALTH AND WELLBEING PROGRAMS IN PRACTICE: THE EVIDENCE 20

3.1 Rhetoric or reality? 20

3.2 The stated benefits of health and wellbeing programs 24

3.3 Best practice guidance 34

4 GUIDANCE TO ASSIST IN PLANNING, DESIGNING, IMPLEMENTING AND EVALUATING HEALTH AND WELLBEING PROGRAMS 44 4.1 Existing guides 44
4.2 Guidance for a successful health and wellbeing program 46 4.3 A reminder on the importance of evaluation 50 4.4 Weaknesses and tips for evaluation 52 4.5 Health and wellbeing tools and resources 52 4.6 Comcare resources 53

5 CHALLENGES 54 5.1 Difficulties associated with implementing health and wellbeing programs 54
5.2 Further Research 55 5.3 Where to next? 57

6 CONCLUDING POINTS 58

7 REFERENCES 61

APPENDIX A—NATIONAL PARTNERSHIP AGREEMENT ON PREVENTATIVE HEALTH (P.6) 66

1 EXECUTIVE SUMMARY

The last 10 years has seen a surge in the popularity of work-based health and wellbeing programs, with many employers having implemented programs that incorporate a wide variety of activities to address the general health and wellbeing of workers, as well as work-related health issues.

There is much theory, and some evidence which supports the positive returns accruing to both workers and employers. There also exists some very good, comprehensive advice on how to plan for, design, implement and manage organisation-specific programs. There is, however, little evidence of rigorous evaluation that has been undertaken that supports the efficacy of many of these programs.

This report includes a review of the literature in relation to the planning, design, implementation and evaluation of health and wellbeing programs, both nationally and internationally. It provides simple guidance to assist organisations and workplaces in designing, developing, implementing and evaluating such programs, and makes recommendations based on a review of international and national best practice.

The guidance contained in this report is based on a three-dimensional comprehensive workplace health promotion (CWHP) model adopted from the Health Communication Unit at the Centre for Health Promotion, University of Toronto that includes programs aimed at targeting the following:

- > lifestyle practices (voluntary health practices)
- > organisational change (organisational culture)
- > occupational health and safety (OHS).

6

The review has identified a particular imbalance in relation to the types of health and wellbeing programs implemented in workplaces, and the lack of rigorous evaluation associated with those programs. There appears to be a wealth of information available on health and wellbeing programs directed at worker 'lifestyle and general health'. Such programs include employers providing access to a broad range of fitness and healthy living programs and reinforcing these with promotional material to assist workers to improve their fitness, reduce/quit smoking or alcohol intake and generally improve their individual personal health. There is also a reasonable amount of information available endorsing the positive benefits arising from many of these programs.

OHS or environmental programs comprise physical safety initiatives and interventions geared around ensuring 'safe' workplaces for workers. These are reasonably well addressed in the literature, although this paper has not sought to review their effectiveness.

However, in relation to the other area where health and wellbeing programs can make a significant contribution—those targeting 'organisational practices'—the volume of literature available is not as plentiful, particularly in the area of evaluation outcomes. Employers need to focus much greater attention and resources on interventions that target workplace factors that directly impact on the psychological health of workers.

The link between unaddressed workplace environmental/organisational factors and worker mental health and consequent absenteeism and illness is increasingly recognised. The literature is clear about the catalysts—poor workplace culture, ineffective managers, lack of work satisfaction, work repetition, work overload, lack of work-life balance, conflict with peers and bullying and harassment. This suggests that workplaces need to be placing more focus on intervening in these areas and demonstrating a commitment to implementing and evaluating the success of such programs.

In conclusion, while there is a great deal of information available about the range of programs in workplaces, little research has been undertaken to evaluate the outcomes of these programs with respect to both the impact on the worker and the employer. The review concludes that employers need to place greater emphasis on, and resources into, evaluating many of these programs.



8

2 HEALTH AND WELLBEING PROGRAMS

2.1 DEFINING HEALTH AND WELLBEING PROGRAMS

Health and wellbeing programs (HWP) are interventions put in place by employers to improve the lifestyle choices and health of workers as a way of preventing chronic illness. HWPs may also target organisational and environmental practices to improve the overall health and safety of the workplace. Increasingly these programs are recognised for potentially influencing worker productivity and performance at work. This is discussed in depth later.

Workplace health promotion (WHP) is an alternative term used to describe the interventions to improve individual worker and organisational health and wellbeing. The Luxembourg Declaration on Workplace Health Promotion in the European Union (2007, p.2) describes WHP 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 the work organisation and working environment, promoting active participation, [and] encouraging personal development'. The European Agency for Safety and Health at Work (2010, p.1) has since added 'enabling healthy choices' as a fourth action.

The term 'wellness' is emerging as another way of communicating the idea that workplace health and wellbeing is more than just about an employee's health. The World Economic Forum in partnership with Right Management (2010, p.4) has defined 'wellness' as 'a state of being that is shaped by engagement and other workplace factors as much as by physical and psychological health'. The World Economic Forum (2008a, p.4) further defines corporate wellness 'as an active process through which organisations become aware of, and make choices towards, a more successful existence. For both the individual and the

organisation, the concept of wellness is one where active steps can be taken that reduces chronic disease and mitigate its debilitating impact on personal lives and organisational productivity'.

Health and wellbeing programs must identify where organisational factors (and not just employee factors) contribute to poor health. According to Santa-Barbara and Shain (2006, p.2) 'programs that focus only on changing employee behaviours, or placing responsibility for stress management solely with employees are not enough. Solid research increasingly and clearly indicates that characteristics of the workplace are also critical. Some corporations produce employee stress just as surely as they produce products and services. By neglecting causes of workplace stress, employers may be nullifying their investment in employee focused health promotion programs. The evidence linking certain workplace characteristics to employee stress and health is as strong as the evidence linking smoking to lung cancer.'

A significant amount of research has been undertaken in Canada in a variety of government and academic institutions in the area of workplace health promotion. For example, research undertaken at the Alberta Centre for Active Living by Plotnikoff et al. (2003) has been influential on many of the Physical Activity Resource Kits developed by Australian State and Territory Governments. This is discussed later in the report.

The Health Communication Unit (THCU) at the Centre for Health Promotion at the University of Toronto has a range of useful health promotion resources available. As noted by THCU (2006, p.9), 'in recent years, organisational culture is being recognized as an increasingly important piece of the workplace wellness puzzle'. Their work is based on a three-dimensional comprehensive workplace health promotion (CWHP) model.

Lifestyle practices (voluntary health practices)—reducing the risk or incidence of worker illness by addressing individual worker lifestyle behaviours through awareness raising, education, supportive environments, and policy. The terms ‘voluntary health practice’, ‘individual lifestyle practice’, and ‘healthy lifestyles’ are often used interchangeably for this factor.

Organisational change (organisational culture)—improving job satisfaction and productivity by changing worker attitudes and perceptions, management practices, and the way work is organised. These factors have been shown to have a dramatic impact on employee health outcomes. These factors are also referred to as psychosocial factors or as part of the psychosocial work environment.

Occupational health and safety—reducing work-related injury, illness, and disability by addressing environmental issues in the workplace, such as ergonomics, chemical hazards, and air quality.

Workplace health promotion interventions



* The terms ‘voluntary health practice’, ‘individual lifestyle practice’ and ‘healthy lifestyles’ are often used interchangeably for this factor.

(Source: THCU, 2006)

THCU model (above) has been adopted for the purposes of this review as it provides a logical model upon which to categorise health and wellbeing programs.

2.2 EXAMPLES OF HEALTH AND WELLBEING PROGRAMS

The breadth of HWPs found in workplace settings is extensive and some examples are provided below.

Lifestyle programs target individual workers in the workplace and may cover:

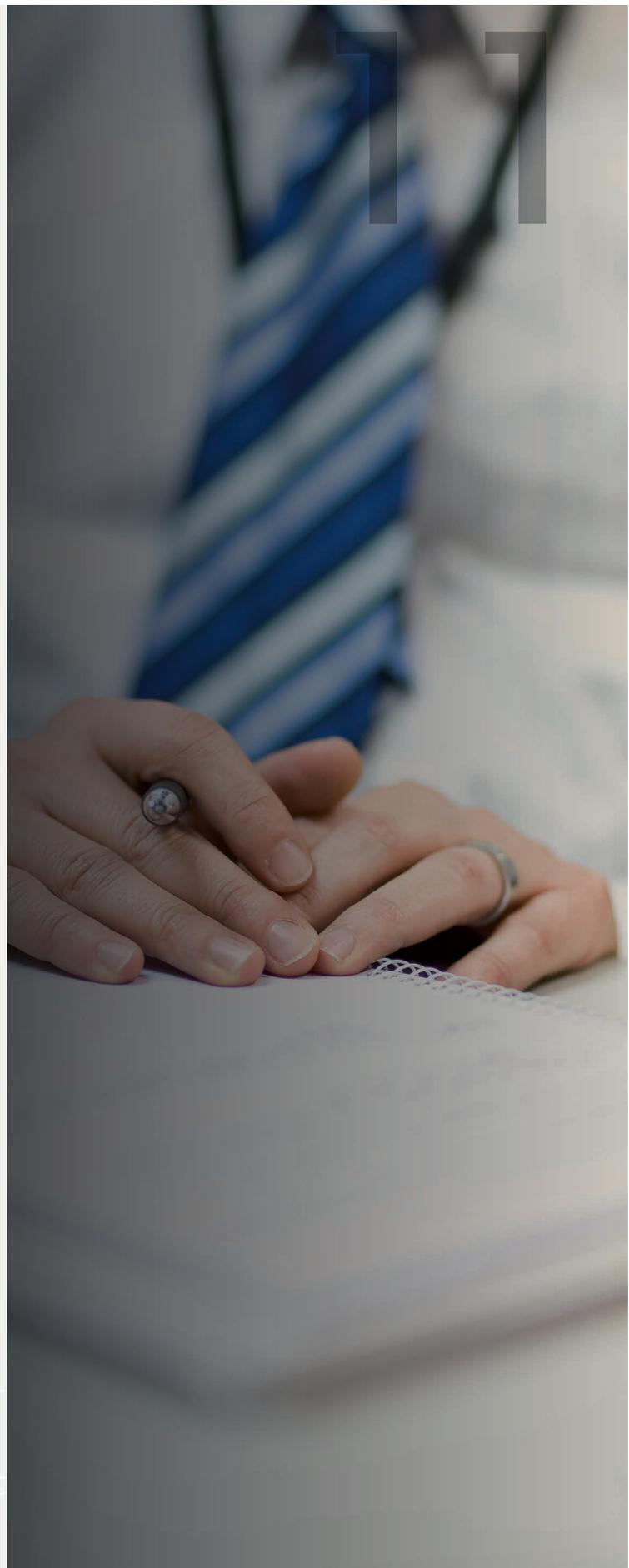
- > exercise and general fitness (yoga, tai chi, relaxation classes, massage therapy)
- > obesity and weight loss
- > stress
- > nutrition
- > impacts of ageing
- > work-life balance
- > reducing/quitting smoking, alcohol and drug use
- > healthy cooking
- > alternative medicine and holistic practices
- > parenting
- > health information e.g. online guidance and information sheets
- > assistance with managing personal health issues e.g. cancer and depression
- > health screening and risk assessments e.g. weight, blood glucose levels, blood pressure and cholesterol
- > counselling
- > provision of fruit, tea/coffee.

Organisational culture programs target the way work is organised and its relationship with the psychological health of workers. Interventions may be directed at:

- > work content and context:
 - what, where and the quality/meaningfulness of work
 - hours and flexibility
 - repetitiveness
 - access to training and other career development opportunities
- > workplace culture and improvements to a broad range of workplace factors, including:
 - morale
 - motivation, satisfaction, workplace engagement
 - management – attitudes, behaviours, styles
 - bullying and harassment leading to psychological injuries
 - leadership/management training for supervisors and managers
 - performance management
 - rewards and recognition
 - OHS Act, incident management policies and implementation on the ground
 - interactions with peers and workplace conflict.

Occupational health and safety (or environmental) **health programs** target the overall safety of the workplace including the physical environment. Interventions may be directed at:

- > safety
 - chemicals
 - air quality
 - hazards
- > infrastructure that either supports health and wellbeing by improving safety or that supports the implementation of health and fitness programs:
 - on-site gym facilities
 - showers
 - bike racks
 - eating and relaxation areas
 - facilities to prepare food/drinks.



2.3 THE DEVELOPMENT OF HEALTH AND WELLBEING PROGRAMS

2.3.1 Australia's health—general population and workforce

A number of reports outline the current picture of Australia's health and provide a background for using the workplace as a setting to improve health.

Overall the Australian Institute of Health and Welfare (AIHW, 2008) tells us that the health status of Australians is steady or improving with few indicators showing unfavourable trends. However areas of concern include:

- > a high incidence of cancer with one in three Australian males and one in four Australian females by age 75, being diagnosed with cancer at some stage in their life
- > obese/overweight population with about 7.4 million adults overweight in 2004–05, and over a third of those being obese
- > an increase in diabetes with prevalence at least doubling in the past two decades.

The report acknowledges that although the level of smoking is falling and is among the lowest for Organisation for Economic Co-operation and Development (OECD) countries, there are opportunities for prevention activities aimed at tobacco smoking, high blood pressure and overweight/obesity.

In 2006 the Australian Bureau of Statistics (ABS, 2006) reported figures that were cause for concern, including that 70 per cent of Australians aged 15 years and over were classified as sedentary or having low exercise levels and that of these 70 per cent, just under half (48 per cent) recorded no or very little exercise in the previous two weeks and were classified as sedentary while 52 per cent recorded a low level of exercise. Many chronic health issues

have been linked to sedentary behaviour. Sedentary lifestyle is considered to be a major contributor to adverse health outcomes such as type 2 diabetes, obesity and cardiovascular disease, colon cancer, high blood pressure, osteoporosis, depression and stroke (Schofield et al., 2009; AIHW, 2008; Medibank Private, 2009). There is also increasing evidence of sedentary behaviour being linked to reduced productivity through absenteeism and presenteeism in the workplace (Medibank Private, 2009).

The concerns about Australian obesity, sedentary behaviour, tobacco and alcohol use are also reflected in workforce surveys, with Medibank Private (2005) revealing some alarming statistics about worker's inactivity, diet, obesity levels, stress levels, risky behaviours, sickness and productivity levels. The survey found that in relation to Australian workers:

- > 10 per cent are completely inactive
- > 40 per cent do minimal exercise
- > 46 per cent live on high fat diets
- > 62 per cent are overweight and of these, 28 per cent are obese
- > 53 per cent felt overwhelmed with stress and pressure for a significant proportion of the time
- > 56 per cent are participating in risky behaviours (including smoking, drinking and lack of sun protection) at medium to high-risk levels
- > over 50 per cent do not get enough sleep
- > 21 per cent had suffered from a medical condition in the three months preceding the survey.

Medibank Private (2005) further analysed the survey results to conclude that:

- > employees with poor overall health status take up to nine times more sick leave than their healthy colleagues
- > healthy employees are nearly three times more productive than employees with poor health
- > the financial cost of poor health and wellbeing is estimated at over \$7 billion per year, nationally.

The Commonwealth Government has responded to concerns about obesity and inactivity, tobacco and alcohol use with a number of initiatives.

In December 2008 all Commonwealth, State and Territory Governments signed a National Partnership Agreement as Council of Australian Governments (COAG) participants to address the rising prevalence of lifestyle related chronic diseases. One of the objectives of the COAG Agreement is to 'support all Australians in reducing their risk of chronic disease by embedding healthy behaviours in the settings of their pre-schools, schools, workplaces and communities, by instituting programs across smoking, nutrition, alcohol, and physical activity risk factors which mobilise the resources of the private, public and non-government sectors' (2008, p.4).

Initiatives to support the goal of 'healthy workers' will include the development of a national healthy workplace charter, voluntary benchmarking, nationally agreed standards of workplace based prevention programs and funding to assist with the delivery of 'healthy living programs in workplaces' (COAG, 2008, p.6—Appendix A).

The Commonwealth Government sponsored National Preventative Health Taskforce (NPHT) developed a strategy to respond to obesity, tobacco and alcohol consumption, with the aim of making Australia a healthier nation by 2020. The NPHT strategy states up front that it is 'needed to prevent hundreds of thousands of Australians dying prematurely, or falling ill and suffering, between now and 2020. It is needed to minimise the impending overload of the health and hospital systems, and to increase the productivity, and therefore the competitiveness, of Australia's workforce. It will assist in avoiding the health and social costs that would otherwise be incurred if we do little or nothing (2009, p.6).' The report notes that the overall cost to the healthcare system associated with these three risk factors is in the order of almost \$6 billion per year while lost productivity is estimated to be almost \$13 billion.

With an estimated 11 million Australians in workplaces the NPHT report identifies this environment as one where small widespread changes could result in significant health improvements. There is growing information that points to the economic return on investment in employee health programs, with the average rate of return estimated at between 2:1 and 5:1 (NPHT, 2009).

2.3.2 International health

The health story is similar in other developed nations, with research in the United States, the United Kingdom and other European countries citing disturbing figures about the social and economic fallout of ill-health on employers and society. According to a UK Government Health, Work and Wellbeing Program (2008) report on the health of Britain's working age population, the annual economic cost of ill-health in terms of working days lost and worklessness was over £100 billion, with an estimated 172 million working days lost due to absence in 2007 and costing employers £13 billion. Worklessness is defined as a 'state which includes not being in paid employment and not actively seeking employment' (p.117).

2.3.3 Impact of poor health on employers and productivity

The research is unanimous—poor health and physical inactivity is impacting on profits and productivity. The incidence of lifestyle disease in workers is also likely to escalate further as the Australian workforce ages, with a consequent reduction in productivity, increased risk of injury and elevated workplace costs (Australian Government Productivity Commission, 2004; Giles-Corti et al., 2004; Howatt & Ritchie 2004; Shephard, 1999).

The increase in preventable disease and workplace injury, resulting from unhealthy living and low levels of physical activity, are a major cause of workplace absence or disruption in today's workforce. Many workplaces are reporting high levels of sick leave, high staff turnover rates, high stress levels amongst workers, poor job satisfaction, workplace accidents, reduced productivity and increasing health-related litigation (ACT Work Safety Commissioner, 2009; Kaplan, 2004; Premier's Physical Activity Council—Tasmania, 2007).

These are compelling reasons for employers to consider how the health of their workforce is compromising productivity and how they can take action to mitigate it. Medibank Private (2005, p.1) states that 'an ageing workforce, and a skills shortage faced by many industries, is making the issue of employee health more pressing for employers. Many employers are becoming increasingly engaged in the health of their employees not only to be socially responsible, but to improve company performance'.

2.4 MANAGING THE COSTS AND EFFECTS OF WORKERS' COMPENSATION

Occupational health and safety legislation has also heightened employers' awareness of their duty of care towards ensuring the health and safety of their workers.

Workplace injury and illness impose significant social and economic costs on injured workers and their families, employers and the wider community. The lack of a nationally consistent approach appears to have imposed significant compliance costs on business and may have led to inequities for injured workers in terms of benefits payable and entitlement to benefits (Australian Government Productivity Commission, 2004, p.viii).

With a total economic cost in excess of \$31 billion annually, work-related fatalities, injuries and illnesses impose significant costs on individuals, businesses the community and the economy as a whole (Australian Government Productivity Commission, 2004, p.xxii).

In 2001–02, preliminary Australian data indicated that 297 compensated fatalities occurred as a consequence of workplace activity. A further 78 fatalities occurred on journeys to and from work. There were almost 139 000 accepted workers' compensation

cases which resulted in a fatality, permanent disability or a temporary disability which resulted in an absence from work of one or more working weeks (National Occupational Health and Safety Commission, 2003).

And the figure may be even higher, with a survey by the Australian Bureau of Statistics (ABS, 2001) finding that many workers who experienced a work-related injury or illness did not apply for workers' compensation. In most cases this was because the injury was considered to be minor, but other reasons included: a lack of awareness of eligibility or the availability of benefits; the negative impact on employment; the effort of making a claim; or the employer agreeing to pay the cost outside a workers' compensation scheme.

Preliminary data released by Safe Work Australia (2010) in January 2010 show there were 131 110 serious workers' compensation claims in 2007–08, which equates to 13.5 claims per 1000 employees or eight claims per million hours worked. The majority of serious claims were for physical injury or disease e.g. sprains and strains. Mental disorders accounted for five per cent of all serious claims.

Mental stress claims continue to be of concern with the estimated financial cost at more than \$14 billion annually according to the Australian Services Union (2009). Within the Comcare scheme the incidence of accepted mental stress claims was observed to have decreased for the period 2004–05 to 2008–09. According to the Safety Rehabilitation and Compensation Commission (SRCC, 2009) during this period mental stress claims accounted for nine per cent of all accepted claims but 34 per cent of total claim costs (includes the cost to date plus estimated outstanding liability) in the same period, with an average total cost per claim of \$148 817. To put this in perspective, body stressing claims accounted for

42 per cent of all accepted claims in the period 2004–05 to 2008–09 with an average total claim cost of \$33 034 (SRCC, 2009). A mental stress claim on average costs 4.5 times more than a body stressing claim in this period.

People are working harder and often for longer hours, have busier lifestyles and are often under financial strain. This can impact on employee performance in the workplace. Conversely, there is increasing evidence of psychological injury occurring as a result of poor workplace practices and unhealthy organisational culture.

Santa-Barbara et al. (2006, p.2) highlight the interrelationship between the home and workplace environments and note that 'home and family stress has a cumulative effect with work produced stress; both feed off and reinforce each other. Workplace programs that help employees deal with home and family stress will also reduce the impact of work produced stress.'

A recent study by WorkCover Tasmania (2009) into the financial, social and health situations of long term workers' compensation recipients found that anxiety and stress related injuries have a very strong negative effect on claimants' social outcomes. The research found that if a claimant's family life deteriorates post injury or illness, this is typically associated with a range of other negative social outcomes. Finally, poor physical functioning, often due to the ongoing and sometimes irreversible effects of the workplace injury, is also associated with a range of negative social outcomes. This in turn can create significant financial costs to the community and stretch public health resources.

2.5 THE WORKPLACE AS A SETTING FOR HEALTH AND WELLBEING

Given most adults spend a significant part of their life at work, the workplace is a logical place to intervene with health promotion activities. The World Health Organisation (2008) has clearly identified the workplace as an important area of action for health promotion and disease prevention. In its Global Strategy on Diet, Physical Activity and Health, the World Health Organisation (2008, p.14) states, 'people need to be given the opportunity to make healthy choices in the workplace in order to reduce their exposure to risk. Further, the cost to employers of morbidity attributed to non-communicable diseases is increasing rapidly. Workplaces should make possible healthy food choices and support and encourage physical activity.'

In terms of importance, the workplace is matched only by the education system as the most effective front line in tackling chronic disease and promoting wellness (Centers for Disease Control and Prevention, 2003). It makes sense to respond to each individual's health and wellbeing on a continuum—starting from birth and being introduced in the home by families, education systems supporting it during schooling years, workplaces supporting it during our working lives, communities supporting it through our social lives, and nursing homes supporting it as we age.

It is argued that the introduction of employee health and wellbeing programs in the workplace serve two purposes: they are of benefit to workers as they target individuals' health and wellbeing while at the same time they are benefiting the employer by assisting to prevent escalating costs, assisting to increase productivity and assisting to improve morale and worker retention.

Employers (both from the private and government sectors) have become increasingly aware that chronic health issues are impacting negatively in the workplace and have therefore taken to producing a wide range of programs and with increasing frequency.

State and Commonwealth Governments have embraced the challenge and have demonstrated their commitment to improving health in the workplace. For example, in Tasmania the Premier's Physical Activity Council was formed in June 2001 to address inactivity in Tasmania. One of the initiatives flowing from the Council (with support from WorkCover Tasmania), was the development in 2007 of the *Get Moving at Work: A resource kit for workplace health and wellbeing programs*, designed to assist workplaces, and particularly employers, wishing to develop a health and wellbeing program (Premier's Physical Activity Council—Tasmania, 2007). All other State and Territory Governments have followed suit and also published on their website similar guidance or kits to assist employers. More information about these can be found in section 4 of this report.

An increase in health and wellbeing programs has also been noted internationally.

2.6 THE EXPANSION OF WORKPLACE HEALTH AND WELLBEING PROGRAMS

A brief historical overview of the expansion of health and wellbeing programs in workplaces both in Australia and overseas can be found in Crowther, Thwaites and Zhou (2004).

McGillivray (2002) reports the increase of corporate health and wellbeing initiatives originated in North America, particularly Canada, in the 1970s, further noting that Canadian research was first to recognise the need for a 'settings' approach to health promotion. Good health, according to the 1987 Ottawa Charter, must be promoted in settings that people learn, work and play within.

The National Public Health Partnership (Bauman et al., 2002) notes that during the 1970s and 1980s many American corporations began to conduct corporate fitness programs that often manifested themselves in the construction of gyms within the worksite that offered circuit training, aerobic classes and weights equipment.

Before health promotion, the only type of health program provided by the employer, were Employee Assistance Programs (EAPs), prevalent between the 1940s and 1970s. EAPs rehabilitated employees suffering substance abuse, primarily alcohol abuse (DeGroot & Kiker, 2003). According to DeGroot et al. many EAPs changed their focus from 'rehabilitative' to 'preventative' and from the 1980s Occupational Health Promotion Programs (OHPPs) became the trend. OHPPs were the first of today's corporate health and wellbeing initiatives.

OHPPs focused on changing behaviours deemed to be health risks because they could create future health difficulties. They targeted 'specific health risks such as high blood pressure, high cholesterol levels, and low fitness levels and many include smoking cessation, stress management, weight control, and nutritional changes' (DeGroot et al., 2003, p.56). It was further outlined that they attempted to decrease the need for health services, aiming to provide the employer a double win by saving health-care costs and improving worker productivity and efficiency.

'Workplace health promotion has become holistic and integrative in nature, addressing both individual risk factors and broader organisational and environmental issues. Moreover, instead of the workplace being used as a convenient location for health professionals to conduct programs aiming at changing individuals, workplace health promotion involves workers and management participating in programs to change the workplace environment to a health promoting setting' (Chu, Driscoll & Dywer, 1997).

In reporting to the Western Australian Department of Sport and Recreation, Hooper and Bull (2009) note that 'since early work in the 1970s and 1980s there has been substantial broadening of the concept and scope of workplace health from that solely focused on screening and individual approaches, to considering the workplace as a whole setting with multiple influences and opportunities, and the need to include change at the organisational level as well as involvement of workers and management in the process. However, they also comment that 'it is notable that although the definitions have changed and many programs are now implemented in workplaces in Australia and elsewhere, the research evidence base is still strongly focused on reporting results of change at the individual level' (p.6).

According to Bauman et al. (2002) the mid 90s saw the transition from the promotion of fitness and physical activity as a single issue, to the implementation of integrated programs. A similar process occurred in the UK: 'Unlike the North America model, where corporations have long been expected to absorb much of the health care costs of their employees, in the UK there has been a history of state provision. However, pressure on welfare state finances has driven governments to look at the potential opportunities within the workplace for alleviating the burden of welfare' (McGillivray, 2002, p.62).

Corporate health and wellbeing initiatives in Australia and the UK became increasingly similar to North America. However, in comparison, Australia's corporate health and wellbeing programs are more 'ad-hoc' (Bauman et al, 2002). Reasons for this, according to Bauman et al, include:

- > the American employer generally pays for an employee's health insurance and the greatest expense are costs associated with 'long-term chronic disease' such as heart disease and cancer
- > the Australian employer's greatest expenses are associated with musculoskeletal injury and stress, and therefore have a much narrower approach to health care.

Harden et al. (1999, p.540) also report that in 'the USA, the number of workplace health promotion programs has grown exponentially since 1980, with 81 per cent of workplaces offering some kind of health promotion program'.

Research undertaken by PricewaterhouseCoopers LLP for the UK Health Work Wellbeing Executive concluded that there had been 'a slow uptake of wellness programs as employers in the UK in general have not considered it their role to improve the health and wellbeing of their workforce' (2008, p.4). They concluded

that while some employers were able to identify demographic, societal and economic benefits (including responding to an ageing workforce, rising costs associated with chronic disease, etc.) that they were also confronted with being unable to put forward a strong business case which demonstrated the positive impacts flowing from workplace wellness programs. 'There is an abundance of literature and case studies that support the idea that wellness programs have a positive impact on intermediate and bottom line benefits. However, there are also numerous references that suggest the evidence remains inconclusive' (2008, p.70).

There is no shortage of information available in the literature about the variety of programs being introduced into workplaces around the world. And there are nearly as many anecdotal reports about the benefits being felt from the introduction of these programs. However, there appears to be far less information available to confirm or validate the benefits of such programs.

One could argue that it has become fashionable for employers to roll out health and wellbeing programs simply as a way of portraying a responsible corporate image. While there may be some merit to this, it is more important that programs are actually planned and executed for the right reasons e.g. based on solid organisational health information. They may otherwise be counterproductive. The only way to truly know whether these programs are hitting the mark and making a difference is to ensure that they are evaluated following implementation, and continually evaluated thereafter. The importance of evaluation is discussed later in this report.

Research undertaken by Crowther et al. (2004) concluded that employers conduct health initiatives because it is the 'right thing to do', as it improves the standing of management with workers.

They assert that rigorous scientific studies have failed to prove that reduced absenteeism and increased productivity are direct (and measurable) benefits of health initiatives, but the weight of evidence suggests that they do contribute to these goals.

Workers often desire health initiatives to improve 'work-life balance'. Integrating health promotion into workplace settings helps workers live more healthy and enjoyable lives. But it cannot be concluded definitively that they will reduce absenteeism, increase productivity or reduce health risks of workers.

While it is pleasing to hear reports about the surge in workplace programs and the potential benefits accruing from them, it is difficult to conclude in some cases that the stated benefits constitute 'evidence' of success without access to documentation surrounding the program's design, operation and evaluation criteria.

If we want to move past the rhetoric that such programs are beneficial and confirm that these programs are making a difference then some basic questions need to be asked:

- > What are the benefits and/or outcomes being sought?
- > Once implemented, has the program been successful in achieving its objectives?
- > How do we know the program has been successful?
How was the program evaluated?
What works/is best practice?

The World Economic Forum (2008b, p.13) sums it up succinctly:

'Health promotion can be implemented successfully in the workplace to the benefit of both individual employees and the organisation. However, programs require careful planning to ensure that the specific needs of each workforce are met. Leadership is critical and partnerships with employee representatives and NGOs can offer many advantages. Focusing on small lifestyle changes that, if sustained, can have lasting benefits is a practical and achievable way to proceed. Communication has to be at the heart of any program, but segmenting the market by gender, geography and, perhaps, by ethnicity is crucial. Simple messaging and practical tools are most likely to bring success and introducing some fun to the program helps maintain interest. Every campaign should be evaluated to ensure that it is having the desired impact and surveys of knowledge and attitudes can usefully be supplemented by objective measures that demonstrate changes in behaviour. Chronic disease requires long-term commitment to behavioural change, which in turn requires a sustained program of health promotion—the investment is small but the return can be substantial.'



20

3 HEALTH AND WELLBEING PROGRAMS IN PRACTICE: THE EVIDENCE

3.1 RHETORIC OR REALITY?

The Sloan Work and Family Research Network (2010) refer to a glossary definition of 'health and wellbeing' from The Business for Social Responsibility (2004) stating that '...these programs often yield quantifiable bottom-line benefits to companies by boosting productivity, reducing absenteeism, cutting healthcare and worker compensation costs, and improving employee recruitment and retention'. The true efficacy of such programs is explored in the next section.

As introduced in the previous section, the literature is not unanimous about the strength of evidence that health and wellbeing programs are making a significant difference to the health and wellbeing of Australian workers, nor whether employers are also reaping the benefits.

This is in part due to the difficulty in ascertaining whether these programs have achieved what they were designed to achieve. Many programs that have been implemented in the workplace have not been rigorously evaluated, nor have findings been published in other cases. Further, many of the claims relating to the benefits flowing from health and wellbeing programs appear to be anecdotal.

According to Bill Snyder (2004) of the Stanford Graduate School of Business 'hard evidence that innovative HR practices boost employee productivity—much less the bottom line—is hard to find'. Researchers from Cornell University echo these words: 'Although the profession of HR has developed around the assumption that HR practices directly impact organisational performance, little empirical research supports this link' (Gardner et al. cited in Center for Advanced Human Resource Studies (CAHRS), 2002, p.1).

The World Economic Forum (2008a, p.5) agrees that 'organisations don't apply the same rigorous measurement approach to wellness programs as they do to almost every other aspect of running their organisation'.

Their report also notes that "inconsistent tools are used to measure 'wellness' with no common definition of the term or methods of gathering the information. Benchmarking or comparative analysis becomes impossible. Only 10 per cent of organisations use an external provider with specialized knowledge and experience in measuring wellness" (p.8).

A number of international studies amplify the lack of evaluation surrounding health and wellbeing programs. Kenneth Pelletier (2005) of the University of California's School of Medicine conducted a series of reviews of over 122 research studies, looking at the clinical and cost-effectiveness of comprehensive, multifactorial health promotion and disease management programs in corporate worksites. While his findings indicate positive clinical and cost outcomes, this finding is tempered by the caveat that there has been a marked decline in both the quantity and quality of studies during 2000 to 2004. Most significant is Pelletier's (2005) concluding note that 'at this time, the most salient issue for managed care organisations and corporations to address is not whether worksite health promotion and disease management programs should be implemented to reduce risks and enhance productivity, but rather how such programs should be designed, implemented, and evaluated to achieve optimal clinical and cost-effectiveness' (pp. 1057-58).

Harden et al. (1999) in the United Kingdom undertook a study to identify and review evaluations of the effectiveness of health promotion programs in the workplace. Their study found that the majority of the outcome evaluations were not sufficiently rigorous to make a strong case for the effectiveness of workplace health promotion and there appeared to be a wide disparity between what counts as 'good practice' within workplace health promotion and what is reported in the evaluation of effectiveness literature. The research by Harden et al. sought to locate evaluations of health promotion interventions in the workplace and classified according to the country where the study was carried out, the health focus; the type of intervention and the extent of involvement of the target population in the planning and implementation of the intervention. Of the 139 relevant evaluations located, 110 were reviewed. In the end 15 evaluations were judged to be methodologically sound and considered. Those not considered were excluded because they either did not develop interventions in partnership with workers or for other methodological reasons (for example those that focused on smoking as these were the subject of other research.) Harden et al. concluded that although many workplace health promotion programs are in progress in the United Kingdom, many programs have either not been formally evaluated or much of the information is unpublished. They also found that health promotion interventions in the workplace more often address disease prevention issues guided by epidemiological data rather than being based on what workers said they wanted or what they thought were the problems that needed addressing and that most programs were targeted at the individual level with supportive organisational modifications being scant.

Right Management undertook research on behalf of the World Economic Forum (2008a, 2010) into the current wellness measurement systems used within public and private sector organisations and NGOs operating in low, medium and high income nations, including Australia. Their research notes that outside of North America, about one in five employers offer wellness programs (Europe 25 per cent, Asia 21 per cent, Australia 20 per cent, Central and South America 19 per cent, and Africa and the Middle East 18 per cent). They also found that outside of the UK and US, wellness measurement is focused on the satisfaction of legislative compliance rather than proactive health promotion and that organisations report that, on the whole, there is no link between their interventions and defined organisational need. Their survey found 40 per cent of responding organisations were unaware of whether their health and wellness measure was validated and further that only 6 per cent of respondents in developed countries used online measurement tools.

While the literature should be treated with some caution about the validity of some claims, there is also compelling evidence suggesting that there are real benefits from health and wellbeing programs.

There is no disputing the medical evidence that interventions aimed at tackling some of the causes of chronic health issues arising from behaviours such as smoking, alcohol, unhealthy diets and sedentary behaviour can improve the health and the quality of life of individuals. Workplaces have a role to play in promoting these endeavours.

The literature indicates that it is much easier to rigorously evaluate the benefits flowing from worker 'health and lifestyle' programs than to evaluate the benefits flowing from 'organisational and environmental' programs. Weight loss can be measured, as can

improvements in blood pressure and flexibility, and of course smoking cessation can be identified. It is far more difficult to rigorously evaluate the benefits flowing from organisational programs such as cultural change initiatives or leadership/management training programs, or programs addressing bullying and harassment that give rise to stress and psychological injury in the workplace. This would explain why the benefits flowing from organisational programs are under-represented in the literature.

In responding to Dame Carol Black's (2008) report, Hassan et al (2009) comment:

'Evidence from the literature and the selected case studies show that many workplace health interventions targeting problems due to work-related antecedent factors such as low back pain, musculoskeletal disorders and mental health disorders can have positive health outcomes. The literature also suggests that interventions aimed at improving damaging lifestyle behaviours such as poor diet, smoking, alcohol abuse and lack of physical activity can be effective in terms of health outcomes. Nevertheless, few studies directly relate workplace interventions to work-related outcomes, and the economic effectiveness of interventions varies greatly across sectors.'



3.2 THE STATED BENEFITS OF HEALTH AND WELLBEING PROGRAMS

3.2.1 Summary of recognised benefits

The World Health Organisation (2008, p.5) states that 'addressing diet and physical activity in the workplace has the potential to improve the health status of workers; contribute to a positive and caring image of the company, improve staff morale; reduce staff turnover and absenteeism; enhance productivity; and reduce sick leave, health plan costs and workers' compensation and disability payments'.

The UK Government's commitment to promoting the positive relationship between work and health was evidenced through its engagement of Dame Carol Black to undertake a review of the health of Britain's working-age population (Black, 2008). In responding to Black's review, the UK Government's Health, Work and Wellbeing Program (2008, p.10) endorsed the findings that 'being in work is good for health, and worklessness leads to poorer health' and acknowledged there was more that could be done to promote the benefits of work to health for workers, employers, healthcare professionals, society and the economy. Their vision states:

'We want to create a society where the positive links between work and health are recognised by all, where everyone aspires to a healthy and fulfilling working life, and where health conditions and disabilities are not a bar to enjoying the benefits of work' (p.9).

In its Position Statement, The Royal Australasian College of Physicians (2010) explored the relationship between work and health and wellbeing. Their findings echo those from similar research undertaken in the United Kingdom and European Union—that good work is good for health and wellbeing and, conversely, long-term work absence, disability and unemployment may have a negative impact on an individual's health and wellbeing. Put simply, happy and healthy workers perform and they perform well and to the benefit of all. This ultimately means fewer absences, reduced turnover, reduced costs all round, not to mention increased productivity, morale, loyalty, and increased profits.

A review of the literature points to a large volume of information arguing that health and wellbeing programs are beneficial to both the worker and the workplace. The ACT Work Safety Commissioner (2009, p.11) summarises the benefits that are represented throughout the literature to include:

- > increased productivity
- > improved staff health and wellbeing
- > staff who feel valued
- > increased staff morale, satisfaction and motivation
- > decreased stress and other work-related illness
- > reduced sick leave
- > fewer workers' compensation claims
- > reduced worker turnover
- > increased return on training and development investment
- > improved corporate citizenship and image

- > increased ability to attract new employees
- > improved industrial relations
- > improved alertness and concentration among staff
- > reduced risk of accidents
- > reduced long term health problems
- > reduced health-related litigation.

Other research (Wellness Proposals, 2009) reports that workplace wellness programs have the following benefits:

- > **Reduced absenteeism:** It has been shown healthier employees spend fewer days away from work due to illness, saving organisations thousands, even millions, of dollars on down time and temporary employment. Additionally, because good health typically carries over into better family choices, your employees could possibly miss less work caring for sick family members.
- > **Controlled increasing health care costs:** Today, employers have a vested interest in health-related issues and reducing unnecessary medical costs that consume corporate profits and employee pay checks. For many companies, medical costs can consume half of corporate profits, or more.
- > **Improved productivity:** While it is not as easily measured as the increase in health care costs, improved employee morale and productivity plays a big role in the success of a company or business.

- > **Improved presenteeism:** Presenteeism is a new phenomenon occurring when employees are at work but do not feel as productive as usual due to stress, depression, injury or illness.
- > **Reduced injuries:** Healthy employees with less risk factors are at a lower risk for injury than those unhealthy employees with more risk factors. Classes are a popular means of trying to prevent injury, including exercise classes, smoking cessation courses, back care programs and stress management lectures. More examples of workplace wellness programs/courses include health education classes, subsidised use of fitness facilities, internal policies that promote healthy behaviour and any other activity, policy or environmental change that affect the health of an employee.
- > **Improved employee morale and retention:** Employee turnover is expensive and an employee wellness program is an added benefit to encourage employee retention. Company sponsored workplace wellness programs send a clear message to employees that management values their wellbeing.

(Source: www.wellnessproposals.com/workplace-wellness-programs.htm)

3.2.2 Australian research

The most recent piece of Australian research discovered as part of this review is work undertaken by the Health and Productivity Institute of Australia (HAPIA, 2010). In reporting on its work, HAPIA (p.7) states it “has identified more than 600 Australian and international studies from the last 20 years that provide ‘compelling evidence’ that workplace health and wellbeing programs improve productivity, creativity and innovation; increase staff morale; improve the management of ageing workers; cut sick-leave rates by an average 25.3 per cent; and slash workers’ compensation costs by more than 40 per cent”. The report also claims ‘employers save an average of \$5.81 for every dollar invested in employee wellbeing’ (p.7).

Comprehensive research undertaken in Australia is that by Ackland, Braham, Bussau, Smith, Grove and Dawson (2005) who conducted a review of workplace health and physical activity (WHPA) programs for the WA Department of Sport and Recreation. Their research was based on surveys received from 130 Western Australian workplaces (small to large workplaces, both non-government and government). It found that half of the HR managers of workplaces surveyed reported they had in place some form of WHPA program, with the majority being large employers with 500+ workers. The most common activities offered with these programs included employee support programs, health promotion seminars, social activities, injury prevention/rehabilitation, pre-employment and regular health screenings, individual counselling and physical activity.

Ackland et al. (2005, p.6) summarised the positive outcomes flowing from WHPA programs as follows: ‘WHPA programs may increase health awareness and strengthen motivation to change behaviour. Areas of positive improvements among employees

include physical activity, nutrition, body composition, smoking cessation, and cardiovascular disease and type 2 diabetes risk. Highlighted economic benefits include reduced absenteeism, workers’ compensation and workplace costs, as well as a potential improvement in productivity’. Importantly, they also noted that ‘from the perspective of our respondents, the important benefits were primarily personal and social, rather than organisational’ (p.7). Interestingly, Ackland et al. noted that ‘with respect to program success, the majority of companies considered a participation rate of something above 50 per cent to be indicative of a successful program’, (p.25) but also noted that if that criterion was used that most WHPA programs would not be judged to be successful. Of particular interest is their finding that queried a higher percentage uptake of program activities among staff of private companies as opposed to government agencies and departments.

Unfortunately the research did not survey workers to obtain their views on the benefits of these programs and any measures of success reported were based on feedback from HR managers. Ackland et al. (2005, p.45) noted that ‘the data from this survey is biased toward the employer or organisation’s perspective, and certain findings ... must not be assumed to represent the belief of all stakeholders’. Importantly, they noted that ‘more scientifically rigorous research is required as valid data are limited and information mostly anecdotal, or based on research conducted overseas in a differing context’ (p.45).

Ackland et al. (2005) report that there is evidence to suggest countless positive improvements in worker health as a result of WHPA programs, although it is unclear to what extent these improvements have been demonstrated through evaluation. Nevertheless, their list of benefits appears to be one of the most comprehensive found. They have grouped the benefits into four areas as follows:

(a) Health benefits

- > increased in physical activity
- > improved nutrition
- > decreased alcohol consumption
- > reduced in substance abuse
- > decreased smoking rates and increased smoking cessation
- > reduced in body fat levels
- > improved cholesterol
- > decreased blood pressure
- > reduced stress levels
- > improved mental health
- > reduced risk of lifestyle disease (e.g. cardiovascular disease, type 2 diabetes)
- > increase in healthy behaviours
- > reduced in health risks.

(b) Economic benefits to organisations

- > improved job performance
- > reduced absenteeism
- > reduced sick leave
- > decreased worksite accidents
- > decreased workplace injuries
- > reduced short-term disability rates and associated costs
- > decreased workers' compensation
- > reduced workplace costs
- > improved cost to benefit ratio
- > potential increase in productivity.

Another economic benefit of WHPA programs is the reduction in 'presenteeism'. This new concept attempts to quantify how existing health conditions of workers limit work performance and negatively influence productivity of the organisation.

(c) Environmental benefits to organisations

- > enhanced working conditions and safety
- > decreased accidents and injuries
- > improved working atmosphere
- > increased social support
- > improved leadership style
- > reduced job stress.

(d) Social benefits to organisations

- > increased job satisfaction
- > enhanced motivation, greater commitment, loyalty
- > improved morale of employees
- > improved communication and teamwork
- > enhanced corporate image
- > improved recruitment
- > lower staff turnover and the retention of quality staff.

Unfortunately it is not possible in this report to explore each of the benefits cited above, however it was found that there are many research reports and journal articles that elaborate on all the benefits listed. For example, a quick search in relation to the stated social benefit 'lower staff turnover and the retention of quality staff' found numerous sources that referred to such benefits. Kaplan (2004) argues that one of the big areas where health and wellbeing programs can be beneficial for the employer is in improving retention rates. According to the Equal Opportunity for Women in the Workplace Agency (2002), it costs \$150 000-200 000 to replace a lawyer, while for a bank teller it's \$30 000. Given the costs associated with high staff turnover, the loss of intellectual property and the induction costs and time associated with replacing staff it is not surprising that employers are looking to health and wellbeing to not only attract staff, but to keep them for as long as possible.

The World Economic Forum (2010, p.8) comments on the relationship between wellness and retention of talent, finding that 'an organisation is four times more likely to lose talent in the next 12 months if its employees take an unfavourable view of its promotion of health and wellbeing'. Of those who have a favourable view of workplace health promotion, 64 per cent plan to stay with the organisation for at least five years.

The following section looks at some Australian case studies where the benefits cited above have been found to emerge.

3.2.3 Australian case studies

This section reports on the success of some Australian programs and the benefits evidenced by both workers and employers. It also covers 'lessons learned' that can be drawn upon to inform best practice in the future. The Western Australian and Tasmanian success stories reported below have been reproduced directly from other sources as per the reference at the conclusion of each summary.

3.2.3.1 Western Australia—Department of Commerce**Program background:**

'Work Safe, Work Well' was developed in July 2007 as a pilot wellness program based at our West Perth office. Due to the successes achieved, this program expanded to reach the rest of the department in July 2008. The vision of the program being to create and maintain a health and wellness culture that not only acknowledges the importance of being healthy and active in the workplace but also provides a supportive environment where we educate, encourage and enable staff to lead healthier active lifestyles, producing healthier employees who are able to reach their full potential.

Our objectives:

- > improve employees' physical health and wellbeing
- > improve employees' mental health i.e. an increase in concentration, morale, motivation, team bonding, and improved staff relationships and job satisfaction by providing an environment dedicated to employee wellbeing
- > improve productivity, by staff who are more energised and resilient
- > reduce illnesses caused by poor lifestyle
- > reduce stress
- > reduce workers compensation premiums
- > reduce absenteeism.

We provide:

- > a needs assessment to determine staff health concerns and activity requests
- > an audit of each workplace to assess the physical, environmental, educational and local neighbourhood environments to determine the barriers and enablers to leading a healthy lifestyle in the workplace
- > health assessments to target the major causes of illness and death and determine the health status of the workforce
- > information sessions to educate staff on healthy lifestyle practices
- > opportunities for staff to exercise at work, e.g. walks at lunch time and exercise classes
- > facilities to enable staff to lead healthier, active lifestyles e.g. bike racks, change rooms and shower facilities

- > opportunities for staff to make positive lifestyle changes e.g. healthy lifestyle/weight loss program
- > advertising and promotion of community health events
- > subsidies for staff to participate in community health events
- > poster campaigns to raise awareness of healthy options and encourage improvements in diet and exercise
- > motivational emails
- > a range of programs to support our wellness message i.e. workplace massages, meditation sessions, and fruit deliveries
- > healthy lifestyle articles for departmental newsletters
- > up-to-date wellness knowledge by attending forums, networking and by conducting research
- > regular evaluation and opportunities for feedback and improvements.

Strengths of our program:

The program content is developed through comprehensive needs assessments, health assessment results and regular opportunities for feedback and suggestions from employees. The program also has:

- > financial and upper management support
- > a dedicated full-time coordinator to facilitate the program (since May 2008)
- > comprehensive evaluation conducted regularly
- > wide range of programs to cater for all staff's needs/interests.

Key results so far:

Healthy Heart Check Results after one year of program implementation compared with pre-program results:

- > healthy weight range increased by 19 per cent, obesity reduced by 12 per cent
- > normal blood pressure improved by 4 per cent
- > ideal/desirable total cholesterol increased by 12 per cent
- > elevated/high stress decreased by 3 per cent
- > sedentary category decreased by 3 per cent.

In the Total Cardiac Risk category, which takes all the risk factors of cardiovascular disease into account, the percentage of staff in the ideal health category has increased by 10 per cent.

To obtain Needs Assessment Follow-up Survey Results, staff were asked whether they perceived they had experienced any benefits from the program. The results showed:

- > 56.1 per cent had experienced improved energy/concentration
- > 53.7 per cent had experienced increased knowledge of health/wellness topics
- > 53.7 per cent had experienced healthier eating habits
- > 46.3 per cent had experienced improved physical health
- > 41.5 per cent had experienced enhanced motivation
- > 41.5 per cent had experienced increased staff morale
- > 39 per cent had experienced improved mental health
- > 36.6 per cent had experienced reduced stress levels
- > 29.3 per cent had experienced better staff relationships
- > 24.4 per cent had experienced increased job satisfaction.

Key lessons already learnt:

- > need champions (volunteers) in each site to motivate and encourage staff participation and assist with meeting program providers
- > need strong support from management
- > need constant motivation for staff's participation

(Western Australian Department of Sport and Recreation and Department of Health (2009), *A resource kit for physical activity and health in the workplace.*)

3.2.3.2 Tasmania – Department of Police and Emergency Management

The Department of Police and Emergency management (DPEM) consists of the Tasmania Police, the State Emergency Service and Forensic Science Service Tasmania and employs around 1245 police officers and 473 State Service and State Emergency Service personnel. The Tasmanian Fire Service also reports to the Secretary DPEM; however, it was not included in this project

Program objectives:

The DPEM 'Healthy Lifestyle Program' provided the direction that would build on their OH&S program and address employee health and wellbeing in a broader sense. It introduced preventative measures and strategies to improve the lifestyles of employees. The program's mission statement is: to provide encouragement, information and opportunities to all employees on the benefits of a healthy and balanced lifestyle.

Getting started:

The initial focus of the program was to establish a clear picture of the existing 'status' of the workforce by checking the general health of employees and determining how much physical activity they were involved in. To do this a Community Business partnership was established with the Menzies Research Institute (MRI) in 2004 to provide expertise in data collection, management and analysis of workplace physical activity promotion. The project was titled Pacing the Police. From a wide range of DPEM departments, 175 volunteers attended a health check, where MRI staff measured the height, weight, waist and hip girths and blood pressure of participants.

Participants completed an international physical activity questionnaire, the Active Australia Survey, and provided demographic information. They were provided with a pedometer and asked to record their steps over 14 days. Pedometer records, along with other data, was considered by MRI and feedback letters were provided to each volunteer outlining their health check results and feedback on physical activity levels. A booklet produced by MRI entitled *Steps to Better Health* was provided to each participant. The research undertaken by MRI provided the initial data that would be used to benchmark the progress during the first stage of DPEM's health and wellbeing project.

The strategies used:

Over the following year the DPEM implemented a range of health and wellbeing strategies.

These included, 'step challenges', hypertension screening, free cholesterol testing and support for employees participating in community physical activity events. Participants were encouraged to continue wearing pedometers to monitor their activity. Twelve months after the initial testing, participants repeated their health check, with subsequent feedback comparing their progress with the original 'baseline data'. Participants was also asked to complete a brief questionnaire to provide feedback on the overall program. A joint partnership with the Department of Health and Human Services' (DHHS) Population Health unit was also initiated. The objective was to increase knowledge of the factors, barriers and enablers influencing nutrition and other lifestyle behaviours in staff of the DPEM. From this they would be able to develop recommendations for a range of appropriate and evidence-based interventions designed to positively address any of the influencing factors identified.



The benefits achieved:

The results of *Pacing the Police* were positive. The results, which compared physical activity, blood pressure and weight, suggested that:

- > there had been a decrease in smoking rates over the 12 months
- > 70 per cent of participants were active compared with 46 per cent of the general population
- > sitting and viewing television decreased
- > blood pressure decreased
- > waist circumference decreased in participants.

The joint partnership with the DHHS delivered a greater understanding of the nutritional benefits received from the program. Some of the benefits identified in the employee audit process were improved physical activity levels of employees, achieving the national activity recommendation of 150 minutes of physical activity a week and a low prevalence of smoking, with five per cent of males and nine per cent of females reporting that they smoked on a daily basis. The tremendous value of this data is that it provides a very clear message for the future direction of the health and wellbeing program, the strategies required and the benchmark data for ongoing measurement. The success of this program has had further benefit for the DPEM, resulting in an ongoing relationship with the DHHS and the establishment of another initiative, entitled: *Good Fuel for Police*. Overall, many participants indicated that the program motivated them to be active and influenced changes in other lifestyle behaviours, including eating and smoking.

(Premier's Physical Activity council—Tasmania (2007), *Get moving at work: A resource kit for workplace health and wellbeing programs*).

3.2.3.3 Victoria—WorkHealth Checks

Another example of the growth of wellness programs relates to the success of the Victorian WorkHealth initiative. WorkHealth Checks provide workers with the opportunity to receive a free and confidential health check in the workplace. The checks are part of WorkSafe Victoria's WorkHealth initiative, which aims to improve the health and wellbeing of workers and boost safety and productivity in Victorian workplaces. By participating in these checks, workers learn more about their risk of heart disease and type 2 diabetes. The checks look at factors that impact personal health such as diet, exercise, smoking and alcohol consumption.

The campaign comes on the back of new research conducted by WorkSafe Victoria on the first 56 000 workers who participated in WorkHealth Checks. The data shows that an alarming 40 per cent of workers who received a WorkHealth check had one or more results indicating a high or very high risk of developing type 2 diabetes and cardiovascular disease. The program aims to deliver far reaching benefits to workers, employers, the Victorian Government and the community at large, by reducing the risk and incidence of chronic disease across the state's working population and the impact of illness and injury on working families.

- > For Victorian workers, addressing lifestyle risk factors can improve their health and wellbeing, reduce the likelihood of developing a chronic disease, improve their quality of life and reduce the likelihood of being injured at work.
- > For Victorian employers, improving the overall health of workers can result in improved worker productivity, vitality and engagement, and reductions in costs associated with absenteeism and work-related injury.

- > For Victoria, the benefits of improved health and wellbeing and reduced chronic disease flow through to reduced workers' compensation and health care costs. The economy will benefit through increased participation and productivity in the workforce.

Since WorkHealth Checks commenced in June 2009, more than 50 000 Victorian workers have received a free check up in their workplace (WorkSafe Victoria, 2010).

3.3 BEST PRACTICE GUIDANCE

While health and wellbeing programs are flourishing in the workplace and the breadth of the programs being implemented is wide, it is not always the case that their planning, design, implementation and evaluation is based on best practice. Best practice suggests that such programs are well planned, have an early intervention and/or prevention focus, are designed and developed with very strong ownership and input from workers, that they are targeted at the stated needs of workers, are suitable for the workplace environment, are implemented and managed within a strong OHS policy framework, and they are regularly monitored and evaluated.

This review found that there is an enormous amount of literature in relation to what might be described as 'best practice' guidance in planning, design, implementation and evaluation of health and wellbeing programs that can assist employers.

3.3.1 Australian research—summary of findings

The Victorian Department of Human Services commissioned a review to determine what types of primary prevention programs in the workplace are most likely to be effective in preventing chronic disease (Bellew, 2008). They found that there was insufficient evidence to determine whether any specific programs are more likely to be effective with particular socioeconomic groups and there was a dearth of well designed studies conducted in Australia. Some studies suggest that returns on investment in WHP over the period 1995–2005 have doubled from a cost to benefit ratio of 1:3 to 1:6.3. Systematic reviews for the health economics of smoking and physical activity interventions indicate that a cautious acceptance of these conclusions on the cost to benefit ratio of WHP is warranted until more robust and specific evidence is available in these areas.

The review contains an excellent summary of the various types of primary prevention programs in the workplace and discusses what types of programs are likely to be most effective in (a) changing risk factors for chronic disease (smoking, nutrition, alcohol, physical activity, stress) and (b) reducing rates of chronic disease. It also provides, where possible, comment on the cost effectiveness of the primary prevention programs.

La Montagne (2009) examined a number of wellbeing programs and OHS systems across different government agencies in Australia, looking at whether recent initiatives represent international best practice and are effective in achieving their objectives. He concluded that current government initiatives fall short on linking (a) health behaviour change and (b) the improvement of working conditions as distinct chronic disease prevention strategies. La Montagne asserts that the initiatives fail to acknowledge and address occupational contributions to chronic disease burden. He advocates integrating health promotion and health protection through the awareness of combined effects of health behaviours and occupational exposures and emphasises the need for wellbeing programs to be implemented within a strong OHS system. This may increase worker motivation to change health behaviours and should increase employer and government motivation to reduce occupational exposures.

La Montagne (2009) proposes that current government WHP initiatives could be improved by highlighting links between individual and occupational risks (to optimise motivation for change in both workers and employers) and by prioritising intervention on occupational contributions. He believes that employers should ensure that chronic disease prevention is the primary goal, with two main objectives; the improvement of health behaviours and the improvement of working conditions. According

to La Montagne, it is essential that employers articulate and address the occupational contributions to targeted chronic diseases as well as the individual.

The improvement of working conditions is particularly important in the area of mental health. As Cotton (2005, p.33) notes, 'improving supportive leadership and the work team climate has the strongest overall positive impact on levels of employee wellbeing and withdrawal behaviour outcomes'.

The literature appears to agree that preventative techniques are the most successful way to achieve results and reduce the range of health issues impacting both the workplace and the home. Interventions need to target the underlying causes of these chronic health issues and they are most likely to be successful when aimed at promoting healthy and positive lifestyles, as well as improving safety and organisational and environmental contributors (hazards) in the workplace.

The Commonwealth Government-sponsored National Preventative Health Taskforce's recent report (2009) cites research echoing the evidence that programs which integrate intervention on 'lifestyle' health behaviours and working conditions are more effective in protecting and improving worker health and wellbeing than isolated or single issue programs.

Comcare (2009a) recently conducted a study into the management of psychological injuries in the workplace. The report outlines various strategies for improving workplace culture and corporate commitment in an attempt to promote safe work practices and prevent psychological injuries including those resulting from work pressure. The study found that in many cases, workplaces implement programs such as wellbeing and awareness activities that focus on personal risks of individuals, but do not consider the

underlying organisational factors that represent a significant risk for psychological injury in the workplace. According to Comcare, this medicalisation of the problem through the diagnosis of 'psychological injury' shifts the focus of the problem of intervention away from workplace stressors and on to the patient.

To reduce this tendency it is essential for health and wellbeing programs to be designed within an employer's broader OHS system where a comprehensive risk assessment of the organisations' health including psychological and physical hazards has taken place. Although risk assessment has traditionally focused on physical hazards it can be applied to mental health hazards (World Health Organisation, 2005). The UK Health and Safety Executive has developed a number of resources to assist organisations identify the risks associated with work related stress (www.hse.gov.uk/stress/standards/step1/index.htm).

3.3.2 Australian research—tips for a sustainable health program

Bellew's (2008) review for the Victorian Department of Human Services identified a range of success factors for WHPs, which include:

- > senior management involvement
- > participatory planning
- > integrating Health Productivity Management/Workplace Health Promotion programs into the organisation's operations
- > strengthening the organisational climate for implementation by making sure that targeted employees have easy access to high-quality training, technical assistance and documentation
- > providing incentives for use and providing feedback on innovation use (all of which enhance motivation) and by making the innovation easily accessible or easy to use
- > giving targeted employees time to learn how to deliver and use the innovation, and redesigning work processes to fit innovation use (all of which increase opportunities or remove barriers)
- > simultaneously addressing individual, environmental, policy, and cultural factors affecting health and productivity
- > targeting several health issues
- > recognition that a person's health is determined by an interdependent set of factors
- > focusing primarily on employees' needs
- > tailoring programs to address specific needs
- > attaining high participation

- > optimising the use of on-site resources
- > ensuring long-term commitment to the program
- > rigorously evaluating programs
- > disseminating successful outcomes/promising practices to key stakeholders.

The Hooper et al. (2009) review for the Western Australian Department of Sport and Recreation identified key learnings that could be used to determine the success and sustainability of a workplace wellbeing program. They include:

1) Management involvement and support

- > Management support for both the program itself and those involved in its implementation (such as the workplace champions) is essential to encourage employee participation.
- > Management support and involvement should be visible to employees—through participation in program activities or via personal endorsement/encouragement of employee participation in organised initiatives.
- > An 'advocate', 'sponsor' within the organisation (i.e. a member of staff who takes a lead role in the planning and implementation of the program) and who visibly supports the project, can be of great benefit providing links to business objectives and planning cycles as well as building management support.
- > Coordinated support from all levels of management within the different working departments of an organisation is needed to ensure equal access, opportunity and support to all employees, regardless of position or job type.

2) Integration with existing business planning and values

- > Integrate workplace health programs with other human resource management policies and practices to form a comprehensive strategy for enhancing the working environment.
- > Integrate health promotion/wellness programs into existing organisational operations and strategies for addressing other work-related issues such as absenteeism/sickness absence management and productivity.
- > Integrate health promotion into occupational health and safety to ensure a prevention focus is the guiding principle for all organisational efforts in this area
- > Health and wellness goals should be embedded in corporate 'missions', 'values' or policies (such as occupational health, health and safety, human resources, return to work agendas, canteen services/contracts and flexible working hours). The creation and adoption of such policies reaffirms both the organisation's and management's commitment to the program and help to ensure the long-term sustainability of the program.

3) Project Planning and Implementation

- > Programs must meet the identified needs and interest of the employees. A 'participatory' approach to planning the program structure and content should ensure employees are consulted and engaged in all planning and delivery processes, helping to create employee ownership for the longer term success of the program.

- > Conducting a 'needs assessment' as part of a project launch or employee questionnaire will help to identify employee interests, likes and dislikes and provide suggestions for different initiatives that may be offered and to tailor the programs to address any specific needs of different employee groups.
- > Adequate provision for the coordination of workplace health programs, through dedicated personnel, time and resources is essential, particularly in the early stages of program development.
- > Program success is less likely when coordination for planning and delivery is left to employee volunteers to run, particularly if they are not provided with sufficient allocation of work time and at least some resources. The development of formalised and recognised 'workplace champion' roles to help plan and implement a workplace health program, to encourage employee engagement and develop employee ownership was found to be advantageous.
- > The skills and expertise of individual(s) leading a workplace health project should not focus solely on health knowledge or an ability to run classes or seminars; rather the desirable skill set should include management, planning, coordination and good communication skills across diverse audiences.
- > Organisations implementing comprehensive workplace health programs may need support from external providers who can bring breadth of expertise, experience and existing resources.
- > Local strategic partnerships, trades unions, business federations and those organisations with a responsibility for increasing physical activity levels or for occupational health should provide support for those employers who want to implement workplace health promotion programs.

- > Similarly, where those individuals responsible for the coordination of the workplace program have no formal or previous background knowledge of health promotion practices, access to training, technical assistance (e.g. health promotion specialists, exercise professionals/instructors etc), and/or documentation (and knowledge of where to find such information) should be made available.
- > Workplace health programs do not need to deliver all initiatives on site. Providing information on, or links to, local resources, providing advice and other information or resources (e.g. services of physical activity experts) could be sufficient.

4) Communication/marketing/promotion

- > Communicating the aims and purpose of workplace health programs to employees is essential to build positive employee engagement.
- > Clear and frequent communication and use of multiple communication channels within the workplace to maximise reach to all employees is essential for success.
- > The use of project branding can create an identity for the workplace health program that can help build recognition of the activities and raise employee awareness.
- > Utilising existing resources (e.g. newsletters, websites) and communication networks within the organisation can make the distribution of program information easier e.g. via email, posters in the work canteen and enclosures with employees' payslips.

5) Develop multi-component programs

- > A workplace health program should aim to cover a multitude of different health-related issues and topics to ensure a variety of behavioural risk factors are addressed and to engage greater numbers of employees with different preferences/likes/dislikes and (health) needs.
- > Avoid an over emphasis of one approach to an issue; this will avoid excluding employees and any perceptions that the program is aimed at a narrow group of employees or one agenda (e.g. 'too sporty', 'only for older employees').
- > Creating a 'supportive physical environment' within the workplace (e.g. the design, facilities and amenities) to support employees in making healthy lifestyle choices (such as to be more active and to eat healthier) should be viewed as an essential component of a workplace health program.
- > Changes (improvements) to the environment and policy demonstrates the organisation's commitment to supporting employees to improve their health.
- > Making changes to the workplace environment and policies is more difficult to achieve in the short-term; thus should be viewed as mid to long-term objectives. They both require significant management support and often greater levels of funding and resources.
- > Organisational policy to support healthy lifestyles should be developed to ensure long-term commitment, resourcing and sustainability. This can be integrated within one or more related policy areas.

6) Indicators of success

- > Expectations for workplace health programs should be realistic and acknowledge that planning, establishing employee engagement and developing management support (at all levels) can take much longer than anticipated to get fully established, thus at least 12 months is necessary as an initial start up phase. Changes to the physical workplace environment and workplace policies can take 2-3 years or longer. Changes in individual behaviours (such as lifestyle risk factors) can take place in the mid term (12 months) and sometimes shorter (6 months) but is highly dependent on employee participation and engagement with the program and initiatives. Behaviour change is difficult to detect on a population level in the short term.

7) Evaluation

- > All workplace health and wellness programs should be well evaluated.
- > Evaluation will provide evidence on whether the program is achieving its stated or expected aims and objectives. If well designed, evaluation can also provide an insight and often help explain why a program has been effective or ineffective; it can also provide accountability.
- > A good evaluation will help to demonstrate the worth of a program over time and provide accountability to management through the assessment of program delivery thus influencing future decisions regarding project sustainability and funding.



40

The work recently undertaken by the Health and Productivity Institute of Australia (HAPIA 2010) provides a concise summary of many of the tips for a sustainable health program. HAPIA suggests that there are 12 guiding principles that include:

- 1) Active support and participation by senior leadership—this goes beyond endorsement and involves active and visible participation. CEOs and other senior leaders must embrace the creation of the vision or mission statement, walk the talk, hold management accountable through, for instance, KPIs; and reward success with incentives or public recognition.
- 2) Workplace health as a shared responsibility—the effective delivery of wellbeing programs hinges on encouraging employers and employees to take and accept responsibility for health in the workplace. Employees who contribute financially to select initiatives, such as gym membership or smoking cessation, are more likely to adhere to programs.
- 3) Engagement of key stakeholders—a healthy workplace is only attainable through the collaborative commitment of all stakeholders groups. Collaboration can be achieved by establishing a workplace health committee, appointing a health coordinator, and identifying and establishing workplace health partnerships with, for instance, external providers and not-for-profit organisations such as the Heart Foundation.
- 4) Supportive environment—healthy choices should be easy choices. A company that undertakes a weight-management program but also provides high-fat, non-nutritious foods in vending machines and at meetings is unlikely to achieve long-term behaviour change. Healthy catering, flexible working arrangements and onsite facilities, such as showers and lockers, are key to a program's success.
- 5) Participatory planning and design—employers must determine employee and organisational needs through a comprehensive needs assessment, develop programs in line with best-practice approaches and with the necessary providers and resources establish cost guidelines (usually \$100 to \$300 per employee per year) and 'make it happen' with strong leadership and an innovative communication and marketing strategy (see principle number 9).
- 6) Targeted workplace health interventions—a multi-faceted workplace health program can be broken down into core components, such as health assessments and flu vaccinations which are available to all employees, discretionary components for high-risk workers, and local components that target the special needs of particular sites or job functions.
- 7) Standards of accreditation—employers should ensure that internal and external health-program providers have a track record in the provision of such services, are members of a relevant industry body (such as HAPIA), use valid and reliable equipment or instruments and provide comprehensive reporting or evaluation.

- 8) High levels of program engagement—the average participation rate among exemplary programs is 60 per cent, and can be achieved by conveniently integrating initiatives into the daily work schedule, keeping programs simple, clearly outlining goals and benefits, including family members where appropriate and ensuring privacy is respected.
- 9) Innovative marketing and communication—creative marketing involves identifying employee needs and ‘selling’ the solution. Campaigns focusing on specific employee behaviours or characteristics such as age and sex are particularly effective.
- 10) Evaluation and monitoring—evaluation is the cornerstone of a best-practice workplace health program. Comprehensive and ongoing evaluation is essential in measuring ROI and ensuring the program continues to meet the needs of employees and the organisation.
- 11) Commitment to ethical business practices—including professional responsibility, confidentiality, professional competency and consumer protection.
- 12) Sustainability—ensure programs are preventative in nature, as opposed to focusing on chronic disease management; avoid activity-oriented programs, concentrate on teaching self-sufficiency skills and set realistic short and long-term expectations.

3.3.3 International research—summary of findings

Shain et al. (2004) argue that taken as a whole, the evidence concerning health promotion in the workplace suggests that health promotion programs will only be effective in enhancing the health status of the workforce when the interventions attend to both individual and environmental influences. They propose that when health promotion programs are run according to certain principles and are operated under supportive conditions they are likely to show a ‘positive return on investment’ (p.646). The authors suggest there are two primary forces affecting health, productivity, efficiency and competitiveness—personal health practices and the organisation of work.

Shain et al. (2004) reviewed two health related interventions—health promotion programs, and workplace organisational interventions—to establish their cost-effectiveness and impact on personal health practices and the organisation of work. Their research identified common characteristics in health promotion programs that are most likely to succeed, including:

- > Attention to the needs of individuals to set their own health related goals and to approach them in a step-wise, incremental fashion. This need can be addressed effectively by assessing and taking stock of the individual’s ‘readiness to change’ and of what the individual is, or is not prepared to do at the time the program or intervention is offered. This is the principle of personal control or ‘self-efficacy’.

- > Attention to the variable needs of individuals for social support as they plan and carry out activities designed to improve their health in some way. This could, for example, mean using a 'buddy' system to achieve some difficult objective such as weight loss or smoking cessation; or it could mean enlisting the active collaboration of family members in making sustainable changes to the content of meals, or the method of their preparation. This is the principle of social support.
- > Attention to the fact that health practices are frequently interdependent; for example, smoking, alcohol use, and caffeine use are often related through complex situational 'triggering' processes. Sleep disruptions and patterns of rest and recreation are often keyed to exercise habits and nutritional practices. It is imperative, therefore, that the design of programs focused on any one health practice should also pay attention to the manner in which other health practices serve to reinforce it either negatively or positively. This is the principle of interactivity.
- > Attention to the fact that everyone has some health risks—some more than others—and everyone has health needs. These risks and needs are no respecters of age, gender, occupation, culture, or socioeconomic status, even though patterned variations according to these variables can be seen. This means simply that programs have to be designed to meet the preferences, aptitudes, and requirements of a wide variety of participants, particularly taking into account variations in life stage, education, culture, and language capacity. This is the principle of wide appeal.
- > Attention to the fact that people are increasingly strapped for time and energy, and need, as much as possible, programs and services to come to them rather than the other way around. This means providing programs in forms that are easily accessible to people who may be at the earliest stages of readiness to change and whose motivation to begin working on some aspect of their health may be fragile at best. Sometimes, this need for easy access can be served best by helping potential participants with the financial resources to seek out their own programs in the communities where they live rather than where they work. Alternatively, it can involve making programs available by the internet in workplaces that can support this kind of infrastructure. This is the principle of convenience.
- > Attention to the preferences and needs of program participants is more likely to be achieved when employees are actively involved in the identification of health issues, in the design of programs, and in decisions about how, when, and by whom they are delivered. This is the principle of employee participation.
- > Environmental or contextual prerequisites. It is essential that the workplace environment be supportive of employees' efforts to take care of their own health. This means two things;
 - Management support refers mostly to ensuring that employees understand and actually feel the commitment of their employers to the protection and promotion of their wellbeing. This commitment may appear in various forms including providing a physically safe working environment, making at least some time available to employees during working hours for health promotion, making

resources available, showing interest through requiring accountability, providing a 'family friendly' workplace through flexible work-time policies, giving adequate notice of travel requirements and providing personal leadership through exemplary behaviour.

- Supportive management climate refers to organising work in ways that promote rather than defeat health and safety, including keeping demands on time and energy within reasonable bounds, maximising the degree to which employees participate in the governance of their own work; and providing adequate recognition and acknowledgement for work well done (Shain et al., 2004, p.646).

According to Shain et al. (2004) the evidence to support the impact of organisation of work interventions (OWIs) on health and productivity is not conclusive. There is a body of research on workplace interventions that are designed to have an effect on how work is organised, and the thought is that this will have an effect on worker health whether this is intended or not. However, the authors argue that most of the research on the outcomes of OWIs ignores this fact, so we are left to deduce from such studies what their probable impact on health may have been.

In reporting to the European Commission in the Evidence of Health Promotion Effectiveness Report, Breucker and Schröer (2000) for the International Union for Health Promotion and Education discuss the effectiveness of workplace health promotion. The criteria used to define wellbeing program success, they suggest, can range from short-term behavioural outcomes, such as changes in attitude or health behaviours, to medium and longer term health outcomes. Indicators of success can also include a variety of economic factors such as absenteeism, turnover, productivity and health care costs depending on the programs objectives. Breucker et al. (2000)

claim 'on the basis of the scientific knowledge available and practical experience, the following factors have been identified as essential for effective WHP activities' (p.98):

- > interdisciplinary effort involving many different players in the company (occupational health and safety, human resources management, quality management, training etc.)
- > participation and co-operation of all players
- > a comprehensive approach, combining activities that focus on the individual with those that address the design of the working and organisational conditions' (Breucker et al., 2000, pp.98-99).

The results of this study indicate that comprehensive WHP combined with OHS practices improves productivity and product and process quality. If these conditions are met, they claim workplace health promotion may also:

- > reduce the burden of work-related diseases and support health related practices of the workforce
- > be a crucial element of health-promoting job and organisational design
- > contribute to building social capital by strengthening individual and organisational resources conducive to health
- > reduce illness-related absenteeism and increase productivity and competitiveness
- > have an impact on various fields of policy. In particular, WHP is a component of modern economic and industrial policy.



44

**4 GUIDANCE TO ASSIST IN
PLANNING, DESIGNING,
IMPLEMENTING AND EVALUATING
HEALTH AND WELLBEING
PROGRAMS**

There are many academic, government and private resources available both nationally and internationally that can be drawn on to assist in the development, ongoing operation and evaluation of health and wellbeing programs. Some resources and sites contain detailed guidance. Many tools are also available to assist in all stages associated with the introduction and ongoing management of HWP.

4.1 EXISTING GUIDES

- > ACT Work Safety Commissioner (2009), *A Guide to Promoting Health and Wellbeing in the Workplace*.
www.worksafety.act.gov.au
- > Northern Territory—Department of Health and Families.
www.health.nt.gov.au/Nutrition_and_Physical_Activity/goNT_be_active/index.aspx
- > Plotnikoff et al. for the Alberta Centre for Active Living (2003), *Workplace Physical Activity Framework*.
www.centre4activeliving.ca/publications/researchandreports/2003_workplace/Framework.htm
- > Premier's Physical Activity Council—Tasmania (2007), *Get Moving at Work: A Resource Kit for Workplace Health and Wellbeing Programs*. www.getmoving.tas.gov.au
- > Queensland—Queensland Health, *National physical activity guidelines*. www.health.qld.gov.au/npag
- > South Australian Office for Recreation and Sport (2006), *Workplace Physical Activity Kit*. www.beactive.com.au
- > Victorian Government—*Go for your life*.
www.goforyourlife.vic.gov.au
- > Western Australia—*Premier's Physical Activity Taskforce*.
www.beactive.wa.gov.au
- > Western Australian Department of Sport and Recreation and Department of Health (2009), *A resource kit for physical activity and health in the workplace*. www.dsr.wa.gov.au
- > WorkSafe Victoria (2010), *Healthy workplace kit: your guide to implementing health and wellbeing programs at work*.
www.workhealth.vic.gov.au

The Premier's Physical Activity Council—Tasmania (2007) acknowledges that its work was strongly influenced by the research undertaken by Plotnikoff et al. (2003) for the Alberta Centre for Active Living and the South Australian Office for Recreation and Sport (2006). Both the ACT Work Safety Commissioner's guide (2009) and the Western Australian resource kit (2009) acknowledge that their content has been strongly influenced by the Tasmanian research. WorkSafe Victoria (2010) has recently designed a new initiative to improve the health and wellbeing of workers which is an abbreviated version of the ACT, Tasmanian, South Australian and Canadian guides.

In addition to the above guides, the review undertaken by Ackland et al. (2005) for the WA Department of Sport and Recreation also identifies current 'best practice' strategies for Workplace Health and Physical Programs.

4.2 GUIDANCE FOR A SUCCESSFUL HEALTH AND WELLBEING PROGRAM

The following formula for a successful health and wellbeing program has been summarised from the guidance materials referred to in the previous section:

Part 1: Setting the Foundations and Planning your Program

Part 2: Constructing and Designing your Program

Part 3: Implementing and Managing your Program

Part 4: Evaluating your Program.

Part 1: Best practice in setting the foundations and planning

Setting the foundation for establishing a health and wellbeing program needs to include the following steps:

1. Establish and ensure ongoing commitment and support, especially from senior management within your workplace.
2. Align any program with strategic business objectives.
3. Integrate with organisation goals and policies. Develop a 'Health and Wellbeing Policy'.
4. Involve employees from all levels of the organisation in the planning process to encourage a sense of program ownership at all levels.
5. Look to build a picture of the health and wellbeing issues currently impacting on workers. This could include conducting a staff health and wellbeing survey or a risk assessment.

6. Implement programs that address the needs of individuals in the organisation.
7. Offer culturally sensitive and appropriate programs to engage economically challenged, minority and underprivileged populations.
8. Manage gender differences to improve workplace health and wellbeing outcomes.
9. Take into account your workplace environment, including infrastructure, policies and procedures.
10. Develop a clear set of goals and objectives.
11. Use an interdisciplinary team of experienced, knowledgeable staff.
12. Promote the benefits to workers and management.

A checklist for setting the foundation:

- > Do we have a commitment to the program from management and staff?
- > Do we have a health and wellbeing leader to drive the program forward?
- > Have we established a person (or committee) responsible for coordination and administration?
- > Have we communicated program detail and direction to staff and sought their input?
- > Do we have an ongoing communication process that invites feedback and encourages participation?
- > Have we found out what the health and wellbeing issues are for staff?

- > Have we assessed the workplace environment (policies, procedures and infrastructure) prior to program implementation?
- > Have we established program benchmarks to allow for ongoing measurement of progress and improvement?

Part 2: Best practice in constructing and designing

The program design phase involves selecting and designing the range of activities to be included in the health and wellbeing program. The range of activities and initiatives selected should flow from the responses and feedback received from staff and management during the planning phase. The workplace environment is also a key determinant of program design and should reflect the social, organisational, community and policy influences on implementation. The size of the organisation, number of workers and availability of resources, as well as any infrastructure limitations are important to consider during program design.

Consider the following when constructing and designing a health and wellbeing program for your workplace:

1. Use a structured approach in response to feedback obtained during the planning phase.
2. Include variety and choice—offer multi-faceted and holistic programs.
3. Select a broad scope of prevention targets from primary to tertiary levels of prevention.
4. Look beyond the workplace for ideas, advice and support.
5. Provide 'virtual' as well as site-based interventions through the improved use of technology.



6. Integrate program activities within the organisation and integrate with external activities and resources where appropriate.
7. Maximise accessibility to programs and eliminate barriers of access to programs, i.e. also target high risk individuals as well as groups.
8. Plan for any recruitment required to support the roll-out of programs.
9. Build knowledge and awareness and promote programs—how are programs going to be promoted to staff?
10. Develop and utilise an annual survey or health appraisal to plan, target individuals and evaluate progress.

A checklist for constructing and designing:

- > How are we going to promote our program?
- > How does our program cater for a range of individual needs?
- > Does our program have a mix of education and action based initiatives?
- > Is our program based on a multi-level approach to the workplace environment?
- > Does our program respond to the employee issues and workplace audit identified in the planning phase?
- > Does our program build on the strengths of our existing resources?
- > Does our program meet the needs of as many workers as possible and recognise varying attitudes and preferences?
- > Have we considered recruiting the right people to support the program?

Part 3: Best practice in implementing and managing

Program implementation involves coordinating the activities associated with your program and the ongoing management of those activities. It requires energy and enthusiasm and regular communication. Leadership is required to manage health and wellbeing program activities, including timing, rollout and recruitment of participants. A mix of strategies that include health and wellbeing awareness and education, together with practical initiatives, should be considered in a planned and structured manner.

Consider the following during implementation of a health and wellbeing program and during the ongoing management phase:

1. Maximise participation.
2. Ensure consistent follow-up process.
3. Use incentives where appropriate, long-term change requires internal motivation.
4. Encourage effective communication strategies.
5. Create a supportive culture.
6. Create a supportive environment so health promotion behaviour is easier to initiate and maintain.
7. Use 'champions' in the organisation to promote the program.
8. Ensure a risk management plan is in place.
9. Ensure there is a record-keeping system in place which includes prior and proposed health and wellbeing initiatives and which tracks progress.
10. Continue to monitor and evaluate during all phases.

A checklist for implementing and managing:

- > Have we determined how, when and where activities are going to be run?
- > Do we have someone who is leading and coordinating activities?
- > Have the activities been implemented?
- > Are we keeping records of the activities?
- > Do we have a risk management plan?

Part 4: Best practice in program evaluation

Program evaluation is a vital component of your health and wellbeing program and enables your organisation to measure the benefits of the program. A variety of strategies may be used for program evaluation and may be broad or focus on specific data. Program evaluation may be based on an initial worker survey and workplace audit, satisfaction surveys and ongoing program evaluations. You may also choose to evaluate your program against benchmarks for productivity, sick leave or worker turnover.

Consider the following:

1. Ensure a regular, comprehensive, systematic evaluation process has been documented.
2. Carry out ongoing evaluation of program goals and objectives.
3. Determine if the program has been implemented as planned.
4. Identify opportunities for improvement in the program.

5. Provide feedback on a regular basis to continually improve the program.
6. Assess if the program is attracting the volume of participants that it intended.
7. Document changes in health and wellbeing attitudes.
8. Assess the perceived value of the program.
9. Assess the overall worker and management satisfaction with the program.
10. Identify the health outcomes (behaviours and status) of the program against measurable criteria.
11. Evaluate improvements in the organisation as a result of the program (e.g. improved productivity due to reduced absenteeism and lower workers' compensation costs).
12. Determine the cost benefit of the program.
13. Determine if the program has met its quality assurance criteria.
14. Establish whether an ongoing commitment to the program is justified.

A checklist for evaluation:

- > Have the activities been evaluated?
- > Have we assessed if the program is making a difference to employees and the organisation?
- > Have we responded to the results of the evaluation?

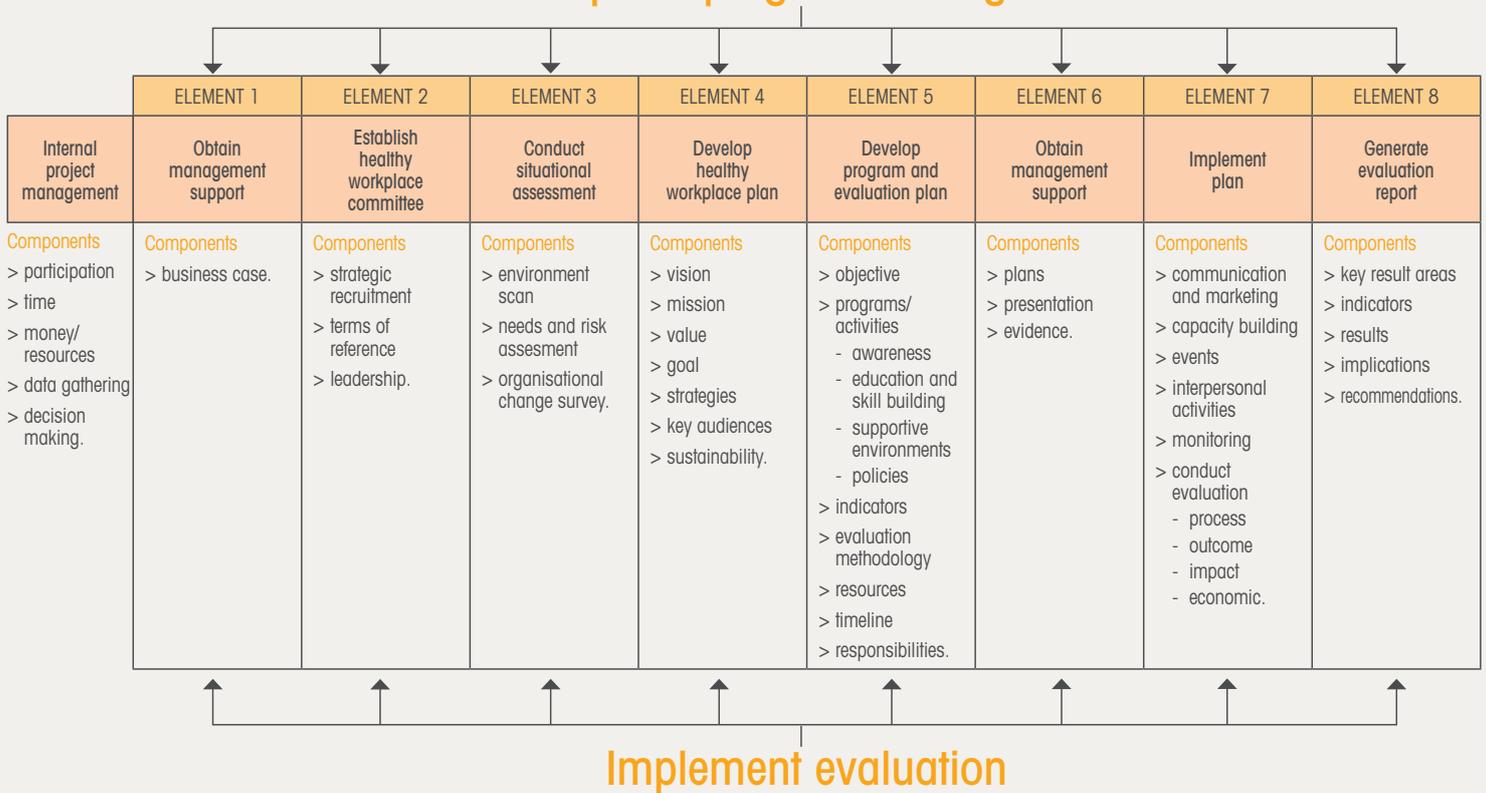
4.3 A REMINDER OF THE IMPORTANCE OF EVALUATION

The Health Communication Unit (THCU) at the University of Toronto highlights the need for comprehensive workplace health promotion (CWHP) initiatives to be evaluated based on goals and objectives set during the planning process (THCU, 2006). The work undertaken during the planning phase will determine the overall success of any program.

This review found the Comprehensive Workplace Health Promotion Planning Framework developed by the THCU provided clear step-by-step guidance to assist in the development of health and wellbeing programs and highlighted the importance of considering evaluation steps as appropriate for each element of the planning framework 'because evaluation is something that will occur throughout your CWHP initiative' (p.13). The principles and steps that form part of the framework is consistent with other models and guides found as part of this review, including the Australian guides referred to above.

Comprehensive workplace health promotion planning framework

Workplace program management



Source: The Health Communication Unit (2006).

4.4 WEAKNESSES AND TIPS FOR EVALUATION

PricewaterhouseCoopers LLP (2008) have summarised the concerns of academics in relation to methodologies that have been used in workplace wellness program evaluations, that provide some useful insights. These include:

- > **Self-selection**—Employees are given the choice of whether or not to participate in programs, the formation and comparison of randomised groups is not possible, potentially weakening the experimental study design.
- > **Short duration of evaluation**—Many evaluations cover a relatively short period of time (1 or 2 years). Subsequently, it can be difficult to determine whether employees permanently or only temporarily adopt new health behaviours and whether improvements in business outcomes are short lived.
- > **Subjectivity of measures**—It can be difficult to measure productivity in some workplaces. Qualitative measures, where adopted to gauge the effectiveness of wellness programs, do not provide quantifiable evidence and can be considered to be weak.
- > **Diffusion of information**—Employees who participate in wellness programs (e.g. the intervention group) and those who do not (e.g. the control group) often work in the same location. Should the control group change their behaviour according to 'leaked' information, differences between the groups may be diminished and relative changes can become less significant.
- > **Statistical issues**—The types of statistical measures applied to evaluations often assume a normal distribution of the data when, in fact, data may be skewed due to the voluntary nature

of many programs. As such, the results calculated using these measures might lead to erroneous conclusions.

- > **Confounding factors**—Workplace wellness programs are offered at work sites and not in controlled environments. Evidently, there are a number of intervening factors that might explain, to some extent, the results of an evaluation (2008, p.70).

4.5 HEALTH AND WELLBEING TOOLS AND RESOURCES

Some of the guides referred to earlier in this chapter contain a variety of tools and resources to assist in the management and evaluation of a health and wellbeing program.

One example is the resource kit by the Western Australian Premier's Physical Activity Taskforce. The kit is comprehensive and provides a range of tools to assist with implementing and managing a health and wellbeing program in the workplace. Some of the resources available include:

1. Sample Health and Wellbeing Policy
2. Sample Health and Wellbeing Survey
3. Sample Workplace Health and Wellbeing Audit Tool
4. Fact Sheet—Healthy eating in the workplace
5. Fact Sheet—Physical activity in the workplace
6. Fact Sheet—Mental health
7. Fact Sheet—Work life balance.

These can be found at www.dsr.wa.gov.au/workplace

Evaluation tools

www.health.vic.gov.au/healthpromotion/evidence_evaluation/cdp_tools.htm

www.centre4activeliving.ca/workplace/steps/evaluating.html

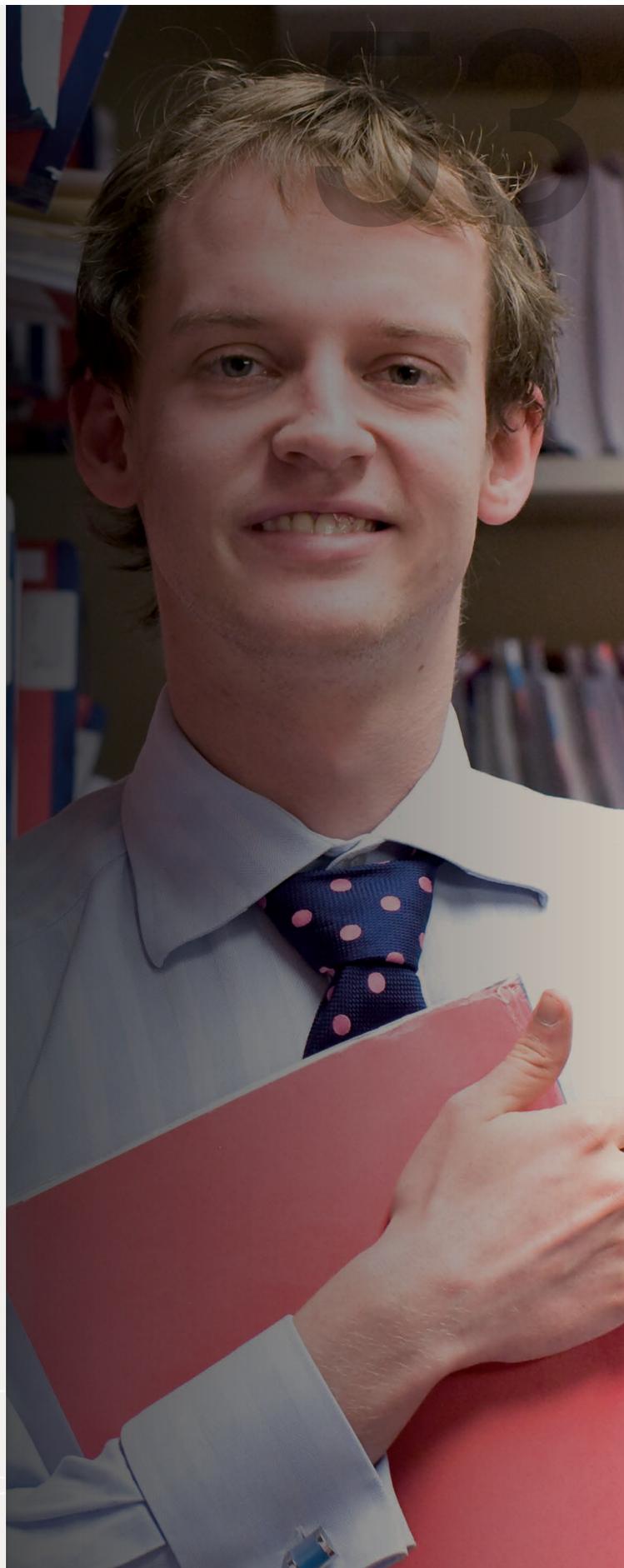
www.centre4activeliving.ca/workplace/steps/evaluating/howtoguide.html

www.thcu.ca/workplace/documents/EvaluationInfoPackFinalWeb.pdf

www.health.vic.gov.au/healthpromotion/downloads/measuring_hp_impacts.pdf

4.6 COMCARE RESOURCES

Comcare has a number of publications relevant to the development and implementation of health and wellbeing programs. Refer to Comcare's website www.comcare.gov.au





5 CHALLENGES

5.1 DIFFICULTIES ASSOCIATED WITH IMPLEMENTING HEALTH AND WELLBEING PROGRAMS

Ackland et al. (2005) identified several common barriers to successful workplace health and physical activity programs including economic pressures, lack of resources, other priorities, difficulties with evaluation, size of the workplace, a lack of participation, lack of time and problems of trust between employees and employers (Ackland et al. 2005, p.13). Their research also provided feedback from service providers in relation to barriers that they commonly experienced in the delivery of workplace health and physical activity (WHPA) programs. These included:

- > **The cost of the program**—Organisational budget restrictions or nil budget allocated for the conduct of WHPA programs. WHPA programs were not prioritised and were seen as an 'optional extra' or a 'luxury item' that could be eliminated when there was a shortage of funds.
- > **Limited management and organisational support**—Lack of understanding by middle and senior management personnel about WHPA programs and their potential impacts/benefits, hence a lack of priority afforded to WHPA programs.
- > **Lack of time**—Linked with priority, lack of time was often cited as a barrier to WHPA implementation. This was especially evident in high risk companies that were focused on high productivity, tight margins, and who tended to minimise the opportunity for staff breaks.
- > **Logistics or lack of basic facilities**—Access to appropriate facilities and infrastructure was a problem for smaller worksites and regional centres where the size and location of the workplace made it difficult to deliver a comprehensive program.

- > **Difficulty in quantifying the impact**—Establishing monitoring and evaluation systems for the accurate quantification of success was difficult when organisations were unwilling to provide accurate data (e.g. use of participation statistics, injury rates, workers' compensation claims and absenteeism records). Concern was also expressed that injury statistics were often misleading and not representative of the true rates.
- > **Going through the motions** – Organisational implementation of a program simply to improve corporate image and industrial relations, where the quality of the WHPA program was not seen as a priority. Service providers indicated that some organisations appeared only interested in 'ticking the boxes' and that creating meaningful change was not seen as important. Another major problem is that some companies do not want to know about individual or endemic problems because they may be obligated to address these problems as part of their duty of care.
- > **Problems with liability and insurance** – Organisational belief that participation in WHPA programs carried the added risk of injury for their workforce.

Ackland et al. (2005) also provide a brief summary of barriers to implementing WHPA programs in two other categories—barriers of the workplace setting; and barriers of the individual (p.67).

The Public Health Agency of Canada highlights motivation and sustainability as two of the biggest obstacles to organisations:

'One of the major challenges organisations face is motivating and sustaining staff commitment to active living interventions. The same can be said for health clubs who have many more members than regular participants. Ultimately, the organisation can only educate and provide the opportunity—it is the employee that must choose a more active lifestyle. However, the organisation can offer incentives that help make active choices easy choices. Sustained communications and education, encouragement, corporate philosophy and behaviour are the critical factors that influence motivation and participation' (Public Health Agency of Canada, 2007—viewed online).

5.2 FURTHER RESEARCH

While there is much discussion about the benefits accruing to both the individual worker and employer from health and wellbeing programs, there is a body of research that also notes that the efficacy of these programs is difficult to gauge given the lack of rigorously evaluated programs. There appears to be a consensus view that the biggest challenge for employers is how to evaluate health and wellbeing programs.

One of the limitations of this review has been that there has been no audit undertaken to document the complete suite of programs that have been trialled or implemented in all Australian workplaces—government and non-government. Without such information, it becomes problematic to reach any conclusion about whether the surge in programs in the workplace is indeed having a positive impact on workers and employers and to what extent that impact can be measured. Comcare could make a positive contribution in this area by considering how it may survey premium paying agencies and licensees to ascertain what programs have been implemented, how they were designed, what outcomes have been achieved, what and how evaluation has been undertaken (if any) and any findings from these programs.

Work is being progressed within the Commonwealth Department of Health and Ageing, under the auspices of the COAG National Partnership Agreement signed in December 2008 by all Commonwealth, State and Territory Governments, to address the rising prevalence of lifestyle related chronic diseases. The Healthy Workers Initiative is one initiative which is focused on using the workplace to deliver preventive health programs and messages and this initiative presents an opportunity for all stakeholders involved to consider how a consistent evidence base for the effectiveness of various activities and programs may be developed (COAG, 2008).

A promising piece of research currently underway is a collaborative 'demonstration project' between the Department of Veterans Affairs (DVA) and the University of South Australia (USA). The project arose from a submission to the Government's Advisory Group on Reform of Australian Government Administration (AGRAGA). The former Prime Minister, the Hon Kevin Rudd MP, announced the formation of an Advisory Group on Reform of Australian Government Administration on 3 September 2009. On Monday 29

March 2010 the Blueprint for Reform was released. The blueprint outlines steps to rejuvenate the Australian Public Service and enable it to serve the government of the day in addressing the challenges facing Australia in the 21st century. Recognising the important challenges over the next 10 years for the public sector as a result of an ageing workforce, the joint DVA/USA project has been designed to look at scientifically evaluating the effectiveness of correcting vitamin deficiency and its impact on decreasing sick leave and increasing effectiveness. In its submission to the AGRAGA (DVA&USA 2009, p.2) it is noted that:

'The approach in DVA has been to support projects that focus on 'wellness' through lifestyle and nutritional advice. This is not new, and similar projects are run on an 'ad hoc' basis throughout the Public Service. However projects, like these, need to be scientifically evaluated, the effectiveness of different approaches compared, and the most successful ones piloted and then instigated across the Public Service. Without evaluation the effective programs cannot be identified and promulgated'.

5.3 WHERE TO NEXT?

One of the most significant findings from this review points to the imbalance in the types of health and wellbeing programs implemented in workplaces, and particularly the lack of rigorous evaluation associated with those programs. As previously stated, there appears to be a wealth of information available on health and wellbeing programs directed at worker 'lifestyle and general health'. Such programs include, for example, employers providing access to a very broad range of fitness and healthy living programs and reinforcing this with promotional material to assist workers to improve their fitness, reduce/quit smoking or alcohol intake and generally improve their personal health. There is also a good amount of information available which endorses the positive benefits arising from many of these programs.

Occupational health and safety or environmental programs comprise physical safety initiatives and interventions geared around ensuring safe workplaces for workers. These are reasonably well addressed in the literature, although this paper has not sought to review their effectiveness.

However, in relation to the other area where health and wellbeing programs can make a significant contribution—those targeting 'organisational practices'—the volume of literature available is not as plentiful, particularly in the area of evaluation outcomes.

The most recent Australian Government Productivity Commission's report highlights the imbalance that exists in addressing psychosocial hazards:

'Given the costs they impose, all jurisdictions give relatively less attention to psychosocial hazards than to physical hazards. All jurisdictions provide guidance material on various aspects of psychosocial health. Victoria and New South Wales provide harmonised guidance on bullying and on fatigue. Only Queensland and Western Australia provide a Code of Practice on bullying. Western Australia and South Australia are the only jurisdictions to have a Code of Practice on working hours, while Western Australia is the only jurisdiction to have a code that addresses occupational violence. Victoria and New South Wales pursue bullying the most vigorously in the courts' (Australian Government Productivity Commission, 2010, p.x).

The link between unaddressed workplace environmental/organisational factors and worker mental health and consequent absenteeism and illness is becoming increasingly recognised. The literature is clear about the catalysts—poor workplace culture, ineffective managers, lack of work satisfaction, work repetition, work overload, lack of work-life balance, conflict with peers and bullying and harassment.

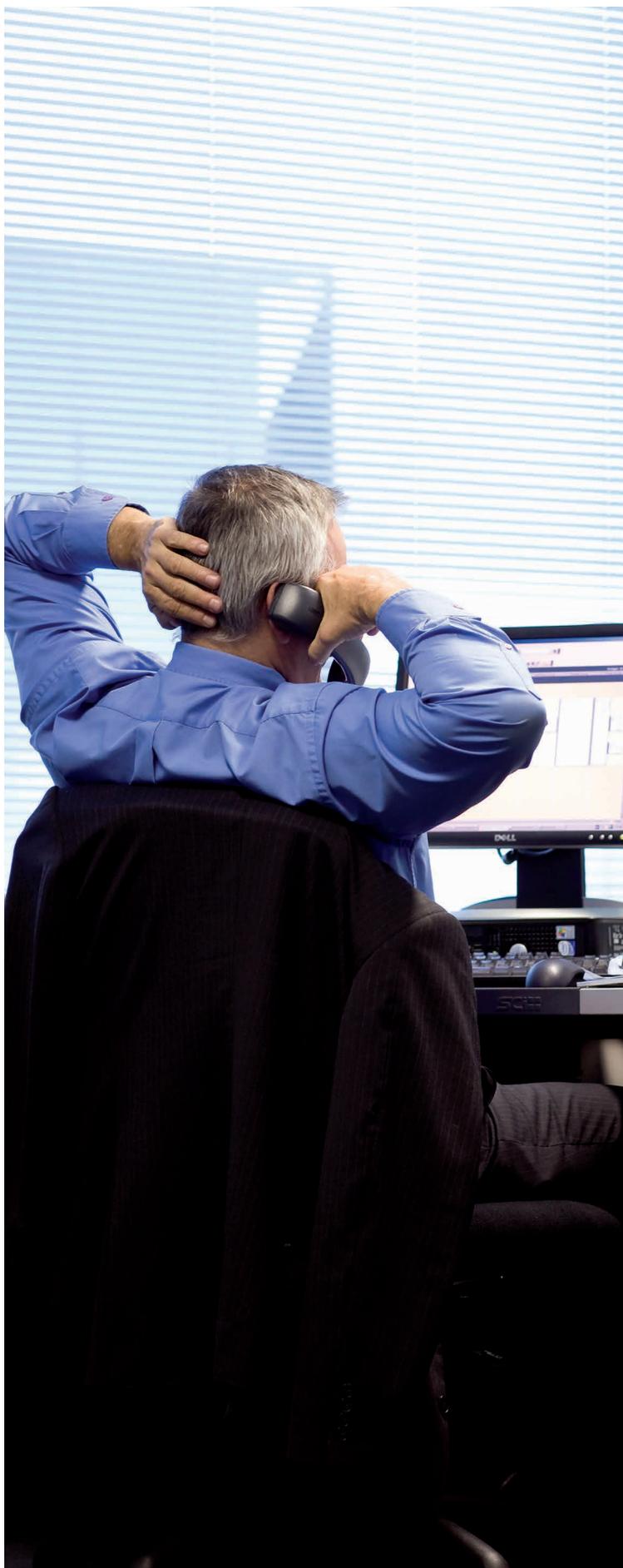
It is time for employers to invest more time and resources into interventions that target workplace factors impacting on the psychological health of workers, in particular the impact that workplace 'content' (what) and 'context' (the organisation's culture) has on the health and wellbeing of their workers.

6 CONCLUDING POINTS



- > Offering a health and wellbeing program is one of many ways an employer can respond to worker and organisational health needs. In recent years there has been a surge in health and wellbeing programs introduced into workplaces.
- > The literature is not unanimous about the strength of evidence that health and wellbeing programs are making a significant difference to the health and wellbeing of Australian workers, nor whether employers are also reaping the benefits. This is in part due to the difficulty in ascertaining whether these programs have achieved what they were designed to achieve. Many programs that have been implemented in the workplace have not been rigorously evaluated, nor have findings been published in other cases. Further, many of the claims relating to the benefits flowing from health and wellbeing programs appear to be anecdotal.
- > Much research has been undertaken which demonstrates the link between a person's health and lifestyle and how chronic health and risky behaviour is impacting on productivity in the workplace (Medibank Private, 2005; Australian Institute of Health and Welfare, 2008).
- > The evidence concerning health promotion in the workplace suggests that programs will only be effective in enhancing the health status of the workforce when the interventions address both individual and environmental influences. This view is echoed by the Commonwealth Government-sponsored National Preventative Health Taskforce's report (2009) which agrees that interventions integrating 'lifestyle' health behaviours and working conditions are more effective in protecting and improving worker health and wellbeing than isolated or single issue programs.

- > While literature commenting on the effectiveness of workplace health and wellbeing programs should be treated with some caution, there is also compelling evidence suggesting that there are real benefits from health and wellbeing programs. There is no disputing the medical evidence that interventions aimed at tackling some of the causes of chronic health issues arising from behaviours such as smoking, alcohol, unhealthy diets and sedentary behaviour can improve the health and the quality of life of individuals. Workplaces have a role to play in promoting these endeavours.
- > The literature indicates that it is much easier to rigorously evaluate the benefits flowing from worker 'health and lifestyle' programs than to evaluate the benefits flowing from 'organisational and environmental' programs. Weight loss can be measured, as can improvements in blood pressure and flexibility, and of course smoking cessation can be identified.
- > It is far more difficult to rigorously evaluate the benefits flowing from organisational programs such as cultural change initiatives or leadership/management training programs, or programs addressing bullying and harassment that give rise to stress and psychological injury in the workplace. This would explain why the benefits flowing from organisational programs are under-represented in the literature.
- > Future research should target supporting employers to invest more time and resources into focussing on interventions in the workplace that target workplace factors directly impacting on the psychological health of workers, in particular the impact that workplace 'content' (what) and 'context' (the organisation's culture) has on the health and wellbeing of their workers.
- > Ideally a risk assessment should take place prior to the implementation of a health and wellbeing program. A risk assessment will determine where interventions need to be targeted, as well as capturing the input and needs of workers.
- > Health and wellbeing programs should be part of a long-term OHS plan.
- > Health and wellbeing programs may help improve worker and organisational health provided they are designed well, monitored closely and the results are evaluated.
- > Evaluation is an essential component of any health and wellbeing program and ongoing evaluation must be built into any program from its inception.
- > There appears to be a consensus view that the biggest challenge for employers is how to evaluate health and wellbeing programs.
- > There is an enormous amount of literature in relation to what might be described as 'best practice' guidance in planning, design, implementation and evaluation of health and wellbeing programs that can assist employers in developing health and wellbeing programs.



Comcare is considering a number of activities arising from this literature review which will support health and wellbeing in the workplace.

For more information please contact Comcare on 1300 366 979.



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APPENDIX A—NATIONAL PARTNERSHIP AGREEMENT ON PREVENTATIVE HEALTH (P.6)

HEALTHY WORKERS

Initiative—States and Territories funded to facilitate delivery of healthy living programs in workplaces:

- (a) focusing on healthy living and covering topics such as physical activity, healthy eating, the harmful/hazardous consumption of alcohol and smoking cessation
- (b) meeting nationally agreed guidelines for these topics, and including support for risk assessment and the provision of education and information
- (c) which could include the provision of incentives either directly or indirectly to employers
- (d) including small and medium enterprises, who may require support from roving teams of program providers
- (e) with support, where possible, from peak employer groups such as chambers of commerce and industry.

Initiative—Commonwealth to develop a national healthy workplace charter with peak employer groups, to conduct voluntary competitive benchmarking, supporting the development of nationally agreed standards of workplace based prevention programs, and national awards for healthy workplace achievements. Commonwealth, in consultation with the States and Territories, may consider taking responsibility for national employers in the future.

www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_preventive_health.pdf



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