



# move europe

A Campaign for the Improvement of  
Lifestyle-related Workplace Health  
Promotion in Europe

## BUSINESS REPORT





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2009

### Project Team:

Coordination of the project:

University of Perugia/Italy: Giuseppe Masanotti

Members:

BKK Bundesverband/Germany: Gregor Breucker, Reinhold Sochert

Oberösterreichische Gebietskrankenkasse/Austria: Elfriede Kiesewetter

Prevent/Belgium: Karla Van den Broek

TNO/The Netherlands: Robert Gründemann, Anja Dijkman

The Romtens Foundation/Romania: Theodor Haratau

Editors: Heinz Leitgöb, Sarah Sebinger

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# Foreword

The ENWHP was formally established in 1996, and since this time it has been at the leading edge of developments in European workplace health promotion. By various means, it developed a joint framework for policy development and good practice implementation. In particular, it established a European umbrella concept for WHP as part of an integrative and comprehensive public health policy. Key elements of this approach include the combination of lifestyle improvement measures and change interventions to provide supportive organisational conditions for health and a strong focus on interdisciplinary approaches. The ENWHP is an informal network of national occupational health and safety institutes, public health, health promotion and statutory social insurance institutions. Through the joint efforts of all its members and partners, it aims to contribute to improving workplace health and well-being and reducing the impact of work-related ill health on the European workforce. Over the past decade, ENWHP has carried out a number of important Europe-wide initiatives which established workplace health promotion (WHP) as a field of action for public health on the European and national levels. There is now a growing awareness among all decision-makers that investments in promoting workplace health yield positive benefits for firms, business, health improvements for citizens and the efficiency of national welfare systems. Based on evidence and past experiences, the ENWHP launched the Move Europe campaign with the financial support of the European Commission (DG SANCO). This campaign set new quality standards for Good Practice in behaviour-related WHP and identified complying models, and is disseminating these results throughout Europe. The campaign was active for two years and involved twenty-nine European countries. Under the leadership of the University of Perugia, a project consortium has been created, consisting of Italy, Germany, Belgium, Romania, the Netherlands and Austria. Moreover, the campaign had the aim of promoting awareness of the benefits of implementing WHP in the workplaces, particularly focusing on the following four fields of life-style related WHP: physical exercise, smoking prevention, nutrition and mental health. Special attention was placed on the field of physical exercise.

The campaign's main concern was to create awareness of the importance that "healthy lifestyles," such as regular physical activity, a balanced diet, abstention from smoking, etc..., have on the maintenance of a state of psycho-physical equilibrium of each individual. Chronic diseases, many associated with lifestyle behaviours, are expected to rise. However, EU estimates show that if people can remain healthy as they live longer, the increase in healthcare spending due to ageing would be halved. This means that we all must focus our efforts on helping citizens age in good health. We must maximise Healthy Life Years by taking initiatives to promote health and prevent diseases throughout the lifespan. According to the WHO, 86% of the deaths, 77% of the loss of Healthy Life Years and 75% of health expenses in Europe are caused by cardiovascular illnesses, cancer, chronic respiratory illnesses and mental health problems.

What all these diseases have in common are modifiable risk factors like: tobacco smoke, overweight and obesity, the low consumption of fruit and vegetables, the excessive intake of fats, and the low level of physical activity.

Acting on these factors would bring an important reduction in the incidence of the aforementioned diseases. According to several studies based on evidence conducted in the USA, Canada and Europe, the workplace seems an ideal place for the success of preventive strategies for the improvement of lifestyles. This has been recognized at the European level; in fact, the workplace has recently been declared an “important field of action for the public health activities”. Indeed, the promotion of health at the workplace is not confined to the business boundaries; it also produces remarkable effects on the health levels of the families and the communities. Besides being a public health issue, the problem of chronic-degenerative diseases also constitutes an interest for the productive world, if we consider the increase of absenteeism and turnover, as well as lower productivity. Therefore, investing in correct lifestyles provides a double payback, economically and in general health terms. In fact, a possible tool has been developed in conjunction with the Corporate Social Responsibility policy in order to rank firms – the Dow-Jones Sustainability Growth Index (DJSGI). Among its various parameters, this tool also evaluates how the firm protects and promotes the health of its workers.

The numbers of this campaign confirm the working world’s interest: In two years, 35,215 contacts have been recorded on the dedicated websites - 5,761 in Italy alone. A total of 2,548 enterprises in Europe asked to be certified and 125 events were realised (seminars, workshops, conferences, round tables, workshop, information days): 2 at the European level, 40 at the national level and 83 at the local level. So, it’s time that all of us – occupational and public health experts, international, national and local politicians, employers and employees associations, governmental and non-governmental organisations – worked together towards reaching the common goal: a healthy and sustainable Europe.

Giuseppe Masanotti MD, PhD  
Projekt Leader



Heinz Leitgöb

# 1. Introduction



# 1. Introduction

## 1.1. The European Network for Workplace Health Promotion

Since its formal founding in 1996, the European Network for Workplace Health Promotion (ENWHP) has become one of leading European institutions in the field of Workplace Health Promotion (WHP) in Europe and can be characterised as an informal network consisting of national occupational health and safety institutes, as well as public health, health promotion, and statutory social insurance institutes. A continuous increase in the number of member states has taken place since the ENWHP was established. Particularly the increasing relevance of Eastern European countries had already been recognized before they joined the EU. The ENWHP is currently made up of 29 members with so-called National Contact Offices (NCO), an Associated Member (Canada) and Network Partners (permanent partners and other partners)<sup>1</sup>.

Furthermore, the ENWHP has a series of collaborative partners who are tied into the work and activities of the network and who have access to the gathered information. The European Commission (EC) has proven to be a permanent partner, primarily the Directorate General for Health and Consumer Affairs (DG Sanco). Moreover, the European Foundation for the Improvement of Living and Working Conditions and the European Agency for Safety and Health at Work can be added to this list. Besides these partner organisations, 23 national networks<sup>2</sup>, which were mainly established in the course of a two-year project (2003-2004) in the member states, meanwhile exist. The goal of these national networks should be to increasingly integrate stakeholders and interested persons/organisations on national and regional levels, thereby guaranteeing a lively exchange of information within and between the participating countries. The implementation of WHP infrastructures helps to deepen the transfer of knowledge throughout Europe and encourages further dissemination of WHP in Europe.

By developing the “Luxembourg Declaration<sup>3</sup>” in 1997, the ENWHP could, for the first time, define a European-wide, unified understanding of WHP that is interdisciplinarily applied and promotes an active inclusion of employees in the WHP agendas. Of central relevance in this respect is the holistic approach, which is based on the combination of measures for positively influencing individual health behaviour, on the one hand, and the daily working conditions (working environment), on the other hand. This focus is manifested in the joint initiatives<sup>4</sup> of the ENWHP, which have been continuously implemented since 1999 and yet cover a wide thematic area: The development of quality criteria as well as the identification of WHP success factors (1997-1999); WHP in small and medium-sized enterprises (1999-2000); WHP in the public administration sector (2000-2002); implementation of infrastructures to promote public health (2002-2004); healthy work in an ageing Europe (2004-2006); and WHP in an enlarging Europe (2005-2007).

## 1.2. Move Europe - A Campaign for the Improvement of Lifestyle-Related Workplace Health Promotion in Europe

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In April 2006, the seventh trans-European initiative of the ENWHP, the “Move Europe” project, was started. Under the leadership of the NCO from Italy (ISPESL/University of Perugia), a total of 25 member countries participated in the three-year campaign aimed at the dissemination of good practices in the field of lifestyle-oriented WHP. The relevance of the presented issues are clear in the face of the worldwide increase in prevalence rates of chronic diseases (heart and other organ diseases, strokes, diabetes, cancer, chronic respiratory diseases, neurological diseases, depression, ...) Thus, the WHO estimates that without specially aimed measures, the number of deaths related to chronic diseases will increase worldwide by 17 percent between 2005 and 2015 (cf. WHO, 2005a: 34). The following table (Table 1) illustrates the estimated disease burden in DALYs (disability adjusted life years<sup>5</sup>), as well as the estimated number of deaths due to the main chronic (non-communicable) diseases for the WHO Europe Region (52 countries) for the year 2005. These diseases cause 86 percent of all deaths and 77 percent of the disease burden.

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1 See: <http://www.enwhp.org/index.php?id=14> (Status: 10/12/2008)

2 Basic information about the national networks is available at:  
<http://www.enwhp.org/index.php?id=15> (Status: 10/12/2008)

3 The declaration was updated in June 2005 and January 2007. The current version is available at:  
[http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Luxembourg\\_Declaration.pdf](http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Luxembourg_Declaration.pdf)  
(Status: 10/12/2008)

4 A brief description of the six common ENWHP initiatives that have been realised so far can be found at:  
<http://www.enwhp.org/index.php?id=13> (Status: 10/12/2008)

5 “The most common widely-used summary measure of the burden of disease is the disability adjusted life year (or DALY), which combines the number of years of healthy life lost to premature death with time spent in less than full health. One DALY can be thought of as one lost healthy year of life” (WHO, 2005: 39).

**Table 1.1: Burden of disease and deaths from non-communicable diseases (NCD) in the WHO European Region, by cause (2005 estimates)**

| Group of causes<br>(selected leading NCD) | Disease burden<br>DALYs (%) | Deaths<br>(%) |
|---|-----------------------------|---------------|
| Cardiovascular diseases                   | 23                          | 52            |
| Neuropsychiatric conditions               | 20                          | 3             |
| Cancer (malignant neoplasms)              | 11                          | 19            |
| Digestive diseases                        | 5                           | 4             |
| Respiratory diseases                      | 5                           | 4             |
| Sense organ disorders                     | 4                           | 0             |
| Musculoskeletal diseases                  | 4                           | 0             |
| Diabetes mellitus                         | 2                           | 2             |
| Oral conditions                           | 1                           | 2             |
| <b>All NCD</b>                            | <b>77<sup>6</sup></b>       | <b>86</b>     |
| <b>All causes</b>                         | <b>100</b>                  | <b>100</b>    |

Source: WHO, 2006: 1

As the table shows, only a few diseases are responsible for the majority of the disease burden, resp., for the number of deaths in Europe: Ranked first are cardiovascular diseases, which cause more than half (52%) of all deaths in the European WHO member states, followed by cancer (19%), which is the second highest killer. In the main axis, the disease burden is distributed into cardiovascular diseases (23%), as well as into neuropsychiatric conditions (20%) and cancer (11%). For cardiovascular diseases and cancer, the proportion of deaths lies above the share of DALYs, which speaks for a shorter period of time between the outbreak of the diseases and the onset of deaths, as well as the outbreak of diseases at an advanced age (especially with cardiovascular diseases). While neuropsychiatric conditions only have lethal consequences to a very small extent, the average duration of the sickness, however, must be considerably higher and the onset of the disease is, on average, earlier. Generally, it does not hold true that chronic disease deaths are restricted to older people. Approximately 16 million people worldwide under the age of 70 die of chronic diseases every year. If one assumes that in 2005 about 35 million deaths worldwide were due to chronic diseases, more than 45 percent of all cases are under 70

at the time of death (cf. WHO, 2005a: 37). Consequently, the point of time for the planned interventions has to already be set in significantly earlier phases of life.

Nowadays, the causes for most of the chronic diseases mentioned are well-known. “The most important modifiable risk factors are: (1) unhealthy diet and excessive energy intake; (2) physical inactivity; (3) tobacco use. These causes are expressed through the intermediate risk factors of raised blood pressure, raised glucose levels, abnormal blood lipids (...), and overweight (...) and obesity. The major modifiable risk factors, in conjunction with the non-modifiable risk factors of age and heredity, explain the majority of new events of heart disease, stroke, chronic respiratory disease and some important cancers.” (WHO, 2005a: 48)<sup>7</sup>.

Accordingly, the focus of Move Europe lies on the identified, basically preventable main risk factors of chronic diseases: (1) smoking prevention, (2) nutrition, (3) physical activity, and (4) combating work-related stress mental health. These partially have a significantly negative influence on the working life/working ability of employees. At the same time, however, the workplace/the company is a central setting for promoting health in general and for developing health-oriented lifestyles in particular.<sup>8</sup> Furthermore, the majority of persons in the company environment have reached stages in life, resp., ages in which health promoting and lifestyle-related interventions can be made in sufficient time so that their positive effects can still fully unfold.

The urgency as well as the relevance of the broad-ranged initiation of measures to curb the central risk factors for chronic diseases can be recognized in the current developmental tendencies in Europe:

(1) **Smoking:** Smoking represents the main cause of premature mortality within the EU. In 2002, about 1.6 million people died from the consequences of smoking (cf. WHO, 2007: 24). Over time, the mortality rate of 35- to 69-year-olds in the EU 25 countries rose from 5 percent in 1975 to over nine percent (1990) to 12 percent in 2000 (Peto et al., 2006<sup>9</sup>). In contrast, the overall adult daily smoking prevalence in Europe has stabilized in the last several years: While it amounted to 28.8 percent in 2002, 28.6 percent was recorded in the year 2005.

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6 The deviation of 77 percent for all NCDs from the sum of the individual NCDs is probably the result of rounding errors.

7 Compare the 20 leading influenceable risk factors for the outbreak of chronic disease: WHO, 2002: 82.

8 [http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Luxembourg\\_Declaration.pdf](http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Luxembourg_Declaration.pdf) (Status: 10/12/2008)

9 Available at: <http://www.heartstats.org/temp/ESspFigsp4.2aspweb08.xls> (Status: 17/12/2008)

The noticeably increasing public attention in European countries regarding smoking prevention and the protection of non-smokers cannot solely be ascribed to the enactment and ratification of restrictive tobacco laws and national campaigns. The 2007 EU Commission Green Paper “Towards a Europe Free from Tobacco Smoke: Policy Options at EU Level,<sup>10</sup>” as well as the “WHO Report on the Global Tobacco Epidemic 2008,<sup>11</sup>” represent the will and effort of supranational organizations to decisively take steps against tobacco consumption as a significant risk factor for chronic diseases.

(2) **Nutrition:** Overweight [Body Mass Index<sup>12</sup> (BMI)  $\geq 25\text{kg/m}_2$ ] as well as the increasing degree of obesity (BMI  $\geq 30\text{kg/m}_2$ ) represent long-term risk factors for cardiovascular diseases, high blood pressure, strokes, Type 2 diabetes, respiratory diseases, arthritis and certain types of cancer. The mean development of overweight and obesity in the 27 EU member states from 2002 to 2010 can be drawn from Table 2: The increasing rates of overweight and obese persons of both sexes in the general population (age: 15 and older) can be observed over time.

**Table 1.2: Mean estimates and projections of the prevalence of overweight and obesity in the 27 EU member states from 2002 to 2010 in percentages (Persons 15 or older)**

| Sex   | Overweight (%) |       |       | Obesity (%) |       |       |
|-------|----------------|-------|-------|-------------|-------|-------|
|       | 2002           | 2005  | 2010  | 2002        | 2005  | 2010  |
| Women | 47.9%          | 48.8% | 50.3% | 15.9%       | 16.7% | 17.9% |
| Men   | 54.9%          | 56.2% | 57.8% | 13.8%       | 14.1% | 15.8% |
| Total | 51.4%          | 52.5% | 54.1% | 14.9%       | 15.4% | 16.8% |

Source: WHO, 2005b: 66ff; own calculations

While the mean estimated share of overweight persons will increase from 51.4 percent to 54.1 percent between 2002 and 2010, a rise from 14.9 percent to 16.8 percent is expected for the group of obese persons. Apart from these prognosticated developments, the degree that has already been reached remains a reason for concern: More than half of the adult population within the EU is overweight and almost one-sixth suffers from obesity.

Combined with inadequate nutrition due to the insufficient consumption of vitamins, minerals and trace elements, the overconsumption of food will significantly contribute to the further spreading of chronic diseases in the future. In order to decisively counteract these developments, efforts have already been undertaken by the EU Commission “to set out an integrated EU approach to contribute to reducing ill health due to poor nutrition, overweight and obesity” (Commission of the European Communities, 2007: 2)<sup>13</sup>.

(3) **Physical activity:** Physical activity and agility are associated with a healthy and long life. Regular movement generally improves glucose metabolism, reduces the amount of body fat and lowers blood pressure. A sedentary lifestyle resulting out of restricted physical activity possibilities in the course of gainful employment, as well as inactive leisure time behaviour, thus correlates often with the occurrence of overweight/obesity, a performance-reduced cardiovascular system, a restricted lung functionality, etc., and can therefore be regarded as further central risk factors for chronic illnesses such as cardiovascular diseases, diabetes or certain types of cancer.

According to the multinational survey Eurobarometer 2006 “Health and Food”, 59 percent of the working population within the EU 25 countries have little or no physical activity during their gainful employment in a typical working week. In the area of leisure time activity, this holds true for 57 percent of the population (cf. TNS Opinion & Social, 2006: 59ff). Hence, it can be concluded that on the mean, more than half of the working population in the EU 25 countries are, aside from the time-intensive areas of living, more or less physically inactive. Besides the direct consequences of the lack of motion, these persons are, to a large extent, exposed to other risk factors like overweight/obesity as indirect consequences of insufficient physical activity.

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10 Available at: [http://ec.europa.eu/health/ph\\_determinants/life\\_style/Tobacco/Documents/gp\\_smoke\\_en.pdf](http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/Documents/gp_smoke_en.pdf) (Status: 17/12/2008)

11 Available at: [http://www.who.int/tobacco/mpower/mpower\\_report\\_full\\_2008.pdf](http://www.who.int/tobacco/mpower/mpower_report_full_2008.pdf) (Status: 17/12/2008)

12 “The prevalence of overweight and obesity is commonly assessed using body mass index (BMI), a height/ weight formula with a strong correlation to body fat content” (WHO, 2002: 60).

13 See also the aforementioned paper: Commission of the European Communities, 2005

(4) **Combating Stress/Mental Health:** According to the Fourth European Working Conditions Survey (EWCS) 2005, 22.3 percent of the working population in the EU 27 countries see themselves confronted with work-related stress. Thus, after backache (24.7%), muscular pain (22.8%) and fatigue, stress is ranked fourth on the list of work-related effects on the body (cf. European Foundation for the Improvement of Living and Working Conditions, 2007: 62). “Employment is beneficial to physical and mental health. Maintaining good mental health in the workplace can also help boost business productivity and at the same time help the EU achieve its Lisbon agenda goals for economic growth and global competitiveness. It can also contribute to general population health goals through health promotion activities. The workplace can provide a healthy culture and environment that is psychologically supportive to the workforce.” (McDaid (Ed), 2008: 5)<sup>14</sup>.

The outlined developments of the four risk factors that are the main foci of “Move Europe” illustrate the relevance and urgency of the project. The consequences of these lifestyle-oriented health problems are manifold and - aside from the individual level - reach far into the company working world as well as on the levels of national economies and the European economic area: Illness-related absences, work disability and early retirement have a negative effect on the productivity and flexibility of companies and necessitates the provision of massive social benefits. With its Lisbon Agenda, the European Union committed itself to the goal of becoming the most competitive and dynamic knowledge-driven economy in the world. Achieving this goal requires well-motivated and healthy employees.

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14 Available at: <http://www.ec-mental-health-process.net/consensus.html> (Status: 07/01/2009)

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Heinz Leitgöb

## 2. Goals and Key Data of the Project

## 2. Goals and Key Data of the Project<sup>1</sup>

The following chapter should provide a short insight into the goals of the “Move Europe” project, as well as the project procedure. First of all, the goals are defined (2.1); subsequently, the participating countries as well as the project timetable are presented (2.2); the processing of the selective central findings of the project evaluation (2.3) concludes this chapter.

### 2.1. Project Goals

The main goal of the project is to contribute towards improving the health status of the citizens in the European Union by disseminating quality- and evidence-based lifestyle-related health promotion at the workplace. This general goal includes convincing European companies and other organisations to invest in programmes which help to improve lifestyle-oriented behaviour in Europe, with a special focus on the following four fields of intervention: “Physical Exercise”, “Smoking Prevention”, “Nutrition”, and “Combating Stress/Mental Health/”. An accompanying goal is to raise more awareness among stakeholders, companies and the general public about the needs and benefits of WHP in the defined target fields, as well as to foster exchange of experience in the field of lifestyle-related WHP. In this regard, the simplification of cross-border knowledge transfer, particularly between states with a further advanced status and those trailing behind, is of fundamental interest. Finally, the general improvement of the practice and quality of (lifestyle-related) WHP is a further fundamental, integral project goal.

In addition to this general direction of the project, further specific goals that should be realised in the course of the project were formulated:

- (1) To develop expertise of quality approaches and a concept for a quality scheme in the field of lifestyle-related WHP.
- (2) To develop instruments and guidelines for the assessment of good practice examples.
- (3) To develop and implement an advocacy strategy which shall lead to efficient alliance building and to a successful recruitment and integration of external expertise in order to increase visibility, as well as the number of supporting multipliers and dissemination channels.
- (4) To attract companies from all countries to participate in the campaign by assessing their WHP activities.
- (5) To develop an online-generated questionnaire for self-assessment that will challenge organisations to self-reflect on WHP and lifestyle topics.
- (6) To collect Models of Good Practice (MOGP) suited for transfer in other companies and countries in all 26 participating countries.
- (7) To create conference platforms for knowledge exchange.

The primary focus is on a participative approach that should attract companies from all 26 countries to actively take part in the project. Companies get involved through the development and provision of a quantitative online questionnaire (Company Health Check) containing the following group of themes: firstly, the current extent of the general integration of WHP into corporate policy and culture was queried; further, the focus of the questionnaire was placed on the ascertainment of company-specific activities in the four core aspects of the project: smoking prevention, nutrition, physical activity, and mental health. The processing, structure and content-related composition of the survey tools are to be thoroughly described in Chapter 3 (The Description of the Developed Quality Criteria and the Company Health Check). These questionnaires served as a self-assessment tool which should be provided to the companies for a self-assessment of the activities they already conducted in the area of lifestyle-oriented WHP, on the one hand, and should serve the project as a source for the gathering of important information and data for implementing the tasks tied to it, on the other hand. In this way, through participating in the survey, contacts (e.g., on-site visits) with the relevant companies were made by the respective project coordinator in the individual countries, with the goal of obtaining a comprehensive picture of the companies regarding their lifestyle-oriented WHP activities. In further consequence, this information served to identify MOGPs, meaning these companies that can be exemplified as role models in at least one of the four areas relevant to the project. Following the MOGP selection process on a national level, these companies underwent a qualitative content analysis in order to be able to extract the essence of the successful practices implemented so far. Results of this analysis will be presented in detail in Chapter 4 (Main Results of the Company Health Check). Moreover, descriptions of all the MOGPs collected during the course of this project can be found on the enclosed CD-ROM.

On the basis of the analysis results, as well as under consideration of the existent literature, a Good Practice Guide for Lifestyle-Oriented WHP that should be understood as a guide, resp., orientation aid to facilitate the future implementation and successful execution of WHP in the relevant topic areas will be developed in a next step. In this regard, the transferability of successful strategies of MOGPs to other companies and countries will be considered. The declared goal was to design the recommendations so that they can be applied in all participating countries, regardless of the existing national diffusion rate of WHP, as well as its existing complexity of application. Chapter 6 (Company Recommendations) of the available report illustrates this Good Practice Guide.

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1 I want to thank Reinhold Sochert and Theodor Haratau for their helpful comments.

In addition to the development of recommendations for companies, the results of the project will be carried over to a series of policy recommendations that are primarily aimed at the national level of countries and are addressed to political decision makers as well as to shareholders in the WHP area. Again, the recommendations are formulated in such a way that they can serve all participating countries, and especially the new member countries, as a basis for policy development in the WHP field. The policy recommendations are processed in Chapter 7 and conclude this report.

## 2.2. Participating Countries and the Project Timetable

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According to the execution of the project goals, the 26 ENWHP countries participating in “Move Europe” shall first be listed in alphabetical order: Austria, Belgium, Bulgaria, Cyprus, the Czech Republic, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Romania, Slovenia, Slovakia, Spain, and the United Kingdom.

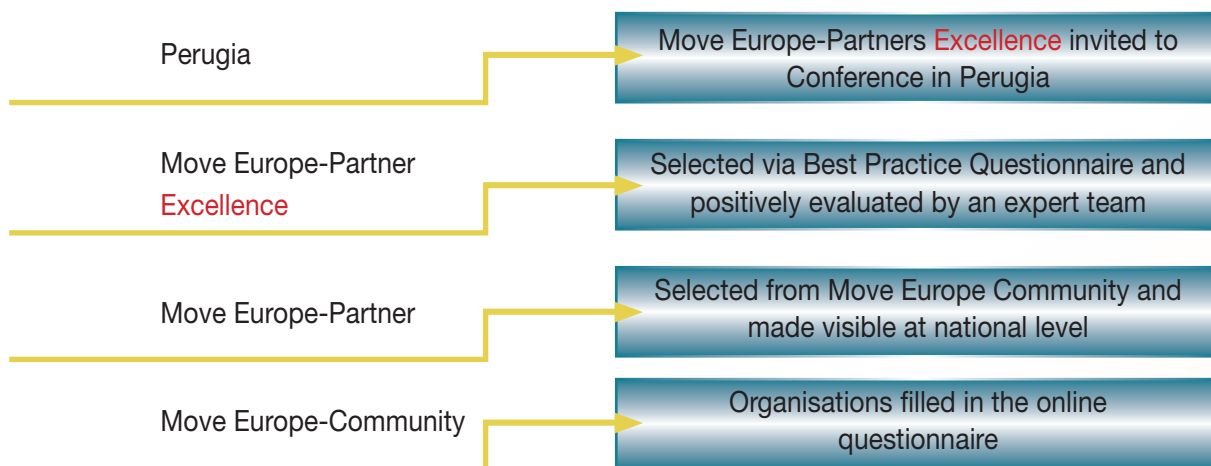
Moreover, the chronological execution of the project shall be outlined in order to provide the reader with an insight into the project activities to attain the previously mentioned goals. First of all, the individual phases of the project are broadly described:

- (1) Based on solid research of existing literature on lifestyle-related WHP and existent quality models in the health field, as well as in the area of occupational safety and health (OSH), a high-level quality standard (“quality model”) was developed within the first 10 months in cooperation with external experts. This quality model resulted in the following tools: A questionnaire for self-assessment (Company Health Check) and a Good Practice Tool for “auditing” companies, called the “Best Practice Questionnaire”, which can be used as a self- assessment tool as well. One criterion incorporated within this guide for selecting MOGPs considered the transferability to other companies and countries.
- (2) In the second phase, the main interest was focused on the construction and expansion of networks and contacts, which should lead to a linking of national interest groups, stakeholders and expert groups into the project and should significantly contribute to the increasing importance of “Move Europe”. On the basis of a gradual partnership model – among other things, by holding so-called open meetings in each participating country – relevant stakeholders and experts from the four lifestyle fields were convinced to actively take part in the project and to let their experiences and competences flow into it. At the kick-off meeting in Brussels in March 2007, Phase 1 of the developed quality standards and the survey tools were presented and afterwards discussed and adapted with pertinent

experts and stakeholders on a European level. Moreover, the established contacts and networks should contribute to widening the scope of cooperation partners, increasing the operating range of “Move Europe” and thereby improving the penetration degree of the project on a national level.

- (3) After the online activation of the prepared Company Health Check, the companies were invited by the National Contact Offices (NCOs) to conduct a self-assessment concerning the extent of existing intra-company lifestyle-oriented WHP and to take part in the survey. According to the campaign concept, the participating countries oriented themselves through the following step-by-step framework to identify MOGP (Move Europe-Partner Excellence):

Figure 2.1.: Framework for MOGP identification



### Move Europe-Community

Every company/organisation which filled in the Company Health Check (CHC) belongs to the wider “Move Europe-Community” and receives the “Move Europe”/ENWHP newsletter. These organisations simply join the campaign and are informed about the progress of the campaign.

### Move Europe-Partner

Move Europe partners are appointed at the national level. There are different ways in place to do so. Several countries (e.g., Austria, Czech Republic ...) count those companies that have achieved at least a certain score (e.g., 70 points or more) in the CHC and are validated

by a phone call or similar easily manageable measures among this group. Other countries (e.g., Germany, the Netherlands ...) insist on having the companies sign the Luxembourg Declaration on Workplace Health Promotion, and providing company logos, as well as a short description of the WHP measures.

### Move Europe-Partner Excellence

The next step is to identify Move Europe-Partner Excellence (Models of Good Practice) in each participating country of the Move Europe-Partners group. This will be supported by the aforementioned “Best Practice Questionnaire”, which can be used as a self-assessment tool or as an instrument for an “auditor” from the National Contact Office of the respective participating country. Based on the information gathered via the “Best Practice Questionnaire”, an expert or a jury conducts an evaluation of the Move Europe Partners, resulting in the identification and selection of MOGPs. The evaluation contains two sets of criteria: Quality criteria (determining the quality of the company case) and transferability criteria (determining if a company case can be transferred or not).

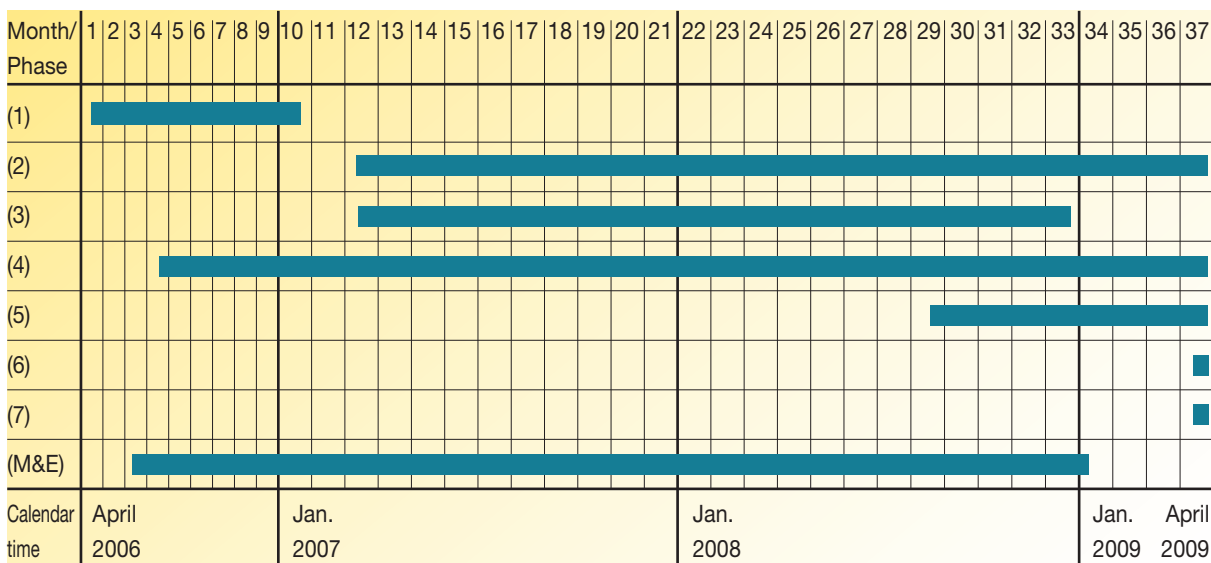
### Perugia Conference

See (7) mentioned below.

- (4) At the same time, marketing and public relations instruments that should contribute to the added value for the companies participating in the initiative and increase the awareness level of the whole project were developed. In this context, all information texts and press materials will be translated and adapted to the needs of the NCOs. A continuous evaluation of the previous project phases, which shall be more precisely explained, will be simultaneously conducted.
- (5) The results, resp., findings of the “Move Europe” project were carefully documented and recorded in the available report.
- (6) During the final conference in April 2009 in Perugia, the project results will be presented. Moreover, two outstanding MOGPs from each country will be nominated and given the opportunity to present their (lifestyle-oriented) WHP strategies at the conference. Above and beyond that, the conference provides companies with the possibility to network with other companies to exchange information and knowledge, as well as to extend contacts to present stakeholders and experts on a European level.
- (7) Towards the end of the project, resp., after the project has been completed (key word: sustainability), it should be assured that the obtained results, resp., findings will be accordingly discussed and disseminated. In this respect, it is considered vitally important that the country-specific consequences targeted to the special needs of the respective participating countries will be derived from the general results, such as the company guidelines and policy recommendations.

The following Figure 2.2. should provide the reader with a graphical overview of the realised project course and a chronological classification of the just described general project steps. As can be inferred from the diagram, overlaps between the individually named project phases have occurred, resp., several central activities are being conducted at the same time.

**Figure 2.2: Approximate timetable of the “Move Europe” project**



**Brief description of the individual project phases:**

- (1) Project Commencement / Development of Quality Criteria and Assessment Instruments
- (2) Introduction and Critical Discussion of the Developed Assessment Tools / Establishment of International Contacts and Partnerships
- (3) Collection of Good/Best-Practice Examples for Lifestyle-Related WHP
- (4) Development and Implementation of an Advocacy and PR Strategy
- (5) Writing of the Final Report
- (6) Final Conference of “Move Europe”
- (7) Application of the Attained Results on a National Level
- (M&E) Monitoring and Evaluation of the Project



### 2.3. Monitoring and Evaluation of the Project

Move Europe is the ENWHP's first project in which a structured evaluation as requested by the funding institution DG SANCO has been attempted, with all its subsequent evaluation activities being performed by a member of the consortium which coordinated the project. At the time the project had been designed, and further on when its work plan was decided upon, the evaluation the consortium had agreed upon consisted of two main components: process evaluation (monitoring) and impact evaluation considered especially at the national level (seen as a participant-oriented approach, with participants being represented by the companies participating in the campaign). These two approaches were designed after a careful assessment of the available resources had been made, and, most probably, few other evaluation approaches would have been necessary and interesting to perform. In addition to these two approaches, a major intention was to get an insight into what extent Move Europe was acknowledged by the general European Public Health community at the European level.

The project embarked on a single strategy of intervention pursuit and the chosen one was the Health Communication strategy, whose characteristics are clearly defined by two of the project objectives – raising awareness among stakeholders and companies, and fostering the exchange of practices. The other two objectives, much more oriented towards changing behaviours, relied a lot on the existence of companies already implementing WHP programs, and therefore fostering actions aimed towards the four topics of the project (smoking prevention, healthy eating, active living through promoting physical exercise and mental health/stress). In this sense, the aim of these two objectives were rather to reinforce and conserve the existing good behaviours of the management of companies which were/are already investing in the health of their employees beyond the regulatory enforced measures.

One could ask whether a multiple strategy of intervention program couldn't have been more effective rather than a single strategy of intervention program but the scale of the program precluded it, since the required resources for moving from communication to communication and education would have been major. However, the obstacle consisting of the necessity to have additional educational activities besides the communication events (through training / panel discussions / roundtable meetings), was overcome in several countries, especially those where the National Contact Office (NCO) of the ENWHP was holding a standing position in terms of education within the public health and occupational health and safety communities.

Nevertheless, multiple communication channels were used for the pursued strategy, such as Intrapersonal channels (individual meetings of the experts involved in the project

both at national and European level), interpersonal channels (department staff as well as other departments in the partner institutes holding the position of NCO), organizational channels (newsletters, bulletins, already existing national/regional campaigns), and mass media channels– only few. The results attained by various countries in communicating the message of the campaign at the national level depended on few nationally existing factors, three of which were of outmost importance, and they are the level of exposure of the NCO to the national companies market (here especially the matching between the used channel – website and the extent to which the NCO has having a performing website is important), the extent to which the National Contact Office was working directly with companies and the number of communicators that the NCO would have at hand so as to be used during the campaign. The best results were achieved by those which had a pre-existing well-designed website, with an already assessed number of hits, compatible with the needs of information of their companies, and those who had national networks active at the national/ local level (not only of companies but public administrations as well), regardless of being networks entirely devoted to workplace health promotion (as in Germany or Austria) or training experts' networks (like in Belgium). The high level of exposure granted by these networks allowed for an effective dispersion of the campaign material as well as a high rate of involvement of companies at the national level in filling in the questionnaire.

In order to assess how Move Europe was being perceived by other European Networks at the time it was unfolded, several interviews were conducted with representatives (PR representatives, executives of these networks, information officers, etc.) of three other European Networks (ENSP, IUHPE and EPHA). Most of those interviewed were working for networks also dealing with those 4 topics on a current basis, and the opinions expressed by them were, therefore, informed ones.

Move Europe's image, as reflected by other European Networks active in the Public Health field, shows a lifestyle-oriented campaign which had a good diffusion of the message across this domain. Dealing with a broad range of companies (all sizes and all sectors) and asking them about comprehensive WHP programs was considered to be an innovative approach, due to the fact that previous programs either considered SMEs, large companies or public administration only.

Some of those interviewed expressed doubts about the usefulness of such a campaign. However, the overall impression was that large campaigns engaging companies across Europe and asking them about their current WHP involvement are successful, especially if they manage to involve other topic-oriented networks. In this regard, future campaigns might want to look into the possibility of getting partners not only at the national level, but at the European level as well, as there are European networks dealing with each life-style issue that are willing to support the campaign through their own members in various countries.



Heinz Leitgöb / Karla Van Den Broek

# 3. The Description of the Developed Quality Criteria and the Company Health Check

## 3. The Description of the Developed Quality Criteria and the Company Health Check

As already mentioned in the previous chapter, the definition of quality criteria for lifestyle-related WHP was a declared and central goal of the “Move Europe” project. This is based on an extensive investigation of the existent questionnaires and assessment tools regarding the main topic areas of healthy eating, smoking prevention, physical activity and stress/mental health, as well as on the evidence and experiences of the successfully completed WHP programmes. In further consequence, the attained quality criteria for WHP constitute the basis for the Company Health Check (CHC), which should serve as a self-assessment tool for the companies in the member countries, as well as an initial criterion for the selection of MOGP.

In order to provide a correct assessment of the WHP status of an organisation, it is important to determine the success factors of existing programmes on WHP. Further, these identified success factors, together with the quality criteria of the ENWHP, form the basis of the criteria used for CHC.

### 3.1. Critical Success Factors of WHP Programmes

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Over the years, many organisations have set up all kinds of WHP activities and programs – sometimes with success, sometimes less successfully. When reviewing WHP programs, it is possible to determine the factors that are critical to success. Only those programs that meet these criteria contribute to the WHP goal of “healthy employees in healthy organisations”. This is why the critical success factors of WHP programs must be at the basis of a questionnaire that assesses the WHP status of an organisation. Reviews of researchers that already studied the benefits and success factors of WHP programs are available in the literature. We have found that researchers all agree that the comprehensiveness of WHP programs is a key success factor. Comprehensiveness, combined with organisational and strategic conditions, are the criteria for successful WHP programs.

### 3.2. Comprehensive Health Promotion

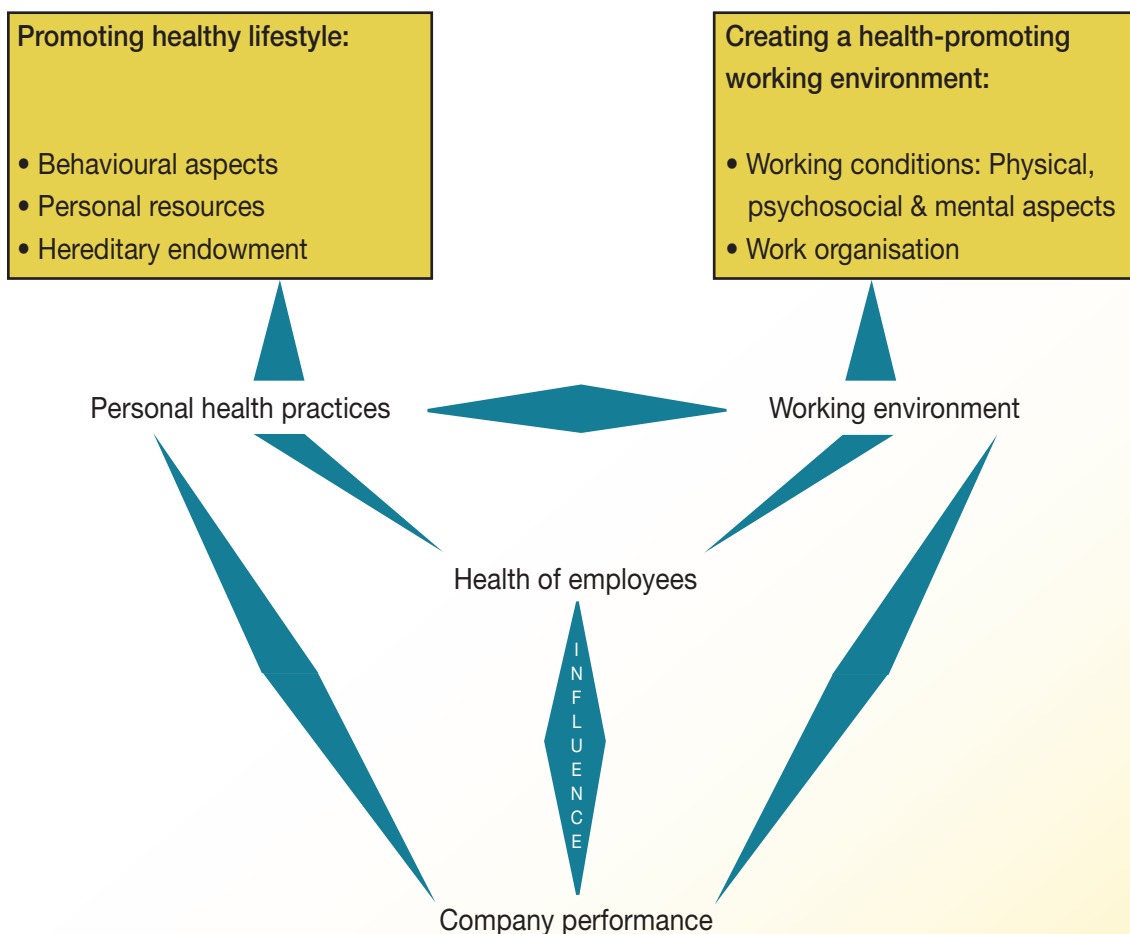
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When an organisation decides to invest in WHP, it is important that the initiatives fulfil certain conditions for success. According to the existing studies, the most effective WHP is comprehensive. It is the first and most important factor that has to be unconditionally fulfilled. This concept of a “comprehensive WHP” approach has been described repeatedly over time, sometimes in a slightly different manner, but always resulting in the same. The comprehensive approach arose when WHP no longer only focused on individual behaviours and lifestyle change, but also included organisational health (Makrides, 2004). Shain and Kramer (2004) put this evolution in a broader context and phrase it as follows:

“ ... it needs to be acknowledged that health, as we experience and observe it in workplace, is produced or manufactured by two major forces: What employees bring with them to the workplace in terms of personal resources, health practices, beliefs, attitudes, values, and hereditary endowment. What the workplace does to employees once they are there in terms of organisation of work in both the physical and psychosocial sense.” Thus, a comprehensive approach to health promotion in the workplace is one in which both individual and organisational influences on health are simultaneously targeted.

These two forces – personal health practices and organisation of work – do not act independently; they interact and influence not only one another, but also the health status of the employees and the productivity of the company. Figure 3.1. provides a graphical overview of an adapted version of the Shain-Kramer model (2004).

Figure 3.1.: Comprehensive WHP, adapted model of Shain/Kramer (2004)



Personal health practices can affect company performance in a direct and an indirect way: Directly, by “lost time” due to smoking breaks, etc., indirectly, by affecting health (e.g., lung cancer due to smoking) leading to absenteeism. The working environment can also affect company performance in two ways: Directly, through the design of physical and psychosocial work systems, and indirectly, through management practices that cause anxiety, depression and other negative emotional states that are antagonistic to company performance (Shain/Kramer, 2004).

For an organisation, this means that direct and indirect influences have to be considered when implementing a WHP program. On one hand, they should promote a healthy lifestyle of their employees, and, on the other hand, they should create a health-promoting working environment. Promoting a healthy lifestyle consists of efforts to help people modify their personal lifestyle behaviours, taking personal resources and hereditary endowment into account (e.g., tobacco use, nutrition, etc). The organisational change approach is used to increase corporate productivity, which is generally a consequence of improved physical and/or psychosocial health.

Based on these statements, comprehensive WHP can be seen as the combination of health promotion, focusing on personal health practices, and organisational change, which ensures that the working environment enables health.

### 3.3. Conditions for Successful Workplace Health Promotion Programs

Several studies and reviews concerning the effectiveness of WHP define conditions under which WHP programs are most likely to succeed. These identified conditions are: (1) the support and involvement of the top management; (2) a supportive environment; (3) WHP programs should be based on outcomes from needs and risks assessments; (4) the participation and involvement of employees; (5) the optimal use of on-site resources; (6) the accessibility of the programs; (7) the integration in organisational processes and procedures; (8) evaluation and monitoring; and (9) an open and ongoing communication. This list of conditions, which will now be explained in more detail, does not claim to be exhaustive; it rather is the result of the reviewed literature.

The first condition, which is important throughout the whole process of developing, implementing and executing a health promotion program, is the support and involvement of the top management (see Gee et al., 1997; Lowe, 2003; Lowe, 2004; Pelletier, 2001; Shain/Kramer, 2004; Theservitz, 2003; Warshaw/Messite, 1998). The support for and the involvement in WHP interventions should be visible and enthusiastic (Peersman et al., 1998), so that employees actually feel the commitment of their employers to the protection and promotion of their well-being (Shain/Kramer, 2004). This commitment can consist of the

continuing allocation of necessary resources (Lowe, 2004; Shain/Kramer, 2004; Warshaw/Messite, 1998), the endorsement of goals and objectives concerning health promotion (European Commission, 2003), the displaying of exemplary behaviour (Lowe, 2004; Shain/Kramer, 2004), and providing an encouraging and physically safe working environment (Shain/Kramer, 2004), etc.

Apart from the support of the top management, several studies agree on the importance of a supportive environment in general (see Lowe, 2004; Makrides, 2004; Pelletier, 2001; Shain/Kramer, 2004). According to these papers, company climate or culture is a crucial determinant in employee health. Therefore, Pelletier (2001) emphasises the importance of an encouraging corporate culture towards health promotion efforts, while Makrides (2004) underlines the positive effect of organisational development to foster a more supportive environment for WHP and the central role of long-term sustainability.

Thesenvitz (2002, 2003) as well as Shain/Kramer stress the fact that individuals have variable needs for social support. WHP programs should pay attention to these different needs and further focus on a definable and modifiable risk factor which constitutes a priority for the specific worker group. In that way, an intervention will be more acceptable to employees and increase their participation (Peersman et al., 1998). Therefore, these programs should be designed to meet the preferences, aptitudes and requirements of a wide variety of participants to be really successful (Gee, 1997; Shain/Kramer, 2004). According to Demmer (1995), organisations should also analyse existing weak points concerning health at work and determine needs and resources of an organisation. This analysis realises the implementation of priorities in the development of WHP programs. Thus, WHP programs should be based on outcomes from needs and risks assessments concerning WHP executed at the workplace.

Attention to preferences and needs of program participants is more likely to be achieved when employees are directly involved in the identification of health issues, in the design of the program, and in decisions about how, when and by whom they are delivered (Demmer, 1995; Shain/Kramer, 2004). As a consequence, the participation and involvement of employees into the WHP process constitute a further very important condition. On one hand, employees should receive the opportunity to have a say in the whole process of developing and maintaining a WHP program, and, on the other hand, they should be stimulated to really participate in these programs. Crucial is the involvement of employees at all organisational levels containing the strategy, the implementation, as well as the evaluation of interventions (Gee, 1997; Lowe, 2004; Peersman et al., 1998; European Agency for Safety and Health at Work, 2002). To achieve employee participation, an organisation should not only involve them in the whole process, but might also provide a mechanism for feedback from participants and non-participants (Warshaw et al., 1998), incentives for participation (Pelletier, 2001) and communication of program plans across divisions and departments to mid-level managers and employees (Warshaw et al., 1998).



Involvement of employees highly correlates with the optimal use of on-site resources. This condition consists of the allocation of (available) human, physical and organisational in-company resources (Peersman et al., 1998). The support of the top management, which was the first condition, is indispensable to the allocation of these resources (Shain/Kramer, 2004; Warshaw et al., 1998).

To enhance employees' participation, programs and facilities should be well accessible (Pelletier, 2001). Following Shain/Suurvali (2001), people are increasingly pressed for time and essentially need programs and services to come to them, rather than the other way around.

The condition integration manifests itself at different levels of the corporate policy. WHP programs should be characterised by a clear statement of goals and objectives which align with the corporate mission and are integrated in organisational processes and procedures (Lowe, 2003; Lowe, 2004, Warshaw et al., 1998). The programs should further be tailored to special features of the workplace environment (Thesenvitz, 2002, 2003).

Determining definitions of goals and objectives facilitates the evaluation and monitoring of the program and thus significantly contributes to the success of WHP programs by keeping track of the activities, participation, as well as outcomes (Warshaw et al., 1998). Evaluation and monitoring outcomes form the basis of potential changes of the program and allow constant improvement (Lowe, 2003; Warshaw et al., 1998). Based on program evaluation, a periodic report prepared for top management should justify the continuation of resource allocation.

To keep WHP in the picture, there should be an open and ongoing communication among the project members, employees and (top) management (Lowe, 2003, 2004). Every member of the organisation and all other stakeholders should be informed about the WHP program in each phase of the project.

To conclude, WHP has to be a comprehensive approach in a multidisciplinary setting in which all members of the organisation are actively engaged. It has to be integrated into existing structures and should align with the corporate mission and the fundamental company values. WHP programs should be characterised by a long-term commitment and have to be monitored/evaluated frequently.

### 3.4. Quality Criteria of Workplace Health Promotion – ENWHP

Based on the guidelines for effective WHP – the critical success factors – the ENWHP (1999) set up quality criteria for WHP. These criteria are based on the European Foundation for Quality Management model supporting the integration of WHP into the quality management system of companies, encompassing six different areas which will be discussed below.

The quality criteria provide assistance in planning and implementing successful, high-quality health promotion measures for all those who are responsible for health at the workplace. In drawing up the criteria, it was assumed that the statutory provisions on occupational health and safety were already fulfilled.

The criteria offer a comprehensive outline for the creation of a modern corporate health policy and make it easier for organisations to determine where they stand along the route and how far they are from achieving their ultimate goals. The criteria present an ideal health-promoting organisation that is unlikely to exist. Thus, an organisation might not have satisfied all the criteria, which does not mean that it cannot be a good practice.

As said before, the criteria are divided into six sectors that produce a comprehensive picture of the quality of WHP activities. An explanation of each of the sectors is provided by the ENWHP.

#### **WHP and corporate policy**

The success of WHP depends on its perception as a vital managerial responsibility and its integration into existing management systems. The criteria for this sector are the existence of a written corporate philosophy on WHP, the integration into existing processes and structures, the provision of resources, the monitoring by the executive team, the integration in training and retraining, and the accessibility for employees.

#### **Human resources and work organisation**

The most important task of health-promoting human resources and work organisation is to consider the skills of the staff. The crucial factor for the success of workplace health promotion is that all employees are actively involved as much as possible in planning and decision-making.

#### **Planning of workplace health promotion**

WHP is successful when it is based on a clear concept, which is continuously reviewed, improved and communicated to the staff.

#### **Social responsibility**

Another crucial factor for the success of WHP is whether and how the organisation fulfils its responsibility in dealing with natural resources. Social responsibility includes the role of the organisation at the local, regional, national and international levels regarding its support of health-promoting initiatives.

#### **Implementation of WHP**

WHP comprises measures for health-promoting job design and the support of healthy behaviour. It is successful when these measures are permanently interlinked and systematically implemented.

### Results of WHP

The success of WHP can be measured by a number of short, medium and long-term indicators.

Emphasis is placed on the extent to which the activities are systematically pursued and on the degree to which they are integrated into the organisation.

## 3.5. Quality Criteria for the Company Health Check

Based on the success factors for WHP programs, as well as on the ENWHP quality criteria, a framework for the Company Health Check (CHC) was developed. While the quality criteria from the ENWHP focus more on the structure and content of such a program, the aspects emerging from literature and good practices are rather contextual criteria. Both criteria can be put beside one another to compare them and look for similarities and differences. The outcome of such a comparison is given in Table 3.1. below:

**Table 3.1.: Developed quality criteria for the Company Health Check**

|   |  |       |
|---|--|-------|
| ■ | support by and involvement of management                     | _____ |
| ■ | support by and active involvement/participation of employees | _____ |
| ■ | ongoing communication between and towards all stakeholders   | _____ |
| ■ | support by the corporate policy                              | _____ |
| ■ | integration in the corporate strategy, systems and processes | _____ |
| ■ | based on a structured approach                               | _____ |
| ■ | based on a needs analysis and/or risk assessment             | _____ |
| ■ | support with the necessary material resources                | _____ |
| ■ | providing information and training on WHP                    | _____ |
| ■ | program evaluation and monitoring                            | _____ |
| ■ | based on effective measures and scientific knowledge         | _____ |
| ■ | characterised by continuous improvements                     | _____ |
| ■ | comprehensive  | _____ |

These conditions comprise all but one criterion from the ENWHP and literature. Social responsibility as a quality criterion is not fully included, since the purpose of the company health check is to give organisations an idea of how effective their WHP programs and policies are concerning the four chosen topics.

Also regarded as a further major quality criterion – as has already been mentioned several times – is the transferability of the implemented measures to other companies, resp. organisations (cf. Wang et al, 2005). In this connection, besides the abovementioned criteria for a successful (effective) realisation of interventions, their level of abstraction stands at the focus of interest: the more general – (largely) independent of the existing specific company conditions – the successful health-promoting activities in companies are kept, the easier these measures allow themselves to be generalised and transferred to other companies without a high adaptation effort. For this reason, all of the MOGPs contained on the CD were tested for the transferability of their measures and can be characterised as so-called “transferability models”.

### 3.6. Company Health Check (CHC)

A central step in preparing the Company Health Check is the review of already existing related questionnaires and assessment tools. The purpose of most of these questionnaires is to support the development of WHP initiatives. While some tools cover health promotion in general, others deal with only one lifestyle-related topic, for example, nutrition. For the Company Health Check, existing questionnaires were compared with the developed quality criteria explained above in combination with the information content they comprise for the relevant topics of smoking, nutrition, exercise and stress.

After consulting several existing questionnaires and reviewing health promotion literature, enough information and ideas were gathered to create a comprehensive Company Health Check on the lifestyle-related topics of interest. The earlier defined quality criteria (see Table 3.1.) built the foundation of the Company Health Check.

Further, the structure is inspired by the process cycle for WHP programs. The process of developing, maintaining and evaluating WHP measures consists of four major steps. These steps can be presented as a problem-solving cycle. An example of such a cycle is given below. The quality criteria can be placed around this cycle, since they are prerequisites for successful WHP.

#### **The major steps in a WHP program are:**

- Setting up of policy and culture;
- Organising and setting up of structures;
- Developing and implementing strategies;
- Evaluating results.

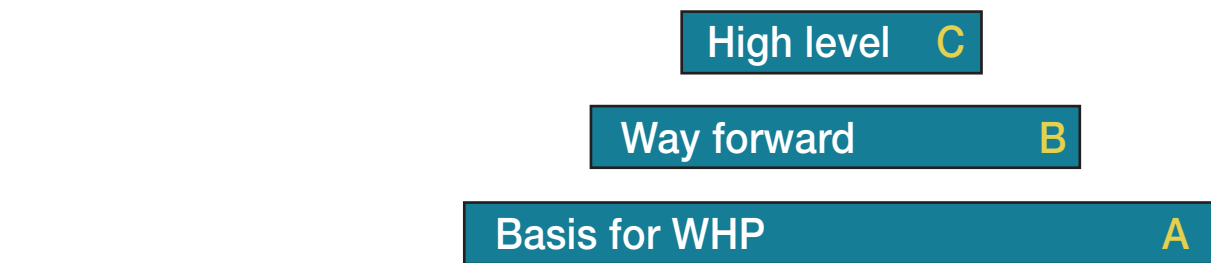
Figure 3.2.: Structure of the Company Health Check



The single steps of this problem-solving cycle were used as a structure for the Company Health Check. For each of the four health topics (nutrition, exercise, smoking and stress), questions covering these four steps in the process of developing, maintaining and evaluating a WHP program will be asked. Questions concerning the other quality criteria are integrated in these four steps. The first part, “policy & culture”, covers WHP in general, while the other three parts are repeated for each of the four health-related topics. This structure also allows the Company Health Check to be focused on one topic, e.g., on smoking. In that case, the questionnaire consists of the “policy & culture” questions, followed by the questions on smoking (organisation & structures, strategies & implementation, results & evaluation).

So, for every step of the WHP program cycle, questions that take into account the level of progress by weighting the questions according to Figure 3.3. were formulated. Thus, the questions got categorised in A, B and C questions. A-questions count for 8 points, B-questions for 4 points and C-questions for 2 points. A-questions are related to basic issues. These elements must be in place in order to develop WHP initiatives. B-questions relate to items that give an indication of the way forward. C-questions deal with elements that indicate a high level of commitment and WHP activities.

Figure 3.3.: Weighting of questions



For each question, a no or yes answer is possible. At the beginning of the questionnaire, each organisation will start with 100 points. If the answer is yes, no points will be extracted. If the answer is no, the corresponding points will be extracted. At the end of the questionnaire, five scores are given:

- the score on smoking prevention,
- the score on healthy eating,
- the score on active living,
- the score on combating stress,
- and the total score

Each score will vary between zero and one hundred, zero meaning that the organisation has answered no to each question of that part and one hundred meaning just the opposite.

To complete the Check, a basic action plan that provides appropriate advice to companies was developed.<sup>1</sup>

1 See also the underlying paper of Karen Muylaert, Rik Op De Breeck and Karla Van den Broek (2007): Company Health Check: An Instrument to Promote Health at the Workplace. Available at: [http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Review\\_and\\_Catalogue\\_CHC\\_\\_2\\_.pdf](http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Review_and_Catalogue_CHC__2_.pdf) (Status: 24/02/2009)

## Annex: The Company Health Check

**Table: 3.1.: The Company Health Check (CHC)**

### Policy & culture

Weight

|   |   |
|---|---|
| Is Workplace Health Promotion (well-being at work, healthy lifestyle/behaviour, occupational health and safety, etc.) part of the organisation mission statement and/or written corporate philosophy? | A |
| Is there a written policy on Workplace Health Promotion in your company/organisation?   | B |
| Is there an involvement and active support of the management in the Workplace Health Promotion policy and related initiatives?  | A |
| Do the staff/employees have the opportunity to participate in the elaboration of the Workplace Health Promotion policy?   | B |
| Do employees receive information on the Workplace Health Promotion policy?  | B |

### Smoking prevention/ organisation & structures

|   |   |
|---|---|
| Is there an action plan (or as part of a Health/OSH plan) for the prevention of smoking/tobacco in your company/organisation?                       | A |
| Did the coordinator and/or the members of the working group receive training and/or adapted information on smoking prevention?                      | C |
| Are there sufficient financial (budget) and/or material (infrastructure, etc.) resources available for developing activities on smoking prevention? | B |
| Are employees involved in developing actions/measures on smoking prevention?  | B |

### Smoking prevention/ strategy & implementation

|  |   |
|--|---|
| Has a needs assessment on smoking prevention been carried out?   | B |
| Is there a total ban of smoking in all working areas and other common areas?   | C |
| If not, is smoking restricted to designated smoking areas?   | B |
| If smoking is only allowed in designated smoking areas, is there sufficient ventilation?   | C |
| Does the company/organisation provide information on the prevention of smoking at the workplace? e.g., via magazine, intranet, e-mail, letter, notice board, information sessions, interviews, campaigns, events, etc. | A |
| Is support offered to employees who are trying to stop smoking? e.g., smoking cessation counselling, group sessions, provision of nicotine replacement therapy, incentive for employees who quit smoking, etc.         | B |
| Is training offered to volunteers (employees) who support colleagues who are trying to stop smoking?   | C |

### Smoking prevention/results & evaluation

|  |   |
|--|---|
| Are the smoking prevention actions/measures evaluated? by discussion in the working group, by an employee survey, etc. | B |
|--|---|

### Healthy eating/ organisation & structures

|   |   |
|---|---|
| Is there an action plan on nutrition/healthy eating and drinking in your company/organisation?  | A |
| Is there a coordinator and/or working group on healthy eating?  | B |
| Did the coordinator and/or the members of the working group receive training and/or adapted information on healthy eating?                      | C |
| Are there sufficient financial (budget) and/or material (infrastructure, etc.) resources available for developing activities on healthy eating? | B |
| Are employees involved in developing actions/measures on healthy eating?  | B |

### Healthy eating/strategy & implementation

|   |   |
|---|---|
| Has a needs assessment on healthy eating been carried out?  | B |
| Is a comfortable, clean eating area (considering food safety) available for employees?  | A |
| Does your company/organisation only offer healthy food and drinks? (no soft drinks, no fast food, no sweets or alcohol)   | C |
| If not, is a healthy food and beverage choice provided and promoted? (by lower prices, free trials, etc.)   | B |
| Is free fruit provided?   | C |
| Is free drinking water provided?  | A |
| Does the company/organisation provide information on healthy eating and drinking at the workplace? e.g. via magazine, intranet, e-mail, letter, notice board, information sessions, interviews, campaigns, events, etc. | A |
| Is support offered to employees on healthy eating? professional counselling of a dietician  | B |

### Healthy eating/results & evaluation

|   |   |
|---|---|
| Are the actions/measures on healthy eating evaluated? by discussion in the working group, by an employee survey, etc. | B |
|---|---|

### Active living/organisation & structures

|   |   |
|---|---|
| Is there an action plan on exercise/active living in your company/organisation? | A |
| Is there a coordinator and/or working group on exercise/active living?          | B |



|   |   |
|---|---|
| Did the coordinator and/or the members of the working group receive training and/or adapted information on exercise/active living?                      | C |
| Are there sufficient financial (budget) and/or material (infrastructure, etc.) resources available for developing activities on exercise/active living? | B |
| Are employees involved in developing actions/measures on exercise/active living?  | B |

### Active living/strategy & implementation

|  |   |
|--|---|
| Has a needs assessment on exercise/active living been carried out?   | B |
| Are exercise activities organised during working hours? (Physical training, breaks for exercises during meetings or for employees with lack of movement (e.g., prolonged VDU work), exercises (warm-up) before starting to work, etc.) | B |
| Is there an offer of exercise activities before/after working time? (jogging group, football team, ping pong, badminton, etc.)   | A |
| Does your company/organisation support walking/cycling to/from work?   | C |
| Do employees have access to off-site and/or on-site exercise facilities/infrastructure? (member card of sport club e.g., reduced member fee)   | B |
| Can employees use showers after taking exercise?   | B |
| Does the company/organisation offer counselling/testing/professional support for employees who want to take exercise?  | C |
| Does the company/organisation provide information on exercise/active living? e.g., via magazine, intranet, e-mail, letter, notice board, information sessions, interviews, campaigns, events, etc.                                     | A |

### Active living/results & evaluation

|   |   |
|---|---|
| Are the actions/measures on exercise/active living evaluated? by discussion in the working group, by an employee survey, etc. | B |
|---|---|

### Stress/organisation & structures

|   |   |
|---|---|
| Is there an action plan to deal with stress in your company/organisation?   | A |
| Is there a coordinator and/or working group on stress prevention?   | B |
| Did the coordinator and/or the members of the working group receive training and/or adapted information on stress prevention?                                 | C |
| Are there sufficient financial (budget) and/or material (infrastructure, etc.) resources available for developing activities for a stress prevention program? | B |
| Are employees involved in developing actions/measures on stress?  | B |

### Stress/strategy & implementation

|  |   |
|--|---|
| Has a risk assessment been carried out regarding stress?   | A |
| Are employees involved in identifying possible sources/causes of stress?   | B |
| Are measures taken to adapt the work load? (deadlines, work speed, quantity of work, etc.)   | B |
| Are measures taken to tackle poor job content? (job rotation [increase changing tasks], job enrichment [including more interesting tasks], job enlargement [including more different tasks]) | B |
| Are measures taken to increase the job control of employees? (flexible working hours, flexible breaks)   | B |
| Does the company/organisation offer confidential counselling or support to employees who suffer from stress?   | B |
| Does the company/organisation provide information on stress? e.g., via magazine, intranet, e-mail, letter, notice board, information sessions, interviews, campaigns, events, etc.           | A |

### Stress/results & evaluation

|  |   |
|--|---|
| Are the actions/measures on stress prevention evaluated? by discussion in the working group, by an employee survey, etc. | B |
|--|---|

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Heinz Leitgöb

# 4. Main Results of the Company Health Check

## 4. Main Results of the Company Health Check

Subsequently, the main results of the Company Health Checks (CHC) described and illustrated in detail in the previous chapter were processed. The survey period extended from 1 April 2007 to 10 December 2008. In 22 member countries, a total of 2,554 companies/organisations, which at least partially filled out the online CHC, were included. Data from 1,721 of these firms can be utilised and enter into the analysis. The following Table 4.1 provides an overview of the aggregate analysis of the CHC.

**Table 4.1.: From the total number to the aggregate analysis of companies in the CHC**

|   |       |
|---|-------|
| Total number of participating countries | 22    |
| Total number of participating companies | 2,554 |
| Completely filled in                    | 1,692 |
| Not completely filled in                | 862   |
| Usable (analysis entirety)              | 1,721 |
| Unusable                                | 833   |

Nearly a third (32.6%) of all the companies assessed by means of the CHC can be described as unusable and are not included in the aggregate analysis. Possible reasons for this are, on one hand, a too high proportion of missing values, and the double recording, resp., multiple recording of companies by repeatedly filling in the online questionnaire, on the other hand.

While an average of 78 companies in each of the 22 countries could provide usable data, it appears that the respective numbers significantly vary between the individual countries. These differences can be explained, on one part, by the particular size of the country (resp., the total number of available companies in this context), as well as by the varying progress of WHP establishment in the specific countries. Therefore, Germany, with 370 companies, ranks first, followed by Belgium (258), the Netherlands (199), Slovenia (177) and the Czech Republic, with a contribution of over 100 companies. These five mentioned countries comprise nearly two-thirds (64.6%) of all usable companies. Table 4.2 identifies the usable companies according to the participating countries.

Table 4.2.: Number, resp., proportion of usable questionnaires ranked by countries

| Country        | No.          | Proportion (%) | Cum. proportion (%) |
|----------------|--------------|----------------|---------------------|
| Germany        | 370          | 21.5%          | 21.5%               |
| Belgium        | 258          | 15.0%          | 36.5%               |
| Netherlands    | 199          | 11.6%          | 48.1%               |
| Slovenia       | 177          | 10.3%          | 58.4%               |
| Czech Republic | 107          | 6.2%           | 64.6%               |
| Hungary        | 84           | 4.9%           | 69.5%               |
| Iceland        | 78           | 4.5%           | 74.0%               |
| Austria        | 78           | 4.5%           | 78.5%               |
| Ireland        | 62           | 3.6%           | 82.1%               |
| Italy          | 48           | 2.8%           | 84.9%               |
| Slovakia       | 48           | 2.8%           | 87.7%               |
| Spain          | 43           | 2.5%           | 90.2%               |
| Norway         | 40           | 2.3%           | 92.5%               |
| Finland        | 31           | 1.8%           | 94.3%               |
| Bulgaria       | 26           | 1.5%           | 95.8%               |
| Cyprus         | 21           | 1.2%           | 97.0%               |
| Greece         | 17           | 1.0%           | 98.0%               |
| United Kingdom | 10           | 0.6%           | 98.6%               |
| Romania        | 8            | 0.5%           | 99.1%               |
| Estonia        | 7            | 0.4%           | 99.5%               |
| Luxembourg     | 6            | 0.3%           | 99.8%               |
| Poland         | 3            | 0.2%           | 100.0%              |
| <b>Total</b>   | <b>1,721</b> | <b>100.0%</b>  |                     |

Furthermore, the usable companies can be divided according to company size for the individual participating countries. In this connection, the following three categories were formed: small-sized companies (SC) with 1 to 49 employees; medium-sized companies (MC), with 50 to 249 employees; and large companies (LC), with over 250 employees.



The distribution of the companies according to company size – measured by the number of employees – will be illustrated in Table 4.3. The discrepancy between the total number of companies in the individual participating countries represented in Table 4.2 and that of the following Table 4.3 results from the non-disclosure of the number of employees in the answering of the questionnaire, as well as from the companies with no employees (one-person companies).

**Table 4.3.: Distribution of companies according to the number of employees**

| Country        | No.          | SC (%)       | MC (%)       | LC (%)       | Total         |
|----------------|--------------|--------------|--------------|--------------|---------------|
| Germany        | 349          | 23.2%        | 20.6%        | 56.2%        | 100.0%        |
| Belgium        | 249          | 27.7%        | 26.9%        | 45.4%        | 100.0%        |
| Netherlands    | 196          | 26.5%        | 25.5%        | 48.0%        | 100.0%        |
| Slovenia       | 176          | 31.8%        | 50.6%        | 17.6%        | 100.0%        |
| Czech Republic | 104          | 26.0%        | 35.5%        | 38.5%        | 100.0%        |
| Hungary        | 84           | 34.5%        | 25.0%        | 40.5%        | 100.0%        |
| Iceland        | 76           | 48.7%        | 35.5%        | 15.8%        | 100.0%        |
| Austria        | 72           | 26.4%        | 26.4%        | 47.2%        | 100.0%        |
| Ireland        | 61           | 23.0%        | 23.0%        | 54.0%        | 100.0%        |
| Slovakia       | 48           | 47.9%        | 35.4%        | 16.7%        | 100.0%        |
| Italy          | 47           | 38.3%        | 21.3%        | 40.4%        | 100.0%        |
| Spain          | 43           | 32.6%        | 16.3%        | 51.1%        | 100.0%        |
| Norway         | 39           | 41.0%        | 23.1%        | 35.9%        | 100.0%        |
| Finland        | 31           | 29.0%        | 16.1%        | 54.9%        | 100.0%        |
| Bulgaria       | 26           | 11.5%        | 50.0%        | 38.5%        | 100.0%        |
| Cyprus         | 21           | 9.5%         | 38.1%        | 52.4%        | 100.0%        |
| Greece         | 17           | 23.5%        | 11.8%        | 64.7%        | 100.0%        |
| United Kingdom | 10           | 20.0%        | 20.0%        | 60.0%        | 100.0%        |
| Romania        | 8            | 62.5%        | 25.0%        | 12.5%        | 100.0%        |
| Estonia        | 7            | 28.6%        | 42.8%        | 28.6%        | 100.0%        |
| Luxembourg     | 6            | 16.7%        | 16.7%        | 66.6%        | 100.0%        |
| Poland         | 3            | 0.0%         | 66.7%        | 33.3%        | 100.0%        |
| <b>Total</b>   | <b>1,673</b> | <b>28.9%</b> | <b>28.5%</b> | <b>42.6%</b> | <b>100.0%</b> |

If one firstly observes the total distribution of all participating countries, it becomes apparent that large companies can increasingly be reached and motivated to conduct the CHC. If one assumes that the majority of countries possess a corporate structure in which the majority is small companies, followed by medium-sized companies, and that large companies account for the lowest proportion, one has to assume in the present data set that there is a substantial underrepresentation of small firms, as well as an overrepresentation of large companies, whose magnitude varies between the individual countries. In this regard, the possible explanation approach could be that (1) large companies can be easier reached, (2) access to these companies can be easier realised, (3) strong contacts of the National Contact Offices (NCOs) to large companies already exist, (4) these firms have much more experience with (lifestyle-oriented) WHP and therefore possess a higher sensitivity for and willingness to fill in the CHC.

In addition to the company size, the economic sectors which the individual companies are involved in were additionally recorded. These were summarized into a total of ten activity fields: (1) agriculture; (2) mining and quarrying of energy-producing materials; (3) construction; (4) manufacturing and industry; (5) hotel and restaurant services; (6) transport; (7) commercial services, banking, insurances; (8) public administration; (9) education; (10) health and social work; (11) other. Category (11) represents a residual category for those companies that cannot be clearly assigned to one of the given fields. For reasons of clarity, only an overall distribution of the usable companies is carried out, meaning that the country-specific distributions are abandoned in this case. The results will be presented in the following Table 4.4.

**Table 4.4.: Distribution of companies according to activity fields**

| Activity field                                     | No.          | Proportion (%)<br>across all countries | Cum.<br>proportion (%) |
|--|--------------|--|------------------------|
| Other  | 363          | 21.0%                                  | 21.0%                  |
| Manufacturing and industry                         | 357          | 20.7%                                  | 41.7%                  |
| Health and social work                             | 273          | 15.9%                                  | 57.6%                  |
| Education  | 220          | 12.8%                                  | 70.4%                  |
| Public administration                              | 205          | 11.9%                                  | 82.3%                  |
| Commercial services, banking, insurances           | 185          | 10.8%                                  | 93.1%                  |
| Construction                                       | 40           | 2.3%                                   | 95.4%                  |
| Transport  | 37           | 2.2%                                   | 97.6%                  |
| Hotel and restaurant services                      | 17           | 1.0%                                   | 98.6%                  |
| Mining and quarrying of energy-producing materials | 13           | 0.8%                                   | 99.4%                  |
| Agriculture  | 11           | 0.6%                                   | 100.0%                 |
| <b>Total</b>                                       | <b>1,721</b> | <b>100.0%</b>                          |                        |

Apart from the residual category “other” (21.0%), the most queried companies (20.7%) are involved in manufacturing and industry field, followed by health and social work (15.9%), education (12.8%), public administration (11.9%), and commercial services, banking and insurances, with 10.8 percent. The remaining activity fields show shares of less than three percent. One cannot speak of a dominance of a particular activity field, because the proportion of no particular field does not significantly rise above all others. It rather appears that the distribution of companies in the individual activity fields across all countries in a rough estimate is consistently representative. Therefore, it is plausible that the activity field of manufacturing and industry comprises the largest proportion, while the mining and quarrying of energy-producing materials as well as agriculture are located pro-rata at the lower end.

In a next step, the central outcome of the CHC – the mean average points awarded for conducted lifestyle-oriented WHP measures (described in Chapter 3.5) – will first be illustrated in Figure 4.1 across all companies and all four lifestyle-related topics (smoking prevention, healthy eating, active living, combating stress) in the project according to each of the participating countries. It should be noted here that the possible range of values lies between 0 and 100 points, and the higher the attained number of points of a company is, the more (lifestyle-oriented) WHP measures have already been realised.

Figure 4.1.: Country average of attained point scores across all four lifestyle-related topics

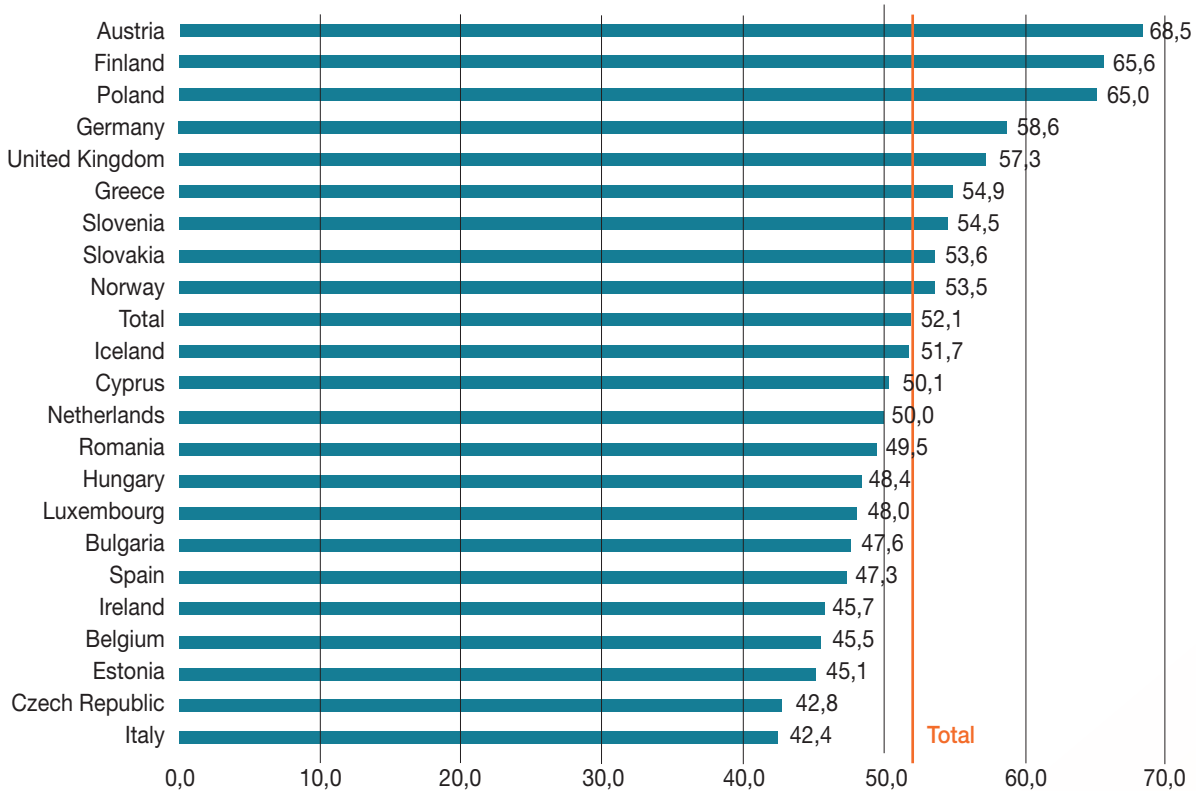


Figure 4.1 shows an average point total of 52.1 points across all companies in all countries. A total of nine countries lie above this total average value, the other 13 below. The observed range of average values lies at 26.1 points and results out of the difference between Austria (68.5 points) and Italy (42.2 points). What should be noted is that the points were awarded on the basis of a self-estimation, and deformations through socially desired responses aimed at achieving the maximum amount of points to create as positive a company picture as possible, etc, cannot be completely ruled out. However, it cannot be assumed that the potential deformation tendencies significantly vary between the single countries. An explanation of country differences cannot be carried out with the provided data.

A differentiation of the average point scores according to the four lifestyle-related topics relevant to the project show that these are subject to substantial variations between, as well as within, the countries. At this point, it should be mentioned that the average of the four lifestyle-related topics does not add up to the total point score, as a total of five questions about the general integration of WHP into company policy and culture, for which points can be given or taken away and therefore factor into the calculation of the total point score as well, are asked at the beginning of the CHC (see CHC in Chapter 3).

Table 4.5.: Country averages of attained point scores,  
differentiated according to the four lifestyle-related topics

| Country              | Smoking prevention | Healthy eating | Active living | Combating stress |
|----------------------|--------------------|----------------|---------------|------------------|
| Austria              | 68.1               | 71.6           | 72.9          | 70.4             |
| Slovakia             | 62.3               | 63.3           | 52.6          | 50.2             |
| Germany              | 59.9               | 59.4           | 67.7          | 61.7             |
| Cyprus               | 59.2               | 53.2           | 67.4          | 50.3             |
| Greece               | 58.6               | 55.7           | 59.6          | 51.7             |
| United Kingdom       | 57.3               | 60.7           | 52.0          | 70.5             |
| Finland              | 56.5               | 66.9           | 77.7          | 60.2             |
| Bulgaria             | 53.9               | 56.5           | 45.2          | 49.9             |
| Belgium              | 53.0               | 47.0           | 43.6          | 49.3             |
| Romania              | 53.0               | 57.0           | 43.6          | 61.2             |
| Netherlands          | 52.5               | 51.0           | 53.4          | 56.3             |
| Spain                | 52.3               | 54.1           | 57.6          | 49.4             |
| Hungary              | 50.4               | 52.0           | 54.0          | 46.1             |
| Slovenia             | 49.2               | 64.3           | 56.5          | 52.1             |
| Ireland              | 48.8               | 50.6           | 41.1          | 48.5             |
| Iceland              | 48.1               | 64.4           | 52.4          | 49.2             |
| Norway               | 47.6               | 52.4           | 61.7          | 61.0             |
| Italy                | 47.6               | 47.6           | 47.9          | 49.6             |
| Luxembourg           | 43.6               | 40.6           | 49.8          | 37.0             |
| Czech Republic       | 42.5               | 51.2           | 49.3          | 44.2             |
| Estonia              | 34.0               | 41.2           | 55.1          | 51.5             |
| Poland               | 3.0                | 52.0           | 0.0           | 0.0              |
| <b>Total</b>         | <b>53.5</b>        | <b>56.1</b>    | <b>56.4</b>   | <b>54.3</b>      |
| <b>Highest score</b> | <b>1x</b>          | <b>7x</b>      | <b>10x</b>    | <b>4x</b>        |
| <b>Lowest score</b>  | <b>8x</b>          | <b>3x</b>      | <b>6x</b>     | <b>7x</b>        |
| <b>Difference</b>    | <b>-7</b>          | <b>+4</b>      | <b>+4</b>     | <b>-3</b>        |

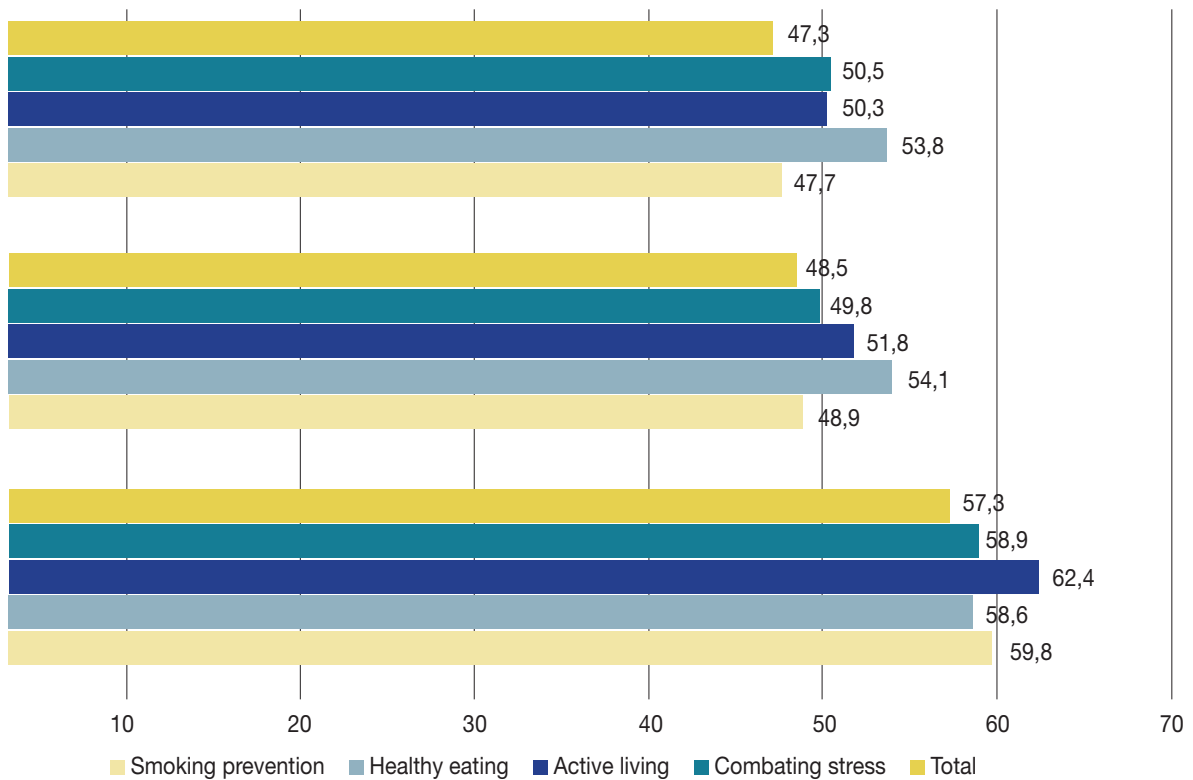
**Explanation:** The blue fields indicate the lifestyle-related topic with the respective highest point score per country; the yellow fields indicate the topic with the lowest point score.

Altogether (on average across all countries), a relatively low variation of point scores between the four topics can be recognized: Therefore, active living, with an average of 56.4 points, is at the top, closely followed by healthy eating (56.1), combating stress (54.3) and smoking prevention, with 53.5 points. The empirically observed range of values of the average point scores between the four lifestyle-related topics therefore lies at merely 2.9 points. Accordingly, the four topics across the countries are developed and established on average to nearly the same extent. However, if the number of the highest and lowest scores is taken into account, one sees that smoking prevention could attain the highest score in all four topics in the countries only once (in Belgium), while it received the lowest point score in eight countries, and is ranked last of the topics, with a difference of -7. Likewise, a negative difference of -3 was identified for combating stress, while healthy eating and active living each recorded a positive difference of +4.

As has already been mentioned, considerable domestic variations of the average point scores between the four lifestyle-related topics can also partially be accounted for. Nevertheless, it can be discerned that many countries consistently show high, resp., low point scores across all four topics, i.e., that the existing domestic variance turns out to be significantly lower in its magnitude than the cross-national variance.

In order to keep to the development of this chapter, a representation of the respective average point scores of the four lifestyle-related topics according to company size will follow. In this regard, the same categories as in Table 4.3 are again valid here, meaning small-sized companies (SC), medium-sized companies (MC) and large companies (LC). The results are shown in Figure 4.2.

Figure 4.2.: Average of attained point scores according to lifestyle-related topics and company size



A look at Figure 4.2 reveals that the point scores and, therefore, the already existing/realised WHP measures/interventions in the large companies are higher, resp., more distinctive on average than in the small- and medium-sized companies. Very similar tendencies can generally be identified for small- and medium sized companies. In view of the individual lifestyle-related topics, it appears that healthy eating stands in the foreground in small- and medium-sized companies, while active living is ranked first in large companies. On the contrary, smoking prevention is, on average, the least pronounced topic in small- and medium-sized companies, while the case in large companies is that healthy eating narrowly ranks ahead of combating stress.

To conclude, the average point scores of the lifestyle-related topics according to the individual activity fields illustrated in Table 4.4 shall be presented in order to be able to identify potential differences in the existence of WHP measures between the areas. The results are presented in Table 4.6.

**Table 4.6.: Average of attained point scores according to lifestyle-related topics and activity field**

| Activity field                                     | Total       | Smoking prevention | Healthy eating | Active living | Combating stress |
|--|-------------|--------------------|----------------|---------------|------------------|
| Mining and quarrying of energy-producing materials | 69.0        | 69.5               | 69.3           | 70.9          | 65.7             |
| Hotel and restaurant services                      | 58.9        | 57.8               | 64.5           | 64.3          | 62.3             |
| Transport  | 56.5        | 57.5               | 59.9           | 62.2          | 60.6             |
| Education  | 55.0        | 53.0               | 64.7           | 54.6          | 52.8             |
| Manufacturing and industry                         | 53.7        | 56.6               | 57.3           | 57.0          | 52.5             |
| Health and social work                             | 52.5        | 55.3               | 56.4           | 55.7          | 57.3             |
| Other  | 50.8        | 50.5               | 53.8           | 56.7          | 53.8             |
| Public administration                              | 49.8        | 53.4               | 50.8           | 57.4          | 54.7             |
| Commercial services, banking, insurances           | 49.0        | 50.3               | 51.3           | 55.0          | 52.7             |
| Agriculture  | 47.5        | 52.6               | 62.1           | 58.9          | 56.8             |
| Construction                                       | 45.4        | 48.7               | 50.9           | 48.6          | 54.6             |
| <b>Total</b>                                       | <b>52.1</b> | <b>53.5</b>        | <b>56.1</b>    | <b>56.4</b>   | <b>54.3</b>      |
| <b>Highest score</b>                               |             | <b>0x</b>          | <b>4x</b>      | <b>5x</b>     | <b>2x</b>        |
| <b>Lowest score</b>                                |             | <b>6x</b>          | <b>1x</b>      | <b>1x</b>     | <b>3x</b>        |
| <b>Difference</b>                                  |             | <b>-6</b>          | <b>+3</b>      | <b>+4</b>     | <b>-1</b>        |

**Explanation:** The blue fields indicate the lifestyle-related topic with the respective highest point score per country; the yellow fields indicate the topic with the lowest point score.

The observed value range of the average total scores amounts to 23.6 points in the activity fields, and are determined by the difference between the area of mining and quarrying of energy-producing materials, with 69.0 points, and construction, with 45.4 points. Consequently, the observed range between the single fields is marginally smaller than between the countries (see Figure 4.1), with 26.1 points. This suggests that very different degrees of (lifestyle-related) WHP dissemination not only exist between the countries, but also between the activity fields in the individual countries. In this regard, it has to be considered that the data from very few companies is available for several fields, and that this data is concentrated on certain individual countries.

If one observes the individual lifestyle-related topics according to the number of the highest, resp., lowest scores in all activity fields, smoking prevention clearly achieves the lowest difference (-6), followed by combating stress (-1). On the other hand, active living (+4) as well as healthy eating show positive differences, i.e., that these topics were repeatedly evaluated the highest across the individual activity fields.





Thomas Fenzl / Phillip Mayring

# 5. Results of the MOGP Content Analysis

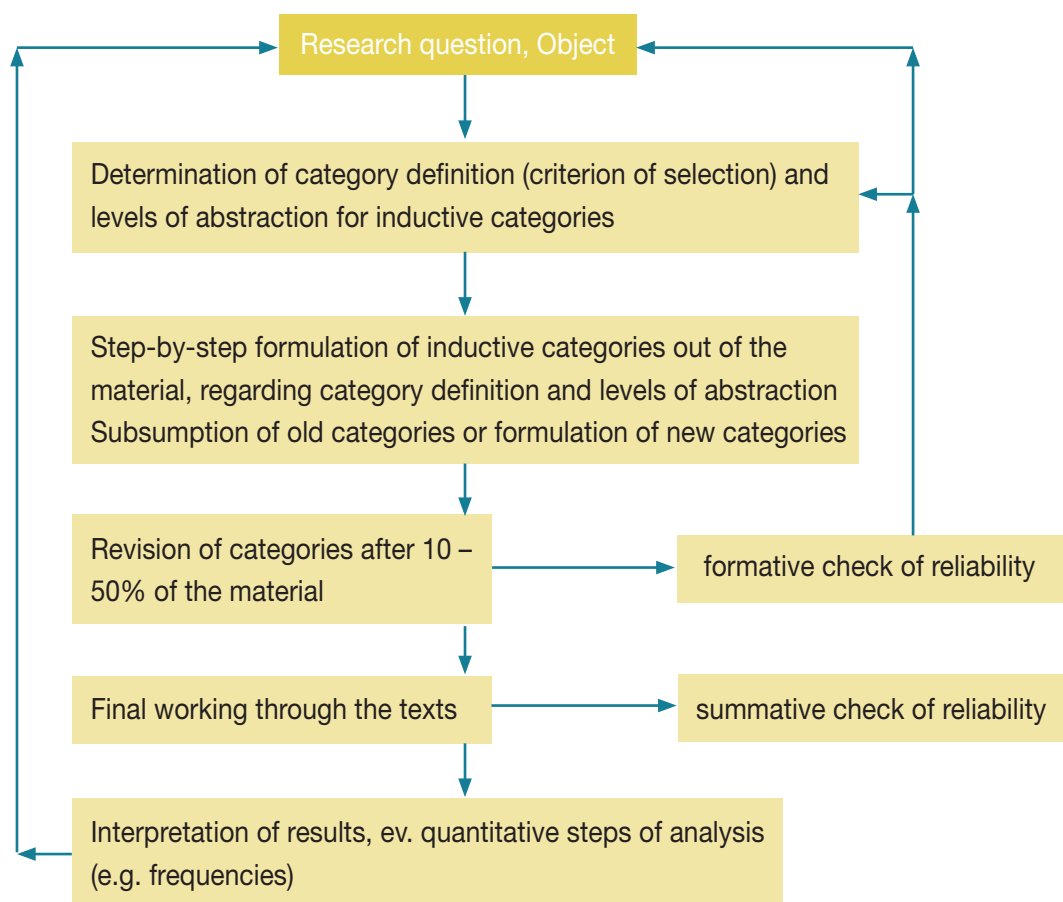
# 5. Results of the MOGP Content Analysis

## 5.1. Qualitative Content Analysis

The qualitative content analysis (Mayring 2007, 10th edition; cf. Mayring, Philipp (2000). Qualitative Content Analysis [28 paragraphs]. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 1(2), Art. 20, <http://nbn-resolving.de/urn:nbn:de:0114-fqs0002204>.) consists of a bundle of techniques for systematic text analysis as an integration of qualitative and quantitative procedures. The main idea thereby is to preserve the advantages of quantitative content analysis as developed within communication science and to transfer and further develop them to qualitative-interpretative steps of analysis.

Different techniques of qualitative content analysis have been worked out; in our context, the procedure of inductive category formation seemed to be adequate. The aim is to condense the main ideas and approaches of workplace health promotion (WHP) from the open-ended questionnaire material. The general step model for this procedure is described in Mayring, 2000:

Figure 1: Step model of inductive category development (Mayring 2000)



## 5.2. The Concrete Concept of Data Analysis

Data for analysis was provided in terms of semi-standardized best-practice questionnaires returned by companies and institutions all over Europe which were preselected as models of good practice (MOGP) on workplace health promotion (WHP). In their reports, the businesses and organizations gave information on how WHP is integrated into their company. Furthermore, they supplied program descriptions for four different health topics, namely smoking prevention, healthy eating, physical activity and combating stress/mental health, in three different sections: firstly, organization and structure; secondly, strategy and implementation; and thirdly, evaluation and results. The organization and structure section included information on action plans, establishment of working groups, available infrastructure, financial resources and several other issues. Concerning strategy and implementation, respondents provided data on needs assessment, availability of information and offered possibilities. In the third section, companies and institutions described how the evaluation was carried out and how the results were processed for future improvement.

In order to bring forth the crucial features and central measures of efficient and effective workplace health promotion, a qualitative content analysis of the provided data was conducted. After working through a first sample of reports, two global categories were formulated as open responses to the items on the semi-standardized best-practice questionnaires not always clearly referred to in the stated questions or sections. Category A includes descriptive elements of terms promoting the implementation of WHP, while Category B contains crucial points for the implementation of WHP.

While reading the responses of companies and institutions carefully, categories were formulated based on the methods of inductive category formation and answers were systematically classified. Formulated categories were reviewed and edited periodically while working through the questionnaires returned by companies and institutions. Furthermore, attention was paid to the fact that categories should have the same level of abstraction. At the beginning, categories were formulated for the integration of WHP, as well as for each of the four different health topics. As some answers were found repeatedly in smoking prevention, healthy food, physical activity and combating stress/mental health, a new section called “General Points,” which contained descriptive elements (A) and crucial points (B) for the implementation of workplace health promotion applicable to all four health topics, was opened. Thus, the qualitative content analysis of the provided data led to the definition of categories in the following topics:

- Integration of WHP
- General Points (Applicable to All 4 Health Topics of WHP)
- Smoking Prevention

- Healthy Food
- Physical Activity
- Combating Stress/Mental Health

In every topic except the area of “General Points,” the set of the two global categories was applied as mentioned before: Class B, including categories referring to crucial points specific to the topic and Class A, containing a set of descriptive elements, namely categories relevant to specific plans and actions as well as measures explicitly taken.

Subsequently, an attempt was made to summarize the categories into classes of a higher level of abstraction where possible and grouped together under topics specific to all of them. The derived topics included:

- Resources (material, time, financial resources, ...)
- Education (awareness, training, instruction, information, attitude, knowledge ...)
- Structure (change of principle procedures, infrastructure, environment, setting...)
- Strategy & implementation (concepts, methods, approach, ...)
- Evaluation (surveys, checks, review and adaption, data collection, ...)
- Objectives (aims and goals of measures ...).

Frequencies of categories were recorded throughout the whole sample according to two guidelines: Firstly, one answer could fall into the scope of several different categories; therefore, the response was counted once in each of the corresponding categories. Secondly, every category was only counted once per respondent, even though multiple answers on the same questionnaire fell into the same category. Hence, the total frequency of each category depicts the number of businesses and organizations applying this same crucial feature or descriptive measure in WHP.

To back up the results of the qualitative content analysis, an interrater check was conducted. A second investigator analyzed a predefined sample of questionnaires and found categories were checked for matching. The interrater check confirmed the formulated categories and revealed that the abstraction level was appropriate.

### 5.3. Data Basis

A total of 65 models of good practice (MOGP) on workplace health promotion (WHP) among European companies and institutions have been evaluated using quantitative content analysis. Semi-standardized best-practice questionnaires were returned from nine countries, providing a wide range of different businesses and organizations, spanning from education and administration to the service sector and the manufacturing industry.

Table 1: Sample of MOGPs

| Country        | MOGPs returned |
|----------------|----------------|
| Austria        | 26             |
| Bulgaria       | 2              |
| Czech Republic | 2              |
| Germany        | 12             |
| Hungary        | 10             |
| Netherlands    | 6              |
| Norway         | 3              |
| Spain          | 1              |
| United Kingdom | 3              |

Not all of the returned reports included information in all four areas of health behavior (smoking, nutrition, physical activity and stress / mental health). Almost all companies and organizations stated that they had established or planned measures in the whole range of workplace health promotion, but for lack of time some of them described only a few fields in detail.

## 5.4. Results & Interpretation

### 4.1 General Points: Applicable to All 4 Specific Areas

The qualitative content analysis of reports returned by companies and organizations found a number of categories which can be named for all four specific fields of workplace health promotion – namely smoking, healthy food, physical activity and mental health/stress – and were therefore summarized under the topic “General Points.”

Topic: RESOURCES

- G\_1. Motivating economic and non-financial incentives
- G\_2. Management motivates employees towards healthy behavior
- G\_3. Awards for employee proposals on WHP measures

Topic: STRUCTURE

- G\_4. Favorable climate and tradition
- G\_5. In-house promotion of WHP measures via multiple channels (poster stands, intranet, homepages, company magazine, newsletter, general health information booklets, personal contact, health portal, ...)
- G\_6. Experts and professionals involved in concrete/actual measures (e.g., fitness trainer, nutritionist, psychologist, medical doctor, physiotherapist, coaching, ...)
- G\_7. In-house/on-site occupational health departments/services
- G\_8. Access to contact persons (hotline, on-site)
- G\_9. Consultations with experts on health topics (individual and/or group sessions)
- G\_10. Variety: offer choice among several options / activities
- G\_11. Cooperation with health insurance funds

Topic: STRATEGY & IMPLEMENTATION

- G\_12. (Individual, personal) tailored measures
- G\_13. Form target groups for measures and actions taken (age, gender, occupation ...)
- G\_14. Involvement of family and friends

Topic: EDUCATION

- G\_15. Role models for health behavior in the company
- G\_16. Provide advice and information (on workplace health promotion / healthy behavior / how to avoid risk)
- G\_17. Well-being and health days
- G\_18. Information package on WHP measures for new employees
- G\_19. Regular workplace health programs (e.g., health behavior campaigns, workshops, presentations and trainings for nutrition, physical activity, drug awareness, health awareness, stress management, overweight program, cancer prevention, ...)
- G\_20. Managers receive training in health management (to proactively support staff)
- G\_21. (High quality) health education / training for employees regarding healthy behavior
- G\_22. Regular training for in-house occupational health staff to remain up-to-date

Topic: EVALUATION

- G\_23. Regular inspections of workplaces
- G\_24. Health management (prevention, health promotion and stress management) as a part of regular job evaluation conversations between managers and employees

G\_25. Periodic (e.g., annual) preventive health & medical checks

G\_26. PC program for personal risk factor analysis

Frequencies of the inductively formed categories are shown in Figure 2. Concerning the categories named for all four specific fields of workplace health promotion, namely smoking, healthy food, physical activity and mental health/stress, the topic structure was most important (named 276 times), followed by education (mentioned 190 times). Categories falling into the topics resource, strategy and evaluation were named significantly less often. Therefore, the results show that the change of principal procedures in the companies, the provision of adequate infrastructures, as well as the education of the staff and the formation of awareness and attitude towards healthy behavior are the most essential measures concerning all areas of workplace health promotion.

Categories mentioned most frequently concerning structure include the in-house promotion of WHP measures via multiple channels, the availability or establishment of in-house or on-site occupational health departments and services (e.g., dentist, first aid, physiotherapist, nurses trained in Cognitive Behavioral Therapy, nutritionist, psychologist, health physician, etc.), the involvement of experts and professionals in concrete measures and the possibility of consultations with them on various health topics (for example, mental health problems, smoking and addiction, exercising, nutrition, and others), either on an individual basis or in group sessions, as well as a favorable climate and tradition in the company (for instance, reasonable communication among staff, mutual respect, colleague help, relationship among colleagues, ...).

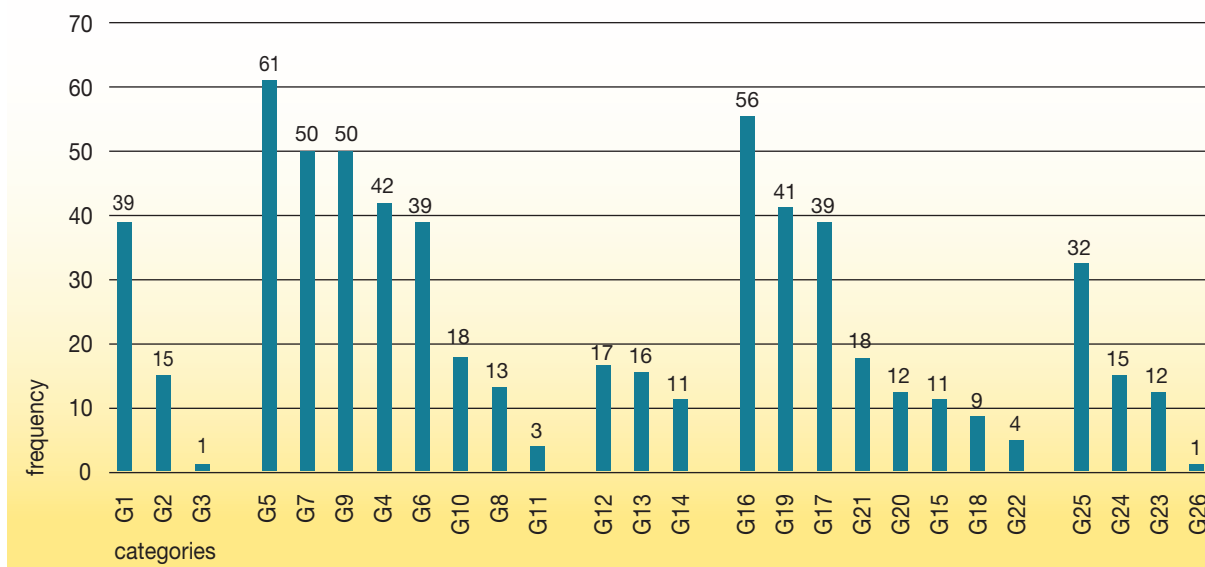
The issues most often stated in the topic of education were: firstly, the provision of advice and information on workplace health promotion, on how to avoid health risk and on healthy behavior in general; secondly, regular workplace health programs including campaigns, workshops, presentations, trainings and health behavior programs; and thirdly, an information package on WHP measures for new employees.

Furthermore, motivating economic and non-financial benefits were mentioned as a vital resource, and periodic preventive health and medical checks, for example, on an annual basis, are an essential tool for the evaluation of the program, for the early detection of health risks and for prevention.



Figure 2: Frequencies of specified categories

General Points (applicable to all 4 specific areas of WHP)



## 4.2 Integration of WHP

### Category B: Crucial Points

Found crucial points (B) in the integration of workplace health promotion among the models of good practice include the following categories grouped together under the mentioned topics:

#### Topic: RESOURCES

- IB1 (Targeted) provision of resources (material and fiscal)
- IB2 Provision of time

#### Topic: EDUCATION

- IB3 Constant communication on social, personal, occupational risk and workplace health issues (between employees and management staff, inter-/supervision, coaching)
- IB4 Increase knowledge, awareness and attitude towards healthy behavior / resources
- IB5 Encourage responsibility for well-being / healthy lifestyle

#### Topic: STRATEGY & IMPLEMENTATION

- IB6 Regular company-wide evaluation and adaption of measures and results
- IB7 Review / adaption of measures / action plans at certain intervals

- IB8 Support by management
- IB9 Broad active participation of the entire staff

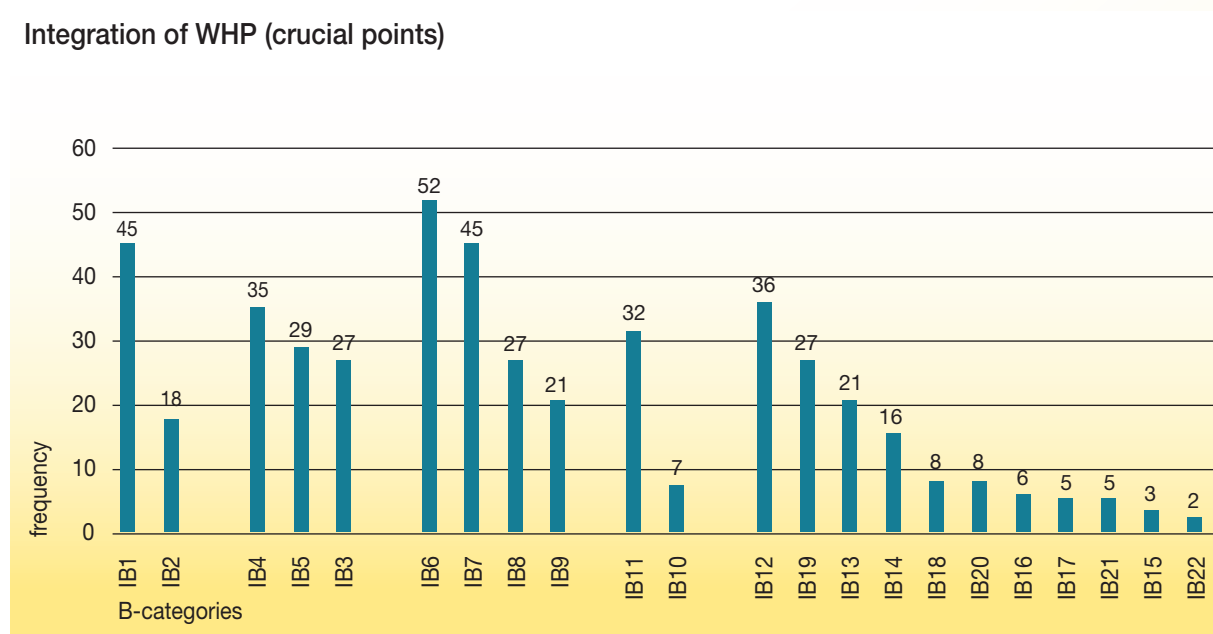
Topic: STRUCTURE

- IB10 Proper project management / thoroughly phased approach (preparing the organization – needs assessment – implementation of the program – a safe tying of the implemented program within the organization)
- IB11 Create a healthy, supportive working environment (feeling of comfort, security and support, labor safety, guaranteed employment, partnership)

Topic: OBJECTIVES

- IB12 Improve overall health of employees
- IB13 Balance work – private life / family
- IB14 Well-being
- IB15 Vitality
- IB16 Investment in human resources
- IB17 Self-help
- IB18 Healthy, vital and capable staff
- IB19 Prevention (keep healthy employee healthy, prevent sickness, sick leave)
- IB20 Occupational safety
- IB21 Healthy employees in a healthy company
- IB22 Happiness

Figure 3: Frequencies of inductively formed categories



The results of the qualitative content analysis show that the crucial points of a successful integration of WHP into the company policy and culture are, firstly, strategy and implementation (counted 145 times), and, secondly, education (90 counts). A thoroughly elaborated and sophisticated concept including regular company-wide evaluations of methods and measures applied as well as reviews of measures and adaption of action plans in specified intervals is as vital as the increase of knowledge in WHP, the creation of awareness towards healthy behavior and the encouragement of responsibility for a healthy life-style. Although appointed resources and a healthy and supportive working environment play important roles, they cannot guarantee the success of a workplace health program unless an elaborated approach is applied and awareness among the staff is raised. Improvement and promotion of the overall health of employees, prevention or, in other words, keeping healthy employees healthy, work-life balance and well-being are the most frequent objectives that workplace health initiatives try to address.

#### **Category A: Descriptive Elements**

The descriptive elements (A) for the integration of workplace health promotion identified in the analysis of the returned best-practice questionnaires include the following set of categories pooled together under the stated keywords:

##### Topic: STRATEGY & IMPLEMENTATION

- IA1 Separate (named) workplace health program
- IA2 2h per week of core working hours free for volunteer collaboration in working groups
- IA3 Health management as a responsibility of company management (discussed in meetings)
- IA4 Integration of WHP into business culture, company activity, management philosophy

##### Topic: STRUCTURE

- IA5 Implementation of WHP working groups
- IA6 Involvement of experts and professionals in planning and evaluation
- IA7 Engagement and involvement of staff in planning / development of WHP

##### Topic: EDUCATION

- IA8 Presentation of results and impact of WHP measures / activities to entire staff

Topic: EVALUATION AND DATA

IA9 Company database to register absence-of-work reasons & duration

IA10 In-house needs / risk assessments to formulate interventions

IA11 Attendance rates / utilization of WHP measures and activities

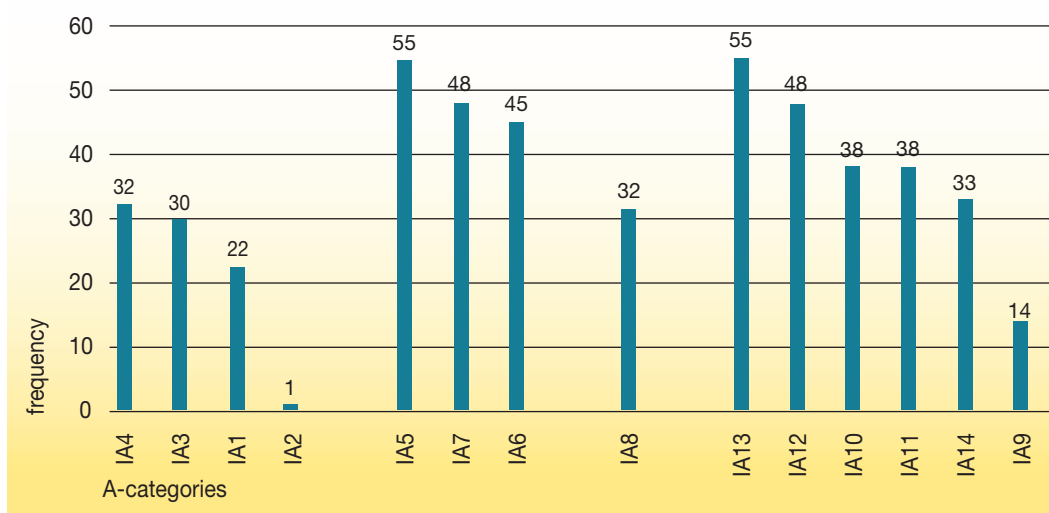
IA12 Employee feedback on WHP measures, action plan and activities

IA13 (Anonymous) employee proposals, inquiries, opinions, complaints, ...

IA14 Regular surveys of lifestyles and health behavior of employees (objective medical – BMI, blood pressure, ... behavioral – nutrition, physical activity, stress management, general health behavior, ... psychological data – motivation, self-management, competence, responsibility for own health, satisfaction, ...)

Figure 4: Frequencies of found categories

#### Integration of WHP (descriptive elements )



Frequencies of inductively formed categories indicate that structure (148 counts) and evaluation (named 226 times), include the most relevant elements describing the integration of workplace health promotion into the company policy and culture. According to the models of good practice, an effective and efficient evaluation should register in-house needs (e.g., desired foods, preferred sports activities, prevention of occupational risks, stress management training, and others), gather employee proposals, inquiries and opinions via blackboards, boxes, regular surveys, online forums and interviews, monitor attendance rates and utilization of provided measures and validate the program by acquiring feedback of the staff on WHP measures and action plans. As to the structure of the integration of workplace health promotion, WHP working groups should be implemented, not only

involving experts and professionals for planning and evaluation, but also including the staff into the process. Furthermore, the presentation of the impact, results and effects of the workplace health program to the entire staff is a crucial element to create awareness among the employees.

### 4.3 Smoking

#### Category B: Crucial Points

Regarding crucial points (B) in smoking, specific measures following sets of grouped categories were identified in the analysis of the models of good practice:

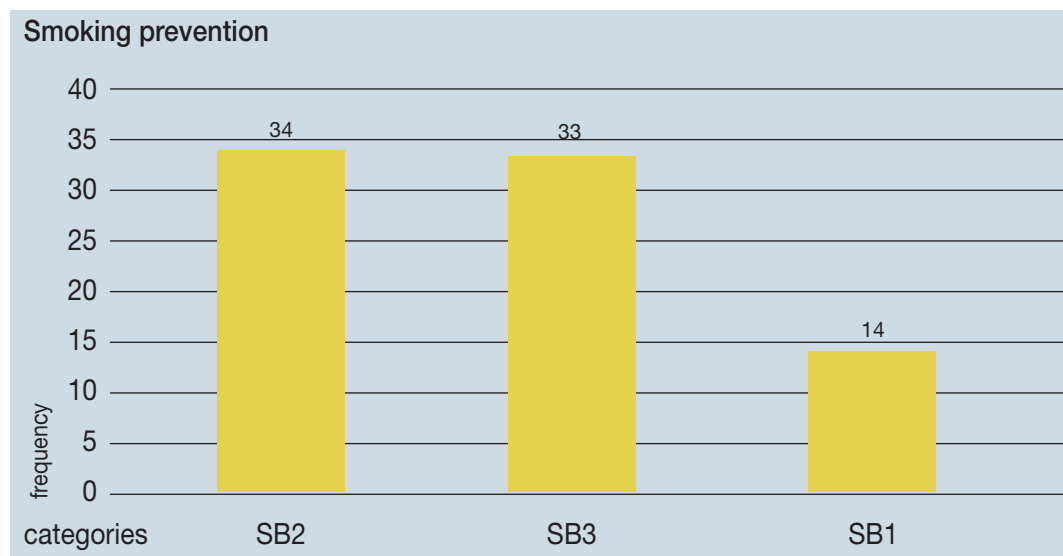
Topic: STRATEGY & IMPLEMENTATION

SB1 Smoking prevention and protecting non-smokers

SB2 Smoke-free areas/environment - ban smoking from workplaces / company territory

SB3 Introduction of stop-smoking programs (in-house or external)

Figure 5: Frequencies of formed categories



#### Category A: Descriptive Elements

Regarding descriptive elements (A) in smoking, specific measures following sets of grouped categories were identified in the analysis of the models of good practice:

Topic: STRATEGY & IMPLEMENTATION

SA1 No smoking in company vehicles

SA2 Smoking in (regulated) breaks only

Topic: STRUCTURE

SA3 Appointed places for smoking

Topic: RESOURCES

SA4 Non-smoking & stop-smoking bonuses

SA5 Provide alternative medicines for smokers

Topic: EVALUATION

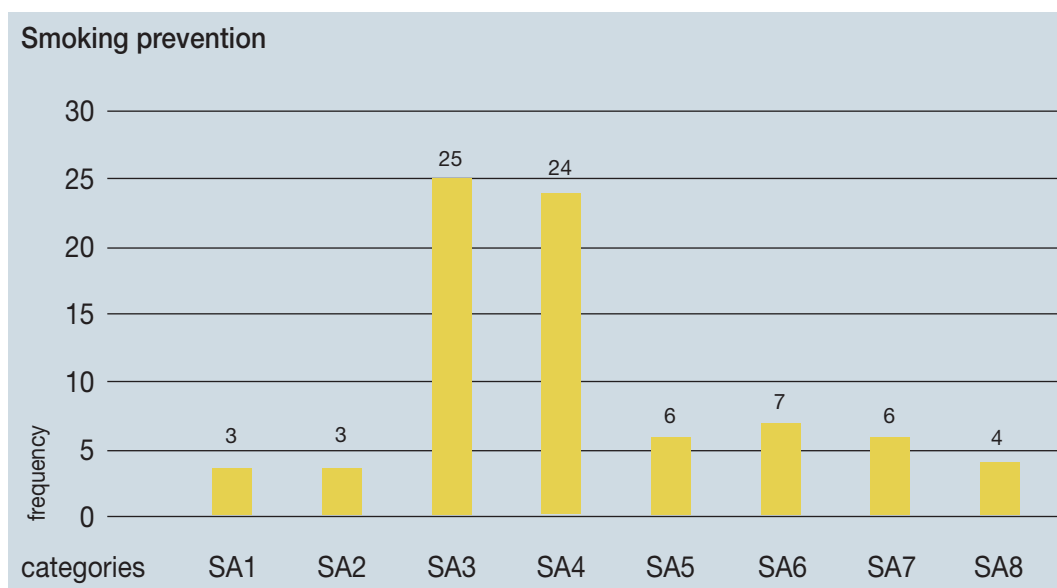
SA6 CO measurements (for evaluation)

SA7 Monitor compliance with smoking prohibition

Topic: EDUCATION

SA8 Counteract addictive behavior at an early stage (young employees)

Figure 6: Frequencies of formed categories



The analysis of the best-practice questionnaires revealed that, besides the general points applicable to all four areas of workplace health promotion, the two most crucial points in the health topic of smoking are: firstly, the provision of a smoke-free environment, meaning smoking bans at the workplaces, offices and company territory as well as the provision of designated smoking areas either outdoors or in restricted areas with sufficient ventilation; and, secondly, the introduction of stop-smoking programs for employees, combined with non-smoking and stop-smoking bonuses, for example, covering the costs of quit-smoking programs partly or fully for employees who succeed in stopping smoking.

## 4.4 Healthy Food

### Category B: Crucial Points

In the healthy food topic area, specific measures following a set of grouped categories concerning crucial points (B) were identified in the analysis of reports returned by companies and organizations:

Topic: EDUCATION

FB1 Awareness towards nutritional balance / healthy nourishment

FB2 Social acceptability of healthy eating

FB3 Confident choosing / conscious eating

Topic: STRUCTURE

FB4 Provide good accessibility to healthy food

FB5 Offer wide choice of healthy foods and drinks (on company territory)

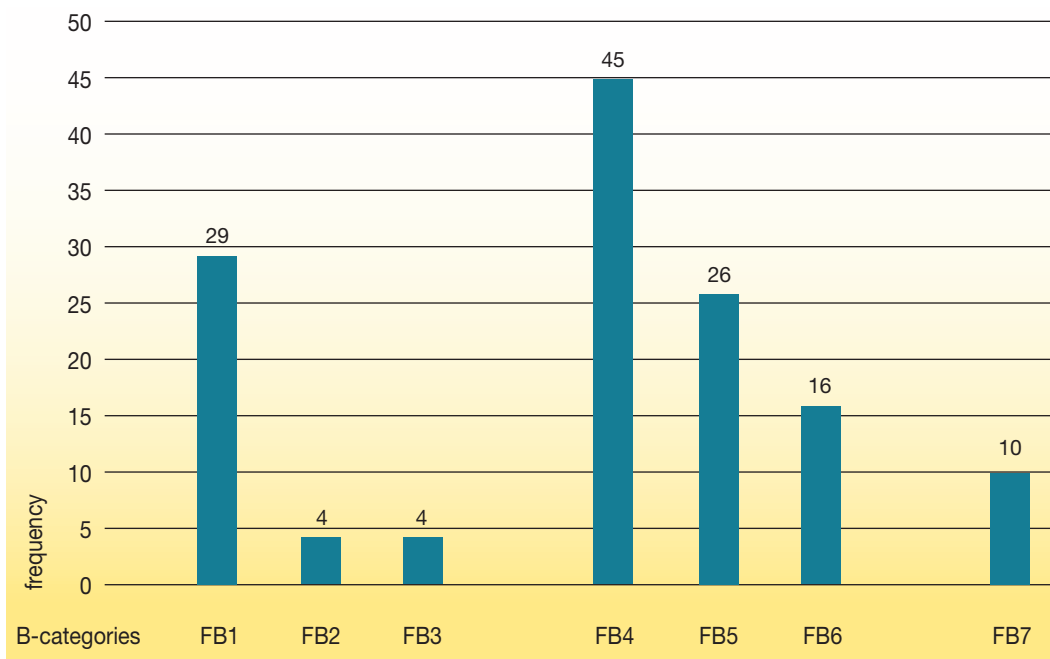
FB6 Quality and value for money (e.g., ingredients, size, ...)

Topic: STRATEGY & IMPLEMENTATION

FB7 Clearly labeled healthy foods

Figure 7: Frequencies of stated categories

### Healthy food (crucial points)



Frequencies of inductively formed categories indicate that structure (87 counts) is the most crucial topic for the promotion of healthy food in a workplace health program, besides the crucial points stated in the section "General Points". Not only a wide choice of healthy foods and drinks with an adequate price-quality ratio should be offered on company grounds (for example, salads, fruits, vegetables, organic products, drinking water, etc.), but they should also be readily accessible, for instance, in canteens, through vending machines, vitality buffets, self-service-stations and others. According to the models of good practice, the provision of and easy accessibility to healthy foods have to be accompanied by the education of employees towards a nutritional balance and healthy nourishment in order to guarantee the efficacy of a healthy food promotion program.

#### **Category A: Descriptive Elements**

The descriptive elements (A) for healthy food-specific measures in workplace health promotion found in the analysis of the returned best-practice questionnaires include the following set of grouped categories:

##### Topic: RESOURCES

- FA1 Actively market healthy choices (healthy eating offers / bonuses)
- FA2 Offer free fresh fruit
- FA3 Offer free healthy beverages throughout company territory
- FA4 Provide lunch vouchers
- FA5 Company covers costs of (healthy) food (e.g., breakfast, lunch) partly/totally

##### Topic: STRUCTURE

- FA6 Provide special diets (e.g., low carbohydrates, low fat, high fiber, ...)
- FA7 Allow for flexible and adequate food breaks
- FA8 Pleasant, clean and excellently equipped canteens, areas for feeding/food preparation
- FA9 Tearooms and kitchenettes for the preparation of warm drinks and meals
- FA10 Eating areas as a place for relaxation, for communication and as meeting points
- FA11 Participation in professional weight loss programs (e.g., in specialized clinics)

##### Topic: EDUCATION

- FA12 Contents of basic nourishment posted (on menu, in dining areas, ...)
- FA13 Training of canteen workers / catering staff / cooks on healthy eating
- FA14 Cooking courses for a health-oriented diet



Topic: STRATEGY & IMPLEMENTATION

FA15 Incorporate healthy options into corporate events and meetings

FA16 Integrate healthy food into daily life

FA17 Motivate employees to eat in company territory

FA18 Ban the sale of cigarettes and alcoholic drinks

FA19 Restaurant/canteen guests choose their own portion size

FA20 In-time preparation of dishes

FA21 Company weight loss programs & competitions

FA22 Best recipe contests and cooking competitions

Topic: EVALUATION

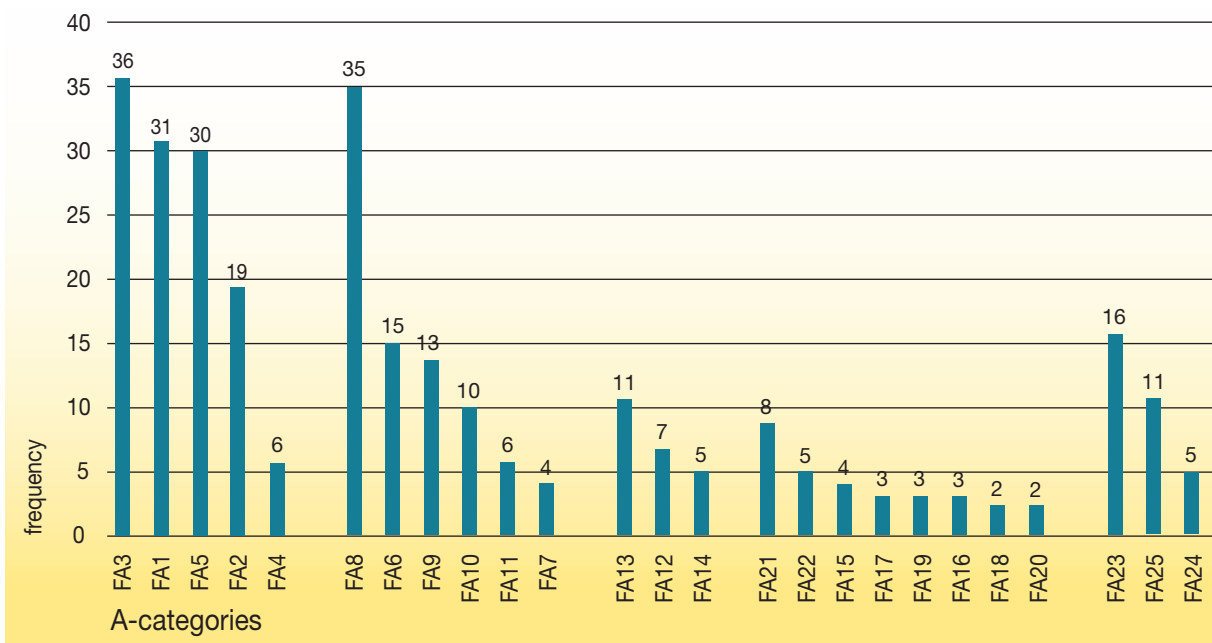
FA23 Regular meetings with canteen operator/catering company/suppliers to improve range and quality of healthy options

FA24 Sales mix analysis to evaluate needs and eating behavior

FA25 Regular status-quo analysis of menus offered and constant optimization

Figure 8: Frequencies of defined categories

Healthy food (descriptive elements )



The qualitative content analysis of the open-ended questionnaires provided by companies and institutions showed that in addition to the general points applicable to smoking, healthy food, physical activity and stress / mental health and the crucial points stated above, descriptive elements in the topics structure (83 counts) and resources (112 counts) are most vital to the promotion of healthy food in a WHP program.

Descriptive elements concerning resources mentioned most frequently by the models of good practice are free healthy beverages – mostly water and tea, but also fruit juice and milk in some cases – offered throughout company territory, active marketing of healthy food (e.g., daily healthy options or meals, discounts on healthy food, buy a healthy soup – get a free low-fat yoghurt, replace cake with free fruit, ...) and that the company should partly or fully cover the costs of healthy food. The provision of pleasant (e.g., design, paintings, green pants, etc.), clean and excellently equipped areas for serving and preparing food (for example, canteens, kitchenettes, buffets and others) is described as a vital structure.

#### 4.5 Physical Activity

##### **Category B: Crucial Points**

The qualitative content analysis of reports on workplace health promotion returned by best-practice companies and organizations found the following set of grouped categories regarding crucial points (B):

Topic: EDUCATION

PB1 Encourage/motivate physical activity

PB2 Importance of physical activity

PB3 Become sound in body and soul

Topic: STRATEGY & IMPLEMENTATION

PB4 Encourage sports activities and participation in social events in non-working hours

PB5 Health-based sports (fitness, prevention and relaxation)

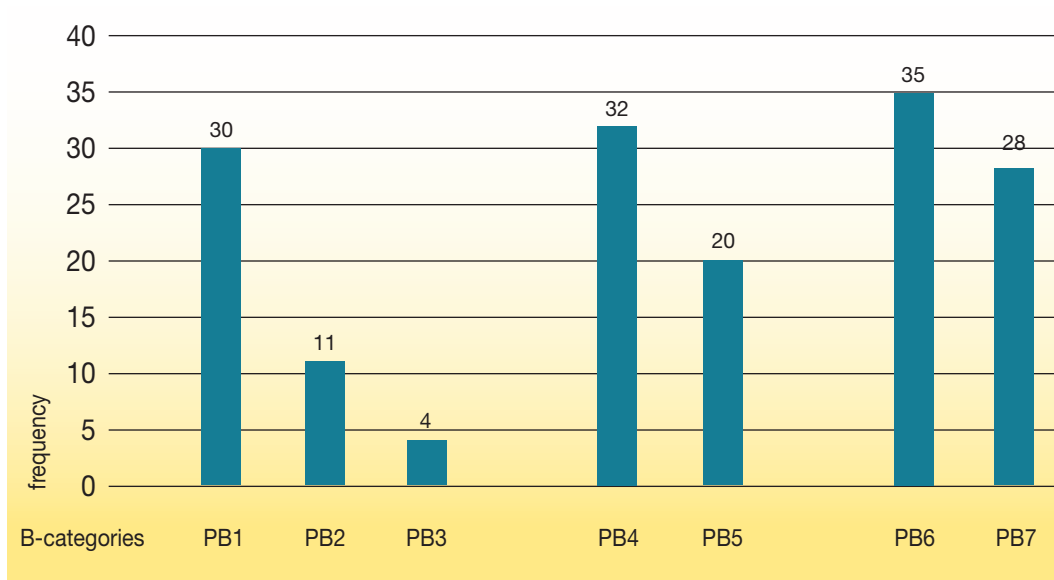
Topic: STRUCTURE

PB6 Options and special programs for physical exercise offered through the company

PB7 Provide good accessibility to activities/physical exercise (on/near company site)

Figure 9: Frequencies of inductively-formed categories

Physical activity (crucial points)



Besides the general crucial points described earlier, the inductive category formation also revealed specifically for the promotion of physical activity that models of good practice do not only educate employees on the importance of physical activity and apply a concept and an approach that encourages participation in social events and sports activities – especially health-based sports for health preservation and prevention of sickness and injuries – but also provide a variety of special programs for physical exercise and activities offered through the company, combined with easy accessibility of those programs, for example, on or near the company site.

**Category A: Descriptive Elements**

Descriptive elements (A) in physical activity-specific measures across the models of good practice in workplace health promotion include the following grouped categories:

Topic: STRUCTURE

- PA1 Wide choice of in-house sports activities and exercising on/near company territory
- PA2 Sports facilities on company site
- PA3 Showering and changing facilities on site
- PA4 Cooperation with external sports centers
- PA5 Allow for safe, active participation at all levels of skill and interest (low threshold)
- PA6 Suitable times for physical activity and exercise lessons

- PA7 Ergonomic workplace (e.g., gymnastic balls instead of regular office seats, ...)
- PA8 Participation in company running events
- PA9 Company sports teams / clubs
- PA10 Provision of rehabilitation procedures when needed

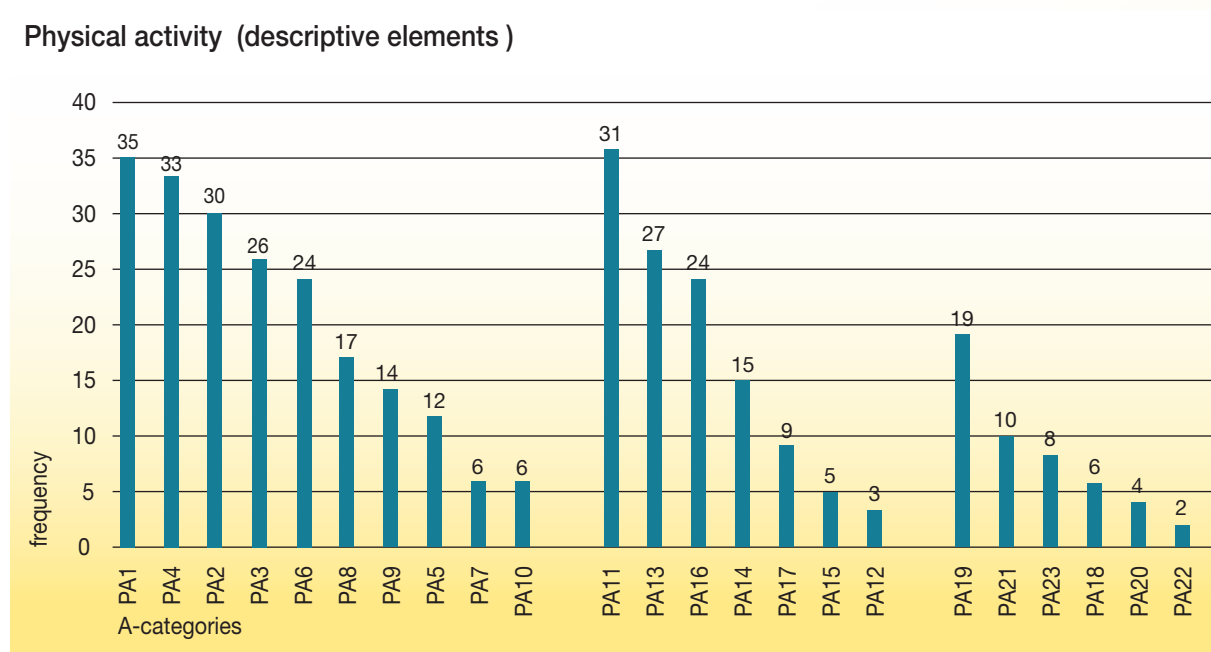
Topic: STRATEGY & IMPLEMENTATION

- PA11 Provide physical and social activities and action days for staff, whole families, friends
- PA12 Familiarize employees with new sports (e.g., Nordic walking, ...)
- PA13 Encourage walks and physical exercise during breaks
- PA14 Special back pain programs
- PA15 Encourage walks, cycle rides and bus travel (also between company locations)
- PA16 Encourage biking to work
- PA17 Physical activity competitions among staff

Topic: RESOURCES

- PA18 Time quota of core working hours for participation in physical activity
- PA19 Offer sports activities and exercising lessons at discount rates or free of charge
- PA20 Discounts for personal trainers / vitality coaches
- PA21 Discounts / vouchers for common recreation facilities
- PA22 Free tickets to social / cultural events
- PA23 Sponsoring of external employee sports activities in sports clubs

Figure 10: Frequencies of found categories



Results of the data analysis indicate that structure (203 counts) and strategy (114 counts) include the essential descriptive elements that add to the crucial points most important to an efficient and effective promotion of physical activity in a WHP program.

The infrastructure and setting provided should make a wide choice of sports activities and exercises (e.g., cardio-vascular training sessions, strength training, yoga, Pilates, aerobics, table tennis, ice hockey, running, and others) available on or near the company territory, either with sports facilities on company grounds (for instance, cardio area, gym, gymnastics room, showering and changing facilities, etc.) or through cooperation with external sports centers and facilities (e.g., discounted or free admission to regional gyms, fitness centers, swimming pools, local clubs for various sports, and others). The most frequently stated elements describing the strategy and concept of the promotion of physical activity by models of good practice include encouraging walks and physical exercising in shorter working breaks and during lunchtime – lunch walks are organized and gymnastic balls, thera-bands, balance boards, exercise booklets as well as exercise instructions on workplace monitors are provided for these purposes in some cases – support for taking the bike to work (for example, by providing guarded bike stands or rental bikes from the company, take-the-bike bonuses, like a free healthy breakfast or discounts for bike purchasers), and the organization of action days and physical as well as social activities for employees, as well as their families and friends (e.g., sports competitions, fishing days, biking tours, hiking tours, running meetings, outdoor weekends, among others).

#### 4.6 Combating Stress / Mental Health

##### Category B: Crucial Points

Regarding crucial points (B) in mental health/stress-specific measures, the following set of grouped categories was identified in the qualitative content analysis of reports on workplace health promotion returned by best-practice businesses and institutions:

Topic: EDUCATION

MB1 Awareness of mental health

Topic: OBJECTIVES

MB2 Mentally healthy workplace

MB3 Family friendly workplace

MB4 Resilience

Topic: STRATEGY & IMPLEMENTATION

MB5 Increase efficacy, pleasure and satisfaction of employees

MB6 Constant improvement in motivating the staff

MB7 Continuous improvement of working conditions

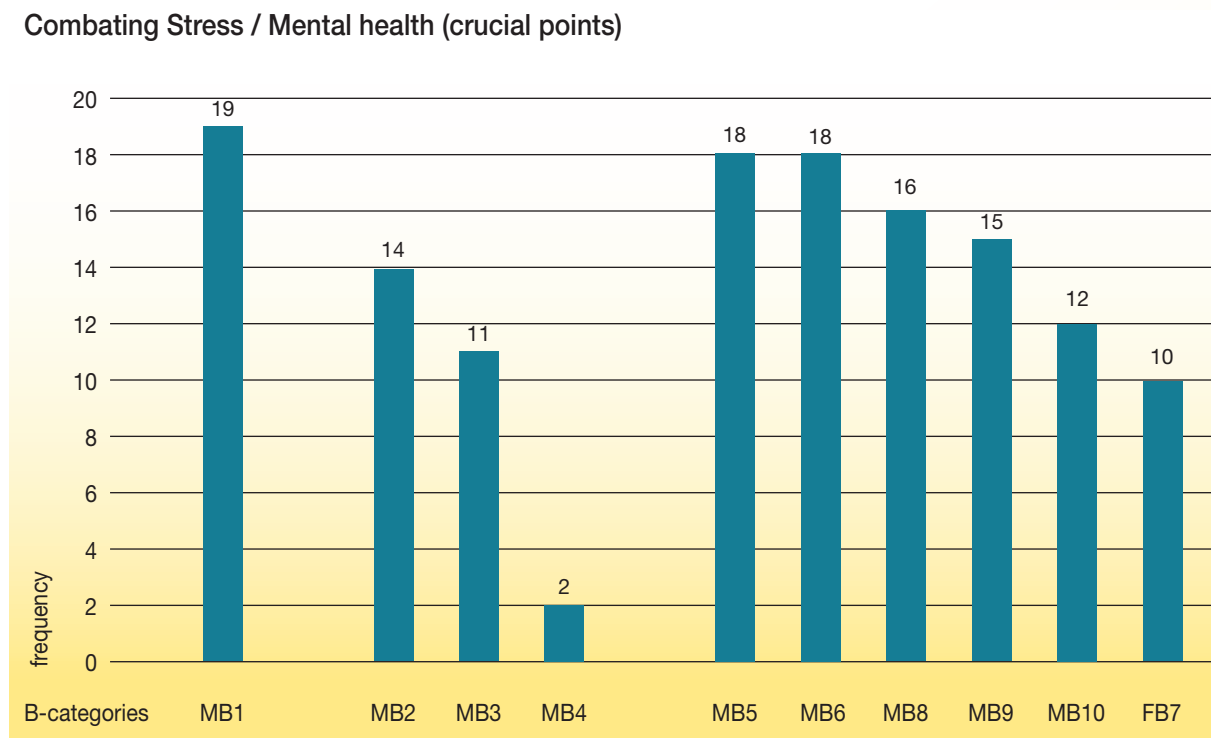
MB8 Stress prevention (avoid harmful levels of stress / reduce stress and control workload)

MB9 Assure adequate employee stress management

MB10 Consider individual capacity in task selection and work rate

Frequencies of categories are depicted in Figure 11. The results of the qualitative content analysis show that the crucial points stated by models of good practice for a successful prevention of stress and promotion of mental health at the workplace mainly include an elaborated concept that maintains and increases the efficacy and satisfaction of employees, continuously motivates the staff, has a worked-out approach on stress prevention to reduce stress and control workload, and that provides adequate stress-management to all company members. Nevertheless, the efficiency of the strategy and the applied methods also crucially depend on the awareness and acceptance of mental health among employees.

Figure 11: Frequencies of formed categories



### **Category A: Descriptive Elements**

The descriptive elements (A) for mental health/stress-specific measures identified in the analysis of the returned best-practice questionnaires include the following set of grouped categories:

#### Topic: STRUCTURE

- MA1 Friendly and pleasant workplace design
- MA2 Barrier-free and suitable workplaces for older employees
- MA3 Special care for retiring employees
- MA4 In-house social service for support of employees already experiencing problems
- MA5 Provide access to contact person when troubled with stress or conflict
- MA6 Physiotherapy services available on company site
- MA7 Provide relaxation areas to cope with stress and physical / mental fatigue
- MA8 Meet short-term childcare needs  
(working mothers and fathers take children to work)
- MA9 Attractive and varying workplace character (mobility and rotation)
- MA10 Broad possibilities and company support for education and training of employees

#### Topic: RESOURCES

- MA11 Incentives for compliance and for provided safe and good working conditions
- MA12 Company provides psychologist if needed

#### Topic: EVALUATION

- MA13 Careful observation of stress-related work absences
- MA14 Regular job evaluation conversations
- MA15 Improvement of sleep
- MA16 Standardized instrument to detect workload, stress, aggression, emotional restraints, ...
- MA17 Employee satisfaction survey

#### Topic: STRATEGY & IMPLEMENTATION

- MA18 Flexibility of working organisation
- MA19 "Forced" regular work breaks

- MA20 Reduce overtime work
- MA21 Involvement of employees in decision-making process (more responsibility)
- MA22 Provide assignments that best suit aptitudes of employees

Topic: EDUCATION

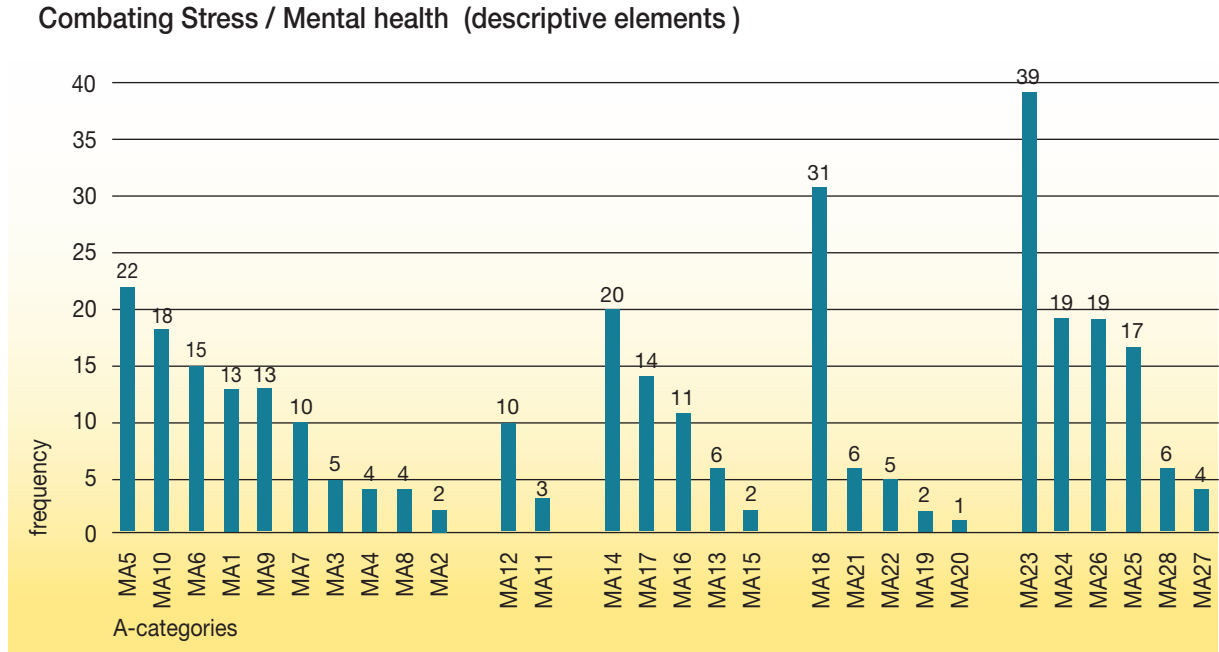
- MA23 Training programs for employees on stress management
- MA24 Training programs for employees on conflict management
- MA25 Team building programs
- MA26 Mental health training for managers / department heads  
(to proactively support staff)
- MA27 Remove stigma around mental health issues
- MA28 Shift cultural perceptions

Frequencies of inductively formed categories are illustrated in Figure 11. The qualitative content analysis of the open-ended questionnaires provided by companies and institutions showed that descriptive elements in the topics structure (106 counts) and education (104 counts) are most vital to stress prevention and mental health promotion at the workplace, besides the general points applicable to all four areas of workplace health promotion.

Descriptive elements concerning structure mentioned most frequently by the models of good practice are a physiotherapy service available on company grounds, the access to contact persons (e.g., psychologist, coach, primary trauma prevention, emergency support, etc.) available on-site or via a hotline for employees that are troubled with stress or conflict, as well as company support for work-related education and training of employees, including staff mobility. The flexibility of work organization is mentioned as a vital approach to the topic and can, for instance, include home offices, flexible working hours (e.g., “flexitime”: fixed presence hours and self-management of remaining work hours) and support for childcare, as well as promotion of workplace return after family-related leave. Above all, the entire staff should be educated on stress and conflict management (e.g., better balance of work and private life, how to set priorities in work tasks, personal effectiveness, meditation, yoga, burnout prevention, breathing exercises, time management, and others).



Figure 12: Frequency of defined categories



## 5.5. Conclusion

### General Points

The results of the qualitative content analysis of the semi-standardized best-practice questionnaires returned by the companies and institutions that were selected as models of good practice in workplace health promotion applicable to all four of the specific fields of workplace health promotion (smoking, healthy food, physical activity and stress/mental health) surveyed indicated that the change of principal procedures in the companies and the provision of adequate structures, as well as the education of the staff and the formation of awareness and attitude towards healthy behavior in the organization, are far more vital to the success of workplace health promotion than the appointed resources.

### Integration of WHP

Although resources and a healthy and supportive working environment play an important role in the integration of workplace health promotion into the company policy and culture, a thoroughly elaborated and sophisticated concept and the creation of awareness and responsibility towards healthy behavior among the employees are the real crucial points. Improvement of the overall health of employees, prevention, well-being and work-life balance should be the key objectives of the program. According to the models of good practice, a successful integration of WHP into the company or organization also includes the establishment of working groups which not only include experts and professionals, but also staff members, a proper evaluation of the program and the presentation of the impact, results and effects of the workplace health program to the entire staff.

### Smoking

Besides the general points applicable to all four areas of workplace health promotion, the two most crucial points in smoking prevention are, firstly, a smoke-free environment, including a smoking ban at workplaces and the provision of designated smoking areas and, secondly, the introduction of stop-smoking programs for employees, combined with bonuses for employees who are non-smokers or who successfully quit smoking.

### Healthy Food

In addition to the general points stated earlier, the creation of an adequate structure and setting, including the provision and easy accessibility of a wide choice of healthy foods and drinks on company territory, combined with an adequate education of employees towards healthy nourishment and a nutritional balance, are the crucial measures essential to the efficacy of a healthy food-specific WHP program. The infrastructure should include pleasant, clean and excellently equipped areas for serving and preparing food. Moreover, free healthy beverages offered throughout company territory and a partial or full absorption of the costs for healthy food by the company are essential resources for a successful promotion of healthy food.

### Physical Activity

Besides the general crucial points described earlier, the promotion of physical activity in models of good practice for WHP includes: firstly, a concept and an approach that encourages physical exercise and sports activities as well as participation in social events during working and non-working hours and on weekends; secondly, an infrastructure and a setting that provides a wide variety of easily accessible special programs for physical exercise and activities either on company territory or through cooperation with external sports centers and facilities; and, thirdly, extensive information on the importance of physical activity to create awareness among employees.

### Combating Stress / Mental Health

Crucial points specifically stated on the promotion and of mental health and stress prevention at the workplace are: an elaborated concept that maintains and increases efficacy and satisfaction of employees, continuously motivates the staff, has a worked-out approach on stress-prevention to reduce stress and control workload and that provides adequate stress-management to all company members, as well as the awareness and acceptance of mental health among employees. The setting should provide a physiotherapy service available on company grounds, an easy access to contact persons on company grounds or via a hotline for employees that are troubled with stress or conflict, as well as company support for work-related education and training of employees. Furthermore, the flexibility of work organization and the education of the entire staff on stress and conflict management are vital to the concept of stress prevention.

Taken together, the study reveals that the efficacy of workplace health promotion does not primarily depend on the appointed resources, but much more on an elaborated and sophisticated approach, the provision of a supportive environment in the company, as well as the education of employees on health topics and the creation of awareness towards health-promoting behavior. For quality assurance, a professional evaluation of the WHP program should be implemented.





Oskar Meggeneder / Heinz Leitgöb

# 6. Policy Recommendations

## 6. Policy Recommendations

The essence of the results gained in the course of the three-year project should now be transferred into a series of policy recommendations that were developed in cooperation with all of the participating countries. In this connection, ideas, visions, wishes but also experiences and concrete proposals of all NCOs (National Contact Office) have been collected, condensed by means of a qualitative content analysis and jointly discussed. As the recommendations are mainly aimed at the national political level, these could – due to the previous multifaceted development, as well as the divergent status quo of lifestyle-oriented Workplace Health Promotion (WHP) in the participating countries – be formulated on a relatively general level. Also to be taken into consideration is that the political system (a strong central state versus a federalist state), the health system (state-run health care system or a social security system) and the role of the interest groups (as possible stakeholders) in the member countries are differently structured, so that the recommendations can sometimes only be applied in an adapted form and sometimes not at all. The succession of recommendations does not constitute a hierarchy, but rather the single proposals are interconnected and represent a conglomerate for the sustainable integration of (lifestyle-oriented) WHP.

### 6.1. Workplace Health Promotion (WPH) as a Holistic Approach

Based on the Luxemburg Declaration (ENWHP, 1997/current version: 2007)<sup>1</sup>, Workplace Health Promotion (WHP) is understood as a holistic approach that should sustainably improve the well-being of people at their working places. In this context, “holistic” stands for the common efforts of employees, employers as well as society to reach the set goals, on the one hand, and for the combination of behaviour- and relation-oriented measures, on the other hand. It is vital to combine activities for risk reduction with the simultaneous expansion of protection factors and health potentials at the workplace.

Following this understanding, the focus of “Move Europe” is mainly placed on shaping workplace framework conditions for a health-conscious behaviour of employees, not by influencing individual behaviour, but rather the behavioural orientation of employee groups (collective behavioural dimension). “The evidence for this argument [lies] on the participation of workers in the workplace health promotion programmes and on the fact that workers actually change their lifestyle as a consequence of the WHP programme” (De Greef/Van Den Broek, 2004:47). Moreover, a positive change in the health behaviour of employees represents only a partial aspect of the comprehensive concept of WHP that was observed in the course of this project. For this reason, the following recommendations are not limited to lifestyle-oriented WHP, but are much more globally formulated and predominantly aimed at the holistic approach.

Basically, the recommendations were divided into three central areas. What follows is an illustration of the recommended activities on the political level. An additional focal point of interest lies in the public financing of WHP. The third main focus is on support measures and the building up of competences in the WHP field.

## 6.2. Political Activities

Coming under the heading of political activities are those proposals for measures that contain the legal establishment of WHP, the development of a national WHP strategy and the involvement of relevant stakeholders affected by WHP. The following illustrated stage plan also corresponds to the global action plan of the WHO in regard to employee health.<sup>2</sup>

### Legal establishment and structuring of WHP through the national legislation as well as the development and adoption of a national health promotion strategy by the responsible parliaments

Although it is clear from the legal-socio viewpoint that the existence of a law does not necessarily change the social reality, the legal establishment of WHP can open the possibility of those involved to utilise their possibilities, under reference to the respective laws, to fully act on a legally safeguarded basis. The national contact offices can take the initiative upon the referral of the coordinated WHP policy and the numerous mutually conducted measures of the ENWHP. Policy areas of public health, employee protection, social security, health care or, ideally, health promotion in a narrower sense, present themselves for establishing WHP in the national laws. Wherever it is applied, it is dependent on the implementation of the mentioned policy areas as well as on the form of legislation. The main focus of efforts towards the legal establishment of WHP will be on that policy area which promises the presumably best possibilities of being transferred into everyday practice. However, because of the holistic approach of WHP, it is necessary to examine which other policy areas can promote the WHP approach.

In member countries with a strong central government that has the sole legislative competence, the law usually also contains the regulatory statutes or at least determines them. In member countries with a politically distinct federal structure, the central government usually decides upon the legal framework, and the legal decisions for carrying out the law usually then lie in the (partially) autonomous regional parliaments. However, this means a more effortful lobbying on the part of the contact offices. The financial safeguarding of an individual budget should be an integral component of such a law (see Financing). If the

1 Available at: [http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Luxembourg\\_Declaration.pdf](http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Luxembourg_Declaration.pdf) (Status: 20/08/2008)

2 Workers' health: draft global plan of action. [http://www.who.int/gb/ebwha/pdf\\_files/WHA60/A60\\_20-en.pdf](http://www.who.int/gb/ebwha/pdf_files/WHA60/A60_20-en.pdf)



framework for capacity building is stipulated in the law, the chance to determine quality requirements advocated by the ENWHP is given through the formulation of requirements concerning the training of actors in the scope of WHP.

Although the creation of a law on a national level is an important first step, it can only be the basis for the next, even more important step: The development of a national strategy for WHP or a general health promotion strategy in which WHP is an important integral component. Member states are increasingly considering the purposefulness of a national public health strategy. In this case, the WHP strategy should latch on here. A law can only offer the necessary legal as well as political support and thus contribute to the legitimacy of intensified measures in the area of health promotion and especially in WHP.

The national health promotion strategies should explicitly focus on WHP, follow the holistic approach and provide the creative leeway for designing regional, resp., local strategies that build upon each other to be able to best possibly adapt the measures for goal attainment to the local conditions. Therefore, it is obvious to involve the respectively relevant actors in the strategy formation. In the WHP field, these are particularly the employer and employee advocacy groups. In countries with a social security system, the responsible social insurance institutions (in most cases, the health insurance institutions) are also to be involved. If NCOs have already been cooperating with the aforementioned stakeholders, the development of a commonly supported strategy will probably face no difficulties. There are examples of successful strategy development on national and European levels. To support strategy development, a panel of scientific experts can doubtlessly make a valuable contribution. If they get involved, it should be assured that these experts follow the ENWHP approach. Such a panel of experts can also play a supportive part in building competences.

### Development of a national action plan

On the basis of a national (workplace) health promotion strategy, a middle-term (five-to ten-year) national action plan is to be developed. This plan contains arranged, measurable goals that are to be fulfilled within a determined time. By means of a periodic monitoring, the goal attainment will be observed closely and feedback will be provided to any institution or panel that has developed an action plan. In this way, the fulfilment of the goals can be checked, and if they have not been achieved, the corresponding suggestions can be made or stipulated. If necessary, a correction of the goals can also take place. In some member countries, the national government exercises restraint in connection with (workplace) health promotion and leaves the field open to private initiatives and providers. In this case, an agreement of the labour ministry and health ministry with the most important stakeholders is to be met so that they can take over responsibility for the goals and the action plan after a joint strategy formation.

### WHP as political cross-section material

(Workplace) health promotion should enter into the individual policy areas as a cross-section material and lead to an involvement, resp., a cooperation of the relevant ministries, whereby a ministry takes over the theme leadership and/or the total responsibility. This also corresponds to the principle of the Health in All Policies of the European Commission (Commission of the European Communities, 2007a). The goal should be to create a unified line/course of action as well as clear divisions of competence – based on the health promotion law and health promotion strategy – which should guarantee a cost-efficient use of available budgets by preventing redundancies (uncoordinated, overlapping measures of the ministries) and a maximum effectiveness through the careful planning of health promotion measures. Especially in the area of WHP, an involvement of the mentioned relevant stakeholders (employer and employee representatives, social insurance institutions, private actors, public health and health promotion facilities) has to take place so that a broadening of the ownership of the strategy and targets can be achieved. In this context, a potentially supportive role of OSH and work inspection should be pointed out, as they have been assigned goals on a European level that are compatible with the strategy of the ENWHP.<sup>3 4</sup>

### Development of a health promotion strategy as well as the formulation of goals on a regional, resp., local level

The landscape of (workplace) health promotion is colourful and diverse. Therefore, on the basis of a national health promotion strategy, supportive regional, resp., local strategies should be developed that are able to take into account the local conditions/structures as best as possible and bring forth concrete as well as detailed goals. The operational “day-to-day business” of WHP is established in this field. For this reason, an increased cooperation, resp., networking of the local executing authorities should be aspired. Important stakeholders at this level are the regional institutions of the aforementioned stakeholders, as well as the companies interested in conducting WHP in their own enterprises, but also firms that serve as “advertisers” for WHP, such as food producers or sporting goods manufacturers. If there is success, especially on a regional and local level, in getting politicians seriously interested in WHP, and if they are prepared to get involved publicly, this will be a positive influence that should not be underestimated, especially when the politician

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3 Council Resolution of 25 June on a new Community strategy on health and safety at work (2007-2010). In: Official Journal of the European 2007, C 145/1-C145/4

4 Improving quality and productivity at work: Community strategy 2007-2012 on health and safety at work. COM(2007) 62 final, Brussels 2007

leads a perceivably healthy lifestyle. When searching for stakeholders, the wider surroundings should also be included, as has already been stressed on the occasion of the 4th initiative (ENWHP Secretariat/BKK Federal Association, 2004:21).

### 6.3. Financing

A secured financing of health promotion should guarantee that the measures to attain the legal pretexts, resp., the aims of the national health promotion strategy can be planned and implemented for the long-term. What is said in the “Political Activity” chapter also applies here: The implementation of the proposals is dependent on the respective national governmental and/or health system.

#### **Annual budget in the national finances for WHP, resp., a budget financed from other sources**

The financing of health promotion measures through subsidies (non-repayable benefits) doubtlessly impede the implementation of a longer-term concept, as no legal claims to subsidies usually exist, so that their expected amount is uncertain; indeed, it is not even certain if subsidies will be distributed at all in a following period. Therefore, a fixed budget in the national finances should be aimed for. Although this can also vary in its amount, at least a legal claim exists in normal cases. The existence of an individual health promotion law would undoubtedly facilitate a legally secured and predictable budget. Principally, a fixed budget can also be secured by other financial means.

In countries with a statutory health insurance system, the budget can be raised through contribution revenues of the health insurers, whereby the expected amount of the budget for the actors can be assured through a fixed contribution from each insured person or a percentage of the contribution revenues. Depending on the way the statutory health insurance is financed, companies and/or employees indirectly provide the budget means – either in the form of a contribution for each employee in the company or the contribution amount is tied to business indicators (e.g., profit before taxes). In this way, the budget for the following period is not exactly calculable, but it would have a distributive joint effect. Depending on the composition of the social security system, it is also to be considered whether the legal occupational injury or occupational disability insurances should or can take over the financing. It is also conceivable that the mentioned insurances could act as additional financers, as a developed WHP culture doubtlessly contributes to reducing their expenses.

Basically, it is always to be examined whether other (additional) financers can also be found. Coming to mind here are, for instance, private health insurances, especially when there are no statutory health insurances. There are undoubtedly others who have a great interest in WHP or draw a benefit from it, such as statutory and private pension insurances,

accident insurances, welfare institutions, sporting goods manufacturers or the food industry. This approach of developing partnerships was recommended, e.g., for the food industry in connection with nutrition, overweight and obesity (Commission of the European Communities, 2007b). In our opinion, these means raised by the mentioned potential financiers are to be rather understood as additional “money” that is used, for instance, for financing focus programmes (like microenterprises). As a focus programme, the topic of alcohol at the workplace, as an example, offers itself well. Nonetheless, in connection with the development of an EU strategy for reducing alcohol consumption (among others, the workplace is explicitly listed), the producers and sellers of alcohol beverages have declared in advance that they would actively participate in reaching the goals (Commission of the European Communities, 2006a). “The participation of for-profit sectors is always controversial to some degree, and the involvement of vested interests of all kinds should be carefully organised in this field where promotion, prevention, rights, information and research actions and funding have major implications.”<sup>5</sup> If these misgivings are taken into account, the involvement of profit-oriented enterprises is completely possible.

#### **Creation of an incentive system for companies for the implementation, resp., anchoring of WHP**

The NCOs offered various proposals, such as tax rebates for companies, the state take-over of accident insurance contributions or a reduction of the health insurance contributions to be paid in the case that quality-assured WHP projects are implemented. However, the assessment of the projects must understandably be done by independent evaluators and the NCOs could lend themselves to these tasks. In any case, this indirect financing of WHP in the form of a bonus system is to be scrutinised, as it has often been shown in WHP that a bonus merely produces a bandwagon effect; this means that the involved persons, institutions or companies would have also conducted the subsidised activities and measures without a bonus. Basically, this form of financing is also to be included in the considerations.

#### **Continuous, assured financing for the organisations that implement WHP**

A part of the estimated budget has to be used for infrastructural measures, i.e., has to flow into those organisations that support companies in realising health promoting projects and offer conceptual advice during the implementation of health promoting measures. In many countries there are own central health promotion organisations (agencies, foundations, institutes, etc) – not seldom on a legal basis – that have the task of driving the development of health promotion in the individual national state forward. Such a national or publicly financed organisation will sensibly execute the health promotion

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5 Report and recommendations of the EU Consultative Platform on Mental Health 2006.  
<http://ec.europa.eu/health/ph-determinants/life-style/mental/green-paper/report-%20recom.pdf>, p. 9

strategy and the development of goals, as well as an action plan or catalogue of measures. As a rule, WHP is the best and furthest developed setting in the member countries. Therefore, it is understandable that in this setting there are numerous activities which also necessitate the commensurate provision of financial means. Because a central health promotion organisation has to serve all settings and target groups, relatively more money will flow into underdeveloped areas. This is certainly comprehensible and desirable, but can also result in WHP, as a well-organised setting, being neglected. Hence, WHP should gain an exceptional position that can be very well perceived by the NCOs. In this way, not one word about protectionism should be spoken, but it should rather be taken into account that the highest return on investment, at least up to now, has been in the WHP setting.

#### 6.4. Support measures and building up competences

In many member states, efforts towards so-called capacity building stand in the forefront of the public health field. This is necessary because the interdisciplinary and population-oriented approach of public health is relatively young, compared to the established health professions, and thus lacks adequately trained people. This is also true for the WHP field, which can be understood as a subarea of public health. A central component for the successful implementation of WHP at the grassroots level is well-trained people who are active in this area. For this reason, the following recommendations particularly refer to the implementation and extension of the corresponding training programs, the building of knowledge networks, as well as the support of companies through the provision of know-how. However, a successful practice of WHP demands a scientific-theoretical reflection, which, on its part, can again positively influence the quality of training at the different levels. Thus, WHP must also be a subject of research and teaching.

##### **Conception and establishment of training courses, seminars and conferences that serve the further training of those persons active in workplace health promotion**

These forms of (further) training of people who are operatively active in WHP should be conducted on the basis of the latest scientific knowledge by acknowledged experts. The training in terms of public health should be applied in a multidisciplinary manner, i.e., to combine the relevant approaches of various scientific disciplines to health promotion (medicine, social sciences, economic sciences, psychology, sports and nutrition sciences, ...), and to exhibit a practice-oriented, resp., application-oriented direction. In practice, WHP very strongly intervenes in the organisational structure of companies and can decisively contribute to organisational development in the enterprises. This means that the transfer of social competences has to be a main focus in the mediation of application-oriented instruments and methods (such as project management, for instance). To bear

in mind here are: moderation techniques, discussion techniques, negotiation techniques, conflict management and presentation techniques.

The training courses and further training measures should be structured in a multi-staged manner, whereby different models are absolutely conceivable. One curriculum possibility would be a basic training in a general management sense, which enables the trainee to conceive and set up complex company and intercompany organisation structures for WHP. A thematic focus, such as certain risk factors, activity groups (older people, migrants, apprentices, women, youth) or other settings (hospital, school, community) can be built upon this basic training. The latter is insofar important because, on one hand, a wider professional spectrum will be opened to the trained persons and, on the other hand, they will be able to act in the sense of a complete health promotion strategy and health promotion policy. In the field of risk factor-related WHP, the imparting of WHP subject matter can be built upon the source professions (nutritional scientist, sports scientist).

In addition to different curricula, however, a separation into primary training and part-time training is necessary. The primary training can either take place as a specialist training (either WHP alone or health promotion in general with elective focus areas or specialisations) at universities of applied sciences or universities or in the form of a post graduate training course after a specialised basic study (social sciences, business sciences, psychology, nutritional sciences, sports sciences). This part-time training can be conducted in the form of training courses at universities of applied sciences or universities, whereby the admission criteria are either a basic study, as mentioned before, or a specialised professional experience and practice (e.g., OSH experts).

Further training possibilities can and must be varied in shape and form in order to fulfil the different training needs. These include the application of instruments and techniques as well as learning content related to risk factors and employee groups. Target groups for training and further education are company actors, employees of organisations who organise or support WHP and commercial providers of services in the WHP field. Besides universities of applied sciences and universities, potential carriers of training and further education are health promotion facilities which are set up or financed by the public sector (the mentioned foundations and agencies) or other intercompany facilities that support and promote WHP (statutory health insurance institutes, organisational units in the ministries that are responsible for WHP). Financing can be provided from the following sources: From those budgets specifically earmarked for “financing”, as well as from contributions from those persons participating in the training measures, resp., the companies and organisations that send them there.

### **Expansion of regional, national and international networks between the relevant institutions**

The establishment of new networks and the further development of existing ones for mutual knowledge transfer should be encouraged at all levels, as these, on one hand,

lead to a rapid growth of knowledge and, on the other hand, open new multiregional and multinational perspectives. This consequently guarantees a continuing further development of knowledge regarding WHP in the countries/regions and, to a certain extent, enables the view of the individual strategies and activities from a meta position. The fact that the development of national forums or networks is an important supporting infrastructure measure was already stressed in the scope of the 4th initiative of the ENWHP (ENWHP Secretariat/BKK Federal Association, 2004:20). Subsequently, an exchange of experiences between the companies about the offer of platforms as well as the construction of regional company networks should additionally be promoted.

### Supportive measures and framework conditions

Posters, brochures, folders and printed material are generally estimated to have a very low effect on health promotion. This may undoubtedly be true if they are used as the sole health promotion instrument. However, they are extremely useful as a supportive measure. Posters can be used to kick-off a main focus campaign. Brochures and folders are employed as advertising material for concrete measures or for project acquisition. Printed material utilised as educational advertisement or as directions for self-study will probably have little effect – due to the social character of WHP alone. However, they can serve well to accompany and support training and to conduct projects (guidelines, check lists). Company actors and commercial providers of WHP can take advantage of these only in a limited scope or sometimes cannot utilise longer-running further training measures. Holding professional and information events, as well as circulating a newsletter, can also benefit these WHP actors. A newsletter can include experiential reports of companies and actors that can encourage people to begin individual activities. For heads of micro- and small-sized companies that conduct WHP projects, but suffer from an acute lack of time, holding project days is also a viable measure. In short, one- or two-day workshops, they get involved in the status of their projects and further develop them under the direction of a trainer or moderator with mutual support. In this way, a “WHP-based”, personal relationship network is created.

Incentives that go beyond the aforementioned financial inducements can be an important contribution to disseminating WHP in the firms and for quality assurance. The declaration of commitment to a WHP charter, the awarding of a WHP quality seal and the offer of a WHP prize are instruments that have proven themselves in practice. Experience has shown that a company culture that is committed to ethical values is a main driver for the WHP business case. Therefore, WHP should be a core element of corporate social responsibility (De Greef//Van Den Broek, 2004:55); one can particularly refer to the European Commission, which has long been involved in the promotion of corporate social responsibility (Commission of the European Communities, 2001; 2006b). The effect of these instruments can be even further strengthened, such as during the announcement

of public contracts, the allocation of public loans or subsidies, when, for example, the awarded WHP quality seal enters into the assessment of the offer or is considered as a precondition for the issuing of the loan or the amount of the subsidy. Finally, it should be stressed once again that the importance of training and further education is not to be underestimated. The WHO has also pointed out that the existence and enforcement of modern legislation as well as education and training are important prerequisites to improve employee health in a changing working world and to implement a secure and healthy, as well as health-promoting company culture (WHO, 2006).

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Christian Scharinger

# 7. Move Europe – Company Recommendations

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## 7.1. Introduction

In recent years, the topic of “health” has become a major issue in our working world. Regardless of the sectors and company sizes, the health of employees is a central key resource of enterprises and companies in Europe.

Therefore, many firms have taken up health-relevant topics and have initiated the corresponding activities and projects. The scope of visible activities is very diverse and ranges from single actions to comprehensive and long-term projects. Very often, the classic lifestyle issues – physical activity, healthy eating, mental health and smoking prevention – stand at the centre of thematic focus. The placing of this emphasis seems conceivable in the respect that these topics, on one hand, are consistent with the traditional understanding of health.

On the other hand, these main focus issues appear at first glance to have a rapid possibility of implementation on the company level. The “Move Europe” campaign of the European Network for Workplace Health Promotion (ENWHP) and the inferred recommendations are applied at this point.

The evaluation of the practice of Workplace Health Promotion (WHP) proves that single measures that purely aim at the behaviour of employees are not sufficient to bring about a sustainable improvement of the health situation in a company. Much more successful are holistic approaches. They assure that health-related focus issues will be established in the organisational culture and thereby incorporate the working conditions as well as address personal health maintenance.

The challenge can be summed up in the following key question: “How can I shape a company in such a way that the employees who work in this company find it easier to behave in a healthy way?” (*“Make the healthy choice the easier choice”* strategy).

In addition to the basic principles of sustainable Workplace Health Promotion (WHP), the recommendations at hand envisage possible ways of access and implementation to the topic areas of healthy eating, physical activity, mental health and smoking prevention.

## 7.2. The WHP Approach and the Move Europe Campaign

In the past years, the concept of WHP was able to establish itself in Europe as an important contribution to the development of “healthy” enterprises. The 1997 Luxemburg Declaration of Workplace Health Promotion in the European Union can be regarded as the most important policy document. According to this declaration, WHP is a modern company strategy and aims to prevent illnesses at the workplace, to strengthen health potentials and to improve well-being at the workplace. This can be achieved by combining the following approaches:

- Improving the work organisation and the working conditions in the company
- Promoting active employee involvement
- Strengthening personal competences.

The Move Europe campaign has set the goal of strengthening the significance of WHP throughout Europe and places the promotion of a healthy lifestyle at the centre of attention. The thematic focus is set on these factors: healthy eating, physical activity, mental health and smoking prevention.

Even if these issues apparently relate to the personal health behaviour of employees at first glance, three aspects should absolutely be observed during the planning and implementation of commensurate projects in the company:

- 2.1. Quality criteria of WHP
- 2.2. Structured approach (management circle)
- 2.3. Target group-oriented approach

### 7.2.1. Quality Criteria of WHP

The concept of WHP is built upon the following basic principles and quality characteristics:

#### 7.2.1.1. A Holistic Health Understanding and Project Understanding

Precisely in the lifestyle-oriented issues of healthy eating, physical activity, mental health and smoking prevention, WHP is concerned with a comprehensive notion of health and not only the personal “risk behaviour” of employees. Therefore, the company framework conditions should always be taken into consideration as well.

#### 7.2.1.2. Participation and Involvement

During the planning and implementation of health-promoting measures, it is not a question of doing something for, but rather doing something together with the employees. Thus, it is vital that the employees have the possibility of actively shaping the company WHP policy. The active involvement of as many company actors (e.g., employee representatives) as possible in the project design and a wider intra-company consensus are important basic requirements.

Workplace health promotion is a mutual process. Hence, the expectations and urgent goals should also be determined as early as possible.

#### 7.2.1.3. Workplace Health Promotion as an Executive Function

The success of health-promoting measures is closely connected to the commitment of company executives. On one hand, the management style and the management culture have direct effects on the subjective health of the staff. On the other hand, executives

have a strong role model function in their own health behaviours. Thus, the support of the company WHP policy through the various levels of management/executive management is a main factor of success.

#### **7.2.1.4. Establishment in the Company**

Even if health-promoting measures are also frequently planned and implemented as a project, they should be integrated into the existing structures and processes of the firm after the end of the project. The goal should be to establish the WHP measures in the company culture. Therefore, health promotion is to sensibly be designed as a long-term strategy.

This manifests itself therein that WHP (well-being at the workplace, promotion of a healthy lifestyle/behaviour, occupational safety and health protection, etc.) is a component of the company mission statement and/or of the written company philosophy. This then needs to also be filled with life.

#### **7.2.1.5. Information and Communication**

Intra-company information and communication structures are a central factor in the planning and implementation of health-promoting measures in the company. Employees should be punctually and continuously informed about the planned and implemented offers and measures to be able to also make health-relevant decisions themselves. Thus, the utilisation of as many different information channels as possible (word-of-mouth, newsletter, intranet ...) is particularly important. In this context, written declarations of WHP (e.g., in the form of a company agreement or the signing of policy documents like the Luxemburg Declaration) in the company have more than just a symbolic meaning.

### **7.2.2. Structured Approach**

An arbitrary single measure is still not workplace health promotion. WHP is implemented in a first phase mostly in the form of innovative projects. Therefore, lifestyle-oriented measures also need a clear intra-company goal and a structured, process-oriented approach in different phases. The following 5 phases have been well proven in practice during the development and implementation of WHP measures:

#### **7.2.2.1. Structure Building**

WHP should not be carried by the commitment and competence of a single person. The danger of failing or the burn-out of a lone warrior is too great. Therefore, the building of an in-house health team in the first step is vital. Representatives from management as well as from the staff should be active therein. Furthermore, the occupational health specialist and external experts should be incorporated. This health team can be led by an internal project supervisor.

### 7.2.2.2. Diagnosis Phase

It would be a mistake to offer arbitrary measures right away or to want to push them through. Before a company begins with individual health-promoting measures, a more exact analysis of the current health situation in the company should be conducted. Sometimes it is a concrete case – e.g., an accident or a severe case of sickness in the company – that ushers in a health promotion project. Then, however, a more exact analysis of other factors also makes sense. The central questions of this diagnosis phase are:

- Which health offers do we already have in the firm?
- What are the main health strains and health resources of our employees?
- How can we best reach our staff with the topics of healthy eating, physical activity, stress management and smoking prevention?
- The planning of appropriate health-promoting measures should only begin after these queries have been extensively analysed by the health team.

### 7.2.2.3. Planning Phase

After the completion of the diagnosis phase, a clear picture of which main focus areas and offers the company will implement in the WHP field should have emerged. At the same time, the company framework conditions such as time structure, availability of employees or also the intra-company information structures should be considered.

### 7.2.2.4. Implementation Phase

The implementation phase has an apparently simple motto: just do it. It should be kept in mind that a one-time action hardly achieves a sustainable effect. Thus, a longer-term and time-coordinated series of health-promoting measures and offers is required. An important instrument is the preparation of an action plan and the execution of defined milestones in the course of the project.

Milestones are the most important stages and stations in the scope of project implementation. They describe the results that should be reached by a defined point in time as precisely as possible and thereby also serve as a basis of decision-making for the further course of action.

### 7.2.2.5 Documentation and Evaluation

In the end, empirical values from the planning and implementation phase should be documented and collected. Unfortunately, this task is neglected in many projects because it often appears to be very cumbersome and costly. However, good project documentation is very important in all project phases. It facilitates the planning and implementation of health-promoting measures in enterprises very much. Not in the least is it the basis for a transfer of knowledge and learning – for other companies as well.

### 7.2.3. Target Group-Oriented Approach

There is hardly an issue in which a target group-oriented approach is as important as in the planning and implementation of health-promoting measures. The subjective health-behaviour and the dealing with the topics of nutrition, physical activity, mental health and smoking prevention are significantly influenced by the affiliation of a person to different groups.

In every company workforce there are WHP-relevant “differences that make a difference.” These differences can refer to traditional socio-demographic differentiations (e.g., gender, age, education, mother tongue ...), to work and organisational areas (e.g., office work, field service, production, sales ...) or to particular health needs (e.g., people with physical disabilities, shift work ...).

Even in small firms there are always two important aspects at the very least that should be observed in this connection.

#### 7.2.3.1. Men/Women

Especially with health issues, the differences between female and male employees are particularly relevant. Health research has shown that the sexes differ from each other in many areas – in life expectancy, in symptoms of disease, in risk behaviour, as well as in the availability of different coping strategies.

Particularly in the lifestyle-oriented topic areas of healthy eating, physical activity, mental health and smoking prevention, a gender-specific planning and implementation of measures is vitally important.

#### 7.2.3.2. Age Groups

In every firm various age groups work together, who, in turn, display different health behaviours and have different interests in health topics. Consequently, older as well as younger employees (e.g., trainees, apprentices) are the main but often very different target groups who should find special consideration in the planning and implementation of health-promoting measures.

The leading basic principles:

- Quality criteria of WHP
- Structured approach (management circle)
- Target group-oriented approach

should already be regarded and kept in mind during the planning of health-promoting measures and projects in the company. As has been substantiated in practice, the implemented measures then show the desired success, too.

Nevertheless, there is no generally valid recipe for success. In this respect, every project is always to be regarded as a “prototype” that is to be specifically developed in the company with the involved actors.

Further developments and new ideas should be continuously pursued and tested as to what extent they are helpful for the individual situation.

The structured management circle and the WHP quality criteria provide assurance on this path.

After these basic recommendations, more specific recommendations regarding the fields of

- healthy eating
- physical activity
- mental health
- smoking prevention

will be offered in the next step

Differences are made between basic recommendations and impulses for the further development of the respective health issues in the enterprise. These impulses should serve as support and should not be seen as a patent recipe, because, as said:

There are many paths towards health; each company should decide for one – for its – path.

### 7.3. Healthy Eating

The topic of healthy eating is a classic field of WHP activity. This can already be explained by the fact that the majority of the working population eats its meals in the company and that the nutritional behaviour is thereby decisively influenced by the framework conditions of the company. In addition to the individual health aspects, this topic area also has the important social function of a common meal in the company.

A main precondition for healthy nutritional behaviour is that the workforce is provided with the knowledge of what healthy eating actually represents. In a next step, it is crucial that this knowledge is/can be appropriately converted into behaviour. Therefore, it is recommended to begin on the offer side and to consider the following possibilities:

#### **Basic Recommendations**

- The preparation and communication of easily understandable information on the topic of healthy eating and healthy beverages. The communication of this information takes place through various information channels (employee magazine, e-mail, intranet, flyers ...)
- The offer of clean and easily accessible dining areas that can be used during work breaks



- The offer of free drinking water and information about the importance of healthy beverages (non-alcoholic and sugar-free)
- The establishing of a healthy food offer, e.g., through a break kiosk with healthy food and sugar-free drinks, fresh break snacks, etc.

### Further Steps

When certain basic offers are established and the company would like to deal with the topic of health-promoting nutrition more comprehensively, these further steps are recommended:

- Establishing a working group on healthy eating with representatives from the staff, management, occupational health and – if available – the company canteen, resp., the canteen operator. This working group should be supported by a company-internal person responsible for planning and coordinating the measures for the project.
- The inclusion of the results of the workplace evaluation, resp., the stipulations according to the employee protection law. Should these evaluations not consider the aspect of healthy eating, this could be suggested as a future focus area.
- The qualification of the members of the working group (e.g., basic knowledge on healthy eating) through external experts.
- Doing an analysis of the actual state of company catering possibilities and the nutritional behaviour of the employees (e.g., through a written survey or through selected interviews). The direct and active involvement of employees in the development of measures and offers regarding healthy eating is important.
- Formulating concrete goals concerning the desired changes. A cost estimate for the development of the appropriate offers and measures will be encouraged.
- Establishing a commensurate project budget allowing for a system of financial incentives (e.g., through lower prices for healthy fare or free trials, free fruit ...).
- Developing an information and consultation offer for healthy eating with the help of external experts (e.g., dieticians, nutritional scientists) in the form of informational presentations or workshops.
- If required, priorities have to be set in redesigning an existing company canteen to make it a “healthy company canteen.” The offer and preparation of the foods and beverages themselves, as well as a system of self-control (e.g., through a system of grease drops, nutrition points ...) should be thought over. This also requires that the meals can be enjoyed in beautifully designed rooms and in a pleasant atmosphere. Not least, the opening times should be adapted to the needs and working times of the employees.
- A further important point is that there is a general smoking ban in the whole company canteen.

- Particularly during the introduction of the “new company canteen”, the utilisation of healthy company food offers should be made attractive through the support of action weeks and information campaigns.
- The mentioned points may also require a special training of the kitchen personnel.
- Offering in-house training sessions on weight reduction in the form of group meetings over the course of several weeks.
- Continuous evaluation and reflection of the taken steps and offers concerning healthy eating (e.g., through discussion in the working group, through an additional employee survey).

As the cited recommendations indicate, during the development and implementation of health-promoting measures on healthy eating issues, it is a matter of creatively and consequently connecting the various aspects and framework conditions. On one hand, the goal is a health-promoting development of individual behaviour and, on the other hand, the establishment of a “company eating culture.”

With a corresponding conception and planning, this offer can not only be healthier, but also more inexpensive than the unhealthy option for all those involved.

## 7.4. Physical Activity

In addition to the topic of healthy eating, the theme of “physical activity” is the second classical starting point for health-promoting measures in the company. Many employees spend their working time sitting or in a one-sided bodily posture. Our working world does little to promote physical activity, which substantially leads to a lack of movement or exercise and the diseases resulting from it.

It is to be basically considered that the integration of daily “movement exercises” in everyday working life implicates a health benefit and, therefore, as many possibilities to move as possible should be perceived.

Here, the company environment also offers an abundance of possibilities to fashion a lifestyle conducive to physical activity. Thus, it is recommended to consider the following possibilities regarding the issue of physical activity:

### Basic Recommendations

- To create an environment conducive to physical activity, companies should assure that the basis of everyday working life is designed to encourage physical activity as much as possible. Therefore, spontaneous physical activity should be consciously stimulated.
- Specific measures and offers of physical activity can contribute to raising awareness

on the behavioural level and additionally impart relevant knowledge. Offers of activities such as Nordic walking or slow running immediately after work have stood the test. Because the social aspects play an important role here, these offers should be provided in the form of group workshops rather than as individual consultations.

- The preparation and communication of easily understandable information on the topic of physical activity. The communication of this information should take place through various information channels (employee newspaper, e-mail, intranet, flyers ...).
- The purchase of computer-supported programmes to support movement at the workplace through instructed movement breaks and compensation exercises.

### Further Steps

For a comprehensive and sustainable establishment of the topic area of “health-promoting physical activity,” the next steps are recommended:

- The establishment of a working group on “health-promoting physical activity” with representatives from the staff, management, occupational health and external physical activity experts. This working group should be supported by a company-internal person responsible for planning and coordinating the measures for the project.
- The analysis of the company working environment under movement-ergonomic aspects. This can either be conducted in the scope of a workplace evaluation, resp., under the stipulations of the employee protection law, whereby most of the occupational-ergonomic aspects (seat height, screen alignment ...) should be emphasised. In addition, an inspection by a trained external expert is sensible.
- The qualification of members of the working group through an external expert in regard to basic knowledge and the starting point for health-promoting physical activity in the company.
- An analysis of physical activity-oriented offers and the physical activity behaviour of employees (e.g., through a written survey or through selected interviews). Direct and active employee involvement in the development of measures and offers regarding health-promoting physical activity is important.
- The evaluation of data – to the extent it is available – which provides information concerning movement-related diseases and impairments of the staff (e.g., diseases of the locomotor system and the muscular-skeletal system...).
- The formulation of concrete goals and the establishment of a commensurate project budget allowing for a system of financial incentives (e.g., through co-payments for fitness studios, ergonomic working appliances, movement-friendly office equipment ...).
- The development of an information and consultation offer for physical activity with the help of external experts (e.g., through sports scientists, Nordic walking instructors, back exercise programmes) in the form of informational presentations or workshops. The offer of group workshops immediately after work hours has been especially

well-proven. Several try-out hours should also be credited as working time.

- The establishment of short breaks for compensation and movement exercises at the immediate workplace. On one hand, these could be instructed and activated through computer-supported programmes. On the other hand, the training of disseminators who instruct their colleagues is well-proven. The training of the respective movement peers is to be planned and organised on time.
- If required, the setting of priorities can result in the construction or redesign of sanitary facilities (e.g., possibilities to take a shower after physical activity). Furthermore, these spatial requirements are important if an active trip to work (e.g., by bicycle) should be encouraged.
- The planning and construction of an in-house “company fitness studio” or an active cooperation with sports facilities and sport clubs in the immediate vicinity of the company (e.g., incentives through free participation in courses and programmes...).
- Continuous evaluation and reflection of the taken steps and offers concerning health-promoting physical activity (e.g., through discussion in the working group, through an additional employee survey).

The recommendations indicate that the goal of establishing a company culture conducive to physical activity should be pursued. This can be experienced, among other things, through bar tables for meetings, through company bicycles or also through events such as the participation in or the organisation of a “business run.”

With a corresponding conception and planning, physical activity can be successfully integrated into the everyday (working) lives of employees consequently and unobtrusively in this way.

## 7.5. Combating Stress/Mental Health

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In nearly all health surveys in companies, the factors of time pressure and stress are ranked high on the scale of health burdens. Psychological burdens have become an unpleasant part of the everyday working lives of more and more employees, and much data indicates that stress and psychological burdens have strongly increased in the working world in recent years.

Overworking and time pressure, performance density and stress, a bad company climate or the behaviour of superiors, a high work tempo and bad, resp., too long working times – all these factors often have negative consequences for mental health.

Therefore, WHP activities should consider the topic area of mental health in any case.

The temptation is thereby great, particularly with mental health issues, to begin alone with individual burden and coping behaviour. However, practice shows that especially the social working conditions have a massive influence on the mental health of employees.

Therefore, in the topic area of “combating stress/mental health,” it is recommended that social factors (e.g., climate of cooperation, managerial culture, field of action and social support in the company) and working processes of the company should already be considered as a first step.

### Basic Recommendations

- Special consideration of the topic of mental health in the scope of employee protection legislation. This should particularly occur through the involvement of occupational psychologists and occupational health specialists.
- The preparation and communication of easily understandable information on the topic of mental health with specific focus areas such as stress management, relaxation exercises, burn-out prevention. The communication of this information should take place through various information channels (employee newspaper, e-mail, intranet, flyers ...).
- Specific presentations and offers on “combating stress/mental health” issues at the workplace. Wellproven are offers that provide information about the fundamentals of mental health as well as those that emphasise the importance of a personal resource management.
- The purchase of computer-supported programmes that impart basic information on the topic of mental health and awaken a personal awareness.

### Further Steps

For a comprehensive and sustainable establishment of the topic area of “combating stress/mental health“, the following steps are recommended:

- The establishment of a working group on “combating stress/mental health” with representatives from the staff, management, occupational health and occupational psychology. This working group should be supported by a company-internal person responsible for planning and coordinating the measures for the project.
- The qualification of the members of the working group in order to be able to analyse and evaluate the strain and resource mechanisms of mental health in the company.
- The analysis of the company working environment under occupational psychology aspects and with the strong involvement of employees. This can be done either in the scope of a special health survey or also in the scope of single interviews. The main focus of this analysis should be on a comprehensive estimation of the actual state of the company in the areas of overworking, underutilisation, work satisfaction, managerial culture, work-life balance.
- The formulation of concrete goals and the establishment of a commensurate project budget for the development and implementation of measures to promote mental health.
- The development of a structured and coordinated action plan under consideration

of relevant aspects such as, e.g., stress management, cooperation relationships, managerial culture, work-life balance.

- Special training and workshops for managers at all levels on the topic of “combating stress/mental health” in the company, with the focus on the influence of managerial culture on the mental health of the staff.
- Analysis and reduction of stress-related environmental factors such as noise, insufficient lighting, heat or cold. Through a combination of these stress factors, it more often comes to stress reactions than through single straining working conditions.
- Analysis and development of specific improvements in cooperation with management and employees regarding work organisation, working times, job rotation, field of action or team development.
- Development of an offer of confidential psychological consultation for managers and employees by the occupational psychologist. In this context, “coupon systems” for a limited number of confidential consulting hours have proven themselves well.
- Development and implementation of an information and seminar offer for employees on the issues of stress management, relaxation exercises and self-management.
- Regular evaluation and assessment of set measures for the promotion of mental health, resp., coping with stress (e.g., through assessment rounds in the working group, feedback from the occupational psychologist or through further employee surveys).
- A possible goal in regard to assuring the sustainability of the corresponding measures could be the development of an “enterprise guideline for mental health in the company”. In these guidelines – worked out in a wide consensus – it should be stated which value a company ascribes to the issue of mental health at the workplace and which measures and approaches management and staff should consider when possible stress situations or individual crisis situations emerge.

As the mentioned recommendations show, on the one hand, the involvement of external experts – among others, of the occupational psychologist – is important in mental health issues. On the other hand, the different measures and developmental steps should always be further developed with regard to the interests of the employees as well.

A comprehensive approach with a broad mix of measures – an appropriate mix of relation-oriented (working conditions) and behaviour-related (personal coping and protection mechanisms) measures – is ideal. A shifting to purely individual and person-centred approaches should be avoided by all means.

Only in this way can companies succeed in developing working conditions and personal ways of behaviour that strengthen mental health and thereby help to successfully cope with stress.

## 7.6. Smoking Prevention

Tobacco consumption in Europe ranks as the most significant health risk, as well as one of the leading causes of premature death.

Passive smoking is also perceived as a dangerous health problem in the modern working world, as atmospheric pollution, with the commensurate poisonous smoke, is very detrimental to health, especially in closed rooms. Therefore, legislative regulations for the protection of non-smokers at the workplace were introduced in numerous European Union countries.

WHP measures cannot and do not want to replace these legal stipulations, but can rather contribute to implementing these on a wider level.

As opposed to other health-relevant topic areas in the company, a mixture of rather restrictive and rather participative approaches should be found while developing measures to reduce tobacco consumption.

### Basic Recommendations

- The preparation and communication of easily understandable information on the topic of tobacco consumption and smoking prevention under particular consideration of the legal framework conditions in the scope of the employee protection law. The communication of this information occurs through various information channels (employee magazine, e-mail, intranet, flyers ...)
- Special consideration of smoking prevention in the scope of the employee protection law and the workplace evaluation (e.g., through personal talks, the according notices of no-smoking zones and smoking bans in company buildings, resp., offices). Limiting the possibilities to smoke to defined and designated smoking zones.
- Specific presentations and workshops on the topic of tobacco consumption and the protection of non-smokers (e.g., by the occupational health specialist).

### Further Steps

For a comprehensive and sustainable establishment of the topic area of “smoking prevention”, the following steps are recommended:

- The establishment of a working group on “smoking prevention” with representatives from the staff, management, and occupational health. This working group should be supported by a company-internal person responsible for planning and coordinating the measures for the project.
- The qualification of the members of the working group on legislative framework conditions and possible implementation measures.
- The analysis of the current status of non-smoker protection in the company. This can be done either in the scope of company inspections or also in the scope of single

interviews. The main focus of this analysis should be on a comprehensive estimation of the actual state of the company in the area of smoking prevention. Further possibilities for involvement exist through health surveys and departmental workshops.

- Drafting and signing of a company agreement, resp., a company guideline on smoking prevention in the firm. This should be drafted and bindingly formulated in the “smoking prevention” working group – if possible, in consensus with the employer and employee representatives. It should also be regulated that a smoking ban exists in all working areas and commonly used rooms in the company.
- Establishment of a commensurate budget for the implementation of building measures or for offering smoking cessation programmes. Possible financial costs can accrue through the construction of ventilation equipment in designated smoking areas.
- Special training and workshops for employees who want to quit smoking. In this context, financial support for workshops on the part of the company and the involvement of spouses and partners who also smoke have proven themselves well in practice.
- Creation of offers for individual consultation for employees who would like to quit smoking (e.g., by the occupational health specialist or the occupational psychologist).
- Regular evaluation and assessment of the implemented measures and their effects, resp., implementation of the regulations agreed upon in the company guidelines (e.g., through assessment rounds in the working group, feedback from the occupational psychologist and through further employee surveys).
- The company guidelines also represent an important building block for assuring sustainable smoking prevention in the company.

## 7.7. Conclusion

The “Move Europe” campaign undertaken by the European Network for Workplace Health Promotion has set its goal of strengthening workplace health promotion throughout Europe. The existing recommendations are based on models of good practice that have been identified in the scope of this initiative.

They are aimed at enterprises that would like to actively promote the health of their employees.

The existing recommendations may serve as a stimulus and are not to be understood as a patent recipe – every company is too specific and too unique for that.

These comments also make it clear that workplace health promotion does not represent a one-time action, but rather describes a process.

In this sense, workplace health promotion in the company is one path that develops by consequently following it.



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