An Roinn Sláinte
Department of Health

A DESCRIPTION OF PUBLIC POLICY MECHANISMS TO SUPPORT HEALTHY WORKPLACES AND WORKPLACE HEALTH PROGRAMMES

A Department of Health Research Paper, 2018

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The views in this report are those of the authors and not necessarily those of the Minister for Health nor the Department of Health.

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EXECUTIVE SUMMARY

The Healthy Workplace Framework is an important component of the Government-led Healthy Ireland agenda, which "aims to create an Irish society where everyone can enjoy physical and mental health and wellbeing to their full potential, and where wellbeing is valued and supported at every level of society".

Workplaces directly influence the physical, mental, economic and social wellbeing of workers and in turn, the health of their families, communities and society. With more than two million people employed in Ireland the workplace offers an ideal setting and infrastructure to support the promotion of health to a large audience. A Healthy Workplace Framework across both public and private sectors aims to encourage and support the development of health and wellbeing programmes in all places of employment. This research paper is an input into the Framework.

This report was prepared for the Health & Wellbeing Programme in the Department of Health in order to answer the question: what public policy mechanisms (e.g. taxation, grant assistance) are described in the literature as ways to incentivise employers to promote healthy workplaces and workplace health programmes?

A healthy workplace is "one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace." (WHO, 2010, p.6). Workplace health programmes can help to achieve healthy workplaces. The former are "a coordinated and comprehensive set of health promotion and protection strategies implemented at the worksite which include programs, policies, benefits, environmental supports, and links to the surrounding community designed to encourage the health and safety of all employees" (CDC).

This report identifies 12 policy mechanisms that have been used, or the literature argues can be used, to encourage or support organisations to take up or expand workplace wellbeing programmes. These mechanisms fall into five categories:

- financial measures,
- regulation and legislation,
- signals of quality practice,
- signals of importance,
- and implementation tools.

Examples are provided in Table 1.

Table 1: Policy mechanisms reported to encourage take-up or expansion of programmes

	Broad Category	Application	Country	Example
	Financial Measures			
1	Fiscal incentives	**	US	Income tax credits toward "wellness activities"
2	Levy systems	*	GB (sectoral)	CITB Levy for training
3	Local 'Budget-pooling'	***	Sweden	SOCSAM scheme, reduce LT SL
	Regulation			
4	Regulation of provision of measures	***	Netherlands/Japan	RTW through OHP/occupational physician
	Regulation for reporting	***	Finland	Written occupational health care Action Plan
6	Other legislative approaches	***	US	Alternative transportation, HI
	Signalling Quality			
7	Accreditation	***	UK	IPS, People Health and Wellbeing Good Practice Award
8	Awards and benchmarking	***	UK/Canada	BC's 'Workwell Benchmark'/NQI org. excellence criteria, incl. lifestyle and health practices.
	Signalling Importance			
9	Organisational pledges	***	England	Workplace Health Charter/ Time to Change
10	Responsible procurement	*	UK	Public sector buyers require some other form of accreditation
11	Investor's perspective	*	England/US	FTSE4 Good Index/The Dow Jones Sustainability Index
	Implementation Tools			
12	Impl. tools and supports	***	Australia	Portals, guides and toolkits, assessment tools, and direct advice

*** = application of a mechanism in a HWP context; ** = intention to use a mechanism for a HWP context; * = application of a mechanism in a different context.

1. INTRODUCTION

1.1 Background and Policy Rationale

The Healthy Workplace Framework is an important component of the Government-led Healthy Ireland agenda, which "aims to create an Irish society where everyone can enjoy physical and mental health and wellbeing to their full potential, and where wellbeing is valued and supported at every level of society".

The Healthy Ireland website notes that as there are over two million people employed in Ireland, the workplace can make an important contribution to healthier communities. Workplaces directly influence the physical, mental, economic and social wellbeing of workers and in turn, the health of their families, communities and society. The workplace therefore offers an ideal setting and infrastructure to support the promotion of health to a large audience. According to the World Health Organisation (WHO), workplace health programmes are one of the best ways to prevent and control chronic disease, and also to support mental health.

Developing a Healthy Workplace Framework involves collaboration and consultation with a number of Government Departments, agencies and private sector companies and organisations. The development of a Healthy Workplace Framework across both public and private sectors aims to encourage and support the development of Health and Wellbeing programmes in all places of employment. Key elements in the development of a Healthy Workplace Framework include this report, undertaken in association with a separate literature view on the effectiveness and cost-effectiveness of workplace wellbeing programmes and a review of models to develop healthy workplaces, a policy landscape paper, a consultation, building capacity, development of an accreditation model, and development of resources.

1.2 Purpose and Scope

The purpose of this report is to describe public policy mechanisms that can be used to incentivise employers to promote workplace wellbeing programmes. This review was prepared for Health & Wellbeing Programme in the Department of Health in order to answer the question:

"What public policy mechanisms (e.g. taxation, grant assistance) are described in the literature as ways to incentivise employers to promote healthy workplaces and workplace health programmes?"

The WHO (2010, p. 6) notes:

"A healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace by considering the following, based on identified needs:

- health and safety concerns in the physical work environment;
- health, safety and well-being concerns in the psychosocial work environment, including organization of work and workplace culture;
- personal health resources in the workplace; and
- ways of participating in the community to improve the health of workers, their families and other members of the community."

The CDC notes "Workplace health programmes are a coordinated and comprehensive set of health promotion and protection strategies implemented at the worksite which include programmes, policies, benefits, environmental supports, and links to the surrounding community designed to encourage the health and safety of all employees."

Workplace wellbeing programmes are a subset of workplace health programmes and for the purpose of this review include health promotion and wellness programmes. These include single or dual focus interventions (e.g. physical activity, dietary behaviour and weight management; smoking and alcohol behaviours; stress, anxiety and depression interventions) and multi-focus programmes. Multi-focus programmes are often referred to in the literature as workplace health promotion programmes, workplace or organisational wellness programmes. They involve a combination of physical activity, weight, nutrition and physical activity interventions, stress management and anxiety/depression interventions, and lifestyle interventions.

1.3 Method and Limitations

Answering the study question requires a description of different public policy mechanisms to support healthy workplaces and workplace health programmes and this report is based on literature found through a search of peer reviewed databases (PubMed and Health Business Elite) and Google.

Key limitations include the fact that the search was restricted to English-language publications. It is also important to bear in mind that the report does not examine the effectiveness per se of different mechanisms but rather provides a description of the different mechanisms reported in the literature.

This report was subject to internal and external review as follows (a) by staff in the Research Services Unit, Department of Health not involved in the production of the review and (b) by professionals working in the area of workplace health promotion and wellbeing (listed in the acknowledgements at the end of this report).

2. OVERVIEW OF POLICY MECHANISMS

Bajorek et al. (2014), based at the Work Foundation, produced a white paper entitled *The Way Forward: Policy options for improving workforce health in the UK.* They identified ten public policy mechanisms from the literature that can in principle be used to encourage or incentivise organisations to take-up or expand healthy workplaces and workplace health programmes.

Our searches of peer-reviewed databases identified an additional six papers discussing policy mechanisms. These covered occupational health care / worksite wellness legislation (encompassing *inter alia* tax credits, health insurance discounts, wellness policies or programs), quality standards, hospital accountability agreements, accreditation and pledges/belief statements. The mechanisms discussed in these papers are encompassed by those identified by Bajorek et al., (2014).

This report added the category "Other legislative approaches" (number 6 below) to reflect some additional examples in this area. Finally, mechanisms that are not mentioned in the material reviewed but are clearly used in practice, and which were located through other database searches for the Report, include information provision (e.g. websites describing and demonstrating programmes) and advice (e.g. 'how-to' guidance documents). These are captured under number 12 below. This report also summarizes the mechanisms under the categories of financial measures, regulation and legislation, signals of quality practice, signals of importance, and implementation tools.

The policy mechanisms are listed below.

1. Fiscal incentives
2. Levy systems
3. Incentivising collaboration through local 'budget-pooling'
4. Regulation of provision of measures
5. Regulation for reporting
6. Other legislative approaches
7. Accreditation
8. Awards and benchmarking
9. Organisational pledges
10. Responsible procurement
11. Investor's perspective
12. Workplace wellbeing implementation tools and supports

The next chapters define each mechanism and provide examples. The definitions are from the paper by Bajorek et al., (2014), and the examples are referenced accordingly.

3. FINANCIAL MEASURES[1]

1. Fiscal incentives

The idea for providing tax incentives for health and wellbeing programmes is based on the suggestion that if such initiatives become tax free, then this may encourage organisations who have not considered health and wellbeing interventions to do so. For example, in the UK many employer-sponsored health interventions are taxed as benefits in kind. Bajorek et al., (2014) outline two different types of fiscal incentive options and one way of ensuring effective provision of either option.

Matched funding is where a government grant is equally matched by employer investment. This option would mean that government could specify precise eligibility criteria for employers to gain funding, however this would also be more administratively complex and so could discourage some potential beneficiaries.

Another type of fiscal incentive is *tax credits* (in the form of tax relief on employer National Insurance contributions). This offers support with fewer strings attached and could be a more immediate and direct way for employers to take advantage of the incentive. However, as the eligibility criteria for the tax credits is broader, it could result in more use of public spending for peripheral purposes, rather than solely on evidence-based health and wellbeing interventions.

Bajorek et al., (2014) note that is has been argued that an effective mechanism for providing either option would be to establish a system of authorised providers who would provide a menu of pre-approved and evidence-based programmes.

Example of Tax Credits in the USA

Lankford (2009) notes that Bills in the category of "tax credits" consisted of those that offered employers income tax credits of varying amounts toward "wellness activities". *None of the "tax credits" bills introduced by 13 states were enacted*. For example, since 2000 New Jersey has submitted, yet has not passed, seven bills with 10% tax credits for employer expenditures toward physical fitness benefits to employees (maximum equivalent of $50 per employee) against the New Jersey gross income tax. This 10% credit would be applicable to such costs as: (1) equipping, operating, and maintaining physical fitness facilities; (2) equipping or sponsoring athletic teams made up of employees; (3) all or part of the costs for group health club memberships; (4) employing people to provide information or instruction

[1] The definitions are from the paper by Bajorek et al., (2014) unless stated otherwise.

in any health or fitness enhancement topics; and (5) any incentive awards to employees for regular engagement in physical activities such as bicycling between home and work.

One barrier was the difference in the interpretation of costs, as noted in the New Jersey fiscal report (as part of A3715 [2005]), specifically the difference in state cost (less income tax revenue) for providing coverage to employees resident in the state ($8 million), versus providing coverage to all employees nationally ($250 million). Lankford (2009)

2. Levy systems

A levy system involves a small levy being paid by eligible organisations, and those who implemented organisational health and wellbeing programmes could claim grants that would be paid for by the levy.

Example of a Levy System in Great Britain – not directly in the wellbeing domain

An example is the levy system for industrial training, such as the Construction Industry Training Board Levy, which is a charge paid by eligible construction businesses. Employers who train their workforce can claim grants, paid for by the levy; employers that pay the levy but do not regularly train their staff help support those who do train, and then this drives up the overall standards and skills supply available to the sector.

However, this is a sectoral scheme and is likely to require modification before it could be applied in the case of organisational health and wellbeing incentives. It would probably be necessary to explore other mechanisms for developing an equivalent health and wellbeing 'levy'. Bajorek et al., (2014)

3. **Incentivising collaboration through local 'budget-pooling'**

Through this mechanism, local stakeholders (including employers) and agencies of government with overlapping interests are encouraged to collaborate more.

Example of Local Budget-pooling for vocational rehabilitation in Sweden

The SOCSAM scheme for local budget-pooling for vocational rehabilitation in Sweden was a cross-sectoral initiative that allowed social insurance and social services to voluntarily move up to 5 per cent of their budgets, along with a matched contribution from health services, to a pooled budget to jointly manage rehabilitation services to help individuals on long-term sick leave return to employment. Along with funding, joint financial management arrangements were set up, helping to foster the development of joint services and a more

holistic approach to activities.

When evaluated, it was found that interdisciplinary collaboration between health and social care professionals improved compared to areas where schemes were not introduced. This Swedish experience also suggests that joint funding arrangements and collaboration at local or regional level, where institutional structures are closer to stakeholders and have a better understanding of local problems, can be effective. Following evaluation, a new scheme to support cooperation across these sectors was rolled out on a voluntary basis nationwide.

Since the early 1990s, there has been some experimentation in Sweden with inter-sectoral collaboration in the field of vocational rehabilitation. Initial positive results led to the 2003 Act of Financial Coordination of Rehabilitation Measures. Although not binding, this legislation made it possible for institutions in the rehabilitation field to form local associations for financial coordination. Evaluation studies of these arrangements show that there can be significant reductions in long-term sick leave where there is local collaboration and financial co-ordination. Bajorek et al., (2014)

4. REGULATION AND LEGISLATION[2]

4. Regulation of provision of measures

This involves regulating the health and wellbeing measures that employers should provide. The provision of certain interventions could become compulsory.

Examples of Regulatory Approaches in the Netherlands and Japan

In the *Netherlands*, employers are liable to pay for up to two years of sick pay at 70 per cent of the previous salary. There is also a strict, state-enforced process for employers and employees to discuss return to work. Measures include: by week six of absence employers must pay for an independent occupational health physician, by week eight they must agree to a rehabilitation plan, and then only after 91 weeks if an individual is assessed as unfit for work they may then be transferred onto the state-administered benefits system.

In *Japan*, regulation goes further in not only encouraging practices which manage return to work but in also regulating for preventative measures. For example, organisations which employ more than fifty people must contract an occupational physician, and those who employ more than one thousand, must provide this specialist full-time. Occupational physicians are responsible for on-site safety inspections, education of employees and provision of annual health check-ups.

It is reported that the main difficulty with this approach is getting employers to comply. In Japan 51.9 per cent of enterprises with 1-4 employees, about 42 per cent of enterprises with 5-9 employees and 20 per cent of organisations with 10-49 employees did not conduct the special health examinations required (Furuki, Hirata & Kage, 2006). This approach generally works best in countries with more statist welfare systems, whereas the UK has a more libertarian model (Black & Frost, 2011). It would therefore require a significant cultural shift, with employers starting to associate the health and wellbeing of employees with a return on investment, in order for compliance rates to be significant. Bajorek et al., (2014)

5. Regulation for reporting

This involves regulation in regard to what organisations should disclose and report regarding health and wellbeing measures and the practices they undertake.

[2] The definitions are from the paper by Bajorek et al., (2014) unless stated otherwise.

The idea behind a regulatory regime where reporting is required is that it challenges organisations to subject their practices to greater public scrutiny and, in doing so, may encourage behaviours which make their activities more robust and contribute to their reputation for being a responsible employer providing a great place to work.

Bajorek et al., (2014) note that Accounting for People [UK] (DTI, 2003) recommended that information regarding human capital management should be included in Operating and Financial Reviews that might become mandatory for UK companies. The mandatory reporting of human capital management gives support to organisations (or individuals) who regard people as a valuable asset for management. Organisations reported associated benefits, including transparency in reporting, reputation gains and gaining a superior assessment of an organisation's performance. A UK Commission for Employment and Skills briefing paper states that draft legislation went before parliament but the requirement to include information on employees never entered into force. It suggests that this was most likely due to 'the difficulty of identifying best practice and imposing consistency in HCR [Human Capital Reporting], and the potential for strong institutional inertia in response to the move' (*Encouraging Employers to use Human Capital Reporting*, 2013).

Example of a legal requirement to report in Finland

Šidagytė et al. (2015) reviewed the background to WHP implementation in 3 countries, Finland, Lativa and Lithuania. In defining WHP, all the countries refer to the Luxembourg Declaration on Workplace Health Promotion in the European Union. All three countries have legislation / regulations on occupational health and safety issues, including WHP. *Only Finland has adopted a specific law on occupational health care (separate from occupational safety)* and of the three countries, Finland alone integrates WHP into other occupational health and safety elements. ILO conventions No. 161 (Occupational Health Services Convention) and No. 187 (Promotional Framework for Occupational Safety and Health Convention) are ratified only in Finland.

The organization of occupational health services in Finland is based on the Occupational Health Care Act. This is in line with ILO Convention No. 161. By enhancing co-operation between employer, employee and occupational health care provider, the Act aims to promote: 1) the prevention of work-related illnesses and accidents, 2) the healthiness and safety of work and the work environment, 3) the health, work ability capacity and functional capacity of employees at different stages of their working careers, 4) the functioning of the workplace community. According to the Act, employers must have a written occupational health care action plan.

In all three countries, the law imposes several occupational safety and health obligations on

both employers and employees. The employer is “responsible for the employees’ health in general”; responsibility for this is generally delegated to occupational health specialists. Apart from in Latvia, WHP is included in their role. In Latvia and Lithuania, small companies are not required to employ occupational health specialists and the employer is allowed to carry out this role. Šidagytė et al. (2015)

6. Other legislative based approaches

Tax credits are discussed as a mechanism requiring legislation earlier. However, Lankford (2009) looked at state legislation for worksite wellness in the US, categorizing and describing the content and status of state legislative bills for worksite wellness. The author found that the four categories of state legislation that appeared to be most common were tax credits (n = 34; 0 passed), wellness policies and programs (n =21; 4 passed), alternative transportation (n = 18; 4 passed), and health insurance (n = 14; 3 passed). Overall, during 2001 to 2006, seven of 27 states enacted worksite wellness bills. In the three categories in which bills passed (wellness policies and programs, alternative transportation, and health insurance), 19% to 22% were enacted. Other examples in relation to legislation are provided below; they involve discounts or contribution towards costs.

Examples of Other Legislative Approaches

State Level Bills

Health insurance is an example of cost-containment legislation. Bills in the category of *"health insurance"* were those that extended discounts to employees or employers on insurance premiums based on employees' participation in Wellness programs or activities. Three bills of 14 were passed in this category. One unenacted bill, Indiana's SB307 (2006), allowed for state employees' participation in a heart health program and a $100 reduction in the share of their health insurance premiums. The heart health program allowed provision of education and programs and included identification, referral, and monitoring of those at high risk for cardiovascular or pulmonary disease.

Bills in the category of *"alternative transportation"* were those that involved on-site support for means other than single automobiles for transportation to work (e.g., bus passes, rail cars, carpools, bicycles). For example, Connecticut introduced a bill which allows state employees to exclude commuting costs (commuter highway vehicles, transit passes, or qualified parking) from taxable wages and compensation. In Washington, employers receive up to $60 per employee per year in tax credits for providing financial incentives to employees who use ride- or car-sharing, public transportation, or non-motorized commuting.

Bills passed in the category of *"wellness policies/ programs"* were limited to cost studies or the establishment of a task force or wellness council. Lankford (2009)

Affordable Care Act

Horwitz et al (2013) analyse the effects of provisions governing worksite wellness programs in the Affordable Care Act. Some of the main objectives of the Act are cost containment, health improvement and the reduction of discrimination in health care markets, and all three find expression in the provisions governing workplace wellness programs. The Affordable Care Act encourages employers to adopt so-called "health-contingent" workplace wellness programs, which reward employees for changing health-related behaviour or improving measurable health outcomes. Horwitz et al (2013)

5. SIGNALLING QUALITY PRACTICES[3]

7. Accreditation

Kite-marks and quality standards aim to raise the quality of employee health and wellbeing outcomes amongst those who sign up to accreditation awards. Once an organisation has signed up to an award, they are inspected or are required to provide necessary information to the kite-mark operator demonstrating that the organisation is reaching the required quality level.

Examples from the UK and Canada are provided below.

Examples of Kite-marking in the UK

The Investors in People (IiP) Standard [UK] was developed in 1990 as a national framework aiming to improve business performance by linking staff development to business objectives. To gain IiP Standard accreditation, organisations must demonstrate their commitment to invest in people to achieve business goals, have a training plan in place that demonstrates how training and development activities contributed to the needs of business and how these were reviewed to show and accommodate any changes in business objectives, demonstrate actions taken to develop workforce skills and training and development activities in place to support changes in job role, and demonstrate that companies had evaluated progress towards the goals, values achieved and any future needs (Hoque, 2003).

Once accreditation has been secured, the organisations are re-assessed every three years. A recent evaluation of the IiP Standard (UKCES, 2013) highlighted that organisations do change practices to meet the Standard, including: improving performance management systems (e.g. modifying appraisals); introducing training for a broader range of staff; and intensifying communication about business strategies. Other improvements included substantial changes to investment in leadership and management development. Investors in People also developed a People Health and Wellbeing Good Practice Award that aimed to help organisations align employee wellbeing and performance. This could be achieved as part of the Standard, or done as a standalone assessment. The award provided a more in-depth focus on issues such as effective planning, supportive management, supportive culture, work-life balance and evaluation. Bajorek et al., (2014)

[3] The definitions are from the paper by Bajorek et al., (2014) unless stated otherwise.

Examples of Accreditation Requirements in Canada

Accreditation by the CCHSA (Canadian Council on Health Services Accreditation) includes work life as one of its four quality dimensions. The work-life descriptors include open communication, role clarity, participation in decision-making, learning environment and well-being. In addition, the CCHSA has developed healthy workplace indicators which will become part of standards used to assess accreditation of healthcare settings across Canada.
Shamian and El-Jardali (2007)

8. Benchmarking and awards

This aims to allow organisations to enhance their organisational self-assessment in relation to health and wellbeing practices, through closely monitoring what is done in their organisation as well as similar organisations. It is regarded as a 'lighter-touch' approach compared with compulsory data reporting. Examples from the UK and Canada are below.

Example of a Workwell Benchmark in the UK

'Business in the Community' have developed a 'Workwell Benchmark' (2013) to encourage more organisations to address the effective use of data collecting and reporting to demonstrate effective business practices, to improve the health and wellbeing of their employees, and to drive business performance improvements. The benefits are that organisations who take part in the Workwell benchmarking process can receive feedback on the strengths and gaps in wellbeing initiatives, and the data will give organisations the opportunity to see how they are doing with regard to health and wellbeing in comparison to their peers and competitors. Additionally, when undertaking benchmarking, organisations will be able to track their progress on the Workwell measures, to reinforce and develop good practice, and drive continuous improvement.

In the Workwell model, the metrics and framework definitions include: demonstrating a robust employee engagement and wellbeing strategy linked to securing business objectives; ensuring a strategic approach to skills and talent that meets current and future business needs; ensuring employee communication and voice supports engagement; taking a proactive approach to building physical and psychological resilience to support sustainable performance; and providing a safe and pleasant environment that supports wellbeing and productivity. Towers Watson (2014) looked at the Workwell benchmark within the FTSE 100 index and found that the metrics that organisations measure are managed effectively, highlighting progress being made in workplace wellbeing, and the beginnings of embedding best practice through public reporting. However, the benchmark tool highlighted a lack of reporting on psychological health and sporadic reporting on mental health, suggesting that stigma and transparency surrounding mental health remains a significant challenge. Bajorek et al., (2014)

Example of an Awards Competition in Canada

Després et al. (2014), in a paper which focuses on reduction of CVD risk factors, outline what is known about health and wellness program delivery systems in Canadian workplaces. They note relevant legislative and policy initiatives to create a context conducive to improve the healthfulness of Canadian workplaces, including the creation of the National Quality Institute in 1992 through Industry Canada (i.e., a federal government Ministry whose mission it is to promote Canada performance on the marketplace) to advance organizational excellence. Through an awards of excellence programme, a set of excellence criteria, including the promotion of appropriate lifestyle and health practices was developed. Annual competitions reward companies in all domains of organizational excellence. Després et al. (2014)

6. SIGNALLING IMPORTANCE

9. Organisational pledges

Organisations can make pledges that encourage them to develop a commitment to workplace health and wellbeing.

Examples from England and Canada are provided below.

Examples of Organisational Pledges in England

Workplace Health Charter: This is a statement of intent showing an organisation's commitment to the health and wellbeing of its staff. Organisations can conduct a self-assessment to discover what they are already doing to meet the charter and where there are gaps that need improvement. The charter is relevant to all NHS Trusts as long as they can demonstrate their commitment to the health and wellbeing of their staff. The charter provides a clear set of wellbeing standards to be met, which takes a holistic approach incorporating both physical and mental health, health promotion and ways that can evaluate the information and services that are available. The aim of the pledge is to develop best practice about health and wellbeing in the workplace. The three areas that are focussed upon are leadership, culture and communication; these cover issues such as: mental health and stress, awareness of drug and alcohol abuse, sickness and absence management, healthy eating and physical activity. Organisations must gather a portfolio of evidence to show what they have done/are doing towards the charter, and once awarded the charter is valid for 2 years before reassessment is necessary.

Time to Change: This pledge is a public statement of aspiration that an organisation wants to tackle mental health, stigma and discrimination. If/when organisations wish to make a time to change pledge, they must develop a plan which details actions to be implemented to improve mental health awareness and reduce stigma, submit it, and then formally sign the pledge at a time to change event. Any organisation can make a pledge, and the more that do so, the more noise is made breaking the silence around mental health. Ways to improve organisational mental health through the time to change pledge include: developing an internal communications campaign; promoting local mental health services and support; and, training staff to address the stigma around mental health. Although organisations will need some evidence to show that the pledge being made has meaning, there is no accreditation, endorsement or quality mark. The main understanding of this pledge is that because the pledge and action plans are owned by the organisation, it means the organisation has responsibility for completing the actions pledged. Bajorek et al., (2014)

Examples of Organisational Pledges in Canada

Quality Worklife Quality Healthcare Collaborative: Strelioff (2007) notes the development by 11 national health organizations of a pan-Canadian collaborative of 45 experts set up to develop an action strategy to improve health workplaces – the Quality Worklife Quality Healthcare Collaborative (QWQHC). The collaborative members adopted a number of belief statements e.g. "We believe it is unacceptable to fund, govern, manage, work or receive care in an unhealthy health workplace".

The QWQHC developed three action strategies embracing evidence-informed management and accountability practices, including developing a standard set of healthy workplace indicators recommended to be included by all healthcare organizations in their management information systems, performance agreements and accountability reports. The standard QWL indicators include:

- Two system level indicators – provincial healthy wp targeted funding and organizational healthy wp program spending
- Seven organisation level indicators – turnover rate, vacancy rate, training and professional development, overtime, absenteeism, workers' compensation, lost time and provider satisfaction (a composite indictor based on the CCHSA – OHA pulse tool).

A priority action from the strategies is the development of enhanced performance and accountability agreements and accreditation standards. Strelioff (2007)

Hospital Accountability Agreements: Considering existing policy initiatives on healthy workplaces for healthcare workers, the Hospital Accountability Agreements in Ontario included in mid-2000 healthy work environment as a measure in the Hospital Accountability Agreement.
Shamian and El-Jardali (2007)

10. Responsible Procurement

Bajorek et al., (2014) note that it can be suggested that if the government wish to highlight the importance of health and wellbeing in the workplace, then there is an argument that public sector organisations should qualify the 'most economically advantageous tender' principle when undertaking public procurement, and ensure that they procure the services of organisations that have reputable policies with regards to organisational health, safety and wellbeing. Public sector clients could ask questions about a supplier's health and safety record, their level of sickness absence, the incidence of mental illness and physical illness in the organisation, and what level of investment in workplace health and wellbeing has been undertaken and what other interventions have been implemented.

Example of responsible procurement in England – not directly in the wellbeing domain

An example of responsible procurement (although not in the health and wellbeing domain) was provided by Ed Miliband in the UK, who suggested that organisations who are seeking to work with the government will have to pay their lowest waged employees the living wage instead of the minimum wage.

Similarly, some public sector buyers have specified when they procure for services that an Investors in People, or some other form of accreditation, is necessary, to ensure that they are procuring responsible organisations. Additionally ISO:9000 quality management accreditation might be a requirement to get on framework agreements, or lists of preferred suppliers. Bajorek et al., (2014)

11. Investor's perspective

Investors could be required to use organisational health and wellbeing data to gain insights into how organisations treat and value their staff. This information, coupled with insights on the health and wellbeing of staff, could be used when deciding whether to invest in an organisation.

Through seeking greater public disclosure from companies that they engage with, investors are indicating that they are interested in the way organisations manage human capital, and that this may have a direct bearing on how an organisation is able to grow and develop and deliver investor or shareholder returns. The premise is that organisations that have positive staff health and wellbeing should have improved productivity; staff motivation and engagement should result in improved margins, innovation and reputation.

Examples of Investor Perspective in the UK and USA – not directly in the wellbeing domain

The *FTSE4Good Index* was launched in 2001, and measures the environmental and social performances of companies that are listed on stock exchanges worldwide (Slager, 2012). Organisations who meet the FTSE4Good Index inclusion criteria are automatically included on this index. The Index is reviewed two times a year, and companies are included or excluded on their performance related to the Index criteria. In a report exploring the impact of the FTSE4Good Index, Slager (2012) highlighted that engagement had a considerable impact on organisational behaviours, policies and management systems so that organisations remained on the Index.

The *Dow Jones Sustainability Index*, launched in 1999, evaluates the sustainability performance of the largest 2,500 companies listed on the Dow Jones Global Total Stock Market Index. As with the FTSE4Good Index, the approach is to reject organisations who do not behave in an ethical manner (including management and labour practices). Organisations must continue to improve their plans and policies to remain on this index which is monitored and updated yearly. Thus, investors could be encouraged to only invest in organisations that have positive health and wellbeing practices and reporting in place, and comply with the established inclusion criteria. Bajorek et al., (2014)

7. IMPLEMENTATIONS TOOLS

12. Workplace wellbeing implementation tools and supports

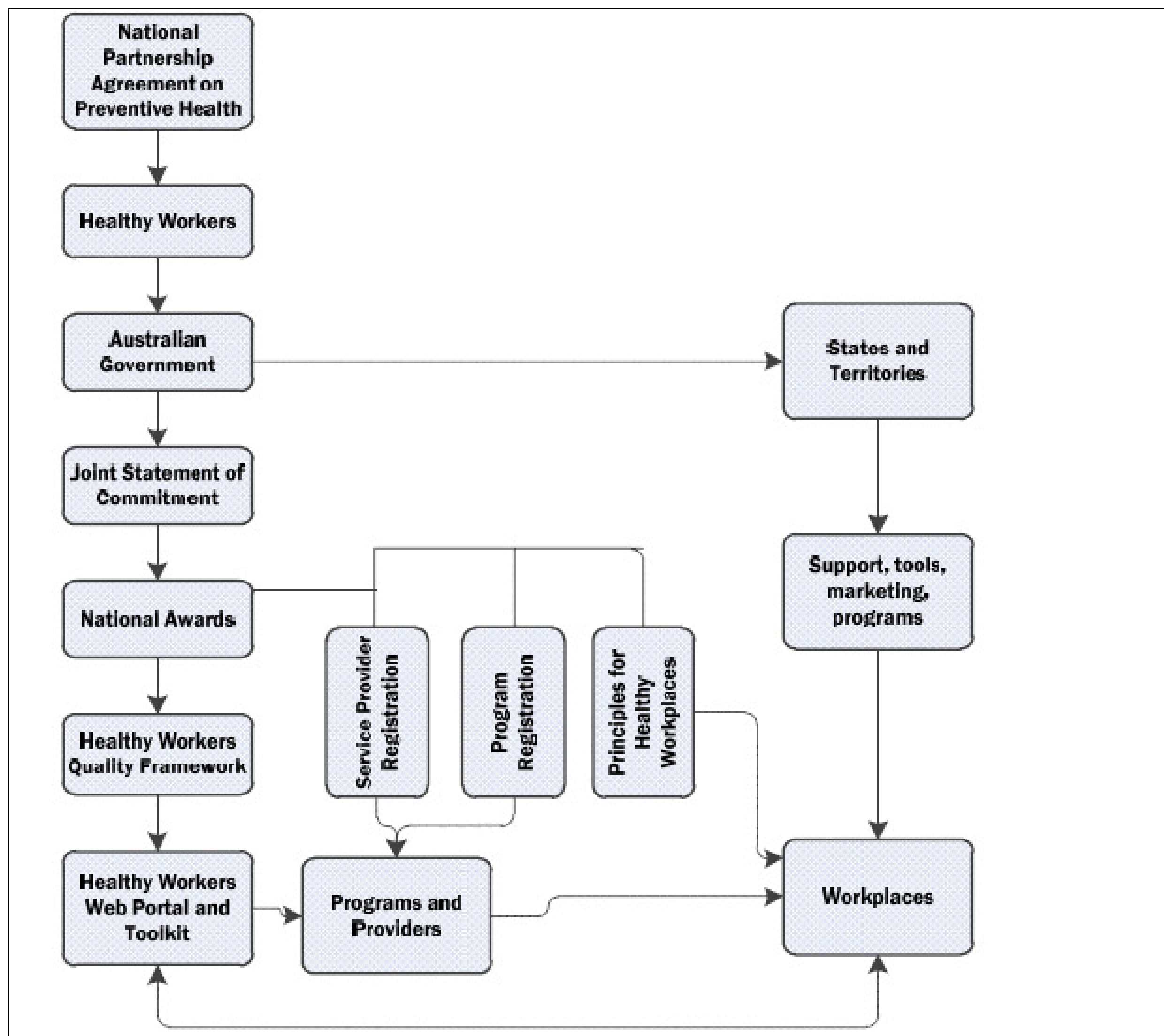
Another example of policy mechanisms is direct public provision of tools or supports to help organisations implement workplace wellbeing programmes and healthy workplace initiatives. Discussed below is the approach in Australia which includes national tools and supports, and State level tools. This is followed by a tool from Scotland to support health system partners' self-assessment of services.

The Australian Government Department of Health and Ageing (the Department) is implementing the Healthy Workers Initiative (HWI), which is one component of three setting-based approaches to reduce the number of Australians at risk of lifestyle-related chronic disease. These initiatives (Healthy Communities, Healthy Workers and Healthy Children) are provided under the National Partnership Agreement on Preventive Health.

The Australian Government is providing funding to the states and territories to facilitate the delivery of healthy living programs in workplaces in their jurisdictions. The Initiative is focusing on reducing smoking rates, improving nutrition – particularly fruit and vegetable intake - increasing rates of physical activity and reducing alcohol consumption. Funding for the states and territories began on 1 July 2011. The Australian Government is further supporting the states and territories through the development of a national awards program, a national workplace health promotion toolkit and web portal for employers, a national Joint Statement of Commitment to promote good health through workplaces and a Healthy Worker Quality Framework.

Figure 1 shows the relationship between all the components of the overall Initiative. This is followed by an example of national tools and supports, and an example of a State level tools and supports in Australia. Finally, an example from Scotland is provided which is aimed at health system partners.

Figure 1: Relationship between all the components of the overall Initiative



Example of National Web Portal and Toolkit – Australia

Department of Health - Healthy Workers Initiative provides a web site (screenshot below) designed for employers. It includes a range of information and tools to assist with making workplaces healthier by encouraging employees to Eat Well, Move More, maintain a Healthy Weight, be Smoke-free and reduce consumption of Alcohol.

The site includes resources on each of the five health issues above, as well as information to assist employers to create and tailor their own healthy workplace program, covering planning, delivering and continuous improvement. There is also information on health issues in specific industries, case studies where some Australian organisations share their experiences with delivering healthy living programs in their workplaces, and resources

developed by individual Australian states and territories.

In the other pages of this section, you will find information on

- The three main stages to assist you to create your own healthier workplace: Getting Started , How to Plan and Deliver your Program, and How to Improve your Program.
- The five Principles for Healthy Workplaces, these underpin the Quality Framework developed for the Healthy Workers initiative, which cover the drivers and inhibitors of successful workplace health promotion for employers.

Example of State level Tools and Supports for Public Sector Organisations - Tasmania

The Tasmanian Government in Australia seeks to increase the efficiency and productivity of the State Service through a culture that values, supports and improves the health and wellbeing of employees. In 2007 the State Government launched *Get Moving at Work: A resource kit for workplace health and wellbeing programs*.

In the 2008-09 State Budget, the Government announced a four-year commitment to implement workplace health and wellbeing programs within the public sector through the Healthy@Work project. This project is managed through the Public Sector Management Office and aims to support the development of workplace health and wellbeing programs within each government agency.

An audit of State Service workplace health and wellbeing activity in December 2008 indicated that six of the 15 agencies had a workplace program in place. For those agencies that had a program in place, there were large differences in the content, quality and method

of development.

The Healthy@Work project aims to support the development of workplace health and wellbeing programs through the use of a consistent, evidence-based model that allows agencies the flexibility to develop a program specific to the needs of their organisation. The Public Sector Management Office of the Department of Premier and Cabinet have prepared the document *Guidelines - Implementing a Workplace Health and Wellbeing Program* to assist Agencies to meet their obligations to develop a workplace health and wellbeing programs as outlined in Ministerial Direction 23.

The Guidelines document the rationale for implementing workplace health and wellbeing programs in an Australian context and address the following:

- The Implementation Cycle for a Workplace Health and Wellbeing Program (including two example templates for a workplace health and wellbeing action plan).
- Key Principles for Implementing a Workplace Health and Wellbeing Program.
- Relationship to Occupational Health and Safety Legislation.
- Resources. The Guidelines note that Agencies can receive support to develop and implement their health and wellbeing program from the Healthy@Work project. Information on the support available can be obtained from www.healthyatwork.tas.gov.au or by telephoning the project phone number.

Example Self-Assessment Framework for NHS Boards and Partners - Scotland

The Scottish Health Offer supports any individual of working age in Scotland who accesses NHS healthcare services and whose health condition is a barrier to work. It has seven key principles and uses a bio-psychosocial approach, embedding early assessment within routine healthcare. This addresses a person's functional capacity, access to services and treatment. This offer applies to patients/clients who may be:

- In employment and attending work, but with a condition that they think may lead to sickness absence or with difficulties at work in the fulfilment of all normal duties;
- In employment, but on sickness absence;
- Out of work and with a condition that they believe limits their ability to enter into and remain at work.

The framework, *Health Works Self-Assessment Framework for NHS Boards and Partners*, reflects each of the seven principles within the Scottish Offer. The aim of the self-assessment is to provide a structured approach across a health system and its relevant partners and to identify, map and understand the services that contribute to the delivery of the Scottish Offer, whether or not they are delivering the full range of services at the time of assessment.

The framework is intended to be used across the whole NHS system and with partner organisations to enable a full review and description of services at the time of assessment. It aims to support the NHS Board and its partners in the identification of all services that are, or could be, engaged in delivering the Scottish Offer and to aid the identification of any gaps or opportunities within the locality.

It is not intended as a measure of quality or performance, but more to provide an internal overview which can then be used to consider existing service delivery, identifying any gaps or duplication, and to inform planning, resource utilisation and redesign. It will review the extent to which the Scottish Offer is embedded in the Board. It should also help to clarify the interface with employability partners.

The framework states that the completed assessment should be a baseline for local planning, and that The Scottish Government, Health and Work Unit is available to provide advice and/or support. It provides the name of a contact person along with their phone number and email address.

8. KEY REPORT FINDINGS

This chapter provides a summary of the policy mechanisms identified to support the use, initial uptake or expansion, of a healthy workplace/workplace health programmes and reference to examples.

*** indicates application of a mechanism for a healthy workplace/workplace health programme.

** indicates intention to use a mechanism for a healthy workplace/workplace health programme although it may not have been enacted.

* indicates application of a mechanism in a context other than a healthy workplace/workplace health programme.

Financial measures

Fiscal incentives can involve matched funding or tax credits.
** US: state legislative bills offering employers income tax credits toward "wellness activities"

Levy systems involve a small levy paid by eligible organisations, and those who implemented organisational health and wellbeing programmes claim grants from the levy.
* Great Britain (sectoral): Construction Industry Training Board Levy for training

Incentivising collaboration through local "budget-pooling" by local stakeholders, such as employers and agencies of government, where those with overlapping interests are encouraged to collaborate more.

*** Sweden: SOCSAM scheme, cross-sectoral initiative for vocational rehabilitation to reduce long-term sick leave.

Regulation

Regulation stating health and wellbeing measures that employers should provide.

*** Netherlands: there is a state-enforced process for employers to discuss and facilitate return to work through independent occupational health physicians before individual is transferred onto the state-administered benefits system.

*** Japan: regulation goes further in not only encouraging practices which manage return to work, but in also regulating for preventative measures such as contracting an

occupational physician who is responsible for on-site safety inspections, education of employees and provision of annual health check-ups.

Regulation stating what organisations should report regarding health and wellbeing measures and the practices they undertake.

*** Finland: employers must have a written occupational health care action plan.

Other legislative approaches in addition to tax credits can support wellness programmes.

*** US: state legislation for wellness policies and programs (proposed in 21 bills, 4 of which are reported to be passed), for alternative transportation (18 proposed and 4 passed), and for health insurance (14 proposed and 3 passed).

Signalling quality

Accreditation aims to raise the quality of employee health and wellbeing outcomes amongst those who sign up to accreditation awards.

*** UK: the Investors in People Standard includes a People Health and Wellbeing Good Practice Award that can be achieved as part of the Standard, or as a standalone assessment.

*** Canada (sectoral): the Canadian Council on Health Services Accreditation includes work life as one of its four quality dimensions.

Benchmarking and awards allow organisations to enhance their organisational self-assessment in relation to health and wellbeing practices through closely monitoring what is done in their organisation as well as similar organisations.

*** UK: Business in the Community's 'Workwell Benchmark' encourages more organisations to address the effective use of data collection and reporting to improve health and wellbeing, and to improve business performance.

*** Canada: National Quality Institute has developed a set of organisational excellence criteria, including the promotion of appropriate lifestyle and health practices.

Signalling importance

Organisational pledges encourage organisations to develop a commitment to workplace health and wellbeing.

*** England: Workplace Health Charter, a statement of an organisation's commitment to the health and wellbeing of its staff.

Responsible procurement by public sector organisations to ensure that procured service providers have reputable policies on health, safety and wellbeing.

* UK: some public sector buyers specify when they procure services that an Investors in People, or some other form of accreditation, is necessary.

Investor's perspective involves providing a means for investors to gain insights into organisational health and wellbeing data when deciding whether to invest.

* England: FTSE4Good Index.

* US: The Dow Jones Sustainability Index.

Implementation tools

Workplace wellbeing implementation tools and supports provided by public bodies to help organisations implement workplace wellbeing programmes and healthy workplace initiatives.

*** Australia: Web portals, implementation guides and toolkits, assessment tools, and direct provision of advice.

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