

Best-Practice Guidelines

Workplace Health in Australia

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Workplace Health
Association Australia





INTRODUCTION:

Why Do We Need These Guidelines?

Chief Executive Officers of leading organisations are often asked what makes their company successful. Increasingly, the answer is ‘our employees are our greatest asset’, or in other words, their human capital.¹

Improving employee health not only has the capacity to control expenses, but also protect, support and enhance human capital.^{2 3} This has led an increasing number of Australian organisations to adopt workplace health programs, with key drivers which include the management of the ageing workforce, workers compensation costs, corporate social responsibility and being an ‘employer of choice’. These organisations are reaping the benefits of a corporate culture which delivers greater job satisfaction, reduced staff-related costs, improved employee engagement, less absenteeism, higher productivity and ultimately higher profits.⁴

Workplace health has progressed from its ‘nice to have’ and ‘right thing to do’ image, and has become a key business performance driver. The question is no longer whether programs should be adopted, but how they should be designed, implemented and evaluated to achieve maximal benefits.⁵ A recent (2015) review of over 150 Australian employers found that Australian employers are becoming “more structured in their approach to work health. The increased use of data in planning and evaluating will result in workplaces implementing more targeted and evidence based solutions for their people and organisations”.⁶

The field of workplace health developed and flourished largely in North America through the 80s

and 90s and over 90% of all publications on workplace health emanate from the US. This poses a problem in terms of program design and implementation in an Australian context where substantially different drivers exist, and the value proposition and cost:benefit modelling is demonstrably different.

There is a need therefore, to establish distinct guidelines for workplace health in Australia which take into account these disparities.

Despite spending 2-4 times as much on health care as comparable countries (such as Australia, UK, NZ, Canada, France, Germany, Norway and Sweden), the US ranks near last in terms of access, efficiency and equity in their health care system.⁷ Most US citizens also obtain health cover as an employment benefit in a “risk rated” insurance market. This means medical costs are more directly the responsibility of employers, thereby creating the need to provide preventative interventions to control the massive costs borne by an organisation for poor employee health. US ROI data therefore, which often includes savings in medical/pharmaceutical costs, will provide an inflated figure and caution is advised in applying these assessment algorithms in an Australian context.

Whilst some of the practices and content/design considerations from the US are applicable to the Australian market, many are not. For this reason, WHAA has developed this comprehensive set of guiding principles to support Best Practice Workplace Health interventions in the Australian setting.

ABOUT:



Workplace Health Association Australia

The Workplace Health Association of Australia (WHAA) is the peak body of workplace health providers in Australia. WHAA (formerly HAPIA) was formed in 2007 by Australia's leading service providers who sought to enhance the professional status of the industry through a commitment to evidence based practices, and to provide unified representation to government and business in relation to the role of the workplace in preventative health.

Our Purpose

WHAA's mission is to contribute to the health reform debate, to improve health outcomes and reduce health system costs through its focus on prevention, particularly preventative services delivered to employees at the worksite.

WHAA also oversees standards and accreditation, funds research, supports evidence-based approaches to workplace health, and promotes ethical business practices within the industry. This ensures our members deliver, and their clients receive evidence-based, outcome-focused services which deliver measurable, cost-effective outcomes.

In 2007, WHAA launched the inaugural Australian Health and Productivity Management Congress which has been conducted annually ever since. This conference has grown to be the most significant event on the Workplace Health calendar and is now supplemented by numerous half-day events in other states. With both national and international speakers, this annual congress targets those who have adopted, or are planning to adopt, workplace health programs for their organisations. The congress highlights the 'asset value' of the workforce, together with the latest trends and research, and best-practice Australian case-studies.

Further Information

For further information regarding WHAA, including a list of our members, please visit our website at www.workplacehealth.org.au

BEST-PRACTICE GUIDELINES - SUMMARY

1. Active support and participation by senior leadership
2. Health as a shared responsibility
3. Engagement of key stakeholders
4. Supportive environment and culture
5. Participatory planning and design
6. Targeted health interventions
7. Evidence base, standards and accreditation
8. High levels of program engagement
9. Oh&s integration
10. Technology and online programs/content
11. ROI – assumptions and calculations
12. Innovative marketing and communication
13. Evaluation and monitoring
14. Commitment to ethical business practices
15. Sustainability

WHAT IS WORKPLACE HEALTH?

As workplace health has evolved, many different terms have been used to describe the industry. This includes workplace health management, corporate health, corporate wellness, and health and productivity management. WHAA believes the term 'Workplace Health' best reflects today's approach which acknowledges the multiple determinants of employee health, and is more holistic and integrative in nature, addressing both individual and organisational factors.^{8 9} This is reflected in the definition below:

Workplace health represents “the combined efforts of employers, employees and society to improve the health and well-being of people at work. This is achieved through a combination of improving the work organisation and the working environment, promoting the active participation of employees in health activities and encouraging personal development.” (adapted from ENWHP, 2007¹⁰)

WHY THE WORKPLACE?

In the changing world of work, motivated, qualified and above all, healthy employees are essential for Australia's future economic prosperity.¹¹ With Australians spending approximately 1/3 of their adult life at work, the workplace plays a pivotal role in the physical, mental, economic and social wellbeing of workers, and in turn, their families.¹² The workplace has subsequently been recognised as a priority setting for health promotion by the World Health Organisation and Australian governments.^{13 14 15 16} This is also reflected in the growing demand for green buildings, the implementation of work/life balance policies, technology to support flexible work practices and the trend to provide amenities such as onsite gymnasiums and child care facilities.¹⁷ There are a number of additional reasons why the workplace is an ideal setting including (but not limited to):^{3 10 18 19}

- Australian employees average 4 health risk factors per person;²⁰
- Ease of access to a large number of people, including hard-to-reach groups;
- Existing infrastructure (e.g. communication channels, supportive environment);
- Opportunity to tailor interventions to support the needs of specific groups of employees (e.g. shift, transport and FIFO workers);
- Cost-efficiency relative to clinical or community-based programs;
- Effectiveness of interventions which can be readily monitored over time;
- Opportunity to address multiple levels of influence on employee wellbeing;
- A greater value proposition as the impact of factors such as productivity, illness/absence and Workcover claims can be accounted for in addition to purely health care costs.
- Through an integrated approach, the opportunity to support and mutually reinforce health and safety, human resources, organisational development; and
- Decreased burden on public health system.

The rise in health care costs continue to outstrip all other cost groups reported by the ABS in their quarterly CPI updates. In the 10 years from June 2005 to June 2015 the average "All Groups CPI" was 2.7%, compared to 4.7% for the "Health CPI".

Prevention represents one of the few mechanisms by which we can viably stem the unsustainable growth

in health care costs. Prevention in the workplace represents a viable, yet largely untapped setting in which to make headway in this important area which impacts Australia's national economic situation, as well as the quality of life and health of our citizens.

A greater focus on workplace health over the coming decades has the potential to deliver benefits for both the Australian working population and employers. Not only through control of health care costs, but also in relation to the productivity of the Australian workforce.

Recognition of the differing priorities of government and business also deserves comment. Whilst health outcomes and health care costs may be high on the government agenda, the top priorities for business are more likely to relate to morale/engagement, corporate values/mission, safety and productivity.²¹ Whilst these priorities are not mutually exclusive, they do require a more nuanced approach to program design, outcomes and reporting.

WORKPLACE HEALTH: A GLOBAL SNAPSHOT

Marketplace activity, together with recent research, provides strong evidence that organisations, nationally and internationally, are increasingly recognising, and valuing, workplace health for the magnitude of benefits to both their organisation and employees.²²



Global Perspectives

The prevalence of workplace health programs globally is rising rapidly.¹⁹ The international movement is led by associations such as the Institute for Health and Productivity Management (U.S.), the European Network for Workplace Health Promotion

and the International Association for Worksite Health Promotion.⁶ Geographically, workplace health programs are most prevalent in North America, where 79% of employers report having workplace health offerings, with the main driver being a reduction in health care costs. Outside of the US, 46-47% of organisations in regions such as Europe, Asia, Australia/NZ and Latin America report offering health promotion options to employees with the main drivers being improved morale/engagement, reducing absence, enhancing safety and improving employee productivity.¹⁹ These statistics should be viewed with a degree of caution due to selection bias of the organisations participating in the survey.

Australian Perspective

The concept of workplace health has developed and gained momentum in Australia since the late 1970's, undergoing a significant evolutionary process.¹⁰ The growth of the industry is due largely to the position it occupies at the confluence of political, economic, technological, safety, injury management and public health developments.²³ This growth peaked in the period 2009-13 when both the Victorian Workhealth Program²⁴ and the National Partnership Agreement on Preventative Health (NPAPH)²⁵ were both operating.

Collectively these programs would have injected around \$990 million into preventative health, with around half this directed to employee based programs. The Workhealth program was successful in delivering 800,000 health checks to 38,000 workplaces in Victoria, however the outcomes of this program will never be fully known due to the participant anonymity requirements of the program. The overwhelming majority of participants therefore, could not be followed up. This was in direct contravention of the WHAA Guidelines with obvious consequences for program outcomes.

The NPAPH was wound up 4 years early as a budgetary cost-cutting measure by the incoming Liberal Government before any significant findings were published. The withdrawal of Federal Government support and the completion of the Workhealth program have resulted in a slowing of industry growth during the 2013-15 period.

Notwithstanding this, an independent industry

report published by IBISWorld in October 2014 stated; "The Corporate Wellness Services industry is in good health. The industry has recorded robust growth over the past five years as companies and governments have recognised the benefits of promoting health and wellbeing in the workplace."²⁶ The 2015 update of this paper was less optimistic.²⁷

The 2015 Bupa Benchmark Survey - Workplace Health in Australia - also provided interesting insights into the industry with over 150 companies responding (50% of these had 500+ employees). Over half of the organisations surveyed have dedicated internal personnel to manage their programs, and within the next one to two years this is expected to rise to over 70% of workplaces²⁸. Similarly, over half of workplaces also engage external health providers to coordinate and deliver programs.

The increasing sophistication of workplaces in their approach to workplace health, with better program design and improved monitoring and reporting, augurs well for the future of such programs.

QUICK FACT: Organisations that don't promote health and wellness are four times more likely to lose talent in the next 12 months.³⁰

Over the past 8 years, the WHAA Best Practice Guidelines have been the preeminent source of principles to guide those operating in this space.

WHAT'S THE VALUE PROPOSITION?

Like their international counterparts, Australian business leaders are recognising that 'healthy employees equal healthy organisations'.⁹

For employees, the benefits of participating in workplace health programs include (but are not limited to):^{3 16 29 31 32}

- Improved health awareness and knowledge (Health Literacy)
- Improved physical and mental wellbeing and resilience
- Increased energy and vitality
- Increased work enjoyment and fulfillment
- Improved concentration and productivity
- Improved team relationships

For employers, the benefits of providing workplace health programs include (but are not limited to):

- Improved productivity
- Increased creativity and innovation
- Improved employee engagement

“Investment by businesses and private health insurers in health management and wellness programs reflects a commercial assessment that such programs generate a positive return on investment.”

- National Health and Hospitals Reform Commission, 2008³⁵

- Improved staff morale
- Reduced sickness-related absenteeism
- Reduced presenteeism (health-related work impairment)
- Increased attraction and retention of staff
- Reduced workplace injury and workers compensation costs
- Improved employee relations
- Improved corporate image
- Managing an ageing workforce

WHAT'S THE EVIDENCE?

Workplace health is not just a ‘nice to have’ for organisations. Strong evidence exists for the effectiveness of such programs, benefiting the wellbeing of employees and the companies which employ them. A win-win situation!

A recent WHAA publication identified over 600 national and international studies published in the past 2 decades, including multiple large meta-evaluations,^{31 27} which provided compelling evidence that workplace health programs provide a solid return on investment (ROI).³

Since the seminal 1982 publication of Roy Shepherd in Medicine and Science in Sports and Exercise³², the first published meta-analysis on the ROI of workplace health programs, at least ten more comprehensive meta-analyses have been published eg. 5, 29, 31.

A number of factors are evident from this enormous body of literature which synthesizes data from over 2,000 journal articles over three decades. This includes;

- 1) The purported outcomes in health, productivity, illness/absence etc. have been repeatedly validated in numerous settings,
- 2) Evidence based multidisciplinary programs yield superior results,
- 3) One recent meta-analysis of 60 studies

involving over half a million employees totaling 226 years of observation demonstrated that workplace health programs resulted in an average

- a) 25.3% decrease in sick leave absenteeism,
- b) 40.7% decrease in workers compensation costs,
- c) 24.2% decrease in disability management costs and
- d) \$5.81 saving for every \$1 invested in employee wellbeing.³³

- 4) The most recent of these meta-analyses from 2014³⁴ put Workplace Health Promotion under the spotlight using more robust methodology than previous studies. After critically analyzing data from 61 studies which included 261,901 participants and 122,242 controls, the average weighted ROI was still quite high (2.38:1). Salient points from this work included;

- a) Higher quality studies showed lower ROIs (presumably due to better measurement criteria),
 - b) US studies show higher ROIs than non-US studies (due to impact of employer paid health care costs which are unique to the US),
 - c) Recent studies yield better ROIs than older studies (companies are getting better at designing and delivering interventions that work),
 - d) Interventions focused on SNAPS (Smoking, Nutrition, Alcohol, Physical Activity and Stress) yielded the best ROIs,
 - e) Multicomponent studies yielded higher ROIs than single interventions,
- 5) Integration of Workplace Health with OH&S tends to yield better overall outcomes

As a result, employees with better health spend more time at work, and are more productive when they are, reinforcing the universal belief that employees are a company's greatest asset.

QUICK FACT: Research indicates that in organisations where workplace health is managed well, financial performance increased by more than 2.5 times.²⁵

BEST PRACTICE GUIDELINES

As no two organisations are identical, it is difficult to have a fixed formula for a successful workplace health program. However, there are key characteristics that successful and sustainable programs share. Consistent with current research and best-practice, there are 15 guiding principles for development and implementation of a results-oriented program.

1. ACTIVE SUPPORT AND PARTICIPATION BY SENIOR LEADERSHIP

Senior leadership support is critical to building and sustaining successful workplace health programs.³⁶ This goes beyond simple endorsement of programs and involves active and visible participation.^{37 38} Indeed, it has been WHAA's experience that when the CEO gets behind workplace health initiatives that things really start to happen!

There are ten primary roles that the senior leadership team, particularly the CEO, must embrace:^{39 40}

1. Creating the vision (e.g. mission statement)
2. Connecting the vision to organisational values, strategy, practice and policy (i.e. build a health culture)
3. Gaining budget and resource commitment

4. Educating and engaging senior management
5. Sharing the vision with employees
6. Serving as a role model (i.e. walk the talk)
7. Ensuring accountability and responsibility (e.g. KPI's for senior management)
8. Rewarding success (e.g. incentives, public recognition)
9. Adapting the program content and delivery in light of new findings (ie. keeping the program current, relevant and efficacious)
10. Integration of work systems/functional units, in particular the integration of OH&S with employee health and wellness initiatives.

QUICK FACT: Management-related factors have been shown to contribute more to success than the content of the (workplace health) intervention.⁴¹

Barriers to leadership support will exist such as limited resources or competing business priorities, but can be overcome in a number of ways. For instance, undertaking a pilot workplace health program with senior management before rolling out a broader program can generate enthusiasm and support and create a cascade effect throughout the organisation.³⁰

“Workplace health is something we do with and for people... it's not something we do to them”

- David Hunnicutt,
WELCOA President, 2009

“When CEOs value healthy lifestyles and openly practice good health habits, the rest of the organisation is likely to follow in their footsteps. To be genuine in promoting health, CEOs need to embrace health as an individual priority. This does not mean they have to be a marathoner or ‘health nazi’, it just means that they value health and wellbeing and take steps to protect it”

- WELCOA 2006



program. This will serve to optimise employee engagement and foster a sense of program ownership. The committee structure, composition and meeting frequency will depend on the size of the organisation and scope of the program. It should include representatives from all levels and sectors of the workforce (including human resources and/or health and safety), who are enthusiastic, motivated, and with strong leadership skills and a health interest. It is suggested that new members be appointed every 1-2 years, and be provided with the required professional development (e.g. training in health promotion principles), allocation of work time and resources to conduct their role effectively.^{10,44}

2. WORKPLACE HEALTH AS A SHARED RESPONSIBILITY

The effective delivery of workplace health programs requires a mutually beneficial partnership between employers and employees which encourages both parties to take and accept responsibility for health in the workplace.⁴² Similarly, experience suggests that part financial contribution by employees for select initiatives (e.g. gym membership, smoking cessation), fosters responsibility for, and ownership of, individual wellbeing, and leads to a higher rate of adherence.



3. ENGAGEMENT OF KEY STAKEHOLDERS

A healthy workplace is only attainable through the commitment and cooperation of employers, employees and employee representatives working collaboratively.⁴³ This can be achieved through a number of strategies including:

Establishing a Workplace Health Committee

This committee is responsible for planning, overseeing and executing the workplace health

Appointing a Workplace Health Coordinator

A Workplace Health Coordinator should be appointed by Senior Leadership or elected by the Workplace Health Committee. Their primary role is to lead the Workplace Health Committee and to coordinate the internal delivery of the program. Ideally this person would have a health background, with skills and expertise in management, planning, coordination and strong communication skills across a diverse range of audiences.³⁸

“Members of a healthy culture are able to systematically align values, norms, peer support, organisational climate with individual and organisational challenges and opportunities. The primary ingredients of a health culture are leadership, knowledge of cultural change, kindness and engagement of the entire population”

- Judd Allen, 2000

Identifying and Establishing Workplace Health Partnerships

To support the delivery of a comprehensive workplace health program, organisations may seek strategic partnerships and/or support from local providers, onsite third parties, not-for-profit organisations (e.g. Heart Foundation, Cancer Council, Beyond Blue) or workplace health providers to provide necessary expertise, experience and resources. A list of WHAA provider members is available on our website www.workplacehealth.org.au – All members are committed to the delivery of evidence based programs which comply with the National Health and Medical Research Council’s “Level III C” evidence base.⁴⁵

4. SUPPORTIVE ENVIRONMENT AND CULTURE

How do you integrate workplace health into the “DNA” of an organisation? Through the development of a supportive environment and culture, or in other words, ‘making healthy choices the easy choices’. As employees spend more waking hours at work than anywhere else, it is not surprising that this fosters higher program participation, adoption and maintenance of healthy behaviours, together with a reduction in major health risks and increased productivity.^{15 35 46}

The ideal workplace environment has been described as a green, campus style, family friendly and smart workplace.¹⁵ The environment can be assessed utilising tools such as the ‘Healthy Places Survey’ developed by Worksafe Queensland⁴⁷, or the ‘Checklist of Health Promoting Environments at Worksites’ (CHEW) which identifies environmental characteristics that influence health-related behaviors.⁴⁸

Such surveys assist management in assessing factors that impact the SNAPOS behaviours (Smoking, Nutrition, Alcohol, Physical Activity, Obesity and Stress);

- existing activities or programs (i.e. Walking challenges, exercise classes, lunchtime games/ activities etc.)
- the physical environment (i.e. Shower/ change facilities, healthy food options at canteens/vending machines, access to drinking water etc.)

“One size doesn’t fit all”

- the policy environment (i.e. active transport, flexible work options etc.), and
- the cultural environment (healthy behaviours valued, peer and organisational support evident)

Workplace culture can also be assessed via an audit to identify the cultural supports for employee health, and areas for improvement, across the following dimensions:³³

- Norms (‘how things get done around here’)
- Values (beliefs about what is important)
- Peer support (assisting colleague to achieve health goals)
- Organisational support (policies, procedures, rewards, communication); and
- Climate (sense of community, shared vision)

“You can’t manage what you can’t measure”

- Peter Drucker, Writer/ Management Consultant (1909-2005)



5. PARTICIPATORY PLANNING AND DESIGN

Establishing Needs

The first step in creating a successful workplace health program is to understand employee and organisational needs. A ‘participatory’ needs assessment will determine the scope, content and approach of health initiatives, and ensure employers

Figure 1. Sample multi-faceted and multi-level strategies to increase physical activity^{15 32}

Cultural:

- Discouragement of sedentary behaviour (e.g. Host 'walk and talk' meetings)
- Physical activity breaks during the working day (e.g. stretching)
- Health-related social functions (e.g. lawn bowls, touch footy)
- Active leadership and participation by senior management
- Promotion of physical activity in everyday work duties

Environmental:

- Provision of active transport facilities in safe, convenient and accessible locations (e.g. bike racks, change rooms, showers)
- Provision of onsite fitness facilities / services
- Proximity to bicycle paths, walkways, parklands and public transport
- Provision of adjustable workstations
- Encouraging use of internal stairwells through motivational signage and making them more accessible
- Provision of maps of suitable lunchtime walking routes to promote walking/jogging

Policy

- Flexible working hours to allow for physical activity (e.g. lunchtime walk)
- Subsidised gym memberships, corporate sporting events or onsite fitness opportunities (e.g. yoga)
- Subsidised equipment purchase (e.g. bike scheme)

Individual:

- Pedometer challenges
- Educational and awareness strategies (e.g. lunch 'n' learn sessions, newsletter articles, online tools, expos, Walk to Work Day)
- Health risk assessments

are investing in the 'right' programs. It will also provide the baseline from which the impact of the future program can be gauged. Groups will invariably differ depending on the nature of the organisation and the type of work performed (e.g. blue collar versus white collar). Social and cultural differences will also play a role. As risks are not static, the needs assessment should then be conducted on an ongoing basis as part of the program management and evaluation process.

The objectives of the needs assessment are to:

- Establish a baseline individual and organisational health profile;
- Determine the direct (e.g. workers compensation costs) and indirect (e.g. absenteeism, productivity) health-related costs to the organisation;
- Identify 'hotspots' across the organisation;

- Determine workplace capacity and/or constraints (e.g. budgetary, communication channels, environment, culture);
- Provide a 'gap analysis' of current onsite and community resources, services and facilities;
- Ensure future health initiatives best meet the needs of employees based on readiness-to-change, health behaviour, risk status, interest, maximising participation and ROI;

A comprehensive needs assessment involves 5 steps:³²

1. Consultation (e.g. key stakeholders, focus groups)
2. Data collection (e.g. organisational demographics and metrics, employee health risk appraisal, workplace environment/culture, past surveys)

"The business case for health management indicates that the critical strategy is to 'keep the healthy people healthy'"

- ('keep the low-risk people low-risk)' Dee Edington, 2009



3. Analysis of data (e.g. trend analysis, benchmarking)
4. Determine priorities (e.g. magnitude, potential impact, feasibility, resources, goals/objectives)
5. Inform stakeholders of the findings and recommendations (i.e. senior leadership/ management, Workplace Health Committee and employees)

Developing the Program

As indicated previously, an effective workplace health program simultaneously addresses the individual, environmental, policy and cultural factors affecting employee wellbeing (see Fig.1).^{28 49} In developing a comprehensive program, it is important to:¹⁶ (note – specialist expertise may be required to support this process)

- Use the needs assessment data to target interventions;
- Learn from others success (e.g. award-winning or best-practice case studies);
- Determine goals and objectives in line with S.M.A.R.T. principles;
- Determine what interventions will be offered and the level of intensity (see SIMPLE criteria below);
- Consider key enablers (e.g. strong leadership) and challenges (e.g. potential timing, employee scepticism) for implementation

- Engage the necessary providers, resources and commitment;
- Devise an operating plan including timelines, roles and responsibilities, budget and marketing, communication, monitoring and evaluation strategy;
- Test the proposed framework with key stakeholders (e.g. senior leadership, Workplace health Committee) to ensure program buy-in;
- Have a long term vision (3-5 years).

The following criteria can be used for choosing suitable interventions for workplace health programs:³²

- S**pecific to needs (e.g. based on goals/objectives, target audience, multi-level)
- I**nnovative (e.g. latest approaches, simple yet flexible)
- M**anageable (e.g. sufficient resources, cost-effectiveness)
- P**eople-oriented (e.g. accessibility, targeted)
- L**asting (e.g. sustainable, follow up, integration with corporate strategy)
- E**vidence-based (e.g. based on reputable studies/interventions)

Financial investment in the workplace health program may vary and fluctuate widely, depending on whether the employer pays all costs, the employee pays all

“A personal health screening opportunity is such an important component (of a workplace health program) that it is virtually impossible to establish any type of effective workplace health program without it”

- WELCOA (2006)

A list of common workplace health interventions are listed below:

Health Risk Assessment (HRA)	Conducted online, face to face or a combination of the two, these vary in length and complexity. Normally conducted onsite with key components including assessment of health behaviours (i.e. physical activity, smoking, alcohol and nutrition) and biometric data (i.e. blood pressure, blood glucose, cholesterol, BMI/WHR, etc.) goal setting, and/or behavioural counselling.
Executive Health Assessments (EHA)	Comprehensive assessment (1-3 hrs) including full physical, medical, blood pathology, mental, lifestyle and work related factors.
Health Screening	A variety of health screenings can be performed either onsite or at a nearby location (e.g. diabetes, hypertension, skin cancer, audiometry/vision, etc.)
Health Coaching	Normally linked to HRA or EHA, this personalised form of coaching can be delivered face to face, online, or telephonically, and is well suited to medium/high risk individuals, with a strong focus on lifestyle-related behaviour change.
Seminars and Workshops	Interventions include a variety of awareness and education activities across a range of health dimensions (e.g. healthy eating, sleep, stress/resilience, exercise, etc) and can be delivered in a variety of formats (e. g. group seminar, expos, webinars).
Employee Assistance Program	Provides staff, managers and often family members with confidential counselling and support for either work-related or personal difficulties, either in a face-to-face, telephonic or online format.
Vaccination Programs	Normally conducted onsite, and include annual flu vaccinations and those to meet occupational health requirements (e.g. for health professionals), together with travel vaccinations and advice for employees required to travel overseas.
Team Building	A variety of interventions fall into this category including subsidised corporate sporting events (e.g. City to Surf) and team challenges (e.g. walking/pedometer challenges).
Pre Employment Medicals	These are intended to evaluate an employees functional capacity to perform the tasks inherent in a job and susceptibility to particular substances, injuries or diseases.
Health Intervention Programs	These interventions can be delivered across a variety of health dimensions (e.g. weight management, smoking cessation, mental health) and via a range of modalities (e.g. online portals, e-learning, face-to-face, telephonic coaching) and formats (e.g. modular), and is largely based on behaviour-change theory.
Facility Design and Management	Professional guidance and/or support regarding the design, establishment and management of onsite gymnasium or health facilities (e.g. layout and design, staffing, programming, OHS requirements).
Health Related Activities	Based on local interest, this can include group exercise classes, relaxation/meditation, cooking classes and massage.
Work Life Balance	This includes initiatives to support work life needs including such factors as priority setting/value clarification, planning and problem solving, financial health, time management and positive parenting.
Walking/Activity Challenges	Individual or team based activity using “wearable” activity monitors (or self report in some circumstances). Variety of time frames and winning conditions (i.e. steps, distance, most consecutive compliant days etc.)
Free to Air Programs	Government sponsored initiatives such as Quitlines, Get Health at Work, Lifeline, etc.
Community Events	Local Fun Runs, fund-raising/charity events, community swimming/riding events (The Gong Ride/Cole Classic etc.)
Health Apps for Smartphones and Tablets	Literally thousands of activity, nutrition, sleep, stress and lifestyle apps are available.
Company Policies	The great enabler - if it's in here, there's a mandate from on high which cannot be overridden on the whim of a supervisor. Policies and guidelines around issues such as flexible work and leave practices, policies that affect structural features of the workplace which may impact an employee's ability to make healthy physical activity and nutritional choices while working. Allowing employees to vary daily arrival/departure times. This time can be used to exercise and to carpool. Provide guidance for making available healthy food choices at company sponsored or co-sponsored meetings, conferences, and other work related events where light food and beverage will be served. Guidelines for tobacco and alcohol use etc.
Active Travel	Companies encourage active commuting through policy, education, facilitation of groups, development of local maps and facilities such as bike racks, lockers and showers.
Avoidance of Prolonged Sitting	Standing desks, pop up reminders at workstations, walk and talk meetings etc.
Disease Management Programs	Programs that target particular common disease states such as diabetes, hypertension, cardiovascular disease and cancer. Often follow from a screening process to identify at risk employees.
Targetted Population Programs	Programs designed for a particular demographic such as “Secret Women’s Business” or “PitStop” for blue collar males or the “Healthy Farmers” program. Tailoring programs for engineers or accountants to account for their preferred learning style and love of numbers can also be extremely helpful.
Work environment	Ensuring the work environment is conducive to healthy behaviours. May include healthy options in Vending Machines and canteens, open stairways for exercisers, shower/locker facilities, walk and talk meetings, standing desks etc.
Skin Checks	A whole or part body skin examination with a medical professional. Should have a well established referral and follow up pathway.
Ergonomic Assessments	Workstation assessments to minimise risk of chronic musculo-skeletal problems (particularly neck, wrist/hand and back).

costs, or the costs are shared.³⁹ WHAA estimates the annual cost per employee to be \$100-\$300 for an effective workplace health program, with targeted cost-effective interventions. Whilst small to medium organisations may question the feasibility of such programs, the proposed framework is often easier to implement in smaller organisations, as the culture is more amenable to change, and communication channels more effective in promoting the benefits between management and employees.³¹

Implementing the Program

This step is all about ‘making it happen’. This requires strong leadership and an innovative engagement, communication and marketing strategy. This is discussed in Guidelines 6 and 8.

6. TARGETED WORKPLACE HEALTH INTERVENTIONS

A multi-faceted workplace health program can be broken down into three types of interventions:⁴²

Core Components which are available to all employees (e.g. health risk assessment, flu vaccination, employee assistance program). The decision as to what is “core” is driven by the underlying philosophy of the program, its objectives, and budgetary constraints;

Discretionary Components which require participants to meet certain eligibility requirements (e.g. high risk employees or those in physically demanding jobs); and

Local Components which cater for the special needs and/or interests of target groups, usually in relation to their site or job function (e.g. team challenges, managing a shiftwork lifestyle).

A variety of delivery mechanisms ensure interventions reach their intended target including:

- Online/Virtual (e.g. Health Portal)
- Webinars
- Telephonic (e.g. coaching, disease management, stress management)
- Face-to-face individual (e.g. EAP counselling, assessments, coaching)
- Face-to-face group (e.g. seminars/workshops)
- Self-managed Programs (via health portal or “apps”)

- Miscellaneous e.g. expos, team-based activities, walking challenges etc.

High cost program elements are often, but not always reserved for higher risk individuals to control program costs.



7. EVIDENCE BASE, STANDARDS AND ACCREDITATION

The delivery of results-orientated workplace health programs requires creative programming led by engaging, well-informed and competent internal and/or external providers. A broad range of disciplines can be involved in the delivery of workplace health services including exercise physiology, nutrition, psychology, coaching, clinically trained practitioners (doctors/nurses) and even “non-health” personnel such as financial planners and career advisors (if financial pressure is a source of stress for an employee, a financial planner may be a better option than a psychologist). In choosing a workplace health or related provider, whether internal or external, the provider should: ^{39 42}

- Have a track record in the provision of services they intend to deploy;
- Provide testimonials/references in support of this;
- Be a member of the relevant industry body (e.g. WHAA, ESSA, DAA, EAPAA etc.);
- Hold the required professional indemnity/liability insurances;
- Use only degree qualified professionals where appropriate (e.g. delivery of health assessments and/or coaching);
- Ensure responsible management and referral of high risk participants;
- Possess and deploy a comprehensive Privacy Policy;
- Have recognised accreditation (e.g. ISO Quality Certification)
- Use valid and reliable equipment or instruments;

- Provide comprehensive reporting and/or evaluation.

A list of accredited workplace health providers who meet the above criteria is available on our website www.workplacehealth.org.au.

LEVEL OF EVIDENCE

Program content should be evidence based.

WHAA have conducted an extensive review of evidence based guidelines and have chosen the minimum standard of evidence with which member organisations are required to comply - NH&MRC Level III-3. Full details of the NH&MRC guidelines can be found at;

https://www.nhmrc.gov.au/files/nhmrc/file/guidelines/developers/nhmrc_levels_grades_evidence_120423.pdf

Companies running workplace health programs should consider adopting such an approach.

NOTE REGARDING COMPLIMENTARY AND ALTERNATIVE MEDICINE (CAM)

Many complimentary/alternative diagnostic and therapeutic modalities fall outside the Level III-3 guidelines. As is often stated, once an alternative therapy has evidence for its efficacy, it ceases to be alternative.

Of particular concern to WHAA are the so called “energetic” therapies of Reiki, Reflexology and Homeopathy, TFH/Kinesiology, together with many herbal remedies, aromatherapy and certain approaches to vitamin/supplement use. Whilst it is beyond the scope of this document to provide a detailed treatise on the evidence base for CAMs, interested parties are referred to the publication “A guide to Evidence-Based Integrative and Complementary Medicine⁵⁰” which assesses the CAMs against the NH&MRC criteria.

8. HIGH LEVELS OF PROGRAM ENGAGEMENT

Generating high levels of employee engagement and participation is essential for workplace health program success and subsequent ROI.^{3 27 28} As the least healthy employees are the least likely to



initially participate in programs, increasing overall participation rates draws higher risk individuals into the program, generating the best ROI (see Figure 2). However, voluntary participation is still paramount.⁵¹

According to Roy Shepherds “Program Attributable Benefits” model of workplace health⁵², outcomes are a function of four variables – prevalence of need, likelihood of participation, likelihood of needs being met and likelihood of positive behaviour changes ensuing. Halving participation would appear to halve the benefits from the program, but because higher participation brings in higher risk participants, the capacity for risk mitigation is significantly greater – halving participation may lower the program benefit by 60-80% (see Fig.2) making the promotion, marketing and engagement functions critical to program success.

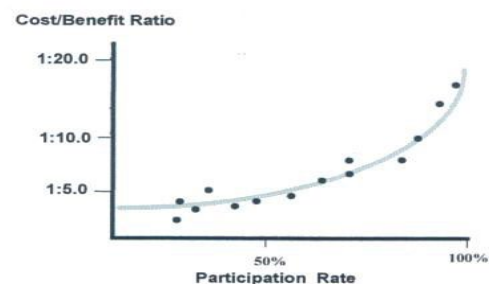


Figure 2. Relationship between participation in workplace health programs and ROI²⁷

The average participation rate among exemplary programs is 60 percent.²⁸ There are a wide range of employee and workplace-related factors which influence participation, hence it is unrealistic to expect/achieve 100%. In addition to creating a supportive environment and culture, a variety of

“Nothing happens until people participate”

- D. Anderson

strategies can be utilised to remove barriers to participation and encourage employees to ‘take the health road’.^{39 42} This includes:

- Participatory approach (see Guidelines 3 and 5).
- Convenient time - integration into daily work schedule (e.g. lunch ‘n’ learn)
- Access - easy and convenient (e.g. flexible delivery for hard-to-reach groups)
- Simplicity - clear outline of benefits and how to participate
- Innovative – new and interesting programs on an annual basis
- Cost - free or cost-sharing basis to foster responsibility/commitment
- Incentives and rewards - encourage or maintain participation (e.g. time off, recognition, merchandise, flexible working arrangements, competitions)
- Support – peer (e.g. buddy systems), management or professional support (e.g. coaching), and extension to family members (where appropriate);
- Privacy and confidentiality – alleviate concerns of data ownership and access
- Goals – setting specific goals (e.g. raising money for charity)
- Targeted – interventions tailored to specific groups (e.g. based on readiness to change, demographic)

9. OH&S INTEGRATION

Unlike workplace health, OH&S is highly regulated in Australian worksites, especially when manual handling, fatigue, confined spaces, hazardous chemicals and/or heavy machinery is involved. There has therefore been a tendency to run OH&S as a separate silo, independent of employee wellbeing, or indeed, have no wellbeing component to support an OH&S strategy. This approach is limiting and undermines the potential benefit that can be obtained through the integration of OH&S with employee health and wellness.

There are compelling reasons to integrate workplace health and OH&S strategies. Over 500,000 work-related injuries occurred in Australia in 2013/14, with 117,815 of these being serious⁵³. Serious claims are 10 times more likely in physically demanding work roles than in professional/technical/finance/insurance roles.

The top 4 “mechanisms of injury” for serious claims are related to either muscular stress or falls. Together these account for around 43% of claims⁵⁴. The 5th most common cause is “Mental Stress”, although the unit cost of mental stress claims is 2-3 times that of the top 4.

Clearly, safety practices and training for manual handling are vitally important for prevention of musculo-skeletal injuries and falls, however closer scrutiny of the data reveals many upstream issues which exacerbate the problem and provide a potential early intervention point. Many of these point to the physical and psychological health of the worker in ways that are not addressed by a traditional OH&S approach.

Consider for example that medical claims are twice as prevalent, seven times more costly and result in 13 times more lost work days in those with high BMI’s.⁵⁵ It is immediately evident that a risk mitigation strategy should encompass worker anthropometrics. This is the domain of workplace health, rather than OH&S, and points to an integrated solution as the best way forward.

Similar data exists for smoking and work related injury (38% higher risk in smokers⁵⁶), and chronic conditions such as hypertension and diabetes (workers with 2 or more chronic conditions have 2½ times longer injury related absences than healthy workers - 9.3 days pa vs. 3.7 days pa)⁵⁷.

Smoking cessation, chronic disease management, weight management and stress management have a massive impact on OH&S outcomes, but are generally outside the scope of OH&S interventions, hence the imperative for an integrated solution.

The efficacy of an integrated approach on issues related to corporate culture was recently validated in a study of 30 workplaces employing over 28,000 workers in five different sectors⁵⁸. The study aimed to evaluate the level of integration between OH&S and well-being services and the impact on employee perceptions, job satisfaction and work-life balance.

Employees at those worksites that deployed an integrated approach were 4.4 times more likely to be proud to work for their company, 7.4 times more likely to be satisfied with their current job, and 1.7

times more likely to balance the demands of work and home.

It is clear that the confluence of OH&S, personal health/anthropometric and behavioural factors provide the input parameters for issues such as “risk of falling” (not to mention concentration/ fatigue issues and numerous other factors). This being the case, an integrated approach combining elements of OH&S with Wellness is most likely to deliver the best outcome.

An integrated Workplace Health/OH&S program is therefore likely to be more effective than the sum of its parts, making a compelling, but often neglected value proposition in terms of OH&S risk mitigation.

10. TECHNOLOGY AND ONLINE SOLUTIONS

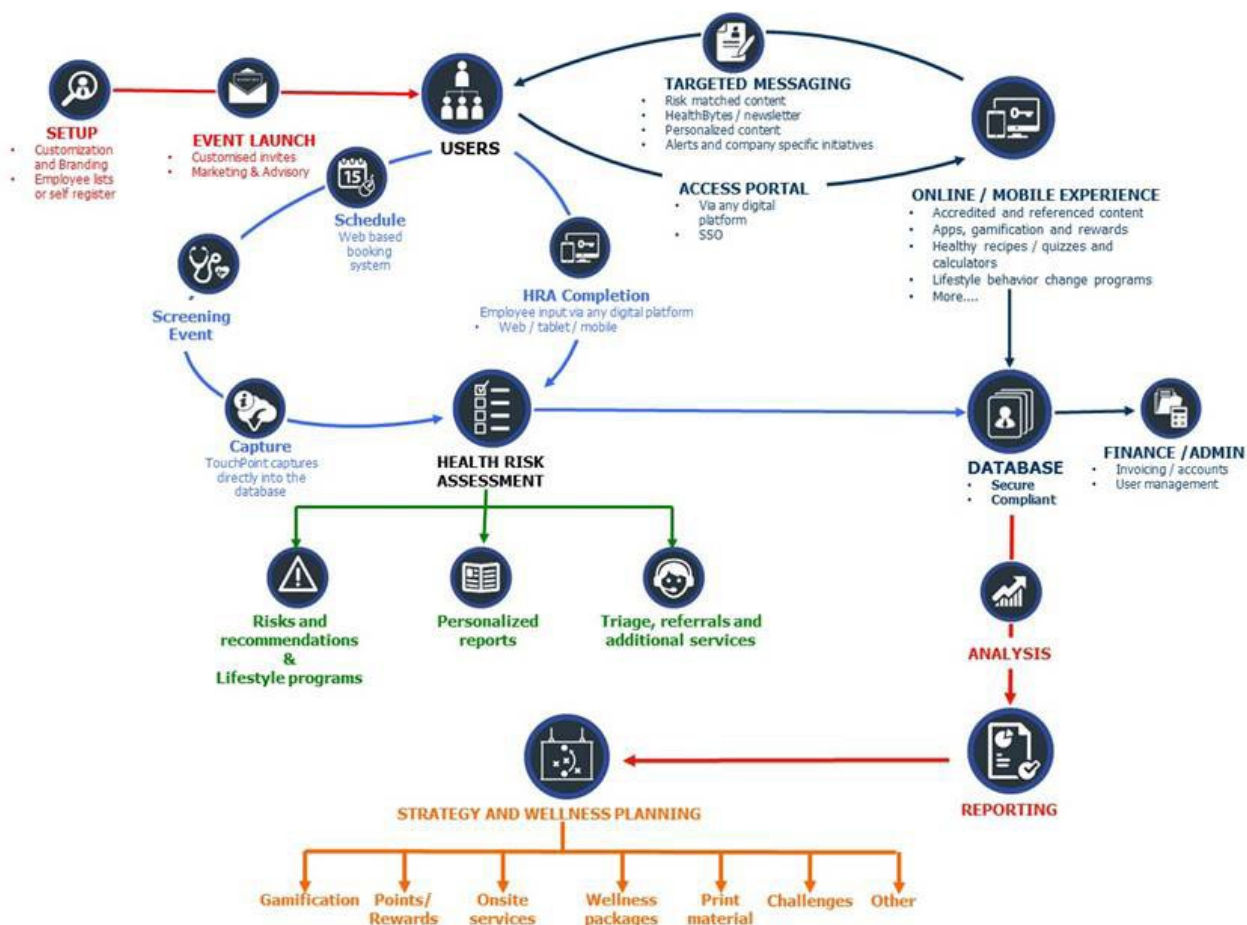
Health portals, online gamification, wearable devices, social networking, self-service health kiosks, health “apps” on smartphones/tablets, rewards programs, motivational messaging and a move towards managing/preventing chronic disease through technology are all changing the landscape in terms of program content and delivery of workplace health programs.

One of the critical issues in relation to technology and Workplace Health is the ability to automate processes and enhance efficiencies when deploying programs. This includes functions such as booking, data collection, analytics and reporting. Costly when deployed manually, but cost effective in the context of a good IT solution.

Without good IT infrastructure, efficiency and scalability are compromised, and inadequate reporting threatens program sustainability if management are unable to measure impact over time.

The landscape is changing significantly in Australia with the 2014 Buck Survey⁵⁹ showing telehealth related activities comprised 4 of the 5 fastest growing areas of workplace health in Australia and NZ.

Online health portals have the capacity to automate numerous processes as demonstrated in the graphic below⁶¹. In the absence of a multifaceted online solution, many of these processes would not occur, or be slow and prohibitively expensive, absorbing much of the employee health budget in administrative costs rather than effective service delivery. The impact on ROI is devastating.

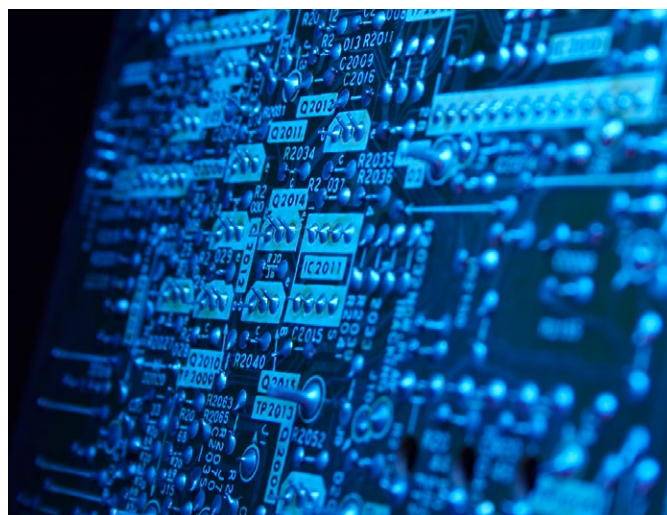


Massive problems require pragmatic, scalable, cost-effective and evidence-based solutions. Cardiovascular disease (CVD), the world's (and Australia's) leading cause of death, is the epitome of such a problem in need of such a solution, and preventing/ managing CVD means managing health behaviours such as nutrition, exercise, stress and smoking – the cornerstones of employee health programs.

Mobile technologies provide a potentially scalable and cost-effective platform to facilitate these needs. In 2014, the number of mobile devices in use exceeded the global population for the first time, and they are multiplying five times faster than we are!⁶² In Australia in 2014, 53% of Australians owned all three major 3 mobile electronic devices – a smartphone, a tablet and a laptop (more than 80% own a smartphone)⁶³.

With 55% of mobile web users now using mobile as either their primary or exclusive means of going online, there is a compelling argument from an accessibility perspective alone for deploying online/ mobile technology within the context of workplace wellness programs.

Recent Australian evidence supporting the efficacy of mobile technology in health promotion and disease management was published in the Journal of the American Medical Association (JAMA). The Tobacco, Exercise and Diet Messages (TEXT ME)



study⁶⁴ was a randomized clinical trial examining the effect of a lifestyle-focused semipersonalised support program delivered by mobile phone text messaging.

There were statistically significant improvements in blood lipids (LDL-Cholesterol), the proportion with blood pressure <140/90 mmHg dropped from 79.2% to 54.9%, BMI decreases 1.3 points, the proportion of regular exercisers increased from 22.5% to 53.8% and smoking prevalence dropped from 44.1% to 25.4%.

The cost of the intervention was estimated at less than \$10 per participant, therefore providing significant health outcomes at a fraction of the cost of more traditional approaches.

It is WHAAs position that the evidence supporting

“How workplaces engage, educate and motivate change and healthier behaviours within their people is also evolving. While more traditional work health methods such as wellness seminars and screening programs remain popular, many workplaces are looking to take advantage of developments in technology which increase the scale, accessibility and affordability of programs. Digital health platforms including wellness portals and mobiles, as well as telehealth programs are all expected to increase in use amongst work health strategies in workplaces during 2015/16”

- The 2015 Bupa Survey⁶⁰

the positive contribution of technology and online/app based services to employee health outcomes is substantial, and that migration of some services to the more cost effective online environment will enhance program outcomes and ROI.

11. RETURN ON INVESTMENT (ROI) – ASSUMPTIONS AND CALCULATIONS



The WHAA Best Practice Guidelines have been developed to help organisations and providers alike understand the factors that underpin good program outcomes with reasonable program expenditures. Return on Investment (ROI) is the metric by which programs can be assessed for cost-efficacy.

WHAA has produced a “White Paper” on ROI which provides significant detail in relation to the concept and its measurement. It is available on the Association Website. A brief synopsis of this paper is provided below.

Program ROIs have been improving over time as both employers and providers assimilate the latest published findings into their programs and explore new and innovative models for behaviour change and engagement⁶⁵. Utilisation of technology and the online medium clearly has the capacity to deliver cost-effective outcomes which dwarf those of programs from previous decades.

The fundamentals of ROI calculation are simple; a) aggregate the costs associated with program delivery (Investment) and b) divide this into the monetised value of the outcome (Return).

The first component requires one to add the costs of components such as provider costs, internal staff costs for those involved in admin/program

management and the cost of downtime associated with employee attendance at activities

The second component is somewhat more difficult as it requires one to put a dollar value on things which are not expressed in financial terms. One must place a monetary value on;

- Improved health – what value do you put on an employee who is leaner and fitter as a result of the program?
- Time frame over which health improvement is sustained (ie. if an employee attends a smoking cessation program and quits, you may very well have a non-smoking employee for the remainder of that individual’s employment. Berman et al (BMJ 2013) estimated the costs associated with a smoking employee to be \$5,816 per annum⁶⁶. If that non-smoking employee remained with the company for 5 years, the value of the benefit is almost \$60K for an investment of a few hundred dollars – ROI $\geq 300:1$. Even if that employee was the only one of ten participants in the program to quit, the ROI still sits at an impressive 30:1).
- Employee of Choice credentials
- Employee morale and engagement, which may manifest as;
 - Reduced absence
 - Improved productivity
 - Reduced staff turnover (attraction/retention positive)
- Improved Mental Health
- Higher Energy, less fatigue
- Reduced illness, accident, injuries, claims and insurance premiums

To our knowledge, no company in Australia has ever extended ROI calculations to this level which is no doubt testimony to the difficulty it presents. Linking employee health and lifestyle data to payroll absence data and Workcover claims data would allow a reasonable analysis of the potential benefits, but data linking, cost, complexity and privacy issues mitigate against this approach.

Moreover, organisations are generally supportive of the concept that healthier employees will deliver a range of benefits, whether they choose to measure them or not. Not measuring outcomes does not imply lack of outcome.

The practicalities of calculating of measuring ROI seem prohibitive, there are however simple methods to determine a ball park figure for ROI. These practices generally follow two generalised paths;

- a) The “Assumptive Method” whereby it is assumed that changes in health status are accompanied by changes in key business metrics in accordance with the published/ validated literature. The assumptions can be generalised (an overall impact per risk factor mitigated) of specific (impact per individual risk factor eliminated and summed).
- b) The “Self-Reported” method where program participants are asked to rate their own productivity using a validated tool such as the WHO/Harvard HPQ⁶⁷ or the Work Limitation Questionnaire (WLQ)⁶⁸. Note: many organisations are sceptical of self-reported productivity measures due to the confounding impact of the “Hawthorne Effect⁶⁹”, however one must consider that the HPQ has been benchmarked by the World Health Organisation in 250,000 face-to-face surveys in over 30 countries including the U.S., Canada, Mexico, most Western European countries, Australia and Japan.

Assumptive Method

Burton et al showed that each risk factor carries a productivity burden (loss) which averages out at 2.4%.⁷⁰ If half the employees within a business eliminated even a single risk, that translates into a 1.2% productivity benefit across all employees. At the Australian average wage of \$58,000, this is a \$700 “return”. If program costs tally to \$100 per employee per annum, ROI comes in at 7:1, and that’s before one accounts for the additional benefits detailed above.

HPQ/WLQ

The HPQ and WLQ both provide a simple mechanism for employees to self-report personal productivity. This is a step further than the assumptive method but does involve additional time and cost.

Ideally, a “pre- and post-” program survey, linked to program attendance and changes in health behaviours and health biometrics affords the best opportunity to drill down into the impact of an employee wellness program.

Most WHAA members are proficient in the application and use of these methods and can support efforts to quantify program impact using validated tools such as those outlined here.

12. INNOVATIVE MARKETING AND COMMUNICATION



The most successful workplace health programs, nationally and internationally, have involved creative marketing. Marketing involves analysing what employees need, selling the value of the solutions, and motivating employees to participate in them.³² Targeted campaigns that focus on specific employee behaviours or characteristics such as age and sex are particularly effective. Effective marketing includes branding to increase program credibility, appeal, recognition and completeness,⁴² together with consideration of the 5Ps, namely:³²

- Product (program, health message or intervention)
- People (target audience e.g. Gen Y, older workers)
- Promotion (creating interest through communication channels)
- Place (distribution channels, physical accessibility)
- Price (incentives and costs)

Having an appealing communications strategy is also necessary to foster and maintain employee interest and participation.¹⁶ There is a wide array of tactics to communicate workplace health efforts including:

- Communicate the aims/purpose of the program, with an emphasis on shared responsibility;

- Emphasise the benefits to management and employees ('what's in it for me');
 - Officially launch the program to introduce the initiative, overcome employee skepticism and generate employee interest;^{7 31}
 - Use existing communication networks to 'spread the word' (e.g. intranet, payslips, newsletters, point-of-sale, team meetings, high-traffic areas);
 - Choose different modes of communication based on specific employee characteristics (e.g. podcasts for Gen Y employees);
 - Provide clear and frequent communication through multiple communication channels to maximise reach to all employees;³⁸
 - Keep messages simple, targeted, personalised, humorous, factual, and eye-catching, and rotate frequently to avoid 'viewer fatigue';
 - Provide opportunities for staff to provide feedback (e.g. department meetings).
4. Process, impact and outcome evaluation, using both qualitative and quantitative methodologies.^{6 39}
 - Process evaluation: evaluates the implementation of strategies (e.g. program satisfaction, quality of programs delivered, participation and program reach);
 - Impact: measures whether the program met its objectives (e.g. health awareness, staff morale);
 - Outcome: evaluates the long-term effect of the program, specifically whether the program met its goal (e.g. improvement in employee health status, ROI, policy development).
 5. An annual review mechanism to regularly scrutinise and review performance. This includes reaffirming management approval, redefining management expectations, and repeating the needs assessment;¹⁰
 6. Linkage to organisational key performance indicators (e.g. workers compensation costs, absenteeism);
 7. Internal (e.g. departmental) and external benchmarking (e.g. Australian normative data including standardisation for age);
 8. Dissemination of results to senior leadership, key stakeholders and employees.⁴³

13. EVALUATION AND MONITORING

Evaluation is the 'cornerstone' of a best-practice workplace health program. Comprehensive and ongoing evaluation is required to measure program impact and calculate ROI, and most importantly, ensure the program continues to meet the needs of both employees and the organisation. This includes assessing not only workplace health outcomes, but changes in the workplace environment and culture, and the effectiveness of different strategies. Typically, comprehensive programs can be expected to show a positive financial return over a period of 2-3 years.³¹ A comprehensive evaluation strategy involves:

1. Clear goals and objectives;
2. An effective data management system which provides clear, simple, accessible and aggregated data in a meaningful format;³⁰
3. Valid and reliable methods and measurements;

14. COMMITMENT TO ETHICAL BUSINESS PRACTICES

The WHAA Code of Ethics (see www.workplacehealth.org.au) serves as a code of professional conduct for all WHAA members including professional responsibility, confidentiality, professional competency, consumer protection, assessment and referral, and procedures for review of member's conduct.

15. SUSTAINABILITY

How do you ensure a workplace health program is sustainable and avoids FAILURE? Below are common problems which can undermine program sustainability, together with possible solutions.^{41 42 44}

Fragmentation of Effort – Human Resources, Health and Safety, Learning and Development and other key parties fail to coordinate their efforts and recognise synergies. This is the antithesis of an “integrated” program where all parties share in the goal/vision for employee wellbeing and support it on all levels.

Activities Focus – Activity-oriented workplace health programs consist of adhoc activities (e.g. yoga classes and massage) as the central focus, which whilst may have a role to play, have limited impact. Such programs lack sustainability, and, once withdrawn, employees generally revert to previous behaviours. Alternatively, results-oriented programs (as described in this document) focus not on providing an ‘activity of the month’, but rather on impacting the organisation’s bottom line.⁴¹

Illness Orientation – The program should be preventative in nature as opposed to focusing on chronic disease management.

Lack of Employee Involvement – Buy-in from employees, unions, and senior leadership and management is critical (see Guideline 5).

Underemphasis on skills – The goal of a best-practice program is to teach self-sufficiency for both employees (e.g. skill building) and organisations (e.g. building capacity to self-govern program).

Regard only for the Individual – As indicated previously, an effective program addresses the multiple determinants of employee health.

Emphasis on short term results The workplace should set realistic short and long term expectations of what the program can achieve (i.e. ‘it won’t happen overnight’). Research, literature and practice suggest it will take 3-5 years to reap the full benefits of workplace health programs. Furthermore, the program must be flexible and sensitive to the priorities and the changing needs of the workplace.⁴⁴

BEST-PRACTICE CASE STUDIES

A large number of Australian organisations have implemented highly successful workplace health programs and are reaping the benefits.

As this list continues to grow, WHAA has decided to maintain a list of case studies on the Association website to ensure the list is current and reflects new and innovative programs/outcomes.

Those wishing to view these studies are directed to;

<http://www.workplacehealth.org.au/UnderstandWorkplaceHealth/case-studies>



FURTHER INFORMATION

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www.workplacehealth.org.au

NATIONAL WORKPLACE HEALTH CONFERENCE

<http://www.whaaevents.com.au/>

REFERENCES

(Endnotes)

- 1 Berger, M.L., Howell, R., Nicholson, S. & Sharda, C. (2003) 'Investing in Healthy Human Capital', *Journal of Occupational and Environmental Medicine*, 45(12): 1213-1225.
- 2 Loeppke, R. (2008) 'The Value of Health and the Power of Prevention', *International Journal of Workplace Health Management*, 1(2): 95-108.
- 3 Health and Productivity Institute Of Australia (HAPIA) (2008) 'Submission to the National Health and Hospitals Reform Commission Review of The Australian Health System', [online], Available: [http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/334/\\$FILE/334%20Health%20and%20Productivity%20Institute%20of%20Australia%20Submission.pdf](http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/334/$FILE/334%20Health%20and%20Productivity%20Institute%20of%20Australia%20Submission.pdf) [2009, October 16]
- 4 Premier's Physical Activity Council (2006) 'Get Moving at Work: A Resource Kit for Workplace Health and Wellbeing Programs', [online], Available: www.getmoving.tas.gov.au [2009, October 16]
- 5 Pelletier, K. (2005) 'A Review and Analysis of the Clinical and Cost-Effectiveness Studies of Comprehensive Health Promotion and Disease Management Programs at the Worksite: Update VI 2000-2004', *Journal of Occupational & Environmental Medicine*, 47(10):1051-1058.
- 6 Workplace Health in Australia – Bupa Benchmark Survey 2015. Available at <http://www.bupawellness.com.au/index.php>
- 7 Data from The Commonwealth Fund; <http://www.commonwealthfund.org>
- 8 Chu, C., Breuker, G., Harris, N., Stitzel, A., Gan, X., Dwyer, S. (2000) 'Health-Promoting Workplaces – International Settings Development', *Health Promotion International*, 15(2):155-167.
- 9 Ryan, M., Chapman, L., and Rink, M. (2008), 'Planning worksite health promotion programs: models, methods, and design implications', *The Art of Health Promotion*, July/August 2008.
- 10 European Network of Workplace Health Promotion (2005) Luxembourg Declaration of Workplace Health Promotion – updated, [online], Available: http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Luxembourg_Declaration.pdf [2009, October 16]
- 11 Business Council of Australia (2008) 'Health is Everybody's Business' [online], Available: <http://www.bca.com.au/DisplayFile.aspx?FileID=483> [2009, November 22]
- 12 Chu, C., Driscoll, T., Dwyer, C. (1997) 'The Health Promoting Workplace: An Integrative Perspective', *Aust NZ Journal of Public Health*, 21(4): 377-385.
- 13 World Health Organisation (1997) 'WHO's Global Healthy Work Approach', Division of Health Promotion, Education and Communication and Office of Occupational Health. WHO: Geneva.
- 14 World Health Organisation (2007) 'Workers' Health Global Plan of Action', Sixtieth World Health Assembly, [online] http://apps.who.int/gb/ebwha/pdf_files/WHA60/A60_R26-en.pdf, [2009, October 16]
- 15 National Preventative Health Taskforce (2008) paper 'Australia – The Healthiest Country by 2020', [online], Available: <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/interim-report-december-2008> [2009, April 6]
- 16 Council of Australian Governments (2008) National Partnership Agreement on Preventative Health [online], Available: http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_preventive_health.rtf [2009, October 16]
- 17 Wesley Corporate Health (2006) 'The Future at Work Health Report', Available www.weshealth.com.au.
- 18 NZWell@Work (2009) 'Workplace Wellness – A Literature Review for NZWell@Work', [online], Available: <http://www.nzwellatwork.co.nz/pdf/wrkplc-wellness-lit-rev-feb09.pdf> [2009, October 16]

- 19 Vaughan-Jones, H. & Barham, L. (2009) 'Healthy Work Challenges and Opportunities to 2030', [online], Available: http://www.theworkfoundation.com/assets/docs/publications/216_Bupa_report.pdf [2009, October 16]
- 20 Good Health Solutions (2007) 'Health, Absence and Productivity Survey'
- 21 Buck Consultants (2014) 'Working Well: A Global Survey of Health Promotion and Workplace Wellness Strategies', [online], Available: <https://www.worldcongress.com/events/HR09015/pdf/thoughtleadership/Global%20Wellness%202008%20Survey%20Report.pdf> [2009, October 16]
- 22 Buck Consultants (2014) 'Working Well: A Global Survey of Health Promotion and Workplace Wellness Strategies', [online], Available: https://www.worldcongress.com/events/HR09015/pdf/thoughtleadership/Global%20Wellness%202008%20Survey%20_Report.pdf [2009, October 16]
- 23 Harris, D.R. (2004) The Changing Health of Australians: Workplace Health, Safety and Productivity, Presentation for the Safety Conference, Safety Institute of Australia (NSW Div), Sydney.
- 24 See <http://www.worksafe.vic.gov.au/safety-and-prevention/health-and-wellbeing/about-workhealth>
- 25 See <http://health.gov.au/internet/anpha/publishing.nsf/Content/npaph>
- 26 IBISWorld Industry Report OD4128 - Corporate Wellness Services in Australia; October 2014
- 27 See <http://www.ibisworld.com.au/industry/corporate-wellness-services.html>
- 28 Workplace Health in Australia – Bupa Benchmark Survey 2015. Available at <http://www.bupawellness.com.au/index.php>
- 29 European Network of Workplace Health Promotion (2004) 'Making the Case for Workplace Health Promotion – analysis of the effects of WHP', [online], Available: http://www.enwhp.org/fileadmin/downloads/report_business_case_01.pdf [2009, October 16]
- 30 Right Management (2009) 'Wellness and Productivity Management', [online], Available: <http://www.rightmanagement.com.au/assets/x/50990>, [2009, October 16]
- 31 Aldana, SG (2001) 'Financial Impact of Health Promotion Programs: a comprehensive review of the literature', American Journal Health Promotion, 15 (5): 296-320.
- 32 Shephard, R. (1992); A Critical Analysis of Worksite Wellness Programs and their Postulated Economic Benefits. Medicine and Science in Sports and Exercise, 24(3), 354-370.
- 33 Chapman, L.S. (2007) Proof Positive. An Analysis of the Cost Effectiveness of Worksite Wellness. Seattle, WA: Chapman Institute.
- 34 The Relationship Between ROI and Quality of Study Methodology on Workplace Health Promotion Programs; Baxter, S. et. al., American Journal of Health Promotion; Vol.8, #6, (2014)
- 35 National Health and Hospitals Reform Commission (2008) 'A Healthier Future for All Australians – Interim Report', [online], Available: <http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/interim-report-december-2008> [2009, October 16]
- 36 World Economic Forum (2008) Working Towards Wellness: The Business Rationale, [online], Available: http://www.weforum.org/pdf/Wellness/Bus_Rationale.pdf, [2009, October 16]
- 37 Health, Work and Wellbeing U.K. (2008) 'Building the Case for Wellness' [online], Available: <http://www.workingforhealth.gov.uk/documents/dwp-wellness-report-public.pdf> www.workingforhealth.gov.uk [2009, October 16]
- 38 Singapore Health Promotion Board (2003) Workplace Health Promotion Program: Pre-Planning Series, [online], Available: http://www.hpb.gov.sg/hpb/default.asp?pg_id=981 [2009, October 16]
- 39 Allen, J. & Hunnicut, D. (2001) 'Fostering Wellness Leadership: A New Model', Special Report: WELCOA.

- 40 Edington, Dee (2009) Zero Trends: Health as a Serious Economic Strategy, Presentation for the 28th Annual Wellness Conference, University of Michigan Health Management Research Centre, [online], Available: <http://www.hmrc.umich.edu/news/WW28.html> [2009, October 16]
- 41 O'Donnell, M. (2001) Health Promotion in the Workplace (3rd ed), Albany, NY: Delmar.
- 42 Hillier, D., Fewell, F., Cann, W., & Shephard, V. (2005), 'Wellness at work: enhancing the quality of our working lives', International Review of Psychiatry, 17(5): 419-431.
- 43 Fleming, M. & Parker, E. (2007) Health Promotion: Principles and Practice in the Australian Context, Sydney: Allen and Unwin.
- 44 Hooper, P. & Bull, F. (2009) 'Healthy Active Workplaces – Review of Evidence and Rationale for Workplace Health', [online], Available: <http://www.dsr.wa.gov.au/index.php?id=2906> [2009, October 16]
- 45 See Table 3, Page 15
https://www.nhmrc.gov.au/files_nhmrc/file/guidelines/developers/nhmrc_levels_grades_evidence_120423.pdf
- 46 Aldana, S., Adams, T. & Earl, A. (2006) Worksite Wellness Implementation Guide, [online], Available: http://www.wellsteps.com/resources/WellSteps_Implementation_Guide.pdf [2009, October 16]
- 47 Healthy Places Survey, Workplaces for Wellness, Worksafe Queensland;
https://www.worksafe.qld.gov.au/_data/assets/pdf_file/0017/83204/healthy-places-survey.pdf
- 48 Oldenburg, B., Sallis, J.F., Harris, D., Owen, N. (2002) 'Checklist of Health Promotion Environments at Worksites (CHEW): Development and Measurement Characteristics', American Journal of Health Promotion, 16(5):288-99.
- 49 Bellew, B. (2008) Primary Prevention of Chronic Disease in Australia Through Interventions in the Workplace Setting: An Evidence Check Rapid Review reviewed brokered by the Sax Institute for the Chronic Disease Prevention Unit, Victorian Government Department of Human Services.
- 50 A Guide to Evidence-based Integrative and Complimentary Medicine, Kotsirilos, V., et. al., Churchill Livingstone (2011).
- 51 Queensland Health State Steering Committee for Health Promotion in the Workplace (1997) 'Better Health for Working People: Guiding Principles'.
- 52 Shephard, R. (1992); A Critical Analysis of Worksite Wellness Programs and their Postulated Economic Benefits. Medicine and Science in Sports and Exercise, 24(3), 354-370.
- 53 Key Workplace Health and Safety Statistics Australia (2015), Safe Work Australia
- 54 Australian Workers Compensation Statistics, 2012-13, Safe Work Australia
- 55 Ostbye, T. et.al. Arch Intern Med. (2007) Apr 23;167(8):766-73.
- 56 Dong, Z.S., Wantg, Z. and Largay, J.A. (2015)
- 57 Casimirri, E., et.al., (2014) International Journal of Occupational Medicine and Environmental Health. Volume 27, Issue 3, Pages 343–354
- 58 Journal of Occupational & Environmental Medicine: September 2015 - Vol 57 #9 - p 958–964
- 59 Buck Consultants (2014) 'Working Well: A Global Survey of Health Promotion and Workplace Wellness Strategies', [online], Available: <https://www.worldcongress.com/events/HR09015/pdf/thoughtleadership/Global%20Wellness%202008%20Survey%20Report.pdf> [2009, October 16]
- 60 Workplace Health in Australia – Bupa Benchmark Survey 2015. Available at <http://www.bupawellness.com.au/index.php>
- 61 Graphic kindly provided courtesy of HealthLogix P/L
- 62 GSMA Intelligence and US Census Bureau (2014)
- 63 Deloitte Media Consumer Survey (2014)

- 64 Journal of Occupational & Environmental Medicine: September 2015 – Vol 57 #9 - p 958–964
- 65 Chapman, L.S. (2007) Proof Positive. An Analysis of the Cost Effectiveness of Worksite Wellness. Seattle, WA: Chapman Institute.
- 66 Berman, M., et. al. Estimating the cost of a Smoking Employee, British Medical Journal Online – Tobacco Control (2013) <http://tobaccocontrol.bmj.com/content/early/2013/05/25/tobaccocontrol-2012-050888.abstract>
- 67 <http://www.hcp.med.harvard.edu/hpq/info.php>
- 68 Lerner, D. et. al. The Work Limitations Questionnaire. Med. Care, (2001), 39(1): 72-85
- 69 Elton Mayo, Hawthorne and the Western Electric Company, The Social Problems of an Industrial Civilisation, Routledge, 1949.
- 70 Burton WN, Chen CY, Conti DJ, Schultz AB, Pransky G, Edington DW. The association of health risks with on-the-job productivity, J Occupational and Environmental Medicine (2005), 47(8):769-77.

Best-Practice Guidelines

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