Workplace health promotion is a fusion of two distinct themes, and in the United Kingdom, one theme has origins in United Kingdom legislation [Health and Safety at Work Act (HSWA), 1974] that promoted safe and healthy working environments. This theme puts the onus on the employer for the organization of the physical and psychosocial work domain. The other theme is related to the behavior, attitude, and lifestyle of the worker and is entrenched in personal responsibility for individual health. In an ideal world, promotion should unify these two concepts. Workplace health promotion is integral to ordinary work practice, the working environment, and the organization and is envisaged as shared between communities, employees, managers, and their environments. The European Union and the Luxembourg Declaration on Workplace Health Promotion further defined workplace health promotion as the combined efforts to improve the health and well-being of people at work. Both the healthy workplace environment and individual lifestyle changes are necessary to achieve health promotion goals, and these should go hand-in-hand. In reality, however, individual behavioral change is too often the focus, rather than the organizational aspects of the worker’s environment.

In the United Kingdom, health promotion activities in the 1980-1990s included smoking, alcohol, and drug education; weight control; exercise; stress management; and screening. New initiatives have been focused on obesity and fitness, exemplified by the recent statement that many young men are not fit enough for recruitment into the British Armed Forces. The former Health Education Authority (HEA) prioritized development and support for health promotion in the workplace. The 1990s saw the emergence of the cost-benefit culture with the development of evaluation and assessment of effectiveness. The HEA report of 1993 found the aims of health promotion were not necessarily incorporated within workplace culture. A subsequent publication established that workplace health initiatives were largely motivated by compliance with legislative requirements, rather than the need to promote positive health.

Influencing Factors for Health Promotion Initiatives

Health promotion initiatives are driven by the belief that economic advantages will be gained from a reduction in absenteeism and accidents and improvement in employee morale. Workers who are motivated and healthy are essential for competitiveness and capacity to innovate.
increased compensation culture that has had a positive impact on health promotion in that the employer has responded to the risk of litigation by encouraging healthy work environments, specifically seen with respect to passive smoking. However, it is estimated that in the United Kingdom, two million people suffer from ill health caused by work-related conditions, and 35 million days are lost annually.\textsuperscript{10,11}

The changing patterns of work include increased part-time work, contracting out, privatization, loss of manufacturing, an increase in the service industry and the number of smaller companies, working from home, and self-employment. All of these have a negative impact on workplace health promotion, making any such initiative difficult to sustain. While there are only a few thousand occupational health doctors and nurses in the United Kingdom, these health professionals seem to over-emphasize health problems with reference to worker lifestyle habits and behaviors and to focus on management and personnel requirements, rather than exposures in the workplace, prevention, and rehabilitation.\textsuperscript{12}

Even when open to all, engagement in health promotion is limited, with those most likely to participate being healthy, white-collar, salaried staff with relatively high levels of education.\textsuperscript{13-15} Barriers to uptake also include the fear that involvement is not confidential. Low participation rates are the limiting factor for any potential public health impact of worksite-based interventions. Therefore evaluation of programs on employee health outcomes, employee families/dependents, and on communities may be difficult.\textsuperscript{16}

Provision of workplace fitness programs within health promotion schemes may fail to reduce absenteeism or to improve the health of the workforce. This may be due to the same user characteristics that also fail in public sector leisure activities.\textsuperscript{17} United Kingdom employers, unlike those in the United States, rarely contribute to private insurance schemes and, therefore, have less incentive to become involved in health promotion. Nevertheless, large organizations with good workforce retention have much to gain by a holistic approach to health promotion programs. Targets for healthier work environments and lifestyle changes could influence better health over an employees’ working life. The infrastructure of large organizations should also facilitate monitoring of take-up and measurement of improvement in health outcomes over time. The National Health Service, the largest employer in Europe, has historically provided long-term employment for a multi-professional workforce, but it has no well-developed strategy for health promotion.

Characteristics

The size of an organization probably has the biggest influence on health promotion activities. Due to economic changes, more people are employed in small- and medium-sized enterprises where there is often no workplace access to occupational health support.\textsuperscript{18} Despite campaigns, such as “Good Health is Good Business,”\textsuperscript{19} many employers remain unaware of long-term risks for workplace health and the need to take a proactive approach to prevention. The European Network for Workplace Health Promotion (ENWHP) observed that targeting large organizations with suitable infrastructure was more likely to be successful. A 1992 Health Education Authority survey of 1,344 workplaces found that larger workplaces addressed heart health, weight control, exercise, and fitness, with 40% undertaking at least one health promotion-related activity in the previous year. Health promotion increased with workplace size and good infrastructure; the size of an organization is therefore a key determinant.

Trade union representation, occupational health services, and workplace health promotion are concentrated in the larger United Kingdom public sector organizations.\textsuperscript{2,14,20} The role of trade unions has mainly influenced the reduction of hazards at work, better working conditions, job conditions, working hours, wages, and job contracts. In 1989 the Labor Research Department study of 500 trade union representatives found common workplace health promotion activities were first aid medical treatment, inspection of hazards, and pre-employment medical screening. Activities that union representatives wanted were stress management, breast screening, and screening for hypertension. Smoking-related health promotion activity was found in 41% where a union was present versus 28% where a union was absent. Workplaces with no health promotion activity were small or medium sized, in the private sector, British owned, and mainly in distribution and catering businesses.

An international feasibility study has demonstrated the importance of partnerships between trade unions, health promoters, and related professionals in efforts to promote employee health. This is of particular importance in view of rapid globalization and the potential for worker health and safety to be overlooked.\textsuperscript{21} Trade unions are involved in workplace health promotion partnerships and networks that include a broad range of industry, Chambers of Commerce, National Health Service (NHS), Health and Safety Executive (HSE), local government, education, legal, and independent consultants.

While small organizations may have fewer health promotion activities, a recent survey, commissioned by the Federation of Small Businesses (FSB), reported that the average number of days small businesses lost to absence per employee was 1.8 days (compared to the average of 8.4 days for businesses of all sizes). Employees of small businesses are therefore around six times less likely to take sick days compared to public-sector workers.\textsuperscript{22} The national health and safety chairman of the FSB suggests that government should offer incentives to small businesses to provide access to occupational healthcare and health promotion initiatives. Smaller firms should be required to pay less in employers’ liability insurance in return for good workplace health and safety initiatives.

Influence of Occupational Health on Health Promotion

The Health and Safety Commission published two reports: Revitalising Health and Safety Program\textsuperscript{23} and Securing Health Together.\textsuperscript{24} These presented a long-term occupational health strategy for England, Scotland, and Wales that by 2010, aimed to
reduce ill health caused by work activity and accidents, the number of working days lost from work-related injury and ill health by 30% and the incidence rate of fatal and major injury accidents by 10%. The Health and Safety Executive commissioned a survey, found that only one-in-seven workers in the United Kingdom had comprehensive occupational health support. The Securing Health Together strategy required base-line information on current provision of occupational health, and this was provided by Pilkington et al in a survey of 4,930 organizations. Over half of the companies reported taking steps to improve the general health of employees. The most frequently provided services were health promotion campaigns and information on healthy lifestyles. Least popular services were private healthcare schemes, access to leisure facilities, and well-person health checks. Where occupational health support was defined to include hazard identification, risk management, and provision of information, then approximately 44% of participating companies fulfilled this definition, equivalent to 15% of all United Kingdom companies after adjustment for company size and sector. A more rigorous definition of occupational health included the three parameters above, (i.e., hazard identification, risk management, and provision of information) plus modifying work activities, occupational health training, measuring workplace hazards, and monitoring trends in health. This definition resulted in an additional 3% of companies fulfilling the wider definition of occupational health support. Again more large companies met the criteria than small companies. Occupational health was found to take second place within health and safety, with no distinct identity and often no budget allocation. Formal evaluation of costs and benefits of occupational health support was limited and most likely in larger companies. Commitment to do more to acquire occupational health support was limited by available resources, particularly for smaller companies across all regions and sectors. There was a recognized lack of knowledge about how to deal with health issues, particularly in micro and small companies. Health and Safety representatives and managers were central to increasing awareness of occupational health issues within smaller companies.

**Workplace Health Promotion at a European Level**

The Health Promotion Unit is represented on the European Network for Workplace Health Promotion (ENWHP) as an informal network of national occupational health and safety institutes, public health, health promotion, and statutory social insurance institutions. It aims through the joint efforts of all its members and partners to contribute to improving workplace health and well-being and reducing the impact of work-related ill health on the European workforce. The Network was formally established in 1996, and since this time, it has been at the leading edge of developments in European workplace health promotion. Over the past three years, the ENWHP has been working on the development of national forums for workplace health promotion, in line with the new health strategy of the European Commission, and linking these infrastructures on a European level. Encouraging this, the fourth European Conference on Promoting Workplace Health was held in Dublin in June 2006. The conference was held in the context of the Irish European Union presidency.

**National Strategies within the United Kingdom**

There are different approaches to health promotion in the four countries of the United Kingdom: England, Wales, Scotland, and Northern Ireland. Within all four home countries, Scotland has been well ahead with a coordinated approach to improving the health of the working population through a developed network, **Scotland Health at Work**.

Health promotion policy in **England** was shared between the Department of Health (DoH) and the Health Education Authority (HEA). The latter's terms of reference were limited, and there was constant disagreement about the extent to which HEA could operate independently. This was illustrated in relation to smoking, where the HEA took a line that was not in agreement with the more voluntary approach favored by Government. The HEA was subsequently split in two, with a research-based arm, the Health Development Agency (HDA), and a more overtly health-promoting arm, Health Promotion England. In 2001, the health-promoting arm was ‘absorbed’ into the DoH and in 2005, the research arm was incorporated into the National Institute of Health and Clinical Excellence. Legislation on smoking in workplaces and public places is to be introduced in 2007, months and years after other countries within the United Kingdom. The London Workplace Health Network includes members from London Boroughs, the National Health Service (NHS), the Health and Safety Executive, the Office of Deputy Prime Minister and consultancies. The London Regeneration Network focuses on 390 voluntary organizations throughout London, particularly companies with fewer than five employees and encourages them to engage in workplace health promotion.

In **Wales**, a strategy document for **Health at Work**, was published in 1996. New initiatives included the appointment of a National Workplace Health Promotion Coordinator, the examination of the needs of small-to-medium enterprises, and the continued implementation of cardiovascular strategies in the workplace. This strategy built on the significant work developed by Heartbeat Wales in the mid-1980s. Each of these initiatives is expected to promote the development of workplace health promotion. At the same time a formal network of workplaces, stakeholders, and assessors involving an accreditation scheme for organizations that promote health at work has been set up. The Wales Counselling at Work Network has focussed on psychological issues at work while Heartbeat Wales made a major contribution with programs for cardiac health improvement. At the local Board level, workplace coordinators have been appointed with responsibility for the development of workplace health promotion plans and the initiation of pilot projects.

**Scotland** has been well ahead with a coordinated approach to improving the health of the working population through a developed network, **Scotland Health at Work**. Many organizations
in Scotland have addressed health promotion in the workplace by developing and implementing health policies, such as those for smoking, alcohol, and food, forming health circles to identify and to take action on workplace health issues, promoting physical activity through membership of sports facilities, providing bicycle racks, encouraging employees to walk during lunch time, providing access to appropriate screening initiatives, and registering with the Scotland Health at Work award scheme. Another aspect is the formation of networks for the different geographical areas. The focus of these groups is to create mechanisms to help small and medium-sized enterprises address worksite and employee health promotion goals.

Northern Ireland, despite having an economy dominated by small businesses, has a well-established workplace health promotion program led by the Health Promotion Agency, known as the Work Well Program. Anticipated benefits include reduction in illness-related absenteeism, fewer working days lost, and, therefore, a long-term decline in the sickness rate; increased motivation among staff, and improvements in the working atmosphere in the company, leading to more flexibility, better communications, and readiness to cooperate; a measurable increase in the quality of products and services, more innovation and creativity, and a rise in productivity and improvement of the public image of the company. The Work Well: Healthy Workplace Guide is the focal point of the Work Well initiative and the starting point for all businesses interested in adopting a healthy workplace strategy. It is aimed at employers, health and safety workers, human resources staff, occupational health staff, and anyone else working in the field of workplace health.

Workplace health policy in the Republic of Ireland is distinctive from that in Northern Ireland, but there are now increasing numbers of cross-border initiatives. The structure emphasizes concepts of self-regulation and monitoring, rather than policing.28 The Happy Heart at Work (HHAW) program, sponsored by the Irish Heart Foundation,29 and in existence since 1992, is a national program designed to suit the Irish context. It aimed to promote a healthy lifestyle through specific modular materials. Evaluation of this program was commissioned with a survey of 785 registered sites. An initial level of interest in the HHAW program was expressed by 40%. Active organizations were less likely to be Irish owned and more likely to operate in shifts or to have an occupational physician among the staff. The program was purported to improve employees’ lifestyle habits and morale and the company’s public image. The drawbacks were its relatively low profile, even in actively participating organizations, and the fact that it was not seen to be independently sustainable without intensive and ongoing support.30 Manufacturing organizations employing more than 200 workers were most likely to take part in HHAW. The Irish Department of Health and Children reported low levels of awareness for health promotion programs among workers with the main obstacle being lack of management commitment.31

Recent National Guidance

The English public health strategy was published in 2004.32 Actions that employers and government can take to promote work and health were addressed, but focused on the NHS as the employer, rather than the English workforce as a whole. Specific sums were allocated to implement the strategy in relation to smoking, exercise, nutrition, sexual health, alcohol, and mental health, but these were largely diverted to cover overspending in other areas. In November 2005, the progress of the program was addressed. The Health and Safety Commission considered whether the Health and Safety at Work Act of 1974 should be amended in response to a changing world of work, and in particular, to ensure the same protection is provided to all workers regardless of their employment status.

In 2006, the Department of Health requested the National Institute for Health and Clinical Excellence to develop public health intervention guidance on workplace health promotion with reference to smoking and what works in motivating and changing employees’ health behavior. The guidance will provide recommendations for good practice based on the best available evidence of effectiveness, including cost-effectiveness.

In conclusion, the situation in the United Kingdom is mixed, but the message that appears with respect to workplace health promotion is that it is up and running in large companies, rather than in smaller ones, and in international companies, rather than home companies, and is more likely to flourish where occupational health professionals are present and where there is good management commitment.

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