WORKPLACE HEALTH PROTECTION AND PROMOTION IN THE POLICY AND PRACTICE OF SOCIAL AND HEALTH INSURANCE INSTITUTIONS

Report on a WHO Meeting

Bilthoven, Netherlands
21–22 October 1999
EUROPEAN HEALTH21 TARGET 13
SETTINGS FOR HEALTH

By the year 2015, people in the Region should have greater opportunities to live in healthy physical and social environments at home, at school, at the workplace and in the local community
(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

The meeting, organized by the WHO European Centre for Environment and Health – Bilthoven Division in collaboration with the Research and Development Centre, Social Insurance Institution, Turku, Finland, had the following objectives: (a) to explore the interest of European social and health insurance organizations in health protection and health promotion at the workplace; and (b) to define the willingness of these organizations to share their experiences in this field. Representatives of social insurance organizations from eight countries participated. The meeting decided to establish a WHO Network of European Social Insurance Organizations for Workplace Health Promotion. The network will focus mainly on: advocating the organizations’ commitment to health promotion; exchange of information on country experience; and the analysis and dissemination of examples of good practice and minimal standards.

Keywords

OCCUPATIONAL HEALTH
WORKPLACE
HEALTH PROMOTION
INSURANCE, HEALTH
SOCIAL SECURITY
EUROPE
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Introduction

A Meeting on Workplace Health Protection and Promotion in the Policy and Practice of Social and Health Insurance Institutions was held in Bilthoven, Netherlands, on 21–22 October 1999. It was convened by the World Health Organization Regional Office for Europe (WHO/EURO) European Centre for Environment and Health (ECEH) in collaboration with the Research and Development Centre, Social Insurance Institution, Turku, Finland. It was opened by Dr Boguslaw Baranski, Regional Adviser for Occupational Health at WHO/ECEH, who said that it was the start of potentially fruitful collaboration between WHO and European social insurance organizations. Dr Jorma Järvisalo was elected Chairperson and Dr Katariina Hinkka Rapporteur.

Scope and purpose of the Meeting

Work-related and non-occupational diseases and injuries which are preventable at the workplace are a significant economic and social burden on enterprises and on national economies. Occupational and non-occupational diseases and injuries are responsible for much preventable suffering and illness, diminished work ability and increased rates of temporary and permanent work disability. They often lead to early retirement and premature deaths. At national level, the high prevalence and early onset of chronic diseases contribute to high expenditure on public health care and to an increased demand for disability pensions and social insurance compensation. In addition, industrial and other enterprises that lack adequate prevention and control procedures contribute to environmental pollution, thus posing health risks to the population at large.

Some countries have started to support the implementation of integrated multidisciplinary approaches to health and safety management at work, sometimes combining it with environmental management. There is a tendency to go beyond compliance with statutory occupational health and safety regulations by introducing everyday health protection and promotion measures agreed between employees and employers on a voluntary, self-regulating basis. Workplace health promotion is a new approach, developed to exploit the workplace as a setting to combat not only occupational accidents and diseases, but also ill health both related and unrelated to work. Workplace health promotion aims at promoting work ability and health at work and is now in the process of extensive implementation by leading commercial companies, public health systems and social insurance institutions. Workplace health promotion is complementary to traditional occupational health. The participation of employees in setting the health and safety targets in an enterprise is necessary in order to achieve high efficiency. The socioeconomic value of good practice in health, environment and safety management in enterprises (GP HESME) is increasingly appreciated by different stakeholders. In many countries, social and health insurance organizations are exploring the usefulness of workplace health promotion in helping them to achieve their statutory objectives.

The Meeting had the following objectives:

• to explore the degree of interest among European social and health insurance organizations in health protection and health promotion measures at the workplace;
• to define the willingness of these organizations to share their experience in this field;
• to establish a European network whose activities would be coordinated by the Research and Development Centre of the Social Insurance Institution, Turku, Finland;
• to agree on the functioning and activities of the network for the years to come.
International perspectives

Dr Volker Schulte (WHO headquarters, Geneva) gave a presentation on the key issues of health promotion in the framework of health and the workplace. He described the organization and programme revisions carried out in 1998 and the future plans foreseen at WHO headquarters. He pointed out that a paradigm shift was going on at headquarters. Evidence-based approaches are being built up and attention is turning towards developing country issues.

Dr Boguslaw Baranski (WHO/EHEC) introduced the viewpoints of WHO in promoting the networking of social insurance institutions and the outcomes of the Third Ministerial Conference on Environment and Health held in London in June 1999. Globalization and recent developments in the WHO health for all strategy make it necessary to develop mechanisms for closer collaboration between WHO and European social and health insurance institutions.

As stated in the 1998 World Health Declaration (www.who.dk), health is a precondition for human wellbeing and a good quality of life. It is a benchmark for measuring progress towards the reduction of poverty, the promotion of social cohesion and the elimination of discrimination. Good health is fundamental to sustainable economic growth. The new health for all policy for the WHO European Region, *HEALTH21: the health for all policy framework for the WHO European Region*, takes account of the fact that intersectoral investment for health not only unlocks new resources for health but also has wider benefits, contributing in the long term to overall economic and social development. This policy was approved by the Member States in September 1998. Its main aims are:

- to promote and protect people’s health throughout their lives; and
- to reduce the incidences of major diseases and injuries, and alleviate the suffering they cause.

These aims are shared by all social and health insurance institutions responsible for helping their customers both in preventing and alleviating the effects of diseases and injuries.

Protection and promotion of people’s health at the workplace by means of effective managerial tools is an important part of the WHO strategy. For the London Conference, the Regional Office arranged a series of consultations with experts from the government sector, enterprises, research institutions and nongovernmental organizations (NGOs). The consultations resulted in the concept of good practice in health, environment and safety management in enterprises (HESME). Good practice in HESME refers to a continuous process of improvement in performance involving all stakeholders within and outside the enterprise. A major component of this practice is comprehensive occupational health, defined as the long-term maintenance of the working ability of employees, taking into account occupational, environmental, social and lifestyle determinants of health. Thus, it aims at prevention of all diseases and injuries which may reduce working capacity, including those not directly related to working conditions. Dissemination of good practice in HESME should be in the interests of social and health insurance institutions, as it involves a great number of their customers.

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1 *HEALTH21: the health for all policy framework for the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6) (www.who.dk).
The London Conference Declaration recognized the importance of instituting workplace measures to meet public health needs and goals. Ministers stated that they would apply a holistic and participatory approach of good practice in health, environment and safety management in industrial and other enterprises as a basis for assessing, strengthening or establishing, as appropriate, national policies designed to facilitate good practice in all types of enterprises (www.who.dk). They invited

WHO and the International Labour Organization to work together to assist countries in developing processes, involving all stakeholders, for implementation of environmental practice which also promotes public health, and to develop close cooperation with the European Commission to assist the candidate countries for membership of the European Union to meet their obligations.

They also declared that they would promote good practice in HESME, in collaboration with all stakeholders such as local authorities, enforcement agencies, business (including small and medium-sized enterprises), trade unions, NGOs, social and private insurance institutions, educational and research institutions, auditing bodies, and providers of prevention services.

Dr Baranski encouraged the participants to familiarize themselves with the programme, as it would certainly have links to the core issues of the planned network. A summary of the scope and purpose of the HESME programme was distributed to participants.

Dr Jorma Järvisalo (Social Insurance Institution, Finland) analysed the role of social insurance institutions in workplace health promotion and the need for an international network. The International Social Security Association (ISSA) had been interested in preventive medicine since the 1960s, and both ISSA and the Regional Office had had meetings on the issue in the early 1970s. The systems for social insurance provisions in various countries differed greatly, even in Europe. Thus there was a need to analyse more deeply how the interests of health promotion and social insurance could be amalgamated into a united programme which could then be used, both internationally and nationally, by social insurance organizations, by them together with their individual and enterprise clients, and by them together with the local communities. Evidently, there are constraints caused by different legislation cultures. Internationally, there is a need to expand the sphere of collaboration from WHO to ISSA, the International Labour Office (ILO), the International Union for Health Promotion and Education (IUHPE) and the European Commission (EC).

As regards the added value to be gained, it is clear that the social insurance sector shares WHO’s three aims for investment in health promotion: health, social development and economic development. At national level, these are important in contributing to the national economy, health and welfare, and social wellbeing. So, the major question to be discussed at the Meeting was whether a European network should be established under the umbrella of WHO. If the answer is yes, the Meeting should determine the terms of reference, the modus operandi, and the action programme for 2000.

In his presentation, Mr Rudiger Krech (WHO/EURO) focused on the triangle of social, economic and health development. He reviewed some major issues related to the changes in business and economy. For instance, during the 1990s nearly half of all companies in the United Kingdom were restructured, and hundreds of thousands of enterprises were downsized. Comprehensive workplace health promotion (WHP) would need to increase attention to organizational development issues, identifying clear trade-offs for business to invest in those
health determinants that would improve social capital, social cohesiveness, economic security, the physical environment or employees’ coping skills. Not only have enterprises increased their flexibility (e.g. in shift work), so have employees, as they usually have multiple roles to coordinate (such as worker, family member and carer). Thus, innovative workplace health promotion should look beyond the factory walls and regard the employee as a 24-hour being, not one of 7.5 hours or less. Mr Krech presented the initial results of a comprehensive WHP project which WHO implements in Germany jointly with one of the main sickness funds in Germany, the AOK Lower Saxony, and the Ministry of Social Affairs and Health, Lower Saxony. In addition to the above ideas, this project attempts to reduce the gap between the development of policy and its implementation in organizations. This necessitates a working and learning environment for all stakeholders, including companies, politicians, researchers and administrators. He described some of the positive outcomes, which have been made possible by the robust infrastructure of the project and its solid learning and working environment, and its basis in a sustainable political commitment.

National reports

Participants from the social insurance sector had been asked to report on their organizations’ relation to health promotion. A set of questions had been sent to them in advance asking about the relationship between WHP and social insurance organizations, including definitions of WHP, practical arrangements for WHP, possible norms or quality standards for WHP, roles of central government and social partners, data on the prevalence of WHP activities at workplaces, bodies involved in research support for WHP, and the role and constraints of social insurance organizations in WHP. These participants were also asked if their organizations were interested in supporting participation in the planned network.

Their reports are summarized on a country basis below.

**Austria** *(Dr Oskar Meggeneder, Oberösterreichische Gebietskrankenkasse, Linz)*

The social security system in Austria is made up of three different systems: unemployment insurance, social benefits and social assistance. Social insurance is divided into three branches: accident insurance, pension insurance and health insurance. The employee safety protection system is advanced.

The General Social Insurance Act formulates the scope and content of health promotion in a very open way, leaving the sickness funds plenty of scope for health-related activities. Health promotion is a field which has been accepted by the whole society. Many projects have been carried out in different settings and with widely varying themes.

WHP is part of general health promotion. Different interest groups have different understandings of health promotion. The Health Promotion Act of 1 January 1999 did not give a clear definition of health promotion.

In the Austrian perspective, WHP:
- begins at the workplace
- attempts to influence conditions affecting health
- creates positive attitudes towards health in companies
- uses the knowledge and experience of the people concerned and increases their competence
- is above all a social process.
Finland (Dr Katariina Hinkka, Social Insurance Institution of Finland, Turku)

The Finnish social protection system is mainly based on residence in the country and is characterized by universal benefits. The basic elements include preventive social and health policy, social and health care services, and social insurance. Preventive action is a central part of social protection.

The Social Insurance Institution (SII) is the most important body carrying out Finnish social security. It is a government agency operating under parliamentary supervision.

Employers are required by law to provide occupational health services to their employees to prevent work-related health hazards. Provision of wider access to health services is optional. The scheme subsidizing occupational health services was revised in 1995 to promote workplace services focusing on prevention and maintenance of work ability.

The SII is required by law to provide rehabilitation. Some forms of rehabilitation are closely integrated with occupational health services.

The Finnish model of WHP concentrates on the maintenance of work ability. The term was first used in 1989 in a recommendation of all major social partners of Finland. Legislation in 1991 laid down that occupational health services must participate in the maintenance of work ability, defined as all the activities employers, employees and cooperative organizations at workplaces carry out together to promote and support the working ability and functional capacity of all persons throughout their working lives. In the latest evaluation meeting the definition was slightly rephrased to move the emphasis towards organizational aspects and the environment.

Maintenance of work ability is implemented on three levels, covering:

1. all employees, irrespective of their state of health, working ability or functional capacity;
2. employees and working communities that are at risk of losing their working ability or functional capacity;
3. employees whose working ability and functional capacity are impaired due to diseases, injuries or defects.

Various evaluation projects have shown that the maintenance of working ability is widespread at workplaces in Finland.

Germany (Dr Gregor Breucker, National Federation of Company Health Insurance Funds, Essen)

The main features of the German social insurance system are the principles of solidarity, autonomous administration and compulsory insurance. The fields of health insurance, accident insurance, pension funds, unemployment insurance, long-term care and nursing insurance operate autonomously but are bound by statutory regulations in their decision-making.

WHP in Germany has evolved through various phases, starting from a single-risk lifestyle approach through a multiple-risk lifestyle approach, the inclusion of the working environment, organizational change, and finally integrated management.

WHP has received general approval in Germany; it is a consensus platform and a political measure. There is a differentiation in legislation between the concepts of hazard, risk and danger.
WHP is optional and can be supplementary to or part of modern occupational safety and health. It also improves the use of resources. The Luxembourg Declaration on Workplace Health Promotion (1997) has been adopted.

Health promotion interventions at the workplace have been understood as any activities that contribute to prevention of workplace hazards by strengthening the factors conducive to health both at individual and organizational level.

**Italy** *(Dr Carlo Ottaviani, National Institute for the Insurance against Labour Accidents and Occupational Diseases (INAIL), Rome)*

In Italy the social security system has predominantly been characterized by payment of provisions and economic benefits and by supply of health assistance. The social insurance system and the public service system carry out social security.

The new prospects for the National Institute for the Insurance against Labour Accidents and Occupational Diseases (INAIL) include prevention, care and rehabilitation.

Occupational health in Italy aims at the safety and protection of workers’ health. Expert physicians take care of primary prevention using a multidisciplinary approach and secondary prevention using a more clinical approach. Occupational diseases are either listed or non-listed. The list is updated periodically. There is a debate going on about reforming the acts on labour accident insurance, for instance to widen the concept of workplace accidents to include commuting accidents.

Health promotion only operates through the work of the physicians as a part of health protection. Health protection and workplace regulations are widening towards prevention.

**Latvia** *(Dr Maris Skujenieks, State Social Insurance Agency, Riga)*

Social protection legislation has been undergoing constant change since Latvia regained its independence. In 1995 an overall social protection reform programme was carried out and seven new acts have been passed since then. Income compensation is assured in case of old age, disability, death of the breadwinner, sickness and maternity, work injury, unemployment and death.

The goals of the State Social Insurance Act passed in 1997 are:

- to give systematic coverage to eligible persons with social insurance
- to determine different contribution rates for each kind of social insurance
- to provide an opportunity to join the pension insurance voluntarily
- to harmonize compulsory contributions with income tax
- to separate the administration of revenue and expenditure
- to provide transparency with regard to the use of the social insurance budget.

Instead of a single insurance budget, there are four separate funds: the State Pension Fund, the Employment Fund, the Work Injury Fund, the Disability and the Maternity Fund.

The Act on Compulsory Social Insurance against Work Injuries and Occupational Diseases was implemented in 1997. It established the Work Injury Fund, which is managed as an independent state social insurance fund under the supervision of the Ministry of Welfare, financed by insurance premiums paid by employers and employees. Via this Fund, the State Social Insurance
Agency will also be responsible for promoting preventive measures and encouraging employers to improve work environments. So far the Agency only has one person in charge of preventive measures.

Money is the main problem together with lack of experience in this field while Latvia is in a transition phase. WHP is so far limited to inspection measures.

**Sweden (Ms Sisko Bergendorff, National Social Insurance Board, Stockholm)**

The Swedish social insurance system is politically determined, compulsory for everyone and allowing for redistribution between risk groups.

Swedish social insurance:

- gives subjective rights that are regulated by the legislation;
- covers the entire population;
- accounts for a relatively large proportion of the population’s collective insurance cover;
- is dominated by income-related insurance payments and complemented by a basic level included in many subsidiary systems;
- has a limited element of means-testing;
- is largely financed by compulsory contributions related to earned income, as well as taxation;
- is subject to taxes on income compensations in the same way as on an earned income.

The National Social Insurance Board and the regional/local social insurance offices constitute the social insurance administration. To reduce the need for sickness insurance benefits, the social insurance offices also participate in preventive measures including:

- the identification of risk groups and risk environments
- the identification of partners for prevention
- the encouragement of employers to take preventive measures.

Of the total expenditure on sickness insurance, 0.3% is allocated for prevention.

Occupational health services are not mandatory. Employers and trade unions make agreements on their provision. At present, 72% of employees are covered by these services. Employers are responsible for providing their employees with good working conditions and preventing occupational diseases and injuries at work. They are also primarily responsible for the rehabilitation of their employees. The objectives of occupational health services include:

- preventive measures (medical, technical, psychological, social measures);
- counselling of employers and employees on the relationship between working conditions and health;
- advice to employers on possible improvements in working conditions;
- vocational rehabilitation.

Thus occupational health services are main actors in the field of health promotion at workplaces.
If the employer is not responsible for rehabilitation measures needed by the employee, social insurance offices are responsible for providing and financing vocational rehabilitation. They also provide vocational rehabilitation for unemployed people. The social insurance offices coordinate the necessary vocational rehabilitation measures in cooperation with employers, occupational health services, employment service, employability institutes, etc.

In Sweden, prevention (rather than promotion) is the term mainly used for all activities referring to health promotion. Occupational health services are expected to work in the domain of health promotion in a stricter sense.

**Switzerland (Dr Rolf Zahnd, SUVA Gesundheitsforderung, Schweizerische Unfallversicherungsanstalt, Berne)**

The social protection system in Switzerland is at quite a good level, thanks to the prevailing democratic structures and high welfare standards. SUVA is the largest accident insurance in the country with a semi-public status and the image of social insurance. It has been one of the main engines for WHP in Switzerland in recent years, and is the only insurance company that has integrated prevention and insurance and combined protection, prevention and rehabilitation.

Health promotion in the sense of the Ottawa Charter is not present in legislation at national level. Some cantons – responsible for most of the health policy decisions – have introduced health promotion into their legislation, but mostly in connection with community and school settings, not at the workplace.

Health protection at the workplace is highly developed and strong. Some new signs of WHP can be identified in accident and sickness insurance. Most WHP activities in Swiss companies are specific, rather than holistic by nature.

The main problem is the incomprehensible and impracticable definition of health promotion, arising in part from the obscure and incomprehensible definition of health itself. This blockage in communication is hindering activities in settings – politics, communities, workplaces, schools, etc.

**United Kingdom (Dr Andrew Auty, Loss Prevention Council, Hertfordshire)**

There are complex systems of ill health prevention, mitigation and compensation for the workforce in the United Kingdom, which have evolved in a fragmentary manner, mostly over the last hundred years. Apart from a multitude of contributions to public and private forms of insurance and a multiplicity of agencies responsible for each aspect, parallel fault and no-fault arrangements further complicate the system.

The health of the workforce (whether in work or unemployed) is cared for and protected by social institutions providing medical care and welfare and by parallel private insurances. Protection of health at work is subject to national regulations and led by government agencies but paid for by employers.

Most initiatives to reform the system would appear to be aimed at reinforcing positive links between prevention, mitigation and compensation while avoiding moral hazard and adverse selection. The roles of public and private insurance have not been optimized; this continues to be developed.
Health promotion in the workplace, in the absence of established risks for ill health or hazards (such as tobacco smoke and high fat diets), appears to be taking some time to reach a practical form. In particular, the ideal goal of involving employees in decision-making about their health needs is not generally being met.

A wholesale reform of the system does not appear to be on the agenda.

For the majority of British companies, improvements in health promotion and protection will not occur without intervention from public and private insurers and their agents. Most firms do not have a sufficient understanding of health as a generator of overheads to stimulate change without the lead being taken by third parties.

**Summary of the country reviews**

Social insurance takes widely varying forms in different countries and there are several definitions for WHP. There is also the question as to what extent the approach is about health promotion in general, for those who work, or provided through the work setting.

Participants considered whether to include unemployed people in the target groups for the planned network, and whether employability might be a uniting link. They also discussed the difficulties in defining the concept of WHP, and what types of activity it should include. The advantages of networking of social insurance organizations were brought in. From the WHO point of view, the members of such a network should define a common interest, and WHO will help with relating the network to other networks.

The discussion continued in two working groups: one considered the justification for a WHO network of social insurance organizations for workplace health promotion; the other looked at the terms of reference and action plan for such a network.

**Reports from the working groups**

Both working groups thought there was a need for a clear definition of WHP. Network members can learn from and support each other. Both groups also emphasized the importance of taking the political level into account.

Health promotion should be put on the agenda of social insurance institutions and introduced into national laws. An infrastructure for exchanging information should be created. Clearly defined ethical principles are necessary.

The network should be made up of social insurance institutions, and the members will act as national coordinators for intranational networks. It should be linked through a collaborative agreement with the Regional Office’s Occupational Health Programme. Partnership with other WHO units, ISSA, the European Commission, ILO and IUHPE should be sought under the umbrella of the Regional Office.

The network should encourage the establishment of informal networks in each country and liaise with other networks to produce national reports.
The network’s activities should include business meetings, web information, a secretariat, newsletters, etc., starting from a small group and gradually extending. Guidelines for WHP can be prepared. The secretariat can organize agenda-based business meetings.

The working groups’ reports were followed by a lively discussion. Participants asked for a justification paper containing the ethical principles at a later development stage, but considered it too early to discuss ethical issues in detail. The latter include the different competing interests social insurance institutes may have at the national level.

Participants thought that a clear definition of the scope and content of WHP was a prerequisite for national networks. The definition contained in the Ottawa Charter was not sufficiently practicable. There was probably a need for definitions at multiple levels in the action areas of the network, ranging from practical to legal and political understanding.

Conclusions and recommendations

Social insurance organizations share a national responsibility for the welfare of their clients. They contribute to the prevention of occupational and non-occupational diseases, which are responsible for much preventable suffering, illness, diminished work ability and increased rates of temporary and permanent work disability. To achieve this, they are committed to using all relevant mechanisms, including the advancement of effective and high quality workplace health programmes and contributing to the improvement of all measures related to the health of working populations. In their operation, the social insurance organizations share a common objective with other partners in the health field. Consequently, they are committed to expanding their services to the field of promotion and protection of health of the insured persons. Collaboration with WHO seems inevitable and fortunate with mutual added value. Promotion and protection of people’s health throughout their lives, reduction of the incidence of major diseases and injuries, and alleviation of suffering caused by these diseases and injuries are the main aims of the WHO HEALTH21 strategy. Social and other insurance organizations were also recognized as major stakeholders in improving health, environment and safety management in enterprises by the Third Ministerial Conference on Environment and Health (London 1999).

In taking the necessary steps, the social insurance sector recognizes its own specific mandate and needs to coordinate with other actors and networks in the field. The first focus in the work of the network will be on health in the world of work.

Conclusion 1
Social and health insurance institutions subscribe to the principles of solidarity and equity contained in health promotion. Their responsibilities are health-related, social and economic and they have to aim at cost-containment in meeting them. They have common objectives and principles in supporting the enhancement of national health and social wellbeing, and see their role as contributing to the process of harmonization and stability in the WHO European Region.

Recommendation 1
Social and health insurance organizations should collaborate in creating discussion and action platforms for:

- society at large, clarifying the institutions’ roles in this respect
- the social insurance institutions, clarifying the common interests and means for collaboration
- the insurance institutes and enterprises
• themselves
• local needs as relevant for their local clients
• individuals as their customers.

For the purpose of coordinating activities at international level, the Meeting decided that a WHO Network of European Social Insurance Organizations for Workplace Health Promotion should be established. The mission of this network should be to encourage policy developments which advocate, include and contribute to the re-orientation of public health policies and services for improvement of health and wellbeing in a society. In its first phase, the network should concentrate on workplaces as a setting for achieving public health objectives.

Conclusion 2
Activities need to be internationally coordinated.

Recommendation 2
The WHO network of European social insurance organizations for WHP should be made up of national members who collect and collate information for wider distribution, using various means. Proper coordination with relevant bodies, such as other WHO units, ISSA, the European Commission, ILO, IUHPE, etc., is a prerequisite. The network should make every effort to publicize its work and commitment.

Conclusion 3
Various internationally accepted concepts and approaches exist for improving the health of the workforce, taking into account occupational, environmental, social and cultural determinants of health and wellbeing.

Recommendation 3
The network, in justifying its work, should seek to define its activities in relation to the values of social security.

Conclusion 4
The main preoccupations of the network should be advocacy of social insurance organizations’ commitment to health promotion, exchange of information regarding country-specific experience, and analysis and dissemination of good practices and minimal standards necessary for proper carrying out of the activities.

Recommendation 4
Country representatives should make every effort to make available the resources for these activities and necessary mechanisms, and to obtain all relevant information in their countries for the purposes of the network. This could require the establishment of a forum or network of social insurance institutions at the national level. To create a proper platform for these activities, an analysis of and possible adjustments to national legislation on social insurance might be necessary. The people and organizations responsible for the network’s activities should also be supported so that they are empowered to carry out their tasks at national and international levels.

Conclusion 5
At the request of the Third Ministerial Conference on Environment and Health, WHO committed itself to advance a programme on health, environment and safety management in enterprises (HESME).
Recommendation 5
The network should assist WHO in its task, contributing to the collection of information on good practices and quality standards and criteria, and to advancement of their application in Member States.

Conclusion 6
The network should analyse international and national research, demonstration and development activities being carried out in its area of action.

Recommendation 6
The network members and national social insurance organizations should consider how to include evaluation mechanisms for their operation in this field. Topics of special interest should include relevance, effectiveness, costs, successful processes and the overall impact of workplace programmes in relation to social insurance operations.

Conclusion 7
The established network should finalize its fundamental justification paper during the first half 2000, publicize its work in the first issue of a newsletter, and establish a web site. The Research and Development Centre of the Social Insurance Institution of Finland should continue to be responsible for coordination. Business meetings should be arranged successively at the premises of the various participating organizations.

Attempts to enrol some more members to the network should be made before the first business meeting, to be organized in Germany in May or June 2000. Development of an outline for a training course on workplace health for social and health insurance personnel should be on the agenda of the first business meeting.

The Research and Development Centre of the Social Insurance Institution of Finland should seek to coordinate the network’s activities with the various international organizations concerned, with the assistance of WHO.
Annex 1

PROGRAMME

Thursday, 21 October 1999

09:45 Opening of the meeting
  Dr Boguslaw Baranski, Regional Adviser, Occupational Health, WHO Regional Office for Europe, European Centre for Environment and Health, Bilthoven Division

09:50 Presentation of participants

09:55 Election of officers

10:00 Health promotion in the framework of health and the workplace – what are the key issues
  Dr Volker Schulte, WHO headquarters, Geneva

10:15 Introduction to the work of the London Conference and its good practice in health, environment and safety management in enterprises (GP HESME)
  Dr Boguslaw Baranski

10:30 Coffee

11:00 Role of social insurance institutions in workplace health promotion
  Dr Jorma Järvisalo, Research and Development Centre, The Social Insurance Institution, Turku, Finland

11:20 Prevention, rehabilitation and compensation: occupational health system in the United Kingdom
  Dr Andrew Auty, Loss Prevention Council, Hertfordshire, United Kingdom

11:40 The contribution of the Austrian social insurance institutions to workplace health promotion
  Dr Oskar Meggeneder, OO Gebietskrankenkasse, Linz, Austria

12:00 The Swiss experience in bringing together workplace health protection and health promotion
  Dr Rolf Zahn, SUVA Gesundheitsförderung, Schweizerische Unfallversicherungsanstalt, Berne, Switzerland

12:20 Workplace health promotion (WHP) in the German health insurance system
  Dr Gregor Breucker, National Federation of Company Health Insurance Funds, Essen, Germany

12:40 Discussion

13:00 Lunch

14:30 Short statements from representatives of Latvia and Sweden

14:50 Workplace health promotion in the Finnish social security system
  Dr Katriina Hinkka, The Social Insurance Institution, Turku, Finland

15:10 New perspectives in the relationship between workplace health and social insurance in Italy
  Dr Ottaviani and Dr Cimaglia, INAIL, Italy

15:30 Coffee

16:00 Discussion

16:40 Building up a plan of the European network of social and health insurance organizations for workplace health promotion
  Introductory remarks: Dr Jorma Järvisalo and Dr Boguslaw Baranski
  Plenary discussion

17:30 Closure of the day
Friday, 22 October 1999

9:00  Overview of meeting progress by the Chairperson

9:10  Investment incentives for workplace health promotion – a demonstration project of investment for health in Germany

Dr Rüdiger Krech, Health Promotion and Investment, WHO Regional Office for Europe, Copenhagen, Denmark

9:30  Plenary session

9:45  Working groups on network justification and plan of work

11.30 Plenary session on the working group results

12:30 Lunch

14:00 Conclusions and recommendations

15:30 Closure of the meeting
Annex 2

PARTICIPANTS

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