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## An Interview with Kent Peterson, MD

entrepreneurs began buying these clinics, aggregating them into regional and later large national clinic networks, such as Concentra. Selling occupational medical clinics became a profitable business for a short time.

A second trend has been the steady evolution of electronic occupational health medical records and occupational health information systems. Dozens of corporations spent millions of dollars developing in-house systems, none of which were effective. Finally, technology advanced enough to spawn a generation of commercial occupational health software systems, some of which have been good enough to survive decades with steady advancements.

**WHI:** As a former president of the American College of Occupational and Environmental Medicine (ACOEM), you will have noticed significantly more published articles in JOEM, ACOEM's official journal, regarding health and productivity management. Is this trend another indication of the changing role of occupational medicine?

**KP:** Health and productivity management reflects a fourth major trend in the evolution of workplace health and safety programs. This transformation is reflected by the changing terminology about our field. (See diagram below)



Industrial medicine focused largely on acute industrial accidents and injuries. As companies addressed both chronic and acute work-related illnesses, the term occupational medicine emerged. The focus of employee health broadened further to include any illness (work- or non-work related), and to promote health and wellness (occupational health). In the 1990s, occupational health professionals acknowledged and began to define the link between health and productivity and integrate cooperative efforts to facilitate workplace effectiveness (health and productivity management).

**WHI:** In 1999, you were co-editor of the *SPM Handbook for Health Assessment Tools* published by the former Society for Prospective Medicine. This publication was a very exhaustive effort to summarize the value and limitations of health assessments including health risk appraisals (HRAs). Today, HRAs are the “de facto” platform for assessing the “health” of an organization. What is your opinion of their value and applicability?

**KP:** HRAs have evolved since the 1970s from statistically questionable personal risk estimates to widely accepted and used health evaluation tools, especially for workplace populations. However, I think aggregate HRA data could be put to fuller use in assessing and managing the health of defined populations. Furthermore, data on future health risks is most useful for younger age populations. As people age, we need to incorporate other metrics into health assessment tools that address needed screening and preventive services, preexisting conditions, likelihood of being hospitalized, drug interactions, and “quality of life” indicators such as activities of daily living, independent functioning, work/life

**WHI:** Since the 1970s, you have been in involved in occupational health, beginning with IBM. How has the role of an occupational physician changed since you first started your career?

**KP:** Enormous changes have occurred in occupational medicine over the last four decades. When I began, the focus of workplace occupational medicine was largely in-house occupational health programs of large companies, primarily through onsite occupational health clinics. For example, IBM had more than 80 physicians, 300 occupational health nurses, 300 safety professionals, 80 industrial hygienists, and corporate toxicology, epidemiology, and a full in-house clinical laboratory department staffing programs worldwide. Many other corporations had much larger in-house programs. Smaller companies had few occupational health resources other than scattered “mom and pop” occupational health clinics run by private occupational physicians.

One major trend has been the outsourcing of in-house occupational health programs and services to community-based occupational medical clinics. As a result, we witnessed an explosion in the number and quality of occupational health clinics, both private and those associated with universities. In the 1980s,

balance, social support, and well-being. It is now possible to build health assessment tools that are custom designed for the unique needs of specific populations.

**WHI:** The area of health and productivity management has evolved over the past 20-odd years. As part of this evolution, the impact of so-called indirect health-related costs on business sustainability has come under the lens. What has the research shown?

**KP:** If only direct medical benefits (such as medical, dental and prescription medications) are measured, health is too easily viewed as an expense to be avoided. If you include the much larger indirect health-related costs such as worker absenteeism, disability, workers compensation, replacement costs, training, morale, and presenteeism (reduced productivity from not being fully present, focused, creative and productive), then the leadership conversation changes. Fastidious research has shown that indirect costs triple total health-related expenses, demanding attention of senior management.

Health needs to be seen as a valuable investment in business success, positively affecting the “top line” revenue, as well as costs. Successful health and productivity management must involve all key business functions, including human resources, health benefits, risk management, line management, corporate communications, in-house medical, industrial hygiene, safety, employee assistance and ergonomics. It is too easy to squeeze one end of a balloon of health-related costs only to drive costs up in another area. A too-frequent example is efforts to reduce medical benefit expenses by shifting costs to workers’ compensation and disability.

**WHI:** Many decision makers view presenteeism as a “fuzzy” number and argue that it’s already factored into the cost of doing business since productivity/engagement is relative to the job and there is no such thing as being 100 percent productive. Do you agree?

**KP:** I strongly disagree. Tools have been developed to accurately measure presenteeism. A decade of research has shown that the cost of presenteeism far exceeds absenteeism or medical care. More importantly, research documents that people differ widely in their willingness and ability to engage and to be fully present in their endeavors. Many factors can affect engagement and presenteeism positively. Employers have rich opportunities to create workplace environments that engage workers, foster worker loyalty, enhance their emotional intelligence, and reduce accidents and illness, by improving their health and fitness, improving efficiency through workplace ergonomics, managing illness, and reducing unnecessary lost time while seeking medical care. As “baby boomers” are nearing retirement, HR professionals now sing a chorus of recruitment and retention. Experienced and

smart employers can increase their human capital at a time of shrinking labor pools of well educated workers.

**WHI:** There seems to be an emerging trend in employee health under the banner of “well-being.” Is this different from the wellness movement or just a new rebranding?

**KP:** The recent originators of the “wellness” concept promoted positive well-being, higher energy levels, creativity, flexibility, and other aspects of quality of life. Unfortunately, the wellness movement was coopted in its infancy into addressing primarily risk factors for cardiovascular disease, cancers, and other chronic illnesses. Most so-called “workplace wellness” programs really became disease prevention and early detection programs. High level wellness was left out of the equation.

The recent emphasis on well-being is more than rebranding, and offers the promise of truly addressing the original concerns that the wellness pioneers envisioned. Employees constantly report having difficulty getting adequate sleep and obtaining work/life balance. The advance of pagers, cell phones, PDAs, tablet computers, constant email, and Internet contact have encouraged multi-tasking and truly challenged work/life balance and quality of life. I think these are what lies behind the emerging discussion of “well-being.”

**WHI:** Spirituality has been a key dimension in most, if not all, wellness models. Yet, within the worksite, “spirituality courses” are rarely offered. Why is this the case?

**KP:** Many people do not believe it is appropriate to include spirituality in wellness programs. I think this is short sighted. It is important to distinguish religion and specific religious organizations from personal spiritual growth and development. An easy place to start is teaching relaxation and stress management, using a wide variety of approaches, (e.g., contemplation, meditation, deep breathing, guided visualization, aerobic exercise, prayer, music, or a host of other techniques). Another good focus is values clarification, (i.e., articulating cherished values so that people know and can articulate their most deeply held values). It is instructive to ask the question “What is sacred to you?” And to facilitate sharing and discussion.

A vital but taboo issue in our society is how well prepared people are to face the end of their lives. That discussion can go far beyond living wills and advanced directives to address questions of what is most important in managing time and life energy, what are people’s longings, what is “incomplete” in people’s lives that might be skillfully addressed, what would people like to accomplish or undertake while still healthy and mobile, what would each of us like to leave behind as a legacy. I consistently find employees eager to discuss these issues and grateful when given the opportunity.

# Creating an Integrated Model of Employee Health

Nicolaas Pronk, PhD, George Pfeiffer, MSE, and Wolf Kirsten, MS

Traditionally, two core goals and related activities that are central to effective and sustainable workplace health programs have been:

1. Protecting employee health—avoiding illness, injury and disability.
2. Promoting employee health—maintaining and improving health, productivity, and general well-being.

In most occupational environments, these goals and activities have been managed separately within organizational silos (e.g., occupational health and safety, benefits/wellness) that have created barriers to integrating services and facilitating a cross-functional approach to employee health and well-being.

Protecting employee health traditionally has been under the auspices of the safety and health committee of an organization and includes activities such as compliance with safety regulations, safety training, hazard protection, and ergonomics, among others. Whereas, promoting employee health usually has been managed by a wellness staff under the human resources/benefit functions and has focused on employee/team health enhancement, risk reduction, and the management of chronic health conditions through targeted programs and appropriate organizational policies, benefits, and environmental supports.

## Integrating Worker Health

The National Institute for Occupational Safety and Health (NIOSH) *Total Worker Health* program<sup>1</sup> is focused on integrating occupational safety and health protection with health promotion to prevent worker injury and illness and to advance the health and well-being of employees. This approach is consistent with goals outlined by the World Health Organization's *Healthy Workplaces: A Global Model for Action*<sup>2</sup> concept and the European Network for Workplace Health Promotion mission.<sup>3</sup> Earlier this year, IAWHP introduced the integrated worker health topic<sup>4</sup> and with this article, formally endorses the strategic integration of worker health protection and promotion to prevent worker injury and illness, advance worker health and well-being, and optimize organizational performance.\*

By incorporating this type of model, IAWHP believes that organizations can better align their employee health promotion and safety programs and benefit from this integration by more effectively protecting, supporting, and enhancing their human capital.

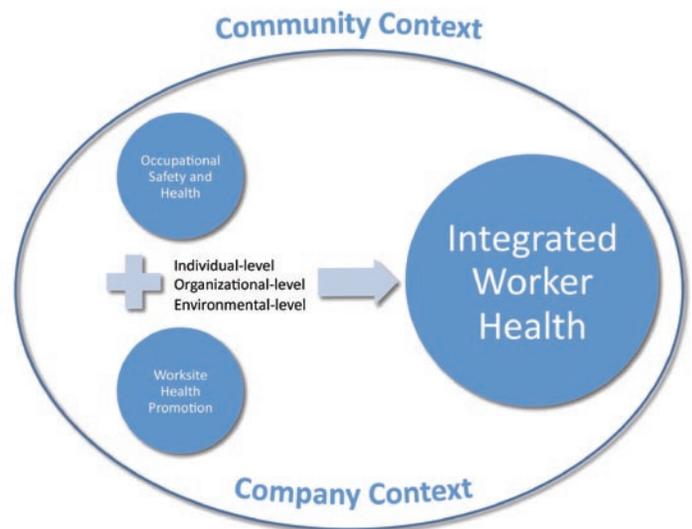


Figure. A New Approach: Integrated Worker Health Protection and Promotion.<sup>4</sup>

## References

1. National Institute for Occupational Safety and Health (NIOSH). [Cited 2012 March 16]. Available from: <http://www.cdc.gov/niosh/twh/>.
2. World Health Organization. *Healthy Workplaces: A global model for action*. See: [http://www.who.int/occupational\\_health/healthy\\_workplaces/en/index.html](http://www.who.int/occupational_health/healthy_workplaces/en/index.html)
3. European Network for Workplace Health Promotion (ENWHP). See: <http://www.enwhp.org/the-enwhp/vision-mission.html>
4. Pronk, N.P. *Integrated worker health: the fusion of worker health protection and promotion*. *ACSM's Health & Fitness Journal* 2012; 16(1):37-40.

\* This Announcement was adopted by the IAWHP International Board of Directors and presented to attendees at the 2012 Annual IAWHP Global Symposium in Las Vegas, Nevada, USA.

For additional information and resources, see [www.iawhp.org](http://www.iawhp.org)



## Enormous Growth in China – is Health Promotion Next?

Wolf Kirsten, MS and Jian Li, MD

In the last 20 years, China has undergone some drastic social and economic changes. As a result of globalization and industrialization, behavior-related chronic disease has become more prevalent than infectious disease, which has left a lasting impact on the health of the Chinese population—especially its workforce. There has been an increase in sedentary lifestyles, a decrease in physical activity, and a growing popularity of fast food that has contributed to drastic increases in the body mass indexes (BMI) of both females and males, which has led to much higher morbidity rates of hypertension and diabetes. For example, diabetes rates jumped from 1.9% in 1993 to 10.7% in 2008. In addition, only 12.5% of men and 8.6% of women currently practice regular physical activity. This pandemic, however, is occurring mostly in urbanized, coastal areas in which societal and behavior patterns have shifted from the traditional lifestyles that still exist in rural areas.

Also contributing to growing health risks in the population is that more than half of Chinese men smoke, and there is a growing but still largely underestimated increase in mental illness and work-related stress. A number of recent research studies in China have pointed out the negative impact of stress.

The increasing adoption of negative Western behaviors are contributing to not only the ill-health of the nation, but also productivity loss within organizations. The World Health Organization and World Economic Forum estimate the financial impact of unhealthy lifestyle habits in China to be \$558 billion in 2015.

### The Early Stages of Health Promotion in China

Workplace health promotion (WHP) is still in the early stages in China. Currently, the main drivers for health-related programs at the workplace are set laws for the protection of workers, emphasizing employers' duties and the rights of workers. Through these laws, employers are held responsible for ensuring the health and safety of their workforce. Enforcing occupational health and safety laws remains a huge challenge in China, and accidents with fatalities are not uncommon.

More proactive health initiatives that are necessary for preventing behavior-related chronic diseases, such as cardiovascular diseases and diabetes, are still lacking on a broad scale. In the 1990s, a large pilot project, which was eventually coined the “Shanghai Model” due to its success, was launched by state authorities in Shanghai in collaboration with the World Health

Organization (WHO). However, even this failed to produce workplace health promotion programming on a large scale.

### Case Study: XSB Technical Battery Company as Part of the “Health-Promoting Enterprises” Initiative

Since 2007, the National Institute for Occupational Health and Poison Control (NIOHP) has established the “Health-Promoting Enterprises” initiative, which aims to develop effective models of workplace health promotion for different industries in different regions of the country to promote workers' health.



The comprehensive activities of the pilot projects include program development, training, baseline surveys, data analysis, and intervention. One such example is the 808-employee XSB Technical Battery Company in Guangzhou. Supported by the Guangdong Academy of Occupational Disease Prevention and Treatment, and the Luogang District Center for Disease Control and Prevention, the company started a workplace health promotion program in 2009. The baseline survey showed a lack of knowledge of occupational health laws and chronic and sexually-transmitted diseases in general. At the same time, only 23% of employees experienced good health and 42% exercised regularly. Labor inspections and health examinations revealed that in some areas workers were exposed to higher levels of lead and noise, which prompted establishing a steering committee with a dedicated budget that led to the following interventions:

- Improved medical exams and documentation
- Health education workshops, bulletin boards, and materials
- Changes to the working, living, and cultural environment (e.g., monitoring lead and noise at the worksite, increased number of health clinics, more trash cans, sports and recreational activities, and a library).
- Health risk assessments and telephone consultations.



One of the intervention measures included the use of personal protective equipment

## Promising Outcomes to Date

- Good participation in workshops and consultations.
- Increased awareness of both occupational disease prevention and lifestyle-related health issues.
- Increased use of personal protection equipment.
- Improved working environment, and less lead pollution.
- Better health status (lower lead levels in blood).
- Enhanced teamwork (workers' health linked to team bonus)

## Future plans

- Further improve the working environment.
- Install locker rooms with showers.
- Start an ergonomics program.
- Seek more social resources for support.
- Become a model enterprise for health promotion.

## What is Needed in the Future

Currently, China is embarking on a major healthcare reform initiative, but more investment and research in workplace health promotion is essential. It is recommended that, in the future, the focus of WHP in China be in five key areas:

1. Differentiated activities for various enterprises.
2. Participation of all stakeholders.
3. Integration with occupational health inspections.
4. Attention to migrant workers and precarious employment.
5. Framework with a focus on work stress.



Health Promotion Workshops



Health Education Materials

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# Growing Your Global Health Promotion Program Successfully

Wolf Kirsten, M.S. and Barry Hall

There is a strong and growing interest among multinational employers to globalize their workplace health promotion strategies and programs. Yet, very few employers have successfully developed and implemented strategies on a broad, global basis. A new research study, “Winning Strategies in Global Workplace Health Promotion: A Study of Leading Organizations” was conducted by Buck Consultants and International Health Consulting to explore and learn from organizations that have achieved success in this area. The research supports and extends the findings of the Annual Global Survey on Health Promotion and Workplace Wellness Strategies,<sup>1</sup> on which Worksite Health International reported previously, and provides insights and successful practices from organizations that have made progress at globalizing their health promotion initiatives.

Interviews (written and telephonic) were conducted with 13 leading global employers: Chevron, The Dow Chemical Company, Dupont, Eaton, Goldman Sachs, IBM, Intel, John Deere, Johnson & Johnson, MOL Group, Novartis, Novo Nordisk and Scania. All of the participating employers have implemented global strategies and have been offering programs to their employees worldwide for a number of years. Interview categories included objectives and drivers for globalizing health promotion, strategy, infrastructure and governance, program elements, regional and cultural challenges, engagement, vendors and suppliers, measurement and metrics.

## Comments from Study Participants

“The level of enthusiasm and engagement is higher in countries in which the concept of workplace health promotion and related programs is newer (e.g., in Asia, Latin America) compared to countries in which it has been around for a while (e.g., in North America and Europe).”

“Certain countries within Europe are still challenging—Germany, Switzerland, Greece—buying into the concept that an employer should be involved in employee health. The concept itself is still difficult for them to embrace. Also, with the healthcare systems in those countries, the question is raised ‘why should we work on this when it’s already offered by the national healthcare system?’”

<sup>1</sup> “WORKING WELL: A Global Survey of Health Promotion and Workplace Wellness Strategies” Buck Consultants, International Health Consulting, Cigna, Pfizer and WorldatWork, 2007-2010.

## Findings

The findings can be summarized by the following eight recommendations, based on successful strategies of the participating organizations:

1. Adequate time and effort should be spent explaining to employees the reasons, goals, and benefits for providing a health promotion program. Employers should recognize that not every employee accepts the notion that their employer should provide such programs, especially for some countries in which it is a new concept.
2. A global strategy should be driven by a central or corporate function that provides guidance and technical support to local sites and business units.
3. Local resources should be engaged for cultural adaptation and implementation. Local health professionals also should be utilized to help drive strategies regionally and function as a link between corporate and local sites and business units.
4. All sites should be provided access to a core level of health promotion programs and policies.
5. In order to improve the mental health and well-being of employees—one of the biggest health promotion challenges of the 21st century—employers must analyze and address the psychosocial working environment as well as work organization.
6. A shared global value proposition should be established, in alignment with key business goals. Metrics should be globally consistent and locally relevant.
7. The value proposition for health promotion should not be justified solely on a financial business case, especially outside the U.S. Equal emphasis should be placed on health and well-being factors.
8. Employers should establish a healthy workplace index and/or menu of services, toward which all sites should strive, and for which sites eventually will be held accountable.

The full benchmarking study report will be available soon at [www.bucksurveys.com](http://www.bucksurveys.com).

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# Worksite Health Promotion for the 21st Century: Part 1

Dee Edington, PhD and Thomas Golaszewski Ed.D

More than forty years ago, noted prognosticator Alvin Toffler wrote that “we must search for our objectives and methods in the future, rather than the past” (Toffler, *Future Shock*, 1970, p. 399). In this first of a series of related articles, we consider Toffler’s comment in the context of assessment. Other issues could easily apply, but that which a profession chooses to measure identifies what it considers to be important.

Sophisticated assessments are critical for the advancement of any profession; however, an over-reliance on past methodologies only stymies its potential. Subsequently, this discussion will address the health risk assessment (HRA). Follow-up commentaries will review other assessment tools and associated topics regarding their future within a 21st century health management and well-being strategy.

We are twelve years into this century, but too often our profession still relies on information sources from the past. The HRA fits this characterization well. Developed nearly forty years ago, largely on information derived from early longitudinal studies (Framingham MA, Tecumseh MI, among others), it may be the profession’s most frequently used measure and perhaps its most notable marketing tool. An HRA identifies need in the user (including the sponsoring worksite) and excites interest in consuming health promotion products and services. No doubt it will continue to play a predominant role in the foreseeable future.

The outcome from the administration of an HRA is typically a list of individual high risks both past and current, which are then shared with the user as an indication of their current health risk status. Early versions of the HRA included calculations of appraised and achievable ages compared to the actual chronological ages. In order to close the gap between appraised and achievable age, individual risk and behavioral change became the interventions of choice.

So what is wrong with this scenario? The problem with this accepted best practice is that despite improvements at the margins and behavior change technologies that coexist with it, we have a United States population with little or no improvement in health risks and behaviors. In fact, the U.S. population and the population of all countries actually may have moved in the opposite direction; we are getting worse. Yet, the profession appears to have been blinded by its unwavering acceptance of the

intuitive solution of individual behavior change with its over-reliance on a dated assessment methodology. The HRA will remain an excellent source of information; however, its weakness may be its continued role as the focal point of individually-based interventions.

To summarize from Toffler’s perspective, we are thirty-plus years into the future yet the health promotion field looks to the past and claims one of its most revered “best practices” as the direction to continue. The field has been so convinced of the intuitive solution of risk identification and behavior change that it has become blinded to the lack of effectiveness of its outcomes. Where are the visionaries, the black belts, the professionals, and the leaders with the courage and wherewithal to discover alternatives? It is time to name the new Toffler’s of the health promotion world lest it find its lack of innovation to be its own risk factor.

Where are the visionaries,  
the black belts, the  
professionals, and the  
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discover alternatives?

\*Full references are available on request.



## Member Insights

*Q. It's standard practice for organizations to assess their initiatives objectively. What are some examples of short, mid-term, and long-term approaches for program evaluation and how can this data be used to improve processes and outcomes?*



**SUSAN BAILEY, MS, CHES, CIC**

Manager, Wellness & Health Promotion  
DTE Energy

We live and learn and to be successful, smart practitioners assess initiatives year-round. At DTE Energy, we collect satisfaction data from our programs and track participation and completion. These short-term measures allow us to adjust our tactics if we see that program uptake is not what we expected or satisfaction results indicate we are off track. On a quarterly basis, we report to leaders on a number of measures including engagement in key programs and completion of health assessments and screenings. These data points were selected because they are actionable—a leader can use the information to encourage completion or participation among his work group and have a sense of where they stand compared to the rest of the organization. Finally, together with our senior leader team, we decided to annually track a variety of metrics that take longer to shift including healthcare utilization, costs, and biometrics. The key is that we worked together with our senior leader team to focus on statistics we believe we can impact through our comprehensive health management strategy. Ultimately, it's not about the specific data you track. More importantly, successful assessment and programming results from tracking data that matters to your organization.

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